FRAMEWORK FOR THE ANNUAL REPORT OF THE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) and Section 2108(e) of the Social Security Act (the Act) provides that each state and territory *must assess the operation of its state child health plan in each federal fiscal year and report to the Secretary, by January 1 following the end of the federal fiscal year, on the results of the assessment. In addition, this section of the Act provides that the state must assess the progress made in reducing the number of uncovered, low-income children. The state is out of compliance with CHIP statute and regulations if the report is not submitted by January 1. The state is also out of compliance if any section of this report relevant to the state's program is incomplete.

The framework is designed to:

- Recognize the ***diversity*** of state approaches to CHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their CHIP programs, **AND**
- Provide ***consistency*** across states in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

The CHIP Annual Report Template System (CARTs) is organized as follows:

- Section I: Snapshot of CHIP Programs and Changes
- Section II: Program's Performance Measurement and Progress
- Section III: Assessment of State Plan and Program Operation
- Section IV: Program Financing for State Plan
- Section V: Program Challenges and Accomplishments

* - When "state" is referenced throughout this template, it is defined as either a state or a territory.

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

FRAMEWORK FOR THE ANNUAL REPORT OF THE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

DO NOT CERTIFY YOUR REPORT UNTIL ALL SECTIONS ARE COMPLETE.

State/Territory: **MA**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a) and Section 2108(e)).

Signature:

Robin Callahan

CHIP Program Name(s): **All, Massachusetts**

CHIP Program Type:

- ☐ CHIP Medicaid Expansion Only
- ☐ Separate Child Health Program Only
- ☒ Combination of the above

Reporting Period: **2016** *Note: Federal Fiscal Year 2016 starts 10/1/2015 and ends 9/30/2016.*

Contact Person/Title: **Robin Callahan, Deputy Medicaid Director**

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Submission Date: **12/29/2016**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)

SECTION I: SNAPSHOT OF CHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your CHIP program , please provide the following information. If you would like to make any comments on your responses, please explain in narrative below this table.

☐Provide an assurance that your state's CHIP program eligibility criteria as set forth in the CHIP state plan in section 4, inclusive of PDF pages related to Modified Adjusted Gross Income eligibility, is accurate as of the date of this report.

Please note that the numbers in brackets, e.g., **[500]** are character limits in the Children's Health Insurance Program (CHIP) Annual Report Template System (CARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	CHIP Medicaid Expansion Program	**Separate Child Health Program**
	*** Upper % of FPL (federal poverty level) fields are defined as <u>Up to and Including</u>**	

Does your program require premiums or an enrollment fee?	☒	No			☐	No		
	☐	Yes			☒	Yes		
	Enrollment fee amount				Enrollment fee amount			
	Premium amount				Premium amount			
	If premiums are tiered by FPL, please breakout by FPL				If premiums are tiered by FPL, please breakout by FPL			
	Premium Amount				Premium Amount			
	Range from	Range to	From	To	Range from	Range to	From	To
	$	$	% of FPL	% of FPL	$12	$ 36	% of FPL 150	% of FPL 200
	$	$	% of FPL	% of FPL	$20	$ 60	% of FPL 200	% of FPL 250
	$	$	% of FPL	% of FPL	$28	$ 84	% of FPL 250	% of FPL 300
	$	$	% of FP L	% of FPL	$	$	% of FPL	% of FPL
	If premiums are tiered by FPL, please breakout by FPL				If premiums are tiered by FPL, please breakout by FPL			
	Yearly Maximum Premium Amount per family		$		Yearly Maximum Premium Amount per family		$	
	Range from	Range to	From	To	Range from	Range to	From	To
	$	$	% of FPL	% of FPL	$	$432	% of FPL 150	% of FPL 200
	$	$	% of FPL	% of FPL	$	$720	% of FPL 200	% of FPL 250
	$	$	% of FPL	% of FPL	$	$1008	% of FPL 250	% of FPL 300
	$	$	% of FPL	% of FPL	$	$	% of FPL	% of FPL
	If yes, briefly explain fee structure in the box below **[500]**				If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate) **[500]**			

			\$432 for families between 150-200% FPL, \$720 for families between 200-250% FPL, \$1008 for families between 250-300% FPL.	
	☐	N/A	☐	N/A

Which delivery system(s) does your program use?	☒	Managed Care	☒	Managed Care
	☒	Primary Care Case Management	☒	Primary Care Case Management
	☒	Fee for Service	☒	Fee for Service
	Please describe which groups receive which delivery system **[500]** Individuals receive (fee-for-services) FFS until they enroll with MCO/PCC, and may also receive premium assistance with wrap benefits provided on a FFS basis.		Please describe which groups receive which delivery system **[500]** Individuals receive FFS until they enroll with MCO/PCC, and may also receive premium assistance with a FFS dental wrap.	

2) Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking the appropriate column.

For FFY 2016, please include only the program changes that are in addition to and/or beyond those required by the Affordable Care Act.

For each topic you responded "yes" to below, please explain the change and why the change was made.

	Medicaid Expansion CHIP Program			**Separate Child Health Program**		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
b) Application	☒	☐	☐	☒	☐	☐
c) Benefits	☐	☒	☐	☐	☒	☐
d) Cost sharing (including amounts, populations, & collection process)	☐	☒	☐	☐	☒	☐
e) Crowd out policies	☐	☒	☐	☐	☒	☐
f) Delivery system	☐	☒	☐	☐	☒	☐
g) Eligibility determination process	☒	☐	☐	☒	☐	☐
h) Implementing an enrollment freeze and/or cap	☐	☐	☒	☐	☐	☒
i) Eligibility levels / target population	☐	☒	☐	☐	☒	☐
j) Eligibility redetermination process	☒	☐	☐	☒	☐	☐
k) Enrollment process for health plan selection	☐	☒	☐	☐	☒	☐
l) Outreach (e.g., decrease funds, target outreach)	☒	☐	☐	☒	☐	☐

m)	Premium assistance	☐	☒	☐	☐	☒	☐
n)	Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	☐	☒	☐	☐	☒	☐
o)	Expansion to “Lawfully Residing” children	☐	☒	☐	☐	☒	☐
p)	Expansion to “Lawfully Residing” pregnant women	☐	☒	☐	☐	☒	☐
q)	Pregnant Women state plan expansion	☐	☒	☐	☐	☒	☐
r)	Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐	☐	☒	☐
s)	Other – please specify						
a)	_____	☐	☐	☐	☐	☐	☒
b)	_____	☐	☐	☐	☐	☐	☒
c)	_____	☐	☐	☐	☐	☐	☒

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	Answer below Answer below.
c) Benefits	
d) Cost sharing (including amounts, populations, & collection process)	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process	Answer below. Answer below.
h) Implementing an enrollment freeze and/or cap	

i) Eligibility levels / target population	
j) Eligibility redetermination process	Answer below. Answer below.
k) Enrollment process for health plan selection	
l) Outreach	Answer below. Answer below.
m) Premium assistance	
n) Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	
o) Expansion to “Lawfully Residing” children	
p) Expansion to “Lawfully Residing” pregnant women	
q) Pregnant Women State Plan Expansion	
r) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
s) Other – please specify	
a.	
b.	
c.	

Enter any Narrative text related to Section I below. **[7500]**

Text related to answer (b): In February 2016, HIX system functionality was updated to require all individuals completing an application to respond to the "Do you intend to reside in Massachusetts?" questions in order to determine if the individual meets program residency requirements. Previously, this question was only asked of the head of household when the individual attested to having an out-of-state address. This paper application (ACA-3) was revised in August 2016 to better align with the online application, clarify language to more effectively gather data, and incorporate certain changes recommended by field workers and advocates. Separate CHIP is the same.
(g)In February 2016, HIX program determination rules were updated to ensure correct calculation of household composition and income counting when at least one household member was marked with administrative closing reasons. In addition, functionality was added to implement the Verified Lawful Presence (VLP) Steps 2/3 process. In June 2016, MassHealth reviewed and refined the system logic for

generation of “Request for Information” (RFI) notices when information cannot be verified or is not reasonably compatible with electronic data sources. In addition, the rules for expiration of timeclocks associated with RFI notices was implemented. Upon expiration of the 90-day timeclock if the individual has not submitted requested verifications, eligibility will be re-determined using data available from electronic federal and state data sources. If no data is available, eligibility will be terminated. Separate CHIP is the same.

(j)In April 2016, MassHealth implemented the annual redetermination process in our HIX system. When a household is selected for annual redetermination, an electronic data match with federal and state data sources is conducted; if information is compatible then the household is auto-renewed and no further action from the household is required. If information is not compatible then it follows the non-auto renewal process and a pre-populated renewal form is sent to the household. The household has 45 days to respond. If the household responds, the case is updated with reported changes and eligibility is re-determined. If no response is received within the timeframe, eligibility will be re-determined using data available from electronic federal and state data sources. If no data is available, eligibility will be terminated. Separate CHIP is the same.

(l) Targeted outreach for Medicaid and CHIP through partners in the community remains the same as in previous years; however MassHealth did consolidate the number of outreach grants to implement a more regional based outreach approach. In FFY15-16, MassHealth awarded 13 grants statewide to hospitals and CHCs to increase enrollment in MassHealth and other health insurance programs, and to help individuals retain their health coverage. MassHealth resumed renewals for our MAGI (Modified Adjusted Gross Income) populations in April of 2016 and our grantees have been instrumental in assisting individuals navigate and renew their health benefits. Separate CHIP is the same.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of two subsections that gather information about the CHIP and/or Medicaid program. Section IIA captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your state. Section IIB captures progress towards meeting your state's general strategic objectives and performance goals.

SECTION IIA: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in CHIP in your state for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 (Unduplicated # Ever Enrolled Year) in your state's 4th quarter data report (submitted in October) in the CHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by CARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2015	FFY 2016	Percent change FFY 2015-2016
CHIP Medicaid Expansion Program	82782	71841	-13.22
Separate Child Health Program	89408	113737	27.21

A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent. **[7500]**

The over 10% decrease in Medicaid expansion and the over 10% increase in separate CHIP are due to the residual effects from system enhancements that were made during the early part of 2015.

2. The tables below show trends in the number and rate of uninsured children in your state. Three year averages in Table 1 are based on the Current Population Survey. The single year estimates in Table 2 are based on the American Community Survey (ACS). CARTS will fill in this information automatically, and significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3.

Table 1: Number and percent of uninsured children under age 19 below 200 percent of poverty, Current Population Survey

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error

1996 - 1998	70	15.5	4.6	1.0
1998 - 2000	68	15.5	4.2	.9
2000 - 2002	40	9.9	2.6	.7
2002 - 2004	53	11.7	3.4	.7
2003 - 2005	50	11.7	3.2	.7
2004 - 2006	44	11.0	2.8	.7
2005 - 2007	36	10.0	2.3	.7
2006 - 2008	35	10.0	2.3	.6
2007 - 2009	23	8.0	1.5	.5
2008 - 2010	25	5.0	1.6	.3
2009-2011	28	5.0	1.8	.3
2010-2012	26	5.0	1.7	0

Table 2: Number and percent of uninsured children under age 19 below 200 percent of poverty, American Community Survey

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number (In Thousands)	Margin of Error	Rate	Margin of Error
2013	10	2.0	.7	.2
2014	11	2.0	.7	.2
2015	7	2.0	.5	.1
Percent change 2014 vs. 2015	0%	NA	0%	NA

A. Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children. **[7500]**

B. Please note any comments here concerning ACS data limitations that may affect the reliability or precision of these estimates. **[7500]**

3. Please indicate by checking the box below whether your state has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

☐ Yes (please report your data in the table below)

☐ No (skip the rest of the question)

Please report your alternate data in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	
Reporting period (2 or more points in time)	
Methodology	
Population (Please include ages and income levels)	
Sample sizes	
Number and/or rate for two or more points in time	
Statistical significance of results	

A. Please explain why your state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children. **[7500]**

B. What is your state's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.) **[7500]**

C. What are the limitations of the data or estimation methodology? **[7500]**

D. How does your state use this alternate data source in CHIP program planning? **[7500]**

Enter any Narrative text related to Section IIA below. **[7500]**

SECTION IIB: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your state's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your CHIP state plan. (If your goals reported in the annual report now differ from Section 9 of your CHIP state plan, please indicate how they differ in "Other Comments on Measure." Also, the state plan should be amended to reconcile these differences). The format of this section provides your state with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- CHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, data from the previous two years' annual reports (FFY 2014 and FFY 2015) will be populated with data from previously reported data in CARTS. If you reported data in the two previous years' reports and you want to update/change the data, please enter that data. If you reported no data for either of those two years, but you now have data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2016).

In this section, the term performance measure is used to refer to any data your state provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are state-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

In addition, please do not report the same data that were reported for Child Core Set reporting. The intent of this section is to capture goals and measures that your state did not report elsewhere. As a reminder, Child Core Set reporting migrated to MACPRO in December 2015. Historical data are still available for viewing in CARTS.

Additional instructions for completing each row of the table are provided below.

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective. **All new goals should include a direction and a target. For clarification only, an <u>example</u> goal would be**: "Increase (direction) by 5 percent (target) the number of CHIP beneficiaries who turned 13 years old during the measurement year who had a second dose of MMR, three hepatitis B vaccinations and one varicella vaccination by their 13th birthday."

Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

- <u>New/revised:</u> Check this box if you have revised or added a goal. Please explain how and why the goal was revised.

- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.
- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

Status of Data Reported:

Please indicate the status of the data you are reporting for each goal, as follows:

- **Provisional**: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2016.

  Explanation of Provisional Data – When the value of the Status of Data Reported field is selected as "Provisional", the state must specify why the data are provisional and when the state expects the data will be final.

- **Final**: Check this box if the data you are reporting are considered final for FFY 2016.
- **Same data as reported in a previous year's annual report**: Check this box if the data you are reporting are the same data that your state reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:

This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which states may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications or some other method unrelated to HEDIS®).

Please indicate whether the measure is based on HEDIS® technical specifications or another source. If HEDIS® is selected, the HEDIS® Version field must be completed. If "Other" measurement specification is selected, the explanation field must be completed.

HEDIS® Version:

Please specify HEDIS® Version (example 2015). This field must be completed only when a user select the HEDIS® measurement specification.

"Other" measurement specification explanation:

If "Other", measurement specification is selected, please complete the explanation of the "Other" measurement specification. The explanation field must be completed when "Other" measurement specification has been selected.

Data Source:

For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and CHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source (specify the other source). For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). In all cases, if another data source was used, please explain the source.

Definition of Population Included in Measure:

Numerator: Please indicate the definition of the population included in the numerator for each measure (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

Denominator: Please indicate the definition of the population included in the denominator for each measure.

For measures related to increasing access to care and use of preventative care, please check one box to indicate whether the data are for the CHIP population only, or include both CHIP and Medicaid (Title XIX) children combined.

- Check one box to indicate whether the data are for the CHIP population only, or include both CHIP and Medicaid (Title XIX) children combined.
- If the denominator reported is not fully representative of the population defined above (the CHIP population only, or the CHIP and Medicaid (Title XIX) populations combined), please further define the denominator. For example, denominator includes only children enrolled in managed care in certain counties, technological limitations preventing reporting on the full population defined, etc.). Please report information on exclusions in the definition of the denominator (including the proportion of children excluded), The provision of this information is important and will provide CMS with a context so that comparability of denominators across the states and over time can occur.

Deviations from Measure Specification

For the measures related to increasing access to care and use of preventative care.

If the data provided for a measure deviates from the measure specification, please select the type(s) of measure specification deviation. The types of deviation parallel the measure specification categories for each measure. Each type of deviation is accompanied by a comment field that states must use to explain in greater detail or further specify the deviation when a deviation(s) from a measure is selected..

The five types (and examples) of deviations are:

- Year of Data (e.g., partial year),
- Data Source (e.g., use of different data sources among health plans or delivery systems),
- Numerator (e.g., coding issues),
- Denominator (e.g., exclusion of MCOs, different age groups, definition of continuous enrollment),
- Other.

When one or more of the types are selected, states are required to provide an explanation.

Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which enrollment or utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

Date Range: available for 2016 CARTS reporting period.
Please define the date range for the reporting period based on the "From" time period as the month and year which corresponds to the beginning period in which utilization took place and please report the "To" time period as the month and year which corresponds to the end period in which utilization took place. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

Performance Measurement Data (HEDIS® or Other):
In this section, please report the numerators and denominators, rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or other methodologies. The form fields have been set up to

facilitate entering numerators and denominators for each measure. If the form fields do not give you enough space to fully report on the measure, please use the "additional notes" section.

The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator). The reporting unit for each measure is the state as a whole. If states calculate rates for multiple reporting units (e.g., individual health plans, different health care delivery systems), States must aggregate data from all these sources into one State rate before reporting the data to CMS. In the situation where a state combines data across multiple reporting units, all or some of which use the hybrid method to calculate the rates, the state should enter zeroes in the "Numerator" and "Denominator" fields. In these cases, it should report the state-level rate in the "Rate" field and, when possible, include individual reporting unit numerators, denominators, and rates in the field labeled "Additional Notes on Measure," along with a description of the method used to derive the state-level rate.

Explanation of Progress:

The intent of this section is to allow your state to highlight progress and describe any quality-improvement activities that may have contributed to your progress. Any quality-improvement activity described should involve the CHIP program, benefit CHIP enrollees, and relate to the performance measure and your progress. An example of a quality-improvement activity is a state-wide initiative to inform individual families directly of their children's immunization status with the goal of increasing immunization rates. CHIP would either be the primary lead or substantially involved in the project. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality-improvement plans. In this section, your state is also asked to set annual performance objectives for FFY 2017, 2018 and 2019. Based on your recent performance on the measure (from FFY 2014 through 2016), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your state set for the year, as well as any quality-improvement activities that have helped or could help your state meet future objectives.

Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations, plans to report on a measure in the future, or differences between performance measures reported here and those discussed in Section 9 of the CHIP state plan.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3)

FFY 2014	FFY 2015	FFY 2016
Goal #1 (Describe) Maintain an overall children's uninsurance rate of no more than 2%	**Goal #1 (Describe)** Maintain an overall children's uninsurance rate of no more than 2%	**Goal #1 (Describe)** Maintain an overall children's uninsurance rate of no more than 2%
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: Since our uninsurance rate for children is so low, we revised the goal to be under 2%.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: CPS American Community Survey data for 2013	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: CPS American Community Survey data for 2014	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: CPS American Survey data for 2015
Definition of Population Included in the Measure: Definition of denominator: Number of children under age 18 in Massachusetts Definition of numerator: Number of uninsured children under age 18 in Massachusetts	**Definition of Population Included in the Measure:** Definition of denominator: Number of children under the age of 18 in Massachusetts Definition of numerator: Number of uninsured children under the age of 18 in Massachusetts	**Definition of Population Included in the Measure:** Definition of denominator: Number of children under the age of 18 in Massachusetts Definition of numerator: Number of uninsured children in Massachusetts
Date Range: **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014	**Date Range:** **From: (mm/yyyy)** 01/2015 **To: (mm/yyyy)** 12/2015
Performance Measurement Data: Described what is being measured: The uninsurance rate for children under 18 in Massachusetts Numerator: 21079 Denominator: 1389165 Rate: 1.5	**Performance Measurement Data:** Described what is being measured: The uninsurance rate for children under 18 in Massachusetts Numerator: 21000 Denominator: 1387000 Rate: 1.5	**Performance Measurement Data:** Described what is being measured: The uninsurance rate for children under 18 in Massachusetts Numerator: 16000 Denominator: 1384000 Rate: 1.2
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:

FFY 2014	FFY 2015	FFY 2016
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** The uninsurance rate for children under 18 decreased from 1.8% to 1.5%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** The uninsurance rate for children under 18 stayed at 1.5% in 2015. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** The uninsurance rate for children under 18 decreased from 1.5% to 1.2% **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2015:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result, will maintain an uninsurance rate among children under 18 of no more than 2%. **Annual Performance Objective for FFY 2016:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result, will maintain an uninsurance rate among children under 18 of no more than 2%. **Annual Performance Objective for FFY 2017:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result, will maintain an uninsurance rate among children under 18 of no more than 2%. *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result, will maintain an uninsurance rate among children under 18 of no more than 2%. **Annual Performance Objective for FFY 2017:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result, will maintain an uninsurance rate among children under 18 of no more than 2%. **Annual Performance Objective for FFY 2018:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result, will maintain an uninsurance rate among children under 18 of no more than 2%. *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children under 18 of no more than 2%. **Annual Performance Objective for FFY 2018:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children under 18 of no more than 2%. **Annual Performance Objective for FFY 2019:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children under 18 of no more than 2%. *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3) (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #2 (Describe) Maintain or reduce the uninsurance rate for Black children under the age of 18 at or below 5%	**Goal #2 (Describe)** To have the rate of children who are continuously insured over a twelve month period be at least 97%.	**Goal #2 (Describe)** Maintain or reduce the uninsurance rate for Hispanic children under the age of 18 at or below 1%
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: The 2014 census data for uninsurance rates for Hispanic/Latino children did not seem to be accurate so we chose a different goal.	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: The 2014 census data for uninsurance rate for Black children under the age of 18 was no longer available, so we chose a different goal.	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: The Massachusetts Center for Health Information and Analysis Health Insurance survey is not published annually so we could not obtain data for 2016.
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: US Census, CPS, 2013	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: 2015 Massachusetts Center for Health Information and Analysis Health Insurance survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: US Census Bureau, 2015 American Community Survey
Definition of Population Included in the Measure: Definition of denominator: The number of black children in MA Definition of numerator: The number of uninsured black children in MA	**Definition of Population Included in the Measure:** Definition of denominator: Number of children under the age of 19 in MA. Definition of numerator: Number of children under the age of 19 in MA who are continuously insured over a twelve month period.	**Definition of Population Included in the Measure:** Definition of denominator: Number of Hispanic children in MA Definition of numerator: Number of uninsured Hispanic children in MA
Date Range: **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 07/2014 **To: (mm/yyyy)** 06/2015	**Date Range:** **From: (mm/yyyy)** 01/2015 **To: (mm/yyyy)** 12/2015
Performance Measurement Data: Described what is being measured: The uninsurance rate for black children in MA Numerator: 5000 Denominator: 154000 Rate: 3.2	**Performance Measurement Data:** Described what is being measured: The number of children in MA who are continuously insured over a 12 month period. Numerator: 1435608 Denominator: 1473930 Rate: 97.4	**Performance Measurement Data:** Described what is being measured: The uninsurance rate for Hispanic children in MA Numerator: 2262 Denominator: 239468 Rate: 0.9
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:

FFY 2014	FFY 2015	FFY 2016
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** This is a new measure. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** This is the first year we are performing this goal. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** This is the first year we are performing this goal **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2015:** Maintain or reduce the uninsurance rate for Black children under the age of 18 at or below 4% **Annual Performance Objective for FFY 2016:** Maintain or reduce the uninsurance rate for Black children under the age of 18 at or below 4% **Annual Performance Objective for FFY 2017:** Maintain or reduce the uninsurance rate for Black children under the age of 18 at or below 4% *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** Massachusetts will continue efforts to enroll every child eligible for health insurance and keep them enrolled and as a result, will maintain a rate of at least 97% for children over a twelve month period **Annual Performance Objective for FFY 2017:** Massachusetts will continue efforts to enroll every child eligible for health insurance and keep them enrolled and as a result, will maintain a rate of at least 97% for children over a twelve month period **Annual Performance Objective for FFY 2018:** Massachusetts will continue efforts to enroll every child eligible for health insurance and keep them enrolled and as a result, will maintain a rate of at least 97% for children over a twelve month period *Explain how these objectives were set:* This objective was set as part of Massachusett's efforts to help children enroll in health insurance and remain enrolled.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** Maintain or reduce the uninsurance rate for Hispanic children under the age of 18 at or below 1%. **Annual Performance Objective for FFY 2018:** Maintain or reduce the uninsurance rate for Hispanic children under the age of 18 at or below 1%. **Annual Performance Objective for FFY 2019:** Maintain or reduce the uninsurance rate for Hispanic children under the age of 18 at or below 1%. *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3) (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?**	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?**

FFY 2014	FFY 2015	FFY 2016
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment

FFY 2014	FFY 2015	FFY 2016
Goal #1 (Describe) Maintain or increase the number of Affordable Care Act (ACA) Certified Application Counselor (CAC) Assister sites at 100 or higher statewide	**Goal #1 (Describe)** Maintain or increase the number of ACA Certified Application Counselor (CAC) Assister sites at 100 or higher statewide.	**Goal #1 (Describe)** Maintain or increase the number of Affordable Care Act (ACA) Certified Application Counselor (CAC) Assister sites at 100 or higher statewide.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: On 10/1/13 Massachusetts phased in a CAC program. This involved converting high-volume Virtual Gateway health application assistance sites to ones that would continue to assist consumers apply for health insurance, but would instead need to meet the more stringent ACA CAC requirements, and begin using the new HIX, rather than the health portion of the Virtual Gateway, which was phased out on 12/31/13. 1000 CAC individuals was selected as the first year's goal.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Records kept by Executive Office of Health and Human Services, the Massachusetts Health Connector, and the Office of Medicaid.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Records kept by the Exectuive Office of Health and Human services, the Massachusetts Health Connector, and the Office of Medicaid.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Records kept by Executive Office of Health and Human Services, the Massachusetts Health Connector, and the Office of Medicaid.
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A
Date Range: **From: (mm/yyyy)** 10/2013 **To: (mm/yyyy)** 09/2014	**Date Range:** **From: (mm/yyyy)** 10/2014 **To: (mm/yyyy)** 09/2015	**Date Range:** **From: (mm/yyyy)** 10/2015 **To: (mm/yyyy)** 09/2016

FFY 2014	FFY 2015	FFY 2016
Performance Measurement Data: Described what is being measured: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY14. Numerator: 0 Denominator: 0 Rate:	**Performance Measurement Data:** Described what is being measured: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY15 Numerator: 193 Denominator: 0 Rate:	**Performance Measurement Data:** Described what is being measured: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY16. Numerator: 0 Denominator: 0 Rate:
Additional notes on measure: The number of organizations meeting this standard went from 0 just before the start of the FFY to 173 as of 9/30/14	Additional notes on measure: The number of organizations meeting this standard went from 173 as of 9/30/14 to 193 as of 9/30/15	Additional notes/comments on measure: The number of organizations meeting this standard went from 193 as of 9/30/15 to 250 as of 9/30/16
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** This is a new objective, given that on October 1, 2013, the implementation of the Affordable Care Act in Massachusetts resulted in the phasing out of the health assistance portion of the Virtual Gateway online system, and the introduction of new rules for application Assisters, as well as a new Health Insurance Exchange website. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** The number of organizations meeting this standard went from 173 as of 9/30/14 to 193 as of 9/30/15 **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** The number of organizations meeting this standard went from 193 as of 9/30/15 to 250 as of 9/30/16 **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.

FFY 2014	FFY 2015	FFY 2016
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2015:** Beginning in November 2014, and as part of the rollout of the Federal Affordable Care Act 2014-2015 Open Enrollment period, Massachusetts introduced a new version of the Health Insurance Exchange that provides much improved functionality over the edition released in October 2013. This version offers enhanced features for consumers, and allows members of the public to more easily apply, themselves, online, for MassHealth and other health benefit programs. This will allow MassHealth to continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs.". **Annual Performance Objective for FFY 2016:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2017:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites (CACs). *Explain how these objectives were set:* This goal is part of MassHealth's mission to screen and enroll all individuals who may be eligible, to simplify and streamline the application process, and to increase the efficiency of MassHealth operations.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act **Annual Performance Objective for FFY 2017:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act **Annual Performance Objective for FFY 2018:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act *Explain how these objectives were set:* This goal is part of MassHealth's mission to screen and enroll all individuals who may be eligible, to simplify and streamline the application process, and to increase the efficiency of MassHealth operations.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2018:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2019:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This goal is part of MassHealth's mission to screen and enroll all individuals who may be eligible, to simplify and streamline the application process, and to increase the efficiency of MassHealth operations.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #2 (Describe) Maintain or increase the percentage of children enrolled in premium assistance at 3.5% or more of overall MassHealth child enrollment	**Goal #2 (Describe)** Maintain or increase the percentage of CHIP children enrolled in premium assistance at 10% or more of overall MassHealth CHIP child enrollment	**Goal #2 (Describe)** Maintain or increase the percentage of CHIP children enrolled in premium assistance at 10% or more of overall MassHealth CHIP child enrollment.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: We were not able to obtain the data needed to report this measure for all children.	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: We are still working on the review of the data for this measure so are unable to report on this goal at this time
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: The number of children in MassHealth at all income levels Definition of numerator: The number of children enrolled in premium assistance at all income levels	**Definition of Population Included in the Measure:** Definition of denominator: All MassHealth CHIP enrolled children Definition of numerator: MassHealth CHIP enrolled children who were enrolled in Premium Assistance	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy)** 10/2013 **To: (mm/yyyy)** 09/2014	**Date Range:** **From: (mm/yyyy)** 10/2014 **To: (mm/yyyy)** 09/2015	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: The percentage of children in MassHealth who receive premium assistance Numerator: 29141 Denominator: 672011 Rate: 4.3	**Performance Measurement Data:** Described what is being measured: The percentage of CHIP children who were enrolled in Premium Assistance Numerator: 25748 Denominator: 168941 Rate: 15.2	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:

FFY 2014	FFY 2015	FFY 2016
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** The 4.3% rate for FFY14 is slightly less than the 4.5% reported for FFY13. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The Commonwealth's efforts towards universal coverage continue to succeed despite increases in health insurance premiums. Providing subsidies to employees so that they can participate in their employer-sponsored insurance is a valuable and cost-effective tool for MassHealth in decreasing uninsurance and increasing enrollment in health insurance of children-particularly within higher income ranges. Enrollment in employer sponsored insurance in Massachusetts continues to be strong and has remained steady since the implementation of health care reform, showing no signs that MassHealth has crowded out private insurance.	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** This is a revised measure. The percentage of CHIP enrolled children receiving Premium Assistance is much higher than the percentage reported last year of all enrolled children receiving Premium Assistance. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The Commonwealth's efforts towards universal coverage continue to succeed despite increases in health insurance premiums. Providing subsidies to employees so that they can participate in their employer-sponsored insurance is a valuable and cost-effective tool for MassHealth in decreasing uninsurance and increasing enrollment in health insurance of children-particularly within higher income ranges. Enrollment in employer sponsored insurance in Massachusetts continues to be strong and has remained steady since the implementation of health care reform, showing no signs that MassHealth has crowded out private insurance.	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**

FFY 2014	FFY 2015	FFY 2016
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2015:** MassHealth will continue to maintain our efforts to maximize employer-sponsored insurance for our members. The approximate proportion of children enrolled in premium assistance will continue to be above 4% **Annual Performance Objective for FFY 2016:** MassHealth will continue to maintain our efforts to maximize employer-sponsored insurance for our members. The approximate proportion of children enrolled in premium assistance will continue to be above 4% **Annual Performance Objective for FFY 2017:** MassHealth will continue to maintain our efforts to maximize employer-sponsored insurance for our members. The approximate proportion of children enrolled in premium assistance will continue to be above 4% *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to maximize private insurance by identifying applicants with access to employer-sponsored insurance and requiring enrollment in such insurance	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** MassHealth will continue to maintain our efforts to maximize employer-sponsored insurance for our members. The approximate proportion of CHIP children enrolled in premium assistance will continue to be above 10%. **Annual Performance Objective for FFY 2017:** MassHealth will continue to maintain our efforts to maximize employer-sponsored insurance for our members. The approximate proportion of CHIP children enrolled in premium assistance will continue to be above 10%. **Annual Performance Objective for FFY 2018:** MassHealth will continue to maintain our efforts to maximize employer-sponsored insurance for our members. The approximate proportion of CHIP children enrolled in premium assistance will continue to be above 10%. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to maximize private insurance by identifying applicants with access to employer-sponsored insurance and requiring enrollment in such insurance.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #3 (Describe) Maintain or increase the number of ACA Certified Application Counselor (CAC) Assisters at 1,000 individuals or more statewide	**Goal #3 (Describe)** Maintain or increase the number of ACA Certified Application Counselor (CAC) Assisters at 1,000 individuals or more statewide	**Goal #3 (Describe)** Maintain or increase the number of ACA Certified Application Counselor (CAC) Assisters at 1,000 individuals or more statewide.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: On 10/1/13 Massachusetts phased in a CAC program. This involved converting high-volume Virtual Gateway health application assistance sites to ones that would continue to assist consumers apply for health insurance, but would instead need to meet the more stringent ACA CAC requirements, and begin using the new HIX, rather than the health portion of the Virtual Gateway, which was phased out on 12/31/13. 1,000 CAC individuals was selected as the first year's goal.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Records kept by Executive Office of Health and Human Services, the Health Connector, and the Office of Medicaid.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Records kept by the Executive Office of Health and Human Services, the Health Connector, and the office of Medicaid.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Records kept by Executive Office of Health and Human Services, the Health Connector, and the Office of Medicaid.
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A
Date Range: **From: (mm/yyyy)** 10/2013 **To: (mm/yyyy)** 09/2014	**Date Range:** **From: (mm/yyyy)** 10/2014 **To: (mm/yyyy)** 09/2015	**Date Range:** **From: (mm/yyyy)** 10/2015 **To: (mm/yyyy)** 09/2016

FFY 2014	FFY 2015	FFY 2016
Performance Measurement Data: Described what is being measured: The number of ACA Certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper. Numerator: 0 Denominator: 0 Rate:	**Performance Measurement Data:** Described what is being measured: The number of ACA certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACAs HIX website, or via paper. Numerator: 0 Denominator: 0 Rate:	**Performance Measurement Data:** Described what is being measured: The number of ACA Certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper. Numerator: 0 Denominator: 0 Rate:
Additional notes on measure: Number of CACs throughout Massachusetts that have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper increased from 0 immediately before the start of FFY2014, to 1,153 as of 9/30/2014.	Additional notes on measure: Number of CACs throughout MA that have the capability to assist in submitting an electronic application on the ACAs HIX website, or via paper increased from 1,153 immediately before the states of FY2014, to 1,654 as of 9/30/2015	Additional notes/comments on measure: Number of CACs throughout Massachusetts that have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper changed from 1654 immediately before the start of FFY2016, to 1551 as of 9/30/2016. While there was a bit of a decrease, the number of CAC organizations increased significantly during the same time period – 193 to 250 (Goal #1) and the number of individuals serving as CACs throughout the Commonwealth far surpass this particular goal of 1,000.
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** This is a new objective, given that on October 1, 2013, the implementation of the Affordable Care Act in Massachusetts resulted in the phasing out of the health assistance portion of the Virtual Gateway online system, and the introduction of new rules for application Assisters, as well as a new Health Insurance Exchange website **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** The number of CACs throughout MA that have the capability to assist in submitting an electronic application on the ACAs HIX website, or via paper increased from 1,153 immediately before the start of FFY2014 to 1,654 as of 9/30/2015 **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to an enrollment in health care programs for children.	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** Number of CACs throughout Massachusetts that have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper changed from 1654 immediately before the start of FFY2016, to 1551 as of 9/30/2016. While there was a bit of a decrease, the number of CAC organizations increased significantly during the same time period – 193 to 250 (Goal #1), and the number of individuals serving as CACs throughout the Commonwealth far surpass this particular goal of 1,000. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.

FFY 2014	FFY 2015	FFY 2016
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2015:** Beginning in November 2014, and as part of the rollout of the Federal Affordable Care Act 2014-2015 Open Enrollment period, Massachusetts introduced a new version of the Health Insurance Exchange that provides much improved functionality over the edition released in October 2013. This version offers enhanced features for consumers, and allows members of the public to more easily apply, themselves, online, for MassHealth and other health benefit programs. This will allow MassHealth to continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs." **Annual Performance Objective for FFY 2016:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2017:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to enroll all eligible individuals, to ease the application and renewal processes for our members, and to expand access to the most up-to-date web-based enrollment resources available to the community.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2017:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2018:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application assisters, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to enroll all eligible individuals, to ease the application and renewal process for our members, and to expand access to the most up-to-date web-based enrollment resources available to the community.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2018:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2019:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to enroll all eligible individuals, to ease the application and renewal processes for our members, and to expand access to the most up-to-date web-based enrollment resources available to the community.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment

FFY 2014	FFY 2015	FFY 2016
Goal #1 (Describe) Since Massachusetts has a joint application for its Medicaid and CHIP programs, collectively known as MassHealth and applications for both programs can be submitted through the HIX, all "Objectives Related to CHIP Enrollment" apply to "Objectives Related to Medicaid Enrollment" also.	**Goal #1 (Describe)** Since Massachusetts has a joint application for its Medicaid and CHIP programs, collectively known as MassHealth and applications for both programs can be submitted through the Virtual Gateway, all "Objectives Related to CHIP Enrollment" apply to "Objectives Related to Medicaid Enrollment" also.	**Goal #1 (Describe)** Since Massachusetts has a joint application for its Medicaid and CHIP programs, collectively known as MassHealth and applications for both programs can be submitted through the Virtual Gateway, all "Objectives Related to CHIP Enrollment" apply to "Objectives Related to Medicaid Enrollment" also.
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:

FFY 2014	FFY 2015	FFY 2016
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:

FFY 2014	FFY 2015	FFY 2016
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:

FFY 2014	FFY 2015	FFY 2016
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2014	FFY 2015	FFY 2016
Goal #1 (Describe) Frequency of Prenatal Care: Improve the percentage of enrolled women who have received at least 81% of the required prenatal care visits to the 2013 national Medicaid 90th percentile rate of 80.12%	**Goal #1 (Describe)** Frequency of Prenatal Care: Improve the percentage of enrolled women who have received at least 81% of the required prenatal care visits to the 2015 national Medicaid 90thpercentile rate of 69.8%	**Goal #1 (Describe)** Improve the percentage of enrolled women who have received at least 81% of the required prenatal care visits to the 2016 national Medicaid 90th percentile rate of 75.8%
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: MassHealth is refocusing its objectives, selecting new measures from the CHIPRA Pediatric Core Set & associated benchmarks. We have focused on the same measures for several years, focusing on data gathered from the CAHPS survey, but changes in the survey tool have limited our ability to assess progress towards meeting benchmarks. With this change, we will be focusing on additional clinical areas, & will leverage the work of our CHIPRA Quality Demonstration Grant & our Adult Core Measures Grant.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2013 ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: HEDIS 2015 for the managed care plans, HEDIS 2013 used for the Primary Care Clinician (PCC) Plan Note –due to rotation of HEDIS measures, the contracted MCOs reported this measure as part of their HEDIS 2015 work. MassHealth last calculated this measure for the PCC Plan as part of its HEDIS 2013 project. As the PCC Plan members represent a significant portion of members eligible for this measure, we are including the PCC Plan's HEDIS 2013 rates as in the weighted average results for this measure. (note – the PCC Plan is scheduled to repeat this measure as part of the 2016 HEDIS measure slate)	**Measurement Specification:** ☒HEDIS. *Specify HEDIS® Version used*: 2016 ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2014	FFY 2015	FFY 2016
Definition of Population Included in the Measure: Definition of numerator: Enrolled pregnant women who have received at least 81% of the required prenatal care visits. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Enrolled prenant women.	**Definition of Population Included in the Measure:** Definition of numerator: Eligible women with a qualifying prenatal care visit, per the measure specifications Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Medicaid and CHIP enrollees who meet continuous enrollment criteria with a live delivery between November 6 of the year prior to the reporting year, and November 5 of the reporting year	**Definition of Population Included in the Measure:** Definition of numerator: Eligible women with a qualifying prenatal care visit, per the measure specifications Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes members enrolled in the PCC Plan, and members who are not enrolled in a managed care organization. (note – PCC Plan members are not included as the most recent rates available for this measure are from HEDIS 2013)
Date Range: **From: (mm/yyyy)** 01/2012 **To: (mm/yyyy)** 12/2012	**Date Range:** **From: (mm/yyyy)** 11/2013 **To: (mm/yyyy)** 11/2014	**Date Range:** **From: (mm/yyyy)** 11/2014 **To: (mm/yyyy)** 11/2015
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 13082 Denominator: 17117 Rate: 76.4	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 8909 Denominator: 13566 Rate: 65.7
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional notes on measure:

FFY 2014	FFY 2015	FFY 2016
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 14328 Denominator: 20979 Rate: 68.3 Additional notes on measure: Date Range: For the Managed Care Organizations From: (mm/yyyy) 11/2013 To: (mm/yyyy) 11/2014 For the PCC Plan – 11/2011-11/2012	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Not applicable, as new focus area and goal chosen. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth(MH)convenes a Quality Workgroup that works on quality improvement activity implementation, support for providers, and/or management of quality components in contracts with MCO plans. In late 2014 this group selected a set of pediatric measures that either impact a large number of enrollees, demonstrate	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** A performance rate of 76.4% for this measure was reported in the 2014 Annual Report. The rate reported in this year's report is 68.3%. Our performance rate for this measure has decreased since the rate reported in last year's CHIP report. However, we note that the national Medicaid 90th percentile also decreased over the past 2 years (The HEDIS national Medicaid 90th percentile 2013 rate was 80.1%, the2014 national Medicaid 90th percentile rate was 78.4%, and the 2015 national Medicaid 90th percentile rate is 69.8%). This overall decrease in performance on this measure, here and nationally, points to the need for continued focus on this measure.	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** A performance rate of 68.3% for this measure was reported in the 2015 Annual Report. The rate reported in this year's report is 65.7%. The HEDIS 2016 rate is below the 90th national Medicaid benchmark, and continues to show room for improvement.

FFY 2014	FFY 2015	FFY 2016
significant room for improvement, and/or align with work that MH is undertaking in the arenas of postpartum care (through its Adult Core Measures grant), child behavioral health care (through the Commonwealth's Child Behavioral Health Initiative) and in supporting the delivery of coordinated care through Primary Care Payment Reform. A subset of this Quality Workgroup will work over the next several months to identify activities to support improved performance on each of the measures selected for focus, and will begin to initiate activities to promote performance improvement in each of these areas. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** national Medicaid 90th percentile for HEDIS 2014 **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an appropriate achievable benchmark of care	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** In 2014,MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure,as well as all the other measures for which performance goals were set in this section of the CHIP report.The workgroup has undertaken several activities to support improved performance on each of the measures, and is working to identify additional activities.To support improvements in the rate at which women receive>81% of the recommended perinatal care visits,MassHealth has leveraged activities underway as part of its Adult Medicaid Quality grant using Text4Baby's ad hoc and standard messages encouraging access to timely prenatal care,and leveraging AMQ grant connections to community-based provider trainings to relay messages.These activities were implemented in a timeframe that occurred later than any timeframes being reported on above. Continued Below **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 (69.8%) **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016 **Annual Performance Objective for FFY 2018:** national Medicaid 90th percentile for HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all measures for which performance goals were set in this section of the CHIP report. To support improvements in the rate at which women receive>81% of the recommended perinatal care visits, MassHealth continues to share information on the availability of Text4Baby (which provides messages encouraging access to timely prenatal care), and is in the process of developing resource sheets for and providers to encourage members to access prenatal care services, and to share information with providers on resources for their patients. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016 **Annual Performance Objective for FFY 2018:** national Medicaid 90th percentile for HEDIS 2017 **Annual Performance Objective for FFY 2019:** national Medicaid 90th percentile for HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:** MassHealth has recently been awarded an Improving Maternal and Infant Health Outcomes in Medicaid and CHIP grant to test a measurement of contraceptive use, and this may present additional opportunities for alignment to support improved rates of perinatal care visits.	**Other Comments on Measure:**

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FY 2014	FFY 2015	FFY 2016
Goal #2 (Describe) Maintain or improve the percentage of children aged 6-20 who were discharged from a hospitalization for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 7 days of discharge at the current level, which exceeds the national 2014 Medicaid 90th percentile rate of 63.21%.	**Goal #2 (Describe)** Maintain or improve the percentage of children aged 6-20 who were discharged from a hospital for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 7 days of discharge at the at a level which exceeds the 2015 national Medicaid 90th percentile rate (63.85%)	**Goal #2 (Describe)** Maintain or improve the percentage of children aged 6-20 who were discharged from a hospital for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 7 days of discharge at a level which meets or exceeds the 2016 national Medicaid 90th percentile rate of 64.2%.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: MassHealth is refocusing its objectives, selecting new measures from the CHIPRA Pediatric Core Set & associated benchmarks. We have focused on the same measures for several years, focusing on data gathered from the CAHPS survey, but changes in the survey tool have limited our ability to assess progress towards meeting benchmarks. With this change, we will be focusing on additional clinical areas, & will leverage the work of our CHIPRA Quality Demonstration Grant & our Adult Core Measures Grant.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: CHIPRA Core Measure Specifications – 2011 specifications used as part of MA's CHIPRA Qualty Demonstration Grant work	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2015 ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify HEDIS® Version used*: 2016 ☐Other. *Explain*:
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of numerator: Percentage of enrolled children aged 6-20 who were discharged from a hospitalization for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 7 days of discharge	**Definition of Population Included in the Measure:** Definition of numerator: Percentage of the denominator eligible group of children who had an outpatient visit, and intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 7 days of discharge. Definition of denominator:	**Definition of Population Included in the Measure:** Definition of numerator: Percentage of the denominator eligible group of children who had an outpatient visit, and intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 7 days of discharge. Definition of denominator:

FY 2014	FFY 2015	FFY 2016
Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Enrolled children aged 6-20 who were discharged from a hospitalization for treatment of selected mental health disorders	☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Children aged 6-20 who meet continuous enrollment criteria and who were hospitalized for selected mental health illnesses in the reporting period.	☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes members not enrolled in Masshealth Managed Care Plans (MCOs and PCC Plan)
Date Range: **From: (mm/yyyy)** 01/2011 **To: (mm/yyyy)** 12/2011	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014	**Date Range:** **From: (mm/yyyy)** 01/2015 **To: (mm/yyyy)** 12/2015
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 1804 Denominator: 2597 Rate: 69.5	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 1665 Denominator: 2447 Rate: 68.0
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional note/commentss on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: 2089 Denominator: 3288 Rate: Additional notes on measure: 63.5,	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FY 2014	FFY 2015	FFY 2016
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Not applicable, as new focus area and goal chosen. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth(MH)convenes a Quality Workgroup that works on quality improvement activity implementation, support for providers, and/or management of quality components in contracts with MCO plans. In late 2014 this group selected a set of pediatric measures that either impact a large number of enrollees, demonstrate significant room for improvement, and/or align with work that MH is undertaking in the arenas of postpartum care (through its Adult Core Measures grant), child behavioral health care (through the Commonwealth's Child Behavioral Health Initiative) and in supporting the delivery of coordinated care through Primary Care Payment Reform. A subset of this Quality Workgroup will work over the next several months to identify activities to support improved performance on each of the measures selected for focus, and will begin to initiate activities to promote performance improvement in each of these areas. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** national Medicaid 90th percentile for HEDIS 2014 **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** A performance rate of 63.5% for this measure was reported in the 2014 Annual Report. This year's rate is 69.5%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**MassHealth notes a difference in denominator size between this year's and last year's reports. Rates reported last year were produced through the CHIPRA grant, by staff new to using Medicaid claims and encounter data, which may have impacted the accuracy of the results. However, as both year's results demonstrate similar rates, we are comfortable with comparing rates for this measure over time. MassHealth has convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on several of the child core set measures. MassHealth is analyzing data to identify specific activities to undertake to support improvements in this measure. Activities will likely include identifying and sharing best practices, and collaborating with entities managing BH provider networks to enhance ongoing activities to support improved follow-up visits. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 (63.85%) **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** A performance rate of 69.5% for this measure was reported in the 2015 Annual Report. This year's rate is 68.0%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all measures for which performance goals were set in this section of the CHIP report. MassHealth supports improvement on this measure through a Pay for Performance initiative with its PCC Plan behavioral health managed care vendor. In 2016, the vendor developed and implemented activities to support timely access to information on hospital admissions to care managers, and best practice sharing among inpatient providers for ensuring that follow-up appointments are made as part of discharge planning. As these activities took place mainly during CY 2016, we would not expect these actions to have had an imipact on HEDIS 2016 rates. MassHealth will continue to monitor performance rates on this measure, and identify opportunities to impact performance. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** National Medicaid 90th percentile rate, HEDIS 2016. **Annual Performance Objective for FFY 2018:** National Medicaid 90th percentile rate, HEDIS 2017.

FY 2014	FFY 2015	FFY 2016
Explain how these objectives were set: MassHealth has identified the national Medicaid 90th percentile as an appropriate achievable benchmark of care.	**Annual Performance Objective for FFY 2018:** national Medicaid 90th percentile for HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile rate, HEDIS 2017. *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #3 (Describe) Increase the percentage of children newly prescribed ADHD medication who had at least 3 follow-up visits in a 10 month period (continuation phase) to the 2013 national Medicaid 90th percentile rate of 63.75%	**Goal #3 (Describe)** Increase the percentage of children newly prescribed ADHD medication who had at least three follow-up visits in a 10 month period (continuation phase) to the 2015 national Medicaid 90th percentile rate of 65.2%.	**Goal #3 (Describe)** Follow-up care for children prescribed Attention Defecit/ Hyperactivity Disorder medication (ADD): Increase the percentage of children newly prescribed ADHD medication who had at least three follow-up visits in a 10 month period (continuation phase) to meet or exceed the 2016 national Medicaid 90th percentile rate of 67.2.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: MassHealth is refocusing its objectives, selecting new measures from the CHIPRA Pediatric Core Set & associated benchmarks. We have focused on the same measures for several years, focusing on data gathered from the CAHPS survey, but changes in the survey tool have limited our ability to assess progress towards meeting benchmarks. With this change, we will be focusing on additional clinical areas, & will leverage the work of our CHIPRA Quality Demonstration Grant & our Adult Core Measures Grant.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2013 ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2015 ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify HEDIS® Version used*: 2016 ☐Other. *Explain*:
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of numerator: Enrolled children newly prescribed ADHD medication who had at least 3 follow-up visits in a 10 month period Definition of denominator: ☐ Denominator includes CHIP population only.	**Definition of Population Included in the Measure:** Definition of numerator: Percent of denominator-eligilble children who remained on the medication the required length of time, and, in addition to the initial follow-up visit had 2 additional visits in the 10 month period following the qualifying prescription.	**Definition of Population Included in the Measure:** Definition of numerator: Percent of denominator-eligible children who remained on the medication the required length of time, and, in addition to the initial follow-up visit had 2 additional visits in the 10 month period following the qualifying prescription.

FFY 2014	FFY 2015	FFY 2016
☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Enrolled children newly prescribed ADHD medication	Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Children aged 6-12 who meet continuous enrollment requirements with a qualifying prescription for ADHD medication in the reporting period.	Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes MassHealth members not enrolled in MassHealth managed care plans (MCOs and PCC Plan)
From: (mm/yyyy) 01/2012 **To: (mm/yyyy)** 12/2012	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014	**Date Range:** **From: (mm/yyyy)** 03/2014 **To: (mm/yyyy)** 02/2015
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 634 Denominator: 1052 Rate: 60.3	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 739 Denominator: 1178 Rate: 62.7	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 719 Denominator: 1064 Rate: 67.6
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Other Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2014	FFY 2015	FFY 2016
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Not applicable, as new focus area and goal chosen. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth(MH)convenes a Quality Workgroup that works on quality improvement activity implementation, support for providers, and/or management of quality components in contracts with MCO plans. In late 2014 this group selected a set of pediatric measures that either impact a large number of enrollees, demonstrate significant room for improvement, and/or align with work that MH is undertaking in the arenas of postpartum care (through its Adult Core Measures grant), child behavioral health care (through the Commonwealth's Child Behavioral Health Initiative) and in supporting the delivery of coordinated care through Primary Care Payment Reform. A subset of this Quality Workgroup will work over the next several months to identify activities to support improved performance on each of the measures selected for focus, and will begin to initiate activities to promote performance improvement in each of these areas. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** national Medicaid 90th percentile for HEDIS 2014 **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** A performance rate of 60.3% for this measure was reported in the 2014 Annual Report. This year's rate is 62.7%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** In 2014, MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report.The workgroup has undertaken several activities to support improved performance on each of the measures,and is working to identify additional activities.To support improvements in the rate at which children newly prescribed ADHD medications receive the recommended number of follow-up visits,the workgroup has implemented a number of activities, including compiling a list of web-based resources for providers and families,and sharing those widely with providers and DPH care coordinators,as well as supporting best practice sharing among providers working on making improvements in performance on this measure. These activities were implemented later than the timeframe reported on as part of the HEDIS 2015 data collection process. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 (65.2%) **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** A performance rate of 62.7% for this measure was reported in the 2015 Annual Report. This year's rate is 67.6% This rate exceeds the national Medicaid 90th percentile. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which children newly prescribed ADHD medications receive the recommended number of follow-up visits, MassHealth convened a best practice sharing webinar for practices participating in Primary Care Payment Reform, compiled a list of web-based resources that may be of use to both members and providers, and disseminated this resource to PCC Plan providers, via a listserv and newsletter, and to MCO Quality Managers. MassHealth is also supporting improvement on this measure through a P4P project with the managed care entity for behavioral health services for the PCC Plan. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** National Medicaid 90th percentile rate, HEDIS 2016 **Annual Performance Objective for FFY 2018:** National Medicaid 90th percentile rate, HEDIS 2017

FFY 2014	FFY 2015	FFY 2016
appropriate achievable benchmark of care	**Annual Performance Objective for FFY 2018:** national Medicaid 90th percentile for HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile rate, HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2014	FFY 2015	FFY 2016
Goal #1 (Describe) Maintain or improve the percentage of children who turned two in the measurement year who received specific vaccines (combo #3) by their second birthday at or above the 2014 national Medicaid 90th percentile rate of 80.86	**Goal #1 (Describe)** Maintain or improve the percentage of children who turned two in the measurement year who received specific vaccines (combination 3) by their second birthday at, or above, the 2015 national Medicaid 90th percentile rate of 81%	**Goal #1 (Describe)** Increase the percentage of adolescents who turned 13 years ond in the measurement year and had specific vaccines (combination 1) by their 13th birthday to the 2016 national Medicaid 90th percentile rate of 86.6%.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: MassHealth is refocusing its objectives, selecting new measures from the CHIPRA Pediatric Core Set & associated benchmarks. We have focused on the same measures for several years, focusing on data gathered from the CAHPS survey, but changes in the survey tool have limited our ability to assess progress towards meeting benchmarks. With this change, we will be focusing on additional clinical areas, & will leverage the work of our CHIPRA Quality Demonstration Grant & our Adult Core Measures Grant.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2014 ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐Other. *Explain*: HEDIS 2015 for 4 (of 5) MCOs, and HEDIS 2013 for the PCC Plan and one MCO. Note – Due to HEDIS measure rotation, most of the contracted MCOs reported this measure as part of their HEDIS 2015 work. The PCC Plan and one MCO reported this measure as part of their HEDIS 2014 work.	**Measurement Specification:** ☒HEDIS. *Specify HEDIS® Version used*: 2016 ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2014	FFY 2015	FFY 2016
Definition of Population Included in the Measure: Definition of numerator: Children who turned two in the measurement year who received specific vaccines (combo #3) by their second birthday. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Children who turned two in the measurement year	**Definition of Population Included in the Measure:** Definition of numerator: Percent of denominator-eligible children who received the vaccines that make up 'combination 3' Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Children who turned 2 years old in the reporting period, and who meet continuous enrollment criteria	**Definition of Population Included in the Measure:** Definition of numerator: Percent of denominator-eligible children who received the vaccines that make up 'combination 1' Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes MassHealth members not enrolled in MassHealth managed care plans (MCOs and PCC Plan)
Date Range: **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014	**Date Range:** **From: (mm/yyyy)** 01/2015 **To: (mm/yyyy)** 12/2015
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 14459 Denominator: 17885 Rate: 80.8	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 13438 Denominator: 16317 Rate: 82.4
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☒ Year of Data, *Explain*. One health plans' data is from HEDIS 2014 N(reporting year 2013) ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 15794 Denominator: 19297 Rate: 81.8 Additional notes on measure: Date Range: From 01/2014 To 12/2014	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2014	FFY 2015	FFY 2016
	For those plans that reported as part of HEDIS 2014 - 01/2103 – 12/2013	
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Not applicable, as new focus area and goal chosen. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth(MH)convenes a Quality Workgroup that works on quality improvement activity implementation, support for providers, and/or management of quality components in contracts with MCO plans. In late 2014 this group selected a set of pediatric measures that either impact a large number of enrollees, demonstrate significant room for improvement, and/or align with work that MH is undertaking in the arenas of postpartum care (through its Adult Core Measures grant), child behavioral health care (through the Commonwealth's Child Behavioral Health Initiative) and in supporting the delivery of coordinated care through Primary Care Payment Reform. A subset of this Quality Workgroup will work over the next several months to identify activities to support improved performance on each of the measures selected for focus, and will begin to initiate activities to promote performance improvement in each of these areas. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** national Medicaid 90th percentile for HEDIS 2014 **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016 *Explain how these objectives were set:* MassHealth has	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** A performance rate of 80.8% for this measure was reported in the 2014 Annual Report. This year's rate is 81.8%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** In late 2014, MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. The workgroup has undertaken several activities to support improved performance on each of the measures, and is working to identify additional activities. To support improvements in the rate at which children receive recommended vaccines, the workgroup has implemented a number of activities, including compiling a list of web-based resources for providers and families, and sharing those widely with providers and the Massachusetts Immunization Program, as well as supporting best practice sharing among providers working on making improvements in performance on this measure. These activities were implemented later than the timeframe reported on as part of the HEDIS 2015 data collection process. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 (81%) **Annual Performance Objective for FFY 2017:**	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** A performance rate of 82.7% for this measure was reported in the 2015 Annual Report. This year's rate is 82.4% **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which adolescents receive recommended vaccines, MassHealth convened a best practice sharing webinar for practices participating in Primary Care Payment Reform, compiled a list of web-based resources that may be of use to both members and providers, and disseminated this resource to PCC Plan providers, via a listserv and newsletter, and to MCO Quality Managers. These activities happened during the latter half of Calendar year 2015, and therefore may not have impacted performance on this measure. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** National Medicaid 90th percentile rate, HEDIS 2016 **Annual Performance Objective for FFY 2018:** National Medicaid 90th percentile rate, HEDIS 2017

FFY 2014	FFY 2015	FFY 2016
identified the national Medicaid 90th percentile as an appropriate achievable benchmark of care	national Medicaid 90th percentile for HEDIS 2016 **Annual Performance Objective for FFY 2018:** national Medicaid 90th percentile for HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile rate, HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:** Note that MA is discontinuing its goal related to the Childhood Imunization Status (CIS) measure because performance rates for this measure have been stable , and have met or exceeded the National Medicaid 90th percentile for Combination 3 for the past two years. The rate for this measure is currently 81.1%, compared to the HEDIS national Medicaid 90th percentile of 79.8%. MassHealth has replaced the CIS goal with a goal for Adolescent Well Care (see below).

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #2 (Describe) Increase the percentage of adolescents who turned 13 years old during the measurement year and had specific vaccines (combo)by their 13th birthday to the 2014 national Medicaid average of 86.46%	**Goal #2 (Describe)** Increase the percentage of adolescents who turned 13 years ond in the measurement year and had specific vaccines (combination 1) by their 13th birthday to the 2014 national Medicaid 90th percentile of 86.5%.	**Goal #2 (Describe)** Improve the percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year to meet or exceed the Medicaid 90th percentile rate of 66.0%.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: MassHealth is refocusing its objectives, selecting new measures from the CHIPRA Pediatric Core Set & associated benchmarks. We have focused on the same measures for several years, focusing on data gathered from the CAHPS survey, but changes in the survey tool have limited our ability to assess progress towards meeting benchmarks. With this change, we will be focusing on additional clinical areas, & will leverage the work of our CHIPRA Quality Demonstration Grant & our Adult Core Measures Grant.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional.. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2014 ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: HEDIS 2014 for 4 (of 5) Managed Care Organizations, HEDIS 2013 for one of the MCOs and the PCC Plan. Note – Due to HEDIS measure rotation, most of the contracted MCOs reported this measure as part of their HEDIS 2015 work. The PCC Plan and one MCO reported this measure as part of their HEDIS 2014 work.	**Measurement Specification:** ☒HEDIS. *Specify HEDIS® Version used*: 2016 ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2014	FFY 2015	FFY 2016
Definition of Population Included in the Measure: Definition of numerator: Adolescents who turned 13 years old during the measurement year and had specific vaccines (combo) by their 13th birthday Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Adolescents who turned 13 years old during the measurement year	**Definition of Population Included in the Measure:** Definition of numerator: Percent of denominator-eligible population who received the vaccines that make up 'combination 1' Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Adolescents who turned 13 years old in the reporting period, and who meet continuous enrollment criteria	**Definition of Population Included in the Measure:** Definition of numerator: The percentage of denominator adolescents with a qualifying visit in the measurement year. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes MassHealth members not enrolled in MassHealth managed care plans (MCOs and PCC Plan)
Date Range: **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014	**Date Range:** **From: (mm/yyyy)** 01/2015 **To: (mm/yyyy)** 12/2015
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 13236 Denominator: 16130 Rate: 82.1	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 9992 Denominator: 146017 Rate: 68.4
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☒ Year of Data, *Explain*. One health plans' data is from HEDIS 2014 (reporting year 2013) ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 13793 Denominator: 16669 Rate: 82.7 Additional notes on measure: Date Range: From 01/2014 to 12/2014	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2014	FFY 2015	FFY 2016
	For one MCO and the PCC Plan - 01/2013 to 12/2013	
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Not applicable, as new focus area and goal chosen. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth(MH)convenes a Quality Workgroup that works on quality improvement activity implementation, support for providers, and/or management of quality components in contracts with MCO plans. In late 2014 this group selected a set of pediatric measures that either impact a large number of enrollees, demonstrate significant room for improvement, and/or align with work that MH is undertaking in the arenas of postpartum care (through its Adult Core Measures grant), child behavioral health care (through the Commonwealth's Child Behavioral Health Initiative) and in supporting the delivery of coordinated care through Primary Care Payment Reform. A subset of this Quality Workgroup will work over the next several months to identify activities to support improved performance on each of the measures selected for focus, and will begin to initiate activities to promote performance improvement in each of these areas. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** national Medicaid 90th percentile for HEDIS 2014 **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016 *Explain how these objectives were set:* MassHealth has	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** A performance rate of 82.1% for this measure was reported in the 2014 Annual Report. This year's rate is 82.7%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** In late 2014, MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. The workgroup has undertaken several activities to support improved performance on each of the measures, and is working to identify additional activities. To support improvements in the rate at which adolescents receive recommended vaccines, the workgroup has implemented a number of activities, including compiling a list of web-based resources for providers and families, and sharing those widely with providers and the Massachusetts Immunization Program, as well as supporting best practice sharing among providers working on making improvements in performance on this measure. These activities were implemented later than the timeframe reported on as part of the HEDIS 2015 data collection process. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2014 (86.5%) **Annual Performance Objective for FFY 2017:**	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** N/A – New goal **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** N/A – New goal **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** National Medicaid 90th percentile, HEDIS 2016 **Annual Performance Objective for FFY 2018:** National Medicaid 90th percentile, HEDIS 2016

FFY 2014	FFY 2015	FFY 2016
identified the national Medicaid 90th percentile as an appropriate achievable benchmark of care.	national Medicaid 90th percentile for HEDIS 2015 **Annual Performance Objective for FFY 2018:** national Medicaid 90th percentile for HEDIS 2016 *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile, HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2014	FFY 2015	FFY 2016
Goal #3 (Describe) Maintain or improve the percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender relative to the 2014 national Medicaid 90th percentile of 82.46%	**Goal #3 (Describe)** Maintain or improve the percentage of children aged 3-17 who had an outpatient visit with a primary care practitioner of obstetrical/gynecological (ob/gyn) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender to the 2015 national Medicaid 90th percentile of 85.6%	**Goal #3 (Describe)** Maintain or improve the percentage of children aged 3-17 who had an outpatient visit with a primary care practitioner or obstetrical/gynecological (ob/gynn) practitioner and whose weight is classified based on body mass indes (BMI) percentile for age and gender to the 2016 national 90th percentile of 86.4%.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: MassHealth is refocusing its objectives, selecting new measures from the CHIPRA Pediatric Core Set & associated benchmarks. We have focused on the same measures for several years, focusing on data gathered from the CAHPS survey, but changes in the survey tool have limited our ability to assess progress towards meeting benchmarks. With this change, we will be focusing on additional clinical areas, & will leverage the work of our CHIPRA Quality Demonstration Grant & our Adult Core Measures Grant.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2014 ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: HEDIS 2015 for 2 (of 5) contracted Managed Care Organziations, and HEDIS 2014 for 3 MCOs and the PCC Plan. Note – Due to HEDIS measure rotation, two of the contracted MCOs reported this measure as part of their HEDIS 2015 work. The PCC Plan and three MCOs reported this measure as part of their HEDIS 2014 work.	**Measurement Specification:** ☒HEDIS. *Specify HEDIS® Version used*: 2016 ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2014	FFY 2015	FFY 2016
Definition of Population Included in the Measure: Definition of numerator: Children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner	**Definition of Population Included in the Measure:** Definition of numerator: Percentage of denominator-eligible children with evidence of BMI percentile documentation in the reporting year Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: children aged 3-17 who meet continuous enrollment criteria and who had a qualifying outpatient visit	**Definition of Population Included in the Measure:** Definition of numerator: Percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and who had evidence of body mass index (BMI) percentile documentation during the measurement year. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes MassHealth members not enrolled in MassHealth managed care plans (MCOs and PCC Plan)
Date Range: **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014	**Date Range:** **From: (mm/yyyy)** 01/2015 **To: (mm/yyyy)** 01/2016
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 193964 Denominator: 233663 Rate: 83	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 204190 Denominator: 244708 Rate: 83.4
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☒ Year of Data, *Explain*. One health plans' data is from HEDIS 2014 (reporting year 2013) ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 186485 Denominator: 225399 Rate: 82.7	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate:

FFY 2014	FFY 2015	FFY 2016
Additional notes on measure:	Additional notes on measure: Date range: From 01/2014 to 12/2014 For the PCC Plan and three MCOs - 1/2013 to 12/2013	Additional notes on measure:
Explanation of Progress: **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Not applicable, as new focus area and goal chosen. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth(MH)convenes a Quality Workgroup that works on quality improvement activity implementation, support for providers, and/or management of quality components in contracts with MCO plans. In late 2014 this group selected a set of pediatric measures that either impact a large number of enrollees, demonstrate significant room for improvement, and/or align with work that MH is undertaking in the arenas of postpartum care (through its Adult Core Measures grant), child behavioral health care (through the Commonwealth's Child Behavioral Health Initiative) and in supporting the delivery of coordinated care through Primary Care Payment Reform. A subset of this Quality Workgroup will work over the next several months to identify activities to support improved performance on each of the measures selected for focus, and will begin to initiate activities to promote performance improvement in each of these areas. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** national Medicaid 90th percentile for HEDIS 2014 **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 **Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2016	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** A performance rate of 83% for this measure was reported in the 2014 Annual Report. This year's rate is 82.7%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** In late 2014, MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. The workgroup has undertaken several activities to support improved performance on each of the measures, and is working to identify additional activities. To support improvements in the rate at which BMI percentile is assessed, the workgroup has implemented a number of activities, including compiling a list of web-based resources for providers and families, and sharing those widely with providers and the Massachusetts Immunization Program, as well as supporting best practice sharing among providers working on making improvements in performance on this measure. These activities were implemented later than the timeframe reported on as part of the HEDIS 2015 data collection process. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** national Medicaid 90th percentile for HEDIS 2015 (85.6%)	**Explanation of Progress:** **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?** A performance rate of 82.7% for this measure was reported in the 2015 Annual Report. This year's rate is 83.4% **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which BMI percentile is assessed, Masshealth convened a best practice sharing webinar for practices participating in Primary Care Payment Reform, compiled a list of web-based resources that may be of use to both members and providers, and disseminated this resource to PCC Plan providers, via a listserv and newsletter, and to MCO Quality Managers. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2017:** National Medicaid 90th percentile, HEDIS 2016 **Annual Performance Objective for FFY 2018:**

FFY 2014	FFY 2015	FFY 2016
Explain how these objectives were set: MassHealth has identified the national Medicaid 90th percentile as an appropriate achievable benchmark of care.	**Annual Performance Objective for FFY 2017:** national Medicaid 90th percentile for HEDIS 2015 **Annual Performance Objective for FFY 2018:** national Medicaid 90th percentile for HEDIS 2016 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	National Medicaid 90th percentile, HEDIS 2017 **Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile, HEDIS 2017 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

1. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your CHIP population? What have you found? **[7500]**

MassHealth collects and reports on selected measures from the HEDIS measure set for its MCO and PCC Plan enrolled populations. Many of the Child Core Set measures are included in the slate of collected HEDIS measures.

Drawing from lessons learned from the state's work on quality measures undertaken as part of MA's CHIPRA Quality Demonstration Grant, MassHealth is calculating results for some of the non-HEDIS measures, using administrative data sets (e.g., DEVT SCREENING, CHILD COHORT FOR FUH).

Additionally, MassHealth is working with the MA Department of Public Health to utilize the MassCHIP system as a source of data for one additional measure from the Child Core Set (LOW BIRTH WEIGHT)

MassHealth uses the HEDIS data and the Child Core Set data as part of the overall quality management strategy used for managing contracts with its contracted Managed Care Organizations (MCOs), and for identifying areas for focus for quality improvement work with the MCOs and for its primary care case management program (the Primary Care Clinician (PCC) Plan).

Measures from the Child Core Set were included in the measure set used for quality incentives and reporting in MassHealth's Primary Care Payment Reform, and are included in the measure set being used to assess performance in MassHealth's Accountable Care Organization pilot program.

Supporting improved performance on selected measures from the Child Core Set is the focus of work being undertaken by MassHealth to pursue and meet performance improvement goals that are included elsewhere in this annual CHIP report.

By using the Child Core Set in these multiple ways, MassHealth is able to monitor, track, and support improvement of care received by the CHIP population

2. What strategies does your CHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your CHIP population? When will data be available? **[7500]**

MassHealth plans to continue to utilize measures from the Child Core Measures set in the manner noted above moving forward. As new measures are added to the Core Set, MassHealth will evaluate its resources and ability to calculate these measures, assess performance on the measures, and identify new opportunities for improvement.

3. Have you conducted any focused quality studies on your CHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found? **[7500]**

No focused quality studies were undertaken this year.

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please include any analyses or descriptions of any efforts designed to reduce the number of uncovered children in the state through a state health insurance connector program or support for innovative private health coverage initiatives health coverage initiatives. **[7500]**

MassHealth HEDIS reports. Annual MassHealth Managed Care Reports that measure plan performance based on selected measures from the HEDIS measures set, are posted online at http://www.mass.gov/eohhs/researcher/insurance/masshealth-reports/masshealth-managed-care-mco-reports.html

Additionally, MassHealth's Managed Care Quality Strategy, which sets forth the values, goals and strategies that reflect MassHealth's commitment to its members receiving high-quality care, are posted

online at http://www.mass.gov/eohhs/researcher/insurance/masshealth-reports/masshealth-managed-care-mco-reports.html

Enter any Narrative text related to Section IIB below **[7500]**.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

A. OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period? **[7500]**

The Health Care Reform (HCR) Outreach and Education Unit coordinates statewide outreach activities, disseminates educational materials related to state and federal Health Care Reform, and collaborates with state and community-based agencies. This coordination helps prevent the duplication of outreach efforts in the community, strengthens the knowledge of providers and residents, and provides information to help individuals make smart choices about their health coverage. The overall functions of the HCR Unit include: managing and providing oversight to the outreach and enrollment grant programs; supporting and managing training and technical assistance for community providers, partners, and grantee organizations around health care reform policy and program changes; and coordinating and collaborating with state agencies around state and federal health care reform policies, messaging, and outreach activities.
In FFY15-16, the unit awarded 13 grants to hospitals and community health centers to increase enrollment in MassHealth and other health insurance programs through outreach and application assistance, as well as providing one-on-one assistance with case maintenance processes to help individuals retain their health insurance coverage. The MAhealthconnector.org is our single "front door" online application system for individuals seeking health coverage.
Grantees assist both families and individuals access health care. From January 1 - June 30, 2016 grantees enrolled over 18,442 individuals into MassHealth, the Health Safety Net and other public health insurance programs available. Of those enrolled, 39% were children in the MassHealth program.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness? **[7500]**

We have found the following methods to be most effective in reaching low-income, uninsured children:
MassHealth outreach grant recipients conducted outreach and enrollment at locations where individuals spend time in routine daily life activities in their own communities rather than requiring individuals to come to a health facility or state agency for application assistance. Applications are submitted on site at the point of engagement through laptops and utilizing the Health Insurance Exchange (HIX)/Integrated Eligibility System (IES) at the MAhealthconnector.org. Grantees ensure services are provided in a culturally and linguistically appropriate fashion. Reaching individuals where they are and conducting services in a way that meets the individual's needs. Equally important is ensuring application assistance, MassHealth outreach grant recipients are vigilant in providing follow-up and case management after enrollment to help newly insured understand their health insurance coverage. This includes grantees setting-up appointments to complete the application using the online system or paperwork, helping explain notices from MassHealth, and helping individuals respond to requests for information from their insurer. Remaining a locally trusted and reliable resource that individuals can turn to for help has been very successful. Many other referrals come to our partners via word of mouth.
MassHealth also continues to work collaboratively with the Massachusetts medical community to train, educate and promote MassHealth policies and initiatives. These collaborations are inclusive of working with over 25 Massachusetts Professional Associations, including the Massachusetts Hospital Association, the Massachusetts League of Community Health Centers, the Massachusetts Medical Society and the Massachusetts Chapter of the American Academy of Pediatrics. MassHealth reaches their respective constituents by presenting at their meetings and hosting provider specific educational forums. Additional outreach efforts include utilizing the web as a major communication vehicle to reach the provider community, creating a @MassHealth Twitter account, conducting one-on-one provider training and hosting targeted face-to-face provider educational and training forums throughout the state as well as conducting training and education sessions online. These tools help ensure MassHealth providers stay current on developments in the MassHealth program.
MassHealth also continues to fund and provide leadership for the Massachusetts Health Care

Training Forum (MTF) program. MTF is a partnership between MassHealth and MassAHEC Network at the University of MA Medical School (UMMS). MTF hosts four regional meetings each quarter that feature presentations to keep health care organizations and community agencies that serve MassHealth members, the uninsured, and underinsured informed of the latest changes in MassHealth and overall state and federal health care reform policies. MassHealth presents information about programmatic operations and policy changes and often leading community advocates share updates about policy developments in state and federal health care reform. MTF also provides information via a listserv of approximately 5,883 members, and a website offering resource information and meeting materials. The website had over 67,889 visitors in FFY15-16. The meetings promote information dissemination, sharing of best practices, and building of community and public sector linkages in order to increase targeted outreach and member education information about MassHealth. In SFY16, MTF program attendance remained steadily high at a total of 2,022 individuals, even after decreasing the number of meetings from five meetings per quarter to four meetings per quarter starting in January of 2016. In addition to those attending the in-person meetings 4,294 participated in webinars and conference call meetings.

3. Which of the methods described in Question 2 would you consider a best practice(s)**? [7500]**

   All of the methods referenced in #2 are considered a best practice. It's very effective to reach individuals where they are in the community and to conduct services in a cultural and linguistic fashion that meets the individual's needs. Submitting applications via an online system with the functionality to provide real time program determination have greatly affected the ability of providers to assist individuals seeking health care.

4. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)?

   ☒ Yes

   ☐ No

   Have these efforts been successful, and how have you measured effectiveness? **[7500]**

   Grantee outreach activities include print, and local grassroots advertisement to the Latino, Portuguese, Vietnamese, Russian, and Chinese communities. MassHealth continues to translate materials into Spanish, Brazilian Portuguese, Chinese, Vietnamese, Haitian Creole, Russian, Cambodian, and Laotian.

   The Member Education Unit conducts in-service presentations to various organizations including but not limited to:

   The Massachusetts Office of Refugees and Immigrants Refugee Resettlement Training Unit; Native American Indian Tribes; School Nurses; Municipal Medicaid Programs through various schools; sister state agencies such as the Department of Public Health, Department of Mental Health, Department of Children and Families (formerly DSS), Department of Department of Developmental Services (formerly DMR), Department of Veteran's Services, and the Office of Substance Abuse; Community Action Councils; the MassachusettsDepartment of Public Health WIC Program, advocates for the homeless, shelters, and other facilities working with the homeless population, Senior Care Organizations, the Massachusetts Head Start Program, the Office of Substance Abuse, Family Support Groups, and the Gay, Lesbian, Bisexual and Transgender Youth Support Project.

   These presentations provide education on a variety of topics including: MassHealth benefits; coverage types; covered services; rights and responsibilities; navigation tools such as website searching; how to access the MAhealthconnector.org; how to access other state health insurance programs; the application process; and post-enrollment information on how to maintain health coverage once it has been obtained. Member Education offers continued support to these organizations via e-mail and telephone in order to ensure proper procedure and an expedited service to the members. These efforts have been successful by encouraging new applicants, dispelling any myths about public programs, and assisting members with health insurance coverage retention.

5. What percentage of children below 200 percent of the Federal poverty level (FPL) who are eligible for Medicaid or CHIP have been enrolled in those programs? [5]

   (Identify the data source used). **[7500]**

Enter any Narrative text related to Section IIIA below. **[7500]**

Response to #5: According to the American Community Survey Data for 2015, .5% of children under 200% FPL in Massachusetts are uninsured. It is extremely challenging to determine what portion of the remaining uninsured are eligible for Medicaid or CHIP, particularly given uncertainty around the immigration status of such individuals. With that said, given the extremely low uninsurance rate for children under 200% FPL and the Commonwealth's extensive efforts to identify and enroll all eligible children, the Commonwealth believes that the number of remaining eligible but unenrolled children is minimal. Since the field above requires a number, we entered 100 but again are unable to verify this number.

B. SUBSTITUTION OF COVERAGE (CROWD-OUT)

All states should answer the following questions. Please include percent calculations in your responses when applicable and requested.

1. **Table 1.**

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☒	No
	☐	Yes
	Specify number of months	
	To which groups (including FPL levels) does the period of uninsurance apply? **[1000]**	
	List all exemptions to imposing the period of uninsurance **[1000]**	
	☐	N/A

Does your program match prospective enrollees to a database that details private insurance status?	☐	No
	☒	Yes
	If yes, what database? **[1000]** Health Management Systems (HMS) conducts a monthly State and National data match using a system called "Match MAX" which identifies health Insurance for all MassHealth members.	
	☐	N/A

2. At the time of application, what percent of CHIP applicants are found to have Medicaid [(# applicants found to have Medicaid/total # applicants) * 100] **[5]**
   and what percent of applicants are found to have other group insurance [(# applicants found to have

other insurance/total # applicants) * 100] **[5]**?
Provide a combined percent if you cannot calculate separate percentages. **[5]** 22

3. What percent of CHIP applicants cannot be enrolled because they have group health plan coverage **[5]** 0

    a. Of those found to have had other, private insurance and have been uninsured for only a portion of the state's waiting period, what percent meet your state's exemptions to the waiting period (if your state has a waiting period and exemptions) [(# applicants who are exempt/total # of new applicants who were enrolled)*100]? **[5]**

    0

4. Do you track the number of individuals who have access to private insurance?

    ☒ Yes
    ☐ No

    If yes, what percent of individuals that enrolled in CHIP had access to private health insurance at the time of application during the last federal fiscal year [(# of individuals that had access to private health insurance/total # of individuals enrolled in CHIP)*100]? **[5]**
    22

Enter any Narrative text related to Section IIIB below. **[7500]**

Question B2 - MassHealth has a joint application for Medicaid and CHIP; as such it is not possible to determine the first statistic. After eligibility determination was done, 22% of CHIP applicant children (children with income in CHIP range) were found to have other insurance.

Question B3 – MassHealth has authorization under an 1115 waiver to enroll children with insurance at CHIP income levels into MassHealth using Title XIX funding. MassHealth does not have a waiting period.

C. ELIGIBILITY

This subsection should be completed by all states. Medicaid Expansion states should complete applicable responses and indicate those questions that are non-applicable with N/A.

Section IIIC: Subpart A: Eligibility Renewal and Retention

1. Do you have authority in your CHIP state plan to provide for presumptive eligibility, and have you implemented this? ☐ Yes ☒ No

    If yes

    a) What percent of children are presumptively enrolled in CHIP pending a full eligibility determination? [5]

    b) Of those children who are presumptively enrolled, what percent of those children are determined eligible and enrolled upon completion of the full eligibility determination those children are determined eligible and enrolled? [5]

2. Select the measures from those below that your state employ to simplify an eligibility renewal and retain eligible children in CHIP?

☒ Conducts follow-up with clients through caseworkers/outreach workers

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program? **[500]**
  MassHealth sends one notice to the family advising of the need to submit the annual review.
- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the state?) **[500]**
  No reminders are sent.

☐ Other, *please explain*: **[500]**

3. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology. **[7500]**

   All of the above strategies have played an important role in making the process work better for our MassHealth members. MassHealth has not conducted a formal evaluation of each outreach strategy, but rather has measured effectiveness through qualitative reporting from our outreach partners. Each month, grantees report on what enrollment and outreach strategies worked best. Findings show it's very effective to follow-up with individuals where they are in the community, conducting services in a cultural and linguistic fashion that meets the individual's needs. Tying enrollment and outreach events to current affairs, such as a Family Fun Day sponsored by the MA Dept. of Children and Families or back to school campaign, is also key to success since these are a natural draw for individuals to attend.

Section IIIC: Subpart B: Eligibility Data

Table 1. Data on Denials of Title XXI Coverage in FFY 2016

States are required to report on all questions (1,1.a.,1.b., and 1.c) in FFY 2016. Please enter the data requested in the table below and the template will tabulate the requested percentages.

Measure	Number	Percent
1. Total number of denials of title XXI Coverage	2743	100
a. Total number of procedural denials	360	13.1
b. Total number of eligibility denials	2383	86.9
i. Total number of applicants denied for title XXI and enrolled in title XIX	0	
(Check here if there are no additional categories ☐) c. Total number of applicants denied for other reasons Please indicate:		

2. Please describe any limitations or restrictions on the data used in this table: Our system determines eligbility at the point of application or redetermination for either Title XIX or Title XXI. Therefore there are no denials for Title XXI that are then enrolled in Title XIX.

Definitions:

1. The "the total number of denials of title XXI Coverage" is defined as the total number of applicants that have had an eligibility decision made for title XXI and denied enrollment for title XXI in FFY 2016. This definition only includes denials for title XXI at the time of initial application (not redetermination).

a. The "total number of procedural denials" is defined as the total number of applicants denied for title XXI procedural reasons in FFY 2016 (i.e., incomplete application, missing documentation, missing enrollment fee, etc.).
b. The "total number of eligibility denials" is defined as the total number of applicants denied for title XXI eligibility reasons in FFY 2016 (i.e., income too high, income too low for title XXI referred for Medicaid eligibility determination/determined Medicaid eligible , obtained private coverage or if applicable, had access to private coverage during your state's specified waiting period, etc.)
    i. The total number of applicants that are denied eligibility for title XXI and determined eligible for title XIX
c. The "total number of applicants denied for other reasons" is defined as any other type of denial that does not fall into 2a or 2b. Please check the box provided if there are no additional categories.

Table 2. Redetermination Status of Children

For this table, reporting is required for FFY 2016.

Table 2a. Redetermination Status of Children Enrolled in Title XXI

Please enter the data requested in the table below in the "Number" column, and the template will automatically tabulate the percentages.

	Number	Percent			
1. Total number of children who are enrolled in title XXI and eligible to be redetermined	84451	100%			
2. Total number of children screened for redetermination for title XXI	84451	100	100%		
3. Total number of children retained in title XXI after the redetermination process	81752	96.8	96.8		
4. Total number of children disenrolled from title XXI after the redetermination process	2699	3.2	3.2	100%	
a. Total number of children disenrolled from title XXI for failure to comply with procedures	1441			53.39	
b. Total number of children disenrolled from title XXI for failure to meet eligibility criteria	1258			46.61	100%
I. Disenrolled from title XXI because income too high for title XXI (If unable to provide the data, check here ☐)					
II. Disenrolled from title XXI					

because income too low for title XXI (If unable to provide the data, check here ☐)					
iii. Disenrolled from title XXI because application indicated access to private coverage or obtained private coverage (If unable to provide the data or if you have a title XXI Medicaid expansion and this data is not relevant check here ☐)	6				0.48
iv. Disenrolled from title XXI for other eligibility reason(s) Please indicate: No longer a state resident, no longer in family group, voluntary withdrawal of application (If unable to provide the data check here ☐)	1252				99.52
c. Total number of children disenrolled from title XXI for other reason(s) Please indicate: (Check here if there are no additional categories ☐)	0				

5. If relevant, please describe any limitations or restrictions on the data entered into this table. Please describe any state policies or procedures that may have impacted the redetermination outcomes data.

Definitions:

1. The "total number of children who are eligible to be redetermined" is defined as the total number of children due to renew their eligibility in federal fiscal year (FFY) 2016, and did not age out (did not exceed the program's maximum age requirement) of the program by or before redetermination. This total number may include those children who are eligible to renew prior to their 12 month eligibility redetermination anniversary date. This total must include ex parte redeterminations, the process when a state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. This total number must also include children whose eligibility can be renewed through administrative redeterminations, whereby the state sends the family a renewal form that is pre-populated with eligibility information already available through program records and requires the family to report any changes.
2. The "total number of children screened for redetermination" is defined as the total number of children that were screened by the state for redetermination in FFY 2016 (i.e., ex parte redeterminations and administrative redeterminations, as well as those children whose families have returned redetermination forms to the state).
3. The "total number of children retained after the redetermination process" is defined as the total number of children who were found eligible and remained in the program after the redetermination process in FFY 2016.
4. The "total number of children disenrolled from title XXI after the redetermination process" is defined as the total number of children who are disenrolled from title XXI following the redetermination process in FFY 2016. This includes those children that states may define as "transferred" to Medicaid for title XIX eligibility screening.

a. The "total number of children disenrolled for failure to comply with procedures" is defined as the total number of children disenrolled from title XXI for failure to successfully complete the redetermination process in FFY 2016 (i.e., families that failed to submit a complete application, failed to provide complete documentation, failed to pay premium or enrollment fee, etc.).
b. The "total number of children disenrolled for failure to meet eligibility criteria" is defined as the total number of children disenrolled from title XXI for no longer meeting one or more of their state's CHIP eligibility criteria (i.e., income too low, income too high, obtained private coverage or if applicable, had access to private coverage during your state's specified waiting period, etc.). If possible, please break out the reasons for failure to meet eligibility criteria in i.-iv.
c. The "total number of children disenrolled for other reason(s)" is defined as the total number of children disenrolled from title XXI for a reason other than failure to comply with procedures or failure to meet eligibility criteria, and are not already captured in 4.a. or 4.b.

The data entered in 4.a., 4.b., and 4.c. should sum to the total number of children disenrolled from title XXI (line 4).

Table 2b. Redetermination Status of Children Enrolled in Title XIX

Please enter the data requested in the table below in the "Number" column, and the template will automatically tabulate the percentages.

	Number	Percent			
1.Total number of children who are enrolled in title XIX and eligible to be redetermined	239383	100%			
2. Total number of children screened for redetermination for title XIX	239383	100	100%		
3. Total number of children retained in title XIX after the redetermination process	231500	96.71	96.71		
4. Total number of children disenrolled from title XIX after the redetermination process	7882	3.29	3.29	100%	
a. Total number of children disenrolled from title XIX for failure to comply with procedures	3946			50.06	
b. Total number of children disenrolled from title XIX for failure to meet eligibility criteria	3936			49.94	100%
v. Disenrolled from title XIX because income too high for title XIX (If unable to provide the data, check here ☐)	28				0.71
vi. Disenrolled from	3908				99.29

title XXI for other eligibility reason(s) Please indicate: No longer in family group, no longer a state resident, voluntary withdrawal (If unable to provide the data check here ☐)					
c. Total number of children disenrolled from title XXI for other reason(s) Please indicate: (Check here if there are no additional categories ☐)	0				

5. If relevant, please describe any limitations or restrictions on the data entered into this table. Please describe any state policies or procedures that may have impacted the redetermination outcomes data.

Definitions:

1. The "total number of children who are eligible to be redetermined" is defined as the total number of children due to renew their eligibility in federal fiscal year (FFY) 2016, and did not age out (did not exceed the program's maximum age requirement) of the program by or before redetermination. This total number may include those children who are eligible to renew prior to their 12 month eligibility redetermination anniversary date. This total must include ex parte redeterminations, the process when a state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. This total number must also include children whose eligibility can be renewed through administrative redeterminations, whereby the state sends the family a renewal form that is pre-populated with eligibility information already available through program records and requires the family to report any changes.
2. The "total number of children screened for redetermination" is defined as the total number of children that were screened by the state for redetermination in FFY 2016 (i.e., ex parte redeterminations and administrative redeterminations, as well as those children whose families have returned redetermination forms to the state).
3. The "total number of children retained after the redetermination process" is defined as the total number of children who were found eligible and remained in the program after the redetermination process in FFY 2016.
4. The "total number of children disenrolled from title XIX after the redetermination process" is defined as the total number of children who are disenrolled from title XIX following the redetermination process in FFY 2016. This includes those children that states may define as "transferred" to CHIP for title XXI eligibility screening.
   a. The "total number of children disenrolled for failure to comply with procedures" is defined as the total number of children disenrolled from title XIX for failure to successfully complete the redetermination process in FFY 2016 (i.e., families that failed to submit a complete application, failed to provide complete documentation, failed to pay premium or enrollment fee, etc.).
   b. The "total number of children disenrolled for failure to meet eligibility criteria" is defined as the total number of children disenrolled from title XIX for no longer meeting one or more of their state's Medicaid eligibility criteria (i.e., income too high, etc.).
   c. The "total number of children disenrolled for other reason(s)" is defined as the total number of children disenrolled from title XIX for a reason other than failure to comply with procedures or failure to meet eligibility criteria, and are not already captured in 4.a. or 4.b.

The data entered in 4.a., 4.b., and 4.c. should sum to the total number of children disenrolled from title XIX (line 4).

Table 3. Duration Measure of Selected Children, Ages 0-16, Enrolled in Title XIX and Title XXI, Second Quarter FFY 2016

The purpose of tables 3a and 3b is to measure the duration, or continuity, of Medicaid and CHIP enrollees' coverage. This information is required by Section 402(a) of CHIPRA. **Reporting on this table is required.**

Because the measure is designed to capture continuity of coverage in title XIX and title XXI beyond one year of enrollment, the measure collects data for 18 months of enrollment. This means that reporting spans two CARTS reports over two years. The duration measure uses a cohort of children and follows the enrollment of the same cohort of children for 18 months to measure continuity of coverage. **States identify a new cohort of children every two years. States identified newly enrolled children in the second quarter of FFY 2016 (January, February, and March of 2016) for the FFY 2016 CARTS report. If your eligibility system already has the capability to track a cohort of enrollees over time, an additional "flag" or unique identifier may not be necessary.**

The FFY 2016 CARTS report is the first year of reporting in the cycle of two CARTS reports on the cohort of children identified in the second quarter of FFY 2016. States will continue to report on the same table in the FFY 2017 CARTS reports. The next cohort of children will be identified in the second quarter of the FFY 2018 (January, February and March 2018).

Instructions: For this measure, please identify newly enrolled children in both title XIX and title XXI in the second quarter of FFY 2016, ages 0 months to 16 years at time of enrollment. Children enrolled in January 2016 must have birthdates after July 1999 (e.g., children must be younger than 16 years and 5 months) to ensure that they will not age out of the program at the 18th month of coverage. Similarly, children enrolled in February 2016 must have birthdates after August 1999, and children enrolled in March 2016 must have birthdates after September 1999. Each child newly enrolled during this time frame needs a unique identifier or "flag" so that the cohort can be tracked over time. If your eligibility system already has the capability to track a cohort of enrollees over time, an additional "flag" or unique identifier may not be necessary. Please follow the child based on the child's age category at the time of enrollment (e.g., the child's age at enrollment creates an age cohort that does not change over the 18 month time span).

Please enter the data requested in the tables below, and the template will tabulate the percentages. In this report you will only enter data on the 6-month enrollment status. **Only enter a "0" (zero) if the data are known to be zero. If data are unknown or unavailable, leave the field blank.**

Note that all data must sum correctly in order to save and move to the next page. The data in each individual row must add across to sum to the total in the "All Children Ages 0-16" column for that row. And in each column, the data within each time period (6, 12 and 18 months) must each sum up to the data in row 1, which is the number of children in the cohort. This means that in each column, rows 2, 3 and 4 must sum to the total in row 1; rows 5, 6 and 7 must sum to the row 1; and rows 8, 9 and 10 must sum to row 1. Rows numbered with an "a" (*e.g.*, rows 3a and 4a) are excluded from the total because they are subsets of their respective rows.

Table 3a. Duration Measure of Children Enrolled in Title XIX

☐**Not Previously Enrolled in CHIP or Medicaid—"**Newly enrolled" is defined as not enrolled in either title XXI or title XIX in the month before enrollment (i.e., for a child enrolled in January 2016, he/she would not be enrolled in either title XXI or title XIX in December 2015, etc.)

☐**Not Previously Enrolled in Medicaid**—"Newly enrolled" is defined as not enrolled in title XIX in the month before enrollment (i.e., for a child enrolled in January 2016, he/she would not be enrolled in title XIX in December 2015, etc.)

Duration Measure, Title XIX	**All Children Ages 0-16**		**Age Less than 12 months**		**Ages 1-5**		**Ages 6-12**		**Ages 13-16**	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
1. **Total number of children newly enrolled in title XIX in the second quarter of FFY 2016**		100%		100%		100%		100%		100%
2.										
Enrollment Status 6 months later										
3. Total number of children continuously enrolled in title XIX										
4. Total number of children with a break in title XIX coverage but re-enrolled in title XIX										
3.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)										
5. Total number of children disenrolled from title XIX										
4.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here										

	☐)										
Enrollment Status 12 months later											
6.	Total number of children continuously enrolled in title XIX										
7.	Total number of children with a break in title XIX coverage but re-enrolled in title XIX										
	6.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)										
8.	Total number of children disenrolled from title XIX										
	7.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)										
Enrollment Status 18 months later											
9.	Total number of children continuously enrolled in title XIX										
10.	Total number of children with a break in title XIX coverage but re-enrolled in title XIX										
	9.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)										
11.	Total number of children disenrolled										

from title XIX										
10.aTotal number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)										

Definitions:

1. The "total number of children newly enrolled in title XIX in the second quarter of FFY 2016" is defined as those children either new to public coverage or new to title XIX, in the month before enrollment. Please define your population of "newly enrolled" in the Instructions section.

2. The total number of children that were continuously enrolled in title XIX for 6 months is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and who were continuously enrolled through the end of June 2016
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and who were continuously enrolled through the end of July 2016
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and who were continuously enrolled through the end of August 2016

3. The total number who had a break in title XIX coverage during 6 months of enrollment (regardless of the number of breaks in coverage) but were re-enrolled in title XIX by the end of the 6 months, is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and who disenrolled and re-enrolled in title XIX by the end of June 2016
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and who disenrolled and re-enrolled in title XIX by the end of July 2016
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and who disenrolled and re-enrolled in title XIX by the end of August 2016

   3.a. From the population in #3, provide the total number of children who were enrolled in title XXI during their break in coverage.

4. The total number who disenrolled from title XIX, 6 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and were disenrolled by the end of June 2016
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and were disenrolled by the end of July 2016
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and were disenrolled by the end of August 2016

   4.a. From the population in #4, provide the total number of children who were enrolled in title XXI in the month after their disenrollment from title XIX.

5. The total number of children who were continuously enrolled in title XIX for 12 months is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and were continuously enrolled through the end of December 2016
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and were continuously enrolled through the end of January 2017

+ the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and were continuously enrolled through the end of February 2017

6. The total number of children who had a break in title XIX coverage during 12 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 12 months, is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and who disenrolled and then re-enrolled in title XIX by the end of December 2016
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and who disenrolled and then re-enrolled in title XIX by the end of January 2017
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and who disenrolled and then re-enrolled in title XIX by the end of February 2017

6.a. From the population in #6, provide the total number of children who were enrolled in title XXI during their break in coverage.

7. The total number of children who disenrolled from title XIX 12 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 1999, who were enrolled in January 2016 and were disenrolled by the end of December 2016
   + the number of children with birthdates after August 1999, who were enrolled in February 2016 and were disenrolled by the end of January 2017
   + the number of children with birthdates after September 1999, who were enrolled in March 2016 and were disenrolled by the end of February 2017

7.a. From the population in #7, provide the total number of children, who were enrolled in title XXI in the month after their disenrollment from title XIX.

8. The total number of children who were continuously enrolled in title XIX for 18 months is defined as the sum of:
   the number of children with birthdates after July 1999,who were newly enrolled in January 2016 and were continuously enrolled through the end of June 2017
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and were continuously enrolled through the end of July 2017
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and were continuously enrolled through the end of August 2017

9. The total number of children who had a break in title XIX coverage during 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 18 months, is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and who disenrolled and re-enrolled in title XIX by the end of June 2017
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and who disenrolled and re-enrolled in title XIX by the end of July 2017
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and who disenrolled and re-enrolled in title XIX by the end of August 2017

9.a. From the population in #9, provide the total number of children who were enrolled in title XXI during their break in coverage.

10. The total number of children who were disenrolled from title XIX 18 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and disenrolled by the end of June 2017
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and disenrolled by the end of July 2017
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and disenrolled by the end of August 2017

10.a. From the population in #10, provide the total number of children who were enrolled in title XXI (CHIP) in the month after their disenrollment from XIX.

Table 3b. Duration Measure of Children Enrolled in Title XXI

Specify how your "newly enrolled" population is defined:

☐**Not Previously Enrolled in CHIP or Medicaid—"**Newly enrolled" is defined as not enrolled in either title XXI or title XIX in the month before enrollment (i.e., for a child enrolled in January 2016, he/she would not be enrolled in either title XXI or title XIX in December 2015, etc.)

☐**Not Previously Enrolled in CHIP**—"Newly enrolled" is defined as not enrolled in title XXI in the month before enrollment (i.e., for a child enrolled in January 2016, he/she would not be enrolled in title XXI in December 2015, etc.)

Duration Measure, Title XXI	**All Children Ages 0-16**		**Age Less than 12 months**		**Ages 1-5**		**Ages 6-12**		**Ages 13-16**	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
1. **Total number of children newly enrolled in title XXI in the second quarter of FFY 2016**		100%		100%		100%		100%		100%
Enrollment Status 6 months later										
2. Total number of children continuously enrolled in title XXI										
3. Total number of children with a break in title XXI coverage but re-enrolled in title XXI										
3.a. Total number of children enrolled in Medicaid (title XXI) during title XXI coverage break (If unable to										

	provide the data, check here ☐)										
4.	Total number of children disenrolled from title XXI										
	4.a. Total number of children enrolled in Medicaid (title XXI) after being disenrolled from title XXI (If unable to provide the data, check here ☐)										
Enrollment Status 12 months later											
5.	Total number of children continuously enrolled in title XXI										
6.	Total number of children with a break in title XIX coverage but re-enrolled in title XXI										
	6.a. Total number of children enrolled in Medicaid (title XXI) during title XXI coverage break (If unable to provide the data, check										

	here ☐)										
7.	Total number of children disenrolled from title XXI										
	7.a. Total number of children enrolled in Medicaid (title XXI) after being disenrolled from title XXI (If unable to provide the data, check here ☐)										
Enrollment Status 18 months later											
8.	Total number of children continuously enrolled in title XXI										
9.	Total number of children with a break in title XXI coverage but re-enrolled in title XXI										
	9.a. Total number of children enrolled in Medicaid (title XXI) during title XXI coverage break (If unable to provide the data, check here ☐)										
10.	Total number of children disenrolled										

from title XXI										
10.aTotal number of children enrolled in Medicaid (title XXI) after being disenrolled from title XXI (If unable to provide the data, check here ☐)										

Definitions:

1. The "total number of children newly enrolled in title XXI in the second quarter of FFY 2016" is defined as those children either new to public coverage or new to title XXI, in the month before enrollment. Please define your population of "newly enrolled" in the Instructions section.

2. The total number of children that were continuously enrolled in title XXI for 6 months is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and who were continuously enrolled through the end of June 2016
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and who were continuously enrolled through the end of July 2016
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and who were continuously enrolled through the end of August 2016

3. The total number who had a break in title XXI coverage during 6 months of enrollment (regardless of the number of breaks in coverage) but were re-enrolled in title XXI by the end of the 6 months, is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and who disenrolled and re-enrolled in title XXI by the end of June 2016
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and who disenrolled and re-enrolled in title XXI by the end of July 2016
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and who disenrolled and re-enrolled in title XXI by the end of August 2016

   3.a. From the population in #3, provide the total number of children who were enrolled in title XIX during their break in coverage.

4. The total number who disenrolled from title XXI, 6 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and were disenrolled by the end of June 2016
   + the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and were disenrolled by the end of July 2016
   + the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and were disenrolled by the end of August 2016

   4.a. From the population in #4, provide the total number of children who were enrolled in title XIX in the month after their disenrollment from title XXI.

5. The total number of children who were continuously enrolled in title XXI for 12 months is defined as the sum of:

the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and were continuously enrolled through the end of December 2016
+ the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and were continuously enrolled through the end of January 2017
+ the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and were continuously enrolled through the end of February 2017

6. The total number of children who had a break in title XXI coverage during 12 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XXI by the end of the 12 months, is defined as the sum of:
the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and who disenrolled and then re-enrolled in title XXI by the end of December 2016
+ the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and who disenrolled and then re-enrolled in title XXI by the end of January 2017
+ the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and who disenrolled and then re-enrolled in title XXI by the end of February 2017

6.a. From the population in #6, provide the total number of children who were enrolled in title XIX during their break in coverage.

7. The total number of children who disenrolled from title XXI 12 months after their enrollment month is defined as the sum of:
the number of children with birthdates after July 1999, who were enrolled in January 2016 and were disenrolled by the end of December 2016
+ the number of children with birthdates after August 1999, who were enrolled in February 2016 and were disenrolled by the end of January 2017
+ the number of children with birthdates after September 1999, who were enrolled in March 2016 and were disenrolled by the end of February 2017

7.a. From the population in #7, provide the total number of children, who were enrolled in title XIX in the month after their disenrollment from title XXI.

8. The total number of children who were continuously enrolled in title XXI for 18 months is defined as the sum of:
the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and were continuously enrolled through the end of June 2017
+ the number of children with birthdates after August 1999, who were newly enrolled in February 2016 were continuously enrolled through the end of July 2017
+ the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and were continuously enrolled through the end of August 2017

9. The total number of children who had a break in title XXI coverage during 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XXI by the end of the 18 months, is defined as the sum of:
the number of children with birthdates after July 1999 , who were newly enrolled in January 2016 and who disenrolled and re-enrolled in title XXI by the end of June 2017
+ the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and who disenrolled and re-enrolled in title XXI by the end of July 2017
+ the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and who disenrolled and re-enrolled in title XXI by the end of August 2017

9.a. From the population in #9, provide the total number of children who were enrolled in title XIX during their break in coverage.

10. The total number of children who were disenrolled from title XXI 18 months after their enrollment month is defined as the sum of:
the number of children with birthdates after July 1999, who were newly enrolled in January 2016 and disenrolled by the end of June 2017
+ the number of children with birthdates after August 1999, who were newly enrolled in February 2016 and disenrolled by the end of July 2017
+ the number of children with birthdates after September 1999, who were newly enrolled in March 2016 and disenrolled by the end of August 2017

10.a. From the population in #10, provide the total number of children who were enrolled in title XIX (Medicaid) in the month after their disenrollment from XXI.

Enter any Narrative text related to section IIIC below. **[7500]**

D. COST SHARING

1. Describe how the state tracks cost sharing to ensure enrollees do not pay more than 5 percent aggregate maximum in the year?

    a. Cost sharing is tracked by:

    ☒ Enrollees (shoebox method)
    If the state uses the shoebox method, please describe informational tools provided to enrollees to track cost sharing. **[7500]**

    ☐ Health Plan(s)
    ☐ State
    ☐ Third Party Administrator
    ☐ N/A (No cost sharing required)
    ☐ Other, please explain. **[7500]**

2. When the family reaches the 5% cap, are premiums, copayments and other cost sharing ceased?
☒ Yes ☐ No

3. Please describe how providers are notified that no cost sharing should be charged to enrollees exceeding the 5% cap. **[7500]**

    Massachusetts' eligibility verification system (EVS) enables providers to recognize no cost sharing is applicable for member via restrictive messaging that displays upon verification of eligibility.

4. Please provide an estimate of the number of children that exceeded the 5 percent cap in the state's CHIP program during the federal fiscal year. **[500]**

5. Has your state undertaken any assessment of the effects of premiums/enrollment fees on participation in CHIP?
☐ Yes
☒ No

    If so, what have you found? **[7500]**

6. Has your state undertaken any assessment of the effects of cost sharing on utilization of health services in CHIP?
☐ Yes
☒ No

    If so, what have you found? **[7500]**

7. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of children's health services in CHIP. If so, what have you found? **[7500]**

Enter any Narrative text related to section IIID below. **[7500]**

E. EMPLOYER SPONSORED INSURANCE PROGRAM (INCLUDING PREMIUM ASSISTANCE PROGRAM(S)) UNDER THE CHIP STATE PLAN OR A SECTION 1115 TITLE XXI DEMONSTRATION

1. Does your state offer an employer sponsored insurance program (including a premium assistance program) for children and/or adults using Title XXI funds?

   ☒ Yes, please answer questions below.
   ☐ No, skip to Program Integrity subsection.

Children

☒ Yes, Check all that apply and complete each question for each authority.

☐ Purchase of Family Coverage under the CHIP state plan (2105(c)(3))
☒ Additional Premium Assistance Option under CHIP state plan (2105(c)(10))
☐ Section 1115 demonstration (Title XXI)
☐ Premium Assistance Option (applicable to Medicaid expansion) children (1906)
☐ Premium Assistance Option (applicable to Medicaid expansion) children (1906A)

Adults

☒ Yes, Check all that apply and complete each question for each authority.

☒ Purchase of Family Coverage under the CHIP state plan (2105(c)(10))
☐ Section 1115 demonstration (Title XXI)
☐ Premium Assistance option under the Medicaid state plan (1906)
☐ Premium Assistance option under the Medicaid state plan (1906A)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

☒ Parents and Caretaker Relatives
☐ Pregnant Women

3. Briefly describe how your program operates (e.g., is your program an employer sponsored insurance program or a premium assistance program, how do you coordinate assistance between the state and/or employer, who receives the subsidy if a subsidy is provided, etc.) **[7500]**

Premium Assistance maximizes private insurance by providing premium assistance if an uninsured child has access to coverage through employer-based insurance, and only offering direct coverage through MassHealth if there is no other access to health insurance. For all applicants, the Commonwealth performs a health insurance investigation, accessing a comprehensive database. Contact is made with all employed members of the household and their employers to determine if employer-sponsored insurance (ESI) is available that meets the basic benefit level, is cost effective and meets an employer contribution level of 50%. If MassHealth-qualifying ESI is available, applicants may receive premium assistance, but may not receive direct coverage. MassHealth does not allow the family to opt out of ESI in order to obtain direct public coverage. This process controls crowd-out by maximizing the state's opportunity to identify applicants with access to ESI and require enrollment.

Once access to ESI is confirmed, children's parents must enroll them in premium assistance or the child's MassHealth will be terminated. Children must be uninsured at the time of application to be eligible for CHIP funding. If they are insured at the time of application they will be eligible for Title XIX under our 1115 waiver.

MassHealth monitors health insurance status of potential members both at the time of application and monthly so that only uninsured children are covered in CHIP. Insurance status is verified through national insurance databases that identify coverage from any source, including noncustodial parents.

MassHealth contracts with Health Management Systems (HMS) which conducts a monthly state and national data match using a system called "Match MAX" which Identifies health Insurance for all potential members.
MassHealth also has a dedicated process to match with a file from the Department of Revenue (DOR) to identify noncustodial parents of applicants and recipients who have court orders for medical support. This process allows us to not only verify existing coverage, but also to enforce the obligation of non-custodial parents by contacting their employers to arrange enrollment of the parent in an employer-sponsored family plan to cover their children.

4. What benefit package does the ESI program use? **[7500]**

Secretary approved per the State Plan amendment approved in March 2002

5. Are there any minimum coverage requirements for the benefit package?

☒ Yes
☐ No

6. Does the program provide wrap-around coverage for benefits?

☒ Yes
☐ No

7. Are there any limits on cost sharing for children in your ESI program?

☒ Yes
☐ No

8. Are there any limits on cost sharing for adults in your ESI program?

☐ Yes
☒ No

9. Are there protections on cost sharing for children (e.g., the 5 percent out-of-pocket maximum) in your premium assistance program?

☒ Yes ☐ No

If yes, how is the cost sharing tracked to ensure it remains within the 5 percent yearly aggregate maximum [7500]? Parents of eligible children are notified of the family out of pocket maximum (calculated using 5 percent of the family income less anticipated required member contribution towards ESI plan). Parents submit receipts for cost incurred and once 5 percent cap amount is met, children receive MassHealth wrap benefits for remainder of family cap year.

10. Identify the total number of children and adults enrolled in the ESI program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in this program even if they were covered incidentally, i.e., not explicitly covered through a demonstration).

_____ Number of childless adults ever-enrolled during the reporting period

_____ Number of adults ever-enrolled during the reporting period

3217 Number of children ever-enrolled during the reporting period

11. Provide the average monthly enrollment of children and parents ever enrolled in the premium assistance program during FFY 2016

Children 13902

Parents _____

12. During the reporting period, what has been the greatest challenge your ESI program has experienced? **[7500]**

The greatest challenge for the ESI program has been and continues to be the maintenance of household information relating to employment, health insurance plan benefits meeting the qualifying standards for coverage (ESI plans are steadily increasing deductibles and out of pocket maximums, health Insurance premiums are increasing, more employers are offering High Deductible Health Plans with Health Savings Accounts).

13. During the reporting period, what accomplishments have been achieved in your ESI program? **[7500]**

The Premium Assistance Unit continues to make enhancements in order to streamline the current process of investigating referrals for access to ESI. This includes targeted approaches to analyzing and working referral files and enhancing relationships with employers to get more timely and accurate updated information. Through the use of monthly scheduled online health insurance verifications, The Premium Assistance Unit has implemented a process during the last reporting period to run the entire active ESI population through a verification process in order to validate that the insurance Premium Assistance is reimbursing for is active prior to the payment file processing. This has helped to reduce occurances of premium reimbursement for inactive insurance plans.

14. What changes have you made or are planning to make in your ESI program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

The goal of the Premium Assistance program is to significantly increase enrollment into the program by use of streamlined investigation processes, system enhancements to better identify members with potential access to ESI, improved program applications/member communication and increased outreach to members. The changes are being implemented as cost avoidance/cost savings measures.

15. What do you estimate is the impact of your ESI program (including premium assistance) on enrollment and retention of children? How was this measured? **[7500]**

There are several factors that MassHealth looks at when measuring the impact of the ESI program on retention of children. The Premium assistance program allows MassHealth to enroll more members into the program because of the cost savings incurred by helping Medicaid eligible members enroll into private health insurance. Because MassHealth helps purchase family plans household members that are not Medicaid eligible are also covered. Enrolling families in ESI and private insurance is critical to retention of children in the program. MassHealth analyzes how many policies are purchased in order to determine cost avoidance and cost savings.

16. Provide the average amount each entity pays towards coverage of the dependent child/parent under your ESI program:

Children		Parent	
State:	314	State:	150
Employer:	50	Employer:	50
Employee:	50	Employee:	50

17. Indicate the range in the average monthly dollar amount of premium assistance provided by the state on behalf of a child or parent.

Children	Low	0	High	2942
Parents	Low		High	

18. If you offer a premium assistance program, what, if any, is the minimum employer contribution? **[500]**

Employers must contribute at least 50% toward the cost of the health insurance.

19. Please provide the income levels of the children or families provided premium assistance.

	From	To
Income level of Children:	% of FPL[5]	% of FPL[5]
Income level of Parents:	% of FPL[5]	% of FPL[5]

20. Is there a required period of uninsurance before enrolling in premium assistance? **[500]**

☐ Yes
☒ No

If yes, what is the period of uninsurance? **[500]**

21. Do you have a waiting list for your program?

☐ Yes
☒ No

22. Can you cap enrollment for your program?

☒ Yes
☐ No

23. What strategies has the state found to be effective in reducing administrative barriers to the provision of premium assistance in ESI? **[7500]** Since Premium Assistance investigates the employers,the employer database that was created for the program is heavily dependent upon in facilitating the process. The process allows MassHealth to gather all of the ESI information that an employer offers including:health insurance plans the employer offers,premiums and tiers,annual open enrollment rates,summary of benefits for each health insurance offered. This process streamlines the determination when other members are being reviewed and are employed by the same employer. The database is updated annually, during the open enrollment periods.

Enter any Narrative text related to Section IIIE below. **[7500]**

For questions #10 & #11 data currently not available for adults/parents during the reporting period.

Response to #19:
Under 1 year: 185 % of FPL to 200% of FPL
1-5 years: 133 % of FPL to 150% of FPL
6-17 years: 114% of FPL to 150 % of FPL
18 years: 0% of FPL to 150 % of FPL

F. PROGRAM INTEGRITY (COMPLETE ONLY WITH REGARD TO SEPARATE CHIP PROGRAMS (I.E. THOSE THAT ARE NOT MEDICAID EXPANSIONS)

1. Does your state have a written plan that has safeguards and establishes methods and procedures for:

(1) prevention: ☒ Yes ☐ No

(2) investigation: ☒ Yes ☐ No

(3) referral of cases of fraud and abuse? ☒ Yes ☐ No

Please explain: **[7500]**

It is important to point out that in Massachusetts Medicaid and CHIP are managed and operated seamlessly as one program known as the MassHealth program. Therefore, while there are no separate fraud and abuse activities for CHIP, all methods and procedures employed by the Commonwealth to detect, investigate, and refer cases of fraud and abuse in the Medicaid program are brought to bear on CHIP. In Massachusetts, state staff performs all application, redetermination, matching, case maintenance, and referral processes for all MassHealth programs, including CHIP. All contractual arrangements regarding fraud and abuse activities apply to CHIP as well as Medicaid.

MassHealth emphasizes aggressive management of its front-end program processes to ensure that services provided are medically necessary, provided by qualified health care providers, provided to eligible residents of the Commonwealth, and that payments are appropriately made. Ongoing efforts to combat fraud, waste, and abuse, including utilization management and regular program and clinical review, are central to all program areas. Sophisticated information systems support MassHealth's efforts to detect inappropriate billings before payment is made, and to ensure that eligibility determinations are accurate.

MassHealth implemented a pre-payment predictive modeling solution in June 2013. The predictive modeling tool uses sophisticated algorithms to analyze claims, builds provider profiles of suspicious billing patterns and assigns risk scores to potentially inappropriate claims.

Equally important are mechanisms for detailed reporting and review of claims after bills are paid to identify inappropriate provider behavior, and methods to ensure that MassHealth identifies members whose changed circumstances may affect their continuing eligibility. As with our front-end processes, information systems are a critical component of MassHealth’s work to identify and address inappropriate payments.

Post-payment activities are an important “second look” and are particularly important to the identification of prosecutable fraud. And when our systems identify potential fraud, MassHealth acts aggressively to pursue the case with the appropriate authorities.

MassHealth has the following documentation regarding established methods and procedures for prevention, investigation, and referral of cases of fraud and abuse:
1) MassHealth Program Integrity Activities Inventory
2) Efforts to Prevent and Identify Fraud, Waste, and Abuse—description and identification of responsible units
3) Provider Compliance activity sheet
4) Utilization Management plan
5) Memorandum of Understanding between the Executive Office of Health and Human Services (EOHHS) and the Office of the Attorney General, Massachusetts Medicaid Fraud Control Unit
6) Interdepartmental Service Agreement between EOHHS and the Department of Revenue (DOR)
7) MassHealth Eligibility Operations Memo 04-04 re: New Member Fraud Referral Process
8) MassHealth Eligibility Operations Memo 01-7 re: Department of Revenue “New Hire” Match
9) MassHealth Eligibility Operations Memo 99-14 re: Annual Eligibility Review Process for Health Care Reform Members on MA-21
10) Contract between EOHHS and MedStat Group to perform Program Integrity gap analysis—deliverables dated June 30, 2005.
11) Eligibility Verification System (EVS)codes—online system for providers to verify MassHealth eligibility at point of service
12) Managed care contract language specifying program integrity and fraud and abuse prevention, detection, and reporting requirements for health plans contracting with MassHealth,

including the requirement to have a compliance plan, designed to guard against fraud and abuse.

Do managed health care plans with which your program contracts have written plans?

☐ Yes

☐ No

Please Explain: **[500]**

2. For the reporting period, please report the

1191 Number of fair hearing appeals of eligibility denials

31 Number of cases found in favor of beneficiary

3. For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

a. Provider Credentialing

45 Number of cases investigated

0 Number of cases referred to appropriate law enforcement officials

b. Provider Billing

64 Number of cases investigated

15 Number of cases referred to appropriate law enforcement officials

c. Beneficiary Eligibility

448 Number of cases investigated

277 Number of cases referred to appropriate law enforcement officials

Are these cases for:

CHIP ☐

Medicaid and CHIP Combined ☒

4. Does your state rely on contractors to perform the above functions?

☒ Yes, please answer question below.

☐ No

5. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors? Please explain : **[7500]**
The Provider Compliance Unit, operated within the University of Massachusetts Medical School (UMMS), and managed by the EOHHS Compliance Office, is our primary post-payment fraud detection unit. Utilizing algorithims and reports found in our data warehouse, and through data analysis, the Provider Compliance Unit reviews paid claims data to detect aberrant trends and outlier

billing patterns that can indicate potential fraud. The Provider Compliance Unit, which works closely with Medicaid Fraud Control Unit and our legal staff, meets our federal regulatory obligation to establish a surveillance utilization control system to safeguard against fraudulent, abusive, and inappropriate use of the Medicaid program.

Additionally, EOHHS's Compliance Office works across units engaged in program integrity to coordinate activities, establish unit specific internal control plans and risk assessments, manage external audit activity, coordinate the CMS Payment Error Rate Measurement (PERM), and establish and monitor compliance with information privacy and security requirements.

Our MMIS system processes provider claims and contains a significant number of sophisticated edits, rules, and other program integrity checks and balances. As a result, approximately 22% of all claims submitted are denied and 1% are suspended for review or verification. The MMIS has been designed with enhanced Program Integrity capabilities, including expanded functionality to add claims edits as needed in order to keep abreast with the latest trends in aberrant or fraudulent claims submissions. Generally, information systems support to MassHealth remains a significant priority of the Executive Office of Health and Human Services, in large part because of the potential of leveraging technology to combat fraud, waste, and abuse in the Medicaid program. The EOHHS Data Warehouse, for example, is a consolidated repository of claims and eligibility data that provides program and financial managers with the ability to develop standard and ad-hoc management reports.

The Claims Operations Unit manages our claims processing contractor and monitors claims activity weekly. The EOHHS Office of Financial Management organizes a weekly Cash Management Team made up of budget, program, and operations staff that closely monitors the weekly provider claims payroll and compares year-to-date cash spending with budgeted spending by both provider type and budget category. The prior authorization unit ensures that certain services are medically necessary before approving the service. Even more sophisticated measures are in place for the pharmacy program. The Drug Utilization Review program at UMMS monitors and audits pharmacy claims and is designed to prevent early refills, therapeutic duplication, ingredient duplication, and problematic drug-drug interaction. In February 2004, our Managed Care Program instituted required reporting on fraud and abuse protections for all of MassHealth’s managed care organizations.

Finally, the MassHealth Operations unit provides close oversight of a contract for customer services to MassHealth members and providers. MassHealth currently employs a single vendor for customer services, responsible for both provider relations and member relations. The integration of these vendor services brings with it many new opportunities in the program integrity area. Our customer services contractor verifies the credentials of all providers applying to participate in our program as well as re-credentialing existing providers and will work closely with the Board of Registration in Medicine, the Division of Professional Licensing, the Department of Public Health, the US Department of Health and Human Services, and the Office of the Inspector General to identify disciplinary actions against enrolled providers.

6. Do you contract with managed care health plans and/or a third party contractor to provide this oversight?

☒ Yes

☐ No

Please explain: **[500]**

The relationship with UMMS as described above is governed by an interagency service agreement (ISA) between the medical school and EOHHS

Enter any Narrative text related to section IIIF below. **[7500]**

G. DENTAL BENEFITS – Please ONLY report data in this section for children in Separate CHIP programs and the Separate CHIP part of Combination programs. Reporting is required for all states with Separate CHIP programs and Combination programs.

If your state has a Combination program or a Separate CHIP program but you are not reporting data in this section on children in the Separate CHIP part of your program, please explain why.

Explain: [7500]

1. Information on Dental Care Children in Separate CHIP Programs (including children in the Separate CHIP part of Combination programs). Include all delivery system types, e.g., MCO, PCCM, FFS.

Data for this table are based on the definitions provided on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

a. Annual Dental Participation Table for Children Enrolled in Separate CHIP programs and the Separate CHIP part of Combination programs (for Separate CHIP programs, please include ONLY children receiving full CHIP benefits and supplemental benefits).

State: MA **FFY:** 2016	**Age Group**						
	Total	**< 1**	**1-2***	**3-5**	**6-9**	**10-14**	**15-18**
Total individuals enrolled for at least 90 continuous days[1]	192205	766	13286	23590	44101	54937	55525
Total Enrollees Receiving Any Dental Services[2] [7]	93182	6	2623	10178	24791	30680	24904
Total Enrollees Receiving Preventive Dental Services[3]	83952	0	2385	9696	23537	27567	20767
Total Enrollees Receiving Dental Treatment	47993	5	298	2717	11812	17743	15418

Services[4]							

[1] **Total Individuals Enrolled for at Least 90 Continuous Days** – Enter the total unduplicated number of children who have been continuously enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days in the Federal fiscal year, distributed by age. For example, if a child was enrolled January 1st to March 31st, this child is considered continuously enrolled for at least 90 continuous days in the Federal fiscal year. If a child was enrolled from August 1st to September 30th and from October 1st to November 30th, the child would not be considered to have been enrolled for 90 continuous days in the federal fiscal year. Children should be counted in age groupings based on their age at the end of the fiscal year. For example, if a child turned 3 on September 15th, the child should be counted in the 3-6 age grouping.

[2]**Total Eligibles Receiving Any Dental Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999 or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

[3]**Total Eligibles Receiving Preventive Dental Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

[4]**Total Eligibles Receiving Dental Treatment Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (or equivalent CDT codes D2000 - D9999 or equivalent CPT codes, that is, only those CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services, and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

Report all dental services data in the age category reflecting the child's age at the end of the federal fiscal year even if the child received services while in two age categories. For example, if a child turned 10 on September 1st, but had a cleaning in April and a cavity filled in September, both the cleaning and the filling would be counted in the 10-14 age category.

b. For the age grouping that includes children 8 years of age, what is the number of such children who have received a sealant on at least one permanent molar tooth[5]? [7]

7431

[5]**Receiving a Sealant on a Permanent Molar Tooth --** Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for 90 continuous days and in the age category of 6-9 who received a sealant on a permanent molar tooth, as defined by HCPCS code D1351 (or equivalent CDT code D1351), based on an unduplicated paid, unpaid, or denied claim. For this line, include sealants placed by any dental professional for whom placing a sealant is within his or her scope of practice. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, 31, and additionally, for those states that cover sealants on third molars, also known as wisdom teeth, the teeth numbered 1, 16, 17, 32.

Report all sealant data in the age category reflecting the child's age at the end of the Federal fiscal year even if the child was factually a different age on the date of service. For example,

if a child turned 6 on September 1st, but had a sealant applied in July, the sealant would be counted in the age 6-9 category.

2. Does the state provide supplemental dental coverage? ☐ Yes ☒ No

If yes, how many children are enrolled? [7]

What percent of the total number of enrolled children have supplemental dental coverage? [5]

Enter any Narrative text related to section IIIG below. **[7500]**

H. CHIPRA CAHPS REQUIREMENT

CHIPRA section 402(a)(2), which amends reporting requirements in section 2108 of the Social Security Act, requires Title XXI Programs (i.e., CHIP Medicaid expansion programs, separate child health programs, or a combination of the two) to report CAHPS results to CMS starting December 2013. While Title XXI Programs may select any CAHPS survey to fulfill this requirement, CMS encourages these programs to align with the CAHPS measure in the Children's Core Set of Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Starting in 2013, Title XXI Programs should submit summary level information from the CAHPS survey to CMS via the CARTS attachment facility. We also encourage states to submit raw data to the Agency for Healthcare Research and Quality's CAHPS Database. More information is available in the Technical Assistance fact sheet, Collecting and Reporting the CAHPS Survey as Required Under the CHIPRA: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSFactSheet.pdf.

If a state would like to provide CAHPS data on both Medicaid and CHIP enrollees, the agency must sample Title XIX (Medicaid) and Title XXI (CHIP) programs separately and submit separate results to CMS to fulfill the CHIPRA Requirement.

Did you Collect this Survey in Order to Meet the CHIPRA CAHPS Requirement? ☐Yes ☒No

If Yes, How Did you Report this Survey (select all that apply):
☐ Submitted raw data to AHRQ (CAHPS Database)
☐ Submitted a summary report to CMS using the CARTS attachment facility (NOTE: do not submit raw CAHPS data to CMS)
☐ Other. Explain:

If No, Explain Why:
Select all that apply (Must select at least one):

☐ Service not covered

☐ Population not covered

- ☐ Entire population not covered
- ☐ Partial population not covered
  Explain the partial population not covered:

☒ Data not available

Explain why data not available
- ☒ Budget constraints
- ☒ Staff constraints
- ☐ Data inconsistencies/accuracy

Please explain:

☐ Data source not easily accessible

Select all that apply:

☐ Requires medical record review
☐ Requires data linkage which does not currently exist
☐ Other:

☐ Information not collected.

Select all that apply:

☐ Not collected by provider (hospital/health plan)
☐ Other:

☐ Other:

☐ Small sample size (less than 30).

Enter specific sample size:

☐ Other. *Explain:*

Definition of Population Included in the Survey Sample:

Definition of Population Included in the Survey Sample:

☐ Denominator includes CHIP (Title XXI) population only.

☐ Survey sample includes CHIP Medicaid Expansion population.
☐ Survey sample includes Separate CHIP population.
☐ Survey sample includes Combination CHIP population.

If the denominator is a subset of the definition selected above, please further define the denominator, and indicate the number of children excluded:

Which Version of the CAHPS® Survey was Used?

☐ CAHPS® 5.0
☐ CAHPS® 5.0H
☐ Other.

Explain:

Which Supplemental Item Sets were Included in the Survey?

☐ No supplemental item sets were included
☐ CAHPS Item Set for Children with Chronic Conditions
☐ Other CAHPS Item Set. Explain:

Which Administrative Protocol was Used to Administer the Survey?

☐ NCQA HEDIS CAHPS 5.0H administrative protocol
☐ AHRQ CAHPS administrative protocol
☐ Other administrative protocol. Explain:

Enter any Narrative text related to section IIIH below. **[7500]**

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2015. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED CHIP PLAN

Benefit Costs	**2016**	**2017**	**2018**
Insurance payments	4620031	5252739	5972097
Managed Care	355847921	357904768	408503270
Fee for Service	265979230	357105886	407591447
Total Benefit Costs	626447182	720263393	822066814
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	$ 626447182	$ 720263393	$ 822066814

Administration Costs			
Personnel			
General Administration	16607017	16607017	16607017
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other (e.g., indirect costs)			
Health Services Initiatives	52998316	52998316	52998316
Total Administration Costs	69605333	69605333	69605333
10% Administrative Cap (net benefit costs ÷ 9)	69605242	80029266	91340757

Federal Title XXI Share	612526213	695084479	784671489
State Share	83526302	94784247	107000658

TOTAL COSTS OF APPROVED CHIP PLAN	696052515	789868726	891672147

2. What were the sources of non-federal funding used for state match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement
- ☐ Other (specify) **[500]**

3. Did you experience a short fall in CHIP funds this year? If so, what is your analysis for why there were not enough federal CHIP funds for your program? **[1500]**

No

4. In the table below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month (PMPM) cost rounded to a whole number. If you have CHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2016		2017		2018	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care	89064	$ 339	93717	$ 368	98613	$ 399
Fee for Service	96514	$ 309	101556	$ 335	106862	$ 363

Enter any Narrative text related to Section IV below. **[7500]**

SECTION V: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted CHIP. **[7500]**

   Massachusetts remains committed to providing access to health insurance to all of its residents. The major elements of the Affordable Care Act were modeled after our state health reforms of 2006 and the implementation of the ACA in the state built on and enhanced our state reform efforts. The state has maintained its highest in the nation insurance rate, measured at 97.2% total and at 98.9% for children in 2015 and there is strong political and fiscal support to maintain or even improve these rates.

2. During the reporting period, what has been the greatest challenge your program has experienced? **[7500]**

   We have had continued challenges with our online, integrated eligibility system but continue to make system and process improvements. State budget revenues have been lower than expectations.

3. During the reporting period, what accomplishments have been achieved in your program? **[7500]**

   We received CMS approval to add applied behavior analysis as a service available to CHIP members.

4. What changes have you made or are planning to make in your CHIP program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

   Massachusetts is embarking on a major payment and delivery system reform that seeks to enhance the health care experience for MassHealth members, improve health outcomes, and make the MassHealth program more sustainable for the future. The reforms, which include transition from fee for service, siloed care toward managed and accountable care models, will impact both Medicaid and CHIP members

   Although our performance on the child core set quality measures is high, we are also looking at ways to improve performance on selected child core set quality measures.

Enter any Narrative text related to Section V below. **[7500]**