MassHealth 2022

Comprehensive Quality Strategy

Commonwealth of Massachusetts

Executive Office of Health and Human Services

Office of Medicaid

Submitted to CMS for comment and feedback on June 2, 2022
Revision of previous version published November 2018

Table of Contents

Introduction

Executive Summary

The Commonwealth of Massachusetts, Executive Office of Health and Human Services Office of Medicaid is pleased to submit an updated **Comprehensive Quality Strategy (CQS)** for assessing and improving the quality of care for its members. MassHealth's mission is to improve the health outcomes of its members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life. MassHealth administers a program combining Massachusetts Medicaid and the Children's Health Insurance Programs (CHIP) that provides health care coverage for over two million residents in Massachusetts and serves as a national model for health care reform.

Several key initiatives and continued activities resulted in significant updates to the CQS that build upon MassHealth's foundational goals and objectives for better care, better health, and lower costs for 2022 and beyond.

MassHealth Initiatives Influencing and Influenced by the 2022 Comprehensive Quality Strategy

Several major and concurrent MassHealth initiatives are influencing and being influenced by the updated MassHealth Comprehensive Quality Strategy.

Since 1997, the **MassHealth 1115 Demonstration** has been a critical initiative that has enabled Massachusetts to achieve and maintain near-universal coverage, sustain the Commonwealth's safety net, expand critical behavioral health services, and implement reforms in the way that care is delivered. With the current 1115 Demonstration, MassHealth leveraged the Delivery System Reform Incentive Program (DSRIP) to establish Accountable Care Organizations (ACOs). The ACO program is advancing accountability for the cost, quality, and experience of care for ACO members, representing over 80% of the eligible MassHealth managed care population.

The state has submitted **a request to renew the current 1115 Demonstration** for the next five years, starting in 2022, focused on the following goals:

- Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model
- Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care
- Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals
- Sustainably support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care
- Maintain near-universal coverage including updates to eligibility policies to support coverage and equity

To achieve the **demonstration goal of advancing health equity,** MassHealth is pursuing strategies to reduce disparities in health and health care quality. The CQS reflects the critical role of MassHealth quality programs in monitoring and incentivizing high quality and equitable care for all MassHealth members, including by:

- Developing infrastructure, training, and activities, both internally and externally, with stakeholders to enhance culturally-sensitive collection of robust, member-level social risk factor data including race, ethnicity, language, disability, sexual orientation, and gender identity
- Ongoing reporting of quality measures stratified by social risk factors to identify clear opportunities and goals to reduce disparities
- Implementing plan performance improvement projects (PIPs) with required health equity components
- Implementing performance and improvement incentives toward reducing disparities in quality of care

EOHHS released its **five-year Roadmap for Behavioral Health Reform (BH Roadmap)** in 2021, charting a path to expand equitable access to behavioral health services. Key components include:

- Ensuring coverage of behavioral health integration in primary care and for preventive behavioral health services for youth
- Better and more convenient community-based alternatives to the emergency department (ED) for urgent and crisis intervention services, including the launch of Community Behavioral Health Centers that will provide access to urgent, and ongoing behavioral health treatment and will provide community and mobile crisis intervention services
- Establishing a 24/7 Behavioral Health Help Line to serve all individuals in the Commonwealth seeking clinical screening and intake, information, resources, and referrals to substance use disorder or mental health treatment services regardless of their insurance coverage

The state's **Integrated Care Programs** continue to make strides toward expanding access statewide and improving quality insights in delivery systems for dual eligible individuals. To bring more integrated, coordinated, and person-centered care options to members who are dually eligible for Medicaid and Medicare, MassHealth programs (e.g., Senior Care Organizations, PACE, One Care) are designed to coordinate and integrate Medicare and Medicaid services. Activities include:

- Inclusion of quality measures in the Program of All-Inclusive Care for the Elderly (PACE), to improve insights to support anticipated service expansion in additional PACE centers, housing, and alternative care facilities
- Launch of the Care Model Focus Initiative (CMFI), increasing focused on performance around key aspects of member experience, service delivery, and program accountability in One Care

Finally, the **COVID-19 Public Health Emergency (PHE)** required unprecedented responsiveness and flexibility on behalf of MassHealth to ensure continued delivery of high quality MassHealth services and network adequacy. Enrollment in MassHealth increased over 25% (or approximately 451,000 members) during the PHE period of March 30, 2020, through March 31, 2022. Health system partners rapidly pivoted from care-as-usual to new virtual care paradigms. Members delayed preventive and other necessary care. Among other vital priorities, MassHealth throughout the PHE has worked to:

- Maintain coverage protection for MassHealth members
- Rapidly expand telehealth coverage
- Stabilize and support providers
- Promote member access to needed care
- Promote access to COVID testing, vaccination, and therapeutics
- Implement performance improvement projects addressing access to and rates of vaccinations

Each of these and other PHE-related interventions introduced novel challenges for quality measurement and improvement, highlighting the need for the CQS to be flexible, adaptive, and responsive to addressing emerging priorities and demanding timely and innovative approaches to assessing and improving the quality and delivery of care for MassHealth members.

2022 Updates

The 2022 CQS has evolved from the initial 2006 managed care strategy and has been updated periodically, with the last update published in November 2018.

The current submission of the CQS includes updated quality goals and strategies to support advancing key initiatives including, but not limited to implementing and evaluating the current 1115 DSRIP Demonstration, requesting the extension of the 1115 Demonstration, implementing the behavioral health roadmap, updating integrated care activities, developing and implementing an ongoing health equity strategy, and responding to the public health emergency.

The following updated quality goals reflect an alignment and commitment to our national, agency, and population health priorities.

MassHealth Quality Goals 2022

1. **Promote better care:** Promote safe and high-quality care for MassHealth members
2. **Promote equitable care**: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience
3. **Make care more value-based**: Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care
4. **Promote person- and family- centered care:** Strengthen member and family-centered approaches to care and focus on engaging members in their health
5. **Improve care through better integration, communication, and coordination** across the care continuum and across care teams for our members

Other key updates include:

- Enhancements to the quality management structure identifying centralized department areas and functions with evolving roles and responsibilities for effective matrixed support, collaboration, and strategic multi-program alignment
- Standing forums and opportunities identified for multi-stakeholder and member-centered engagement to support strategic development, implementation, and monitoring of quality programs
- Continued annual review and confirmation of quality requirements and standards per the managed care rules
- Incorporation of updated guidance and adaption of templates provided by CMS in the “Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit” released in 2021.

2022 Quality Strategy Stakeholder Feedback and Areas for Consideration

Internal and external stakeholders have provided valuable input and feedback over the last year in the development of MassHealth quality programs that inform the CQS. Through various committees, forums and opportunities for comment, stakeholders have identified important areas for continued discussion and consideration in the advancement of person-centered, integrated care and quality outcomes for our members.

The quality strategy was posted for comment in May 2022. Comments, if received, are to be considered and incorporated into future updates of the CQS.

No comments regarding the CQS were received during the public comment period.

Section 1: Scope

Per 42 CFR 438.340(a) and 42 CFR 457.1240(e), CMS requires state Medicaid and CHIP agencies that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and certain primary care case management (PCCM) entities to develop and maintain a Medicaid and CHIP quality strategy to assess and improve the quality of health care and services provided by Managed Care Plans (MCPs).

MassHealth's quality strategy was first developed in 2006 to fulfill managed care quality requirements and improve the quality of managed care services. It has since been updated periodically and continues to detail and address the managed care requirements. While a managed care strategy is foundational to the overall strategy, the CQS more broadly guides improvement of the quality of services and continuum of care delivered to all MassHealth members including managed care and fee-for-service (FFS) populations. The CQS draws upon shared goals and strategies across programs, alignment in measurement and improvement priorities, as well as targeted performance objectives and activities developed to meet the needs of specific populations.

The CQS is a living document of evolving strategy and policies as well as a reflection of ongoing quality program development and implementation. As such, the CQS is available on the MassHealth website for public comment and feedback for consideration in future updates of the CQS.

The CQS includes the following sections:

Section 1: An outline of the scope of the CQS and contents of the sections of the document

Section 2: Background and overview of MassHealth programs, plans and services

Section 3: The quality management structure at MassHealth, stakeholder and member engagement structure and opportunities, and the process for developing, reviewing, and evaluating the CQS

Section 4: MassHealth's CQS which includes overarching priorities, quality goals, and objectives that are supported through quality program measurement, reporting, performance, and incentives

Section 5: Assessment and appropriateness of care reflected in contract management, data collection and monitoring, quality improvement, and external quality review

Section 6: State standards around access inclusive of availability and coverage of services, coordination and continuity of care, and monitoring and compliance

Section 7: Improvement and interventions, including intermediate sanctions

Section 8: Key initiatives impactful to the CQS

Section 9: Future opportunities as part of an evolving CQS

Appendices: Please refer to **Appendix A** for definitions of acronyms used throughout this document and other referenced appendices supporting the CQS. (e.g., participating plans, MassHealth quality goals and objectives, quality measures, baseline, and targets)

Section 2: MassHealth Background

2.1 Overview

MassHealth covers more than 2 million (approximately 30%) Massachusetts residents, including over 40% of children (720,000), and is critical to maintaining the Commonwealth's level of coverage at over 97%. Approximately 70% of MassHealth members are enrolled with managed care plans, with the remaining 30% in fee-for-service (FFS) plans.

MassHealth began enrolling adults and children in managed care in 1997 as part of a 1115 Demonstration approved in 1995 to expand Medicaid eligibility. This demonstration covered families and children up to 200% of the federal poverty level (FPL). That same year, the Massachusetts legislature passed Chapter 170 combining the Children's Health Insurance Program (CHIP) with Medicaid and expanded Medicaid coverage for children through the age of 18 from the previous level of 133% FPL to 150% FPL.

Beginning in 2018, MassHealth's leveraged its 1115 Demonstration to create the most significant delivery system reforms for MassHealth in over two decades. The 1115 Demonstration enabled the following:

- Restructuring the delivery system towards integrated, value-based, and accountable care
- Improving the integration of physical health, behavioral health, and long-term services and supports
- Addressing the opioid crisis through expanded access to a broad spectrum of recovery-oriented substance use disorder services.

These reforms established a nationally-leading model of Accountable Care Organizations (ACOs) – provider-led organizations that take accountability for improving quality of care while controlling costs. The model addresses member needs, incorporating Community Partners (CPs) and Flexible Services (a program wherein ACOs provide a set of housing and nutritional supports to certain members). MassHealth also expanded coverage of substance use disorder (SUD) services.

The current 1115 Demonstration is authorized through June 30, 2022. MassHealth has submitted a request for a demonstration extension that builds upon the ACO model. *Additional information on the request for extension may be found in Section 8 as part of strategic initiatives.*

MassHealth is also committed to providing the highest quality, integrated, coordinated care to individuals who are eligible for both MassHealth and Medicare. These dually eligible members have among the most complex care needs of the populations served by either Medicaid or Medicare. Members may be dually eligible because they have a disability, or they are over age 65 and low-income. Many dually eligible members utilize a broad range of health care services, including medical and behavioral health services, as well as long-term services and supports that sustain their ability to live independently in the community or are provided in a nursing facility.

Historically, most dual eligible members have received their care on a fee-for-service basis from both Medicare and Medicaid, navigating the health and long-term care systems to obtain needed services through two different payers. This legacy system presents significant challenges given the complex care needs of this population and creates the potential for members to not get all the care they need at the time they need it most.

2.2 MassHealth Managed Care Programs

Today, MassHealth operates the following managed care programs:[1]

Accountable Care Organization (ACO) Program: ACOs are a network of primary care providers who work in partnership with hospitals, specialists, LTSS providers, and state agencies to coordinate all of a member's care. ACOs focus on improving this coordination, better engaging members in their care, and integrating behavioral health care, medical care, long-term services and supports, and health-related social services. ACOs are accountable for the quality, member experience and cost of care for members. MassHealth has three ACO delivery models.

- **Accountable Care Partnership Plan (ACPP):** ACPPs are groups of primary care providers (PCPs) who work with just one managed care organization to create a full network of providers that includes PCPs, specialists, behavioral health providers, and hospitals.
- **Primary Care ACO (PCACO):** PCACOs are groups of primary care providers or PCPs forming an ACO responsible for members' care and the coordination of care. PCACOs work directly with MassHealth to provide primary care to members and to coordinate the full range of services available to them. PCACOs work with the MassHealth network of specialists and hospitals. PCACO members receive behavioral health services through the state's Managed Behavioral Health Vendor.

MCO-Administered ACO: A network of PCPs who contract with one or more MCOs to provide integrated and coordinated care for members. MCO-Administered ACOs are not presented as an enrollment option because members are enrolled with the MCO and attributed to the contracted ACO through the MCO they are enrolled with.

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

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

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

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

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

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

In accordance with the managed care rule, the Accountable Care Partnership Plan, MCO, One Care and SCO programs are considered MCOs, and for the purposes of this document, will be referred to as managed care entities (MCEs). Primary Care ACOs are considered primary care case management entities (PCCM entities). The PCC Plan is considered a PCCM. MassHealth's Managed Behavioral Health Vendor, which serves members enrolled in the PCC Plan and Primary Care ACOs, and certain other populations is a Prepaid Inpatient Health Plan (PIHP) and is also referred to as Managed BH Vendor in this document. MassHealth does not contract with any Prepaid Ambulatory Health Plans (PAHPs) as defined in 42 CFR 438.2. The CQS under 42 CFR 438.340 relates to (but is not limited to) MCEs, PIHPs, and to PCCM entities as described in 42 CFR 438.310(c)(2).

A complete list of MassHealth managed care plans is provided in **Appendix B.**

Table 1: Summary of Managed Care Plans (MCPs) in 2021

Plan Name	MCP Type	Managed Care Authority	Populations Served	Membership Dec 2021
Accountable Care Partnership Plan (ACPP)	MCE	1115	Managed care eligible Medicaid members under age 65.	681,739
Primary Care ACO (PCACO)	PCCM Entity	1115	Managed care eligible Medicaid members under age 65.	466,474
MCO Program (including MCO-Administered ACOs)	MCE	1115	Managed care eligible Medicaid members under age 65.	113,763
PCC Plan	PCCM	1115	Managed care eligible Medicaid members under age 65.	116,614
Managed Behavioral Health Vendor	PIHP	1115	Medicaid members under age 65 who are enrolled in the PCC Plan or a Primary Care ACO (PCACO); children in state custody not otherwise enrolled in managed care, and certain children enrolled in MassHealth who have commercial insurance as their primary insurance	638,000 (inclusive of members in the PCC Plan or a Primary Care ACO)
One Care	MCE	Financial Alignment Initiative (FAI) Demonstration	Dual eligible Medicaid members ages 21-64 at the time of enrollment with MassHealth and Medicare coverage.	31,746

Plan Name	MCP Type	Managed Care Authority	Populations Served	Membership Dec 2021
Senior Care Organizations (SCO)	MCE	1915(a)/1915(c)	Medicaid members over age 65 and dually eligible members over age 65.	70,330

2.3 Additional MassHealth Programs

The CQS reflects overarching goals and aligned priorities with shared objectives or strategies wherever possible to meet the requirements of the specific programs and needs for serving its populations. Other programs, services, and supports provide important care to members through fee-for-service or managed care benefits.

Community Partners Program

Community Partners (CPs) collaborate with ACOs and MCOs to provide care coordination and care management supports to individuals with significant behavioral health issues needs and/or complex LTSS needs. Eligible members include ACO or MCO members who are adults with complex BH needs or children and adults with complex LTSS needs. PCC Plan and MassHealth's FFS members affiliated with the Department of Mental Health's Adult Community Clinical Supports Program are also eligible.

Hospital Programs

MassHealth manages an acute care hospital network and providers for its FFS, PCC Plan, and Primary Care ACO populations. Acute hospital contracts will apply to covered hospital inpatient and outpatient services provided to MassHealth members and recipients of Emergency Aid to the Elderly, Disabled and Children at any acute hospital inpatient departments, outpatient departments, and satellite clinics.

A Request for Application (RFA) detailing hospital contract requirements (inclusive of quality requirements) is issued each year and may be found on the Commonwealth's official procurement record system website: COMMBUYS

MassHealth also manages a psychiatric inpatient hospital network and providers. Similar to the acute hospital network, psychiatric inpatient hospitals provide covered services to MassHealth FFS members eligible to receive those services and recipients of the Emergency Aid to the Elderly, Disabled and Children Program. Information on psychiatric inpatient hospital services regulations may be found: regs-psychinphospital.pdf | Mass.gov

Long-Term Services and Supports (LTSS)

MassHealth provides a robust system of care for members of all ages who require services to enable them to live independently and with dignity, participate in communities, and improve quality of life. State plan LTSS services are offered through a variety of delivery systems, including fee-for-service, integrated care plans, and the Program of All-Inclusive Care for the Elderly (PACE).

Services managed by the MassHealth Office of Long-Term Service and Supports (OLTSS) include:

- Community-based LTSS: Adult Day Health, Adult Foster Care, Continuous Skilled Nursing, Day Habilitation, Group Foster Care and Personal Care Attendant Program (PCA).
- Facility-based LTSS: Nursing Facility Services and Chronic Disease and Rehabilitation Hospital (CDRH) Services.

- Other Covered Services: Durable Medical Equipment (DME), Orthotics and Prosthetics, Oxygen and Respiratory Therapy, Hospice Services, Home Health Agency (except Continuous Skilled Nursing), Nursing Facility and CDRH services for the first 100 days, and Therapies (including Physical Therapy, Occupational Therapy and Speech Therapy).

One Care, SCO, and PACE cover all community-based and facility-based LTSS services and Other Covered Services. ACOs and MCOs cover the set of Other Covered Services. LTSS services, including Nursing Facility Services and CDRH services after the first 100 days, are provided on a fee-for-service (FFS) basis by MassHealth directly to eligible ACO and MCO members.

Program of All-Inclusive Care of the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is an integrated care demonstration program for members aged 55 and older who are nursing facility eligible but can live safely in the community. PACE offers a complete range of medical and supportive services to participants via a coordination of care model that operates from a PACE center. Coordinated care is planned and provided by an interdisciplinary team (IDT) of providers that includes physicians, nurse practitioners, nurses, social workers, rehabilitation and recreation therapists, health aides, and others. The PACE model is designed to keep frail elders living in the community safely for as long as possible.

Section 3: Quality Management at MassHealth

3.1 Quality Management Structure and Process

MassHealth quality management and processes are present at various levels within the agency. The MassHealth Quality Office and other centralized departments at MassHealth work with programs to develop quality strategy, policy, and plans that guide and support planning and implementation.

In late 2020, MassHealth created a new executive leadership position, Deputy Chief Medical Officer, to specifically oversee MassHealth Quality, its office, and clinical support functions. The structure provides a hub for subject matter expertise and support to strengthen quality programming across MassHealth and to address access and integration of services, accountability and monitoring of quality performance and improvement, reduction in disparities in care, and overall quality reporting and evaluation.

As Demonstrated in Figure 1, this model enables MassHealth to leverage centralized department areas and program collaboration to identify overarching goals and priorities, develop quality strategies, and ensure cross-program communication and program alignment where possible while recognizing and supporting program-specific priorities aimed at serving the needs of specific MassHealth populations.

Figure 1: Quality Management Structure at MassHealth

The quality management process and key quality functions are illustrated below. Key areas include strategic planning, program design for quality, measurement, accountability and improvement, data collection, analysis, and reporting and evaluation.

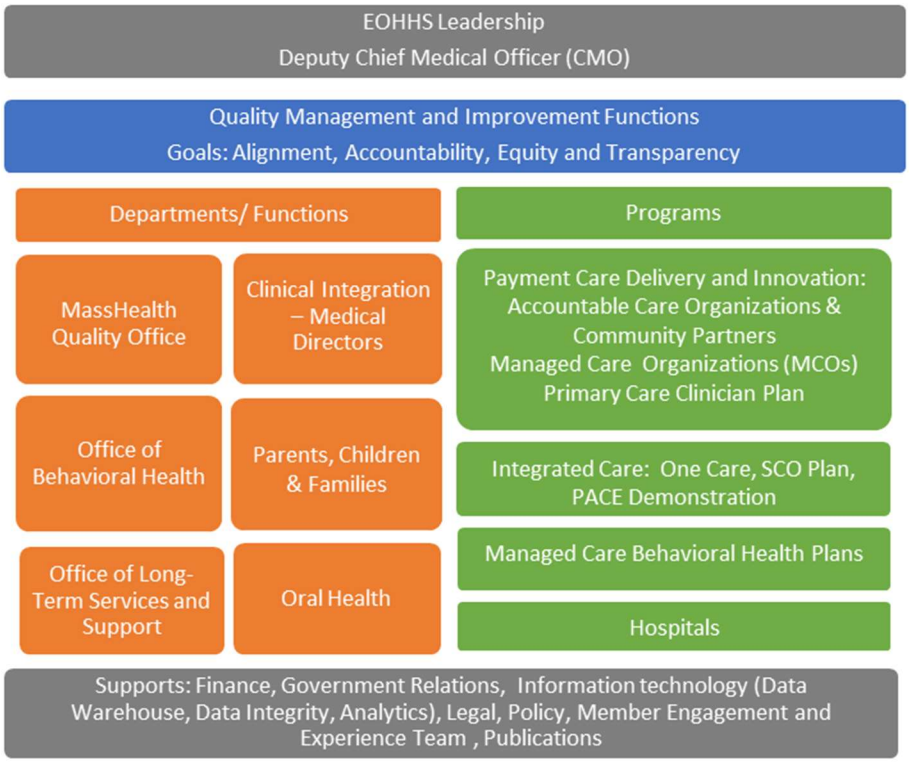
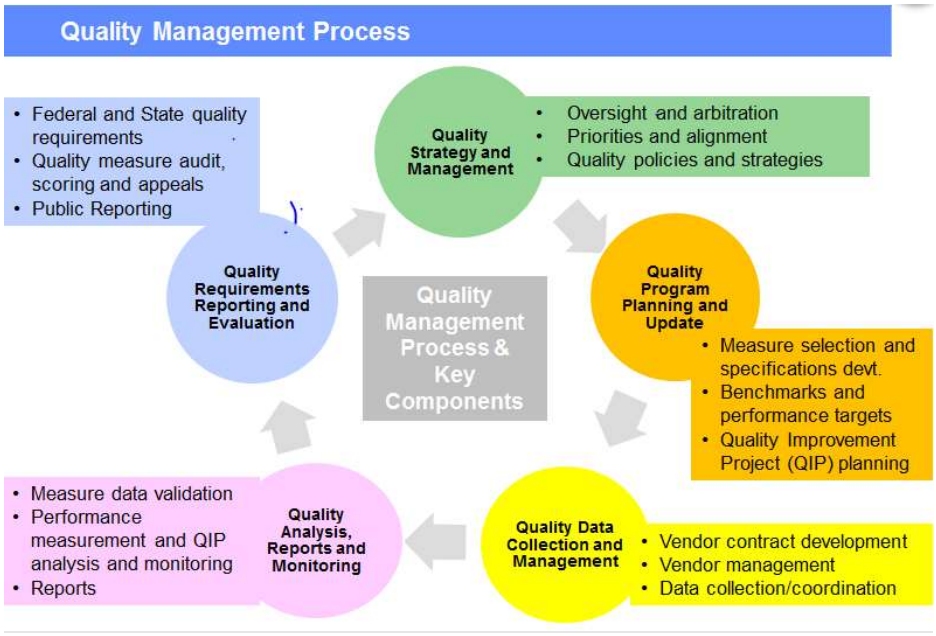


Figure 2: Quality Management Process



The MassHealth Quality Office and other centralized functions conduct activities that include but are not limited to working collaboratively with MassHealth programs to:

- Develop and monitor the Comprehensive Quality Strategy (CQS)
- Identify and select measures and specifications for use in quality incentive programs
- Develop performance benchmarks and targets and other quality program requirements
- Procure and manage vendors for data collection, audit, External Quality Review, and other services
- Monitor and assess quality measure performance and improvement programs
- Facilitate and participate in cross-cutting quality initiatives throughout MassHealth
- Coordinate and participate in external stakeholder engagement related to quality

Detailed activities that describe the collaborative work of centralized quality and program staff are further summarized below in Table 2.

Table 2: Key Quality Activities or Initiatives

Quality Management Function	Centralized Activities	Program Activities
Quality Strategy and Management	• CQS development, updates, and evaluation • Alignment of strategic priorities, quality goals, quality policies, and program design principles	• CQS and evaluation inputs • Program-specific design and management
Quality Program Planning	• External alignment/use of quality measures (e.g., CMS Core Measures, standardized national quality	• Plan/provider engagement • Contract development and management • Program measure slates

Quality Management Function	Centralized Activities	Program Activities
	measures, Statewide Quality Measure Set) • Alignment of measures across programs where appropriate • Coordinated approaches to quality performance/incentives • Coordinated approaches to benchmarking and target setting (e.g., establishing baselines, use of national or regional benchmarks)	• Program-specific targets • Quality incentive/payment design
Data Collection and Management	• Vendor management – oversight of scope and multi-program projects; Comprehensive Quality Measure Vendor (CQMV), Member Experience Survey (MES) vendor • Collection and aggregation of plan and provider submissions of quality measure data	• Vendor collaboration/operational management of deliverables • Measure specifications management • Clinical quality data collection • Data/measure validation processes with program providers/plans • QA of data, quality measure, and survey results
Quality Analysis, Performance Improvement and Monitoring	• Statewide and cross-program analysis of performance • Analysis and identification of opportunities for improvement • Identification and alignment of quality improvement priorities • Oversight of PIP compliance across programs • External Quality Review Organization (EQRO) and measure audit vendor management	• Data validation • Measure audit/chart review – operational processes • Plan and provider engagement with quality results and changes in performance • Quality improvement project planning and monitoring
Reporting and Evaluation	• External quality review and evaluation – vendor management (e.g., EQRO) • EQRO - performance measure validation, PIP evaluations • Core measure reporting • Managed care rule reporting requirements	• Provider or plan performance reports • Audit and appeals processes • Contractor and program evaluation • EQR technical reports • Website posting requirements for quality related activities • Plan Accreditation

MassHealth Internal Quality Committee

The MassHealth Internal Quality Committee (IQC) is an agency-wide committee designed to discuss and address issues and develop recommendations that guide program staff and leadership across MassHealth on key topics and issues that drive quality strategy, programming, measurement, evaluation, and improvement activities. Membership includes clinical and non-clinical quality leaders, MassHealth program representatives, and representatives from functional areas that support quality (e.g., legal, information technology, finance, and policy). The committee is staffed by the MassHealth Quality Office and chaired by the director of the Quality Office. IQC goals and objectives are as follows:

- Support inter-program collaboration, information-sharing, and identification of quality improvement best practices
- Support alignment and transparency across programs
- Develop and implement quality program structures, including quality measurement, member experience, reporting, and evaluation
- Synchronize quality program and payment reform activities where possible
- Share and publicize quality program activities across MassHealth and externally through public reporting
- Evaluate quality program activities and make recommendations for improvement and best practices

3.2 Stakeholder and Member Engagement

External stakeholder engagement is an important source of guidance throughout the process informing quality programs as well as broader statewide quality priorities, strategies, and initiatives.

MassHealth engages with external stakeholders that include consumer advocates; health care providers such as community health centers, hospitals, behavioral health providers; LTSS providers; community organizations, payers, and associations; other Massachusetts Executive Office of Health and Human Services (EOHHS) state agencies; and subject matter experts.

Examples of current quality topic areas with active stakeholder engagement impacting our CQS include:

- Health disparities and health equity
- Integration across physical health, behavioral health, and long-term services and supports
- Member experience
- Social determinants of health
- Measurement gaps (e.g., behavioral health, oral health, and maternal health)
- Advancement in quality measurement (risk-adjustment for outcome measures, electronic measurement)
- Opportunities to reduce administrative burden of quality measurement, data collection, and reporting
- Alignment or de-duplication of external requirements (reporting, accreditation, and certification) where possible

State agencies or organizations also inform the design and operation of MassHealth quality programs. They include the following entities:

- Center for Health Information and Analysis
- Department of Children and Families
- Department of Developmental Services
- Executive Office of Elder Affairs
- Department of Mental Health
- Department of Public Health
- Department of Transitional Assistance
- Department of Youth Services
- Health Policy Commission

Table 3 is a summary of external stakeholder forums that meet on a periodic basis (e.g., standing bi-weekly, monthly, bi-monthly, and quarterly meetings)

Table 3: Summary of external stakeholder forums

Stakeholder Forums / Members	Meeting Activity
• EOHHS Quality Measurement Alignment Taskforce (QMAT): State agencies, providers, payers, measurement experts, member advocates • EOHHS Quality Measurement Alignment Taskforce (QMAT) Technical Advisory Groups: State agencies, providers, payers, measurement experts, member advocates	• Statewide review and alignment of quality measures for use in global payment contracts • Collaboration on statewide priorities (e.g., health equity, measurement gaps, and electronic measurement) • Statewide review of social risk factor data standards and health equity incentives
• Delivery System Reform Incentive Payment (DSRIP) Quality Sub-Committee • Hospital Quality Advisory Committee	• Guidance on quality program planning and implementation design (e.g., measures, data collection, and benchmarking)
• Delivery System Reform Implementation Advisory Council (DSRIC)	• Engagement on program design and implementation (informs in totality DSRIP programs)
• ACO/MCO Quality Program Office Hours • BH and LTSS Community Partners Program Office Hours	• Engagement with program contractors to support program implementation
• One Care Implementation Council • Senior Care Options Advisory Committee • Disability and Eligibility Advocates Meetings • Care Model Focus Initiative (CMFI) • *MassHealth also requires its health plans and hospitals to engage members through Consumer Advisory Councils/Patient Family Advisory Councils*	• Member focused engagement • Members are also included in other multi-stakeholder forums listed (e.g., QMAT, DSRIP Quality Sub-Committee)
• ACO/MCO Medical Director's Forum • Children's Behavioral Health Initiative (CBHI) Meetings: Providers and CBHI Network management staff from MCO/ACOs/MH and MH's managed behavioral health vendor • OLTSS/HCBS Provider Meetings: Home Health, Adult Foster Care, Durable Medical Equipment, and Personal Care Management	• Engagement with providers to support program design, implementation, monitoring and improvement

Stakeholder Forums / Members	Meeting Activity
• BH Provider Meetings: Inpatient and outpatient BH providers with relevant state licensing agencies including DMH and DPH	

Member Engagement

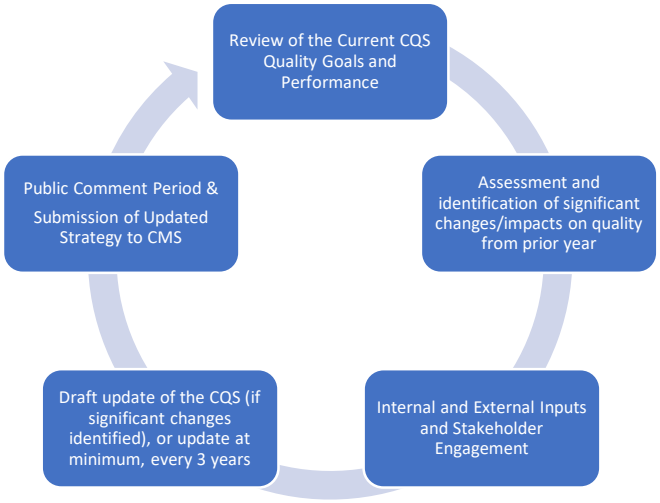
MassHealth members are key stakeholders; it is critical to include, engage, and incorporate their voice across the programs that serve them. The members' voice informs the CQS through participation in statewide or strategic initiatives (e.g., measure alignment, health equity, behavioral health roadmap), quality program design, ongoing implementation, and performance monitoring and improvement.

A dedicated Member Engagement and Experience (MEE) Team at MassHealth works to strengthen member experience within the care delivery system through enhanced member communication, education, and engagement initiatives. The MEE team also works internally to increase and promote understanding of the member perspective to help inform program and policy development in partnership with internal and other external stakeholders. This work includes meeting with external stakeholders, holding targeted discussion groups, and managing complaints and escalations.

3.3 Quality Strategy Development, Update and Management Process

The CQS is prepared by the MassHealth Quality Office with guidance and input from the MassHealth IQC and other internal and external stakeholders. It is a year-long iterative process revisited annually.

Figure 3: Annual CQS Process



Quality Strategy Updates

MassHealth annually reviews the CQS and updates the CQS as needed, but no less than every three years. The review and revision process involves reviewing and assessing goals and performance and engaging with the Internal Quality Committee for input. MassHealth also solicits input from external stakeholders and MassHealth's External Quality Review Organization (EQRO). MassHealth works with CMS to ensure that the CQS meets all content requirements set forth in 42 CFR 438.340. MassHealth will continue to comply with the reporting requirements of its approved waivers and submits quarterly and annual reports to CMS on waiver implementation and effectiveness.

In accordance with 42 CFR 438.340(b)(10), states must define what constitutes a "significant change" that would require revising the CQS more frequently than every three years. Factors that constitute a significant change and necessitate revision of the MassHealth CQS include:

- A dramatic restructuring of quality management or substantial initiatives impacting quality within the agency
- Significant changes to the state's Medicaid program including, but not limited to, adding or shifting of populations to the state's different managed care programs
- A significant change in membership demographics or the provider network
- A material change in the measures or targets, number/types of program entities, or timeframes for quality reporting
- Identified patterns of quality deficiencies identified through analysis of the annual reporting or performance data submitted by MCEs
- Changes to quality standards or requirements resulting from regulatory authorities or legislation at the state or federal level

Availability of the CQS for Public Comment

Following final review by the IQC and internal leadership, the draft CQS is posted to the MassHealth quality webpage for public comment. Feedback is noted in the CQS, with additional consideration and incorporation into future updates of the strategy. Following collection and review of feedback and comments from the internal and external review process, the CQS is submitted to CMS for review and comment prior to adopting it as final.

The most current version of the CQS is available on the MassHealth quality reports and resources web page: MassHealth Quality Reports and Resources | Mass.gov

3.4 Evaluation of the Effectiveness of the Quality Strategy

As required under 42 CFR 438.340(c)(2), the state must review and update its quality strategy as needed, but no less than every three years. The state's review of the quality strategy must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years.

Triennially, MassHealth conducts a review and evaluation of CQS effectiveness during the previous three measurement periods (calendar years). The current CQS Evaluation is available on the MassHealth quality reports and resources web page. MassHealth Quality Reports and Resources | Mass.gov

Annually, MassHealth engages the following activities:

- Review of measure/key indicator performance to assess progress toward quality goals and objectives.
- Review of EQR reports to assess the managed care programs' effectiveness in providing quality accessible services.

Section 4: MassHealth Quality Strategy

The Comprehensive Quality Strategy (CQS) articulates overarching goals and objectives for improving members' experience as well as quality and delivery of care. It is grounded in national priorities and guided by agency-wide and population health priorities. It identifies specific measures and targets for accountability and promotes focused projects and initiatives aimed at driving performance and quality

improvement. The CQS also reflects an ongoing strategic effort to support overarching agency priorities and achieve alignment across agency programs and populations balance with recognizing and meeting the special needs of our diverse populations.

4.1 MassHealth Priorities

National Priorities

The CQS continues to align with CMS and the National Quality Strategy's three aims for better care, healthy people and communities, and affordable care. These aims remain foundational and relevant since their inception in 2012 to guide the goals and strategies of the CQS.

The CQS has since augmented the three aims to also align with improving the health care workforce experience, hence a "Quadruple Aim," critical to advancing and sustainably improving health and the quality of healthcare. MassHealth activities and goals associated with investments in training and workforce, reducing provider burden, and monitoring provider experience (through provider surveying) have direct impacts on the delivery and quality of care.

MassHealth Agency Priorities

MassHealth quality goals and objectives support important overarching agency priorities to:

- Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model
- Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care
- Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals
- Sustainably support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care
- Maintain near-universal coverage including updates to eligibility policies to support coverage and equity

Population Health Priorities

Additionally, the following high-level priority areas or domains drive improvement in population health among MassHealth members and are addressed across the goals, strategies, and activities in the CQS.

- Domain 1: Preventive and Pediatric Health
- Domain 2: Care Coordination and Integration
- Doman 3: Care for Acute and Chronic Conditions
- Domain 4: Member Experience

4.2 MassHealth Quality Goals and Objectives

The following quality goals reflect an alignment and commitment to our national, agency, and population health priorities.

Quality Goals:

1. **Promote better care:** Promote safe and high-quality care for MassHealth members

2. **Promote equitable care**: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience
3. **Make care more value-based**: Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care
4. **Promote person- and family- centered care:** Strengthen member and family-centered approaches to care and focus on engaging members in their health
5. **Improve care through better integration, communication, and coordination** across the care continuum and across care teams for our members

The CQS strives to align agency-wide quality improvement goals and objectives that reflect a shared set of priorities to guide planning and implementation across MassHealth programs.

Table 4: Quality Goals and Objectives/Strategies: Improve health care delivery, experience, and outcomes

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

Table 4: Quality Goals and Objectives/Strategies: Improve health care delivery, experience, and outcomes

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

4.3 Quality Measurement and Reporting

Measures by managed care programs are outlined in **Appendix C** and are subject to public reporting requirements pursuant to 42 CFR 438.340(b)(3)(i).

Quality Measurement

MassHealth identifies and employs quality indicators or measures to monitor the quality of care provided to its members. MassHealth's quality measurement strategy reflects a data driven approach to define expected quality processes or outcomes that support our overarching quality goals and strategies and to inform and strive for continuous quality improvement with MassHealth plans and providers.

Quality performance is captured for comparison within the MassHealth agency and across Medicaid programs nationally. MassHealth uses standardized measure sets and judiciously modifies or adapts measures where appropriate to reflect the unique program populations served and where there are clear gaps in measurement. Consideration is also given to the availability of national and regional benchmarks and alignment with MassHealth and CMS priorities.

MassHealth selects quality measures incorporating the following principles or criteria:

- Selecting aligned measures, where possible, with local and national frameworks (Massachusetts QMAT aligned measure set, CMS Core Measure Sets, CMS MIPS, CMS Star Ratings, and other program measures)
- Utilizing nationally endorsed and/or validated measures (e.g., HEDIS, Joint Commission, CDC measures) wherever possible
- Adopting non-standard measures only as an exception when there is a clear measurement gap to address a critical program priority or population

- Utilizing patient-reported measures and outcome measures where possible

MassHealth quality measures fall into broad categories:

- **Process measures** are based on what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition. These measures typically reflect generally accepted recommendations for clinical practice or what members may expect to receive for care. The majority of standard quality measures generally available are process measures (e.g., depression screening and follow-up).
- **Outcome measures** represent the impact of health care services or interventions on the health status of patients. Outcome measures represent a "gold standard" in measuring quality. There are generally fewer standard outcome measures available. Outcome measures are best used with appropriate risk-adjustment that correct for differing characteristics within a population, such as patient health status and other factors (e.g., readmissions).
- **Member experience measures** are patient reported measures about members' experience and satisfaction with the care or services they received. Currently members of MCOs, ACOs, PCC, SCOs, and One Care Plans receive surveys related to their primary care visit. Members of the MassHealth CP program receive surveys about their behavioral health care and LTSS services. All MassHealth members (managed and non-managed care) may also receive surveys related to their inpatient hospital stays.
- **Structural measures** are utilized to support development of infrastructure or dedicated activity for an emerging priority or initiative. Structural measures are often time-limited and may impact and be replaced by related process or evidence-based outcome measures.

Public Reporting

At a statewide level, MassHealth collects, monitors, and reports on the CMS Medicaid Adult and Medicaid /CHIP Child Core Measure Sets. MassHealth continues to report annually on the majority of core measures (with very few exceptions), based on the availability of data and feasibility of collection. 2020 measures and results may be found on the CMS State Profiles website (Massachusetts | Medicaid.gov).

In accordance with 42 CFR 438.340, MassHealth annually publishes the results of managed care quality performance of its contracted organizations using a mix of plan submitted HEDIS data and MassHealth generated results. Outcomes are reported for each contracted MCE and the PCC Plan. In addition to reported plan-level rates, MassHealth calculates a MassHealth Weighted Mean (MHWM), which is a weighted average and reflects an overall performance rate for all the plans reporting data for that measure. These rates are compared to national benchmarks (i.e., HEDIS). Annual reporting of these measures may be found on the MassHealth quality website (MassHealth Quality Reports and Resources | Mass.gov).

As part of the 2021 MassHealth Evaluation Report and public reporting requirements, measures will be reported at the program contract level employing performance measures identified in managed care contracts.

4.4 Quality Performance

MassHealth identifies program-specific measure slates for plan or provider quality performance. The program measure slates may have various reporting, accountability or performance incentive requirements associated with them (e.g., pay-for-reporting (P4R), pay-for-performance (P4P), quality

withholds, quality improvement projects). The measures address quality goals and objectives with identified baselines and targets for improvement. Program measures selected strive to align across national, state, or MassHealth programs wherever possible to promote shared goals, priorities, and comparability across populations. In addition, alignment of performance measures promote parsimony, recognizing provider burden and resources to effectively address quality performance and improvement.

Additional quality measures may be monitored by MassHealth. Monitoring measures may be novel measures reflecting potentially emerging priorities to be incorporated for future performance measurement. Older high performing measures may be monitored to ensure continued high performance. Other measures may be used to conduct longitudinal measurement over time.

Identifying Performance Targets

To establish performance targets for managed care programs, plan-level performance or baselines are determined and may be compared to national or regional benchmarks (e.g., NCQA HEDIS measures). Where external benchmarks are not available, targets are informed by initial baseline performance, relative peer performance, or improvement over time.

For standard measures (e.g., HEDIS), MassHealth uses the national Medicaid 90th percentile as the primary goal benchmark against which state and individual plan performance is compared. The Medicaid 75th percentile is used to reflect a threshold goal for performance. This percentile represents a level of performance met or exceeded by the top 25% of Medicaid plans. Additionally, MassHealth regularly compares its performance on the CMS Adult and Child Core Measure Sets with other states (e.g., state median) as part of CMS publicly reported state profiles.

At a program level (e.g., ACO program or One Care), MassHealth may establish additional performance targets. For example, these targets may include other nationally established benchmarks, such as Medicare Star ratings, or regional benchmarks that often exceed national performance. A baseline may be established with annual gap-to-goal targets for improvement to reach a goal benchmark over time.

Please see **Appendix C** for CQS overarching quality goals, associated measures reflecting these goals, baseline performance and targets by program.

4.5 Performance Measurement and Incentives

ACO and MCO Programs

The ACO models' emphasis is on coordination, quality, and cost effectiveness, with a strong member focus. The ACO entities engage in performance measurement and performance improvement projects designed to achieve improvements in clinical care and non-clinical care processes, outcomes, and member experience. ACO and MCO members with complex BH and LTSS needs also participate in the Community Partners (CP) Program. CPs participate in performance measurement additionally, to further support improvements to address the care and needs of the population.

Ongoing measurement is central to holding ACOs and CPs accountable for providing sustainable, high-value care across a variety of measures. Measures are used both for reporting and payment purposes. The ACO payment model includes financial incentives for ACOs to provide strong performance on cost and quality. To ensure appropriate accountability, all ACOs bear some degree of downside risk; different ACO models and risk tracks allow ACOs to appropriately match their level of downside risk to their capabilities and financial readiness. Similarly, the CP program includes financial incentives for quality performance.

Massachusetts will also direct MCOs and ACOs to adopt payment mechanisms under 42 CFR 438.6(c) such as, but not limited to administering performance-based quality incentive programs for hospitals, adopting minimum or maximum fee schedules, or providing a uniform dollar or percentage increase for network providers that provide a particular service under the contract.

Through 2022, examples of payment mechanisms include:

- Disability Access Incentive — Massachusetts directs MCOs to make payments to all contracted hospitals based on reporting and performance related to disabled members access to medical and diagnostic equipment.
- Hospital Quality Incentive — Massachusetts directs MCOs to make payments to two hospitals designated as "Essential MassHealth hospitals" based on hospital quality performance and improvement.
- Integrated Care Incentive — Massachusetts directs Accountable Care Partnership Plans to make payments to its single non-federal, non-state, public hospital based on the accountable care performance of such hospital-owned or affiliated primary care providers.
- Behavioral Health Quality Incentive — Massachusetts directs the state's Managed Behavioral Health Vendor (Prepaid Inpatient Health Plan) to make payments to non-federal, non-state public hospitals in its network based on BH quality performance.

Additional Programs

MassHealth programs that are not under the purview of managed care quality requirements also operate quality programs to ensure the ongoing quality and experience of care. Opportunities for increased coordination and integration of care is a goal for the evolving CQS to address shared population health priorities, coordination, and follow-up of care for members across settings.

Hospital Programs

Per contractual obligations with the Commonwealth, acute care hospital providers are required to participate in quality initiatives that require a portion of the hospital's reimbursement for its fee-for service population to be based on its performance incentives on quality measures.

This acute hospital P4P program serves members accessing care in the inpatient setting. The acute hospital program aligns with the priorities and goals for quality measurement performance with particular focus and priority on maternal and newborn health, patient safety, care coordination, behavioral health, and member experience. For more detailed information on the hospital quality measures and other resources, please refer to: EOHHS Technical Specifications Manuals | Mass.gov.

The inpatient psychiatric hospital program also incorporates a quality incentive funded through an assessment pool focused on a subset of hospital measures that address the special needs of its population.

Efforts are made to align the MassHealth hospital quality reporting standards with guidelines for hospital measurement and reporting systems the Center for Medicare and Medicaid Services (CMS) and other national stakeholder groups developing hospital inpatient quality measures support. Examples of measures include nationally reported patient safety, member experience, and clinical quality measures (e.g., AHRQ, HCAHPS, CMS and The Joint Commission).

Long-Term Services and Supports

The Office of Long-Term Services and Supports (OLTSS) with the integrated care team is finalizing performance measures for its fee-for-service (FFS) and managed care populations in 2022. The measures will focus on the continuum of care for the disability community and align with quality measurement efforts across MassHealth programs and payment methodologies.

The anticipated approach captures measures that demonstrate the LTSS provider's engagement in the member's care in the community and inpatient setting, access to services and supports, the quality of services delivered, as well as qualitative methods to understand the member's and caregiver's experience of care.

The selection of finalized measures will be informed by current measures identified in SCO and One Care managed care programs, engagement and member experience measures used in the ACO and CP quality programs, as well as national developments in measurement (CMS Measures Under Consideration, NCQA annual proposed measures).

MassHealth anticipates updates to the CQS as performance goals are identified and finalized in 2022.

Section 5: Quality Assessment and Appropriateness of Care

The Comprehensive Quality Strategy (CQS) is designed to reflect standards associated with quality assessment and how the Commonwealth evaluates the quality of health care and services furnished by managed care plans.

Quality assessment in MassHealth occurs through at least three mechanisms:

- **Contract management requirements** – Manage care plan contracts include quality and health equity provisions. A typical contract includes requirements for measure reporting, performance, and improvement. MassHealth contract managers and quality staff review submissions and evaluate whether the plan has satisfactorily met the contract requirements.
- **State-level data collection and monitoring** - MassHealth routinely collects HEDIS and other performance measure data from its managed care plans.
- **Quality improvement performance programs** - Each MCE and the Managed BH Vendor is required to complete two performance improvement projects annually in accordance with 42 CFR 438.330(d).

5.1 Contract management

Assessing Health Care Needs

Each managed care entity (MCE) is required to have systems in place to assess members identified as having special health care needs. MCEs are required to identify members at increased risk to have complex or chronic medical needs requiring specialized health care services, including persons with multiple chronic conditions, co-morbidities, and/or co-existing functional impairments, and including persons with physical, mental/substance use, and/or developmental disabilities, such as persons with cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities.

Further, plans are required to assess the quality and appropriateness of care furnished to members with special health care needs, including by developing individualized care plans, ensuring timely and coordinated care, and ensuring the development of clinical protocols and approaches to the provision of

care that are appropriate for the members' needs. In addition, MCEs are required to screen all members for health-related social needs.

MCEs may rely on information shared by the Commonwealth. This includes Categories of Assistance, such as Supplemental Security Income (SSI), to which MassHealth assigns members.

Members' disability status may be further identified through screening individuals at the point of service (need for accommodation or special assistance) or via survey (e.g., utilizing the standard HHS question set for identifying disability status related to disability type (e.g., cognitive, hearing, mobility, vision, self-care, and independent living).

Behavioral Health Screening Among Children

On December 31, 2007, EOHHS began requiring primary care providers to use standardized behavioral health screening tools when administering the BH screening component of the well-child visit to all MassHealth enrolled children under the age of 21 pursuant to the Commonwealth's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical Protocol and Periodicity Schedule.

MassHealth routinely reviews and updates its menu of BH screening tools. The update is informed by current research and identification of evidence-based tools that are considered standards and adopted by nationally recognized child and behavioral health organizations (e.g., Bright Horizons).

Addressing and Reducing Disparities

MassHealth's current activities include:

- Identification of members' social risk data (e.g., race, ethnicity, and language) captured through enrollment data and other sources
- Incorporating community-level social determinants of health into risk adjustment for the accountable care and managed care rate setting process.
- Requirements for health plans to provide culturally and linguistically appropriate care
- Implementation of the Disability Access Incentive
- Provision of additional services through the Flexible Services Programs
- Introduction of quality related requirements and metrics (e.g., health related social needs screening measure).

Over the next five years and as part of the renewal of the 1115 Demonstration, MassHealth proposes building on current efforts through significant new investments and updated expectations to address health equity.

MassHealth anticipates updates to the CQS as we continue our work on advancing health equity.

Highlights of Current Activity

Data Collection of Social Risk Factors and Analysis

- MassHealth seeks to improve the ability to identify and address health care disparities through the collection and analysis of member data. Data for identifying potential disparities comes from multiple sources. At the time of enrollment, MassHealth members may voluntarily self-declare their race, ethnicity, and primary language. These data can be linked to claims data and analyzed. Health plans receive this information, when available, through daily transmittal of the HIPAA 834 file.
- It is anticipated that these data may be supplemented further through other sources including health plans and providers that currently provide these data through new requirements (e.g.,

HEDIS reporting) or existing activity as part of the clinical data collection or reporting process. Other state data sources are also under consideration.

- Member experience surveys collect self-reported race, ethnicity, primary language, chronic conditions, and disability status data. These data permit subgroup analyses of the completed surveys. Because the survey data are always anonymous, there is no possibility of linking survey data to other types of data such as claims.

Culturally and Linguistically Appropriate Care

- MassHealth seeks to reduce disparities among its members. All health plans are currently required to provide culturally and linguistically appropriate care to ensure that the communication and language access needs of all members are met.
- To address barriers associated with health care system navigation, payment and delivery reform efforts are driving the integration of care that includes links to community resources as well as measurement of the social determinants of health.
- For all members, MassHealth publications are printed in English and Spanish, with translations available upon request in at least 16 languages.

Health-Related Social Needs

- MassHealth offers the Community Support Program (CSP) through managed care. CSP includes supports for people experiencing chronic homelessness and/or substance use or mental health disorders or (upon approval from CMS) individuals with justice involvement living in the community. The CSP also provides additional outreach and support so that members can engage in their care, use treatment services, and adhere to their clinical treatment plans. This short-term, mobile, and flexible program offers intensive case management services to individuals considered "at risk" in their communities.
- The current 1115 Demonstration authorizes MassHealth's Flexible Services Program (FSP), which provides evidence-based supports for ACO members with nutritional and housing supports needs. Flexible Services offer ACOs the opportunity to test different approaches to improve members' health outcomes and to reduce TCOC as well as health disparities where it aligns with the member's care plan and specific HRSN resources are identified.

5.2 State-level Data Collection and Monitoring

HEDIS Quality Measures and CAHPS Member Experience

MassHealth collects and uses the results of HEDIS quality measures and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as part of its reporting and quality incentive programs to: 1) identify opportunities for improvement 2) inform its approach to quality management work undertaken with other managed care entities, and 3) support reporting of core measures and reporting of plan-level measure rates. MassHealth currently monitors submissions of HEDIS data from several of its managed care plans, including MCOs, SCOs, and One Care.

The HEDIS and CAHPS measure results also guide and align MassHealth's work in supporting the Primary Care Clinician (PCC) Plan providers in quality measurement and improvement work. MassHealth calculates HEDIS measure data for monitoring purposes for its PCC Plan.

MassHealth currently monitors plan-level submissions of CAHPS member experience surveys submitted for the MCO, SCO, and One Care programs. A Clinician Group (CG-CAHPS) version was first implemented in 2019 by MassHealth for the ACO program for adults and children receiving primary care services.

Member experience surveys were also implemented in 2019 for the BH and LTSS populations for the ACO and Community Partner programs. Below is a table summarizing current member experience data collected from plans. Note that MassHealth administers the ACO and PCC program surveys.

Table 5: National patient experience surveys required by MassHealth

Survey Tool	Program(s)	Population	Survey Level
CAHPS 5.0H	MCO	Adults and Children	Plan
CAHPS-Medicare Advantage Plan	SCO, One Care	Dual eligible members enrolled in MassHealth and Medicare	Plan
Clinician Group (CG) CAHPS (Adapted by Massachusetts Health Quality Partners)	ACO	Adults and Children	ACO
Clinician Group (CG) CAHPS (Adapted by Massachusetts Health Quality Partners)	PCCM	Adults and Children	Plan
Hospital (H) CAHPS	Acute Hospitals	Adult	Hospital
MassHealth LTSS Survey	ACO LTSS CP Program	Adults and Children	ACO Community Partners
MassHealth Behavioral Health Survey	ACO BH CP Program	Adults Only	ACO Community Partners
PIHP (Behavioral Health Plan) Survey	PIHP	Adults	Plan
One Care Experience Survey	One Care	Dual eligible adults 18-65 enrolled in MassHealth and Medicare	Plan
One Care Quality of Life Survey	One Care	Dual eligible adults 18-65 enrolled in MassHealth and Medicare	Plan

5.3 Quality Improvement Performance Projects

MassHealth requires MCEs and the Managed BH Vendor to conduct performance improvement projects (PIPs) annually, in compliance with federal requirements. MCEs and the Managed BH Vendor are required to develop PIP topics in priority areas MassHealth selects to align with the CQS goals and strategies.

Through identification of opportunities for improvement, and implementing, testing, and evaluating interventions at the contract level, PIPs are intended to improve the care and services provided to MassHealth members. Below are current PIP topic areas or domains for programs for which they are required.

TABLE 6: Current EQR PIP Topics, by Program

EXTERNAL QUALITY REVIEW – 2022 PERFORMANCE IMPROVEMENT PROJECT TOPICS

Program	Domain 1	Domain 2	Domain 3
ACPP **MCO**	Health Equity: Reducing or eliminating health disparities with the goal of attaining the highest level of health for all people. Plans may select to focus their PIPs on the following disparity-sensitive measures: • Controlling High Blood Pressure • Comprehensive Diabetes Care • Initiation and Engagement in Treatment • Childhood Immunization Status Prenatal and Postpartum Care	Prevention and Wellness: Reducing the occurrence and complexity of disease while improving level of functioning and quality of life. • Increasing vaccination rates with at least one specific intervention focused on reducing health inequities.	Access to Care: Ensuring the timeliness and availability of health care services to achieve optimal health outcomes. • Reducing barriers to accessing telehealth services for either behavioral or physical health.
SCO **One Care**	Care Coordination/ Planning: Coordinating and planning care activities and sharing information with all members of patient's care team.	Prevention and Wellness: Reducing the occurrence and complexity of disease while improving level of functioning and quality of life. • Increasing Flu vaccination rates with at least one specific intervention focused on reducing health inequities.	
Behavioral Health Plan	Improving rates of follow-up for alcohol and other drug use disorder after discharge.	Improving follow-up after inpatient discharge by improving access to telehealth services.	

PIPs conducted across MassHealth typically run on a 3-year cycle: one baseline and two remeasurement periods. MassHealth may modify the PIP cycle to address immediate or emerging priorities, including but not limited to public health emergencies or implementation of new contracts or plans. Building upon MassHealth priorities to meaningfully address health equity and focus on MassHealth's highest risk populations, MassHealth requires that within each PIP, there is at least one health equity focused intervention.

Reviews of 2021 PIPs are currently being finalized and will be available thereafter. Prior cycle PIPs and details may be found in the annual EQR Technical Reports found on the MassHealth Reports and Resources web page: MassHealth Quality Reports and Resources | Mass.gov

MassHealth anticipates updates to the CQS as the 2022 PIP cycle finalizes project priorities and PIPS for the next three-year cycle.

5.4 External Quality Review

MassHealth monitors compliance with contractual and federal requirements in multiple ways. **Appendix D** lists the specific reports MassHealth uses to ensure compliance. The External Quality Review Organization (EQRO) also provides valuable compliance review functions.

External Quality Review

Massachusetts contracts with a qualified External Quality Review Organization (EQRO) in accordance with 42 CFR 438.354. Massachusetts currently contracts with Innovative Resource Group LLC d/b/a KEPRO to complete external quality review functions for all MCOs, Accountable Care Partnership Plans, Primary Care ACOs, the Managed BH Vendor, One Care Plans, SCOs and the PCC Plan.

The current EQRO contract has been in effect over the last 9 years and will be ending on 6/30/2022. EOHHS anticipates entering into a new vendor contract in summer 2022 for a duration of 3 years with options for renewal. EQR Technical Reports are reviewed with particular attention paid to areas of low performance. EQRO findings and recommendations inform the development of and monitor progress towards meeting quality strategy goals and objectives.

Mandatory Activities

Massachusetts contracts for the following mandatory EQR activities set forth in 42 CFR 438.358(b):

1. Annual validation of performance measures reported to EOHHS, as directed or calculated by EOHHS.
2. Annual validation of performance improvement projects required by EOHHS.
3. At least once every three years, review of compliance with standards mandated by 42 CFR 438, Subpart E and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to members.
4. Validation of MassHealth-developed network adequacy and availability of services standards required under 42 CFR 438.68 and 438.206. More information may be found in the annual EQR Technical Reports on the MassHealth Reports and Resources web page: MassHealth Quality Reports and Resources | Mass.gov

Covered Entities

All managed care entities will participate in an EQRO review. MassHealth has determined that the most efficient mechanism for quality oversight of these entities will be the EQRO.

Review Cycle

Annually, following each project year, the EQRO produces a full technical report for MassHealth review and approval. Once finalized, the report is posted to the MassHealth website and submitted to CMS prior to the April 30th each year. The technical reports cover all mandatory EQR activities, and any other optional activities requested by MassHealth.

Managed Care Entity Responsibilities

Each MCE is required through their contracts to take all steps necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS to conduct External Quality Review (EQR) Activities identified above, in accordance with 42 CFR 438.358. Additional information on MassHealth contracts may be accessed at: MassHealth Health Plan Contracts | Mass.gov.

For additional information on EQR and access to the annual EQR Technical Reports, please visit the MassHealth Reports and Resources web page: MassHealth Quality Reports and Resources | Mass.gov.

Non-Duplication Provisions

MassHealth encourages the EQRO to use the NCQA Managed Care Toolkit to reduce duplication of effort of review when possible. Many MassHealth MCEs are NCQA-accredited and/or certified and opportunity exists to leverage documents which are produced for accreditation and other purposes to fulfill EQR requirements.

When applicable and upon MassHealth approval, MassHealth requires information from a review of an MCE or Managed BH Vendor performed by a Medicare or private accrediting entity contribute to the EQRO's findings related to reporting of mandatory activities. The use of reports from HEDIS audits and NCQA health plan accreditations are used to fulfill aspects of performance measure validation and compliance activities, minimizing duplication of effort and significantly reducing administrative burden.

Section 6: State Access Standards

All MassHealth managed care entities (MCEs) and Managed BH Vendor are required to maintain standards for access to care including availability of services, care coordination and continuity of care, and coverage and authorization of services required by 42 CFR 438.206-438.210; however, coverage and authorization of service requirements do not apply to PCACOs.

Standards described in this section are detailed further in plan contracts available on-line. MassHealth Health Plan Contracts | Mass.gov

6.1 Accessibility and Availability of Services

In accordance with the standards in 42 CFR 438.206, MassHealth ensures that services covered under contracts are accessible and available to members in a timely manner. Each plan must maintain and monitor a network of providers that is supported by written agreements and sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each plan considers, but is not limited to the following areas:

- Anticipated MassHealth enrollment
- Expected use of services by members, considering the characteristics and health care needs of specific MassHealth member populations
- Types of providers (in terms of training, experience, and specialization) required to furnish contracted services
- Geographic location of providers and MassHealth managed care members, considering distance, travel time, and modes of transportation MassHealth managed care members typically use, and whether the location provides physical access for MassHealth members with disabilities

MassHealth requires its MCEs and the Managed BH Vendor to credential network providers as required by 42 CFR 438.214. MassHealth also requires its MCEs ensure that its network includes sufficient family planning providers to ensure timely access to covered services.

In 2020, MassHealth, in conjunction with its EQRO, initiated an evaluation process to identify the strengths of the health plan's provider networks and offer recommendations for bridging network gaps. This evaluation process is termed Network Adequacy Validation. The EQRO analyzed the current performance of the plans based on MassHealth's required time and distance standards while identifying gaps in coverage by geographic area and specialties.

For information on the process and findings, please see the 2020 EQR Technical Reports on the MassHealth Reports and Resources web page: MassHealth Quality Reports and Resources | Mass.gov.

Cultural Considerations

- MassHealth requires that medical and behavioral health (BH) services and care are delivered in a culturally competent manner and address any barriers to access. MassHealth participates in efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural backgrounds. All MCEs are required to ensure availability of multi-lingual providers and skilled medical interpreters for the commonly used languages in each community.

  Written information is available to members in prevalent languages, as the Commonwealth determines. Prevalent languages are those spoken by 5% or more of MassHealth members. Through analyses of

MassHealth data (both state-wide and EOHHS regional (Boston, Metro West, Central MA, Western MA, Northeastern MA, and Southeastern MA)), EOHHS has currently defined Spanish and English as the prevalent languages in which written information must be made available.

- At the time of enrollment, MCEs must identify members' needs for culturally and linguistically appropriate services, which must include accommodations for individuals who are Deaf or Hard of Hearing, with vision impairments, and/or have language preferences. MassHealth plans make available, free of charge, oral interpretation services in all non-English languages to assist members with interpretation of all written materials provided to members. Informational materials distributed to members via mail are accompanied by a card that indicates that the enclosed materials are important and should be translated immediately. The card also provides information on how the member may obtain help with getting the materials translated.

- In addition, all plans are required, to the degree possible, to complete population profiles that describe geographic location, settings, and socio-demographics (e.g., age, gender, race, ethnicity, and housing status) of the member population. These activities are part of an overall community needs assessment that informs how plans can develop goals and activities that engage members and their communities toward health improvements.

6.2 Access and Availability

All MCEs and the Managed BH Vendor are required to maintain a provider network that, at a minimum, provides members access to all Medically Necessary Medical and Behavioral Health Covered Services according to contracted standards.

MCEs and the Managed BH Vendor are required to ensure adequate access to covered services for all members and facilitate access to non-covered services. All services need to be accessible and available to members in a timely manner. Accessibility is defined as the extent to which members can obtain services at the time they are needed. Availability is defined as the extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership.

Overall, MCEs and Managed BH Vendor must assure their capacity to serve members in accordance with the access and availability standards MassHealth specifies by submitting reports on an annual basis, and whenever there is a significant change to the operations of the provider network or the provider network itself that would affect the adequacy and capacity of services.

Standards also include ensuring access to covered services in accordance with state and federal laws for persons with disabilities by ensuring that network providers are aware of and comply with such laws so that physical and communication barriers do not inhibit members from obtaining services.

In accordance with 42 CFR 438.206(c)(1)(iii), MCEs and Managed BH Vendor must make covered services available 24 hours a day, seven days a week when medically necessary.

Requirements for Physical Health Services:

- Emergency Services that are available immediately upon presentation at the service delivery site, including non-network and out-of-area facilities; and in accordance with 42 U.S.C. §1396u-2(b)(2) and 42 CFR 434.30, provide coverage for Emergency Services to Enrollees 24-hours a day and seven days a week without regard to prior authorization or the Emergency Service Provider's relationship to the MCO or ACO.
- Primary Care services that are available:

    - Within 48 hours of the Enrollee's request for Urgent Care;
    - Within 10 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and
    - Within 45 calendar days of the Enrollee's request for Non-Symptomatic Care, unless an appointment is required more quickly to assure the provision of screenings in accordance with the schedule established by the EPSDT Periodicity Schedule
- Primary Care or Urgent Care during extended hours to reduce avoidable inpatient admissions and emergency department visits
- Specialty Care that is available:
    - Within 48 hours of the Enrollee's request for Urgent Care;
    - Within 30 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and
    - Within 60 calendar days for Non-Symptomatic Care.

Requirements for members newly placed in the care or custody of DCF:

- Within 7 calendar days of receiving a request from a DCF caseworker, a DCF Health Care Screening shall be offered at a reasonable time and place. DCF Health Care Screening shall attempt to detect life threatening conditions, communicable diseases, and/or serious injuries, or indication of physical or sexual abuse; and
- Within 30 calendar days of receiving a request from a DCF caseworker, a comprehensive medical examination, including all age-appropriate screenings according to the EPSDT Periodicity Schedule shall be offered at a reasonable time and place.

Requirements for Receiving Behavioral Health Services:

- Emergency Services immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present at any qualified Provider, whether a Network Provider or a non-Network provider.
- Emergency Services Program Services immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present for such services.
- Urgent Care within 48 hours for services that are not Emergency Services or routine services.
- All Other Behavioral Health Services within 14 calendar days.

Requirements for Receiving Services Described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:

- Non-24-Hour Diversionary Services – within two calendar days of discharge;
- Medication Management – within 14 calendar days of discharge;
- Other Outpatient Services – within seven calendar days of discharge; and
- Intensive Care Coordination Services – within the time frame directed by EOHHS.
- The Contractor shall ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or MassHealth Fee-For-Service, as applicable.

Pharmacy services must be provided in accordance with usual and customary community standards; members must receive access to pharmacy services in a timely manner,

For all other service, members must receive access in accordance with usual and customary community standards.

MCEs and the Managed BH Vendor may request an exception to the contracted access standards by submitting a written request to MassHealth. The request must include alternative standards that are equal to or exceed the usual and customary community standards for accessing care.

MCEs and the Managed BH Vendor are required to monitor and document access and appointment scheduling and use statistically valid sampling methods to monitor compliance with the appointment/access standards. Prompt action will be taken to address any access deficiencies, including but not limited to taking corrective action. Additional details regarding access and availability standards are available through individual contracts and EQRO reports.

For more information and detail please visit: [MassHealth Health Plan Contracts | Mass.gov]

6.3 Coordination and Continuity of Care

MassHealth plans must support coordinated care by ensuring that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care delivered to the member. All members receive timely and coordinated access to all medically necessary services, including BH and specialty services. Plans are required to link staff in other agencies and/or community service organizations if the agency/organization is already involved in meeting the member's needs, or if the agency/organization is identified as helpful in meeting such needs.

MassHealth requires that plans exercise best efforts to provide coordinated covered and non-covered services in settings such as adult and family shelters (especially for members who are homeless), at a member's home when office visits are unsafe or inappropriate for a member's health status, at the member's place of employment or school, and other residential placements, especially for children in the custody of the Commonwealth. Children and youth under 22 years of age who are in the care or custody of the Massachusetts Department of Children and Families and meet certain medical necessity criteria due to severe traumatic injury or birth defects are enrolled in a special complex care management program aimed at providing complex multi-disciplinary care in community-based foster home settings.

Contracted plans ensure that a care management approach is coordinated with a dedicated group of clinicians and other professionals including the member; the member's guardian, representative and/or family member(s) as appropriate; the member's PCP as appropriate; providers from relevant specialties, sub-specialties, and other ancillary health care services (e.g., mental health and substance abuse, nutrition, and rehabilitation, as appropriate); a Care Management Coordinator; and one or more Care Management individuals representing the Plan or Subcontractor.

A. Continuity of Care

To ensure that members successfully transition to their new health plans and continue to have access to all the services they need, MassHealth requires that contracted MCEs provide appropriate continuity of care (CoC). The CoC period for MassHealth ranges from 30 days for most ACO, MCO, and PCC Plan members to up to 90 days One Care and SCO members

- MCO, ACPP, and PCACO: New members that enroll from another MassHealth MCP, FFS, or commercial carrier are provided with 30-day continuity of care period. The CoC period may be extended for ACO, MCO, and PCC members up to 90 days for members receiving Applied Behavior Analysis (ABA) services and members whose PCP moves to a new MassHealth plan.

- Managed BH Vendor: Requires development of CoC plans for special populations including children in the care and/or custody of the Commonwealth who change providers due to changes in their foster care arrangements or for other reasons, and participants who transfer from the Integrated Care Management Program (ICMP) to Practice Based Care Management (PBCM) and/or pilot ACO care management programs.
- One Care: requires a CoC for all members enrolling from FFS or members changing One Care Plans. The aim of these policies and procedures is to minimize disruption of care and ensure uninterrupted access to Medically Necessary Services. The One Care CoC period is completed when members sign their care plan – usually within 90 days but the CoC must be extended until the care plan is complete.
- SCO: MassHealth requires that SCOs provide a 90-day CoC period for members that are passively enrolled into a SCO plan.

Detailed CoC requirements are included in all MCP contracts, and these policies and procedures cover a full range of services. Examples of these services include: durable medical equipment; prosthetics, orthotics and supplies; physical therapy, occupational therapy or speech therapy; scheduled surgeries; out-of-area specialty services; nursing home admissions; honoring of prior authorizations and prior approvals for services for the duration of such prior authorizations and prior approval; access emergency services at any emergency room, including from out-of-network providers; honoring of existing prescriptions for covered drugs; and accepting and utilizing medical records, claims histories, and prior authorizations from an member's previous MCP.

In addition, MCPs have specific policies and procedures for members who, at the time of their transition, are pregnant or have special or significant health care needs, including behavior health or substance use needs and complex medical conditions (e.g., terminal illness, receiving inpatient care at time of enrollment) that may require a longer CoC period. In certain cases, CoC for these individuals may be extended beyond the 30- or 90-day period.

B. Program-Specific Requirements for Care Coordination

Generally, all MCPs must maintain care management programs for any member (adults and children) who needs assistance coordinating physical and BH services and benefits to maintain optimal levels of health, though some programs require care management services for all members.

Some of the programs have additional program-specific requirements for care coordination. The following are example activities by MassHealth MCPs, but do not represent the totality of requirements.

1. **ACO and MCO Programs**

Initial Care Needs Screening

Like the other MCPs, the MCO and ACO Programs must identify members' the health and functional needs. They must develop, implement, and maintain procedures for completing an initial care needs screening for each and complete the screening within 90 days of the member's Effective Date of enrollment.

In addition to other requirements, the survey instrument MCOs and ACOs use to conduct the initial care needs screening must include questions on member demographics, and health history, including chronic illness, current treatment, and self-perceived health status. It must also include questions to identify members with special health care needs, members that need culturally and linguistically appropriate services, and members requiring medical and diagnostic equipment, as well as members' health concerns/goals and children's care needs, including evaluating characteristics of the members' families and homes. Furthermore, like the other MCPs, the MCO and ACO program care needs screening also evaluates member needs for behavioral-health-related services, as well as any LTSS-related services. These evaluations must include an assessment of members' current use of such services, as well as any unmet needs.

Transitional Care Management Program

Per their contracts, MCOs and ACOs must develop and implement transitional care protocols with all network or affiliated hospitals to ensure follow-up with a member within 72 hours of discharge from any type of hospital inpatient stay or emergency department visit, a home visit, an in-office appointment, a telehealth visit, or phone conversation, as appropriate. MCOs and ACOs are required to ensure that post-discharge plans are appropriate based on the needs of the member and identify the need for follow-up services. These protocols must be developed in partnership with CPs as applicable and integrate other care management activities and personnel such as care coordinators or clinical care managers.

2. **Senior Care Options**

Comprehensive Assessment

Comprehensive assessments for members enrolled in the Senior Care Organizations (SCOs) are conducted every six months, when there is a change in health status, and quarterly for any member with a Complex Care Need. A Complex Care Need is defined as any condition or situation that demonstrates the member's need for expert coordination of multiple services, including, but not limited to clinical eligibility for institutional long-term care and medical illness, psychiatric illness, or cognitive impairment that requires skilled nursing to manage essential unskilled services and care.

SCOs are required to maintain a Centralized Member Record (CER) that documents current medical, functional, and social status. The CER must be available 24/7 to nurse case managers and the member's

clinicians to manage emergency and urgent care, as well as to manage transitions across institutional and community settings of care.

3. **One Care**

Comprehensive Assessments

One Care plans must complete Comprehensive Assessments for each new member within 90 days of the member's effective enrollment date, annually, and whenever the member experiences a major change that is not temporary, affects their health status, and/or requires review or revision of their Individualized Care Plan. Comprehensive Assessments are documented in the Centralized Member Record and include domain areas the Commonwealth specifies. Domain areas include health status, medications, functional status, personal goals, housing status, social supports, and more. Results of the Comprehensive Assessments are used to inform the Individualized Care Plan.

Long-term Supports (LTS) Coordinator

MassHealth requires each One Care plan to offer members an LTS Coordinator to participate as part of the member's care team. The LTS Coordinator brings expertise in community supports to the member and assists with the coordination of their LTSS as applicable. The LTS Coordinator's primary responsibilities are to: ensure person-centered care, counsel potential members; provide communication and support needs; and act as an independent facilitator and liaison between the member, the One Care plan, and their service providers. LTS Coordinators help members identify and understand their needs and the kind of help and supports they want from the One Care plan, including:

- Identification of community services and resources
- Development of an Individualized Care Plan that includes services that will support members' health, safety, independence, and/or recovery
- Connection to the services in members' Individualized Care Plan
- Helping members understand and protect their rights as a One Care member

Member needs for LTSS and BH should be identified through the Comprehensive Assessment. The member's care plan should reflect their goals and preferences for addressing their LTSS and BH needs. In addition, the Comprehensive Assessment would also identify any functional limitations an individual may have and need assistance in addressing.

4. **PCC Plan**

Integrated Care Management Program (ICMP) and Practice-Based Care Management (PBCM)

In collaboration with the Managed BH Vendor, the PCC Plan provides increased support and coordination of care for members who have complex medical and/or BH care needs and whose overall health care may benefit from the assistance of a care manager and increased support for the providers that regularly manage their care. In addition, select PCC Plan service locations may contract with the Managed BH Vendor to conduct their own Practice-Based Care Management (PBCM) programs that mirror the standards of the plan-based CMP.

6.4 Coverage and Authorization of Services

In accordance with 42 CFR 438.210, each MassHealth MCE and the Managed BH Vendor must specify the amount, duration, and scope of each covered service. Services may be no less than the amount, duration, and scope for the same services furnished to beneficiaries under MassHealth FFS, may not be compromised solely because of diagnosis, type of illness, or condition of a member, and must be rendered in accordance with the

medical necessity standard. All MCEs operate under the same definition of medical necessity as MassHealth fee-for-service.

MassHealth MCEs implement written policies and procedures for processing requests for authorizations of services. Authorization decisions must be based on consistently applied review criteria and consultation with requesting providers, when appropriate, and must be conducted in a timely fashion as required by regulation and contract.

Denials, reductions, terminations, and modifications of services must be made by a health professional that has appropriate clinical expertise in treating the member's condition or disease and must notify the requesting provider and member of the determination in a timely manner, as codified in entity contracts, suitable to the urgency of the member's condition.

All MCEs are required to follow grievance procedures related to adverse action decisions as detailed in their contracts.

6.5 Additional Monitoring and Compliance

A. Health Information Systems

MCEs and the Managed BH Vendor must maintain a health information system (or systems) that collects, analyzes, integrates, and reports data in accordance with 42 CFR 438.242 and that support all aspects of the quality management programs. The system must collect data on member and provider characteristics and on services furnished to members. Contracted plans including the Managed BH Vendor, ensure that data received from providers is accurate and complete by:

- Verifying the accuracy and timeliness of reported data
- Screening the data for completeness, logic, and consistency
- Collecting service information in standardized formats to the extent feasible and appropriate

MassHealth requires MCEs and the Managed BH Vendor to certify that information, data, and documentation in all reports are true, accurate, and complete.

B. Clinical Practice Guidelines

MCEs implement evidence-based practice through dissemination and use of practice guidelines. The guidelines must stem from recognized organizations that develop evidence-based clinical practice guidelines with involvement from board-certified providers from appropriate specialties. Prior to adoption, guidelines must be reviewed by the plan's Medical Director, as well as other practitioners and network providers, as appropriate. Guidelines must consider the needs of members and be reviewed and updated, as appropriate, at least every two years. Plans are required to disseminate guidelines to all new network providers and, upon request, to all members or potential members.

Guidelines must be available on the plan's web site. In addition**,** plans must develop explicit processes for monitoring adherence to guidelines, including ensuring that decisions regarding utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. MCEs also must establish processes for reviewing and updating guidelines.

Guidelines that MassHealth endorses include, but are not limited to, the following:

- MassHealth All Provider Manual –Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical and Dental Protocol and Periodicity Schedule, Appendix W (2020)
- Massachusetts Health Quality Partners Guidelines for Adult and Pediatric Preventive Care (2021)

- Massachusetts Health Quality Partners Guidelines for Perinatal Care (2021)
- Massachusetts Department of Public Health and CDC Immunization Schedules and Guidelines

Section 7: Improvement and Interventions

7.1: Improvement and Interventions

Improvement strategies described throughout this document are designed to advance the quality of care delivered by MCEs through ongoing measurement and intervention.

MassHealth convenes internal and external committees as well as workgroups to ensure stakeholders have opportunities to advise, share best practices, and contribute to inform quality measurement, quality program design, monitoring of results, and development of improvement projects and program services. Examples of these committees include the Delivery System Reform Incentive Payment (DSRIP) subcommittee, DSRIC, SCO Advisory Committee, One Care Implementation Council, and the Massachusetts Quality Measurement Alignment Taskforce. Please refer to Table 3 earlier in this document for a full list.

Improvement strategies described throughout this document are designed to advance the quality of care MCEs deliver, including periodic review and dissemination of standard practice guidelines, ongoing measurement, evaluation, and interventions. Targeted interventions are developed through the formal PIPs process and are not limited to participation in other performance management or quality improvement collaboration opportunities (e.g., corrective action plans, affinity groups, pilot measurement, or improvement activities).

7.2: Intermediate Sanctions

EOHHS monitors compliance through routine reporting requirements, regular meetings with entities, and ongoing communications as appropriate and necessary.

EOHHS may apply intermediate sanctions to MCEs if any of the entities act or fail to act as follows:

- Fail substantially to provide medically necessary items or services
- Impose excess co-payments, premiums, or charges on members
- Discriminate among members on the basis of health status or need for services
- Misrepresent or falsify information submitted to EOHHS or CMS
- Misrepresent or falsify information to members or providers
- Fail to comply with the requirements for physician incentive plans

Plan contracts identify additional circumstances under which sanctions may be imposed, including, but not limited to:

- Failure to comply with federal or state statutory or regulatory requirements
- Violation of restrictions or other requirements regarding marketing materials
- Failure to comply with any corrective action plan MassHealth requires
- Failure to comply with financial solvency requirements
- Failure to comply with the contract

A list of additional plan sanctions, as per 42 CFR 438.702, includes, but is not limited to:

- Suspension of payment for members enrolled after the effective date of the sanction

- Appointment of temporary management to oversee the operation of the plan in those circumstances set forth in 42 USC §1396 u-2(e)(2)(B) and 42 CFR 438.706
- Notification to affected members of their right to disenroll
- Suspension of enrollment or disenrollment of members
- Termination of the contract
- Additional sanctions allowed under federal law or state statue or regulation that address areas of noncompliance

Section 8: Key Initiatives Impacting the CQS

8.1 Delivery System Reform

Since 1997, the MassHealth 1115 Demonstration has been a critical tool in enabling Massachusetts to achieve and maintain near-universal coverage, sustain the Commonwealth's safety net, expand critical behavioral health services, and implement reforms in the way that care is delivered.

The MassHealth ACO program launched in 2018 with accountability for total cost of care, quality, and member experience. Seventeen of the state's largest provider systems have become ACOs; more than 80% of eligible MassHealth members are now enrolled in an ACO and 100% of Safety Net Hospitals now participate in an ACO.

ACOs are provider-led organizations held contractually responsible for the quality, coordination, and total cost of members' care. MassHealth's ACO approach focuses on improving integration and delivery of care for members with behavioral health (BH) needs and those with dual diagnoses of substance abuse disorder as well as integration of long-term services and supports (LTSS) and health-related social services.

ACOs are required to establish relationships with community based BH and LTSS organizations selected to contract with MassHealth as Community Partners (CPs), furthering the integration of care. This shift from fee-for-service (FFS) to accountable, total cost of care models is central to the Commonwealth's goals of a sustainable MassHealth program.

- Early results from the ACO program demonstrate:
    - ACOs are strengthening connections to primary care, with primary care visits increasing 2% from 2018 to 2019, and 12% higher for ACO-enrolled members than non-ACO-enrolled members.
    - ACOs are reducing preventable acute utilization, with reductions in avoidable admissions by 11% from 2018 to 2019, as compared to a 2% reduction for non- ACO-enrolled members.
    - ACOs are improving clinical quality, with 2018 quality scores high (performance year 1), which increased in 2019 for a significant majority of quality measures.
- ACO care coordination programs funded by the DSRIP program are working, with 70% of programs demonstrating positive results.
- The Behavioral Health and Long-Term Services & Supports Community Partners programs provide enhanced care coordination for the highest-risk MassHealth members. BH and LTSS CPs have actively engaged approximately 20,000 of MassHealth's hardest-to-reach members, with promising early progress demonstrating a more than 3-fold increase in member engagement in 2019 from 2018.

- The Flexible Services Program has enabled ACOs to partner with social service organizations (SSOs), establishing 38 new ACO-SSO partnerships and providing housing and nutritional supports aimed at improving health outcomes and/or reducing health care costs.
- Massachusetts continued to have the highest rate of insurance in the nation at 97%, with 98.7% of children under 18 insured as of 2019, as well as among the lowest exchange premiums in the nation during the 2018-2021 time period.[2]

Future advancement in accountable care

In December 2021, the Massachusetts Executive Office of Health and Human Services (EOHHS) submitted a request to extend the MassHealth Section 1115 Demonstration ("1115 waiver") to the Centers for Medicare and Medicaid Services (CMS).

MassHealth's proposed 1115 Demonstration extension reflects intensive and ongoing stakeholder engagement

- Workgroups including over 100 participants met throughout 2020 and in early 2021 to inform policy design
- A broad range of stakeholders were engaged throughout the process, including consumer advocates, health care providers such as community health centers, hospitals, and behavioral health providers, LTSS providers, as well as community organizations

MassHealth anticipates updates to the CQS as performance goals are identified and finalized and contingent on a program extension starting in 2023.

8.2 Behavioral Health Reform

A five-year roadmap for behavioral health reform (BH Roadmap) was released in 2021, charting a path to expand equitable access to behavioral health services. The Roadmap is based upon statewide listening sessions and feedback collected since 2019.

Nearly 700 individuals, families, and others identified key challenges and gaps in the system:

- Individuals and families often do not know what services are available or how to connect to them
- Not enough behavioral health providers accept insurance (public or private) or have long waiting lists
- People often turn to the emergency department during a behavioral health crisis because there is no effective system for immediate urgent care in the community
- **Individuals often cannot get mental health and addiction treatment at the same location, even though mental health conditions and substance use disorder (SUD) often co-occur**
- Culturally competent behavioral health care for racially, ethnically, and linguistically diverse communities can be difficult to find

[2] "Average Marketplace Premiums by Metal TIER, 2018-2021." Kaiser Family Foundation State Health Facts, December 10, 2020. https://www.kff.org/state-category/health-coverage-uninsured/

Currently only 50% of people in Massachusetts who have a mental illness receive treatment despite significant improvements to treatment capacity made over the past five years. Too often, people first experience mental health or substance use treatment when they experience an emergency and end up at a hospital Emergency Department. These challenges have been further exacerbated by the COVID-19 pandemic.

Key components of the Roadmap include:

- Ensuring coverage of behavioral health integration in primary care and for preventive behavioral health services for youth
- Better and more convenient community-based alternatives to the emergency department (ED) for urgent and crisis intervention services, including the launch of Community Behavioral Health Centers that will provide access to urgent, and ongoing behavioral health treatment and will provide community and mobile crisis intervention services
- Establishing a 24/7 Behavioral Health Help Line to serve all individuals in the Commonwealth seeking clinical assessment and intake, information, resources, and referrals to substance use disorder or mental health treatment services regardless of their insurance

A critical piece of implementing the Roadmap is the creation of a 24-7 Behavioral Health Help Line that will help individuals and families connect with a provider, before there is a mental health emergency, for routine or urgent help in their community or at home. The Help Line will be available to all Massachusetts residents starting in 2023.

Newly designated Community Behavioral Health Centers (CBHCs) anticipated in 2023 will support expanded availability of outpatient evaluation and treatment in communities across the state. CBHCs will serve as an entry point for timely, high-quality mental health and substance use treatment on an urgent and ongoing basis and receive enhanced funding to support flexible, person-centered treatment.

In addition to this front door, the Roadmap proposes reforms to make outpatient assessment and treatment more readily available through several changes including:

- Expanded access to treatment, including nights and weekends for a subset of behavioral health providers
- More behavioral health treatment—including mental health and addiction services—at primary care offices
- Better, more convenient community-based alternatives to the emergency department for crisis intervention services

These reforms do not replace or disrupt existing services or provider relationships. Rather, they aim to improve access to these services with more options for care and treatment and access to culturally relevant care with investments in workforce competency.

MassHealth anticipates updates to the CQS as we continue our progress on the behavioral health strategy.

8.3 Health Equity Initiative

Over the next five years and as part of the renewal of the 1115 demonstration, MassHealth proposes building on past efforts through significant new incentives for health care provider organizations and plans tied to addressing structural racism and reducing health disparities. This

innovative proposal goes beyond most existing quality programs, reflecting a growing interest in the Commonwealth and nationally to advance health equity as an essential tenet of high-quality care.

Through this effort, MassHealth aims to gain more insight at the state, ACO, and hospital level into health and health care disparities experienced by its members to make measurable progress toward closing identified disparities within the waiver period. To that end, MassHealth seeks to implement incentive programs that achieve the following:

- Complete and accurate social risk factor data for MassHealth members
- Periodic, stratified reporting on quality performance indicators by social risk factors, and
- Significant reductions in health disparities over time.

Incentives will be designed to ensure providers serving disproportionately socially-at risk populations will not be disadvantaged by the introduction of incentives. This incentive proposal complements other investments MassHealth proposes in the health equity space, including student loan repayment for behavioral health clinicians in high-Medicaid practices and strategies to address health-related social needs.

To advance health equity, MassHealth proposes health equity incentives consisting of three health-equity related subcomponents:

- **Sub-component 1: Collection of complete, accurate, and self-reported social risk factor data**

  Complete and accurate social risk factor data will be essential to identifying inequities, informing interventions, and monitoring progress over time. Collection and reporting of member-level data on social risk factors may include race, ethnicity, language, disability, sexual orientation, and gender identity. MassHealth intends to set ambitious performance targets for social risk factor data completeness to facilitate sufficient levels for analysis of disparities. Lack of sufficient completeness will hinder identification, action, and evaluation of interventions on inequities.

- **Sub-component 2: Identify and monitor health and health care inequities through stratified reporting**

  MassHealth anticipates leveraging stratified performance reporting for at least two purposes:

  1. To support ACO, ACO-participating hospital, and non-state-owned public hospital health equity programming and quality improvement activities
  2. For public reporting of health equity performance, once technical thresholds for validity and reliability are met

  MassHealth intends to set ambitious targets for stratified reporting of quality metrics by social risk factors to promote health care providers' capacity to access, analyze, and interpret social risk factor data in service of health equity goals. MassHealth also intends to use public reporting to enhance transparency around health equity performance across the system.

- **Sub-component 3: Reduce identified inequities through targeted and evidence-based interventions**

MassHealth proposes selecting a subset of "target metrics" which would be used to incentivize reductions in specific disparities. MassHealth intends to select target metrics using both stratified reporting data from the early years of the demonstration, as well as a predetermined set of criteria, including but not limited to:

- Relevance and importance to the MassHealth population
- Scope of inequity and population impacted
- Evidence based supporting relationship between a social risk factor and health or healthcare outcome
- Conceptual and/or empirical basis for intervention, and
- Technical feasibility (including expectation that sufficient data completeness is achieved to facilitate valid baseline and annual performance)

MassHealth intends to work with ACOs and hospitals to select a smaller number of target metrics/dimensions of inequity for each entity, allowing for variability in that subset across entities. The agency anticipates this approach would offer an appropriate balance between incentives for targeted action on MassHealth-wide priorities and specific priorities plans and providers identify based on the unique characteristics of their populations served. Entity performance will be determined by improvement towards or achievement of benchmarks MassHealth establishes using program or external performance data, as relevant and available.

MassHealth anticipates updates to the CQS as we continue our progress on advancing health equity.

Section 9: Future Opportunities

MassHealth is committed to continued evolution and advancement of its CQS to improve and monitor the quality of care for its members with the goal of better care, better health, and lower costs.

Opportunities to advance the CQS and goals and meet the unique and often complex needs of our population include:

- Reaffirming key priorities across the organization to drive population health with focus on maternal and child health, preventative care, and chronic health conditions.
- Implementing the behavioral health roadmap to ensure expanded access to coordinated and integrated physical and mental health care and services.
- Continuing to understand and improve our members' experience by focusing on the experience of member program populations and subpopulations (e.g., disability, stratifications by social risk factors) for members receiving primary care, behavioral health, long-term services and support, and potentially other services.
- Aligning measurement and quality improvement to focus priorities and reduce burden to providers and payers both internal to the organization and at a statewide and national level
- Leveraging technologies and advancements in timely quality measurement, collection, and reporting to support more timely monitoring and improvement

The CQS reflects an active, ongoing, and iterative process engaging both our internal organization across programs and functions as well as our external stakeholder community. MassHealth is committed to its own continuous quality improvement, enhancement of processes, and opportunities to enhance engagement, program development, implementation, and monitoring quality across MassHealth. This will be critical to MassHealth's overall success in serving its members.

Appendices

Appendix A: Acronyms

Acronym	Definition
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plan
AHRQ	Agency for Healthcare Research and Quality
BH	Behavioral Health
BMC	Boston Medical Center
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBHI	Children's Behavioral Health Initiative
CDC	Centers for Disease Control and Prevention
CDRH	Chronic Disease Rehabilitation Hospital
CER	Centralized Member Record
CG-CAHPS	Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey
CHIP	Children's Health Insurance Program
CMFI	Care Model Focus Initiative
CMP	Care Management Program
CMS	Centers for Medicare and Medicaid Services
CoC	Continuity of Care
COVID-19	Coronavirus Disease
CP	Community Partner
CQS	Comprehensive Quality Strategy
CSA	Community Service Agency
CSP	Community Support Program
DME	Durable Medical Equipment
DMH	Department of Mental Health
DSRIC	Delivery System Reform Implementation Advisory Council
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ESP	Emergency Services Program
FFS	Fee-for-Service
FPL	Federal Poverty Level
HEDIS	Healthcare Effectiveness Data and Information Set
ICMP	Integrated Care Management Program
IQC	Internal Quality Committee
LTS	Long Term Supports
LTSS	Long Term Services and Supports
MEE	Member Engagement and Experience
MCE	Managed Care Entity
MCP	Managed Care Plans
MHWM	MassHealth Weighted Mean
MEE	Member Engagement and Experience
MES	Member Experience Survey
MCO	Managed Care Organization
MCP	Managed Care Plan

Acronym	Definition
NCQA	National Committee for Quality Assurance
OLTSS	Office of Long-Term Services and Supports
P4P	Pay-for-performance
P4R	Pay-for-reporting
PBCM	Practice Based Care Management
PACE	Program of All-Inclusive Care for the Elderly
PAHP	Prepaid Ambulatory Health Plan
PCA	Personal Care Attendant
PCC	Primary Care Clinician (Plan)
PCCM	Primary Care Case Management
PCCP	Primary Care Clinician Plan
PCP	Primary Care Physician
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QI	Quality Improvement
QIP	Quality Improvement Project
QM	Quality Management
QMAT	Quality Measurement Alignment Taskforce
RELD	Race, Ethnicity, Language, Disability
SCO	Senior Care Options or Senior Care Organizations
SL	Service Location
SOGI	Sexual Orientation and Gender Identity
SRF	Social Risk Factor
SSI	Supplemental Security Income
SUD	Substance Use Disorder
VBP	Value-Based Payment

Appendix B: MassHealth Managed Care Plans (MCPs)

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

Appendix C: Quality Measures, Baselines and Targets

Reference: Managed Care Plan Measures in following appendices are associated with at least one MassHealth Quality Goal and Objective.

Appendix C-1: Statewide Measures: Core Measures (Managed Care Plans: MCEs, PCC Plan)

	Quality Goals and Objectives: Improve health care delivery, experience, and outcomes
1.	**Promote better care:** Promote safe and high-quality care for MassHealth members
1.1	Focus on timely preventative, primary care services with access to integrated care and community-based services and supports
1.2	Promote effective prevention and treatment to address acute and chronic conditions in at-risk populations
1.3	Strengthen access, accommodations, and experience for members with disabilities, including enhanced identification and screening, and improvements to coordinated care
2.	**Promote equitable care:** Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience
2.1	Improve data collection and completeness of social risk factors (SRF), which include race, ethnicity, language, disability (RELD) and sexual orientation and gender identity (SOGI) data
2.2	Assess and prioritize opportunities to reduce health disparities through stratification of quality measures by SRFs, and assessment of member health-related social needs
2.3	Implement strategies to address disparities for at-risk populations including mothers and newborns, justice-involved individuals, and members with disabilities
3.	**Make care more value-based:** Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care
3.1	Advance design of value-based care focused on primary care provider participation, behavioral health access and integration and coordination of care of long-term services and supports
3.2	Develop accountability and performance expectations for measuring and closing significant gaps on health disparities
3.3	Align or integrate other population, provider, or facility-based programs (i.e., hospital, integrated care programs)
3.4	Implement robust quality reporting, performance and improvement, and evaluation processes
4.	**Promote person and family-centered care:** Strengthen member and family-centered approaches to care and focus on engaging members in their health
4.1	Promote requirements and activities that engage providers and members in their care decisions through communications that are clear, timely, accessible, and culturally and linguistically appropriate
4.2	Capture member experience across our populations for members receiving acute care, primary care, behavioral health, and long-term services and supports
4.3	Utilize member engagement processes to systematically receive feedback to drive program and care improvement
5.	**Improve care** through better integration, communication, and coordination across the care continuum and across care teams for our members
5.1	Invest in systems and interventions to improve verbal, written, and electronic communications among caregivers to reduce harm or avoidable hospitalizations and ensure safe and seamless care for members
5.2	Proactively engage high and rising-risk members to streamline care coordination and ensure members have an identified single accountable point of contact
5.3	Streamline and centralize behavioral health care to increase timely access and coordination of appropriate care options and reduce mental health and SUD emergencies

Statewide Performance Target: Targets are based on the national HEDIS Medicaid 75th and 90th percentile as the primary benchmark or targets against which statewide plan performance is compared. The Medicaid 75th percentile is used to reflect a minimum or threshold standard for performance. The Medicaid 90th performance is used to reflect a goal target for performance. Performance targets vary from year to year as benchmarks are updated annually at a national level.

Measure ID	Quality Measure	Baseline (2020)	MassHealth Goal(s) (Objective(s))
NCQA -CIS	Childhood Immunization Status (combo 10)	52.1%	1.1, 3.4
NCQA-PPC	Timeliness of Prenatal Care	84.3%	1.1, 2.2, 3.4
NCQA-IMA	Immunization for Adolescents (combo 2)	44.0%	1.1, 3.4
NCQA-AMR	Asthma Medication Ratio	58.5%	1.1, 1.2
NCQA-CBP	Controlling High Blood Pressure	56.8%	1.1, 1.2, 2.2, 3.4
NCQA-CDC	Comprehensive Diabetes Care: A1c Poor Control (lower is better)	43.3%	1.1, 1.2, 2.2, 3.4
NCQA- APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	36.5%	1.2, 3.4, 5.1, 5.2
AHRQ – Plan CAHPS (Adult scores)	Getting Needed Care Getting Care Quickly How Well Doctors Communicate Customer Service Coordination of Care Ease of Filling out Forms Overall Rating Items (Summary=8+9+10) Overall Rating Items (Summary=9+10) Flu Vaccinations Advising Smokers and Tobacco Users to Quit Discussing Cessation Mediations Discussing Cessation Strategies	85.9 83.1 91.9 86.8 85.8 96.7 82.3 64.8 46.6 80.3 62.4 55.3	3.4, 4.2
NCQA-FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	45.8%	3.4, 5.1- 5.3
NCQA-FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	66.7%	3.4 5.1-5.3
NCQA-FUM-7	Follow-up After Emergency Department Visit for Mental Illness (7 days)	73.5%	3.4, 5.1-5.3
NCQA-FUM-30	Follow-up After Emergency Department Visit for Mental Illness (30 days)	80.5%	3.4, 5.1-5.3
NCQA-FUA-7	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	22.9%	3.4, 5.1-5.3
NCQA-FUA-30	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	33.1%	3.4, 5.1-5.3
NCQA-PCR	Plan All-Cause Readmissions (Observed/Expected Ratio)	1.1461	1.2, 3.4, 5.1, 5.2
NCQA-IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	48.1%	1.2, 3.4, 5.1-5.3
NCQA-IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	17.5%	1.2, 3.4, 5.1-5.3

Appendix C-2: ACO and MCO Program Measures

ACO and MCO Performance Targets: Targets for HEDIS measures are based on the regional HEDIS Medicaid 75th and 90th percentile as the benchmark or targets against for which ACO and MCO plan performance is compared. The Medicaid 75th percentile is used to reflect a minimum or threshold standard for performance. The Medicaid 90th performance is used to reflect a goal target for performance. The baselines were based on CY2017 data where possible. Annual targets are based on gap to goal performance to reach the 90th percentile during the five years of the demonstration (Measurement Year 2018-Measurement Year 2022).

For measures that are not HEDIS measures, and absent of external benchmarks, MassHealth employs an approach that assesses initial baseline performance of the ACOs (e.g., 2017). Fixed targets are determined in review of average, median and individual ACO performance to determine reasonable threshold percentile that can be as low as the 25th percentile to account for newer measures that can have a lot of variation among entities, and a goal typically at the 90th percentile.

Measure ID	Quality Measure *(+ not included in MCO program)*	ACO Baseline 2020	MCO Baseline 2020	MassHealth Goals/ Objectives
NCQA-PPC	Timeliness of Prenatal Care	84.5%	75.0%	1.1, 2.1, 3.1
CG-CAHPS	Willingness to Recommend+	(Adult) 85.2 (Child) 90.9	+	3.1, 4.2
CG-CAHPS	Communication+	(Adult) 87.1 (Child) 91.2	+	3.1, 4.2
CG-CAHPS	Integration of Care+	(Adult) 78.1 (Child) 80.2	+	3.1, 4.2
CG-CAHPS	Knowledge of Patient+	(Adult) 81.6 (Child) 87.2	+	3.1, 4.2
NCQA-FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	48.2%	44.8%	3.1, 5.1 – 5.3
NCQA-FUM-7	Follow-up After Emergency Department Visit for Mental Illness (7 days)	73.1%	73.0%	3.1, 5.1 – 5.3
NCQA-IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	46.4%	54.4%	1.2, 3.1, 5.1-5.3
NCQA-IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	15.9%	21.7%	1.2, 3.1, 5.1-5.3
NCQA-DSF	Screening for Depression and Follow-Up Plan+	37.1%	+	1.1, 3.1, 5.1, 5.2

Appendix C-3: Managed Behavioral Health Vendor Program Measures

Managed BH Vendor Performance Targets: Measure targets are based on the national HEDIS Medicaid 75th and 90th percentile as the primary benchmarks or targets against which plan performance is compared. The Medicaid 75th percentile is used to reflect a minimum or threshold standard for performance. The Medicaid 90th performance is used to reflect a goal target for performance. Performance targets vary from year to year as benchmarks are updated annually at a national level.

Measure ID	Quality Measure	Baseline 2020	MassHealth Goals/Objectives
ADD-I	Follow-Up Care for Children Prescribed ADHD Medication (initiation)	37.4%	1.2, 3.4, 5.1, 5.2
ADD-C	Follow-Up Care for Children Prescribed ADHD Medication (continuation)	40.7%	1.2, 3.4, 5.1, 5.2
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	33.0%	1.2, 3.4, 5.1, 5.2
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	73.4%	1.2, 3.4, 5.1, 5.2
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 day)	76.0%	3.4, 5.1 – 5.3
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness (7 day)	82.1%	3.4, 5.1 – 5.3
FUA-7	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 day)	20.8%	3.4, 5.1 – 5.3
FUA-30	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day)	32.0%	3.4, 5.1 – 5.3
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 day)	48.3%	3.4, 5.1 – 5.3
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 day)	68.1%	3.4, 5.1 – 5.3
IET-I	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (7 day)	45.3%	1.2, 3.4, 5.1-5.3
IET-E	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (30 day)	17.4%	1.2, 3.4, 5.1-5.3
AMM-A	Antidepressant Medication Management (acute)	60.7%	1.2, 3.4, 5.1, 5.2
AMM-C	Antidepressant Medication Management (continuation)	50.4%	1.2, 3.4, 5.1, 5.2

Appendix C-4 Senior Care Option Program Measures

SCO Performance Targets: Measure targets are based on the national HEDIS Medicare and Medicaid 75th and 90th percentile as the primary benchmarks or targets against which plan performance is compared. The Medicare 75th percentile is used to reflect a minimum or threshold standard for performance. The Medicare or Medicaid 90th percentile performance is used to reflect a goal target for performance. Performance targets vary from year to year as benchmarks are updated annually at a national level.

Measure ID	Quality Measure	Baseline 2020	MassHealth Goals/ Objectives
NCQA-COL	Colorectal Cancer Screening	76.2%	1.1, 2.2, 3.4
NCQA-FVO NQF0041	Influenza Immunization (age 65+) (CAHPS)	NA	1.1, 3.4, 4.2
CMS127v9 NQF 1653	Pneumococcal Immunization	NA	1.1, 3.4
NCQA- COA	Care For Older Adults: Advance Care Plan	77.0%	1.1, 3.4, 4.1
NCQA-TRC	Transitions of Care: Medication Reconciliation Post-Discharge	54.3%	1.2, 3.4, 5.1
NCQA-PBH	Persistence of Beta Blocker Treatment After Heart Attack	90.9%	1.1, 1.2, 3.4
NCQA-CBP	Controlling High Blood Pressure	61.2%	1.1, 1.2, 2.2
NCQA-PCE-C	Pharmacotherapy Management of COPD Exacerbation Corticosteroids	74.5%	1.1, 1.2, 3.4
NCQA-PCE-B	Pharmacotherapy Management of COPD Exacerbation Bronchodilators	90.8%	1.1, 1.2, 3.4
NCQA-SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	23.9%	1.2, 3.4
NCQA-DAE	Use of High-Risk Medications in the Elderly - Total	21.6%	1.2, 3.4, 5.1
NCQA-DDE	Potentially Harmful Drug Disease Interactions in the Elderly (total)	32.4%	1.2, 3.4, 5.1
NCQA-FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	37.3%	3.4, 5.1- 5.3
NCQA-FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	61.0%	3.4, 5.1- 5.3
NCQA PCR	Plan All-Cause Readmission (Observed/Expected Ratio)	1.1493	1.2, 3.4, 5.1, 5.2
NCQA-OMW	Osteoporosis Management in Women Who Had a Fracture	25.5%	1.2, 3.4, 5.1
NCQA-AMM-A	Antidepressant Medication Management Acute	78.9%	1.2, 3.4, 5.1, 5.2
NCQA-AMM-C	Antidepressant Medication Management Continuation	65.1%	1.2, 3.4, 5.1, 5.2

Appendix C-5: One Care Program Measures

One Care Performance Targets: For HEDIS measures in the One Care measure slate, MassHealth uses the HEDIS Medicaid or Medicare 90th percentile as the primary benchmark against which plan performance is compared. The Medicaid or Medicare 75th percentile is used to reflect a minimum standard of performance. Minimum performance targets are the HEDIS 75th percentile and vary from year to year as benchmarks are updated.

Measure ID	Quality Measure	Baseline 2020	MassHealth Goals/Objectives
FVO	Influenza Vaccination	70.5%	1.1, 3.4
NCQA-CBP	Controlling High Blood Pressure	56.7%	1.1, 1.2, 3.4
NCQA-CDC	Comprehensive Diabetes Care: A1c Poor Control (lower is better)	53.0%	1.1, 1.2, 3.4
MA 1.3	Access to LTS Coordinator - Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment	99.6%	1.1, 1.3, 2.3, 3.4, 5.2
MA 5.1	Tracking of Demographic Information - Percent of members whose demographic data are collected and maintained in the MMP Centralized Enrollee Record (race/ethnicity/ primary language/homelessness/disability type/LGBTQ identity	83.9%	2.1, 3.4
AHRQ CMS – Core 2.1	Medicare Advantage Prescription Drug Plan CAHPS – Timely Assessment - Percent of members with an initial assessment completed within 90 days of enrollment	89.8%	3.4, 4.2, 5.2
MA 1.2	Documentation of Care Plan Goals - Percent of members with documented discussions of care goals	98.9%	3.4, 5.2
NCQA-FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	70.8%	3.4, 5.1 – 5.3
NCQA-IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	40.6%	1.2, 3.4, 5.1-5.3
NCQA-IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	11.4%	1.2, 3.4, 5.1-5.3
NCQA-PCR (<65)	Plan All-Cause Readmission (observed/expected ratio) (18-64 years)	1.0440	1.2, 3.4, 5.1-5.3