



MassHealth

Comprehensive Quality Strategy

Effectiveness Evaluation

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid

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Introduction

The Commonwealth of Massachusetts, Executive Office of Health and Human Services (EOHHS) Office of Medicaid is pleased to submit the **Comprehensive Quality Strategy (CQS) Effectiveness Evaluation** (“Evaluation”) for the MassHealth CQS published in November 2018 (“2018 CQS”) and covering the three-year period of Calendar Years (CY) 2019 through 2021.

In accordance with 42 CFR §438.340(c)(2), EOHHS evaluates the effectiveness of the CQS at least every three years to assess whether MassHealth has met or made progress on its quality strategy goals. This Evaluation will use data collected during CY 2019–2021, reflecting a quality performance measurement period for Measurement Year (MY) 2018 through 2020 (1/1/18 – 12/31/20).

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

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

MassHealth Managed Care Programs

MassHealth operated the managed care programs¹ or managed care plans (MCPs) listed below during the time period covered by the 2018 CQS. These MCPs are the focus of this Evaluation.

Detail on current programs is found in the 2022 Comprehensive Quality Strategy (CQS), available on the MassHealth quality reports and resources webpage: www.mass.gov/info-details/masshealth-quality-reports-and-resources. The MCPs are as follows:

Accountable Care Organizations (ACO) – ACOs are provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for the value of care provided, measured by better outcomes and reduced cost. MassHealth had three ACO delivery models.

1. Accountable Care Partnership Plan (ACPP): ACPPs have a network of PCPs who have exclusively partnered with an MCO to use their provider network to provide integrated and coordinated care for members. Accountable Care Partnership Plans are paid a prospective capitation rate for all attributed members. ACPPs are responsible for all contractually covered services and take on

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 applicable conditions. Nothing in this document should be read to alter or amend any contractual obligation. To the extent any discrepancies or conflicts exist between this document and the contract, the language of the contract controls.

full insurance risk. Accountable Care Partnership Plans pay provider claims for all plan-covered services.

2. **Primary Care ACO (PCACO):** A PCACO is a network of PCPs who contract directly with MassHealth, using MassHealth's provider network, including the Behavioral Health (BH) Plan to provide integrated and coordinated care for members. A PCACO does not receive capitation payments for providing services to attributed members. MassHealth pays providers on a fee for service basis directly. Behavioral health providers must enroll with the BH Plan and are paid in accordance with their BH Plan provider agreements. PCACOs use the MassHealth network for specialty services and have the option of defining a Referral Circle. If a member's specialist is part of the Referral Circle identified by the member's PCACO, the member will not need a referral to receive services from that specialist.
3. **MCO-Administered ACO:** a network of PCPs who contract with one or more MCOs and use the MCO provider networks to provide integrated and coordinated care for members. MCO-Administered ACOs are not presented as an enrollment option because members will be enrolled with the MCO and attributed to the contracted ACO through the MCO they are enrolled with. MCOs pay claims to providers in their networks.

Managed Care Organization (MCO) Program – a capitated model for managed care eligible members under the age of 65. Members are not eligible for managed care programs if they have any kind of third-party insurance.

Primary Care Clinician (PCC) Plan Program – a primary care case management (PCCM) model of managed care for members under age 65 without any third-party insurance, with a capitated BH Plan. Though not required to comply with managed care rules, MassHealth includes the PCC Plan (a PCCM) in the managed care strategy and evaluation where appropriate.

Behavioral Health Plan – a capitated BH model that provides and/or manages behavioral health services to members of the PCC Plan and PCACO, children in the care and/or custody of the Department of Children and Families and the Department of Youth Services, or members who have third-party insurance or are eligible for Medicaid and Medicare ("dually eligible").

Integrated Care Programs To bring more integrated, coordinated, and person-centered care options to dually eligible members, two programs are offered to dually eligible members:

One Care – An integrated care capitated model for persons with disabilities (between the ages of 21–64 at time of enrollment), who are eligible for full benefits through both the Medicaid and Medicare programs.

Senior Care Options (SCO) – a capitated model for members aged 65 and older, including dually eligible members. SCO plans provide full range of medical, behavioral health, and long-term services and supports.

In accordance with 42 CFR 438, the ACPP, 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). PCACOs are considered primary care case management (PCCM) entities. The PCC Plan is considered a PCCM. The BH Plan 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 2018 CQS relates to (but is not limited to) MCEs, PIHPs, and PCCM entities. Though not required to comply with managed care rules, the 2018 CQS includes the PCC Plan (a PCCM) in the managed care strategy and evaluation where appropriate.

Evaluation Methodology

The evidence base for this CQS includes MassHealth quality measure performance rates from the three-year period from Measurement Year (MY) 2018 through 2020 (1/1/2018 – 12/31/2020). MassHealth used three major criteria in selecting quality measures for inclusion in this Evaluation:

1. Alignment with the original quality strategy goals, as presented in the 2018 CQS;
2. Alignment with the CMS Core Measure Sets, as recommended in CMS's Medicaid and CHIP Managed Care Quality Strategy Toolkit.
3. Alignment with measure slates used to assess MCP contract performance.

In evaluating performance, MassHealth looked at:

1. Change in measure rates from baseline year (MY 2018) to comparison year (MY 2020), and directionality over the three measurement periods (MY 2018-MY 2020) and
2. Comparison of MassHealth measure rates for MY 2020 to national benchmarks (e.g., NCQA Quality Compass National Medicaid 75th percentile rate).

For each measure, MassHealth noted whether MassHealth's aggregate (weighted mean across plans) performance in MY 2020 was equal to or better than the MY 2020 National Medicaid 75th percentile. If not, MassHealth considered whether the MassHealth rate had improved from MY 2018 to MY 2020 using the "Gap to Goal" methodology outlined in CMS's guidance to Medicare-Medicaid programs on Quality Withhold methodology (available at www.cms.gov/files/document/mmpqualitywithholdtechnicalnotesdy2-10.pdf). Where MassHealth's MY 2020 measure rate met/exceeded the benchmark or met/exceeded the Gap to Goal improvement target, MassHealth indicated this by highlighting the cell containing either the benchmark or the Gap to Goal target, as appropriate.

The body of this report will only present data on a subset of measures that clearly relate to the quality goals referenced in the 2018 CQS. For Goal 6, MassHealth provides a narrative discussion of the work it has undertaken to develop measurement capacity for implementation during the current 1115 Demonstration Waiver period because MassHealth was unable to identify quality measures to directly assess performance.

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

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

MassHealth CQS Quality Goals and Measures

Table 1: 2018 CQS Goals and Measures of Progress (2019-2021)

Quality Goal	Measures
1. Transform to a member-centered culture of care focused on engaging members in their health	<ul style="list-style-type: none"> • Getting Needed Care (Composite) • Getting Care Quickly (Composite) • How Well Doctors Communicate (Composite) • Customer Service (Composite) • Ease of Filling Out Forms (Item) • Coordination of Care (Item)
2. Improve communication, coordination, and care integration	<ul style="list-style-type: none"> • Follow-Up After Hospitalization for Mental Illness (FUH) • Follow-Up After Emergency Department Visit for Mental Illness (FUM) • Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) • Transitions of Care - Medication Reconciliation Post-Discharge (TRC-MRP) • Plan All-Cause Readmissions (PCR)
3. Focus on preventive, patient-centered primary care, and community-based services and supports	<ul style="list-style-type: none"> • Childhood Immunization Status (CIS) • Immunizations for Adolescents (IMA) • Well-Child Visits in First 15 Months of Life - 6+ visits (W15) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile Documentation (WCC-BMI) • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS)
4. Promote effective prevention and treatment to address chronic diseases or priority conditions	<ul style="list-style-type: none"> • Comprehensive Diabetes Care: A1C Poor Control (CDC-Poor) • Controlling High Blood Pressure (CBP) • Asthma Medication Ratio (AMR) • Follow-up Care for Children Prescribed ADHD Medication (ADD) – Initiation • Follow-up Care for Children Prescribed ADHD Medication (ADD) – Continuation • Antidepressant Medication Management (AMM) – Acute Phase • Antidepressant Medication Management (AMM) – Continuation Phase
5. Engage communities through population health and best practices for healthy living	<ul style="list-style-type: none"> • Health-Related Social Needs Assessment (HRSN) • BH Community Partner Engagement (CPE-BH) • LTSS Community Partner Engagement (CPE-LTSS)
6. Identify and address health disparities to provide equitable care	<ul style="list-style-type: none"> • Capacity development to measure and identify health equities using REL stratified data • Submission of MCP member level data to support stratification of disparity sensitive quality measures.

Quality Goal 1: Transform to a member-centered culture of care focused on engaging members in their health.

To evaluate progress toward meeting this goal, MassHealth leveraged the adult health plan CAHPS data submitted by MassHealth's MCPs. Specifically, MassHealth used the following composites and single question items from the CAHPS 5.1H Medicaid Adult Member Satisfaction Survey:

- Getting Needed Care (Composite)
- Getting Care Quickly (Composite)
- How Well Doctors Communicate (Composite)
- Customer Service (Composite)
- Ease of Filling Out Forms (Item)
- Coordination of Care (Item)

All six of these CAHPS composites/items are included in the CMS Adult Core Set.

Table 2: Quality Goal 1 Measures and Performance

HCAHPS 5.1 Composite/Item	Description	MassHealth MY 2018 Rate	MassHealth MY 2019 Rate	MassHealth MY 2020 Rate	Benchmark (MY 20 75th)	Gap to Goal
Getting Needed Care (Composite)	Q9, Q20	83.5%	80.2%	85.9%	86.5%	84.5%
Getting Care Quickly (Composite)	Q4, Q6	81.8%	83.0%	83.4%	84.7%	82.9%
How Well Doctors Communicate (Composite)	Q12, Q13, Q14, Q15	92.9%	91.1%	91.5%	93.9%	93.9%
Customer Service (Composite)	Q24, Q25	88.0%	86.8%	89.0%	91.1%	89.0%
Ease of Filling Out Forms (Item)	Q27	93.2%	95.5%	96.7%	97.0%	94.2%
Coordination of Care (Item)	Q17	87.1%	85.9%	85.5%	88.4%	88.1%

For Goal 1, MassHealth met the Gap to Goal improvement target on four of the six CAHPS composites/items: Getting Needed Care, Getting Care Quickly, Customer Service, and Ease of Filling Out Forms. However, rates on two of the six items in Goal 1 (How Well Doctors Communicate, and Coordination of Care) declined slightly over the MY 2018–2020 period. MassHealth did not meet the MY 2020 benchmark rate on the six composites/items.

Quality Goal 2: Improve communication, coordination, and care integration.

To assess progress toward meeting Goal 2, MassHealth used six HEDIS measures:

- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Transitions of Care - Medication Reconciliation Post-Discharge (TRC-MRP)
- Plan All-Cause Readmissions (PCR)

Five of these six measures are included the Adult and Child Core sets. The one non-Core Set measure, TRC-MRP, is a contractually required measure for MassHealth's SCO programs.

Table 3: Quality Goal 2 Measures and Performance

Measure	Description	MassHealth MY 2018 Rate	MassHealth MY 2019 Rate	MassHealth MY 2020 Rate	Benchmark (MY 20 75th)	Gap to Goal
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	37.7%	47.6%	36.5%	36.8%	N/A*
FUH	Follow-Up After Hospitalization for Mental Illness (7 Days, Age 18-64)	46.7%	42.7%	45.8%	43.8%	N/A*
FUM	Follow-Up After Emergency Department Visit for Mental Illness (7 days, Age 18-64)	73.0%	72.8%	73.5%	45.6%	N/A*
FUA	Follow-Up after Emergency Department Visit for Alcohol and other Drug Abuse or Dependence (7 days, Age 18-64)	22.5%	23.9%	22.9%	18.3%	N/A*
TRC-MRP	Medication Reconciliation Post-Discharge	65.9%	65.9%	54.4%	80.8%	67.4%
PCR	Plan All-Cause Readmissions (Observed/Expected Ratio, Age 18-64)	0.9929	1.2086	1.1461	0.9619	0.9898

* N/A = Gap to Goal does not apply because either MassHealth MY 2018 or MY 2020 performance was above MY 2020 benchmark.

MassHealth exceeded the benchmark rate on three of the six measures identified for Goal 2: Follow-Up After Hospitalization for Mental Illness (7 day), Follow-Up After Emergency Visit for Mental Illness (7 day), and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or

Dependence (7 day). Rates were stable during the three-year period. The rate for APM improved strongly in MY 2019 as compared to the prior year. MassHealth's performance in MY 2020 was just below the 75th national Medicaid percentile benchmark. Rates for the remaining two measures (TRC-MRP and PCR) represent opportunities for improvement for MassHealth.

Quality Goal 3: Focus on preventive, patient-centered primary care, and community-based services and supports.

For Goal 3, MassHealth again selected six HEDIS measures to assess progress towards meeting the goal:

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Well-Child Visits in First 15 Months of Life - 6+ visits (W15)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile Documentation (WCC-BMI)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)

All six of these measures are in the CMS Core Sets. Four of the six measures come from the Child Core Set, reflecting the importance of primary care measures to that set. (Please note that the W15 measure specification was changed for the MY 2020 cycle, adding a component measuring primary care visits in the period from 15-30 months of life; for continuity with MY 2018 and 2019, MassHealth is only considering the 0-15 months sub-measure here.)

Table 4: Quality Goal 3 Measures and Performance

Measure	Description	MassHealth MY 2018 Rate	MassHealth MY 2019 Rate	MassHealth MY 2020 Rate	Benchmark (MY 20 75th)	Gap to Goal
BCS	Breast Cancer Screening (50-64)	69.3%	69.4%	63.2%	58.7%	N/A*
CCS	Cervical Cancer Screening (21-64)	70.8%	70.1%	65.8%	63.9%	N/A*
CIS	Childhood Immunization Status (combo 10)	50.6%	49.2%	52.1%	45.5%	N/A*
IMA	Immunization for Adolescents (combo 2)	36.0%	38.4%	44.0%	43.6%	N/A*

Measure	Description	MassHealth MY 2018 Rate	MassHealth MY 2019 Rate	MassHealth MY 2020 Rate	Benchmark (MY 20 75th)	Gap to Goal
WCC-BMI	Weight Assessment and Counseling (BMI)	85.3%	86.6%	82.7%	82.7%	N/A*
W15	Well-Child Visits in First 15 Months of Life (6+ visits)	81.6%	82.3%	75.9%	61.2%	N/A*

* N/A = Gap to Goal does not apply because either MassHealth MY 2018 or MY 2020 performance was above MY 2020 benchmark.

MassHealth's overall performance was quite strong in relation to the measure benchmarks for Quality Goal 3. MassHealth met or exceeded the 75th national Medicaid percentile for all six of the measures. However, MassHealth did experience absolute declines in rates on the four non-immunization measures over the course of the MY 2018-2020 period, particularly between 2019 and 2020.

The potential impacts of COVID on measure performance are discussed in the Progress on Quality Strategy Goals and Objectives and Goal Revision section of this Evaluation.

Quality Goal 4: *Promote effective prevention and treatment to address chronic diseases or priority conditions.*

MassHealth identified seven HEDIS measures to assess effectiveness in meeting Quality Goal 4:

- Comprehensive Diabetes Care: A1C Poor Control (CDC-Poor)
- Controlling High Blood Pressure (CBP)
- Asthma Medication Ratio (AMR)
- Follow-up Care for Children Prescribed ADHD Medication (ADD) – Initiation
- Follow-up Care for Children Prescribed ADHD Medication (ADD) – Continuation
- Antidepressant Medication Management (AMM) – Acute Phase
- Antidepressant Medication Management (AMM) – Continuation Phase

These measures are all part of the CMS Core Sets. The ADD measure is part of the Child Core Set, while AMR is in both the Adult and Child Sets.

Table 5: *Quality Goal 4 Measures and Performance*

Measure	Description	MassHealth MY 2018 Rate	MassHealth MY 2019 Rate	MassHealth MY 2020 Rate	Benchmark (MY 20 75th)	Gap to Goal
CDC-Poor	Comprehensive Diabetes Care: A1C Poor Control (18-64,	33.5%	35.8%	43.3%	38.4%	N/A*

Measure	Description	MassHealth MY 2018 Rate	MassHealth MY 2019 Rate	MassHealth MY 2020 Rate	Benchmark (MY 20 75th)	Gap to Goal
	lower rate is better)					
CBP	Controlling High Blood Pressure (18-64)	67.9%	68.4%	56.8%	62.5%	N/A*
AMR	Asthma Medication Ratio (All Ages)	58.7%	55.6%	58.5%	70.9%	59.9%
ADD-Init	Follow-up Care for Children Prescribed ADHD Medication - Initiation	49.3%	53.0%	45.7%	49.1%	N/A
ADD-Cont	Follow-up Care for Children Prescribed ADHD Medication - Continuation	62.3%	64.0%	54.8%	62.5%	63.3%
AMM-Acute	Antidepressant Medication Management (18-64) - Acute Phase	53.5%	56.0%	54.8%	61.8%	54.5%
AMM-Cont	Antidepressant Medication Management (18-64) - Continuation Phase	39.3%	42.2%	40.7%	45.6%	40.3%

N/A = Gap to Goal does not apply because either MassHealth MY 2018 or MY 2020 performance was above MY 2020 benchmark.

For this Quality Goal, MassHealth met the Gap to Goal improvement target for the Antidepressant Medication Management measure (both Acute and Continuation phases). MassHealth's performance on CDC-Poor Control, CBP, and ADD-Continuation declined substantially in MY 2020 compared to the prior two years.

The potential impacts of COVID on measure performance are discussed in the Progress on Quality Strategy Goals and Objectives and Goal Revision section of this Evaluation.

Quality Goal 5: *Engage communities through population health and best practices for healthy living.*

MassHealth selected three state-developed measures to assess our performance on Quality Goal 5. These measures are:

- Health-Related Social Needs Assessment (HRSN)
- BH Community Partner Engagement (CPE-BH)

- LTSS Community Partner Engagement (CPE-LTSS)

The three measures are part of a group of MassHealth-specific measures that were developed for the MassHealth Accountable Care Organization (ACO) Program, which was the focus of the previous waiver period. The measures are included in the performance incentive payment calculations which are central to program's strategy of value-based payment.

Table 6: Quality Goal 5 Measures and Performance

Measure	Description	MassHealth MY 2018 Rate	MassHealth MY 2019 Rate	MassHealth MY 2020 Rate	Benchmark	Gap to Goal
HRSN	Health-Related Social Needs Assessment	12.1%	20.0%	18.4%	23.5%	4.4%
CPE-BH	Behavioral Health Community Partner Engagement	4.9%	8.7%	10.5%	12.2%	1.4%
CPE-LTSS	LTSS Community Partner Engagement	1.0%	4.0%	4.9%	9.2%	1.3%

The benchmarks used for this Quality Goal differ from those in Goals 1–4. The benchmarks and Gap to Goal targets come from the performance incentive payment calculation methodology, which MassHealth developed and were agreed upon with CMS during the 1115 Demonstration period (2017–2022). For Quality Goal 5, the table above demonstrates that while rates did not rise to the benchmark level, ACO program performance improved strongly over the three-year period and the rate improvements substantially exceeded the Gap to Goal target in all three cases.

Quality Goal 6: Identify and address health disparities to provide equitable care.

To achieve Goal 6, MassHealth's primarily focused on capacity development to work toward the stratification of disparity sensitive quality measures by race, ethnicity, and language. Initially, MassHealth worked with a subset of its MCPs (non-dual Medicaid plans for members under the age of 65, specifically ACOs, MCOs, and the PCC Plan) to submit to MassHealth member-level detail data with their annual HEDIS rate submissions. This subgroup of MCPs successfully submitted the member level data. MassHealth refined its submission approach to address data inconsistencies, eventually expanding its member level data collection requirements to its integrated care plans. Currently, MassHealth is collecting member level data from all MCPs except the BH Plan but hopes to expand requirements to include the BH Plan in 2023.

In addition, MassHealth worked with UMass Chan Medical School to develop an imputed data file for MassHealth CY2019 and CY2020 membership. The imputed data file was shared with MassHealth's comprehensive quality measure vendor, Telligen, and used to stratify ACO and hospital performance on

select quality metrics. MassHealth is currently using data from both the imputed and member level data files to identify health inequities.

MassHealth continues to evolve its strategies for identifying and addressing health disparities. In CY 2022, EOHHS initiated a major initiative to incentivize acute care hospitals and MCPs to reduce health disparities. As part of this agency-wide health equity strategy, EOHHS is implementing processes whereby ACOs, MCOs, and acute care hospitals will collect and submit standard self-reported Race, Ethnicity, Language, Disability, Sexual Orientation, and Gender Identity (RELDSOGI) data. Standard data elements were identified through a statewide effort (Quality Measurement Alignment Taskforce) consisting of statewide agencies, providers, payers, subject matter experts, and member advocates in 2021. Reporting will begin in 2023 with a goal of improving the completeness and accuracy of RELDSOGI data so EOHHS and MCPs can more accurately monitor stratified performance and eventually reduce inequities among the MassHealth member population.

CMS Child and Adult Core Set Performance

Performance on the Child and Adult Core Set measures has been relatively stable for the period between MY2018 and MY2020 when compared to National Medicaid benchmarks, with exceptions in two areas where MassHealth's measure performance declined in MY2020:

- Preventive care screenings – screening rates for breast and cervical cancer (BCS/CCS), and for chlamydia (CHL);
- Primary-care sensitive measures of chronic disease management – for adult members, performance on measures of high blood pressure control (CBP) and A1C poor control among diabetic members (CDC-Poor); for child members, monitoring measures relating to medications for ADHD (ADD-Initiation and ADD-Continuation) and antipsychotics (APM).

These measures were likely impacted by the Covid-19 Public Health Emergency, as discussed on pages 14-15. MassHealth will continue to closely monitor performance in these areas. For details on Adult and Child Core Set Performance see Appendix C.

State Responsiveness to External Quality Review Organization (EQRO) Recommendations

MassHealth's CY 2022 External Quality Review reports (review period CY 2021) included several recommendations that the EQRO made to improve and revise the 2018 CQS and associated activities. The following section highlights those EQRO recommendations and MassHealth's responses.

EQR Recommendations and MassHealth Responses

Provider Network Recommendations

Recommendation #1: Work with partners statewide to address workforce and infrastructure solutions to increase the availability of behavioral health and substance use disorder services.

MassHealth Response to Recommendation #1: In 2021, MassHealth released a five-year strategy for behavioral reform with the goal of expanding equitable access to behavioral health services. Development of this strategy, referred to as the Behavioral Health Roadmap (Roadmap), began in 2019 after a series of listening sessions with more than 700 families, individuals, and other stakeholders. Details about the Roadmap are included in MassHealth's recently revised quality strategy, submitted to CMS and published in 2022 ("2022 CQS").

The Roadmap is designed to address access challenges in the behavioral healthcare systems, by:

- Ensuring coverage of behavioral health integration in primary care and for preventive behavioral health services for youth.
- Providing 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 (CBHCs) 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 insurance.
- Instituting a process to evaluate non-English speaking members' choice of primary care and behavioral health providers in prevalent languages.
- Verifying the accuracy of provider directory information.

Recommendation #2: Consider increasing oversight of MCP network adequacy compliance.

MassHealth Response to Recommendation #2: MassHealth monitors MCP compliance with state network standards annually and more frequently when there are significant changes to MCP networks. For MassHealth's review, MCPs are required to submit to MassHealth, both annually and ad hoc, provider lists and provider-to-enrollee ratios for:

- Primary Care Providers
- Obstetrics and Gynecologists
- Acute and Rehabilitation Hospitals, and Urgent Care Centers
- Physician Specialists
- Pharmacies
- Behavioral Health providers

MassHealth is currently exploring other reporting mechanisms to assess MCP network adequacy compliance, such as assessing ease of getting a timely appointment and hours of operation.

In addition to annual and ad hoc network compliance reporting, MassHealth also monitors MCP network compliance through its EQR network validation process. Beginning in 2023, MassHealth's EQRO will initiate enhanced network validation activities, alternating between access and availability surveys and provider directory validation activities. MassHealth's EQRO will conduct provider directory surveys biennially to validate information published in the MCPs web-based Medicaid provider directories. The goal of this activity is to ensure that members are being provided accurate and up-to-date information regarding the plan provider networks.

Recommendation #3: Consider the practical feasibility of its network adequacy standards, especially those for the less populated areas of Berkshire, Dukes, and Nantucket counties.

MassHealth Response to Recommendation #3: MassHealth already makes exceptions for less populated areas or where there are limited providers. MassHealth is evaluating the network standards in light of market norms in service areas across the Commonwealth.

Health Equity Recommendations

Recommendation #4: Improve quality of its Race, Ethnicity, and Language (REL) data and address issues related to enrollment updates with no REL data overwriting plan-collected data. (Access)

MassHealth Response to Recommendation #4: In CY 2022, EOHHS began a major initiative to implement significant new incentives for acute care hospitals and MCPs tied to reducing health disparities; this work will continue over the next five years as part of the renewal of the 1115 Demonstration for 2022-2027. This innovative proposal reflects growing interest in the Commonwealth and nationally to advance health equity as an essential tenet of high-quality care.

As part of this agency-wide health equity strategy, MassHealth is implementing processes whereby ACOs, MCOs, and acute care hospitals will be collecting and submitting member self-reported Race, Ethnicity, Language, Disability, Sexual Orientation, and Gender Identify (RELDSOGI) data. Reporting will begin in 2023 with a goal of improving the completeness and accuracy of RELDSOGI data so EOHHS and MCPs can more accurately monitor stratified performance and eventually reduce inequities among the MassHealth member population.

Performance Improvement Projects (PIPs) Recommendations

Recommendation #5: Adopt a standard set of criteria for Performance Improvement Projects topic selections including but not limited to focus on agency priorities, areas of poor performance, and initiatives that target at least 10 percent or more of an MCPs population.

MassHealth Response to Recommendation #5: MassHealth currently has a standard process for selecting PIP topics. Prior to the commencement of a PIP cycle, the MassHealth Quality Office works with MCP program leads to review agency and program priorities, as well as MCP performance on quality measure slates. MassHealth then uses this information to identify priority domain areas and associated performance measures on which MCPs are to focus their PIPs. MassHealth approves PIP topics and proposed interventions prior to implementation.

Communication Pathways Recommendations

Recommendation #6: Consider sponsoring a statewide consumer advisory council with the charter of advising MassHealth on its priorities for managed care plan performance management.

MassHealth Response to Recommendation #6: MassHealth has a dedicated Member Engagement and Experience (MEE) Team that 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.

In addition to the MEE, MassHealth has several different member/stakeholder committees (listed below) for specific programs and initiatives. These committees serve as a source of guidance for informing quality programs as well as broader statewide quality priorities, strategies, and initiatives.

- One Care Implementation Council
- Senior Care Options Advisory Committee
- Disability and Eligibility Advocates Meetings
- Care Model Focus Initiative (CMFI)
- MassHealth required MCP engagement with members through Consumer Advisory Councils and Patient/Family Advisory Councils

Progress On Quality Strategy Goals and Objectives and Goal Revision

In this Evaluation, MassHealth selected 28 quality measures to evaluate progress toward meeting Quality Goals 1-5. Of these, MassHealth met the MY 2020 benchmark on nine measures and met the Gap to Goal target on nine others. MassHealth thus met either the benchmark or Gap to Goal improvement target on nearly two-thirds of the measures. This shows that while MassHealth did make considerable progress towards meeting Goals 1-5 during the three-year period, opportunities for improvement remain available, particularly in the chronic disease/priority conditions domain (Goal 4). For Goal 6, MassHealth focused on building the necessary capacity to support achievement of this goal going forward, namely measurement and identification of disparities within the MassHealth population.

Notably, MassHealth made this progress notwithstanding the unprecedented COVID-19 Public Health Emergency (PHE) that began in CY2020. While the precise impact of the PHE is unknown, it is assumed that it impacted results as follows.

- COVID testing, cases, and hospitalizations overwhelmed the health care system in 2020.
- Members delayed preventive and other necessary care.
- Enrollment in MassHealth increased over 25% during the PHE period of March 30, 2020, through March 31, 2022.

In evaluating quality measure performance, these unusual circumstances should be taken into consideration.

While MassHealth is encouraged by the fact that it observed Gap to Goal improvements despite the PHE, MassHealth also retains the goal of raising performance to the benchmark level. For this reason, MassHealth is maintaining the quality goals and associated measures discussed in this Evaluation for its revised 2022 CQS, which was operationalized in Q3 2022. Goals presented in the updated quality strategy have been modified to reflect updates to organizational priorities.

Appendices

Appendix A: MassHealth Managed Care Plans

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

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

Appendix D: 2020 EQR Performance Improvement Projects (PIPs)

Appendix A: MassHealth Managed Care Plans

Program	MCP Type	Managed Care Authority	Name of Plan
Accountable Care Organization (ACO) ACO (ACPP)	MCE	1115	<ul style="list-style-type: none"> Be Healthy Partnership Berkshire Fallon Health Collaborative BMC HealthNet Plan Community Alliance BMC HealthNet Plan Mercy Alliance BMC HealthNet Plan Signature Alliance BMC HealthNet Plan Southcoast Alliance Fallon 365 Care My Care Family Tufts Health Together with Atrius Health Tufts Health Together with Beth Israel Deaconess Care Organization (BIDCO) Tufts Health Together with Boston Children's ACO Tufts Health Together with Cambridge Health Alliance (CHA) Wellforce Care Plan
ACO (PCACO)	PCCM entity	1115	<ul style="list-style-type: none"> Community Care Cooperative (C3) Mass General Brigham Steward Health Choice
MCO-Administered ACO	MCE	1115	<ul style="list-style-type: none"> Lahey-MassHealth Primary Care Organization
Managed Care Organization (MCO)	MCE	1115	<ul style="list-style-type: none"> BMC HealthNet Plan Tufts Health Together
Senior Care Options (SCO)	MCE	1915(a)/1915(c)	<ul style="list-style-type: none"> BMC HealthNet Plan Senior Care Options Commonwealth Care Alliance NaviCare (HMO) Senior Whole Health Tufts Health Plan Senior Care Options United HealthCare
One Care	MCE	Demonstration	<ul style="list-style-type: none"> Commonwealth Care Alliance Tufts Health Plan Unify United HealthCare Connected
PCC Plan	PCCM	1115	NA (MassHealth)
Behavioral Health Plan	PIHP	PIHP	<ul style="list-style-type: none"> Massachusetts Behavioral Health Partnership (MBHP)

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

Appendix B-1: Contract Level Performance, MY2018 (ACO and MCO Programs)

2018 quality measure performance for individual ACO and MCO plans is presented in Table B-1. Program-level totals are weighted means (WM), or medians when indicated with an asterisk (*). Please see Appendix A for a list of MassHealth’s managed care plans.

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

Ref	2018 Measure	ACO WM	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	MCO WM	BMC MCO	THP MCO
CIS	Childhood Immunization Status (combo 10)	49.9%*	40.2%	63.7%	38.0%	46.4%	25.8%	59.3%	68.3%	62.9%	55.7%	46.7%	47.7%	58.0%	40.0%	67.9%	52.1%	35.3%	NA	--	--	--
PPC	Timeliness of Prenatal Care	80.8%*	87.2%	86.5%	66.4%	75.4%	94.9%	71.9%	81.3%	84.7%	46.7%	75.4%	80.8%	85.8%	81.1%	80.5%	83.2%	64.5%	48.5%	--	--	--
IMA	Immunization for Adolescents (combo 2)	32.2%*	13.2%	26.5%	24.6%	35.0%	45.0%	27.0%	30.5%	50.6%	35.3%	47.9%	34.0%	43.6%	28.0%	50.4%	38.2%	29.9%	NA	--	--	--
EOHHS/ADA	Oral Health Evaluation	61.6%	62.6%	65.5%	63.5%	57.4%	64.7%	64.1%	70.5%	63.2%	63.2%	56.3%	60.6%	58.1%	50.8%	61.5%	63.1%	59.2%	54.6%	54.2%	51.4%	55.5%
EOHHS	Health-Related Social Needs Screening	9.5%	10.9%	12.7%	9.5%	32.4%	1.5%	1.0%	13.4%	24.1%	14.6%	22.6%	1.5%	0.0%	1.5%	0.7%	19.5%	9.0%	0.0%			
CBP	Controlling High Blood Pressure	67.2%	61.3%	76.6%	64.2%	60.3%	73.5%	76.9%	66.9%	69.1%	63.6%	58.2%	72.7%	72.5%	78.6%	69.1%	67.2%	60.1%	65.2%	--	--	--
AMR	Asthma Medication Ratio	53.3%	40.9%	56.8%	55.5%	50.9%	55.8%	54.9%	56.4%	51.8%	64.5%	48.2%	59.3%	54.3%	46.5%	50.6%	51.6%	51.4%	45.6%	55.5%	50.8%	57.2%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	31.9%	26.5%	22.1%	36.7%	39.2%	36.5%	26.8%	23.8%	34.1%	52.7%	36.7%	31.9%	26.3%	27.0%	35.8%	28.7%	44.3%	26.8%	--	--	--
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	0.9676	0.8953	0.7835	1.0218	0.7794	0.8059	0.7313	0.9049	1.1688	0.5757	1.0320	0.9992	1.0443	0.9387	0.9906	0.9349	0.9740	1.0253	19.4%	19.8%	19.2%
EOHHS	Risk adjusted ratio (obs/exp) of ED visits for members 18-65 identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	1.2782	1.1815	1.1080	1.2871	1.0402	1.3632	1.0977	1.5355	1.4721	1.5091	1.2750	1.0668	1.2596	1.2377	1.3677	1.0953	1.4221	1.4694	0.9891	0.9642	1.0150
EOHHS	Risk adjusted ratio (obs/exp) of Acute Unplanned Admissions for Individuals with Diabetes (Adult)	0.6162	0.7411	0.5472	0.6880	0.5804	0.7175	0.7224	0.6359	0.6905	0.8254	0.6116	0.7234	0.7514	0.6214	0.5317	0.5748	0.6064	0.6367	0.7695	0.7663	0.7706
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	44.3%	51.9%	31.5%	39.0%	54.9%	33.5%	33.9%	44.9%	60.8%	27.6%	46.8%	43.5%	50.6%	42.6%	43.3%	44.8%	42.0%	52.2%	49.8%	51.1%	48.7%
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	17.0%	24.4%	11.8%	14.3%	18.4%	10.6%	14.2%	15.7%	16.6%	9.5%	18.4%	18.8%	21.2%	19.6%	17.2%	16.9%	16.0%	19.1%	22.5%	23.9%	21.3%

Ref	2018 Measure	ACO WM	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	MCO WM	BMC MCO	THP MCO
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	49.4%	47.1%	47.3%	42.9%	52.4%	45.5%	45.1%	43.6%	48.0%	52.4%	45.4%	55.5%	51.6%	55.0%	51.2%	52.4%	52.1%	52.3%	47.4%	47.8%	47.1%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	76.0%	69.2%	79.8%	77.0%	77.0%	73.0%	73.9%	73.3%	71.7%	83.5%	77.5%	77.8%	73.5%	82.1%	75.8%	76.9%	72.2%	68.9%	72.6%	70.2%	74.4%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	36.4%	NA	35.2%	31.4%	33.3%	36.8%	46.2%	NA	17.1%	34.9%	41.5%	36.3%	NA	NA	44.7%	41.2%	34.0%	NA	26.6%	24.3%	27.4%
DSF	Screening for Depression and Follow-Up Plan	40.2%	4.7%	18.2%	6.3%	61.3%	40.2%	19.6%	37.7%	41.6%	44.5%	44.3%	9.5%	57.6%	22.1%	58.6%	52.1%	24.8%	41.0%			
DRR	Depression Remission or Response	4.8%*	4.9%	0.0%	0.0%	1.7%	9.1%	NA	4.8%	10.7%	4.3%	8.1%	NA	2.7%	NA	4.8%	1.3%	NA	9.2%			
EOHHS	LTSS Community Partner Engagement	1.0%	4.3%	1.9%	1.3%	0.1%	0.0%	0.0%	2.4%	0.0%	2.1%	2.3%	0.7%	6.9%	1.6%	0.7%	0.5%	0.4%	2.9%	0.2%	0.0%	0.4%
EOHHS	Community Tenure - BSP (Risk adjusted O/E ratio)	0.7827	0.4181	0.2851	0.3513	0.6962	0.8003	0.8474	0.9106	0.8292	0.9369	0.9088	0.8971	0.8590	0.8832	0.7840	0.7902	0.7805	0.9190	1.1738	1.2469	1.0987
EOHHS	Community Tenure - LTSS (non-BSP) Risk adjusted O/E ratio	0.9324	0.4525	0.3564	0.5097	0.7388	1.0903	0.9534	0.9605	1.0618	0.8605	1.0404	0.8822	0.9971	1.0032	0.9707	0.9869	1.0764	0.8382	1.2318	1.2624	1.2035
EOHHS	Behavioral Health Community Partner Engagement	4.9%	3.5%	1.3%	4.5%	2.1%	0.0%	3.9%	3.0%	1.5%	NA	11.2%	1.1%	5.2%	5.1%	2.6%	3.5%	5.1%	2.7%	1.2%	0.9%	1.5%
EOHHS	Adult: Overall Rating and Care Delivery: Willingness to recommend	90.4%	83.1%	89.8%	93.0%	87.9%	88.5%	84.2%	91.2%	85.0%	89.2%	86.7%	89.9%	90.4%	83.1%	89.8%	93.0%	87.9%	88.5%			
EOHHS	Child: Overall Rating and Care Delivery: Willingness to recommend	94.5%	88.7%	90.8%	92.8%	90.3%	89.6%	89.3%	94.4%	88.1%	91.6%	92.7%	92.7%	94.5%	88.7%	90.8%	92.8%	90.3%	89.6%			
EOHHS	Adult: Overall Rating and Care Delivery: Communication	90.4%	85.5%	91.2%	94.5%	89.9%	87.4%	88.1%	90.6%	87.7%	90.4%	89.3%	89.0%	90.4%	85.5%	91.2%	94.5%	89.9%	87.4%			
EOHHS	Child: Overall Rating and Care Delivery: Communication	94.9%	90.0%	91.8%	93.1%	91.8%	90.0%	88.3%	93.0%	90.2%	92.4%	93.5%	91.9%	94.9%	90.0%	91.8%	93.1%	91.8%	90.0%			
EOHHS	Adult: Person-Centered Integrated Care: Integration of Care	81.8%	77.7%	80.2%	86.5%	80.6%	80.7%	79.8%	81.9%	76.2%	81.8%	79.7%	82.3%	81.8%	77.7%	80.2%	86.5%	80.6%	80.7%			
EOHHS	Child: Person-Centered Integrated Care: Integration of Care	85.1%	77.4%	77.7%	81.1%	77.8%	78.4%	79.9%	81.9%	74.2%	79.7%	81.7%	72.2%	85.1%	77.4%	77.7%	81.1%	77.8%	78.4%			
EOHHS	Adult: Person-Centered Integrated Care: Knowledge of Patient	84.3%	80.6%	85.1%	91.1%	84.5%	81.3%	81.8%	85.1%	81.6%	85.3%	83.9%	85.1%	84.3%	80.6%	85.1%	91.1%	84.5%	81.3%			
EOHHS	Child: Person-Centered Integrated Care: Knowledge of Patient	91.8%	85.5%	87.4%	89.3%	87.6%	86.0%	83.4%	89.3%	85.2%	87.5%	89.5%	87.8%	91.8%	85.5%	87.4%	89.3%	87.6%	86.0%			

Appendix B-2: Contract Level Performance, MY 2019 (ACO and MCO Programs)

2019 quality measure performance for individual ACO and MCO plans is presented in Table B-2. Program-level totals are weighted means (WM). Please see Appendix A for a list of MassHealth’s managed care plans.

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

Ref	2019 Measure	Total ACO	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	Total MCO	BMC MCO	THP MCO
CIS	Childhood Immunization Status (combo 10)	56.1%	44.3%	64.1%	54.7%	48.9%	29.9%	60.3%	72.8%	72.9%	56.8%	55.0%	53.8%	63.6%	37.7%	65.8%	56.3%	49.1%	NA	--	--	--
PPC	Timeliness of Prenatal Care	85.5%	94.5%	90.5%	85.6%	91.2%	98.1%	75.9%	86.4%	89.3%	36.4%	84.2%	80.3%	91.0%	95.9%	88.3%	85.2%	75.2%	75.8%	--	--	--
IMA	Immunization for Adolescents (combo 2)	44.7%	20.0%	33.6%	44.5%	54.0%	52.8%	33.6%	30.6%	55.7%	44.3%	57.7%	38.0%	53.6%	30.9%	63.0%	36.0%	31.9%	NA	--	--	--
EOHHS /ADA	Oral Health Evaluation	61.0%	60.2%	64.9%	63.1%	57.0%	63.8%	64.3%	67.0%	62.5%	62.4%	55.4%	58.5%	58.2%	49.7%	60.8%	63.4%	58.7%	55.9%	54.5%	52.9%	55.5%
EOHHS	Health-Related Social Needs Screening	20.0%	11.7%	6.8%	10.5%	4.9%	0.0%	25.5%	36.3%	32.8%	42.8%	40.6%	0.0%	0.0%	2.7%	1.2%	40.6%	2.7%	2.4%			
CBP	Controlling High Blood Pressure	69.7%	74.5%	79.3%	70.8%	78.2%	67.1%	80.7%	65.8%	68.6%	70.9%	59.9%	75.2%	75.5%	80.2%	63.6%	73.2%	73.9%	67.6%	--	--	--
AMR	Asthma Medication Ratio	55.0%	43.6%	54.5%	54.4%	48.4%	51.6%	58.6%	58.7%	51.9%	NA	50.3%	57.7%	52.0%	50.2%	51.4%	57.4%	56.2%	51.4%	51.8%	48.7%	52.7%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	30.5%	33.8%	26.0%	29.4%	35.2%	27.1%	29.3%	24.9%	27.4%	61.1%	31.3%	35.8%	22.3%	27.8%	32.4%	26.9%	34.6%	22.6%	--	--	--
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.0666	0.9530	1.1260	1.0870	0.9818	1.2052	0.9950	1.0984	1.0077	1.4157	1.1616	0.8385	0.9792	1.1458	1.1451	1.0746	0.9080	1.0212	12.6%	10.7%	14.1%
EOHHS	Risk adjusted ratio (obs/exp) of ED visits for members 18-65 identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	1.0581	0.9736	0.9254	0.9926	0.8990	1.1546	0.8914	1.2224	1.1817	1.1274	1.0439	0.8628	0.9652	0.8791	1.2263	0.9831	1.1387	1.0459	0.8687	0.8449	0.8940
EOHHS	Risk adjusted ratio (obs/exp) of Acute Unplanned Admissions for Individuals with Diabetes (Adult)	0.6055	0.6085	0.6425	0.6991	0.6005	0.6354	0.6372	0.6338	0.7318	NA	0.5950	0.5160	0.7471	0.6054	0.5573	0.5900	0.5778	0.6849	0.6860	0.7259	0.6532
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	46.1%	50.5%	39.0%	39.5%	56.6%	39.0%	34.7%	51.2%	62.5%	31.4%	50.4%	45.6%	53.5%	45.6%	44.7%	44.3%	42.1%	51.0%	53.3%	54.9%	51.9%
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	16.6%	20.2%	13.3%	14.8%	19.1%	13.3%	12.3%	14.3%	13.9%	8.6%	18.6%	19.0%	19.2%	19.6%	18.0%	14.2%	16.3%	17.7%	22.3%	23.7%	21.0%

Ref	2019 Measure	Total ACO	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	Total MCO	BMC MCO	THP MCO
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	48.0%	42.7%	41.2%	40.0%	45.2%	34.7%	48.6%	38.5%	48.2%	55.5%	46.4%	51.2%	47.8%	54.9%	48.4%	52.9%	52.1%	51.7%	41.7%	45.6%	38.9%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	76.0%	72.2%	78.9%	73.1%	71.4%	71.5%	78.5%	68.3%	76.1%	85.3%	75.6%	76.8%	73.1%	77.8%	76.1%	77.5%	74.8%	69.4%	72.1%	69.5%	74.1%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	45.2%	NA	35.2%	45.6%	43.7%	51.0%	54.2%	NA	43.4%	47.7%	63.6%	50.0%	NA	71.0%	42.3%	36.6%	38.7%	NA	28.1%	20.6%	31.7%
DSF	Screening for Depression and Follow-Up Plan	44.6%	28.6%	37.6%	47.1%	49.0%	37.9%	21.6%	49.6%	61.3%	57.7%	52.4%	25.3%	60.3%	40.6%	54.6%	36.2%	34.8%	42.9%			
DRR	Depression Remission or Response	4.9%	5.3%	15.7%	0.0%	3.3%	11.8%	NA	2.5%	6.6%	4.3%	4.9%	NA	7.9%	4.9%	3.1%	0.8%	8.3%	14.3%			
EOHHS	LTSS Community Partner Engagement	4.0%	2.9%	4.3%	5.2%	7.3%	9.4%	4.4%	3.6%	0.0%	3.5%	4.1%	9.0%	9.1%	2.9%	2.3%	1.8%	3.6%	9.5%	5.9%	5.3%	6.3%
EOHHS	Community Tenure - BSP (Risk adjusted O/E ratio)	0.7716	0.2794	0.2542	0.2690	0.7061	0.5177	0.6726	0.9747	0.7366	0.7392	0.9246	0.7970	0.8606	0.7265	0.8034	0.8075	0.7996	0.8579	0.9879	1.0741	0.8926
EOHHS	Community Tenure - LTSS (non-BSP) Risk adjusted O/E ratio	0.8889	0.4416	0.3271	0.3812	0.7841	0.8932	0.7436	0.8908	1.0274	0.8484	1.0709	0.7747	1.2343	0.8539	0.9364	0.8726	0.9743	0.7656	0.9635	1.0899	0.8002
EOHHS	Behavioral Health Community Partner Engagement	8.7%	3.9%	11.0%	6.1%	11.9%	3.0%	5.6%	6.8%	6.1%	NA	12.6%	11.2%	13.3%	11.9%	8.0%	4.9%	10.5%	3.7%	4.8%	4.4%	5.2%
EOHHS	Adult: Overall Rating and Care Delivery: Willingness to recommend	86.8%	86.5%	89.0%	86.0%	85.7%	87.0%	89.5%	83.2%	88.5%	91.3%	86.4%	85.0%	87.0%	87.8%	84.0%	88.6%	86.9%	88.0%			
EOHHS	Child: Overall Rating and Care Delivery: Willingness to recommend	91.6%	88.8%	93.3%	93.2%	88.0%	90.6%	93.3%	90.7%	91.8%	93.6%	88.8%	90.5%	88.0%	92.9%	87.9%	92.7%	91.7%	84.6%			
EOHHS	Adult: Overall Rating and Care Delivery: Communication	88.9%	88.5%	90.3%	88.4%	88.2%	89.9%	90.8%	84.6%	89.9%	92.6%	89.2%	86.5%	88.3%	89.9%	87.0%	89.6%	89.9%	89.9%			
EOHHS	Child: Overall Rating and Care Delivery: Communication	92.4%	89.2%	93.7%	93.0%	90.6%	92.4%	94.1%	90.2%	91.1%	93.7%	91.2%	92.5%	90.1%	93.1%	89.9%	92.9%	93.1%	97.7%			
EOHHS	Adult: Person-Centered Integrated Care: Integration of Care	80.2%	78.0%	83.3%	78.1%	75.9%	76.9%	82.3%	75.5%	81.1%	81.0%	78.9%	78.7%	80.2%	79.9%	75.6%	81.4%	80.4%	82.3%			
EOHHS	Child: Person-Centered Integrated Care: Integration of Care	81.1%	78.4%	81.8%	80.6%	76.8%	76.6%	80.9%	77.6%	77.5%	82.5%	79.4%	80.4%	80.2%	83.1%	75.3%	81.0%	81.0%	89.8%			
EOHHS	Adult: Person-Centered Integrated Care: Knowledge of Patient	83.3%	82.2%	84.1%	83.1%	81.0%	84.8%	85.2%	79.8%	84.9%	89.2%	83.7%	81.1%	82.9%	84.2%	80.1%	84.2%	84.6%	84.6%			
EOHHS	Child: Person-Centered Integrated Care: Knowledge of Patient	88.1%	83.2%	88.8%	88.7%	84.9%	87.2%	90.6%	87.4%	86.8%	90.1%	87.0%	86.4%	85.8%	87.9%	84.5%	88.9%	88.7%	96.8%			

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

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

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

Ref	2020 Measure	Total ACO	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	Total MCO	BMC MCO	THP MCO
CIS	Childhood Immunization Status (combo 10)	57.1%	40.9%	58.4%	40.3%	51.3%	44.5%	64.3%	55.2%	70.4%	57.5%	61.1%	48.5%	61.9%	47.5%	64.9%	60.7%	52.3%	NA	38.5%	22.0%	55.1%
PPC	Timeliness of Prenatal Care	84.5%	82.3%	90.8%	67.6%	90.5%	95.9%	73.7%	82.5%	92.1%	57.6%	82.2%	77.1%	85.9%	81.7%	89.0%	85.6%	83.7%	70.4%	75.0%	64.0%	86.0%
IMA	Immunization for Adolescents (combo 2)	44.6%	15.7%	39.2%	38.7%	47.2%	54.1%	33.3%	23.6%	56.0%	45.5%	56.8%	40.4%	55.8%	56.6%	63.7%	28.7%	35.5%	NA	31.9%	21.8%	42.0%
EOHHS /ADA	Oral Health Evaluation	44.7%	39.6%	49.2%	49.9%	38.8%	48.0%	50.5%	40.3%	46.9%	46.3%	38.5%	44.1%	44.3%	36.8%	42.5%	48.1%	42.8%	33.1%	41.2%	37.2%	43.2%
EOHHS	Health-Related Social Needs Screening	18.4%	6.3%	6.3%	3.4%	6.1%	5.6%	19.5%	14.6%	14.4%	47.4%	29.4%	18.7%	0.2%	13.4%	23.6%	17.3%	2.2%	0.0%			
CBP	Controlling High Blood Pressure	61.4%	59.4%	69.1%	58.2%	60.6%	61.6%	65.5%	57.9%	60.3%	59.7%	57.4%	68.9%	69.0%	70.8%	51.3%	68.6%	68.1%	54.7%	39.0%	25.9%	52.1%
AMR	Asthma Medication Ratio	59.5%	68.9%	79.9%	77.6%	57.3%	58.5%	63.5%	59.0%	51.2%	73.0%	54.2%	65.5%	50.4%	47.6%	57.6%	55.9%	55.9%	47.7%	55.7%	50.8%	57.3%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	40.8%	41.8%	32.4%	34.8%	41.8%	40.3%	35.1%	31.3%	46.6%	65.9%	43.1%	40.0%	31.8%	37.9%	42.6%	37.8%	48.1%	42.6%	53.4%	67.8%	39.1%
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.2322	1.5292	1.3217	1.5886	1.1258	1.0737	1.2513	1.1819	1.3088	1.2928	1.3510	1.0038	1.4405	1.0783	1.2497	1.1740	1.1020	1.2006	8.3%	5.3%	11.2%
EOHHS	Risk adjusted ratio (obs/exp) of ED visits for members 18-65 identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	1.4560	1.3665	1.3107	1.4966	1.1816	1.4016	1.2682	1.5251	1.7839	1.7350	1.5331	1.2101	1.3772	1.2107	1.5674	1.3215	1.5447	1.3974	1.2168	1.2584	1.1782
EOHHS	Risk adjusted ratio (obs/exp) of Acute Unplanned Admissions for Individuals with Diabetes (Adult)	0.6570	0.6277	0.5244	0.6138	0.5639	0.7258	0.6553	0.7006	0.7347	0.7999	0.6482	0.5866	0.8183	0.6209	0.6572	0.6486	0.7040	0.7911	0.7379	0.7472	0.7295
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	46.4%	59.6%	58.0%	39.8%	53.2%	36.1%	36.3%	48.8%	63.1%	31.5%	49.0%	47.1%	57.7%	42.1%	47.0%	41.5%	41.4%	55.0%	54.4%	56.3%	52.8%

Ref	2020 Measure	Total ACO	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	Total MCO	BMC MCO	THP MCO
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	15.9%	22.0%	13.0%	14.1%	16.4%	13.1%	12.0%	13.1%	17.0%	5.7%	17.9%	19.3%	17.1%	18.1%	17.6%	13.3%	15.1%	15.5%	21.7%	21.7%	21.6%
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	48.2%	39.4%	49.3%	37.0%	49.8%	32.9%	47.1%	39.1%	56.5%	54.6%	46.7%	64.6%	51.6%	52.6%	49.3%	52.6%	46.6%	48.6%	44.8%	46.2%	43.8%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	73.1%	68.9%	84.9%	74.5%	75.8%	66.8%	77.1%	65.4%	70.0%	84.4%	70.3%	75.7%	66.1%	79.2%	72.7%	73.9%	68.9%	69.4%	73.0%	70.4%	74.9%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	37.7%	18.4%	27.7%	35.9%	37.7%	61.0%	50.3%	NA	33.3%	37.0%	41.1%	33.3%	52.8%	48.8%	40.8%	34.1%	38.8%	NA	28.1%	16.3%	30.7%
DSF	Screening for Depression and Follow-Up Plan	37.1%	8.7%	25.0%	25.6%	39.3%	22.8%	16.1%	35.4%	31.8%	57.5%	36.0%	8.8%	39.2%	92.0%	48.3%	40.9%	33.9%	28.8%			
DRR	Depression Remission or Response	3.4%	1.2%	NA	0.7%	1.1%	5.4%	0.0%	4.5%	0.7%	1.9%	7.2%	3.4%	5.0%	9.1%	9.5%	0.0%	1.2%	9.2%			
EOHHS	LTSS Community Partner Engagement	4.9%	11.1%	6.8%	11.5%	2.7%	11.1%	4.9%	3.9%	5.1%	6.2%	4.3%	5.1%	2.7%	5.2%	6.8%	2.8%	3.6%	4.4%	4.5%	3.8%	5.2%
EOHHS	Community Tenure - BSP (Risk adjusted O/E ratio)	1.4001	0.7194	0.7741	1.0932	1.1979	0.8334	0.9439	1.1031	0.9283	0.7500	1.7257	1.4910	1.7097	1.4943	1.4492	1.5555	1.3731	1.1536	1.5260	1.9929	1.0077
EOHHS	Community Tenure - LTSS (non-BSP) Risk adjusted O/E ratio	1.9144	1.3621	1.1632	1.0303	1.3599	2.1370	1.5113	2.2548	2.0592	1.3107	2.3243	1.4286	3.2018	1.8086	1.8586	2.0781	2.1844	2.0115	1.9440	2.1147	1.7023
EOHHS	Behavioral Health Community Partner Engagement	10.5%	10.3%	17.0%	12.7%	12.4%	17.6%	16.2%	10.8%	7.5%	NA	11.4%	10.6%	12.9%	10.0%	8.3%	7.9%	10.2%	9.1%	4.1%	3.4%	4.7%
EOHHS	Adult: Overall Rating and Care Delivery: Willingness to recommend	85.2%	85.2%	87.5%	85.3%	81.2%	85.0%	87.6%	83.7%	83.8%	91.5%	83.0%	82.1%	82.8%	88.7%	82.3%	86.8%	86.1%	87.8%			
EOHHS	Child: Overall Rating and Care Delivery: Willingness to recommend	90.9%	89.8%	92.3%	92.0%	87.6%	88.6%	93.6%	89.8%	91.0%	92.1%	89.0%	89.5%	89.7%	93.4%	86.8%	92.3%	93.2%	82.3%			
EOHHS	Adult: Overall Rating and Care Delivery: Communication	87.1%	86.3%	88.4%	86.8%	84.2%	87.5%	89.5%	85.2%	86.1%	93.4%	87.3%	84.5%	85.0%	89.4%	84.2%	88.0%	88.1%	87.8%			
EOHHS	Child: Overall Rating and Care Delivery: Communication	91.2%	91.4%	91.3%	90.5%	90.4%	91.0%	93.7%	89.8%	89.9%	92.7%	89.9%	91.6%	89.7%	93.0%	87.2%	91.8%	93.4%	81.3%			

Ref	2020 Measure	Total ACO	FH BERK	FH 365	FH WFC	HNE	AHP	THP ATRIUS	THP BIDCO	THP CHA	THP CHILDREN'S	BMC BACO	BMC MERCY	BMC SIGN	BMC SCOAST	C3	MGB	STEWARD	LAHEY	Total MCO	BMC MCO	THP MCO
EOHHS	Adult: Person-Centered Integrated Care: Integration of Care	78.1%	75.0%	80.6%	79.6%	71.7%	75.4%	80.4%	75.4%	72.4%	82.6%	74.8%	75.3%	74.2%	80.2%	72.0%	78.0%	78.0%	78.8%			
EOHHS	Child: Person-Centered Integrated Care: Integration of Care	80.2%	84.5%	81.7%	75.6%	77.4%	77.0%	83.2%	78.4%	74.7%	82.2%	77.9%	79.7%	76.7%	84.2%	73.3%	78.4%	82.3%	64.3%			
EOHHS	Adult: Person-Centered Integrated Care: Knowledge of Patient	81.6%	80.1%	82.8%	83.0%	78.7%	82.1%	84.0%	80.4%	80.0%	89.6%	80.8%	77.5%	79.8%	83.6%	78.1%	82.6%	82.8%	83.4%			
EOHHS	Child: Person-Centered Integrated Care: Knowledge of Patient	87.2%	86.1%	87.5%	87.9%	85.6%	84.9%	89.8%	86.6%	86.7%	89.1%	85.5%	87.1%	83.8%	89.3%	84.0%	88.1%	89.2%	71.8%			

Appendix B-4: Contract Level Performance, MY2018 (One Care and SCO)

2018 Quality measure performance for individual OneCare and SCO plans is presented in Table B-4.

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

Ref	2018 Measure	Total OneCare	CCA OneCare	THP OneCare	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United
CBP	Controlling High Blood Pressure	72.3%	72.0%	74.2%	74.3%	56.7%	81.0%	73.5%	75.9%	77.1%	70.3%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	39.1%	40.9%	27.6%							
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	0.8838	0.8806	0.8996	0.9028	1.1718	0.7050	0.5304	0.9599	0.7113	0.5967
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	41.7%	41.6%	42.6%							
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	12.3%	12.0%	14.5%							
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	42.9%	41.6%	51.6%	36.8%	NA	33.3%	46.0%	35.9%	45.7%	23.3%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	77.2%	76.9%	79.8%							
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	72.9%	72.1%	78.3%	65.0%	NA	68.6%	72.0%	59.0%	68.6%	55.8%
COL	Colorectal Cancer Screening				80.5%	68.5%	80.4%	66.1%	84.2%	75.8%	82.5%
PBH	Persistence of Beta Blocker Treatment After Heart Attack				97.4%	NA	NA	NA	NA	NA	93.8%
PCE-C	Pharmacotherapy Management of COPD Exacerbation Corticosteroids				78.2%	87.9%	73.7%	76.3%	80.1%	78.9%	79.9%
PCE-B	Pharmacotherapy Management of COPD Exacerbation Bronchodilators				90.0%	97.0%	94.2%	84.0%	89.0%	88.6%	91.2%
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD				27.4%	NA	28.6%	22.7%	24.5%	36.7%	29.6%
TRC	Transitions of Care: Medication Reconciliation Post Discharge				65.9%	73.7%	70.8%	87.0%	69.3%	59.4%	53.5%
OMW	Osteoporosis Management in Women Who Had a Fracture				38.5%	NA	43.2%	NA	21.7%	NA	42.6%
FVO NQF0041	Influenza Immunization (age 65+)				--	--	--	--	--	--	--
CMS127v9	Pneumococcal Immunization				--	--	--	--	--	--	--

Ref	2018 Measure	Total OneCare	CCA OneCare	THP OneCare	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United
DDE	Potentially Harmful Drug Disease Interactions in the Elderly (total) (lower rate is better)				46.1%	NA	45.8%	52.3%	44.9%	47.1%	44.8%
DAE-1Rx	Use of High-Risk Medications in the Elderly One RX				21.2%	19.5%	19.6%	23.8%	20.4%	17.2%	22.7%
DAE-2Rx	Use of High-Risk Medications in the Elderly Two RX				16.0%	13.7%	15.6%	20.3%	15.0%	13.6%	16.3%
AMM-A	Antidepressant Medication Management Acute				70.4%	NA	72.7%	71.7%	72.5%	63.8%	68.6%
AMM-C	Antidepressant Medication Management Continuation				57.7%	NA	58.4%	59.5%	59.1%	52.4%	57.3%
COA	Care for Older Adults: Advance Care Plan				83.9%	88.5%	87.7%	69.4%	97.2%	97.0%	73.0%
AAP MA-5	Access to Preventive/Ambulatory Health Services	97.5%	97.8%	95.6%							
MMP CW-12	Medication Adherence for Diabetes	76.0%	78.0%	67.0%							
MMP CW13	Encounter Data Completeness	--	--	--							
MMP CW7	Annual Flu Vaccination	68.0%	69.0%	61.0%							

Appendix B-5: Contact Level Performance, MY2019: (OneCare and SCO)

2019 Quality measure performance for individual OneCare and SCO plans is presented in Table B-5. Program-level totals are weighted means (WM). Please see Appendix A for a list of MassHealth’s managed care plans.

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

Ref	2019 Measure	Total OneCare	CCA OneCare	THP OneCare	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United
CBP	Controlling High Blood Pressure	72.3%	72.0%	74.2%	74.3%	56.7%	81.0%	73.5%	75.9%	77.1%	70.3%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	39.1%	40.9%	27.6%							
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	0.8838	0.8806	0.8996	0.9028	1.1718	0.7050	0.5304	0.9599	0.7113	0.5967
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	41.7%	41.6%	42.6%							
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	12.3%	12.0%	14.5%							
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	42.9%	41.6%	51.6%	36.8%	NA	33.3%	46.0%	35.9%	45.7%	23.3%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	77.2%	76.9%	79.8%							
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	72.9%	72.1%	78.3%	65.0%	NA	68.6%	72.0%	59.0%	68.6%	55.8%
COL	Colorectal Cancer Screening				80.5%	68.5%	80.4%	66.1%	84.2%	75.8%	82.5%
PBH	Persistence of Beta Blocker Treatment After Heart Attack				97.4%	NA	NA	NA	NA	NA	93.8%
PCE-C	Pharmacotherapy Management of COPD Exacerbation Corticosteroids				78.2%	87.9%	73.7%	76.3%	80.1%	78.9%	79.9%
PCE-B	Pharmacotherapy Management of COPD Exacerbation Bronchodilators				90.0%	97.0%	94.2%	84.0%	89.0%	88.6%	91.2%

Ref	2019 Measure	Total OneCare	CCA OneCare	THP OneCare	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD				27.4%	NA	28.6%	22.7%	24.5%	36.7%	29.6%
TRC	Transitions of Care: Medication Reconciliation Post Discharge				65.9%	73.7%	70.8%	87.0%	69.3%	59.4%	53.5%
OMW	Osteoporosis Management in Women Who Had a Fracture				38.5%	NA	43.2%	NA	21.7%	NA	42.6%
FVO NQF0041	Influenza Immunization (age 65+)				--	--	--	--	--	--	--
CMS127v9	Pneumococcal Immunization				--	--	--	--	--	--	--
DDE	Potentially Harmful Drug Disease Interactions in the Elderly (total) (lower rate is better)				46.1%	NA	45.8%	52.3%	44.9%	47.1%	44.8%
DAE-1Rx	Use of High-Risk Medications in the Elderly One RX				21.2%	19.5%	19.6%	23.8%	20.4%	17.2%	22.7%
DAE-2Rx	Use of High-Risk Medications in the Elderly Two RX				16.0%	13.7%	15.6%	20.3%	15.0%	13.6%	16.3%
AMM-A	Antidepressant Medication Management Acute				70.4%	NA	72.7%	71.7%	72.5%	63.8%	68.6%
AMM-C	Antidepressant Medication Management Continuation				57.7%	NA	58.4%	59.5%	59.1%	52.4%	57.3%
COA	Care for Older Adults: Advance Care Plan				83.9%	88.5%	87.7%	69.4%	97.2%	97.0%	73.0%
AAP MA-5	Access to Preventive/Ambulatory Health Services	97.5%	97.8%	95.6%							
MMP CW-12	Medication Adherence for Diabetes	80.0%	81.0%	72.0%							
MMP CW13	Encounter Data Completeness	--	76.0%	91.0%							
MMP CW7	Annual Flu Vaccination	68.0%	69.0%	61.0%							

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

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

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

Ref	2020 Measure	Total OneCare	CCA OneCare	THP OneCare	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United
CBP	Controlling High Blood Pressure	56.7%	58.4%	42.8%	61.2%	57.9%	59.4%	57.7%	53.7%	54.0%	70.3%
CDC	Comprehensive Diabetes Care: A1C Poor Control (lower is better)	53.0%	53.5%	48.5%							
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	1.0440	1.0029	1.3639	1.1729	1.0711	1.0143	1.1841	1.0924	1.2503	1.2454
IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	40.6%	40.6%	41.0%							
IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	11.4%	11.5%	10.4%							
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	50.0%	50.6%	44.1%	37.3%	NA	45.5%	25.5%	40.0%	37.8%	36.4%
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	79.6%	79.5%	80.5%							
FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	70.8%	71.2%	67.1%	61.0%	NA	69.7%	53.2%	53.3%	67.6%	60.0%
COL	Colorectal Cancer Screening				76.2%	69.4%	75.7%	61.7%	74.2%	63.9%	86.1%
PBH	Persistence of Beta-Blocker Treatment After Heart Attack				90.9%	NA	NA	NA	NA	NA	NA
PCE-C	Pharmacotherapy Management of COPD Exacerbation Corticosteroids				74.5%	NA	73.8%	78.2%	73.9%	77.4%	70.9%
PCE-B	Pharmacotherapy Management of COPD Exacerbation Bronchodilators				90.8%	NA	91.4%	94.3%	86.8%	91.5%	90.1%
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD				23.9%	NA	19.9%	22.5%	24.7%	25.3%	26.6%

Ref	2020 Measure	Total OneCare	CCA OneCare	THP OneCare	Total SCO	BMC HNET	CCA SCO	Navi-care	SWH	THP SCO	United
TRC	Transitions of Care: Medication Reconciliation Post Discharge				54.3%	72.9%	49.6%	85.4%	43.6%	43.1%	57.2%
OMW	Osteoporosis Management in Women Who Had a Fracture				25.5%	NA	16.3%	43.8%	NA	NA	22.6%
FVO NQF0041	Influenza Immunization (age 65+)				--	--	--	--	--	--	--
CMS127v9	Pneumococcal Immunization				--	--	--	--	--	--	--
DDE	Potentially Harmful Drug Disease Interactions in the Elderly (total) (lower rate is better)				32.4%	30.7%	31.1%	35.7%	31.2%	32.5%	32.9%
DAE-1Rx	Use of High-Risk Medications in the Elderly One RX				--	--	--	--	--	--	--
DAE-2Rx	Use of High-Risk Medications in the Elderly Two RX				--	--	--	--	--	--	--
DAE - Total	Use of High-Risk Medications in the Elderly - Total (lower rate is better)				21.6%	17.8%	23.3%	25.0%	19.4%	18.3%	22.4%
AMM-A	Antidepressant Medication Management Acute				78.9%	87.2%	78.2%	78.4%	83.4%	71.7%	78.1%
AMM-C	Antidepressant Medication Management Continuation				65.1%	76.9%	64.6%	64.5%	74.1%	54.6%	62.0%
COA	Care for Older Adults: Advance Care Plan				77.0%	35.8%	70.4%	70.6%	97.4%	98.0%	65.1%
AAP MA-5	Access to Preventive/Ambulatory Health Services	96.2%	96.4%	93.9%							
MMP CW-12	Medication Adherence for Diabetes Medications	85.0%	85.0%	83.0%							
MMP CW13	Encounter Data Completeness	--	94.0%	88.0%							
MMP CW7	Annual Flu Vaccination	71.0%	72.0%	69.0%							

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

Table C.1: Adult Core Measure Set Performance

Acronym	Measure Description	MY2018 Rates	MY2019 Rates	MY2020 Rates	National 75 th	National 90 th
AMM	Antidepressant Medication Management – Acute (18-65)	53.3%	56.0%	54.8%	61.8%	67.7%
AMM	Antidepressant Medication Management – Acute: over 65	70.5%	NR	78.9%	82.9%	86.4%
AMM	Antidepressant Medication Management - Continuation	39.3%	42.2%	40.7%	45.6%	52.5%
AMM	Antidepressant Medication Management – Continuation: Over 65	57.9%	NR	65.1%	68.8%	74.5%
AMR	Asthma Medication Ratio: Ages 19-50	50.1%	46.6%	47.4%	60.0%	64.1%
AMR	Asthma Medication Ratio: Ages 51-64	59.0%	57.2%	54.4%	61.2%	66.7%
BCS	Breast Cancer Screening	74.3%	69.4%	63.2%	58.7%	63.8%
BCS	Breast Cancer Screening: Over 65	NR	NR	75.6%	77.1%	80.1%
COB	Concurrent Use of Opioids and Benzodiazepines	17.2%	3.9%	3.8%	NA	NA
CBP	Controlling High Blood Pressure: 18-65	67.9%	68.4%	56.8%	62.5%	66.4%
CBP	Controlling High Blood Pressure: Over 65	74.3%	NR	61.2%	77.1%	77.4%
CCS	Cervical Cancer Screening	70.8%	70.1%	64.4%	63.9%	68%
CDC	Comprehensive Diabetes Care – A1C Poor Control (lower rate is better)	33.5%	35.8%	43.3%	38.4%	34.1%
CDC	Comprehensive Diabetes Care – A1C Poor Control: Over 65 (lower rate is better)	NR	NR	28.9%	17.3%	13.9%
CDF	Screening for Depression and Follow-up Plan – Ages 18 and Older	NR	42.9%	36.4%	NA	NA
CHL	Chlamydia Screening in Women Ages 21-24	72.3%	71.6%	65.8%	65.5%	70.7%
CCP	Contraceptive Care Postpartum Women Ages 21-44: Most/Moderate – 3 days	12%	12.8%	15.5%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 21-44- Most/Moderate – 60 days	46.8%	48.9%	46.9%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 21-44- LARC – 3 days	2.6%	2.7%	5.2%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 21-44 LARC – 60 days	16.3%	17.7%	16.2%	NA	NA
CCW	Contraceptive Care All Women Ages 21-44: Most/Moderately Effective	29.9%	23.7%	19.7%	NA	NA
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 day	22.5%	23.9%	22.9%	18.3%	23.1%
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 day: Over 65	NR	NR	14.2%	13.9%	18.2%
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 day	32.8%	34.7%	33.1%	26.7%	33.1%
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 day: Over 65	NR	NR	22.6%	20.2%	25%
FUH	Follow-Up After Hospitalization for Mental Illness -7 day: 18-65	46.7%	42.7%	45.8%	43.8%	53.7%
FUH	Follow-Up After Hospitalization for Mental Illness -7 day: Over 65	36.7%	NR	33.2%	36.3%	50.0%
FUH	Follow-Up After Hospitalization for Mental Illness - 30 day: 18-65	69.1%	65.5%	66.7%	63.4%	70.4%

Acronym	Measure Description	MY2018 Rates	MY2019 Rates	MY2020 Rates	National 75 th	National 90 th
FUH	Follow-Up After Hospitalization for Mental Illness - 30 day: Over 65	65.1%	NR	61.0%	58.6%	69.7%
FUM	Follow-Up After Emergency Department Visit for Mental Illness – 7 day: 18-65	73.0%	72.8%	73.5%	49.5%	61.4%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 day: Over 65	NR	NR	63.8%	36.8%	51.4%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 day: 18-65	80.2%	80.0%	80.5%	64.6%	73.6%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 day: Over 65	NR	NR	72.4%	50.8%	62.3%
FVA	Flu Vaccinations for Adults Ages 18-64	46.9%	48.1%	46.6%	44.3%	50.6%
MSC	Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers to Quit	77.6%	80.1%	80.3%	79.3%	82.1%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment -Initiation (18-64)	47.2%	48.7%	48.1%	49.0%	54.2%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment -Initiation: 65+	NR	NR	38.9%	40.9%	46.2%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment -Engagement (18-64)	18.5%	18.5%	17.3%	18.4%	23.2%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement): 65+	NR	NR	6.7%	6.4%	9.2%
OHD	Use of Opioids at High Dosage in Persons Without Cancer	10.7%	8%	7.2%	NA	NA
PCR-O/E	Plan All-Cause Readmissions (observed to expected ratio)	0.9929	1.2086	1.1461	0.9163	0.8349
PPC	Prenatal and Postpartum Care – Postpartum Care	67.6%	77.0%	79.7%	79.6%	83.7%
PQI01	Diabetes Short-Term Complications Admission Rate (per 100000 member months)	13.1	13.9	14.1	NA	NA
PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 member months)	59.5	56.4	38.3	NA	NA
PQI08	Heart Failure Admission Rate (per 100,000 member months)	17.3	18.9	16.5	NA	NA
PQI15	Asthma in Younger Adults Admission Rate (per 100,000 member months)	9.3	6.6	5.3	NA	NA
SSA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	70.8%	69.0%	69.2%	68.9%	73.1%
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	79.2%	81.4%	73.2%	79.7%	82.5%
CAHPS	Getting Needed Care	85.2%	80.2%	85.9%	86.5%	88.6%
CAHPS	Getting Care Quickly	81.8%	83.0%	83.1%	84.7%	87.2%

Acronym	Measure Description	MY2018 Rates	MY2019 Rates	MY2020 Rates	National 75 th	National 90 th
CAHPS	How Well Doctors Communicate	92.9%	91.1%	91.1%	93.9%	95.2%
CAHPS	Customer Service	88.0%	86.8%	86.8%	91.1%	92.2%

Table C.2: Child Core Set Performance

Acronym	Measure Description	MY2018 Rates	MY2019 Rates	MY2020 Rates	National 75th	National 90th
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation	49.3%	53.0%	45.7%	49.1%	56%
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation	62.3%	64.0%	54.8%	62.4%	67.6%
AMB-ED	Ambulatory Care - Emergency Department Visits: <1 year	89/1000	90.6/1000	49.8/1000	NA	NA
AMB-ED	Ambulatory Care - Emergency Department Visits: 1-9 years	44.8/1000	43.8/1000	23.4/1000	NA	NA
AMB-ED	Ambulatory Care: Emergency Department Visits: 10-19 years	34.1/1000	33.5/1000	20.7/1000	NA	NA
AMR	Asthma Medication Ratio: Ages 5 -11	67.1%	64.7%	73.8%	82.5%	85.1%
AMR	Asthma Medication Ratio: Ages 12-18	63.6%	58.3%	65.1%	73.8%	78%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	37.9%	47.6%	36.5%	36.8%	44.6%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	76.7%	80.1%	76.3%	69.4%	76.3%
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: Most/Moderate - 3 days	7.8%	11.0%	14.1%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: Most/Moderate - 60 days	49.2%	50.0%	49.7%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: LARC - 3 days	5.2%	7.2%	10.1%	NA	NA
CCP	Contraceptive Care Postpartum Women Ages 15 to 20: LARC - 60 days	23.1%	24.8%	25.3%	NA	NA
CCW	Contraceptive Care - All Women Ages 15 to 20 Most/Moderate Effective Methods	32.0%	19.8%	13.3%	NA	NA
CDF	Screening for Depression and Follow-up Plan: Ages 12-17	NR	51.1%	41.1%	NA	NA
CHL	Chlamydia Screening in Women Ages 16 to 20	71.9%	71.9%	63.4%	58.8%	65.3%
CIS	Childhood Immunization Status (combo 10)	50.6%	49.2%	52.1%	45.5%	53.6%
DEV	Developmental Screening in the First Three Years of Life	78.0%	75%	71.4%	NA	NA
FUH	Follow-Up After Hospitalization for Mental Illness – 7 days	60.2%	55.7%	59.6%	58.3%	68.0%
FUH	Follow-Up After Hospitalization for Mental Illness - 30 days	81.0%	78.3%	79.1%	79.5%	83.7%

Acronym	Measure Description	MY2018 Rates	MY2019 Rates	MY2020 Rates	National 75th	National 90th
IMA	Immunization for Adolescents (combo 2)	36.0%	38.4%	44.0%	43.55%	50.61%
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	86.3%	83.0%	84.3%	89.3%	92.2%
SFM	Sealant Receipt on First Molars	NA	NA	66.3%	NA	NA
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI percentile (Total)	85.3%	86.6%	82.7%	82.7%	87.2%
W30	Well-Child Visits in the First 30 Months of Life – First 15 months	NA	NA	75.9%	61.5%	68.7%
W30	Well-Child Visits in the First 30 Months of Life – 15 -30 months	NA	NA	84.4%	76.2%	83.2%
WCV	Child and Adolescent Well-Care Visits	NA	NA	63.1%	54%	62.2%

Appendix D: 2020 EQR Performance Improvement Projects (PIPs)

Appendix D summarizes 2020 PIP topic areas, PIP topics, and provides example interventions. More information on the PIPs and the PIP validation process and results is available in the EQR Annual Technical Reports, accessible on the MassHealth Quality reports and resources web page: www.mass.gov/info-details/masshealth-quality-reports-and-resources.

Appendix D-1: ACO (ACCP) Program PIPs 2020: Summary of Topic Areas, Goals, and Intervention Examples (26 PIPs: 13 contracts, 2 projects each)

PIP Topic	PIP Aim/Goal and Intervention Examples
Behavioral Health – Care, Coordination, and Integration	<ul style="list-style-type: none">• Aim/Goal - Increasing the rate of follow-up visits within seven days of discharge for members hospitalized for a mental illness (5 projects)• Intervention Example - Met with high-risk and high-utilizing members prior to discharge, and follow up within 48 hours of discharge, to ensure coordination of care.• Aim/Goal - Utilizing Health-Related Social Needs Screening to identify both pediatric and adult members in need of additional services to improve health outcomes (4 projects)• Intervention Example - Incorporated SDOH screening tool into the electronic medical record.• Aim/Goal - Improving Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (5 projects)• Intervention Example - Provider education and referral options for members with substance use disorders.• Aim/Goal - Improving the rate of depression screenings and follow-up plans (7 projects)• Intervention Example - PHQ-9 screening, and analysis of workflow challenges in differently sized practices.

PIP Topic	PIP Aim/Goal and Intervention Examples
<p>Care for Acute and Chronic Conditions</p> <p>Focus on sub-populations (e.g., Children, diabetes)</p>	<ul style="list-style-type: none"> • Aim/Goal - Focus on improving Asthma Control and Medication Adherence (1 project) • Intervention Example -Member education program combining telephonic and in-person counseling and text messaging on the proper use of asthma medication and how to self-manage their condition. • Aim/Goal - Improving Rates of Controlling High Blood Pressure (1 project) • Intervention Example - Member classes on how to self-monitor blood pressure with a fitted automatic blood pressure cuff (provided). Nurse outreach in 7 days to discuss the readings and next steps as indicated. • Aim/Goal - Improving Rates of CDC – A1C testing for the diabetic population (1 project) • Intervention Example -Generation of gaps in care registries with providers outreach to telephone non-adherent members. • Aim/Goal -Improve outcomes in diabetic patients through integrated care management (1 project) • Intervention Example - Registries of members with diabetes and housing, food, and transportation issues shared with Community Health Workers (CHWs), who collaborate with primary care teams to identify the appropriate treatment pathway. • Aim/Goal - Improving Rates of Immunizations for Adolescents - Combo 2 (1 project) • Intervention Example - Provider training on motivational interviewing and persuasion techniques

Appendix D-2: MCO Program PIPs 2020: Summary of Topic Areas, Goals, and Intervention Examples (4 PIPs: 2 contracts, 2 projects each)

PIP Topic	PIP Aim/Goal and Intervention Examples
Behavioral Health – Care, Coordination, and Integration	<ul style="list-style-type: none"> • Aim/Goal - Improving Follow Up After Hospitalization for a Mental Illness • Intervention Example - Educated high-volume inpatient facilities about the importance of scheduling follow-up visits within 7 days of discharge • Aim/Goal - Improving Behavioral Health Screening for Adolescent Members • Intervention Example - Medical Directors telephoned PCPs identified as high performing to learn of best practices
Care for Acute and Chronic Conditions Focus on sub-populations (e.g., Children, diabetes)	<ul style="list-style-type: none"> • Aim/Goal - Utilize Health-Related Social Needs Assessment Screening to Improve Pediatric Members' Health Outcomes • Intervention Example - Outreach calls, if a yes response to at least one of the questions targeting weight management and nutrition counseling needs. • Aim/Goal - Improving Asthma Control and Medication Adherence Among the MassHealth Population • Intervention Example - Member education program included an expanded texting program for members who opt in.

Appendix D-3: SCO Program PIPs 2020: Summary of Topic Areas, Goals, and Intervention Examples (12 PIPs: 6 entities, 2 projects each)

PIP Topic	PIP Aim/Goal and Intervention Examples
Behavioral Health – Care, Coordination, and Integration	<ul style="list-style-type: none"> • Aim/Goal - Improving SCO Member Access to Behavioral Health Depression Services • Intervention Example - PHQ-2 administered; if score is ≥ 3, the member was administered the PHQ-9. If score is ≥ 10, members were referred to the indicated level of care. • Aim/Goal - Cognitive Impairment and Dementia: Detection and Care Improvement • Intervention Example - Positive Mini-Cog© or cognitive assessment screening reviewed; as needed, address evaluation, treatments, services, support for dementia-related needs and referrals to dementia specialists • Aim/Goal - Increasing Rates of Follow-Up After Hospitalization for Mental Illness • Intervention Example - Letters to members missing a 7-day follow-up appointment; follow-up care coordination activities within the 30-day post-discharge window. • Aim/Goal -Improving Treatment for Depression • Intervention Example - A gap list highlighting members at risk of low medication adherence, and depression is provided to providers, for screening purposes • Aim/Goal - Decrease Readmissions to Inpatient Behavioral Health Facilities by Better Managing Transitions of Care • Intervention Example -Care manager- facility collaboration on pre-discharge planning. Within 2 business days of discharge, members administered a standardized transitions assessment. Within 7 days of discharge, medication reconciliations conducted. Weekly contact for 30 days post-discharge. • Aim/Goal - Improving Antidepressant Medication Management (AMM) for Members Diagnosed with Depression • Intervention Example - Pharmacist outreach to members diagnosed with major depression and prescribed antidepressant medication who were non-adherent, and whose prescriptions were due for refill within 3 days OR not yet refilled.
Care for Acute and Chronic Conditions	<ul style="list-style-type: none"> • Aim/Goal - Improving Health Outcomes for SCO Members with Diabetes • Intervention Example - Input from members on diabetes educational materials was collected via focus group and at a Member Advisory Council meeting • Aim/Goal - Increasing the Rate of Retinal Eye Exams among Diabetic Enrollees • Intervention Example - Diabetes gaps-in-care letters sent to unique PCPs with a combined panel of unique members needing a diabetic retinal eye exam as of 6/1/2019. • Aim/Goal - Improving SCO Member Adherence to Medication Regimens for Managing Their Diabetes

PIP Topic	PIP Aim/Goal and Intervention Examples
	<ul style="list-style-type: none"> • Intervention Example - Members provided a 90-day supply of oral diabetic medications. Hypothesis: reduced trips to the pharmacy contributes to adherence. • Aim/Goal - Cardiac Disease Management • Intervention Example - Chronic disease self-management classes. • Aim/Goal - Reducing the Chronic Obstructive Pulmonary Disease (COPD) Admission Rate through Identification and Management of COPD and Co-Morbid Depression • Intervention Example - Outreach conducted to PCPs with members with co-occurring depression and COPD to ensure appropriate referrals are made and antidepressants prescribed • Aim/Goal -Increasing the Rate of Annual Preventive Dental Care Visits • Intervention Example - Member text message and mail reminders to schedule preventive dental visits and maintain oral health.

Appendix D-4: OneCare Program P - IPs 2020: Summary of Topic Areas, Goals, and Intervention Examples (4 PIPS: 2 entities, 2 projects each)

PIP Topic	PIP Aim/Goal and Intervention Examples
Behavioral Health – Care, Coordination, and Integration	<ul style="list-style-type: none"> • Aim/Goal - Cardiovascular Disease (CVD) Prevention in One Care Members with Mental Illness and Multiple Risk • Intervention Example - Health-coaching and support for members with mental illness whose smoking put them at high risk of cardiovascular disease. • Aim/Goal - Improve Therapy Visit Rate for Members with Depression • Intervention Example - Community health center PCPs informed in writing of members with a diagnosis of depression but did not receive BH therapy services. PCP follow-up calls made.
Care for Acute and Chronic Conditions	<ul style="list-style-type: none"> • Aim/Goal - Reducing Emergency Department (ED) Utilization • Intervention Example - Member outreach following ED visits to encourage primary care follow up visits. • Aim/Goal - Improve the Rate of Cervical Cancer Screening • Intervention Example - Interactive Voice Recognition (IVR) phone reminders to members with gaps to schedule cervical cancer screening services and offering help with appointment scheduling.