MassHealth Comprehensive Quality Strategy

November 2018

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Section 1. Introduction

The 2018 MassHealth Comprehensive Quality Strategy is an update to the MassHealth Managed Care Quality Strategy, required by 42 CFR 438 subpart E under the managed care rule. The MassHealth Managed Care Quality Strategy was first developed in 2006 to fulfill managed care quality requirements and improve the quality of managed care services in Massachusetts. That document served as a foundation for the development and maintenance of a broader quality strategy, which aims to assess the quality of care that all of our beneficiaries receive, and sets forth measurable goals for improvement across programs.

This update establishes a more comprehensive Quality Strategy, broadening the scope of the initial strategy (and previous updates) which focused on regulatory managed care requirements. This updated version reflects MassHealth's transition to an evolving, comprehensive strategy and serves as a framework for agency-wide quality activities, while maintaining adherence to the regulatory managed care requirements. Contents include:

- A background on MassHealth, including strategic goals and objectives, quality oversight, and the quality strategy development process;
- Description of agency-wide quality goals and key activities/efforts that support achievement of those goals, including the following key elements:
    - Identification of shared goals and aims;
    - Selection of agency-wide activities designed to achieve these goals and aims;
    - Measurement and monitoring progress toward achieving these goals and aims;
    - Identification of benchmark sources used to establish targets for performance; and
    - Description of processes for development, implementation, evaluation and reporting
- Managed care-specific quality requirements in accordance with 42 CFR 438 subpart E.

This comprehensive Quality Strategy presents an opportunity to bring together the numerous quality programming, measurement and improvement efforts that take place across the agency. Additionally, this strategic framework facilitates a move toward alignment of agency-wide initiatives that reflect MassHealth priorities and address the special needs of our populations.

This updated Quality Strategy incorporates the initial "Quality Considerations for Medicaid and CHIP programs" guidance communicated by CMS in its November 2013 State Health Official Letter (PDF). CMS guidance will continue to inform our framework for quality improvement and measurement.

Section 2. MassHealth Program Background

Section 2.1 Overview

MassHealth (Massachusetts' Medicaid and Children's Health Insurance Programs) provides health coverage to 1.82 million, or about 1 in 4, Massachusetts residents and is essential to maintaining the Commonwealth's high level of insurance coverage at over 97 percent. Approximately 70 percent of MassHealth members are enrolled in managed care entities (MCEs, also referred to as plans throughout this document), with the remaining 30 percent in the Fee for Service program (FFS). 2018 marks a

dramatic shift in service delivery models with a significant portion of the MassHealth managed care population, previously enrolled in traditional managed care plans, such as the Managed Care Organization Program and the Primary Care Clinician Plan, receiving services through Accountable Care Organization (ACO) programs.

Section 2.2 MassHealth Strategic Goals and Objectives

MassHealth is dedicated to improving the health outcomes of its diverse members by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life.

To achieve this mission, MassHealth has identified a series of strategic goals and associated objectives. In 2017, the goals were reviewed by the MassHealth Quality Committee to determine their alignment with current programmatic and quality activities. The Quality Committee, in conjunction with MassHealth leadership, revised these foundational goals, to better capture the current landscape. Recent changes in the Massachusetts Medicaid program include the implementation of payment and delivery system reforms, through which the Commonwealth aims to further emphasize value in care delivery, better meet member needs through more integrated and coordinated care, and moderate the cost trend while maintaining clinical quality of care.

MassHealth Strategic Goals:

MassHealth goals aim to:

1. Deliver a seamless, streamlined, and accessible patient-centered member experience, with focus on preventative, patient-centered primary care, and community-based services and supports
2. Enact payment and delivery system reforms that promote member-driven, integrated, coordinated care; and hold providers accountable for the quality and total cost of care.
3. Improve integrated care systems among physical health, behavioral health, long-term services and supports and health-related social services.
4. Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals.
5. Maintain our commitment to careful stewardship of public resources through innovative program integrity initiatives.
6. Create an internal culture and infrastructure to support our ability to meet the evolving needs of our members and partners.

MassHealth Strategic Objectives:

To meet its goals of improved patient care, outcomes and moderated cost trends, MassHealth identified the following objectives:

- Purchase quality health care services and drive delivery system change at the organizational and state level
- Improve the health care delivery system's capacity to deliver expanded medical care and other services
- Improve care processes at the member and provider level
- Protect the health care interests of members through monitoring of quality care and services,
- Advance patient care and delivery innovations that improve member services and outcomes

- Focus health care improvements on enrollee demographics and cultural needs to help improve health equity

Section 2.3 MassHealth Managed Care Programs

MassHealth began enrolling adults and children in managed care in 1997 as part of an 1115 waiver approved in 1995 to expand Medicaid eligibility. This waiver covered families and children up to 200 percent 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 percent FPL to 150 percent FPL. Chapter 170 also provided presumptive eligibility for children while income and other information to verify eligibility were obtained.

Over time, MassHealth managed care programs have expanded to include seniors and members dually eligible for MassHealth and Medicare (dually eligible members). Today, MassHealth operates the following managed care programs:[1]

- Accountable Care Organization (ACO) Program- a population-based payment model for members under the age of 65 and without any third party insurance, wherein the entities have financial accountability for the cost and quality of their members' care. There are three types of ACOs in Massachusetts.
- 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 model of managed care for members under the age of 65 and without any third party insurance, with a capitated Behavioral Health plan.
- Behavioral Health (BH) plan – a capitated BH model for members under the age of 65 and younger who are enrolled in the PCC Plan or a Primary Care ACO and children in the care and/or custody of the Department of Children and Families and the Department of Youth Services, or who have third-party insurance or are dually eligible members.
- One Care – a capitated model for dual eligible members ages 21-64.
- Senior Care Options (SCO) Program – a capitated model for members age 65 and older, including dually eligible members.

Accountable Care Organizations

In 2018, MassHealth introduced a new managed care enrollment option to its existing MCO and PCC plans. Beginning in March 2018, members were able to enroll in Accountable Care Organizations. Accountable Care Organizations (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 established three types of ACO delivery models.

- An Accountable Care Partnership Plan is 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

[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.

members. Accountable Care Partnership Plans are responsible for all contractually covered services and take on full insurance risk. Accountable Care Partnership Plans pay provider claims for all plan-covered services.

- A Primary Care ACO is a network of PCPs who contract directly with MassHealth, using MassHealth's provider network, including the BH Plan to provide integrated and coordinated care for members. A Primary Care ACO does not receive capitation payments for 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. Primary Care ACOs will 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 Primary Care ACO, the member will not need a referral to receive services from that specialist.

- An MCO-Administered ACO is a network of PCPs who may contract with one or multiple 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.

Key priorities for all models in the ACO program include a focus on integration of members' physical, behavioral health (BH) and long-term services and supports (LTSS) needs and building linkages to social services. All ACOs are accountable for providing high-value, cross-continuum care across a range of measures. The ACOs may earn savings if they meet certain quality thresholds.

Table 1: Summary of Managed Care provides a list of the current types of managed care programs that serve MassHealth members. All managed care programs typically operate on a calendar year with the exception of a shortened year in 2018 (March-December 2018) when the MCO program contracts were re-procured and ACO programs were newly introduced. More than 850,000 members were enrolled with ACOs following the program launch in March 2018.

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). MassHealth's BH vendor, which serves members enrolled in the PCC Plan and Primary Care ACOs, and certain other populations, is a Prepaid Inpatient Health Plan (PIHP). MassHealth does not contract with any Prepaid Ambulatory Health Plans (PAHPs) as defined in 438.2. The quality strategy under 42 CFR 438.340 relates to MCOs, Prepaid Inpatient Health Plans (PIHPs), and to PCCM entities as described in 438.310(c)(2). Though not required to comply with the managed care rule, MassHealth includes the PCC Plan (a PCCM) in its strategy, where appropriate.

Table 1: Summary of Managed Care Programs in 2018

	Medicaid Only					Members Dually eligible or 65+**	
Managed Care Program Type:	Accountable Care Partnership Plan, ACO Program	Primary Care, ACO Program (PCCM Entity)	MCO Program	PCC Plan	PIHP for BH*	One Care	SCO Program
Number of Contractors	13	3	2	N/A	1	2	6
Federal Authority	1115 waiver	1115 waiver	1115 waiver	1115 waiver	1115 waiver	Demonstration	1915(a)/ 1915(c)
Type of Contract	Managed Care Organization	PCCM Entity	Managed Care Organization	PCCM	PIHP	Managed Care Organization	Managed Care Organization
Approximate Membership	511,755	340,694	170,569	118,515	524,970	20,540	57,468

* some children enrolled in the BH Plan have TPL or are also enrolled in Medicare
**some SCO Members are Medicaid-only members

Section 2.4 Fee-For-Service Programs

MassHealth operates several programs outside the purview of the managed care rule that cover services provided on a fee-for-service basis. While these programs are beyond the required the scope of the managed care quality strategy, they play an important role in care delivery in Massachusetts.

Long-Term Services and Supports

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, managed care entities, and the PACE program. Services managed by the MassHealth Office of Long-Term Service and Supports 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 Services
- Other Covered Services, including: Durable Medical Equipment (DME), Orthotics and Prosthetics, Oxygen and Respiratory Therapy, Hospice Services, Home Health Agency (except Continuous Skilled Nursing), Nursing Facility and Chronic Disease Rehabilitation Hospital (CDRH) services for the first 100 days, and Therapies (including Physical Therapy, Occupational Therapy and Speech Therapy).

The One Care, SCO, and PACE programs 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 members. In future years, it is expected that some or all LTSS services will be ACO and MCO-covered services.

Hospital Programs

MassHealth manages an acute care hospital network and providers for its Fee-for-Service, PCC Plan and Primary Care ACO populations. MassHealth also manages a psychiatric hospital network and providers for its Fee-For-Service program.

As part of their contractual obligations with the Commonwealth, acute care and psychiatric hospital providers are required to participate in quality initiatives that require a portion of the hospital's reimbursement to be based on its performance on quality indicators

Section 2.5 Other MassHealth Programs

Other programs, services and supports provide important care to members.

Program of All Inclusive Care of the Elderly

The Program of All -Inclusive Care for the Elderly (PACE) is for members age 55 and older who require a Nursing facility level of care. PACE provides managed care through direct contracts with PACE providers rather than through managed care entities. The PACE model is centered on the core belief that given a choice, most elders, the disabled, and their families would choose to receive care in their homes and communities rather than in a nursing home.

Community Partners Program

One of MassHealth's strategies to improve coordinated care and population health management is to invest in Community Partners to collaborate with ACOs and MCOs to provide care coordination and care management supports to individuals with significant behavioral health issues needs and/or complex long-term services and supports (LTSS) need. Eligible members include ACO or MCO members who are adults with complex BH needs, or children and adults with complex LTSS needs. CP supports are not available to members in the PCC Plan or in MassHealth's fee-for-service program unless the member is affiliated with the Department of Mental Health's Adult Community Clinical Supports program.

Section 2.6 Strategic Partnerships

MassHealth managed care is implemented in an environment where multiple strategic partners within the Commonwealth participate in the design and operation of its managed care programs. Strategic partners include:

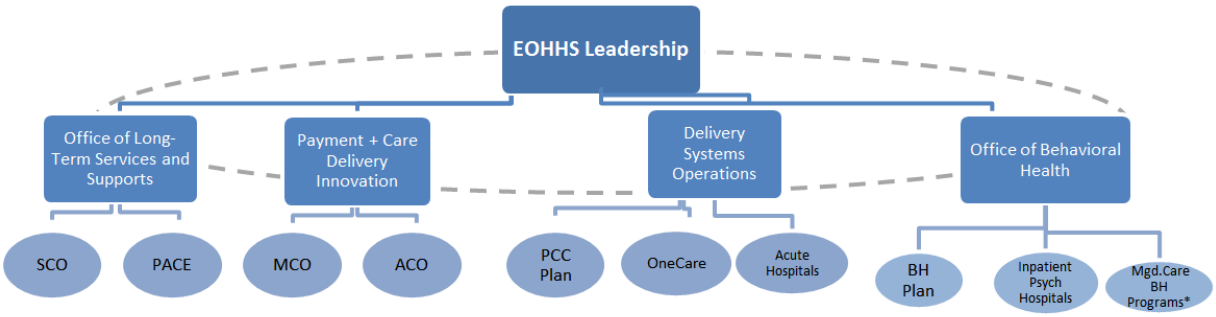
- Department of Mental Health
- Department of Public Health
- Department of Transitional Assistance
- Department of Youth Services
- Department of Children and Families
- Department of Developmental Services
- Executive Office of Elder Affairs

Section 3. Quality Management at MassHealth

Section 3.1 Functional Quality Management

MassHealth quality management cuts across all programs and units, with each unit contributing to and supporting key functions. As demonstrated in Figure 1: Functional Chart of Quality Management in MassHealth, four major units at MassHealth work in conjunction with a centralized quality office to plan and implement quality programs. Program directors work in collaboration with each other, quality and other functional units across the organization, such as clinical affairs, analytics, legal, finance, and policy to develop, implement and monitor quality programs and activities.

Figure 1: Functional Chart of Quality Management in MassHealth



*The Office of Behavioral Health contributes to oversight of behavioral health-related contractual obligations across programs.

Key quality functions include designing for quality, measurement, and improvement. These functions may be conducted at the member, provider, health plan or MassHealth level.

Quality Functions (Supported by MassHealth Quality Office and Programs)		
Design for Quality *Quality Program Planning and Implementation*	*Measurement and Monitoring* *Data Analysis and Quality Improvement*	*Remediation and Evaluation* *Assessment, Evaluation and Report*
Activities		
Member-focused	*Provider-focused*	*Agency-focused*

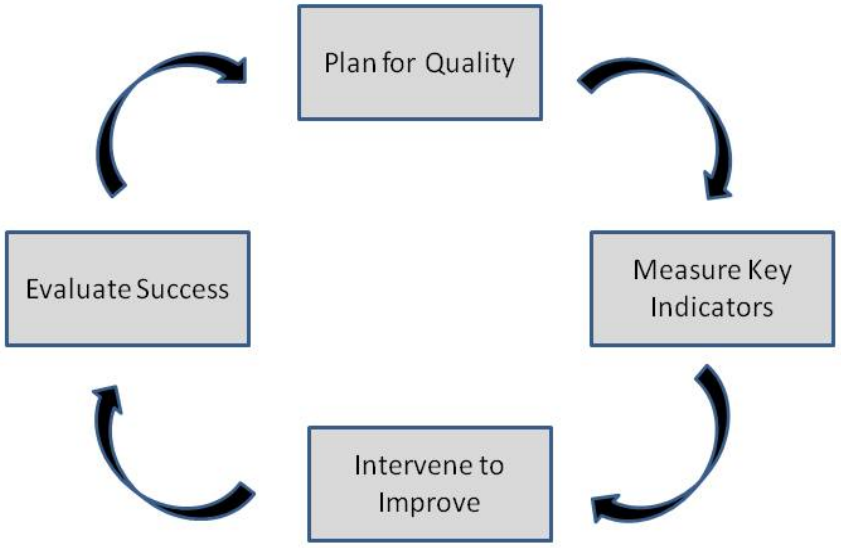
Quality management functions are present at various levels within the agency, leveraging core quality processes in a centralized unit (i.e., the MassHealth Quality Office) as well as an internal MassHealth Quality Committee that includes representatives from quality programs. This model enables MassHealth to effectively develop and manage overarching priorities and quality strategies that align across the agency, as well as address program-specific implementation processes and population needs.

As seen in Figure 2, the quality management process follows a plan-do-study-act (PDSA) model. Under this model, MassHealth plans for quality initiatives, identifies and measures key metrics, reacts to these findings by intervening to continuously improve the process, and evaluates for success in its programs

using short-term and longitudinal evaluation indicators. Additional tools or methodologies may also be incorporated to compliment this process further as necessary.

The quality strategy continues to evolve to reflect the balance of centralized and program-level activity, increase the alignment of priorities and goals (where appropriate) and develop increased strategic focus across the organization.

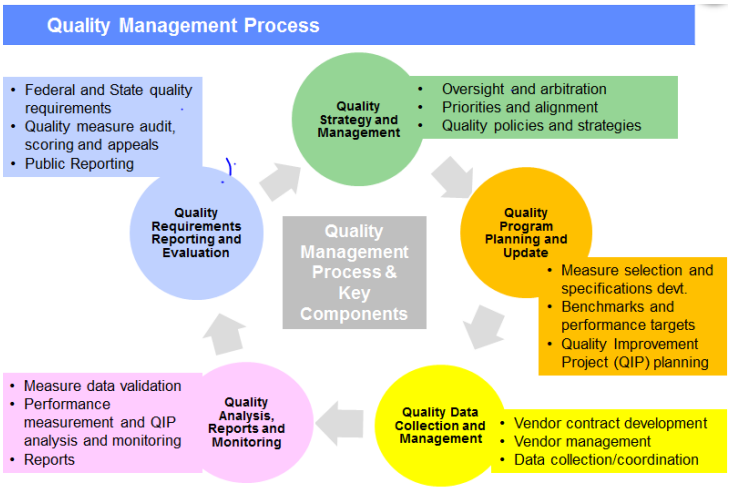
Figure 2: MassHealth Quality Management Process



Section 3.2 MassHealth Quality Office

The MassHealth Quality Office is a central office that supports program development, implementation planning, analysis, performance monitoring and evaluation activities across programs. Key components of quality management are summarized in Figure 3.

Figure 3: Quality Management



MassHealth Quality Office activities include but are not limited to working collaboratively with programs to:

- 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

Section 3.3 MassHealth Quality Committee

To support agency-wide collaboration, strategy and program development, the MassHealth Quality Committee is convened by the MassHealth Quality Office, and serves as a forum to:

- Share program activities and developments
- Discuss cross-cutting quality program issues
- Develop and recommend approaches to addressing quality measurement, improvement, and evaluation activities.
- Review data to assess performance measures and activities and the extent to which they may result in improved efficiency or effectiveness of programs

This workgroup is comprised of quality staff integral to the development and alignment of contractual, quality and programmatic activities. The work of the quality committee is guided by the triple aim of providing better health and better services for MassHealth members while maintaining cost-efficiency. Several key committee activities are described withinTable 2: MassHealth Quality Committee Key Activities

Table 2: MassHealth Quality Committee Key Activities

Activity	Tasks
Quality Program Planning	Obtain stakeholder input
	Define program priorities
	Select measures
	Assess alignment and relevance across programs
Implementation	Identify goals and/or benchmarks for performance and quality improvement
	Plan for data monitoring and use
Quality Improvement	Identify best practices
	Modify process and make improvements
Program Evaluation	Determine efficiency and effectiveness
	Consider outcomes-based impact for members

Section 3.4 Quality Steering Committee

A Quality Steering Committee is under development to provide oversight and direction in the identification of strategic priorities, guiding principles and policies in quality program planning and management across the agency. The group will also serve to promote cross-program workgroups and initiatives (such as the MassHealth Quality Committee) to align these priorities and policies, and focus resources to achieve the Commonwealth's goals and objectives. The Quality Steering Committee will include senior leaders representing programs, quality, clinical quality subject matter experts, IT/data systems and analytics, policy, legal and finance. The committee will be co-chaired by the Chief Medical Officer and the head of the MassHealth Quality Office, the MassHealth Quality Director.

Section 3.5 Quality Strategy Development Process

The 2018 Comprehensive Quality Strategy (CQS) was drafted with guidance and input from the MassHealth Quality Committee. The CQS is considered a living document reflective of the ongoing quality program development and implementation. The CQS draws upon shared goals, objectives and priorities across programs as well as unique objectives and activities developed to meet the needs of specific populations. Following internal review by the executive staff and MassHealth program quality representatives, the CQS was made available to external stakeholders through the posting of a draft document for public comment on the MassHealth web site.

Input on the CQS will be obtained through engagement and comments from external stakeholders. This feedback informs the development and annual update, as necessary, of MassHealth quality programs. Through various committees, forums and opportunities for comment, stakeholders have highlighted important areas for continued commitment and ongoing development as part of the CQS. The strategy was posted for public comment in October 2018. Specific opportunities for advancement of the current CQS are discussed in Section 4.4).

Section 3.6 External Stakeholder Engagement

Stakeholder engagement is a critical component to ongoing MassHealth quality program planning, monitoring and also the CQS. MassHealth engages with various stakeholders representing payers, providers, members, member advocates, associations, other EOHHS state agencies as well as subject matter experts addressing special population (e.g., BH, LTSS) and quality areas (e.g., member experience, measurement, SDOH). Examples include:

- Delivery System Reform Incentive Payment (DSRIP) Quality Sub-Committee
- EOHHS' Quality Measurement Taskforce (also called EOHHS Quality Alignment Taskforce)
- ACO/MCO Quality Program Office Hours for ACO and MCO contractors
- Acute Hospital Quality Taskforce Advisory
- BH and LTSS CP meetings
- OTLSS Stakeholder meetings
- One Care Implementation Council
- Monthly meetings with provider groups including Home Health, Adult Foster Care, Durable Medical Equipment, and Personal Care Management.
- Monthly meetings with Children's Behavioral Health Initiative (CBHI) providers and CBHI Network management staff from MCO/ACOs/MBHP.
- Monthly Advocates Meetings attended by several member advocate organizations

MassHealth and its programs engage stakeholders through these various committees and initiatives, in order to obtain input from a broad set of organizations and individual stakeholders. Stakeholder

engagement will continue to represent an important source of guidance for specific quality programs as well as broader strategic agency and statewide development of quality strategies and initiatives. MassHealth members are key stakeholders, and MassHealth maintains its commitment to engage and incorporate member input across all programs.

Section 3.7 Review and Update of Quality Strategy

MassHealth will conduct an annual review of the CQS and, at least every three years, complete an update to its quality strategy. As part of this triennial update process, MassHealth will solicit input from internal and external stakeholders and through a public comment period. The feedback provided by stakeholders, including MassHealth members and their representatives, will be taken into consideration and incorporated, as appropriate, into an updated CQS.

MassHealth will work 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, submitting quarterly and annual reports to CMS on the implementation and effectiveness of the waivers.

In accordance with 42 CFR 438.204(b)(11), the state must define what constitutes a "significant change" that would require revision of the CQS at an interval more frequent than three years. Massachusetts identified factors that would necessitate strategy revision before the third year. They include:

- A dramatic restructuring of quality management within the agency
- A material change in the numbers, types, 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, or
- A significant change in membership demographics or the provider network.

The most recent version of the CQS will be available on the MassHealth web site.

Section 3.8 Evaluating the Effectiveness of the Quality Strategy

MassHealth will engage in regular activities to assess the effectiveness of its Comprehensive Quality Strategy. These include:

- Annual strategy review process conducted by internal stakeholders
- Use of performance indicators to assess progress toward quality goals and objectives. MassHealth will review performance on key indicators annually, reviewing rates at the plan and program levels. MassHealth will also review trended performance data to identify patterns of high or low rates that may require additional action.
- Annual review of External Quality Review (EQR) reports to assess the effectiveness of managed care programs in providing quality, accessible services. EQR technical reports include comparative plan performance on performance improvement projects, performance measurement validation and compliance reviews. The reports will also include recommendations on how the Commonwealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

Section 4. MassHealth Quality Strategy

MassHealth identified key priority areas and quality goals that are applicable across programs and determine an appropriate measurement strategy to assess progress against these goals.

Section 4.1 MassHealth Priority Areas and Quality Goals

In accordance with the desire to create a comprehensive quality strategy, the following high-level priority areas were selected to drive improvement in population health among MassHealth members.

1. Promoting Maternal, Child and Family Health
2. Healthy Living and Chronic Disease Prevention and Control
3. Reducing Emergency Department and Hospital Utilization
4. Promoting Mental Health and Reducing Addiction by Prevention, Treatment and Care Integration
5. Promoting Person-centered Long-term Services and Supports

These priorities guide many agency activities, including key quality measurement activities which assess the quality of care provided to MassHealth members. In alignment with these principles, the agency identified a set of quality goals to inform the development, implementation, and oversight of quality across MassHealth programs. In addition, MassHealth programs identified key activities that serve as examples of work that is being conducted in support of these goals. They are meant to provide a snapshot of key activities, rather than a comprehensive list. Some activities may support more than one goal.

The overarching MassHealth Quality Goals, in addition to associated agency-wide objectives and activities, are identified in Table 3: MassHealth Quality Goals, Objectives and Activities These goals, objectives and activities are the framework through which Massachusetts conceives of and executes its vision for advancing the Triple Aim of "better health, better healthcare, and lower cost."

Table 3: MassHealth Quality Goals, Objectives and Activities

Quality Goal	Objectives	Activities (Examples)
1. Transform to a member-centered culture of care focused on engaging members in their health	1.1 Ensure the delivery of information that is clear, engaging, timely, accessible, and culturally and linguistically appropriate to our members and providers 1.2 Solicit regular member and provider feedback to drive process improvement and report back lessons learned and next steps	• Facilitate a dedicated workgroup focused on Medical and Diagnostic Accessibility • Measure member experience • Provide disability access incentive payments aimed to improve accessibility for medical and diagnostic equipment for members with disabilities (438.6c)
2. Improve communication, coordination and care	2.1 Enact payment and delivery system reforms that promote	• Implement pay-for-reporting for the following activities:

integration	integrated, coordinated care and hold providers accountable for the quality and total cost of care 2.2 Ensure care coordination is seamless and easy to navigate from a member perspective. 2.3 Implement delivery system and provider payment initiatives under MCO or PIHP contracts.	Care plan coordination, comprehensive assessment, health-related social service assessment (ACO) • Include community health workers as part of the BH Plan staffing in PCC Practices • Provide care coordination and case management services to enrollees through plans (One Care)
3. Focus on preventative, patient-centered primary care, and community-based services and supports	3.1 Ensure that members will have access to an interdisciplinary care team, including appropriate representation from community-based BH and LTSS providers. 3.2 Engage community-based organizations in partnerships to better communicate with our members and to improve member access	• Implement integrated Care and BH Quality Incentive payments to improve integration of for primary care members, and those receiving BH services, respectively • Require interdisciplinary care teams include input from BH providers • Require ACOs and Community Partners to report on and numerous metrics related to BH, SUD, and integration that may qualify for shared savings.
4. Promote effective prevention and treatment to address chronic diseases or priority conditions	4.1 Improve population health and care coordination through payment reform 4.2 Prioritize access to integrated models of care delivery for high-cost members with complex care needs 4.3 Promote active member engagement in the development of their care plan and self-management strategies for chronic diseases 4.4 Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder	• Require ACO reporting and performance on Prevention and Wellness and Chronic Disease Management • Expand practice-based and plan-based care management via BH Plan contract • Focus quality improvement activities on chronic disease management and BH (SCO, ACO, MCO, One Care, the BH plan.) • Implement SUD Waiver to expand residential rehabilitation services, recovery support navigators and peer supports for recovery for individuals with

	services.	substance use disorders
5. Engage communities through population health and best practices for healthy living.	5.1 Address social determinants of health in members' care. 5.2 Balance the needs of large health systems with those of small community providers.	• Develop risk adjustment model for social determinants of health for quality measures. • Require completion of health-related social needs assessments and measure completion of assessments for quality (ACO and MCO) • Implement community partner program to provide BH and LTSS care management, support related to health-related social needs, and health and wellness coaching
6. Identify and address health disparities to provide equitable care	6.1. Use data to better measure and address disparities in care and access. 6.2 Create an internal culture and infrastructure to support our ability to meet the evolving needs of our members and partners	• Evaluation of risk adjustment based on social determinants of health including race and ethnicity for the evaluation of quality in LTSS fee for service services • Evaluate adequacy of new ACO/MCO networks at addressing language and cultural competency, and ADA compliance including sufficient access to services for the deaf and hard of hearing. (OBH)

Section 4.2 : Quality Performance Measurement and Oversight

In alignment with the above-noted priority areas, MassHealth developed a set of performance indicators to monitor the quality of care provided to its members. Massachusetts' measurement strategy was driven by a desire to obtain data that can inform continuous quality improvement and be used for comparison within the MassHealth agency and across Medicaid programs nationally. In selecting its set of quality indicators, MassHealth reviewed standardized measure sets and made modifications where appropriate to reflect the unique patient populations served by its programs. Consideration was also given to the availability of national benchmarks and alignment with MassHealth and CMS priorities.

Generally, MassHealth quality indicators fall into three broad categories:

- **Performance measures**- Clinical and non-clinical measures were identified for priority tracking by MassHealth and represent key areas of interest for the agency. Within each program, MassHealth identified a subset of measures appropriate for the population served. These measures are outlined in Appendix 2 and are subject to public reporting requirements as

described in 42 CFR 438.10(c)(3). Several of the measures that are included in the performance measurement subset also belong to the 2018 Adult and Child Core Measure Sets (See Section 5.2). Within the ACO program, performance on these measures is a factor in the payment structure.

- **Member experience-** Member experience is a critical quality indicator and as such, all MCOs, ACOs, SCOs and One Care Plans are required to conduct member experience surveys and report on member satisfaction with the health plan. In addition to a primary care member survey, the ACO program is developing member experience surveys targeted toward members with BH and LTSS needs. Data from all program surveys will be used to enhance the care experience of members and advance the goals of providing better, patient-centered care. The BH Plan is required to biennially administer PCC satisfaction surveys and stratify results by provider type and specialty.
- **Monitoring measures-** Clinical, non-clinical, and patient reported measures will be used to ensure continued high performance and monitor areas of opportunity that can be addressed via quality improvement initiatives. Monitoring measures are indicators that MassHealth considers important and may be used to conduct longitudinal measurement over time. Measures identified for monitoring are generally not part of pay-for-performance programs.

MassHealth also addresses compliance with other contract, state and federal obligations; those activities are not the focus of this document

Identifying Performance Targets

In order to assess baseline rates and establish targets across areas of member experience, performance and monitoring measures, plan-level rates will be compared to appropriate national or regional benchmarks for standard measures. Many of these benchmarks will be obtained from the National Committee for Quality Assurance's (NCQA) Medicaid Quality Compass. Where external benchmarks are not available, MassHealth will use baseline performance and targets established through initial or historical performance (e.g., for new or emerging measures).

The identification of clear performance targets is essential to effective interpretation of state-wide and program-specific measurement activity. Additional information about performance measurement and monitoring can be found in Section 5.2 National Performance Measures and Member Experience, which provides additional detail about MassHealth's performance measurement strategy and Section 6.2 Measurement and Improvement Standards, which details program-specific requirements for measurement.

Section 4.3 Performance Measurement in Other Programs

Several MassHealth Programs that are not under the purview of managed care quality requirements operate robust quality measurement programs to ensure the ongoing quality and experience of care. Many of these efforts are in substantial alignment with other priorities and goals for quality measurement and monitoring across the agency.

The Office of Long-Term Services and Supports (OLTSS) is currently developing a quality measure slate for its FFS services, which will cover the entire continuum of care for the disability community and be aligned with quality measurement efforts across MassHealth payment methodologies as well as CMS's meaningful measures program.

OLTSS will implement a multi-modal approach to measuring LTSS given its unique place in the continuum of care. This approach will capture quantitative measures at the individual level that

demonstrate the LTSS provider's engagement in the member's acute care, as well as qualitative methods to understand the member and caregiver's experience of care.

Home Health, DME, Hospice, and Nursing Facilities all have quality measurement programs. The Chronic Disease and Rehabilitation Hospitals have a quality bonus program, and the Hospital Program operates a pay-for-performance program which measures key indicators of quality for acute hospitals and determines reimbursement based on the hospital's performance on those measures.

The Community Partner Program is also developing a quality measure slate.

Section 4.4 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, and the comprehensive quality strategy. 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 members.

Key areas include:

- Continued dialogue regarding strategic goals, objectives and priorities guiding the Quality Strategy
- Ongoing member and advocate engagement
- Addressing disparities and social determinants of health in quality measures
- Integration across physical, behavioral health, and long-term services and supports
- Focus on member experience surveys and patient-reported measurement
- Identifying potential opportunities to:
    - Reduce administrative burden of quality measures and streamline survey collection, reporting, and validation, where possible
    - Align with or reduce duplication of external requirements (reporting, accreditation, and certification) where possible.
- Continued measure considerations (e.g., oral health, risk-adjustment for additional outcomes measures, increased adoption and implementation of EHR systems)

Section 5. Assessment

The CQS is designed to also reflect standards associated with quality assessment and how the Commonwealth will evaluate the quality of health care and services furnished by managed care entities.

Section 5.1 Quality and Appropriateness of Care

A. Quality Assessment in MassHealth

Quality assessment in MassHealth occurs through at least three mechanisms:

- **Contract management**- All managed care contracts and contracts with entities participating in capitated payment programs includes quality provisions. A typical contract includes requirements for quality measurement, quality improvement, and reporting. MassHealth contract managers and quality staff review submissions from the entities and evaluate whether the managed care entity has satisfactorily met the contract requirements.

- **Quality improvement performance programs**- Each managed care entity is required to complete two performance improvement projects annually in accordance with 42 CFR 438.330(d)
- **State-level data collection and monitoring** - MassHealth routinely collects HEDIS and other performance measure data from its managed care plans. The use of performance measurement for quality monitoring is discussed in further detail in Section 5.2.

B. Special Health Care Needs

Each managed care entity must have mechanisms in place to assess enrollees identified as having special health care needs. Special health care needs are specifically defined in each managed care contract though generally, these enrollees may include, at a minimum, those who have or are 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. For each enrollee that the managed care program confirms as having special health care needs, the individual's need for ongoing treatment and monitoring must be determined. In addition, for members including but not limited to enrollees with special health care needs, who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each managed care entity must have a mechanism in place to allow such enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

In identifying enrollees with special health care needs, managed care entities may rely on information shared by the Commonwealth. This includes Categories of Assistance, such as SSI disabled only, to which enrollees are assigned by MassHealth, as well as information provided by other State agencies. Plans are required to assess the quality and appropriateness of care furnished to enrollees with special health care needs through a variety of means including the establishment of individualized care plans as appropriate, ensuring timely and coordinated care, and ensuring the development of clinical protocols and approaches to the provision of care that are appropriate for the enrollees' needs.

C. Behavioral Health Screening Among Children

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

The menu of BH screening tools is reviewed routinely. As part of this review, an environmental scan is undertaken which includes a search for new screening tools, updates to research on tools that are on the current menu, and evidence supporting screening tools proposed for consideration by providers or other stakeholders. This information is compiled and assessed according to criteria established by MassHealth clinician reviewers that include reliability, validity, sensitivity and specificity. Input is then solicited from a stakeholder group, whose membership reviews a summary of tools and make recommendations regarding which should be added to or deleted from the existing menu. MassHealth reviews these recommendations and issues a final decision.

D. Preventing and Reducing Disparities

The ability to identify and address health care disparities begins with the collection and analysis of patient data. Data regarding potential disparities come from several different sources. First, 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. A second source of data for monitoring disparities comes from the periodic patient surveys. The demographic section at the end of the survey collects information about self-reported race, ethnicity, primary language and chronic conditions. These data permit subgroup analyses of the survey returns. Because the survey data are always anonymous, there is no possibility of linking the survey returns to other types of data such as claims.

MassHealth seeks to reduce disparities among its members. All health plans are 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 16 languages.

MassHealth also offers the Community Support Program (CSP) through managed care, a service which includes supports for refugees, people experiencing chronic homelessness and, substance use or mental health disorders, and provides additional outreach and support so that members can 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. Programs like CSP advance health equity by offering services in the community, developing self-management skills among clients and addressing co-occurring BH and substance use issues that affect a member’s ability to engage in care.

Section 5.2 National Performance Measures and Member Experience

MassHealth’s experience with performance measurement extends back to 1996 when it began collecting and reporting on HEDIS measures for the managed care products with which it contracted, including the PCC Plan (the state's primary care case management program) and the MCOs. In 2010, MassHealth began collecting HEDIS measures for the SCOs, and in 2014, MassHealth began collecting HEDIS measures for One Care.

In addition to the collection of the HEDIS measures, MassHealth also collects and voluntarily reports on CMS Adult and Child Core Measure Set performance measures. Collection and reporting on the Core sets began as part of two CMS grant funded projects: the CHIPRA Quality Improvement Demonstration grant (2010) and the Adult Quality Medicaid grant (2011). MassHealth continues to report on the maximum number of measures that it can, given availability of data and resources. In January 2018, MassHealth reported 17 measures from the Adult Core Set and 23 measures from the Child Core Set, with measurement reflecting services delivered in CY2016.

MassHealth uses the results of HEDIS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) as part of its quality incentive programs to identify opportunities for improvement and to inform its approach to quality management work undertaken with other managed care entities. The HEDIS and CAHPS results also guide MassHealth’s work in supporting the PCC Plan's providers in quality improvement work.

MassHealth currently monitors plan-level submissions of CAHPs member experience surveys submitted for the MCO and SCO programs. A Clinician Group CG-CAHPS version survey is planned for its first cycle of implementation in 2019 for the ACO program for adults and children receiving primary care services.

In addition, member experience surveys are also under development and slated for implementation in 2019 for the BH and LTSS populations for the ACO and CP program.

Table 3: National patient experience surveys required by MassHealth

Survey Tool	Program	Population	Survey Level
CAHPS 5.0H	MCO, SCO	Adults and Children	Plan
CAHPS-Medicare Advantage Plan	One Care	Younger population Persons with mobility impairments, language screening, interpreter services	Plan
CAHPS – CG	ACO	Adults and Children	ACO
LTSS Survey (TBD) – Under development to be finalized in 2018	ACO LTSS CP Program	Adults and Children	ACO Community Partners
Behavioral Health Survey – Under development to be finalized in 2018	ACO BH CP Program	Adults and Children	ACO Community Partners

Section 5.3 Monitoring and Compliance

MassHealth monitors compliance with contractual and Federal requirements in multiple ways. Appendix 1 lists the specific reports used by MassHealth to ensure compliance. The External Quality Review also provides valuable compliance review functions.

Section 5.4 External Quality Review

Massachusetts contracts with a qualified External Quality Review Organization (EQRO) in accordance with 42 CFR 438.354. Massachusetts 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 BH plan, One Care and SCOs.

A. Mandatory Activities

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

1. Annual validation of performance measures reported to EOHHS, as directed by EOHHS, or calculated by EOHHS;
2. Annual validation of performance improvement projects required by EOHHS; and
3. At least once every three years, review of compliance with standards mandated by 42 CFR Part 438, Subpart E, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees.

Validation of network adequacy will be added following the release of the CMS protocol.

B. 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.

C. Review Cycle

In March following each project year, a full technical report for the measurement year is issued. The report validates performance measures for the MCOs, SCOs, PIHP, One Care, both ACO models and the PCC Plan. Performance improvement projects are validated for the MCOs, SCO, PIHP, One Care and Accountable Care Partnership Plans. EQR participation for MCOS which were re-procured in 2018 and both ACO models is slated to begin in 2019, following their first year of operation.

D. 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, in accordance with 42 CFR 438.358.

E. 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 certified and opportunity exists to leverage documents which are produced for accreditation and other purposes in order to fulfill EQR requirements.

In 2017, MassHealth amended the EQRO contract to require, when applicable and upon EOHHS approval, the use of information from a review of an MCO or PIHP performed by a Medicare or a private accrediting entity to contribute to the EQRO's findings related to reporting of mandatory activities. The use of reports from HEDIS audits and NCQA health plan accreditations significantly reduces duplication of effort and administrative burden. Materials from the aforementioned accreditations and audits were used to fulfill aspects of performance measure validation and compliance activities during the most recent review.

Section 6. State Standards

Section 6.1 Access Standards

All MassHealth MCEs 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. (Coverage and authorization of service requirements do not apply to Primary Care ACOS.)

A. 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 enrollees 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 must take into account the following:

- Anticipated MassHealth enrollment
- Expected use of services by enrollees, considering the characteristics and health care needs of specific MassHealth enrollee populations

- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish contracted services
- Numbers of network providers who are not accepting new MassHealth patients
- Geographic location of providers and MassHealth managed care enrollees, considering distance, travel time and modes of transportation typically used by MassHealth managed care enrollees, and whether the location provides physical access for MassHealth enrollees with disabilities

Plans must provide female enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. MassHealth contracted plans must also provide for a second opinion from a qualified health care professional within the provider network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.

Timely access to care and services, taking into account the urgency of the need, is a requirement of all plans. Availability standards must ensure that network providers offer members appointments for covered health care services and medically necessary specialty care. Network providers must offer hours of operation that are no less than the hours of operation offered to commercial enrollees, or MassHealth Fee-For-Service if the Provider serves only Enrollees or other Members. Plans monitor providers for compliance with the standards regularly and may take corrective action to come into compliance with the access standards.

If a plan's network is unable to provide necessary services covered under its contract that plan must sufficiently cover those necessary services in a timely manner for as long as the plan's network is unable to provide those services. MassHealth plans must negotiate agreements with out-of-network providers with respect to payment.

Cultural Considerations

MassHealth requires that medical/surgical and 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 enrollees, including those with limited English proficiency and diverse cultural backgrounds. All MCEs ensure availability of multi-lingual providers and skilled medical interpreters for the commonly used languages in each community. Written information is available to enrollees in prevalent languages, as determined by the Commonwealth. Prevalent languages are those spoken by 5% or more of MassHealth enrollees. Through analyses of MassHealth data, state-wide and by EOHHS region (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 enrollees' needs for culturally and linguistically appropriate services, which may include hearing and vision impairment and language preference. MassHealth plans make available, free of charge, oral interpretation services in all non-English languages to assist enrollees with interpretation of all written materials provided to enrollees. 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 enrollee may obtain help with getting the materials translated.

In addition, all plans are required to complete population profiles which 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 which informs how plans can develop goals and activities that engage members and their communities toward health improvements.

BH Covered Services

All MCEs and the BH Plan are required to maintain a provider network that at a minimum, members have access to all Medically Necessary Behavioral Health Covered Services according to the following standards:

- Inpatient Services within 60 miles or 60 minutes travel time from the member's residence, whichever requires less travel time;
- Emergency Services Program (ESP) services as available based on the ESP Provider list;
- Intensive Care Coordination and Family Support and Training Services provided by community service agencies (CSA) as available based on the CSA Provider list;
- Other Intensive Home and Community-Based Services, which require Network Providers to travel to the members' residence for services are available in all cities and towns in the Commonwealth; and
- All other BH Covered Services within 30 miles or 30 minutes travel time from the Covered Individual's residence, whichever requires less travel time.

Unique Covered Services

MassHealth adds services to the usual Medicare (for One Care and SCO plans) and Medicaid covered benefits to advance wellness, recovery, self-management of chronic conditions, independent living, and as alternatives to high-cost acute and long-term institutional services. Additional services in some of the MCE contracts include, for example, community crisis stabilization, Community Support Program, acute treatment and clinical support services for substance abuse, psychiatric day treatment, day services, home care, and respite care.

B. Program-Specific Requirements for Availability

The following describes examples of Program-specific activities to monitor access to care and availability of services.

1) MCO, Accountable Care Partnership Plan Programs, SCOs, One Care

The MCOs, Accountable Care Partnership Plans, One Care plans and SCOs ensure through written contracts with providers that enrollees will have access to covered services within a reasonable travel distance. Both walking and public transportation are taken into account when determining access and availability.

The network of primary care providers must be sufficient to provide the enrollee with a choice of at least two PCPs who are located within a 15 miles or 30 minutes of the enrollee, have qualifications and experience commensurate with the health care needs of the enrollee, and have the ability to communicate with enrollees in a culturally and linguistically appropriate manner.

2) PCC Plan

Provider Contracts

MassHealth primary care providers seeking to participate in the PCC Plan must enroll as participating providers in the PCC Plan prior to any assignment of Members to their service locations (SL). During the provider's enrollment process, the PCC signs a contract to accept any Member assigned to the PCC's panel unless the PCC is not medically qualified to provide care for that member. This contractually assures that there is no discrimination on the basis of race, color, national origin, age, physical or mental disability, marital status, sexual orientation, health care status, or need for health care services. Further, the PCC's contract includes standards for appointment timelines and coordination and tracking of referrals as well as requirements for the development and implementation of written action plans around specific quality improvement activities. The responsibilities of the contractor for PCC Plan Management Support Services (currently the BH Plan) include a biannual review of PCCs' compliance with the PCC Plan contract and implementing and reviewing a plan for correcting any deficiencies found.

Primary Care Network Report

The PCC Plan monitors its primary care provider network through monthly reports. The reports give a snapshot of MassHealth enrollment by PCC Service Location (SL) and whether the SL is open to new enrollees. The second report is the PCC Changes Report which includes new SLs and increases or decreases in the number of members enrolled at any SL.

3) SCO Program

Access to Home- and Community-Based Services

The SCO program ensures that providers demonstrate the capacity to deliver or arrange for the services in the home of the enrollees. This obligation applies to both scheduled and unscheduled visits. Service sites must include, but not be limited to, a member's private residence, a nursing or assisted-living facility.

C. Coordination and Continuity of Care

MassHealth plans must support coordinated care by ensuring that each enrollee 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 enrollee. Timely and coordinated access to all medically necessary services, including BH and specialty services is provided to all enrollees. Plans are required to provide linkages with staff in other agencies and/or community service organizations if the agency/organization is already involved in meeting the enrollee'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 enrollees who are homeless, at an enrollee's home, when office visits are unsafe or inappropriate for an enrollee's health status, at the Enrollee'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 enrollee, the enrollee's guardian, representative and/or family member(s) as appropriate; the enrollee's Primary Care Physician (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); and a Care Management Coordinator and one or more Care Management individuals representing the plan, or Subcontractor.

MassHealth requires that contracted plans also provide appropriate continuity of care for new members that enroll from another MassHealth MCE. These policies and procedures must aim to minimize disruption of care and ensure uninterrupted access to Medically Necessary Services. Detailed continuity of care requirements are included in all MCE contracts.

D. Program-Specific Requirements for Care Coordination

Plans must maintain care management programs for any enrollee (adults and children) who needs assistance in coordinating physical and BH services and benefits to maintain optimal levels of health.

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

1) ACO and MCO Programs

Initial Care Needs Screening

Like the other MCEs, the MCO and ACO Program must ensure that the health and functional needs of member are identified. They must develop, implement, and maintain procedures for completing, an initial Care Needs Screening for each Enrollee, and complete the screening within 90 days of the Enrollee's Effective Date of Enrollment.

In addition to other requirements, the survey instrument used by MCOs and ACOs to conduct the Initial Care Needs Screening must include questions on member demographics, 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, need for culturally and linguistically appropriate services, medical and diagnostic equipment, health concerns/goals, and care needs experienced by children, including evaluating characteristics of the Enrollees' families and homes. Furthermore, like the other MCEs, the MCO and ACO program 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:

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 discharge from any type of hospital inpatient stay or emergency department visit, through a home visit, in-office appointment, 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 BH community partners and LTSS community partnership and integrate other care management activities and personnel, such as care coordinators or clinical care managers.

2) SCO Program

Comprehensive Assessments

Comprehensive assessment for members enrolled in the Senior Care Options (SCO) Plans are conducted and re-assessed every six months; when there is a change in status and quarterly for any enrollee with a Complex Care Need. Complex Care Need is defined as any condition or situation that demonstrates the Enrollee'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.

SCO plans are required to maintain a Centralized Enrollee Record (CER) that documents current medical, functional, and social status. The CER must be available 24/7 to nurse case managers and the enrollee's clinicians to manage emergency and urgent care, as well as to manage transitions across institutional and community settings of care.

3) One Care Program

Comprehensive Assessments

One Care plans must complete Comprehensive Assessments for each new Enrollee within 90 days of the enrollee's effective enrollment date, at least annually, and whenever the enrollee 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 Enrollee Record and inclusive of domain areas specified by the Commonwealth. 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 Coordinator brings expertise in community supports to the member and assists with the coordination of his/her LTSS and BH needs, as applicable. The IL-LTS Coordinator's primary responsibilities are to: ensure person-centered care, counsel potential Enrollees; provide communication and support needs; and act as an independent facilitator and liaison between the Enrollee, 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 that are available
- Development of a personal care plan that includes services that will support members' health, safety, independence, and/or recovery
- Connection to the services in members' personal care plans; and
- Helping members understand and protect their rights as a One Care plan 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 (CMP)

In collaboration with the BH Plan 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. Select PCC SLs contract with the BH Plan to conduct their own Practice-Based Care Management programs that mirror the standards of the plan-based CMP.

E. Coverage and Authorization of Services

In accordance with 42 CFR 438.210, each MassHealth MCE 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 fee-for-service, may not be compromised solely because of diagnosis, type of illness, or condition of an enrollee, 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.

Written policies and procedures for processing requests for authorizations of services are in place and implemented by MassHealth MCEs. 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 enrollee's condition or disease, and must notify the requesting provider and enrollee in a timely manner, as codified in entity contracts, suitable to the urgency of the enrollee's condition.

Grievance procedures related to adverse decisions can be found in Section 6.2 of the Quality Strategy.

Section 6.2 Measurement and Improvement Standards

Contracts with MCEs require ongoing quality assessment and performance improvement of the services provided to members as required in 42 CFR 438.236- 438.242. Continuous monitoring and improvement activities include identifying current levels of quality and areas for improvement, designing interventions to achieve improvement, and documenting progress towards quality goals. The standards in this section address MassHealth managed care quality measurement and improvement activities.

A. 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 of board-certified providers from appropriate specialties. Prior to adoption, the 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 enrollees 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 enrollees or potential enrollees. 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, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. Managed care entities 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 (2017)
- Massachusetts Health Quality Partners Guidelines for Adult and Pediatric Preventive Care 2018
- Massachusetts Health Quality Partners Guidelines for Perinatal Care (2018)
- Massachusetts Department of Public Health and CDC Immunization Schedules and Guidelines
- Tobacco Treatment Guidelines, Quitworks Implementation Kit

B. Quality Assessment and Performance Improvement Program

Managed care entities must establish ongoing performance improvement projects that focus on clinical and nonclinical areas and involve measurement of performance using objective quality indicators, implementation of interventions to achieve improvements, evaluation of the effectiveness of interventions, and planning and initiation of activities for sustaining improvement.

The annual HEDIS measurement initiative addresses both access and clinical quality. HEDIS measures are selected with consideration of measure relevance to MassHealth and its stakeholders, as well as action-ability. Data are collected by the plans, submitted to MassHealth, and summarized in an annual report. Contracted SCO plans must report clinical indicator data in accordance with the specific HEDIS measures developed for Medicare Advantage Special Needs Plans (SNPs) by the National Commission on Quality Assurance (NCQA), to the extent they are relevant to the SCO population.

C. Program-Specific Requirements for Measurement and Improvement

Several of the MCEs have additional requirements for measurement and improvement. The following are examples of activities by MassHealth MCEs.

1) MCO and ACO Program

Quality Improvement Goals (QI Goals)

MassHealth requires Accountable Care Partnership Plans, MCOs, SCOs, One Care and the BH Plan to conduct performance improvement projects, per Commonwealth specifications of QI goals and measures. For Accountable Care Partnership Plans and MCOs, QI goals focus on two priority areas: 1) behavioral health and 2) chronic disease management. The selected QI Goals measures and specifications are as consistent as possible with corresponding performance measurement indicators to minimize duplicity and resource burden on plans and also to enhance comparability with national benchmarks.

The QI Goals measurement cycle spans a 2 or 3-year period which includes planning/baseline, mid-cycle, and final evaluations to allow for tracking of improvement gains. For each QI goal cycle, EOHHS will establish a series of QI goal domains as well as approve and/or designate measurement and quality improvement activities. Annually, MCEs submit a progress report, focused on planning and modification to the previous year's plans, and an annual reports measuring progress from the previous year. MCOs and Accountable Care Partnership Plans are also required to submit an annual QM/QI Work Plan, inclusive of all elements outlined in their contracts.

Performance Measurement

MCO, ACPPS Accountable Care Partnership Plans, and Primary Care ACOs, are required to collect and report on a slate of measures identified by EOHHS, including HEDIS, CAHPS measures as set

forth in managed care contracts. The ACO program emphasizes performance measurement through its payment structure detailed in Section D: ACO Performance Measurement and Payments.

2) SCO Program

Performance Measurement

SCO plans are required to collect and report on HEDIS measures as set forth in Appendix L of their contract. Their Quality Management Programs must include a process to utilize HEDIS results in designing QM/QI activities

SCO Performance Improvement Projects

Plans contracted by the SCO Program are required to annually develop two specific performance improvement projects focusing on BH or chronic disease management and provide documentation on each project.

Annual Enrollee Survey for Contracted SCO Plans

Plans must conduct an annual SCO-level CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor and report CAHPS data to EOHHS annually.

3) One Care Program

Performance Measurement

One Care plans are required to collect and report on HEDIS, CAHPS, the Health Outcomes Survey and additional measures as set forth in the Memorandum of Understanding between CMS and the State related to the One Care demonstration project.

Continuous Review and Monitoring

Several working groups support the quality review and monitoring of One Care. The Plan Quality Workgroup includes quality and medical staff from the plans and contract monitoring takes place on a daily basis.

Quality Improvement Projects

The One Care plans report annually on two quality improvement projects. One project maintains a focus area on improving outcomes for members with a chronic condition. The other focuses on a second quality improvement area. Plans are expected to use information about their member population to develop interventions that have a high impact on a significant number of members.

4) PCC Plan Quality Program

In collaboration with the BH Plan, the PCC Plan produces reports to assist PCCs in addressing members with high and emerging risk as identified through a claims-based algorithm. PCCs refer members as needed to the BH Plan for integrated care management supports. Through Plan Management Support Services, which include face-to-face site visits, the data are used to support the development of practice-level quality improvement initiatives.

The PCC Plan also participates in the annual collection and review of HEDIS measurement to assess quality of care.

D. ACO Performance Measurement and Payments

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 Enrollee satisfaction. ACO and MCO members with complex BH and LTSS needs also participate in the Community Partners (CP) program. CPs also participate in performance measurement consistent with the ACO program and unique to the program, specific to addressing and monitoring the care and needs of the population. Ongoing measurement will be central to holding ACOs accountable for providing high-value care across a variety of measures that is sustained over time. These measures will be used both for payment purposes, as well as reporting to MassHealth and CMS. The ACO payment model includes significant financial incentives for ACOs to provide strong performance on cost and quality. To ensure appropriate accountability on the part of ACOs, 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.

E. Health Information Systems

MCEs 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 enrollee and provider characteristics and on services furnished to enrollees. Contracted plans, including the BH Plan, 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; and
- Collecting service information in standardized formats to the extent feasible and appropriate

MassHealth requires MCEs to certify that information, data, and documentation in all reports is true, accurate, and complete.

Section 7. Improvement and Interventions

Section 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 various collaborative workgroups to ensure stakeholders have opportunities to advise, share best practices, and contribute to the development of improvement projects and program services. Examples of these workgroups include the MassHealth Quality Committee, the Quality Technical Advisory Group, and the Delivery System Reform Incentive Payment (DSRIP) subcommittee.

MassHealth also implements activities through grant work. In 2015, Massachusetts received a four- year CMS grant designed to improve the ability to report on use of most/moderately effective methods of contraception, including Long Acting Reversible Contraceptives (LARCs) and to support improvements in the delivery of these contraceptive types. The Maternal and Infant Health Initiative grant activities include:

1. Implement the most reliable and valid method for reporting on the contraceptive care measures
    - Identify opportunities to improve the quality of claims and encounter data
    - Identify opportunities to improve claims data submitted by providers

2. Measure, design and implement provider-level reporting for quality improvement, using the results of the measure
    - Develop reports for provider practices to share data on use rates for most/moderate effective contraception methods, including LARCs
    - Supply technical assistance, such as benchmarking and sharing best practices, to help practices achieve their quality improvement goals

Section 7.2 : Intermediate Sanctions

A. 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 managed care entities 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 enrollees
- Discriminate among enrollees on the basis of health status or need for services
- Misrepresent or falsify information submitted to EOHHS or CMS
- Misrepresent or falsify information to enrollees, 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 required by MassHealth
- 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 Enrollees enrolled after the effective date of the sanction
- The 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 enrollees of their right to disenroll
- Suspension of enrollment, or disenrollment of enrollees
- Termination of the contract
- Additional sanctions allowed under federal law or state statue or regulation that address areas of noncompliance

Section 8. Delivery System Reform

Section 8.1 Advancing Accountable Care

As described above, ACOs are provider-led organizations that are held contractually responsible for the quality, coordination and total cost of members' care. MassHealth's ACO approach places a significant focus on improving integration and delivery of care for members with 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. Therefore, ACOs will be required to maintain formal relationships with community-based BH and LTSS organizations selected to contract with MassHealth as Community Partners, furthering the integration of care. This shift from fee-for-service to accountable, total cost of care models is central to the Commonwealth's goals of a sustainable MassHealth program.

Section 8.2 Performance-Based Incentive Payments

Delivery system reform efforts seek to shift payments to risk-based alternative payment models that are centered on accountability for quality, integration and total cost of care. Consistent with this goal, Massachusetts will direct MCEs 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. 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 "Essential MassHealth hospitals" based on hospital quality improvement. These include Cambridge Health Alliance and UMass Memorial Health Care.

- Integrated Care Incentive— Massachusetts will direct Accountable Care Partnership Plans affiliated with Cambridge Health Alliance to make payments to non-federal, non-state, public hospitals based on the accountable care performance of such hospitals' owned or affiliated primary care providers.

- Behavioral Health Quality Incentive—Massachusetts will direct the BH Plan (the state's Prepaid Inpatient Health Plan) to make payments to non-federal, non-state public hospitals in its network based on BH quality performance.

Section 8.3 Evaluation

As required under 42 CFR 438.6(c)(2)(i)(D), the State must have a plan to evaluate the extent to which quality care and improvements, in concert with payment mechanisms and performance measure incentives, achieve the goals and objectives identified in the quality strategy. The State will use process improvement, outcomes, system transformation, and innovative measures and indicators to support and evaluate the program. To the extent possible, measures will be drawn from nationally recognized measure sets.

As part of the broader 1115 waiver Evaluation Plan, other agency-wide quality programs and their implementation will be evaluated with consideration given to both overall and specific program impact on promoting systems of integrated and coordinated care; demonstrated improvement in care quality and member experience; and impact of expanded MassHealth coverage to include increased coverage

and services (e.g., community partners coordinating BH and LTSS care for members with complex needs, access to additional services focused on the BH population and flexible services).

Section 9. Future Opportunities

MassHealth is committed to ongoing development, implementation, monitoring and evaluation of a vigorous quality management program that aims to effectively and efficiently improve and monitor the quality of care for its members. MassHealth has been able to create and evolve its program with strong leadership support and a drive to embrace the Triple Aim of better health, better healthcare, and lower costs. Opportunities to advance our comprehensive agency-wide quality strategy and goals to support these aims and meet the needs of our unique and often complex needs of our population include:

- Identifying key priorities across the organization to drive population health.
- Ensuring access to expanded value-added coordinated and integrated services.
- Continuing to understand and improve our members experience core to patient-centered care.
- 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.
- Advancements in quality measurement, collection and reporting.

Development, implementation, monitoring and evaluation of the quality strategy are real-time, ongoing and iterative processes. MassHealth is committed to enhancement of processes and opportunities for transparent stakeholder engagement with the quality strategy and programs across MassHealth. Such input will be critical to MassHealth's overall success in providing high quality care for members.

Appendix 1 Managed Care Entity Program Reporting Requirements

This section includes examples of the reporting requirements for entities covered by the Strategy. Reporting requirements are subject to change.

Program	Report Title	Description
Availability of Services: Delivery networks CFR Sections: • 42 CFR 438.206 - Availability of services • 42 CFR 438.207 – Assurances of adequate capacity and services		
MCO and Accountable Care Partnership Plan Program	PCP Geographic-Access Report	• Annual report and geo-access maps of adult and pediatric PCP geographic locations by service area
	PCP-to-Enrollee Ratio Report	• Annual report of open and closed adult, pediatric, family and OB/GYN PCPs per number of enrollees by Service Area (includes data collection methodologies)
	Specialist –to-Enrollee Ratio Report	• Annual report of number of specialists by specialty type per number of enrollees by Service Area
	Pharmacy Network Geographic-Access Report	• Annual geo-access map of pharmacy network by service area
	Significant Changes in Provider Network Report	• Immediate notice and Annual Summary report of significant changes in provider network that will affect the adequacy and capacity of services
	PCP Network Turnover Rate	• Annual PCP turnover w/in MCO network (considering voluntary turnover and terminations)
	PCP Assignment Accuracy Report	• Annual report of number/percentage of enrollees not having an assigned PCP or w/ incorrect PCP assignment at any point > 15 days of effective enrollment (includes auditing/ monitoring activities, data sources, and methodologies)
	Enrollee Change of PCP Report	• Annual report of voluntary Enrollee change of PCPs, with components including Enrollees with multiple/frequent PCP changes, PCPs with higher relative rates of Enrollee disenrollment, and summary of top 10 reasons for PCP changes
	Summary Access and Availability Analysis Report	• Annual report of key findings from all access reports and data sources(e.g. grievance system, telephone contacts with access /availability associated reason codes, provider site visits, use of out of network alternatives due to access/availability, care management staff experiences with scheduling appointments)
	Non-Compliant Pharmacies Report	• Annual, if applicable list of pharmacies that demonstrate a pattern of inappropriately denying prescriptions to Enrollees, and steps taken to resolve the situations
	Mail Order Pharmacy Program Report	• Annual, if applicable summary of Mail Order Pharmacy Program including, number of Enrollees, enrollments/ disenrollments, top 10 utilized drugs, requests for drugs not included in Program, % of early refills requested, # and method of refills, medication compliance rate.
	Credentialing Policy	• Annual changes to credentialing policies and procedures
	Provider Suspensions and Termination Notification	• Immediate notice of any independent action taken by the MCO to suspend or terminate network provider;

Program	Report Title	Description
	Provider Suspensions and Termination Report	• Annual list of providers that MCO suspended or terminated upon notice of suspension or termination by MassHealth, and list of provides suspended or terminated by MCO independently.
	Provider Policies and Procedures	• Prospective for review and prior approval, MCO Policies and Procedures. New drafts and any changes to the most recent printed and electronic versions of the Provider procedures and policies which affect the process by which Enrollees receive care (relating to both medical health and Behavioral Health, if separate.)
	Provider Manual	• Annual, provider manual which includes specific information about MCO covered services, non MCO covered services, and other requirements relevant to provider responsibilities.
One Care Program	LTS Coordinator Report	• Monthly Assessment progress tracking tool
	Enrollment Report	• Monthly Enrollment Report
	Credentialing Policy	• If amended, submit credentialing policies and procedures to EOHHS and demonstrate that all providers within network are credentialed accordingly
	PCP Turnover Rate	• Annual PCP turnover rate, reported separately for those who leave the plan voluntarily, and those PCPs who are terminated.
	Provider Manual	• Annual update to provider manual should be submitted to EOHHSS and CMS; in the event of no substantial changes, the plan may certify there are no substantial changes
SCO Program	Report of members of Provider Network by Zip Code and capacity for accepting new enrollees	• Upon event: Provider network changes must be reported to State and CMS within 5 business days
PCC Plan and Primary Care ACO BH Program	Network Provider Geographic Access Report	• Quarterly
	Provider Network Semiannual Report	• Annual report of provider sites, credentials and covered services
	Use of Out-of –Network Providers	• Quarterly
	Significant Changes in Provider Network	• Daily report of significant changes ink provider network
	Provider Expertise/Specialty Report	• Semi-annual report listing providers and their areas of expertise
	Emergency Services Program Activity	• Monthly report of utilization and follow-up of ESP encounters
	DMH Daily Admission	• Daily report on inpatient admissions of DMH clients.
	Inpatient Cases Awaiting Resolution and Discharge (CARD) Census Report	• Monthly report on covered individuals who do not meet the Inpatient or CBAT Services Level of Care criteria but remain in an inpatient setting awaiting discharge or members previously met one of these criteria and were discharged during the reporting month
Availability of Services: Timely access CFR Sections: • 42 CFR 438.206 - Availability of services • 42 CFR 438.207 – Assurances of adequate capacity and services		

Program	Report Title	Description
MCO and Accountable Care Partnership Plan Program	Telephone Statistics Report	• Monthly report of telephone answer statistics including, number of calls received, number /percentage of calls abandoned, number/ percentage calls answered w/in 30 seconds , average speed of answer
PCC Plan and Primary Care ACO BH Program	Clinical Access Line Report	• Quarterly report of telephone answering statistics
	Telephone Statistics Report	• Quarterly report including a separate section for clinical calls, provider and member services calls, and PCC hotline calls that include the number of calls, received, answered/abandoned as well as the measures of performance standards on calls within 30 seconds, and average speed of answer
Coordination and continuity of care CFR Section: • 42 CFR 438.208 - Coordination and continuity of care		
MCO and Accountable Care Partnership Plan Program	PCP Assignment Accuracy Report	• Annual report of number/percentage of enrollees not having an assigned PCP or w/ incorrect PCP assignment at any point > 15 days of effective enrollment (includes auditing/ monitoring activities, data sources, and methodologies)
	Medical and Behavioral Health Organizational Chart/Management Level Staff Changes	• Annual organizational chart detailing individuals in each position and management level vacancies, staff changes, restructuring, and status of filling vacancies.
	Changes to Key Personnel	• As relevant, notice of new personnel, including resume and job description for specified positions
Primary Care ACO	Changes to Key Personnel	• As relevant, notice of new personnel, including resume and job description for specified positions
	Care Management Program Evaluation	• Biannual report of evaluation of Care Management Program
One Care Program	Organizational Chart	• Annual submission of organizational chart that includes senior and mid-level managers for the organization
	No Utilization	• Annual report of enrollees who have been enrolled for one year or more with no utilization, including explanation of outreach activities to engage enrollees.
PCC Plan ad Primary Care ACO BH Program	Service Access and Continuity of Care Measures Report	• Semi-Annual report, stratified by level of care and age with data on readmissions, inpatients diversions, follow-up after hospitalization and medication monitoring following discharge
PCC Plan BH Program	Care Management Referrals Report Care Management Utilization and Cost Report	• Semi-Annual reports of referrals to and utilization of care management
SCO Program	Health Outcome Survey	• Annual Health Outcomes Survey (HOS) per CMS requirements
Coverage and authorization of services CFR Section: • 42 CFR 438.210 - Coverage and authorization of services		
PCC Plan and Primary Care	Service Authorization and Utilization Review Report	• Quarterly report regarding services authorized and denied

Program	Report Title	Description
ACO BH Program	CBHI Authorizations	• Monthly report of CBHI service authorizations
MCO and Accountable Care Partnership Plan Program	Accident/Trauma Report	• Semi-Annual report of members identified as having medical services as a result of an accident or other loss
	TPL Form	• Same day notice of Enrollee receiving TPL
	Benefit Coordination Plan	• As relevant, benefit coordination plan and proposed changes submitted for review and approval
Enrollment and disenrollment CFR Section: • 42 CFR 438.226 - Enrollment and disenrollment		
MCO and Accountable Care Partnership Plan Program	Membership Discrepancy Report Unreachable Enrollees PCP Assignment Report	• Monthly report of enrollees identified on EOHHS's file but not enrolled in MCE's plan, enrollees not identified on EOHHS's file but enrolled in the MCE's plan, and enrollee changes of address.
SCO Program	Disenrollment reasons	• Annual reports of disenrollments by reason
Grievance systems CFR Section: • 42 CFR 438.228 - Grievance systems		
MCO and Accountable Care Partnership Plan Program	Enrollee Inquiries	• Annual report identifying the number and type of the top 10 inquiries received
	Enrollee Grievances	• Annual report identifying the number and type of administrative grievances received from an enrollee or his/her appeal representative (quality of care, access, attitude/service, billing/finance) , the action taken for the grievances for which trends are observed, the average time frame for resolution of grievances in each category
	Enrollee Appeals	• Annual report identifying the number and type of each internal appeal (level I and II) received from an Enrollee or his/her designee, the action taken for each such internal appeal, whether the internal appeal is expedited (in which case there is only one level), the time frame for resolution of each internal appeal.
	Notifications of Upheld Internal Appeals Decisions	• Within 1 business day, the case summaries of all final internal appeal decisions, including upheld second level appeals, upheld expedited appeals and those upheld during first level appeals, when MCO knows that enrollee will skip to second level appeal for BOH appeal
	Grievance and Internal Appeals Policies and Procedures	• Upon request, copies of amendments to Grievance and Appeals policies and procedures
	Implementation of BOH Decision	• Within 30 calendar days, report that MCO acted upon BOH decision including list of actions.
Primary Care ACO	Grievance and Internal Appeals Policies and Procedures	• Upon request, copies of amendments to Grievance and Appeals policies and procedures
One Care Program	Enrollee grievances	• Monthly report of all internal grievances demonstrating timely acknowledgement, review and response to all grievances

Program	Report Title	Description
SCO Program	Report of number and types of complaints and appeals filed by enrollees	• Monthly report of complaints, and appeals, including reporting on how and in what time frame the complaints were resolved
PCC Plan and Primary Care ACOBH Program	Appeals report	• Semi-Annual report of clinical and administrative appeals
	Adverse Reportable Incidents	• Same day and annual reports
	Grievance and Appeals Report	• Semi-Annual report of grievances and internal appeals including the type of grievance or internal appeal, type of resolution, and timeframes for resolution
Subcontractual relationships and delegation CFR Section: • 42 CFR 438.230 - Subcontractual relationships and delegation		
MCO and Accountable Care Partnership Plan Program	Notification of Termination	• Within three business days, notice of MCE's termination of any material subcontractor, or notice by any material subcontractor of intention to terminate a contract
	Procurement and re-procurement of Service from Material Subcontractor	• At least 60 days prior, notice of procurement or reprocurement of material subcontractor.
Primary Care ACO	Material Subcontractor List	• Annual submission of material subcontractor list
	Notification of termination	• On the same-day of contractor notification, notice of MCE's termination of any material subcontractor
Quality assessment CFR Section: • 42 CFR 438.240 -- Quality assessment and performance improvement program		
MCO and Accountable	HEDIS and other Quality Measures	• Annual report, prepared by an external contractor of performance measurement

Program	Report Title	Description
	Enrollee and Provider Incentives Notification	• Ad-hoc report information relating to planned and implemented Provider Performance Incentives.
	CAHPS Report	• Annual submission of results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).
Primary Care ACOs	HEDIS and other Quality Measures	• Annual report, prepared by an external contractor of performance measurement
One Care Program	HEDIS	• Annual report of measurement consistent with Medicare requirements for HEDIS and additional measures required by EOHHS or Part D.
SCO Program	HEDIS and other clinical indicators	• Annual report of performance measurement
	CAHPS Report	• Annual submission of results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).
PCC Plan and Primary Care BH Program	HEDIS	• Annual reports, prepared by external contractors of performance measurement
	BH Screening and well-child visits	• Quarterly report of the number of behavioral health screenings and well child visits.
	CBHI Cost and Utilization	• Monthly report on the cost and utilization of CBHI related services
	BH Cost and Utilization	• Quarterly report of overall cost and utilization of behavioral health services
Performance improvement CFR Section: • 42 CFR 438.240 -- Quality assessment and performance improvement program		
MCO and Accountable Care Partnership Plan Program	Quality improvement goal reports	• Semi-Annual reports of progress toward QI goals.
One Care Program	Quality Improvement Report	• Semi-Annual report of QI initiatives and results of evaluation
SCO Program	Quality management goal reports	• Semi-Annual reports of progress toward QI goals.
PCC Plan and Primary Care ACO BH Program	QM Activities Report	• Annual summary of MCE's quality management activities for the year
	Performance specifications and clinical criteria	• Annual submission of clinical criteria and performance specifications.
	Medical record review	• Annual review of medical records
Information systems CFR Section: • 42 CFR 438.242 - Health information systems		
MCO and Accountable Care Partnership Plan Program	Encounter data	• Monthly submission of encounter data

Program	Report Title	Description
One Care Program	Encounter data	• Monthly submission of provider encounter data to CM and EOHHS and a monthly basis per CMS and EOHHS specifications
SCO Program	Utilization reports	• Annual reports in key areas of hospital, nursing facility, and community service
PCC Plan and Primary Care ACO BH Program	Encounter data	• Quarterly submission of encounter data
EQRO activities CFR Section: • External oversight – 42 CFR 438.310 – 438.370		
MCO, Accountable Care Partnership Plan, PCC PLAN BH, One Care and SCO Programs	Technical Report of mandatory EQR activities	• Validation of performance improvement projects • Validation of performance measures • Compliance with strategy standards
Primary Care ACO	Technical Report of mandatory EQR activities	• Validation of performance measures • Compliance with strategy standards

Appendix 2 Performance Measures

The following table summarizes performance measures collected across programs. Additional measures are also collected for ongoing monitoring and quality assurance purposes.

Table 4: Performance Measures by MassHealth Priority and Program

Measure	Steward	NQF #	ACO	MCO	PCCP	SCO	One Care	BH PIHP
Domain 1: Maternal, Childhood and Family Health Promotion								
Childhood Immunization Status	NCQA	0038	X	X	X			
Timeliness of Prenatal Care	NCQA	1517	X	X	X		X	
Immunization for Adolescents	NCQA	1407	X	X	X			
Oral Health Evaluation	ADA	2517	X	X				
Health-Related Social Needs Screening	EOHHS	N/A	X					
Domain 2: Healthy living, Chronic Disease Prevention and Control								
Controlling High Blood Pressure	NCQA	0018	X	X	X	X	X	
Asthma Medication Ratio	NCQA	1800	X	X	X			
Use of Appropriate Medications for Asthma	NCQA	0036					X	
Comprehensive Diabetes Care: Poor Control	NCQA	0059	X	X	X		X	
Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108						X
Colorectal Cancer Screening	NCQA	0034				X	X	
Persistence of Beta Blocker Treatment After Heart Attack	NCQA	0074				X	X	
Pharmacotherapy Management of COPD Exacerbation	NCQA	0549				X		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NCQA	0577				X	X	
Medication Reconciliation Post Discharge	NCQA	0097				X	X	
Osteoporosis Management in Women Who Had a Fracture	NCQA	0053				X	X	
Influenza Immunization	NCQA	0041				X		
Pneumococcal Immunization	CMS	1653				X		
Potentially Harmful Drug Disease Interactions in the Elderly	NCQA	2993				X		
Screening for alcohol abuse: percentage of Enrollees reporting alcohol utilization in the CAGE risk areas, and						X		

Measure	Steward	NQF #	ACO	MCO	PCCP	SCO	One Care	BH PIHP
percentage of those referred for counseling.								
Use of High-Risk Medications in the Elderly	NCQA	0022				X		
Eye examination every two years: percentage of Enrollees who received vision screening in the past two years	CMS/ EOHHS requirement					X		
Hearing examination every two years: percentage of Enrollees who received a hearing screening in the past two years.	CMS/ EOHHS requirement					X		
Annual Monitoring for Patients on Persistent Medication	NCQA	2371				X	X	
Domain 3: Reducing Emergency Department Utilization and Hospitalization								
Plan All-Cause Readmission	NCQA	1768	X	X	X	X		
Emergency Department Visits for Adults with Mental Illness, Addiction, or Co-occurring Conditions	EOHHS	N/A	X	X				
Acute Unplanned Admissions for Individuals with Diabetes (Adult)	EOHHS		X	X				
Domain 4: Promote Mental Health and Reduce Addiction through Prevention, Treatment and Care Integration								
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	NCQA	0004	X	X	X		X	X
Follow-Up After Hospitalization for Mental Illness (7 days)	NCQA	0576	X	X	X	X	X	X
Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence*	NCQA	2605	X	X	X		X	X
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	2800	X	X	X			X
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	NCQA	1932						X
Antidepressant Medication Management	NCQA	0105				X	X	X
Screening for Depression and Follow-Up	NCQA	0418	X					

Measure	Steward	NQF #	ACO	MCO	PCCP	SCO	One Care	BH PIHP
Depression Remission or Response	NCQA	N/A	X					
Domain 5: Person-Centered Long-Term Services and Supports								
Advance Care Plan	NCQA	0326				X	X	
LTSS Community Partner Engagement	EOHHS	N/A	X	X				
Community Tenure	EOHHS	N/A	X	X				
Behavioral Health Community Partner Engagement	EOHHS		X	X				

*some programs report sub-measures only.