MassHealth Restructuring: 2018 Baseline Report

Executive Office of Health & Human Services

January 2020

FOR POLICY DEVELOPMENT PURPOSES ONLY

Executive summary

- In 2018, Massachusetts implemented its most **significant Medicaid re-structuring in 20 years,** creating:
  - **Accountable Care Organizations (ACOs)**
  - **Community Partners (CPs),** serving members with complex needs
  - **Delivery System Reform Incentive Payment (DSRIP) Program,** investing in statewide infrastructure

- In the first year of the programs, MassHealth gathered **baseline information on the delivery system.**

- This document is the **first public reporting of baseline data** of the MassHealth delivery system re-structuring.

- This report includes:
  - **Cost baseline:** Average baseline annual cost per member was $5,600, with significant variation among ACOs
  - **ACO financials:** Overall, ACO financial performance was at -1.7% for 2018. **Financial performance varied**, with 8 ACOs in surplus for 2018
  - **Quality and member experience performance:** Baseline data shows areas for improvement across the system

Contents

Context: What is the MassHealth re-structuring?

- On June 30, 2017, **MassHealth's federal 1115 demonstration waiver was set to expire.**

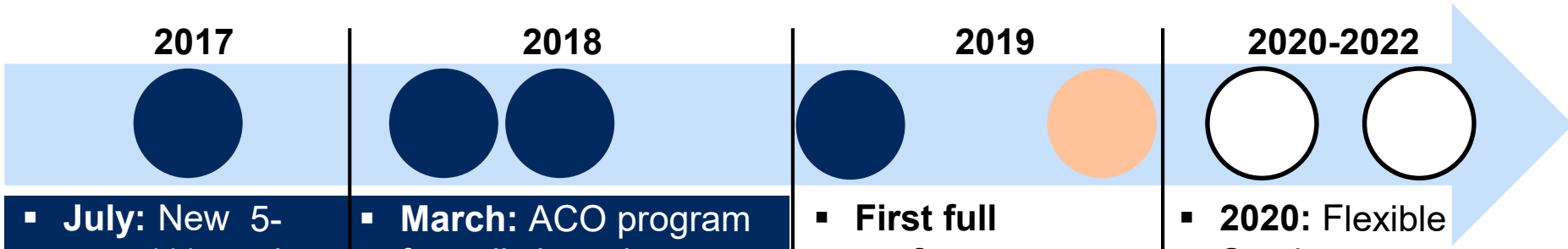
- This gave MassHealth an **urgent window of opportunity** to negotiate a new waiver with the federal government.

- From 2010 to 2016, MassHealth experienced **unsustainable growth**, a fee-for-service model for providers that resulted in **fragmented care**, and a fundamental program structure that **had not changed in 20 years.**

- Starting in 2016, MassHealth initiated an **intensive stakeholder engagement and design process** to restructure the program.

- As a result, MassHealth successfully negotiated a **new 5-year 1115 demonstration waiver,** effective July 1, 2017 through June 30, 2022, that:
  - Authorized a transition to **integrated, accountable care models** (ACOs and Community Partners)
  - Included **$1.8B of new, one-time investment** for delivery system reform (DSRIP) activities

Context: MassHealth re-structuring timeline



2017

- **July:** New 5-year 1115 waiver effective
- **August:** 17 ACO contracts
- **December:** 27 CP contracts
- **DSRIP investments begin after contracts signed**

2018

- **March:** ACO program formally launches
- **March – July:** Continuity of care period to support member transitions
- **July:** CP program launches
- **Baseline data** gathered on cost, quality, and delivery system reform **(10 month performance year 3/1/18-12/31/18)**

2019

- **First full performance year**
- **January:** Member experience surveys
- **End of Year:** Report released on 2018 baseline
- DSRIP funding **begins to taper**

2020-2022

- **2020:** Flexible Services program launches
- **2022:** Current 1115 waiver expires in June
- DSRIP funding **continues to decrease, ending in 2022**

Context: What are MassHealth Accountable Care Organizations?

- ACOs are health care organizations that are rewarded for **better health outcomes, lower cost, and improved member experience.**

- ACOs are responsible for achieving these results through **team-based care coordination** and integration of behavioral and physical health care. ACOs are also responsible for taking a whole person view of their members, including long term services and supports and health related social needs.

- MassHealth members enrolled in an ACO select, or are assigned, a **specific primary care provider** and have **access to networks of specialty providers** (e.g., hospitals, specialists, behavioral health providers) that participate in their plan.

- ACOs assume **upside and downside risk** and are financially accountable for specific quality measures.
  - **The 1115 waiver does not assume savings in the first 2 years** of the ACO program. Starting in the third year, the state is accountable for savings, ramping up to 2.1% savings (off baseline trend) by Year 5.

- ACOs represent a **diverse range of provider systems:**
  - Hospital-based and community primary care-based ACOs
  - Large, statewide and regional ACOs
  - Provider-led and provider-health plan partnership ACOs

Context: What are MassHealth Community Partners?

- Community Partners (CPs) contract with ACOs to provide **wrap-around expertise and support for behavioral health (BH) services and long-term services and supports (LTSS).**

- CPs serve **the most complex ACO members**, with serious mental illness, substance use disorders, co-occurring disorders, or disabilities that require long-term services and supports.

- CPs are paid to **engage** these members and collaborate with the health care system to **coordinate and improve** their care.

- CPs are **community-based organizations** with expertise in supporting the populations they serve.

Context: What is the Delivery System Reform Incentive Payment (DSRIP) Program?

- CMS authorized **$1.8B** in **one-time** DSRIP funding for **upfront investments in the delivery system.**

- Funding is divided among **3 main streams** over 5 years:

ACOs	CPs	Statewide Investments
$1B	**$550M**	**$115M**

- ACOs and CPs use funding to **launch innovative programs** and coordinate care for their members. Funding is **tied to performance on quality and the total cost of care.**

- DSRIP funding is **time limited and ends in 2022.**

Contents

Overview of 2018 rollout: by the numbers

17

 # MassHealth ACOs

- Partnerships of payers and providers across all geographic regions of the Commonwealth.

885,000

 # Members successfully transitioned to ACOs

- >75% of managed care eligible members. Exceeded expectations of 850,000 enrollees.
- Transition emphasized continuity of members' care and strengthened relationships with primary care providers.

27

 # MassHealth CPs

- Longstanding community-based organizations with expertise supporting members with complex needs.

48,600

 # Members assigned to CPs

- These members represent many of the most vulnerable.

$290.3M

$ DSRIP funds spent by ACOs and CPs by 12/31/18[1]

- Funds intended to improve quality and member experience, and reduce total cost of care.

[1] DSRIP spending began in 2017 as part of a "preparation period" leading up to program launch; those funds are included for purposes of this report

ACOs represent innovative partnerships of payers and providers

13
Accountable Care Partnership Plans ("Model A")

- **Partnership** between a single health plan and provider-led ACO.
- Receive monthly capitated payments from MassHealth based on enrollment and member risk scores.
- Take on **full insurance risk** for population.

3
Primary Care ACOs ("Model B")

- **Provider-led** ACO contracts directly with MassHealth
- Use MassHealth's network of providers .
- Providers receive fee-for-services payments from MassHealth; ACOs accountable for performance but not insurance risk.

1
MCO-Administered ACO ("Model C")

- Provider-led ACO contract with one or more of **MassHealth's MCOs.**
- MCO receives capitated payment from MassHealth; pays ACO according to MassHealth-approved arrangement.

Over 75% of eligible MassHealth members enrolled in an ACO

1.8M
Total MassHealth Members

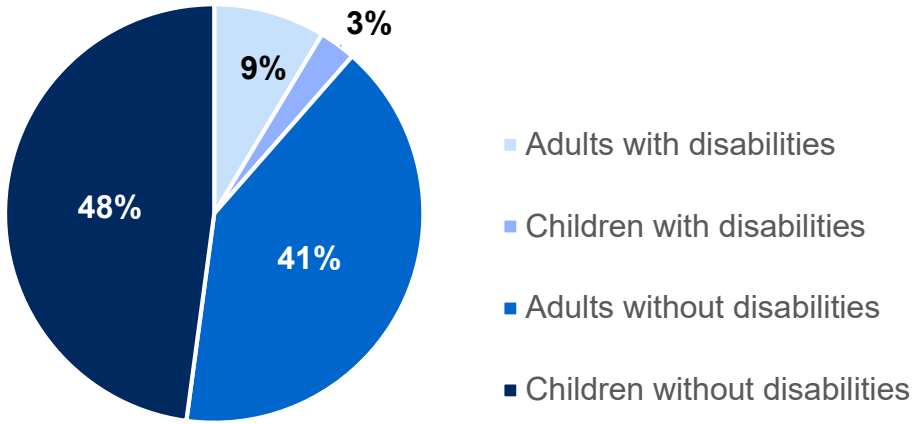
1.1M
Eligible to enroll in ACOs

850,00
Initial ACO Estimated Enrollment

885,000
(75% of those eligible)
Enrolled in ACOs

266,000
Enrolled in non-ACO options[1]

Distribution of ACO population[2]



[1]Traditional MCOs or MassHealth-run PCC Plan
[2]Based on MassHealth eligibility determination

2018 enrollment by ACO

ACO Type	Health plan	ACO Name	# of Members as of 11/17/18	% of Members
Accountable Care Partnership Plans ("Model A")	BMC HealthNet Plan	Boston Accountable Care Organization	110,401	12.5%
		Mercy Medical Center	28,555	3.2%
		Signature Healthcare	18,300	2.1%
		Southcoast Health	16,398	1.9%
	Fallon Health	Health Collaborative of the Berkshires	15,786	1.8%
		Reliant Medical Group	30,881	3.5%
		Wellforce	52,888	6.0%
	Health New England	Baystate Health Care Alliance	38,521	4.4%
	Allways Health Plan	Merrimack Valley ACO	32,490	3.7%
	Tufts Public Plans	Atrius Health	31,845	3.6%
		Boston Children's Health ACO	86,107	9.8%
		Beth Israel Deaconess Care Organization	36,665	4.1%
		Cambridge Health Alliance	28,148	3.2%
Primary Care ACOs ("Model B")	Community Care Cooperative (C3)		115,184	13.0%
	Partners HealthCare Choice		107,866	12.2%
	Steward Health Choice		124,420	14.1%
MCO-Administered ACO ("Model C")	Lahey Health*		10,946	1.2%
		ACO Total	***885,401***	***100%***

*Enrollment as of 11/30/18

Roll-out success: continuity of care

For members with a new plan or provider network, MassHealth worked closely with ACOs and other providers to **ensure a smooth transition.**

A four month **"continuity of care"** period supported members in maintaining **scheduled appointments, authorized services, and standing drug prescriptions.**

- Starting in the fall of 2017, MassHealth:
  - Hosted **events across the state** to support transition
  - Created a new **website dedicated to helping members choose a plan**
  - Distributed **notices and updated member handbooks** with new plan information
  - **Held webinars and in-person trainings** for providers and stakeholders to prepare for ACO program launch
  - **Ensured that all health plans exchanged important information before launch**, such as authorizations for services and prescriptions, for members who were changing plans

Roll-out success: primary care assignment

Each MassHealth ACO member has a dedicated primary care provider (PCP) to assist them with navigating the complex health care delivery system.

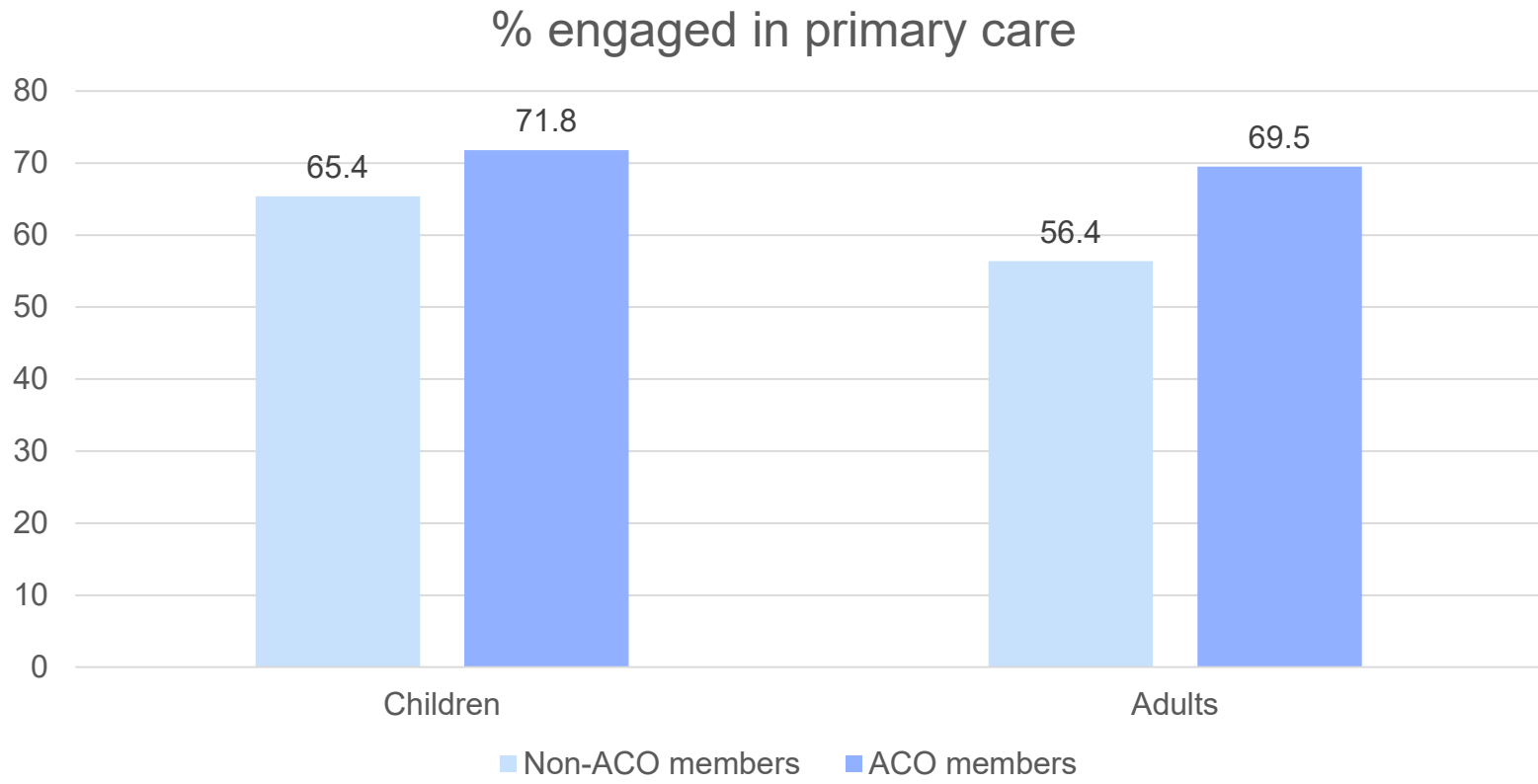
This PCP provides the "medical home" for members and is responsible for helping them get the **right care in the right setting at the right time.**

- MassHealth used members' existing PCP relationships to **enroll them in their corresponding ACOs whenever possible.**
- It was **challenging to identify an existing PCP** for certain members:10-20% of members either had **no PCP relationship** or had **multiple, uncoordinated visits** to several PCPs.
- MassHealth ensured **each PCP would have only 1 ACO to work with** for primary care services for their MassHealth population, simplifying previous many-to-many relationships.
- **Responsibilities of PCPs include**: providing primary care services, referrals, coordinating with specialists, and supporting the goal of reducing unnecessary emergency room and inpatient hospital utilization.

Rollout success: Members enrolled in ACOs more likely to engage with primary care in 2018

Engagement with primary care is a **foundational component** of the ACO care model.

This **baseline data is a promising start**, although further monitoring of member primary care vs. hospital/ED utilization in 2019 is needed to understand the impact of ACOs.



CP rollout required significant coordination with ACOs

On July 1, 2018, the **Community Partners program officially launched.**

Launching the CP program required **significant work** by ACOs and CPs to develop **collaborative working relationships** and joint infrastructure.

- MassHealth contracted with 27 CPs to **ensure statewide coverage.**
- Each ACO was required to partner with several CPs in its region.
- The ACO-CP model requires both entities to form a **single, integrated team** to seamlessly coordinate members' care.
- This process produced an **unprecedented level of collaboration and dialogue** between the state's major health care systems and the community-based organizations that make up the CP program.

CPs represent longstanding community expertise*

Behavioral Health CPs
Behavioral Health Network, Inc.
Behavioral Health Partners Of Metrowest, LLC
Boston Coordinated Care Hub
Brien Center Community Partner Program
Central Community Health Partnership (BH)
Clinical And Support Options, Inc.
Community Care Partners, LLC
Community Counseling Of Bristol County, Inc.
Community Healthlink, Inc.
Coordinated Care Network
Eliot Community Human Services, Inc.
Innovative Care Partners, LLC (BH)
Lahey Health Behavioral Services
Lowell Community Health Center, Inc.
Riverside Community Partners
South Shore Community Partnership
Southeast Community Partnership, LLC
SSTAR Care Community Partners

Long Term Services & Supports CPs
Boston Allied Partners
Care Alliance of Western Massachusetts
Central Community Health Partnership (LTSS)
Family Service Association
Innovative Care Partners, LLC (LTSS)
LTSS Care Partners, LLC
Massachusetts Care Coordination Network
Merrimack Valley Community Partner
North Region LTSS Partnership

*Additional detail on CPs and affiliated partners in appendix

Overview of DSRIP Program

- DSRIP funding ($1.8B total) is **time-limited and decreases over 5 years.**

- ACOs and CPs use DSRIP funds to **design and test innovative programs**, with the expectation that they measure those programs' outcomes, **and to stand up infrastructure required for population health management.**

- By the end of 2018, **ACOs and CPs spent $290.3M** in DSRIP funding:
    - **$247.1M** by ACOs* (see Slide 21)
    - **$43.2M** by CPs (see Slide 23)

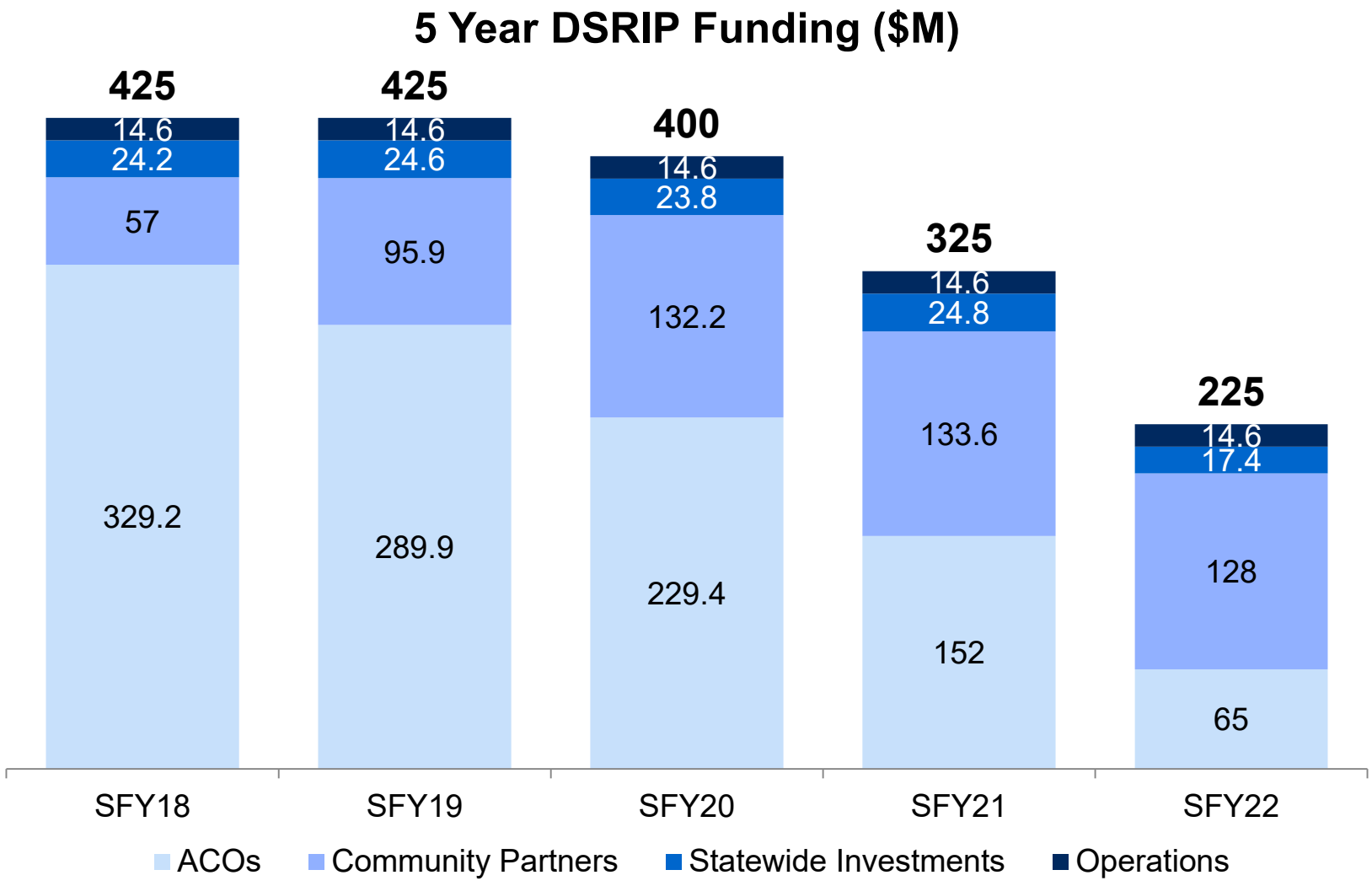
- ACOs and CPs had to receive MassHealth approval for **investment plans** by demonstrating that their investments would support **population health management**, not duplicate other available funds, and be measurable.

- Additionally, **$21.6M of DSRIP funding was used for Statewide Investments** by the end of 2018 to support workforce development (training, hiring, retention), technical assistance for ACOs and CPs, and related initiatives.

Detailed DSRIP funding charts by ACO, CP, and Statewide Investments programs included in appendix

* Certain ACOs also received an additional **$54.4M** for safety net hospital (DSTI) glide-path funding

DSRIP is time-limited and declines over 5 years



DSRIP investments: by the numbers

450

# of different ACO investments/programs supported by DSRIP in 2018

- Initiatives implemented by ACOs to improve quality of member care and lower total cost of care.

$118M

$ spent on personnel/staff by ACOs in 2018

- Significant investment in workforce to support ACO efforts.

$35.5M

$ spent on infrastructure by CPs in 2018

- Build out infrastructure to implement CP program, such as establishing workflows, integrating electronic systems, purchasing tablets to facilitate in-person connections, etc.

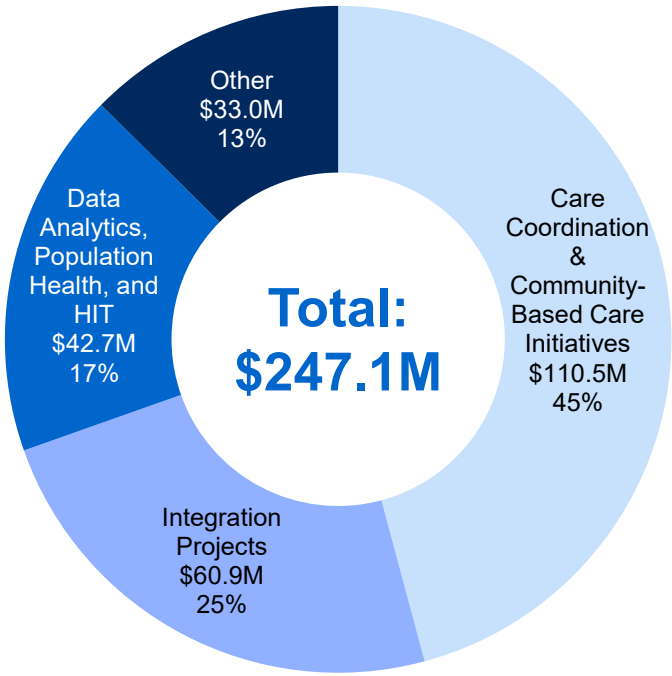
$7.9M

$ paid to CPs for care coordination supports provided between 7/1/18 to 12/31/18

- Payments for outreach, assessing needs, care planning, care coordination, etc.

ACO DSRIP spending

ACO DSRIP Expenditures
through 12/31/18



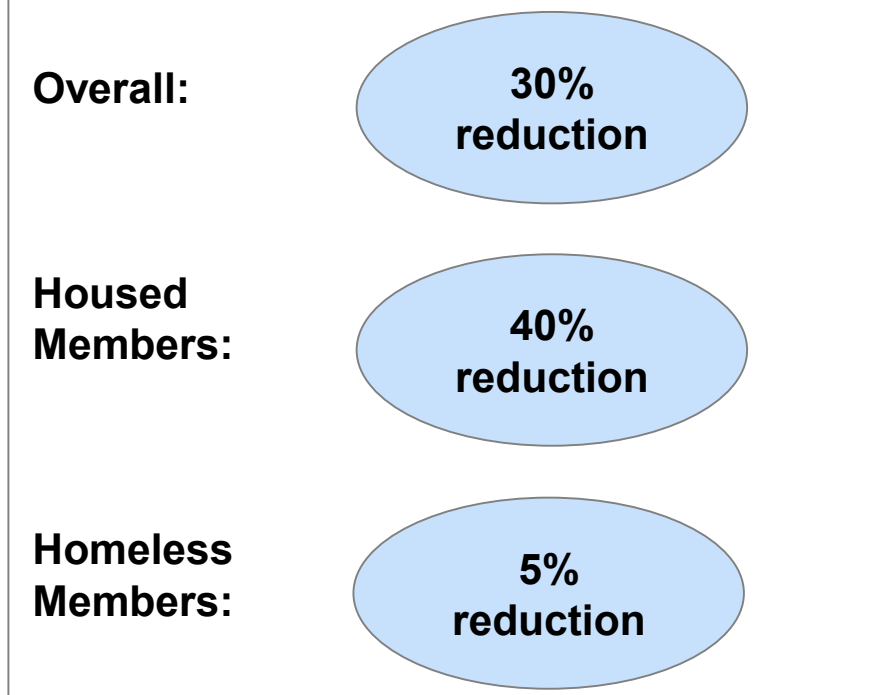
- **Care Coordination & Community-Based Care Initiatives:** Strengthen care coordination/ management and community-based programming.
- **Integration Projects:** Increase organizational capacity, as well as integration amongst physical health, BH, LTSS, and health-related social services.
- **Data Analytics, Population Health, and Health Information Technology:** Improve data collection, analytic platforms, algorithm development, EHR and care management software improvements, and interoperability.
- **Other:** Support workforce development, culturally and linguistically appropriate services, and other investments.

DSRIP funding per ACO included in appendix

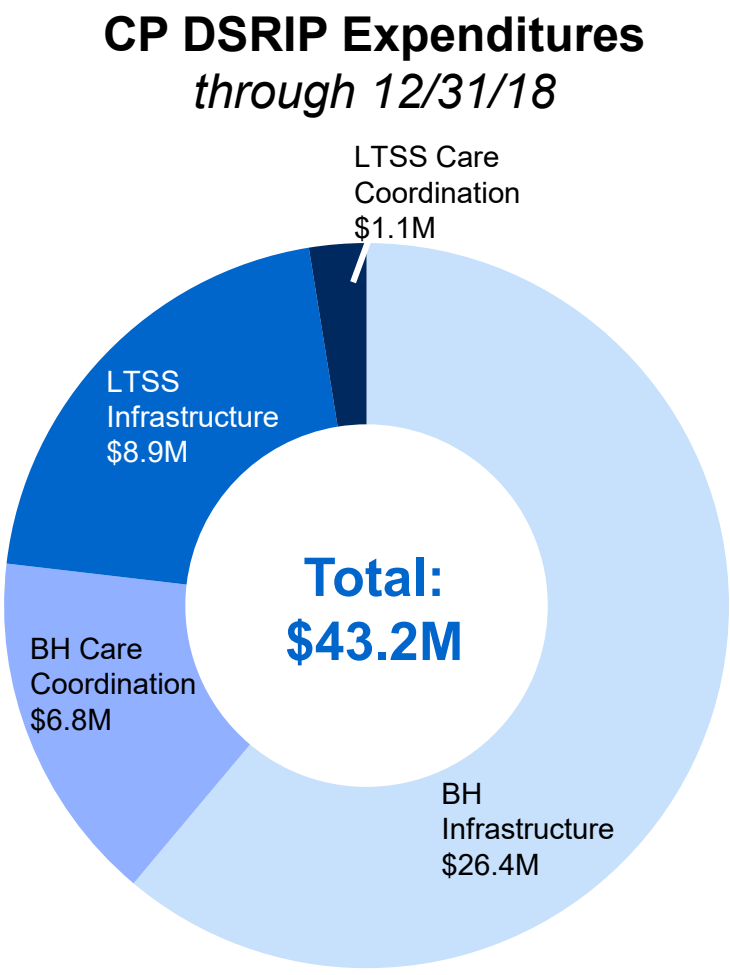
ACO example of success: BMC/BACO's Complex Care Management Program has reduced hospital and emergency department visits by 30%

- BACO used **sophisticated analytics** to identify members at-risk for high costs, and then tasked **multidisciplinary teams** to help them stay healthy.
- This program dramatically reduced ED visits and hospital stays, **saving money and improving members' quality of life**. The analytics and staff for the program are made possible by DSRIP dollars.
- **Many ACOs have similar programs**, with several reporting positive early outcomes.

Reduction in hospitalizations (inpatient and emergency department)



CP DSRIP spending



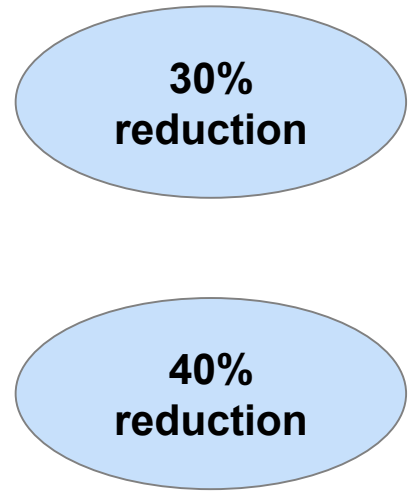
- **Infrastructure:** Investments in technology, workforce development (e.g., recruitment and training expenses), business start up costs, and operational infrastructure (e.g., data analytics staff).
- **Care coordination**: Payment for outreach, assessing needs, care planning, care coordination, etc.

DSRIP funding per CP included in appendix

CP example of success: Community Counseling of Bristol County's (CCBC) supports reduced hospital utilization

- CCBC deploys "feet on the street" to **engage members in their community** (on the street, at coffee shops, etc.).
- Their team helps members **attend appointments and become empowered** to manage their conditions.
- Preliminary data suggests members enrolled with the CCBC CP have had a **significant reduction in hospital utilization.**
- CCBC's approach is fully funded by DSRIP as part of the **Community Partners program**. Other Community Partners around the state are employing similar techniques, with some similar results.

Reduction in hospital utilization for members enrolled in CCBC's Community Partner program



Overview of Statewide Investments: by the numbers

184
 # student loans for community-based clinicians

$6M
$ in student loan repayment

- Empowers and incentivizes clinicians to work at safety net provider organizations.

640
 # community health workers and peer specialists trained

- Key members of the extended care team, who help engage members in their care.

92
 # technical assistance (TA) projects funded at ACOs/CPs

$10M
$ of technical assistance support

- Provides access to a curated catalog of 47 TA vendors with expertise in 9 different domains.

1,200
 # monthly active users of DSRIP TA website*

- High interest from ACOs and CPs since program launch.

DSRIP funding per Statewide Investments program included in appendix

* MA DSRIP TA Marketplace: https://www.ma-dsrip-ta.com/

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Overview of 2018 baseline cost data and ACO financial performance

The ACO program accounts for **$4.8B of MassHealth spending**, with an average **annual total cost of care per member of $5,600.**

Total Cost of Care Baseline

- **ACO baseline performance on total cost of care varied:** for members with similar characteristics, the average cost for a member varied by **up to 30%** across ACOs.

Financial Performance

- Overall**, actual medical spending exceeded capitation/benchmark by ~1.7%** in 2018, but financial performance varied among ACOs, with 8 ACOs in gains (prior to risk sharing) for 2018.

- Overall financial performance was driven in large part by **decreased member enrollment in the latter part of 2018 that increased overall member acuity.**

Total cost of care: Overview of medical costs in 2018

~$4.8B Total spent on covered services for ACO members[1]

~$5,600 Average per member per year (PMPY) spending[2]

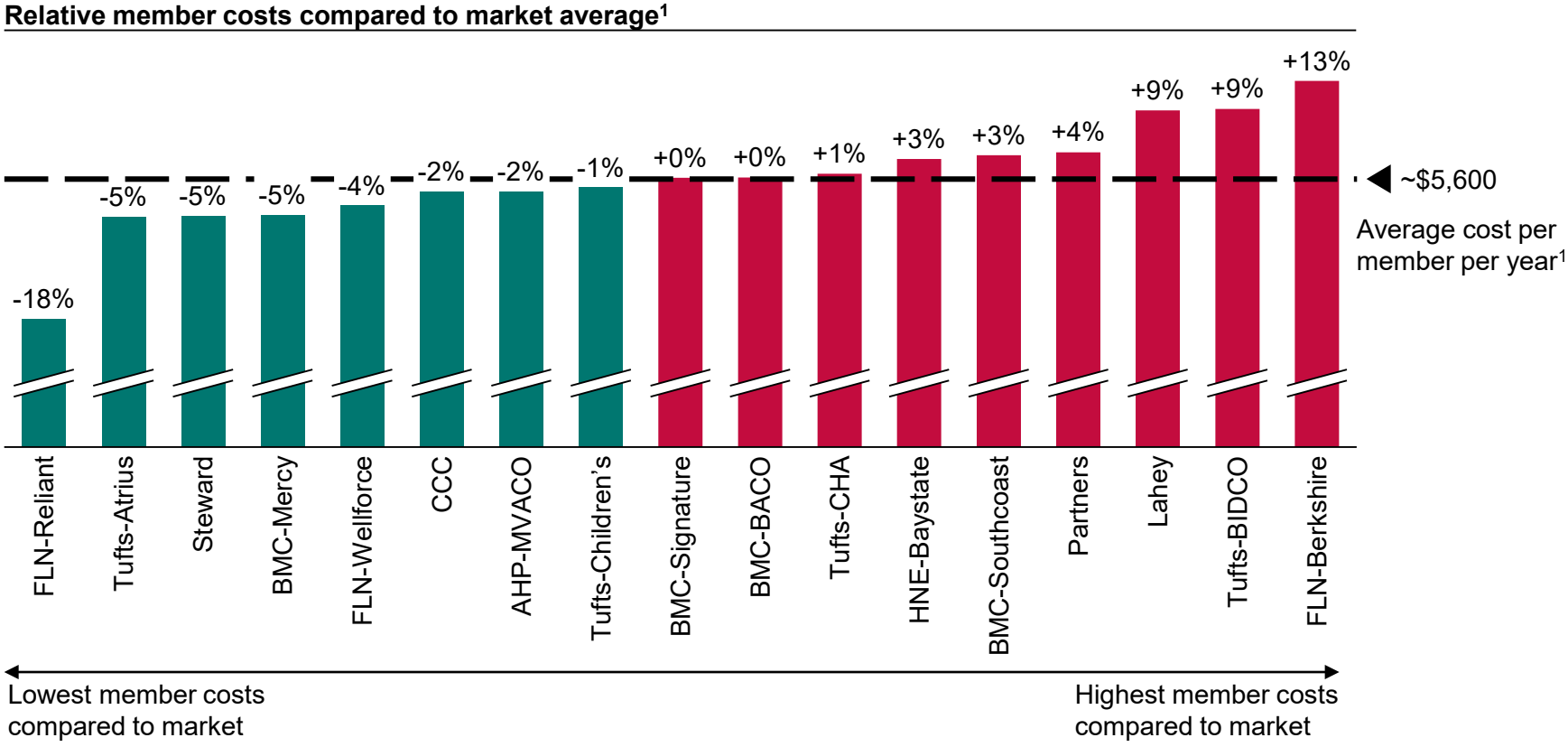
Average PMPY	With disabilities[3]	Without disabilities[3]
Adults	~$19,200	~$6,300
Children/Youth	~$9,900	~$2,300

[1]March – December 2018 medical expenditures, annualized, price normalized to MassHealth fee schedule; includes medical spend (e.g., Hepatitis C Rx and High Cost Drugs), but excludes add-on services (e.g., ABA, CBHI)
[2]March – December 2018 medical expenditures, annualized, price normalized to MassHealth fee schedule, divided by number of member months, multiplied by twelve
[3]Non-disabled adults include RC IA, RC IX, RC X

ACOs' 2018 costs varied, even when controlling for population and price

For members with similar characteristics, the average cost for a member varied by **up to 30%** across ACOs.

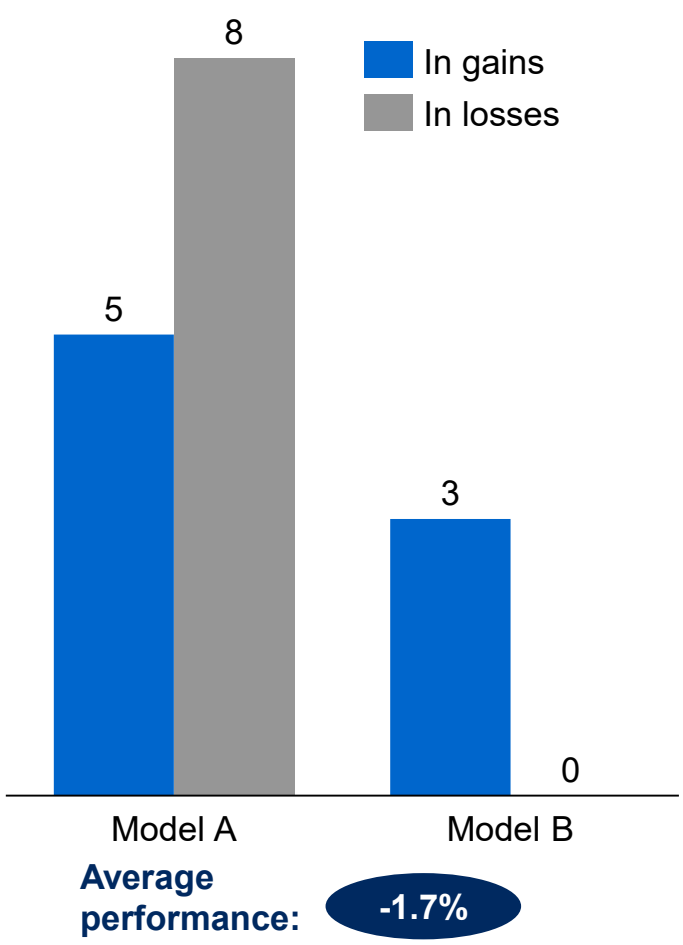
This variation was measured after adjusting for population risk and for the price of services – variation was primarily driven by different **patterns of utilization and sites of care.**



1March – September 2018 medical expenditures, price normalized, risk-normalized, and population-mix normalized annualized; includes medical spend (e.g., Hepatitis C Rx and High Cost Drugs), but excludes add-on services (e.g., ABA, CBHI)

Financial performance: 2018 performance varied among ACOs

2018 total cost of care compared against capitation rates/benchmark[1]
# of ACOs



Model C results to-be-determined during final reconciliation in 2020

- Actual medical spending exceeded capitation/benchmark by -1.7%, but **financial performance varied** – 8 ACOs were in gains for 2018.
- Performance was driven in large part by **decreased MassHealth enrollment that increased overall member acuity** in the latter parts of 2018.
  - MassHealth enrollment dropped in the second half of 2018.
  - Members that remained on the caseload tended to have more complex needs on average.
  - Note: Model A ACOs bear insurance risk (i.e., responsible for bearing risk on unexpected changes in risk or utilization).

[1]March – December 2018 medical expenditures, non-price normalized; includes medical spend (e.g., Hepatitis C Rx and High Cost Drugs), but excludes add-on services (e.g., ABA, CBHI)

Contents

Overview of clinical quality and member experience

- MassHealth identified **22 clinical quality and member experience measures** in alignment with CMS and stakeholder input:
  - **20 clinical quality measures**
  - **2 member experience** measure areas: overall care delivery and integration

- **Several measures were created by MassHealth to go beyond traditional quality measures** and provide insight on performance in high priority areas. There are no existing standards for these measures.

- In 2018, ACOs were **accountable for reporting** complete and accurate data on all clinical quality and member experience measures. After 2018, ACOs and CPs will start being **financially accountable for their performance** on these measures.

- Because each ACO's quality score was based entirely on reporting in the 2018 baseline year, each ACO scored 100%. I**n future years, ACOs' scores will be based in part on performance** and will likely vary more.

22 clinical quality and member experience measures

	Measures
1.	Follow Up After Emergency Dept. Visit for Mental Illness
2.	Poor Control of HbA1c Levels (Diabetes Care)
3.	Follow Up After Hospitalization for Mental Illness
4.	Metabolic Monitoring for Children or Adolescents on Antipsychotics
5.	Initiation and Engagement of Alcohol, Opioid or other Drug Use Treatment
6.	Appropriate Medications for Asthma
7.	Controlling High Blood Pressure
8.	Screening for Depression and Follow Up Plan
9.	Unplanned Hospital Readmissions
10.	Childhood Immunizations
11.	Adolescent Immunizations
12.	Timeliness of Prenatal Care
13.	Health Related Social Needs Screening
14.	Emergency Department Visits for Individuals with Serious Mental Illness or Addiction
15.	Behavioral Health Care in the Community
16.	Acute Unplanned Hospital Admissions for Diabetes
17.	Depression Remission/Response
18.	Behavioral Health Community Partner Engagement
19.	Long Term Service and Supports Community Partner Engagement
20.	Oral Health Evaluation
21.	Overall Quality of Care
22.	Integration/ Care Coordination

20 Clinical Quality Measures

2 Member Experience Measures

2018 scores provide a baseline for overall quality and member experience performance

- **All ACOs reported baseline quality information.**

- Each measure has or will have an **"attainment threshold"** and a **"goal benchmark"** based on **regional or national standards.** These benchmarks are established with stakeholder input and are approved by CMS.
  - Attainment thresholds represent **satisfactory performance.**
  - Goal benchmarks represent a **deliberately high standard**. Not all ACOs are expected to meet the goal benchmark, especially in the first year.

- For measures without existing standards, CMS and MassHealth agreed to develop **benchmarks based on ACO baseline performance.**

Clinical quality: summary of 2018 results

To **establish a baseline for clinical quality**, ACOs submitted data from their administrative and health record systems and were independently audited by MedReview, Inc.

Relative to 2018 baseline**, there is room for improvement on all 12 clinical quality measures** with existing attainment thresholds and goal benchmarks.

12 Measures with existing regional and national benchmarks. Overall, ACOs **met the attainment threshold on nearly all measures**, with variation among individual ACOs.

8 Measures that MassHealth and CMS are **in the process of establishing** scores and/or benchmarks.

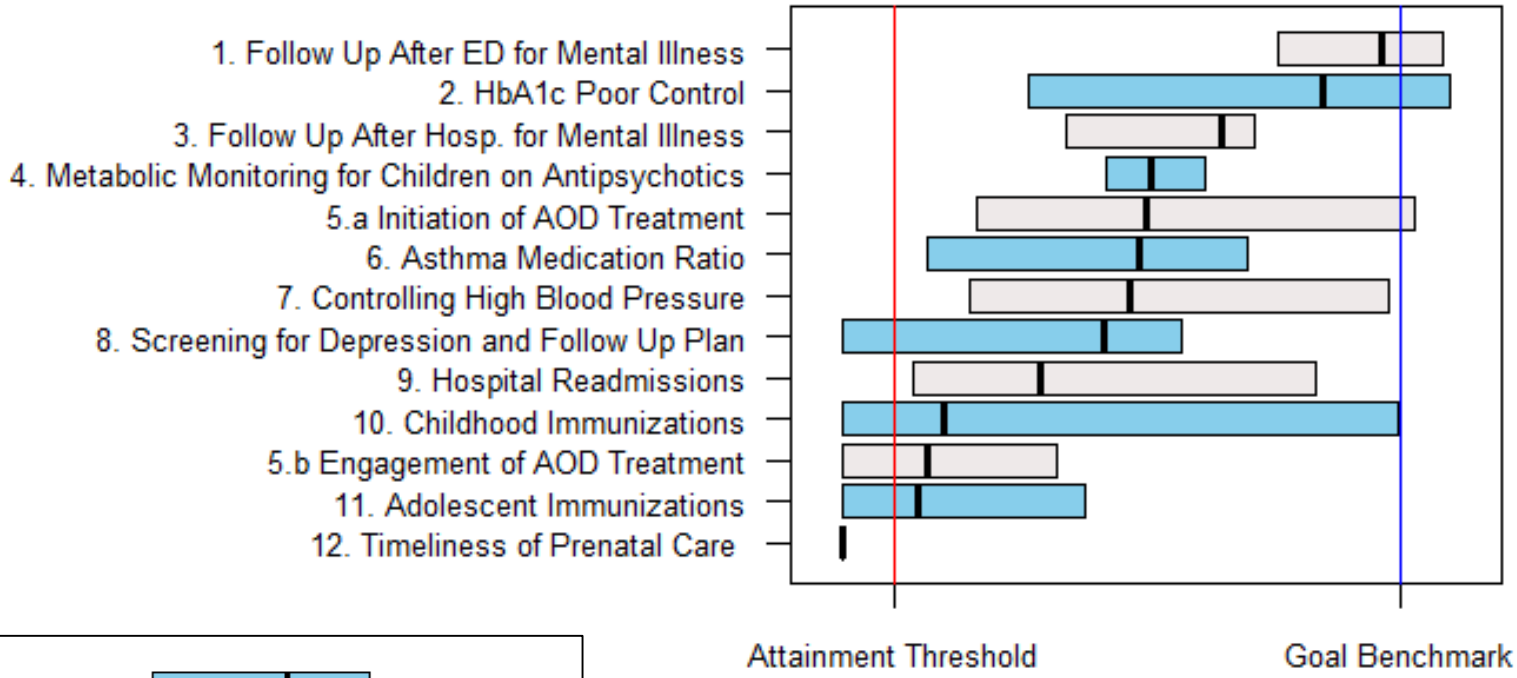
Clinical quality: 12 measures with regional and national benchmarks

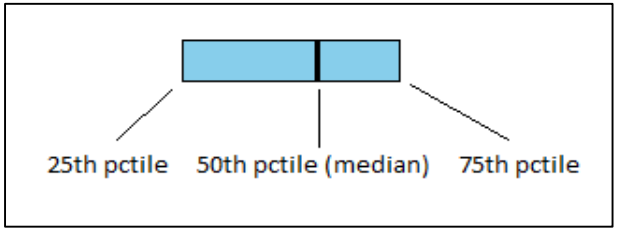
	Measure	Description
1	Follow Up After ED for Mental Illness	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge
2	Comprehensive Diabetes Care: HbA1c Poor Control*	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (>9.0%)
3	Follow Up After Hospitalization for Mental Illness	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge
4	Metabolic Monitoring for Children or Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing
5a & 5b	Initiation and Engagement of AOD Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive 2 or more additional services within 30 days of the initiation visit
6	Appropriate Medications for Asthma	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had appropriate medications
7	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled
8	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age who had an outpatient visit with a screening for depression and a follow-up plan if the screen was positive
9	Hospital Readmissions*+ ^	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age
10	Childhood Immunizations	Percentage of members who received all recommended immunizations by their 2nd birthday
11	Adolescent Immunizations	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series
12	Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment

** Lower score is better* *+ Reported as observed/expected rate* *^Benchmarks pending finalization from CMS*

Note: for purposes of efficiency, some measure titles have been abbreviated

Clinical quality: Overall, ACOs exceed attainment threshold on nearly all of the 12 measures, with variation among ACOs





Please note:

- These charts show how ACOs performed and how they varied relative to the benchmarks, but the bars are not to scale with each other, and should not be used to determine the relative performance between one measure and another.
- Initiation and Engagement of AOD Treatment: This measure is reported as 2 rates on the previous page.
- Timeliness of Prenatal Care: There is little variation among ACO scores on this measure; to a large extent (as compared to other measures), this measure requires ACOs to collect data from providers in other healthcare systems, which ACOs reported to be challenging, especially in the transition year of 2018.
- **For exact values see Appendix.**

Clinical quality: 8 measures that MassHealth and CMS are in the process of establishing scores and/or benchmarks

Measures without regional or national benchmarks

	Measure	Description
13	Health Related Social Needs Screening	Percentage of members 0-64 years old who were screened for health-related social needs in the measurement year
14	ED Visits for Individuals with SMI or Addiction	Number of ED visits for members 18-64 years old with a diagnosis of serious mental illness, substance abuse, or co-occurring conditions
15	Community Tenure	Number of days that members with BH diagnoses spend in the community, rather than an acute, chronic or post-acute institutional health care setting
16	Acute Unplanned Admissions for Diabetes	Rate of acute unplanned admissions for individuals 18-64 years old with diabetes
17	Depression Remission/Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who receive follow-up PHQ-9 and experienced remission or response within 4 to 8 months of the initial elevated score

MassHealth is developing benchmarks with CMS

Additional measures awaiting scores

18	BH CP Engagement	Percentage of members engaged with a BH CP with an active care plan
19	LTSS CP Engagement	Percentage of members engaged with a LTSS CP with an active care plan
20	Oral Health Evaluation	Percentage of members under age 21 who received an oral evaluation within the year

These measures are still being calculated; MassHealth will report them in the 2020 report

Overview of member experience

- **MassHealth contracted with Massachusetts Health Quality Partners (MHQP) to survey approximately 30,000 members in 2018 to build a baseline** view of their experience of the health care system.

- **MassHealth administered three types of surveys for adults and children:**
  - **Primary care:** issued to members who had a primary care visit
  - **Behavioral health:** issued to a subset of members who visited a behavioral health provider
  - **Long term services and supports:** issued to a subset of members who used long term services and supports

- **ACOs are accountable for performance on two member experience measures**:
  - Overall care delivery
  - Integration/ coordination of care

- For 2018, these measures are calculated based on results from a subset of questions **in the primary care survey**, which was based on a nationally validated tool.

- In future years, MassHealth may incorporate results from additional questions in the primary care survey, and the BH and LTSS surveys, which were **newly developed to support a more complete picture of the experience of the Medicaid population.**

Member experience: summary of 2018 results

- 2018's **baseline member experience results:**
  - Members expressed satisfaction with their individual providers
  - Members expressed the need for increased coordination or help managing behavioral health and other specialists and services
  - ACO scores are similar to, but slightly lower than, comparable surveys performed by commercial health plans

- This baseline **identifies clear opportunities** for ACOs to improve how well the health care delivery system serves MassHealth members, especially in the integration and coordination of behavioral health care.

- In future years, ACOs will be **accountable for maintaining and improving** member experience (ACO payments will depend on member experience scores).

- Additional questions from the primary care, behavioral health, and long term services and supports surveys that were **not used to calculate baseline 2018 member experience measures** are included in the appendix.

Member experience: baseline scores exceeded threshold, but did not meet goal benchmarks

	Measure	Statewide Score	Threshold	Goal
21	Overall care delivery	89.80	75.00	92.00
22	Integration/coordination of care	82.40	*71.25	*86.25

Detail: Overall care delivery (#21)

Question topics	Description	Adult/ Child	Statewide Score	Threshold	Goal
Willingness to Recommend	Overall measure of the experience and the provider	Adult	87.1	75	92
		Child	91.3		
Communication	Effective communication between provider and patient or caregiver	Adult	89.2	75	92
		Child	92.3		

Detail: Integration/coordination of care (#22)

Integration of Care	Effective coordination of services (e.g., labs, referrals, follow-up, and information exchanged between provider, patient, and services)	Adult	80.5	*70	*85
		Child	80.7	*70	*85
Knowledge of Patient	Provider knowledge of important medical information about patient and understanding patient's challenges to staying healthy	Adult	83.7	*70	*85
		Child	88.1	*75	*90

*Proposed benchmarks pending approval from CMS

Contents

Next phase

- **Successful rollout and implementation** was a major effort that extended **well into late summer/early fall** of 2018.
- The ACO model requires **more accurate and detailed rate structures** than MassHealth's previous structure. Predicting the risk of the Medicaid population is challenging with Medicaid enrollment and caseload churn.
- **New quality measures** in the behavioral health and long-term services and support space will require additional data and testing before they are valid.
- The on-the-ground work of **delivery system reform takes time**. Engaging members, navigating a complex system, and dealing with universal challenges to integration are some of the barriers ACOs and CPs encounter.

Next phase

- **2018's robust baseline data** has identified clear opportunities for ACOs, CPs, and MassHealth:
  - MassHealth has **refined the ACO rate structure** for 2020, incorporating learnings from 2018
  - Some ACOs are **focusing their efforts to manage total cost of care in** areas that were identified in 2018 as being drivers of their performance.
  - MassHealth is working with ACOs to **identify and address specific opportunities for improvement**
  - ACOs have begun **evaluating the success of individual DSRIP-funded programs,** with the goal of building on successes while phasing out others as DSRIP funding decreases
  - ACOs are developing plans to use DSRIP "**Flexible Services**" funding to pay for **certain nutrition and housing supports** as a pilot strategy to reduce TCOC and improve health outcomes for certain members

Appendix

BH CPs

- MassHealth has contracted with eighteen (18) BH CPs throughout the state.
- CPs are contracted to cover certain Service Areas.

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Behavioral Health Network, Inc.		**Western:** Holyoke, Springfield, Westfield
Behavioral Health Partners of Metrowest, LLC	• *Advocates, Inc.* • *South Middlesex Opportunity Council* • *Spectrum Health Systems, Inc.* • *Wayside Youth and Family Support, Family Continuity (FCP), Inc.*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn **Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
Boston Coordinated Care Hub	• *McInnis Health Group/Boston Health Care for the Homeless Program* • *Bay Cove Human Services, Inc.* • *Boston Public Health Commission* • *Boston Rescue Mission, Inc.* • *Casa Esperanza, Inc.* • *Pine Street Inn, Inc.* • *St. Francis House; Victory Programs, Inc.* • *Vietnam Veterans Workshop, Inc.*	**Greater Boston:** Boston Primary
Brien Center Community Partner Program		**Western:** Adams, Pittsfield
Central Community Health Partnership	• *The Bridge of Central Massachusetts* • *Alternatives Unlimited, Inc.* • *LUK, Inc.* • *Venture Community Services* • *AdCare*	**Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester

BH CPs (cont.)

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Clinical and Support Options, Inc.		**Central:** Athol **Western:** Adams, Greenfield, Northampton, Pittsfield
Community Counseling of Bristol County		**Southern:** Attleboro, Brockton, Taunton
Community Healthlink, Inc.		**Central:** Gardner-Fitchburg, Worcester
Community Care Partners, LLC	• *Vinfen Corporation* • *Bay Cove Human Services, Inc.*	**Greater Boston:** Boston Primary, Revere, Somerville, Quincy **Northern:** Haverhill, Lawrence, Lowell, Lynn, Malden, Salem **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, Wareham
Coordinated Care Network	• *High Point Treatment Center* • *Brockton Area Multi Services, Inc. (BAMSI)* • *Bay State Community Services, Inc.* • *Child & Family Services, Inc.* • *Duffy Health Center* • *Steppingstone, Inc.*	**Greater Boston:** Quincy **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, Wareham
Eliot Community Human Services, Inc.		**Greater Boston:** Revere, Somerville **Northern:** Beverly, Gloucester, Lowell, Lynn, Malden, Salem, Woburn **Central:** Framingham, Waltham

BH CPs (cont.)

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Innovative Care Partners, LLC	• *Center for Human Development* • *Gandara Mental Health Center, Inc.* • *Service Net, Inc.*	**Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
Lowell Community Health Center, Inc.	• *Lowell House, Inc.*	**Northern:** Lowell
Lahey Health Behavioral Services		**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn
Riverside Community Partners	• *Brookline Community Mental Health Center, Inc.* • *The Dimock Center, Inc.* • *The Edinburg Center, Inc.* • *North Suffolk Mental Health Association, Inc.* • *Upham's Corner Health Center*	**Greater Boston:** Boston Primary, Revere, Somerville, Quincy **Northern:** Lowell, Lynn, Malden, Woburn **Central:** Framingham, Southbridge, Waltham
Southeast Community Partnership	• *South Shore Mental Health Center, Inc.* • *Gosnold, Inc.* • *FCP, Inc. dba Family Continuity*	**Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, Wareham
South Shore Community Partnership	• *South Shore Mental Health Center, Inc.* • *Spectrum Health Systems, Inc.*	**Greater Boston:** Quincy
Stanley Street Treatment and Resources (SSTAR) Care Community Partners	• *SSTAR* • *Greater New Bedford Community Health Center, Inc.* • *HealthFirst Family Care Center, Inc.* • *Fellowship Health Resources, Inc.*	**Southern:** Attleboro, Barnstable, Fall River, Falmouth, New Bedford, Oak Bluffs, Orleans, Taunton, Wareham

LTSS CPs

- MassHealth has contracted with nine (9) LTSS CPs throughout the state.
- CPs are contracted to cover certain Service Areas.

LTSS CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Boston Allied Partners	• *Boston Medical Center Corporation* • *Boston Senior Home Care, Inc.* • *Central Boston Elder Services* • *Southwest Boston Senior Services d.b.a Ethos*	**Greater Boston:** Boston-Primary
Care Alliance of Western Massachusetts	• *WestMass Elder Care, Inc.* • *Greater Springfield Senior Services, Inc.* • *Highland Valley Elder Services, Inc.* • *LifePath, Inc.* • *Elder Services of Berkshire County, Inc.* • *Stavros Center for Independent Living* • *Behavioral Health Network, Inc.*	**Central:** Athol **Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
Central Community Health Partnership	• *Alternatives Unlimited* • *The Bridge of Central Massachusetts, Inc.* • *LUK, Inc.* • *Venture Community Services, Inc.* • *AdCare*	**Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester
Family Service Association		**Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oaks Bluff, Orleans, Plymouth, Taunton, Wareham

LTSS CPs (cont.)

LTSS CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Innovative Care Partners, LLC	• *Center for Human Development* • *Gandara Mental Health Center, Inc.* • *Service Net, Inc.*	**Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
LTSS Care Partners, LLC	• *Vinfen* • *Bay Cove Human Services* • *Justice Resource Institute* • *Boston Center for Independent Living* • *Mystic Valley Elder Services* • *Somerville Cambridge Elder Services* • *Boston Senior Home Care, Inc.*	**Greater Boston:** Boston-Primary, Revere, Somerville, Quincy **Northern:** Malden **Southern:** Brockton
Massachusetts Care Coordination Network	• *Advocates, Inc.* • *Boston Center for Independent Living, Inc.* • *HMEA* • *BayPath Elder Services, Inc.* • *Brockton Area Multi Services, Inc. (BAMSI)*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oaks Bluff, Orleans, Plymouth, Taunton, Wareham **Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
Merrimack Valley Community Partnership	• *Elder Services of Merrimack Valley* • *Northeast Independent Living*	**Northern:** Haverhill, Lawrence, Lowell
North Region LTSS Partnership	• *Bridgewell, Inc.* • *Northeast Arc, Inc.*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn

DSRIP funding by ACO

ACO Name	Funding as of 12/31/18
Atrius Health	$8.2M
Boston Accountable Care Organization	$37.4M
Baystate Health Care Alliance	$10.8M
Boston Children's Health ACO	$19.6M
Health Collaborative of the Berkshires	$5.1M
Beth Israel Deaconess Care Organization	$11.4M
Community Care Cooperative	$39.7M
Cambridge Health Alliance	$11.1M
Lahey Health	$2.0M
Mercy Medical Center	$7.8M
Merrimack Valley ACO	$10.8M
Partners HealthCare Choice	$18.8M
Reliant Medical Group	$8.8M
Signature Healthcare	$4.9M
Steward Health Choice	$33.2M
Southcoast Health	$5.5M
Wellforce	$12.0M
Total	**$247.1M**

DSRIP funding by CP

CP Name	Infrastructure funding as of 12/31/18	Care Coordination funding as of 12/31/18
Alternatives Unlimited, Inc.	$0.9M	$0.1M
Behavioral Health Network	$3.3M	$0.6M
Behavioral Health Partners of Metrowest	$1.5M	$0.7M
Boston Alliance Partners	$1.0M	$0.1M
Boston Health Care for the Homeless	$1.1M	$0.1M
Brien Center	$1.0M	$0.1M
Care Alliance of Western MA	$1.1M	$0.1M
Clinical and Support Options	$1.2M	$0.1M
Community Care Partners	$2.3M	$0.8M
Community Counseling of Bristol County	$0.8M	$0.5M
Community Healthlink	$1.0M	$0.1M
Eliot Community Partner	$2.2M	$0.4M
Family Service Association	$0.7M	$0.1M
Greater Lowell Behavioral Health	$0.7M	$0.1M
High Point Treatment Center	$2.5M	$0.7M
Innovative Care Partners, LLC LTSS	$1.2M	$0.3M
Innovative Care Partners, LLC. BH	$1.3M	$0.6M
Lahey Health and BH Services	$1.3M	$0.4M
LTSS Care Partners	$1.1M	$0.1M
Massachusetts Care Coordination Network	$1.2M	$0.2M
Merrimack Valley CP	$1.0M	$0.1M
Northern Region LTSS Partner	$0.8M	$0.0M
Riverside Community Care, Inc	$2.0M	$0.3M
Southeast	$1.1M	$0.4M
Southshore	$0.6M	$0.1M
Stanley Street Treatment and Resources	$1.3M	$0.5M
The Bridge of Central Massachusetts, Inc.	$1.3M	$0.4M
TOTAL	**$35.3M**	**$7.9M**

DSRIP funding by Statewide Investments program

Program	Funding as of 12/31/18
Community-Based Workforce	
Student Loan Repayment Program	$1,825,000
Behavioral Health Workforce Development Program	$725,200
Community Partners (CP) Recruitment Incentive Program	$867,500
Primary Care/Behavioral Health Special Projects Program	$1,062,206
Family Medicine/Family Nurse Practitioner Residency Program	$150,000
Community Mental Health Center (CMHC) Behavioral Health (BH) Recruitment Program	$1,120,000
Subtotal | Community-Based Workforce	$5,749,906
Frontline Workforce	
Community Health Worker (CHW) Training Capacity Expansion Grant Program	$383,236
Peer Specialist Training Capacity Expansion Grant Program	$284,447
Community Health Worker (CHW) Supervisor Training Grant Program	$148,234
Competency-Based Training Program	$901,943
Subtotal | Frontline Workforce	$1,717,860
Capacity Building for ACOs, CPs, CSAs, and Providers	
Technical Assistance Program for ACOs and CPs	$9,326,012
Community Health Center (CHC) Readiness Program	$1,000,000
Standardized Online Training for CPs and CSAs	$150,834
Alternative Payment Methods (APM) Preparation Fund	$2,200,000
Subtotal | Capacity Building for ACOs, CPs, CSAs, and Providers	$12,676,846
Initiatives to Address Statewide Gaps in Care Delivery	
Enhanced Diversionary Behavioral Health Activities	$1,300,000
Accessibility Improvement Program	$278,592
Subtotal | Initiatives to Address Statewide Gaps in Accessibility	$1,578,592
Total Statewide Investments Spending Thru 12/31/18	**$21,630,652**

How to read the quality measure charts

Charts are shown that **summarize key information** about ACO quality performance.

- The **distribution of ACO performance** for each measure is represented by a rectangle; the left bound is the **25th percentile** ACO performance. The right bound is the **75th percentile**; the thick black line in the middle represents the **median.**

- This chart allows easy comparison of this distribution against the **attainment threshold and goal benchmark** by lining these up (the red line and blue line, respectively); because the attainment threshold and goal benchmark values actually **vary from measure to measure**, lining them up like this requires the **scale for each measure to vary as well.**

- Therefore, these charts show how ACOs performed and how they varied **relative to the benchmarks**, but the bars are not to scale with each other and should not be used to determine the **relative performance between one measure and another.**

Detailed quality results: Measures for which 50% or more ACO scores met or exceeded attainment thresholds

Measure	Description	How it is scored	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had appropriate medications	0 – 100	62.2	57.9	64.4	57.2	67.5
Controlling High Blood Pressure^	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	0 – 100	67.2	63.6	72.8	62	73
Child Immunization	Percentage of members who received all recommended immunizations by their 2nd birthday	0 – 100	49.9	40.2	60.2	48.9	59.4
Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	0 – 100	32.2	26.9	39.6	31.4	49.4
Comprehensive Diabetes Care: A1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (>9.0%)	0 – 100 *(lower is better)*	31.9	36.7	26.8	39	30.6

^Benchmarks pending finalization from CMS

Detailed quality results: Measures for which 50% or more ACO scores met or exceeded attainment thresholds

Measure	Description	How it is scored	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Metabolic Monitoring for Children or Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	0 – 100	35.8	33.8	42.3	31	40.5
Follow Up After ED Visit	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge	0 – 100	75.8	73	77.5	62.6	76.3
Follow Up After Hospitalization for Mental Health	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	0 – 100	51.2	45.5	52.4	39.1	57.7

Detailed quality results: Measures for which 50% or more ACO scores met or exceeded attainment thresholds

Measure	Description	How it is scored	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Hospital Readmissions^	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age	0 – 1.0 *(lower is better)*	0.94	1.0	0.8	1.01	0.77
Initiation AOD Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis	0 – 100	43.5	39	50.6	36.8	50.2
Engagement AOD Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who receive 2 or more additional services within 30 days of the initiation visit	0 – 100	16.9	14.3	18.8	16.4	23.8
Depression Screen Follow Up Plan^	Percentage of members 12 to 64 years of age who had an outpatient visit with a screening for depression and a follow-up plan if the screen was positive	0 – 100	40.2	19.9	45	27.3	58.4

^Benchmarks pending finalization from CMS

Detailed quality results: Median ACO score is lower than attainment threshold – 1 measure

Measure	Description	How it is scored	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment	0 – 100	80.8	71.6	84.7	86	93.6

The following HEDIS measures are Adjusted, Unaudited, HEDIS Rates:

- Asthma Medication Ratio
- Initiation and Engagement of Alcohol or Drug Abuse or Dependence Treatment
- Controlling High Blood Pressure
- Childhood Immunization Status
- Prenatal and Postpartum Care: Timeliness
- Immunizations for Adolescents
- Comprehensive Diabetes Care: A1c Poor Control
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Follow Up After Emergency Department Visit for Mental Illness (7-Days)
- Follow Up After Hospitalization for Mental Illness (7-Days)
- Plan All Cause Readmissions

Additional member experience questions: areas for monitoring in primary care survey

Question topics	Description	Adult/ Child	Statewide Score
Self-Management Support	Provider engagement with patients to talk about their goals for their health and things that make it hard to take care of their health	Adult	63.1
		Child	51.2
Behavioral Health	Provider engagement with patients to talk about their behavioral health needs	Adult	64.9
		Child	*Not Applicable
Child Development	Provider engagement with patients to talk about their child's physical, emotional and social development	Child	71.0
Pediatric Prevention	Provider engagement with patients to talk about their child's home environment (addressing exercise, food, computer, safety etc)	Child	67.3
Office Staff	Helpfulness of the office staff, and being treated with courtesy and respect	Adult	86.4
		Child	86.9
Organizational Access	Access to timely routine and urgent appointments, and same day response to questions	Adult	80.7
		Child	86.1
Overall Provider Rating	Rating of provider	Adult	88.3
		Child	91.1
Child Provider Communication	Effective communication between provider and patient	Child only	95.7

*There is no BH child composite in the primary care CAHPS survey. Please note a separate child BH survey was tested this year as part of the ACO program and is under evaluation.

Additional member experience questions: behavioral health survey

MassHealth developed a new tool to survey experience of behavioral health services for the first time.

The tool does not yet have validated benchmarks, but because of the importance of this unique lens on the performance of the healthcare system, MassHealth is **reporting baseline aggregate data** from this survey and may use these composites in future member experience scores.

Question topics	Description	Adult/Child	Statewide Score
Willingness to Recommend	Overall measure of the experience and the provider(s)	Adult	80.6
		Child	79.5
Communication	Effective communication between provider and patient	Adult	86.8
		Child	87.1
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information about the patient	Adult	72.2
		Child	74.8
Care Plan	Effective care planning including identification and assessment of needs, services included in the plan, & member choice of providers and services	Adult	73.8
		Child	75.0
Services Helpful	Services helpful in daily living activities	Adult	59.3
		Child	64.7
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	56.2
		Child	53.4
Needs Met	How well needs for mental health service, substance use treatment, and prescription medication were met	Adult	81.8
		Child	77.5
Service Scheduling	Access and availability to services	Adult	75.3
		Child	74.4
Overall Rating	Rating of overall behavioral health services in the last 12 months	Adult	75.6
		Child	75.7

Additional member experience questions: LTSS survey

MassHealth developed a new tool to survey experience of long term services and supports for the first time.

The tool does not yet have validated benchmarks, but because of the importance of this unique lens on the performance of the healthcare system, MassHealth is **reporting baseline aggregate data** from this survey and may use these composites in future member experience scores.

Question topics	Description	Adult/Child	Statewide Score
Willingness to Recommend	Overall measure of the experience with LTSS services	Adult	86.0
		Child	86.2
Communication	Effective communication between provider and patient	Adult	86.3
		Child	85.6
Care Plan	Effective care planning including identification and assessment of needs, services included in the plan, & member choice of providers and services	Adult	75.9
		Child	76.3
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information	Adult	76.7
		Child	75.3
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	75.8
		Child	71.6
Services Helpful	Services helpful in daily living activities	Adult	59.2
		Child	69.2
Needs Met - Core Services	How well needs for core LTSS services were met (e.g., physical therapy, skilled nursing, day programs)	Adult	82.8
		Child	81.8
Needs Met – Non-core Services	How well needs for non-core LTSS services were met (e.g., assistive technology, transportation services)	Adult	84.0
		Child	83.0
Service Scheduling	Access to and availability of services	Adult	81.7
		Child	81.0
Overall Rating	Rating of overall LTSS services	Adult	78.5
		Child	78.0