MassHealth Delivery System Restructuring: 2021 Update Report

Executive Office of Health & Human Services

January 2024

Executive Summary (1 of 2)

- In 2018, Massachusetts implemented its most **significant Medicaid restructuring* in 20 years to move away from a fee-for-service model** by creating:
  - **Accountable Care Organizations (ACOs)**
  - **Community Partners (CPs),** serving members with complex needs
  - **Delivery System Reform Incentive Payment (DSRIP) Program,** investing in statewide infrastructure

- This is the **fourth public report** on the MassHealth delivery system restructuring; **it primarily covers its fourth calendar year (2021),** in comparison to 2019 and 2020 which are covered in prior reports.**

- During 2021, MassHealth had 17 ACOs providing care for **~1.1M members** with a composite expense of **~$6.3B.**

- **The COVID-19 pandemic continued to have a significant impact** on health care delivery and outcomes in 2021, and also impacted **performance data**:
  - **MassHealth caseload and ACO enrollment significantly increased** due to Medicaid coverage protections during the federal Public Health Emergency (PHE), and as a result **total spend increased** even though per member spend and utilization was lower in 2021 compared to 2019.
  - In response to concerns over the pandemic's impact on individual quality measures, MassHealth and CMS agreed to certain **benchmark reductions** for ACO/CP measures.

- **This report is focused on the 2017-2022 1115 demonstration's performance data**. At the time of this report's release, MassHealth is implementing the 2022-2027 1115 demonstration extension. This report does not cover this extension.

*See Appendix for further background on the 2018 restructuring.

**Prior reports are available at: https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program

Executive Summary (2 of 2)

By 2021, ACOs were showing early signs of impact, despite the effects of the pandemic.

- ACOs maintained **higher primary care utilization** relative to other plans, even during the pandemic when access was an issue. PCP visits were 11% higher for ACOs than non-ACOs on average from 2019 to 2021.
- ACOs had the structure to **respond rapidly to the evolving impacts of the pandemic**, enabling them to launch **telehealth**, establish **vaccination clinics and education** focused on underserved populations, and address **behavioral health (BH) emergency department (ED) boarding.**
- The confounding effects of the pandemic made cost and quality outcomes difficult to interpret. However, in 2021, **ACOs demonstrated improvements in some quality measures from 2020, though many measures did not reach their pre-pandemic performance levels**.
- The **CPs** and **Flexible Services Program** meaningfully engaged members to improve care coordination and address health-related social needs while starting to show early positive outcomes in quality and cost.
  - **CPs**, which provide community-based care coordination for members with significant behavioral health (BH) and long-term services and supports (LTSS) needs, continued to make **gains in member outreach and engagement**
  - Between 2018 and 2021, there was a **25% reduction in ED visits** and a **40% reduction in BH inpatient admissions** among members enrolled in the BH CP program, and **19% lower total cost of care (TCOC)** following graduation from the CP program compared to the 12 months preceding enrollment.
- The **Flexible Services Program,** which launched in 2020 and provides housing and nutrition support to certain members, saw **rapid growth** in 2021, and quickly became a significant part of ACOs' pandemic response and population health strategies, with **services provided more than doubling from 2020.**

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Context for Delivery System Restructuring Efforts: the COVID-19 pandemic

In 2021, the **COVID-19 pandemic*** continued to have ongoing impacts on health care delivery, utilization, and access.

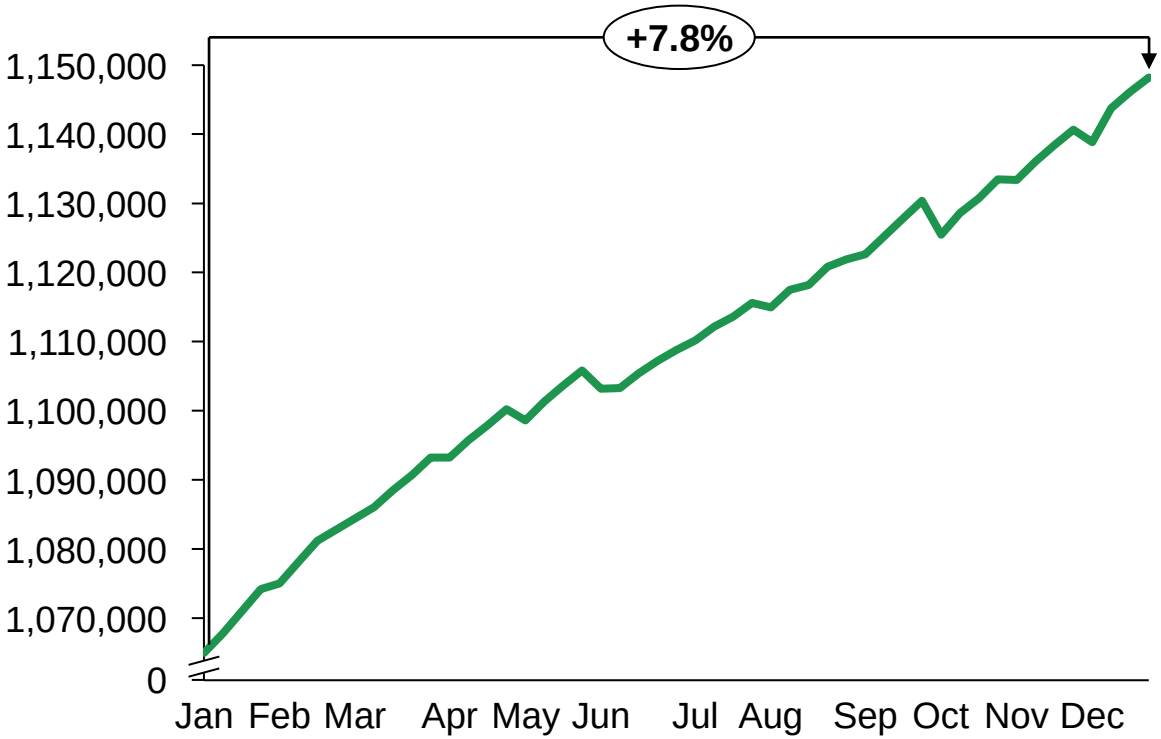
- The pandemic significantly changed underlying factors such as **patterns of care, clinical norms, and MassHealth enrollment.**
- The pandemic also placed a **strain on the healthcare workforce** and resulted in **significant workforce shortages**, leading to challenges with healthcare access. Staff funded through the DSRIP Program were redeployed to support pandemic response efforts.
- **Behavioral and mental health needs rose** as a result of the pandemic, with providers seeing increased demand for BH services. ACOs collaborated with MassHealth to reduce ED boarding and better support members with high BH risk.
- With the roll-out of the COVID vaccine, **ACOs stood up vaccination clinics** tailored to their unique populations, **engaged community organizations** to address vaccine hesitancy, and **outreached members** directly to encourage vaccination uptake. ACOs, Managed Care Organizations (MCOs), and the Primary Care Clinician (PCC) plans achieved similar rates of COVID-19 vaccination.
- MassHealth continued to collaborate with the Centers for Medicare & Medicaid Services (CMS), its ACOs, CPs, and other providers involved in the restructuring efforts, to meet goals, modify program design as necessary, and leverage the innovations and flexibilities to assist with pandemic response.

*Note: this report is not intended to be a comprehensive summary of the COVID-19 pandemic nor of MassHealth or the Executive Office of Health and Human Services (EOHHS) pandemic response efforts. This report focuses primarily on the pandemic and response efforts as they directly relate to the delivery system restructuring, and ACO and associated programs.

ACO Caseload Increased Significantly throughout 2021

2021 weekly snapshots

Average # of members in ACOs*



	Average Members**	% change
2019	888,421	
2020	974,558	9.7%
2021	1,105,665	13.5%

Key takeaways:

- Redeterminations paused in March 2020 and remained paused throughout 2021 due to the federal PHE
- Growth of 7.8% from January 2021 to December 2021
- Average annual membership growth of 13.5% over 2020
- Growth was concentrated in non-disabled groups

*Includes 13 Accountable Care Partnership Plans (ACPPs), which are partnerships between ACOs and managed care plans, and three Primary Care ACOs (PCACOs), which are provider ACOs contracted directly with MassHealth. Excludes MCO-Administered ACOs. See appendix for more information about ACOs.

**January – December 2021 average member months for ACPP and PCACO models. Excludes MCO-Administered ACOs with an average membership of 9,565. Year-over-year % change is restricted to the ACPP and PCACO population.

Key Impacts of the COVID-19 Pandemic on MassHealth Restructuring

Specifically, the **COVID-19 pandemic impacted MassHealth's delivery system** restructuring in four key areas:

1. **Caseload and ACO enrollment continued to increase significantly.**
    - MassHealth paused routine redeterminations of members' eligibility in accordance with federal guidance starting in March 2020, leading caseload to **increase by 10% in 2020, and by an additional 13.5%** in 2021.
2. **Per member utilization and spend were lower compared to 2019,** while **total spend increased** due to increased caseload.
    - Some areas of utilization bounced back from 2020, including ED, outpatient hospital, and primary care indicating **return toward more typical care patterns as the pandemic continued**.
3. **MassHealth and CMS made temporary changes to quality scoring methodology** to account for the pandemic's disruptive impacts on patterns of care and changing clinical guidance.
    - While 2021 data was deemed usable for quality scoring purposes, MassHealth and CMS adjusted quality measure benchmarks for measures with a negative change in median-level performance.
    - In 2021, **ACOs already showed a rebounding of some quality metrics post-2020.**
4. **MassHealth, ACOs, and CPs** pivoted delivery system reform efforts in response to the pandemic, including investments in **telehealth** capabilities, **COVID vaccination**, engaging members in returning to normal care, and addressing **housing and nutrition** needs.

Even in the Context of the COVID-19 Pandemic, MassHealth's Restructuring Efforts Were Already Showing Early Promising Results in 2021

Key examples of progress

- **ACOs strengthened member connection to primary care**. PCP visits were 11% higher for ACOs than non-ACOs on average from 2019 to 2021.
- **ACO members saw greater declines in inpatient admissions*** from 2019 to 2021 where ACOs saw a 16% decline versus a 5% decline for non-ACO members**.**
- **ACOs improved clinical quality.** In 2021, ACOs already showed a rebounding of some quality metrics post-2020 (see p. 43-49)
- **CPs succeeded at engaging the hardest-to-reach members** with complex BH and LTSS needs
  - CPs enrolled ~44,000 unique members in 2021, increased engagement rates over pre-pandemic levels, and sustained improvement on members' cost and outcomes including trends that pre-dated the pandemic's impact on care patterns.
- The **Flexible Services Program**, which provides nutrition and housing support to certain members, saw rapid and substantial growth **increasing the number of unique members served by 70% from 2020**.

*Physical health inpatient admissions, excluding BH admissions

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Delivery System Reform: ACOs

In 2021, ACOs continued to deal with impacts of the COVID-19 pandemic which brought with it increased enrollments, efforts to re-engage members in normal care, and the launch of the COVID vaccine. A few themes emerged during this period:

1. ACOs retained members and **increased enrollment over the course of 2021,** growing to a total average enrollment of 1,115,230 (13% growth over year-end 2020).
2. The ACO program **continued to see utilization declines from 2019 to 2021** driven by ongoing impacts of the pandemic. However, some utilization increases from 2020, including in ED, outpatient hospital, and primary care, demonstrated the **return of some more typical care patterns as the pandemic continued**.
3. **ACOs continued pivoting programs in response to the evolving impacts of the pandemic.** In particular, ACOs rolled out initiatives to vaccinate members for COVID and to address BH ED boarding.
4. With DSRIP dollars declining (as planned in the fourth of five years of the DSRIP program), ACOs further adapted their population health strategies and made ongoing **funding decisions based on demonstrated outcomes and experience of their DSRIP programs.**
5. ACOs made **rapid and substantial growth in the second year of the Flexible Services Program**. Flexible Services quickly became a significant part of ACOs' COVID and population health strategies, with **services provided more than doubling from 2020** *(see next section of this report for detail)*

1 ACOs Retained Members and Increased Enrollment from 2020 to 2021

Enrollment data as of 12/31/21						
ACO Type	**Health Plan**	**ACO Name**	**% of ACO Total**	**# of Average Members***	**% Adults**	**% Children**
Accountable Care Partnership Plans (ACPP)	BMC HealthNet Plan	Boston Accountable Community Alliance	12.6%	140,749	63%	37%
		Mercy Medical Center	2.9%	32,086	59%	41%
		Signature Healthcare	2.0%	22,393	63%	37%
		Southcoast Health	1.8%	19,889	73%	27%
	Fallon Health	Health Collaborative of the Berkshires	1.8%	19,537	74%	26%
		Reliant Medical Group	3.6%	40,062	48%	52%
		Wellforce	5.4%	60,527	54%	46%
	Health New England	Baystate Health Care Alliance	4.0%	44,095	57%	43%
	Allways Health Plan	Merrimack Valley ACO	3.6%	40,344	54%	46%
	Tufts Public Plans	Atrius Health	3.6%	39,961	55%	45%
		Boston Children's Health ACO	10.9%	121,790	4%	96%
		Beth Israel Deaconess Care Organization	3.9%	43,216	74%	26%
		Cambridge Health Alliance	3.1%	34,056	54%	46%
Primary Care ACOs (PCACO)	Community Care Cooperative (C3)		14.1%	157,791	58%	42%
	Mass General Brigham		12.8%	142,215	55%	45%
	Steward Health Choice		13.2%	146,958	56%	44%
MCO-Administered ACO	Lahey Health		0.9%	9,565	91%	9%
ACO Total			**100%**	**1,115,230***	**50%**	**50%**

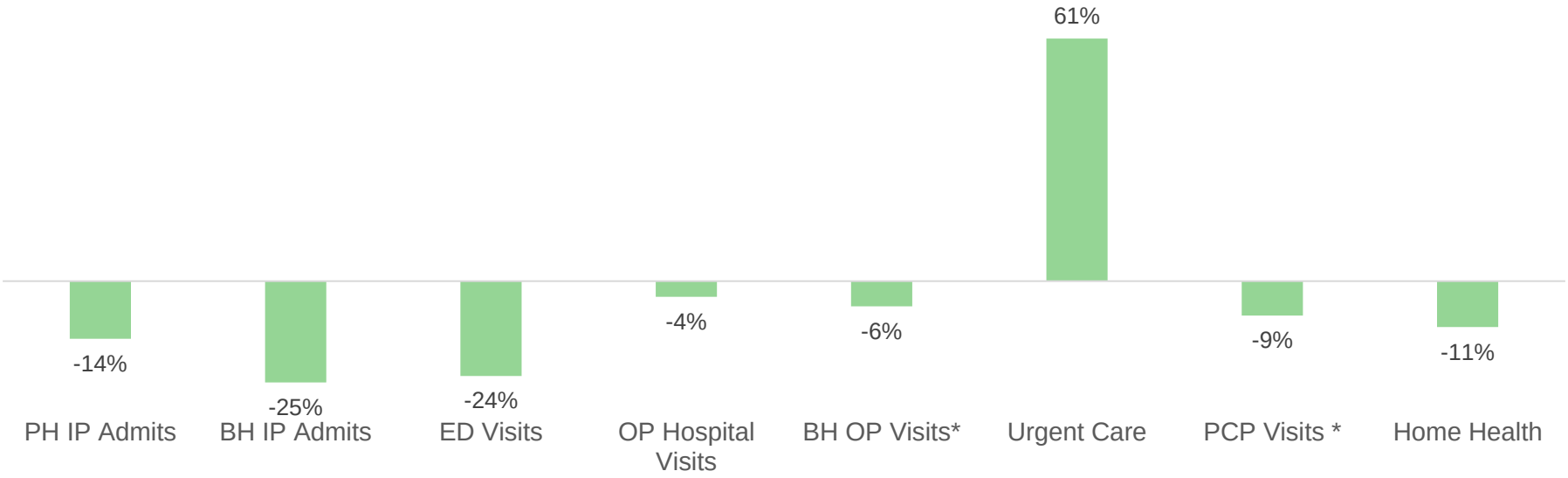
Enrollment as of 12/31/21, data pulled on 05/31/2023; MCO-administered ACO data pulled on 09/22/2023
*Note this reflects average members enrolled; see appendix (p. 65) for total unique members enrolled by managed care option.

13% growth over year-end 2020 ACO enrollment (986,914)

2 There Were Significant Market-Level Utilization Shifts When Comparing 2019 to 2021

- Most services continue to see utilization declines from 2019, **ranging from -4% to -25%.**
  - Urgent Care saw a 61% increase due to removal of referral requirements for certain plans and overall changes in patterns of care.
- The utilization rates below reflect **ongoing pandemic impacts** (e.g., holds on elective procedures during COVID spikes and overall lower acuity of the population).
- While rates are generally down from 2019, **some services are seeing increases over 2020 including ED, Outpatient Hospital, and Primary Care with increases of 5%, 24%, and 9%**, **respectively** (see Appendix slide 67)**.** This indicates a return of some normal care as the impact of the pandemic lessened.

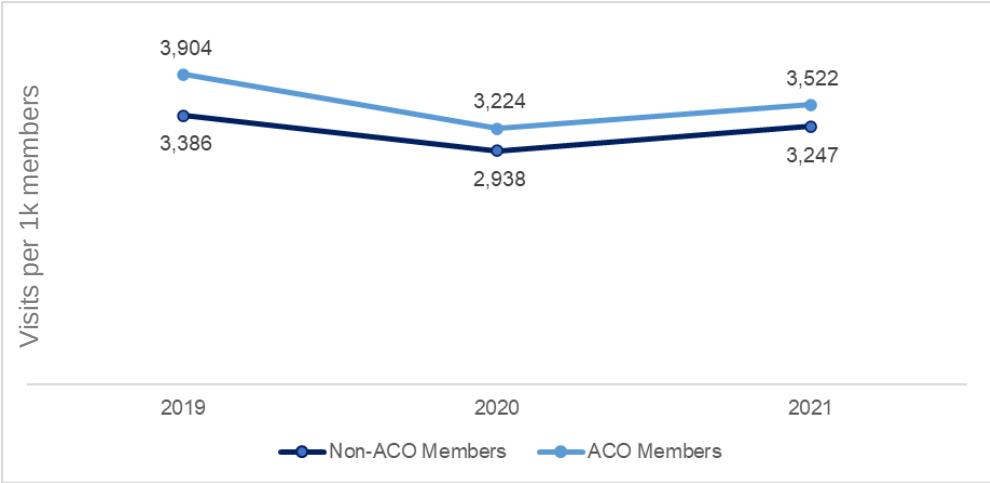
2019-2021 Market-Level Utilization Trends



*Includes in-person visits and visits delivered via telehealth. Includes ACO, MCO and PCC Plan utilization. See appendix for comparison of 2021 to 2020.
Note: Utilization trends do not reflect the impact of temporary rate increases implemented in response to the COVID-19 PHE

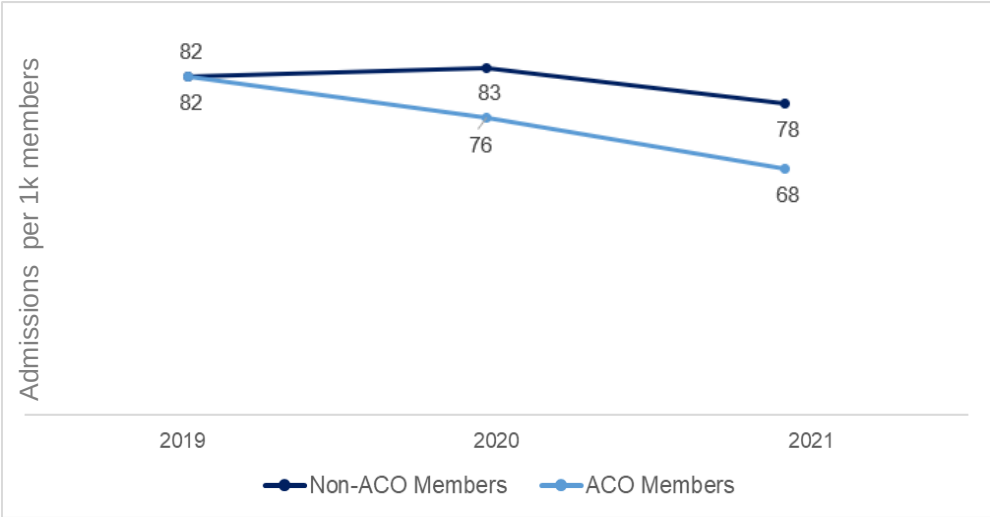
2 Members in ACOs Have Retained Higher Rates of Primary Care and Achieved Sharper Declines in Physical Health Inpatient Admissions

2019-2021 PCP Visits



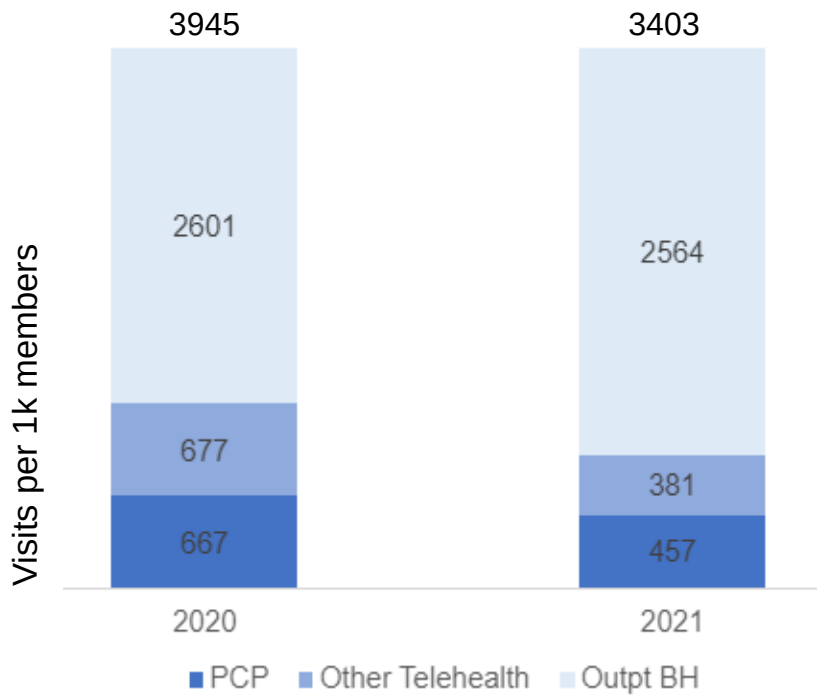
- From 2019 to 2021, PCP visits remained higher among ACO members than non-ACO members.
  - **PCP visits were higher among ACO members by 11% on average**.

2019-2021 Physical Health Inpatient Admissions



- ACO members saw greater declines in Physical Health (PH) Inpatient Admissions from 2019 to 2021 compared to non-ACO members.
  - From 2019 to 2021, **ACOs saw a 16% decline in PH inpatient admissions versus a 5% decline for non-ACO plans.**

2 Telehealth Utilization for Outpatient BH Services Remained Consistent while Telehealth Utilization for PCP and Other Services Declined from 2020 to 2021 for ACO and Non-ACO Members



- Health care providers **pivoted to services delivered via telehealth** amidst the pandemic in 2020 and 2021.
  - Telehealth rates were 0.005 visits per member in 2019.
- Telehealth utilization did not vary significantly between members enrolled in ACOs and those enrolled in other managed care plans.
- **Outpatient BH services** accounted for ~75% of total telehealth utilization for ACO and non-ACO members in 2021.

3 ACOs Continued to Focus on COVID Response Efforts and Rolled Out Many Initiatives to Drive Vaccination Efforts

ACOs developed robust outreach and engagement strategies for vaccination, with ~47% of ACO members fully vaccinated for COVID-19 in 2021.*

Vaccination Clinics

ACOs stood up various types of **vaccination clinics to best serve their unique populations**. These included pop-up clinics at community events, ambulatory vaccination clinics and key community sites such as schools and churches.

Example - Tufts Cambridge Health Alliance: Leveraged internal data to identify clusters of un-vaccinated individuals and set up community-based vaccination clinics twice per week.

Community Engagement

Through strategic partnerships, ACOs **engaged community organizations to address vaccine hesitancy** by connecting members to trusted community members.

Example - My Care Family: Regularly met with a vaccination coalition in Lawrence consisting of medical practitioners, health plan representatives, public health officials and others. This led to coordinated and comprehensive vaccination efforts across the Lawrence area.

Direct Member Outreach

ACOs and their partners **continued to engage in direct member outreach** to encourage vaccination uptake and inform members of their options.

Example - Fallon Health: Implemented communication campaigns (including text campaigns and direct phone calls) targeted at un-vaccinated members in high-risk locations. This was coupled with outreach efforts from member care teams and case workers.

*COVID-19 vaccination rates in 2021 were similar for ACO, MCO, and PCC plan members, at 47.4%, 49.3%, and 47.2%, respectively.
Source: Massachusetts Immunization Information System (MIIS), data pulled on January 4, 2022.

3 ACOs Collaborated with MassHealth to Address BH ED Boarding and Better Support Members with High BH Risk

- In 2021, Massachusetts experienced a large volume of members presenting in EDs seeking inpatient BH care. One of the key drivers identified was that members who were discharged would routinely return to the ED and, due to a shortage of beds for longer term placements, would spend prolonged periods of time awaiting placement.
- MassHealth initially worked with ACOs to establish a definition for members to be identified as having a high BH risk and to track ED admissions and outcome measures and develop performance management actions.
- Although the initial definition was found to be too broad and was updated, the interactions with the plans led to a better understanding of member outcomes and served as the building block to develop a more robust engagement and performance management strategy for 2022 and 2023.

Example: MGB implemented a pilot program to better address ED Boarding.

The program sought to support patients in adhering to their post-discharge treatment plans and help prevent re-admissions by providing education and real-time guidance about emergency service utilization. This was done by:

Improving patient identification by leveraging electronic portals for knowledge of when a patient is admitted, discharged or transferred for a primary psychiatry diagnosis

Enhancing communication between hospital and ambulatory care teams to support care planning, including working with emergency department navigators and inpatient care management teams in hospitals in and outside the MGB system to build relationships for improved patient care

Providing patient support post-discharge to identify and remove barriers to treatment adherence, follow-up with BH treatment and connect back to primary care for those with medical care needs

4 DSRIP Strategies Continued to Mature, with ACOs Targeting Investments in Programs with Demonstrated Outcomes

- As time-limited DSRIP funding declined in each successive year of the reform, ACOs evaluated and compared their DSRIP-funded investments to make data-driven choices about which to scale/sustain and which to sunset.
- ACO DSRIP spending was at its highest in 2018 ($189.3M) and continually decreased in the years since then as expected ($173.7M in 2019, $135.7M in 2020, $87.5 in 2021) as ACOs decreased spending on Integration Projects and Data Analytics, Population Health, and HIT Projects.
- In 2021, when making decisions on funding for DSRIP supported programs, **ACOs were required to tie a program's demonstrated outcomes with funding decisions** and if the program had not shown positive outcomes justify the ongoing investment in the program.

Example: In 2021, BMC-Signature continued DSRIP investment in their Complex Care Management (CCM) program based on demonstrated reductions in inpatient and ED visits

- The CCM program at Signature was designed to deliver increased clinical effectiveness and efficiency by providing integrated and holistic care management for high-risk-and-cost patient populations.
- The program was evaluated and showed positive outcomes on two measures compared to baseline for graduated members: 1) inpatient utilization decreased by 50% and, 2) ED utilization decreased by 44%.

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Flexible Services Program: Summary of 2021 Progress

- The Flexible Services Program allows ACOs to pilot innovative programs to provide nutritional and housing supports, with the goal of improving overall member health and outcomes

- The Flexible Services Program was **one of 2021's key successes.** In its second year, the program experienced **rapid and substantial growth, became more efficient,** and demonstrated **promising early outcomes**

- The Flexible Services Program **grew faster in 2021 when compared to 2020, providing more services to more members.**

    - **Services* provided more than doubled** (2020: 9,673; 2021: 21,051) along with a **70% increase in unique members** served (2020: 6,133; 2021: 10,466)

    - In 2021, the **cumulative dollars spent on Flexible Services supports doubled** from $3.4M in Q1 to $7.1M in Q4

- Despite being early in implementing the Flexible Services Program, preliminary analyses of individual Flexible Services programs had already begun to show **improvements for members with diabetes (reductions in A1c) and total cost of care**

*MH defines Flexible Services in terms of member-quarters or number of quarters members have received services. A unique member that received services across 4 quarters would count towards 4 services provided.

ACOs Partnered with SSOs to Offer 76 Flexible Services Programs in 2021

- In 2021, ACOs partnered with community-based Social Services Organizations (SSOs) to offer **76 Flexible Services programs** focused on nutrition and housing support services and goods.
- Compared to 2020, both the number of available programs and partnerships between ACOs and SSOs **increased by approximately 25%.**

ACOs and SSOs launched 76 programs in the following domains in 2021:

- 37 Housing
- 38 Nutrition
- 1 Housing/Nutrition

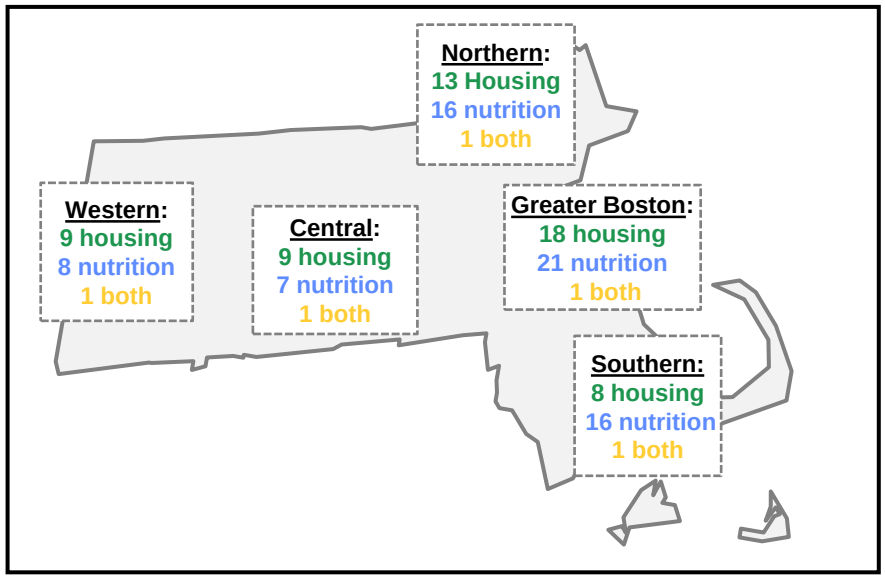
ACOs partnered with **38 SSO partners** to deliver Flexible Services in 2021, including:

- 22 Housing SSOs
- 13 Nutrition SSOs
- 3 Housing/Nutrition SSOs

All **17 ACOs offered at least 1 Flexible Services program** in calendar year (CY) 2021.

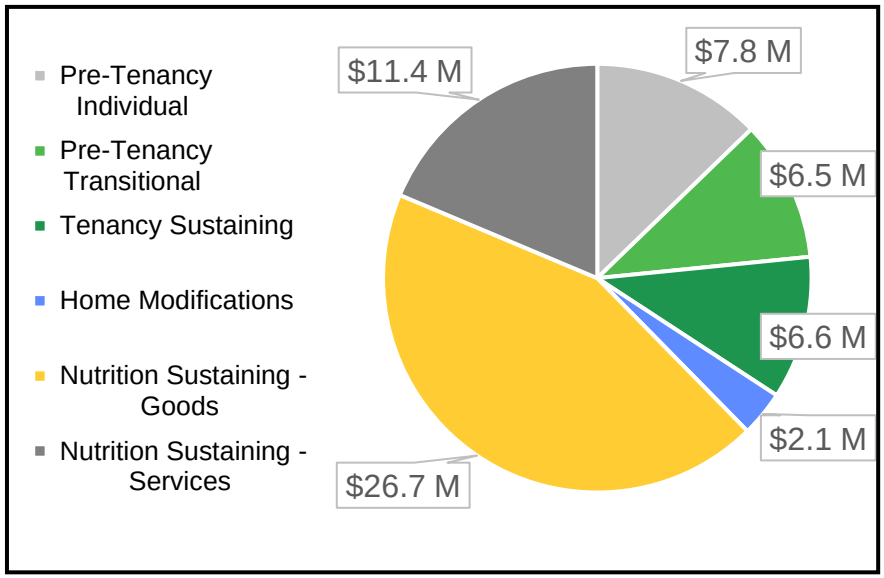
ACOs implemented Flexible Services in every geographic region of the state, across the full breadth of supports allowed by the program

Number of Flexible Services Programs Serving Each Region By Domain



Note: Several programs operated across more than one region of the Commonwealth and are counted more than once above.

Flexible Services Program Funding Breakdown by Sub-Domain ($M)

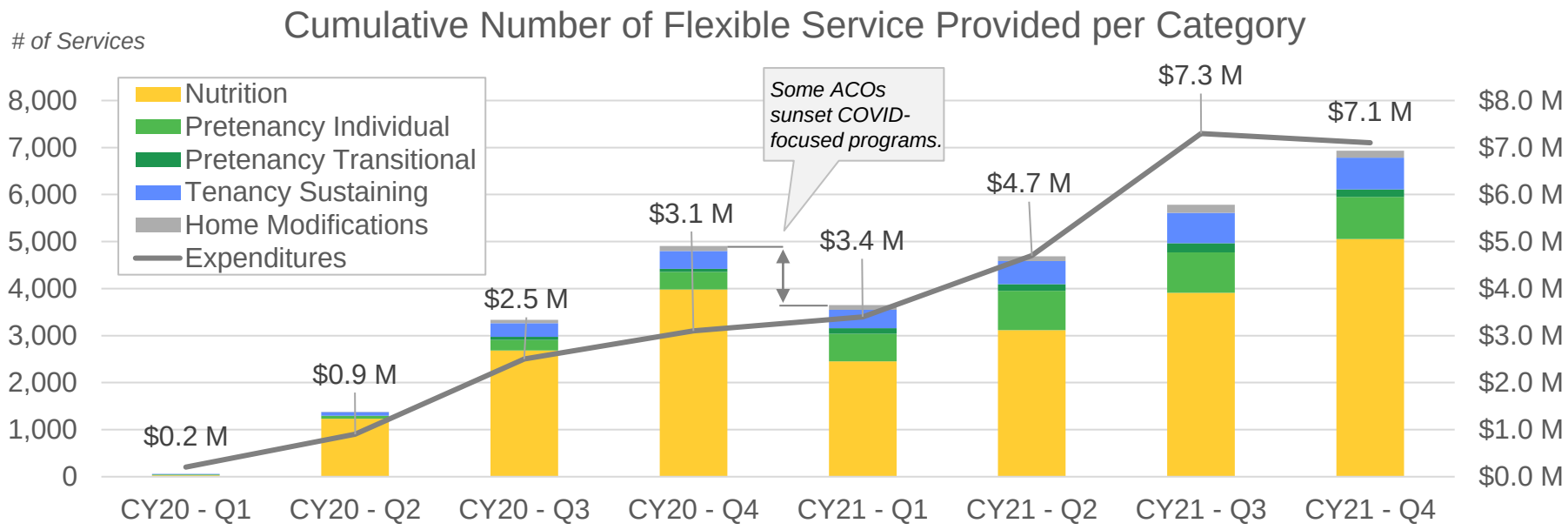


Total CY21 Allocated Funds with rollover: $84.8M
Total CY21 Allocated Funds without rollover: $38.2M
Total Budgeted in CY21: $61M
% Budgeted of Total Allocation with rollover: 72%

In 2020 and 2021, there was continuous growth in Flexible Services uptake each quarter

- **Flexible Services expenditures more than tripled** from CY20 to CY21 ($6.8M to $22.6M), corresponding to a **70% increase in unique members served** (6,133 to 10,466).
- Cumulatively across CY20 and CY21, almost **31,000 Flexible Services were provided to almost 14,400 unique members.***

Flexible Services	# of Members Served		$ Spent	
	Total CY20	Total CY21	Total CY20	Total CY21
# of Unique Members / $ Spent per year	6,133	10,466	$6.8M	$22.6M
# of Unique Members / $ Spent Across All Quarters	14,397		$29.4M	



* MH defines Flexible Services in terms of member-quarters or number of quarters members have received services. A unique member that received services across 4 quarters would count towards 4 services provided.

Flexible Services: Early Promising Results

In 2021, individual ACOs and SSOs were already seeing early improvements in clinical and social outcomes, costs, and utilization. As the Flexible Services Program progresses, MassHealth will closely track results and evaluate if specific interventions/models are more impactful than others.

***ACO Highlight*: Community Care Cooperative** *observed encouraging initial impacts on health outcomes, cost, and utilization based on their CY2021 members served.*

- **Clinical Improvements**: members receiving home-delivered medically-tailored meals (MTM) in first half CY21 saw positive trends including:
  - **Average reduction in hemoglobin A1c levels (HbA1c) of 0.9%,** from 9.3% to 8.4% (p=.001)
  - More members achieved goal of reduced HbA1c: **71% of members had HbA1c >9.0% prior to receiving MTM vs 38% of members after 7 months**
  - Members with HbA1c >9.0% prior to enrollment had greatest improvement: **49% saw a reduction in their HbA1c to achieve goal of <9.0% within 7 months of starting MTM**. The average decline in HbA1c for those members was 2.4%
- **TCOC Reduction: $5,552 reduction in annualized TCOC** for members who received nutrition supports (p<0.001).

***SSO Highlight*: Project Bread** *observed positive initial impacts on food security and fruit and vegetable consumption based on their CY2021 members served.*

- **Social Improvements**
  - **25.1% decrease in member reported food insecurity (p<.001)** for members receiving nutrition services (N = 486) for 6 months, (services include nutrition education, food vouchers, coordination, transportation)
  - **29.2% increase in the availability of appropriate/healthy food (p<.001)** reported by members receiving services for 6 months (N= 466)

Note: different "N's" result from variations in survey completeness for initial and 6-month assessments.

Increased fruit and vegetable consumption	*N*	*Change after 6 months*
Fruit consumption	483	1/3 serving increase
Vegetable consumption	481	1/4 serving increase

Flexible Services: Early Promising Results (Continued)

ACO Highlight: Berkshire Fallon Health Collaborative observed encouraging initial impacts on housing status based on their CY2021 members served.

Housing Placement and Maintenance:

- Berkshire's Tenancy Preservation Program and Housing Support Intervention Program reported **84% and 92% of members successfully housed** in their programs, respectively (n=16 and n=23).
- In further results from the above programs, **79% and 84% of members maintained housing for 6 months** after placement (n=15 and n=21).

Member Story: Positive Social Outcomes

A member facing various challenges regarding housing (e.g., in need of financial assistance and guided support for the housing search process) was referred by Berkshire to a housing program. This program successfully provided the member:

- Assistance with **housing search** and **placement** (e.g., applications submitted for subsidized housing)
- **Assistance with obtaining additional financial resources** (e.g., applications for financial assistance were submitted and approved for rental arrears and future rental stipends)
- **Continued guidance and connection to community resources** (e.g., referred into food delivery program)

SSO Flexible Services Preparation Fund

The SSO Flexible Services Preparation Fund was a grant program launched in 2019 to support infrastructure and capacity needs of SSOs participating in the Flexible Services Program.

Purpose:

- In collaboration with the Massachusetts Department of Public Health, the Fund supports qualified SSOs participating in the Flexible Services Program by **funding investments in technology, data exchange, business practice elements**, and other areas where close collaborative communication with ACOs is needed
- Lead **learning communities** where SSOs and ACOs can **enhance learning and skills development**, as well as **strengthen networks**, so that organizations can more effectively carry out the goals of the overall Flexible Services Program

By the end of 2021:

- **19 SSOs** received a total of **$3.9M to design and implement referral systems,** provide **timely, culturally appropriate care, and collaborate on the design and implementation of communication and data tracking systems**
  - An SSO reflected on the support it received through the Preparation Fund - *"There is no way we could have undertaken [the Flexible Services Program] without the financial support. Even though the idea of integration of systems would be on our wish list, that would not have happened on a short term because we would not have had resources."*
  - At the end of the grant period, **17 of the 19 SSOs** were receiving referrals, enrolling those referrals into Flex Services programs, and reporting back to the ACOs information on participants. This was **an increase from 9 SSOs at baseline**.

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Community Partners: Summary of 2021 progress

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

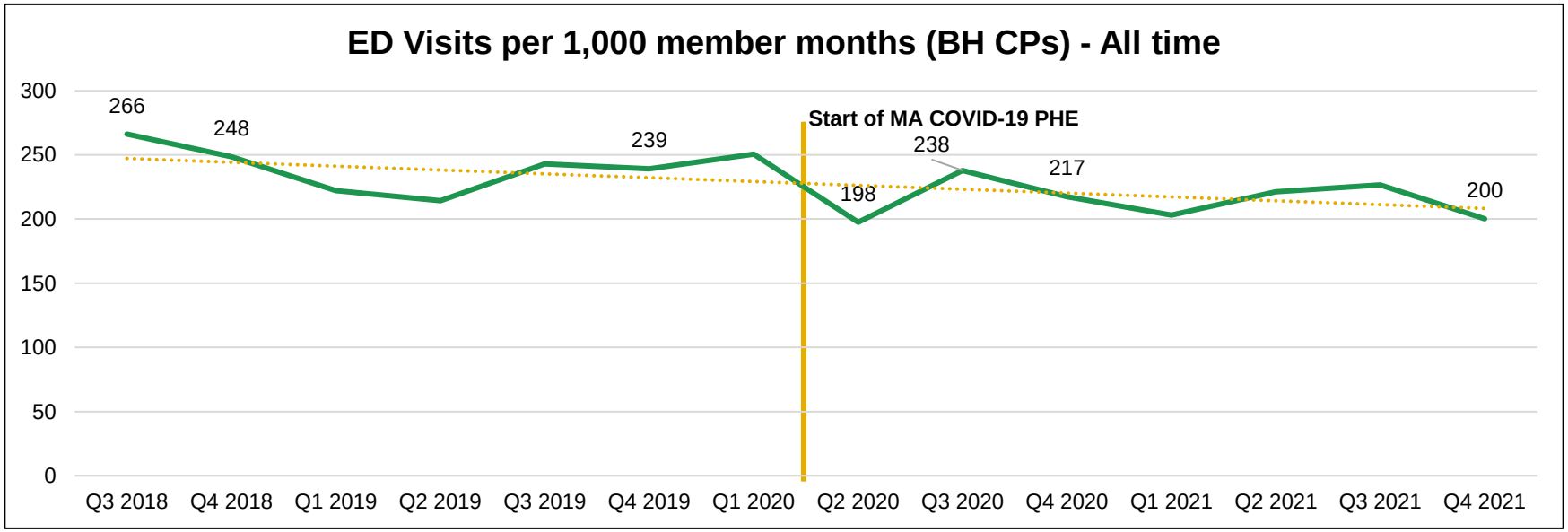
- In 2021, the CP program continued to see positive trends in utilization and cost measures, including:
  - Between 2018 and 2021, there was a 25% reduction in ED visits and a 40% reduction in BH inpatient admissions among members enrolled in the BH CP program*
  - Data also show that reductions in ED and BH inpatient utilization rates correlate with longer enrollment in the CP program
  - Risk-adjusted TCOC was 19% lower for BH CP members following graduation from the CP program vs. members in the 12 months preceding enrollment
  - However, these observed reductions may be confounded by overall utilization declines driven by the pandemic and changes in the CP population over time.

- 2021 continued to present **many of the same COVID-19 related challenges** of 2020, including:
  - Transitioning care coordination relationships to telehealth modalities
  - Increased health and social needs among members
  - Staffing challenges
  - New barriers to communication with providers (e.g., accessing PCPs)

- In spite of these challenges, CPs continued to make **gains in member outreach and engagement**. During 2021, CPs:
  - Enrolled ~44,000 unique members
  - Increased the annual engagement rate** of actively enrolled members from 53% to 58%
  - Reduced the statewide average days to a complete care plan (a key indicator of successful coordination with PCPs) from 176 to 152 days (14% reduction)

*Comparing ED utilization and BH inpatient admissions of members enrolled in BH CP in Q3 of 2018 to members enrolled in BH CP in Q4 of 2021
**Engagement rate represents the % of members enrolled at least 1 day in that month who had a Care Plan completed within the past 12 months

ED visits among BH CP members continued to decline since the start of the program

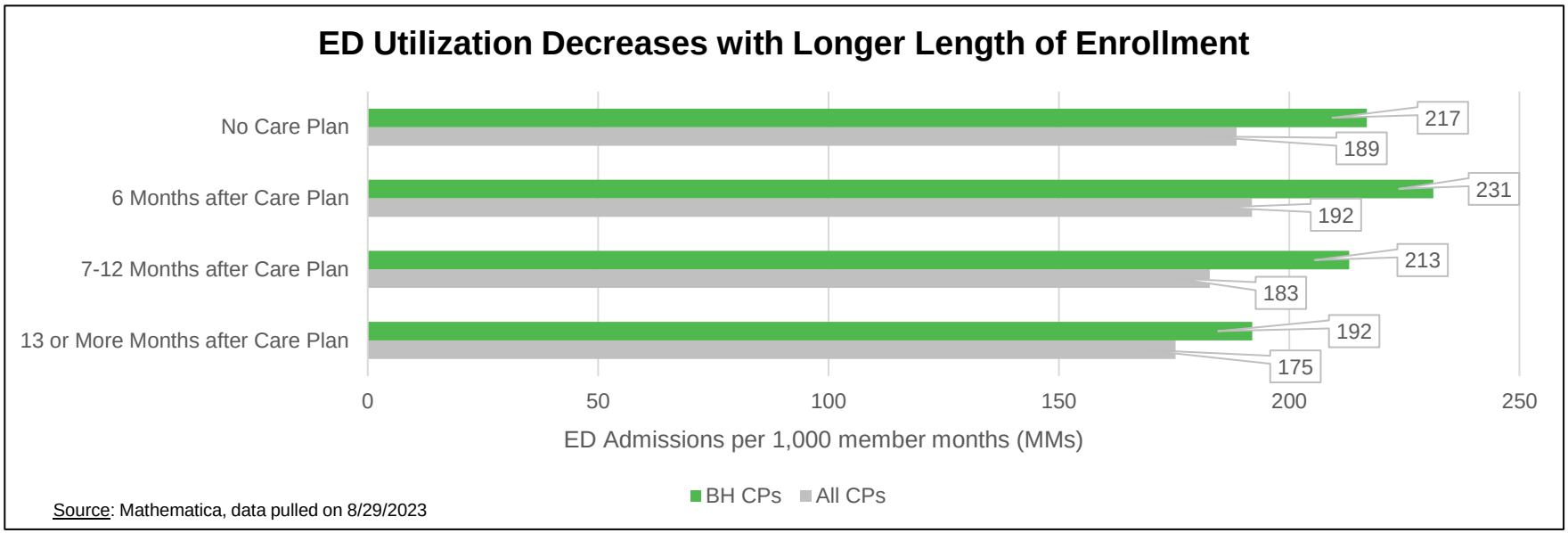


Source: Mathematica, data pulled on 8/29/2023 reflecting the ED utilization of members receiving BH CP services by quarter.

- **ED visits have continued to decline among BH CP members** since the start of the program, from 266 ED visits per 1,000 member months in Q3 of 2018 to 200 ED visits by Q4 of 2021.
- Since the start of the program (from Q3 of 2018 to Q4 of 2021), the BH CP Program saw a **25% reduction** in ED visit utilization among BH CP members.*
- In 2021 (from Q4 of 2020 to Q4 of 2021), the BH CP Program saw an **8% reduction** in ED visit utilization among BH CP members enrolled in 2021.

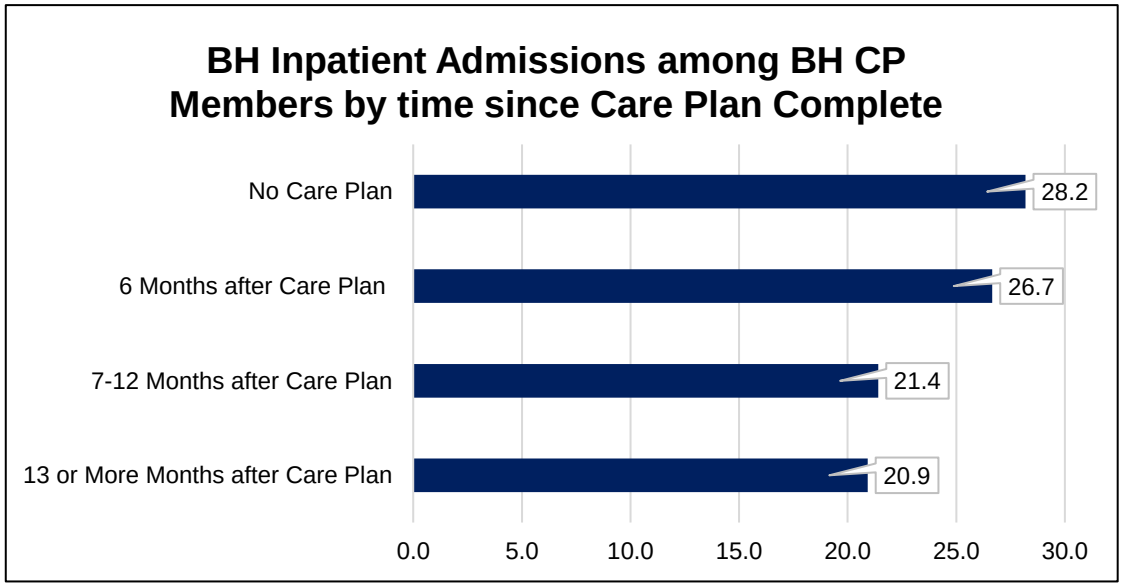
*Comparing ED utilization of members enrolled in BH CP in Q3 of 2018 to members enrolled in BH CP in Q4 of 2021

In 2021, there was a 12% reduction in ED Utilization from the start of their enrollment to 13 months or more after a Care Plan among BH CP members



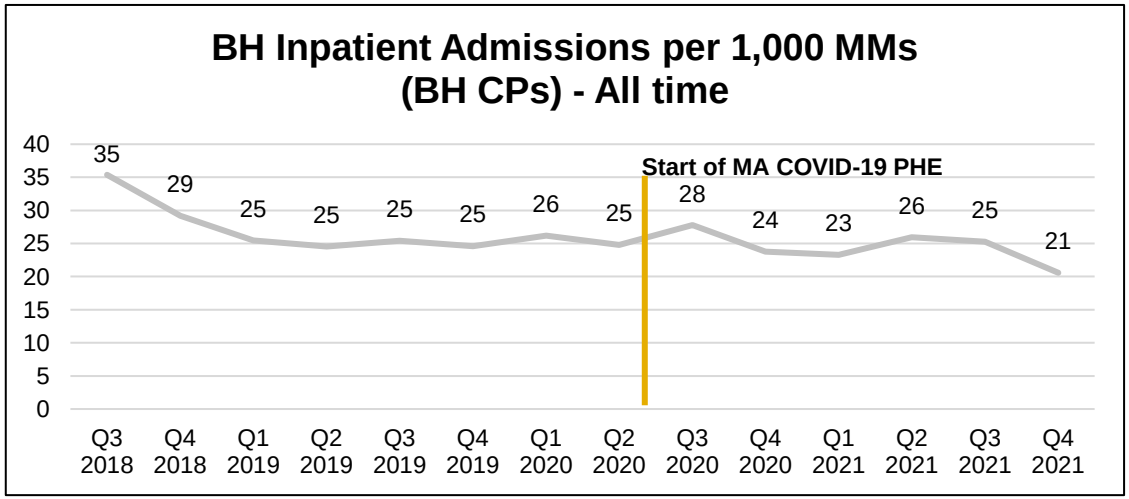
- In 2021, there was a **17% reduction in ED utilization** among BH CP members between 6 months after a Care Plan (231 admissions/1K MMs) and 13 or more months after a Care Plan (192 admissions/1K MMs).
- There was also a **12% reduction in ED utilization** from the time a BH CP member was enrolled (217 admissions/1K MMs) to when the member reached 13 months or more after a Care Plan (192 admissions/1K MMs).
- Overall, **the longer a member is enrolled in the CP Program, the less utilization of the ED** they had, despite an initial increase in ED usage at the beginning of their enrollment.

In 2021, BH inpatient admissions continued to decline among BH CP members, reaching a 24% reduction correlated with length of enrollment in BH CPs



Source: Mathematica, data pulled on 8/29/2023

CP members have a significant decrease in inpatient admissions once they have reached 7 months of enrollment and have a completed care plan. **In 2021, BH CP members had a 24% reduction in BH inpatient admissions from the time they were enrolled to reaching 7-12 months after a Care Plan.** This is maintained the longer CP members remain enrolled with the CP Program.

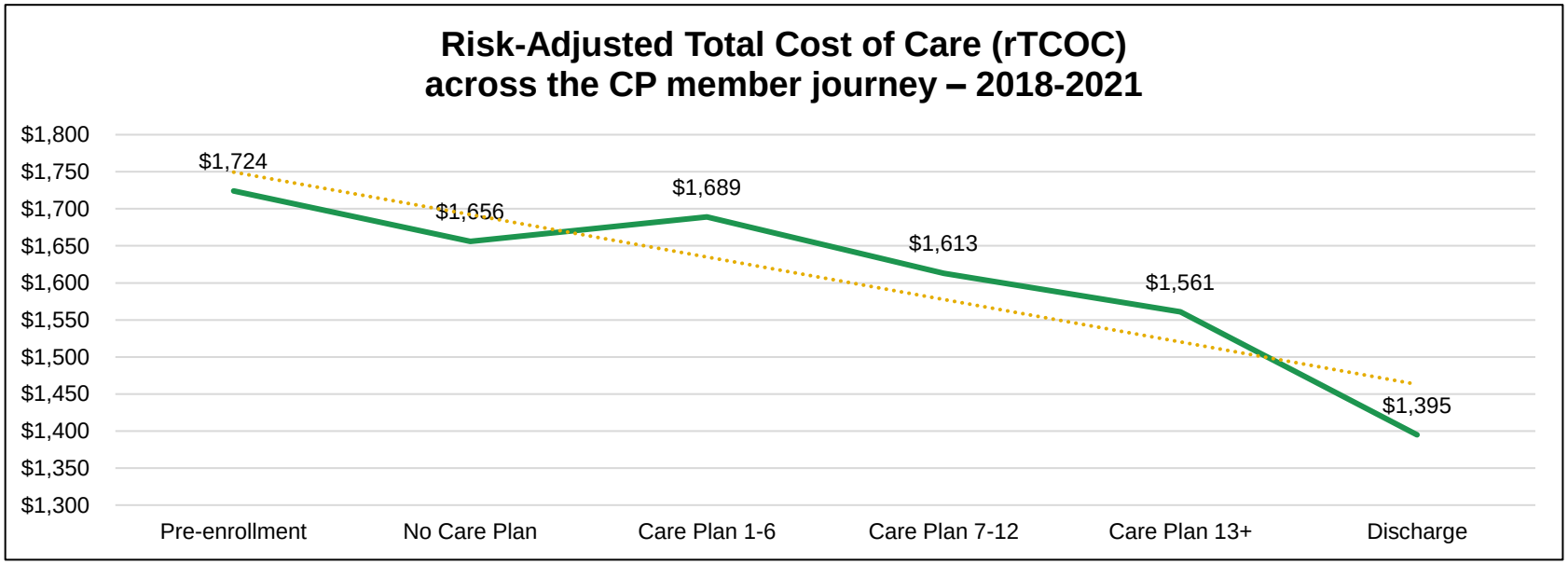


In 2021, **BH inpatient admissions among BH CP members declined by 9%,** from 23 admissions per 1,000 MMs in Q1 to 21 admissions per 1,000 MMs in Q4.

Since the start of the program (Q3 2018 to Q4 2021), there was a **40% decline in BH inpatient admissions among BH CP members**

Source: Mathematica, data pulled on 8/29/2023 reflecting the BH inpatient admissions of members receiving BH CP services by quarter.

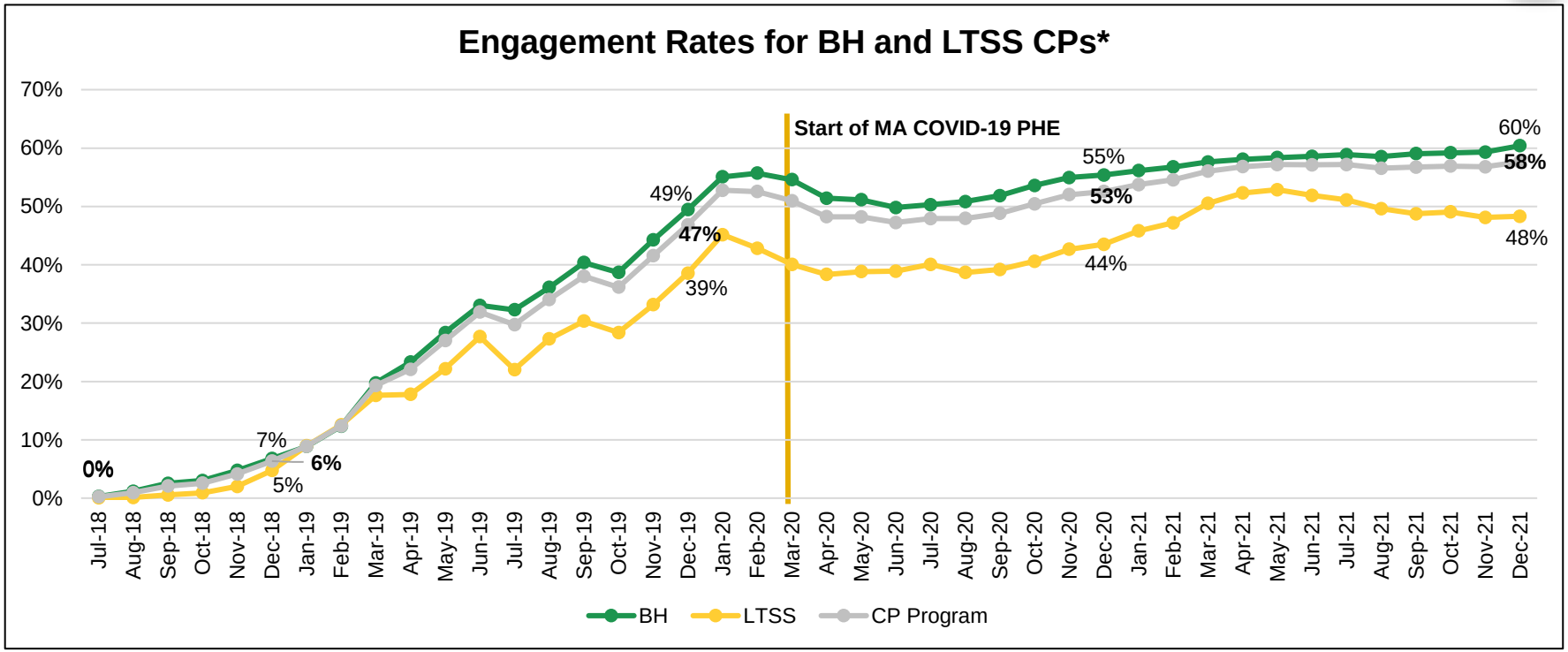
Risk-Adjusted Total Cost of Care (rTCOC) continued to decline in 2021 the longer CP Members are engaged in the CP Program



Source: Mathematica, data pulled on 8/29/2023

- rTCOC is the average amount paid on claims by Medicaid and ACOs/MCOs per CP member per month, risk adjusted within the CP population and excluding members who are dually-eligible for Medicaid and Medicare.
- This graph represents all CP members enrolled in the program between 2018 – 2021 and shows the change in rTCOC throughout their time enrolled in the program.
- Overall, **rTCOC decreases throughout the time that CP members are engaged with a CP**
  - On average, CP members have a **19% lower rTCOC** upon discharge compared to CP members in the 12 months prior to enrollment ($1,395 vs. $1,724).

CP member engagement continued to improve during 2021

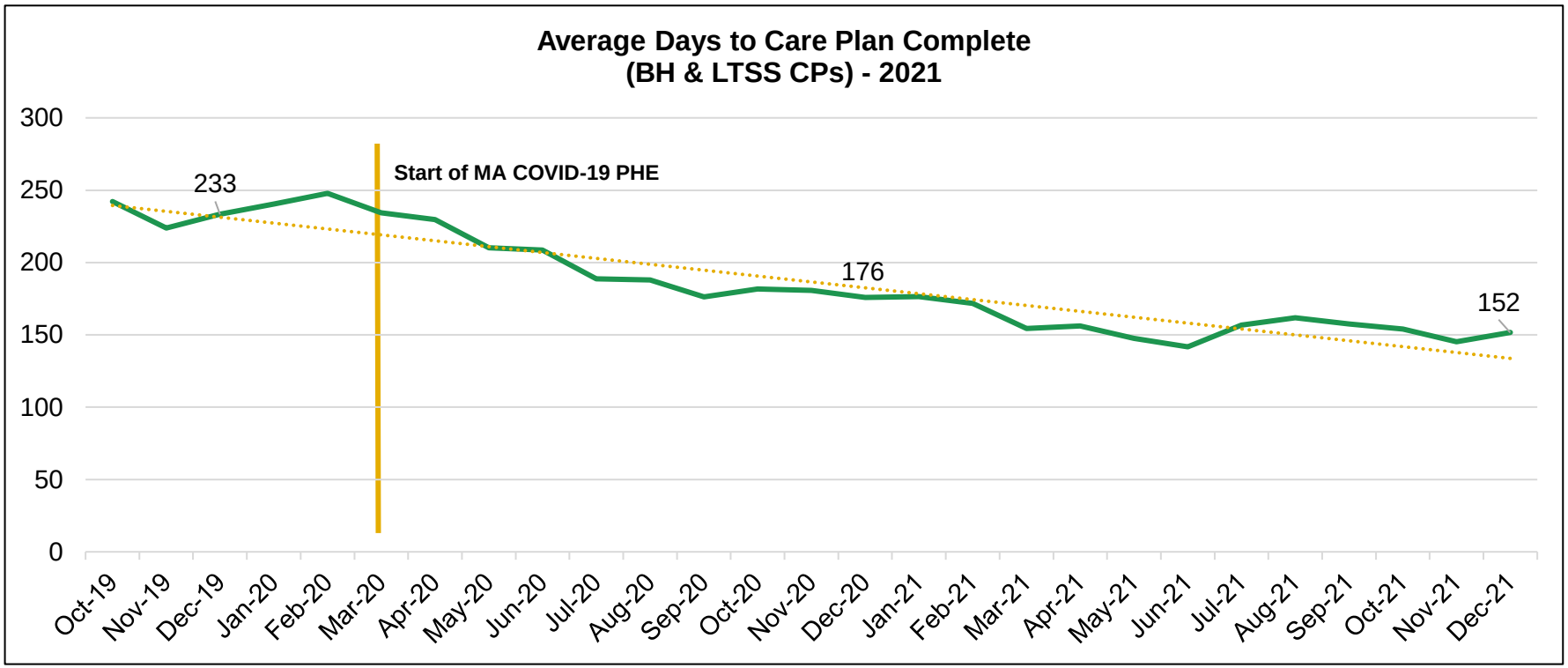


Source: Data Warehouse, April 3, 2023

- As of December 2021, **58% of members enrolled in CPs were engaged***
- This is an **increase from 53%** in December 2020, 47% in December 2019, and 6% in December 2018, the year the CP program launched.

*Engagement rate represents the % of members enrolled at least 1 day in that month in a CP, who had a Care Plan completed within the past 12 months. Members who have been disenrolled from the program in a given month are not included in the denominator for that month.

CPs reduced Days to Care Plan Complete in 2021, building on improvements in outreach and engagement from 2018-2020



Source: Mathematica, data pulled on 8/29/2023

- CP members are considered engaged in the CP Program once their Care Plan is completed and approved by their PCP. The Days to Care Plan Complete measure provides insight into how quickly and efficiently CPs are conducting outreach and engaging members and coordinating with other members of the care team

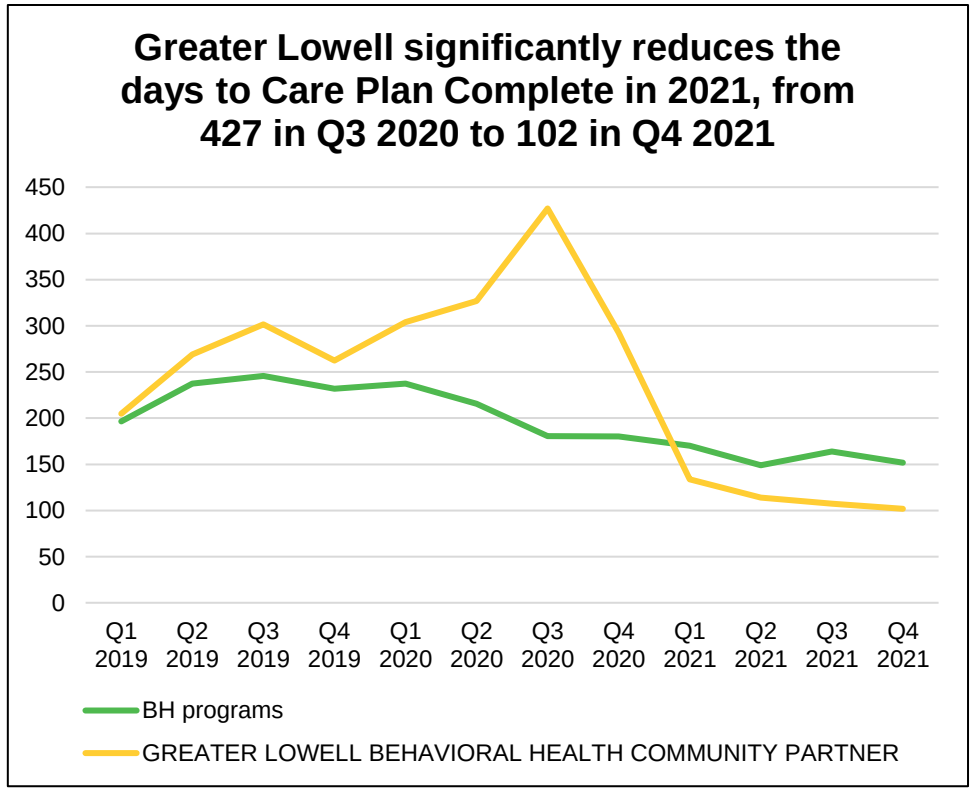
- During 2021, **CPs continued to bring down the average number of days to Care Plan Complete**, from 176 days in January 2021 to 152 days in December 2021.

Examples of CP Success: Lowell Community Health Center Improves Member Engagement Timelines

In 2021, MassHealth engaged with the Lowell Community Health Center, Inc. (Greater Lowell) BH CP around performance data related to engagement and care plan complete timelines. As a result of these engagements and reviewing MassHealth-provided performance data, Greater Lowell CP developed a strategy to focus on decreasing time from enrollment to Assessment and Care Plan milestones.

Strategies implemented:

- Tighter roster management processes
- 5-day turn-around timeline expectations with nurses for review of comprehensive assessments and care plans
- Review of care plan status at each touchpoint with Members
- Member incentives, such as gift cards, for completing program milestones such as care plan and follow up after discharge
- Improved escalation processes with ACO/MCOs for outstanding care plan reviews and signatures



Source: Mathematica, data pulled on 8/29/2023

These strategies resulted in **over a 300-day reduction and sustained improvement in the days to Care Plan Complete** for their BH CP members from 427 days in Q3 2020 to 102 days in Q4 2021

Contents

Overview of DSRIP Program

- The **Delivery System Reform Incentive Payment (DSRIP)** program is a **$1.8 billion**, five-year investment program authorized through MassHealth's 1115 demonstration to support MassHealth's restructuring efforts

- ACOs and CPs used 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**

- In CY2021, **ACOs and CPs spent $205.4M** in DSRIP funding:
  - **$110.1M** by ACOs (Startup/Ongoing: $87.5M; and Flexible Services: $22.6M)*
  - **$95.3M** by CPs (Infrastructure and Care Coordination)

- The most common type of DSRIP-funded ACO program in CY2021 was **care coordination and care management programs** (338 programs costing $49M; e.g., embedding community health workers in EDs to help members navigate the health care system and share resources upon ED departure)**

- From 7/1/18 to 12/31/21, ACOs and CPs cumulatively spent **$962.8M** in DSRIP funding:
  - **$673.4M** by ACOs (Startup/Ongoing and Flexible Services)
  - **$289.4M** by CPs (Infrastructure and Care Coordination)

- Additionally, **$5.2M of DSRIP funding was used for Statewide Investments in 2021** to support workforce development (training, hiring, retention), technical assistance for ACOs and CPs, and related initiatives.

See Appendix for detailed DSRIP funding charts by ACO, CP, and Statewide Investments programs

*Certain ACOs also received an additional $100.3M for safety net hospital (Delivery System Transformation Initiative) glide-path funding from the beginning of DSRIP through 12/31/2021.

**See p. 37-38 for additional details on how ACOs and CPs utilized their DSRIP funding

2021 DSRIP Investments: by the Numbers

778

# of different ACO investments/programs supported by DSRIP

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

$65.5M

$ spent on personnel/staff by ACOs

- Significant investment in workforce (e.g., care coordinators, community health workers, IT staff) to support ACO efforts

$14.5M

$ spent on infrastructure by CPs

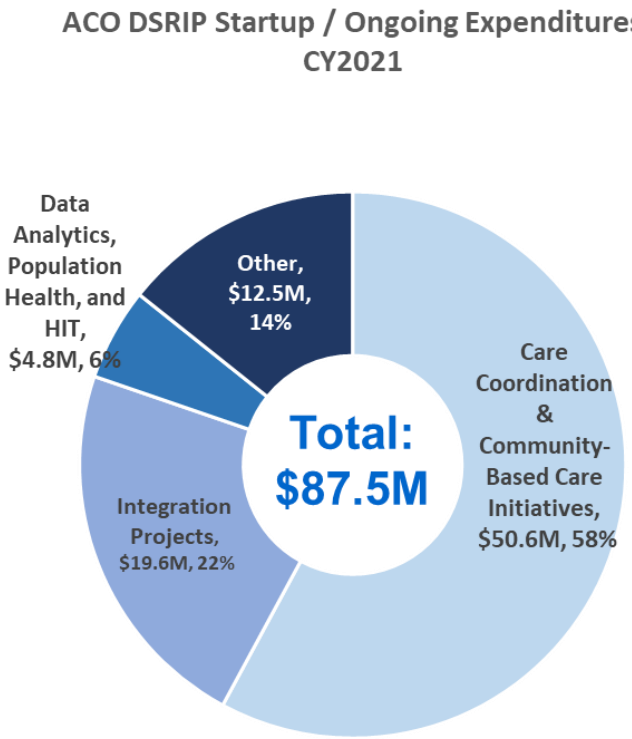
- Build out infrastructure to implement CP program, such as establishing workflows, integrating electronic systems, purchasing tablets to facilitate in-person connections, etc.

$80.9M

$ paid to CPs for care coordination supports

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

ACO DSRIP Startup / Ongoing Investments: Overview by Category

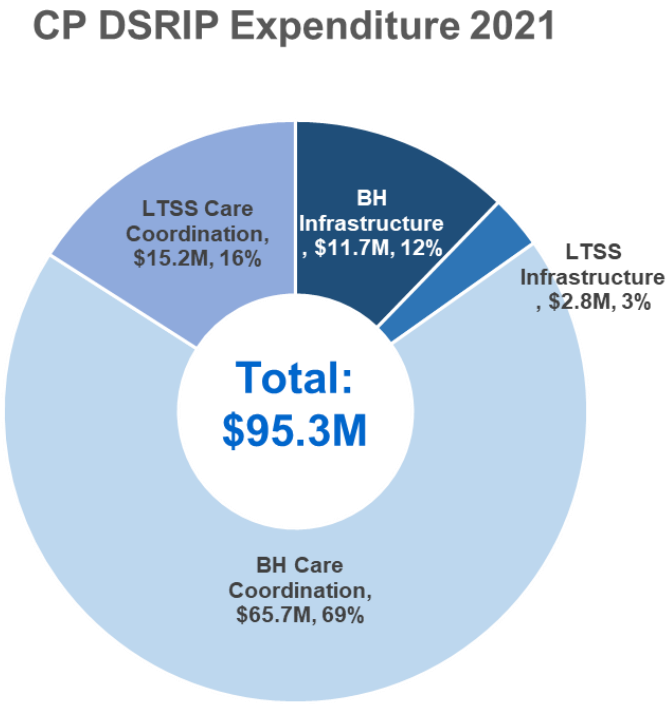


CY2021 Startup/Ongoing expenditure data ($87.5M) reflects a decrease from the CY2020 report ($135.7M), which corresponds with an overall decrease in DSRIP funding provided to ACOs. ACO DSRIP allocation percentages by category remained relatively constant between 2020 and 2021.

- **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

*Expenditures do not include ACO Delivery System Transformation Initiative (DSTI) or ACO Flexible Services Expenditures; See appendix for DSRIP funding per ACO.

CP DSRIP Investments: Overview by Category



- **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.

CY21 expenditure data ($95.3M) reflects an increase from CY20 expenditures ($80.7M), driven by an increase in Care Coordination payments. The percentage of total CP expenditures attributed to Care Coordination increased from 74% (CY20) to 85% (CY21). The factors contributing to this increase include continued flexibilities in response to the COVID-19 pandemic (including allowing care coordinators to conduct telehealth visits) and an overall decrease in the CP Infrastructure allocations.

See appendix for DSRIP expenditures by CP

DSRIP Health-Related Social Needs Spending

One of MassHealth's key priorities for its ACO program is to better address the **health-related socials needs** (HRSNs) of its ACO-enrolled members. ACOs have two funding sources available to address HRSNs:

General DSRIP Funds

- ACOs may use general DSRIP funds on investments such as infrastructure, technology, and workforce in support of ACO goals, and some ACOs have leveraged this funding to address HRSNs.
- CPs may also use DSRIP funds to address certain HRSNs.
- Funds Spent On HRSNs*† – CY17: $7.4M, CY18: $34.3M, CY19: $44M, CY20: $32.9M, CY21: $20.5M**

Flexible Services

- "Flexible Services" funding can be used to pay for certain nutrition and housing supports, including pre-tenancy supports (e.g., transitional assistance), tenancy sustaining supports, home modifications, and nutrition supports, for certain ACO members
- The Flexible Services Program launched in January 2020.
- Details on Flexible Services spending and utilization can be found on p. 18-24.

* ACOs and CPs made investments in housing stabilization and supports, nonmedical transportation, nutrition, investments that addressed multiple HRSNs, and IT investments that were related to HRSNs. ACOs and CPs did not explicitly report making investments in utility assistance, physical activity, or sexual assault and domestic violence supports.
† It is likely that ACOs/CPs allocated more than this funding to HRSNs. For instance, many ACOs allocated funds to various care management programs, which likely provide some level of support for a member's health-related social needs. However, if the HRSN linkage was not explicitly stated in the ACO or CP budgets, the funding allocation tied to those programs was not included in the total amounts referenced above.
**Flexible Services was launched in 2020; a sizeable portion of HRSN funding shifted over to that program. Additionally, overall general DSRIP expenditures decreased by 36% from CY20 ($135.7M) to CY21 ($87.5M), which is similar to the 38% reduction in general DSRIP funds used to address HRSNs from CY20 to CY21

Statewide Investments: by the Numbers – Workforce

Cumulative through CY20	CY21	
216	91	**# student loans repaid for community-based clinicians**
$8.4M	$2.7M	**$ in student loan repayment**
90%		**% of BH and primary care providers who received student loan repayment awards from 2018-2021 that are honoring their multi-year service commitment** • Empowers and incentivizes clinicians to work at and remain in safety net provider organizations
732	295	**# community health workers and peer specialists trained** • Key members of the extended care team, who help engage members in their care
26	8	**# community health center-based Family Medicine and Family Nurse Practitioner residency training slots supported** • Clinicians trained in community-based residency programs more likely to remain in community upon training completion

See appendix for DSRIP funding per Statewide Investments program

Statewide Investments: by the Numbers – Technical Assistance

Cumulative through CY20	CY21	
167	116	**# technical assistance (TA) projects funded at ACOs/CPs**
$15.3M	$6.5M	**$ of technical assistance support** • ACOs and CPs were given funds to purchase TA support from a curated catalog of 47 TA vendors with expertise in 9 different domains (e.g., population health management, care coordination/integration, performance improvement)
2,013	2,453	**# average 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/

Contents

Overview of 2021 Quality Data and Performance

ACO and CP quality score performance

- The varying impact of the pandemic across ACO and CP quality measures, as well as the addition of various COVID-based scoring modifications in 2020 and 2021, **makes the comparison of year over year overall quality performance difficult.**

- However, at a high-level, **clinical quality performance improved for ACOs** (73.90% vs. 61.24%) and CPs (70.64% vs. 36.92%) **when comparing 2021 to 2020 performance**
  - In 2021, of the measures that showed substantial declines in performance from 2019 to 2020, five of six ACO measures and all four CP measures demonstrated partial recovery from their respective previous declines.
  - Despite these improvements, **many measures did not reach their pre-pandemic performance levels***

- **Member experience results were similar to 2019-2020**, and demonstrated strong levels of satisfaction with providers, and ongoing opportunities for increased care coordination

*Note: Despite the ongoing PHE, MassHealth and CMS determined 2021 data was usable for official quality scoring. This is in contrast to 2020 when data was deemed unusable due to the pandemic. In response to concerns over the pandemic's impact on individual quality measures, MassHealth and CMS agreed to certain benchmark reductions for ACO/CP measures demonstrating 2019-2020 performance declines. See the appendix for more details on benchmark reductions and for the ACO and CP measure slates.

Clinical Quality: Overview of ACO and CP Performance in 2019, 2020, and 2021

- **ACO/CP clinical quality performance improved for ACOs (61.24% vs. 73.90%) and CPs (36.92% vs. 70.64%)** when comparing 2020 performance data to 2021 performance data
- **Improvements above reflect both measure level increases as well as benchmarks reductions implemented in 2021**. However, the expansion of measures in pay-for-performance status and differences in scoring methodologies (as a result of COVID-19) place limitations on year-over-year comparisons

ACO	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)*	2020 Actual Quality Score (based on actual 2020 data)	2021 Actual Quality Score (based on actual 2021 data)
Measures where median ACO passed Attainment Threshold	14/16 (87.5%)	14/16 (87.5%) – *note: mirrors 2019 by definition*	10/16 (62.5%)	16/18 (88.9%)
Median ACO quality score	75.71%	97.14%	61.24% (proxy score)	73.90%
CP				
Measures where median CP passed Attainment Threshold	15/15 (100.0%)	15/15 (100.0%) - note: mirrors 2019 by definition	11/15 (73.3%)	20/20 (100.0%)
Median CP quality score	34.96%	55.53%	36.92% (proxy score)	*70.64%*

*Official Quality Scores from 2020 utilized data from 2019 plus scoring modifications to help mitigate the impact of the PHE on quality accountability. See appendix for ACO and CP measures (p. 69-71).

ACO Clinical Quality: ACO-level Comparison across 2019, 2020, and 2021

In 2021, nearly all ACOs improved their quality performance compared to 2020, and approximately half showed improvements compared to 2019.

ACO	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)**	2020 Actual Quality Score (based on actual 2020 data)*	2021 Actual Quality Score (based on actual 2021 data)
Berkshire Fallon Health Collaborative	67.19	89.34	39.18	74.39
Fallon 365 Care	66.52	100	78.76	96.62
Wellforce Care Plan	76.90	90.4	53.05	57.95
BeHealthy Partnership	85.78	98.96	68.04	67.64
My Care Family	90.23	97.97	55.22	69.21
Tufts Health Together with Atrius Health	75.71	94.68	68.76	76.59
Tufts Health Together with BIDCO	66.83	88.94	34.33	60.51
Tufts Health Together with CHA	99.18	100	65.74	73.90
Tufts Health Together with Boston Children's ACO	72.19	89.17	71.58	81.00
BMC HealthNet Plan Community Alliance	96.01	93.99	61.02	74.90
BMC HealthNet Plan Mercy Alliance	66.93	94.53	66.14	72.04
BMC HealthNet Plan Signature Alliance	100.00	98.96	61.63	81.93
BMC HealthNet Plan Southcoast Alliance	74.55	93.53	70.28	87.33
Community Care Cooperative	80.28	95.85	61.24	88.81
Partners HealthCare Choice	74.53	93.52	54.93	63.52
Steward Health Choice	64.24	90.15	50.19	68.23
Lahey	80.82	80.77	45.31	52.86

*2021 Official Quality Scores compared to 2020 Actual Quality Scores and 2019 Official Quality Scores.
**2020 Official Quality Scores included adjustments determined with CMS in light of PHE-related challenges and were used for ACO quality-based payments. 2020 Actual Quality Score is provided for comparison purposes only and was not tied to payments.

ACO Clinical Quality: 2021 Measures with Substantial Performance Drop

- In 2020, six ACO quality measures demonstrated substantial drops in performance from 2019 to 2020 (likely due to COVID) and were deemed priority measures for monitoring in 2021

- In 2021, five of these measures demonstrated partial recovery from their 2019-2020 declines. The table below demonstrates the percentage of initial performance drops in 2020 recovered by the end of 2021

Measure	Performance Monitoring			
	2019-2020 Perf. Drop	2019-2021 Perf. Drop	Recovery	Recovery %
Metabolic monitoring for children using antipsychotics	-7.35	-5.56	+1.79	24%
Diabetes care: a1c poor control	-11.03	-3.88	+7.15	65%
Controlling high blood pressure	-12.64	-6.07	+6.57	52%
Oral health evaluation	-16.72	-7.44	+9.28	56%
Screening for depression and follow-up plan	-8.98	-3.66	+5.32	60%
ED Visits for individuals with mental illness and/or addiction (observed/expected ratio)	-0.40	-0.48	-	-

CP Clinical Quality: BH CP-level Comparison, 2019 vs. 2020 vs. 2021

In 2021, clinical quality performance improved among most BH CPs relative to 2020 and 2019.*

BH CP	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)**	2020 Actual Quality Score (based on actual 2020 data)	2021 Official Quality Score (based on actual 2021 data)
Boston Coordinated Care Hub	62.88	71.35	43.68	32.92
South Shore Community Partnership	30.03	48.59	40.37	83.80
Brien Center Community Partner Program	16.70	52.14	27.82	56.53
Eliot Community Human Services	60.78	73.52	44.04	88.09
Behavioral Health Network, Inc.	64.45	74.79	27.20	61.05
Clinical and Support Options, Inc.	34.20	62.63	27.64	70.64
Lahey Health Behavioral Services	16.78	32.19	14.90	45.76
Community Healthlink, Inc.	25.70	48.84	26.38	43.92
Lowell Community Health Center, Inc,	23.25	49.01	58.16	92.06
Sstar Care Community Health Center, Inc.	41.45	53.68	64.57	56.18
Community Counseling of Bristol County, Inc.	75.05	79.33	57.62	81.68
Riverside Community Care	21.85	51.51	21.67	93.88
Coordinated Care Network	67.95	67.95	36.92	89.08
Central Community Health Partnership	23.40	50.70	19.16	94.14
Innovative Care Partners, LLC	26.33	49.57	83.16	100.00
Community Care Partners, LLC	45.38	54.41	35.22	63.88
Behavioral Health Partners of MetroWest, LLC	32.55	47.29	43.89	100.00
Southeast Community Partnership, LLC	44.73	55.37	31.01	45.20

*2021 Official Quality Scores compared to 2020 Actual Quality Scores and 2019 Official Quality Scores.
**2020 Official Quality Scores included adjustments determined with CMS in light of PHE-related challenges and were used for CP quality-based payments. 2020 Actual Quality Score is provided for comparison purposes only and was not tied to any CP quality-based payments.

CP Clinical Quality: LTSS CP-level Comparison, 2019 vs. 2020 vs. 2021

In 2021, clinical quality performance improved among most LTSS CPs relative to 2020 and 2019.*

LTSS CP	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)**	2020 Actual Quality Score (based on actual 2020 data)	2021 Actual Quality Score (based on actual 20 21 data)
Care Alliance of Western Mass	27.48	55.32	29.59	60.94
Merrimack Valley Community Partner	90.44	90.44	49.48	62.10
North Region LTSS Partnership	43.52	48.98	48.79	100.00
Central Community Health Partnership	42.96	49.50	50.21	77.46
Family Service Association	69.12	75.36	22.92	63.52
Massachusetts Care Coordination Network	34.96	57.58	39.79	85.31
Boston Allied Partners	13.80	55.92	18.79	43.70
Innovative Care Partners, LLC	49.08	76.92	62.51	100.00
LTSS Care Partners, LLC	27.92	65.54	10.41	51.61

*2021 Official Quality Scores compared to 2020 Actual Quality Scores and 2019 Official Quality Scores.
**2020 Official Quality Scores included adjustments determined with CMS in light of PHE-related challenges and were used for CP quality-based payments. 2020 Actual Quality Score is provided for comparison purposes only and was not tied to any CP quality-based payments.

CP Clinical Quality: 2020 Measures with Substantial Performance Drop

- In 2020, four of the 13 measures demonstrated substantial drops in performance from 2019 to 2020 (likely due to COVID) and were deemed priority measures for monitoring in 2021

- In 2021, all measures demonstrated partial to near full recovery from 2019-2020 declines. The table below demonstrates the percentage of initial performance drops in 2020 recovered by the end of 2021

Measure	CP Type	Performance Monitoring			
		2019-2020 Perf. Drop	2019-2021 Perf. Drop	Recovery	Recovery %
Annual Treatment Plan	BH CP	-7.36	-0.92	+6.44	88%
Diabetes Screening for Individuals w/Bipolar Disorder	BH CP	-5.37	-4.33	+1.04	19%
Oral Health Evaluation	LTSS CP	-15.43	-1.37	+14.06	91%
Hospital Readmissions (observed/ expected ratio)	LTSS CP	-0.45	-0.27	+0.18	40%

Contents

Member Experience: Summary of 2019, 2020, and 2021 Results

- **ACOs are accountable for performance on two member experience measures**:* 1) Overall care delivery; and 2) Integration/ coordination of care
  - These measures are based on results from a subset of questions **in the primary care survey**, based on a nationally validated tool

- As in 2020, members in 2021 expressed **strong levels of satisfaction** with their providers, and **the need for increased coordination managing BH and other specialists and services**

- As with 2019-2020 results, 2021 continues to **identify opportunities for progress**, especially in the **integration and coordination of BH care**, and in the **experience for the LTSS population**

Performance Measure	2019 Aggregate Statewide Score	2020 Aggregate Statewide Score	2021 Aggregate Statewide Score*	Threshold	Goal
Overall Care Delivery	89.9	88.6	88.9	75.0	92.0
Integration/ Coordination of Care	83.2	81.8	80.8	71.25	86.25

*Measurement Year 2021 member experience scores continue to **likely and variably be impacted by the COVID period** when the surveys were issued in early 2022; MassHealth continued to contract with Massachusetts Health Quality Partners (MHQP) to survey approximately 30,000 members about their 2021 experience of the health care system to build on the 2018-2020 survey results

ACO Patient Safety

- ACPPs and MCOs report two types of patient safety-related events on an annual basis:

Serious Reportable Events (SREs)	Events that occur in hospital or hospital-licensed ambulatory surgical center (ASC) facilities that result in an adverse patient outcome that has been identified as usually or reasonably preventable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the hospital or ASC
Provider Preventable Conditions (PPCs)	PPCs are a Health Care Acquired Condition or an Other Provider Preventable Condition as defined by CMS regulations and MassHealth policy.

- **SRE events increased slightly** in 2021 compared to prior program years or historical MCO data. However, the rate per 1,000 members decreased indicating that any increases in event volume **are likely related to increases in ACO/MCO membership**.
- Both **PPC events and rate per 1,000 members decreased** in 2021.
- Overall, the **occurrence of these events is relatively rare** and the numbers are small (e.g., <5 per ACO/MCO).

Event	Metric	Plan Type	Year 4 (2021)	Year 3 (2020)	Year 2 (2019)	Year 1 (Mar - Dec.2018)	Prior MCO*
SREs	Range per plan	ACPP	0 to 13	0 to 13	0 to 14	0 to 9	
		MCO	3 to 35	7 to 19	4 to 21	3 to 36	0 to 17
	Rate per 1000 members	Combined	0.08	0.11	0.12	0.09	
PPCs	Range per plan	ACPP	0 to 25	0 to 29	0 to 17	0 to 10	
		MCO	3 to 40	7 to 51	1 to 19	3 to 62	0 to 23
	Rate per 1000 members	Combined	0.10	0.21	0.09	0.13	

Contents

Overview of 2021 Cost Data and ACO Financial Performance

Overall spend

- In 2021, the ACO program accounted for $6.3B of MassHealth spending, with an average annual total cost of medical services per member of ~$5,700
- ACO medical spend per member declined on average by approximately 3% from 2019 to 2021:
  - Decline concentrated in child population; adult member per year spend was flat
  - Decreases in inpatient and other routine care were offset by increases in pharmacy and temporary provider rate increases

Financial Performance

- Most ACOs experienced financial gains in 2021 due to decreased utilization during the PHE and an increase in the number of non-disabled, less acute members

Variation in spend

- Among 13 ACPPs, profit/loss performance varied by **up to ~18 percentage points** across ACPPs after applying adjustments
- Among 3 PCACOs, performance varied by **up to ~2 percentage points** across PCACOs after applying adjustments

New Pricing Policies: Market Adjustment

- In 2021, MassHealth implemented new pricing policies to adjust for changes that impacted the market as a whole. Through these changes, MassHealth ensures that actual funding (i.e., the rate / benchmark) is adjusted to meet actual costs for the ACO/MCO program overall while continuing to incentivize individual ACOs to perform better than the market. The main changes included:
  - **Concurrent risk score** adjustments which adjust for member acuity throughout the year
  - **Market corridor** which applies a market-wide adjustment in instances of significant profits or losses across all plans

Total Cost of Care: Comparison across 2019, 2020, & 2021

While **total spend increased** in 2021, **average per member per year spending dropped** compared to 2019, driven by the **child population.** Adult member per year spend increased slightly from 2019 to 2021.

Overall trend*

2019	2020	2021	
~$5.2B	~$5.5B	~$6.3B	Total spent on covered services for ACO members
~$5,900	~$5,700	~$5,700	Average per member per year (PMPY) spending

Trend by population type**

	2019		2020		2021		2021 vs 2019 % Change	
Average PMPY	With disabilities[2]	Without disabilities[2]	With disabilities[2]	Without disabilities[2]	With disabilities[2]	Without disabilities[2]	With disabilities[2]	Without disabilities[2]
Adults	~$20,100	~$6,600	~$20,300	~$6,600	~$21,100	~$6,700	5%	1%
Children	~$10,700	~$2,500	~$10,100	~$2,300	~$10,400	~$2,200	-3%	-12%

*January – December 2020 & 2021 medical expenditures; includes all medical covered services (incl. maternity supplemental and HCD), and excludes ABA, CBHI, and HCV. Excludes MCO-Administered ACOs.

**Non-disabled adults include RC IA, RC IX, RC X; disabled adults include RC IIA; non-disabled children include RC IC; disabled children include RC II C

Notes:

- Total spend and PMPY figures are not directly comparable to estimates in previous annual reports
- This 2021 deck utilizes a different data source than the 2019 version. The main differences from 2019 are that this deck utilizes a full year of data (2019 was annualized with data through Sep 2019), the expenses are not price normalized to the MassHealth fee schedule, HCV is excluded, and maternity supplemental is included.

Total Cost of Care: Category of Service Breakdown, 2019 vs. 2020 vs. 2021

Trend by category of service* (ACPP & PCACO combined)

Average PMPY	2019	2020	2021	2019 vs. 2021 % change
Inpatient Hospital	1,249	1,222	1,033	-17%
Outpatient Hospital	1,135	971	1,078	-5%
Inpatient BH	221	243	219	-1%
Outpatient BH	647	647	632	-2%
Professional services	971	862	925	-5%
Pharmacy	1,381	1,472	1,579	14%
All other	272	265	259	-5%
Total	5,875	5,682	5,725	-3%

- Pharmacy was the only category to consistently trend upwards and saw the largest increase, driven by a shift to a partially unified formulary**
- All other categories saw a decrease in cost of care during this time period. Inpatient spend saw the largest decrease, down 17% in 2021 compared to 2019
- Total spend in 2021 was impacted by **temporary provider rate increases**

*January – December 2020 & 2021 medical expenditures. Inpatient includes inpatient physical health maternity and non-maternity. Outpatient includes outpatient hospital, emergency room, and lab and radiology (facility). Pharmacy includes high-cost drugs and excludes HCV. All Other includes DME and supplies, emergency transportation, LTC, home health, and other medical services. Excludes MCO-Administered ACOs.

**The partial unified formulary unifies drug coverage across MassHealth plans for certain classes of drugs. This unification simplified prescriber management, streamlined member continuity of care, and maximized savings from rebates received by MassHealth. To maximize these rebates, plans were required to shift to some higher cost drugs driving increases in plan pharmacy spend. This increased spend was fully funded through plans' rates. Savings accrued to the state are not shown in these figures.

Notes: Total spend and PMPY figures are not directly comparable to estimates in previous annual reports. This 2021 deck utilizes a different data source than the 2019 version. The main differences from 2019 are that this deck utilizes a full year of data (2019 was annualized with data through Sep 2019), the expenses are not price normalized to the MassHealth fee schedule, HCV is excluded, and maternity supplemental is included.

Financial Performance: Most ACOs saw financial gains in 2021, driven by decreased utilization during the PHE

2021 projected performance against capitation rates/benchmark*
# of ACOs

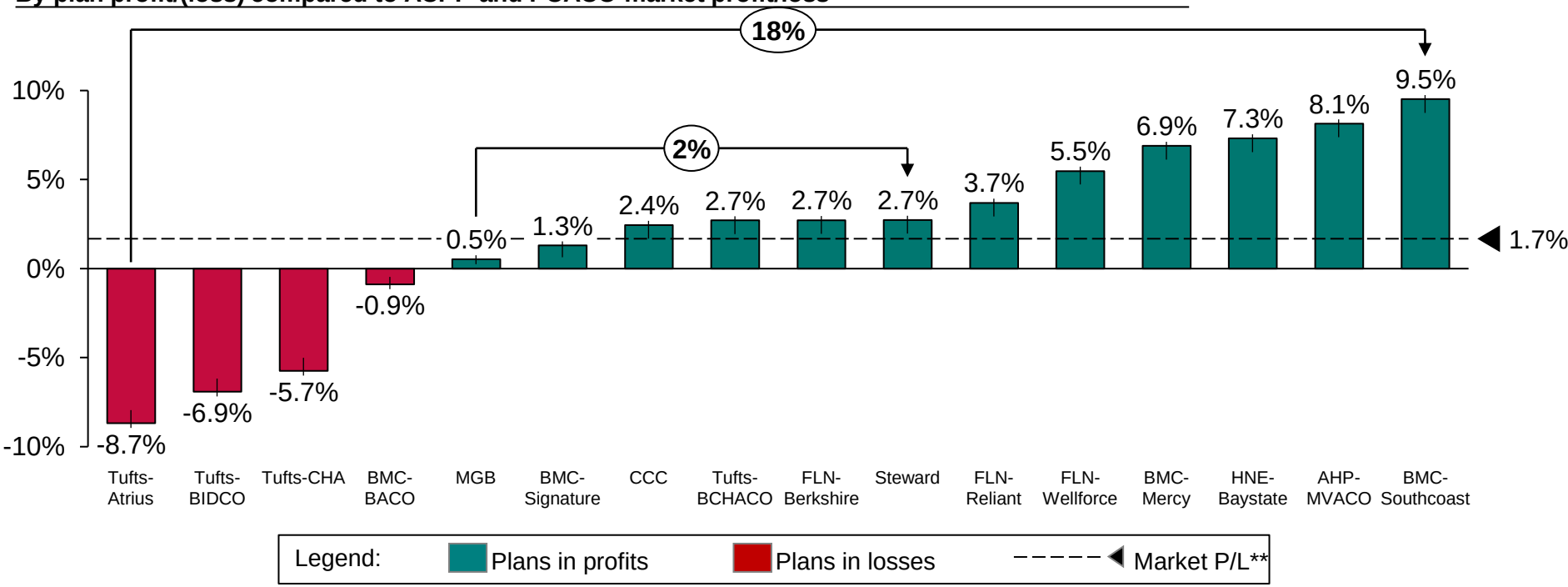
	ACPP	PCACO
>2% gains	**8**	**2**
+/- 2% of breakeven	**2**	**1**
>2% losses	**3**	**0**
	13	**3**

- Due to decreased utilization during the PHE, most ACOs experienced financial gains in 2021
- For 2021 and beyond, MassHealth adjusted funding to meet actual costs for the ACO program overall.
  - This is done by adjusting for situations in which the market overall is in savings or losses due to some market-wide trend (e.g., pandemic utilization changes, shifts in acuity of the overall caseload).
  - Even in the context of these adjustments, individual ACOs remain incented to perform better than the market overall

*January – December 2021 core medical expenditures. ACPP and PCACO data sourced from the 2021 refresh market corridor report which reflects concurrent risk scores and the market corridor adjustment. Figures subject to final reconciliation (including final concurrent risk scores and market corridor adjustments), all percentages presented are prior to risk-sharing. Excludes MCO-Administered ACOs.

ACO Financial Performance Varied by Plan

By plan profit/(loss) compared to ACPP and PCACO market profit/loss*



- ACPP/PCACO market experienced 1.7% gains after applying concurrent risk scores and the market corridor adjustment (see p. 54)
- Across the ACPP market, performance varied by **up to ~18 percentage points** across ACOs.
- Across the PCACO market, performance varied by **up to ~2 percentage points** across ACOs.

*January – December 2021 core medical expenditures. ACPP and PCACO data sourced from the 2021 refresh market corridor report which reflects concurrent risk scores and the market corridor adjustments. Figures subject to final reconciliation (including final concurrent risk scores and market corridor adjustments), all percentages presented are prior to risk-sharing. Excludes MCO-Administered ACOs.

**The Market % profit/loss above will not tie out to the 2021 refresh market corridor report because the above data excludes MCO and PCC plans

Contents

Conclusion of 2017-2022 1115 Demonstration

Continued recovery from / response to the pandemic

- In the final year of the 2017-2022 1115 demonstration, ACOs, CPs, and MassHealth continued to address the effects of the pandemic on MassHealth members and the healthcare workforce
- Efforts to re-engage members in care, ramp up home- and community-based services, continue telehealth use as appropriate, promote BH access, and address workforce shortages continued to be crucial.

Planning for the end of DSRIP funding

- 2022 marked the last full year for DSRIP funding to support ACO population health strategies as well as funding for the CPs, Flexible Services, and Statewide Investments
- ACOs continued to iterate and refine their DSRIP spending and population health strategies as DSRIP funding declined in the last year, requiring ACOs to continue to prioritize programs that demonstrated success and sustainability
- MassHealth underwent a planning phase to review the successes and challenges of the 2017-2022 waiver, launched stakeholder meetings, and drafted the next 1115 demonstration proposal to continue to invest in and build off of the reforms accomplished under the 2017-2022 demonstration

Building on successes for the 2022-2027 1115 demonstration

- In drafting the 2022-2027 1115 demonstration proposal, MassHealth took the most successful program designs and best practices being tested under the 2017-2022 demonstration and incorporated them as core, funded expectations for ACOs, CPs, and primary care practices in 2023 and beyond.
- Critical investment areas include:
  - Enhanced care coordination by ACOs and CPs serving members with complex needs
  - Increased resources to support health equity and health-related social needs along with critical investments in strategic focus areas (e.g., maternal health, pediatrics)
  - High-value MassHealth-serving primary care practices
- Additional information about MassHealth's 2022 – 2027 1115 demonstration extension can be found at: https://www.mass.gov/info-details/1115-masshealth-demonstration-waiver

Appendix

- Additional context on the 2018 restructuring
- 2020 to 2021 utilization trends
- Quality and member experience: detail
- Lists of MassHealth CPs
- DSRIP funding detail by entity and funding stream

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 LTSS and HRSN

- 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, BH providers) that participate in their plan

- ACOs assume **upside and downside risk** and are financially accountable for specific quality measures

- 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 LTSS

- 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**
  - $1B ACO allocation includes **$149M allocated for Flexible Services** investments, which provide goods and services to address **health-related social needs**. See p. 18-24 for more detail

- DSRIP funding is **time limited and ends in Q1 2023**

2021 Enrollment by Managed Care Enrollment Option

Plan Type	Health Plan	ACO Name	Unique Members Enrolled as of 12/31/21		2021 Disenrollments**		Difference Between % Enrolled and Disenrolled
			#	%	#	%	
Accountable Care Partnership Plans (ACPP)	BMC HealthNet Plan	Boston Accountable Care Organization	146,483	11%	5,509	8%	**2.8%**
		Mercy Medical Center	33,139	2%	1,201	2%	**0.7%**
		Signature Healthcare	23,320	2%	909	1%	**0.4%**
		Southcoast Health	20,431	1%	801	1%	**0.3%**
	Fallon Health	Health Collaborative of the Berkshires	20,334	1%	359	1%	**1.0%**
		Reliant Medical Group	40,387	3%	1,142	2%	**1.3%**
		Wellforce	62,262	5%	2,802	4%	**0.6%**
	Health New England	Baystate Health Care Alliance	45,715	3%	1,514	2%	**1.2%**
	Allways Health Plan	Merrimack Valley ACO	42,187	3%	1,370	2%	**1.1%**
	Tufts Public Plans	Atrius Health	41,730	3%	1,123	2%	**1.4%**
		Boston Children's Health ACO	125,668	9%	4,045	6%	**3.4%**
		Beth Israel Deaconess Care Organization	45,289	3%	1,748	2%	**0.8%**
		Cambridge Health Alliance	36,002	3%	1,351	2%	**0.7%**
Primary Care ACOs (PCACO)	Community Care Cooperative (C3)		166,063	12%	10,471	15%	**-2.8%**
	Mass General Brigham		148,344	11%	5,875	8%	**2.5%**
	Steward Health Choice		152,814	11%	9,184	13%	**-1.9%**
	ACO Total*		**1,150,168**	**83%**	**49,404**	**70%**	
Managed Care Organizations	**MCO-BMC Health Net Plan**		44,779	3%	4,648	7%	**-3.3%**
	MCO-Tufts Public Plans		69,258	5%	4,707	7%	**-1.6%**
PCC Plan	**PCC Plan**		115,685	8%	12,060	17%	**-8.6%**
	Total		**1,379,890**	**100%**	**70,819**	**100%**	

This 2021 comparison of the health plans' *"% of 2021 Enrollees"* to *"% of 2021 Disenrollments"* is generally in line with disenrollments for ACOs and MCOs but shows an increase in disenrollments for the PCC Plan.

*Note this reflects total unique members enrolled as compared to average members shown on slide 10. This total excludes 11,417 members in the Lahey Health ACO (as of 12/31/2021); members cannot enroll directly into Lahey Health – they must be enrolled in either BMC Health Net Plan or Tufts Public Plans

**These numbers represent disenrollment *events*, which differ from the snapshot enrollment number reported in the earlier column, from 1/1/2021 to 12/31/21 that are driven by the member (e.g., a member calling the Customer Service Center to disenroll from an ACO).

Appendix

- Additional context on the 2018 restructuring
- 2020 to 2021 utilization trends
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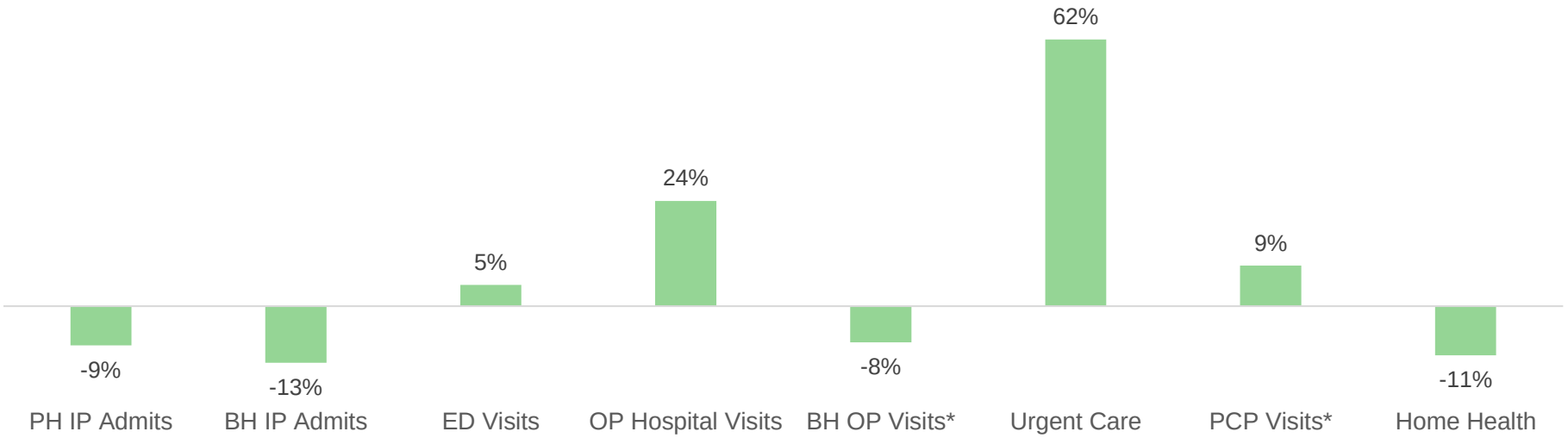
There were significant utilization shifts from 2020 to 2021 driven by the pandemic and lower member acuity

- Utilization **declines ranged from -8% to -13%** while **increases ranged from 5% to 62%** when comparing 2021 to 2020.
- **Urgent Care and Outpatient Hospital visits** saw the largest increases, with **Primary Care and ED** also seeing small increases.
- Utilization shifts are driven by holds on elective procedures, members deferring care or seeking care in alternative settings due to the COVID-19 PHE and overall lower acuity of the population.



*Includes in-person visits and visits delivered via telehealth. Includes ACO, MCO and PCC Plan utilization.
Note: Utilization trends do not reflect the impact of temporary rate increases implemented in response to the COVID-19 PHE

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ACO Quality Measures: 21 Clinical Quality and Member Experience Measures

	Measures	First Performance Year
1.	Follow Up After Emergency Dept. Visit for Mental Illness	2020
2.	Poor Control of HbA1c Levels (Diabetes Care)	2019
3.	Follow Up After Hospitalization for Mental Illness	2019
4.	Metabolic Monitoring for Children or Adolescents on Antipsychotics	2019
5.	Initiation and Engagement of Alcohol, Opioid or other Drug Use Treatment	2019
6.	Appropriate Medications for Asthma	2019
7.	Controlling High Blood Pressure	2020
8.	Screening for Depression and Follow Up Plan*	2022
9.	Unplanned Hospital Readmissions	2021
10.	Childhood Immunizations	2019
11.	Adolescent Immunizations	2019
12.	Timeliness of Prenatal Care	2019
13.	Health Related Social Needs Screening	2021
14.	Emergency Department Visits for Individuals with Serious Mental Illness or Addiction	2021
15.	Community Tenure*	2022
16.	Depression Remission/Response	2021
17.	Behavioral Health Community Partner Engagement	2021
18.	Long Term Service and Supports Community Partner Engagement	2021
19.	Oral Health Evaluation	2021
20.	Overall Quality of Care	2019
21.	Integration/ Care Coordination	2021

19 Clinical Quality Measures

2 Member Experience Measures

*In 2021, these measure were in reporting-only status; the remaining measures were in pay-for-performance status.

CP Quality Measures: Clinical Quality and Member Experience Measures

BH/ LTSS #	Measures	BH CP	LTSS CP	ACO Crossover
1	Community Partner Engagement	X	X	X
2	Annual Treatment/Care Plan Completion	X	X	
3	Enhanced Person-Centered Care Planning	X	X	
4	Follow-up with CP after acute or post-acute stay (3 days)	X	X	
5	Follow-up with CP after ED visit	X		X
6	Annual primary care visit	X	X	
7.A	Initiation of Alcohol, Opioid, or Other Drug Abuse of Dependence Treatment	X		X
7.B	Engagement of Alcohol, Opioid, or Other Drug Abuse of Dependence Treatment	X		X
8	Follow-up After Hospitalization for Mental Illness (7 days)	X		X
9	Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication	X		
10	Antidepressant Medication Management	X		
11	ED Visits for Adults with SMI, Addiction or Co-occurring Conditions	X		X
12	Hospital Readmissions	X	X	X
13	Oral Health Evaluation		X	X
14	All-Cause ED visits		X	
15	Member Experience: Member Engagement and Care Planning	X	X	X

ACO Clinical Quality Measures

	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	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater
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
13	Health Related Social Needs Screening	Percentage of members who were screened for health-related social needs in the measurement year
14	Emergency Dept Visits for Individuals with Serious Mental Illness or Addiction	Number of ED visits for members 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions
15	Depression Remission and/or Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who received follow-up evaluation with PHQ-9 and experienced response or remission in 4 to 8 months following the elevated score
16	Behavioral Health Community Partner Engagement	Percentage of members 18 to 64 years of age who engaged with a BH Community Partner and received a treatment plan within 3 months (122 days) of Community Partner assignment
17	Long Term Service and Supports Community Partner Engagement	Percentage of members 18 to 64 years of age who engaged with a LTSS Community Partner and received a treatment plan within 3 months (122 days) of Community Partner assignment
18	Oral Health Evaluation	Percentage of members under age 21 years who received a comprehensive or periodic oral evaluation during the year
19	Community Tenure	Percentage of eligible days that members w/psychotic disorders or LTSS services reside in their community settings

ACO Clinical Quality: Measures Meeting Attainment, 2019, 2020, 2021

MEASURE	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)	2021 Official Quality Score (based on actual 2021 data)
Follow-up after ED for Mental Illness	Yes	Yes	Yes	Yes
Diabetes Poor Control	Yes	Yes		Yes
Follow-up After Hospitalization	Yes	Yes	Yes	Yes
Metabolic Monitoring	Yes	Yes	Yes	Yes
Initiation of AOD Treatment	Yes	Yes	Yes	Yes
Engagement of AOD Treatment				Yes
Controlling High Blood Pressure	Yes	Yes		Yes
Screening for Depression	Yes	Yes	Yes	Yes
Childhood Immunization	Yes	Yes	Yes	Yes
Immunization for Adolescents	Yes	Yes	Yes	Yes
Timeliness of Prenatal Care	Yes	Yes		Yes
Depression Remission / Response	Yes	Yes	Yes	Yes
Asthma Medication Ratio			Yes	
Oral Health Evaluation	Yes	Yes		Yes
Health Related Social Screening	Yes	Yes	Yes	Yes
ED Visits for Individuals w/Serious Mental Illness and/or Addiction	Yes	Yes		Yes
Behavioral Health CP Engagement	Yes	Yes	Yes	Yes
LTSS CP Engagement	Yes	Yes	Yes	Yes
Total	**16/18**	**16/18**	**16/18**	**16/18**

Note: Performance above describes the median ACO for each given metric

CP Clinical Quality: Measures Meeting Attainment 2019, 2020, 2021

MEASURE	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)	2021 Official Quality Score (based on 2021 data)
BH CP				
Community Partner Engagement	Yes	Yes	Yes	Yes
Enhanced Annual Treatment Plan Completion	Yes	Yes	Yes	Yes
Annual Primary Care Visit	Yes	Yes	Yes	Yes
Diabetes Screening for Ind. w/ Schizophrenia or Bipolar Disorder who are using Antipsychotic Meds	Yes	Yes		Yes
Initiation of AOD Treatment	Yes	Yes	Yes	Yes
Engagement of AOD Treatment	Yes	Yes	Yes	Yes
Follow Up After Hospital Visit for Mental Illness	Yes	Yes	Yes	Yes
ED Visits for Individuals w/Serious Mental Illness and/or Addiction	Yes	Yes	Yes	Yes
Hospital Readmission	Yes	Yes		Yes
LTSS CP				
Community Partner Engagement	Yes	Yes	Yes	Yes
Enhanced Annual Care Plan Completion	Yes	Yes	Yes	Yes
Annual Primary Care Visit	Yes	Yes	Yes	Yes
Oral Health Evaluation	Yes	Yes		Yes
All Cause ED Visits	Yes	Yes	Yes	Yes
Plan All Cause Readmission	Yes	Yes		Yes
Total	**15/15**	**15/15**	**11/15**	**15/15**

Note: Performance above describes the median CP rate for each given metric

Quality Measure Benchmark Reductions due to COVID-19 PHE

Given concerns over the pandemic's impact on quality measure performance, MassHealth and CMS agreed to the following stepwise methodology for determining ACO and CP **benchmark reductions** applicable to PY2021 quality measure calculations

Step 1:

- Assess each measure for a drop in performance from CY2019 to CY2020
- Performance drop is determined by any negative change in median level performance across ACOs/CPs

Step 2:

- For any measure with a performance drop identified in Step 1, adjust that measure's Attainment Threshold and Goal Benchmark to exactly match the median performance drop

Example:

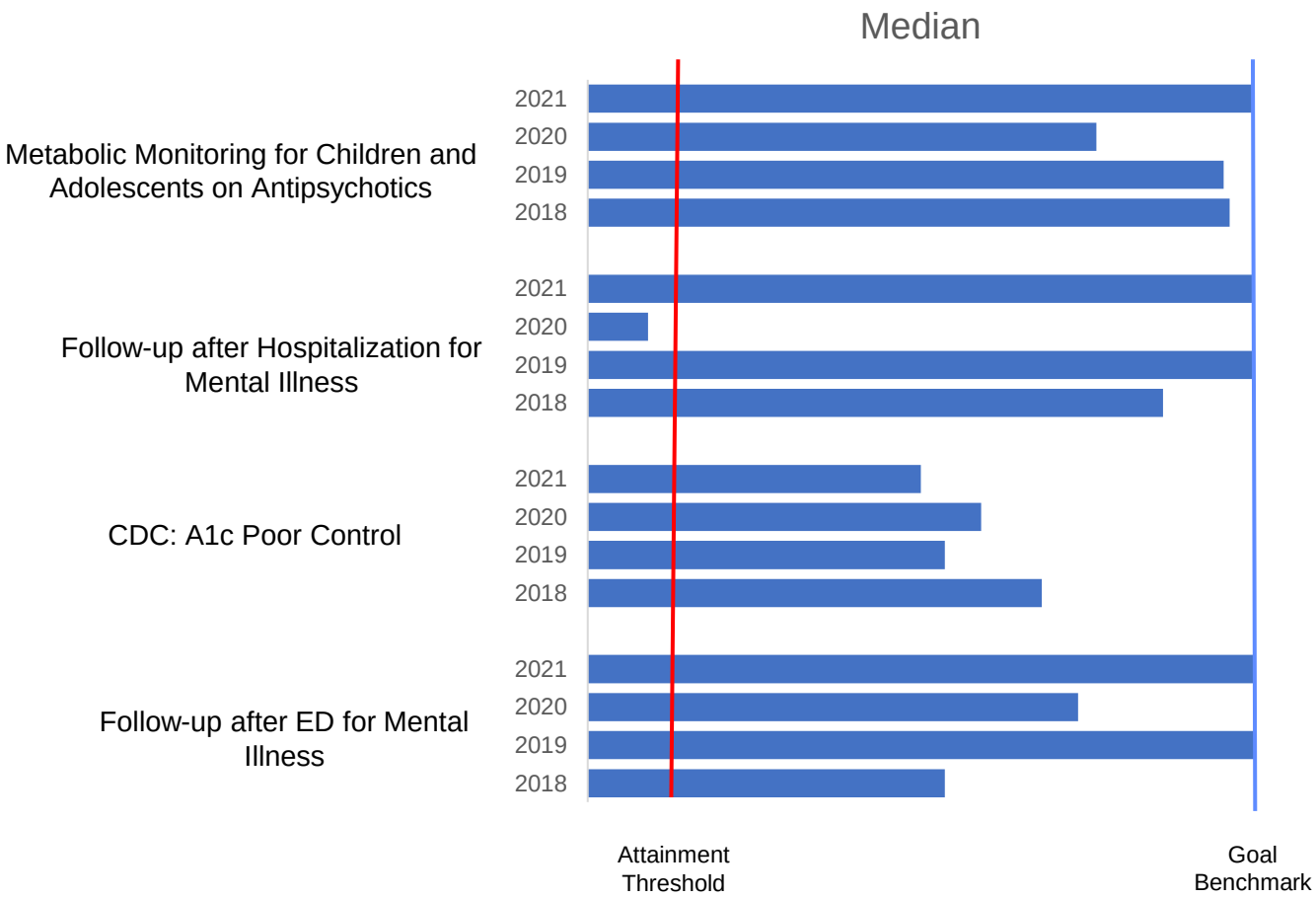
- Measure: Childhood Immunization Status
- Attainment Threshold: 48.9%
- Goal Benchmark: 59.4%
- CY2019 Median Performance: 55.7%
- If the CY2020 ACO median performance drops by 4.1 points, then the Attainment Threshold and Goal Benchmark would be adjusted to 44.8% and 55.3%, respectively.

How to Read the Quality Measure Charts on Upcoming Slides

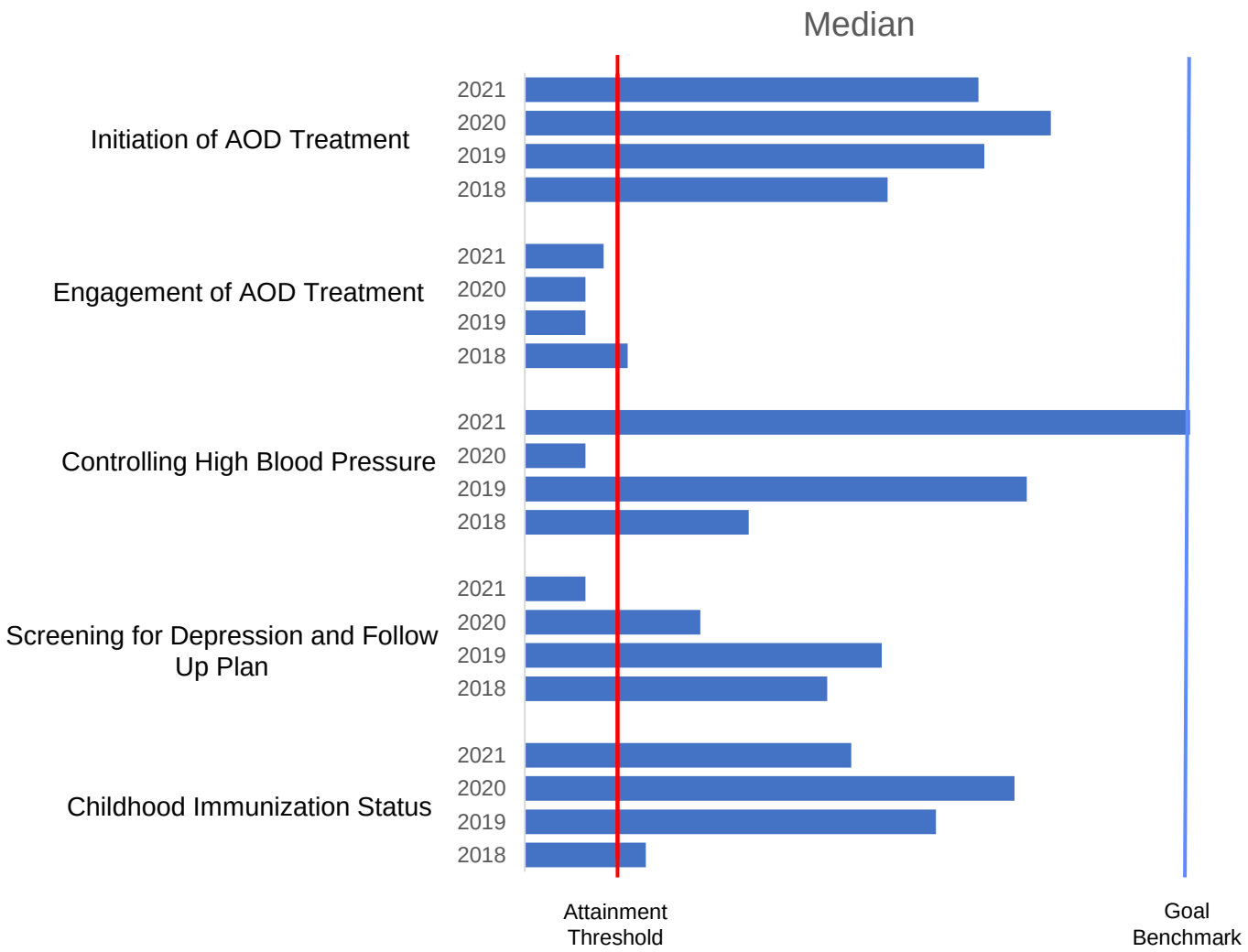
Charts are shown that **summarize key information** about ACO quality performance

- The **median** quality score per measure per year is represented by the bar chart
- This chart allows easy comparison of the median scores 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 the medians 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

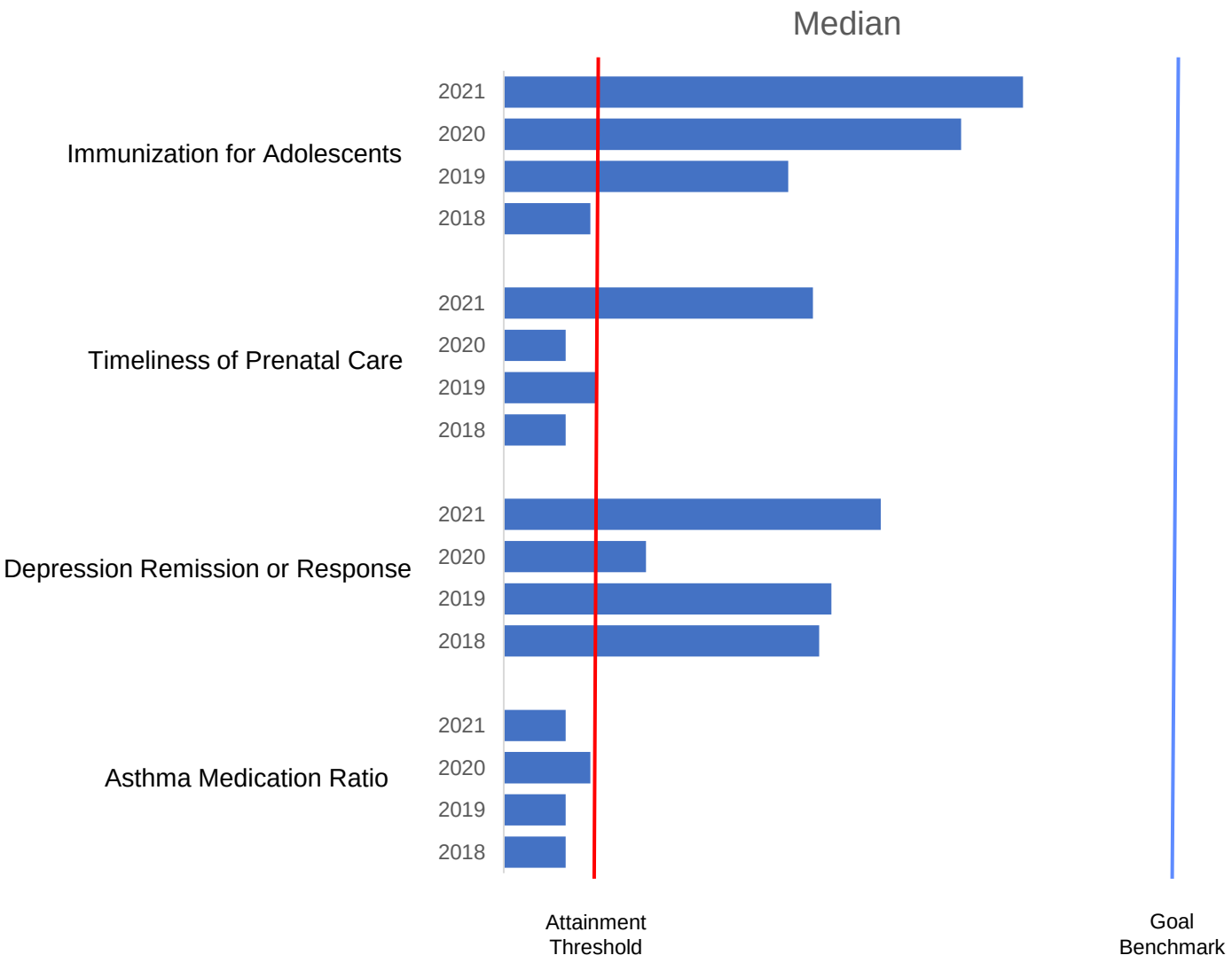
ACO Clinical Quality: Overview of measure scores and comparison between 2018-2021



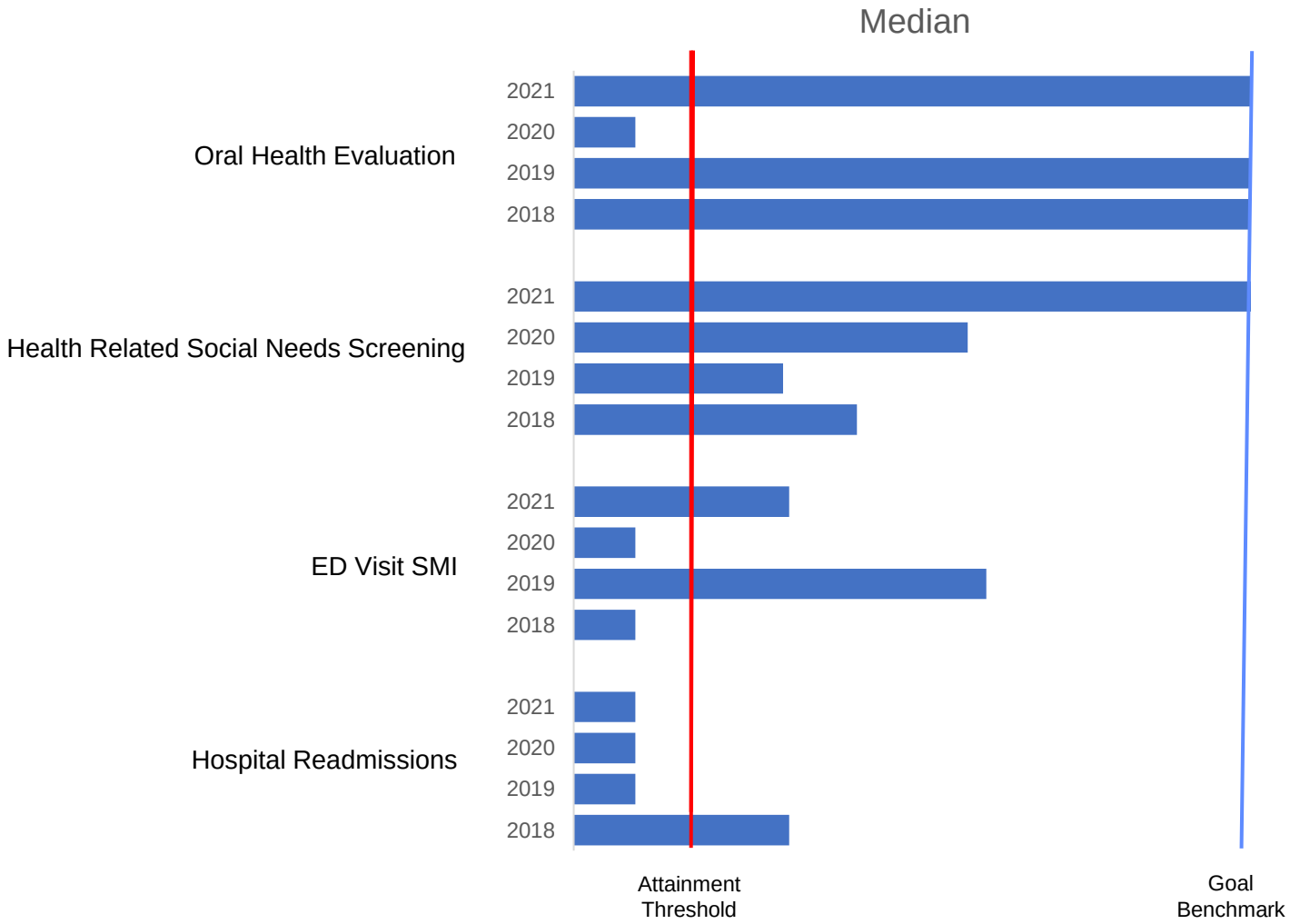
ACO Clinical Quality: Overview of measure scores and comparison between 2018-2021



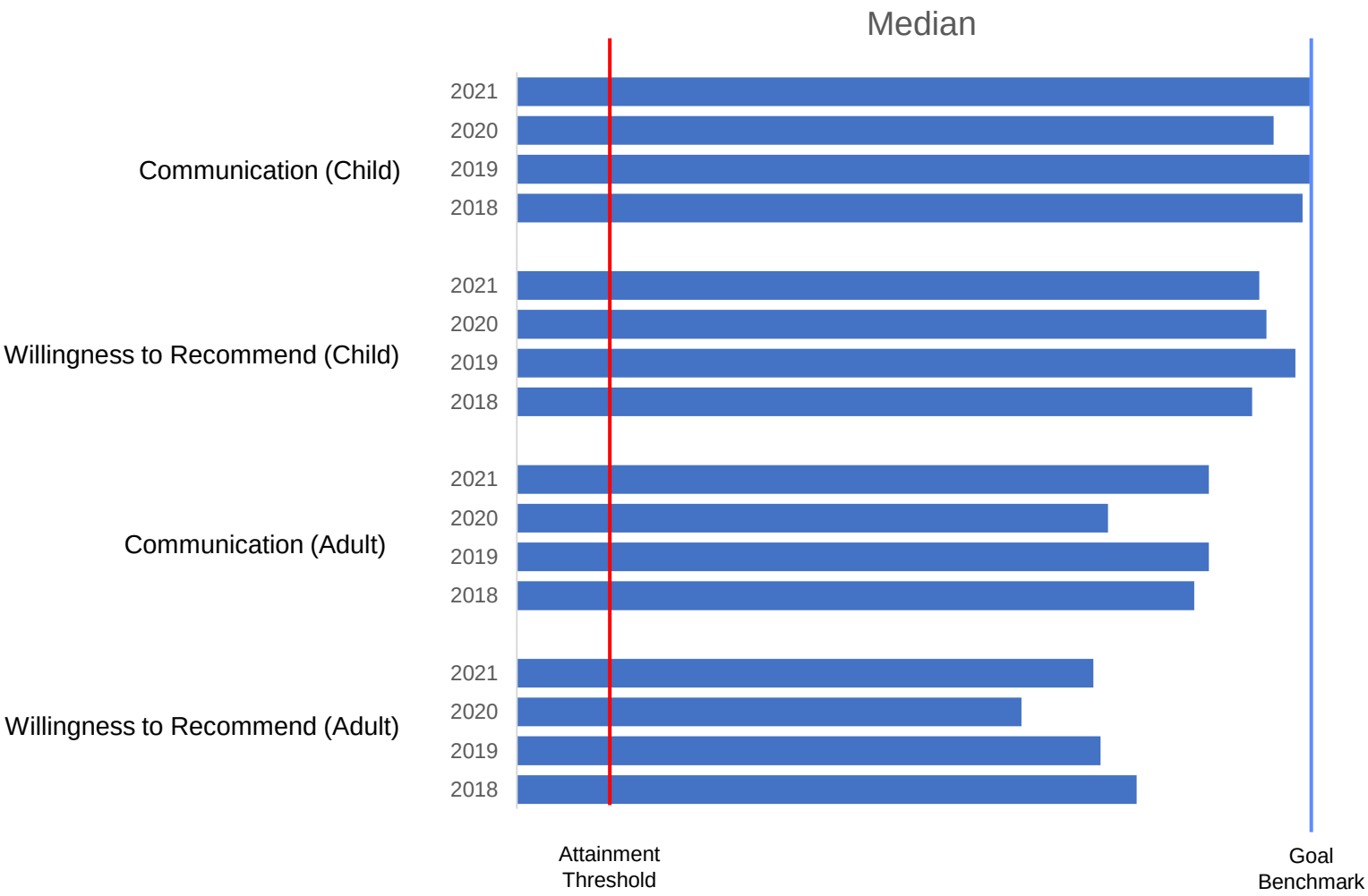
ACO Clinical Quality: Overview of measure scores and comparison between 2018-2021



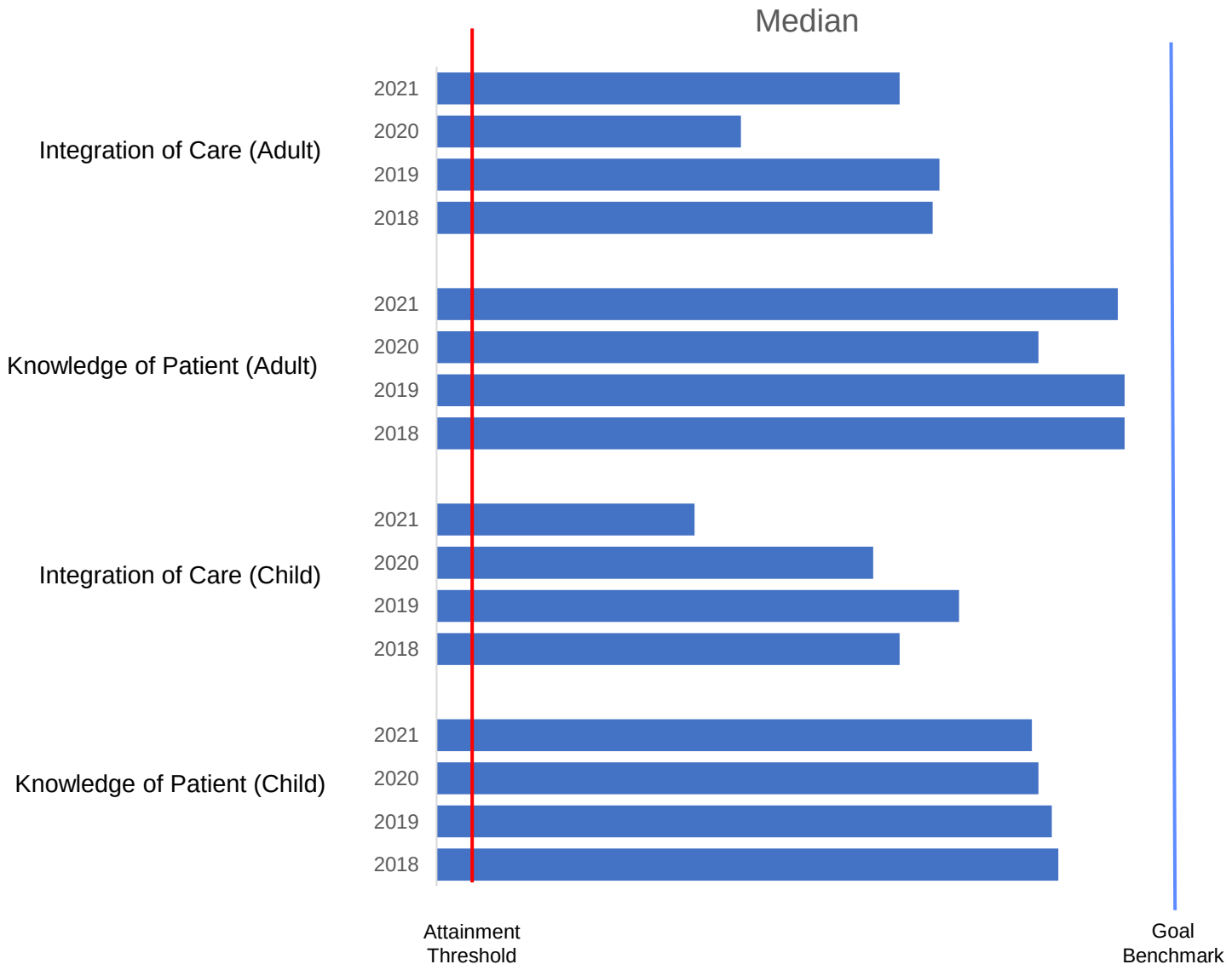
ACO Clinical Quality: Overview of measure scores and comparison between 2018-2021



ACO Member Experience: Overview of measure scores and comparison between 2018-2021



ACO Member Experience: Overview of measure scores and comparison between 2018-2021



Detailed Quality Results (1 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
1. 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	2018	75.8	73.0	77.5	59.69	73.39
			2019	75.6	72.2	77.5		
			2020	72.9	68.9	75.8		
			2021	76.3	73.9	80.6		
2. 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)*	2018	31.9	36.7	26.8	50.03	41.63
			2019	29.3	33.8	26.9		
			2020	40.3	35.1	42.6		
			2021	33.2	31.9	39.0		
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	2018	51.2	45.5	52.4	39.1	57.7
			2019	48.2	42.7	52.1		
			2020	49.3	46.6	52.6		
			2021	47.5	45.5	50.9		
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	0 – 100	2018	35.8	33.8	42.3	23.06	32.56
			2019	46.7	42.6	53.4		
			2020	37.7	33.7	44.9		
			2021	40.7	34.3	49.6		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed Quality Results (2 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
5.a 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	2018	43.5	39.0	50.6	36.8	50.2
			2019	45.6	39.5	51.2		
			2020	47.1	41.4	55.0		
			2021	45.5	41.5	53.7		
5.b 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	2018	16.9	14.3	18.8	15.56	22.96
			2019	16.3	14.0	19.2		
			2020	15.5	13.1	17.6		
			2021	15.8	13.8	18.6		
6. 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	2018	62.2	57.9	64.4	57.2	67.5
			2019	52.0	51.4	57.4		
			2020	57.6	54.2	65.5		
			2021	54.2	53.0	57.2		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed Quality Results (3 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
7. Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	0 – 100	2018	67.2	63.6	72.8	50.96	64.06
			2019	73.2	67.6	75.5		
			2020	60.6	58.2	68.6		
			2021	67.2	60.8	70.6		
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	0 – 100	2018	40.2	19.9	45	28.0	58.3
			2019	42.9	36.2	52.4		
			2020	33.9	25.0	39.3		
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	0 – 1.0 *(lower is better)*	2018	0.94	1.0	0.8	1.18	0.93
			2019	1.1	1.1	0.98		
			2020	1.25	1.3	1.1		
			2021	1.2	1.1	1.5		
10. Childhood Immunization	Percentage of members who received all recommended immunizations by their 2nd birthday	0 – 100	2018	49.9	40.2	60.2	48.9	59.4
			2019	55.7	49.1	63.7		
			2020	56.4	48.3	61.3		
			2021	53.5	46.9	57.3		

** Lower score is better; Screening for Depression and Follow up Plan was not part of the quality score for 2021. + Reported as observed/expected rate*

Detailed Quality Results (4 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
11. Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	0 – 100	2018	32.2	26.9	39.6	31.4	49.4
			2019	41.1	33.2	53.7		
			2020	43.0	35.0	55.9		
			2021	45.6	40.9	50.9		
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	0-100	2018	80.8	71.6	84.7	82.11	89.71
			2019	86.4	80.3	91.0		
			2020	82.5	77.1	89.0		
			2021	85.2	76.7	88.8		
13. Health Related Social Needs	Percentage of members who were screened for health-related social needs in the measurement year	0-100	2018	9.5	1.5	14.6	1.5	23.5
			2019	6.8	2.4	32.9		
			2020	13.4	5.6	18.7		
			2021	25.1	11.0	32.1		
14. Emergency Department Visits for Individuals with Serious Mental Illness or Addiction*+	Number of ED visits for members 18 to 64 years of age with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	0.00-1.00	2018	1.28	1.11	1.42	1.54	1.28
			2019	.99	.93	1.14		
			2020	1.40	1.31	1.53		
			2021	1.5	1.3	1.6		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed Quality Results (5 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
15. Depression Remission and/or Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who received follow-up evaluation with PHQ-9 and experienced response or remission in 4 to 8 months following the elevated score	0-100	2018	4.8	1.6	8.3	1.7	9.2
			2019	4.9	3.2	8.1		
			2020	5.3	2.0	11.7		
			2021	5.6	2.4	10.8		
16. Behavioral Health CP Engagement	Percentage of members 18 to 64 years of age who engaged with a BH CP and received a treatment plan within 3 months (122 days) of CP assignment	0-100	2018	3.5	2.2	5.1	5.4	12.2
			2019	6.8	4.9	11.2		
			2020	10.6	9.1	12.7		
			2021	11.2	10.0	16.7		
17. Long Term Services and Supports CP Engagement	Percentage of members 18 to 64 years of age who engaged with a LTSS CP and received a care plan within 3 months (122 days) of CP assignment	0-100	2018	1.3	0.0	2.3	2.9	9.2
			2019	4.1	2.9	7.3		
			2020	5.1	3.9	6.8		
			2021	8.7	6.3	10.6		
18. Oral Health Evaluation	Percentage of members under age 21 years who received a comprehensive or periodic oral evaluation during the year	0-100	2018	62.6	58.1	63.5	34.28	43.28
			2019	60.8	58.2	63.4		
			2020	44.1	39.6	48.0		
			2021	53.3	48.3	55.1		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed Quality Results (6 of 6): MES Performance Measures

Measure	Description	How it is scored	Survey Group	Year	Median Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Willingness to Recommend	Overall measure of the experience and the provider	0 – 100	Adult	2018	87.9	86.0	89.8	75.0	92.0
				2019	87.0	86.0	88.5		
				2021	85.3	84.4	87.3		
			Child	2018	90.8	89.3	92.8	75.0	92.0
				2019	90.7	88.8	92.9		
				2021	90.2	87.3	91.4		
Communication	Effective communication between provider and patient or caregiver	0 – 100	Adult	2018	89.3	87.7	90.4	75.0	92.0
				2019	89.6	88.3	89.9		
				2021	87.8	86.2	88.8		
			Child	2018	91.8	90.0	93.1	75.0	92.0
				2019	92.5	90.6	93.1		
				2021	91.1	89.9	92.2		
Integration of Care	Effective coordination of services (e.g., labs, referrals, follow-up, and information exchanged between provider, patient, and services)	0 – 100	Adult	2018	79.8	77.7	81.8	70.0	85.0
				2019	79.9	78.0	81.0		
				2021	76.8	75.3	79.7		
			Child	2018	78.4	77.4	81.1	70.0	85.0
				2019	80.4	77.6	81.0		
				2021	78.4	77.4	79.7		
Knowledge of Patient	Provider knowledge of important medical information about patient and understanding patient's challenges to staying healthy	0 – 100	Adult	2018	84.1	81.6	85.1	70.0	85.0
				2019	84.1	82.2	84.6		
				2021	82.3	81.3	83.1		
			Child	2018	87.6	85.5	89.3	75.0	90.0
				2019	87.4	86.4	88.8		
				2021	86.1	84.9	87.9		

^Benchmarks pending finalization from CMS

Primary Care Member Experience Measure Performance

Detail: Overall Care Delivery (#21)

Question Topics	Description	Adult/ Child	Statewide Score				Threshold	Goal
			2018	2019	2020	2021		
Willingness to Recommend	Overall measure of the experience and the provider	Adult	87.1	86.8	85.2	85.3	75.0	92.0
		Child	91.3	91.6	90.9	90.2		
Communication	Effective communication between provider and patient or caregiver	Adult	89.2	88.9	87.1	87.6	75.0	92.0
		Child	92.3	92.4	91.2	90.8		

Detail: Integration/Coordination of Care (#22)

Question Topics	Description	Adult/ Child	Statewide Score				Threshold	Goal
			2018	2019	2020	2021		
Integration of Care	Effective coordination of services (e.g., labs, referrals, follow-up, and information exchanged between provider, patient, and services)	Adult	80.5	80.2	78.1	78.6	70.0	85.0
		Child	80.7	81.1	80.2	79.3	70.0	85.0
Knowledge of Patient	Provider knowledge of important medical information about patient and understanding patient's challenges to staying healthy	Adult	83.7	83.3	81.6	82.0	70.0	85.0
		Child	88.1	88.1	87.2	86.6	75.0	90.0

Member Experience: Additional Primary Care Composites & Questions

Question topics	Description	Adult/ Child	Statewide Score			
			2018	2019	2020	2021
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	63.1	59.2	61.3
		Child	51.2	54.4	52.3	53.5
Behavioral Health*	Provider engagement with patients to talk about their behavioral health needs	Adult	64.9	68.0	63.7	65.2
Child Development**	Provider engagement with patients to talk about their child's physical, emotional and social development	Child	71.0	72.1	68.4	70.0
Pediatric Prevention**	Provider engagement with patients to talk about their child's home environment (addressing exercise, food, computer, safety, etc.)	Child	67.3	68.5	65.3	65.9
Office Staff	Helpfulness of the office staff, and being treated with courtesy and respect	Adult	86.4	86.4	84.1	84.4
		Child	86.9	87.1	86.2	85.6
Organizational Access	Access to timely routine and urgent appointments, and same day response to questions	Adult	80.7	80.3	78.1	77.5
		Child	86.1	85.8	84.2	82.2
Overall Provider Rating	Rating of provider	Adult	88.3	88.0	86.7	87.1
		Child	91.1	91.6	91.0	90.6
Child Provider Communication**	Effective communication between provider and patient	Child	95.7	95.7	95.2	94.9

*There is no BH Child composite in the Primary Care survey.
**These composites are in the Child Primary Care survey only.

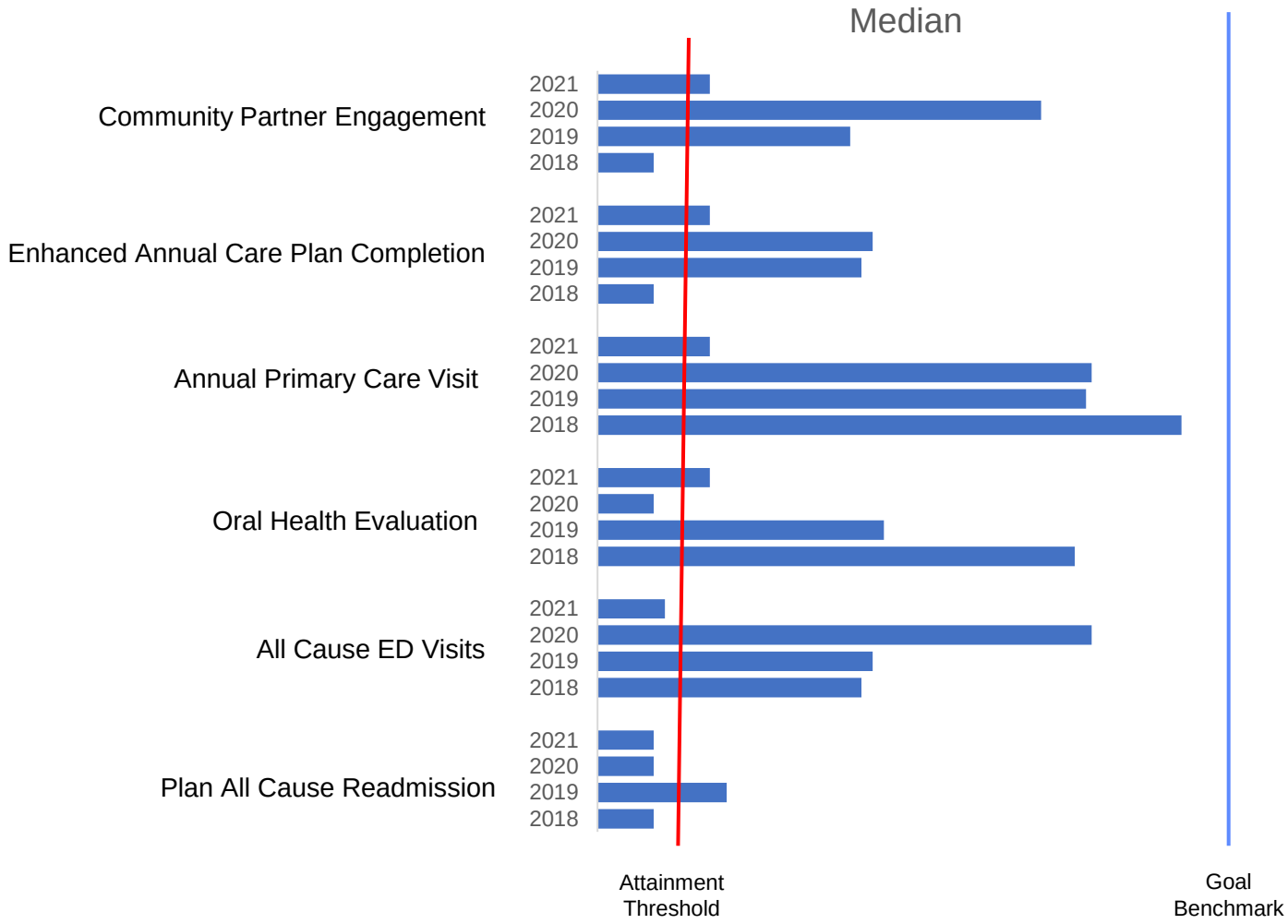
Member Experience: BH Composites (Sets of Questions)

Question topics	Description	Adult/ Child	Statewide Score			
			2018	2019	2020	2021
Willingness to Recommend	Overall measure of the experience and the provider(s)	Adult	80.6	79.4	80.1	79.4
		Child	79.5	81.2	79.0	75.8
Communication	Effective communication between provider and patient	Adult	86.8	85.6	85.5	84.7
		Child	87.1	87.8	86.1	81.8
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	71.3	72.2	71.1
		Child	74.8	78.4	73.6	73.2
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	69.9	70.1	67.9
		Child	75.0	71.0	68.8	66.8
Member Engagement w/ Care Team	How often help or advice was received when member contacted someone from care team	Adult	--	--	74.0	71.3
		Child	--	--	75.3	67.9
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	56.2	58.2	57.3	55.1
		Child	53.4	56.0	55.6	53.8
Needs Met BH	How well needs for mental health service, substance use treatment, and prescription medication were met	Adult	81.8	72.1	72.2	70.2
		Child	77.5	70.8	66.2	63.0
Service Scheduling	Access and availability to services	Adult	75.3	75.2	75.6	73.6
		Child	74.4	77.0	75.1	69.0
Overall Rating	Rating of overall behavioral health services in the last 12 months	Adult	75.6	74.7	75.5	73.7
		Child	75.7	77.0	74.4	71.7
Healthy Living in Community	Care team support in ability to manage physical & mental health, participate in activities with friends/family, self-care at place of residence	Adult	--	--	68.3	67.2
		Child	--	--	70.3	68.6

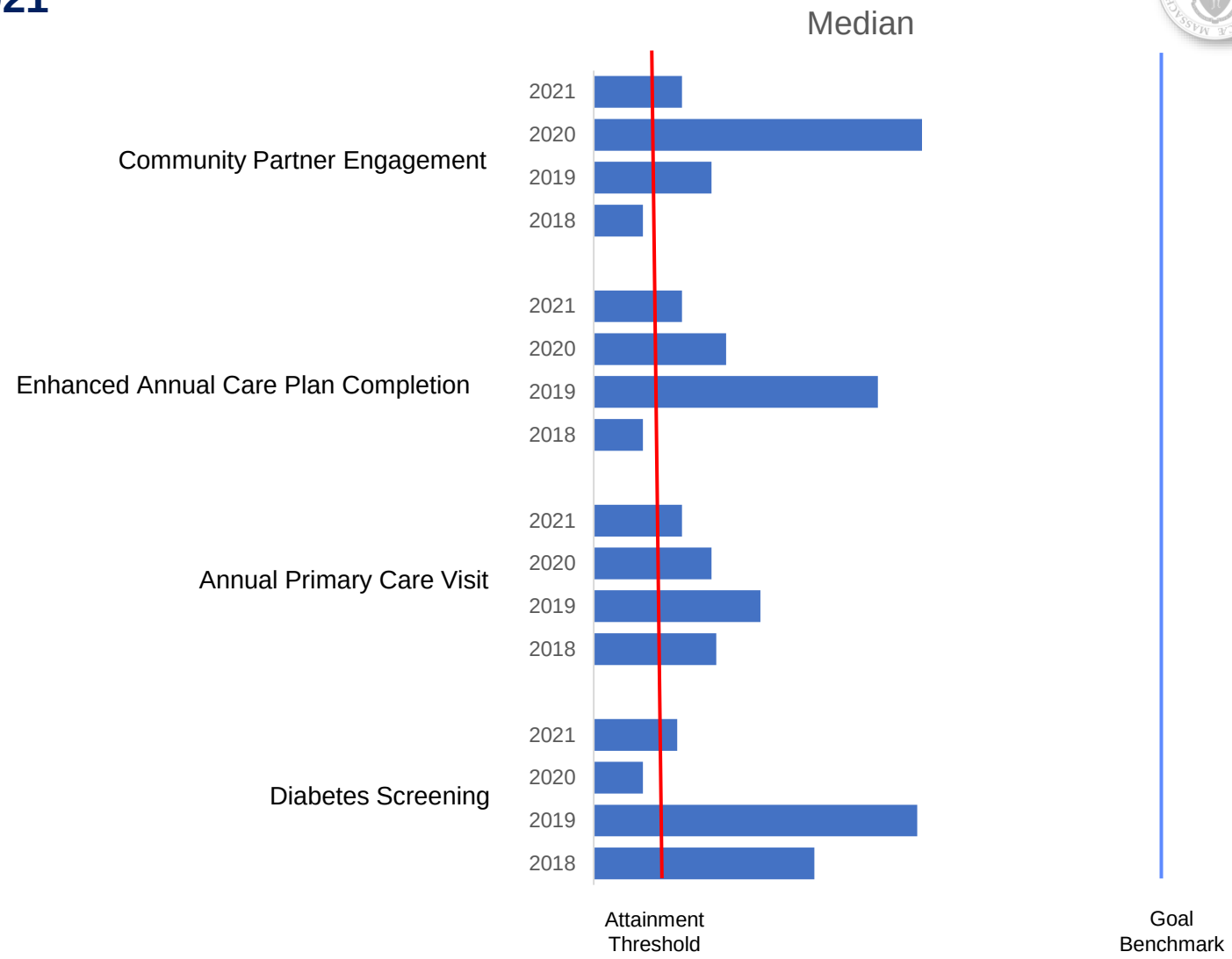
Member Experience: LTSS Composites (Sets of Questions)

Question topics	Description	Adult/ Child	Statewide Score			
			2018	2019	2020	2021
Willingness to Recommend	Overall measure of the experience with LTSS services	Adult	86.0	84.9	84.6	84.1
		Child	86.2	82.3	87.3	86.1
Communication	Effective communication between provider and patient	Adult	86.3	86.3	87.0	85.9
		Child	85.6	85.5	87.3	84.5
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information	Adult	76.7	74.3	73.5	74.4
		Child	75.3	64.2	73.7	73.8
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	71.3	71.4	71.1
		Child	76.3	71.3	71.1	71.5
Member Engagement w/ Care Team	How often help or advice was received when member contacted someone from care team	Adult	--	--	74.7	74.2
		Child	--	--	72.8	70.4
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	75.8	73.8	71.7	71.6
		Child	71.6	61.4	70.2	63.6
Needs Met - Core Services	How well needs for core LTSS services were met (e.g., physical therapy, skilled nursing, day programs)	Adult	82.8	74.8	74.6	73.8
		Child	81.8	71.3	69.2	70.8
Needs Met – Non-core Services	How well needs for non-core LTSS services were met (e.g., assistive technology, transportation services)	Adult	84.0	78.3	77.7	76.2
		Child	83.0	77.8	74.9	73.3
Service Scheduling	Access to and availability of services	Adult	81.7	81.5	80.9	80.3
		Child	81.0	79.1	81.9	80.2
Overall Rating	Rating of overall LTSS services	Adult	78.5	75.1	78.0	75.9
		Child	78.0	74.6	77.1	77.7
Healthy Living in the Community	Care team support in ability to manage physical & mental health, participate in activities with friends/family, self-care at place of residence	Adult	--	--	67.6	67.7
		Child	--	--	71.7	69.9

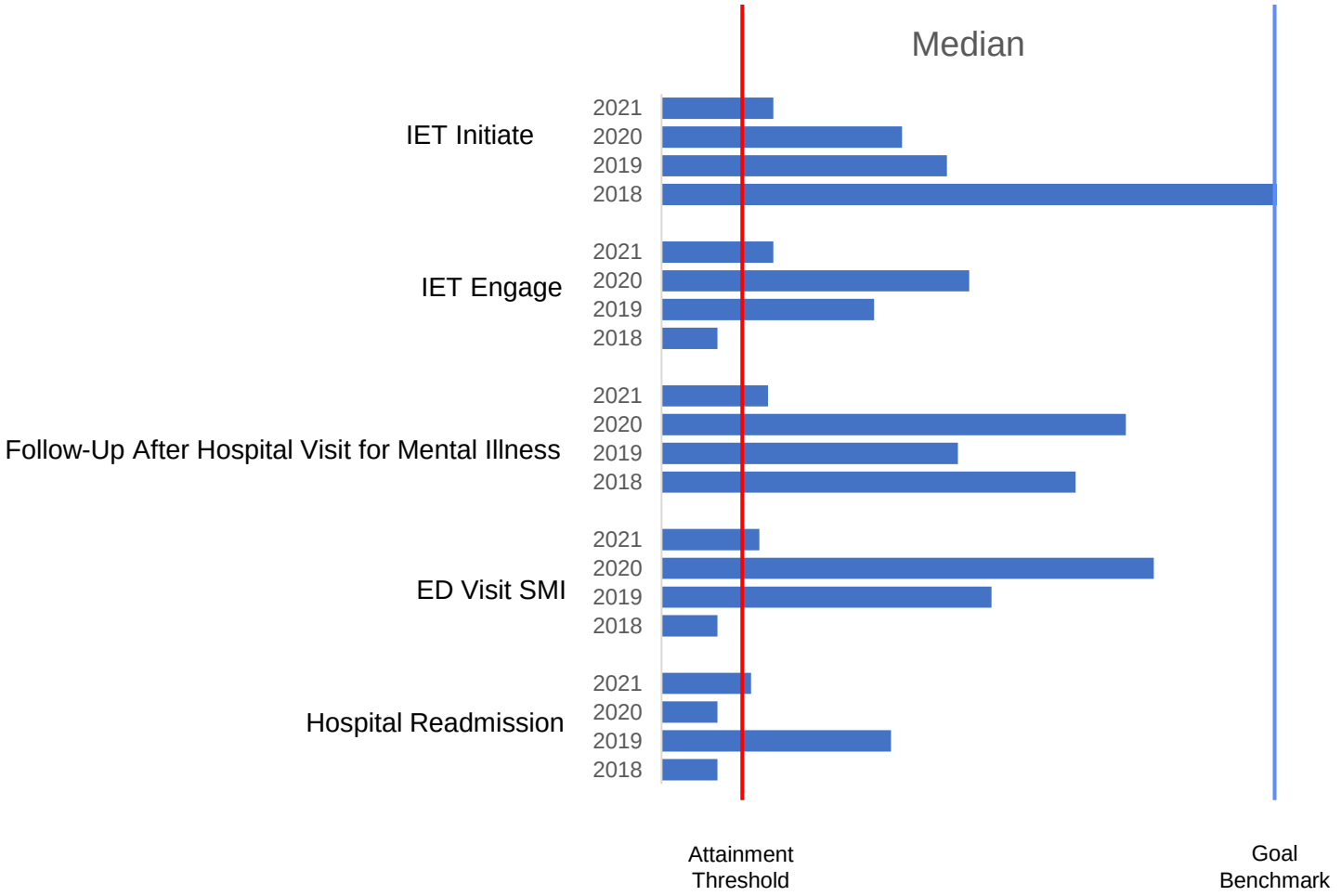
LTSS CP Clinical Quality: Overview of measure scores and comparison between 2018-2021



BH CP Clinical Quality: Overview of measure scores and comparison between 2018-2021



BH CP Clinical Quality: Overview of measure scores and comparison between 2018-2021



Detailed BH CP Quality Results (1 of 7)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Community Partner Engagement	The percentage of Behavioral Health Community Partner assigned enrollees 18 to 64 years of age with documentation of engagement within 122 days of the date of assignment to a BH CP.	0 – 100	2018	2.4	1.0	8.5	4.04	11.71
			2019	5.1	4.0	8.7		
			2020	8.4	6.7	11.2		
			2021	10.1	7.2	14.0		
Enhanced Person-Centered Care Planning	Percentage of enrollees 18 to 64 years of age with timely completion of a new or updated Care Plan during the measurement year	0 – 100	2018	7.0	3.7	19.0	36.03	57.66
			2019	53.3	45.3	62.3		
			2020	46.5	42.8	62.1		
			2021	52.9	40.3	58.2		
Follow-up with BHCP after acute or post-acute stay (3 days)	Percentage of discharges from acute or post-acute stays for enrollees 18 to 64 years of age that were succeeded by a follow-up with a Contractor within 3 business days of discharge	0 – 100	2018	1.0	0.7	2.5	13.13	22.16
			2019	4.9	3.3	8.7		
			2020	15.6	13.1	20.3		
			2021	21.0	11.2	24.2		
Follow-up with BH CP or provider after ED visit	Percentage of ED visits for enrollees 18 to 64 years of age that had a follow-up visit within 7 days of the ED visit	0 – 100	2018	.4	.0	1.4	24.62	51.98
			2019	11.5	6.8	23.1		
			2020	31.3	24.6	45.9		
			2021	40.6	30.1	51.4		

Detailed BH CP Quality Results (2 of 7)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Annual primary care visit	Percentage of enrollees 18 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	0 – 100	2018	52.6	47.4	60.3	46.18	64.13
			2019	54.2	50.0	61.9		
			2020	52.4	48.2	58.4		
			2021	60.2	57.3	66.7		
Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of enrollees 18 to 64 years of age who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiated treatment within 14 days of diagnosis	0 – 100	2018	N/A	N/A	N/A	78.67	85.11
			2019	81.8	79.2	83.3		
			2020	81.3	80.0	84.1		
			2021	94.8	93.4	96.3		
Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of enrollees 18 to 64 years of age who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who received ≥2 additional services within 30 days of the initiation visit	0 – 100	2018	N/A	N/A	N/A	53.16	63.70
			2019	56.1	53.2	62.1		
			2020	57.9	55.5	61.4		
			2021	65.2	62.3	69.0		

Detailed BH CP Quality Results (3 of 7)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	0 – 100	2018	49.5	45.8	52.1	40.24	54.62
			2019	46.5	40.2	49.4		
			2020	51.2	49.6	55.1		
			2021	52.4	47.8	55.2		
Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening test during the measurement year	0 – 100	2018	87.1	84.6	91.4	79.27	86.29
			2019	88.6	84.6	90.8		
			2020	83.3	79.8	85.9		
			2021	84.3	83.6	87.7		
Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on antidepressant medication treatment	0 – 1.0	2018	N/A	N/A	N/A	42.29	51.78
			2019	N/A	N/A	N/A		
			2020	34.7	30.4	38.2		
			2021	52.3	47.1	54.3		

Detailed BH CP and LTSS CP Quality Results (4 of 7)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
BH CP MEASURES								
ED Visits for Adults with SMI, Addiction, or Co-occurring Conditions	The rate of ED visits for enrollees 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	Utilization per 1000 member months (lower is better)	2018	243.1	267.0	219.4	241.1	179.26
			2019	210.5	241.1	196.5		
			2020	192.7	223.1	176.1		
			2021	195.2	174.3	204.9		
Hospital Readmissions (Adult)	The rate of acute unplanned hospital readmissions within 30 days of discharge for enrollees 18 to 64 years of age	0-10 (lower is better)	2018	2.7	2.9	2.5	2.45	1.82
			2019	2.0	2.1	1.6		
			2020	2.3	2.5	2.1		
			2021	2.1	1.9	2.1		
LTSS CP MEASURES								
Community Partner Engagement	Percentage of assigned enrollees 3 to 64 years of age with documentation of engagement within 122 days of assignment to a Community Partner	0-100	2018	1.0	0.8	1.1	2.43	7.45
			2019	4.2	2.4	5.4		
			2020	5.9	3.5	6.2		
			2021	9.6	7.7	11.2		
Enhanced Person-Centered Care Planning	Percentage of enrollees 18 to 64 years of age with timely completion of a new or updated Care Plan during the measurement year	0-100	2018	6.1	3.4	8.8	48.05	59.74
			2019	52.4	44.2	61.9		
			2020	52.6	48.1	54.1		
			2021	63.8	47.4	73.0		

Detailed LTSS CP Quality Results (5 of 7)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Follow-up with LTSS CP After Acute or Post-Acute Stay (3 Business Days)	Percentage of discharges from acute or post-acute stays for enrollees 3 to 64 years of age that were succeeded by a follow-up with a Contractor within 3 business days of discharge	0-100	2018	0.8	0.0	1.7	8.04	30.71
			2019	3.4	1.9	8.5		
			2020	13.8	8.6	23.5		
			2021	24.7	12.5	38.5		
Annual primary care visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	0-100	2018	59.1	55.9	69.1	44.77	62.45
			2019	63.2	53.2	66.6		
			2020	58.2	49.2	67.1		
			2021	75.2	64.8	77.1		
Oral Health Evaluation	Percentage of enrollees 3 to 20 years of age who received a comprehensive or periodic oral evaluation within the measurement year	0-100	2018	67.7	57.8	68.7	45.73	53.95
			2019	64.9	61.5	68.5		
			2020	49.0	42.5	50.8		
			2021	63.1	60.6	65.1		
All-Cause ED Visits	The rate of ED visits for enrollees 3 to 64 years of age	0-100 (lower is better)	2018	66.2	71.6	61.7	74.91	51.50
			2019	65.8	75.0	55.0		
			2020	56.7	63.5	49.3		
			2021	69.7	67.9	76.5		
Hospital Readmissions	The rate of acute unplanned hospital readmissions within 30 days of discharge for enrollees 18 to 64 years of age	0.0-2.0 obs/exp ratio (lower is better)	2018	1.6	1.7	1.2	1.7	1.45
			2019	1.5	1.5	1.3		
			2020	1.7	1.8	1.5		
			2021	1.7	1.6	1.9		

Detailed BHCP Quality Results (6 of 7): MES Performance Measures

Measure	Description	How it is scored	Survey Group	Year	Median Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
BH CP									
Care Team Engagement	Composites related to member connection to care team and resources available within community setting	0 – 100	Adult	2019	66.9	65.0	69.3	63.0	73.0
				2020	66.3	64.8	68.8		
				2021	65.6	62.8	66.9		
Healthy Living in the Community		0 – 100	Adult	2019	N/A	N/A	N/A	64.97	73.92
				2020	66.9	65.3	70.7		
				2021	67.0	64.6	68.6		
Member Engagement with Care Team		0 – 100	Adult	2019	71.2	69.9	74.9	67.0	77.0
				2020	74.2	67.9	75.5		
				2021	69.9	63.9	73.8		

Detailed LTSS CP Quality Results (7 of 7): MES Performance Measures

Measure	Description	How it is scored	Survey Group	Year	Median Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
LTSS CP									
Care Team Engagement	Composites related to member connection to care team and resources available within community setting	0 – 100	Adult	2019	70.2	68.1	73.0	64.8	74.8
				2020	70.8	66.5	72.3		
				2021	66.3	65.5	72.5		
			Child	2019	70.3	63.7	71.8	60	75
				2020	68.9	66.4	72.4		
				2021	70.8	64.0	71.2		
Healthy Living in the Community		0 – 100	Adult	2019	N/A	N/A	N/A	68.8	71.7
				2020	71.0	69.1	71.2		
				2021	68.1	66.2	70.9		
			Child	2019	N/A	N/A	N/A	NA	NA
				2020	70.0	65.0	75.0		
				2021	71.6	69.2	73.8		
Member Engagement with Care Team		0 – 100	Adult	2019	72.0	68.9	77.8	70.0	80.0
				2020	73.2	71.9	76.7		
				2021	72.0	69.6	73.3		
			Child	2019	66.6	58.8	71.4	50.0	80.0
				2020	72.9	69.4	82.3		
				2021	61.5	57.9	66.6		

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BH CPs

- In 2021, MassHealth 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		**Greater Boston:** Quincy **Southern:** Attleboro, Brockton, Fall River, New Bedford, Plymouth, 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, Waltham **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:** Boston Primary, Revere, Somerville, Quincy **Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn **Central:** Framingham, Gardner-Fitchburg, Waltham **Southern:** Brockton

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 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	• *Riverside Community Care* • *Brookline Community Mental Health 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	• *Aspire Health Alliance (Formerly 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, LLC.	• *Aspire Health Alliance (Formerly 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.*	**Greater Boston:** Quincy **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Taunton, Wareham

LTSS CPs

- In 2021, MassHealth 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, Revere
Care Alliance of Western Massachusetts	• *WestMass Elder Care, Inc.* • *Behavioral Health Network, Inc.*	**Central:** Athol **Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
Central Community Health Partnership	• *The Bridge of Central Massachusetts, Inc.* • *Open Sky Community Services, Inc. (formerly Alternatives Unlimited, 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, Oak Bluffs, 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 (JRI)* • *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 **Central:** Waltham
Massachusetts Care Coordination Network	• *Seven Hills Family Services, Inc.* • *Advocates, Inc.* • *Boston Center for Independent Living, Inc.* • *BayPath Elder Services, Inc.* • *Brockton Area Multi Services, Inc. (BAMSI)*	**Greater Boston:** Quincy, Revere **Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, Wareham **Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
Merrimack Valley Community Partnership	• *Elder Services of Merrimack Valley* • *Northeast Independent Living Program, Inc.*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn
North Region LTSS Partnership	• *Bridgewell, Inc.* • *Northeast Arc, Inc.* • *Greater Lynn Senior Services*	**Greater Boston:** Revere **Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn

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DSRIP Expenditures by ACO (Excluding Delivery System Transformation Initiatives Funding)

ACO Name	CY2021 Startup/Ongoing Expenditures	CY 2021 Flexible Services Expenditures	CY 2021 Total DSRIP Expenditures
Atrius Health	$2.4M	$90K	$2.5M
Boston Accountable Care Organization	$9.3M	$2,018K	$11.3M
Baystate Health Care Alliance	$2.8M	$1,231K	$4.1M
Boston Children's Health ACO	$16.4M	$2,676K	$19.1M
Health Collaborative of the Berkshires	$1.6M	$839K	$2.4M
Beth Israel Deaconess Care Organization	$2.7M	$432K	$3.2M
Community Care Cooperative	$11.5M	$5,637K	$17.2M
Cambridge Health Alliance	$2.3M	$654K	$3.0M
Lahey Health	$0.4M	$215K	$0.6M
Mercy Medical Center	$2.1M	$126K	$2.2M
Merrimack Valley ACO	$3.0M	$2,222K	$5.3M
Partners HealthCare Choice	$11.1M	$2,300K	$13.4M
Reliant Medical Group	$2.2M	$55K	$2.2M
Signature Healthcare	$2.1M	$119K	$2.2M
Steward Health Choice	$11.4M	$3,292K	$14.7M
Southcoast Health	$1.2M	$109K	$1.3M
Wellforce	$4.8M	$610K	$5.4M
Total	**$87.5M**	**$22.6M**	**$110.1M**

DSRIP Expenditures by CP

CP Name	CY 2021 Infrastructure Expenditures	CY 2021 Care Coordination Payments	Total 2021 DSRIP Expenditures
Alternatives Unlimited, Inc.	$0.1M	$1.0M	$1.2M
Behavioral Health Network	$0.6M	$5.0M	$5.6M
Behavioral Health Partners of Metrowest	$0.9M	$6.9M	$7.8M
Boston Alliance Partners (BMC/BAP)	$0.3M	$1.8M	$2.0M
Boston Health Care for the Homeless	$0.3M	$3.3M	$3.6M
Brien Center	$0.4M	$0.9M	$1.4M
Care Alliance of Western MA (CAWM)	$0.0M	$1.2M	$1.2M
Clinical and Support Options	$0.1M	$0.8M	$0.9M
Community Care Partners (CCP)	$1.8M	$7.4M	$9.2M
Community Counseling of Bristol County (BH)	$1.2M	$8.4M	$9.7M
Community Healthlink	$0.3M	$1.5M	$1.8M
Eliot Community Partner	$0.6M	$5.9M	$6.4M
Family Service Association	$0.4M	$1.6M	$2.1M
Greater Lowell Behavioral Health	$0.3M	$1.8M	$2.0M
High Point Treatment Center (HPTC) (BH)	$1.0M	$5.4M	$6.4M
Innovative Care Partners, LLC (ICP) LTSS	$0.3M	$4.5M	$4.8M
Innovative Care Partners, LLC. (ICP) BH	$0.6M	$1.8M	$2.5M
Lahey Health and BH Services	$0.2M	$1.7M	$2.0M
LTSS Care Partners (LTSSCP)	$0.4M	$1.4M	$1.8M
Massachusetts Care Coordination Network (MCCN) (LTSS)	$0.7M	$2.1M	$2.8M
Merrimack Valley CP (ESMV)	$0.3M	$0.9M	$1.1M
Northern Region LTSS Partner (GLSS)	$0.3M	$0.7M	$1.0M
Riverside Community Care, Inc.	$1.1M	$4.6M	$5.8M
Southeast	$0.7M	$3.1M	$3.7M
Southshore	$0.3M	$1.4M	$1.7M
Stanley Street Treatment and Resources	$0.8M	$3.1M	$3.9M
The Bridge of Central Massachusetts, Inc. (The Bridge) (BH)	$0.4M	$2.5M	$3.0M
TOTAL	**$14.5M**	**$80.9M**	**$95.3M**

DSRIP Funding by Statewide Investments Program

Program	Funding as of 12/31/2021
Community-Based Workforce	
Student Loan Repayment Program	$10.1M
Behavioral Health Workforce Development Program	$1.7M
Community Partners (CP) Recruitment Incentive Program	$1.1M
Primary Care/Behavioral Health Special Projects Program	$2.9M
Family Medicine/Family Nurse Practitioner Residency Program	$6.7M
Community Mental Health Center (CMHC) Behavioral Health (BH) Recruitment Program	$3.7M
Subtotal | Community-Based Workforce	$26.4M
Frontline Workforce	
Community Health Worker (CHW) Training Capacity Expansion Grant Program	$1.1M
Peer Specialist Training Capacity Expansion Grant Program	$0.5M
Community Health Worker (CHW) Supervisor Training Grant Program	$0.8M
Competency-Based Training Program	$2.9M
Subtotal | Frontline Workforce	$5.4M
Capacity Building for ACOs, CPs, CSAs, and Providers	
Technical Assistance Program for ACOs and CPs	$24.8M
Community Health Center (CHC) Readiness Program	$2.0M
Standardized Online Training for CPs and CSAs	$0.5M
Alternative Payment Methods (APM) Preparation Fund	$2.2M
Subtotal | Capacity Building for ACOs, CPs, CSAs, and Providers	$29.5M
Initiatives to Address Statewide Gaps in Care Delivery	
Enhanced Diversionary Behavioral Health Activities	$1.3M
Accessibility Improvement Program	$5.5M
Subtotal | Initiatives to Address Statewide Gaps in Accessibility	$6.8M
Total Statewide Investments Spending Thru 12/31/2021	**$68.2M**