MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Massachusetts Care Coordination Network (MCCN)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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Massachusetts Care Coordination Network (MCCN)

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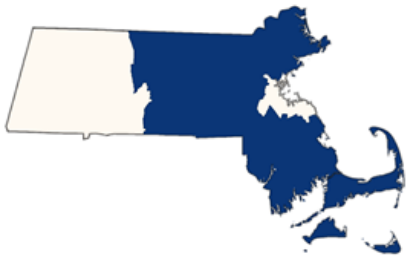
A Long-Term Services and Supports Community Partner

Organization Overview

MCCN operates in the Northern, Central and Southern with strong Affiliated Partners and Material Subcontractors, all of whom have long histories within the three service regions. Partner organizations are health and human services agencies that provide integrated comprehensive care coordination for people who have complex lifelong needs.

SERVICE AREA



POPULATIONS SERVED

- MCCN serves individuals with complex long-term services and supports (LTSS) needs, brain injury or cognitive impairments, physical disabilities, and intellectual and developmental disabilities (I/DD), including autism.
- MCCN supports children and youth (ages 3 - 21), and older adults (up to age 64) with LTSS needs. Individuals for whom English is not their primary language are supported by culturally competent staff and solid system for accessing language supports, both electronically and in person.

2,040
Members Enrolled as of December 2019

FOCUS AREA	IA FINDINGS	
Organizational Structure and Engagement	*On Track*	
Integration of Systems and Processes	*On Track*	
Workforce Development	*On Track*	
Health Information Technology and Exchange	*On Track*	*Limited Recommendations*
Care Model	*On Track*	*Limited Recommendations*

IMPLEMENTATION HIGHLIGHTS

- MCCN's Quality Management Committee developed a measure of caregiver stress, implemented strategies to support caregivers, and set associated quality improvement goals.
- MCCN decentralized the care plan submission process which is now managed by MCCN regional supervisors. Regional supervisors built relationships with primary care providers (PCPs) and educated them about the CP program and reduced the time care plans are outstanding pending PCP signatures.
- MCCN established read-only access to some ACO partners' electronic health records, allowing care coordinators to monitor members' participation in preventative care, identify barriers to accessing care, and ensure quality metrics are met.

Statewide Investment Utilization:

- Student Loan Repayment Program, 3 Care Coordinators participating
- Community Health Worker Trainings
- Technical Assistance
- CP Recruitment Incentive Program

A complete description of the sources can be found on the reverse/following page.

LIST OF SOURCES FOR INFOGRAPHIC

Organization Overview	A description of the organization as a whole, not limited to the Community Partner role.
Service area maps	Shaded area represents service area based on zip codes; data file provided by MassHealth.
Members Enrolled	Community Partner Enrollment Snapshot (12/13/2019)
Population Served	Paraphrased from the CPs Full Participation Plan.
Implementation Highlights	Paraphrased from the required annual and semi-annual progress reports submitted by the CP to MassHealth.
Statewide Investment Utilization	Information contained in reports provided by MassHealth to the IA

INTRODUCTION

Centers for Medicare and Medicaid Services' (CMS') requirements for the MassHealth Section 1115 Demonstration specify that an independent assessment of progress of the Delivery System Reform Incentive Payment (DSRIP) Program must be conducted at the Demonstration midpoint. In satisfaction of this requirement, MassHealth has contracted with the Public Consulting Group to serve as the Independent Assessor (IA) and conduct the Midpoint Assessment (MPA). The IA used participation plans, annual and semi-annual reports, and key informant interviews (KIIs) to assess progress of Community Partners (CPs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018.

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of five focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator[1] (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download).

The question addressed by this assessment is:

> *To what extent has the CP taken organizational level actions, across five areas of focus, to transform care delivery under an accountable and integrated care model?*

This report provides the results of the IA's assessment of the CP that is the subject of this report. The CP should carefully consider the recommendations provided by the IA, and MassHealth will encourage the CP to take steps to implement the recommendations, where appropriate. Any action taken in response to the recommendations must comply with contractual requirements and programmatic guidance.

MPA FRAMEWORK

The MPA findings cover five "focus areas" or aspects of health system transformation. These were derived from the DSRIP logic model (Appendix I) by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement
2. Integration of Systems and Processes
3. Workforce Development
4. Health Information Technology and Exchange
5. Care Model

Table 1 shows the CP actions that correspond to each focus area. The CP actions are broad enough to be accomplished in a variety of ways by different organizations, and the scope of the IA is to assess progress, not to determine the best approach for a CP to take.

The focus area framework was used to assess each entity's progress. A rating of "On track" indicates that the CP has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated "On track with limited recommendations" or, in the case of

[1] The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

more substantial gaps, “Opportunity for improvement.” See Methodology section for an explanation of the threshold setting process for the ratings.

Table 1. Framework for Organizational Assessment of CPs

Focus Area	CP Actions
Organizational Structure and Governance	• CPs established with specific governance, scope, scale, & leadership • CPs engage constituent entities in delivery system change
Integration of Systems and Processes	• CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) • CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) • CPs establish structures and processes for joint management of performance and quality, and problem solving
Workforce Development	• CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	• CPs develop health information technology and exchange (HIT/HIE) infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP, and externally (e.g. Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs); behavioral health (BH), long term services and supports (LTSS), and specialty providers; social service delivery entities)
Care Model	• CPs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))

METHODOLOGY

The IA employed a qualitative approach to assess CP progress towards DSRIP goals, drawing on a variety of data sources to assess organizational performance in each focus area. The IA performed a desk review of participants’ submitted reports and of MassHealth supplementary data, covering the period of July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018. These included Full Participation Plans, annual and semi-annual reports, budgets and budget narratives. A supplementary source was the transcripts of KIIs of CP leaders conducted jointly by the IA and the IE.

The need for a realistic threshold of expected progress, in the absence of any pre-established benchmark, led the IA to use a semi-empirical approach to define the state that should be considered “On track.” As such, the IA’s approach was to first investigate the progress of the full CP cohort in order to calibrate expectations and define thresholds for assessment.

Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans and annual and semi-annual reports. This horizontal review identified a broad range of activities and capabilities that fell within the focus areas, yielding specific operational examples of how CPs can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item and its relevance to the focus area. A descriptive definition of On track performance for each focus area was developed from the items that had been adopted by a plurality of entities. Items that had been accomplished by only a small number of CPs were considered to be

promising practices, not expectations at midpoint. This calibrated the threshold for expected progress to the actual performance of the CP cohort as a whole.

Qualitative coding of documents was used to aggregate the data for each CP by focus area, and then coded excerpts were reviewed to assess whether and how each CP had met the defined threshold for each focus area. The assessment was holistic and did not require that entities meet every item listed for a focus area. A finding of On track was made where the available evidence demonstrated that the entity had accomplished all or nearly all of the expected items, and no need for remediation was identified. When evidence from coded documents was lacking for a specific action, additional information was sought through a keyword search of KII transcripts. Prior to finalizing the findings for an entity, the team convened to confirm that thresholds had been applied consistently and that the reasoning was clearly articulated and documented.

See Appendix II for a more detailed description of the methodology.

CP BACKGROUND[2]

Massachusetts Care Coordination Network (MCCN) is long-term services and supports (LTSS) CP.

MCCN is the largest LTSS CP in Massachusetts and is a partnership of six health and human services agencies, Advocates, Brockton Area Multi Service (BAMSI), Bay Path Elder Services, Boston Center for Independent Living, and Horace Mann Education Associates (as a non-voting member), with Seven Hills Family Services serving as the lead entity. The Affiliated Partners (APs) and Material Subcontractors, all have long histories in the three service regions in which the CP operates. As a LTSS CP, MCCN provides integrated comprehensive care coordination for people who have complex lifelong needs.[3]

MCCN's service area spans across the Northern, Southern, and Central regions of Massachusetts. MCCN serves MassHealth members in these areas who present with complex LTSS needs, brain injury or cognitive impairments, physical disabilities, intellectual disabilities, and developmental disabilities (including autism). MCCN also coordinates LTSS services for older adults (up to age 64), children and youth (ages three-21), and individuals, residing in the CP service area, for whom English is not their primary language.

As of December 2019, 2,040 members were enrolled with MCCN[4].

SUMMARY OF FINDINGS

The IA finds that MCCN is On track or On track with limited recommendations in five of five focus areas..

Focus Area	IA Findings
Organizational Structure and Engagement	On track
Integration of Systems and Processes	On track
Workforce Development	On track
Health Information Technology and Exchange	On track with limited recommendations
Care Model	On track with limited recommendations

[2] Background information is summarized from the organizations Full Participation Plan.

[3] Some CPs enter into agreements with Affiliated Partners: organizations or entities that operate jointly under a formal written management agreement with the CP to provide member supports.

[4] Community Partner Enrollment Snapshot (12/13/2019).

FOCUS AREA LEVEL PROGRESS

The following section outlines the CP's progress across the five focus areas. Each section begins with a description of the established CP actions associated with an On track assessment. This description is followed by a detailed summary of the CP's results across all indicators associated with the focus area. This discussion includes specific examples of progress against the CP's participation plan as well as achievements and or promising practices, and recommendations where applicable. The CP should carefully consider the recommendations provided by the IA, and MassHealth will encourage CPs to take steps to implement the recommendations, where appropriate. Any action taken in response to the recommendations must be taken in accordance with program guidance and contractual requirements.

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

- ✓ **Executive Board**
    - has a well-established executive board which regularly holds meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies; and
    - is led by governing bodies that interface with Affiliated Partners (APs) through regularly scheduled channels (at least quarterly).
- ✓ **Consumer Advisory Board (CAB)**
    - has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.
- ✓ **Quality Management Committee (QMC)**
    - has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

Results

The IA finds that MCCN is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

MCCN's leadership team, including representatives from each AP, meets monthly. MCCN's core leadership team includes the Director, Program Manager, IT Coordinator, Healthcare Data Analyst, Marketing Specialist, and Billing Specialist. MCCN convenes leadership committees dedicated to operations, quality, and governance; these meet regularly to discuss operations, strategize more efficient and effective workflows to support the care coordination staff, and ensure that all partners are kept apprised of necessary program information.

Consumer Advisory Board

MCCN has established and maintains a CAB that meets quarterly. To date, MCCN's CAB has held four meetings. CAB membership includes members engaged in CP supports, family members, and other caregivers who reflect the diversity of the MCCN population. Currently the CAB is comprised of

11 members and chaired by a member who is engaged in MCCN's supports. To encourage participation on the board, MCCN offers CAB members a grocery store gift card incentive for each meeting they attend.

MCCN relies on the relationships care coordinators have with their assigned members and members' families to assist with the recruitment of CAB members. MCCN seeks to include CAB members that represent different disabilities, cultures, and geographic areas so that the board is representative of the population served.

Quality Management Committee

MCCN's QMC membership includes members engaged in CP supports, CP management, care supervisors, and care coordinators. The QMC meets monthly and is responsible for maintaining MCCN's QI plan. In addition to developing quality measures that focus on the target population's health, MCCN's QMC has established a QI initiative focused on caregiver stress. MCCN reports that this quality initiative will allow the CP to better understand the needs of caregivers and implement strategies to support these individuals. Quality management program activities and results are reported to the MCCN QMC on a quarterly basis.

Recommendations

The IA has no recommendations for the Organizational Structure and Engagement focus area.

Promising practices that CPs have found useful in this area include:

- ✓ **Executive Board**
    - holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs);
    - conducting one-on-one quarterly site visits with APs and CEs;
    - holding weekly conferences with frontline staff to encourage interdisciplinary collaboration;
    - identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)[5] Joint Operating Committee;
    - establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and
    - staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.
- ✓ **Consumer Advisory Board**
    - seeking proven best practices for member recruitment and meeting structure from experienced organizations in the service area(s) that have successfully run their own consumer/patient advisory groups;

[5] For the purpose of this report, the term ACO refers to all ACO health plan options: Accountable Care Partnership Plans, Primary Care ACO plans, and the Managed Care Administered ACO plan.

- adapting meeting schedules to accommodate the needs of members. For example, scheduling meetings at times feasible for members who are queuing at homeless shelters in the afternoon;
- hosting meetings in centrally located community spaces that are easy to get to and familiar to members;
- adapting in-person participation requirements to allow participation by phone and providing quiet space and phone access at locations convenient for members;
- limiting CP staff presence at CAB meetings to a small number of consistent individuals, so that members are the majority in attendance and become familiar with the staff;
- sending reminders to members in multiple formats prior to each meeting to increase attendance, including reminder letters and phone calls;
- incentivizing participation by paying members for their time, most often through relevant and useful gift cards;
- incentivizing participation by providing food at meetings; and
- presenting performance data and updates to CAB members to show how their input is driving changes in the organization.

✓ **Quality Management Committee**

- establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
- scheduling regular presentations about best practices related to quality metrics;
- adopting a purposeful organizational QI strategy such as Lean Six Sigma or PDSA cycles;
- integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data; and
- ensuring that management or executive level staff roles explicitly include oversight of performance data analysis, identification of performance gaps, and reporting gaps as potential QI initiatives through the appropriate channels.

2. INTEGRATION OF SYSTEMS AND PROCESSES

On Track Description

Characteristics of CPs considered On track:

✓ **Joint approach to member engagement**

- has established centralized processes for the exchange of care plans;
- has a systematic approach to engaging Primary Care Providers (PCPs) to receive sign-off on care plans;
- exchanges and updates enrollee contact information among CP and ACO/MCO regularly; and

- dedicates staff resources to ensure timely (usually daily) reviews of ACO/MCO spreadsheets to assist with outreach and engagement efforts.

✓ **Integration with ACOs and MCOs**

- holds meeting with key contacts at ACOs/MCOs to identify effective workflows and communication methods;
- conducts routine case review calls with ACOs/MCOs about members; and
- dedicates staff resources for the timely review of real-time enrollee clinical event data (Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT)) to facilitate clinical integration).

✓ **Joint management of performance and quality**

- conducts data-driven quality initiatives to track and improve member engagement;
- has established comprehensive care plan review processes with ACOs/MCOs to support care coordinators in their effort to engage PCPs in comprehensive care plan review; and
- disseminates audit reports to each member organization, in some cases using an interactive dashboard to disseminate data on key quality metrics.

Results

The IA finds that MCCN is **On track with no recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

MCCN has implemented a centralized process to exchange care plans and other member files with ACO and MCO partners. These Documented Processes include the exchange of member files via Secure File Transfer Protocol (SFTP), secure email, and a secure file-sharing application. Documented Processes are in place for the sharing of assignment data, member assignment changes, LTSS outreach data, care coordination information, recommended LTSS services, and member information. The Associate Director of MCCN is the primary point of contact for the ACO and MCO partners and facilitates the exchange of information via designated SFTP sites or secure email depending on the agreed upon Documented Process.

To engage PCPs in the approval of member care plans, MCCN decentralized the care plan submission process. Regional supervisors were given the responsibility of engaging PCP offices in the care plan process rather than MCCN's central management team. Through this approach, MCCN regional supervisors have fostered relationships with the larger practices in their regions, increased PCP education about the CP program, and reduced the overall number of days care plans are left pending PCP signature.

MCCN has hired three associate care coordinators who are responsible for verifying and updating member contact information and conducting initial outreach to assigned members. Associate care coordinators verify and update contact information by calling PCP offices and reviewing ENS/ADT notifications. In 2019, MCCN conducted a pilot program focused on increasing the percentage of completed comprehensive assessments with one ACO partner. MCCN implemented bi-weekly calls to exchange member information based on recent assignment files. Once members are engaged with MCCN, the CP collaborates with ACOs to maintain member engagement, organize the member's care team, and reduce redundancies in care.

Integration with ACOs and MCOs

MCCN attends quarterly meetings with ACO and MCO partners. MCCN uses this forum to identify operational efficiencies and develop strategies to ensure effective bi-directional communication between the entities. MCCN also conducts regular case conferences with ACO partners. Case conferences give the MCCN regional supervisor and care coordinators an opportunity to exchange contact information for hard to reach members and reduce the duplication of services. With one ACO partner, MCCN facilitates bi-weekly in-person meetings with the ACO care manager, PCP designee, and the MCCN care coordinator to discuss member cases and obtain care plan sign-off.

To facilitate clinical integration with ACOs/MCOs, MCCN has subscribed to ENS/ADT notifications. Currently, six of MCCN's ACO partners are connected to MCCN's contracted ENS vendor. MCCN reports that a number of local acute care hospitals, skilled nursing facilities, and health home agencies are also connected to this ENS. MCCN regional supervisors, care coordinators, and associate care coordinators review ENS/ADT notification on a daily basis and have real-time alerts emailed to them. Notifications from these partners have allowed MCCN care coordinators to conduct outreach more effectively to members and complete three-day post Discharge face-to-face member visits.

> CP Administrator Perspective: *"We have found the ACO-CP relationship to be most effective when case conferences are a regular integrated component of our collaboration. This increases member engagement, organizes the member's care team, reduces redundancies, and ensures that a member's care plan is person-centered and comprehensive."*

Joint management of performance and quality

MCCN has focused its quality management efforts on process measures related to member outreach and engagement. MCCN tracks progress on the number of members assigned, engaged, and discharged; number and type of outreach and Qualifying Activities conducted; documentation and timeframe for signing member agreements; documentation and timeframe for developing the LTSS care plan; care transitions; and returned approved care plans.

MCCN has also developed outcomes measures related to the member population, healthcare delivery, and cost to track and improve member outcomes and engagement in collaboration with ACO/MCO partners. In 2019, MCCN's analytics team obtained baseline data to measure outcomes more effectively. Additionally, MCCN hired a healthcare data analyst who has been able to analyze and establish baseline data for outreach and engagement metrics.

MCCN has established processes with ACOs/MCOs to support care coordinators' efforts to engage PCPs in care plan review and approval. MCCN regional supervisors, who have established relationships with local PCP offices, manage the care plan transmittal process and promote timely completion and approval of the care plan. Additionally, MCCN leadership has worked with ACOs and MCOs to standardize Documented Processes which has led to a more streamlined care planning process. MCCN and ACO partners have also discussed best practices and identified barriers to the care plan transmission process. The entities focus on the specific systems, people, and other concerns that interfere with the process.

MCCN disseminates real-time status reports that monitor and evaluate performance on outreach, care planning, and quality management activities to the care coordinator supervisors and care coordination staff as a means of increased accountability. MCCN has created a quality dashboard that allows the care teams to assess their performance and view member information in real time.

Recommendations

The IA has no recommendations for the Integration of Systems and Processes focus area.

Promising practices that CPs have found useful in this area include:

✓ **Joint approach to member engagement**

- adopting systems, preferably automated, that process new ACO member files instantaneously, inputting member information in the applicable platform and reconciling those members with existing eligibility lists, enabling the CP to engage with the new member list without delay;
- redesigning workflows and automated notifications so that receipt of a comprehensive assessment from an ACO/MCO partner generates a new outreach attempt;
- establishing on-demand access to full member records through partners' EHRs;
- tracking members' upcoming appointments through partners' EHRs to enable staff to connect with members in the waiting room prior to their appointment;
- negotiating fast track primary care appointments with practice sites to ensure that members receive timely care and to enable PCPs to engage with and sign off on the member's care plan;
- collaborating with interdisciplinary staff, such as CE and AP program managers, clinical care managers, nurses, and care coordinators to develop a promising practices toolkit for PCP engagement and care plan sign-off;
- hiring a dedicated community liaison to build relationships with PCPs and educate them about the benefits provided by the CP program;
- embedding care coordination staff at PCP practices, particularly those that require an in-person visit as a prerequisite for care plan sign off;
- determining the date of the member's last PCP visit within a month of that member's assignment, and proactively scheduling an appointment on behalf of any member who has not had a PCP visit in the prior 12 months;
- developing a single point of contact for ACO/MCO partner referrals to review prospective members, research previous treatment history, and to strategize on how to accommodate new members with current CP care team capacity;
- identifying a lead member organization or CP care team to align with each ACO/MCO partner to promote and facilitate relationship building between CP care teams and ACO/MCO clinical staff; and
- implementing a real-time communication tool such as secure texting to communicate with ACO practices about shared members.

✓ **Integration with ACOs and MCOs**

- attending regularly occurring case conferences with PCPs to review member cases and obtain PCP sign-off on care plans;
- collaborating with state agencies to improve management of mutual members. For example, creating an FAQ document to explain how the two organizations may effectively work together to provide the best care for members or conducting complex case conferences;

- scheduling joint visits with the PCP, ACO/MCO clinical care team representative, and the CP care coordinator to present a unified team to the member and establish distinct support roles and who the member can contact in to address various needs; and
- collaborating with PCP practice sites so that CP care coordinators are invited to meet with members onsite prior to their clinical appointments.

✓ **Joint management of performance and quality**

- monitoring process metrics associated with member outreach and engagement such as the number of interactions staff have with members, how many interactions typically lead to member engagement, and the types of actions most conducted by CP staff;
- sending weekly updates to all ACO partners listing members who recently signed a participation form, members who have a comprehensive assessment outstanding, and members who have unsigned care plans that are due or overdue;
- having clinical staff perform comprehensive care plan reviews to improve the quality and thoroughness of those plans prior to submission to PCPs for sign-off;
- developing dashboards that combine data from MassHealth, ACO and MCO partners, and the EHR to track members' affiliations and enrollment status, thus helping staff target members for engagement;
- generating a reminder list of unsigned care plans for ACO and MCO key contacts;
- maintaining a dedicated web portal to share information with CP care teams across member organizations. Shared information includes contact information of primary care practices; the LTSS/BH provider network and local social services providers; training materials; and policies and procedures;
- developing a daily report that compares ACO member information in the Eligibility Verification System (EVS) to information contained in the CP's EHR to identify members' ACO assignment changes and keep the members' records in the EHR up to date; and
- embedding staff at local Emergency Departments (EDs) to improve outreach to members not engaged in regular care, particularly members experiencing homelessness, and connect them to care coordination supports.

3. WORKFORCE DEVELOPMENT

On Track Description

Characteristics of CPs considered On track:

✓ **Recruitment and retention**

- does not have persistent vacancies in planned staffing roles;
- offers a variety of incentives to attract candidates and retain staff, and uses a variety of mechanisms to recruit and retain staff; and
- employs tactics to ensure diversity in the workplace and design staff incentives and performance bonuses around CP priorities such as enrollee engagement, signed care plans and intensive care coordination.

- ✓ **Training**
    - develops policies and procedures to ensure staff meet the contractual training requirements and offer training to all new staff based on program requirements; and
    - holds ongoing (often monthly) training to ensure staff are up to date on best practices and advancements in the field.

Results

The IA finds that MCCN is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

MCCN reports no persistent vacancies in planned staff roles; nearly all positions are currently filled. MCCN has been able to mitigate staff recruitment and retention challenges, despite competition among other CPs for the same candidates. MCCN utilized talent management software, human resource recruiters, and external job boards to recruit candidates. MCCN has taken member enrollment volume into consideration when hiring care coordinators and is cognizant of potential care coordinator caseloads. MCCN's APs offer competitive salaries and a robust benefits package to attract candidates. MCCN has hired a diverse workforce, successfully recruiting staff who are culturally and linguistically reflective of the member population served.

To recruit and retain care coordination staff, MCCN utilized the DSRIP SWI Student Loan Repayment program. Additionally, MCCN incentivizes staff retention with bonuses for care coordinators based on longevity and achievement of staff performance milestones. MCCN's benefits plan also offers opportunities for conference and seminar attendance and other career advancement opportunities. Despite investments in retention, MCCN has experienced staff turnover through all regions, with care coordination staff reporting frustration with the expectations of the position. To address this challenge, MCCN has made staff retention a focus of the QMC and has developed a staff satisfaction survey to better understand how to retain staff. MCCN circulates the survey to CP staff annually.

Training

MCCN has developed a training manual and schedule for staff. MCCN's training model ensures that staff meet all contractual training requirements. New staff participate in an in-person orientation training taught by the MCCN APs. During orientation, all staff receive training in whistleblower policy, ethical conduct, fraud, waste, and abuse, records privacy/confidentiality and HIPAA, identification and notification of potential abuse, statement of confidentiality, violence in the workplace, sexual harassment, and cultural competency. Training in core competencies for MCCN's program is ongoing. Modules include Introduction to LTSS care, eligibility criteria for MassHealth State Plan LTSS, MassHealth Community Partners program guide, use of the care management software for the CP program, competencies in care planning and development, grievance procedures for members, motivational interviewing, independent living and recovery principles, enrollee engagement strategies, eligibility for the MassHealth State Plan, etc.

MCCN conducts ongoing training through quarterly educational meetings and annual refresher trainings on the core competencies. In addition, MCCN gives staff access to an online learning management system where educational materials can be accessed at any time. MCCN has also had staff attend DSRIP SWI pop-up events hosted through the MA DSRIP TA Marketplace[6], and reports

[6] The Massachusetts Delivery System Reform Incentive Payment Technical Assistance Marketplace (MA DSRIP TA Marketplace) provides resources and training for MassHealth Accountable Care Organizations (ACOs), Community Partners (CPs), and Community Service Agencies (CSAs).

that these learning opportunities advance MCCN's goal of learning from stakeholders in other states that can help inform their work in Massachusetts.

> CP Administrator Perspective: *"MCCN care coordinators are in all three regions, the North, Central and, South regions. Quarterly, all care coordinators meet for an in-person meeting. These meetings provide education and support to our care coordinators such as care planning activities, and on occasion, have invited outside agencies to present information and education on their services. This has proven to be beneficial to the care coordinators."*

Recommendations

The IA has no recommendations for the Workforce Development focus area.

Promising practices that CPs have found useful in this area include:

- ✓ **Promoting diversity in the workplace**
    - compensating staff with bilingual capabilities at a higher rate.
    - establishing a Diversity and Inclusion Committee to assist Human Resources (HR) with recruiting diverse candidates;
    - advertising in publications tailored to non-English speaking populations;
    - attending minority focused career fairs;
    - recruiting from diversity-driven college career organizations;
    - tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives;
    - implementing an employee referral incentive program to leverage existing bilingual and POC CP staff's professional networks for recruiting;
    - advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers; and
    - recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.
- ✓ **Recruitment and retention**
    - implementing an internship program in partnership with higher education institutions to create a pool of eligible applicants whom the CP can hire after graduation;
    - assessing applicants based on skill sets rather than credentials, then offering onsite training to close any gaps;
    - conducting staff satisfaction surveys to assess the CP's strengths and opportunities for improvement related to CP workforce development and retention;
    - making staff retention a priority initiative of the QMC to leverage existing quality improvement structures and engage leadership to monitor progress towards retention goals;

- implementing opportunities for peer mentoring and other supports; For example, scheduling office hours that allow care coordinators to network and receive support from experienced staff and/or have direct communication with CP leadership;
- reducing staff training burden by allowing experienced staff to test of out of basic training exercises and instead participate in more advanced training modules;
- instituting a management training program to provide lower level staff a path to promotion;
- allowing flexible work hours and work from home options for care coordination staff;
- striving to maintain a balanced ratio of care coordinators to members served, to avoid unmanageable workloads and staff burnout;
- offering retention bonuses to staff that are separate from performance-based bonuses; and
- participating in SWI loan assistance for qualified professional staff.

✓ **Training**

- providing staff with paid time to attend outside trainings that support operational and performance goals;
- assessing the effectiveness of training modules at least annually to ensure that staff felt the module's objectives were met and that staff are getting what they need to fill knowledge or skill gaps;
- updating training modules on an annual basis to ensure they reflect the latest best practices;
- developing a learning management system that tracks staff's completion of required trainings and provides online access to additional on-demand training modules;
- including role-playing exercises in trainings to reinforce best practices of key skills;
- partnering with local educational institutions to provide staff access to professional certification training programs;
- providing new staff with opportunities to shadow experienced care coordinators in the field prior to taking on their own caseload to build tangible skills and foster relationships between team members; and
- making use of online trainings designed and offered by MassHealth.

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of CPs considered On track:

✓ **Implementation of EHR and care management platform**

- uses ENS/ADT alerts and integrates ENS notifications into the care management platform.

- ✓ **Interoperability and data exchange**
    - uses SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
    - uses Mass HIway[7] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.
- ✓ **Data analytics**
    - develops a dashboard, overseen by a multidisciplinary team, to monitor documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management; and
    - reports progress toward goals to the QMC, which determines opportunities for improvement, design interventions, and track the effectiveness of interventions.

Results

The IA finds that MCCN is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

MCCN has implemented a care management platform across all APs and has contracted with a statewide ENS vendor. MCCN has leveraged its access to ENS/ADT notifications to obtain updated member contact information, identify "high utilizers," and receive discharge notifications to enable timely outreach efforts. MCCN staff check for ENS notifications daily and receive email alerts from the system.

Interoperability and data exchange

MCCN has the capability to exchange member files via SFTP, secure e-mail, and a secure file-sharing application. MCCN has developed a process to automate the intake of documents received from ACO/MCO partners via SFTPs into the care management platform. MCCN is prepared to connect to the Mass HIway but has not yet operationalized a connection to this system. MCCN reports that the MCOs have not confirmed that this method of communication will be used and cites this as the reason for not implementing a connection to Mass HIway at this point.

In recent documentation, MCCN reports that it is able to share and/or receive member contact information, comprehensive assessments, and care plans with all or nearly all ACOs and MCOs. MCCN reports that it is able to electronically share and/or receive member contact information with most PCPs, comprehensive needs assessments electronically with some PCPs, and care plans with all or nearly all PCPs.

To further interoperability and data exchange efforts, MCCN has gained read-only access to some partner ACOs' EHR systems. MCCN reports that this ability has allowed care coordinators to monitor members' participation in preventative care, identify barriers to accessing care, and ensure that quality metrics are being met.

Data analytics

MCCN has established a quality dashboard that tracks performance on key performance metrics and informs reports that are used to monitor program performance. MCCN has hired a healthcare data

[7] Mass HIway is the state-sponsored, statewide, health information exchange.

analyst who creates reports that track member engagement, staff productivity, due dates, and progress on QI initiatives and contract requirements. These reports also promote more efficiency and help care coordinators understand and achieve their performance targets. To further enhance its data analytics capability, MCCN has implemented a technology solution that calculates quality measure performance based on data in the care management platform.

Reports on quality measures and performance goals are developed by the Director of Quality Management and the IT data coordinator, who present results to the QMC on a quarterly basis.

Recommendations

The IA encourages MCCN to review its practices in the following aspects of the Health Information Technology and Exchange focus area, for which the IA did not identify sufficient documentation to assess progress:

- integrating ENS/ADT notifications into the care management platform.

Promising practices that CPs have found useful in this area include:

✓ **Implementation of EHR and care management platform**

- adopting enterprise exchange software that automatically retrieves files from partner SFTPs and moves them into the CP's EHR.

✓ **Interoperability and data exchange**

- developing electronic information exchange capabilities that enable a CP to exchange information with community organizations that do not have EHRs and ACO/MCO partners and PCPs whose method of data sharing is fax or secure email; and
- connecting with regional Health Information Exchanges (HIEs).

✓ **Data analytics**

- designing a data warehouse to store documentation and performance data from multiple sources in a central location that can underwrite a performance dashboard;
- incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress;
- updating dashboards daily for use by supervisors, management, and the QMC; and
- incorporating Healthcare Effectiveness Data and Information Set metrics into dashboards to support integration with ACO/MCO partners.

5. CARE MODEL

On Track Description

Characteristics of CPs considered On track:

✓ **Outreach and engagement strategies**

- ensures staff are providing supports that are tailored to and reflective of the population racially, ethnically and linguistically;
- uses peer supports and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities; and

- has a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations.

✓ **Person-centered care model**

- ensures goals are documented in the care plan so that the team is engaged in supporting the enrollee towards achieving goals; and
- uses person-centered modalities so that care coordinators can assist enrollees in setting health and wellness goals.

✓ **Managing transitions of care**

- manages transitions of care with established processes including routine warm handoffs between transitions of care teams and CP care team.

✓ **Improving members' health and wellness**

- standardizes processes for connecting members with community resources and social services.

✓ **Continuous quality improvement (QI)**

- has a structure for enabling continuous QI in quality of care and member experience.

Results

The IA finds that MCCN has an **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

MCCN hired associate care coordinators to conduct initial member outreach. These staff are also responsible for verifying and updating member contact information by calling PCP offices and reviewing ENS/ADT notifications. MCCN also hired an enhanced outreach specialist to conduct outreach for hard-to-reach members but will not continue this position in the future due to the cost.

MCCN ensures that staff are providing supports that are tailored to and reflective of the member population. Members are supported by a diverse cohort of care coordinators who are representative and/or knowledgeable of the cultural and linguistic needs of the member population. MCCN has also contracted with an interpretation service to support members with language needs not met by MCCN or agency staff.

Person-centered care model

MCCN care coordinators are trained in person-centered care planning and ensure that care plans reflect members' goals. MCCN staff employ a person-centered care approach to advocate for and with enrollees. Care coordinators use motivational interviewing skills to engage members and their families in care plan development, ensuring the care plan is responsive to the member's identified LTSS needs. In 2019, MCCN's care coordination staff completed MassHealth's Best Practices in Writing a Care Plan training via the MA DSRIP TA Marketplace.

Care coordinators reference the member's LTSS assessment and ACO comprehensive assessment when developing the care plan to identify all stakeholders in the member's care. MCCN also documents each member's health and wellness goals in the care plan so that the member's care team can collaborate with the member to meet their intended goals.

Managing transitions of care

To manage members' transitions of care, MCCN staff receive and review ENS/ADT notification on a daily basis and are able to act on these notifications immediately. MCCN regional supervisors, care coordinators, and associate care coordinators receive ENS/ADT notifications via email in real time. MCCN care coordinators will join transitions of care meetings with ACOs, as necessary. When MCCN is notified of a member being discharged, MCCN care coordinators immediately follow-up with the member and the ACO to schedule necessary post-discharge visits. This process has facilitated MCCN staff's ability to complete the required post-discharge face-to-face meeting with members within the required three day timeframe.

MCCN reports that all its APs and material subcontractors have experience managing transitions in care.

Improving members' health and wellness

To help members achieve their health and wellness goals, MCCN care coordinators have linguistically and developmentally appropriate written materials and referral resources available to share with members for numerous health-related topics and activities including smoking cessation and weight loss classes. In addition to health education materials, MCCN has developed relationships with PCP offices, creating a referral network that care coordinators refer members to for their health and wellness needs.

Continuous quality improvement

To ensure continuous QI in quality of care and member experience, MCCN implemented a staff satisfaction survey that resulted in actionable feedback to improve staff retention and reduce turnover. MCCN is using feedback to ensure that staff feel valued and supported, empowering staff to provide quality care to members.

Additionally, MCCN has implemented a dashboard software that visualizes performance on key performance metrics. MCCN has also shared dashboard visualizations with ACO partners, to demonstrate MCCN's impact.

Recommendations

The IA encourages MCCN to review its practices in the following aspects of the Care Model focus area, for which the IA did not identify sufficient documentation to assess progress:

- using Peer Support and/or CHWs to support CP members throughout the provision of CP supports and activities; and
- developing a community outreach strategy to reach assigned members who cannot easily be reached telephonically.

Promising practices that CPs have found useful in this area include:

✓ **Outreach and engagement strategies**

- acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);
- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;

- providing free transportation options for members to engage with services[8];
- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and
- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

✓ **Person-centered care model**

- addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;
- setting small initial goals that a member is likely to achieve to build member confidence in the engagement;
- developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs; and
- allowing members to attend care planning meetings by phone or teleconference.

✓ **Managing transitions of care**

- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
- establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
- meeting an enrollee in person once care coordinators receive alerts that they were admitted;
- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[9];
- establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and
- having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.

✓ **Improving members' health and wellness**

- allowing PCPs or other providers to access referrals through a centralized hub powered by the care management platform;
- negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms; and

[8] CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.
[9] Where members have authorized sharing of SUD treatment records.

- contracting with national databases for community resources to develop a library of available supports.

✓ **Continuous quality improvement**

- providing a “Passport to Health” to members that contains health and emergency contact information and serves as the member’s advance directive in healthcare emergencies and transitions of care;
- administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey;
- scheduling regular meetings to disseminate best practices related to key quality measures to all CP staff; and
- creating materials such as posters and checklists that define best practices and providing implementation guidance to staff.

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that MCCN is On track or On track with limited recommendations across all five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. No recommendations are provided in the following focus areas:

- Organizational Structure and Engagement
- Integration of Systems and Processes
- Workforce Development

The IA recommends that MCCN review its practices in the following aspects of the focus areas, for which the IA did not identify sufficient documentation to assess or confirm progress:

Health Information Technology and Exchange

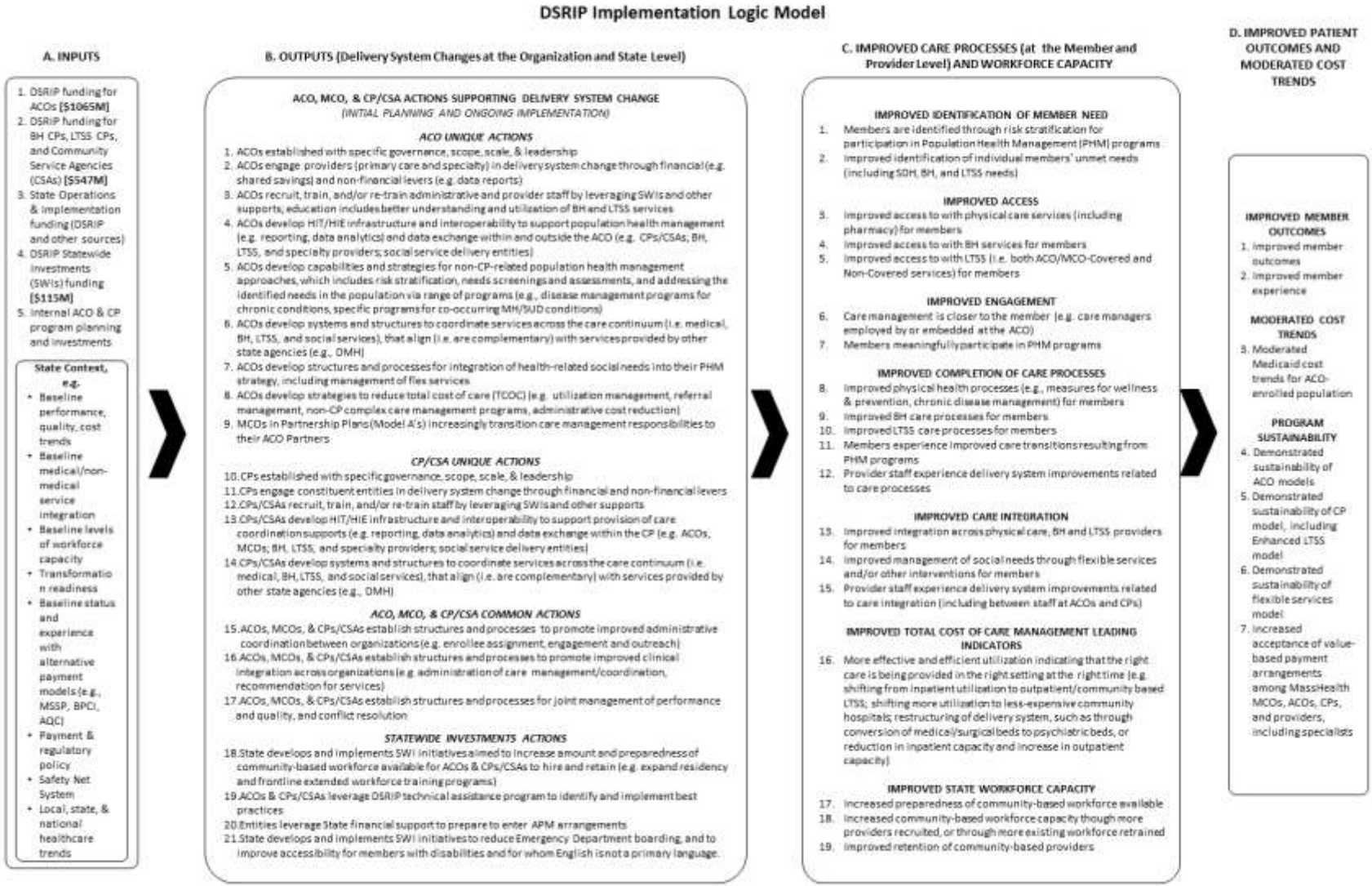
- integrating ENS/ADT notifications into the care management platform.

Care Model

- using Peer Support and/or CHWs to support CP members throughout the provision of CP supports and activities; and
- developing a community outreach strategy to reach assigned members who cannot easily be reached telephonically.

MCCN should carefully self-assess the areas noted above, and consider the corresponding promising practices identified by the IA for each focus area. Any action taken in response to the recommendations must comply with contractual requirements and programmatic guidance.

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL



APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, and key informant interviews (KIIs) to assess progress of Community Partners (CPs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018.

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator[10] (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download).

The question addressed by this assessment is:

> *To what extent has the CP taken organizational level actions, across five areas of focus, to transform care delivery under an accountable and integrated care model?*

DATA SOURCES

The MPA drew on multiple data sources to assess organizational performance in each focus area, including both historical data contained in the documents that CPs were required to submit to MassHealth, and newly collected data gathered by the IA and/or IE. The IA performed a desk review of documents that CPs were required to submit to MassHealth, including participation plans, annual and semi-annual reports. The IE developed a protocol for CP Administrator KIIs, which were conducted jointly by the IA and the IE.

List of MPA data sources:

Documents submitted by CPs to MassHealth covering the reporting period of July 1, 2017 through December 31, 2019:

- Full Participation Plans
- Semi-annual and Annual Progress Reports
- Budgets and Budget Narratives

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

The CP MPA assessment findings cover five “focus areas” or aspects of health system transformation. These were derived from the DSRIP logic model, by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement
2. Integration of Systems and Processes

[10] The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

3. Workforce Development
4. Health Information Technology and Exchange
5. Care Model

Table 1 shows the CP actions that correspond to each focus area. This framework was used to assess each CP's progress. A rating of On track indicates that the CP has made appropriate progress in accomplishing each of the actions for the focus area. Where gaps in progress were identified, the CP was rated "On track with limited recommendations" or, in the case of more substantial gaps, "Opportunity for improvement."

Table 1. Framework for Organizational Assessment of CPs

Focus Area	CP Actions
Organizational Structure and Governance	• CPs established with specific governance, scope, scale, & leadership • CPs engage constituent entities in delivery system change
Integration of Systems and Processes	• CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) • CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) • CPs establish structures and processes for joint management of performance and quality, and problem solving
Workforce Development	• CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	• CPs develop health information technology and exchange (HIT/HIE) infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP, and externally (e.g. Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs); behavioral health (BH), long term services and supports (LTSS), and specialty providers; social service delivery entities)
Care Model	• CPs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))

ANALYTIC APPROACH

The CP actions are broad enough to be accomplished in a variety of ways by different CPs, and the scope of the IA is to assess progress, not to prescribe the best approach for an CP. Moreover, no pre-established benchmark is available to determine what represents adequate progress at the midpoint. The need for a realistic threshold of expected progress led the IA to use a semi-empirical approach to define the state that should be considered On track. Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans, which identified a broad range of activities and capabilities that fell within the logic model actions. This provided specific operational examples of how CPs can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item, and relevance to the focus area. A descriptive definition of On track performance for each focus area was developed from the items that had been adopted by a plurality

of CPs. Items that had been accomplished by only a small number of CPs were considered to be emerging practices, and were not included in the expectations for On track performance. This calibrated the threshold for expected progress to the actual performance of the cohort as a whole.

Qualitative coding of documents to focus areas, and analysis of survey results relevant to each focus area, were used to assess whether and how each CP had accomplished the actions for each focus area. The assessment was holistic, and as such did not require that CPs meet every item on a list. A finding of On track was made where the available evidence demonstrated that the entity had accomplished all or nearly all of the expected items, and there are no recommendations for improvement. Where evidence was lacking in the results of desk review and survey, keyword searches of KII interview transcripts were used to seek additional information. Prior to finalizing the findings for an entity, the multiple reviewers convened to confirm that thresholds were applied consistently, and that the reasoning was clearly articulated and documented.

A rating of On track indicates that the CP has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated On track with limited recommendations or, in the case of more substantial gaps, Opportunity for improvement.

DATA COLLECTION

Key Informant Interviews

Key Informant Interviews (KII) of CP Administrators were conducted in order to understand the degree to which participating entities are adopting core CP competencies, the barriers to transformation, and the organization's experience with state support for transformation.[11] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[11] KII were developed by the IE and conducted jointly by the IE and the IA. The IA utilized the KII transcripts as a secondary data source; the IA did not perform a full qualitative analysis of the KII.

APPENDIX III: ACRONYM GLOSSARY

ACPP	Accountable Care Partnership Plan
CP	Accountable Care Organization
ADT	Admission, Discharge, Transfer
AP	Affiliated Partner
APR	Annual Progress Report
BH CP	Behavioral Health Community Partner
CAB	Consumer Advisory Board
CCCM	Care Coordination & Care Management
CCM	Complex Care Management
CE	Consortium Entity
CHA	Community Health Advocate
CHEC	Community Health Education Center
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
CP	Community Partner
CSA	Community Service Agency
CWA	Community Wellness Advocate
DMH	Department of Mental Health
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Record
ENS	Event Notification Service
EOHHS	Executive Office of Health and Human Services
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HLHC	Hospital-Licensed Health Centers
HRSN	Health-Related Social Need
HSIMS	Health Systems and Integration Manager Survey
IA	Independent Assessor
IE	Independent Evaluator
JOC	Joint Operating Committee
KII	Key Informant Interview
LGBTQ	lesbian, gay, bisexual, transgender, queer, questioning
LCSW	Licensed Independent Clinical Social Worker
LPN	Licensed Practical Nurse
LTSS CP	Long Term Services and Supports Community Partner
MAeHC	Massachusetts eHealth Collaborative
MAT	Medication for Addiction Treatment
MCO	Managed Care Organization

MPA	Midpoint Assessment
NCQA	National Committee for Quality Assurance
OBAT	Office-Based Addiction Treatment
PCP	Primary Care Provider
PFAC	Patient and Family Advisory Committee
PHM	Population Health Management
PT-1	MassHealth Transportation Program
QI	Quality Improvement
QMC	Quality Management Committee
RN	Registered Nurse
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
SUD	Substance Use Disorder
SVP	Senior Vice President
SWI	Statewide Investments
TCOC	Total Cost of Care
VNA	Visiting Nurse Association

APPENDIX IV: CP COMMENT

Each CP was provided with the opportunity to review their individual MPA report. The CP had a two week comment period, during which it had the option of making a statement about the report. CPs were provided with a form and instructions for submitting requests for correction (e.g., typos) and a comment of 1,000 word or less. CPs were instructed that the comment may be attached as an appendix to the public-facing report, at the discretion of MassHealth and the IA.

Comments and requests for correction were reviewed by the IA and by MassHealth. If the CP submitted a comment, it is provided below. If the CP requested a minor clarification in the narrative that added useful detail or context but had no bearing on the findings, the IA made the requested change. If a request for correction or change had the potential to impact the findings, the IA reviewed the MPA data sources again and attempted to identify documentation in support of the requested change. If documentation was identified, the change was made. If documentation was not identified, no change was made to the report but the information provided by the CP in the request for correction is shown below.

CP Comment

None submitted.