

Massachusetts Quality Measure Alignment Taskforce Recommended Health Equity Measure Accountability Framework for ACO Contracts January 2023

Introduction

In fall 2021, the Massachusetts Executive Office of Health and Human Services (EOHHS) established the Health Equity Technical Advisory Groups as subgroups of the Quality Measure Alignment Taskforce (Taskforce). There were two Advisory Groups: the Accountability Advisory Group and the Data Standards Advisory Group.

The Accountability Advisory Group met from January to June 2022 to develop principles for introducing accountability for health equity measures into global budget-based risk contracts (such as MassHealth and commercial ACO contracts). A list of the Accountability Advisory Group members can be found in the [Appendix](#).

The Taskforce reviewed and provided feedback on the Health Equity Accountability Advisory Group's recommendations in June 2022. EOHHS then posted the document for public comment in July 2022. The Taskforce received 11 distinct submissions weighing in on the draft Accountability Framework and processed this feedback during its September 2022 meeting.

The framework summarizes the Taskforce's final recommended approach for introducing accountability¹ into ACO contracts for health equity measures after consideration of the Accountability Advisory Group's work and input from the public and Taskforce staff. The effective date of this framework shall be considered January 1, 2023. The framework does not focus on other potential methods to promote ACO accountability for health equity (e.g., contractual requirements for ACOs).

This framework is organized using four categories of health equity measures. Each measure category is focused on different aspects of health equity measurement, ranging from health equity data collection to measures that access removal of barriers to health equity. There are measure concepts for each measure category, which include the description of a particular type of measure that could be implemented in an ACO contract.

ACOs and payers can implement measure concepts from different measure categories simultaneously (e.g., a contract could introduce accountability for measure concept 1b and 4a simultaneously). It is not expected that each ACO contract include all (or even most) of these measure concepts. When ACOs and payers implement a specific measure concept, they should ensure that the ACO meets the implementation guidance for preceding measure concepts (e.g.,

¹ There are two major forms of accountability: financial accountability (e.g., incentives and disincentives for collecting data, reporting performance, meeting identified goals, etc.) and non-financial accountability (e.g., confidential and/or public reporting of performance, public recognition, reporting on quality improvement initiative results, participation in learning collaboratives, etc.).

meet measure concept 1a and any relevant points captured under the implementation guidance for that measure concept before introducing accountability for measure concept 1b).

When introducing accountability for these measure concepts, ACOs and payers should:

1. only be held accountable for actions that are reasonable for them to take, and for which performance can be measured, to reduce or eliminate identified equity barriers associated with social risk factors and health-related social needs (HRSN)²
 - a. e.g., an ACO may be held accountable for the proportion of patients with an identified HRSN referred to services, the proportion of providers and staff that complete racial equity trainings, and/or ensuring there is sufficient representation of different races, ethnicities, languages and other demographics among providers. While ACOs are encouraged to take action to improve equity, they are not expected to be held accountable for ending racism outside of their organization or building affordable housing units).
2. not publicly report performance in a manner that could be easily misinterpreted (see implementation guidance for more information).

Applicability to Other Risk Contracts

This accountability framework may be applied to other types of risk contracts where quality measures are included (e.g., general acute care hospital contracts, post-acute care contracts, skilled nursing facility contracts, free-standing behavioral health hospital contracts). When doing so, providers and payers must be mindful of the following:

1. Measures that fall into Category 1 can be used without any modification. Measures that fall into Categories 2, 3 and 4, however, must be appropriate and relevant for the care setting. For example, a post-acute care contract may include measures that assess receipt and quality of episodic care or screening for patients' needs and/or barriers to equitable care. It may not be appropriate to include measures focused on longitudinal care (e.g., regular preventative services, care management for chronic conditions).
2. There should be measures focused on assessing equitable access to care across populations, as non-ACO care settings may have a greater ability to select which patients they serve than do ACOs.

Actions to Address Potential Barriers to Achieving Measure Performance

There are several potential barriers that may prohibit ACOs from achieving measure performance. ACOs and payers should strive to take action to address these barriers when introducing accountability for health equity measures. Two barriers and potential solutions include:

² The term health-related social needs (HRSN) is sometimes used interchangeably with social determinants of health (SDOH). HRSN are person-specific risk factors that impact individual health status. SDOH can carry the same meaning and/or refer to upstream risk factors that impact population health (which can be positive or negative).

1. **Barrier:** There may be limited community resources to provide social supports for patients in need.

Potential solutions:

- a. Prioritize measures focused on social needs with a greater availability of resources (e.g., food insecurity rather than affordable housing).
 - b. Emphasize the importance of establishing and evaluating partnerships with community-based organizations, even when there may be resource shortages. For example, Oregon’s Medicaid program requires its Coordinated Care Organizations (CCOs) to engage cross-sector community partners and develop and evaluate a plan to improve community supports through its [System-Level Social-Emotional Health measure](#).
2. **Barrier:** It may be harder for safety net providers to demonstrate achievement or improvement because they serve populations with disproportionate social risk and experience disparities in payment levels.

Potential solutions (which may vary based on measure type, e.g., process, outcome, patient experience, cost):

- a. Ensure measures, which draw from the Massachusetts Aligned Measure Set, have ACO-specific opportunity for equity improvement. The definition of opportunity for equity improvement is up to the discretion of an ACO and payer but should not deprioritize opportunities where improvement may be hard to achieve.
- b. Focus on measuring improvement rather than comparison to an absolute benchmark. ACOs and payers, however, may choose to use an absolute benchmark and adjust benchmarks to account for barriers faced by safety net providers, such as the relative social needs profile of the ACO, if both parties can agree upon a credible data-informed basis for doing so.
 - i. There are no standard accepted methods for social risk adjustment. If ACO performance or quality measure targets are to be adjusted to account for social risk, there should be care taken to ensure the social risk adjustment methodology is valid, reliable and specific to quality measurement.³ Finally, when considering application of social risk adjustment, ACOs and payers should consider how adjusting for social risk may or may not moderate the motivation to address disparities.
- c. Stratify measure performance to understand how quality measure performance may differ by provider group type.
- d. Consider use of social risk adjustment to mitigate unfair impact.
 - i. In order to apply social risk adjustment to measurement of health equity performance, ACOs and payers must first invest in analyses to assess the impact of social risk variables on quality measure performance to inform potential future methodologies. Such analyses should separately assess

³ ACOs and payers should refer to the Taskforce’s definition of validity and reliability, which can be found in the Measures and Implementation Parameters document on the Taskforce website: <https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce#aligned-measure-set>.

- the impact for each variable, as well as the intersectionality of two or more variables, on quality measure performance.
- ii. Compare quality measure performance without any adjustment, with clinical risk adjustment, and with social risk adjustment to assess which approach is most reasonable.
 - iii. Explore where it may be most feasible and appropriate to incorporate social risk adjustment. For example, it may be more feasible and appropriate to adjust payments or quality measure targets to account for social risk rather than adjusting quality measure performance.
- e. Examine use of additional health equity investments. Such payments can be a time-limited, upfront payment to support capacity building and practice transformation or a separate health equity investment pool that is only available for providers who have been historically underfunded and serve low-income populations in areas of high social vulnerability.⁴

⁴ For more information, refer to the Health Care Payment Learning and Action Network's (HCPLAN) Health Equity Advisory Team's (HEAT) recommendations for advancing health equity through alternative payment models: <http://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs.pdf>.

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Measure Category 1: Measures that Assess the Collection of Health Equity Data

This measure category focuses on improving the availability and accuracy of health equity data. By health equity data, we mean race, ethnicity, language, disability status, sexual orientation, gender identity and sex data.

Measure Concept 1a: Adoption of health equity data standards and implementation of a process for collecting, storing and assessing the completeness and accuracy of health equity data

Measure examples: ACO has adopted and implement the Massachusetts standards for collecting and storing health equity data

This measure concept ensures that an ACO has processes in place to collect, store and assess the completeness⁵ and accuracy⁶ of health equity data in a standard, consistent manner. Health equity data standards should align with the statewide standards, which will be recommended to the Taskforce for adoption by EOHHS.

Implementation Guidance:

It is important for an ACO (and a payer) to have clear language that explains to patients/members why organizations are gathering health equity data and how those organizations will protect patients' privacy.

Measure Concept 1b: ACO health equity data completeness

Measure example: Percentage of patients for which an ACO has complete health equity data

This measure concept evaluates an ACO's level of data completeness for one or more health equity data category (e.g., race, disability status). The timeline for introducing accountability may vary based on the category of health equity data (e.g., introducing accountability for race and ethnicity data collection may precede accountability for sexual orientation and gender identity data collection).

Accountability can begin to be applied in the form of a pay-for-reporting measure. This allows an ACO to develop experience with collecting data and reporting measure performance. It also allows time for ACOs and payers to gather baseline data before setting an improvement or achievement target (see measure concept 1c). Pay-for-reporting data may be confidential and financial levers may only apply if an ACO fails to report performance in accordance with the terms of their contract. The period for how long a measure can hold pay-for-reporting status

⁵ Health equity data are considered to be complete if an ACO or payer possess self-reported data collected using prospective data standards for at least 90% of ACO-attributed patients or health plan-enrolled members. Self-reported answers of "I am not sure / don't know" and "I choose not to answer" are considered complete responses.

⁶ Health equity data are considered accurate if they are self-reported. Imputed race and ethnicity data used according to the implementation guidance on pages 5 and 6 herein may be considered accurate as well.

may reasonably vary based on the ACO's capabilities. Use of time limits, such as two years, may be necessary to ensure movement from pay-for-reporting to pay-for-performance.

Implementation Guidance:

1. Health equity data collected by ACOs should preferably be patient self-reported for the purpose of contractual accountability. When sufficient patient self-reported race and ethnicity data are not fully available, data used for the purpose of contractual accountability may include imputed health equity data. Otherwise, analyses that are based on the subset of the population for which patient self-reported race and ethnicity data are available may underreport inequities.
 - a. Health equity data used for accountability purposes, including imputed race and ethnicity data, should align with the same principles of validity and reliability as for overall performance data. While patient self-reported data are the preference and priority, imputed race and ethnicity data may be used as a basis for accountability in a manner that accounts for data validity and reliability. For example:
 - i. Imputed race and ethnicity data should only be used for population-level accountability and should not be used to guide clinical care at the individual level.
 - ii. If the algorithm used to impute race and ethnicity assigns probabilities for each individual, the calculation may assign a portion of each individual to various race and ethnicity categories based on the probabilities rather than assigning an individual to a single category with the highest probability, if doing so improves (and does not worsen) the validity and reliability of equity measurement.
 - b. In the short term (i.e., for a three-year time period) and when coupled with contemporaneous efforts to gather patient self-reported data, imputed race and ethnicity data may be used as the primary basis for accountability programs that aim to improve equity of care, when the only alternative is to substantially delay deployment of these programs. In the long term, if self-reported race and ethnicity data are persistently missing for a proportion of patients, imputed data may be used for these patients in accountability programs, rather than excluding these patients' data from accountability programs altogether or assigning them "unknown race" or similar missing data values.
 - c. Health equity data should *not* include imputed disability status, gender identity, language, sex and sexual orientation data.
2. Health equity data can be collected either by an ACO or payer. ACOs and payers should (a) collaborate on facilitating data sharing to avoid unnecessary re-screening of patients/members and (b) consider how to best explain to patients/members why organizations are collecting these health equity data and how organizations will protect patients' privacy. If ACOs are collecting health equity data, they should work with patients to identify when to collect health equity data (e.g., patient registration, during

an appointment) and analyze data to identify where to collect health equity data (e.g., office visit, ED visit).

3. Accountability should be applied for all attributed patients, not patients seen during the measurement year, because:
 - a. payers may have collected health equity data upon enrollment that they can share with ACOs and/or
 - b. ACOs may have health equity data on an attributed patient seen in a prior measurement year.
4. The health equity data response options “I choose not to answer” and “I am not sure / don’t know” should be classified as complete health equity data. ACOs and payers should coordinate efforts to improve patient response rates, as referenced above, and should collect data at least annually, making multiple, good faith efforts to re-ask health equity data questions if a patient declines to answer. ACOs and payers should assess who responds with “I choose not to answer” and “I am not sure / don’t know” to try and inform efforts to improve health equity data collection.

Measure Concept 1c: ACO health equity data completeness relative to prior performance and/or a target

Measure example: Percentage of patients for which an ACO has complete health equity data as compared to an improvement and/or an achievement target

This measure concept compares an ACO’s level of health equity data completeness to a pre-determined improvement and/or achievement target.

Implementation Guidance:

1. The achievement target against which to compare performance should never be 100 percent.
2. Accountability for safety net providers should focus on measuring improvement rather than comparison to an absolute benchmark. ACOs and payers, however, may choose to use an absolute benchmark and adjust benchmarks to account for barriers faced by safety net providers, such as the relative social needs profile of the ACO, if both parties can agree upon a credible data-informed basis for doing so.

Measure Category 2: Measures that Stratify Performance Using Health Equity Data

This measure category focuses on comparing and reducing inequities in performance between one or more sub-populations. This measure category requires having complete and accurate health equity data.

Measure Concept 2a: ACO reporting of stratified performance using health equity data

Measure examples: Any priority process, outcome, patient experience, or access quality measure(s)

This measure concept focuses on ensuring that an ACO can stratify performance on a measure using health equity data.

Implementation Guidance:

1. ACOs and payers should draw priority measures for stratification with known inequities from the Massachusetts Aligned Measure Set. Measures should only be used if there is ACO-specific opportunity for equity improvement and adequate denominator size. The determination of an opportunity for equity improvement is left to the judgement of an ACO and payer but should not deprioritize opportunities where improvement may be hard to achieve. The definition of adequate denominator size should be agreed upon by the ACO and payer.⁷
2. An ACO should have a process to collect, store and assess the completeness and accuracy of health equity data in a standard, consistent manner prior to implementing accountability for measure stratification as outlined in measure concept 1a.
3. Accountability can begin to be applied in the form of a pay-for-reporting measure. This allows an ACO to develop experience with collecting data and reporting measure performance. It also allows time for ACOs and payers to gather baseline data before setting an improvement or achievement target (see measure concept 2b). Pay-for-reporting data may be confidential and financial levers may only apply if an ACO fails to report performance in accordance with the terms of its contract. The period for how long a measure can hold pay-for-reporting status may reasonably vary based on the ACO's capabilities. Use of time limits, such as two years, may be necessary to ensure movement to using measure concept 2b.

Measure Concept 2b: ACO reduction of inequities in performance among select groups by a certain value (e.g., percentage point difference, percent improvement)

Measure examples: Gap (inequity) reduction for a specific minoritized population(s) relative to the majoritized population, and/or improved performance for the minoritized population, for a priority process, outcome, patient experience, or access measure(s)

⁷ ACOs and payers could refer to NCQA's definition of adequate denominator size for HEDIS measures.

This measure concept assesses whether an ACO reduced the inequities in performance among two or more subgroups by a defined value, which can be defined an absolute reduction or percentage improvement.

Implementation Guidance:

1. An ACO should have complete and valid health equity data prior to implementing accountability for inequity reduction as outlined in measure concept 2a. This will help mitigate against penalizing ACOs for having more complete demographic data that may highlight more inequities compared to ACOs that have less complete demographic data that effectively hide inequities.
2. Any performance reporting (confidential and public) should:
 - a. indicate the level of confidence in the data used to stratify performance if applicable and
 - b. contextualize performance so as to (i) not imply select populations are responsible for poor health outcomes or (ii) discourage others from using performance to restrict access to care for select populations.
3. Accountability should reward improvements in health disparities only if the disparity reduction is not solely the result of performance decline for the comparison population.
4. Targets can vary to reflect the relative social needs profile of the ACO. For example, there could be separate targets for ACOs that predominantly serve Medicaid and Medicaid/Medicare dually eligible patients (e.g., 50 percent of its patients are insured through Medicaid, Medicaid and Medicare, or are uninsured) and ACOs that predominantly serve commercial patients (e.g., 50 percent of its patients are commercially insured), or another measure to distinguish the relative social needs of the populations served by different ACOs. If ACO performance or quality measure targets are to be adjusted to account for social risk, there should be care taken to ensure the social risk adjustment methodology is valid, reliable and specific to quality measurement.⁸ When considering application of social risk adjustment, ACOs and payers should consider how adjusting for social risk may or may not moderate the motivation to address disparities.
5. Accountability should be applied in a way that ensures the performance calculation is statistically sound (e.g., financial incentives for performance should only be applied for measures with adequate denominator size). Performance measurement, when possible, should combine data across payers to ensure there is sufficient denominator size to support assessment.
 - a. ACOs and payers can still pursue quality improvement activities to advance equity for measures that have insufficient denominator size to apply accountability.

⁸ There are no standard accepted methods for social risk adjustment as of October 2022. In this absence, ACOs and payers should refer to the Taskforce’s definition of validity and reliability, which can be found in the Measures and Implementation Parameters document on the Taskforce website: <https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce#aligned-measure-set->

Measure Category 3: Population-level Measures Focused on Known Inequities

This measure category focuses on improving care for a specific population with known inequities (e.g., persons with mental illness, Black mothers). It does not focus on reducing the inequities in performance between two sub-populations.

Measure Concept 3a: ACO reporting of population-level quality measures with known inequities

Measure examples: ED Visits for Individuals with Mental Illness, Addiction, or Co-Occurring Conditions, prenatal care visits for Black women, patient perception of care coordination for individuals with disabilities

This measure concept focuses on ensuring that an ACO can report performance on a population-level quality measure with known inequities.

Implementation Guidance:

1. Such measures should draw from the Massachusetts Aligned Measure Set, which identifies priority quality measures with known inequities in Massachusetts that can be applied at the ACO level, that align with statewide health priorities and that are recommended by the Quality Measure Alignment Taskforce. Measures should only be used if there is ACO-specific opportunity for equity improvement and adequate denominator size. The determination of an opportunity for equity improvement is left to the judgement of an ACO and payer but should not deprioritize opportunities where improvement may be hard to achieve. The definition of adequate denominator size should be agreed upon by the ACO and payer.⁹
2. Accountability can begin to be applied in the form of a pay-for-reporting measure. This allows an ACO to develop experience with collecting data and reporting measure performance. It also allows time for ACOs and payers to gather baseline data before setting an improvement or achievement target (see measure concept 3b). Pay-for-reporting data may be confidential and financial levers may only apply if an ACO fails to report performance in accordance with the terms of its contract. The period for how long a measure can hold pay-for-reporting status may reasonably vary based on the ACO's capabilities. Use of time limits, such as two years, may be necessary to ensure movement to using measure concept 3b.

Measure Concept 3b: ACO performance on population-level quality measures with known inequities relative to prior performance and/or a target

Measure examples: Measures from the prior measure concept as compared to an improvement and/or an achievement target

This measure concept compares an ACO's performance on a population-level quality measure with known inequities to a pre-determined improvement and/or achievement target.

⁹ ACOs and payers could refer to NCQA's definition of adequate denominator size for HEDIS measures.

Implementation Guidance:

1. The achievement target against which to compare performance should never be 100 percent.
2. Accountability for safety net providers should focus on measuring improvement rather than comparison to an absolute benchmark. ACOs and payers, however, may choose to use an absolute benchmark and adjust benchmarks to account for barriers faced by safety net providers, such as the relative social needs profile of the ACO, if both parties can agree upon a credible data-informed basis for doing so.
3. Targets can vary to reflect the relative social needs profile of the ACO. For example, there could be separate targets for ACOs that predominantly serve Medicaid and Medicaid/Medicare dually eligible patients (e.g., 50 percent of its patients are insured through Medicaid, Medicaid and Medicare, or are uninsured) and ACOs that predominantly serve commercial patients (e.g., 50 percent of its patients are commercially insured), or another measure to distinguish the relative social needs of the populations served by different ACOs. If ACO performance or quality measure targets are to be adjusted to account for social risk, there should be care taken to ensure the social risk adjustment methodology is valid, reliable and specific to quality measurement.¹⁰ When considering application of social risk adjustment, ACOs and payers should consider how adjusting for social risk may or may not moderate the motivation to address disparities.
4. Accountability should be applied in a way that ensures the performance calculation is statistically sound (e.g., financial incentives for performance should only be applied for measures with adequate denominator size). Performance measurement, when possible, should combine data across payers to ensure there is sufficient denominator size to support assessment.
 - a. ACOs and payers can still pursue quality improvement activities to advance equity for measures that have insufficient denominator size to apply accountability.

¹⁰ There are no standard accepted methods for social risk adjustment as of October 2022. In this absence, ACOs and payers should refer to the Taskforce’s definition of validity and reliability, which can be found in the Measures and Implementation Parameters document on the Taskforce website: <https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce#aligned-measure-set->

Measure Category 4: Measures that Assess Removal of Barriers to Health Equity

This measure category includes measures that assess actions to remove structural barriers (e.g., food security, translator services) and cultural barriers (e.g., adequate and representative staffing) to health equity. The timeline for introducing accountability may vary based on the focus of the identified barrier (e.g., introducing accountability for social risk screening may precede accountability for housing-focused barriers). ACOs should only be held accountable for actions that are reasonable for them to take, and for which performance can be measured, to reduce or eliminate identified barriers associated with social risk factors and HRSN (e.g., an ACO may be held accountable for the proportion of patients with an identified HRSN referred to services, the proportion of providers and staff that complete racial equity trainings, and/or ensuring there is sufficient representation of different races, ethnicities, languages and other demographics among providers. While ACOs are encouraged to take action to improve equity, they are not expected to be held accountable for ending racism outside of their organization or building affordable housing units).

For measures that require screening for a need(s) and/or barrier(s)

Measure Concept 4a: ACO reporting of a completed assessments to identify patients' needs and/or barriers to equitable care

Measure examples: Health-related social needs screening, assessment of patient need for language services, next available appointment, patient perception of providers showing interest in patient's concerns

This measure concept focuses on screening to identify patients' needs and/or barriers that may be preventing equitable care.

Implementation Guidance:

1. Accountability can begin to be applied in the form of a pay-for-reporting measure. This allows an ACO to develop experience with collecting data and reporting measure performance. It also allows time for ACOs and payers to gather baseline data before setting an improvement or achievement target (see measure concept 4b). Pay-for-reporting data may be confidential and financial levers may only apply if an ACO fails to report performance in accordance with the terms of its contract. The period for how long a measure can hold pay-for-reporting status may reasonably vary based on the ACO's capabilities. Use of time limits, such as two years, may be necessary to ensure movement to using measure concept 4b.

Measure Concept 4b: ACO performance on assessments to identify a patients' needs and/or barriers to equitable care relative to prior performance and/or a target

Measure examples: Measures from the prior measure concept as compared to an improvement and/or an achievement target

This measure concept compares an ACO's screening rate to a pre-determined improvement and/or achievement target.

Implementation Guidance:

1. The achievement target against which to compare performance should never be 100 percent.
2. Accountability for safety net providers should focus on measuring improvement rather than comparison to an absolute benchmark. ACOs and payers, however, may choose to use an absolute benchmark and adjust benchmarks to account for barriers faced by safety net providers, such as the relative social needs profile of the ACO, if both parties can agree upon a credible data-informed basis for doing so.
3. Targets can vary to reflect the relative social needs profile of the ACO. For example, there could be separate targets for ACOs that predominantly serve Medicaid and Medicaid/Medicare dually eligible patients (e.g., 50 percent of its patients are insured through Medicaid, Medicaid and Medicare, or are uninsured) and ACOs that predominantly serve commercial patients (e.g., 50 percent of its patients are commercially insured), or another measure to distinguish the relative social needs of the populations served by different ACOs. If ACO performance or quality measure targets are to be adjusted to account for social risk, there should be care taken to ensure the social risk adjustment methodology is valid, reliable and specific to quality measurement.¹¹ When considering application of social risk adjustment, ACOs and payers should consider how adjusting for social risk may or may not moderate the motivation to address disparities.
4. Accountability should be applied in a way that ensures performance calculation is statistically sound (e.g., financial incentives for performance should only be applied for measures with adequate denominator size). Performance measurement, when possible, should combine data across payers to ensure there is sufficient denominator size to support assessment.
 - a. ACOs and payers can still pursue quality improvement activities to advance equity for measures that have insufficient denominator size to apply accountability.

For all measures in this measure category

Measure Concept 4c: ACO reporting of patient referral to a service, closing the loop with a community-based organization following a referral and/or provision of a service

Measure examples for measures that require screening: Referral to social service, implementation of interpreter services, expansion of evening hours, receipt of culturally competent care

Measure examples for measures that don't require screening: Care site accessibility for persons with limited mobility, provision of low-bandwidth telehealth services

¹¹ There are no standard accepted methods for social risk adjustment as of October 2022. In this absence, ACOs and payers should refer to the Taskforce's definition of validity and reliability, which can be found in the Measures and Implementation Parameters document on the Taskforce website: <https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce#aligned-measure-set->

This measure concept focuses on referring a patient to a service, closing the loop with a community-based organization following a referral and/or providing a service to a patient, which may follow identification of a positive need.

Implementation Guidance:

1. If an ACO contract begins with referring a patient to a service, there should be a subsequent measure concept that assesses receipt of a service(s) following referral.
2. The determination of an opportunity for equity improvement is left to the judgement of an ACO and payer but should not deprioritize opportunities where improvement may be hard to achieve. The definition of adequate denominator size should be agreed upon by the ACO and payer.¹²
3. There should be *some* supports in place to which an ACO can refer a patient before accountability is applied to this measure. It is not feasible to delay introduction of accountability until there are *sufficient* supports in place before screening and referring a patient to or providing a patient with services because: (a) there may never be sufficient supports in place and (b) the definition of sufficient may vary based on the organization and over time. ACOs and payers can stratify measure performance by population need and age to assess the impact of service availability on measure performance.
 - a. By sufficient, we mean having enough supports in place for a patient to have their social need fully addressed if they choose to seek support. The operational definition of “sufficient supports” will vary by social need.
4. ACOs should only be held accountable for actions that are reasonable for them to take, and for which performance can be measured, to reduce or eliminate identified equity barriers associated with social risk factors and HRSN. For example, an ACO may be held accountable for the proportion of patients with an identified HRSN referred to services, the proportion of providers and staff that complete racial equity trainings, and/or ensuring there is sufficient representation of different races, ethnicities, languages and other demographics among providers. While ACOs are encouraged to take action to improve equity, they are not expected to be held accountable for ending racism outside of their organization or building affordable housing units.

Measure Concept 4d: ACO performance in patient referral to and/or provision of a service relative to prior performance and/or a target

Measure examples: Measures from the prior measure concept as compared to an improvement and/or an achievement target

This measure concept compares an ACO’s rate of referral or service provision to a pre-determined improvement and/or achievement target.

Implementation Guidance:

1. The achievement target should never be 100 percent.
2. If an ACO contract begins with referring a patient to a service, there should be a subsequent measure concept that assesses receipt of a service(s) following referral.

¹² ACOs and payers could refer to NCQA’s definition of adequate denominator size for HEDIS measures.

3. Targets can vary to reflect the relative social needs profile of the ACO. For example, there could be separate targets for ACOs that predominantly serve Medicaid and Medicaid/Medicare dually eligible patients (e.g., 50 percent of its patients are insured through Medicaid, Medicaid and Medicare, or are uninsured) and ACOs that predominantly serve commercial patients (e.g., 50 percent of its patients are commercially insured), or another measure to distinguish the relative social needs of the populations served by different ACOs. If ACO performance or quality measure targets are to be adjusted to account for social risk, there should be care taken to ensure the social risk adjustment methodology is valid, reliable and specific to quality measurement.¹³ When considering application of social risk adjustment, ACOs and payers should consider how adjusting for social risk may or may not moderate the motivation to address disparities.
4. Accountability should be applied in a way that ensures the performance calculation is statistically sound (e.g., financial incentives for performance should only be applied for measures with adequate denominator size). Performance measurement, when possible, should combine data across payers to ensure there is sufficient denominator size to support assessment.
 - a. ACOs and payers can still pursue quality improvement activities to advance equity for measures that have insufficient denominator size to apply accountability.

¹³ There are no standard accepted methods for social risk adjustment as of October 2022. In this absence, ACOs and payers should refer to the Taskforce’s definition of validity and reliability, which can be found in the Measures and Implementation Parameters document on the Taskforce website: <https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce#aligned-measure-set>.

Appendix

Health Equity Accountability Technical Advisory Group Members

- George “Leo” Blandford (Outer Cape Health Services)
- Stacy Coggershall (Fallon Health)
- Esteban Greshanik (Brigham and Women’s Hospital)
- Dennis Heaphy (Disability Policy Consortium)
- Charles Homer (Economic Mobility Pathways)
- Katherine Howitt (Blue Cross Blue Shield of Massachusetts Foundation)
- Vikram Kambampati (Massachusetts Behavioral Health Partnership)
- Juan Fernando Lopera (Beth Israel Lahey Health)
- Elena Mendez-Escobar (Boston Medical Center)
- Alon Peltz (Point32Health)
- Paul Pirraglia (Baystate Health; BeHealthy ACO)
- Deborah Plummer (Blue Cross Blue Shield of Massachusetts)
- Charles Redd (Fairview Hospital and Berkshire Health System)
- Hannah Rinehardt (Massachusetts Care Coordination Network)
- Liz Sanchez (Massachusetts League of Community Health Centers)
- Christina Severin (Community Care Cooperative)
- Amy Sousa (The Guild for Human Services)
- Christine Vogeli (Massachusetts General Brigham)
- Joseph Weinstein (Steward Healthcare Network)