

**Massachusetts Executive Office of Health and Human Services
Quality Alignment Taskforce**

Report on Work through July 2018

September 7, 2018

DRAFT

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I. Introduction

A. Background

Quality measurement serves an important role in ensuring the quality of health care, identifying areas for improvement and facilitating accountability. The role of quality measurement will continue to expand with the federal and state policy mandates to shift the U.S. health care system from fee-for-service (FFS) reimbursement to alternative payment models (APMs), where payments to providers are tied to quality and cost efficiency.^{1,2,3} The incorporation of quality measures into APM contracts serves the essential role of promoting high quality patient care and preventing the withholding of necessary care.

APM adoption among the three largest Massachusetts-based insurers, representing 63 percent of the commercial population, grew from 47 percent to 56 percent from 2014 to 2016. In 2016, the rate of APM adoption was 42 percent for the overall commercial population, 37 percent for non-Medicare Advantage Medicare contracts, and 36 percent for MassHealth managed care organization contracts. The uptake of APMs in Massachusetts is anticipated to further increase with the 2018 launch of MassHealth's Accountable Care Organization (ACO⁴) program.⁵

Currently, there is a lack of alignment of quality measures across private and public programs in the Commonwealth. The Health Policy Commission (HPC) and Center of Health Information and Analysis (CHIA) evaluated measures across the market. This review included measures in the following categories: (i) APM contracts by three large commercial payers⁶; (ii) the then-pilot MassHealth ACO program⁷; and (iii) the Centers for Medicare and Medicaid Services (CMS) and the Core Quality Measures Collaborative (CQMC) measure set. A total of 106 measures were reviewed, and as seen in **Figure 1**, only one measure was found in all five measure sets and 62 measures were unique to just one measure set.⁸

¹ Patient Protection and Affordable Care Act, Public law 111-148 (2010).

² An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation, Chapter 224 (2012).

³ Medicare Access and CHIP Reauthorization Act of 2015, Public law 114-10 (2015).

⁴ For the purposes of this report, an ACO is defined as a provider organization that has entered into a global budget-based risk contract with a commercial or MassHealth payer.

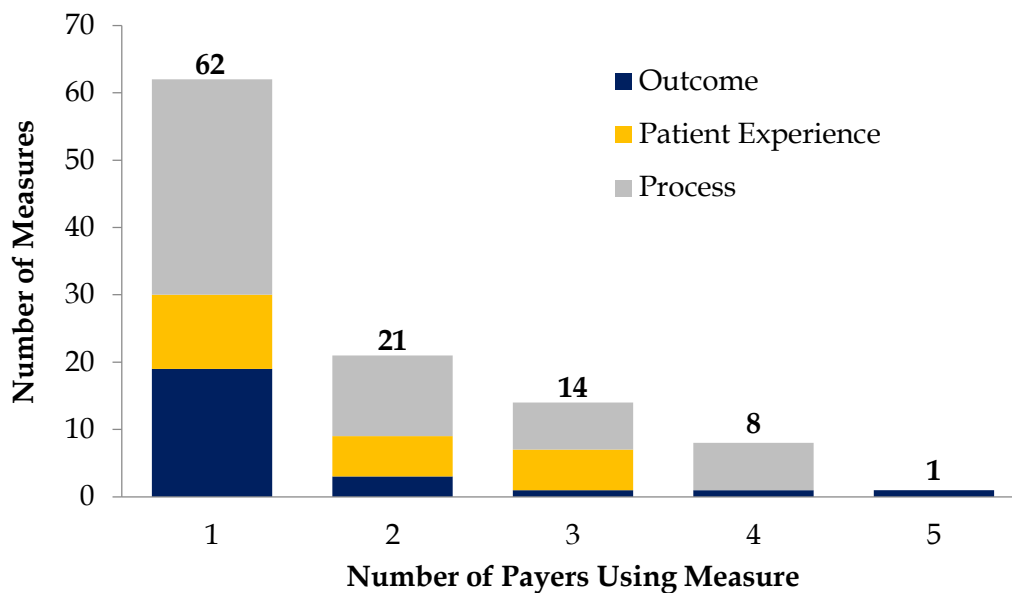
⁵ Health Policy Commission. 2017 Cost Trends Report. 2018 March

⁶ We included measures which the three largest commercial payers (Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan) reported using in at least 10 of their contracts.

⁷ MassHealth has updated its measure set for its DSRIP ACO program. More information can be found in Section V below.

⁸ For more information on alignment of measures for the three main commercial payers, see the "HPC Data Points, Issue 5: Quality Measurement Misalignment in Massachusetts" at www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/hpc-datapoint-5-quality-measurement-misalignment.html. Last accessed July 27, 2018.

Figure 1: Measure Misalignment among Major Massachusetts Payers and Predominance of Measures



Furthermore, there is a financial burden associated with quality measurement. The Massachusetts Health & Hospital Association (MHA) conducted an analysis of the resources used by Massachusetts hospitals to report quality measures required by state and federal agencies. Based on conservative financial estimates provided by survey respondents and extrapolated to account for non-survey respondents, MHA estimated that the 2016 statewide expenditure on quality measurement for providers alone was more than \$67 million.⁹ Whether or not this level of investment in quality measurement is warranted in order to assure high quality care in the Commonwealth, it is a sizable administrative expense.

Some of the burden associated with reporting on quality measures may be unavoidable. For example, some of the lack of alignment of quality measures stems from reporting requirements mandated by CMS for Medicare. Efforts to align performance measures at the state level are unlikely to have a major impact at the federal level, nor is it likely to reduce payer reporting requirements to national accreditation organizations like the National Committee for Quality Assurance (NCQA).

As the role of and cost associated with quality improvement grows, so does the need for advancing a coordinated quality strategy, both nationally and in the Commonwealth. There have been two federal efforts of note to align quality measure sets. First, the Institute of Medicine (now the Academy of Medicine) recommended 15 core measures primarily for monitoring national and regional performance in its 2015 report titled "Vital Signs: Core Metrics

⁹ Massachusetts Health & Hospital Association. MHA quality measurement and reporting resources survey results summary, 2016. A national study found US physician practices in four common specialties spend, on average, 785 hours per physician and more than \$15.4 billion dealing with the reporting of quality measures. See Casalino LP et al. "[US Physician Practices Spend More Than \\$15.4 Billion Annually To Report Quality Measures](#)" *Health Affairs* 2016 35:3, 401-406.

for Health and Health Care Progress.”¹⁰ Second, CMS released seven core measure sets developed by the Core Quality Metrics Committee (CQMC), a partnership between the health insurance industry, provider organizations, medical professional societies, and the National Quality Forum (NQF) between 2016 and 2017.¹¹ Uptake of the CQMC Measure Set has thus far been limited in Massachusetts and nationally.¹²

In parallel, states, such as Oregon, Rhode Island, and Washington have taken initiative to develop their own aligned measure sets through legislation or regulation.¹³ These state-led efforts to facilitate measure alignment provide an opportunity to create measure sets specific to a state’s priorities and population and can be maintained in a timely manner. State-specific measure sets may, however, pose challenges for provider and payer organizations with a presence in multiple states.

In Massachusetts, the Executive Office of Health and Human Services (EOHHS), has prioritized improving population health outcomes and administrative simplification through payment reform. Aligning quality measures in Massachusetts will help convey a unified message on quality measurement to providers and payers, in an effort to promote and support quality improvement in key areas. It should also reduce the administrative burden of reporting and the need for providers to respond to differing contractual requirements for quality improvement focus – both of which are time consuming, costly and contribute to physician burnout.^{14,15}

B. Convening of the Quality Alignment Taskforce and DSRIP Quality Subcommittee

In 2017, the EOHHS convened a Quality Alignment Taskforce (Taskforce) to help define an aligned measure set for use in global budget-based risk contracts, which are inclusive of

¹⁰ Institute of Medicine. *Vital Signs: Core Metrics for Health and Health Care Progress*. National Academies Press, Washington, DC, 2015.

¹¹ See “Core Quality Measures Collaborative Release” at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-16.html and “Release of Core Quality Measures Collaborative Pediatric Core Measure Set” at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-28.html. Last accessed July 26, 2018.

¹² See “Adoption of Core Quality Measures Collaborative Core Measure Sets” at www.ahip.org/adoption-of-core-quality-measures-collaborative-core-measure-sets/. Last accessed August 22, 2018.

¹³ See “Health Plan Quality Metrics Committee” at www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics-Committee.aspx, “Rhode Island OHIC Regulation 2” at www.ohic.ri.gov/documents/2016-OHIC-Regulation-2-amendments-2016-12-12-Effective-2017-1-1.pdf and “Performance Measures” at www.hca.wa.gov/about-hca/healthier-washington/performance-measures. Last accessed July 26, 2018.

¹⁴ Research has shown electronic health record (EHR) use contributing to physician burnout, and a significant amount of physician time spent using EHRs involves entering data required to generate clinical quality measures. Strongwater S and Lee TH. “Are EMRs to Blame for Physician Burnout?” *New England Journal of Medicine Catalyst*, October 24, 2016.

¹⁵ Physician Burnout. Agency for Healthcare Research and Quality. See www.ahrq.gov/professionals/clinicians-providers/ahrq-works/burnout/index.html. Last accessed July 25, 2018.

MassHealth ACO and commercial ACO contracts. EOHHS's objectives were to a) reduce the administrative burden on provider organizations associated with operating under multiple, non-aligned contractual measure sets, including burden associated with resources dedicated to varied quality improvement initiatives and to measure reporting, and b) focus provider quality improvement efforts on state health opportunities and priorities. Specifically, the Secretary convened the Taskforce to recommend an aligned measure set for voluntary adoption by private and public payers and by providers in global budget-based risk contracts. Importantly, the Taskforce excluded payer/ ACO contracts for Medicare populations¹⁶ from its scope and did not consider measures for use in public reporting or in tiering of provider networks.

EOHHS also convened a Delivery System Reform Incentive Payment (DSRIP) Quality Subcommittee (Subcommittee), a subgroup of the Taskforce. The Subcommittee was designed to advise MassHealth on performance measures and performance assessment methodologies for the MassHealth ACO and Community Partner programs.

EOHHS issued a Notice of Opportunity on March 17, 2017 seeking individuals with expertise in health care quality measurement from the following constituencies:

- representatives from provider organizations (including medical, behavioral health, and long-term services and supports (LTSS)) with experience in and responsibility for quality improvement and reporting;
- representatives from commercial and Medicaid managed care health plans with experience in and responsibility for performance measurement activities related to alternative payment models;
- consumer and family/caregiver advocates, and
- representatives from academia and/or the research community with expertise in quality measurement methods and best practices.

Twenty stakeholder organization representatives and 10 state agency personnel were selected to participate on the Taskforce. Eleven members from stakeholder organizations and three members from state agency partners also participated as members of the Subcommittee. **Table 1** includes information about each stakeholder and state agency representative who served on the Taskforce between May 2017 and July 2018.

¹⁶ The Taskforce did, however, consider whether candidate measures were in use by Medicare in its ACO contracts.

Table 1: Taskforce Members

Stakeholder Organizations
<ul style="list-style-type: none"> • Mark Alexakos, MD, MPP (Lynn Community Health Center)⁺ • Richard Antonelli, MD, MS (Boston Children’s Hospital)⁺ • Arlene Ash, PhD (University of Massachusetts Medical School)⁺ • Barrie Baker, MD, MBA (Tufts Health Public Plans)* • Dennis Heaphy, MEd, MPH (Disability Policy Consortium)⁺ • Lisa Iezzoni, MD, MSc (Massachusetts General Hospital / Harvard Medical School)⁺ • Thomas Isaac, MD, MBA, MPH (Atrius Health) • Melinda Karp, MBA, represented two or more times by Elissa Adair, PhD (Commonwealth Care Alliance)⁺ • Renee Altman Nefussy (Tufts Health Plan) • Holly Oh, MD, represented two or more times by Stephanie Giannetto, MS (The Dimmock Center; Community Care Cooperative)⁺ • Elisabeth Okrant, MPH (Massachusetts Behavioral Health Partnership / Beacon Health Options)⁺ • Dan Olshansky, LICSW (Behavioral Health Network)⁺ • Claire Cecile Pierce, MD (South End Community Health Center / Harvard Medical School)*,⁺ • Michael Sherman, MD, MBA, MS, represented two or more times by Tina Whitney, RN, BSN, CCM (Harvard Pilgrim Health Care) • Barbra Rabson, MPH, represented two or more times by Karen Smith, MCP (Massachusetts Health Quality Partners)⁺ • Dana Gelb Safran, ScD, represented by Wei Ying, MBA (Blue Cross Blue Shield of Massachusetts) • Robert Schreiber, MD (Hebrew SeniorLife)* • Jacqueline Spain, MD (Health New England) • Aswita Tan-McGrory, MBA, MSPH (The Disparities Solutions Center at Massachusetts General Hospital) • Christian Dankers, MD, MBA, previously represented by Neil Wagle, MD, MBA* and Eric Weil, MD* (Partners HealthCare)
State Agencies
<ul style="list-style-type: none"> • Lauren Peters, JD and Ipek Demirsoy, MBA, Taskforce Co-Chairs, both previously represented by Alice Moore, JD* (Executive Office of Health and Human Services) • David Whitham (Executive Office of Health and Human Services)* • Katherine Fillo, PhD, RN-BC (Massachusetts Department of Public Health)⁺ • David Tringali, MA (Massachusetts Department of Mental Health)⁺ • Ray Campbell, MPA, represented two or more times by Lisa Ahlgren, MPH, and Cristi Carman, MPH (Center for Health Information and Analysis) • Katie Shea Barrett, MPH (Health Policy Commission) • Linda Shaughnessy, MBA (MassHealth)⁺ • Clara Filice, MD, MPH, MHS,⁺ previously represented by Alon Peltz, MD,

- MBA, MHS,* and by Randi Berkowitz, MD (MassHealth)*
- Gail Grossman (Massachusetts Department of Developmental Services)*
 - Roberta Herman, MD, represented two or more times Rachelle Mercier, Esq., MPH (Group Insurance Commission)
 - Kevin Beagan, MPH, MPP, represented two or more times by Marissa Vertes (Division of Insurance)

*Indicates a member who no longer participates on the Taskforce.

+Indicates a member who also participates on the Subcommittee.

EOHHS engaged Bailit Health Purchasing, LLC (Bailit Health) to staff and facilitate the meetings.

The Taskforce centered its work around two primary goals. The first goal was to gain consensus on an aligned quality measure set for payers and providers to implement in global budget-based risk contracts. The second goal was to identify strategic priority areas for measure development where measure gaps exist.

There were 19 Taskforce meetings and 14 Subcommittee meetings between May 2017 and July 2018. This report, prepared by Bailit Health, primarily focuses on describing the work of the Taskforce and recommendations for next steps (**Sections II, III, and IV**), and includes a brief description of the work of the Subcommittee (**Section V**).

II. Quality Alignment Taskforce Measure Selection Process

The Taskforce adopted several parameters to help inform its initial measure review process. First, it focused on measures for both adult (non-elderly) and pediatric populations. Then, it selected 16 performance measure domains¹⁷; each domain identifies an important area of focus for the overall measure set. The Taskforce deferred consideration and adoption of Inpatient Care measures until its second year of work. The 16 performance measure domains can be found in **Table 2**.

Table 2: Performance Measure Domains¹⁸

1. Preventive Care	9. Health Behaviors
2. Behavioral Health	10. Patient Experience
3. Opioid Prescribing and Treatment	11. Care Coordination
4. Acute Care	12. Integration
5. Maternity Care ¹⁹	13. Patient/Provider Communication
6. Chronic Illness Care	14. Patient Engagement
7. Equity	15. Team-based Care
8. Social Determinants of Health	16. Relationship-centered Care

¹⁷ Domains are defined as categories of similar measures.

¹⁸ The Taskforce subsequently revised the “Preventive Care” domain to “Preventive Care/Early Detection” and incorporated the “Behavioral Health” domain into the “Preventive Care/Early Detection” and “Chronic Illness Care” domains.

¹⁹ The Taskforce did not consider hospital-based maternity care measures but will do so in the future.

Because one of the Taskforce’s primary objectives was to facilitate measure alignment across payer global budget-based risk contracts²⁰, the Taskforce limited its initial review of candidate measures by drawing on measures from 12 measure sets. These included three measure sets that were currently in use in by the state’s three largest insurers in their global budget-based risk contracts, three local and state measure sets, and six national measure sets. **Table 3** summarizes the 12 measure sets from which the Taskforce drew the initial measures for consideration.

Table 3: Measure Sets of Interest

Measures currently in use in global budget-based risk contracts by providers and payers
<ul style="list-style-type: none"> • Harvard Pilgrim Health Care (2017) • Blue Cross Blue Shield of MA (2017) • Tufts Health Plan (2017)
Measures found in local and state measure sets
<ul style="list-style-type: none"> • Boston Public Health Commission (2016) • MassHealth Delivery System Reform Incentive Payment (DSRIP) ACO Measure Set – <i>payment measures only</i> (2017) • Massachusetts Standard Quality Measure Set (2017)
Measures found in national measure sets
<ul style="list-style-type: none"> • CMS/AHIP Core Quality Measures Collaborative (February 2016) • CMS Medicaid Child Core Set (2017) • CMS Medicaid Adult Core Set (2017) • CMS Medicare Part C & D Star Ratings Measures (2017) • CMS Merit-based Incentive Payment System (2017) • NCQA Health Plan Ranking (2017)

The Taskforce initially considered measures that addressed one of the Taskforce’s performance measure domains and were found in at least two of the 12 measure sets of interest. The Taskforce made exceptions when none of the measure sets contained measures within one of the domains of interest (e.g., Care Coordination). Because the Taskforce performed its work in parallel to and in coordination with MassHealth’s development of an ACO contractual measure set, the Taskforce also gave special consideration to all measures found in the MassHealth DSRIP ACO Measure Set. At the suggestion of a Taskforce member, the Taskforce also considered all measures in the CQMC Measure Set because it was identified to be a robust, well-developed measure set.

During the initial round of measures review, the Taskforce reviewed candidate measures by population and by domain and decided if it wanted to tentatively endorse each measure. This initial review included robust discussion about each measure, evaluation of current statewide performance and opportunity for improvement, applicability of the measure to multiple payers,

²⁰ The Taskforce noted that quality measures used for APM accountability are sometimes distinct from those used to measure public health.

and analysis of adequate denominator size at the individual payer and ACO level, when possible. Taskforce members did not always agree on which measures to tentatively endorse due to differing opinions on the measure’s ability to meaningfully impact clinical practices and patient outcomes relative to the burden associated with reporting the measure. The Taskforce debated the merits of such measures until members reached consensus.²¹ In the second and final round of measures review, the Taskforce formally applied nine guiding principles it previously selected to help evaluate each tentatively endorsed measure to ensure each measure aligned with the Taskforce’s priorities. There were four principles the Taskforce applied to individual measures, and five principles to the measure set as a whole. **Table 4** below lists the Taskforce’s guiding principles. Bailit Health and state staff scored each of the tentatively endorsed measures against the Taskforce’s guiding principles and presented the results to the Taskforce. Measures did not need to satisfy all of the guiding principles in order to be selected. During this round of measures review, the Taskforce gave final endorsement to 25 measures.

Table 4: Measure Set Guiding Principles

Principles to be applied to individual measures
<ol style="list-style-type: none"> 1. Evidence-based, scientifically acceptable, nationally-endorsed and valid at the level at which it is being used (ACO-level in particular).²² 2. Required data should be either readily available, not overly burdensome to collect, or, if burdensome, of demonstrable value for improving patient care. 3. Represents an opportunity for improvement. 4. Is important to consumers and supports the triple aim of better care, better health and lower cost.
Principles to be applied to the measure set
<ol style="list-style-type: none"> 1. Prioritize health outcomes, including measures sourced from clinical and patient-reported data. 2. Provide a largely complete and holistic view of the entity being evaluated (e.g., ACO, primary care practice, hospital). 3. The measure set should strive for parsimony. 4. Taken as a whole, high performance on the proposed measure set should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care. 5. Promotes value²³ for consumers, purchasers, and providers.

²¹ For example, members were conflicted on whether the Taskforce should include “Tobacco Use: Screening and Cessation Intervention” in its Measure Set. Some members noted that the measure assesses a “check-the-box” process completed by providers that has little impact on clinical outcomes, while others expressed interest in including the measure given the negative impact of tobacco use on health, especially for certain patient populations. The Taskforce decided against endorsing the measure and agreed to seek an outcomes-focused tobacco measure for future measure implementation.

²² Shall include but not be limited to measures endorsed by the National Committee for Quality Assurance (NCQA) and/or the NQF.

²³ “Value” has different meanings from the perspectives of consumer, purchasers and providers, but may include patient-centeredness, evidence-based, clinical effectiveness, and cost-effectiveness among other value attributes.

III. Quality Alignment Taskforce Results and Outcomes

A. Structure of the Massachusetts Aligned Measure Set

The Taskforce reached consensus on six categories to define the use of the Taskforce's measures that received final endorsement. For payers that voluntarily choose to adopt the measures, those payers and their contracting ACOs are expected to primarily select measures for use in their contracts from the two main categories of measures – the Core Set and the Menu Set. The **Core Set** includes measures that payers and ACOs are expected to use, while the **Menu Set** includes all other measures from which payers and ACOs may choose to supplement the Core measures in their contractual measure set (with the possible exceptions described below).²⁴

The Taskforce adopted the following principles specific to Core Measure Set adoption:

1. No more than five in number
2. Outcomes-oriented
3. At least one measure is focused on behavioral health
4. Universally applicable to the greatest extent possible
5. Crucial from a public health perspective
6. Comprised of measures that are highly aligned across existing payer global budget-based risk contract measures
7. Enhances value

In addition, the Taskforce identified four categories of measures to supplement the Core and Menu Sets. While the Taskforce did not anticipate this to be of frequent occurrence, payers and providers could elect to include measures from the On Deck and Developmental Sets (defined below) as part of their contractual measure sets.

- The **Monitoring Set** includes measures that the Taskforce identified to be a priority area of interest, but because recent performance was high, or data not currently available, were not endorsed for Core or Menu Set use. Monitoring Set measures are intended to be used for performance tracking to ensure performance does not decline. If performance does decline, the Monitoring Set measures may be reconsidered by the Taskforce for inclusion in the Core and Menu Sets. The Taskforce recommended that Monitoring Set measures that utilize claims data be calculated at the ACO level, while measures that utilize clinical data be calculated at alternative levels (e.g., hospital, state).
- The **On Deck Set** includes measures that the Taskforce has endorsed for the Core or Menu Set, and which the Taskforce will move into those sets in the two or three years following endorsement to give providers time to prepare for reporting.
- The **Developmental Set** includes measures and measure concepts that address priority areas for the Taskforce, but the measure has not yet been defined, validated and/or tested for implementation.

²⁴ The Taskforce did not have substantive discussion about public reporting of the measure set. Taskforce members requested the opportunity to reconsider the measure set with public reporting in mind in the future should Taskforce leadership or the Legislature have interest.

- The **Innovation** measure category includes measures which address a) clinical topics or clinical outcomes in the Core or Menu Sets utilizing a novel approach or b) clinical topics that are not addressed in the Core or Menu Sets. Innovation measures are intended to advance measure development and therefore cannot include measures that have been previously considered and rejected by the Taskforce as Core or Menu measures. Innovation measures can be used as pay-for-performance or pay-for-reporting at the mutual agreement of the payer and ACO. For payers choosing to voluntarily adopt the Massachusetts Aligned Measure Set and its associated parameters, use of Innovation measures, at the outset, will not be limited in number. The Taskforce recommended monitoring and revisiting use of Innovation measures. The Taskforce also recommended evaluating Innovation measures, once developed and tested, for inclusion in the Menu, On Deck, or Developmental Sets.

Early in the Taskforce process, members discussed and could not agree on whether the Aligned Measure Set should solely be a “menu” from which insurers and providers would choose, or if there should also be a small core set of measures that all insurer-provider contracts would be expected to utilize.²⁵ Providers generally advocated for adoption of a Core Set with a Menu Set, while insurers argued for only a Menu Set.

When the Taskforce revisited the question of Core and Menu Measure Sets in the spring of 2018, it formally voted to endorse a Core and a Menu Set approach or a Menu-only Set approach. At this time, the Taskforce revised the definition of Core measures to adhere to a set of seven guiding principles, as described above. The overwhelming majority of members formally voted in support of a Core and Menu Set approach. Two insurer Taskforce members voted for a Core and Menu Set, while three voted in opposition. One provider group agreed with the concept of a Core and Menu set, but given the specific measures under consideration for inclusion in the Core Set opted for the Menu-only Set option. **Table 5** below provides the results of this vote.

Table 5: Members Voting for or Against a Core and Menu Set Approach²⁶

Vote	Number of Votes
Core and Menu Set	20
Menu-only Set	4
Absent and therefore, unable to vote	3

²⁵ Allowance for exceptions in special instances was discussed, e.g., adult core measures that were not applicable for patients served by a pediatric ACO.

²⁶ Two initial Taskforce members, Rob Schreiber and David Whitham, were no longer Taskforce members at the time of the vote and therefore were not included in the total vote count. In addition, MassHealth only had one vote.

B. Composition of the Massachusetts Aligned Measure Set

The Taskforce reviewed 151 measures during its initial round of measures review.²⁷ As a result, the Taskforce tentatively endorsed 33 measures for the Core or Menu Sets, four Monitoring measures, and 16 Developmental measures and chose to not endorse 98 measures. During the second and final round, the Taskforce endorsed four Core measures, 17 Menu measures, and eight Monitoring measures. The Taskforce did not endorse any On Deck measures, but retained the category for future use.

The Taskforce wanted to adopt a depression outcome measure as a Core measure, but technical challenges with implementation of a single measure led to a compromise solution: insurers and providers would select at least one behavioral health measure for contracting (from a list of one substance use treatment measure and four depression treatment measures). The Taskforce recommended that over time the Taskforce work towards future endorsement of a common depression outcome measure based on collaboration and learning, refinement, and advancements in payers' and providers' ability to address technical challenges.

Table 6 below summarizes the final Massachusetts Aligned Measure Set recommended by the Taskforce. For the Core Measure Set, acronyms in parentheses refer to the organization that developed and/or maintains the measure's specifications.

Table 6: Recommended Massachusetts Aligned Measure Set

Core Measures
1. Controlling High Blood Pressure
2. Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
3. CG-CAHPS ²⁸ (MHQP ²⁹ version) ³⁰
4. At least one of the following behavioral health measures: a. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (either the Initiation or Engagement Phase) OR b. At least one of the following depression-related measures: i. Depression Screening and Follow-Up (CMS or NCQA) ii. Depression Response – Progress Towards Remission (MNCM) iii. Depression Remission (MNCM) iv. Depression Remission or Response (HEDIS)

²⁷ During the review process the Taskforce recognized that the best achievable performance rate for all measures was not 100% for many reasons.

²⁸ Clinician and Group Consumer Assessment of Healthcare Providers and Systems. See www.ahrq.gov/cahps/surveys-guidance/cg/index.html.

²⁹ Massachusetts Health Quality Partners. See <http://mhqp.org>.

³⁰ The Taskforce considered several surveys, such as the ACO CAHPS and CG-CAHPS surveys, and endorsed the MHQP-modified version of the CG-CAHPS survey because it was widely in use by both Medicaid and commercial payers in the state. The Taskforce did not endorse a specific survey measures or group of measures.

Menu Measures
5. Childhood Immunization Status (Combo 10)
6. Immunizations for Adolescents (Combo 2)
7. Influenza Immunization
8. Chlamydia Screening
9. Breast Cancer Screening
10. Cervical Cancer Screening
11. Colorectal Cancer Screening
12. Asthma Medication Ratio
13. Comprehensive Diabetes Care: Eye Exam
14. Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
15. Metabolic Monitoring for Children and Adolescents on Antipsychotics
16. Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
17. Follow-Up After Hospitalization for Mental Illness (7-Day)
18. Follow-Up After Hospitalization for Mental Illness (30-Day)
19. Follow-up After Emergency Department Visit for Mental Health (7-Day)
20. Continuity of Pharmacotherapy for Opioid Use Disorder
21. Use of Imaging Studies for Low Back Pain
Monitoring Measures
1. Well-Child Visits in the First 15 Months of Life
2. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
3. Adolescent Well-Care Visit
4. Comprehensive Diabetes Care: Hemoglobin A1c Testing
5. Comprehensive Diabetes Care: Medical Attention for Nephropathy
6. Contraceptive Care - Postpartum
7. Prenatal & Postpartum Care - Timeliness of Prenatal Care
8. Incidence of Episiotomy ³¹

The Core and Menu Sets were established with the expectation that they would be reassessed annually by the Taskforce, including to consider changes in national clinical guidelines and national measure specifications. The Taskforce will define this annual review process as part of its next phase of work, as outlined in Section IV below.

The Taskforce endorsed the concept of Innovation measures to enable payers and providers flexibility to pursue the development and implementation of novel measures. These Innovation measures will allow focus on specific clinical conditions or populations that are of mutual interest to a payer-ACO dyad.

Finally, over the course of the Taskforce meetings, members periodically identified gaps in existing available measures relative to the Taskforce's identified priorities. The gaps were specific to a condition, a treatment, a population, or a dimension of care (e.g., outcome). In some instances, measures were identified to require additional developmental work prior to being considered for adoption. In other cases, members identified a measure concept that

³¹ "Incidence of Episiotomy" was categorized in the maternity care domain. This measure could also be categorized as an inpatient hospital measure.

needed further analysis to be developed into a measure. **Appendix A** lists the developmental measures and measure concepts identified as of July 2018.

C. Implementation of the Recommended Massachusetts Aligned Measure Set

Taskforce staff initially suggested that the Taskforce recommend that payers electing to voluntarily adopt the Massachusetts Aligned Measure Set implement the set in their ACO contracts effective January 1, 2019. Taskforce staff further suggested that any new or revised contracts should include measures from the Core and Menu Measure Sets and changes to measures should be incorporated if the Taskforce identified the change at least six months in advance of the contractual performance period. This policy would not apply to changes in specifications to HEDIS measures (typically released in July each year).³²

The Taskforce was uncertain that implementation of the measure set by January 1, 2019 was feasible, given the length and complexity of commercial payer/ACO contract negotiations. Payer representatives argued that they could not open multi-year contracts without opening the entirety of their contracts to renegotiations. In addition, payer representatives said they needed between six to 18 months' notice of contractual measures changes. Based on this feedback, Taskforce staff and payer representatives recommended that payers voluntarily adopting the Massachusetts Aligned Measure Set incorporate the measures into contracts with ACOs with renewal dates on or after January 1, 2020. Further, they recommended that any changes to the Massachusetts Aligned Measure Set be established annually no later than March for contract implementation in the subsequent calendar year. The Taskforce will continue its discussion relative to implementation during its next meeting in September 2018.

The Taskforce also agreed to post the final Massachusetts Aligned Measure Set on the EOHHS website and invite the public to submit written feedback. Taskforce staff will compile feedback and will share it with the Taskforce to inform the annual review process in 2019.

IV. Quality Alignment Taskforce Next Steps and Future Directions

The Taskforce identified several areas of future work. First, the Taskforce recommended that the state assess implementation of the Massachusetts Aligned Measure Set into global budget-based risk contracts. In response, the HPC and CHIA committed to monitoring implementation of the Aligned Measure Set over the next year and to sharing this information with the Taskforce. While adoption of the Aligned Measure Set will be voluntary, two organizations have already expressed a commitment to utilizing the Measure Set. MassHealth and the Group Insurance Commission³³ have updated their respective contractual measure sets to align with Massachusetts Aligned Measure Set as a result of the Quality Alignment Taskforce. As of the date of the Taskforce's July meeting, adoption of the Aligned Measure Set was voluntary, and at least one commercial insurer has confirmed that it will not adopt the measure set in its contracts.

³² Payers, when reporting to NCQA, are already required by NCQA to adhere to changes in specifications to HEDIS measures for the following measurement period (e.g., changes made in July 2018 for calendar year 2019).

³³ The GIC has adopted the measure set for their contracts with health plans.

Second, the Taskforce will shift its attention to begin addressing measure gaps and Developmental measures. This will include prioritizing on which Developmental measures to focus and identifying resources to develop, test, and then implement these measures. In some instances, this work will require the Taskforce to convene one or more subgroups. For example, the Taskforce already expressed interest in creating a work group to discuss how to stratify measures for the purpose of measuring equities and disparities, including identifying which data points to use (e.g., race/ethnicity, gender, language) for stratification. This work group could also identify a short list of social determinants of health (SDOH)-related ICD-10 codes for provider and plans to begin collecting. The Taskforce has already indicated a willingness to collaborate with other work groups, such as the MassHealth-convened Social Services Integration Workgroup focused on SDOH. In addition, the Taskforce has expressed interest in collaborating with other states that are also developing measures, such as Oregon. The Taskforce aims to identify a process to advance Developmental measure and measure concepts in the fall of 2018. Third, the Taskforce will begin considering measures in performance measure domains not considered for the 2019 Massachusetts Aligned Measure Set. As part of this work, the Taskforce recommended considering measures related to inpatient care, which could also include convening a work group to help determine how to adapt facility-based measures for ACOs. In addition, the Taskforce also expressed an interest in considering service utilization measures, namely, the utilization measures that MassHealth is currently including in its DSRIP ACO Measure Set. The Taskforce also discussed the idea of utilizing multi-payer case-mix data to generate adequate denominator sizes for at least select measures that would otherwise be problematic when generated on an individual payer basis (e.g., select pediatric-focused behavioral health measures). If it can determine a feasible way to implement this strategy, the Taskforce may consider measures in additional performance measure domains.

Fourth, the Taskforce will need to develop a process to provide ongoing maintenance of the measure set. The Taskforce recommended an annual review process that will consider whether the Massachusetts Aligned Measure Set addresses the statewide health priorities; incorporate any changes to the Measure Set in response to public comment; update the Measure Set to reflect any changes in measure specifications, endorsement status, or changes in opportunity for improvement; modify which measures are included in the Core and Menu Sets once there is greater clarity around which measures payers and ACOs are including in their contracts; discuss if there are any measures to remove; and track performance for measures in the Monitoring Set.

V. DSRIP Quality Subcommittee Summary

MassHealth convened the DSRIP Quality Subcommittee (Subcommittee) to advise MassHealth on quality measures and methodology for the ACO and the Community Partner measure sets. Over the Subcommittee's initial year of work (June 2017 through June 2018), the group provided MassHealth with ongoing technical assessments of the measure specifications, the performance goals for each measure, the categorization of measures into "performance" (payment) and "monitoring" domains, and the timeline for moving new measures to the payment incentive measure slate. MassHealth is developing member experience surveys for three categories of its population: its ACO population, Behavioral Health Community Partner

population, and Long-Term Services and Supports (LTSS) Community Partner population.³⁴ The Subcommittee helped inform MassHealth on which questions to include in the survey and each survey's target population.

The Subcommittee worked closely to advise MassHealth as it developed measures that addressed key aspects of MassHealth ACO performance for which the DSRIP ACO Measure Set lacked a robust measure. Development areas included measures related to care planning, care integration, and community tenure.^{35,36} Because MassHealth is required to receive CMS approval on any revisions to the measure slate and specifications, the conversations with the Subcommittee were iterative and spanned several meetings in order to respond to CMS' feedback on MassHealth's proposed changes. The Subcommittee also considered how to address alignment issues with the parallel development of the Massachusetts Aligned Measure Set.

The MassHealth DSRIP ACO Measure Set includes 22 pay-for-performance quality measures, member experience survey measures (discussed above), and 28 monitoring measures. ACOs will be financially accountable for performance on ten pay-for-performance measures starting in 2019 and for all 22 measures in 2020. ACOs will also be held accountable for performance on member experience starting in 2019 and increasingly in 2020.

The MassHealth DSRIP Behavioral Health Community Partner Measure Set includes 13 pay-for-performance measures and the LTSS Community Partner Measure Set includes eight pay-for-performance measures. Each program will also include member experience survey measures. Behavioral Health and LTSS Community Partners will be held financially accountable for the pay-for-performance and member experience measures beginning in 2020.

The quality measure sets for MassHealth ACOs, Behavioral Health Community Partners, and LTSS Community Partners can be found in **Appendix B**.³⁷ MassHealth expects to finalize these member experience surveys with the Massachusetts Health Quality Partners this year.

MassHealth regularly consulted with the Subcommittee for advice on how to modify the ACO Measure Set to align with the Massachusetts Aligned Measure Set being developed by the Taskforce. In the end, there were three instances in which MassHealth's measure set did not align with the Massachusetts Aligned Measure Set. The Taskforce recommended that MassHealth's adoption of the Aligned Measure Set allow for deviations to meet Medicaid-specific program needs. These modifications are outlined in **Table 7**.

³⁴ MassHealth is utilizing the MHQP version of the CG-CAHPS survey for its ACO population and is developing two separate surveys for its Behavioral Health and LTSS Community Partner populations.

³⁵ The absence of a measure is because there are either no currently existing, validated measures in the identified areas or measures that the Subcommittee deemed to sufficiently address the Subcommittee's intended purpose.

³⁶ As of the date of this report MassHealth's development of these measures was not complete.

³⁷ The ACO, Behavioral Health Community Partner, and LTSS Community Partner Measure Sets were developed by MassHealth. Only the Subcommittee, not the Taskforce, provided MassHealth with feedback on these measure sets.

Table 7: Massachusetts Aligned Measure Set Modifications for MassHealth

Modification	Rationale for Modification
Inclusion of Prenatal and Postpartum Care – Timeliness of Prenatal Care.	Addressed a MassHealth priority focus area. The Taskforce’s measure set did not include any maternity care measures.
Inclusion of readmission and acute unplanned admission for individuals with diabetes measures.	The Taskforce chose not to consider any utilization measures for its initial measure set.
Inclusion of several measures that do not need to align with the Massachusetts Aligned Measure Set because they are not applicable to a commercially insured population (e.g., Oral Health Evaluation, Behavioral Health Community Partner and LTSS Community Partner Engagement).	Addressed MassHealth-specific services and populations.

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Appendix A: Taskforce-Identified Developmental Measures and Measure Concepts by Domain as of July 2018

Prevention/Early Detection
<p><u>Measures that Require Developmental Work</u></p> <ol style="list-style-type: none"> 1. Developmental Screening for Behavioral Health Needs: Under Age 21 2. Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentist <p><u>Measure Concepts</u></p> <ol style="list-style-type: none"> 3. Oral health 4. Obesity reduction 5. Pediatric behavioral health 6. Tobacco quit rate
Chronic Illness Care
<p><u>Measures that Require Developmental Work</u></p> <ol style="list-style-type: none"> 7. Optimal Diabetes Care 8. Optimal Asthma Control <p><u>Measure Concepts</u></p> <ol style="list-style-type: none"> 9. Blood pressure control 10. Pediatric asthma 11. Pediatric behavioral health 12. Statin therapy (medication intensity or medical/LDL goal) for patients with diabetes
Acute Care
<p><u>Measures that Require Developmental Work</u></p> <ol style="list-style-type: none"> 13. Functional Status Assessment for Total Knee Replacement 14. Functional Status Assessment for Total Hip Replacement <p><u>Measure Concepts</u></p> <ol style="list-style-type: none"> 15. Overall functional status
Maternity Care
<p><u>Measure Concepts</u></p> <ol style="list-style-type: none"> 16. Outcomes-focused maternity care measures
Equity
<p><u>Measure Concepts</u></p> <ol style="list-style-type: none"> 17. Stratify existing measures by race/ethnicity, age, gender, language, disability status, etc. 18. Stratify measures, to the extent that data systems allow, by subpopulations, to be defined at a later time, as a Developmental measure for monitoring purposes
Social Determinants of Health
<p><u>Measures that Require Developmental Work</u></p> <ol style="list-style-type: none"> 19. Social Services Screening

Patient Experience
<u>Measure Concepts</u>
20. A modified version of CG-CAHPS that supplements, modifies, or substitutes questions (including, potentially, the PPIC and PICS)
21. A modified version of CG-CAHPS for a non-primary care attributed population
Care Coordination
<u>Measure Concepts</u>
22. Care management and coordination of services
23. Care planning
Integration
<u>Measures that Require Developmental Work</u>
24. Community Tenure
<u>Measure Concepts</u>
25. Integration, notably for behavioral health populations and for when a member is involved with one or more state agencies
Patient Engagement
<u>Measure Concepts</u>
26. Patient activation
Other
<u>Measure Concepts</u>
27. Accessibility of specialist care
28. Clinician burnout/provider satisfaction
29. Consumer affordability of health care
30. Disability-adjusted life years
31. EHR interoperability
32. Life status measures, potentially including kindergarten readiness, high school graduation rate and other measures
33. Measures specific to vulnerable populations (e.g., those with sickle cell disease)
34. Overall sense of well-being and health outcomes
35. Patient-reported outcome measures

Appendix B: MassHealth DSRIP ACO, Behavioral Health Community Partner, and Long-term Services and Supports Community Partner Measure Sets as of July 2018³⁸

MassHealth DSRIP ACO Quality Measure Set								
#	Measure Name	Measure Description	Data Source	Measure Payment Status (P = Performance, R= Reporting, P4R = Pay for Reporting)				
				2018	2019	2020	2021	2022
Domain 1 – Prevention & Wellness								
1	Childhood Immunization Status	Percentage of members who received all recommended immunizations by their 2nd birthday	Hybrid	P4R	P	P	P	P
2	Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	Hybrid	P4R	P	P	P	P
3	Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment	Hybrid	P4R	P	P	P	P
8	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	Hybrid	P4R	P	P	P	P
9	Comprehensive Diabetes Care: A1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	P4R	P	P	P	P
7	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Admin	R	P	P	P	P
10	Follow-up Care for Children Prescribed ADHD Medication (Initiation)	Percentage of members 6 to 12 years of age who were newly prescribed ADHD medication and had a follow-up care visit within 30 days of when the first ADHD medication was dispensed	Admin	R	P	P	P	P
12	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	Admin	R	P	P	P	P

³⁸ The ACO, Behavioral Health Community Partner, and LTSS Community Partner Measure Sets were developed by MassHealth with CMS. The Subcommittee, and not the Taskforce, provided MassHealth with feedback on these measure sets.

15	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Admin	R	P	P	P	P
21	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥ 2 additional services within 30 days of the initiation visit	Admin	R	P	P	P	P
Domain 2 - Care Integration								
4	Oral Health Evaluation	Percentage of members under age 21 years who received a comprehensive or periodic oral evaluation during the year	Admin	R	R	P	P	P
5	Tobacco Use: Screening and Cessation Intervention	Percentage of members 18 to 64 years of age who were screened for tobacco use one or more times within 24 months, and if identified as a tobacco user, received cessation counseling intervention	Hybrid	P4R	R	P	P	P
6	Depression Screening and Follow-Up for Adolescents and Adults	Percentage of members age 12 to 64 years of age who were screened for clinical depression, and if screened positive for depression, who received follow-up care within 30 days	Hybrid	P4R	R	P	P	P
11	Depression Remission or Response*	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who received follow-up evaluation with PHQ-9 and experienced response or remission in 4 to 8 months following the elevated score	Hybrid	P4R	R	P*	P	P
13	ED Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions	Number of ED visits for members 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	Admin	R	R	P	P	P
14	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of ED visits for members 18 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge	Admin	R	R	P	P	P
16	Hospital Readmissions (Adult)	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age	Admin	R	R	P	P	P
17	Health-Related Social Needs Screening	Percentage of members who were screened for health-related social needs in the measurement year	Hybrid	P4R	R	P	P	P

18	Behavioral Health Community Partner Engagement	Percentage of members 18 to 64 years of age who engaged with a BH Community Partner and received a treatment plan within 3 months (92 days) of Community Partner assignment	Admin	R	R	P	P	P
19	Long-Term Services and Supports Community Partner Engagement	Percentage of members 3 to 64 years of age who engaged with an LTSS Community Partner and received a care plan within 3 months (92 days) of Community Partner assignment	Admin	R	R	P	P	P
20	Community Tenure: BH and LTSS Community Partner Members*	The number of eligible days ACO assigned members 18 to 64 years of age who are assigned to either a Behavioral Health (BH) or a Long-Term Services and Supports (LTSS) Community Partner (CP) resided in their home or in a community setting without utilizing acute or post-acute inpatient services	Admin	R	R	P*	P	P
22	Acute Unplanned Admissions for Individuals with Diabetes	This measure will assess the case-mix adjusted rate of acute unplanned hospital admissions for individuals 18 to 64 years of age with diabetes.	Admin	-	R	P	P	P
Domain 3 - Patient Experience: Overall Rating and Care Delivery								
23	Overall Rating and Care Delivery	Composite Related to Communications and Willingness to Recommend (To be finalized)	Survey	R	P	P	P	P
Domain 4 - Patient Experience: Person-Centered Integrated Care								
24	Person-centered Integrated Care	Composites Related to Care Planning, Self-Management and Integration of Care (To be finalized)	Survey	R	R	P	P	P

* - indicates the measure will be weighted 50% relative to all other measures in BP3 (2020)

Behavioral Health Community Partner Measure Slate									
#	Measure Name	Measure Description	Data	Measure Payment Status (P= Performance, R= Reporting)					
				2018	2019	2020	2021	2022	
Domain 1: Care Integration									
1	Community Partner Engagement	Percentage of enrollees 18 to 64 years of age who engaged with a BH Community Partner and received a completed treatment plan within 3 months (92 days) of Community Partner assignment	Admin	R	R	P	P	P	
2	Annual Treatment Plan Completion	Percentage of enrollees 18 to 64 years of age who received a completed a treatment plan within the measurement year	Admin	R	R	P	P	P	
2*	Enhanced Person-Centered Care Planning	TBD Measure will speak to content, timeliness, and person-centeredness of an iterative care plan	TBD	--	--	R	P	P	
3	Follow-up with CP after acute or post-acute stay (3 days)	Percentage of acute or post-acute stays for enrollees 18 to 64 years of age where the member received follow-up from the BH CP within 3 business days of discharge	Admin	R	R	P	P	P	
4	Follow-up with any provider after ED visit	Percentage of ED visits for enrollees 18 to 64 years of age where the member received follow-up within 7 days of ED discharge	Admin	R	R	P	P	P	
Domain 2: Population Health									
5	Annual primary care visit	Percentage of enrollees 18 to 64 years of age who had an annual primary care visit in the measurement year	Admin	R	R	P	P	P	
6	Community Tenure	Rate of eligible days CP enrollees 18 to 64 years of age resided in a community setting without utilizing acute or post-acute inpatient services	Admin	R	R	P	P	P	
7	Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of enrollees 18 to 64 years of age who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiated treatment within 14 days of diagnosis	Admin	R	R	P	P	P	
8	Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of enrollees 18 to 64 years of age who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who received ≥2 additional services within 30 days of the initiation visit	Admin	R	R	P	P	P	
9	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Admin	R	R	P	P	P	
10	Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening	Admin	R	R	P	P	P	

11	Tobacco Use: Screening and Cessation Intervention	TBD	Admin	--	R	P	P	P
Domain 3: Avoidable Utilization								
12	ED Visits for Adults with SMI, Addiction, or Co-occurring Conditions	The rate of ED visits for enrollees 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	Admin	R	R	P	P	P
13	Hospital Readmissions (Adult)	The rate of acute unplanned hospital readmissions within 30 days of discharge for enrollees 18 to 64 years of age	Admin	R	R	P	P	P

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LTSS Community Partner Measure Slate								
#	Measure Name	Measure Description	Data	Measure Payment Status (P= Performance, R= Reporting)				
				2018	2019	2020	2021	2022
Domain 1: Care Integration								
1	Community Partner Engagement	Percentage of enrollees 3 to 64 years of age who engaged with a LTSS Community Partner and received a completed care plan within 3 months (92 days) of Community Partner assignment	Admin	R	R	P	P	P
2	Annual Care Plan Completion	Percentage of enrollees 3 to 64 years of age who received a completed a care plan within the measurement year	Admin	R	R	P	P	P
2*	Enhanced Person-Centered Care Planning	TBD Measure will speak to content, timeliness, and person-centeredness of an iterative care plan	TBD	--	--	R	P	P
3	Follow-up with CP after acute or post-acute stay (3 days)	Percentage of acute or post-acute stays for enrollees 3 to 64 years of age where the member received follow-up from the LTSS CP within 3 business days of discharge	Admin	R	R	P	P	P
Domain 2: Population Health								
4	Community Tenure	The rate of eligible days CP enrollees 3 to 64 years of age resided in a community setting without utilizing acute or post-acute inpatient services	Admin	R	R	P	P	P
5	Annual primary care visit	Percentage of enrollees 3 to 64 years of age who had an annual primary care visit in the measurement year	Admin	R	R	P	P	P
6	Oral Health Evaluation	Percentage of enrollees 3 to 20 years of age who received a comprehensive or periodic oral evaluation within the measurement year	Admin	R	R	P	P	P
Domain 3: Avoidable Utilization								
7	Hospital Readmissions (Adult)	The rate of acute unplanned hospital readmissions within 30 days of discharge for enrollees 18 to 64 years of age	Admin	R	R	P	P	P
8	Emergency Department Visits	The rate of all-cause emergency department (ED) visits for enrollees 3 to 64 years of age	Admin	R	R	P	P	P