MassHealth

MassHealth Managed Care Quality Strategy

December 2013

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Section 1: Introduction

This is the third revision of the Massachusetts Managed Care Quality Strategy, a strategy required by 42 CFR 438, et seq. The Strategy was first developed in 2006 and updated in 2008 and 2010. This document includes the elements of the Quality Strategy required by CMS, but also includes state specific managed care quality goals and measures.

Section 1A: Managed Care Goals, Objectives and Overview

History of Massachusetts Medicaid and CHIP Managed Care

Massachusetts began enrolling families and children in managed care in 1997 as part of an 1115 waiver approved in 1995 to expand Medicaid eligibility. The 1997 waiver covered families and children up to 200 percent of the federal poverty level (FPL). The same year, the Massachusetts legislature passed Chapter 170 combining the Children's Health Insurance Program (CHIP) with Medicaid by expanding Medicaid coverage for children through the age of 18 from the previous level of 133 percent FPL to 150 percent FPL. Chapter 170 also provided presumptive eligibility for children while income and other information to verify eligibility were obtained.

Over time, MassHealth managed care programs have expanded to seniors and members with dual eligibility. MassHealth operates or is in the final stages of preparing to implement, the following managed care programs:

- Managed Care Organization (MCO) Program – a capitated model for members under the age of 65. Members are not eligible for managed care programs if they have any kind of TPL.
- Primary Care Clinician (PCC) Plan Program – the Plan is a primary care case management model of managed care for members under the age of 65 and without any third party insurance, with a capitated Behavioral health (BH) plan (PCC Plan BH Program)
- Senior Care Options (SCO) Program – a capitated model for dually eligible members age 65 and older
- Program of the All -Inclusive Care for the Elderly (PACE) Program, for members age 55 and older – managed care through direct contracts with providers rather than through managed care entities
- OneCare – a capitated model for dually eligible members under the age of 65
- Primary Care Payment Reform (PCPR) – a new managed care program with a bundled payment to the PCC through direct contracts with the PCC rather than through managed care entities. for members of the PCC Plan which provides a bundled payment to the PCC primary care clinician

The entities required by federal regulations (42 CFR 438.2) to be covered by the quality strategy and the products they offer are displayed in Table 1. For the purposes of this document, these entities will be described as managed care plans, or manage care entities (MCEs). The BBA relates to managed care entities, rather than the programs offered by the entity. Sub-contracted services (e.g. behavioral health) are not included in the table. Though not required, the PCC Plan will be included in the strategy, where appropriate.

Table 1: MassHealth Managed Care Entities and Services Provided, 2013[1]

Medicare Status	Members under age 65			Members 65+
	Non-dually eligible		Dually eligible	Dually eligible
Program Managed Care Entity	MCO Program	PCC Plan Behavioral Health Care	One Care Program	SCO Program
Boston Medical Center Health Net	X			
Commonwealth Care Alliance			X	X
Fallon Health Plan	X		X	X
Health New England	X			
Massachusetts Behavioral Health Partnership		X		
Neighborhood Health Plan	X			
Network Health	X		X	
Senior Whole Health				X
Tufts Health Plan Senior Care Options				X
United Healthcare				X

Goals for MassHealth Managed Care

The entire MassHealth enterprise engaged in an extensive and comprehensive strategic planning process in calendar year 2012. That process resulted in an updated mission statement and five strategic goals. These goals and objectives, as well as the Triple Aim of "better health, better healthcare, lower cost," serve as a framework for Quality Strategy Goals.

MassHealth Goals and Objectives

MassHealth Mission Statement: To improve the health outcomes of our diverse members, their families and their communities, by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life.

MassHealth Strategic Goals

Goal 1: Deliver a seamless, streamlined, and accessible member experience

Goal 2: Promote integrated care systems that share accountability for better health, better care, and lower costs

Goal 3: Shift the balance toward preventative, patient-centered primary care, and community-based services and supports

Goal 4: Maintain our commitment to careful stewardship of public resources through innovative program integrity initiatives

Goal 5: Create an internal culture and infrastructure to support our ability to meet the evolving needs of our members and partners

The goals above were in turn mapped to specific objectives by the MassHealth strategic planning team. Many of the objectives touch the managed care programs of MassHealth.

Table 2: MassHealth goals mapped to strategic objectives related to managed care programs[2]

MassHealth Strategic Goals	MassHealth Strategic Objectives
1: Deliver a seamless, streamlined, and accessible member experience	1.1 Deliver information that is clear, engaging, timely, accessible, and culturally and linguistically appropriate to our members and providers 1.2 Engage community-based organizations in partnerships to better communicate with our members and to improve member access 1.3 Solicit regular member and provider feedback to drive process improvement and report back lessons learned and next steps
2: Promote integrated care systems that share accountability for better health, better care, and lower costs	2.1 Use alternative payment methodologies to promote care delivery innovations such as team based care, group visits, telehealth, virtual office visits, and community health workers 2.2 Prioritize access to integrated models of care delivery for high cost members with complex care needs 2.3 Promote and scale the patient-centered medical home model across all MassHealth programs 2.4 Operationalize primary-care behavioral health integration 2.5 Align quality measures across initiatives and tie payments to quality 2.6 Leverage payment strategies to drive adoption and use of EHRs to enhance care coordination and quality improvement 2.7 Give providers access to timely data to accelerate care improvement
3: Shift the balance toward preventative, patient-centered primary care, and community-based services and supports	3.1 Invest in community-based behavioral health and long-term services and supports that promote independent living 3.2 Promote active member engagement in the development of their care plan and self-management strategies for chronic diseases 3.3 Hold providers accountable for reducing readmissions, ER visits and admissions for ambulatory sensitive conditions such as asthma and diabetes 3.4 Partner more closely with other agencies for development and rollout of prevention and wellness initiatives across MassHealth Programs 3.5 Creatively engage and incentivize members to participate in wellness initiatives focused on smoking cessation and obesity
4: Maintain our commitment to careful stewardship of public resources through innovative program integrity initiatives	4.1 Hold contracted entities accountable for identifying and reporting fraud.
5: Create an internal culture and infrastructure to support our ability to meet the evolving needs of our members and partners	5.1 Meet members where they are 5.2 Be data driven

Objectives for MassHealth Managed Care Programs

Overall, MassHealth Managed Care Goals mirror the Agency's goals:

1 Deliver a seamless, streamlined, and accessible experience to all managed care members.

2 Promote managed care systems that provide integrated care and that share accountability for better health, better healthcare, and cost efficient care.

[2] Presentation prepared by Dr.Julian Harris and Corbin Petro, **MassHealth Strategic Planning Document 2012-2014,** MassHealth Program: Boston, MA, November 2012.

3 Encourage managed care systems to shift the balance toward preventative, patient-centered primary care, and community-based services and supports.

Strategic Partnerships

MassHealth managed care is implemented in an environment where multiple strategic partners with the state participate. Strategic partners include:

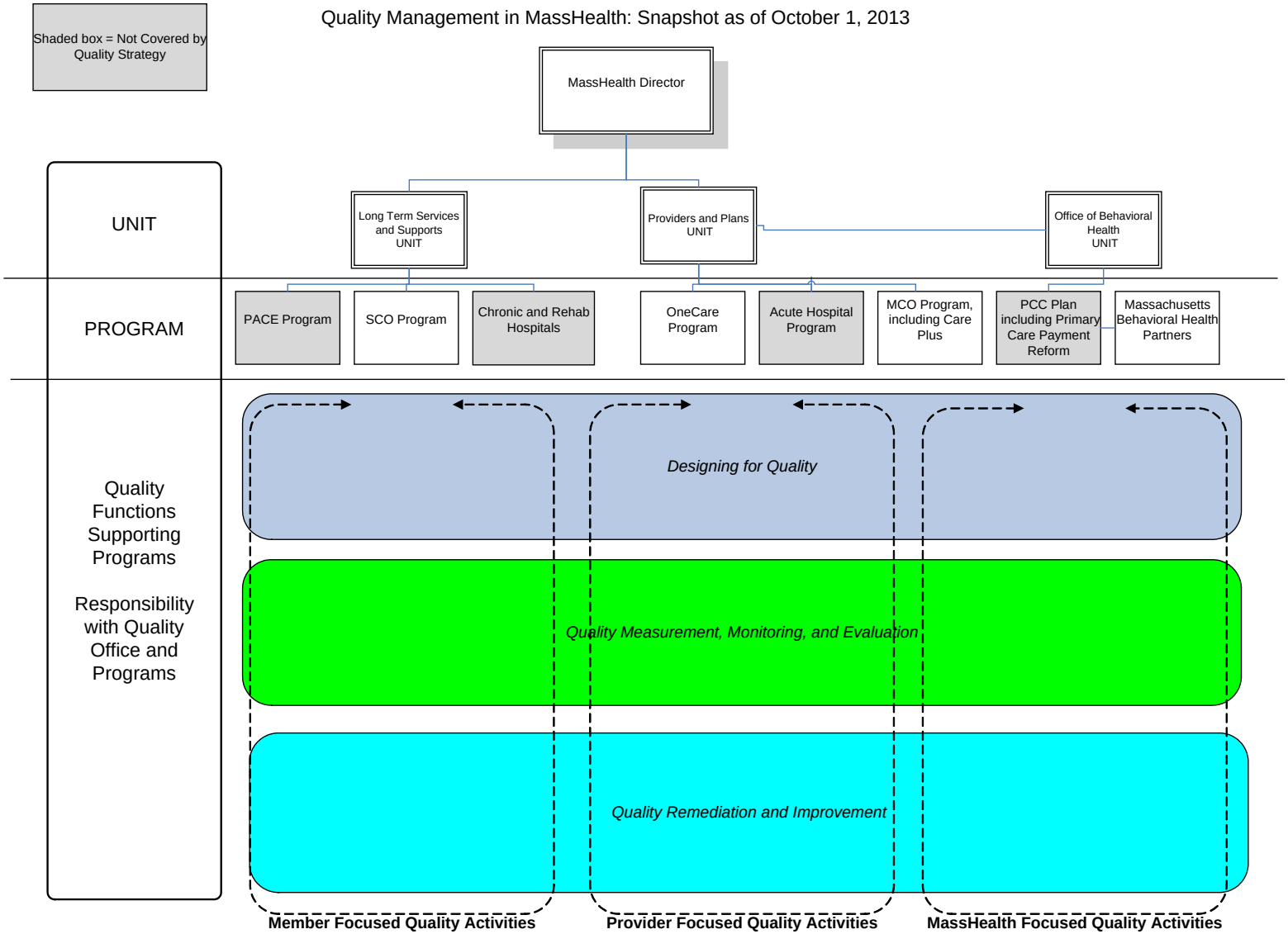
- Department of Mental Health
- Department of Public Health
- Department of Youth Services
- Department of Children and Families
- Department of Developmental Services

Quality Management in MassHealth

MassHealth quality management functions cut across all programs and units. Functions include designing for quality, measurement, and improvement (see bars on Figure 1). These functions may be conducted at the member, provider or MassHealth level (see dotted lines running perpendicular to the function bars).

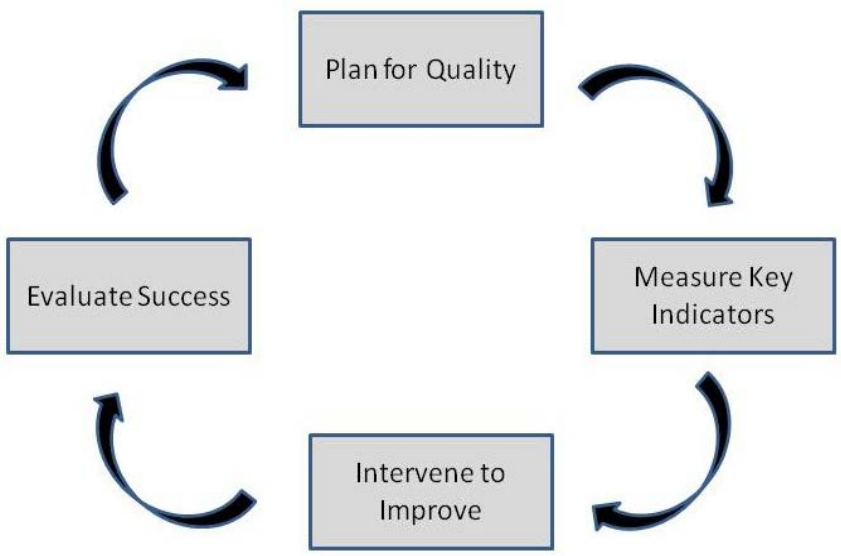
Some functions are centralized in a dedicated quality office, the MassHealth Quality Office (MQO); others reside in quality management positions at the program level. A Quality Manager's Committee consisting of quality management staff from within the programs meets quarterly to discuss cross-cutting quality activities, including the Quality Strategy.

Figure 1: A Functional Chart of Quality Management in MassHealth



The process for managing quality is shown in Figure 2.

Figure 2: MassHealth Quality Management Process



Section 1B: Development & Review of Quality Strategy

Strategy Development

This Strategy was developed with input from multiple stakeholders, subject to a public comment period, and will be updated routinely (see below, "Ongoing Review of Strategy").

The 2013 Strategy was drafted by a workgroup comprised of State staff familiar with managed care contractual and programmatic activities and facilitated by a member of the MQO. The staff represented the Office of Providers and Plans, the Office of Behavioral Health, the Office of Medicaid, the Office of Long Term Services and Supports. After internal review by the executive staff of the offices and departments listed above, the Strategy was made available to external stakeholders including the managed care community, providers, consumer advocates and MassHealth enrollees through a posting of a draft of the document on the MassHealth web site and published notice in the Massachusetts Register.

Ongoing Review of Strategy

The 2013 Quality Strategy document represents the first major refocusing of the structure and content of the strategy since the first strategy was published in 2006. Monitoring goals and objectives in relation to the strategy will be the responsibility of the Quality Managers' Committee. In addition, the Quality Managers' Committee will undertake to review the document for relevance and currency at least annually.

Section 2: Assessment

Section 2A: Quality and Appropriateness of Care

Quality Assessment in MassHealth

Quality assessment in MassHealth occurs through at least three mechanisms:

- Contract management
- Program management dashboards
- State-level data collection and monitoring

Contract management and quality assessment

All managed care contracts and contracts with entities participating in capitated payment programs include quality provisions. A typical contract includes requirements for quality measurement, quality improvement, and reporting. Contract managers in each program review submissions from the entities and evaluate whether the managed care entity has satisfactorily met the contract requirements.

Program management dashboards

The MassHealth Quality Office in collaboration with MassHealth stakeholders from different MassHealth programs is working to develop and implement several dashboards that would permit MassHealth managers to monitor their programs on key indicators and that would aid in identifying quality improvement goals. Dashboards under development include a multi-program Managed Care Dashboard, an Operations Dashboard, and a Medical Trends Report.

The Managed Care Dashboard includes indicators that measure performance across multiple domains such as eligibility and enrollment, access and availability, cost of care, use of services, behavioral health, chronic care management, dental care, care integration, member satisfaction and services, program and data integrity. The initial measurement set is primarily based on nationally recognized measures, such as HEDIS®[3]. In addition to serving as a management tool for performance monitoring and improvement, the Managed Care Dashboard will also serve to promote transparency and standard measurement across MassHealth programs.

State-level quality assessment

MassHealth routinely collects HEDIS data from its managed care plans and periodically conducts patient experience surveys of managed care members. HEDIS and patient experience data are summarized in reports which are posted on the MassHealth website. Table 3 and Table 4 in Section 2B show the HEDIS and other measures collected by managed care entities and reported to MassHealth that relate to CMS core sets. Table 5 displays other HEDIS measures that MassHealth requires MCEs to collect.

Special Health Care Needs

Each managed care plan must have mechanisms in place to assess enrollees identified as having special health care needs. These enrollees may include, at a minimum, those who have or are at increased risk to have chronic physical, developmental, or behavioral health conditions. For each enrollee that the managed care program confirms as having special health care needs, the individual's need for ongoing treatment and monitoring must be determined. In addition, for those determined through an assessment by appropriate health care professionals to need a course of treatment or regular care

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

monitoring, each managed care program must have a mechanism in place to allow such enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

In identifying enrollees with special health care needs, managed care entities may rely on information shared by the State. This includes Categories of Assistance, such as SSI disabled only, to which enrollees are assigned by MassHealth, as well as information provided by other State agencies.[4]

On December 31, 2007, EOHHS began requiring primary care providers to offer to use standardized behavioral health screening tools when administering the behavioral health screening component of the well-child care visit as required by the Commonwealth's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical Periodicity Schedule to all MassHealth enrolled children under the age of 21.

Preventing Disparities

Data regarding potential disparities come from several different sources. First, at the time of enrollment, MassHealth members self-declare their race, ethnicity and primary language. These data can be linked to claims data and analyzed. A second source of data for monitoring disparities comes from the periodic patient surveys. The demographic section at the end of the survey includes information about self-reported race, ethnicity, primary language and chronic conditions. These data permit subgroup analyses of the survey returns. Because the survey data are always anonymous, there is no possibility of linking the survey returns to other types of data such as claims. Finally, contracts with the managed care organizations include requirements for the entities to report data by sub-populations to ensure that quality of care is uniform across all enrollees.

Section 2B: National Performance Measures

MassHealth collects and reviews a substantial proportion of the CMS adult and child core performance measures as shown in Table 3 and Table 4. Only the Child and Adult Core measures are reflected in these tables.

MassHealth's experience with performance measurement extends back to 1996 when it began collecting and reporting on HEDIS measures for its managed care 'products' - the Primary Care Clinician (PCC) Plan (the state's primary care case management program) and the Managed Care Organizations (MCOs) with which it contracts. In 2010, MassHealth began collecting HEDIS measures for the Senior Care Organizations (SCOs). MassHealth uses a measure rotation approach to determining which measures will be included in each annual administration of HEDIS, so measures are not collected each year. MassHealth has also collected CAHPS measures since 2001 on a biennial basis.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Core Measures

The CHIPRA measures are collected and calculated at both the plan and practice-level for managed care members.

[4] Identification of enrollees receiving services from DMH, DYS, and DSS

Table 3: CMS Child Core Measures Used by MassHealth

Measure	First collected (or to be collected)	Program[5]
Prevention and Promotion		
Frequency of ongoing prenatal care	1997	MCO, PCC Plan
Timeliness of prenatal care	2005	MCO, PCC Plan
Childhood immunization status	1996	MCO, PCC Plan
Immunizations for adolescents	1998	MCO, PCC Plan
BMI documentation 2-18 year olds	2014	MCO, PCC Plan, PCPR
Developmental screening using standardized tools	2014	MCO, PCC Plan, PCPR
Chlamydia screening for women	2010	MCO, PCC Plan, PCPR
Well Care Visits in first 15 months of life	1997	MCO, PCC Plan, PCPR
Well Care Visits in the 3rd, 4th, 5th, and 6th years of life	1997	MCO, PCC Plan, PCPR
Adolescent Well Care Visits	2004	MCO, PCC Plan, PCPR
Eligibles receiving preventive dental services	2010	MCO, PCC Plan
Management of Acute Conditions		
Dental treatment	2010	MCO, PCC Plan
ED utilization	2010	MCO, PCC Plan, PCPR
Management of Chronic Conditions		
Asthma patients with >= 1 asthma related ED visits	2010	MCO, PCC Plan
Follow-up care for children with ADHD	2009	MCO, PCC Plan, PCPR
Follow-up after hospitalization for mental illness	1996	MCO, PCC Plan, PCPR
Annual HbA1c testing for children with diabetes	2010	MCO, PCC Plan
Family Experiences of Care		
CAHPS Health Plan survey*	2001	MCO, PCC Plan, PCPR

* Health Plan Survey in 2001, 2004, 2013. CAHPS-CG in 2008, 2011, 2013.

Adult Core Measures

Table 4: CMS Adult Core Measures Used by MassHealth

Measure	First collected (or to be collected)	Program[4]
Prevention and Health Promotion		
Adult BMI assessment	2014	MCO, PCC Plan, PCPR, One Care

[5] MCO= Boston Medical Center Healthnet, Fallon Health Plan, Neighborhood Health Plan, Network Health, Health New England.
PCC Plan=Primary Care Clinician Plan
PCPR=Primary Care Payment Reform Initiative
SCO= Commonwealth Care Alliance, Fallon Total Care, Senior Whole Health, Tufts Health Plan Senior Care Options, United Healthcare
One Care= Commonwealth Care Alliance, Fallon Total Care, Senior Care Options

Measure	First collected (or to be collected)	Program[4]
Breast cancer screening	1996	MCO, PCC Plan, PCPR, One Care
Cervical cancer screening	1996	MCO, PCC Plan, PCPR, One Care
Medical assistance with smoking and tobacco use	2014	PCPR
Screening for clinical depression	2014	MCO, PCC Plan, PCPR, One Care
Plan all-cause readmission	2013	SCOs, MCO, PCC Plan, PCPR, One Care
Diabetes short-term complications admission rate	2014	MCO, PCC Plan, PCPR, One Care
COPD admissions	2014	MCO, PCC Plan, PCPR, One Care
CHF admissions	2014	MCO, PCC Plan, PCPR, One Care
Adult asthma admission rate	2014	MCO, PCC Plan, PCPR, One Care
Chlamydia screening in women	2010	MCO, PCC Plan, PCPR, One Care
Management of Acute Conditions		
Follow-up after hospitalization for mental illness	1996	MCO, PCC Plan, PCPR, One Care, SCO
Elective delivery	Began with RFA 2012	Hospital P4P program
Management of Chronic Conditions		
Controlling high blood pressure	2005	MCO, PCC Plan, PCPR, One Care, SCO
CDC: HgbA1c testing	2002	MCO, PCC Plan, PCPR, One Care
Antidepressant medication management	2003	MCO, PCC Plan, PCPR, One Care, SCO
Family Experiences of Care		
CAHPS Health Plan survey	2001	MCO, PCC Plan, PCPR, One Care
Care Coordination		
Transition record transmitted to health care professional	Began with RFA 2012	Hospital P4P program, One Care
Availability		
Initiation and engagement of alcohol and other drug dependence treatment	2007	MCO, PCC Plan, PCPR, One Care
Prenatal and post-partum care	2005	MCO, PCC Plan, PCPR, One Care

Other National Measures

MassHealth requires reporting on several measures that are not part of either the CHIPRA or Adult Core sets. These measures are displayed in Table 5.

Table 5: Other HEDIS measures required by MassHealth

Measure	First collected (or to be collected)	Program[4]
Glaucoma screening in older adults	2010	SCO
Care for older adults – advanced care planning	2012	SCO
Medication reconciliation post discharge	2013	SCO
Osteoporosis management in women who h ad a fracture	2010	SCO
Annual monitoring for patients on persistent medication;	2010	SCO
Potentially harmful drug-disease interactions in the elderly;	2010	SCO
Use of high-risk medications in the elderly	2010	SCO
Frequency of ongoing prenatal care	1997	MCO, PCC Plan
Mental health utilization	1997	MCO, PCC Plan
Board certification	2010	SCO
Colorectal cancer screening	2010	SCO
Pharmacotherapy management of COPD exacerbation	2013	SCO

Table 6 shows the patient experience surveys that MassHealth requires and reviews as part of its quality assessment strategy.

Table 6: National patient experience surveys required by MassHealth

Survey Tool	Program	Survey Level
CAHPS 5.0H	MCO, PCC Plan, One Care	Plan level
CAHPS – CG	PCPR, SIM grant, PCMHI	Practice level
Health Outcomes Survey (HOS)	One Care	Plan level
Home and Community Based Services Experience Survey (when final)	One Care	Plan level
Young and Bullock	One Care	Plan level

MassHealth Use of Performance Measures

MassHealth uses the results of HEDIS and CAHPS to identify opportunities for improvement and to inform its approach to quality management work undertaken with the managed care entities. The HEDIS and CAHPS results also guide MassHealth's work in supporting the PCC Plan's providers in quality improvement work.

Section 2C: Monitoring and Compliance

MassHealth monitors compliance with contractual and Federal requirements multiple ways. Appendix 1 lists the specific reports used by MassHealth to ensure compliance.

Section 2D: External Quality Review

Massachusetts contracts with a qualified External Quality Review Organization (EQRO) in accordance with 42 USC 1396u-2(c)(2) and 42 CFR 438.310, et seq.. Since 2006, Massachusetts has contracted with Innovative Resource Group LLC D/B/A APS Healthcare Midwest (APS) for external quality review functions.

Mandatory Activities

Massachusetts contracts for the following mandatory activities set forth in 42 CFR 438.358(b):

- Annual validation of performance measures reported to EOHHS, as directed by EOHHS, or calculated by EOHHS;
- Annual validation of performance improvement projects required by EOHHS; and
- At least once every three years, review of compliance with standards mandated by 42 CFR Part 438, Subpart D, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees.

Voluntary Activities

Massachusetts plans to add the validation of encounter data to the activities performed by the EQRO as an optional activity pursuant to 42 CFR 438.358(c). This activity will commence as soon as details are negotiated between MassHealth and the EQRO vendor.

Covered Entities

All managed care entities will now participate in an EQRO review, including the three new One Care Plans and the previously exempted SCO program entities (see Table 1). MassHealth has determined that the most efficient mechanism for quality oversight of these entities will be the EQRO.

Review Cycle

MassHealth is transitioning the external quality review (EQR) process from a fiscal year (July through June) to a calendar year (January through December). In order to achieve this transition, the project year extends 18 months during the first cycle, from July 1, 2012 through December 31, 2013. Commencing with the CY 2014 cycle, the project year will be 12 months.

In December of each project year, a full technical report for the measurement year assesses performance measures for the MCOs, SCO, PIHP, and the PCC Plan, and performance improvement projects for the MCOs, SCO, and PIHP.

Managed Care Entity Responsibilities

Each managed care entity (MCE) is required to take all steps necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS to conduct External Quality Review (EQR) Activities, in accordance with 42 CFR 438.358. The MCE must:

- Designate a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:
  - Oversee and be accountable for compliance with all aspects of the EQR activity;
  - Coordinate with staff responsible for aspects of the EQR activity and ensure that staff responds to requests by the EQRO and EOHHS staff in a timely manner;
  - Serve as the liaison to the EQRO and EOHHS and answer questions or coordinate responses to questions from the EQRO and EOHHS in a timely manner; and

    - Ensure timely access to information systems, data, and other resources, as necessary for the EQRO to perform the EQR Activity and as requested by the EQRO or EOHHS.
- Maintaining data and other documentation necessary for completion of EQR Activities specified above. The MCE shall maintain such documentation for a minimum of seven years;
- Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or EOHHS;
- Participating in MCE-specific and cross-MCE meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and EOHHS;
- Implementing actions, as directed by EOHHS, to address recommendations for quality improvement made by the EQRO, and sharing outcomes and results of such activities with the EQRO and EOHHS in subsequent years; and
- Participating in any other activities deemed necessary by the EQRO and approved by EOHHS.

Non-Duplication Provisions

MassHealth encourages the EQRO to use the NCQA Managed Care Toolkit at http://www.ncqa.org/Portals/0/Public%20Policy/2012_NCQA_Medicaid_Managed_Care_Toolkit_Summary_-_March_2012_Final.pdf to reduce duplication of effort of review.

Section 3: State Standards

Section 3A: Access Standards

All MassHealth MCEs (MCO Program, One Care Program, SCO Program) are required to maintain standards for access to care including availability of services, care coordination and continuity of care, and coverage and authorization of services required by 42 CFR 438.206-438.210.

Availability of Services

In accordance with the standards in 42 CFR 438.206 MassHealth ensures that services covered under contracts are accessible to enrollees and that the service contracts address geographic, organizational and equitable access. Each Plan must maintain and monitor a network of providers that is supported by written agreements and sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each plan must take into account the following:

- Anticipated MassHealth enrollment
- Expected use of services by enrollees, considering the characteristics and health care needs of specific MassHealth enrollee populations
- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish contracted services
- Numbers of network providers who are not accepting new MassHealth patients

- Geographic location of providers and MassHealth managed care enrollees, considering distance, travel time and modes of transportation typically used by MassHealth managed care enrollees, and whether the location provides physical access for MassHealth enrollees with disabilities

Plans must provide female enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the network to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. MassHealth contracted plans must also provide for a second opinion from a qualified health care professional within the provider network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.

Timely access to care and services, taking into account the urgency of the need, is a requirement of all Plans. Availability standards must ensure that network providers offer members appointments for covered health care services and medically necessary specialty care twenty four hours a day, seven days a week. Plans monitor providers for compliance with the standards regularly and take corrective action to come into compliance with the access standards.

If a Plan's network is unable to provide necessary services covered under its contract that Plan must sufficiently cover those necessary services in a timely manner for as long as the Plan's network is unable to provide those services. MassHealth Plans must negotiate agreements with out-of-network providers with respect to payment.

Program-Specific Requirements for Availability

The following describes examples of Program-specific activities to monitor access to care and availability of services.

MCO Program

Cultural Considerations

MassHealth requires that services and care are delivered in a culturally competent manner and address any barriers to access. MassHealth participates in efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural backgrounds. All Plans ensure availability of multi-lingual providers and skilled medical interpreters for the commonly used languages in each community. Written information is available to enrollees in prevalent languages, as determined by the State. Prevalent languages are those spoken by 5% or more of MassHealth enrollees. Through analyses of MassHealth data, State-wide and by EOHHS region (Boston, Metro West, Central MA, Western MA, Northeastern MA and Southeastern MA), EOHHS has currently defined Spanish and English as the prevalent languages in which written information must be made available.

In addition MassHealth plans make available, free of charge, oral interpretation services in all non-English languages to assist enrollees with interpretation of all written materials provided to enrollees. Informational materials distributed to members via mail is accompanied by a babel card that indicates that the enclosed materials are important and should be translated immediately. The babel card also provides information on how the enrollee may obtain help with getting the materials translated.

Quality Improvement Goals

MassHealth's Managed Care Organization (MCO) Program Quality Improvement Goals (Goals) specifications require that MCOs implement quality interventions in a culturally competent manner. In addition, the most recent cycle of Goals evaluates how MCOs align their staffing structure with the range of diversity among members receiving services and care.

PCC Plan

Primary Care Network Report

The PCC Plan monitors its primary care provider network through two monthly reports. One is the PCC Provider Report. This report gives a snapshot of MassHealth enrollment by service location (SL) and whether the SL is open to new enrollees. The second report is the PCC Changes Report which includes new SLs and increases or decreases in the number of members enrolled at any SL.

Health Disparities

Primary Care Clinician (PCC) Plan members receive inpatient services through the MassHealth Acute Hospitals contracted to provide services for MassHealth members with Fee-for-Service benefits. Acute hospitals are required in their contract with the Commonwealth to report on a Health Disparities measure. This composite measure is comprised of aggregate data from all individual "clinical process measures" (i.e., a maternity measure set, pediatric asthma measure set, community acquired pneumonia measure set, and surgical care infection prevention measure set). Hospitals must ensure that all clinical measures data collected include Race, Hispanic Indicator, and Ethnicity codes and allowable values as required by DHCFP regulations (now known as the Center for Health Information and Analysis). (See http://massqex.ehs.state.ma.us/massqex/index/hqi.)

One Care Program

Unique Covered Services

The One Care Program adds services to the usual Medicare and Medicaid covered benefits to advance wellness, recovery, self-management of chronic conditions, independent living, and as alternatives to high-cost acute and long-term institutional services. Additional services include community crisis stabilization, Community Support Program, acute treatment and clinical support services for substance abuse, psychiatric day treatment, day services, home care, respite care, peer support, care transitions assistance, and Community Health Workers.

Assurances of Adequate Capacity and Services

MassHealth requires Plans to retain the capacity to serve expected enrollment in their service areas in accordance with MassHealth's standards for access to care and to provide supporting documentation that demonstrates compliance with CMR 438.206.

Coordination and Continuity of Care

Procedures for how coordination of care is monitored are required by all MassHealth MCEs. These procedures include determining need for targeted case management services, establishing referral processes, development of disease management services and procedures for authorizing out of network services.

MassHealth Plans must ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the

health care delivered to the enrollee. Timely and coordinated access to all medically necessary services, including behavioral health and specialty services is provided to all enrollees. Plans are required to provide linkages with staff in other agencies and/or community service organizations if the agency/organization is already involved in meeting the enrollee's needs, or if the agency/organization is identified as helpful in meeting such needs.

Plans must have mechanisms in place to assess enrollees identified as having special health care needs. For each enrollee that the managed care program confirms as having special health care needs, the individual's need for ongoing treatment and monitoring must be determined. In addition, for those determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each Plan must have a mechanism in place to allow such enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

In identifying enrollees with special health care needs, managed care entities may rely on information shared by the State. This includes Categories of Assistance, such as SSI disabled only, to which enrollees are assigned by MassHealth, as well as information provided by other State agencies.

Plans are required to deliver specified health services, including well child screenings, use of the standardized behavioral health screening tools in accordance with the EPSDT Medical Protocol and Periodicity Schedule for members under the age of 21, prenatal and postpartum services for female members, management of members with asthma, or other chronic or long-term health conditions including HIV/AIDS, mental illness, or substance use disorders.

Plans must maintain care management programs for any enrollee (adults and children) who needs assistance in coordinating physical and behavioral health services and benefits to maintain optimal levels of health. Moreover, care management programs must be structured to accommodate the range of care needs exhibited by enrollees, to include, at a minimum, the following specific levels of care management: Case Management, Wellness and Disease Management, Complex Care Management and Intensive Clinical Management. These programs must include enrollee education for disease self-management, provider education for practicing evidence-based medicine, and periodic assessments of performance and enrollee outcomes.

MassHealth requires that Plans exercise best efforts to provide coordinated covered and non-covered care management services in settings such as adult and family shelters, especially for enrollees who are homeless, at an enrollee's home, when office visits are unsafe or inappropriate for an enrollee's health status, at the Enrollee's place of employment or school and other residential placements especially for children in the custody of the Commonwealth. Children and youth under 22 years of age who are in the care or custody of the Massachusetts Department of Children and Families and meet certain medical necessity criteria due to severe traumatic injury or birth defects are enrolled in a special complex care management program aimed at providing complex multi-disciplinary care in community-based foster home settings.

Contracted Plans ensure that a care management approach is coordinated with a dedicated group of clinicians and other professionals including the enrollee, the enrollee's guardian, representative and/or family member(s) as appropriate; the enrollee's Primary Care Physician (PCP); as appropriate; providers from relevant specialties, sub-specialties, and other ancillary health care services (e.g., mental health and substance abuse, nutrition, and rehabilitation, as appropriate); and a Care Management Coordinator and one or more Care Management individuals representing the Plan, or Subcontractor.

The Care Management Coordinator determines whether an Individual Care Plan (ICP) should be developed to address an enrollee's unique care needs and if so, developing, following and monitoring the enrollee's ICP, maintaining ongoing management and assessment of an enrollee's care needs as indicated in the care plan and ensuring the regular contacts between the Care Coordinator, the enrollee's PCP and the enrollee.

Program-Specific Requirements for Care Coordination

Some of the programs have additional program-specific requirements for care coordination. The following are example activities by MassHealth MCEs.

MCO Program

Health Needs Assessment (HNA)

Plans ensure that each new enrollee receives an HNA form and make best efforts to have enrollees complete their HNA. All MCEs implement an outreach and follow-up process to encourage members to complete the HNA. Members are contacted by a care manager or care facilitator and/or a member services representative to fill-out the HNA form.

Contracted Plans identify enrollees with special health care needs based on information contained in an enrollee's HNA and claims, pharmacy, and discharge data, Provider referral, predictive modeling, or any other available resources. Such enrollees include, at a minimum, those:

- Who have or are at increased risk to have chronic physical, developmental, or behavioral health condition(s);
- Who require an amount or type of services beyond those typically required for individuals of similar age; and
- Who may receive these services from an array of public and/or private providers across health, education and social systems of care.

SCO Program

Comprehensive Assessments

Comprehensive assessment for members with complex care management needs enrolled in the Senior Care Options (SCO) Plans are conducted and re-assessed every six months; when there is a change in status and quarterly for any enrollee with a Complex Care Need. Complex Care Need is defined as any condition or situation that demonstrates the Enrollee's need for expert coordination of multiple services, including, but not limited to: clinical eligibility for institutional long term care; and medical illness, psychiatric illness, or cognitive impairment that requires skilled nursing to manage essential unskilled services and care.

SCO Plans are required to maintain a Centralized Enrollee Record (CER) that documents current medical, functional, and social status. This centralized enrollee record must be available 24/7 to nurse case managers and the enrollee's clinicians to manage emergency and urgent care, as well as to manage transitions across institutional and community settings of care.

One Care Program

Independent Living Long-term Services and Supports Coordinator (IL-LTSS)

The One Care Program requires each MCE to offer members an IL-LTSS Coordinator to participate as part of the member's care team. The coordinator brings expertise and community

supports to the member and assists with the coordination of his/her LTSS needs. The IL-LTSS Coordinator's primary responsibilities are to: ensure person-centered care, counsel potential Enrollees; provide communication and support needs; and act as an independent facilitator and liaison between the Enrollee, the ICO and their service providers.

PCC Plan

Integrated Care Management Program (CMP)

In collaboration with the Massachusetts Behavioral Health Partnership (MBHP), the PCC Plan provides increased support and coordination of care for members who have complex medical and /or behavioral health care needs and whose overall health care may benefit from the assistance of a care manager; and increased support for the providers that regularly manage their care. In addition, through its contract with MBHP, the Plan operates a Nurse Advice Line available to members 24 hours per day/7 days per week via a toll free telephone number.

Coverage and Authorization of Services

Each MassHealth MCE must specify the amount, duration, and scope of each covered service. Services may be no less than the amount, duration, and scope for the same services furnished to beneficiaries under MassHealth fee-for-service, may not be compromised solely because of diagnosis, type of illness, or condition of an enrollee, and must be rendered in accordance with the medical necessity standard. All MassHealth Plans operate under the same definition of medical necessity as MassHealth fee-for-service.

Written policies and procedures for processing requests for authorizations of services are in place and implemented by MassHealth MCEs. Authorization decisions must be based on consistently applied review criteria and consultation with requesting providers, when appropriate, and must be conducted in a timely fashion as required by regulation and contract.

Denials, reductions, terminations and modifications of services must be made by a health professional that has appropriate clinical expertise in treating the enrollee's condition or disease, and must notify the requesting provider and enrollee in a timely manner, as codified in entity contracts, suitable to the urgency of the enrollee's condition.

Grievance procedures related to adverse decisions can be found on page 23 of the Quality Strategy.

Section 3B: Structure and Operations Standards

MassHealth has contractual requirements in place for ensuring MCE compliance with the structure and operational standards of 42 CFR 438.214.

Provider Selection

Service delivery by appropriately qualified individuals promotes patient safety and represents an essential structural component of a high quality delivery system. This standard ensures that managed care entities implement written policies and procedures for the selection and retention of providers.

Each Plan establishes documented processes to credential and re-credential providers with whom it has signed contracts or participation agreements. The State requires that the scope and structure of the processes for credentialing, at a minimum, be consistent with recognized industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant State regulations, including regulations issued by the Board of Registration of Medicine at 243 CMR 3.13. Plans contracted

for the SCO Program must follow the CMS Medicare Advantage credentialing requirements and provide complete records during onsite survey or upon request from CMS or the state.

Contracting Plans are required to implement written policies and procedures that comply with the requirements of 42 CFR 438.214 regarding the selection, retention and exclusion of providers. Plans must maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the Contractor's Provider Network. All providers, including behavioral health providers, must be credentialed prior to becoming Network Providers and have had a site visit prior to delivering services to members. When establishing contractual relationships with providers, managed care entities may not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. At least every three years, Plans maintain a documented re-credentialing process that takes into consideration various forms of data including, but not limited to, grievances, results of quality reviews conducted, utilization management information collected, and enrollee satisfaction surveys collected.

Plans may not contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act (42 U.S.C. 1320a-7). In addition, entities may not authorize any providers terminated or suspended from MassHealth to treat enrollees and must deny payment to such providers. This does not preclude Plans from terminating or suspending providers for cause prior to action by MassHealth. Plans are responsible for providing timely notification to enrollees when a provider has been terminated or suspended. SCO Plans must also exclude providers who have been terminated or suspended from the Medicare program. Regular MassHealth Provider Review Committee meetings are conducted with representatives of the MCO Program, BH Program, and PCC Plan who attend these meetings and notify affected entities when MassHealth suspends or terminates a provider.

Enrollee Information

All Plans are required by MassHealth to provide enrollee notices, informational materials and instructional material in a manner and format that may be easily understood, in accordance with 42 CFR 438.10. This includes the Plan's capacity to meet the needs of non-English linguistic groups in their service areas and to make available materials in alternative format(s) upon request. Information distributed via mail must be accompanied by a babel card. On an annual basis, MCEs must provide enrollees with notice of their right to request and obtain information on the various items required in 42 CFR 438.10(f). For SCO Plans, enrollee materials must comply with both Medicaid MCO and Medicare Advantage regulations, and must be approved by CMS and the state before they can be used.

Confidentiality

Section 438.224 of 42 CFR requires that managed care entities and the State take appropriate steps to safeguard personal health information. Plans may use and disclose individually identifiable health information only if done in a manner that is in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

In accordance with the confidentiality requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), MassHealth operates a Privacy and Security Office to ensure compliance with the HIPAA Privacy and Security requirements.

Enrollment and Disenrollment

MassHealth Plans are required to adhere to requirements for enrollment and disenrollment (voluntary as well as involuntary) procedures in accordance with 42 CFR 438.5. Plans may not disenroll an individual because of any of the following: an adverse change in the enrollee's health status, utilization patterns, or behavior related to special needs. Contracted Plans must accept all persons who voluntarily enroll or are assigned to their plan. Members may switch health plans at any time without cause.

Grievance Systems

Plans are required to maintain a member grievance system in accordance with 42 CFR 438.228. Contracted entities must establish internal processes that allow enrollees the right to file a grievance about medical services and to appeal and request a fair hearing as the result of any adverse action or inaction taken by the entity. Each Plan also must notify enrollees of grievance and appeals processes and decisions in a timely manner.

Enrollees, or designated representatives, have a right to file a Grievance, Internal Appeal, or Board of Hearings Appeal regarding any adverse decision. Plans must maintain written policies and procedures for the filing by Enrollees or Appeals Representatives and for the receipt, timely resolution, and documentation by the Contractor of any and all Inquiries, Grievances, and Internal Appeals, per contract specifications.

Once the first or second level of the managed care program internal appeals process has been exhausted (when required), the State permits enrollees to request and obtain a State fair hearing, as detailed in MassHealth regulations (expedited appeals have only one level). MassHealth Member Services provides a system of tracking and maintaining member grievances. Members who are dually-eligible and enrolled in the SCO Program have access to both MassHealth fair hearings and the Medicare Advantage grievance and appeal process. .

Subcontractual Relationships and Delegation

MassHealth typically contracts with different providers and vendors of services to deliver the full package of services to enrollees. All MassHealth Plans are accountable for the actions and performance of any subcontractor. Plans must oversee and remain accountable for any functions and responsibilities that are delegated to subcontractors, including ongoing monitoring and formal review of subcontractor performance, and corrective action(s), given identification of deficiencies or areas for improvement.

Section 3C: Measurement and Improvement Standards

Plan contracts require ongoing quality assessment and performance improvement of the services provided to members as required in 42 CFR 438.236- 438.242. Continuous monitoring and improvement activities include identifying current levels of quality and areas for improvement, designing interventions to achieve improvement, and documenting progress towards quality goals. The standards in this section address MassHealth managed care quality measurement and improvement activities.

Practice Guidelines

Plans implement evidence-informed practice through dissemination and use of practice guidelines. The guidelines must stem from recognized organizations that develop evidence-based clinical practice guidelines with involvement of board-certified providers from appropriate specialties. Prior to adoption, the guidelines must be reviewed by the Plan's Medical Director, as well as other practitioners and network providers, as appropriate.

Guidelines must consider the needs of enrollees and be reviewed and updated, as appropriate, at least every two years. In addition**,** Plans must develop explicit processes for monitoring adherence to guidelines, including ensuring that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. Managed care entities also must establish processes for reviewing and updating guidelines.

With respect to behavioral health, MBHP adopts any practice guidelines established by the Massachusetts Department of Mental Health for the provision of covered services, disseminates such guidelines to their network providers and, upon request, to covered individuals, and ensures that decisions regarding utilization management, covered individual education, coverage of services, and other areas to which such practice guidelines apply are consistent with the practice guidelines.

Guidelines that MassHealth endorses include, but are not limited to, the following:

- Massachusetts Health Quality Partners Guidelines for Adult and Pediatric Preventive Care 2012/ 2013 http://www.mhqp.org/guidelines/preventivePDF/MHQP_PreventiveCareGuidelines_Adult_2012.pdf and http://www.mhqp.org/guidelines/preventivePDF/MHQP_PreventiveCareGuidelines_Ped_2012.pdf
- Massachusetts Department of Public Health Immunization Schedule (2013)
- Massachusetts Health Quality Partners Guidelines for Perinatal Care (2013)
- National Heart, Lung and Blood Institute (NHLBI) Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (2007)
- MassHealth All Provider Manual - Appendix W. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical and Dental Protocol and Periodicity Schedule (2011)

Quality Assessment and Performance Improvement Program

Managed care entities must establish ongoing performance improvement projects that focus on clinical and nonclinical areas and involve measurement of performance using objective quality indicators, implementation of interventions to achieve improvements, evaluation of the effectiveness of interventions, and planning and initiation of activities for sustaining improvement.

The annual HEDIS measurement initiative addresses both access and clinical quality. HEDIS measures are selected on a rotating basis with consideration of measure relevance to MassHealth and its stakeholders, as well as action-ability. Data are collected by the plans, submitted to MassHealth, and summarized in an annual report. Contracted SCO Plans must report clinical indicator data in accordance with the specific HEDIS measures developed for Medicare Advantage Special Needs Plans (SNPs) by the National Commission on Quality Assurance (NCQA), to the extent they are relevant to the SCO population.

Program-Specific Requirements for Measurement and Improvement

Several of the MCEs have additional requirements for measurement and improvement. The following are examples of activities by MassHealth MCEs.

MCO Program

Managed Care Quality Improvement Goals (QI Goals)

MassHealth requires Plans to conduct performance improvement projects, per State specifications of QI goals and measures. QI goals focus on five priority areas: population identification, access and availability, wellness and health promotion, disease management, and care management. The selected QI Goals measures and specifications are as consistent as possible with corresponding HEDIS indicators to minimize duplicity and resource burden on Plans and also to enhance comparability with national benchmarks.

The QI Goals measurement cycle spans a 2-year period, with mid-cycle and final evaluation periods to allow for tracking of improvement gains. For the 2013-2014 cycle, MassHealth will measure the success of the Care Management Program by evaluating if the metrics and interventions are implemented as planned, yielding their intended results, and resulting in meaningful changes in health outcomes.

Plans are required to submit baseline, mid-cycle and final written reports and host presentations regarding progress on QI goals for EOHHS staff at the end of each cycle. MassHealth has also initiated QI projects for measuring and improving care delivery and health outcomes for special needs populations. These include Reducing Disparities in Health Outcomes and patient-centered outcomes of enrollees in need of Complex Care Management interventions.

Tables 7 and 8 present the quality measures and interventions for the 2013-2014 Goal Cycle.

Table 7: MCO QI Goal Measures 2013-2014 Cycle

QI Goal Domain	QI Goal Measures
Population Identification (MassHealth and Care Management)	Measure 1: Member Demographic Profile Measure 2: Health Needs Assessment and ID of Health Service Need Measure 3: Health Needs Assessment and ID of Behavioral Health Services Measure 4: Member Outreach with No Utilization After One Year or More Measure 5: Care Management Identification Source Measure 6: Referral Source for Care Management Measure 7: Care Management and Health Needs Assessment Measure 8: Members Identified for Care Management Measure 9: Member Outreach for Care Management Measure 10: Member Engagement in care Management
Access and Availability	Measure 1: Adult's Access to Preventive/Ambulatory Health Services Measure 2: Children and Adolescents' Access to Primary Care Practitioners Measure 3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): 14 Days Measure 4: Initiation and Engagement of Alcohol and Other Drug

	Dependence Treatment (IET): 30 Days Measure 5: Timeliness of Prenatal Care Measure 6: Postpartum Care Measure 7: Frequency of Ongoing Prenatal Care Measure 8: Emergency Department (ED) Visits Measure 9: Emergency Department (ED) Visits for Ambulatory Care Sensitive Conditions Measure 10: Mental Health Utilization
Wellness and Health Promotion	Measure 1: Weight Assessment for Children/Adolescents Measure 2: Adult BMI Assessment Measure 3 Adolescent Well-Care Visits Measure 4: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years Measure 5: Well-Child Visits in the First 15 Months of Life
Disease Management	Measure 1: Use of Appropriate Medications for People with Asthma Measure 2: Asthma Medication Ratio Measure 3: Hemoglobin A1c (HbA1c Testing) Measure 4: HbA1c Poor Control (>9.0%) Measure 5: HbA1c Control (<8.0%) Measure 6: HbA1c Control (<7.0%) Measure 7: High Blood Pressure Control (Diabetes) Measure 8: LDL-C Screening (Diabetes) Measure 9: Eye Exam-Retinal (Diabetes) Measure 10: Antidepressant Medication Management-Effective Acute Phase Treatment Measure 11: Antidepressant Medication Management-Effective Continuation Phase Treatment Measure 12: 30 Day Follow-up After Hospitalization for Mental Illness Measure 13: 7 Day Follow-up After Hospitalization for Mental Illness
Coordination of Care	Measure 1: Timely Transition of Transition Record-Hold Measure 2: Transition Record with Specified Elements Received by Discharge Patients-Hold Measure 3: Individualized Care Plan (ICP) Goals Unmet Measure4: Complex Care Face to Face Consultations Measure 5: Complex Care Home Visits

Table 8: MCO QI Goal Interventions 2013-2014 Cycle

QI Goal Domain	QI Goal Quality Interventions
Population Identification (MassHealth and Care Management)	1. Demonstration by an MCO of a diverse care management staffing structure aligned with the range of diversity among members receiving care management services. 2. Design and implement one outreach strategy for members with no utilization after one year or more based on Appendix A Exhibit Q-7 (Enrollees with zero service utilization). 3. Design and implement one strategy to engage members in care management by level of care management need. 4. Design and implement one outreach strategy for members who are identified, but refuse care management. 5. Implement HNA-C evaluation to determine effectiveness of identifying member's for care management.
Access and Availability	1. Design and implement one provider-focused intervention designed to support members in their continuation of alcohol and other drug dependence treatment after diagnosis. 2. Design and implement one provider-focused intervention designed to reduce ED visits for members with ambulatory care sensitive conditions. 3. Design and implement one member-oriented intervention designed to educate members on the importance of keeping scheduled preventive visits with a health care provider and appropriate follow-up. 4. Design and implement one member-oriented intervention designed to improve outreach to members on postpartum visits, including during discharge planning process.
Wellness and Health Promotion	1. Design and implement one strategy implemented to improve outreach to children (age 7-11) and adolescents who are overdue for well-visits. 2. Design and implement one provider-focused intervention focusing on facilitating nutritional and physical activity counseling with members. 3. Design and implement one member-oriented intervention designed to educate members on health promotion and wellness, including those with special health care needs.
Disease Management	1. Design and implement one intervention designed to educate members about self-management and adherence to treatment for their disease or condition. Please choose two conditions from the list provided below. a. Asthma b. Diabetes

	c. Heart Disease d. Hypertension 2. Design and implement one provider-focused intervention designed to improve member adherence to antidepressant medications. 3. Design and implement one discharge planning strategy implemented that improve aftercare coordination and outreach for follow-up care for members hospitalized with a behavioral health condition.
Coordination of Care	1. Design and implement one intervention that encourages collaboration between MCO care management staff and with other clinical or non-clinical staff, behavioral health services, and other community resources regarding member's plan of care. 2. Design and implement one culturally appropriate care coordination strategy that takes into consideration the cultural diversity of the members seeking healthcare.

SCO Program

SCO Performance Improvement Projects

Plans contracted for the SCO Program are required to annually develop two specific performance improvement projects in the primary care, long term care, or behavioral health areas as well as provide documentation on each project.

Annual Enrollee Survey for Contracted SCO Plans

Plans conduct an annual survey of all enrollees to assess access, coordination of care and enrollee experience. In addition Plans contracted with the SCO Program report annually on the following clinical indicators:

- Preventable hospitalizations
- Discharge planning
- Preventive immunization
- Cancer screening
- Disease management
- Management of dementia
- Appropriate use of nursing facilities
- Alcohol abuse prevention and treatment
- Abuse and neglect identification
- Health promotion and wellness

One Care Program

Member Experience Surveys

The One Care program has adopted a multi-pronged approach to monitoring the experience of members with the program. In addition to the Medicare-required CAHPS and Health Outcomes Surveys (HOS), the One Care MCEs will be required to periodically conduct the Young and

Bullock Mental Health Recovery Measure survey and the national Home and Community Based Services (HCBS) Experience Survey. The later survey includes questions about behavioral health, community inclusion, employment, LTSS, and direct service workers and is to be completed by members who use the home and community based services.

Quality Improvement Projects

The One Care program includes three mandated quality improvement projects. The first project seeks to better understand the use of Long-Term Services Coordinators by enrollees. Plans will conduct independent interviews of a sample of enrollees to understand their experience with an LTS Coordinator to identify best practices and implement improvements. The second project focuses on Emergency Department (ED) utilization and the root causes for ED use. A sample of members who have had recent ED visits will be interviewed to better understand reasons for ED utilization and the impact of long term services and supports (LTSS) on such usage.

The final project addresses access to care to determine if enrollees experience barriers to health care and if so, to understand the nature of those barriers. Such barriers may include inaccessible medical equipment, signage, communication from Plan or providers, inadequate access to appropriate physicians for enrollees with intellectual disabilities, incomplete or poor care due to negative attitudes about disability and/or recovery from providers. As with the other two QIPs, One Care Plans will be required to conduct independent interviews with a sample of enrollees to understand their experience with access barriers.

PCC Plan Program

Member Level Reports for PCCs

In collaboration with MBHP, the PCC Plan produces web-based reports to assist PCCs in addressing gaps in services, coordinating member care, and identifying opportunities for quality improvement. The member level reports include a registry of members by PCC Service Location (SL) with prospective dates for routine and disease-specific medical appointments and tests; and a registry of members by SL who are eligible for and /or engaged in the Integrated Care Management Program. In addition, in 2014, the PCC SLs will be able to access their rates of performance on selected clinical measures in a web-based dashboard format. Through Performance Management Support Services, which includes face-to-face site visits, the data re used to develop practice-level quality improvement initiatives.

Pay for Performance Behavioral Health and Care Management Outcome Incentives

MBHP behavioral health performance projects are based on annual measurement of improvements in the broad areas of Initiation and Engagement in Alcohol and Other Drug Dependence Treatment, Follow-up after Hospitalization for Mental Illness; Follow-up for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication; and Service Integration for Department of Mental Health Clients. Additionally, annual measurement of outcomes in the Integrated Care Management Program includes Reduction in Polypsychopharmacology; Member Satisfaction; Reduction in Preventable Hospitalizations; and Improvement in Participant Health-Related Quality of Life. Incentive payment for each measure is based on an attainment, improvement or a benchmark level of improvement over baseline.

Health Information Systems

Plans must maintain a health information system (or systems) that collects, analyzes, integrates and reports data. The system must collect data on enrollee and provider characteristics and on services

furnished to enrollees. Contracted Plans, including MBHP ensure that data received from providers is accurate and complete by:

- Verifying the accuracy and timeliness of reported data
- Screening the data for completeness, logic, and consistency; and
- Collecting service information in standardized formats to the extent feasible and appropriate

MassHealth requires MCOs and MBHP to certify that information, data, and documentation in all reports is true, accurate, and complete.

Section 4: Improvement and Interventions

Section 4A: Improvement and Interventions

Improvement strategies described throughout this document are designed to improve the quality of care delivered by MCEs through ongoing measurement and intervention.

MassHealth convenes various collaborative workgroups to ensure stakeholders have opportunities to advise, share best practices, and contribute to the development of improvement projects and program services. Examples of these stakeholder groups are listed below.

- The Medical Directors Workgroup is a forum for the MCO, PCC, PACE, and SCO chief medical officers and medical directors to share best practices, create synergies, and identify opportunities for collaboration that could lead to greater efficiencies and reduction of duplicated efforts.
- The MassHealth Quality Management Committee meets bi-monthly to promote the sharing of information and advisement about quality and management of quality across MassHealth. Membership includes program directors from the Office of Provider and Plans, MassHealth Quality Office, Office of Behavioral Health, and Office of Long Term Services and Supports.

Statewide Grant Activities

Massachusetts successfully applied for and received two CMS grants to design quality improvement interventions related to the CHIPRA measure set and the Adult Core Measure Set. These activities are described below.

CHIPRA

In 2010, Massachusetts was awarded a five-year quality demonstration project established under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The demonstration is designed to create innovative approaches to improving the quality of care for children. MassHealth was awarded the grant to:

- Administer and evaluate the use of 24 core measures for children's healthcare quality endorsed by the Agency for Health Care Quality (Category A);

- Support the implementation of a medical home model of care at select child-serving practices across Massachusetts (Category C); and

- Convene a Statewide Child Health Quality Coalition to provide advice and guidance to the State and to identify gaps in pediatric quality measures (Category E).

The Massachusetts Initiative also includes an evaluation to examine each of the project categories.

Adult Core Measure Grant

In 2012, MassHealth was awarded a grant to develop staff capacity to collect, report, analyze and use data from the Initial Core of Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Initial Core Set). MassHealth will collect data and report on measures from the Adult Initial Core Set in both years of the grant and will include licensing HEDIS software to expand MassHealth's HEDIS measurement capacity.

Additionally, this grant will enhance MassHealth's capacity to use quality measurement information. This may involve strategies of hiring analytic staff, designing targeting training programs for all staff working with data, and developing the skills to conducting drill-down analyses to uncover disparities.

As part of this grant, MassHealth will also conduct two quality improvement projects (QIPs) related to the Initial Core Set. The QIPs topics focus on substance abuse and postpartum visits. The first QIP seeks to identify barriers and opportunities to behavioral health screening and the initiation and engagement of substance abuse treatment. The second QIP focuses on discovering and testing ways to improve post-partum visit rates among women who have recently given birth.

Nursing Facility Pay for Performance (NF P4P)

Since 2008, EOHHS has rewarded nursing facilities for excelling in or improving the quality of services delivered to MassHealth members. This program touches members in multiple programs. The NF P4P initiative measures performance of facilities and provides monetary incentives for meeting selected program requirements or benchmarks. Participation in the program is voluntary. During fiscal year 2013, facilities were required to submit an application and select one of two components.

- Consistent Assignment: The consistent assignment component was implemented to provide continuity with fiscal year 2012's program. Facilities focusing on consistent assignment had to demonstrate the current level of consistent staff assignment used by the facility using the methodology from Advancing Excellence in America's Nursing Homes Campaign's Consistent Assignment Tracking Tool.
- Clinical indicators: For facilities selecting the quality measure option, performance was evaluated based on specific benchmarks from a selected quality measure from the Minimum Data Set (MDS) 3.0 data reports that facilities submit to CMS. The selected long stay quality measure was the percent of long-stay residents who received an antipsychotic medication.

Eligibility for the program included not having an immediate jeopardy designation by the Massachusetts Department of Public Health or be designated by CMS as a special focus facility. Facilities had to be enrolled with MassHealth and needed at least one paid MassHealth day during the measurement year. Nursing facilities were also required to demonstrate their Cooperative Effort Policy to ensure that facilities have equal representation of staff (e.g. administrators and CNAs) at their Quality Committee (QC) meetings.

The fiscal year 2014 budget appropriated funding for the NF P4P Program. Specific detail on program development and requirements are currently under way. The selected long-stay quality measures in the FY14 program include:

- *Percent of long-stay residents who received an antipsychotic medication*
- *Percent of long stay high-risk residents with pressure ulcers*

- *Percent of long stay residents with a Urinary Tract Infection*

Program Specific Interventions

PCC Plan Program

Hospital Pay for Performance (Hospital P4P)

The MassHealth Hospital Pay-for-Performance (P4P) Program rewards participating hospitals for achieving quality and performance standards, including reducing racial and ethnic health disparities. The Acute Hospital Request for Application (RFA) outlines the terms for earning RY2014 incentive payments to report on the following measures categories: Maternity, Community Acquired Pneumonia, Pediatric Asthma, Surgical Care Infection Prevention, Health Disparities, Care Coordination Measures (Inpatient), Emergency Department Measure Set.

Section 4B: Intermediate Sanctions

Intermediate Sanctions

EOHHS monitors compliance with this Strategy through routine reporting requirements, regular meetings with entities, and ongoing communications as appropriate and necessary. To ensure that the Strategy continues to embody the vision and values described, the Strategy will undergo reviews and updating process as appropriate moving forward.

EOHHS may apply intermediate sanctions to managed care entities if any of the entities act or fail to act as follows:

- Fail to provide medically necessary services
- Impose excess premiums or charges on enrollees
- Discriminate among enrollees on the basis of health status or need for services
- Misrepresent or falsify information submitted to EOHHS or CMS
- Misrepresent or falsify information to enrollees or providers
- Fail to comply with the requirements for physician incentive plans

Plan contracts identify additional circumstances under which sanctions may be imposed including:

- Failure to comply with federal or state statutory or regulatory requirements
- Violation of restrictions or other requirements regarding marketing materials
- Failure to comply with any corrective action plan required by MassHealth
- Failure to comply with financial solvency requirements
- Failure to comply with the contract

Additionally, contracted Plans may impose sanctions if its contracted entities fail to comply with quality improvement plan requirements and enforce additional sanctions on disenrollment of enrollees and service area limitations. Other EOHHS contracted Plans may impose sanctions if contracted entities fail to comply, as determined from audit findings, with any provision of the contract related to Direct Service Reserve Accounts (DSRAs). These sanctions may include civil monetary penalties, appointment of a temporary manager, suspension of new enrollment and suspension of payment as per 438.702. A list of additional Plan sanctions includes:

- Withholding of administrative payments
- Withholding of Performance Incentive bonuses
- Adjusting or withholding of Service Compensation Payments
- Adjusting or withholding ECPs or other Capitation Rate payments
- Adjusting or withholding the DMH Administrative Compensation Rate or DMA Administrative Compensation Rate payments and Withholding gain from any risk-sharing arrangement.

Termination of Contract

EOHHS may terminate any Plan Contract immediately and without prior written notice. EOHHS shall provide written notice to the Contractor upon such termination.

Section 5: Delivery System Reform

Massachusetts is embarking on three delivery system reform projects in FY14. The Care Plus Program expands Medicaid under the Affordable Care Act (ACA). The other two initiatives change the payment mechanism for participating providers. The One Care Program offers managed care for dually eligible individuals while the Primary Care Payment Reform initiative offers a bundled payment to PCC Plan providers who historically have been paid on a fee-for-service basis.

Because the One Care Program was new in the Fall of 2013 and contractual details have already been negotiated and signed, many of the programmatic aspects have been woven into previous sections of this Strategy. The description below summarizes selected aspects of the Program.

MassHealth Care Plus Program

The Care Plus Program (CarePlus) will provide comprehensive health care coverage to adults between 21 and 65 years old and with incomes no greater than 133% of the Federal Poverty Level. Coverage began on January 1, 2014.

One Care Program

The One Care demonstration for dual eligible individuals began coverage on October 1, 2013. The demonstration blends Medicare and Medicaid funding to pay participating plans a per-member-per-month capitation. The population covered by the demonstration includes 111,000 individuals aged 21-64 who are dually eligible for MassHealth and Medicare benefits. Over two-thirds have a behavioral health diagnosis and approximately 50% have a chronic medical diagnosis. The majority of these members currently reside in the community. Covered services in the One Care Program include

- Medicare Services: All Part A, Part B, and Part D services
- Medicaid State Plan Services
- Additional Behavioral Health Diversionary Services: community crisis stabilization, Community Support Program, acute treatment and clinical support services for substance abuse, psychiatric day treatment
- Additional Community Support Services: day services, home care, respite care, peer support, care transitions assistance, Community Health Workers

- Added services are designed to advance wellness, recovery, self-management of chronic conditions, independent living, and as alternatives to high-cost acute and long-term institutional services

Three Massachusetts plans have three-way contracts between CMS, EOHHS, and the MCE: Commonwealth Care Alliance, Fallon Total Care, and Network Health.

Eligibility for the One Care Program

To be eligible for enrollment in One Care, an individual must be:

- Age 21 to 64 at the time of enrollment;
- Eligible for MassHealth Standard or CommonHealth;
- Enrolled in Medicare Parts A & B and eligible for Medicare Part D;
- Without other comprehensive insurance;
- Not enrolled in a Home and Community-based Services (HCBS) waiver; and
- Not residing in an Intermediate Care Facility (ICF/MR)
- Not currently enrolled in managed care

Members are being enrolled in three waves. Self-selected enrollment began October 1, 2013 where an eligible individual chose to enroll in the Program. On January 1, 2014, members are being enrolled through auto-assignment, unless they have opted out following the receipt of their enrollment notice in early November. The second wave of auto-assignment will be effective April 1, 2014.

Quality monitoring

Based on input from CMS, MassHealth, One Care Plans and the community of dually eligible individuals, the quality assessment framework for the One Care Program focuses on monitoring access to care and services (timeliness, appropriateness and adequacy), ensuring that services and care are delivered in accordance with contractual standards and clinical guidelines (preventative care and other HEDIS measures) and assessing outcomes – clinical, quality of life indicators and member satisfaction. The final quality framework for the demonstration included input from CMS, MassHealth, One Care Plans and the community of dually eligible individuals.

Measures to be reported for ongoing One Care Plan performance monitoring and outcomes include:

- HEDIS, HOS, and CAHPS measures consistent with Medicare requirements
- All existing Part D metrics
- Additional MassHealth-proposed metrics pertinent to target population, in such areas as:
  - Care management, appropriate care, follow-up for behavioral health
  - Person-centered care planning, management, transitions
  - Access to care, including LTSS services and ADA compliance

Data sources include claims and utilization data, grievances and appeals, and enrollee and provider surveys conducted by providers and/or One Care Plans, as directed by EOHHS

Quality improvement

The One Care program includes three mandated quality improvement projects. The first project seeks to better understand the use of Long-Term Services Coordinators by enrollees. Plans will conduct independent interviews of a sample of enrollees to understand their experience with an LTS Coordinator to identify best practices and implement improvements. The second project focuses on Emergency Department (ED) utilization and the root causes for ED use. A sample of members who have had recent ED visits will be interviewed to better understand reasons for ED utilization and the impact of long term services and supports (LTSS) on such usage.

The final project addresses access to care to determine if enrollees experience barriers to health care and if so, to understand the nature of those barriers. Such barriers may include inaccessible medical equipment, signage, communication from Plan or providers, inadequate access to appropriate physicians for enrollees with intellectual disabilities, incomplete or poor care due to negative attitudes about disability and/or recovery from providers. As with the other two QIPs, One Care Plans will be required to conduct independent interviews with a sample of enrollees to understand their experience with access barriers.

Primary Care Payment Reform (PCPR)

The Primary Care Payment Reform demonstration seeks to expand access to primary care, improve patient experience, quality, and efficiency through care management and coordination, and to incorporate behavioral health care with primary care. This initiative is designed to support primary care delivery by giving providers flexibility and the resources needed to deliver care and services.

A primary care payment system that combines a shared savings/risk arrangement with quality incentives is currently in development by MassHealth. The proposed model will be designed to support primary care through a patient-centered medical home in collaboration with integrated behavioral health services.

Eligibility for the PCPR

MassHealth members enrolled in the PCC Plan or one of the five contracted MCOs and assigned to one of the sites participating in the demonstration will be affected by the PCPR. Implementation will begin March 2014.

Quality monitoring

Table 9 presents the quality measures for the PCPR initiative.

Table 9: Measures for Comprehensive Primary Care Payment Reform

#	NQF #	Measure Name	Measure Steward	Data Collection Options	Data Submission Requirements	Payment		
						Yr 1	Yr 2	Yr 3
Adult Prevention and Screening								
1	421	Adult weight screening and follow up	CMS	Medical record	EOHHS Data Portal	P4R	P4R	P4Q [6]

[6] No Quality Measure will be used in pay-for-quality or Shared Savings / Risk until it has been reported for two years and until EOHHS has determined that the results are valid and available for the majority of Participants. In general, EOHHS will only use measures in P4Q if the variation in performance is clinically meaningful and statistically significant.

#	NQF #	Measure Name	Measure Steward	Data Collection Options	Data Submission Requirements	Payment		
						Yr 1	Yr 2	Yr 3
2	28	Tobacco use assessment and tobacco cessation intervention	CMS	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
3	33	Chlamydia screening	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
4	32	Cervical cancer screening	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	P4Q	SS
5	31	Mammography screening	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	P4Q	SS
Behavioral Health (Adult and Pediatric)								
6	418	Depression screening	CMS	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
7	4	Initiation and engagement of alcohol/drug dependence treatment	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
8	576	Follow up after hospitalization for mental illness (includes children and adults)	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
9	108	ADHD medication management for children	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
Pediatric Health (excluding behavioral health measures)								
10	36	Asthma medication	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
11	24	BMI assessment and counseling	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
12	1506	Adolescent immunization	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
13	1448	Developmental screening in first three years	CAMHI	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
14	1392	Well child visits: <15 months	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4Q	SS
15	1516	Well child visits, 3-6 years, adolescent	NCQA (HEDIS)	Claims	None – EOHHS to calculate	P4R	P4Q	SS
16		Adolescent well visits	NCQA (HEDIS)	Claims	None – EOHHS to calculate	P4R	P4Q	SS
17	38	Childhood immunizations	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
Adult Chronic Conditions								
18	731	Diabetes composite	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q

#	NQF #	Measure Name	Measure Steward	Data Collection Options	Data Submission Requirements	Payment		
						Yr 1	Yr 2	Yr 3
19	18	Hypertension: Controlling high blood pressure	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
Access (Adult and Pediatric)								
20	6	CAHPS	AHRQ	Survey	None	N/A	N/A	P4Q
21		Ambulatory Sensitive Emergency Department Visits	Mercer	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
Care Coordination (Adult and Pediatric)								
22	6	CAHPS	AHRQ	Survey	None	N/A	N/A	P4Q
23	97	Medication reconciliation (all patients, regardless of age)	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q

N/A: Not applicable
P4R: Pay for reporting
P4Q: Pay for quality performance
SS: Shared savings

State Innovation Model Grant

In 2013, Massachusetts was one of six states awarded State Innovation Model Grant by CMS to transform Massachusetts' care delivery and payment system. The $44 million grant seeks to strengthen primary care, reward quality, encourage providers to take accountability for total cost of care, coordinate with community and public health resources, integrate behavioral health, and promote primary care payment reform.

The SIM grant will build on measurement already conducted by MassHealth for other programs such as PCPR and assist with the financing of key aspects of measurement such as patient surveys.

Health Homes Initiative

Massachusetts is preparing a State Plan Amendment to establish Health Homes for members with either (1) a Serious and Persistent Mental Illness (SPMI) or (2) Serious Emotional Disturbance (SED). Through Health Homes, MassHealth aims to strengthen its mental health centers and Community Service Agency (CSA), providers in order to improve integrated care. Massachusetts Health Home providers will improve coordination of care for individuals with complex needs and high costs, as part of the broader MassHealth initiative to improve care for its population.

Massachusetts is developing a Health Homes approach that is well coordinated and aligned with other health care reform and cost control measures. In particular, there will be strong connections between Health Homes and the Primary Care Payment Reform (PCPR) Initiative.

Section 6: Conclusions and Opportunities

MassHealth maintains a vigorous quality management program that effectively and efficiently monitors the quality of care for members who are enrolled in managed care programs. It has been able to create and maintain its program with strong leadership support and a drive to embrace the Triple Aim of better health, better healthcare, and lower costs.

The challenges faced by MassHealth in delivering its ambitious agenda are no different than the challenges faced by any organization or state undergoing transformative change. Change is hard. Organization change requires re-defining culture at the staff level and re-designing infrastructure at the organizational level. Change takes time.

The daily commitment of the individuals at all levels in MassHealth ensures the success of MassHealth's Quality Strategy.

Appendix 1 Managed Care Entity Program Reporting Requirements

This section includes only the reporting requirements for entities covered by the Strategy.

Program	Report Title	Description
Availability of Services: Delivery networks BBA Sections: • 42 CFR 438.206 - Availability of services • 42 CFR 438.207 – Assurances of adequate capacity and services		
MCO Program	PCP Geographic-Access Report	• Annual report and geo-access maps of adult and pediatric PCP geographic locations by service area
	PCP-to-Enrollee Ratio Report	• Annual report of open and closed adult, pediatric, family and OB/GYN PCPs per number of enrollees by Service Area (includes data collection methodologies)
	Top 5 High Volume Specialists, BH Providers and OB/GYNs Geographic-Access Report	• Annual report of geographic access to top 5 high volume specialty types, as defined by EOHHS, BH Providers and OB/GYNs based on MCO-specific utilization
	Specialist –to-Enrollee Ratio Report	• Annual report of number of specialists by specialty type per number of enrollees by Service Area
	Pharmacy Network Geographic-Access Report	• Annual geo-access map of pharmacy network by service area
	Significant Changes in Provider Network Report	• Immediate notice and Annual Summary report of significant changes in provider network that will affect the adequacy and capacity of services
	PCP Database	• Monthly complete database of all network PCPs including unique physician identifiers
	PCP Network Turnover Rate	• Annual PCP turnover w/in MCO network (considering voluntary turnover and terminations)
	PCP Assignment Accuracy Report	• Annual report of number/percentage of enrollees not having an assigned PCP or w/ incorrect PCP assignment at any point > 15 days of effective enrollment (includes auditing/ monitoring activities, data sources, and methodologies)
	Enrollee Change of PCP Report	• Annual report of voluntary Enrollee change of PCPs, with components including Enrollees with multiple/frequent PCP changes, PCPs with higher relative rates of Enrollee disenrollments, and summary of top 10 reasons for PCP changes
	Summary Access and Availability Analysis Report	• Annual report of key findings from all access reports and data sources(e.g. grievance system, telephone contacts with access /availability associated reason codes, provider site visits, use of out of network alternatives due to access/availability, care management staff experiences with scheduling appointments)
	Non-Compliant Pharmacies Report	• Annual, if applicable list of pharmacies that demonstrate a pattern of inappropriately denying prescriptions to Enrollees, and steps taken to resolve the situations
	Mail Order Pharmacy Program Report	• Annual, if applicable summary of Mail Order Pharmacy Program including, number of Enrollees, enrollments/ disenrollments, top 10 utilized drugs,

Program	Report Title	Description
		requests for drugs not included in Program, % of early refills requested, # and method of refills, medication compliance rate.
	Credentialing Policy	• Annual changes to credentialing policies and procedures
	Provider Suspensions and Termination Notification	• Immediate notice of any independent action taken by the MCO to suspend or terminate network provider;
	Provider Suspensions and Termination Report	• Annual list of providers that MCO suspended or terminated upon notice of suspension or termination by MassHealth, and list of provides suspended or terminated by MCO independently.
	Provider Policies and Procedures	• Prospective for review and prior approval, for new and MassHealth covered benefits/services or changes in eligibility information, semi-annual for copies of all final products, recent printed and electronic versions of policies and procedures which affect the process by which enrollees receive care as well as any updates to the MCO's internal grievance and appeals policies and internal authorization policies
	Provider Manual	• Annual, provider manual which includes specific information about MCO covered services, non MCO covered services, and other requirements relevant to provider responsibilities.
SCO Program	Report of members of Provider Network by Zip Code and capacity for accepting new enrollees	• Annual report of the number of PCPs and those with closed practices • Upon event: Provider network changes must be reported to State and CMS within 5 business days
PCC PLAN BH Program	Network Provider Geographic Access Report	• Annual
	Provider Network Semiannual Report	• Annual report of provider sites, credentials and covered services
	Provider Changes Report	• Quarterly report of network changes
	Significant Changes in Provider Network	• Daily report of significant changes ink provider network
	Provider Expertise/Specialty Report	• Semi-annual report listing providers and their areas of expertise
	Emergency Services Program Activity	• Semi-annual report of utilization and follow-up of ESP encounters
	DMH Daily Admission	• Daily report on inpatient admissions of DMH clients.
	Inpatient Cases Awaiting Resolution and Discharge (CARD) Census Report	• Weekly report on covered individuals who do not meet the Inpatient or CBAT Services Level of Care criteria but remain in an inpatient setting awaiting discharge or members previously met one of these criteria and were discharged during the reporting month
	CANS	• Monthly report of the number of Children and Adolescent Needs Assessments (CANS) completed.
Availability of Services: Timely access BBA Sections: • 42 CFR 438.206 - Availability of services • 42 CFR 438.207 – Assurances of adequate capacity and services		
MCO Program	Telephone Statistics Report	• Monthly report of telephone answer statistics including, number of calls received, number /percentage of calls abandoned, number/ percentage calls answered w/in 30 seconds , average speed of answer
PCC PLAN BH Program	Clinical Access Line Report	• Quarterly report of telephone answering statistics

Program	Report Title	Description
PCC PLAN BH Program	Telephone Statistics Report	• Quarterly report including a separate section for clinical calls, provider and member services calls, and PCC hotline calls that include the number of calls, received, answered/abandoned as well as the measures of performance standards on calls within 30 seconds, and average speed of answer
Coordination and continuity of care BBA Section: • 42 CFR 438.208 - Coordination and continuity of care		
MCO Program	PCP Assignment Accuracy Report	• Annual report of number/percentage of enrollees not having an assigned PCP or w/ incorrect PCP assignment at any point > 15 days of effective enrollment (includes auditing/ monitoring activities, data sources, and methodologies)
	Medical and Behavioral Health Organizational Chart/Management Level Staff Changes	• Annual organizational chart detailing individuals in each position and management level vacancies, staff changes, restructuring, and status of filling vacancies.
	Changes to Key Personnel	• As relevant, notice of new personnel, including resume and job description for specified positions
PCC PLAN BH Program	Service Access and Continuity of Care Measures Report	• Semi-Annual report, stratified by level of care and age with data on readmissions, inpatients diversions, follow-up after hospitalization and medication monitoring following discharge
	Care Management Referrals Report Care Management Utilization and Cost Report	• Semi-Annual reports of referrals to and utilization of care management
	Special Services for Pregnant Women	• Semi-Annual
	Inpatient Treatment Planning	• Semi-Annual
SCO Program	Health Outcome Survey	• Annual Health Outcomes Survey (HOS) per CMS requirements
Coverage and authorization of services BBA Section: • 42 CFR 438.210 - Coverage and authorization of services		
PCC PLAN BH Program	Service Authorization and Utilization Review Report	• Semi-Annual report regarding services authorized and denied
	CBHI Authorizations	• Monthly report of CBHI service authorizations
MCO Program	Accident/Trauma Report	• Semi-Annual report of members identified as having medical services as a result of an accident or other loss
	Data Matching	• Monthly enrollment files of Commercial membership
	TPL Form	• Same day notice of Enrollee receiving TPL
	Benefit Coordination Plan	• As relevant, benefit coordination plan and proposed changes submitted for review and approval
Enrollment and disenrollment[7] BBA Section: • 42 CFR 438.226 - Enrollment and disenrollment		

Program	Report Title	Description
MCO Program	Membership Discrepancy Report Unreachable Enrollees PCP Assignment Report	• Monthly report of enrollees identified on EOHHS's file but not enrolled in MCE's plan, enrollees not identified on EOHHS's file but enrolled in the MCE's plan, and enrollee changes of address.
SCO Program	Enrollees medically eligible for nursing facility services	• Quarterly report on enrollees who are medically eligible for nursing facility service
	Disenrollment reasons	• Annual reports of disenrollments by reason • Annual report of mortality data
Grievance systems BBA Section: • 42 CFR 438.228 - Grievance systems		
MCO Program	Enrollee Inquiries	• Annual report identifying the number and type of the top 10 inquiries received
	Enrollee Grievances	• Annual report identifying the number and type of administrative grievances received from an enrollee or his/her appeal representative (quality of care, access, attitude/service, billing/finance) , the action taken for the grievances for which trends are observed, the average time frame for resolution of grievances in each category
	Enrollee Appeals	• Annual report identifying the number and type of each internal appeal (level I and II) received from an Enrollee or his/her designee, the action taken for each such internal appeal, whether the internal appeal is expedited (in which case there is only one level), the time frame for resolution of each internal appeal.
	Notifications of Upheld Internal Appeals Decisions	• Within 1 business day, the case summaries of all final internal appeal decisions, including upheld second level appeals, upheld expedited appeals and those upheld during first level appeals, when MCO knows that enrollee will skip to second level appeal for BOH appeal
	Grievance and Internal Appeals Policies and Procedures	• Within 30 days, copies of amendments to Grievance and Appeals policies and procedures
	Board of Hearings (BOH) Appeals Report	• Annual report of number and type of BOH appeals received from an enrollee or his/her designee
	Notification of BOH hearings	• Immediate notice of date of BOH appeal and any identifying information linking hearing to prior State notice
	Implementation of BOH Decision	• Within 30 calendar days, report that MCO acted upon BOH decision including list of actions.
SCO Program	Report of number and types of complaints and appeals filed by enrollees	• Monthly report of complaints, and appeals, including reporting on how and in what time frame the complaints were resolved
PCC PLAN BH Program	Appeals report	• Annual report of clinical and administrative appeals
	Adverse Reportable Incidents	• Same day and annual reports
	Grievance and Appeals Report	• Semi-Annual report of grievances and internal appeals including the type of grievance or internal appeal, type of resolution, and timeframes for resolution
Subcontractual relationships and delegation BBA Section: • 42 CFR 438.230 - Subcontractual relationships and delegation		
MCO Program	Notification of Termination	• Within three business days, notice of MCO's termination of any material

Program	Report Title	Description
		subcontractor, or notice by any material subcontractor of intention to terminate a contract
	Procurement and re-procurement of Service from Material Subcontractor	• At least 60 days prior, notice of reprocurement or reprocurement of material subcontractor.
Quality assessment BBA Section: • 42 CFR 438.240 -- Quality assessment and performance improvement program		
MCO Program	HEDIS	• Annual report, prepared by an external contractor of performance measurement
SCO Program	HEDIS and other geriatric clinical indicators	• Annual report of performance measurement
PCC PLAN BH Program	HEDIS Satisfaction survey	• Annual reports, prepared by external contractors of performance measurement
	BH Screening and well-child visits	• Quarterly report of the number of behavioral health screenings and well child visits.
	Psychotropic medications for child	• Quarterly report of volume and types of psychotropic medications prescribed for children.
	CBHI ICC Key Indicators	• Monthly report on key indicators of the Intensive Care Coordination program
	CBHI Cost and Utilization	• Monthly report on the cost and utilization of CBHI related services
	BH Cost and Utilization	• Quarterly report of overall cost and utilization of behavioral health services
	CANS Compliance	• Quarterly report CANS compliance
Performance improvement BBA Section: • 42 CFR 438.240 -- Quality assessment and performance improvement program		
MCO Program	Quality improvement goal reports	• Semi-Annual reports of progress toward QI goals.
SCO Program	Quality management goal reports	• Annual reports of progress towards QM goals
PCC PLAN BH Program	QM Activities Report	• Annual summary of MCE's quality management activities for the year
	Performance specifications and clinical criteria	• Annual submission of clinical criteria and performance specifications.
	Medical record review	• Annual review of medical records
Information systems BBA Section: • 42 CFR 438.242 - Health information systems		
MCO Program	Encounter data	• Monthly submission of encounter data
SCO Program	Utilization reports	• Annual reports in key areas of hospital, nursing facility, and community service
PCC PLAN BH Program	Encounter data	• Quarterly submission of encounter data
EQRO activities BBA Section: • External oversight – 42 CFR 438.310 – 438.370		

Appendix 2

Program	Report Title	Description
MCO, PCC PLAN BH, and SCO Programs	Technical Report of mandatory EQR activities	• Validation of performance improvement projects • Validation of performance measures • Compliance with strategy standards