Draft Evaluation Plan for the Massachusetts 1115 Demonstration Waiver

Introduction

Since its launch in 1997, the MassHealth 1115 Demonstration Waiver ("waiver") has served as a vehicle for expanding coverage, encouraging better coordination and cost containment through managed care, and supporting safety net providers. On November 4, 2016, the Centers for Medicare and Medicaid Services (CMS) approved the sixth extension of the waiver for the period July 1, 2017 through June 30, 2022. This extension seeks to transform the delivery of care for most MassHealth members and to change how that care is paid for, with the goals of improving quality and establishing greater control over spending. The waiver also addresses the epidemic of opioid drug use in Massachusetts. The waiver extension seeks to advance five goals:

- Goal 1: Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care
- Goal 2: Improve integration of physical, behavioral and long-term services
- Goal 3: Maintain near-universal coverage
- Goal 4: Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals
- Goal 5: Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services

The waiver draft evaluation design contained in this document is meant to meet the requirements of the independent evaluation described in the MassHealth Medicaid Section 1115 Demonstration Special Terms and Conditions (STC), Section XI: Evaluation. This evaluation design addresses the research questions and hypotheses suggested by CMS as well as additional areas of importance to the MassHealth waiver implementation.

The evaluation will explore the research questions and hypotheses related to the overarching aims of the demonstration, as well as those linked to specific goals. Although this document refers to key elements of the DSRIP funding (e.g. Community Partners and Flexible Services), a separate independent evaluation design (see hypothesis 2d below) will allow for component analysis of the initiatives funded by the DSRIP and will be submitted under separate cover per the STC.

Demonstration Evaluation Aim:

As stated in STC 84(b), the overarching aim of the independent evaluation is to "evaluate whether the preponderance of the evidence about the costs and effectiveness of the demonstration when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes."

The primary mechanism by which MassHealth intends to advance Goals 1 and 2 is by promoting the formation of Accountable Care Organizations (ACOs) and Community Partners (CPs) to organize the delivery of care for MassHealth members under the age of 65 without other insurance coverage. ACO and CP development will receive additional support from the Delivery System Reform Incentive Program (DSRIP).

Evaluation Research Questions and Hypotheses

Overarching Evaluation Question

Did the payment and delivery system reforms facilitated by the waiver lead to decreases in the total cost of care (TCOC) while maintaining or improving quality?

- Hypothesis A: Waiver-enabled payment and delivery system reforms will result in reductions in the total cost of care (TCOC) for MassHealth's managed care population.
- Hypothesis B: Waiver-enabled payment and delivery system reforms will maintain or improve clinical quality.
- Hypothesis C: Waiver-enabled payment and delivery system reforms will maintain or improve members' experiences with care.

As a general principle, throughout the evaluation and design, total costs under the demonstration to estimates of what costs would have been without the demonstration, accounting for changes in provider rates, health care utilization, and administrative activities will be compared. Comparisons of changes in access and quality within managed care populations will rely on standard metrics as summarized in the attached measures table and compared to the non-managed care population where appropriate and possible.

Waiver Goal 1: Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care.

Research Question 1

Did the waiver's payment and delivery system reforms promote systems of integrated and coordinated care?

- Hypothesis 1a: The waiver's support will result in new partnerships and collaborations between ACOs and community partners offering behavioral health and long-term services and supports.
- Hypothesis 1b: The waiver's support will increase acceptance of TCOC risk-based payments among MassHealth providers.
- Hypothesis 1c: The waiver's support will lead to stronger aggregate provider networks in the ACO and MCO programs relative to the Primary Care Clinician (PCC) plan in relation to types and breadth of providers, as well as quality and outcomes of services.

- Hypothesis 1d: The waiver's support will increase the use of Electronic Health Records (EHRs) and other infrastructure capabilities designed to improve interconnectivity among providers.

Evaluation Approach for Goal 1

Study Design:
Hypothesis 1a:

- The requirements for contracting between managed care entities and community partners as a result of the waiver and the number and nature of contracts executed will be identified.
- The volume, nature, and providers of non-medical services used by ACOs will be examined.

Hypothesis 1b:

- The level of acceptance of TCOC payments will be determined by examining the total outlay of Medicaid funds going to entities in the form of risk-based payments versus fee-for-service comparing changes over time starting with pre-waiver baselines.

Hypothesis 1c:

- Network adequacy using specific Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses in, addition to Managed Care Organizations' (ACO models and MCOs) reported compliance with MassHealth network adequacy standards regarding types and breadth of providers, will be measured.
- Trends in social, behavioral and LTSS service use, by type and in total, for all managed care enrollees and within patient groups (such as those with quadriplegia) with needs for such services will be tracked.
- Quality and outcomes will be examined by measuring: the fraction of relevant population groups with any of the above services; among people with any such service use, its "volume" (e.g., numbers of visits/encounters, and the estimated cost of all services); among those who used services, looking for reductions in avoidable hospitalizations.

Hypothesis 1d:

- The number of provider organizations within the ACOs and CPs that have adopted EHRs will be tracked.
- The number of provider organizations within the ACOs and CPs that are connected to the Mass HIway will be tracked.

Data Needed for Evaluation: Documents that define the new contractual requirements for managed care entities, community partners, and service providers as a result of the waiver; documentation regarding the parties to, timing, scope, and nature of contracts actually executed; transactional data (bills or encounter records) relating to the volume, cost, nature of and providers of non-medical services used by ACOs; and data from the Massachsuetts eHealth Institute (MeHI) that reports EHR adoption and HIway connection rates among providers operating throughout the Commonwealth.

Study Populations: All potential partners to new contracting arrangements providing services to MassHealth members under the age of 65.

Access, Service Delivery Improvement, Health Outcomes, Satisfaction, and Cost Measures: The only questions considered here relate to the nature and amount of delivery system reorganization into integrated risk-bearing networks.

Data Analysis Plans: Simple descriptive statistics will be used to examine year-over-year changes in delivery system integration during the waiver period. Reporting will capture numbers of distinct providers, and the total volume cost of specified services delivered under accountable care contracts.

Waiver Goal 2: Improve integration of physical, behavioral and long-term services.

Research Question 2
Has the waiver promoted integrated care systems that demonstrate improved care quality and member experience?

- Hypothesis 2a: The waiver support for integration of physical, behavioral and long-term services will result in improved coordination across silos of care (e.g., physical health, behavioral health, LTSS, and social supports) as well as quality and outcomes of care.
- Hypothesis 2b: The waiver will lead to improved experience of care, especially through member engagement in primary care and/or closer coordination among providers.
- Hypothesis 2c: Accountability provisions under the waiver initiative will result in reductions in the growth of avoidable inpatient utilization.
- Hypothesis 2d: DSRIP funding for developing Community Partners and Flexible Services will contribute to increased integration of care systems and improved member experience.

Evaluation Approach for Goal 2

Study Design:
Hypothesis 2a:

- Encounter data will be used to examine trends in the receipt of behavioral health, LTSS and social support services for members of ACOs overall, and within groups of patients especially likely to need each of these kinds of services.

Hypothesis 2b:

- Trends in CAHPS survey responses will be examined with regard to patient experience related to the timing, nature, and scope of services received. Data will be examined overall, and within groups of patients especially those likely to need specific kinds of services.

Hypothesis 2c:

- Trends in care quality including potentially avoidable admisisons and other quality and outcome measures from the ACO measure slate will be examined.

Hypothesis 2d:

- Data from DSRIP-funded programs will be reviewed to assess contributions to the overall success of the waiver, and to achieving specific performance measures and outcomes as described in the DSRIP protocol Appendix E. In addition, return on investment (ROI) analyses will be performed to assist the state in determining which investments might be continued after the waiver period. Note that a detailed evaluation design for the DSRIP program will be submitted for review to CMS by June 30, 2018 consistent with the STC.

Most questions will be examined longitudinally for MassHealth members overall, looking at year-over-year changes for enrollee groups (principally PCC plan vs. managed care), and separately within policy relevant subgroups, such as, people with behavioral health and those with LTSS needs. Changes in trends for measures and outcomes will be considered prior to, and following, programmatic changes enabled by the waiver. Trends in utilization and costs will be examined (risk-adjusted) for the managed care sector as a whole, and in comparison to the PCC plan.

The qualitative arm of the evaluation will entail case studies of select ACOs throughout the demonstration period to understand implementation and to pinpoint the conditions associated with higher and lower performing ACOs and CPs. Replication logic will be used to identify organizational conditions associated with specific operational outcomes such as successful vs. problematic implementation; improved care quality vs. static or declining care quality; and reduced care costs vs. flat or increasing care costs.

Data Needed for Evaluation: Both qualitative and quantitative data will be collected to evaluate Goal 2. The core quantitative data for examining the impact on the populations participating in managed care will be derived from required reporting from organizations providing these services. Data for measuring overall trends for comparing costs and service use between managed and non-managed care populations (overall and within utilization categories) will be derived from state's MMIS and data warehouse systems in two kinds of files: utilization records (claims/encounter data) and person-level files (descriptions of member characteristics, eligibility for special programs, etc.).

Qualitative data related to implementation and member experience will be derived from key informant interviews and patient surveys. This information will be used to conduct

"internal validity analyses" in which changes in the organization, cost and use of services will be linked to the time frames during which, and the populations for which, reforms were actually implemented. Qualitative data from key informant interviews will be used to understand the facilitators and barriers to successful implementation, which can inform how best to revise and modify implementation during the demonstration period and inform future replication efforts.

Study Population: The total study population for examining these hypotheses will be MassHealth members under the age of 65 with a special emphasis on those participating in managed care. Many questions will be examined within the subpopulations that would reasonably be expected to be affected by particular programs – such as the impact of integrated systems of care on members who have unmet needs for behavioral health care and/or long-term care services.

For the qualitative phase, the study population will consist of select ACO sites and within those sites, a purposeful sample of key informants representing a cross-section of administrative, clinical and support staff involved in implementing organizational change under the demonstration. To understand the initial implementation, baseline site visits will identify a sample of ACOs representing the range of adopted models. In subsequent site visits, findings will be used from the quantitative arm of the evaluation to identify and study ACO sites that perform relatively well or underperform with respect to key outcomes of interest, such as care cost and care quality.

Access, Service Delivery Improvement, Health Outcomes, Satisfaction, and Cost Measures: To measure the impact of payment reforms, measures that MassHealth will require from its accountable care entities will be relied upon (see measure table, Attachment A). MassHealth will strive to ensure that these new data will be collected at the person-level, and standardized across the entire sector without which neither comparisons with the PCC plan, nor with the pre-waiver period, will be possible.

Data Analysis Plans: Describing member characteristics, cost and utilization (and bivariate relationships among these) for the MassHealth population overall and by program (PCC vs. various managed care models) will be a first approach, as well as changes in these features and relationships over time. Difference-in-difference analyses will be the primary strategy for testing hypotheses relating to the effects of specific interventions and the effects of the combined reforms. Prior to modeling, examining distributions of key variables, to inform how to construct analytic variables (e.g., an expectation to "top-code" very expensive cases; noting that, choosing an appropriate top-coding threshold requires examining the entire cost distribution, eliminating data errors, and distinguishing predictable high costs – such as those incurred by people who require a $300,000/year drug – from random, insurable events, such as, costs incurred by a third-degree burn victim). Informed by qualitative research, a "stepped-wedge" design will be used to take advantage of the "natural experiment" provided by the phase-in of delivery innovations.

For some questions that relate specifically to populations with extremely low turnover, differences in person-level trajectories for long-term stayers who remain in a program that is not affected by waiver-based changes will be examined, versus those who switch programs (e.g., from PCC to managed care) versus those who do not change programs, but their programs undergo waiver-encouraged changes.

Data analysis and interpretation will be "risk-adjusted" where appropriate – that is, examining outcomes and changes in outcomes after accounting for differences in, and changes in, relevant patient characteristics – except in settings where there is controversy about whether risk adjustment is appropriate, in which case the approach will be to conduct and present both raw and risk adjusted analyses.

For the qualitative arm of the evaluation, content coding and analysis to determine major themes present in the interviews will be used both within and across study ACO sites. Coded and sorted data will then serve as the basis of creating site-specific reports and data matrices, both of which will facilitate cross-ACO comparisons. Through this process, how the program was implemented at study sites will be assessed, including, similarities and differences across sites that vary on performance, and how the program was implemented overall.

Waiver Goal 3: Maintain near-universal coverage.

Research Question 3
What is the impact of the waiver's investments in improved enrollment and redetermination processes and insurance subsidies on insurance rates?

- Hypothesis 3: The waiver's investments in improved enrollment procedures and insurance subsidies will be associated with the continued maintenance of near-universal coverage in Massachusetts.

Evaluation Approach for Goal 3

Study Design and Outcome Measures:
Hypothesis 3:

- Describing trends in the distributions of existing measures to track five population-level measures: 1) Among Massachusetts residents under the age of 65, number (and fraction) of uninsured; 2) Volume and cost of uncompensated care and supplemental payments to hospitals; 3) Number of individuals accessing the Health Safety Net; 4) Number of individuals who take up Qualified Health Plan coverage with assistance from the Commonwealth Health Insurance Connector Authority (Health Connector) subsidy program; and 5) Number of individuals who are waiver-eligible but have employer-sponsored coverage.

Background: The waiver invests in several improvements to facilitate and sustain enrollment in insurance coverage, including: streamlined redetermination procedures for select MassHealth members; developing comprehensive enrollment materials and

trainings to support consumer choice; providing subsidies to low income people to purchase health insurance; and improved eligibility system and website/consumer functionality. The overall approach for addressing the research question and hypothesis under Goal 3 will be a descriptive analysis of existing population-level measures examining changes in state-wide insurance rates and related metrics.

Data Needed for Evaluation: Secondary data sources will be exclusively relied upon for the population-level measures: data sets and operational statistics from the Massachusetts Center for Health Information and Analysis, MassHealth, and the Health Connector. The datasets will include: the Massachusetts Health Insurance Survey, Health Safety Net claims enrollment data, and the Health Connector subsidy program data.

Study Population: With the exception of the measure related to the statewide coverage rate, where the study population is residents of the Commonwealth, all waiver-eligible individuals will be studied. There is no comparison population for this evaluation component, whose purpose is to determine whether near-universal coverage is maintained. Where feasible and useful, select population-level measures will be compared to national trends.

Data Analysis: Summary statistics for each PLM at three time points over the waiver period, baseline, mid-point and end-point will be provided. The analytic approach for each measure will vary by data source and measures. While the data will be reported on an annual basis, some data sources contain monthly capture of various activities (e.g., the number of demonstration eligible accessing employer sponsored insurance), while other data are only available on an annual basis. Data will be presented in tables and graphs in order to display trends over time for each population-level measure.

Timeline: Summary statistics for each population-level measure at three time points over the demonstration period will be provided: baseline, mid-point and end-point.

Waiver Goal 4: Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals

Research Question 4:
What is the impact of safety net funding investments on safety-net provider hospital performance and financial sustainability?

- Hypothesis 4a: Increasing the portion of funding for safety-net hospitals under the Public Health Transformation and Incentive Initiative (PHTII) and Disproportionate Share Hospital (DSH) pool will result in improved care quality at these sites.
- Hypothesis 4b: Supplemental payments to hospitals funded through the DSH pool will help to address their underlying financial needs so they can continue to serve Medicaid and uninsured residents.

Evaluation Approach for Goal 4

Study Design:
Hypothesis 4a:

- Identify trends in quality measures at Cambridge Health Alliance and safety net payment eligible hospitals to examine if funding changes have improved overall quality outcomes.

Hypothesis 4b:

- Track uncompensated care and supplemental payments at safetynet hospitals to assess uncompensated care costs before and after supplemental payments.

The approach will be to monitor and track hospital performance (CHA and the safety-net hospitals) and the degree to which each meets performance targets (and thus receives the at-risk portion of the PHTII and safety net payments during the waiver period). The following outcome measures will be used: 1) ACO performance measures defined for DSRIP (CHA and safety-net hospitals) 2) ACO participation and "strengthened outcome improvement measurement slate" for on-going PHTII initiatives related to behavioral health integration (CHA only). Additionally, supplemental payments to safey-net hospitals will be tracked (i.e., Safety Net Provider Payments). The outcome measure will be each hospital's remaining uncompensated care costs post-supplemental payments.

Background: Under the waiver, two existing programs will continue, but with modifications. These are the Public Health Transformation and Incentive Initiative (PHTII) and the Disproportionate Share Hospital (DSH) pool. PHTII provides funds to CHA, the Commonwealth's only non-state, non-federal public acute hospital to support delivery system transformation. In the new waiver, an increasing portion of PHTII funding will be at-risk based on two activities: 1) Participation in an ACO model and demonstrated success on corresponding ACO performance measures (specifically the same performance goals established under DSRIP) 2) Continuation and strengthening of initiatives approved through PHTII in the prior demonstration period, including but not limited to initiatives focused on behavioral health integration and demonstrated success on corresponding performance measures.

DSH provides funding to support payments for uncompensated care provided to Medicaid and low-income, uninsured individuals. Under the waiver, a new component of the DSH pool is Safety Net Provider Payments, intended to provide ongoing financial support to the state's safety-net hospitals. These hospitals serve a disproportionately high proportion of Medicaid and uninsured patients, and have budget shortfalls related to providing a lot of care that is uncompensated. An increasing portion of these payments will be at risk, and hospitals will be required to meet the same performance goals established for DSRIP in order continue to receive these payments.

Data Needed for Evaluation: Data sources include: 1) PHTII and hospital safety-net Reports for Payment that hospitals under these programs will be required to submit,

detailing key accomplishments in the reporting period towards the associated metrics, and outcome and improvement measures 2) state cost reports 3) data provided by MassHealth on supplemental payments to safety-net hospitals.

Study Population: The study population will be patients served by CHA and the 14 safety-net hospitals eligible for safety net payments. CHA has among the highest concentration of patients participating in MassHealth programs of any acute hospital in the Commonwealth. The study population will also include a purposeful sample of key informants at select hospitals.

Data Analysis: A data set will be created to capture and track hospital performance measures annually throughout the demonstration period. These data will support high-level analysis of the degree to which hospitals participating in PHTII and hospitals eligible for safety net payments meet performance goals related to care quality and cost, and to ACO participation.

Waiver Goal 5: Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services.

Research Question 5:
What is the impact of expanding MassHealth coverage to include residential services and recovery support services on care quality and outcomes for members with substance use disorders (SUD)?

- Hypothesis 5a: Expanding coverage to include residential services and recovery support services will result in improved care quality and outcomes for patients with SUD.
- Hypothesis 5b: Expanding coverage to include residential services and recovery support services will result in reduced care costs for patients with SUD.
- Hypothesis 5c: Expanding coverage to include residential services and recovery support services will result in reduced Opioid drug overdoses.

Evaluation Approach for Goal 5

Study Design:
Hypothesis 5a:
- Trends in care quality and outcomes for patients with SUD will be examined, including who is, and who is not receiving needed services.

Hypothesis 5b:
- Trends will be examined in total costs of care for patients with SUD.

Hypothesis 5c:
- Trends in numbers of opioid overdoses will be examined.

Substance use disorder (SUD) services are offered by the Department of Public Health's Bureau of Substance Abuse Services (BSAS) and by MassHealth. Before the demonstration's approval, MassHealth services were limited to outpatient counseling,

methadone treatment, short-term detoxification services, and short-term residential services. To improve state-wide capacity and respond to the opioid crisis, the demonstration will expand SUD treatment in the Commonwealth by adding Medicaid coverage for 24-hour community-based rehabilitation though high-intensity Residential Services, transitional support services (including recovery coaches and navigators), and Residential Rehabilitation. With the exception of recovery coaching services (which are limited to MassHealth members in an MCO or ACO), all MassHealth members except those in MassHealth Limited are eligible for expanded substance use disorder services as part of the waiver. A primary aim of these new services is to divert SUD patients from inpatient mental health and substance use disorders services to community-based environments.

Data Needed for Evaluation: Data for this evaluation will include: 1) MassHealth enrollment and claims/encounter data for all MassHealth members under the age of 65 and the Department of Public Health's Chapter 55 data.

Outcome Measures: Outcome measures will include cost and utilization, quality and patient outcomes. Costs and utilization will be examined, including TCOC and within categories, such as, inpatient, residential rehabilitation, coaching, etc. Care quality measures will include initiation and engagement in SUD treatment; medication assistance treatment (MA) use; avoidable ED use and inpatient hospitalizations. Care outcomes will include rates of long-term recovery and both fatal and non-fatal overdoses, as well as a subset of National Outcome Measures, to look for decreases in criminal justice involvement and increases in stable housing.

Study Population: MassHealth members with substance use disorders (alcohol or other drugs).

Data Analysis Plans: Broadly, the same analytic strategies described for the Goal 2 aims will be applied. There will be an examination of changes in the total size of the population with identified SUD, and its characteristics, and trends in the tracked measures, both with and without risk adjustment.

Summary of data needed for the waiver evaluation: Data needed for evaluating specific hypotheses are linked to the waiver goals, research questions, hypotheses and evaluation plans as described above. In summary, the evaluation plan will require:

- Medicaid enrollment, encounters and claims data for the entire under 65 population for a minimum of two years prior to the start of the demonstration through 2022.
- Cost data related to managed care payments and related cost reports
- Exact specifications of the algorithms used to calculate the standardized ACO measure slate and a person-level data file indicating who is eligible for each measure and the outcome on that measure for that person, and similar data for the CPs.
- Data from patient surveys.

- Access to the exact requirements for network adequacy specified in contracts between MH and the managed care entities.
- The PHTII and safety-net hospital data used to calculate eligibility for these facilities' at-risk payments.
- State cost reports, and supplemental payments to safety-net hospitals.
- MeHI data on EHR adoption and HIway connection rates.
- Access to ACO and CP sites to conduct key informant interviews.

Assurances needed to obtain data: Data for this evaluation will be based on existing data sources where available. However, most of the needed information is Medicaid program-related administrative, clinical, management, and program-specific data that will need to be provided to the independent evaluator. It is anticipated that the Independent Evaluator will function as a Business Associate of the Executive Office of Health and Human Services and thus be provided with the necessary data to complete the activities outlined in the evaluation plan. As such, the Business Associate will comply with all the requirements of the HIPAA Rules applicable to a Business Associate as well as specific requirements included in data use agreements.

Timeline: (see Attachment B: MassHealth 1115 Waiver Evaluation Timeline Linked to Key Milestones and DSRIP Program)

As specified in the STC, a draft Interim Evaluation Report will be submitted to CMS one year prior to this renewal period ending June 30. 2022. A preliminary draft of the Summative Evaluation Report (SER) for the demonstration period starting July 1, 2017 through June 30, 2022 will be submitted 180 days before the end of the demonstration, and a final SER will be submitted for CMS review within 500 calendar days of the end of the demonstration period. The DSRIP evaluation design will be submitted to CMS by June 30, 2018 and the DSRIP Interim Report by June 30, 2020 consistent with STC and DSRIP protocol.

Massachusetts agrees to post the final approved Evaluation Design, Interim Evaluation Report and Summative Evaluation report on the Commonwealth's website within 30 days of approval by CMS.

Process to Select Evaluator:

MassHealth intends to select the University of Massachusetts Medical School (UMMS) as its independent evaluator for the overall 1115 waiver. MassHealth is explicitly authorized to enter into Interdepartmental Services Agreements (ISAs) with UMMS for the purpose of obtaining, among other things, consulting services related to quality assurance and program evaluation and development for the MassHealth program. See e.g. Chapter 133 of the Acts of 2016, line item 4000-0321.

Furthermore, no competitive procurement is required for ISAs. ISAs are explicitly exempt from Massachusetts state procurement regulations that otherwise require

competitive procurements. Instead, ISAs are governed by 815 CMR 6.00, which requires state agencies to use good business practices to determine whether entering into an ISA provides the best value to the Commonwealth. No competitive procurement is required for the state agency to reach the conclusion that another state agency provides best value.

Massachusetts may consider a procurement for a separate DSRIP evaluator.

Attachments:

- Attachment A: Proposed Measure Tables
- Attachment B: MassHealth 1115 Waiver Evaluation Timeline Linked to Key Milestones and DSRIP Program

Attachment A: Proposed Measure Tables

ACO Measure Slate

#	Measures	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
	Prevention & Wellness											
1	Well child visits in first 15 months of life	Percentage of ACO attributed members who turned 15 months old during the measurement period and who had 6 or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life.	H	NCQA – Health Plan	1392	NCQA Quality Compass	Yearly	R	P	P	P	P
2	Well child visits 3-6 yrs	Percentage of ACO attributed members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	H	NCQA – Health Plan	1516	NCQA Quality Compass	Yearly	R	P	P	P	P
3	Adolescent well-care visit	Percentage of ACO attributed members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetricianand gynecology (OB/GYN) practitioner during the measurement period.	H	NCQA – Health Plan	N/A	NCQA Quality Compass	Yearly	R	P	P	P	P
4	Weight Assessment / Nutrition Counseling and Physical Activity for Children/Adolescents	Percentage of ACO attributed members 3 to 17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement period: (1) body mass index (BMI) percentile documentation, (2) counseling for nutrition, and (3) counseling for physical activity.	H	NCQA - ACO	24	NCQA Quality Compass	Yearly	R	P	P	P	P
5	Prenatal Care	Timeliness of Prenatal Care: The percentage of deliveries of live births to ACO attributed members (up to age 65) between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of attribution to the ACO.	H	NCQA – Health Plan	1517	NCQA Quality Compass	Yearly	R	P	P	P	P
6	Postpartum Care	Postpartum Care: The percentage of deliveries of live births to ACO attributed members (up to age 65) between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.	H	NCQA – Health Plan	1517	NCQA Quality Compass	Yearly	R	P	P	P	P
7	Oral Evaluation, Dental Services	Percentage of ACO attributed members under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	American Dental Association on behalf of the Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
8	Tobacco Use: Screening and Cessation Intervention	Percentage of ACO attributed members ages 18 to 64 who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	H	American Medical Association on behalf of the Physician Consortium for Performance	28	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
9	Adult BMI Assessment	Percentage of ACO attributed members ages 18 to 64 who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement period	H	NCQA - ACO	N/A	NCQA Quality Compass	Yearly	R	P	P	P	P

10	Immunization for Adolescents	Percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday. The measure will calculate a combination rate using Combo-1. [2017 HEDIS Spec will be updated Oct 2016 to include HPV vaccine.]	H	NCQA - ACO	1407	NCQA Quality Compass	Yearly	R	P	P	P	P
	Chronic Disease Management											
11	Controlling High Blood Pressure	Percentage of ACO attributed members 18 to 64 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement period, based on age/condition-specific criteria	H	NCQA - ACO	18	NCQA Quality Compass	Yearly	R	P	P	P	P
12	COPD or Asthma Admission Rate in Older Adults	All discharges with a principal diagnosis code for COPD or asthma in adults ages 40 to 64, for ACO attributed members with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.	C	CMS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
13	Asthma Medication Ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA – Health Plan	1800	NCQA Quality Compass	Quarterly	R	P	P	P	P
14	Comprehensive Diabetes Care: A1c Poor Control	The percentage of patients 18 to 64 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	H	NCQA – Health Plan	59	NCQA Quality Compass	Yearly	R	P	P	P	P
15	Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 ACO attributed member months ages 18 to 64. Excludes obstetric admissions and transfers from other institutions.	C	CMS	272	NCQA Quality Compass	Quarterly	R	P	P	P	P
	Behavioral Health / Substance Abuse											
16	Developmental Screening for behavioral health needs: Under Age 21	Percentage of ACO attributed members under age 21 screened for behavioral health needs using an age appropriate EOHHS approved developmental screen	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
17	Screening for clinical depression and documentation of follow-up plan: Age 12+	Percentage of ACO attributed members age 12 to 64 screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	H	CMS	418	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
18	Depression Remission at 12 months	Percentage of ACO attributed members age 18-64 with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months (Defined as PHQ-9 score less than 5). Or a response to treatment at 12 months (+/- 30 days) after diagnosis or initiating treatment. (Patient Health Questionnaire-9 (PHQ-9) score decreased by 50% from initial score at 12 months (+/- 30 days).	H	Minnesota Community Measurement (also adapted by CMS and NCQA)	710	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P

19	Initiation and Engagement of AOD Treatment (Initiation)	Percentage of ACO attributed members ages 13 to 64 diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	C	NCQA - ACO	4	NCQA Quality Compass	Quarterly	R	P	P	P	P
20	Initiation and Engagement of AOD Treatment (Engagement)	Percentage of ACO attributed members ages 13 to 64 diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	C	NCQA - ACO	4	NCQA Quality Compass	Quarterly	R	P	P	P	P
21	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for ACO attributed members ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA - ACO	576	NCQA Quality Compass	Quarterly	R	P	P	P	P
22	Follow-up care for children prescribed ADHD medication - Initiation Phase	Percentage of ACO attributed members 6 to 12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	C	NCQA - ACO	108	NCQA Quality Compass	Quarterly	R	P	P	P	P
23	Follow-up care for children prescribed ADHD medication - Continuation Phase	Percentage of ACO attributed members 6 to 12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	C	NCQA - ACO	108	NCQA Quality Compass	Quarterly	R	P	P	P	P
24	Opioid Addiction Counseling	Percentage of ACO attributed members ages 18 to 64 with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
	Long Term Services and Supports											
25	Assessment for LTSS	Percentage of ACO attributed members (up to age 65) with an identified LTSS need with documentation of an age appropriate EOHHS-approved assessment.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
	Integration											
26	Utilization of Behavioral Health Community Partner Care Coordination Services	Percentage of ACO attributed, BH CP-eligible members (up to age 65) who had at least one Behavioral Health Community Partner care coordination support during the measurement period.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
27	Utilization of Outpatient BH Services	Percentage of ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD that have utilized outpatient BH services during the measurement period	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R

28	Hospital Admissions for SMI/SUD Population	Risk-adjusted percentage of ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD who were hospitalized for treatment of selected mental illness diagnoses or substance use disorder (regardless of primary or secondary diagnosis)	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
29	Emergency Department Utilization for SMI/SUD Population	Risk-adjusted ratio of observed to expected ED visits during the measurement period, for ACO attributed members (up to age 65) with a diagnosis of SMI and/or SUD for a selected mental illness or substance use disorder that is either the primary or secondary diagnosis	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
30	Emergency Department Care Coordination of ED Boarding Population	Percentage of patients boarding in the ED for whom a referral was made by the ED to the PCP or Community Partner (CP) upon discharge. Boarding defined as ≥ 48 hours in the ED.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
31	Utilization of LTSS Community Partners	Percentage of ACO-attributed, LTSS CP-eligible members (up to age 65) who received at least one LTSS CP support during the measurement period	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
32	All Cause Readmission among LTSS CP eligible	Percentage of ACO attributed, LTSS CP eligible members (up to age 65) who were hospitalized and subsequently readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
33	Social Service Screening	Percentage of ACO attributed members (up to age 65) who were screened for social service needs.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
34	Utilization of Flexible Services	Percentage of ACO-attributed members (up to age 65) recommended by their care team to receive flexible services support that received flexible services support.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
35	Care Plan Collaboration Across PC, BH, LTSS, and SS, Providers	Percentage of ACO attributed members (up to age 65) identified for care management/care coordination with documentation of a care plan that: - is developed by/shared with primary care, behavioral health, LTSS, and social service providers, as applicable - addresses needs identified in relevant assessments/screenings - is approved by member (or caregiver, as appropriate).	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P

36	Community Tenure	Measure will assess ACO's ability to support and retain member placement in the community. Measure under development: Potential examples include: 1. Percentage of ACO attributed members who transitioned to the community from an LTC facility and did not return to a facility during the subsequent 12 months period. 2. Percentage of Days in Community for members with at least one index discharge from a LTC facility: (Total Eligible Days – Total Institutional Care Days)/Total Eligible Days 3. Average or median days of community tenure for ACO attributed members with an index discharge (during the measurement year) from a long term stay institution to a community setting who were admitted to a long term stay institution within 180 day period following the index discharge. Note: Community setting definition should follow CMS HCBS Final Rule 2249-F and 2296-F.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
	Avoidable Utilization											
37	Potentially Preventable Admissions	Risk-adjusted ratio of observed to expected ACO attributed members who were hospitalized for a condition identified as "ambulatory care sensitive"	C	3M	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	P	P	P	P
38	All Condition Readmission	Risk-adjusted ratio of observed to expected ACO attributed members (up to age 65) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	CMS*	1789*	EOHHS benchmarks derived from baseline data	Quarterly	R	P	P	P	P
39	Potentially Preventable Emergency Department Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO attributed members ages 18 to 64 per 1,000 member months.	C	3M	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	R	R	R
Member Experience			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P

***** CMS specifications as documented in NQF #1789 will be utilized with changes to the age range (up to age 64 rather than 65 and above) and the insured population (Medicaid rather than Medicare)

BH CP Quality Measure Slate. ***Measures will be calculated for those CP eligible members engaged with the CP***

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Prenatal Care	Timeliness of Prenatal Care: The percentage of deliveries of live births to ACO/MCO/health plan enrollees (any age) between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of assignment to the BH CP.	C	NCQA	1517	NCQA Quality Compass	Quarterly	R	R	P	P	P
2	Annual primary care visit	Percent of CP-engaged members who had an annual primary care visit in the last 15 months	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
II. Chronic Disease Management												
3	COPD or Asthma Admission Rate in Older Adults	All discharges with a principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO/MCO/health plan enrollees with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.	C	CMS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
4	Asthma Medication Ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA	1800	NCQA Quality Compass	Quarterly	R	R	P	P	P
5	Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 ACO/MCO/health plan member months ages 18 to 64. Excludes obstetric admissions and transfers from other institutions.	C	CMS	272	NCQA Quality Compass	Quarterly	R	R	P	P	P
III. Behavioral Health / Substance Use Disorder												
6	Initiation and Engagement of AOD Treatment (Initiation)	The percentage of ACO/MCO/health plan adolescent and adult members with a new episode of AOD who received the following: Initiation of AOD Treatment	C	NCQA	4	NCQA Quality Compass	Quarterly	R	R	P	P	P
7	Initiation and Engagement of AOD Treatment (Engagement)	The percentage of ACO/MCO/health plan attributed adolescent and adult members with a new episode of AOD who received the following: Engagement of AOD Treatment	C	NCQA	4	NCQA Quality Compass	Quarterly	R	R	P	P	P
8	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for ACO/MCO/health plan enrollees ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576	NCQA Quality Compass	Quarterly	R	R	P	P	P
9	Follow-up After Hospitalization for Mental Illness (3-day) by BH CP	Percentage of discharges for BH CP-enrolled members ages 21 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had a face-to-face encounter with a BH CP within 3 days of discharge	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
IV. Member Experience												
A. Access			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
B. Care Planning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
C. Participation in Care Planning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
D. Quality and Appropriateness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
E. Health and Wellness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
F. Social Connectedness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
G. Self Determination			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
H. Functioning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
Self Reported Outcomes			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
J. General Satisfaction			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
V. Integration												
12	Social Service Screening	Percentage of CP-engaged members who were screened for social service needs	H	EOHHS	N/A		Quarterly	R	R	P	P	P
13	Utilization of Flexible Services	Percentage of ACO-enrolled, CP-engaged members (up to age 64) recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A		Yearly	R	R	P	P	P
14	Utilization of Outpatient BH Services	Percentage of ACO/MCO/health plan enrollees that have utilized outpatient BH services during the measurement period	C	EOHHS	N/A		Quarterly	R	R	P	P	P
VI. Avoidable Utilization												
15	All Condition Readmission	Risk-adjusted ratio of observed to expected ACO/MCO/health plan enrollees CP CP-engaged (up to age 64) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
16	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO/MCO/health plan enrollees CP-engaged ages 18 to 64 per 1,000 member months.	C	3M	N/A		Quarterly	R	R	P	P	P
VII. Engagement												
17	BH Comprehensive Assessment /Care Plan in 90 Days	Percentage of ACO/MCO/health plan-enrolled, BH CP assigned members with documentation of a comprehensive assessment and approval of a care plan by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to BH CP.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
11	Rate of Care Plan Completion	Percentage of ACO/MCO/health plan-enrolled, BH CP assigned member who had a completed care plan during the measurement period	H	EOHHS	N/A		Quarterly	R	R	P	P	P

LTSS CP Quality Measure Slate. ***Measures will be calculated for those CP eligible members engaged with the CP***

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Well child visits 3-6 yrs	Percentage of ACO/MCO enrollees 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	C	NCQA	1516	NCQA Quality Compass	Quarterly	R	R	P	P	P
2	Adolescent well-care visit	Percentage of ACO/MCO enrollees 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement period.	C	NCQA	N/A	NCQA Quality Compass	Quarterly	R	R	P	P	P
3	Oral Evaluation, Dental Services	Percentage of ACO/MCO enrollees under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
II. Member Experience												
A. Service Delivery			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
B. Health and Wellness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
C. Choice and Control/Consumer Voice			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
D. Effectiveness/Quality of Care			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
III. Integration												
6	Utilization of Flexible Services	Percentage of ACO-enrolled, CP-engaged members (up to age 64) recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A		Yearly	R	R	P	P	P
7	Social Service Screening	Percentage of CP-engaged members who were screened for social service needs	H	EOHHS	N/A		Yearly	R	R	P	P	P
8	Annual primary care visit	Percent of CP-engaged members who had an annual primary care visit in the last 15 months	C	EOHHS	N/A		Quarterly	R	R	P	P	P
IV. Avoidable Utilization												
9	All Cause Readmission	Risk-adjusted ratio of observed to expected ACO/MCO enrolled, CP-engaged members (up to age 64) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789	EOHHS benchmarks derived from baseline data	Quarterly	R	R	P	P	P
10	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO/MCO enrolled, CP-engaged members ages 18 to 64 per 1,000 member months.	C	3M	N/A		Quarterly	R	R	P	P	P
V. Engagement												
11	LTSS Care Plan in 90 days	Percentage of ACO/MCO enrolled, LTSS CP assigned members with documentation of a LTSS care plan that is approved by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to LTSS CP.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
5	Rate of Care Plan Completion	Percentage of ACO/MCO -enrolled, LTSS CP assigned member who had a completed care plan during the measurement period	H	EOHHS	N/A		Yearly	R	R	P	P	P

Attachment B: MassHealth 1115 Waiver Evaluation Timeline Linked to Key Milestones and DSRIP Program