FRAMEWORK FOR THE ANNUAL REPORT OF THE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) and Section 2108(e) of the Social Security Act (the Act) provide that each state and territory* must assess the operation of its state child health plan in each federal fiscal year and report to the Secretary, by January 1 following the end of the federal fiscal year, on the results of the assessment. In addition, this section of the Act provides that the state must assess the progress made in reducing the number of uncovered, low-income children. The state is out of compliance with CHIP statute and regulations if the report is not submitted by January 1. The state is also out of compliance if any section of this report relevant to the state's program is incomplete.

The framework is designed to:

- Recognize the **diversity** of state approaches to CHIP and allow states **flexibility** to highlight key accomplishments and progress of their CHIP programs, **AND**
- Provide **consistency** across states in the structure, content, and format of the report, **AND**
- Build on data **already collected** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance **accessibility** of information to stakeholders on the achievements under Title XXI

The CHIP Annual Report Template System (CARTS) is organized as follows:

- Section I: Snapshot of CHIP Programs and Changes
- Section II: Program's Performance Measurement and Progress
- Section III: Assessment of State Plan and Program Operation
- Section IV: Program Financing for State Plan
- Section V: Program Challenges and Accomplishments

* - When "state" is referenced throughout this template it is defined as either a state or a territory.

***<u>Disclosure</u>. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

DO NOT CERTIFY YOUR REPORT UNTIL ALL SECTIONS ARE COMPLETE.

State/Territory: **MA**

Name of State/Territory

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a) and Section 2108(e)).

Signature: **Alison Kirchgasser**

CHIP Program Name(s): **All, Massachusetts**

CHIP Program Type:

- ☐ CHIP Medicaid Expansion Only
- ☐ Separate Child Health Program Only
- ☒ Combination of the above

Reporting Period: **2019** **(Note: Federal Fiscal Year 2019 starts 10/1/2018 and ends 9/30/2019)**

Contact Person/Title: **Alison Kirchgasser, CHIP Director**

Address: **EOHHS, Office of Medicaid**

City: **Boston** State: **MA** Zip: **02108**

Phone: **617-573-1741** Fax:

Email: **alison.kirchgasser@state.ma.us**

Submission Date: **12/30/2019**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)

Section I. Snapshot of CHIP Program and Changes

1) To provide a summary at-a-glance of your CHIP program, please provide the following information. If you would like to make any comments on your responses, please explain in the narrative section below this table.

☒ Provide an assurance that your state's CHIP program eligibility criteria as set forth in the CHIP state plan in section 4, inclusive of PDF pages related to Modified Adjusted Gross Income eligibility, is accurate as of the date of this report.

Please note that the numbers in brackets, e.g., **[500]** are character limits in the Children's Health Insurance Program (CHIP) Annual Report Template System (CARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

CHIP Medicaid Expansion Program

Upper % of FPL (federal poverty level) fields are defined as Up to and Including

Does your program require premiums or an enrollment fee?
☒ NO
☐ YES
☐ N/A

Enrollment fee amount:
Premium fee amount:
If premiums are tiered by FPL, please breakout by FPL.

Premium Amount From ($)	Premium Amount To ($)	From % of FPL	Up to % of FPL

Yearly Maximum Premium Amount per Family: $

If premiums are tiered by FPL, please breakout by FPL.

Premium Amount From ($)	Premium Amount To ($)	From % of FPL	Up to % of FPL

Premium Amount From ($)	Premium Amount To ($)	From % of FPL	Up to % of FPL

If yes, briefly explain fee structure: **[500]**

Which delivery system(s) does your program use?

☒ Managed Care
☒ Primary Care Case Management
☒ Fee for Service

Please describe which groups receive which delivery system: **[500]**
Individuals receive FFS until they enroll with MCO/PCC, and may also receive premium wrap assistance with a FFS dental wrap.

Separate Child Health Program

Upper % of FPL (federal poverty level) fields are defined as Up to and Including

Does your program require premiums or an enrollment fee?
☐ NO
☒ YES
☐ N/A

Enrollment fee amount:
Premium fee amount:
If premiums are tiered by FPL, please breakout by FPL.

Premium Amount From ($)	Premium Amount To ($)	From % of FPL	Up to % of FPL
12	36	150	200
20	60	200	250
28	84	250	300

Yearly Maximum Premium Amount per Family: $

If premiums are tiered by FPL, please breakout by FPL.

Premium Amount From ($)	Premium Amount To ($)	From % of FPL	Up to % of FPL
	432	150	200
	720	200	250
	1008	250	300

If yes, briefly explain fee structure: **[500]**

$432 for families between 150-200% FPL, $720 for families between 200-250% FPL, $1008 for families between 250-300% FPL.

Which delivery system(s) does your program use?

☒ Managed Care
☒ Primary Care Case Management
☒ Fee for Service

Please describe which groups receive which delivery system: **[500]**
Individuals receive FFS until they enroll with MCO/PCC, and may also receive premium wrap assistance with a FFS dental wrap.

2) Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking the appropriate column.

	Medicaid Expansion CHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
b) Application	☒	☐	☐	☒	☐	☐
c) Benefits	☐	☒	☐	☐	☒	☐
d) Cost sharing (including amounts, populations, & collection process)	☐	☒	☐	☐	☒	☐
e) Crowd out policies	☐	☒	☐	☐	☒	☐

	Yes	No Change	N/A	Yes	No Change	N/A
f) Delivery system	☐	☒	☐	☐	☒	☐
g) Eligibility determination process	☒	☐	☐	☒	☐	☐
h) Implementing an enrollment freeze and/or cap	☐	☒	☐	☐	☒	☐
i) Eligibility levels / target population	☐	☒	☐	☐	☒	☐
j) Eligibility redetermination process	☐	☒	☐	☐	☒	☐
k) Enrollment process for health plan selection	☐	☒	☐	☐	☒	☐
l) Outreach (e.g., decrease funds, target outreach)	☐	☒	☐	☐	☒	☐
m) Premium assistance	☐	☒	☐	☐	☒	☐
n) Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	☐	☒	☐	☐	☒	☐
o) Expansion to "Lawfully Residing" children	☐	☒	☐	☐	☒	☐
p) Expansion to "Lawfully Residing" pregnant women	☐	☒	☐	☐	☒	☐
q) Pregnant Women state plan expansion	☐	☒	☐	☐	☒	☐
r) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐	☐	☒	☐
s) Other – please specify						
a)	☐	☐	☒	☐	☐	☒
b)	☐	☐	☒	☐	☐	☒
c)	☐	☐	☒	☐	☐	☒

3) For each topic you responded "yes" to above, please explain the change and why the change was made, below:

Medicaid Expansion CHIP Program

Topic	List change and why the change was made
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	

Topic	List change and why the change was made
b) Application	In October 2018, the paper application, (ACA-3) and the HIX online application were revised to update the list of allowable deductions. Updates were made to clarify instructions.
c) Benefits	
d) Cost sharing (including amounts, populations, & collection process)	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process	MassHealth added additional changes to Reasonable Compatibility rules for verification of income to consider income verified if both self-attested income and income returned from electronic data sources are both under applicable income thresholds.
h) Implementing an enrollment freeze and/or cap	
i) Eligibility levels / target population	
j) Eligibility redetermination process	
k) Enrollment process for health plan selection	
l) Outreach	
m) Premium assistance	
n) Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	
o) Expansion to "Lawfully Residing" children	
p) Expansion to "Lawfully Residing" pregnant women	
q) Pregnant Women State Plan Expansion	
r) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
s) Other – please specify	
a)	

Topic	List change and why the change was made
b)	
c)	

Separate Child Health Program

Topic	List change and why the change was made
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	In October 2018, the paper application, (ACA-3) and the HIX online application were revised to update the list of allowable deductions. Updates were made to clarify instructions.
c) Benefits	
d) Cost sharing (including amounts, populations, & collection process)	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process	MassHealth added additional changes to Reasonable Compatibility rules for verification of income to consider income verified if both self-attested income and income returned from electronic data sources are both under applicable income thresholds.
h) Implementing an enrollment freeze and/or cap	
i) Eligibility levels / target population	
j) Eligibility redetermination process	
k) Enrollment process for health plan selection	
l) Outreach	
m) Premium assistance	
n) Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	

Topic	List change and why the change was made
o) Expansion to "Lawfully Residing" children	
p) Expansion to "Lawfully Residing" pregnant women	
q) Pregnant Women State Plan Expansion	
r) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
s) Other – please specify	
a)	
b)	
c)	

Enter any Narrative text related to Section I below. **[7500]**

Section II Program's Performance Measurement and Progress

This section consists of two subsections that gather information about the CHIP and/or Medicaid program. Section IIA captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your state. Section IIB captures progress towards meeting your state's general strategic objectives and performance goals.

Section IIA: Enrollment And Uninsured Data

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1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in CHIP in your state for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 (Unduplicated Number Ever Enrolled Year) in your state's 4th quarter data report (submitted in October) in the CHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by CARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response. If the information displayed in the table below is inaccurate, please make any needed updates to the data in SEDS and then refresh this page in CARTS to reflect the updated data.

Program	FFY 2018	FFY 2019	Percent change FFY 2018-2019
CHIP Medicaid Expansion Program	92251	88869	-3.67
Separate Child Health Program	135568	144503	6.59

   A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent. **[7500]**

2. The tables below show trends in the number and rate of uninsured children in your state. Three year averages in Table 1 are based on the Current Population Survey. The single year estimates in Table 2 are based on the American Community Survey (ACS). CARTS will fill in the single year estimates automatically, and significant changes are denoted with an asterisk (*).If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3.

Table 1: Number and percent of uninsured children under age 19 below 200 percent of poverty, Current Population Survey

Period	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
	Number (In Thousands)	Std. Error	Rate	Std. Error
1996 - 1998	70	15.5	4.6	1.0
1998 - 2000	68	15.5	4.2	.9
2000 - 2002	40	9.9	2.6	.7
2002 - 2004	53	11.7	3.4	.7
2003 - 2005	50	11.7	3.2	.7
2004 - 2006	44	11.0	2.8	.7
2005 - 2007	36	10.0	2.3	.7
2006 - 2008	35	10.0	2.3	.6
2007 - 2009	23	8.0	1.5	.5
2008 - 2010	25	5.0	1.6	.3
2009 - 2011	28	5.0	1.8	.3
2010 - 2012	26	5.0	1.7	0

Table 2: Number and percent of uninsured children under age 19 below 200 percent of poverty, American Community Survey

Period	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
	Number (In Thousands)	Margin of Error	Rate	Margin of Error
2013	10	2.0	.7	.2
2014	11	2.0	.7	.2
2015	7	2.0	.5	.1
2016	6	2.0	.4	.2
2017	7	2.0	.5	.1
2018	8	2.0	.6	.2
Percent change 2017 vs. 2018	14.3%	N/A	20.0%	N/A

A. Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children. **[7500]**
In FFY18 Massachusetts saw a small increase in the uninsurance rate, perhaps because of uncertainty about whether the ACA would be repealed and whether CHIP would be reauthorized. Although the above table shows the insurance rate is generally holding steady for a subset of children in Massachusetts for the past few years, FFY19 saw more children gain health insurance coverage and Massachusetts is largely reported as having the highest rate of coverage in the nation as discussed in Goal 1 in Section IIB.

B. Please note any comments here concerning ACS data limitations that may affect the reliability or precision of these estimates. **[7500]**

3. Please indicate by checking the box below whether your state has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

☐ Yes (please report your data in the table below)
☒ No (skip to Question #4)

Please report your alternate data in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Topic	Description
Data source(s)	
Reporting period (2 or more points in time)	
Methodology	
Population (Please include ages and income levels)	
Sample sizes	
Number and/or rate for two or more points in time	
Statistical significance of results	

A. Please explain why your state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.
[7500]

B. What is your state's assessment of the reliability of the estimate? Please provide standard errors, confidence intervals, and/or p-values if available.
[7500]

C. What are the limitations of the data or estimation methodology?
[7500]

D. How does your state use this alternate data source in CHIP program planning?
[7500]

Enter any Narrative text related to Section IIA below. **[7500]**

Section IIB: State Strategic Objectives And Performance Goals

This subsection gathers information on your state's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your CHIP state plan. (If your goals reported in the annual report now differ from Section 9 of your CHIP state plan, please indicate how they differ in "Other Comments on Measure." Also, the state plan should be amended to reconcile these differences). The format of this section provides your state with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- CHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, data from the previous two years' annual reports (FFY 2017 and FFY 2018) will be populated with data from previously reported data in CARTS. If you reported data in the two previous years' reports and you want to update/change the data, please enter that data. If you reported no data for either of those two years, but you now have data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2019).

In this section, the term performance measure is used to refer to any data your state provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are state-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

In addition, please do not report the same data that were reported for Child Core Set reporting. The intent of this section is to capture goals and measures that your state did not report elsewhere. As a reminder, Child Core Set reporting migrated to MACPRO in December 2015. Historical data are still available for viewing in CARTS.

Additional instructions for completing each row of the table are provided below.

A. Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective. **All new goals should include a direction and a target. For clarification only, an example goal would be**: "Increase (direction) by 5 percent (target) the number of CHIP beneficiaries who turned 13 years old during the measurement year who had a second dose of MMR, three hepatitis B vaccinations and one varicella vaccination by their 13th birthday."

B. Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

- New/revised: Check this box if you have revised or added a goal. Please explain how and why the goal was revised.

- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.

- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

C. Status of Data Reported:

Please indicate the status of the data you are reporting for each goal, as follows:

- Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2019.

  Explanation of Provisional Data – When the value of the Status of Data Reported field is selected as "Provisional", the state must specify why the data are provisional and when the state expects the data will be final.

- Final: Check this box if the data you are reporting are considered final for FFY 2019.

- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your state reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

D. Measurement Specification:

This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which states may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications or some other method unrelated to HEDIS®).

Please indicate whether the measure is based on HEDIS® technical specifications or another source. If HEDIS® is selected, the HEDIS® Version field must be completed. If "Other" measurement specification is selected, the explanation field must be completed.

HEDIS® Version:
Please specify HEDIS® Version (example 2016). This field must be completed only when a user selects the HEDIS® measurement specification.

"Other" measurement specification explanation:

If "Other", measurement specification is selected, please complete the explanation of the "Other" measurement specification. The explanation field must be completed when "Other" measurement specification has been selected.

E. Data Source:

For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and CHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source (specify the other source). For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). In all cases, if another data source was used, please explain the source.

F. Definition of Population Included in Measure:

Numerator: Please indicate the definition of the population included in the numerator for each measure (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

Denominator: Please indicate the definition of the population included in the denominator for each measure.

For measures related to increasing access to care and use of preventative care, please

- Check one box to indicate whether the data are for the CHIP population only, or include both CHIP and Medicaid (Title XIX) children combined.
- If the denominator reported is not fully representative of the population defined above (the CHIP population only, or the CHIP and Medicaid (Title XIX) populations combined), please further define the denominator. For example, denominator includes only children enrolled in managed care in certain counties, technological limitations preventing reporting on the full population defined, etc.). Please report information on exclusions in the definition of the denominator (including the proportion of children excluded), The provision of this information is important and will provide CMS with a context so that comparability of denominators across the states and over time can occur.

G. Deviations from Measure Specification

For the measures related to increasing access to care and use of preventative care.

If the data provided for a measure deviates from the measure specification, please select the type(s) of measure specification deviation. The types of deviation parallel the measure specification categories for each measure. Each type of deviation is accompanied by a comment field that states must use to explain in greater detail or further specify the deviation when a deviation(s) from a measure is selected.

The five types (and examples) of deviations are:

- Year of Data (e.g., partial year),
- Data Source (e.g., use of different data sources among health plans or delivery systems),
- Numerator (e.g., coding issues),
- Denominator (e.g., exclusion of MCOs, different age groups, definition of continuous enrollment),
- Other.

When one or more of the types are selected, states are required to provide an explanation.

Please report the year of data for each performance measure. The year (or months) should correspond to the period in which enrollment or utilization took place. Do not report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

H. Date Range: available for 2019 CARTS reporting period.

Please define the date range for the reporting period based on the "From" time period as the month and year which corresponds to the beginning period in which utilization took place and please report the "To" time period as the month and year which corresponds to the end period in which utilization took place. Do not report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

I. Performance Measurement Data (HEDIS® or Other):

In this section, please report the numerators and denominators, rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on

whether you are reporting using HEDIS® or other methodologies. The form fields have been set up to facilitate entering numerators and denominators for each measure. If the form fields do not give you enough space to fully report on the measure, please use the "additional notes" section.

The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator). The reporting unit for each measure is the state as a whole. If states calculate rates for multiple reporting units (e.g., individual health plans, different health care delivery systems), states must aggregate data from all these sources into one state rate before reporting the data to CMS. In the situation where a state combines data across multiple reporting units, all or some of which use the hybrid method to calculate the rates, the state should enter zeroes in the "Numerator" and "Denominator" fields. In these cases, it should report the state-level rate in the "Rate" field and, when possible, include individual reporting unit numerators, denominators, and rates in the field labeled "Additional Notes on Measure," along with a description of the method used to derive the state-level rate.

J. Explanation of Progress:

The intent of this section is to allow your state to highlight progress and describe any quality-improvement activities that may have contributed to your progress. Any quality-improvement activity described should involve the CHIP program, benefit CHIP enrollees, and relate to the performance measure and your progress. An example of a quality-improvement activity is a state-wide initiative to inform individual families directly of their children's immunization status with the goal of increasing immunization rates. CHIP would either be the primary lead or substantially involved in the project. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality-improvement plans. In this section, your state is also asked to set annual performance objectives for FFY 2020, 2021 and 2022. Based on your recent performance on the measure (from FFY 2017 through 2019), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your state set for the year, as well as any quality-improvement activities that have helped or could help your state meet future objectives.

K. Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations, plans to report on a measure in the future, or differences between performance measures reported here and those discussed in Section 9 of the CHIP state plan.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3)

FFY 2017	FFY 2018	FFY 2019
Goal #1 (Describe) Maintain an overall children's uninsurance rate of no more than 2%	**Goal #1 (Describe)** Maintain an overall children's uninsurance rate of no more than 2%	**Goal #1 (Describe)** Maintain an overall children's uninsurance rate of no more than 1.5%.
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☒ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:* This is a new target rate for Massachusetts. We are revising the metrics in Goal 1 and Goal 2 to align more closely.
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify:* ☐ Other. *Specify:* CPS/American Community Survey for 2016	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify:* ☐ Other. *Specify:* CPS American Community Survey for 2017	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify:* ☐ Other. *Specify:* CPS/American Community Survey for 2018
Definition of Population Included in the Measure: Definition of denominator: Number of children under the age of 18 in Massachusetts Definition of numerator: Number of uninsured children in Massachusetts	**Definition of Population Included in the Measure:** Definition of denominator: Number of children age 18 and under in Massachusetts Definition of numerator: Number of uninsured children in Massachusetts	**Definition of Population Included in the Measure:** Definition of denominator: Number of children under the age of 18 in Massachusetts Definition of numerator: Number of uninsured children in Massachusetts
Date Range: **From: (mm/yyyy)** 01/2016 **To: (mm/yyyy)** 12/2016	**Date Range:** **From: (mm/yyyy)** 01/2017 **To: (mm/yyyy)** 12/2017	**Date Range:** **From: (mm/yyyy)** 01/2018 **To: (mm/yyyy)** 12/2018
Performance Measurement Data: Described what is being measured: The uninsurance rate for children under 18 in Massachusetts Numerator: 12709 Denominator: 1375244 Rate: 0.9	**Performance Measurement Data:** Described what is being measured: The uninsurance rate for children 18 and under in Massachusetts Numerator: 21885 Denominator: 1478961 Rate: 1.5	**Performance Measurement Data:** Described what is being measured: The uninsurance rate for children under 18 in Massachusetts Numerator: 17956 Denominator: 1470670 Rate: 1.2
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** The uninsurance rate for children under 18 decreased from 1.2% to .9%	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** The uninsurance rate increased slightly which, as noted in Section IIA, may be due to uncertainty about whether the ACA would be repealed and whether CHIP would be reauthorized. Additionally, this year's data includes 18 year olds, whereas the ACS data in previous years only included children up to age 17. However, the uninsurance rate still meets the goal of under 2%.	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** The uninsurance rate for children under 18 decreased from 1.5% to 1.2%
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children under 18 of no more than 2%. **Annual Performance Objective for FFY 2019:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children under 18 of no more than 2%. **Annual Performance Objective for FFY 2020**: Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children under 18 of no more than 2%. *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children 18 and under of no more than 2%. **Annual Performance Objective for FFY 2020:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children 18 and under of no more than 2%. **Annual Performance Objective for FFY 2021:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children 18 and under of no more than 2%. *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children 18 and under of no more than 1.5%. **Annual Performance Objective for FFY 2021:** Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children 18 and under of no more than 1.5%. **Annual Performance Objective for FFY 2022**: Massachusetts will continue efforts to enroll every child eligible for health insurance and as a result will maintain an uninsurance rate among children 18 and under of no more than 1.5%. *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3) (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #2 (Describe) Maintain or reduce the uninsurance rate for Hispanic children under the age of 18 at or below 1%	**Goal #2 (Describe)** Maintain or reduce the uninsurance rate for Hispanic children age 18 or under at or below 2%	**Goal #2 (Describe)** Maintain or reduce the uninsurance rate for Hispanic children under the age of 18 at or below 1.5%
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☒ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:* This is a new target rate for Massachusetts. We are revising the metrics in Goal 1 and Goal 2 to align more closely.
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify:* ☐ Other. *Specify:* US Census Bureau, 2016 American Community Survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify:* ☐ Other. *Specify:* US Census Bureau, 2017 American Community Survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify:* ☐ Other. *Specify:* US Census Bureau, 2018 American Community Survey
Definition of Population Included in the Measure: Definition of denominator: Number of Hispanic children under 18 in MA Definition of numerator: Number of uninsured Hispanic children under 18 in MA	**Definition of Population Included in the Measure:** Definition of denominator: Number of Hispanic children age 18 or under in MA Definition of numerator: Number of uninsured Hispanic children age 18 or under in MA	**Definition of Population Included in the Measure:** Definition of denominator: Number of Hispanic children age 18 or under in MA Definition of numerator: Number of uninsured Hispanic children in MA
Date Range: **From: (mm/yyyy)** 01/2016 **To: (mm/yyyy)** 12/2016	**Date Range:** **From: (mm/yyyy)** 01/2017 **To: (mm/yyyy)** 12/2017	**Date Range:** **From: (mm/yyyy)** 01/2018 **To: (mm/yyyy)** 12/2018
Performance Measurement Data: Described what is being measured: The uninsurance rate for Hispanic children in MA Numerator: 3411 Denominator: 243853 Rate: 1.4	**Performance Measurement Data:** Described what is being measured: The uninsurance rate for Hispanic children in MA Numerator: 5893 Denominator: 267249 Rate: 2.2	**Performance Measurement Data:** Described what is being measured: The uninsurance rate for Hispanic children in MA Numerator: 5293 Denominator: 273165 Rate: 1.9
Additional notes on measure:	**Additional notes on measure**:	**Additional notes on measure:**

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** The uninsurance rate for this population increased slightly so we did not meet this goal this year. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Given the increase in uninsurance in this population, we will work on targeted outreach strategies for this population.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** The uninsurance rate for this population increased slightly which, as noted in Section IIA, may be due to uncertainty about whether the ACA would be repealed and whether CHIP would be reauthorized. Additionally, this year's data includes 18 year olds, whereas the ACS data in previous years only included children up to age 17. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** The uninsurance rate for this population improved and we came closer to meeting this goal this year. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** We will work on targeted outreach strategies for this population.
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** Reduce the uninsurance rate for Hispanic children under the age of 18 to at or below 1%. **Annual Performance Objective for FFY 2019:** Reduce the uninsurance rate for Hispanic children under the age of 18 to at or below 1%. **Annual Performance Objective for FFY 2020:** Reduce the uninsurance rate for Hispanic children under the age of 18 to at or below 1%. *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** Reduce the uninsurance rate for Hispanic children age 18 or under to at or below 2% **Annual Performance Objective for FFY 2020:** Reduce the uninsurance rate for Hispanic children age 18 or under to at or below 2% **Annual Performance Objective for FFY 2021:** Reduce the uninsurance rate for Hispanic children age 18 or under to at or below 2% *Explain how these objectives were set:* The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** Reduce the uninsurance rate for Hispanic children under the age of 18 to at or below 1.5%. **Annual Performance Objective for FFY 2021:** Reduce the uninsurance rate for Hispanic children under the age of 18 to at or below 1.5%. **Annual Performance Objective for FFY 2022:** Reduce the uninsurance rate for Hispanic children under the age of 18 to at or below 1.5%. Explain how these objectives were set: The Commonwealth will continue to maximize its efforts to enroll every eligible child in health insurance. Despite these efforts, it is likely there will always be a small percentage of the population that reports being uninsured, and the uninsurance rate may also fluctuate depending on economic conditions. The Commonwealth may need to reevaluate this goal each year, and will adjust it as more data becomes available regarding the theoretical floor for the rate of uninsurance among children.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3) (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify:* ☐ Other. *Specify:*
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019**: **Annual Performance Objective for FFY 2020**: *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** **Annual Performance Objective for FFY 2020:** **Annual Performance Objective for FFY 2021:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** **Annual Performance Objective for FFY 2021:** **Annual Performance Objective for FFY 2022:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure**:

Objectives Related to CHIP Enrollment

FFY 2017	FFY 2018	FFY 2019
Goal #1 (Describe) Maintain or increase the number of ACA Certified Application Counselor (CAC) Assister sites at 100 or higher statewide.	**Goal #1 (Describe)** Maintain or increase the number of Affordable Care Act (ACA) Certified Application Counselor (CAC) Assister sites at 100 or higher statewide.	**Goal #1 (Describe)** Maintain or increase the number of Affordable Care Act (ACA) Certified Application Counselor (CAC) Assister sites at 100 or higher statewide.
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☒ Other. *Specify:* Records kept by Executive Office of Health and Human Services, the Massachusetts Health Connector, and the Office of Medicaid.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☒ Other. *Specify:* Records kept by Executive Office of Health and Human Services, the Massachusetts Health Connector and Office of Medicaid.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☒ Other. *Specify:* Records kept by Executive Office of Health and Human Services, the Massachusetts Health Connector, and the Office of Medicaid.
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY17.	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY18.	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY19.
Date Range: **From: (mm/yyyy)** 10/2016 **To: (mm/yyyy)** 09/2017	**Date Range:** **From: (mm/yyyy)** 10/2017 **To: (mm/yyyy)** 09/2018	**Date Range:** **From: (mm/yyyy)** 10/2018 **To: (mm/yyyy)** 09/2019
Performance Measurement Data: Described what is being measured: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY17. Numerator: 232 Denominator: 0 Rate:	**Performance Measurement Data:** Described what is being measured: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY18. Numerator: 251 Denominator: 0 Rate:	**Performance Measurement Data:** Described what is being measured: The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY19. Numerator: 264 Denominator: 0 Rate:

FFY 2017	FFY 2018	FFY 2019
Additional notes on measure:	**Additional notes on measure:** The number of organizations meeting this standard went from 232 as of 9/30/17 to 251 as of 9/30/18.	**Additional notes on measure:** The number of organizations meeting this standard went from 251 as of 9/30/18 to 264 as of 9/30/19
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** The number of organizations meeting this standard went from 250 as of 9/30/16 to 232 as of 9/30/17. While there was a bit of a decrease, the number of CAC organizations throughout the Commonwealth far surpass this particular goal of 100. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** The number of organizations meeting this standard increased from 232 as of 9/30/17 to 251 as of 9/30/18. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** The number of organizations meeting this standard went from 251 as of 9/30/18 to 264 as of 9/30/19 **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2019:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2020:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This goal is part of MassHealth's mission to screen and enroll all individuals who may be eligible, to simplify and streamline the application process, and to increase the efficiency of MassHealth operations.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2020:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2021:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This goal is part of MassHealth's mission to screen and enroll individuals who may be eligible, to simplify and streamline the application process, and to increase the efficiency of MassHealth operations.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2021:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2022:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This goal is part of MassHealth's mission to screen and enroll all individuals who may be eligible, to simplify and streamline the application process, and to increase the efficiency of MassHealth operations.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #2 (Describe) Maintain or increase the percentage of CHIP children enrolled in premium assistance at 10% or more of overall MassHealth CHIP child enrollment.	**Goal #2 (Describe)** Maintain or increase the percentage of CHIP children enrolled in premium assistance at 2.5% or more of overall MassHealth CHIP child enrollment.	**Goal #2 (Describe)** Maintain or increase the percentage of CHIP children enrolled in premium assistance at 2.5% or more of overall MassHealth CHIP child enrollment.
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☒ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:* Decreased goal due to result last year which reflects new way of looking at the data.	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*
Definition of Population Included in the Measure: Definition of denominator: All children ever enrolled in CHIP during the fiscal year Definition of numerator: All CHIP children in premium assistance during the fiscal year	**Definition of Population Included in the Measure:** Definition of denominator: All children ever enrolled in CHIP during the fiscal year. Definition of numerator: All CHIP children in premium assistance during the fiscal year.	**Definition of Population Included in the Measure:** Definition of denominator: All children ever enrolled in CHIP during the fiscal year Definition of numerator: All CHIP children ever enrolled in CHIP Premium Assistance during the fiscal year
Date Range: **From: (mm/yyyy)** 10/2016 **To: (mm/yyyy)** 09/2017	**Date Range:** **From: (mm/yyyy)** 10/2017 **To: (mm/yyyy)** 09/2018	**Date Range:** **From: (mm/yyyy)** 10/2018 **To: (mm/yyyy)** 09/2019
Performance Measurement Data: Described what is being measured: The percentage of CHIP children who were enrolled in Premium Assistance Numerator: 4733 Denominator: 220128 Rate: 2.2	**Performance Measurement Data:** Described what is being measured: The percentage of CHIP children who were enrolled in premium assistance. Numerator: 5644 Denominator: 227819 Rate: 2.5	**Performance Measurement Data:** Described what is being measured: The percentage of CHIP children who were enrolled in Premium Assistance Numerator: 7607 Denominator: 233372 Rate: 3.3

FFY 2017	FFY 2018	FFY 2019
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** We were unable to report on this measure last year due to data issues. In looking at the rate for FFY15, it appears we used the number of all children (both Medicaid and CHIP) on premium assistance for the numerator and just CHIP enrolled children for the denominator resulting in an artificially high rate of 15%. Since CHIP children by definition must be uninsured upon enrollment and since the only CHIP children in premium assistance are those for whom we found access to insurance during an investigation, it is not surprising that the rate of CHIP children in premium assistance is low. Therefore we will revise this goal for next year. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The Commonwealth's efforts towards universal coverage continue to succeed despite increases in health insurance premiums. Providing subsidies to employees so that they can participate in their employer-sponsored insurance is a valuable and cost-effective tool for MassHealth in decreasing uninsurance and increasing enrollment in health insurance of children-particularly within higher income ranges. Enrollment in employer sponsored insurance in Massachusetts continues to be strong and has remained steady since the implementation of health care reform, showing no signs that MassHealth has crowded out private insurance.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** We changed the goal to reflect the more accurate picture of CHIP member enrollment in premium assistance. In years prior to FFY16, it appears the premium assistance CHIP enrollment number was overstated to include both Medicaid and CHIP members. Since CHIP children by definition must be uninsured upon enrollment and since the only CHIP children in premium assistance are those for whom we found access to insurance during an investigation, it is not surprising that the rate of CHIP children in premium assistance is low. We set this year's goal to be slightly higher than the result from FFY17 and met this new goal. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The Commonwealth's efforts towards universal coverage continue to succeed despite increases in health insurance premiums. Providing subsidies to employees so that they can participate in their employer-sponsored insurance is a valuable and cost-effective tool for MassHealth in decreasing uninsurance and increasing enrollment in health insurance of children-particularly within higher income ranges. Enrollment in employer sponsored insurance in Massachusetts continues to be strong and has remained steady since the implementation of health care reform, showing no signs that MassHealth has crowded out private insurance.	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** The performance in 2019 was better than in 2018 as the percentage of CHIP children enrolled in Premium Assistance increased from 2.5% to 3.3%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The Commonwealth's efforts towards universal coverage continue to succeed despite increases in health insurance premiums. Providing subsidies to employees so that they can participate in their employer-sponsored insurance is a valuable and cost-effective tool for MassHealth in decreasing uninsurance and increasing enrollment in health insurance of children-particularly within higher income ranges. Enrollment in employer sponsored insurance in Massachusetts continues to be strong and has remained steady since the implementation of health care reform, showing no signs that MassHealth has crowded out private insurance.

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** MassHealth will continue to maintain our efforts to maximize employer-sponsored insurance for our members. As described above, we will revise the goal for next year to be that the approximate proportion of CHIP children enrolled in premium assistance will continue to be above 2%. **Annual Performance Objective for FFY 2019:** Maintain the approximate proportion of CHIP children enrolled in premium assistance above 2%. **Annual Performance Objective for FFY 2020:** Maintain the approximate proportion of CHIP children enrolled in premium assistance above 2%. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to maximize private insurance by identifying applicants with access to employer-sponsored insurance and requiring enrollment in such insurance.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** MassHealth will continue our efforts to maximize employer-sponsored insurance for our members and will maintain the approximate proportion of CHIP children enrolled in premium assistance at or above 2.5%. **Annual Performance Objective for FFY 2020:** Maintain the approximate proportion of CHIP children enrolled in premium assistance at or above 2.5%. **Annual Performance Objective for FFY 2021:** Maintain the approximate proportion of CHIP children enrolled in premium assistance at or above 2.5%. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to maximize private insurance by identifying applicants with access to employer-sponsored insurance and requiring enrollment in such insurance.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** MassHealth will continue our efforts to maximize employer-sponsored insurance for our members and will maintain the approximate proportion of CHIP children enrolled in premium assistance at or above 2.5% **Annual Performance Objective for FFY 2021:** MassHealth will continue our efforts to maximize employer-sponsored insurance for our members and will maintain the approximate proportion of CHIP children enrolled in premium assistance at or above 2.5% **Annual Performance Objective for FFY 2022:** MassHealth will continue our efforts to maximize employer-sponsored insurance for our members and will maintain the approximate proportion of CHIP children enrolled in premium assistance at or above 2.5% *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #3 (Describe) Maintain or increase the number of ACA Certified Application Counselor (CAC) Assisters at 1,000 individuals or more statewide.	**Goal #3 (Describe)** Maintain or increase the number of ACA Certified Application Counselor (CAC) Assisters at 1,000 individuals or more statewide.	**Goal #3 (Describe)** Maintain or increase the number of ACA Certified Application Counselor (CAC) Assisters at 1,000 individuals or more statewide.
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☒ Other. *Specify:* Records kept by Executive Office of Health and Human Services, the Health Connector, and the Office of Medicaid.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☒ Other. *Specify:* Records kept by Executive Office of Health and Human Services, the Health Connector, and the Office of Medicaid.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☒ Other. *Specify:* Records kept by Executive Office of Health and Human Services, the Health Connector, and the Office of Medicaid.
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: The number of ACA Certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper.	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: The number of ACA Certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper.	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: The number of ACA Certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper
Date Range: **From: (mm/yyyy)** 10/2016 **To: (mm/yyyy)** 09/2017	**Date Range:** **From: (mm/yyyy)** 10/2017 **To: (mm/yyyy)** 09/2018	**Date Range:** **From: (mm/yyyy)** 10/2018 **To: (mm/yyyy)** 09/2019

FFY 2017	FFY 2018	FFY 2019
Performance Measurement Data: Described what is being measured: The number of ACA Certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper. Numerator: 1437 Denominator: 0 Rate:	**Performance Measurement Data:** Described what is being measured: The number of ACA Certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper. Numerator: 1214 Denominator: 0 Rate:	**Performance Measurement Data:** Described what is being measured: The number of ACA Certified Application Counselor Assisters throughout Massachusetts that have met CAC training and contractual requirements and have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper. Numerator: 1515 Denominator: 0 Rate:
Additional notes on measure: We discovered the metric supplied for this goal since FFY 2014 has been slightly off from the actual number for the time period covered in this report. Revised numbers are 1268 for FFY 14, 1484 for FFY15 and 1495 for FFY16.	**Additional notes on measure:**	**Additional notes on measure:** Number of CACs throughout Massachusetts that have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper increased from 1,214 in FFY2018, to 1,515 in FFY2019.
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** Number of CACs throughout Massachusetts that have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper changed from 1495 immediately before the start of FFY2017, to 1437 as of 9/30/2017. While there was a slight decrease this year compared to FFY16, it is normal for the number of certified individuals to fluctuate up or down throughout the year, this change is well within our expectations, and the number of individuals serving as CACs throughout the Commonwealth continues to hold steady and far surpasses the goal of 1,000. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** Number of CACs throughout Massachusetts that have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper changed from 1437 immediately before the start of FFY2018, to 1214 as of 9/30/2018. While there was a decrease this year compared to FFY17, it is normal for the number of certified individuals to fluctuate up or down throughout the year, this change is well within our expectations, and the number of individuals serving as CACs throughout the Commonwealth continues to hold steady and surpasses the goal of 1,000. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** Number of CACs throughout Massachusetts that have the capability to assist in submitting an electronic application on the ACA's HIX website, or via paper increased from 1,214 in FFY2018, to 1,515 in FFY2019. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The effort to continuously increase the number of CACs statewide has the capacity to increase access to and enrollment in health programs for children.

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2019:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2020:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to enroll all eligible individuals, to ease the application and renewal processes for our members, and to expand access to the most up-to-date web-based enrollment	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2020:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2021:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to enroll all eligible individuals, to ease the application and renewal processes for our members, and to expand access to the most up-to-date web-based enrollment.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2021:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. **Annual Performance Objective for FFY 2022:** We will continue to devote resources in order to maintain or increase the number of web-based health benefit application Assisters, known as "CACs" under the Affordable Care Act. *Explain how these objectives were set:* This objective was set as part of MassHealth's commitment to enroll all eligible individuals, to ease the application and renewal processes for our members, and to expand access to the most up-to-date web-based enrollment resources available to the community.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment

FFY 2017	FFY 2018	FFY 2019
Goal #1 (Describe) Since Massachusetts has a joint application for its Medicaid and CHIP programs, collectively known as MassHealth and applications for both programs can be submitted through the Virtual Gateway, all "Objectives Related to CHIP Enrollment" apply to "Objectives Related to Medicaid Enrollment" also.	**Goal #1 (Describe)**	**Goal #1 (Describe)** Since Massachusetts has a joint application for its Medicaid and CHIP programs, collectively known as MassHealth and applications for both programs can be submitted through the HIX, all "Objectives Related to CHIP Enrollment" apply to "Objectives Related to Medicaid Enrollment" also.
Type of Goal: ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019:** **Annual Performance Objective for FFY 2020:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** **Annual Performance Objective for FFY 2020:** **Annual Performance Objective for FFY 2021:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** **Annual Performance Objective for FFY 2021:** **Annual Performance Objective for FFY 2022:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*	Type of Goal: ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019:** **Annual Performance Objective for FFY 2020:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** **Annual Performance Objective for FFY 2020:** **Annual Performance Objective for FFY 2021:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** **Annual Performance Objective for FFY 2021:** **Annual Performance Objective for FFY 2022:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify:* ☐ Other. *Specify:*
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** **Annual Performance Objective for FFY 2019:** **Annual Performance Objective for FFY 2020:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** **Annual Performance Objective for FFY 2020:** **Annual Performance Objective for FFY 2021:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** **Annual Performance Objective for FFY 2021:** **Annual Performance Objective for FFY 2022:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2017	FFY 2018	FFY 2019
Goal #1 (Describe) Improve the percentage of women with a live birth in the reporting period and who had a prenatal care visit in the first trimester, or within 42 days of enrollment to the 2017 National Medicaid 90th percentile rate of 91.67%	**Goal #1 (Describe)** Improve the percentage of women with a live birth in the reporting period and who had a prenatal care visit in the first trimester, or within 42 days of enrollment to the 2018 National Medicaid 90th percentile rate of 90.75%	**Goal #1 (Describe)** Improve the percentage of women with a live birth in the reporting period and who had a prenatal care visit in the first trimester, or within 42 days of enrollment to the 2019 National Medicaid 90th percentile rate of 91.0%
Type of Goal: ☒ New/revised. *Explain:* ☐ Continuing. ☐ Discontinued. *Explain:* New goal related to perinatal care services, in substitution for the goal related to frequency of prenatal care that was in the FFY 2016 report, as NCQA has removed the frequency of prenatal care from HEDIS 2018.	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒ HEDIS. *Specify version of HEDIS used:* 2017 ☐ Other. *Explain*:	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2018 ☐ Other. *Explain*:	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2019 ☐ Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2017	FFY 2018	FFY 2019
Definition of Population Included in the Measure: Definition of numerator: Women with a qualifying prenatal care visit in the required timeframes Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.	**Definition of Population Included in the Measure:** Definition of numerator: Women with a qualifying prenatal care visit in the required timeframes Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes members not enrolled in the PCC Plan, MCOs, or in OneCare	**Definition of Population Included in the Measure:** Definition of numerator: Women with a qualifying prenatal care visit in the required timeframes Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.
Date Range: **From: (mm/yyyy)** 11/2015 **To: (mm/yyyy)** 11/2016	**Date Range:** **From: (mm/yyyy)** 11/2016 **To: (mm/yyyy)** 11/2017	**Date Range:** **From: (mm/yyyy)** 11/2017 **To: (mm/yyyy)** 11/2018
HEDIS Performance Measurement Data: *(If reporting with HEDIS)* Numerator: 18618 Denominator: 21088 Rate: 88.3	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 16932 Denominator: 19573 Rate: 86.5	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 8612 Denominator: 10214 Rate: 84.13
Deviations from Measure Specifications: ☐ Year of Data, *Explain.* ☐ Data Source, *Explain.* ☐ Numerator, *Explain.* ☐ Denominator, *Explain.* ☐ Other, *Explain.*	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain.* ☐ Data Source, *Explain.* ☐ Numerator, *Explain.* ☐ Denominator, *Explain.* ☐ Other, *Explain.*	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain.* ☐ Data Source, *Explain.* ☐ Numerator, *Explain.* ☐ Denominator, *Explain.* ☐ Other, *Explain.*
Additional notes on measure:	**Additional notes on measure**:	**Additional notes on measure**:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** Not applicable - new goal **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on all measures for which performance goals were set in the FFY 2015 and 2016 CHIP report. In the past year, the group has worked to draft two materials designed to support pregnant members to access prenatal care early, and supporting providers in helping make connections for their members with community-based resources related to pregnancy and MCH care. We expect these materials to be finalized and disseminated in the upcoming year. Though the group was working to support improvement on the Frequency of Perinatal Care measure, we are aware that NCQA will not include this measure in HEDIS 2018. As the materials in development are designed to support both early and frequent access to prenatal care, they are likely to also be impactful for the Timeliness of Prenatal Care measure that is replacing the frequency of prenatal care goal in this CHIP report.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** This year's reported rate is lower than last year's reported rate of 88.3%. It is important to note that the national benchmark also declined. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth has convened an Internal Pediatric Q1 workgroup to identify and implement activities to support improved performance on all measures for which performance goals were set in the FFY 2015, 2016, and 2017 CHIP report. In the past year, the group completed work on two materials designed to support pregnant members to access prenatal care early, and supporting providers in helping make connections for their members with community-based resources related to pregnancy and MCH care, and these materials are now posted on the MassHealth website. In addition to the quality improvement activities listed above, the Prenatal and Postpartum Care HEDIS measure (PPC) is part of the ACO, MCO, and PCC Plan 2019 performance measure slates (measurement period –CY 2018). For the ACO program, the PPC measure is one of several measures that factor into an overall ACO DSRIP accountability scores which are used to determine ACO payments.	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** This year's reported rate of 84.3% is lower than last year's reported rate of 86.5%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth serves on an advisory committee for the MA Perinatal Neonatal Quality Improvement Network with summits held twice a year discussing diverse maternal health topics for QI across the state. Through a Pediatric and Perinatal QIP, a toolkit for practices and providers was developed incorporating CAC, midwife, and EIPP feedback. Materials have been designed to support pregnant members' access to prenatal care early and to support providers in helping make connections for their members with community-based resources related to pregnancy and MCH care. In addition to the QI activities listed above, the PPC measure is part of the ACO, MCO, and PCC Plan 2019 performance measure slates, measurement period – CY 2018. Past performance has been based on plan HEDIS rates. 2019 (CY2018) performance was the first year of data collection from the ACO program. Higher than normal churn in the marketplace (for members transitioning to the ACO program, effective March 2018),changes(cont'd below)

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** national Medicaid 90th percentile for HEDIS 2018 **Annual Performance Objective for FFY 2019:** national Medicaid 90th percentile for HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile for HEDIS 2020 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** National Medicaid HEDIS 90th percentile for HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid HEDIS 90th percentile for HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid HEDIS 90th percentile for HEDIS 2021 *Explain how these objectives were set:* MassHealth has identified the National Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** National Medicaid HEDIS 90th percentile for HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid HEDIS 90th percentile for HEDIS 2021 **Annual Performance Objective for FFY 2022:** National Medicaid HEDIS 90th percentile for HEDIS 2022 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:** Add'l notes on QI: in data collection approach, as well as reductions in sample size/populations may be factors contributing to the variation in rate performance. For the ACO program, the PPC measure is part of the ACO pay-for-performance measure slate that will be used to calculate a quality score impacting state DSRIP and individual ACO payments. MassHealth is also planning periodic convening of an external committee of ACO/MCO medical directors for CY 2020 focused on quality performance.

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FY 2017	FFY 2018	FFY 2019
Goal #2 (Describe) Maintain or improve the percentage of children aged 6-20 who were discharged from a hospital for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 7 days of discharge at a level which meets or exceeds the 2017 national Medicaid 90th percentile rate of 65%.	**Goal #2 (Describe)** Maintain or improve the percentage of children aged 6-20 who were discharged from a hospital for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 7 days of discharge at a level which meets or exceeds the 2018 national Medicaid 90th percentile rate of 54.13%	**Goal #2 (Describe)** Maintain or improve the percentage of children aged 6-20 who were discharged from a hospital for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 7 days of discharge at a level which meets or exceeds the 2019 national Medicaid 90th percentile rate of 51.7%.
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒ HEDIS. *Specify version of HEDIS used:* 2017 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2018 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2019 ☐ Other. *Explain:*
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*

FY 2017	FFY 2018	FFY 2019
Definition of Population Included in the Measure: Definition of numerator: Percentage of the denominator eligible group of children who had an outpatient visit, and intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 7 days of discharge Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.	**Definition of Population Included in the Measure:** Definition of numerator: Percentage of the denominator eligible group of children who had an outpatient visit, and intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 7 days of discharge. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes members not enrolled in the PCC Plan	**Definition of Population Included in the Measure:** Definition of numerator: Percentage of the denominator eligible group of children who had an outpatient visit, and intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 7 days of discharge Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.
Date Range: **From: (mm/yyyy)** 01/2016 **To: (mm/yyyy)** 12/2016	**Date Range:** **From: (mm/yyyy)** 01/2017 **To: (mm/yyyy)** 12/2017	**Date Range:** **From: (mm/yyyy)** 01/2018 **To: (mm/yyyy)** 12/2018
HEDIS Performance Measurement Data: *(If reporting with HEDIS)* Numerator: 1717 Denominator: 2578 Rate: 66.6	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 1265 Denominator: 2219 Rate: 57	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 1000 Denominator: 1813 Rate: 55.2
Deviations from Measure Specifications: ☐ Year of Data, *Explain.* ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐Denominator, *Explain.* ☐ Other, *Explain*.
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**

FY 2017	FFY 2018	FFY 2019
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** A performance rate of 68% for this measure was reported in the 2016 Annual Report. This year's rate is 66.6%. Although the rate decreased, it is above the 90th percentile goal for 2017 of 65%. Due to the decrease in the rate since last year, it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth (MH) convened an internal Pediatric QI wrkgrp to id & implement activities to support improved performance on this measure & all measures for which performance goals were set. MH supports improvement on this measure through a Pay 4 Performance initiative with its PCC Plan behav hlth mngd care vendor. In 2016, the vendor reviewed data on follow-up visit rates for children & implemented a process where care mngrs working w/ chldrn w/ serious emotional disturbance received notification when 1 of their enrolled members was hospitalized for a BH condition, in order to support the care mngr's ability to facilitate arrangements for timely F/U after discharge. This process remains in place & the vendor is monitoring the impact on F/U visit rates for the children impacted by the process change. (Cont. in next box)	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** This year's reported rate is lower than the last reported rate of 66.6%, however, the measure specifications for the numerator changed since last year. Additionally, the national benchmark demonstrated a similar decline from last year's benchmark measure. MA's rates on this measure remain above the 90th percentile. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** This measure is a P4P measure focus area for the PCC Plan's Behavioral Health Managed Care Entity, and is also included in the Performance Measure slate for MassHealth's ACO program.	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** This year's reported rate of 55.2% is lower than the last reported rate of 57.0%. Additionally, the national benchmark demonstrated a similar decline from last year's benchmark for this measure. MA's rates on this measure remain above the 90th percentile. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** This measure is a P4P measure focus area for the PCC Plan's Behavioral Health Managed Care Entity and also included in the Performance Measure slate for MassHealth's ACO program. In addition, behavioral health coordination and integration is a performance improvement project (PIP) focus for ACO and MCOs. QI planning and projects around discharge and follow up with mental health providers have been identified. To support the program QI efforts, MassHealth's internal Clinical Quality Improvement team is actively planning the periodic convening of an external committee of MCO/ACO medical directors for the next year (CY 2020) that will be focused on quality performance and performance.

FY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018**: The vendor also supports best practice sharing among inpatient providers on ways to support F/U visits being made as part of discharge planning through facilitating discussions at regular meetings the vendor holds with these providers. National Medicaid 90th percentile rate, HEDIS 2018. **Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile rate, HEDIS 2019. **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile rate, HEDIS 2020. *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** National Medicaid HEDIS 90th percentile rate HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid HEDIS 90th percentile rate HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid HEDIS 90th percentile rate HEDIS 2021 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020**: National Medicaid HEDIS 90th percentile rate HEDIS 2020 A**nnual Performance Objective for FFY 2021:** National Medicaid HEDIS 90th percentile rate HEDIS 2021 **Annual Performance Objective for FFY 2022:** National Medicaid HEDIS 90th percentile rate HEDIS 2022 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #3 (Describe) Increase the percentage of children newly prescribed ADHD medication who had at least three follow-up visits in a 10 month period (continuation phase) to meet or exceed the 2017 national Medicaid 90th percentile rate of 69.47%	**Goal #3 (Describe)** Increase the percentage of children newly prescribed ADHD medication who had at least three follow-up visits in a 10 month period (continuation phase) to meet or exceed the 2018 national Medicaid 90th percentile rate of 69.14%.	**Goal #3 (Describe)** Increase the percentage of children newly prescribed ADHD medication who had at least three follow-up visits in a 10 month period (continuation phase) to meet or exceed the 2019 national Medicaid 90th percentile rate of 69.15%
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒ HEDIS. *Specify version of HEDIS used:* 2017 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2018 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2019 ☐ Other. *Explain:*
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*
Definition of Population Included in the Measure: Definition of numerator: Percent of denominator-eligible children who remained on the medication the required length of time, and, in addition to the initial follow-up visit, had 2 additional visits in the 10 month period following the qualifying prescription. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.	**Definition of Population Included in the Measure:** Definition of numerator: Percent of denominator-eligible children who remained on the medication the required length of time, and in addition to the initial follow-up visit had 2 additional visits in the 10 month period following the qualifying prescription. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes MassHealth members not enrolled in MassHealth managed care plans (MCOs and PCC Plan)	**Definition of Population Included in the Measure:** Definition of numerator: Percent of denominator-eligible children who remained on the medication the required length of time, and, in addition to the initial follow-up visit, had 2 additional visits in the 10 month period following the qualifying prescription. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.

FFY 2017	FFY 2018	FFY 2019
Date Range: **From: (mm/yyyy)** 01/2016 **To: (mm/yyyy)** 12/2016	**Date Range:** **From: (mm/yyyy)** 01/2017 **To: (mm/yyyy)** 12/2017	**Date Range:** **From: (mm/yyyy)** 01/2018 **To: (mm/yyyy)** 12/2018
HEDIS Performance Measurement Data: *(If reporting with HEDIS)* Numerator: 816 Denominator: 1232 Rate: 66.2	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 852 Denominator: 1361 Rate: 62.6	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 320 Denominator: 514 Rate: 62.3
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain.* ☐ Other, *Explain*.
Additional notes on measure:	**Additional notes on measure**:	**Additional notes on measure:**
Other Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** A performance rate of 67.6% for this measure was reported in the 2016 Annual Report. This year's rate is 66.2%. The rate declined since last year and falls below the benchmark set for this goal – which is the 90th percentile for HEDIS 2017 national Medicaid (69.47%). Thus, it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. This year, and adding to activities undertaken over the past year, MassHealth gathered ideas from providers working on the ADHD measure, and is currenly drafting a resource for primary care providers who are looking to make improvements in their rates of ADHD medication follow-up visits. The resource includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. These activities will be finalized after the measurement period being examined as part of this measure.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** In the 2017 Annual Report, MassHealth reported a performance rate of 66.2%. This year's rate is 62.6%. The MassHealth rate declined since last year and falls below the benchmark set for this goal – which is the 90th percentile for HEDIS 2018 national Medicaid (69.14%). Thus it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. This year, and adding to activities undertaken over the past year, MassHealth gathered ideas from providers working on the ADHD measure, and is currently drafting a resource for primary care providers who are looking to make improvements in their rates of ADHD medication follow-up visits. The resource includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. These activities will be finalized after the measurement period being examined as part of this measure. (continued below)	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** In the 2018 Annual Report, MassHealth reported a performance rate of 62.6%. This year's rate is 62.3%. The MassHealth rate declined slightly and may be due to variation. The benchmark set for this goal – which is the 90th percentile for HEDIS 2019 national Medicaid has not notably changed (69.14% to 69.15%), and thus it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Last year through the internal Perdiatric QI workgroup, MassHealth gathered ideas from providers working on the ADHD measure, and was in process (into this year) of drafting a resource for primary care providers who are looking to make improvements in their rates of ADHD medication follow-up visits. The resource includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. MassHealth continues to collect and monitor the ADHD (continuation) measure through its annual HEDIS data collection.The 2019 HEDIS cycle includes, MCO, a subset of the ACO, and the PCC Plan populations. MassHealth will also continue to report the ADHD (continuation) as a Child (continued below)

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** National Medicaid 90th percentile rate, HEDIS 2018 **Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile rate, HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile rate, HEDIS 2020 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile rate, HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile rate, HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid 90th percentile rate, HEDIS 2021 *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile rate, HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid 90th percentile rate, HEDIS 2021 **Annual Performance Objective for FFY 2022:** National Medicaid 90th percentile rate, HEDIS 2022 *Explain how these objectives were set:* The Medicaid 90th percentile has been determined to be an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:** Additional explanation of quality improvement activities: In addition to the QI activities mentioned above, MassHealth intends to continue to collect and monitor the ADD (continuation) measure through its annual HEDIS data collection. The 2019 HEDIS cycle includes MCO, a subset of the ACO, and the PCC Plan populations. MassHealth will also continue to report the ADD (continuation) as a Child Core Measure.	**Other Comments on Measure:** Additional notes on quality improvement activities: Core Measure. The ADHD measure is part of the ACO pay-for-performance measure slate that will be used to calculate a quality score impacting state DSRIP and individual ACO payments. To support the program QI efforts, MassHealth's internal Clinical Quality Improvement team is actively planning to periodically convene an external committee of ACO and MCO medical directors for the next year (CY 2020)that will be focused on quality performance.

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2017	FFY 2018	FFY 2019
Goal #1 (Describe) Increase the percentage of adolescents who turned 13 years old in the measurement year and had specific vaccines (combination 1) by their 13th birthday to the 2017 national Medicaid 90th percentile rate of 86.8%.	**Goal #1 (Describe)** Increase the percentage of adolescents who turned 13 years old in the measurement year and had specific vaccines (combination 1) by their 13th birthday to the 2018 national Medicaid 90th percentile rate of 88%.	**Goal #1 (Describe)** Increase the percentage of adolescents who turned 13 years old in the measurement year and had specific vaccines (combination 1) by their 13th birthday to the 2018 national Medicaid 90th percentile rate of 88%.
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒ HEDIS. *Specify version of HEDIS used:* 2017 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2018 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2019 ☐ Other. *Explain:*
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*
Definition of Population Included in the Measure: Definition of numerator: Percent of denominator-eligible children who received the vaccines that make up 'combination 1' Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.	**Definition of Population Included in the Measure:** Definition of numerator: Denominator-eligible children who received the vaccines that make up 'combination 1' Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded:	**Definition of Population Included in the Measure:** Definition of numerator: Percent of denominator-eligible children who received the vaccines that make up 'combination 1' Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.
Date Range: **From: (mm/yyyy)** 01/2016 **To: (mm/yyyy)** 12/2016	**Date Range:** **From: (mm/yyyy)** 01/2017 **To: (mm/yyyy)** 12/2017	**Date Range:** **From: (mm/yyyy)** 01/2018 **To: (mm/yyyy)** 12/2018

FFY 2017	FFY 2018	FFY 2019
HEDIS Performance Measurement Data: *(If reporting with HEDIS)* Numerator: 16105 Denominator: 20022 Rate: 80.4	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 17303 Denominator: 20851 Rate: 84.4	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 5669 Denominator: 6818 Rate: 83.1
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** A performance rate of 82.4% for this measure was reported in the 2016 Annual Report. This year's rate is 80.4%. The rate declined since last year and continues to fall below the benchmark set for this goal – which is the 90th percentile for HEDIS 2017 national Medicaid (86.8%). Thus, it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which adolescents receive recommended vaccines , MassHealth gathered ideas from providers working on the IMA measure, and is currently drafting a resource for primary care providers who are looking to make improvements in their adolescent immunization rates. The resource includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. These activities will be finalized after the measurement period being examined as part of this measure.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** This years' rate is higher than last year's rate of 80.4% **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which adolescents receive recommended vaccines, MassHealth gathered ideas from providers working on the IMA measure, and is currently drafting a resource for primary care providers who are looking to make improvements in their adolescent immunization rates. The resource includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. These resource documents are currently in the process of being finalzed and should be distributed shortly after the submission of this report. (continued below)	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** This years' rate of 83.1% is slightly lower than last year's rate of 84.4%. While continuing to close the gap from 2017, this remains an area for improvement with the national 90th benchmark currently at 89.5% **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Last year, MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which adolescents receive recommended vaccines, MassHealth gathered ideas from providers working on the IMA measure to draft (this year) a resource for primary care providers who are looking to make improvements in their adolescent immunization rates. The resource includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. In addition to the quality improvement activities listed above, this measure is part of the ACO, MCO, and PCC Plan 2019 performance measure slates (measurement period – CY 2018). (continued below)

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** National Medicaid 90th percentile rate, HEDIS 2018 **Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile rate, HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile rate, HEDIS 2020 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** National Medicaid HEDIS 90th percentile for HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid HEDIS 90th percentile for HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid HEDIS 90th percentile for HEDIS 2021 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020**: National Medicaid 90th percentile rate, HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid 90th percentile rate, HEDIS 2021 **Annual Performance Objective for FFY 2022:** National Medicaid 90th percentile rate, HEDIS 2022 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:** Additional notes on quality improvement activities: In addition to the quality improvement activities listed above, the IMA measure is part of the ACO, MCO, and PCC Plan 2019 performance measure slates (measurement period – CY 2018). For the ACO program, the IMA measure is one of several measures that factor into an overall ACO DISRIP accountability scores which are used to determine ACO payments.	**Other Comments on Measure:** Additional notes on quality improvement activities: This measure will be used to calculate a quality score impacting state DSRIP and individual ACO payments. To support the program QI efforts, MassHealth's internal Clinical Quality Improvement team is actively planning to periodically convene an external committee of ACO and MCO medical directors for the next year (CY 2020) that will be focused on quality performance.

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #2 (Describe) Improve the percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year to meet or exceed the 2017 Medicaid 90th percentile rate of 68%.	**Goal #2 (Describe)** Improve the percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year to meet or exceed the 2018 Medicaid 90th percentile rate of 66.8%.	**Goal #2 (Describe)** Maintain the percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year to meet or exceed the 2019 Medicaid 90th percentile rate of 68.1%
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional.. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	Status of Data **Reported**: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒ HEDIS. *Specify version of HEDIS used:* 2017 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2018 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2019 ☐ Other. *Explain:*
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*
Definition of Population Included in the Measure: Definition of numerator: Adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.	**Definition of Population Included in the Measure:** Definition of numerator: Adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Excludes members not in the PCC Plan or an MCO	**Definition of Population Included in the Measure:** Definition of numerator: Adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.

FFY 2017	FFY 2018	FFY 2019
Date Range: **From: (mm/yyyy)** 01/2016 **To: (mm/yyyy)** 12/2016	**Date Range:** **From: (mm/yyyy)** 01/2017 **To: (mm/yyyy)** 12/2017	**Date Range:** **From: (mm/yyyy)** 01/2018 **To: (mm/yyyy)** 12/2018
HEDIS Performance Measurement Data: *(If reporting with HEDIS)* Numerator: 121942 Denominator: 183838 Rate: 66.3	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 116943 Denominator: 172503 Rate: 67.8	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 31439 Denominator: 45853 Rate: 68.6
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2017	FFY 2018	FFY 2019
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** A performance rate of 68.4% for this measure was reported in the 2016 Annual Report. This year's rate is 66.3%. This rate is lower than the rate reported last year and is below the benchmark set for this goal – which is the 90th percentile for HEDIS 2017 national Medicaid (68%). Thus, it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which adolescents receive annual well-care, MassHealth gathered ideas from providers working on the Immunization for Adolescents measure, as improvements in performance on this measure require supporting engaging adolescents in attending well-care visits. MassHealth is currently drafting a resource for primary care providers who are looking to make improvements in their adolescent visit and immunization rates, which includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. These materials will be disseminated after the measurement period being examined in this report.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** This year's reported rate is higher than the reported rate of 66.3%, and remains above the 90th percentile **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which adolescents receive annual well-care, MassHealth gathered ideas from providers working on the Immunization for Adolescents measure, as improvements in performance on this measure require supporting engaging adolescents in attending well-care visits. MassHealth is currently drafting a resource for primary care providers who are looking to make improvements in their adolescent visit and immunization rates, which includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects.	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** This year's reported rate of 68.6% is higher than the last reported rate of 67.8%, and remains above the 90th percentile which also increased. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth continues to utilize the internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which adolescents receive annual well-care, MassHealth gathered ideas from providers working on the Immunization for Adolescents measure, as improvements in performance on this measure require supporting and engaging adolescents in attending well-care visits. MassHealth drafted a resource for primary care providers who are looking to make improvements in their adolescent visit and immunization rates, which includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. (continued below)

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** National Medicaid 90th percentile, HEDIS 2018 **Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile, HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile, HEDIS 2020 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** National Medicaid HEDIS 90th percentile HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid HEDIS 90th percentile HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid HEDIS 90th percentile HEDIS 2021 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile, HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid 90th percentile, HEDIS 2021 **Annual Performance Objective for FFY 2022:** National Medicaid 90th percentile, HEDIS 2022 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:** More on quality improvement activities: These materials are in the process of being finalized and should be disseminated shortly after the submission of this report. In addition to the QI activities mentioned above, MassHealth intends to continue to collect and monitor the AWC measure through its annual HEDIS data collection. The 2019 HEDIS cycle includes, MCO, a subset of the ACO, and the PCC Plan populations. MassHealth will also continue to report the AWC measure as a Child Core Measure.	**Other Comments on Measure:** Additional notes on quality improvement activities: In addition to the QI activities mentioned above, MassHealth intends to continue to collect and monitor the AWC measure through its annual HEDIS data collection. The 2019 HEDIS cycle includes, MCO, a subset of the ACO, and the PCC Plan populations. MassHealth will also continue to report the AWC measure as a Child Core Measure.

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2017	FFY 2018	FFY 2019
Goal #3 (Describe) Maintain or improve the percentage of children aged 3-17 who had an outpatient visit with a primary care practitioner or obstetrical/gynecological (ob/gynn) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender to the 2017 national 90th percentile of 87.5%.	**Goal #3 (Describe)** Maintain or improve the percentage of children aged 3-17 who had an outpatient visit with a primary care practitioner or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender to the 2018 national 90th percentile of 87.98%.	**Goal #3 (Describe)** Maintain or improve the percentage of children aged 3-17 who had an outpatient visit with a primary care practitioner or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender to the 2018 national 90th percentile of 90.4%.
Type of Goal: ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*	**Type of Goal:** ☐ New/revised. *Explain:* ☒ Continuing. ☐ Discontinued. *Explain:*
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒ HEDIS. *Specify version of HEDIS used:* 2017 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2018 ☐ Other. *Explain:*	**Measurement Specification:** ☒ HEDIS. *Specify version of HEDIS used:* 2019 ☐ Other. *Explain:*
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify:* ☐ Other. *Specify:*

FFY 2017	FFY 2018	FFY 2019
Definition of Population Included in the Measure: Definition of numerator: Children aged 3-17 who had an outpatient visit with a primary care practitioner or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender during the measurement year. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.	**Definition of Population Included in the Measure:** Definition of numerator: Children aged 3-17 who had an outpatient visit with a primary care practitioner or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender during the measurement year. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded:	**Definition of Population Included in the Measure:** Definition of numerator: Children aged 3-17 who had an outpatient visit with a primary care practitioner or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: MassHealth members enrolled in managed care plans (MCOs, Accountable Care Partnership Plan ACOs, and PCC Plan) are included in the rates. Members in the Primary Care ACOs and the MH FFS program are excluded.
Date Range: **From: (mm/yyyy)** 01/2016 **To: (mm/yyyy)** 12/2016	**Date Range:** **From: (mm/yyyy)** 01/2017 **To: (mm/yyyy)** 12/2017	**Date Range:** **From: (mm/yyyy)** 01/2018 **To: (mm/yyyy)** 12/2018
HEDIS Performance Measurement Data: *(If reporting with HEDIS)* Numerator: 250007 Denominator: 292369 Rate: 85.5	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 239797 Denominator: 292207 Rate: 82.1	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 62879 Denominator: 73750 Rate: 85.3
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator, *Explain*. ☐ Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	**Additional notes on measure:**	**Additional notes on measure:**

FFY 2017	FFY 2018	FFY 2019
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?** A performance rate of 83.4% for this measure was reported in the 2016 Annual Report. This year's rate is 85.5%. This rate is higher than the rate reported last year but continues to be below the benchmark set for this goal – which is the 90th percentile for HEDIS 2017 national Medicaid (87.5%). Thus, it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which children have their BMI percentile assessed and documented, MassHealth gathered ideas from providers working on the WCC measure, and is currently drafting a resource for primary care providers who are looking to make improvements in their BMI percentile assessment and documentation rates. The resource includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. These materials will be finalized after the measurement period being examined in this report.	**Explanation of Progress:** **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** MassHealth reported a performance rate of 85.5% in the 2017 Annual Report. This year's rate is 82.1%. This rate is lower than the rate reported last year and continues to be below the benchmark set for this goal – which is the 90th percentile for HEDIS 2018 national Medicaid (87.98%). Thus, it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth convened an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which children have their BMI percentile assessed and documented, MassHealth gathered ideas from providers working on the WCC measure, and is currently drafting a resource for primary care providers who are looking to make improvements in their BMI percentile assessment and documentation rates. The resource includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. These materials are in the process of being finalized should be publically available shortly.(continued below)	**Explanation of Progress:** **How did your performance in 2019 compare with the Annual Performance Objective documented in your 2018 Annual Report?** MassHealth reported a performance rate of 82.1% in the 2017 Annual Report. This year's rate is 85.3%. This rate is higher than the rate reported last year, but continues to be below the benchmark set for this goal – which is the 90th percentile for HEDIS 2019 national Medicaid (90.4%). Thus, it remains an area of focus for improvement. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** MassHealth continues to utilize an internal Pediatric QI workgroup to identify and implement activities to support improved performance on this measure, as well as all the other measures for which performance goals were set in this section of the CHIP annual report. To support improvements in the rate at which children have their BMI percentile assessed and documented, MassHealth gathered ideas from providers working on the WCC measure and started drafting a resource for primary care providers who are looking to make improvements in their BMI percentile assessment and documentation rates. The resource finalized in 2019 includes a summary of practice-based activities that providers have implemented, as well as steps and tips to help practices develop and implement quality improvement projects. (continued below)

FFY 2017	FFY 2018	FFY 2019
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2018:** National Medicaid 90th percentile, HEDIS 2018 **Annual Performance Objective for FFY 2019:** National Medicaid 90th percentile, HEDIS 2019 **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile, HEDIS 2020 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2019:** National Medicaid HEDIS 2019 90th percentile **Annual Performance Objective for FFY 2020:** National Medicaid HEDIS 2020 90th percentile **Annual Performance Objective for FFY 2021:** National Medicaid HEDIS 2021 90th percentile *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2020:** National Medicaid 90th percentile, HEDIS 2020 **Annual Performance Objective for FFY 2021:** National Medicaid 90th percentile, HEDIS 2021 **Annual Performance Objective for FFY 2022**: National Medicaid 90th percentile, HEDIS 2022 *Explain how these objectives were set:* MassHealth has identified the national Medicaid 90th percentile as an achievable benchmark
Other Comments on Measure:	**Other Comments on Measure:** More on quality improvement activities: In addition to the QI activities mentioned above, MassHealth intends to continue to collect and monitor the WCC, BMI measure through its annual HEDIS data collection. The 2019 HEDIS cycle includes, MCO, a subset of the ACO, and the PCC Plan populations. MassHealth will also continue to report the WCC measure as a Child Core Measure.	**Other Comments on Measure:** Additional notes on quality improvement activities: In addition to the QI activities mentioned above, MassHealth intends to continue to collect and monitor the WCC, BMI measure through its annual HEDIS data collection. The 2020 HEDIS cycle includes, MCO, a subset of the ACO, and the PCC Plan populations. MassHealth will also continue to report the WCC measure as a Child Core Measure.

1. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your CHIP population? What have you found? **[7500]**

   MassHealth collects and reports on select HEDIS measures through its performance and monitoring measure slates for its ACO, MCO, and PCC Plan enrolled populations. Many of these reported measures are also part of the Child Core Set and are reported annually to CMS through the MACPro system. Additionally, MassHealth continues to calculate several non-HEDIS, Child Core measures relevant to the CHIP population:

   • Using administrative claims and encounter data sets, MassHealth caculates rates for the Developmental Screening in the First Three Years of Life (DEV-CH) and Dental sealants (SEAL-CH) measures.
   • MassHealth also continues to work with the MA Department of Public Health to utilize the MassCHIP system as a data source to calculate the Live Births Weighing less than 2,500 grams (LBW-CH).

   MassHealth has been calculating these non-HEDIS, Child Core measures since it's participation in the CHIPRA Quality Demonstration Grant.

   MassHealth uses the HEDIS and Child Core Set data as part of the overall quality management strategy. Specifically the measures are used to:
   • Assess ACO/MCO quality performance and for ACOs determine payments based on that performance;
   • Assess ACO and MCO contract compliance; and
   • Identify ACO, MCO, and PCC Plan quality improvement focus areas.

   Supporting improved performance on selected measures from the Child Core Set is the focus of work being undertaken by MassHealth to pursue and meet performance improvement goals that are included elsewhere in this annual CHIP report. By using the Child Core Set in these multiple ways, MassHealth is able to monitor, track, and support improvement of care received by the CHIP population

   Other activity:
   • MassHealth serves on advisory committee for MA Perinatal Neonatal Quality Improvement Network and served on a taskforce working on toolkit for moms with OUD.

   • MassHealth is on the MA maternal morbidity and mortality review committee of all maternal deaths in the state during pregnancy or within 1 year after birth. The workgroup has yielded a lot of important data briefs including maternal mental health and maternal death.

2. What strategies does your CHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your CHIP population? When will data be available? **[7500]**

   • In the future, MassHealth anticipates continuing to utilize the Child Core Measure Set in the manner noted above. As new measures are added to the Core Set, MassHealth will evaluate its resources and ability to calculate these measures, assess performance on the measures, and identify new opportunities for improvement.
   • Masshealth was part of the Long-Acting Reversible Contraceptive (LARC) ASTHO multi-state collaborative to enhance LARC access in policies and practice. We are following up with work on LARC access, especially in the postpartum period, and have DSRIP funds focused on enhanced provision of training for all methods of birth control, and enhanced training to improve LARC access. Timing and availability of data TBD.

3. Have you conducted any focused quality studies on your CHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found? **[7500]**

   No focused quality studies were undertaken this year.

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please include any analyses or descriptions of any efforts designed to reduce the number of uncovered children in the state through a state health insurance connector program or support for innovative private health coverage initiatives. **[7500]**

   Annual MassHealth Managed Care Reports that measure plan performance based on selected measures from the HEDIS measures set, Quality Strategy and Survey Reports are posted online at: https://www.mass.gov/service-details/masshealth-managed-care-reports-and-surveys. Periodic updates are posted and anticipated in 2020.

Enter any Narrative text related to Section IIB below. [7500]

Section III: Assessment of State Plan and Program Operation

Please reference and summarize attachments that are relevant to specific questions

Please note that the numbers in brackets, e.g., [7500] are character limits in the CHIP Annual Report Template System (CARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

Section IIIA: Outreach

1. How have you redirected/changed your outreach strategies during the reporting period? **[7500]**

   The Outreach and Education Unit coordinates statewide outreach activities, disseminates educational materials related to MassHealth and ACOs/MCOs, and collaborates with state and community-based agencies. This coordination helps prevent the duplication of outreach efforts in the community, strengthens the knowledge of providers and residents, and provides information to help individuals make smart choices about health coverage. The overall functions of the Unit include: managing and providing oversight to outreach and enrollment grant programs; supporting and managing training and technical assistance for community providers, partners, certified assisters (including Certified Application Counselors (CACs) and Navigators), and grantee organizations around health care reform policy and program changes; and coordinating and collaborating with state agencies around state and federal health care policies, messaging, and outreach activities.

   On March 1, 2018, MassHealth managed care options were expanded to include integrated, accountable care models. Accountable Care Organizations (ACOs) are provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for value – better cost and outcomes – not volume. This rollout impacted roughly 1.2M MassHealth managed care eligible members.

   On July 1, 2018, MassHealth launched the Community Partner program. Behavioral Health (BH) and Long-Term Services and Supports (LTSS) Community Partners (CPs) are community-based entities that work with Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs) to provide care management and coordination to certain members identified by MassHealth, ACOs, and MCOs. BH CPs provide supports to certain members with significant behavioral health needs, including serious mental illness and addiction. LTSS CPs provide supports to certain members with complex LTSS needs, such as children and adults with physical and developmental disabilities and brain injuries.

   MassHealth members enrolled in an ACO or MCO may be eligible to participate in the CP Program. Where members have other state agency or provider supports, CPs will supplement and coordinate with those supports but will not duplicate the functions provided by them.

   Outreach and training on these significant changes continued in FFY19.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness? **[7500]**

   We have found the following methods to be most effective in reaching low-income, uninsured children: MassHealth outreach staffs facilitated enrollment events collaborating with local health centers and partner organizations across the Commonwealth. Events help members' complete renewals and health plan selection. Enrollment events are opportunities for new applicants and

current members to attend, meet with MassHealth staff to ask questions about their coverage, and seek assistance in understanding how to use their health care. These events were to reach individuals where they are and conduct services in a way that meets the individual's needs.

MassHealth continues to fund and provide leadership for the Massachusetts Health Care Training Forum (MTF) program. MTF is a partnership between MassHealth and MassAHEC Network at the University of MA Medical School (UMMS). MTF utilizes a range of communication methods to reach health and human service workers in various fields to communicate State public health insurance related program and policy information, as well as information about related State programs. Communication methods include a total of 16 regional meetings held throughout the fiscal year in 4 regions of the State, program updates/e-mail communications and a regularly updated program website which features a number of resources and tools, including a growing number of State program webinar opportunities. The quarterly in-person meetings feature presentations to keep health care organizations and community agencies that serve MassHealth members, the uninsured, and underinsured informed of the latest changes in MassHealth and overall state and federal health care policies. MassHealth presents information about programmatic operations and policy changes and often leading community advocates often share updates about policy developments in state and federal health care. MTF also provides information via a listserv of approximately 7,326 members, and a website offering resource information and meeting materials. The website had approximately 32,000 page views in FFY19. The meetings promote information dissemination, sharing of best practices, and building of community and public sector linkages in order to increase targeted outreach and member education information about MassHealth. In SFY19, MTF program attendance totaled 1,810 in person with another 1,333 who attended via webinars and conference call meetings.

3. Which of the methods described in Question 2 would you consider a best practice(s)? **[7500]**

   All of the methods referenced in #2 are considered a best practice. It's very effective to reach individuals where they are in the community and to conduct services in a cultural and linguistic fashion that meets the individual's needs.

4. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)?

   ☒ Yes
   ☐ No

   Have these efforts been successful, and how have you measured effectiveness? **[7500]**

   The Member Education Unit conducts in-service presentations to various organizations including but not limited to: Native American Indian Tribes; School Nurses; School-based Medicaid Programs; sister state agencies such as the Department of Public Health (DPH), Department of Mental Health, Department of Children and Families, Department of Developmental Services, Department of Veteran's Services, and the Bureau of Addiction Services at DPH; Community Action Councils; the Brain Injury Association of Massachusetts; various ethnic cultural organizations (including the Latino, Vietnamese, Brazilian, and Somalian populations), advocates for the homeless, shelters, and other facilities working with the homeless population, Senior Care Organizations, the Massachusetts Head Start Program, Family Support Groups, and the Gay, Lesbian, Bisexual and Transgender Youth Support Project.

   These presentations provide education on a variety of topics including: MassHealth benefits; coverage types; covered services; rights and responsibilities; navigation tools such as website searching; how to access the MAhealthconnector.org; how to access other state health insurance programs; the application process; and post-enrollment information on how to maintain health coverage once it has been obtained. Member Education offers continued support to these organizations via e-mail and telephone in order to ensure proper procedure and an expedited service to the members. These efforts have been successful by encouraging new applicants, dispelling any myths about public programs, and assisting members with health insurance coverage retention.

5. What percentage of children below 200 percent of the federal poverty level (FPL) who are eligible for Medicaid or CHIP have been enrolled in those programs? **[5]** 100

   (Identify the data source used). **[7500]**

   ACS 2018

Enter any Narrative text related to Section IIIA below. **[7500]**

According to ACS data for 2018, .6% of children under 200% FPL in Massachusetts are uninsured. It is extremely challenging to determine what portion of the remaining uninsured are eligible for Medicaid or CHIP, particularly given uncertainly around the immigration status of such individuals. With that said, given the extremely low uninsurance rate for children for children under 200% FPL and the Commonwealth's extensive efforts to identify and enroll all eligible children, the Commonwealth believes that the number of remaining eligible but unenrolled children is minimal. Since the field above requires a number, we entered 100, but again, we are unable to verify this number.

Section IIIB: Substitution of Coverage (Crowd-out)

Please answer the following questions as they apply to your state's program (some questions are not applicable to Medicaid expansion programs.) Medicaid expansion states should complete applicable responses and indicate those questions that are non-applicable with N/A. Please include percent calculations in your responses when applicable and requested.

1. Does your separate CHIP program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?

   ☒ No
   ☐ Yes
   ☐ N/A

   If no, skip to question 5. If yes, answer questions 2-4:

2. How many months does your program require a child to be uninsured prior to enrollment?

3. To which groups (including FPL levels) does the period of uninsurance apply? **[1000]**

4. List all exemptions to imposing the period of uninsurance **[1000]**

Please answer questions 5, 7, 8 (and 6 and 9 if applicable) regardless of the response the state provided to question 1.

5. Does your program match prospective enrollees to a database that details private insurance status?

   ☐ No
   ☒ Yes
   ☐ N/A

6. If answered yes to question 5, what database? **[1000]**

   Health Management Systems (HMS) conducts a monthly State and National data match which identifies health insurance for all MassHealth members.

7. What percent of individuals screened for CHIP eligibility cannot be enrolled because they have group health plan coverage? **[5]** 0

    a. Of those found to have had employer sponsored insurance and have been uninsured for only a portion of the state's waiting period, what percent meet the state's exemptions and federally required exemptions to the waiting period [(# individuals subject to the waiting period that meet an exemption/total # of individuals subject to the waiting period)*100]? **[5]** 0

8. Do you track the number of individuals who have access to private insurance?

    ☒ Yes
    ☐ No

9. If yes to question 8, what percent of individuals that enrolled in CHIP had access to private health insurance at the time of application during the last federal fiscal year [(# of individuals that had access to private health insurance/total # of individuals enrolled in CHIP)*100]? **[5]** 9.38

Enter any Narrative text related to Section IIIB below. **[7500]**
Question 2 – MassHealth has authorization under an 1115 Demonstration to enroll children with employer sponsored insurance at CHIP income levels into MassHealth using Title XIX funding so there are no denials for this reason. As noted in Question 1, MassHealth does not have a waiting period.

Section IIIC: Eligibility

This subsection should be completed by all states. Medicaid Expansion states should complete applicable responses and indicate those questions that are non-applicable with N/A.

Section IIIC: Subpart A: Eligibility Renewal and Retention

1. Do you have authority in your CHIP state plan to provide for presumptive eligibility, and have you implemented this?

    ☒ Yes
    ☐ No

    If yes,

    a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination? **[5]** 0

    b. Of those children who are presumptively enrolled, what percent of those children are determined eligible and enrolled upon completion of the full eligibility determination? **[5]** 27

2. Select the measures from those below that your state employs to simplify an eligibility renewal and retain eligible children in CHIP.

    ☐ Conducts follow-up with clients through caseworkers/outreach workers

    ☒ Sends renewal reminder notices to all families

    - How many notices are sent to the family prior to disenrolling the child from the program? **[500]**
      MassHealth sends one notice to the family advising of the need to submit the annual review.

    - At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been

received by the state?) **[500]**
No reminder notices are sent

☐ Other, please explain: **[500]**

3. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology. **[7500]**

   All of the above strategies have played an important role in making the process work better for our MassHealth members. MassHealth has not conducted a formal evaluation of each outreach strategy, but rather has measured effectiveness through qualitative reporting from our outreach partners. Past findings show it's very effective to follow-up with individuals where they are in the community, conducting services in a cultural and linguistic fashion that meets the individual's needs. Tying enrollment and outreach events to current affairs, such as a Family Fun Day sponsored by the MA Dept. of Children and Families or back to school campaign, is also key to success since these are a natural draw for individuals to attend.

Section IIIC: Subpart B: Eligibility Data

Table 1. Data on Denials of Title XXI Coverage in FFY 2019

States are required to report on all questions (1, 1.a., 1.b., and 1.c) in FFY 2019. Please enter the data requested in the table below and the template will tabulate the requested percentages.
If you are unable to provide data in this section due to the single streamlined application, please note this in the response to question 2.

Measure	Number	Percent
1. Total number of denials of title XXI coverage	3415	100
a. Total number of procedural denials	1752	51.3
b. Total number of eligibility denials	1663	39.5
i. Total number of applicants denied for title XXI and enrolled in title XIX	0	
☒ (Check here if there are no additional categories) c. Total number of applicants denied for other reasons Please indicate:		

2. Please describe any limitations or restrictions on the data used in this table:

   We have a joint application and determine applicants for the richest benefit for which they are eligible. Therefore we do not deny applications for title XXI and enroll them in title XIX but rather just enroll them directly into title XIX.

Definitions:

1. The "the total number of denials of title XXI coverage" is defined as the total number of applicants that have had an eligibility decision made for title XXI and denied enrollment for title XXI in FFY

2019. This definition only includes denials for title XXI at the time of initial application (not redetermination).

a. The “total number of procedural denials” is defined as the total number of applicants denied for title XXI procedural reasons in FFY 2019 (i.e., incomplete application, missing documentation, missing enrollment fee, etc.).

b. The “total number of eligibility denials” is defined as the total number of applicants denied for title XXI eligibility reasons in FFY 2019 (i.e., income too high, income too low for title XXI /referred for Medicaid eligibility determination/determined Medicaid eligible , obtained private coverage or if applicable, had access to private coverage during your state’s specified waiting period, etc.)

    i. The total number of applicants that are denied eligibility for title XXI and determined eligible for title XIX.

c. The “total number of applicants denied for other reasons” is defined as any other type of denial that does not fall into 2a or 2b. Please check the box provided if there are no additional categories.

Table 2. Redetermination Status of Children

For tables 2a and 2b, reporting is required for FFY 2019.

Table 2a. Redetermination Status of Children Enrolled in Title XXI.

Please enter the data requested in the table below in the "Number" column, and the template will automatically tabulate the percentages.

Description	Number	Percent			
1. Total number of children who are enrolled in title XXI and eligible to be redetermined	213729	100%			
2. Total number of children screened for redetermination for title XXI	213729	100	100%		
3. Total number of children retained in title XXI after the redetermination process	178014	83.29	83.29		
4. Total number of children disenrolled from title XXI after the redetermination process	35715	16.71	16.71	100%	
a. Total number of children disenrolled from title XXI for failure to comply with procedures	26064			72.98	
b. Total number of children disenrolled from title XXI for failure to meet eligibility criteria	9651			27.02	100%
i Disenrolled from title XXI because income too high for title XXI (If unable to provide the data, check here ☐)	2696				27.93
ii Disenrolled from title XXI because income too low for title XXI (If unable to provide the data, check here ☐)	0				
iii Disenrolled from title XXI because application indicated access to private coverage or obtained private coverage (If unable to provide the data or if you have a title XXI Medicaid Expansion and this data is not relevant check here ☐)	0				
iv Disenrolled from title XXI for other eligibility reason(s) Please indicate: Moved out of state, deceased, no longer in family group (If unable to provide the data check here ☐)	6955				72.07
c. Total number of children disenrolled from title XXI for other reason(s) Please indicate: (Check here if there are no additional categories ☒)					

5. If relevant, please describe any limitations or restrictions on the data entered into this table. Please describe any state policies or procedures that may have impacted the redetermination outcomes data **[7500]**.

   If a member's income becomes too low for title XXI they are placed into a title XIX aid category and we do not count that transfer as a denial. MassHealth has authorization under an 1115 Demonstration to enroll children with employer sponsored insurance at CHIP income levels into MassHealth using Title XIX funding. We do not count transfers from title XXI into title XIX as a denial.

Definitions:

1. The "total number of children who are eligible to be redetermined" is defined as the total number of children due to renew their eligibility in federal fiscal year (FFY) 2019, and did not age out (did not exceed the program's maximum age requirement) of the program by or before redetermination. This total number may include those children who are eligible to renew prior to their 12 month eligibility redetermination anniversary date. This total must include ex parte redeterminations, the process when a state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. This total number must also include children whose

eligibility can be renewed through administrative redeterminations, whereby the state sends the family a renewal form that is pre-populated with eligibility information already available through program records and requires the family to report any changes.

2. The "total number of children screened for redetermination" is defined as the total number of children that were screened by the state for redetermination in FFY 2019 (i.e., ex parte redeterminations and administrative redeterminations, as well as those children whose families have returned redetermination forms to the state).
3. The "total number of children retained after the redetermination process" is defined as the total number of children who were found eligible and remained in the program after the redetermination process in FFY 2019.
4. The "total number of children disenrolled from title XXI after the redetermination process" is defined as the total number of children who are disenrolled from title XXI following the redetermination process in FFY 2019. This includes those children that states may define as "transferred" to Medicaid for title XIX eligibility screening.
    a. The "total number of children disenrolled for failure to comply with procedures" is defined as the total number of children disenrolled from title XXI for failure to successfully complete the redetermination process in FFY 2019 (i.e., families that failed to submit a complete application, failed to provide complete documentation, failed to pay premium or enrollment fee, etc.).
    b. The "total number of children disenrolled for failure to meet eligibility criteria" is defined as the total number of children disenrolled from title XXI for no longer meeting one or more of their state's CHIP eligibility criteria (i.e., income too low, income too high, obtained private coverage or if applicable, had access to private coverage during your state's specified waiting period, etc.). If possible, please break out the reasons for failure to meet eligibility criteria in i.-iv.
    c. The "total number of children disenrolled for other reason(s)" is defined as the total number of children disenrolled from title XXI for a reason other than failure to comply with procedures or failure to meet eligibility criteria, and are not already captured in 4.a. or 4.b.
    The data entered in 4.a., 4.b., and 4.c. should sum to the total number of children disenrolled from title XXI (line 4).

Table 2b. Redetermination Status of Children Enrolled in Title XIX.

Please enter the data requested in the table below in the "Number" column, and the template will automatically tabulate the percentages.

Description	Number	Percent			
1. Total number of children who are enrolled in title XIX and eligible to be redetermined	420355	100%			
2. Total number of children screened for redetermination for title XIX	420355	100	100%		
3. Total number of children retained in title XIX after the redetermination process	386992	92.06	92.06		
4. Total number of children disenrolled from title XIX after the redetermination process	33363	7.94	7.94	100%	
a. Total number of children disenrolled from title XIX for failure to comply with procedures	24169			72.44	
b. Total number of children disenrolled from title XIX for failure to meet eligibility criteria	9194			27.56	100%
i. Disenrolled from title XIX because income too high for title XIX (If unable to provide the data, check here ☐)	578				6.29
ii. Disenrolled from title XIX for other eligibility reason(s) Please indicate: Moved out of state, deceased, no longer in family group (If unable to provide the data check here ☐)	8616				93.71
c. Total number of children disenrolled from title XIX for other reason(s) Please indicate: (Check here if there are no additional categories ☒)					

5. If relevant, please describe any limitations or restrictions on the data entered into this table. Please describe any state policies or procedures that may have impacted the redetermination outcomes data **[7500]**.

    We don't count disenrollments from title XIX because income is too high for title XIX, instead those members are moved into title XXI aid category if they are eligible for title XXI. The number in the chart represents disenrollments due to being too high for title XXI and therefore ineligible for either Medicaid or CHIP.

Definitions:

1. The "total number of children who are eligible to be redetermined" is defined as the total number of children due to renew their eligibility in federal fiscal year (FFY) 2019, and did not age out (did not exceed the program's maximum age requirement) of the program by or before redetermination. This total number may include those children who are eligible to renew prior to their 12 month eligibility redetermination anniversary date. This total must include ex parte redeterminations, the process when a state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. This total number must also include children whose eligibility can be renewed through administrative redeterminations, whereby the state sends the family a renewal form that is pre-populated with eligibility information already available through program records and requires the family to report any changes.
2. The "total number of children screened for redetermination" is defined as the total number of children that were screened by the state for redetermination in FFY 2019 (i.e., ex parte redeterminations and administrative redeterminations, as well as those children whose families have returned redetermination forms to the state).
3. The "total number of children retained after the redetermination process" is defined as the total number of children who were found eligible and remained in the program after the redetermination process in FFY 2019.
4. The "total number of children disenrolled from title XIX after the redetermination process" is defined as the total number of children who are disenrolled from title XIX following the redetermination process in FFY 2019. This includes those children that states may define as "transferred" to CHIP for title XXI eligibility screening.
    a. The "total number of children disenrolled for failure to comply with procedures" is defined as the total number of children disenrolled from title XIX for failure to successfully complete the redetermination process in FFY 2019 (i.e., families that failed to submit a complete application, failed to provide complete documentation, failed to pay premium or enrollment fee, etc.).
    b. The "total number of children disenrolled for failure to meet eligibility criteria" is defined as the total number of children disenrolled from title XIX for no longer meeting one or more of their state's Medicaid eligibility criteria (i.e., income too high, etc.).
    c. The "total number of children disenrolled for other reason(s)" is defined as the total number of children disenrolled from title XIX for a reason other than failure to comply with procedures or failure to meet eligibility criteria, and are not already captured in 4.a. or 4.b.
    The data entered in 4.a., 4.b., and 4.c. should sum to the total number of children disenrolled from title XIX (line 4).

Table 3. Duration Measure of Selected Children, Ages 0-16, Enrolled in Title XIX and Title XXI, Second Quarter FFY 2018

The purpose of tables 3a and 3b is to measure the duration, or continuity, of Medicaid and CHIP enrollees' coverage. This information is required by Section 402(a) of CHIPRA. **Reporting on this table is required**.

The measure is designed to capture continuity of coverage for a cohort of children in title XIX and title XXI for 18 months of enrollment. This means that reporting spans two CARTS reports over two years, with enrollment status at 6 months being reported in the first reporting year, and 12 and 18 month enrollment status reported in the second reporting year. **States identify a new cohort of children every two years. States identify newly enrolled children in the second quarter of FFY 2018 (January, February, and March of 2018) for the FFY 2018 CARTS report. This same cohort of children will be reported on in the FFY 2019 CARTS report for the 12 and 18 month status of children newly identified in quarter 2 of FFY 2018 If your eligibility system already has the capability to track a cohort of enrollees over time, an additional "flag" or unique identifier may not be necessary.**

The FFY 2019 CARTS report is the second year of reporting in the cycle of two CARTS reports on the cohort of children identified in the second quarter of FFY 2018. For the FFY 2018 report, States only reported on lines 1-4a of the tables. **In the FFY 2019 report, no updates will be made to lines 1-4a. For the FFY 2019 report, data will be added to lines 5-10a.**The next cohort of children will be identified in the second quarter of the FFY 2020 (January, February and March of 2020).

Instructions: For this measure, please identify newly enrolled children in both title XIX (for Table 3a) and title XXI (for Table 3b) in the second quarter of FFY 2018, ages 0 months to 16 years at time of enrollment. Children enrolled in January 2018 must have birthdates after July 2001 (e.g., children must be younger than 16 years and 5 months) to ensure that they will not age out of the program at the 18th month of coverage. Similarly, children enrolled in February 2018 must have birthdates after August 2001, and children enrolled in March 2018 must have birthdates after September 2001. Each child newly enrolled during this time frame needs a unique identifier or "flag" so that the cohort can be tracked over time. If your eligibility system already has the capability to track a cohort of enrollees over time, an additional "flag" or unique identifier may not be necessary. Please follow the child based on the child's age category at the time of enrollment (e.g., the child's age at enrollment creates an age cohort that does not change over the 18 month time span)

Please enter the data requested in the tables below, and the template will tabulate the percentages. In the FFY 2019 report you will enter data on lines 5-7a related to the 12-month enrollment status of children identified on line 1. You will also enter data on lines 8-10a related to the 18-month enrollment status of children identified on line 1. **Only enter a "0" (zero) if the data are known to be zero. If data are unknown or unavailable, leave the field blank.**

Note that all data must sum correctly in order to save and move to the next page. The data in each individual row must add across to sum to the total in the "All Children Ages 0-16" column for that row. And in each column, the data within each time period (6, 12 and 18 months) must each sum up to the data in row 1, which is the number of children in the cohort. This means that in each column, rows 2, 3 and 4 must sum to the total in row 1; rows 5, 6 and 7 must sum to row 1; and rows 8, 9 and 10 must sum to row 1. These tables track a child's enrollment status over time, so when data are added or modified at each milestone (6, 12, and 18 months), there should always be the same total number of children accounted for in line 1 "All Children Ages 0-16" over the entire 18 month period. **Rows numbered with an "a" (e.g., rows 3a and 4a) are excluded from the totals because they are subsets of their respective rows. The system will not move to the next section of the report until all applicable sections of the table for the reporting year are complete and sum correctly to line 1.**

Table 3 a. Duration Measure of Children Enrolled in Title XIX

☒ Not Previously Enrolled in CHIP or Medicaid—"Newly enrolled" is defined as not enrolled in either title XXI or title XIX in the month before enrollment (i.e., for a child enrolled in January 2018, he/she would not be enrolled in either title XXI or title XIX in December 2017, etc.)

☐ Not Previously Enrolled in Medicaid—"Newly enrolled" is defined as not enrolled in title XIX in the month before enrollment (i.e., for a child enrolled in January 2018, he/she would not be enrolled in title XIX in December 2017, etc.)

Table 3a. Duration Measure, Title XIX	All Children Ages 0-16		Age Less than 12 months		Ages 1-5		Ages 6-12		Ages 13-16	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1. Total number of children newly enrolled in title XIX in the second quarter of FFY 2018	21634	100%	8672	100%	5141	100%	5292	100%	2529	100%
Enrollment status 6 months later										
2. Total number of children continuously enrolled in title XIX	16297	75.33	7134	82.93	3653	71.06	3734	70.56	1776	70.23
3. Total number of children with a break in title XIX coverage but re-enrolled in title XIX	1025	4.74	201	2.32	364	7.08	308	5.82	152	6.01
3.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)	266	1.23	45	0.52	74	1.44	104	1.97	43	1.7
4. Total number of children disenrolled from title XIX	4312	19.93	1337	15.42	1124	21.86	1250	23.62	601	23.76
4.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)	1082	5	146	1.68	317	6.17	427	8.07	192	7.59
Enrollment status 12 months later										
5. Total number of children continuously enrolled in title XIX	14170	65.5	6708	75.69	3048	59.29	3033	57.31	1381	54.61
6. Total number of children with a break in title XIX coverage but re-enrolled in title XIX	2188	10.11	358	4.13	718	13.97	735	13.89	377	14.91
6.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)	619	2.86	76	0.88	190	3.7	233	4.4	120	4.74
7. Total number of children disenrolled from title XIX	5276	24.39	1606	18.52	1375	26.75	1524	28.8	771	30.49
7.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)	1672	7.73	350	4.04	462	8.99	581	10.98	279	11.03
Enrollment status 18 months later										
8. Total number of children continuously enrolled in title XIX	10220	47.24	4588	52.91	2333	45.38	2239	42.31	1060	41.91

Table 3a. Duration Measure, Title XIX	All Children Ages 0-16		Age Less than 12 months		Ages 1-5		Ages 6-12		Ages 13-16	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
9. Total number of children with a break in title XIX coverage but re-enrolled in title XIX	3849	17.79	1148	13.24	1038	20.19	1132	21.39	531	21
9.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)	1266	5.85	501	5.78	277	5.39	341	6.44	147	5.81
10. Total number of children disenrolled from title XIX	7565	34.97	2936	33.86	1770	34.43	1921	36.3	938	37.09
10.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)	3306	15.28	1599	18.44	607	11.81	738	13.95	362	14.31

Definitions:

1. The "total number of children newly enrolled in title XIX in the second quarter of FFY 2018" is defined as those children either new to public coverage or new to title XIX, in the month before enrollment. Please define your population of "newly enrolled" in the Instructions section.

2. The total number of children that were continuously enrolled in title XIX for 6 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who were continuously enrolled through the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who were continuously enrolled through the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who were continuously enrolled through the end of August 2018

3. The total number who had a break in title XIX coverage during 6 months of enrollment (regardless of the number of breaks in coverage) but were re-enrolled in title XIX by the end of the 6 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and re-enrolled in title XIX by the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and re-enrolled in title XIX by the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and re-enrolled in title XIX by the end of August 2018
   3.a. From the population in #3, provide the total number of children who were enrolled in title XXI during their break in coverage.

4. The total number who disenrolled from title XIX, 6 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were disenrolled by the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were disenrolled by the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were disenrolled by the end of August 2018
   4.a. From the population in #4, provide the total number of children who were enrolled in title XXI in the month after their disenrollment from title XIX.

5. The total number of children who were continuously enrolled in title XIX for 12 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were continuously enrolled through the end of December 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were continuously enrolled through the end of January 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were continuously enrolled through the end of February 2019

6. The total number of children who had a break in title XIX coverage during 12 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 12 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and then re-enrolled in title XIX by the end of December 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and then re-enrolled in title XIX by the end of January 2019
   + the number of children with birthdates after September 2001 who were newly enrolled in March 2018 and who disenrolled and then re-enrolled in title XIX by the end of February 2019

   6.a. From the population in #6, provide the total number of children who were enrolled in title XXI during their break in coverage.

7. The total number of children who disenrolled from title XIX 12 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 2001, who were enrolled in January 2018 and were disenrolled by the end of December 2018
   + the number of children with birthdates after August 2001, who were enrolled in February 2018 and were disenrolled by the end of January 2019
   + the number of children with birthdates after September 2001, who were enrolled in March 2018 and were disenrolled by the end of February 2019

   7.a. From the population in #7, provide the total number of children, who were enrolled in title XXI in the month after their disenrollment from title XIX.

8. The total number of children who were continuously enrolled in title XIX for 18 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were continuously enrolled through the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were continuously enrolled through the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were continuously enrolled through the end of August 2019

9. The total number of children who had a break in title XIX coverage during 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 18 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and re-enrolled in title XIX by the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and re-enrolled in title XIX by the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and re-enrolled in title XIX by the end of August 2019

   9.a. From the population in #9, provide the total number of children who were enrolled in title XXI during their break in coverage.

10. The total number of children who were disenrolled from title XIX 18 months after their enrollment month is defined as the sum of:
    the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and disenrolled by the end of June 2019
    + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and disenrolled by the end of July 2019
    + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and disenrolled by the end of August 2019

    10.a. From the population in #10, provide the total number of children who were enrolled in title XXI (CHIP) in the month after their disenrollment from XIX.

Table 3b. Duration Measure of Children Enrolled in Title XXI

Specify how your "newly enrolled" population is defined:

☒ Not Previously Enrolled in CHIP or Medicaid—"Newly enrolled" is defined as not enrolled in either title XXI or title XIX in the month before enrollment (i.e., for a child enrolled in January 2018, he/she would not be enrolled in either title XXI or title XIX in December 2017, etc.)

☐ Not Previously Enrolled in CHIP—"Newly enrolled" is defined as not enrolled in title XXI in the month before enrollment (i.e., for a child enrolled in January 2018, he/she would not be enrolled in title XXI in December 2017, etc.)

Table 3b. Duration Measure, Title XXI	All Children Ages 0-16		Age Less than 12 months		Ages |1-5		Ages 6-12		Ages 13-16	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1. Total number of children newly enrolled in title XXI in the second quarter of FFY 2018	7556	100%	430	100%	2077	100%	3448	100%	1601	100%

Table 3b. Duration Measure, Title XXI	All Children Ages 0-16		Age Less than 12 months		Ages 1-5		Ages 6-12		Ages 13-16	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Enrollment status 6 months later										
2. Total number of children continuously enrolled in title XXI	3734	49.42	197	45.81	1015	48.87	1705	49.45	817	51.03
3. Total number of children with a break in title XXI coverage but re-enrolled in title XXI	541	7.16	34	7.91	151	7.27	247	7.16	109	6.81
3.a. Total number of children enrolled in Medicaid (title XIX) during title XXI coverage break (If unable to provide the data, check here ☐)	287	3.8	19	4.42	84	4.04	128	3.71	56	3.5
4. Total number of children disenrolled from title XXI	3281	43.42	199	46.28	911	43.86	1496	43.39	675	42.16
4.a. Total number of children enrolled in Medicaid (title XIX) after being disenrolled from title XXI (If unable to provide the data, check here ☐)	1469	19.44	96	22.33	416	20.03	661	19.17	296	18.49
Enrollment status 12 months later										
5. Total number of children continuously enrolled in title XXI	2392	31.66	127	29.53	654	31.49	1094	31.73	517	32.29
6. Total number of children with a break in title XXI coverage but re-enrolled in title XXI	1217	16.11	79	18.37	340	16.37	552	16.01	246	15.37
6.a. Total number of children enrolled in Medicaid (title XIX) during title XXI coverage break (If unable to provide the data, check here ☐)	494	6.54	40	9.3	147	7.08	216	6.26	91	5.68
7. Total number of children disenrolled from title XXI	3947	52.24	224	52.09	1083	52.14	1802	52.26	838	52.34
7.a. Total number of children enrolled in Medicaid (title XIX) after being disenrolled from title XXI (If unable to provide the data, check here ☐)	1934	25.6	121	28.14	563	27.11	865	25.09	385	24.05
Enrollment status 18 months later										
8. Total number of children continuously enrolled in title XXI	1701	22.51	93	21.63	472	22.73	760	22.04	376	23.49
9. Total number of children with a break in title XXI coverage but re-enrolled in title XXI	1549	20.5	104	24.19	420	20.22	708	20.53	317	19.8
9.a. Total number of children enrolled in Medicaid (title XIX) during title XXI coverage break (If unable to provide the data, check here ☐)	699	9.25	65	15.12	195	9.39	302	8.76	137	8.56
10. Total number of children disenrolled from title XXI	4306	56.99	233	54.19	1185	57.05	1980	57.42	908	56.71
10.aTotal number of children enrolled in Medicaid (title XIX) after being disenrolled from title XXI (If unable to provide the data, check here ☐)	2194	29.04	112	26.05	631	30.38	1005	29.15	446	27.86

Definitions:

1. The "total number of children newly enrolled in title XXI in the second quarter of FFY 2018" is defined as those children either new to public coverage or new to title XXI, in the month before enrollment. Please define your population of "newly enrolled" in the Instructions section.

2. The total number of children that were continuously enrolled in title XXI for 6 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who were continuously enrolled through the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who were continuously enrolled through the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who were continuously enrolled through the end of August 2018

3. The total number who had a break in title XXI coverage during 6 months of enrollment (regardless of the number of breaks in coverage) but were re-enrolled in title XXI by the end of the 6 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and re-enrolled in title XXI by the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and re-enrolled in title XXI by the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and re-enrolled in title XXI by the end of August 2018

   3.a. From the population in #3, provide the total number of children who were enrolled in title XIX during their break in coverage.

4. The total number who disenrolled from title XXI, 6 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were disenrolled by the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were disenrolled by the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were disenrolled by the end of August 2018

   4.a. From the population in #4, provide the total number of children who were enrolled in title XIX in the month after their disenrollment from title XXI.

5. The total number of children who were continuously enrolled in title XXI for 12 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were continuously enrolled through the end of December 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were continuously enrolled through the end of January 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were continuously enrolled through the end of February 2019

6. The total number of children who had a break in title XXI coverage during 12 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XXI by the end of the 12 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and then re-enrolled in title XXI by the end of December 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and then re-enrolled in title XXI by the end of January 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and then re-enrolled in title XXI by the end of February 2019

   6.a. From the population in #6, provide the total number of children who were enrolled in title XIX during their break in coverage.

7. The total number of children who disenrolled from title XXI 12 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 2001, who were enrolled in January 2018 and were disenrolled by the end of December 2018
   + the number of children with birthdates after August 2001, who were enrolled in February 2018 and were disenrolled by the end of January 2019
   + the number of children with birthdates after September 2001, who were enrolled in March 2018 and were disenrolled by the end of February 2019

   7.a. From the population in #7, provide the total number of children, who were enrolled in title XIX in the month after their disenrollment from title XXI.

8. The total number of children who were continuously enrolled in title XXI for 18 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were continuously enrolled through the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were continuously enrolled through the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were continuously enrolled through the end of August 2019

9. The total number of children who had a break in title XXI coverage during 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XXI by the end of the 18 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and re-enrolled in title XXI by the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and re-enrolled in title XXI by the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and re-enrolled in title XXI by the end of August 2019

   9.a. From the population in #9, provide the total number of children who were enrolled in title XIX during their break in coverage.

10. The total number of children who were disenrolled from title XXI 18 months after their enrollment month is defined as the sum of:
    the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and disenrolled by the end of June 2019
    + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and disenrolled by the end of July 2019
    + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and disenrolled by the end of August 2019
    10.a. From the population in #10, provide the total number of children who were enrolled in title XIX (Medicaid) in the month after their disenrollment from XXI.

Enter any Narrative text related to Section IIIC below. **[7500]**

For Section IIIC: Subpart A: Question 1- please note that the percent of children presumptively enrolled in CHIP is .0006% which is 11 children. Of those 11 children, we enrolled 3, or 27%.

Section IIID: Cost Sharing

1. Describe how the state tracks cost sharing to ensure enrollees do not pay more than 5 percent aggregate maximum in the year? If the state checks N/A for this question because no cost sharing is required, please skip to Section IIIE.

   a. Cost sharing is tracked by:

   ☒ Enrollees (shoebox method)

   If the state uses the shoebox method, please describe informational tools provided to enrollees to track cost sharing. **[7500]**

   The Well-Child Care Claim form and the 5% Max Claim Form are available on https://www.mass.gov/service-details/masshealth-member-forms

   ☐ Health Plan(s)
   ☐ State
   ☐ Third Party Administrator
   ☐ N/A (No cost sharing required)
   ☐ Other, please explain. **[7500]**

2. When the family reaches the 5% cap, are premiums, copayments and other cost sharing ceased?
   ☒ Yes
   ☐ No

3. Please describe how providers are notified that no cost sharing should be charged to enrollees exceeding the 5% cap. **[7500]**

   Massachusetts' eligibility verification system (EVS) enables providers to recognize no cost sharing is applicable for member via restrictive messaging that displays upon verification of eligibility.

4. Please provide an estimate of the number of children that exceeded the 5 percent cap in the state's CHIP program during the federal fiscal year. **[500]**

   9,370

5. Has your state undertaken any assessment of the effects of premiums/enrollment fees on participation in CHIP?

   ☐ Yes
   ☒ No If so, what have you found? **[7500]**

6. Has your state undertaken any assessment of the effects of cost sharing on utilization of health services in CHIP?

   ☐ Yes
   ☒ No If so, what have you found? **[7500]**

7. If your state has increased or decreased cost sharing in the past federal fiscal year, how is the state monitoring the impact of these changes on application, enrollment, disenrollment, and utilization of children's health services in CHIP. If so, what have you found? **[7500]**

Enter any Narrative text related to Section IIID below. **[7500]**

Section IIIE: Employer sponsored insurance Program (including Premium Assistance)

1. Does your state offer an employer sponsored insurance program (including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI Demonstration) for children and/or adults using Title XXI funds?

   ☒ Yes, please answer questions below.
   ☐ No, skip to Program Integrity subsection.

   Check all that apply and complete each question for each authority

   ☒ Purchase of Family Coverage under the CHIP state plan (2105(c)(3))
   ☐ Additional Premium Assistance Option under CHIP state plan (2105(c)(10))
   ☐ Section 1115 Demonstration (Title XXI)

2. Please indicate which adults your state covers with premium assistance. (Check all that apply.)

   ☒ Parents and Caretaker Relatives
   ☐ Pregnant Women

3. Briefly describe how your program operates (e.g., is your program an employer sponsored insurance program or a premium assistance program, how do you coordinate assistance between the state and/or employer, who receives the subsidy if a subsidy is provided, etc.) **[7500]**

   Premium Assistance maximizes private insurance by providing premium assistance if an uninsured child has access to coverage through employer-based insurance, and only offering direct coverage through MassHealth if there is no other access to health insurance. For all applicants, the Commonwealth performs a health insurance investigation, accessing a comprehensive database. Contact is made with all employed members of the household and their employers to determine if employer-sponsored insurance (ESI) is available that meets the basic benefit level, is cost effective and meets an employer contribution level of 50%. If MassHealth-qualifying ESI is available, applicants may receive premium assistance, but may not receive direct coverage. MassHealth does not allow the family to opt out of ESI in order to obtain direct public coverage. This process controls crowd-out by maximizing the state's opportunity to identify applicants with access to ESI and require enrollment into that coverage. Once access to ESI is confirmed, children's parents must enroll them in the ESI with premium assistance or the child's MassHealth will be terminated. Children must be uninsured at the time of application to be eligible for CHIP funding. If they are insured at the time of application they will be eligible for Title XIX under our 1115 waiver. MassHealth monitors health insurance status of potential members both at the time of application and monthly so that only uninsured children are covered in CHIP. Insurance status is verified through national insurance databases that identify coverage from any source, including noncustodial parents.

MassHealth contracts with Health Management Systems (HMS) which conducts monthly state and national data matches identifying health insurance for all potential members. MassHealth also has a dedicated process to match with a file from the Department of Revenue (DOR) to identify noncustodial parents of applicants and recipients who have court orders for medical support. This process allows us to not only verify existing coverage, but also to enforce the obligation of non-custodial parents by contacting their employers to arrange enrollment of the parent in an employer-sponsored family plan to cover their children.

4. What benefit package does the ESI program use? **[7500]**

   Secretary approved per the State Plan amendment approved in March 2002

5. Are there any minimum coverage requirements for the benefit package?

   ☒ Yes
   ☐ No

6. Does the program provide wrap-around coverage for benefits?

   ☒ Yes
   ☐ No

7. Are there limits on cost sharing for children in your ESI program?

   ☒ Yes
   ☐ No

8. Are there any limits on cost sharing for adults in your ESI program?

   ☐ Yes
   ☒ No

9. Are there protections on cost sharing for children (e.g., the 5 percent out-of-pocket maximum) in your premium assistance program?

   ☒ Yes
   ☐ No

   If yes, how is the cost sharing tracked to ensure it remains within the 5 percent yearly aggregate maximum **[7500]**? Parents of eligible children are notified of the family out of pocket maximum (calculated using 5 percent of the family income less anticipated required member contribution towards ESI plan). Parents submit receipts for cost incurred and once 5 percent cap amount is met, children receive MassHealth wrap benefits for remainder of family cap year.

10. Identify the total number of children and adults enrolled in the ESI program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in this program even if they were covered incidentally, i.e., not explicitly covered through a demonstration).

    0 Number of childless adults ever-enrolled during the reporting period

    754 Number of adults ever-enrolled during the reporting period

    7607 Number of children ever-enrolled during the reporting period

11. Provide the average monthly enrollment of children and parents ever enrolled in the premium assistance program during FFY 2019.

    Children 20267
    Parents 6184

12. During the reporting period, what has been the greatest challenge your ESI program has experienced? **[7500]**

    The greatest challenge for the ESI program has been and continues to be the maintenance of household information relating to employment and health insurance plan benefits meeting the qualifying standards for coverage (ESI plans are steadily increasing deductibles and out of pocket maximums, health Insurance premiums are increasing, more employers are offering High Deductible Health Plans with Health Savings Accounts).

13. During the reporting period, what accomplishments have been achieved in your ESI program? **[7500]**

    The Premium Assistance Unit continues work toward the goal of increasing enrollment into the program by making enhancements to streamline the process of investigating referrals for access to ESI. This includes targeted approaches to analyzing and working referral files and enhancing relationships with employers to get more timely and accurate updated information. Enrollment numbers have steadily increased over the course of the year due to consistent efforts.

14. What changes have you made or are planning to make in your ESI program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

    The goal of the Premium Assistance program is to increase enrollment into the program by use of streamlined investigation processes, enhanced employer reporting as well as system enhancements to better identify members with potential access to ESI, improved program applications/member communication and increased outreach to members and employers. The changes are being implemented as cost avoidance/cost savings measures.

15. What do you estimate is the impact of your ESI program (including premium assistance) on enrollment and retention of children? How was this measured? **[7500]**

    There are several factors that MassHealth looks at when measuring the impact of the ESI program on retention of children. The Premium Assistance program allows MassHealth to enroll more members into the program because of the cost savings incurred by helping Medicaid eligible members enroll into private health insurance. Because MassHealth helps purchase family plans household members that are not Medicaid eligible are also covered. Enrolling families in ESI is critical to retention of children in the program. MassHealth analyzes how many policies are purchased in order to determine cost avoidance and cost savings.

16. Provide the average amount each entity pays towards coverage of the dependent child/parent under your ESI program:

Population	**State**	**Employer**	**Employee**
Child	314	157	157
Parent	150	75	75

17. Indicate the range in the average monthly dollar amount of premium assistance provided by the state on behalf of a child or parent.

	Low	**High**
Children	0	4000
Parent		

18. If you offer a premium assistance program, what, if any, is the minimum employer contribution? **[500]**

    Employers must contribute at least 50% toward the cost of the health insurance.

19. Please provide the income levels of the children or families provided premium assistance.

Income level of	**From**	**To**
Children	0 % of FPL **[5]**	300 % of FPL **[5]**
Parents	0 % of FPL **[5]**	300 % of FPL **[5]**

20. Is there a required period of uninsurance before enrolling in premium assistance?

    ☐ Yes
    ☒ No

    If yes, what is the period of uninsurance? **[500]**

21. Do you have a waiting list for your program?

    ☐ Yes
    ☒ No

22. Can you cap enrollment for your program?

    ☒ Yes
    ☐ No

23. What strategies has the state found to be effective in reducing administrative barriers to the provision of premium assistance in ESI? **[7500]**

    Since Premium Assistance investigates employers and the insurance offered to employees, maintaining an employer database is critical in facilitating the investigation process. The process allows MassHealth to gather all of the ESI information that an employer offers including: the names of all health insurance plans the employer offers, premiums and tiers, annual open enrollment rates,summary of benefits for each health insurance offered. This process of gathering and storing current employer insurance information streamlines the determination when other members are being reviewed and are employed by the same employer. The database is updated annually, during the open enrollment periods.

Enter any Narrative text related to Section IIIE below. **[7500]**

Full Response to #19:

Under 1 year: 185 % of FPL to 300% of FPL

1-5 years: 133 % of FPL to 300% of FPL

6-17 years: 114% of FPL to 300 % of FPL

18 years: 0% of FPL to 300 % of FPL

Section IIIF: Program Integrity

COMPLETE ONLY WITH REGARD TO SEPARATE CHIP PROGRAMS, I.E., THOSE THAT ARE NOT MEDICAID EXPANSIONS)

1. Does your state have a written plan that has safeguards and establishes methods and procedures for:

   (1) prevention:
   ☒ Yes
   ☐ No
   (2) investigation:
   ☒ Yes
   ☐ No
   (3) referral of cases of fraud and abuse?
   ☒ Yes
   ☐ No

   Please explain: **[7500]**

   It is important to point out that in Massachusetts Medicaid and CHIP are managed and operated seamlessly as one program known as the MassHealth program. Therefore, while there are no separate fraud and abuse activities for CHIP, all methods and procedures employed by the Commonwealth to detect, investigate, and refer cases of fraud and abuse in the Medicaid program are brought to bear on CHIP. In Massachusetts, state staff performs all application, redetermination, matching, case maintenance, and referral processes for all MassHealth programs, including CHIP. All contractual arrangements regarding fraud and abuse activities apply to CHIP as well as Medicaid.

   MassHealth emphasizes aggressive management of its front-end program processes to ensure that services provided are medically necessary, provided by qualified health care providers, provided to eligible residents of the Commonwealth, and that payments are appropriately made. Ongoing efforts to combat fraud, waste, and abuse, including utilization management and regular program and clinical review, are central to all program areas. Sophisticated information systems support MassHealth's efforts to detect inappropriate billings before payment is made, and to ensure that eligibility determinations are accurate.

   MassHealth implemented a pre-payment predictive modeling solution in June 2013. The predictive modeling tool uses sophisticated algorithms to analyze claims, builds provider profiles of suspicious billing patterns and assigns risk scores to potentially inappropriate claims.

   MassHealth Program Integrity continues to participate in the PARIS match.

   Equally important are mechanisms for detailed reporting and review of claims after bills are paid to identify inappropriate provider behavior, and methods to ensure that MassHealth identifies members whose changed circumstances may affect their continuing eligibility.As with our front-

end processes, information systems are a critical component of MassHealth's work to identify and address inappropriate payments.

Post-payment activities are an important "second look" and are particularly important to the identification of prosecutable fraud. And when our systems identify potential fraud, MassHealth acts aggressively to pursue the case with the appropriate authorities.

MassHealth has the following documentation regarding established methods and procedures for prevention, investigation, and referral of cases of fraud and abuse:

1) MassHealth Program Integrity Activities Inventory

2) Efforts to Prevent and Identify Fraud, Waste, and Abuse—description and identification of responsible units

3) Provider Compliance activity sheet

4) Utilization Management plan

5) Memorandum of Understanding between the Executive Office of Health and Human Services (EOHHS) and the Office of the Attorney General, Massachusetts Medicaid Fraud Control Unit

6) Interdepartmental Service Agreement between EOHHS and the Department of Revenue (DOR)

7) MassHealth Eligibility Operations Memo 04-04 re: New Member Fraud Referral Process

8) MassHealth Eligibility Operations Memo 01-7 re: Department of Revenue "New Hire" Match

9) MassHealth Eligibility Operations Memo 99-14 re: Annual Eligibility Review Process for Health Care Reform Members on MA-21

10) Contract between EOHHS and MedStat Group to perform Program Integrity gap analysis—deliverables dated June 30, 2005.

11) Eligibility Verification System (EVS)codes—online system for providers to verify MassHealth eligibility at point of service

12) Managed care contract language specifying program integrity and fraud and abuse prevention, detection, and reporting requirements for health plans contracting with MassHealth
MassHealth Eligibility Operations Memo 01-7 re: Department of Revenue "New Hire" Match

Do managed health care plans with which your program contracts have written plans?

☒ Yes
☐ No

Please Explain: **[500]**

All managed care health plan contracts require that they have written plans.

2. For the reporting period, please report the

13899 Number of fair hearing appeals of eligibility denials

179 Number of cases found in favor of beneficiary

3. For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

   Provider Credentialing

   273 Number of cases investigated

   0 Number of cases referred to appropriate law enforcement officials

   Provider Billing

   72 Number of cases investigated

   27 Number of cases referred to appropriate law enforcement officials

   Beneficiary Eligibility

   1375 Number of cases investigated

   1375 Number of cases referred to appropriate law enforcement officials

Are these cases for:

CHIP ☐

Medicaid and CHIP Combined ☒

4. Does your state rely on contractors to perform the above functions?

   ☒ Yes, please answer question below.

   ☐ No

5. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors? Please explain: **[7500]**

   The Provider Compliance Unit, operated within the University of Massachusetts Medical School (UMMS), and managed by the MassHealth Program Integrity Unit, is our primary post-payment fraud detection unit. Utilizing algorithms and reports found in our data warehouse, and through data analysis, the Provider Compliance Unit reviews paid claims data to detect aberrant trends and outlier billing patterns that can indicate potential fraud. The Provider Compliance Unit works closely with Program Integrity to meet our federal regulatory obligation to establish a surveillance utilization control system to safeguard against fraudulent, abusive, and inappropriate use of the Medicaid and CHIP programs.

   Additionally, MassHealth oversees a Third Party Administrator contract with Optum which is responsible for carrying out program integrity activities, including on-site audits, desk reviews and algorithms, focused on long-term supports and services (LTSS) providers. MassHealth Program Integrity works closely with Optum across multiple weekly coordination calls and provides detailed input on all audit findings of non-compliance and associated overpayments.

   MassHealth Program Integrity also works across units engaged in program integrity to coordinate activities, establish unit specific internal control plans and risk assessments, manage external audit activity, coordinate the CMS Payment Error Rate Measurement (PERM), and establish and monitor compliance with information privacy and security requirements.

   Our MMIS system processes provider claims and contains a significant number of sophisticated edits, rules, and other program integrity checks and balances. As a result, in both FFY18 and FFY19 approximately 22% of all claims submitted were denied and 1% were suspended for manual review, verification and pricing. The MMIS has been designed with enhanced Program Integrity capabilities, including expanded functionality to add claims edits as needed in order to keep abreast with the latest trends in aberrant or fraudulent claims submissions. Generally, information systems support to MassHealth remains a significant priority of the Executive Office

of Health and Human Services, in large part because of the potential of leveraging technology to combat fraud, waste, and abuse in the Medicaid and CHIP programs. The EOHHS Data Warehouse, for example, is a consolidated repository of claims and eligibility data that provides program and financial managers with the ability to develop standard and ad-hoc management reports.

The Claims Operations Unit manages our claims processing contractor and monitors claims activity weekly. The EOHHS Office of Financial Management organizes a weekly Cash Management Team made up of budget, program, and operations staff that closely monitors the weekly provider claims payroll and compares year-to-date cash spending with budgeted spending by both provider type and budget category. The prior authorization unit ensures that certain services are medically necessary before approving the service. Even more sophisticated measures are in place for the pharmacy program. The Drug Utilization Review program at UMMS monitors and audits pharmacy claims and is designed to prevent early refills, therapeutic duplication, ingredient duplication, and problematic drug-drug interaction. In February 2004, our Managed Care Program instituted required reporting on fraud and abuse protections for all of MassHealth's managed care organizations.

Finally, MassHealth contracts with two vendors, one who supports the Office of Long Term Services and Supports (LTSS) and the other that supports the Delivery Service Operations Unit. These two vendors provide customer service to MassHealth members and providers. Our customer service contractors verify the credentials of all providers applying to participate in our program as well as re-credentialing existing providers and will work closely with the Board of Registration in Medicine, the Division of Professional Licensing, the Department of Public Health, the US Department of Health and Human Services, and the Office of the Inspector General to identify disciplinary actions against enrolled providers.

6. Do you contract with managed care health plans and/or a third party contractor to provide this oversight?

   ☒ Yes

   ☐ No

   Please Explain: **[500]**

   MassHealth's contracted managed health care plans provide oversight of their material subcontractors performing program integrity functions. MassHealth provides oversight of the two EOHHS-contracted vendors, Optum and UMMS, as noted in the response to #5 above, performing program integrity functions.

Enter any Narrative text related to Section IIIF below. **[7500]**

Response to Question #4- The Provider Compliance Unit, operated within the University of Massachusetts Medical School (UMMS), and managed by the MassHealth Program Integrity Unit, is our primary post-payment fraud detection unit. Utilizing algorithms and reports found in our data warehouse, and through data analysis, the Provider Compliance Unit reviews paid claims data to detect aberrant trends and outlier billing patterns that can indicate potential fraud. The Provider Compliance Unit works closely with Program Integrity to meet our federal regulatory obligation to establish a surveillance utilization control system to safeguard against fraudulent, abusive, and inappropriate use of the Mediaid program.

Additionally, MassHealth oversees a Third Party Administrator contract with Optum which is responsible for carrying out program integrity activities, including on-site audits, desk reviews and algorithms, focused on long-term supports and services (LTSS) providers. MassHealth Program Integrity works closely with Optum across multiple weekly coordination calls and provides detailed input on all audit findings of non-compliance and associated overpayments.

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Our MMIS system processes provider claims and contains a significant number of sophisticated edits, rules, and other program integrity checks and balances. As a result, approximately 22% of all claims submitted are denied and 1% are suspended for manual review, verification and pricing. The MMIS has been designed with enhanced Program Integrity capabilities, including expanded functionality to add claims edits as needed in order to keep abreast with the latest trends in aberrant or fraudulent claims submissions. Generally, information systems support to MassHealth remains a significant priority of the Executive Office of Health and Human Services, in large part because of the potential of leveraging technology to combat fraud, waste, and abuse in the Medicaid program. The EOHHS Data Warehouse, for example, is a consolidated repository of claims and eligibility data that provides program and financial managers with the ability to develop standard and ad-hoc management reports.

The Claims Operations Unit manages our claims processing contractor and monitors claims activity weekly. The EOHHS Office of Financial Management organizes a weekly Cash Management Team made up of budget, program, and operations staff that closely monitors the weekly provider claims payroll and compares year-to-date cash spending with budgeted spending by both provider type and budget category. The prior authorization unit ensures that certain services are medically necessary before approving the service. Even more sophisticated measures are in place for the pharmacy program. The Drug Utilization Review program at UMMS monitors and audits pharmacy claims and is designed to prevent early refills, therapeutic duplication, ingredient duplication, and problematic drug-drug interaction. In February 2004, our Managed Care Program instituted required reporting on fraud and abuse protections for all of MassHealth's managed care organizations.

Finally, MassHealth contracts with two vendors, one who supports the Office of Long Term Services and Supports (LTSS) and the other that supports the Office of Provider & Pharmacy Programs. These two vendors provide customer service to MassHealth members and providers. Our customer service contractors verify the credentials of all providers applying to participate in our program as well as re-credentialing existing providers and will work closely with the Board of Registration in Medicine, the Division of Professional Licensing, the Department of Public Health, the US Department of Health and Human Services, and the Office of the Inspector General to identify disciplinary actions against enrolled providers.

Section IIIG: Dental Benefits:

Please ONLY report data in this section for children in Separate CHIP programs and the Separate CHIP part of Combination programs. Reporting is required for all states with Separate CHIP programs and Combination programs. If your state has a Combination program or a Separate CHIP program but you are not reporting data in this section on children in the Separate CHIP part of your program, please explain why. Explain: **[7500]**

Data for this table are based on the definitions provided on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

1. **Information on Dental Care for Children in Separate CHIP Programs (including children in the Separate CHIP part of Combination programs). Include all delivery system types, e.g. MCO, PCCM, FFS.**

   Data for this table are based on the definitions provided on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

   a. **Annual Dental Participation Table for Children Enrolled in Separate CHIP programs and the Separate CHIP part of Combination programs (for Separate CHIP programs, please include ONLY children receiving full CHIP benefits and supplemental benefits).**

FFY 2019	Total (All age groups)	<1 year	1 – 2 years	3 – 5 years	6 – 9 years	10–14 years	15–18 years
Total Individuals Enrolled for at Least 90 Continuous Days[1]	233949	874	15176	30921	53331	71081	62566
Total Enrollees Receiving Any Dental Services[2] [7]	140788	16	4124	16834	36340	24668	35806
Total Enrollees Receiving Preventive Dental Services[3] [7]	127483	0	3909	16221	34630	43037	29686

[1] **Total Individuals Enrolled for at Least 90 Continuous Days** – Enter the total unduplicated number of children who have been continuously enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days in the federal fiscal year, distributed by age. For example, if a child was enrolled January 1st to March 31st , this child is considered continuously enrolled for at least 90 continuous days in the federal fiscal year. If a child was enrolled from August 1st to September 30th and from October 1st to November 30th, the child would not be considered to have been enrolled for 90 continuous days in the federal fiscal year. Children should be counted in age groupings based on their age at the end of the fiscal year. For example, if a child turned 3 on September 15th, the child should be counted in the 3-6 age grouping.

[2] **Total Enrollees Receiving Any Dental Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999 or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

[3] **Total Enrollees Receiving Preventive Dental Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes

FFY 2019	Total (All age groups)	<1 year	1 – 2 years	3 – 5 years	6 – 9 years	10–14 years	15–18 years
Total Enrollees Receiving Dental Treatment Services[4] [7]	73577	13	608	4308	17092	28137	23419

b. **For the age grouping that includes children 8 years of age, what is the number of such children who have received a sealant on at least one permanent molar tooth[5]? [7]**
10425

2. **Does the state provide supplemental dental coverage?**

☐ Yes
☒ No

If yes, how many children are enrolled? [7]

What percent of the total number of enrolled children have supplemental dental coverage? [5]

Enter any Narrative text related to Section IIIG below. **[7500]**

that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

[4] **Total Enrollees Receiving Dental Treatment Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (or equivalent CDT codes D2000 - D9999 or equivalent CPT codes, that is, only those CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services, and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

Report all dental services data in the age category reflecting the child's age at the end of the federal fiscal year even if the child received services while in two age categories. For example, if a child turned 10 on September 1st, but had a cleaning in April and a cavity filled in September, both the cleaning and the filling would be counted in the 10-14 age category.

[5] **Receiving a Sealant on a Permanent Molar Tooth** -- Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for 90 continuous days and in the age category of 6-9 who received a sealant on a permanent molar tooth, as defined by HCPCS code D1351 (or equivalent CDT code D1351), based on an unduplicated paid, unpaid, or denied claim. For this line, include sealants placed by any dental professional for whom placing a sealant is within his or her scope of practice. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, 31, and additionally, for those states that cover sealants on third molars, also known as wisdom teeth, the teeth numbered 1, 16, 17, 32.

Report all sealant data in the age category reflecting the child's age at the end of the federal fiscal year even if the child was factually a different age on the date of service. For example, if a child turned 6 on September 1st, but had a sealant applied in July, the sealant would be counted in the age 6-9 category.

Section IIIH: CHIPRA CAHPS Requirement:

CHIPRA section 402(a)(2), which amends reporting requirements in section 2108 of the Social Security Act, requires Title XXI Programs (i.e., CHIP Medicaid Expansion programs, Separate Child Health Programs, or a combination of the two) to report CAHPS results to CMS starting December 2013. While Title XXI Programs may select any CAHPS survey to fulfill this requirement, CMS encourages these programs to align with the CAHPS measure in the Children's Core Set of Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Starting in 2013, Title XXI Programs should submit summary level information from the CAHPS survey to CMS via the CARTS attachment facility. We also encourage states to submit raw data to the Agency for Healthcare Research and Quality's CAHPS Database. More information is available in the Technical Assistance fact sheet, Collecting and Reporting the CAHPS Survey as Required Under the CHIPRA: https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf

If a state would like to provide CAHPS data on both Medicaid and CHIP enrollees, the agency must sample Title XIX (Medicaid) and Title XXI (CHIP) programs separately and submit separate results to CMS to fulfill the CHIPRA Requirement.

Did you Collect this Survey in Order to Meet the CHIPRA CAHPS Requirement?
☐ Yes
☒ No

If Yes, How Did you Report this Survey (select all that apply):
☐ Submitted raw data to AHRQ (CAHPS Database)
☐ Submitted a summary report to CMS using the CARTS attachment facility (NOTE: do not submit raw CAHPS data to CMS)
☐ Other. Explain:

If No, Explain Why:
Select all that apply (Must select at least one):

☐ Service not covered
☒ Population not covered
- ☐ Entire population not covered
- ☒ Partial population not covered

  Explain the partial population not covered: Primary Care Case Management (PCC) and FFS population were not covered.

☒ Data not available

Explain why data not available
- ☒ Budget constraints
- ☒ Staff constraints
- ☐ Data inconsistencies/accuracy

Please explain:
- ☐ Data source not easily accessible

Select all that apply:
- ☐ Requires medical record review
- ☐ Requires data linkage which does not currently exist
- ☐ Other:

☒ Information not collected.
Select all that apply:
☒ Not collected by provider (hospital/health plan)
☐ Other:

☐ Other:

☐ Small sample size (less than 30)
Enter specific sample size:
☐ Other. Explain:

Definition of Population Included in the Survey Sample:

Definition of population included in the survey sample:
☐ Denominator includes CHIP (Title XXI) population only.
☐ Survey sample includes CHIP Medicaid Expansion population.
☐ Survey sample includes Separate CHIP population.
☐ Survey sample includes Combination CHIP population.

If the denominator is a subset of the definition selected above, please further define the denominator, and indicate the number of children excluded:

Which Version of the CAHPS® Survey was Used?
☐ CAHPS® 5.0.
☐ CAHPS® 5.0H.
☐ Other. Explain:

Which Supplemental Item Sets were Included in the Survey?
☐ No supplemental item sets were included
☐ CAHPS Item Set for Children with Chronic Conditions
☐ Other CAHPS Item Set. Explain:

Which Administrative Protocol was Used to Administer the Survey?
☐ NCQA HEDIS CAHPS 5.0H administrative protocol
☐ HRQ CAHPS administrative protocol
☐ Other administrative protocol. Explain:

Enter any Narrative text related to Section IIIH below. **[7500]**

Section III I: Health Service Initiatives (HSI) Under the CHIP State Plan

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, states have the option to use up to 10 percent of actual or estimated Federal expenditures to develop state-designed Health Services Initiatives (HSI) (after first funding costs associated with administration of the CHIP state plan), as defined in regulations at 42 CFR 457.10, to improve the health of low-income children.

All states with approved HSI program(s) described in the CHIP state plan should answer "Yes" to question 1, and complete questions 2 and 3. If the state has an approved HSI that is not currently operating using Title XXI funds, please check "Yes", to question 1, include the program name and description in the table for question 2, and indicate in the narrative portion of this section that the state is not currently implementing the program.

1) Does your state operate HSI(s) to provide direct services or implement public health initiatives using Title XXI funds?

☒ Yes, please answer questions below.

☐ No, please skip to Section IV.

2) In the table below, please provide a brief description of each HSI program operated in the state in the first column. In the second column, please list the populations served by each HSI program. In the third column, provide estimates of the number of children served by each HSI program. In the fourth column, provide the percentage of the population served by the HSI who are children below your state's CHIP FPL eligibility threshold.

HSI Program	Population Served by HSI Program	Number of Children Served by HSI Program	Percent of Low-income Children Served by HSI Program[6]
Healthy Families: This Newborn Home Visiting Program, called "Healthy Families", provides a neonatal and postnatal parenting education and home visiting program.	Families with at-risk newborns.	2,667	N/A
Essential School Health Services: This program provides school nurse services.	Students in K-12 who receive school nurse services	N/A	N/A

[6] The percent of children served by the HSI program who are below the CHIP FPL threshold in your state should be reported in this column.

HSI Program	Population Served by HSI Program	Number of Children Served by HSI Program	Percent of Low-income Children Served by HSI Program[6]
Safe Spaces: This program provides suicide prevention and violence prevention programs for Gay, Lesbian, Bisexual and Transgender youth.	Community agencies serve young LGBT people throughout the state and agencies can have specific focus groups such as homeless youth.	385	N/A
State-funded WIC: This program provides the same services as the federally funded Women Infants and Children Program Services.	Pregnant women and mothers with children under age 5.	22,829	100%
Smoking Prevention and Cessation Programs: This program provides media campaigns and youth training initiatives to discourage tobacco use among young people.	Young people throughout Massachusetts	N/A	N/A
Family Planning Programs: This program provides services such as exams, referrals, counseling, and education.	Clients of community based agencies including clinics, health centers, etc.	15,735	N/A
Project to Prevent Out of Home Residential Placements: The Department of Developmental Services provides an array of community based services to help young people continue to live at home with their families.	Clients of the Department of Developmental Disabilities who are at high-risk of needing institutional level care.	254	N/A

HSI Program	Population Served by HSI Program	Number of Children Served by HSI Program	Percent of Low-income Children Served by HSI Program[6]
School Breakfast: The Department of Elementary and Secondary Education provides funds for school breakfasts	Children in K-12 schools.	186, 747	N/A
Safe and Successful Youth: This program provides funding for communities to design and implement strategies to reduce high risk behaviors among young males.	At-risk young people	1886	N/A
Teen Pregnancy Prevention: The Department of Public Health funds community based programs which implement strategies to reduce teen pregnancies	Teens at high risk of becoming pregnant	5922	N/A
Youth Violence Prevention: The Department of Public Health provides funding to community based organizations which provide activities aimed at preventing and reducing at-risk behavior among young people	High risk youth	7036	N/A

HSI Program	Population Served by HSI Program	Number of Children Served by HSI Program	Percent of Low-income Children Served by HSI Program[6]
Young Parent Support Program: The Department of Children and Families provides funding for community based organizations that provide outreach, home visits, mentoring, and parent groups in order the strengthen the skills of young parents	High-risk families	829	N/A
Child at Risk Hotline: Provides a resource for reports of child abuse and neglect	Children at risk of abuse or neglect	87,601	N/A
Services for Homeless Youth: The Department of Early Education and Care provides funds to community organizations that provide support services for homeless youth	Homeless youth	583	N/A
Children's Medical Security Plan: Provides preventive and primary care services to uninsured children under the age of 19	Uninsured Children under the age of 19	52,486	N/A
Pediatric Sexual Assault Nurse Examiner (SANE) Program: The Department of Public Health provides funding which is used to aid adolescents and children who disclose sexual assault	Adolescents and children who disclose sexual assault and report to SANE designated emergency departments or Children's Advocacy Centers in MA	1110	N/A

HSI Program	Population Served by HSI Program	Number of Children Served by HSI Program	Percent of Low-income Children Served by HSI Program[6]
Pediatric Palliative Care Program (PPC): The Department of Public Heath administers this program to help children with life-limiting illnesses and their families	Children age 18 and younger with life-limiting illnesses	588	N/A

3) Please define a metric for each of your state's HSI programs that is used to measure the program's impact on improving the health of low-income children. In the table below, please list the HSI program title in the first column, and include a metric used to measure that program's impact in the second column. In the third column, please provide the outcomes for metrics reported in the second column. States that are already reporting to CMS on such measures related to their HSI program(s) do not need to replicate that reporting here and may skip to Section IV.

HSI Program	Metric	Outcome
Healthy Families: This Newborn Home Visiting Program, called "Healthy Families", provides a neonatal and postnatal parenting education and home visiting program	Percentage of children with a primary care provider	94%
Essential School Health Services: Provides school nurse services	Proportion of students at funded ESHS programs with special health care needs who have an Individual Health Care Plan	24%
Safe Spaces: This program provides suicide prevention and violence prevention programs for Gay, Lesbian, Bisexual and Transgender youth.	Number of youth who receive direct services to decrease risk for suicidal (and self-harm) behaviors or violence.	385
State-funded WIC: Provides the same services as the federally funded Women Infants and Children Program Services	Percentage of WIC infants breastfeeding at 3 months	43.3%

HSI Program	Metric	Outcome
Smoking Prevention and Cessation Programs: Provides media campaigns and youth training initiatives to discourage tobacco use among young people	Percentage of youth in Massachusetts who report using tobacco products	24.6%
Family Planning Programs: Provides services such as exams, referrals, counseling, and education	Percentage of female clients who were pregnant at the time they sought services at a funded site	3.5%
Project to Prevent Out of Home Residential Placements: The Department of Developmental Services provides an array of community based services to help young people continue to live at home with their families.	Percentage of clients who successfully avoid out-of-home placement	87%
School Breakfast: The Department of Elementary and Secondary Education provides funds for school breakfasts	Number of school children in Massachusetts who receive nutritious breakfast	186747
Safe and Successful Youth: Provides funding for communities to design and implement strategies to reduce high risk behaviors among young males.	Number of clients enrolled in SSY case management services	755
Teen Pregnancy Prevention: The Department of Public Health funds community based programs which implement strategies to reduce teen pregnancies	Number of youth provided evidence-based sexuality education programming	5922
Youth Violence Prevention: The Department of Public Health provides funding to community based organizations which provide activities aimed at preventing and reducing at-risk behavior among young people	Number of youth aged 18 or younger who receive direct services	7036

HSI Program	Metric	Outcome
Young Parent Support Program: The Department of Children and Families provides funding for community based organizations that provide outreach, home visits, mentoring, and parent groups in order the strengthen the skills of young parents	Number of children whose parents received parenting education service	555
Child at Risk Hotline: Provides a resource for reports of child abuse and neglect	Percentage of calls answered and processed	92.8%
Services for Homeless Youth: The Department of Early Education and Care provides funds to community organizations that provide support services for homeless youth	Number of monthly slots made available during the year for homeless youth.	7000
Children's Medical Security Plan: Provides preventive and primary care services to uninsured children under the age of 19	Percent of eligible children receiving covered services per month	19%
Pediatric Sexual Assault Nurse Examiner (SANE) Program: The Department of Public Health provides funding which is used to aid adolescents and children who disclose sexual assault.	Children and youth under age 19 that received a consult from a pediatric Sexual Assault Nurse Examiner (SANE)	1110
Pediatric Palliative Care Program (PPC): The Department of Public Health administers this program to help children with life-limiting illnesses and their families	Number of children and youth under age 19 determined by a physician to have a potentially life-limiting illness served by this program	588

Enter any Narrative text related to Section III I below. **[7500**]
Additional information related to Programs in Table 2

For the number of children served by the Essential School Health Services program, we answered "N/A." This is because there are more than 4.6 million student health encounters recorded annually, but there is no data on the number of unduplicated users.

For the percent of low-income children served by the State Funded WIC Program, we answered 100%. We would also note that the program uses WIC eligibility criteria which is 185% FPL.

For the number of children served by the Smoking Prevention and Cessation Program we answered "N/A." This is because program services are primarily through outreach initiatives and the media campaign, so there is no specific client count.

For the number of children served by the Child at Risk Hotline we answered 87,601 and would note that this is the number of calls in over the year, but we do not have an unduplicated child count.

If the percent of low-income children served by the HSI program is listed as “N/A,” then the specific statistic is not captured.

Section IV. Program financing for State Plan

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-federal funds).
(Note: This reporting period equals federal fiscal year 2019. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)

COST OF APPROVED CHIP PLAN

Benefit Costs	**2019**	**2020**	**2021**
Insurance payments	20261295	21103932	21981613
Managed Care	268741116	299900400	312468309
Fee for Service	413069873	431593589	449680357
Total Benefit Costs	702072284	752597921	784130279
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	$ 702072284	$ 752597921	$ 784130279

Administration Costs	**2019**	**2020**	**2021**
Personnel			
General Administration	29099153	29099153	29099153
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other (e.g., indirect costs)			
Health Services Initiatives	49090613	49090613	49090613
Total Administration Costs	78189766	78189766	78189766
10% Administrative Cap (net benefit costs ÷ 9)	78008032	83621991	87125587

	2019	**2020**	**2021**
Federal Title XXI Share	686630604	635552581	560508029
State Share	93631446	195235106	301812016
TOTAL COSTS OF APPROVED CHIP PLAN	780262050	830787687	862320045

2. What were the sources of non-federal funding used for state match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement
- ☐ Other (specify) **[500]**

3. Did you experience a short fall in CHIP funds this year? If so, what is your analysis for why there were not enough federal CHIP funds for your program? **[1500]**

No

4. In the tables below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month (PMPM) cost rounded to a whole number. If you have CHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

A. Managed Care

Year	Number of Eligibles	PMPM ($)
2019	174784	$247
2020	176553	$254
2021	178339	$263

A. Fee For Service

Year	Number of Eligibles	PMPM ($)
2019	58588	$341
2020	59181	$352
2021	59780	$363

Enter any Narrative text related to Section IV below. **[7500]**
In the chart in Question 1 above: Note that the FFY19 (for the first column) is based on actual FFP claimed with two adjustments (i.e., drug rebates and collections paybacks) so that the amount claimed is less than the amount we would have claimed without these adjustments based on actual spending. The difference is due to drug rebates and collections adjustments.

Section V: Program Challenges and Accomplishments

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted CHIP. **[7500]**

   Massachusetts remains committed to ensuring health coverage for all of its residents and continues to have the lowest uninsurance rate for children in the country. In order to promote mental health parity and improve access to behavioral health treatment for children and families, both the state legislature and the administration have demonstrated commitment to making state-wide changes. In this context, MassHealth has begun to implement the first of a series of policy changes designed to incentivize timely access to appropriate and effective behavioral health care in community settings.

2. During the reporting period, what has been the greatest challenge your program has experienced? **[7500]**

   The greatest challenge is providing the full spectrum of behavioral health services to children with the right care at the right time in the right setting. One of MassHealth's highest priorities is to redesign our outpatient behavioral health system to ensure the right care in the right setting can be delivered to all of our members, including children. In recognition of the longstanding difficulties facing children and families who are trying to access behavioral health treatment, both the state legislature and the administration have demonstrated commitment to making state-wide changes. In this context, MassHealth has begun to implement the first of a series of policy changes designed to incentivize access to right-sized and on-time behavioral health care in community settings.

   Massachusetts' priorities in this area include:
   - Supporting behavioral health promotion and crisis prevention by moving the intervention point "upstream" – away from crisis and 24-hour behavioral health treatment and toward integrated primary care and outpatient behavioral health treatment
   - Expanding access to same-day urgent and outpatient mental health and substance use treatment
   - Improving timely access to appropriate, community-based crisis stabilization and evaluation services
   - Increasing the availability of mental health services delivered in schools
   - Enhancing workforce competency to deliver evidence-based models of treatment for youth and families, including dyadic therapy focused on the caregiver-child relationship and specialized treatments for trauma

3. During the reporting period, what accomplishments have been achieved in your program? **[7500]**

   Massachusetts is very proud of the health insurance coverage we provide to children in the Commonwealth and our standing as the state with the lowest uninsurance rate in FFY19. During FFY19 MassHealth reported on 22 of the 26 Child Core Set measures, an important step in achieving mandatory reporting of the full child core set in 2024.

4. What changes have you made or are planning to make in your CHIP program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

   We have recently redoubled our commitment to children in our combined CHIP and Medicaid program by creating a leadership position to support the development and implementation of a

children's health policy agenda. This Senior Director will work closely with the CHIP Director and other MassHealth staff on children's coverage issues.

The initial focus of the Senior Director will be across three areas:

1. Behavioral health, focused on developing strategies to ensure prevention, early intervention, and on-time access to treatment;

2. Children with medical complexity, focused on treatment, case management, and care coordination;

3. Children in our current Accountable Care Organizations, increasing the focus on the needs of children and families.

In addition, the Massachusetts combined CHIP and Medicaid program has undertaken an inter-agency initiative to improve access to quality behavioral health services, with a particular focus on youth and families. Strategies under this initiative include:

- Collaborating across child-serving EOHHS agencies, including the Department of Children and Families, the Department of Youth Services, the Department of Mental Health, and the Department of Public Health, to design new service delivery models, promote flexible payment structures, and streamline agency requirements

- Increasing rates for 24-hour diversionary behavioral health services for youth

- Exploring options to address gaps in the treatment continuum (e.g., intensive outpatient services)

- Funding provider training in infant and early childhood behavioral health assessment

Enter any Narrative text related to Section V below. **[7500]**