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# External Quality Review Massachusetts Behavioral Health Partnership Annual Technical Report, Calendar Year 2023



**Commonwealth of Massachusetts**  
Executive Office of Health and  
Human Services

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# I. Executive Summary

## Massachusetts Behavioral Health Partnership

External quality review (EQR) is the evaluation and validation of information about quality of, timeliness of, and access to health care services furnished to Medicaid enrollees. The objective of the EQR is to improve states' ability to oversee managed care plans (MCPs) and to help MCPs to improve their performance. This annual technical report (ATR) describes the results of the EQR for the Massachusetts Behavioral Health Partnership (MBHP) that manages behavioral health care for MassHealth's members enrolled in the primary care accountable care organizations (PC ACOs) and the Primary Care Clinician Plan (PCCP).

Massachusetts's Medicaid program (known as "MassHealth"), administered by the Massachusetts Executive Office of Health and Human Services (EOHHS), contracted with Beacon Health Options, Inc. to provide behavioral health care for PC ACO and PCCP members during the 2023 calendar year (CY). MBHP is a network of behavioral health providers who manage behavioral health care for MassHealth's PC ACOs and PCCP. MBHP also serves children in state custody who are not otherwise enrolled in managed care, as well as certain children enrolled in MassHealth who have commercial insurance as their primary insurance. MBHP served 443,767 MassHealth members during the CY 2023.

## Purpose of Report

The purpose of this ATR is to present the results of EQR activities conducted to assess the quality of, timeliness of, and access to health care services furnished to Medicaid enrollees, in accordance with the following federal managed care regulations: *Title 42 Code of Federal Regulations (CFR) Section (§) 438.364 External review results (a) through (d)* and *Title 42 CFR § 438.358 Activities related to external quality review*. EQR activities validate two levels of compliance to assert whether MBHP met the state standards and whether the state met the federal standards as defined in the CFR.

## Scope of External Quality Review Activities

MassHealth contracted with IPRO, an external quality review organization (EQRO), to conduct four mandatory EQR activities for MBHP, as outlined by the Centers for Medicare and Medicaid Services (CMS). As set forth in *Title 42 CFR § 438.358 Activities related to external quality review(b)(1)*, these activities are:

- (i) **CMS Mandatory Protocol 1: Validation of Performance Improvement Projects (PIPs)** – This activity validates that MBHP performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- (ii) **CMS Mandatory Protocol 2: Validation of Performance Measures** – This activity assesses the accuracy of performance measures (PMs) reported by MBHP and determines the extent to which the rates calculated by the MBHP follow state specifications and reporting requirements.
- (iii) **CMS Mandatory Protocol 3: Review of Compliance with Medicaid and CHIP<sup>1</sup> Managed Care Regulations** – This activity determines MBHP's compliance with its contract and with state and federal regulations.
- (iv) **CMS Mandatory Protocol 4: Validation of Network Adequacy** – This activity assesses MBHP's adherence to state standards for travel time and distance to specific provider types, as well as the MBHP's ability to provide an adequate provider network to its Medicaid population.

The results of the EQR activities are presented in individual activity sections of this report. Each of the activity sections includes information on:

- technical methods of data collection and analysis,
- description of obtained data,
- comparative findings, and
- where applicable, the MBHP's performance strengths and opportunities for improvement.

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<sup>1</sup> Children's Health Insurance Program.

All four mandatory EQR activities were conducted in accordance with CMS EQR protocols. CMS defined *validation* in *Title 42 CFR § 438.320 Definitions* as “the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.”

## High-Level Program Findings

The EQR activities conducted in CY 2023 demonstrated that MassHealth and the MBHP share a commitment to improvement in providing high-quality, timely, and accessible care for members.

IPRO used the analyses and evaluations of CY 2023 EQR activity findings to assess the performance of MBHP in providing quality, timely, and accessible health care services to Medicaid members. MBHP evaluated against state and national benchmarks for measures related to the **quality, access, and timeliness** domains. These plan-level findings and recommendations are discussed in each EQR activity section, as well as in the **MCP Strengths, Opportunities for Improvement, and EQR Recommendations** section.

The overall findings for the MBHP program were also compared and analyzed to develop overarching conclusions and recommendations for MassHealth. The following provides a high-level summary of these findings.

## MassHealth Medicaid Comprehensive Quality Strategy

State agencies must draft and implement a written quality strategy for assessing and improving the quality of health care services furnished by their MCPs, as established in *Title 42 CFR § 438.340*.

### Strengths:

MassHealth’s quality strategy is designed to improve the quality of health care for MassHealth members. It articulates managed care priorities, including goals and objectives for quality improvement.

Quality strategy goals are considered in the design of MassHealth managed care programs, selection of quality metrics and quality improvement projects, as well as in the design of other MassHealth initiatives.

Consequently, MassHealth programs and initiatives reflect the priorities articulated in the strategy and include specific measures. Measure targets are explained in the quality strategy by each managed care program.

MassHealth reviews and evaluates the effectiveness of its quality strategy every 3 years. In addition to the triennial review, MassHealth also conducts an annual review of measures and key performance indicators to assess progress toward strategic goals. MassHealth relies on the annual EQR process to assess the managed care programs’ effectiveness in providing high-quality, accessible services.

### Opportunities for Improvement:

Although MassHealth evaluates the effectiveness of its quality strategy, the most recent evaluation, which was conducted on the previous quality strategy, did not clearly assess whether the state met or made progress on its strategic goals and objectives. The evaluation of the current quality strategy should assess whether the state successfully promoted better care for MassHealth members (goal 1), achieved measurable reductions in health care inequities (goal 2), made care more value-based (goal 3), successfully promoted person- and family-centered care (goal 4), and improved care through better integration, communication, and coordination (goal 5).

For example, to assess if MassHealth achieved measurable reductions in health care inequities (goal 2), the state could look at the core set measures stratified by race/ethnicity; to assess if MassHealth made care more

value-based (goal 3), the state could look at the number of enrollees in value-based arrangements. The state may decide to continue with or revise its five strategic goals based on the evaluation.

### **General Recommendations for MassHealth:**

- *Recommendation towards achieving the goals of the Medicaid quality strategy* – MassHealth should assess whether the state met or made progress on the five strategic goals and objectives described in the quality strategy. This assessment should describe whether the state successfully promoted better care for MassHealth members (goal 1), achieved measurable reductions in health care inequities (goal 2), made care more value-based (goal 3), successfully promoted person- and family-centered care (goal 4), and improved care through better integration, communication, and coordination (goal 5). The state may decide to continue with or revise its five strategic goals and objectives based on the evaluation.<sup>2</sup>

IPRO's assessment of the *Comprehensive Quality Strategy* is provided in **Section II** of this report.

### ***Performance Improvement Projects***

State agencies must require that contracted MCPs conduct PIPs that focus on both clinical and non-clinical areas, as established in *Title 42 CFR § 438.330(d)*. The validation of MBHP' PIPs conducted in CY 2023 demonstrated the following strengths and weaknesses.

#### **Strengths:**

The plans developed and implemented multi-level interventions that focused on member, provider, and health plan levels.

#### **Opportunities for Improvement:**

The PIP processes in place prior to IPRO becoming the EQRO of record for Massachusetts had several limitations that impacted and were reflected in MBHPs' PIPs, including the following weaknesses observed across all plans:

- Lack of clearly defined aims and interventions.
- Lack of formal barrier analysis to assess factors underlying suboptimal performance on performance indicators at baseline and inform the development of interventions tailored to the unique needs and characteristics of the member population.
- Limited/absent use of process measures to track progress with respect to intervention implementation.
- Modifications made to interventions throughout the PIP cycle were generally not evident and where evident, were not documented uniformly.
- Efforts to promote sustainability and spread were not clearly and/or uniformly documented across interventions.

### **General Recommendations for MassHealth:**

*Recommendation for MassHealth towards accelerating the effectiveness of MBHP PIPs:*

- Standardized structure and reporting requirements should be established to define and describe PIP aims and interventions.
- All Plans should be required to conduct an initial barrier analysis at the outset of every PIP and document it in PIP proposal submission. Additionally, Plans should be required/expected to conduct additional analyses throughout the process as additional barriers are discovered.

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<sup>2</sup> Considerations for addressing the evaluation of the quality strategy are described in the *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit* on page 29, available at [Medicaid and Children's Health Insurance Program \(CHIP\) Managed Care Quality Strategy Toolkit](#).

- For each PIP intervention, Plans should be required to track implementation progress with at least one intervention-specific process measure. Rates should be tracked/reported on at least a quarterly basis throughout the PIP cycle.
- Plans should be required to document modifications made to interventions throughout the PIP cycle in a uniform fashion within the PIP template.
- Plans should be required to document efforts to promote sustainability and spread in a standardized manner across all interventions (and PIPs) in the final PIP report.

MBHP-specific PIP validation results are described in **Section III** of this report.

### **Performance Measure Validation**

IPRO validated the accuracy of PMs and evaluated the state of health care quality in the MBHP program.

#### **Strengths:**

The use of quality metrics is one of the key elements of MassHealth's quality strategy. At a statewide level, MassHealth monitors the Medicaid program's performance on the CMS Medicaid Adult and Child Core Sets measures. On a program level, each managed care program has a distinctive slate of measures selected to reflect MassHealth quality strategy goals and objectives.

The MBHP is evaluated on the Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are calculated by MBHP and reported to the MassHealth. IPRO conducted performance measure validation (PMV) to assess the accuracy of HEDIS PMs and to determine the extent to which HEDIS performance measures follow MassHealth's specifications and reporting requirements. IPRO conducted a full Information Systems Capabilities Assessment (ISCA), a primary source validation (PSV), and a check on the processes used to collect, calculate, and report the PMs. The results showed that the data and processes used to produce HEDIS rates by the MBHP were fully compliant with information system standards.

When IPRO compared MBHP's HEDIS rates to the National Committee for Quality Assurance (NCQA) Quality Compass®, MBHP's rates were above the national Medicaid 90<sup>th</sup> percentile for the following measures:

- Follow-Up After Emergency Department Visit for Mental Illness (7 days)
- Follow-Up After Emergency Department Visit for Mental Illness (30 days)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)
- Pharmacotherapy for Opioid Use Disorder

#### **Opportunities for Improvement:**

Performance varied with the opportunities for improvement in the following areas:

- Follow-Up Care for Children Prescribed ADHD Medication (Initiation)
- Follow-Up Care for Children Prescribed ADHD Medication (Continuation)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Initiation of Alcohol and Other Drug Abuse or Dependence Treatment

#### **General Recommendations for MassHealth:**

- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.



PMV findings are provided in **Section IV** of this report.

### **Compliance Review**

IPRO evaluated MBHP's compliance with Medicaid and CHIP managed care regulations in accordance with Protocol 3 of the CMS EQR Protocols. The remote interview with MBHP was conducted between September 18 and September 19, 2023.

#### **Strengths:**

MassHealth's contracts with MBHP outline specific terms and conditions that MBHP must fulfill to ensure high-quality care, promote access to healthcare services, and maintain the overall integrity of the healthcare system.

MassHealth established contractual requirements that encompass all 14 compliance review domains consistent with CMS regulations. This includes regulations that ensure access, address grievances and appeals, enforce beneficiary rights and protections, as well as monitor the quality of healthcare services provided by MBHP. MassHealth collaborates with MBHP to identify areas for improvement, and MBHP actively engages in performance improvement initiatives.

MassHealth monitors MBHP's compliance with contractual obligations via regular audits, reviews, and reporting requirements. MBHP undergoes compliance reviews every 3 years. The next compliance review will be conducted in the contract year 2026.

The validation of MBHP conducted in CY 2023 demonstrated that the plan has a high commitment to its members and providers, as well as strong operations. Of the 14 review areas, MBHP scored 100% on 7 and 90% or more on 4 topics.

#### **Opportunities for Improvement:**

MBHP performed below 90% in the following three domains: Coordination and Continuity of Care, Provider Selection, and Subcontractual Relationships and Delegation. Gaps were identified in policy documentation, particularly in the areas of Provider Selection, Availability of Services, Subcontracting, Enrollee Rights and Confidentiality. In the areas of Enrollee Rights and Confidentiality, some policies were applicable to other states, but not Massachusetts. In a few instances, MBHP was not able to provide evidence that all required reports had been transmitted in a timely manner to EOHHS. In the area of Subcontractual Relationships and Delegation, some provisions in the agreements, such as record retention, need to be updated to reflect EOHHS-specific requirements.

#### **General EQR Recommendations for MassHealth:**

- *Recommendation towards better policy documentation* - The state should direct MBHP to thoroughly review its policies and procedures, integrating all Massachusetts contract requirements into relevant policies.
- *Recommendation towards addressing gaps identified through the compliance review* – To effectively address the areas of non-compliance, MassHealth should establish direct communication with MBHP to discuss the identified issues. MBHP should ensure alignment of policy requirements with the contract terms to guarantee comprehensive coverage and ensure timely submission of all required reports to MassHealth, maintaining the evidence of transmittal. MBHP should also amend existing contracts to require 10 years of record retention and ensure that future contracts comply with this requirement.

MBHP-specific results for compliance with Medicaid and CHIP managed care regulations are provided in **Section V** of this report.

## Network Adequacy Validation

Title 42 CFR § 438.68(a) requires states to develop and enforce network adequacy standards.

### Strengths:

MassHealth developed time and distance standards for adult and pediatric primary care providers (PCPs), obstetrics/gynecology (ob/gyn) providers, adult and pediatric behavioral health providers (for mental health and substance use disorder [SUD]), adult and pediatric specialists, hospitals, pharmacy services, and long-term services and supports (LTSS). MassHealth did not develop standards for pediatric dental services because dental services are carved out from managed care.

Network adequacy is an integral part of MassHealth's strategic goals. One of the goals of MassHealth's quality strategy is to promote timely preventative primary care services with access to integrated care and community-based services and supports. MassHealth's strategic goals also include improving access for members with disabilities as well as increasing timely access to behavioral health care and reducing mental health and SUD emergencies.

Travel time and distance standards and availability standards are defined in the MassHealth contract with MBHP. Network adequacy was calculated on a county level, where 90% of health plan members residing in a county had to have access within the required travel time and/or distance standards, depending on a provider type.

### Opportunities for Improvement:

IPro evaluated MBHP provider network to determine compliance with the time and distance standards established by MassHealth. IPro requested in-network provider data with geo-access report templates utilized by MassHealth. IPro found that the structure geo-access report templates may drive duplication of records submitted for analysis.

IPro also identified and corrected several issues with network provider data submitted by MBHP. After data issues were resolved and duplicate records were removed, IPro assessed access for a total of 26 provider types. MBHP demonstrated adequate networks for only 2 out of 26 provider types across all 14 counties.

IPro conducted provider directory audits and calculated the percentage of providers with verified telephone number, address, and specialty information as well as providers' participation in Medicaid and panel status. The accuracy of information varied widely. Provider directory accuracy thresholds were not established.

### General Recommendations for MassHealth:

- *Recommendation towards network data integrity* - The format of the submission templates should be adjusted to improve data submission accuracy and reduce duplications of the data.
- *Recommendation towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access.
- *Recommendations towards better provider directories* – The findings from the 2023 Provider Directory Audit should be used to improve and develop further network adequacy activities.

MBHP-specific results for network adequacy are provided in **Section VI** of this report.

## Member Experience of Care Survey

The overall objective of the member experience surveys is to capture accurate and complete information about consumer-reported experiences with health care.

### Strengths:

MassHealth requires MBHP to conduct satisfaction surveys of covered individuals and share the results with the state on an annual basis. MBHP contracted with SPH Analytics to administer a standardized survey, referred to as the MBHP's Member Satisfaction Survey.

When IPRO compared MBHP's survey results to the benchmark goals set by MassHealth, MBHP scored above the benchmark for the measure related to appointment access, as well as five measures in the Acceptability of MBHP Practitioners category, and four measures in the Scope of Service category. The following measures were topped-out at 100%:

- How satisfied are you with language assistance (Answer key: very or somewhat satisfied)
- How satisfied are you with accuracy of language assistance (Answer key: very or somewhat satisfied)
- How satisfied are you with ease of getting language assistance (Answer key: very or somewhat satisfied)
- How satisfied are you with timeliness of getting language assistance (Answer key: very or somewhat satisfied)

### Opportunities for Improvement:

Sixteen of MBHP measures scored below the benchmark goal. All measures in the Experience of Care category scored below the set goal.

Summarized information about health plans' performance is not available on the MassHealth website. Making survey reports publicly available could help inform consumers about health plan choices.

MBHP's Member Satisfaction Survey does not adhere to CMS technical specifications for the mandatory reporting of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H Child Version (CPC-CH) measure. To adhere to Medicaid Child Core Set reporting guidance issued by CMS, MassHealth would need to follow the HEDIS protocol and ensure that all measure-eligible Medicaid and CHIP beneficiaries are included in the state reporting of the child CAHPS Health Plan Survey measure. This includes children enrolled in multiple delivery systems, like managed care, primary care case management, and fee for service.<sup>3</sup> Child Core Set reporting is mandatory beginning with FFY 2024 reporting.

### General Recommendations for MassHealth:

- *Recommendation towards better performance on member experience of care measures* – Considering the high scores and some measures reaching 100% satisfaction, MassHealth should discuss with MBHP a possibility of refining or expanding the survey to capture more nuanced feedback. MassHealth should work with MBHP to review complaints and grievances to identify additional survey questions and areas for improvement.
- *Recommendation towards sharing information about member experiences* – IPRO recommends that MassHealth publish summary results from member experience surveys on the MassHealth Quality Reports and Resources website and make the results available to MassHealth enrollees.

MBHP-specific results for member experience of care surveys are provided in **Section VII** of this report.

## Recommendations

Per *Title 42 CFR § 438.364 External quality review results (a)(4)*, this report is required to include recommendations for improving the quality of health care services furnished by MBHP and recommendations on how MassHealth can target the goals and the objectives outlined in the state's quality strategy to better

support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to Medicaid managed care enrollees.

### ***EQR Recommendations for MassHealth***

Summary or recommendations for MassHealth:

- *Recommendation towards achieving the goals of the Medicaid quality strategy* – MassHealth should assess whether the state met or made progress on the five strategic goals and objectives described in the quality strategy.
- *Recommendation for MassHealth towards accelerating the effectiveness of MBHP PIPs:*
  - Standardized structure and reporting requirements should be established to define and describe PIP aims and interventions.
  - All Plans should be required to conduct an initial barrier analysis at the outset of every PIP and document it in PIP proposal submission. Additionally, Plans should be required/expected to conduct additional analyses throughout the process as additional barriers are discovered.
  - For each PIP intervention, Plans should be required to track implementation progress with at least one intervention-specific process measure. Rates should be tracked/reported on at least a quarterly basis throughout the PIP cycle.
  - Plans should be required to document modifications made to interventions throughout the PIP cycle in a uniform fashion within the PIP template.
  - Plans should be required to document efforts to promote sustainability and spread in a standardized manner across all interventions (and PIPs) in the final PIP report.
- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.
- *Recommendation towards better policy documentation* - The state should direct MBHP to thoroughly review its policies and procedures, integrating all Massachusetts contract requirements into relevant policies.
- *Recommendation towards addressing gaps identified through the compliance review* – To effectively address the areas of non-compliance, MassHealth should establish direct communication with MBHP to discuss the identified issues. MBHP should ensure alignment of policy requirements with the contract terms to guarantee comprehensive coverage and ensure timely submission of all required reports to MassHealth, maintaining the evidence of transmittal. MBHP should also amend existing contracts to require 10 years of record retention and ensure that future contracts comply with this requirement.
- *Recommendation towards network data integrity* - The format of the submission templates should be adjusted to improve data submission accuracy and reduce duplications of the data.
- *Recommendation towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access.
- *Recommendations towards better provider directories* – The findings from the 2023 Provider Directory Audit should be used to improve and develop further network adequacy activities.
- *Recommendation towards better performance on member experience of care measures* – Considering the high scores and some measures reaching 100% satisfaction, MassHealth should discuss with MBHP a possibility of refining or expanding the survey to capture more nuanced feedback. MassHealth should work with MBHP to review complaints and grievances to identify additional survey questions and areas for improvement.
- *Recommendation towards sharing information about member experiences* – IPRO recommends that MassHealth publish summary results from member experience surveys on the MassHealth Quality Reports and Resources website and make the results available to MassHealth enrollees.

### ***EQR Recommendations for MBHP***

MBHP-specific recommendations related to the **quality** of, **timeliness** of, and **access** to care are provided in **Section IX** of this report.

## II. Massachusetts Medicaid Managed Care Program

### Managed Care in Massachusetts

Massachusetts's Medicaid program provides healthcare coverage to low-income individuals and families in the state. Massachusetts's Medicaid program is funded by both the state and federal government, and it is administered by the Massachusetts EOHHS.

MassHealth's mission is to improve the health outcomes of its members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life. MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.<sup>4</sup>

MassHealth provides a range of health care services, including preventive care, medical and surgical treatment, and behavioral health services. It also covers the cost of prescription drugs and medical equipment as well as transportation services, smoking cessation services, and LTSS. In addition, MassHealth offers specialized programs for certain populations, such as seniors, people with disabilities, and pregnant women.

### MassHealth Medicaid Quality Strategy

*Title 42 CFR § 438.340* establishes that state agencies must draft and implement a written quality strategy for assessing and improving the quality of health care services furnished by the managed care programs with which the state is contracted.

MassHealth has implemented a comprehensive Medicaid quality strategy to improve the quality of health care for its members. The quality strategy is comprehensive, as it guides quality improvement of services delivered to all MassHealth members, including managed care and fee-for-service populations. MassHealth's strategic goals are listed in **Table 1**.

**Table 1: MassHealth's Strategic Goals**

Strategic Goal	Description
1. <b>Promote better care</b>	Promote safe and high-quality care for MassHealth members.
2. <b>Promote equitable care</b>	Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience.
3. <b>Make care more value-based</b>	Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care.
4. <b>Promote person and family-centered care</b>	Strengthen member and family-centered approaches to care and focus on engaging members in their health.
5. <b>Improve care</b>	Through better integration, communication, and coordination across the care continuum and across care teams for our members.

Quality strategy goals are considered in the design of MassHealth managed care programs, selection of quality metrics, and quality improvement projects for these programs, as well as in the design of other MassHealth initiatives. For the full list of MassHealth's quality goals and objectives see **Appendix A, Table A1**.

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<sup>4</sup> [MassHealth 2022 Comprehensive Quality Strategy \(mass.gov\)](https://www.mass.gov/info-details/masshealth-2022-comprehensive-quality-strategy)

## MassHealth Managed Care Programs

Under its quality strategy, EOHHS contracts with managed care organizations (MCOs), accountable care organizations (ACOs), behavioral health providers, and integrated care plans to provide coordinated health care services to MassHealth members. Most MassHealth members (70%) are enrolled in managed care and receive managed care services via one of seven distinct managed care programs described next.

1. The **Accountable Care Partnership Plans** (ACPPs) are health plans consisting of groups of primary care providers who partner with one managed care organization to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As accountable care organizations, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high quality care to MassHealth enrollees. To select an Accountable Care Partnership Plan, a MassHealth enrollee must live in the plan's service area and must use the plan's provider network.
2. The **Primary Care Accountable Care Organizations** (PC ACOs) are health plans consisting of groups of primary care providers who contract directly with MassHealth to provide integrated and coordinated care. A PC ACO functions as an accountable care organization and a primary care case management arrangement. In contrast to ACPPs, a PC ACO does not partner with just one managed care organization. Instead, PC ACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. **Managed Care Organizations** (MCOs) are health plans run by health insurance companies with their own provider network that includes primary care providers, specialists, behavioral health providers, and hospitals.
4. **Primary Care Clinician Plan** (PCCP) is a primary care case management arrangement, where Medicaid enrollees select or are assigned to a primary care provider, called a Primary Care Clinician (PCC). The PCC provides services to enrollees including the coordination, and monitoring of primary care health services. PCCP uses the MassHealth network of primary care providers, specialists, and hospitals as well as the Massachusetts Behavioral Health Partnership's network of behavioral health providers.
5. **Massachusetts Behavioral Health Partnership** is a health plan that manages behavioral health care for MassHealth's Primary Care Accountable Care Organizations and the Primary Care Clinician Plan. MBHP also serves children in state custody, not otherwise enrolled in managed care and certain children enrolled in MassHealth who have commercial insurance as their primary insurance.<sup>5</sup>
6. **One Care** Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services as well as long-term services and support. This plan is for enrollees between 21 and 64 years old who are dually enrolled in Medicaid and Medicare.<sup>6</sup>
7. **Senior Care Options** (SCO) plans are coordinated health plans that cover services paid by Medicare and Medicaid. This plan is for MassHealth enrollees 65 or older and it offers services to help seniors stay independently at home by combining healthcare services with social supports.<sup>7</sup>

See **Appendix B, Table B1** for the list of health plans across the seven managed care delivery programs, including plan name, MCP type, managed care authority, and population served.

## Quality Metrics

One of the key elements of MassHealth's quality strategy is the use of quality metrics to monitor and improve the care that health plans provide to MassHealth members. These metrics include measures of access to care, patient satisfaction, and quality of health care services.

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<sup>5</sup> Massachusetts Behavioral Health Partnership. Available at: <https://www.masspartnership.com/index.aspx>

<sup>6</sup> One Care Facts and Features. Available at: <https://www.mass.gov/doc/one-care-facts-and-features-brochure/download>

<sup>7</sup> Senior Care Options (SCO) Overview. Available at: <https://www.mass.gov/service-details/senior-care-options-sco-overview>



At a statewide level, MassHealth monitors the Medicaid program's performance on the CMS Medicaid Adult and Child Core Sets measures. On a program level, each managed care program has a distinctive slate of measures. Quality measures selected for each program reflect MassHealth quality strategy goals and objectives. For the alignment between MassHealth's quality measures with strategic goals and objectives, see **Appendix C, Table C1**.

Under each managed care program, health plans are either required to calculate quality measure rates or the state calculates measure rates for the plans. Specifically, MCOs, SCOs, One Care Plans and MBHP calculate HEDIS rates and are required to report on these metrics on a regular basis, whereas ACOs' and PCCP's quality rates are calculated by MassHealth's vendor Telligen®. MassHealth's vendor also calculates MCOs' quality measures that are not part of HEDIS reporting.

To evaluate performance, MassHealth identifies baselines and targets, compares a plan's performance to these targets, and identifies areas for improvement. For the MCO and ACO HEDIS measures, targets are the regional HEDIS Medicaid 75<sup>th</sup> and 90<sup>th</sup> percentiles. The MBHP and PCCP targets are the national HEDIS Medicaid 75<sup>th</sup> and 90<sup>th</sup> percentiles, whereas the SCO and One Care Plan targets are the national HEDIS Medicare and Medicaid 75<sup>th</sup> and 90<sup>th</sup> percentiles. The 75<sup>th</sup> percentile is a minimum or threshold standard for performance, and the 90<sup>th</sup> performance reflects a goal target for performance. For non-HEDIS measures, fixed targets are determined based on prior performance.

### ***Performance Improvement Projects***

MassHealth selects topics for its PIPs in alignment with the quality strategy goals and objectives, as well as in alignment with the CMS National Quality Strategy. Except for the two PCCM arrangements (i.e., PC ACOs and PCCP), all health plans are required to develop two PIPs. MassHealth requires that within each project there is at least one intervention focused on health equity, which supports MassHealth's strategic goal to promote equitable care.

### ***Member Experience of Care Surveys***

Each MCO, One Care Plan, and SCO independently contracts with a certified CAHPS vendor to administer the member experience of care surveys. MassHealth monitors the submission of CAHPS surveys to either NCQA or CMS and uses the results to inform quality improvement work.

For members enrolled in an ACP, a PC ACO, and the PCCP, MassHealth conducts an annual survey adapted from CG-CAHPS that assesses members experiences with providers and staff in physician practices and groups. Survey scores are used in the evaluation of ACOs' overall quality performance.

Individuals covered by MBHP are asked about their experience with specialty behavioral health care via the MBHP's Member Satisfaction Survey that MBHP is required to conduct annually.

### ***MassHealth Initiatives***

In addition to managed care delivery programs, MassHealth has implemented several initiatives to support the goals of its quality strategy.

#### **1115 Demonstration Waiver**

The MassHealth 1115 demonstration waiver is a statewide health reform initiative that enabled Massachusetts to achieve and maintain near universal healthcare coverage. Initially implemented in 1997, the initiative has developed over time through renewals and amendments. Through the 2018 renewal, MassHealth established ACOs, incorporated the Community Partners and Flexible Services (a program where ACOs provide a set of housing and nutritional support to certain members) and expanded coverage of SUD services.



The 1115 demonstration waiver was renewed in 2022 for the next five years. Under the most recent extension, MassHealth will continue to restructure the delivery system by increasing expectations for how ACOs improve care. It will also support investments in primary care, behavioral health, and pediatric care, as well as bring more focus on advancing health equity by incentivizing ACOs and hospitals to work together to reduce disparities in quality and access.

### **Quality and Equity Incentive Programs**

Quality and Equity Incentive Programs are initiatives coordinated between MassHealth's Accountable Care Organizations and acute hospitals with an overarching goal to improve quality of care and advance health equity. Health equity is defined as the opportunity for everyone to attain their full health potential regardless of their social position or socially assigned circumstance. ACOs quality and equity performance is incentivized through programs implemented under managed care authority. Hospitals quality performance is incentivized through the "Clinical Quality Incentive Program" implemented under State Plan Authority, while hospitals equity performance is incentivized through the "Hospital Quality and Equity Initiative" authorized under the 1115 Demonstration Waiver. Under the "Hospital Quality and Equity Initiative," private acute hospitals and the Commonwealth's only non-state-owned public hospital, Cambridge Health Alliance, are assessed on the completeness of social needs data (domain 1), performance on quality metrics and associated reductions in disparities (domain 2), and improvements in provider and workforce capacity and collaboration between health system partners (domain 3). MassHealth's ACOs and hospitals work towards coordinated deliverables aligned in support of the common goals of the incentive programs.<sup>8</sup> For example, in 2023, ACOs and hospitals partnered to work together on equity-focused performance improvement projects.

### **Roadmap for Behavioral Health**

Another MassHealth initiative that supports the goals of the quality strategy is the five-year roadmap for behavioral health reform that was released in 2021. Key components of implementing this initiative include the integration of behavioral health in primary care, community-based alternatives to emergency department for crisis interventions, and the creation of the 24-7 Behavioral Health Help Line (BHHL) that became available in 2023. The Behavioral Health Help Line is free and available to all Massachusetts residents.<sup>9</sup>

### ***Findings from State's Evaluation of the Effectiveness of its Quality Strategy***

Per *Title 42 CFR 438.340(c)(2)*, the review of the quality strategy must include an evaluation of its effectiveness. The results of the state's review and evaluation must be made available on the MassHealth website, and the updates to the quality strategy must consider the EQR recommendations.

MassHealth reviews and evaluates the effectiveness of its quality strategy every three years. In addition to the triennial review, MassHealth also conducts an annual review of measures and key performance indicators to assess progress toward strategic goals. MassHealth also relies on the EQR process to assess the managed care programs' effectiveness in providing high quality accessible services.

### **IPRO's Assessment of the Massachusetts Medicaid Quality Strategy**

Overall, MassHealth's quality strategy is designed to improve the quality of health care for MassHealth members. It articulates managed care priorities, including goals and objectives for quality improvement.

Quality strategy goals are considered in the design of MassHealth managed care programs, selection of quality metrics, and quality improvement projects, as well as in the design of other MassHealth initiatives. Consequently, MassHealth programs and initiatives reflect the priorities articulated in the strategy and include specific measures. Measures' targets are explained in the quality strategy by each managed care program.

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<sup>8</sup> MassHealth QEIP Deliverables Timelines. Available at: [download \(mass.gov\)](#). Accessed on 12.29.2023.

<sup>9</sup> Behavioral Health Help Line FAQ. Available at: [Behavioral Health Help Line \(BHHL\) FAQ | Mass.gov](#). Accessed on 12.29.2023.

Topics selected for PIPs are in alignment with the state’s strategic goals, as well as with the CMS National Quality Strategy. PIPs are conducted in compliance with federal requirements and are designed to drive improvement on measures that support specific strategic goals (see **Appendix C, Table C1**).

Per *Title 42 CFR § 438.68(b)*, the state developed time and distance standards for the following provider types: adult and pediatric primary care, ob/gyn, adult and pediatric behavioral health (for mental health and SUD), adult and pediatric specialists, hospitals, pharmacy, and LTSS. The state did not develop standards for pediatric dental services because dental services are carved out from managed care.

MassHealth’s quality strategy describes MassHealth’s standards for network adequacy and service availability, care coordination and continuity of care, coverage, and authorization of services, as well as standards for dissemination and use of evidence-based practice guidelines. MassHealth’s strategic goals include promoting timely preventative primary care services with access to integrated care and community-based services and supports. MassHealth’s strategic goals also include improving access for members with disabilities, as well as increasing timely access to behavioral health care and reducing mental health and SUD emergencies.

The state documented the EQR-related activities, for which it uses nonduplication. HEDIS Compliance Audit™ reports and NCQA health plan accreditations are used to fulfill aspects of PMV and compliance activities when plans received a full assessment as part of a HEDIS Compliance Audit or NCQA accreditation, worked with a certified vendor, and the nonduplication of effort significantly reduces administrative burden.

The quality strategy was posted to the MassHealth quality webpage for public comment, feedback was reviewed, and then the strategy was shared with CMS for review before it was published as final. MassHealth evaluates the effectiveness of its quality strategy and conducts a review of measures and key performance indicators to assess progress toward strategic goals. The evaluation of the effectiveness of the quality strategy should describe whether the state successfully promoted better care for MassHealth members (goal 1), achieved measurable reductions in health care inequities (goal 2), made care more value-based (goal 3), successfully promoted person- and family-centered care (goal 4), and improved care through better integration, communication, and coordination (goal 5). IPRO recommends that the evaluation of the current quality strategy, published in June 2022, clearly assesses whether the state met or made progress on its five strategic goals and objectives. For example, to assess if MassHealth achieved measurable reduction in health care inequities (goal 2), the state could look at the core set measures stratified by race and ethnicity; to assess if MassHealth made care more value-based (goal 3), the state could look at the number of enrollees in value-based arrangements. The state may decide to continue with or revise its five strategic goals based on the evaluation.

### III. Validation of Performance Improvement Projects

#### Objectives

*Title 42 CFR § 438.330(d)* establishes that state agencies require contracted MCPs to conduct PIPs that focus on both clinical and non-clinical areas. The purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCP.

Section 8.2.D.2 of MBHP's contract with MassHealth requires MBHP to develop PIPs designed to achieve significant improvements in clinical care and non-clinical care processes that are expected to improve health outcomes, as well as satisfaction of covered individuals, network providers, and primary care clinicians (PCCs), as MBHP provides services to members of the MassHealth PCC plan. MassHealth requires that within each PIP, there is at least one intervention focused on health equity. MassHealth can also modify the PIP cycle to address immediate priorities.

For the CY 2023, MBHP was required to submit two PIP reports in the following priority areas selected by MassHealth in alignment with its quality strategy goals:

- Priority area 1: improving rates of follow-up for alcohol and other drug use disorder after discharge.
- Priority area 2: improving follow-up after inpatient discharge by improving access to telehealth services.

Both PIPs were remeasurement projects that continued MBHP's work started in 2021. Specific MBHP PIP topics are displayed in **Table 2**.

**Table 2: MBHP PIP Topics – CY 2023**

MCP	PIP Topics
MBHP	<p><b>PIP 1: FUA – Year 2 Remeasurement Report</b> Improving rates of follow-up for alcohol and other drug use disorder after ED discharge (HEDIS FUA and measure) and the percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) use or dependence who received the following: initiation of AOD treatment, engagement of AOD treatment (IET)</p> <p><b>PIP 2: Telehealth – Year 2 Remeasurement Report</b> Improving follow-up after inpatient discharge by improving access to telehealth services</p>

*Title 42 CFR § 438.356(a)(1)* and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an External Quality Review Organization (EQRO) to perform the annual validation of PIPs. To meet federal regulations, MassHealth contracted with IPRO, an EQRO, to perform the validation of PIPs conducted by MBHP during the 2023 CY.

#### Technical Methods of Data Collection and Analysis

MBHP concluded their PIPs in March of 2023 and submitted closeout reports to IPRO in July and August of the same year. The report template and validation tool were developed by IPRO by merging a template that had been in use by health plans since the inception of their projects, with IPRO's standardized template. This integration allowed IPRO to enhance the original template report and include additional questions about successes and challenges encountered during the PIP and sustainability efforts.

In the closeout reports, MBHP described project goals, anticipated barriers, interventions, performance measures, and their evaluation of the effectiveness of the project. MBHP completed these reports electronically and submitted them to IPRO through a web-based project management and collaboration platform. IPRO was available for health plan questions and ad hoc calls related to the PIP throughout this process.

The analysis of the collected information focused on several key aspects, including an assessment of the quality of the data, appropriateness of the interventions, and interpretation of the results. It aimed to evaluate an alignment between the interventions and project goals and whether reported improvements could be maintained over time. The analysis of other PIP elements, such as the appropriateness of the topic, aim statement, population, sampling methods, and the variables, was conducted during the baseline and remeasurement years.

Description of Data Obtained

Information obtained throughout the reporting period included project description and goals, aim statement, population analysis, stakeholder involvement and barriers analysis, intervention parameters, and performance improvement indicators.

Conclusions

IPRO assigned two validation ratings. The first rating assessed IPRO’s overall confidence in the PIP's adherence to acceptable methodology throughout all project phases, including the design, data collection, data analysis, and interpretation of the results. The second rating evaluated IPRO’s overall confidence in the PIP's ability to produce significant evidence of improvement. Evidence of improvement was assessed in multiple activities throughout the PIP cycle, including identification of barriers, intervention selection and implementation, data informed modifications to interventions, and improvement of performance indicator rates. Both ratings used the following scale: high confidence, moderate confidence, low confidence, and no confidence.

- **Rating 1: Adherence to Acceptable Methodology - Validation results summary:** The ratings for PIPs adherence to acceptable methodology vary, with the Telehealth PIP receiving high confidence and the IET PIP receiving moderate confidence.
- **Rating 2: Evidence of Improvement - Validation results summary:** IPRO reviewers were moderately confident that both PIPs produced significant evidence of improvement.

PIP validation results are reported in Table 3 for MBHP.

Table 3: MBHP PIP Validation Confidence Ratings – CY 2023

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: IET	Moderate Confidence	Moderate Confidence
PIP 2: Telehealth	High Confidence	Moderate Confidence

CY: calendar year; PIP: performance improvement project; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.

## MBHP PIPs

MBHP PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 4–7**.

**Table 4: MBHP PIP 1 Summary, 2023**

<b>MBHP PIP 1: Improving rates of follow-up for alcohol and other drug use disorder after ED discharge (HEDIS FUA and measure) and the percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) use or dependence who received the following: initiation of AOD treatment, engagement of AOD treatment (IET)</b>		
<b>Validation Summary</b>		
Confidence Rating 1: PIP Adhered to Acceptable Methodology – Moderate Confidence		
Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence		
<b>Aim</b>		
To increase the percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) use or dependence who received initiation of AOD treatment and engagement of AOD treatment (IET). In addition, the scope of this project is also to improve care coordination and successful engagement in treatment for members who enter the emergency department (ED) with a primary diagnosis of alcohol and other drug use disorder or dependence (AOD), also commonly referred to as substance use disorder (SUD).		
<b>Interventions in 2023</b>		
<ul style="list-style-type: none"> <li>Expand the use of community support personnel (RC, RSN and CSP) for members in the IET cohort as a way of increasing rates of initiation and engagement in treatment.</li> <li>Initiation of a case manager follow-up with MBHP members who frequently use the ED (HEDIS FUA).</li> <li>Intervention 1 (creation of a Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) predictive model) was discontinued in 2023.</li> </ul>		
<b>Performance Improvement Summary</b>		
<ul style="list-style-type: none"> <li><b>Performance Indicator Results Summary:</b> <ul style="list-style-type: none"> <li>Indicator 1: discontinued.</li> <li>Indicator 2: IET: Initiation demonstrated slight improvement and Engagement performance declined slightly.</li> <li>Indicator 3: IET: Community Resources Used: Performance level declined.</li> <li>Indicator 4: FUA 7- and 30-day rate: For both rates, performance declined slightly.</li> </ul> </li> <li><b>Summary of factors associated with success:</b> Interventions were sound but may need reworking to prove successful.</li> <li><b>Summary of challenges/barriers faced during the PIP:</b> Members shifted to ACPs, and working with provider sites to connect members to community supports.</li> <li><b>Summary of how entities will use the PIP findings:</b> MBHP stated that their existing interventions were not as successful as planned and should work to either enhance them or develop new interventions for improving both FUA and IET rates. MBHP should develop targeted interventions to address the needs of sup-populations where disparities exist.</li> </ul>		

**Table 5: MBHP PIP 1 Performance Measures and Results**

Indicator	Reporting Year	Rate
Indicator 1: FUA – 7 days	2022 (baseline, MY 2022 data)	18.10%
Indicator 1: FUA – 7 days	2023 (remeasurement year 1)	Discontinued
Indicator 2: FUA – 30 days	2022 (baseline, MY 2022 data)	27.48%
Indicator 2: FUA – 30 days	2023 (remeasurement year 1)	Discontinued
Indicator 3: IET Initiation	2022 (baseline, MY 2022 data)	43.38%*
Indicator 3: IET Initiation	2023 (remeasurement year 1)	44.53%
Indicator 4: IET Engagement	2022 (baseline, MY 2022 data)	16.95%*
Indicator 4: IET Engagement	2023 (remeasurement year 1)	16.64%
Indicator 5: Utilization of Community Support for IET Population Discharged from ATS Inpatient Stay	2022 (baseline, MY 2022 data)	7.4%*

Indicator	Reporting Year	Rate
Indicator 5: Utilization of Community Support for IET Population Discharged from ATS Inpatient Stay	2023 (remeasurement year 1)	5.9%
Indicator 6: FUA – 7 days	2022 (baseline, MY 2022 data)	41.8%*
Indicator 6: FUA – 7 days	2023 (remeasurement year 1)	40.94%
Indicator 7: FUA – 30 days	2022 (baseline, MY 2022 data)	54.39%*
Indicator 7: FUA – 30 days	2023 (remeasurement year 1)	52.02%

\*MBHP reported different rates in the 2022 report. For indicator 3, MBHP reported 90.60% as the baseline rate. For indicator 4, MBHP reported 35.34% as the baseline rate. For indicator 5, MBHP reported 15.03% as the baseline rate. For indicator 6, MBHP reported 18.10% as the baseline rate. For indicator 7, MBHP reported 27.48% as the baseline rate. The table above has been adjusted to the rates reported in the 2023 PIP report.

**Table 6: MBHP PIP 2 Summary, 2023**

MBHP PIP 2: Improving follow-up after inpatient discharge by improving access to telehealth services
<b>Validation Summary</b> Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence
<b>Aim</b> To increase the utilization of telehealth as a modality for outpatient treatment within the context of the HEDIS FUH measure, which captures the rate of follow-up visits within 7 and 30 days for outpatient mental health care following discharge from inpatient mental health care.
<b>Interventions in 2023</b> <ul style="list-style-type: none"> <li>▪ Modify discharge form to allow inpatient (IP) providers to report telehealth as a type of appointment, including that telehealth capability was assessed with the member.</li> <li>▪ MBHP Provider Quality Managers (PQMs) to implement collaborative strategic plans for IP providers who, based on comparative performance data, may be candidates for increasing the percentage of aftercare appointments scheduled as telehealth appointments.</li> <li>▪ Recruit additional OP providers, who are proficient with the use of telehealth, to offer open access (timely same day appointments), to be listed on the Massachusetts Behavioral Health Access (MABHA) website.</li> <li>▪ Educate outpatient providers to include telehealth coding on claims.</li> </ul>
<b>Performance Improvement Summary</b> <ul style="list-style-type: none"> <li>▪ <b>Performance Indicator Results Summary:</b> The performance of the FUH telehealth rate was maintained when looking back to 2020 from 2022. The impact of the Covid-19 pandemic may have confounded the 2021 results. It would be helpful to report the overall FUH rates for 2020, 2021, and 2022 to determine whether overall improvement was demonstrated.</li> <li>▪ <b>Summary of factors associated with success:</b> Collaboration among various departments within MBHP enhanced coordination of effort that contributed to success, as well as building interventions into existing provider systems.</li> <li>▪ <b>Summary of challenges/barriers faced during the PIP:</b> MBHP reported that the length of time to develop and implement the interventions was a major challenge. The Covid-19 pandemic was associated with both success and failure and its impact may have affected the measure rates.</li> <li>▪ <b>Summary of how entities will use the PIP findings:</b> MBHP will share its findings with its provider councils and will continue to message providers about coding practices for telehealth visits.</li> </ul>

**Table 7: MBHP PIP 2 Performance Measures and Results**

Indicator	Reporting Year	Rate
Indicator 1: Percentage of completed post-discharge (7-day) follow-up visits conducted via telehealth (coded as telehealth-modifier 02)	2021 (baseline, MY 2021 data)	38.05%
Indicator 1: Percentage of completed post-discharge (7-day) follow-up visits conducted via telehealth (coded as telehealth-modifier 02)	2022 (remeasurement year 1)	52.03%
Indicator 1: Percentage of completed post-discharge (7-day) follow-up visits conducted via telehealth (coded as telehealth-modifier 02)	2023 (remeasurement year 2)	37.2%
Indicator 2: Percentage of completed post-discharge (30-day) follow-up visits conducted via telehealth (coded as telehealth-modifier 02)	2021 (baseline, MY 2021 data)	41.70%
Indicator 2: Percentage of completed post-discharge (30-day) follow-up visits conducted via telehealth (coded as telehealth-modifier 02)	2022 (remeasurement year 1)	54.59%
Indicator 2: Percentage of completed post-discharge (30-day) follow-up visits conducted via telehealth (coded as telehealth-modifier 02)	2023 (remeasurement year 2)	41.2%

### Recommendations

- Recommendation for PIP 1: MBHP may want to consider a similar or new intervention to notify ACPs of members who are high utilizers since the current intervention appears to be limited in its reach. MBHP noted that it is considering sharing information with its ACPs, and a similar "high risk" utilization report may prove to be effective.
- Recommendation for PIP 1: MBHP should consider working with their contracted EDs and develop a similar notification process where the ED notifies MBHP of members using the ED soon after discharge, giving the MBHP staff time to intervene and help arrange an outpatient visit. This intervention would also capture members who visit the ED only once during the study period, a cohort currently not included in the intervention.
- Recommendation for PIP 1: MBHP can assume a larger role in connecting members to community services rather than relying on providers to develop the linkages. This could be done by establishing a relationship with these services and directly referring members to the supports. MBHP can utilize their care management staff to oversee the care, help make appointments, and monitor attendance.
- Recommendation for PIP 1: MBHP should develop interventions specifically targeting sub-populations where the results indicate disparities of care.
- Recommendation for PIP 2: MBHP may want to consider addressing disparities with a targeted intervention towards sub-populations. The satisfaction survey indicated some differences in telehealth acceptance but it's unclear that the differences were sizable enough to warrant targeted interventions.



## IV. Validation of Performance Measures

### Objectives

The purpose of PMV is to assess the accuracy of PMs and to determine the extent to which PMs follow state specifications and reporting requirements.

### Technical Methods of Data Collection and Analysis

MassHealth contracted with IPRO to conduct PMV to assess the data collection and reporting processes used to calculate the MBHP PM rates.

MassHealth evaluates MBHP quality performance on a slate of HEDIS measures and one non-HEDIS measure. All MBHP HEDIS PMs were calculated by Inovalon®, an NCQA-certified vendor, to produce HEDIS measure rates. The one non-HEDIS measure rate was calculated using code developed by the MBHP.

MBHP received and processed behavioral health claims from providers and medical and pharmacy claims data from MassHealth. MBHP used this data for HEDIS and non-HEDIS measure calculation.

IPRO conducted a full ISCA to confirm that MBHP's information systems were capable of meeting regulatory requirements for managed care quality assessment and reporting. This included a review of the claims processing systems, enrollment systems, provider data systems, and encounter data systems. To this end, MBHP completed the ISCA tool and underwent a virtual site visit.

For the non-HEDIS measure, source code review was conducted with the MBHP to ensure compliance with the measure specifications when calculating the measures rate. For the HEDIS measures, the NCQA measure certification was accepted in lieu of source code review because the MBHP used Inovalon, an NCQA-certified vendor, to produce HEDIS measure rates.

PSV was conducted on MBHP systems during the virtual site review to confirm that the information from the primary source matched the output information used for measure reporting.

IPRO also reviewed processes used to collect, calculate, and report the PMs. The data collection validation included accurate numerator and denominator identification and algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately.

Finally, IPRO evaluated measure results and compare rates to industry standard benchmarks to validate the produced rates.

### Description of Data Obtained

The following information was obtained from the MBHP:

- A completed ISCA tool.
- Denominator and numerator compliant lists for the following two measures:
  - Follow-Up After Hospitalization for Mental Illness (FUH) - 7 Days, and
  - Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Initiation Phase .
- Rates for HEDIS measures for MY 2022.
- NCQA Measure Certification report for HEDIS measures.
- Rates for non-HEDIS measures for MY 2022.



## Conclusions and Comparative Findings

IPRO found that the data and processes used to produce HEDIS and non-HEDIS rates by the MBHP were fully compliant with information system standards. Findings from IPRO's review are displayed in **Table 8**.

**Table 8: MBHP Compliance with Information System Standards – MY 2022**

IS Standard	MBHP
1.0 Medical Services Data	Compliant
2.0 Enrollment Data	Compliant
3.0 Practitioner Data	Compliant
4.0 Medical Record Review Processes	N/A
5.0 Supplemental Data	N/A
6.0 Data Preproduction Processing	Compliant
7.0 Data Integration and Reporting	Compliant

MBHP: Massachusetts Behavioral Health Partnership; IS: information system; MY: measurement year; N/A: not applicable.

## Validation Results

- **Information Systems Capabilities Assessment (ISCA):** The ISCA is conducted to confirm that the MBHP's information systems (IS) were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, provider data systems. No issues were identified.
- **Source Code Validation:** Source code review is conducted to ensure compliance with the measure specifications when calculating measure rates. NCQA measure certification for HEDIS measures was accepted in lieu of source code review. Source code review was conducted for the non-HEDIS measure. No issues were identified.
- **Medical Record Validation:** No measures were reported using hybrid methodology. Therefore, medical record review validation was not required.
- **Primary Source Validation (PSV):** PSV is conducted to confirm that the information from the primary source matches the output information used for measure reporting. No Issues were identified.
- **Data Collection and Integration Validation:** This includes a review of the processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately. No issues were identified.
- **Rate Validation:** Rate validation is conducted to evaluate measure results and compare rates to industry standard benchmarks. No issues were identified. All required measures were reportable.

## Comparative Findings

IPRO compared the MBHP rates to the NCQA HEDIS MY 2022 Quality Compass national Medicaid percentiles. MassHealth's benchmarks for MBHP rates are the 75<sup>th</sup> and the 90<sup>th</sup> Quality Compass national percentile. The Quality Compass percentiles are color-coded to compare to the MBHP rates, as explained in **Table 9**. **Table 10** displays the HEDIS PMs for MY 2022 for MBHP.

Best Performance (rates above the 90<sup>th</sup> percentile):

- Follow-Up After Emergency Department Visit for Mental Illness (7 days)
- Follow-Up After Emergency Department Visit for Mental Illness (30 days)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)
- Pharmacotherapy for Opioid Use Disorder

Varied Performance (rates above the 50<sup>th</sup> but below the 90<sup>th</sup> percentile):

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)
- Antidepressant Medication Management (Acute)
- Antidepressant Medication Management (Continuation)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Follow-Up After Hospitalization for Mental Illness (7 days)
- Follow-Up After Hospitalization for Mental Illness (30 days)
- Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Needs Improvement (rates below 50<sup>th</sup> percentile):

- Follow-Up Care for Children Prescribed ADHD Medication (Initiation)
- Follow-Up Care for Children Prescribed ADHD Medication (Continuation)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Initiation of Alcohol and Other Drug Abuse or Dependence Treatment

**Table 9: Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2022 Quality Compass National Medicaid Percentiles.**

Key	How Rate Compares to the NCQA HEDIS Quality Compass NE Regional Percentiles
<25 <sup>th</sup>	Below the NE regional Medicaid 25 <sup>th</sup> percentile.
≥25 <sup>th</sup> but <50 <sup>th</sup>	At or above the NE regional Medicaid 25 <sup>th</sup> percentile but below the 50 <sup>th</sup> percentile.
≥50 <sup>th</sup> but <75 <sup>th</sup>	At or above the NE regional Medicaid 50 <sup>th</sup> percentile but below the 75 <sup>th</sup> percentile.
≥75 <sup>th</sup> but <90 <sup>th</sup>	At or above the NE regional Medicaid 75 <sup>th</sup> percentile but below the 90 <sup>th</sup> percentile.
≥90 <sup>th</sup>	At or above the NE regional Medicaid 90 <sup>th</sup> percentile.
N/A	No NE regional benchmarks available for this measure or measure not applicable (N/A).

**Table 10: MBHP HEDIS Performance Measures – MY 2022**

HEDIS Measure	MBHP
Follow-Up Care for Children Prescribed ADHD Medication (Initiation)	39.81% (≥25th but <50th)
Follow-Up Care for Children Prescribed ADHD Medication (Continuation)	44.69% (<25th)
Metabolic Monitoring for Children and Adolescents on Antipsychotics	36.45% (≥50th but <75th)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.79% (≥25th but <50th)
Follow-Up After Emergency Department Visit for Mental Illness (7 days)	77.29% (≥90th)
Follow-Up After Emergency Department Visit for Mental Illness (30 days)	83.65% (≥90th)
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	41.34% (≥90th)
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	53.22% (≥75th but <90th)
Follow-Up After Hospitalization for Mental Illness (7 days)	42.50% (≥50th but <75th)
Follow-Up After Hospitalization for Mental Illness (30 days)	64.28% (≥50th but <75th)

HEDIS Measure	MBHP
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	44.24% (≥25th but <50th)
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	16.91% (≥50th but <75th)
Antidepressant Medication Management (Acute)	71.37% (≥75th but <90th)
Antidepressant Medication Management (Continuation)	56.06% (≥75th but <90th)
Pharmacotherapy for Opioid Use Disorder	47.23% (≥90th)

MBHP: Massachusetts Behavioral Health Partnership; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; ADHD: attention deficit hyperactivity disorder.

## V. Review of Compliance with Medicaid and CHIP Managed Care Regulations

### Objectives

The objective of the compliance review process is to determine the extent to which Medicaid managed care entities comply with federal quality standards mandated by the Balanced Budget Act of 1997 (BBA).

The purpose of this compliance review was to assess One Care Plans compliance with federal and state regulations regarding access to care; structure and operations; grievance policies; provider network relations and network adequacy; quality measurement; and utilization management (UM).

This section of the report summarizes the 2023 compliance results. The next comprehensive review will be conducted in 2026, as the compliance validation process is conducted triennially.

### Technical Methods of Data Collection and Analysis

IPRO's review of compliance with state and federal regulations was conducted in accordance with Protocol 3 of the CMS EQR Protocols.

Compliance reviews were divided into 14 standards consistent with the CMS February 2023 EQR protocols:

- Disenrollment requirements and limitations (42 CFR 438.56)
- Enrollee rights requirements (42 CFR 438.100)
- Emergency and post-stabilization services (42 CFR 438.114)
- Availability of services (42 CFR 438.206)
- Assurances of adequate capacity and services (42 CFR 438.207)
- Coordination and continuity of care (42 CFR 438.208)
- Coverage and authorization of services (42 CFR 438.210)
- Provider selection (42 CFR 438.214)
- Confidentiality (42 CFR 438.224)
- Grievance and appeal systems (42 CFR 438.228)
- Subcontractual relationships and delegation (42 CFR 438.230)
- Practice guidelines (42 CFR 438.236)
- Health information systems (42 CFR 438.242)
- Quality assessment and performance improvement program (QAPI) (42 CFR 438.330)

The 2023 annual compliance review consisted of three phases: 1) pre-onsite documentation review, 2) remote interviews, and 3) post-onsite report preparation.

### Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of MassHealth's policies and procedures, IPRO prepared 14 review tools to reflect the areas for review. These 14 tools were submitted to MassHealth for approval at the outset of the review process. The tools included review elements drawn from the state and federal regulations. Based upon MassHealth's suggestions, some tools were revised and issued as final. These final tools were submitted to MassHealth in advance of the remote review.

Once MassHealth approved the methodology, IPRO sent MBHP a packet that included the review tools, along with a request for documentation and a guide to help MBHP staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure File Transfer Protocol (FTP) site.

To facilitate the review process, IPRO provided MBHP with examples of documents that they could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also provided, along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO randomly selected a sample of cases for the plans to provide in each area, which were reviewed remotely.

Prior to the review, MBHP submitted written policies, procedures and other relevant documentation to support its adherence to state and federal requirements. MBHP was given a period of approximately four weeks to submit documentation to IPRO. To further assist MBHP staff in understanding the requirements of the review process, IPRO convened a conference call for all MCPs undergoing the review, with MassHealth staff in attendance. During the conference call, IPRO detailed the steps in the review process, the audit timeline, and answered any questions posed by MBHP staff.

After MBHP submitted the required documentation, a team of IPRO reviewers was convened to review policies, procedures, and materials, and to assess MBHP's concordance with the state contract requirements. This review was documented using review tools IPRO developed to capture the review of required elements and record the findings. These review tools with IPRO's initial findings were used to guide the remote conference interviews.

### **Remote Interviews**

The remote interview with MBHP was conducted between September 18 and September 19, 2023. Interviews with relevant plan staff allow the EQR to assess whether the plan indeed understands the requirements, can articulate in their own words, the internal processes, and procedures to deliver the required services to members and providers, and draw the relationship between the policies and the implementation of those policies. Interviews discussed elements in each of the review tools that were considered less than fully compliant based upon initial review. Interviews were used to further explore the written documentation and to allow MBHP to provide additional documentation, if available. MBHP's staff was given 2 days from the close of the onsite review to provide any further documentation.

### **Post-onsite Report Preparation**

Following the remote interviews, review tools were updated. These post-interview tools included an initial review determination for each element reviewed and identified what specific evidence was used to assess that MBHP was compliant with the standard or a rationale for why MBHP was partially compliant or non-compliant and what evidence was lacking. For each element that was deemed less than fully compliant, IPRO provided a recommendation for MBHP to consider in order to attain full compliance.

Each draft post-interview tool underwent a second level of review by IPRO staff members who were not involved in the first level of review. Once completed, the post-interview tools were shared with MassHealth staff for review. Any updates or revisions requested by MassHealth were considered and if appropriate, edits were made to the post-interview tools. Upon MassHealth approval, the post-interview tools were sent to MBHP with a request to respond to all elements that were determined to be less than fully compliant. MBHP was given 3 weeks to respond to the issues noted on the post-interview tools. MBHP was asked to indicate if they agree or disagree with IPRO's determinations. If disagreeing, MBHP was asked to provide a rationale and indicate documentation that had already been submitted to address the requirement in full. After receiving MBHP's response, IPRO re-reviewed each element for which MBHP provided a citation. As necessary, review scores and recommendations were updated based on the response.

For each standard identified as Partially Met or Not Met, the MCP was required to provide a timeline and high-level plan to implement the correction. MBHP is expected to provide an update on the status of the implementation of the corrections when IPRO requests an update on the status of the ATR recommendations, which is part of the annual external quality review process.

### Scoring Methodology

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by the total possible points. A three-point scoring system was used: Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points. The scoring definitions are outlined in **Table 11**.

**Table 11: Scoring Definitions**

Scoring	Definition
Met = 1 point	Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and MCP staff interviews provided information consistent with documentation provided.
Partially Met = 0.5 points	Any one of the following may be applicable: <ul style="list-style-type: none"> <li>Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. MCP staff interviews, however, provided information that was not consistent with the documentation provided.</li> <li>Documentation to substantiate compliance with some but not all of the regulatory or contractual provisions was provided, although MCP staff interviews provided information consistent with compliance with all requirements.</li> <li>Documentation to substantiate compliance with some but not all of the regulatory or contractual provisions was provided, and MCP staff interviews provided information inconsistent with compliance with all requirements.</li> </ul>
Not Met = 0 points	There was an absence of documentation to substantiate compliance with any of the regulatory or contractual requirements and MCP staff did not provide information to support compliance with requirements.
Not Applicable	The requirement was not applicable to the MCP. N/A elements are removed from the denominator

### Description of Data Obtained

Compliance review tools included detailed regulatory and contractual requirements in each standard area. The MCPs were provided with the appropriate review tools and asked to provide documentation to substantiate compliance with each requirement during the review period. Examples of documentation provided by MCPs included: policies and procedures, standard operating procedures, workflows, reports, member materials, care management files, and utilization management denial files, as well as appeals, grievance, and credentialing files.

### Conclusions and Comparative Findings

MBHP was compliant with many of the Medicaid and CHIP managed care regulations and standards. MBHP achieved compliance score of 100% in the following domains:

- Disenrollment requirements and limitations
- Emergency and post-stabilization services
- Assurances of adequate capacity and services
- Confidentiality
- Grievance and appeal systems
- Practice guidelines
- Quality assessment and performance improvement program

However, MBHP performed below 90% in the following three domains:

- Coordination and continuity of care
- Provider selection
- Subcontractual relationships and delegation

Table 12 presents MBHP's compliance scores for each of the 14 review domains.

**Table 12: MBHP Performance by Review Domain – 2023 Compliance Validation Results**

CFR Standard Name (Review Domain)	CFR Citation	MBHP
<b>Overall compliance score</b>	<b>N/A</b>	<b>94.6%</b>
Disenrollment requirements and limitations	438.56	100.0%
Enrollee rights requirements	438.100	92.3%
Emergency and post-stabilization services	438.114	100.0%
Availability of services	438.206	90.0%
Assurances of adequate capacity and services	438.207	100.0%
Coordination and continuity of care	438.208	87.9%
Coverage and authorization of services	438.210	98.1%
Provider selection	438.214	87.1%
Confidentiality	438.224	100.0%
Grievance and appeal systems	438.228	100.0%
Subcontractual relationships and delegation	438.230	75.0%
Practice guidelines	438.236	100.0%
Health information systems	438.242	94.4%
Quality assessment and performance improvement program (QAPI)	438.330	100.0%

CFR: Code of Federal Regulations; QAPI: Quality Assurance and Performance Improvement.

## VI. Validation of Network Adequacy

### Objectives

*Title 42 CFR § 438.68(a)* requires states to develop and enforce network adequacy standards. At a minimum, states must develop time and distance standards for the following provider types: adult and pediatric primary care, ob/gyn, adult and pediatric behavioral health (for mental health and SUD), adult and pediatric specialists, hospitals, pediatric dentists, and LTSS, per *Title 42 CFR § 438.68(b)*.

The state of Massachusetts has developed access and availability standards based on the requirements outlined in *Title 42 CFR § 438.68@*. One of the goals of MassHealth's quality strategy is to promote timely preventative primary care services with access to integrated care and community-based services and supports. MassHealth's strategic goals also include improving access for members with disabilities, as well as increasing timely access to behavioral health care and reducing mental health and SUD emergencies.

MassHealth's access and availability standards for the MBHP are described in Section 3 of the First Amended and Restated Behavioral Health Vendor Contract with MBHP. MBHP must ensure that at a minimum 90% of enrollees have access to all medically necessary behavioral health covered services within specific travel time or distance standards defined in Section 3.1.G of the MBHP contract. MBHP is also required to make covered services available 24 hours a day, seven days a week when medically necessary.

*Title 42 CFR § 438.356(a)(1)* and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet federal regulations, MassHealth contracted with IPRO, an EQRO, to perform the validation of MBHP's provider network. IPRO evaluated MBHP's provider networks compliance with MassHealth's geo-access requirements as well as the accuracy of the information presented in MBHP's online provider directory.

### Technical Methods of Data Collection and Analysis

IPRO evaluated MBHP's provider network to determine compliance with the travel time and distance standards established by MassHealth. According to the MBHP's contract, at least 90% of health plan members in each county must have access to in-network providers in accordance with the time-OR-distance standards defined in the contract.

IPRO reviewed MassHealth network availability standards and worked together with the state to define network adequacy indicators. Network adequacy indicators were defined through a series of meetings with IPRO and MassHealth that took place between April and August 2023. The detailed MBHP's network adequacy standards and indicators are listed in **Appendix D (Tables D1 to D6)**.

IPRO requested in-network providers data on August 1, 2023, with a submission due date of August 29, 2023. MBHP submitted data to IPRO following templates developed by MassHealth and utilized by MCOs and ACPPs to report providers lists to MassHealth on an annual basis. The submitted data went through a careful and significant data clean up and deduplication process. If IPRO identified missing or incorrect data, MBHP was contacted and asked to resubmit. Duplicative records were identified and removed before the analysis.

IPRO entered into an agreement with Quest Analytics™ to calculate MBHP's geo-access reports. The analysis showed whether MBHP had a sufficient network of providers for all covered individuals residing in the same county. While the analysis is conducted for members who live in the same county, providers do not have to practice in that county; a provider must be available within a specified travel time or distance from the covered individual's ZIP code of residence. IPRO aggregated the results to identify counties with deficient networks.



When MBHP appeared to have network deficiencies in a particular county, IPRO reported the percent of covered individuals in that county who had adequate access.

In addition, using MBHP’s online provider directory, IPRO validated the accuracy of the information published in the provider directories through reveal calls to provider practices. IPRO reviewers contacted a sample of practice sites to confirm providers’ participation with the Medicaid managed care plan, specialty, telephone number, and address. The validation of provider directories included the following behavioral health provider types:

- Adult Psychiatry
- Advanced Practice Reg Nurse (Nurse Practitioner)
- Applied Behavioral Analysts (ABA)
- Behavior Management Therapist
- Licensed Alcohol and Drug Counselors (includes counselors that range from a scale of 1-7 based on the licensure level of the provider)
- Licensed Certified Social Worker
- Licensed Independent Clinical Social Worker
- Licensed Mental Health Counselor
- Licensed Psychologist (Doctorate Level)
- Methadone Maintenance Program
- Outpatient Clinical/Mental Health Center
- Psychiatric Nurse Mental Health Clinical Specialist
- Psychiatry
- Youth Psychiatry

## Description of Data Obtained

Validation of network adequacy for CY 2023 was performed using in-network providers data submitted by MBHP to IPRO. IPRO requested a complete specialists and behavioral health providers list which included facility/provider name, address, phone number, and the national provider identifier (NPI). IPRO also received a complete list of MBHP covered individuals from the state.

Geo-access reports were generated by combining the following files together: data on all providers and service locations contracted to participate in MBHP’s network, covered individuals’ enrollment data, service area information provided by MassHealth, and network adequacy standards and indicators.

For the provider directory validation, provider directory web address was reported to IPRO by MBHP and is available here: [masspartnership.com/member/FindBHProvider.aspx](https://masspartnership.com/member/FindBHProvider.aspx).

## Conclusions

IPRO found multiple issues with in-network provider data submitted by MBHP for analysis. For example, individual provider names were submitted where facilities were requested and listed under the same address and NPI as the facility; also, facility departments were submitted in addition to the facility name under the same facility’s NPI and address leading to duplication of records. After removing duplicate records, IPRO’s analysis showed that MBHP had adequate networks of 2 provider types in all 14 counties.

## Time and Distance Standards

**Tables 13–16** show the number of counties with an adequate network of providers by provider type. ‘Met’ means that MBHP had an adequate network of that provider type in all counties.

**Table 13: Number of Counties with an Adequate Network of Inpatient Service Providers**

“Met” means that MBHP had an adequate network of that provider type in all 14 counties.

Provider Type	Standard – 90% of Covered Individuals in a County who Have Access	The number of counties where MBHP had an adequate network
Psych Inpatient Adult	2 providers within 60 miles or 60 minutes	13 out of 14 (Partially Met)
Psych Inpatient Adolescent	2 providers within 60 miles or 60 minutes	13 out of 14 (Partially Met)
Psych Inpatient Child	2 providers within 60 miles or 60 minutes	13 out of 14 (Partially Met)
Managed Inpatient Level 4	2 providers within 60 miles or 60 minutes	9 out of 14 (Partially Met)

MBHP: Massachusetts Behavioral Health Partnership.

**Table 14: Number of Counties with an Adequate Network of BH Diversionary Services**

“Met” means that MBHP had an adequate network of that provider type in all 14 counties.

Provider Type	Standard – 90% of Covered Individuals in a County who Have Access	The number of counties where MBHP had an adequate network
Community Crisis Stabilization	2 providers within 30 miles or 30 minutes.	9 out of 14 (Partially Met)
Community-Based Acute Treatment for Children and Adolescents (CBAT)	2 providers within 30 miles or 30 minutes.	5 out of 14 (Partially Met)
Monitored Inpatient (Level 3.7)	2 providers within 30 miles or 30 minutes.	7 out of 14 (Partially Met)
Clinical Support Services for Substance Use Disorders (Level 3.5)	2 providers within 30 miles or 30 minutes.	6 out of 14 (Partially Met)
Community Support Program (CSP)	2 providers within 30 miles or 30 minutes.	13 out of 14 (Partially Met)
Partial Hospitalization Program (PHP)	2 providers within 30 miles or 30 minutes.	10 out of 14 (Partially Met)
Psychiatric Day Treatment	2 providers within 30 miles or 30 minutes.	4 out of 14 (Partially Met)
Structured Outpatient Addiction Program (SOAP)	2 providers within 30 miles or 30 minutes.	11 out of 14 (Partially Met)
Program of Assertive Community Treatment (PACT)	2 providers within 30 miles or 30 minutes.	8 out of 14 (Partially Met)
Intensive Outpatient Program (IOP)	2 providers within 30 miles or 30 minutes.	12 out of 14 (Partially Met)
Recovery Coaching	2 providers within 30 miles or 30 minutes.	13 out of 14 (Partially Met)
Recovery Support Navigators	2 providers within 30 miles or 30 minutes.	13 out of 14 (Partially Met)
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	2 providers within 30 miles or 30 minutes.	12 out of 14 (Partially Met)

MBHP: Massachusetts Behavioral Health Partnership; CBAT: community-based acute treatment for children and adolescents.

**Table 15: Number of Counties with an Adequate Network of BH Outpatient Services**

“Met” means that MBHP had an adequate network of that provider type in all 14 counties.

Provider Type	Standard – 90% of Covered Individuals in a County who Have Access	The number of counties where MBHP had an adequate network
BH Outpatient	2 providers within 30 miles or 30 minutes.	14 out of 14 (Met)
Psychiatry	2 providers within 30 miles or 30 minutes.	11 out of 14 (Partially Met)
Psychology	2 providers within 30 miles or 30 minutes.	13 out of 14 (Partially Met)
Psych APN	2 providers within 30 miles or 30 minutes.	13 out of 14 (Partially Met)
Opioid Treatment Programs	2 providers within 30 miles or 30 minutes.	14 out of 14 (Met)
Applied Behavior Analysis	2 providers within 30 miles or 30 minutes.	9 out of 14 (Partially Met)

MBHP: Massachusetts Behavioral Health Partnership.

**Table 16: Number of Counties with an Adequate Network of BH Intensive Community Treatment**

“Met” means that MBHP had an adequate network of that provider type in all 14 counties.

Provider Type	Standard – 90% of Covered Individuals in a County who Have Access	The number of counties where MBHP had an adequate network
In-Home Behavioral Services	2 providers within 30 miles or 30 minutes.	11 out of 14 (Partially Met)
In-Home Therapy Services	2 providers within 30 miles or 30 minutes.	13 out of 14 (Partially Met)
Therapeutic Mentoring Services	2 providers within 30 miles or 30 minutes.	13 out of 14 (Partially Met)

### **MBHP Network Deficiencies**

A detailed analysis of network deficiencies is presented below. If at least 90% of MBHP members in one county had adequate access, then the network availability standard was met. But if less than 90% of members in one county had adequate access, then the network was deficient. **Tables 17–20** show counties with deficient networks.

**Table 17: MBHP Counties with Network Deficiencies of BH Inpatient Service Provider**

Provider Type	County with a Deficient Network	Percent of Covered Individuals with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Psych Inpatient Adult	Nantucket	9.7%	2 providers within 60 miles or 60 minutes.
Psych Inpatient Adolescent	Nantucket	9.7%	2 providers within 60 miles or 60 minutes.
Psych Inpatient Child	Nantucket	9.7%	2 providers within 60 miles or 60 minutes.
Managed Inpatient Level 4	Berkshire	0.0%	2 providers within 60 miles or 60 minutes.
Managed Inpatient Level 4	Franklin	0.2%	2 providers within 60 miles or 60 minutes.
Managed Inpatient Level 4	Hampden	0.5%	2 providers within 60 miles or 60 minutes.
Managed Inpatient Level 4	Hampshire	12.4%	2 providers within 60 miles or 60 minutes.
Managed Inpatient Level 4	Nantucket	0.0%	2 providers within 60 miles or 60 minutes.

**Table 18: MBHP Counties with Network Deficiencies of BH Diversionary Services**

Provider Type	County with a Deficient Network	Percent of Covered Individuals with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Community Crisis Stabilization	Barnstable	0.0%	2 providers within 30 miles or 30 minutes.
Community Crisis Stabilization	Berkshire	19.8%	2 providers within 30 miles or 30 minutes.
Community Crisis Stabilization	Bristol	63.7%	2 providers within 30 miles or 30 minutes.

Provider Type	County with a Deficient Network	Percent of Covered Individuals with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Community Crisis Stabilization	Dukes	0.0%	2 providers within 30 miles or 30 minutes.
Community Crisis Stabilization	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Barnstable	7.2%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Berkshire	0.0%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Dukes	0.0%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Essex	87.9%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Franklin	0.0%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Hampden	0.0%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Hampshire	0.0%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.
Community-Based Acute Treatment for Children and Adolescents (CBAT)	Worcester	65.5%	2 providers within 30 miles or 30 minutes.
Monitored Inpatient (Level 3.7)	Barnstable	5.9%	2 providers within 30 miles or 30 minutes.
Monitored Inpatient (Level 3.7)	Berkshire	0.0%	2 providers within 30 miles or 30 minutes.
Monitored Inpatient (Level 3.7)	Dukes	0.0%	2 providers within 30 miles or 30 minutes.
Monitored Inpatient (Level 3.7)	Franklin	0.0%	2 providers within 30 miles or 30 minutes.
Monitored Inpatient (Level 3.7)	Hampden	2.1%	2 providers within 30 miles or 30 minutes.
Monitored Inpatient (Level 3.7)	Hampshire	17.8%	2 providers within 30 miles or 30 minutes.
Monitored Inpatient (Level 3.7)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.
Clinical Support Services for Substance Use Disorders (Level 3.5)	Barnstable	63.5%	2 providers within 30 miles or 30 minutes.

Provider Type	County with a Deficient Network	Percent of Covered Individuals with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Clinical Support Services for Substance Use Disorders (Level 3.5)	Berkshire	0.0%	2 providers within 30 miles or 30 minutes.
Clinical Support Services for Substance Use Disorders (Level 3.5)	Essex	71.3%	2 providers within 30 miles or 30 minutes.
Clinical Support Services for Substance Use Disorders (Level 3.5)	Franklin	0.0%	2 providers within 30 miles or 30 minutes.
Clinical Support Services for Substance Use Disorders (Level 3.5)	Hampden	2.1%	2 providers within 30 miles or 30 minutes.
Clinical Support Services for Substance Use Disorders (Level 3.5)	Hampshire	17.8%	2 providers within 30 miles or 30 minutes.
Clinical Support Services for Substance Use Disorders (Level 3.5)	Middlesex	85.8%	2 providers within 30 miles or 30 minutes.
Clinical Support Services for Substance Use Disorders (Level 3.5)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.
Community Support Program (CSP)	Nantucket	4.9%	2 providers within 30 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Berkshire	3.3%	2 providers within 30 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Dukes	63.0%	2 providers within 30 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Franklin	88.4%	2 providers within 30 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Nantucket	0.5%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Barnstable	0.0%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Berkshire	0.0%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Bristol	23.5%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Dukes	0.0%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Franklin	0.0%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Hampden	0.0%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Hampshire	0.0%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Plymouth	88.6%	2 providers within 30 miles or 30 minutes.
Psychiatric Day Treatment	Worcester	67.9%	2 providers within 30 miles or 30 minutes.
Structured Outpatient Addiction Program (SOAP)	Barnstable	82.7%	2 providers within 30 miles or 30 minutes.
Structured Outpatient Addiction Program (SOAP)	Berkshire	20.9%	2 providers within 30 miles or 30 minutes.
Structured Outpatient Addiction Program (SOAP)	Nantucket	0.5%	2 providers within 30 miles or 30 minutes.

Provider Type	County with a Deficient Network	Percent of Covered Individuals with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Program of Assertive Community Treatment (PACT)	Barnstable	41.7%	2 providers within 30 miles or 30 minutes.
Program of Assertive Community Treatment (PACT)	Berkshire	0.8%	2 providers within 30 miles or 30 minutes.
Program of Assertive Community Treatment (PACT)	Bristol	51.2%	2 providers within 30 miles or 30 minutes.
Program of Assertive Community Treatment (PACT)	Dukes	40.4%	2 providers within 30 miles or 30 minutes.
Program of Assertive Community Treatment (PACT)	Hampden	21.5%	2 providers within 30 miles or 30 minutes.
Program of Assertive Community Treatment (PACT)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.
Intensive Outpatient Program (IOP)	Dukes	27.6%	2 providers within 30 miles or 30 minutes.
Intensive Outpatient Program (IOP)	Nantucket	4.1%	2 providers within 30 miles or 30 minutes.
Recovery Coaching	Nantucket	4.9%	2 providers within 30 miles or 30 minutes.
Recovery Support Navigators	Nantucket	4.9%	2 providers within 30 miles or 30 minutes.
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	Barnstable	69.9%	2 providers within 30 miles or 30 minutes.
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.

MBHP: Massachusetts Behavioral Health Partnership; Psych APN: psychiatric advanced nurse; PCNS: psychiatric clinical nurse specialist; CNP: certified nurse practitioner; CBAT: community-based acute treatment for children and adolescents; SUD: substance use disorder.

**Table 19: MBHP Counties with Network Deficiencies of BH Outpatient Services**

Provider Type	County with a Deficient Network	Percent of Covered Individuals with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Psychiatry	Barnstable	88.7%	2 providers within 30 miles or 30 minutes.
Psychiatry	Dukes	76.9%	2 providers within 30 miles or 30 minutes.
Psychiatry	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.
Psychology	Nantucket	28.7%	2 providers within 30 miles or 30 minutes.
Psych APN	Nantucket	4.4%	2 providers within 30 miles or 30 minutes.
Applied Behavior Analysis	Barnstable	33.2%	2 providers within 30 miles or 30 minutes.
Applied Behavior Analysis	Berkshire	1.2%	2 providers within 30 miles or 30 minutes.
Applied Behavior Analysis	Dukes	0.0%	2 providers within 30 miles or 30 minutes.
Applied Behavior Analysis	Franklin	7.2%	2 providers within 30 miles or 30 minutes.
Applied Behavior Analysis	Nantucket	0.0%	2 providers within 30 miles or 30 minutes.

MBHP: Massachusetts Behavioral Health Partnership; Psych APN: psychiatric advanced nurse.

**Table 20: MBHP Counties with Network Deficiencies of BH Intensive Community Treatment**

Provider Type	County with a Deficient Network	Percent of Covered Individuals with Access in that County	Standard – 90% of Enrollees in a County who Have Access
In-Home Behavioral Services	Barnstable	50.8%	2 providers within 30 miles or 30 minutes.
In-Home Behavioral Services	Dukes	3.6%	2 providers within 30 miles or 30 minutes.
In-Home Behavioral Services	Nantucket	1.9%	2 providers within 30 miles or 30 minutes.
In-Home Therapy Services	Nantucket	4.1%	2 providers within 30 miles or 30 minutes.
Therapeutic Mentoring Services	Nantucket	4.4%	2 providers within 30 miles or 30 minutes.

MBHP: Massachusetts Behavioral Health Partnership.

### **Provider Directory Validation**

IPRO validated the accuracy of provider directories for a sample of provider types chosen by MassHealth. **Table 21** shows the percentage of providers in the directory with verified telephone number, address, specialty information, Medicaid participation, and panel status. **Table 22** shows the most frequent reasons why information in the directories was incorrect or could not be validated.

**Table 21: Provider Directory Accuracy – MBHP**

Provider Type	Goal	MBHP Accuracy Rate
Psychiatry	Not Defined	33.33%*
Applied Behavioral Analysts (ABA)	Not Defined	15.38%*
Licensed Certified Social Worker	Not Defined	0.00%*
Licensed Independent Clinical Social Worker	Not Defined	7.69%*
Licensed Mental Health Counselor	Not Defined	7.69%*
Licensed Psychologist (Doctorate Level)	Not Defined	7.69%*
Outpatient Clinical/Mental Health Center	Not Defined	46.15%*
Psychiatric Nurse Mental Health Clinical Specialist	Not Defined	9.09%*
Psychiatry	Not Defined	33.33%*
All BH Providers/Facilities**	Not Defined	14.17%

\*Sample Size less than 30, interpret with caution. \*\* All BH Providers/Facilities include also Advanced Practice Reg Nurse, Behavior Management Therapist, Licensed Alcohol and Drug Counselors Provider Type including counselors that range from a scale of 1-7 based on the licensure level of the provider, and Methadone Maintenance Program.

**Table 22: Frequency of Failure Types – Behavioral Health Services**

Type of Failure	MBHP
Contact Fails*	76
Provider not at the site	17
Provider does not accept the health plan	6
Provider not accepting new patients	2
Provider reported a different specialty	2

\*The “Contact Fails” category includes the following reasons: answering machine/voicemail (3 calls), answering service (3 calls), constant busy signal (3 calls), disconnected telephone number (1 call), no answer (3 calls), put on hold for more than 5 minutes (3 calls), wrong telephone number (1 call).

### **Recommendations**

- *Network Adequacy Data Integrity Recommendations:* IPRO recommends that MBHP reviews and deduplicates in-network provider data before the submission of data for analysis.



- *Network Adequacy Time/Distance Recommendations:* IPRO recommends that MBHP expands its network when a deficiency is identified. When additional providers are not available, MBHP should provide an explanation of what actions are being taken to provide adequate access for covered individuals residing in those counties.
- *Network Adequacy Provider Directory Recommendation:* MBHP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans. MBHP should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory.



## VII. Quality-of-Care Surveys – Member Satisfaction Survey

### Objectives

The overall objective of member experience surveys is to capture accurate and complete information about consumer-reported experiences with health care.

Section 8.4.C of the MassHealth MBHP contract requires MBHP to conduct satisfaction surveys of covered individuals and share the results with MassHealth. The MBHP's Member Satisfaction Survey is a standardized survey designed to collect members ratings of behavioral health treatment and satisfaction with services.

### Technical Methods of Data Collection and Analysis

MBHP contracted with SPH Analytics to administer the survey. The standardized survey tool assesses member experience with specialty behavioral health care, including mental health and chemical dependency services. MBHP designed the survey tool, which was redesigned in 2019 and 2020 to enhance its readability. For MY 2021, MBHP included additional questions about members' telehealth experience. For MY 2022, only minimal question/phrasing changes were made. The survey is organized across six different categories. **Table 23.** provides a list of all six survey categories.

**Table 23: MBHP Member Satisfaction Survey Categories**

Survey Categories
<ul style="list-style-type: none"><li>• Appointment Access</li><li>• Appointment Availability</li><li>• Acceptability of MBHP Practitioners</li><li>• Acceptability of Telehealth Services</li><li>• Scope of Service</li><li>• Experience of Care</li></ul>

The sample frame included members randomly selected from MBHP's outpatient population. SPH Analytics selected a random sample of members who had a claim between the third quarter of 2021 through the end of the second quarter of 2022. Members receive a mail packet including a cover letter, mail survey, and business return envelope. Three weeks after the initial mailing, SHP reached out to nonrespondents by phone. Language line assistance was provided when requested. **Table 24** provides a summary of the technical methods of data collection.

**Table 24: MBHP Member Satisfaction Survey – Technical Methods of Data Collection, MY 2022**

Technical Methods of Data Collection	MBHP
Survey vendor	SPH Analytics
Survey tool	MBHP's Member Satisfaction Survey
Survey timeframe	11/02/2022 - Initial mailing began 11/28/2022 - Phone collection began 1/12/2023 - Data collection closed
Method of collection	Mail and telephone
Sample size	12 500
Response rate	3.2%

## Description of Data Obtained

IPRO received a copy of the MY 2022 *MBHP Member Experience Annual Report* produced for Beacon Health Options. The report included descriptions of the project objectives and methodology, as well as survey results and analyses.

## Conclusions

To determine MBHP's strengths and opportunities for improvement, IPRO compared the survey results to the benchmark goals set by MBHP. Measures performing above the goal were considered strengths; measures performing at the same level as the goal were considered average; and measures performing below the goal were identified as opportunities for improvement, as explained in **Table 25**.

**Table 25: Key for MBHP Member Satisfaction Performance Measure Comparison to the Benchmark Goal**

Color Key	How Rate Compares to the Benchmark Goal
< Goal	Below the goal.
= Goal	At the goal.
> Goal	Above the goal.
N/A	Not applicable.

**Tables 26–30** show the results of the 2023 MBHP Member Experience Survey. In the Appointment Access and Availability categories, one measure exceeded the goal. In the Acceptability of MBHP Practitioners category, five measures exceeded the goal. In the Acceptability of Telehealth Services category, goals were not identified. In the Scope of Service category, five measures exceeded the goal, and four measures were topped out at 100%. In the Experience of Care category, however, all measures were below the goal.

**Table 26: MBHP Member Satisfaction Survey Performance – Appointment Access and Availability**

Member Experience MBHP Measure	MBHP	Benchmark Goal
When you needed non-life-threatening Emergency Care, did you have to wait? (Answer key: less than 6 hours)	75.4% (>Goal)	≥ 73.2% less than 6 hours
When you needed Urgent Care, when was the earliest appointment that was offered to you? (Answer key: an appointment within 24 hours or an appointment between 25 to 48 hours)	84.7% (<Goal)	≥ 93.9% within 48 hours
When you had a first-time appointment, when was the earliest appointment that was offered to you? (Answer key: an appointment within 10 business days)	65% (<Goal)	≥ 66.2%
In the last 12 months, how often were treatment locations close enough for you? (Answer key: always or usually)	84.8% (<Goal)	≥ 89.6%

**Table 27: MBHP Member Satisfaction Survey Performance – Acceptability of MBHP Practitioners**

Member Experience MBHP Measure	MBHP	Benchmark Goal
In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? A. Language? (Answer key: always or usually)	93.4% (>Goal)	≥91.9%
In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? B. Communication? (Answer key: always or usually)	90.7% (<Goal)	≥91.0%
In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? C. Religious? (Answer key: usually or always)	70% (>Goal)	≥69.5%

Member Experience MBHP Measure	MBHP	Benchmark Goal
In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? D. Cultural? (Answer key: usually or always)	74.8% (>Goal)	≥73.3%
In the last 12 months, how often were those you saw for counseling or treatment just right for your needs? (Answer key: always or usually)	84.1% (<Goal)	≥84.8%
How satisfied are you with all your counseling or treatment in the last 12 months? (Answer key: very satisfied or somewhat satisfied)	91.7% (>Goal)	≥91.0%
In the last 12 months, have you stayed overnight in a hospital or facility for any mental health or substance use services? IF YES: how satisfied are you with the treatment you got from this facility?	81% (<Goal)	≥92.5%
Do you feel the number of days approved for your stay was enough? (Answer key: yes)	90% (>Goal)	≥78.8%
How satisfied are you with the ease of getting needed mental health or substance use care in the last 12 months? (Answer key: very satisfied or somewhat satisfied)	84% (<Goal)	≥88.3%

**Table 28: MBHP Member Satisfaction Survey Performance – Acceptability of Telehealth Services**

Member Experience MBHP Measure	MBHP	Benchmark Goal
In the last 12 months, have you had any services via telehealth? (Answer key: yes)	78.5%	N/A
1. If Yes, who did you go to for services via telehealth? Existing provider (previously providing in-person service)	72.6%	N/A
2. If Yes, who did you go to for services via telehealth? New provider	18.8%	N/A
3. If Yes, who did you go to for services via telehealth? MD Live	1.5%	N/A
4. If Yes, who did you go to for services via telehealth? Other	7.1%	N/A
1. How did you receive the telehealth service? Video/Audio (by smartphone or tablet/computer)	60.2%	N/A
2. How did you receive the telehealth service? Audio only (landline or cell phone)	39.8%	N/A
How satisfied are you with the following: 1. Overall satisfaction with telehealth	94.3%	N/A
How satisfied are you with the following: 2. Scheduling your telehealth visit	93.7%	N/A
How satisfied are you with the following: 3. Help you were given in preparing for your telehealth visit	94.9%	N/A
How satisfied are you with the following: 4. Session length	92.2%	N/A
How satisfied are you with the following: 5. Call quality	92.7%	N/A
How satisfied are you with the following: 6. Effectiveness of telehealth compared to in-person services	84.2%	N/A
How satisfied are you with the following: 7. Usefulness of telehealth	92.0%	N/A
How satisfied are you with the following: 8. Communication about next steps following telehealth visit and/or treatment plan	89.3%	N/A
Which of the following apply to your experience? (Select all that apply) 1. I did not have a hard time using telehealth	76.9%	N/A
Which of the following apply to your experience? (Select all that apply) 2. Not having access to needed technology to participate	7.4%	N/A
Which of the following apply to your experience? (Select all that apply) 3. Not having access to internet/Wi-Fi connection	5.6%	N/A
Which of the following apply to your experience? (Select all that apply) 4. Unable to get needed services in preferred language	1.9%	N/A

Member Experience MBHP Measure	MBHP	Benchmark Goal
Which of the following apply to your experience? (Select all that apply) 5. Other reasons it was not easy using telehealth services	10.6%	N/A
How would you like to receive future services? 1. in person	13.9%	N/A
How would you like to receive future services? 2. telehealth	33.2%	N/A
How would you like to receive future services: 3. combination of in-person and telehealth	47.6%	N/A
How would you like to receive future services: 4. No opinion/not applicable	5.3%	N/A
How likely are you to recommend telehealth to a friend? (Answer key: 6 to 10)	81.4%	N/A

**Table 29: MBHP Member Satisfaction Survey Performance – Scope of Service**

Member Experience MBHP Measure	MBHP	Benchmark Goal
In the last 12 months, have you called MBHP for any reason? IF YES: how many calls to an MBHP staff member did it take to get all the information you needed?	78.2% (>Goal)	≥74.5%
How often did MBHP staff member(s) treat you with courtesy and respect? (Answer key: always or usually)	95.5% (>Goal)	≥90.7%
How often did MHQP staff member(s) give you all the information or help you needed? (Answer key: always or usually)	82% (<Goal)	≥82.8%
How satisfied are you with the quality of services you got from MBHP staff member(s)? (Answer key: very or somewhat satisfied)	86.9% (<Goal)	≥91.2%
Overall satisfaction with language assistance (Answer key: very or somewhat satisfied)	100% (>Goal)	≥85%
Accuracy of language assistance (Answer key: very or somewhat satisfied)	100% (>Goal)	≥85%
Ease of getting language assistance (Answer key: very or somewhat satisfied)	100% (>Goal)	≥85%
Timeliness of getting language assistance (Answer key: very or somewhat satisfied)	100.0%	[BLANK]
How satisfied are you with the quality of service you got when you called MBHP to find a provider? (Answer key: very or somewhat satisfied)	74.4% (<Goal)	83.30%
How satisfied are you with the services you get from MBHP? (Answer key: very or somewhat satisfied)	90.9% (<Goal)	≥92.9%
How likely would you be to recommend MBHP to your family and friends? (Answer key: very or somewhat satisfied)	90.5% (<Goal)	≥93.8%

**Table 30: MBHP Member Satisfaction Survey Performance – Experience of Care**

Member Experience MBHP Measure	MBHP	Benchmark Goal
Did those you saw for counseling or treatment tell you what side effects of those medicines to watch for? (Answer key: yes)	80.8% (<Goal)	≥ 84.5%
In the last 12 months, how much were you helped by the counseling or treatment you had? (Answer key: a lot or somewhat)	86.8% (<Goal)	≥ 91.3%
A personal doctor is a doctor you see for your physical health. In the last 12 months, how often did your personal doctor seem to know about the counseling or treatment you had? (Answer key: always or usually)	77.6% (<Goal)	≥ 79.8%
In the last 12 months, how often did those you have seen for counseling and treatment seem to know about the care you had from medical doctors? (Answer key: always or usually)	72.7% (<Goal)	≥ 79.4%

## VIII. MCP Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results(a)(6) require each annual technical report include “an assessment of the degree to which each MCO, PIHP,<sup>10</sup> PAHP,<sup>11</sup> or PCCM entity has effectively addressed the recommendations for QI<sup>12</sup> made by the EQRO during the previous year’s EQR.” **Table 31** displays the MBHP’s responses to the recommendations for QI made during the previous EQR, as well as IPRO’s assessment of these responses.

**Table 31: MBHP Response to Previous EQR Recommendations**

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<b>PIP 2 Telehealth:</b> The plan has identified that members prefer in-person visits. The plan should look at the in-person follow-up visit rate as well as telehealth rate.	MBHP conducted a second-phase analysis during the second year of the IPP. This involved stratifying inpatient aftercare planning data by telehealth and in-person, combining it with HEDIS FUH data to determine 7-day follow-up rates. The analysis including rates based on scheduled and conducted visits, was included in the final summary report submitted to IPRO.	Addressed
<b>PMV:</b> MBHP HEDIS rates were below the 25th percentile for the following measures: <ul style="list-style-type: none"> <li>Follow-Up Care for Children Prescribed ADHD Medication (initiation)</li> <li>Follow-Up Care for Children Prescribed ADHD Medication (continuation)</li> </ul> NCQA Measures: MBHP should conduct a root cause analysis and design quality improvement interventions to increase quality measures’ rates and to improve members’ appropriate access to the services evaluated by these measures.	MBHP observed an increase in Follow-up Care for Children Prescribed ADHD Medication Initiation and Continuation measures, but both remain below the national 75 <sup>th</sup> percentile. A workgroup will be formed to identify interventions for improving follow-up rates. The goal is to implement interventions in MY 2024 and monitor quarterly for effectiveness. The focus of the interventions will include addressing disparities, using member-level reports, and care coordination for ADHD.	Partially Addressed
<b>Compliance:</b> MBHP needs to revise its geo-access reporting to meet MassHealth standards for accessibility.	MBHP continues to assess its provider network to ensure adequate availability. MBHP plans to add a member choice of at least two providers measure in the 2023 reporting cycle to follow contract requirements. MBHP will address deficiencies through improvement activities as needed.	Partially Addressed
<b>Network:</b> Access was assessed for a total of 25 provider types. MBHP had deficient networks for 14 provider types: <ul style="list-style-type: none"> <li>Psych APN (PCNS or CNP)</li> <li>Psychiatry</li> <li>CBAT-ICBAT-TCU</li> </ul>	MBHP identified a coding error in the report that was submitted to EQRO, thus this cannot be considered an accurate assessment of its network capabilities. A new process will be implemented to improve the accuracy of the reports. This process will involve the network team reviewing all reports for accuracy and having a	Partially Addressed

<sup>10</sup> Prepaid inpatient health plan.

<sup>11</sup> Prepaid ambulatory health plan.

<sup>12</sup> Quality improvement.

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<ul style="list-style-type: none"> <li>• Clinical Support Services for SUD (Level 3.5)</li> <li>• Intensive Outpatient Program</li> <li>• Monitored Inpatient (Level 3.7)</li> <li>• Partial Hospitalization Program</li> <li>• Program of Assertive Community Treatment</li> <li>• Psychiatric Day Treatment</li> <li>• RRS for SUD (Level 3.1)</li> <li>• Structured Outpatient Addiction Program</li> <li>• Managed Inpatient (Level 4)</li> <li>• In-Home Behavioral Services</li> <li>• Applied Behavior Analysis</li> </ul> <p>MBHP should expand its network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those counties.</p>	validation process documented and in place by December 20023.	
<p><b>Quality-of-Care Surveys:</b> MBHP should utilize the results of the Member Satisfaction Survey to drive performance improvement as it relates to member experience.</p>	<p>MBHP uses its annual Member Satisfaction Survey to drive performance improvement in Member experience. The Quality Management team reviews survey results annually, identifies improvement opportunities, and convenes stakeholders to devise interventions. Monitoring includes tracking the implementation of interventions throughout the year and evaluating their success with subsequent Member surveys. MBHP provided examples demonstrating the application of this process, such as addressing challenges in telephonic communication and improving access to routine care appointments.</p>	Addressed

<sup>1</sup> IPRO assessments are as follows: **addressed:** MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed:** MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement:** MCP's QI response did not address the recommendation; improvement was not observed, or performance declined. MBHP: Massachusetts Behavioral Health Partnership; MCP: managed care plan; EQR: external quality review; SUD: substance use disorder; PIP: performance improvement project; HEDIS: Health Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization for Mental Illness; CBAT-ICBAT-TCU: community-based acute treatment for children and adolescents-intensive community-based acute treatment for children and adolescents-transitional care unit.

## IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations

**Table 32** highlight MBHP's performance strengths, opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of CY 2023 EQR activities as they relate to **quality**, **timeliness**, and **access**.

**Table 32: MBHP Strengths, Opportunities for Improvement, and EQR Recommendations**

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: IET	None.	Interventions addressing sub-populations where disparities were evidenced should be developed and implemented.	<b>Recommendation for PIP 1:</b> In the future, MBHP should develop interventions specifically targeting sub-populations where the results indicate disparities of care.	Quality, Timeliness, Access
PIP 2: Telehealth	Collaboration among various departments within MBHP enhanced coordination of effort contributed to successes, as well as interventions that were built into existing provider systems.	External factors may have impacted the PIP results. Some interventions require a longer time frame for implementation.	<b>Recommendation for PIP 2:</b> MBHP may want to consider addressing disparities with a targeted intervention towards sub-populations. The satisfaction survey indicated some differences in telehealth acceptance but it's unclear that the differences were sizable enough to warrant targeted interventions.	Quality, Timeliness, Access
PMV: NCQA measures	<p>MBHP demonstrated compliance with IS standards. No issues were identified.</p> <p>MBHP HEDIS rates were above the 90<sup>th</sup> national Medicaid percentile of the NCQA Quality Compass on the following measures:</p> <ul style="list-style-type: none"> <li>Follow-Up After Emergency Department Visit for Mental Illness (7 days)</li> <li>Follow-Up After Emergency Department Visit for Mental Illness (30 days)</li> </ul>	<p>The Follow-Up Care for Children Prescribed ADHD Medication (Continuation) measure rate was below the 25<sup>th</sup> percentile.</p> <p>Rates for the following measures were at or above the 25<sup>th</sup> percentile but below the 50<sup>th</sup> percentile:</p> <ul style="list-style-type: none"> <li>Follow-Up Care for Children Prescribed ADHD Medication (Initiation)</li> <li>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</li> <li>Initiation of Alcohol and Other Drug Abuse or Dependence Treatment</li> </ul>	MBHP should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access



Activity	Strengths	Weaknesses	Recommendations	Standards
	<ul style="list-style-type: none"> <li>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)</li> <li>Pharmacotherapy for Opioid Use Disorder</li> </ul>			
Compliance Review	MBHP demonstrated compliance with most of the federal and state contractual standards	<p>Lack of compliance with 10 requirements in the following domains:</p> <ul style="list-style-type: none"> <li>Enrollee rights and protections (1)</li> <li>Coordination and continuity of care (3)</li> <li>Coverage and authorization of services (1)</li> <li>Provider Selection (3)</li> <li>Subcontractual Relationships and Delegations (2)</li> </ul> <p>Partial compliance with 17 requirements in the following domains:</p> <ul style="list-style-type: none"> <li>Enrollee Rights and Protections (9)</li> <li>Availability of services (2)</li> <li>Coordination and continuity of care (2)</li> <li>Provider Selection (2)</li> <li>Subcontractual Relationships and Delegations (1)</li> <li>Health information systems (1)</li> </ul>	MBHP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 2/2/2024. IPRO will monitor the status of all recommendations as part of the EQR processes and follow up with the MCP before the end of CY 2024.	Quality, Timeliness, Access
Network Adequacy: Data Integrity	MBHP submitted all requested in-network providers' data.	<p>IPRO found multiple issues with in-network provider data submitted by MBHP for analysis. Individual provider names were submitted where facilities were requested and listed under the same NPI and address as the facility. Facility departments were submitted in the data, in addition to the facility name, under the facility's NPI and address. Duplicated data was submitted in the facility tabs, both the NPI Registered Name and DBA Name were submitted in the data.</p>	<p><b><u>Recommendation</u></b></p> <p>IPRO recommends that MBHP deduplicate in-network provider data before data files are submitted for analysis.</p>	Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
Network Adequacy: Time/Distance Standards	MBHP demonstrated adequate networks of BH Outpatient providers and Opioid Treatment Programs.	<p>Access was assessed for a total of 26 provider types.</p> <p>MBHP had deficient networks of all provider types except for two.</p>	<p><b>Recommendations</b></p> <p>MBHP should expand its network when members' access can be improved and when network deficiencies can be closed by available providers.</p> <p>When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those counties.</p>	Access, Timeliness
Network Adequacy: Provider Directory	MBHP's highest provider directory accuracy rate was 46.15% for the Outpatient Clinical/Mental Health Center.	<p>MBHP's accuracy rate was below 20% for the following provider types:</p> <ul style="list-style-type: none"> <li>Applied Behavioral Analysts (ABA) (15.38%)</li> <li>Psychiatric Nurse Mental Health Clinical Specialist (9.09%)</li> <li>Licensed Independent Clinical Social Worker (7.69%)</li> <li>Licensed Mental Health Counselor (7.69%)</li> <li>Licensed Psychologist (Doctorate Level) (7.69%)</li> <li>Licensed Certified Social Worker (0.00%)</li> </ul>	<p><b>Recommendations</b></p> <p>MBHP should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory. MBHP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans.</p>	Access Timeliness
Quality-of-care surveys	<p>MBHP exceeded its benchmark goal on 11 measures. The following measures were topped-out at 100%:</p> <ul style="list-style-type: none"> <li>How satisfied are you with language assistance (Answer key: very or somewhat satisfied)</li> <li>How satisfied are you with accuracy of language assistance (Answer key: very or somewhat satisfied)</li> </ul>	<p>Sixteen of MBHP measures scored below the benchmark goal.</p> <p>Appointment Access</p> <ul style="list-style-type: none"> <li>When you needed Urgent Care, when was the earliest appointment that was offered to you? (Answer key: an appointment within 24 hours or an appointment between 25 to 48 hours)</li> <li>When you had a first-time appointment, when was the earliest appointment that was offered to you? (Answer key: an appointment within 10 business days)</li> </ul> <p>Appointment Availability:</p>	MBHP should utilize the results of the Member Satisfaction Survey to drive performance improvement as it relates to member experience. Considering the high scores and some measures reaching 100% satisfaction, MBHP should also utilize complaints and grievances to identify new questions, expand the survey, and gain deeper insights.	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
	<ul style="list-style-type: none"> <li>How satisfied are you with ease of getting language assistance (Answer key: very or somewhat satisfied)</li> <li>How satisfied are you with timeliness of getting language assistance (Answer key: very or somewhat satisfied)</li> </ul>	<ul style="list-style-type: none"> <li>In the last 12 months, how often were treatment locations close enough for you? (Answer key: always or usually)</li> </ul> <p>Acceptability of MBHP practitioners</p> <ul style="list-style-type: none"> <li>In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? b. Communication? (Answer key: usually or always)</li> <li>In the last 12 months, how often were those you saw for counseling or treatment just right for your needs? (Answer key: always or usually)</li> <li>In the last 12 months, have you stayed overnight in a hospital or facility for any mental health or substance use services? IF YES: how satisfied are you with the treatment you got from this facility?</li> <li>How satisfied are you with the ease of getting needed mental health or substance use care in the last 12 months? (Answer key: very satisfied or somewhat satisfied)</li> </ul> <p>Scope of Service</p> <ul style="list-style-type: none"> <li>How often did MBHP staff member(s) give you all the information or help you needed? (Answer key: always or usually)</li> <li>How satisfied are you with the quality of services you got from MBHP staff member(s)? (Answer key: very or somewhat satisfied)</li> <li>How satisfied are you with the quality of service you got when you called MBHP to find a provider? (Answer key: very or somewhat satisfied)</li> </ul>		

Activity	Strengths	Weaknesses	Recommendations	Standards
		<ul style="list-style-type: none"> <li>How satisfied are you with the services you get from MBHP? (Answer key: very or somewhat satisfied)</li> <li>How likely would you be to recommend MBHP to your family and friends? (Answer key: very or somewhat satisfied)</li> </ul> <p>Experience of Care</p> <ul style="list-style-type: none"> <li>Did those you saw for counseling or treatment tell you what side effects of those medicines to watch for? (Answer key: yes)</li> <li>In the last 12 months, how much were you helped by the counseling or treatment you had? (Answer key: a lot or somewhat)</li> <li>A personal doctor is a doctor you see for your physical health. In the last 12 months, how often did your personal doctor seem to know about the counseling or treatment you had? (Answer key: always or usually)</li> <li>In the last 12 months, how often did those you have seen for counseling and treatment seem to know about the care you had from medical doctors? (Answer key: always or usually)</li> </ul>		

MBHP: Massachusetts Behavioral Health Partnership; EQR: external quality review; PIP: performance improvement project; IET: Initiation and Engagement in Treatment; ACP: Accountable Care Partnership Plan; ED: Emergency Department; FUH: Follow Up after Hospitalization; IS: Information systems; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; ADHD: attention deficit hyperactivity disorder; EQRO: external quality review organization; Psych APN: psychiatric advanced nurse; PCNS: psychiatric clinical nurse specialist; CNP: certified nurse practitioner; SUD: substance use disorder; RRS for SUD: Residential Rehabilitation Services for Substance Use Disorder; FUH: Follow-Up After Hospitalization for Mental Illness. FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.

## X. Required Elements in EQR Technical Report

The BBA established that state agencies contracting with MCPs provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCP. The federal requirements for the annual EQR of contracted MCPs are set forth in *Title 42 CFR § 438.350 External quality review (a) through (f)*.

States are required to contract with an EQRO to perform an annual EQR for each contracted MCP. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by CMS.

Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as “the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement.”

Federal managed care regulations outlined in *Title 42 CFR § 438.364 External review results (a) through (d)* require that the annual EQR be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that MCPs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCPs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

Elements required in EQR technical report, including the requirements for the PIP validation, PMV, and review of compliance activities, are listed in **Table 33**.

**Table 33: Required Elements in EQR Technical Report**

Regulatory Reference	Requirement	Location in the EQR Technical Report
<i>Title 42 CFR § 438.364(a)</i>	All eligible Medicaid and CHIP plans are included in the report.	All MCPs are identified by plan name, MCP type, managed care authority, and population served in <b>Appendix B, Table B1</b> .
<i>Title 42 CFR § 438.364(a)(1)</i>	The technical report must summarize findings on quality, access, and timeliness of care for each MCO, PIHP, PAHP, and PCCM entity that provides benefits to Medicaid and CHIP enrollees.	The findings on quality, access, and timeliness of care for the MBHP are summarized in <b>Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations</b> .
<i>Title 42 CFR § 438.364(a)(3)</i>	The technical report must include an assessment of the strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by MCOs, PIHPs, PAHPs, or PCCM entity.	See <b>Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations</b> for a chart outlining MBHP’s strengths and weaknesses for each EQR activity and as they relate to quality, timeliness, and access.
<i>Title 42 CFR § 438.364(a)(4)</i>	The technical report must include recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity.	Recommendations for improving the quality of health care services furnished by the MBHP are included in each EQR activity section ( <b>Sections III–VII</b> ) and in <b>Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations</b> .

Regulatory Reference	Requirement	Location in the EQR Technical Report
<i>Title 42 CFR § 438.364(a)(4)</i>	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy, under <i>Title 42 CFR § 438.340</i> , to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP beneficiaries.	Recommendations for how the state can target goals and objectives in the quality strategy are included in <b>Section I, High-Level Program Findings and Recommendations</b> , as well as when discussing strengths and weaknesses of the MBHP or activity and when discussing the basis of performance measures or PIPs.
<i>Title 42 CFR § 438.364(a)(5)</i>	The technical report must include methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities.	Methodologically appropriate, comparative information about the MBHP is included across the report in each EQR activity section ( <b>Sections III–VII</b> ) and in <b>Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations</b> .
<i>Title 42 CFR § 438.364(a)(6)</i>	The technical report must include an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	See <b>Section VIII. MCP Responses to the Previous EQR Recommendations</b> for the prior year findings and the assessment of MBHP's approach to addressing the recommendations issued by the EQRO in the previous year's technical report.
<i>Title 42 CFR § 438.364(d)</i>	The information included in the technical report must not disclose the identity or other protected health information of any patient.	The information included in this technical report does not disclose the identity or other PHI of any patient.
<i>Title 42 CFR § 438.364(a)(2)(iiv)</i>	The technical report must include the following for each of the mandatory activities: objectives, technical methods of data collection and analysis, description of data obtained including validated performance measurement data for each PIP, and conclusions drawn from the data.	Each EQR activity section describes the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.
<i>Title 42 CFR § 438.358(b)(1)(i)</i>	The technical report must include information on the validation of PIPs that were underway during the preceding 12 months.	This report includes information on the validation of PIPs that were underway during the preceding 12 months; see <b>Section III</b> .
<i>Title 42 CFR § 438.330(d)</i>	The technical report must include a description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle.	The report includes a description of PIP interventions associated with each state-required PIP topic; see <b>Section III</b> .
<i>Title 42 CFR § 438.358(b)(1)(ii)</i>	The technical report must include information on the validation of each MCO's, PIHP's, PAHP's, or PCCM entity's performance measures for each MCO, PIHP, PAHP, and PCCM entity performance measure calculated by the state during the preceding 12 months.	This report includes information on the validation of MBHP's performance measures; see <b>Section IV</b> .
<i>Title 42 CFR § 438.358(b)(1)(iii)</i>	Technical report must include information on a review, conducted within the previous three-year period, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in Title 42 CFR § 438.330.  The technical report must provide MCP results for the 11 Subpart D and QAPI standards.	This report includes information on a review, conducted in 2023, to determine MBHP's compliance with the standards set forth in Subpart D and the QAPI requirements described in <i>Title 42 CFR § 438.330</i> ; see <b>Section V</b> .

## XI. Appendix A – MassHealth Quality Goals and Objectives

Table A1: MassHealth Quality Strategy Goals and Objectives – Goal 1

Goal 1	Promote better care: Promote safe and high-quality care for MassHealth members
1.1	Focus on timely preventative, primary care services with access to integrated care and community-based services and supports
1.2	Promote effective prevention and treatment to address acute and chronic conditions in at-risk populations
1.3	Strengthen access, accommodations, and experience for members with disabilities, including enhanced identification and screening, and improvements to coordinated care

Table A2: MassHealth Quality Strategy Goals and Objectives – Goal 2

Goal 2	Promote equitable care: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience
2.1	Improve data collection and completeness of social risk factors (SRF), which include race, ethnicity, language, disability (RELD) and sexual orientation and gender identity (SOGI) data
2.2	Assess and prioritize opportunities to reduce health disparities through stratification of quality measures by SRFs, and assessment of member health-related social needs
2.3	Implement strategies to address disparities for at-risk populations including mothers and newborns, justice-involved individuals, and members with disabilities

Table A3: MassHealth Quality Strategy Goals and Objectives – Goal 3

Goal 3	Make care more value-based: Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care
3.1	Advance design of value-based care focused on primary care provider participation, behavioral health access, and integration and coordination of care
3.2	Develop accountability and performance expectations for measuring and closing significant gaps on health disparities
3.3	Align or integrate other population, provider, or facility-based programs (e.g., hospital, integrated care programs)
3.4	Implement robust quality reporting, performance and improvement, and evaluation processes

Table A4: MassHealth Quality Strategy Goals and Objectives – Goal 4

Goal 4	Promote person and family-centered care: Strengthen member and family-centered approaches to care and focus on engaging members in their health
4.1	Promote requirements and activities that engage providers and members in their care decisions through communications that are clear, timely, accessible, and culturally and linguistically appropriate
4.2	Capture member experience across our populations for members receiving acute care, primary care, behavioral health, and long-term services and supports
4.3	Utilize member engagement processes to systematically receive feedback to drive program and care improvement



**Table A5: MassHealth Quality Strategy Goals and Objectives – Goal 5**

Goal 5	Improve care through better integration, communication, and coordination across the care continuum and across care teams for our members
5.1	Invest in systems and interventions to improve verbal, written, and electronic communications among caregivers to reduce harm or avoidable hospitalizations and ensure safe and seamless care for members
5.2	Proactively engage members with high and rising risk to streamline care coordination and ensure members have an identified single accountable point of contact
5.3	Streamline and centralize behavioral health care to increase timely access and coordination of appropriate care options and reduce mental health and SUD emergencies

## XII. Appendix B – MassHealth Managed Care Programs and Plans

Table B1: MassHealth Managed Care Programs and Health Plans by Program

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Accountable Care Partnership Plan (ACPP)	<p>Groups of primary care providers working with one managed care organization to create a full network of providers.</p> <ul style="list-style-type: none"> <li>Population: Managed care eligible Medicaid members under 65 years of age.</li> <li>Managed Care Authority: 1115 Demonstration Waiver.</li> </ul>	<ol style="list-style-type: none"> <li>BeHealthy Partnership Plan</li> <li>Berkshire Fallon Health Collaborative</li> <li>East Boston Neighborhood Health WellSense Alliance</li> <li>Fallon 365 Care</li> <li>Fallon Health – Atrius Health Care Collaborative</li> <li>Mass General Brigham Health Plan with Mass General Brigham ACO</li> <li>Tufts Health Together with Cambridge Health Alliance (CHA)</li> <li>Tufts Health Together with UMass Memorial Health</li> <li>WellSense Beth Israel Lahey Health (BILH) Performance Network ACO</li> <li>WellSense Boston Children’s ACO</li> <li>WellSense Care Alliance</li> <li>WellSense Community Alliance</li> <li>WellSense Mercy Alliance</li> <li>WellSense Signature Alliance</li> <li>WellSense Southcoast Alliance</li> </ol>
Primary Care Accountable Care Organization (PC ACO)	<p>Groups of primary care providers forming an ACO that works directly with MassHealth's network of specialists and hospitals for care and coordination of care.</p> <ul style="list-style-type: none"> <li>Population: Managed care eligible Medicaid members under 65 years of age.</li> <li>Managed Care Authority: 1115 Demonstration Waiver.</li> </ul>	<ol style="list-style-type: none"> <li>Community Care Cooperative</li> <li>Steward Health Choice</li> </ol>
Managed Care Organization (MCO)	<p>Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals.</p> <ul style="list-style-type: none"> <li>Population: Managed care eligible Medicaid members under 65 years of age.</li> <li>Managed Care Authority: 1115 Demonstration Waiver.</li> </ul>	<ol style="list-style-type: none"> <li>Boston Medical Center HealthNet Plan WellSense</li> <li>Tufts Health Together</li> </ol>
Primary Care Clinician Plan (PCCP)	<p>Members select or are assigned a primary care clinician (PCC) from a network of MassHealth hospitals, specialists, and the Massachusetts Behavioral Health Partnership (MBHP).</p>	Not applicable – MassHealth

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
	<ul style="list-style-type: none"> <li>Population: Managed care eligible Medicaid members under 65 years of age.</li> <li>Managed Care Authority: 1115 Demonstration Waiver.</li> </ul>	
Massachusetts Behavioral Health Partnership (MBHP)	<p>Capitated behavioral health model providing or managing behavioral health services, including visits to a licensed therapist, crisis counseling and emergency services, SUD and detox services, care management, and community support services.</p> <ul style="list-style-type: none"> <li>Population: Medicaid members under 65 years of age who are enrolled in the PCCP or a PC ACO (which are the two PCCM programs), as well as children in state custody not otherwise enrolled in managed care.</li> <li>Managed Care Authority: 1115 Demonstration Waiver.</li> </ul>	MBHP (or managed behavioral health vendor: Beacon Health Options)
One Care Plan	<p>Integrated care option for persons with disabilities in which members receive all medical and behavioral health services and long-term services and support through integrated care. Effective January 1, 2026, the One Care Plan program will shift from a Medicare-Medicaid Plan (MMP) demonstration to a Medicare Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) with a companion Medicaid managed care plan.</p> <ul style="list-style-type: none"> <li>Population: Dual-eligible Medicaid members aged 21–64 years at the time of enrollment with MassHealth and Medicare coverage.</li> <li>Managed Care Authority: Financial Alignment Initiative Demonstration.</li> </ul>	<ol style="list-style-type: none"> <li>1. Commonwealth Care Alliance</li> <li>2. Tufts Health Plan Unify</li> <li>3. UnitedHealthcare Connected for One Care</li> </ol>
Senior Care Options (SCO)	<p>Medicare Fully Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs) with companion Medicaid managed care plans providing medical, behavioral health, and long-term, social, and geriatric support services, as well as respite care.</p> <ul style="list-style-type: none"> <li>Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age.</li> <li>Managed Care Authority: 1915(a) Waiver/1915(c) Waiver.</li> </ul>	<ol style="list-style-type: none"> <li>1. WellSense Senior Care Option</li> <li>2. Commonwealth Care Alliance</li> <li>3. NaviCare Fallon Health</li> <li>4. Senior Whole Health by Molina</li> <li>5. Tufts Health Plan Senior Care Option</li> <li>6. UnitedHealthcare Senior Care Options</li> </ol>

### XIII. Appendix C – MassHealth Quality Measures

Table C1: Quality Measures and MassHealth Goals and Objectives Across Managed Care Entities

Measure Steward	Acronym	Measure Name	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	AMM	Antidepressant Medication Management – Acute and Continuation	N/A	N/A	X	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	AMR	Asthma Medication Ratio	X	X	N/A	N/A	N/A	1.1, 1.2, 3.1
EOHHS	BH CP Engagement	Behavioral Health Community Partner Engagement	X	X	N/A	N/A	N/A	1.1, 1.3, 2.3, 3.1, 5.2, 5.3
NCQA	COA	Care for Older Adult – All Submeasures	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.1
NCQA	ACP	Advance Care Planning	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.1
NCQA	CIS	Childhood Immunization Status	X	X	N/A	N/A	N/A	1.1, 3.1
NCQA	COL	Colorectal Cancer Screening	N/A	N/A	X	N/A	N/A	1.1, 2.2, 3.4
EOHHS	CT	Community Tenure	X	X	N/A	N/A	N/A	1.3, 2.3, 3.1, 5.1, 5.2
NCQA	HBD	Hemoglobin A1c Control; HbA1c control (>9.0%) Poor Control	X	X	N/A	X	X	1.1, 1.2, 3.4
NCQA	CBP	Controlling High Blood Pressure	X	X	X	X	N/A	1.1, 1.2, 2.2
NCQA	DRR	Depression Remission or Response	X	N/A	N/A	N/A	N/A	1.1, 3.1, 5.1
NCQA	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
EOHHS	ED SMI	Emergency Department Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions	X	X	N/A	N/A	N/A	1.2, 3.1, 5.1–5.3
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (30 days)	N/A	N/A	X	N/A	X	3.4, 5.1–5.3
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	X	X	N/A	N/A	X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (30 days)	N/A	N/A	X	X	X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (7 days)	X	X	X	N/A	X	3.4, 5.1–5.3
NCQA	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	N/A	N/A	N/A	N/A	X	3.4, 5.1–5.3

Measure Steward	Acronym	Measure Name	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	N/A	N/A	N/A	N/A	X	3.4, 5.1–5.3
NCQA	ADD	Follow-up for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (HEDIS)	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
EOHHS	HRSN	Health-Related Social Needs Screening	X	N/A	N/A	N/A	N/A	1.3, 2.1, 2.3, 3.1, 4.1
NCQA	IMA	Immunizations for Adolescents	X	X	N/A	N/A	N/A	1.1, 3.1
NCQA	FVA	Influenza Immunization	N/A	N/A	N/A	X	N/A	1.1, 3.4
MA-PD CAHPs	FVO	Influenza Immunization	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.2
NCQA	IET – Initiation/Engagement	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment – Initiation and Engagement Total	X	X	X	X	X	1.2, 3.4, 5.1–5.3
EOHHS	LTSS CP Engagement	Long-Term Services and Supports Community Partner Engagement	X	X	N/A	N/A	N/A	1.1, 1.3, 2.3, 3.1, 5.2
NCQA	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	X	X	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
ADA DQA	OHE	Oral Health Evaluation	X	X	N/A	N/A	N/A	1.1, 3.1
NCQA	OMW	Osteoporosis Management in Women Who Had a Fracture	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
NCQA	PBH	Persistence of Beta-Blocker Treatment after Heart Attack	N/A	N/A	X	N/A	N/A	1.1, 1.2, 3.4
NCQA	PCE	Pharmacotherapy Management of COPD Exacerbation	N/A	N/A	X	N/A	N/A	1.1, 1.2, 3.4
NCQA	PCR	Plan All Cause Readmission	X	X	X	X	N/A	1.2, 3.4, 5.1, 5.2
NCQA	DDE	Potentially Harmful Drug – Disease Interactions in Older Adults	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
CMS	CDF	Screening for Depression and Follow-Up Plan	X	N/A	N/A	N/A	N/A	1.1, 3.1, 5.1, 5.2
NCQA	PPC – Timeliness	Timeliness of Prenatal Care	X	X	N/A	N/A	N/A	1.1, 2.1, 3.1
NCQA	TRC	Transitions of Care – All Submeasures	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
NCQA	DAE	Use of High-Risk Medications in the Older Adults	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
NCQA	SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	N/A	N/A	X	N/A	N/A	1.2, 3.4

## XIV. Appendix D – MassHealth MBHP Network Adequacy Standards and Indicators

**Table D1: MBHP Network Adequacy Standards and Indicators – Inpatient Services**

Network Adequacy Standards Source: First Amended and Restated MBHP Contract - Section 3.1.G.8	Indicator	Definition of the Indicator
<b>Inpatient Service Provider Types:</b> <ul style="list-style-type: none"> <li>Psych Inpatient Adult</li> <li>Psych Inpatient Adolescent</li> <li>Psych Inpatient Child</li> <li>Managed Inpatient Level 4</li> </ul> <p>Covered individuals must have access to 2 inpatient service providers within 60 miles or 60 minutes of their residence.</p> <p>MBHP must ensure that, at a minimum, 90% of covered individuals have access to all Medically Necessary BH Services.</p>	<b>Inpatient Service Providers:</b> 90% of covered individuals have access to 2 inpatient service providers within 60 miles or 60 minutes within a covered individual's ZIP code of residence.	<b>Numerator:</b> number of covered individuals in a county for whom one of the following is true: <ul style="list-style-type: none"> <li>Two unique in-network providers are a 60-minute drive or less from a covered individual's ZIP code of residence; OR</li> <li>Two unique in-network providers are 60 miles or less from a covered individual's ZIP code of residence.</li> </ul> <b>Denominator:</b> all covered individuals in a county.

**Table D2: MBHP Network Adequacy Standards and Indicators – Diversionary Services and Outpatient Services**

Network Adequacy Standards Source: First Amended and Restated MBHP Contract - Section 3.1.G.8	Indicator	Definition of the Indicator
<b>Diversionary Services:</b> <ul style="list-style-type: none"> <li>Community Crisis Stabilization (New)</li> <li>Community-Based Acute Treatment for Children and Adolescents (CBAT)</li> <li>Monitored Inpatient (Level 3.7)</li> <li>Clinical Support Services for Substance Use Disorders (Level 3.5)</li> <li>Community Support Program (CSP)</li> <li>Partial Hospitalization (PHP)</li> <li>Psychiatric Day Treatment</li> <li>Structured Outpatient Addiction Program (SOAP)</li> <li>Program of Assertive Community Treatment (PACT)</li> </ul>	<b>BH Diversionary and Outpatient Services:</b> 90% of covered individuals have access to 2 BH service providers within 30 miles or 30 minutes within the covered individual's ZIP code of residence.	<b>Numerator:</b> number of covered individuals in a county for whom one of the following is true: <ul style="list-style-type: none"> <li>Two unique in-network providers are a 30-minute drive or less from a covered individual's ZIP code of residence; OR</li> <li>Two unique in-network providers are 30 miles or less from a covered individual's ZIP code of residence.</li> </ul> <b>Denominator:</b> all covered individuals in a county.

<b>Network Adequacy Standards</b> <b>Source: First Amended and Restated MBHP Contract</b> <b>- Section 3.1.G.8</b>	<b>Indicator</b>	<b>Definition of the Indicator</b>
<ul style="list-style-type: none"> <li>• Intensive Outpatient Program (IOP)</li> <li>• Recovery Coaching</li> <li>• Recovery Support Navigators</li> <li>• Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)</li> </ul> <p><b>Outpatient Services - Standard Outpatient Services:</b></p> <ul style="list-style-type: none"> <li>• BH Outpatient</li> <li>• Psychiatry</li> <li>• Psychology</li> <li>• Psych APN</li> <li>• Opioid Treatment Programs</li> </ul> <p><b>Outpatient Services - Intensive Home or Community-Based Services for Youth:</b></p> <ul style="list-style-type: none"> <li>• In-Home Behavioral Services</li> <li>• In-Home Therapy Services</li> <li>• Therapeutic Mentoring Services</li> <li>• Other Behavioral Health Services:</li> <li>• Applied Behavioral Analysis</li> </ul> <p>Covered Individuals must have access to 2 providers for all other BH Covered Services within 30 miles or 30 minutes of their residence.</p> <p>MBHP must ensure that, at a minimum, 90% of covered individuals have access to all Medically Necessary BH Services.</p>		

CBAT: community-based acute treatment for children and adolescents.