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External Quality Review Primary Care Accountable Care Organizations Annual Technical Report, Calendar Year 2022



Commonwealth of Massachusetts
Executive Office of Health and
Human Services

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I. Executive Summary

Primary Care Accountable Care Organizations

External quality review (EQR) is the evaluation and validation of information about quality, timeliness, 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 primary care accountable care organizations (PC ACOs) that furnish health care services to Medicaid enrollees in Massachusetts.

Massachusetts's Medicaid program, administered by the Massachusetts Executive Office of Health and Human Services (EOHHS, known as "MassHealth"), contracted with three PC ACOs during the 2022 calendar year (CY). 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 (PCCM) 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). MassHealth's PC ACOs are listed in **Table 1**.

Table 1: MassHealth's PC ACOs – CY 2022

PC ACO Name	Abbreviation Used in the Report	Members as of December 31, 2022	Percent of Total PC ACO Population
Community Care Cooperative	C3 ACO	182,003	36.74%
Mass General Brigham	MGB ACO	159,474	32.19%
Steward Health Choice	Steward	153,891	31.07%

The **Community Care Cooperative (C3 ACO)** is an ACO that serves 182,003 MassHealth enrollees. C3 ACO was formed in 2016 by leaders from nice federally qualified health centers (FQHCs). It is the only ACO in Massachusetts founded by and governed by FQHCs.¹

The **Mass General Brigham (MGB ACO)** is an ACO that serves 159,474 MassHealth enrollees. MGB ACO was founded by Brigham and Women's Hospital and Massachusetts General Hospital, two leading academic medical centers. In addition to academic medical centers, MGB ACO includes specialty hospitals, community hospitals, a rehabilitation network, a health insurance plan, a physician network, a teaching organization, and many locations for urgent and community care.²

The **Steward Health Choice (Steward)** is an ACO that serves 153,891 MassHealth enrollees. Steward is a part of the Steward Health Care System. Steward's network includes hospitals, urgent care centers, and skilled nursing facilities.³

Purpose of Report

The purpose of this ATR is to present the results of EQR activities conducted to assess the quality, timeliness, 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

¹ [About Us - C3 - Community Care Cooperative](#)

² [Our Story | Mass General Brigham](#)

³ [Steward Health Choice Is a MassHealth Plan | Steward Health Choice](#)

compliance to assert whether the PC ACOs 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 mandatory EQR activities for its PC ACOs. As a type of a PCCM arrangement, PC ACOs are subject to two of the mandatory EQR activities, 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 2: Validation of Performance Measures** – This activity assesses the accuracy of performance measures (PMs) reported by each PC ACO and determines the extent to which the rates calculated by the PC ACOs follow state specifications and reporting requirements.
- (ii) **CMS Mandatory Protocol 3: Review of Compliance with Medicaid and CHIP⁴ Managed Care Regulations** – This activity determines PC ACOs' compliance with its contract and with state and federal regulations.

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 PC ACOs' performance strengths and opportunities for improvement.

Both 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 2022 demonstrated that MassHealth and the PC ACOs share a commitment to improvement in providing high-quality, timely, and accessible care for members.

IPRO used the analyses and evaluations of CY 2022 EQR activity findings to assess the performance of MassHealth's PC ACOs in providing quality, timely, and accessible health care services to Medicaid members. The individual PC ACOs were evaluated against state and national benchmarks for measures related to the **quality, access, and timeliness** domains, and results were compared to previous years for trending when possible. These plan-level findings and recommendations for each PC ACO 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 PC ACO program were also compared and analyzed to develop overarching conclusions and recommendations for MassHealth. The following provides a high-level summary of these findings for the MassHealth Medicaid PC ACO program.

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*.

⁴ Children's Health Insurance Program.

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. Measures' targets are explained in the quality strategy by each managed care program.

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 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.

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

Performance Improvement Projects

MassHealth selected topics for its performance improvement projects (PIP) in alignment with the quality strategy goals and objectives. As a type of a PCCM arrangement, PC ACOs were not subject to the validation of PIPs, and PC ACOs did not conduct any PIPs.

Performance Measure Validation

IPRO validated the accuracy of PMs and evaluated the state of health care quality in the PC ACO 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.

PC ACOs are evaluated on a set of Healthcare Effectiveness Data and Information Set (HEDIS[®]) and non-HEDIS (i.e., measures that are not reported to the National Committee for Quality Assurance [NCQA] via the Interactive Data Submission System [IDSS]). All quality measures rates are calculated by MassHealth's vendor Telligen[®].

IPRO conducted the Information Systems Capabilities Assessment (ISCA) and confirmed that MassHealth's information systems were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. IPRO found that MassHealth was fully compliant with information system standards.

Opportunities for improvement:

Medical record review validation was conducted to confirm that the PC ACOs followed appropriate processes to report rates using the hybrid methodology. Each PC ACO provided charts for sample records for medical record review validation. While all PC ACOs met the 80% threshold for the selected sample charts appropriately abstracted, some concerns were identified with chart abstraction for one PC ACO. The identified concerns had no impact to the overall rates.

The review of the processes used to collect, calculate, and report the PMs uncovered that the provider specialty mapping processes used for measurement year (MY) 2021 were not current and need to be updated. This finding also did not impact reported rates.

When IPRO compared the statewide averages to the NCQA Quality Compass[®] percentiles, 6 out of 12 statewide averages were below the New England (NE) regional 25th percentiles. The CIS rate was below the 50th percentile, and the CBP, CDC, and FUM rates were below the 75th percentile. The 75th percentile is used by MassHealth to reflect a minimum (threshold) standard for performance. The IMA and APM measures were above the 75th percentile but below the 90th. All PC ACOs scored below the 25th percentile on the IET Initiation and Engagement measures.

For the state specific (non-HEDIS) measures, IPRO compared the statewide averages to goal benchmarks determined by MassHealth. The statewide averages for 6 out of 18 state-specific measures were above the goal benchmarks. The statewide average for 9 out of 18 measures were below the goal benchmark. For three measures, the benchmark values were not available.

Performance measure validation (PMV) findings are provided in **Section III** of this report.

Compliance

The compliance of PC ACOs with Medicaid and CHIP managed care regulations was evaluated by MassHealth's previous EQRO. The most current review was conducted in 2021 for the 2020 contract year. IPRO summarized the 2021 compliance results and followed up with each plan on recommendations made by the previous EQRO. IPRO's assessment of whether PC ACOs effectively addressed the recommendations is included in **Section VI** of this report. The compliance validation process is conducted triennially, and the next comprehensive review will be conducted in contract year 2024.

PC ACO-specific results for compliance with Medicaid and CHIP managed care regulations are provided in **Section IV** 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 surveys ACO members about their experiences with PCPs using the Primary Care Member Experience Survey (PC MES), based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician & Group Survey (CG-CAHPS). The CG-CAHPS survey asks members to report on their experiences with providers and staff in physician practices and groups.

PC ACOs are contractually required to participate in the MassHealth member satisfaction activities and to use survey results in designing quality improvement initiatives.

MassHealth uses the survey results to assess ACO performance. Four of the member experience measures are included in the calculation of the ACOs' quality score that impacts a portion of the savings that ACOs earn.

Opportunities for improvement:

MassHealth currently excludes members with telehealth-only visits from the survey sample and uses the survey instrument based on the CG-CAHPS 3.0 survey tool. The newer 3.1 version of CG-CAHPS survey tool was updated to reference in-person, phone, and video visits. Updating the PC MES survey instrument to reflect the 3.1 version would allow MassHealth to capture information from a more complete population of members.

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.

IPRO compared the PC ACOs' adult and child PC MES results to statewide scores calculated for all ACOs, including ACPPs and PC ACOs. PC ACO-specific results for member experience of care surveys are provided in **Section V** 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 the PC ACOs 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

- *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.⁵
- *Recommendation towards accelerating the effectiveness of PIPs* – While regulations do not require PCCM entities to conduct PIPs as a part of their quality assurance and performance improvement (QAPI) programs, states may choose to require their PCCM entities to do so. States that require PCCM entities to conduct PIPs

⁵ 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](#).

should consider validating those PIPs.⁶ PC ACOs serve a large portion of MassHealth’s enrollees. IPRO recommends that MassHealth require PC ACOs to validate PIPs.

- *Recommendation towards accurate calculation of PMs* – IPRO recommends improving oversight of medical record review processes to confirm accuracy of abstracted data reported by PC ACOs and updating provider specialty mapping to improve measure rate accuracy.
- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and CAHPS Health Plan Survey 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 capturing complete information about member experiences with health care* – IPRO recommends that MassHealth consider including telehealth-only members in the survey sample and update the PC MES survey instrument to reflect the 3.1 version of the CG-CAHPS tool.
- *Recommendation towards sharing information about member experiences with health care* – 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 PC ACO Plans

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

⁶ CMS External Quality Review (EQR) Protocols, October 2019. Available at: [CMS External Quality Review \(EQR\) Protocols \(medicaid.gov\)](https://www.medicaid.gov).

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. The Massachusetts's Medicaid program is funded by both the state and federal government, and it is administered by the Massachusetts EOHSS, known as MassHealth.

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.⁷

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 long-term services and support (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 2**.

Table 2: MassHealth's Strategic Goals

Strategic Goal	Description
1. Promote better care	Promote safe and high-quality care for MassHealth members.
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.
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.
4. Promote person and family-centered care	Strengthen member and family-centered approaches to care and focus on engaging members in their health.
5. Improve care	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. MassHealth's managed care programs, quality metrics, and initiatives are described next in more detail. For the full list of MassHealth's quality goals and objectives see **Appendix A, Table A1**.

⁷ [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 MCOs, 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 location, 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.⁸
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.⁹
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.¹⁰

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.

⁸ Massachusetts Behavioral Health Partnership. Available at: <https://www.masspartnership.com/index.aspx>

⁹ One Care Facts and Features. Available at: <https://www.mass.gov/doc/one-care-facts-and-features-brochure/download>

¹⁰ 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 75th and 90th percentiles. The MBHP and PCCP targets are the national HEDIS Medicaid 75th and 90th percentiles, whereas the SCO and One Care Plan targets are the national HEDIS Medicare and Medicaid 75th and 90th percentiles. The 75th percentile is a minimum or threshold standard for performance, and the 90th 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 ACPP, 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 substance use disorder (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.

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 following: behavioral health integration in primary care, community-based alternatives to emergency department for crisis interventions, and the creation of the 24-7 Behavioral Health Help Line that will become available in 2023.

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.

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, obstetrics/gynecology (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 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 PC ACO PM rates.

MassHealth evaluates PC ACO quality performance on a slate of measures that includes HEDIS and non-HEDIS measures. All PC ACO PMs were calculated by MassHealth's vendor Telligen. Telligen subcontracted with SS&C Health (SS&C), an NCQA-certified vendor, to produce both HEDIS and non-HEDIS measures rates for all PC ACOs.

MassHealth adjudicates claims for the PC ACOs and receives encounter data from a behavioral health vendor (Massachusetts Behavioral Health Partnership) for members enrolled in the PC ACOs. MassHealth provided Telligen with PC ACO's claims and encounter data files on a quarterly basis through a comprehensive data file extract referred to as the mega-data extract. Telligen extracted and transformed the data elements necessary for measure calculation.

Additionally, Telligen collected and transformed supplemental data received from individual PC ACOs to support rate calculation. Telligen also used SS&C's clinical data collection tool, Clinical Repository, to collect PC ACO-abstracted medical record data for hybrid measures. SS&C integrated the administrative data with the abstracted medical record data to generate the final rates for the PC ACO hybrid measures.

IPRO conducted a full ISCA to confirm that MassHealth'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, MassHealth completed the ISCA tool and underwent a virtual site visit.

For the non-HEDIS measure rates, source code review was conducted with SS&C to ensure compliance with the measure specifications when calculating measures rates. For the HEDIS measures, the NCQA measure certification was accepted in lieu of source code review because SS&C used its HEDIS-certified measures software (CareAnalyzer®) to calculate final administrative HEDIS rates.

For measures that use the hybrid method of data collection (i.e., administrative, and medical record data), IPRO conducted medical record review validation. Each PC ACO provided charts for sample records to confirm that the PC ACOs followed appropriate processes to abstract medical record data. SS&C used its HEDIS-certified measures software (CareAnalyzer) to calculate final hybrid measure HEDIS rates, as well.

Primary source validation (PSV) was conducted on MassHealth systems to confirm that the information from the primary source matched the output information used for measure reporting. To this end, MassHealth provided screenshots from the data warehouse for the selected records.

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 compared rates to industry standard benchmarks in order to validate the produced rates.

Description of Data Obtained

The following information was obtained from MassHealth:

- A completed ISCA tool.
- Denominator and numerator compliant lists for the following two measures:
 - Follow-Up After Hospitalization for Mental Illness (FUH; within 7 days); and
 - Follow-Up After Emergency Department Visit for Mental Illness (FUM; within 7 days).
- Rates for HEDIS and non-HEDIS measures.
- Screenshots from the data warehouse for PSV.
- Lists of numerator records that were compliant by medical record abstraction for the following:
 - Controlling High Blood Pressure (CBP); and
 - Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care (PPC-Prenatal).

The following information was obtained from the PC ACOs:

- Each PC ACO provided the completed medical record validation tool and associated medical records for the selected sample of members for medical record review validation.

Validation Findings

- **Information Systems Capabilities Assessment (ISCA):** There were no concerns with encounter data received from the behavioral health vendor for members enrolled in the PC ACOs. No issues were identified.
- **Source Code Validation:** Source code review was conducted with SS&C for the PC ACO's non-HEDIS measure rates. No issues were identified.
- **Medical Record Validation:** All PC ACOs met the 80% threshold for the selected sample charts appropriately abstracted. Some concerns were identified with chart abstraction for one PC ACO. The abstraction was not supported by data in the medical record, or no chart was available to support the abstraction. Since the 80% pass threshold was met, there was no impact to the overall rates. No other issues were identified.
- **Primary Source Validation (PSV):** One issue was identified in the identification of the denominator for the FUH measure. One of the codes used for identifying the denominator was not in the HEDIS value set. The bias determination threshold for the FUH measure is plus or minus five percentage points in the reported rate. Since this finding did not impact the rate by plus or minus five percentage points, there was no overall impact to the reported rates. No other issues were identified.
- **Data Collection and Integration Validation:** It was identified that the provider specialty mapping processes used for MY 2021 were not current and need to be updated. This finding did not impact reported rates. No other issues were identified.
- **Rate Validation:** Rate validation is conducted to evaluate measure results and compare rates to industry standard benchmarks. All required measures were reportable.

Recommendations:

1. PC ACOs and MassHealth should improve oversight of medical record review processes to confirm accuracy of abstracted data reported by PC ACOs.
2. MassHealth should update provider specialty mapping to improve measure rate accuracy.

IPRO found that the data and processes used to produce HEDIS and non-HEDIS rates for the PC ACOs were fully compliant with all seven of the applicable NCQA information system standards. Findings from IPRO's review are displayed in **Table 3**.

Table 3: PC ACO Compliance with Information System Standards – MY 2021

IS Standard	Community Care Cooperative (C3) ACO	Mass General Brigham (MGB) ACO	Steward Health Choice (Steward) ACO
1.0 Medical Services Data	Compliant	Compliant	Compliant
2.0 Enrollment Data	Compliant	Compliant	Compliant
3.0 Practitioner Data	Compliant	Compliant	Compliant
4.0 Medical Record Review Processes	Compliant	Compliant	Compliant
5.0 Supplemental Data	Compliant	Compliant	Compliant
6.0 Data Preproduction Processing	Compliant	Compliant	Compliant
7.0 Data Integration and Reporting	Compliant	Compliant	Compliant

IS: information system; MY: measurement year.

Conclusions and Comparative Findings

IPRO aggregated the PC ACO rates to provide methodologically appropriate, comparative information for all PC ACOs consistent with guidance included in the EQR protocols issued in accordance with *Title 42 CFR § 438.352(e)*.

IPRO compared the statewide averages to the NCQA HEDIS MY 2021 Quality Compass New England (NE) regional percentiles. The statewide averages were calculated across all MassHealth’s ACOs, including ACPPs and PC ACOs.

IPRO also compared PC ACOs’ rates to the NCQA HEDIS MY 2021 Quality Compass New England (NE) regional percentiles for Medicaid health maintenance organizations (HMOs) for all measures where available. MassHealth’s benchmarks for PC ACO rates are the 75th and the 90th Quality Compass New England regional percentile. The regional percentiles are color-coded to compare to the PC ACO rates, as explained in **Table 4**.

Table 4: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2021 Quality Compass New England (NE) Regional Percentiles.

Color Key	How Rate Compares to the NCQA HEDIS MY 2021 Quality Compass NE Regional Percentiles
Orange	Below the NE regional Medicaid 25 th percentile.
Light Orange	At or above the NE regional Medicaid 25 th percentile but below the 50 th percentile.
Gray	At or above the NE regional Medicaid 50 th percentile but below the 75 th percentile.
Light Blue	At or above the NE regional Medicaid 75 th percentile but below the 90 th percentile.
Blue	At or above the NE regional Medicaid 90 th percentile.
White	No NE regional benchmarks available for this measure or measure not applicable (N/A).

When compared to the MY 2021 Quality Compass New England (NE) regional percentiles, C3 had three HEDIS rates above the 90th percentile, whereas MGB and Steward had one rate each above the 90th percentile. All other rates were below the 75th percentile, which MassHealth considers a minimum (threshold) standard for performance. All PC ACOs scored below the 25th percentile on the IET Initiation and Engagement measures. **Table 5** displays the HEDIS PMs for MY 2021 for all PC ACOs and the statewide averages.

Table 5: PC ACO HEDIS Performance Measures – MY 2021

HEDIS Measure	C3 ACO	MGB ACO	Steward ACO	ACO Statewide Average
Childhood Immunization Status (combo 10)	61.44%	55.31%	53.53%	50.91%
Timeliness of Prenatal Care	90.55%	81.14%	89.29%	81.16%
Immunization for Adolescents (combo 2)	62.29%	33.58%	40.63%	47.98%
Controlling High Blood Pressure	55.96%	67.64%	61.31%	66.05%
Asthma Medication Ratio	58.10%	54.24%	54.22%	55.64%
Comprehensive Diabetes Care: A1c Poor Control ¹ (Lower is better)	39.89%	26.22%	42.82%	35.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	60.83%	34.25%	46.44%	41.52%
Follow-Up After Hospitalization for Mental Illness (7 days)	47.23%	52.92%	47.98%	39.10%
Follow-up After Emergency Department Visit for Mental Illness (7 days)	72.52%	76.26%	74.33%	77.07%
Plan All-Cause Readmissions (Observed/Expected Ratio)	1.145	1.065	1.098	1.335
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	45.51%	42.42%	41.47%	48.39%
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	16.09%	13.78%	14.33%	15.77%

¹ A lower rate indicates better performance.

PC ACO: primary care accountable care organization; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year.

For the state-specific measures, IPRO compared the rates to the goal benchmarks determined by MassHealth. Goal benchmarks for PC ACOs were fixed targets calculated with COVID-based adjustments. Benchmarks were not available for three measures. **Table 6** shows the color key for state-specific PM comparison to the state benchmark.

Table 6: Color Key for State-Specific Performance Measure Comparison to the state benchmark

Color Key	How Rate Compares to the State Benchmark
Orange	Below the state benchmark
Gray	At the state benchmark.
Blue	Above the state benchmark.
White	Not applicable (N/A).

Table 7 shows state-specific PMs for MY 2021 for all PC ACOs and the statewide averages. C3 ACO had six rates above the state benchmark, while MGB had five and Steward had four rates above the state benchmark. Primary Care Member Experience Survey (PC MES) measures were not included in the performance measure validation.

Table 7: PC ACO State-Specific Performance Measures – MY 2021

Measure	C3 ACO	MGB ACO	Steward ACO	ACO Statewide Average	State Benchmark
Oral Health Evaluation	53.32%	55.44%	49.81%	51.25%	43.28%
Acute Unplanned Admissions for Individuals with Diabetes (Adult; Score)	14.858	13.813	14.756	15.493	N/A
Community Tenure (CT) – Bipolar, Schizophrenia or Psychosis (BSP; Observed/Expected Ratio)	1.630	1.761	1.628	1.151	TBD
Community Tenure (CT) – Non-BSP (Observed/Expected Ratio)	2.390	2.321	2.657	1.751	TBD
Health-Related Social Needs Screening	26.28%	22.14%	8.76%	23.64%	23.50%
Risk-Adjusted Ratio (Observed/Expected) ED Visits for Members Aged 18–65 Years Identified with a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions (lower is better)	1.639	1.474	1.631	1.453	1.28
Behavioral Health Community Partner Engagement	10.10%	11.50%	9.17%	13.10%	12.20%
LTSS Community Partner Engagement	9.80%	3.86%	5.85%	9.22%	9.20%
PC MES Willingness to Recommend+ Adult	81.89	88.74	85.27	85.31	90.40
PC MES Willingness to Recommend+ Child	86.43	92.37	91.35	90.16	91.30
PC MES Communication+ Adult	85.99	89.60	87.79	87.61	90.20
PC MES Communication+ Child	87.76	92.66	91.91	90.84	90.80
PC MES Integration of Care+ Adult	75.16	79.74	78.02	78.57	82.90
PC MES Integration of Care+ Child	73.53	78.35	79.75	79.33	89.10
PC MES Knowledge of Patient+ Adult	79.89	84.98	82.27	82.03	83.30
PC MES Knowledge of Patient+ Child	83.01	88.94	87.69	86.60	89.10
Screening for Depression and Follow-Up Plan	50.74	40.11	37.06	40.88	49.32
Depression Remission or Response	9.47	0.77	1.30	6.95	9.20

PC ACO: primary care accountable care organization PC MES: Primary Care Member Experience Survey; MY: measurement year; ED: emergency department; LTSS: long-term services and support; N/A: not applicable; TBD: to be determined.

IV. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

The objective of the compliance validation 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 compliance of PC ACOs with Medicaid and CHIP managed care regulations was evaluated by MassHealth's previous EQRO. The most current review was conducted in 2021 for contract year 2020. This section of the report summarizes the 2021 compliance results. The next comprehensive review will be conducted in 2024, as the compliance validation process is conducted triennially.

Technical Methods of Data Collection and Analysis

Compliance reviews were divided into 11 standards consistent with the CMS October 2021 EQR protocols. Based on the PC ACO contract, several of the review area functions were retained at the state level and not covered under the PC ACO contract. The areas that are noted as "N/A" were not applicable to the PC ACO review:

- Availability of Services
 - Enrollee Rights and Protections
 - Enrollment and Disenrollment
 - Enrollee Information – N/A
- Assurances and Adequate Capacity of Services – N/A
- Coordination and Continuity of Care
- Coverage and Authorization of Services – N/A
- Provider Selection
- Confidentiality
- Grievance and Appeal Systems
- Subcontractual Relations and Delegation
- Practice Guidelines – N/A
- Health Information Systems – N/A
- Quality Assessment and Performance Improvement

Scoring Methodology

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by total possible points. A three-point scoring system was used: Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points. For each standard identified as Partially Met or Not Met, the PC ACO was required to submit a corrective action plan (CAP) in a format agreeable to MassHealth. The scoring definitions are outlined in **Table 8**.

Table 8: Scoring Definitions

Scoring	Definition
Met = 1 point	Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and PC ACO 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"> • Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. PC ACO staff interviews, however, provided information that was not consistent with documentation provided. • Documentation to substantiate compliance with some but not all the regulatory or contractual provision was provided, although PC ACO staff interviews provided information consistent with compliance with all requirements. • Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided, and PC ACO staff interviews provided information inconsistent with compliance with all requirements.
Not Met = 0 points	There was an absence of documentation to substantiate compliance with any of the regulatory or contractual requirements and PC ACO staff did not provide information to support compliance with requirements.

Description of Data Obtained

Compliance review tools included detailed regulatory and contractual requirements in each standard area. The PC ACOs 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 PC ACOs 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

PC ACOs were compliant with many of the Medicaid and CHIP managed care regulations and standards. The highest compliance scores were achieved in the Coordination and Continuity of Care domain. Steward achieved the highest overall score of 96.4%, followed by the MGB ACO with a score of 94.5%, but both PC ACOs performed below 90% on the Grievance and Appeals Systems standard. The C3 ACO performed below 90% in the Subcontractual Relationships and Delegation domain and scored 50% in the Confidentiality domain. Each PC ACO’s scores are displayed in **Table 9**.

Table 9: CFR Standards to State Contract Crosswalk – 2021 Compliance Validation Results

CFR Standard Name ¹	CFR Citation	C3 ACO	MGB ACO	Steward
Overall compliance score		89.4%	94.5%	96.4%
Availability of Services	438.206	92.3%	92.6%	91.1%
Enrollee Rights and Protections	438.10	90.0%	100%	100%
Enrollment and Disenrollment	438.56	N/A	N/A	N/A
Enrollee Information	438.10	98.9%	94.6%	97.8%
Assurances of Adequate Capacity and Services	438.207	N/A	N/A	N/A
Coordination and Continuity of Care	438.208	100%	99.1%	100%
Coverage and Authorization of Services	438.210	N/A	N/A	N/A
Provider Selection	438.214	N/A	N/A	N/A
Confidentiality	438.224	50.0%	100%	100%
Grievance and Appeal Systems	438.228	96.9%	84.4%	87.5%
Subcontractual Relationships and Delegation	438.230	86.8%	97.4%	94.7%
Practice Guidelines	438.236	N/A	N/A	N/A
Health Information Systems	438.242	N/A	N/A	N/A
QAPI	438.330	100%	87.5%	100%

¹ The following compliance validation results were conducted by MassHealth’s previous external quality review organization. CFR: Code of Federal Regulations; QAPI: Quality Assurance and Performance Improvement; N/A: not applicable.

V. Validation of Quality-of-Care Surveys – Primary Care Member Experience Survey

Objectives

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

Section 3.3.A. and Appendix B of the PC ACO Contract with MassHealth states that MassHealth will use survey instruments, like the CG-CAHPS survey, to evaluate the enrollee experience with MassHealth’s ACO program.

Since 2017, MassHealth has worked with the Massachusetts Health Quality Partners (MHQP), an independent non-profit measurement and reporting organization, to survey adult and pediatric ACO members about their experiences with PCPs using the PC MES.

MassHealth’s PC MES is based on the CG-CAHPS survey, which asks members to report on their experiences with providers and staff in physician practices and groups. The CG-CAHPS survey results can be used to monitor the performance of physician practices and groups and to reward them for high-quality care.

Technical Methods of Data Collection and Analysis

The program year (PY) 2021 PC MES was administered between February– May 2022 by the Center for the Study of Services (CSS), an independent survey research organization and MHQP’s subcontractor.

The adult and child PC MES survey instruments were based on the CG-CAHPS 3.0 surveys developed by the Agency for Health Care Research and Quality (AHRQ) and the NCQA. The PY 2021 PC MES adult and child surveys included Patient-Centered Medical Home (PCMH) survey items and the Coordination of Care supplemental items.

Seventeen ACOs participated in the PY 2021 survey, including 13 ACPPs, 3 PC ACOs, and the Lahey ACO. Across the seventeen ACOs, MassHealth members were attributed to ACO practices that were grouped into 36 medical groups. This report provides the results for the PC ACOs.

For the PC MES adult and child surveys, respondents could complete surveys in English or Spanish (in paper or on the web), or in Portuguese, Chinese, Vietnamese, Haitian Creole, Arabic, Russian, or Khmer (on the web only). All members received an English paper survey in mailings, and members on file as Spanish-speaking also received a Spanish paper survey in mailings. The mail only protocol involved receiving up to two mailings. The email protocol involved receiving up to four emails and up to two mailings.

The sample frame included members 18 years of age or older for the adult survey or 17 years of age or younger for the child survey, who had at least one in-person primary care visit at one of the ACO’s practices during the measurement year (January 1 – November 24, 2021), and who were enrolled in one of the ACOs on the anchor date (November 24, 2021). Members who only had primary care telehealth visits during MY 2021 were excluded from the sample frame. **Table 10** provides a summary of the technical methods of data collection.

Table 10: PC MES – Technical Methods of Data Collection, MY 2021

PC MES – Technical Methods of Data Collection	
Adult CAHPS survey	
Survey vendor	MHQP
Survey tool	MassHealth PC MES, based on the CG-CAHPS 3.0 survey instrument
Survey timeframe	February–May 2022
Method of collection	Mailings and emails
Sample size – all ACOs	117,455
Response rate	10.0%
Child CAHPS survey	
Survey vendor	MHQP
Survey tool	MassHealth PC MES, based on the CG-CAHPS 3.0 survey instrument
Survey timeframe	February–May 2022
Method of collection	Mailings and emails
Sample size – all ACOs	154,822
Response rate	5.0%

To assess PC ACO performance, IPRO compared PC ACO scores to statewide averages calculated as the cumulative top-box survey results across all MassHealth’s ACOs. The top-box scores are the survey results for the highest possible response category.

Description of Data Obtained

IPRO received copies of the final PY 2021 technical and analysis reports produced by MHQP. These reports included comprehensive descriptions of the project technical methods and survey results. IPRO also received separate files with the PC ACO-level results and statewide averages.

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all PC ACOs, IPRO compared each PC ACO’s results to the statewide scores for adults and children. The statewide scores are the cumulative top-box survey results for MassHealth enrollees attributed to the 17 MassHealth ACOs. Measures performing above the statewide score were considered strengths; measures performing at the statewide score were considered average; and measures performing below the statewide score were identified as opportunities for improvement, as explained in **Table 11**.

Table 11: Color Key for PC MES Performance Measure Comparison Score

Color Key	How Rate Compares to the Statewide Average
Orange	Below the statewide score.
Gray	At the statewide score.
Blue	Above the statewide score.
White	Statewide score.

Table 12 displays the results of the PC MES adult Medicaid survey for PY 2021. The MGB ACO exceeded the statewide score for 9 out of 10 adult PC MES measures. Steward ACO and C3 ACO exceeded the statewide score for five measures and two measures, respectively.

Table 12: PC MES Performance – Adult Member, PY 2021

PC MES Measure	C3 ACO	MGB ACO	Steward ACO	Statewide Score
Adult Behavioral Health	69.3	70.5	62.4	65.2

PC MES Measure	C3 ACO	MGB ACO	Steward ACO	Statewide Score
Communication	86.0	89.6	87.8	87.6
Integration of Care	75.2	79.7	78.0	78.6
Knowledge of Patient	79.9	85.0	82.3	82.0
Office Staff	81.4	86.6	84.7	84.4
Organizational Access	72.1	79.6	79.2	77.5
Overall Provider Rating	84.2	90.2	87.4	87.1
Self-Management Support	61.8	65.4	61.0	61.3
Willingness to Recommend	81.9	88.7	85.3	85.3

PC MES: Primary Care Member Experience Survey; PY: program year.

Table 13 displays the results of the PC MES child Medicaid survey for PY 2021. The C3 ACO scored below the statewide score for all 12 child PC MES measures. The MGB ACO and Steward ACO exceeded the statewide score for 10 measures and eight measures, respectively.

Table 13: PC MES Performance – Child Member, PY 2021

PC MES Measure	C3 ACO	MGB ACO	Steward ACO	Statewide Score
Communication	87.8	92.7	91.9	90.8
Integration of Care	73.5	78.4	79.8	79.3
Knowledge of Patient	83.0	88.9	87.7	86.6
Office Staff	80.2	86.2	88.1	85.6
Organizational Access	74.9	82.8	84.7	82.2
Overall Provider Rating	87.6	92.4	91.7	90.7
Self-Management Support	51.5	59.0	48.3	53.5
Willingness to Recommend	86.4	92.4	91.4	90.2
Child Development	65.2	72.7	69.2	70.0
Child Provider Communication	93.7	95.7	95.2	94.9
Pediatric Prevention	62.9	70.8	63.2	65.9

PC MES: Primary Care Member Experience Survey; PY: program year.

VI. 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,¹¹ PAHP,¹² or PCCM entity has effectively addressed the recommendations for QI¹³ made by the EQRO during the previous year’s EQR.” Tables 14–16 display the PC ACOs’ responses to the recommendations for QI made during the previous EQR, as well as IPRO’s assessment of these responses.

C3 ACO Response to Previous EQR Recommendations

Table 17 displays the PC ACO’s progress related to the PC ACO External Quality Review CY 2021, as well as IPRO’s assessment of the PC ACO’s response.

Table 14: C3 PC ACO Response to Previous EQR Recommendations

Recommendation for C3 PC ACO	C3 PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>Compliance 1: C3 needs to revise and/or implement policies and procedures to address the deficient areas to bring the PC ACO into full compliance with federal and state contract requirements.</p>	<p>To accurately reflect its contractual obligations, C3 updated the following policies and procedures pertinent to the EQR findings:</p> <ul style="list-style-type: none"> • Material Subcontract Oversight - Updated to address the finding of inconsistent monitoring of our Material Subcontractors. • Member Education, Orientation, and Informational Materials - Updated to address the finding of not accounting for the contractual Member Rights of “Indian Enrollees” in our policies. • Member Protections Grievances - Updated to include appropriate clinical oversight of grievance regarding quality of care. <p>The “Provider Termination” policy still needs to be completed. The policy will be drafted and approved in Q1 of 2023. The drafting will be completed by the Compliance team and will follow the standard policy review process. In terms of monitoring, all policies are reviewed annually through our P&P Committee and all new or updated policies are signed off on by Executive Leadership.</p>	<p>Partially addressed</p>
<p>Compliance 2: C3 needs to create and implement a formal monitoring and annual performance review process, including processes for initiating corrective action, as appropriate.</p>	<p>This is in reference to C3’s Material Subcontractor monitoring and oversight. C3 developed a policy which mirrors their contractual obligations. C3 is in the process of submitting this policy to EOHS for approval via our contractually required Readiness Review process. The oversight and monitoring of C3’s Material Subcontractors will be further standardized and more closely aligned with contractual obligations. Key Performance Indicators and other measures of success can be more easily tracked and corrective actions will be known and more easily accomplished.</p>	<p>Partially addressed</p>

¹¹ Prepaid inpatient health plan.

¹² Prepaid ambulatory health plan.

¹³ Quality improvement.

Recommendation for C3 PC ACO	C3 PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>Compliance 3: C3 needs to revise its subcontractual agreements to add provisions for the right to audit and inspect records, making premises, facilities, equipment records, systems available for audit, and timeframes for the right to audit.</p>	<p>C3 drafted language to include in all Material Subcontractor contracts which states their responsibilities more clearly regarding the EOHHS ACO contract. However, not all contracts have been amended to reflect these changes. The contract amendment language has been drafted and C3 is working to ensure this gets included in the next round of amendments. We believe this can be accomplished during Q1 of 2023. C3’s Material Subcontractors will gain a better understanding of the EOHHS contractual requirements and make themselves amenable to any audit requirements.</p>	<p>Partially addressed</p>
<p>Compliance 4: C3 needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review.</p>	<ul style="list-style-type: none"> • Section 2.8(H): Enrollee Services. Indian Health Care Provider. – C3 updated policies and plans to update our Member Handbook accordingly. The Handbook has yet to be updated due to the timing of the annual review and update process with EOHHS. • Section 2.8(G): Enrollee Services. Member Protections. - Member Rights are communicated to all Health Centers via our Provider Handbook. C3’s Compliance Workgroup (compliance-leads from all C3-affiliated Health Centers) have also reviewed all contractually required Member Rights since the EQR finding. • Section 2.5: Enrollment and Education Activities. Notice of Termination. - C3 still has to implement an official policy, however C3 has enhanced their oversight of this requirement with the Health Centers. To ensure appropriate oversight of the EOHHS ACO contractual requirements, C3 Compliance created a form to streamline the reporting of relevant information regarding the notification to Members of “provider terminations” (i.e., PCPs leaving practices). Provider termination notification to Members is one of the responsibilities delegated to participating FQHCs. The form is designed to capture all relevant information from each organization to ensure compliance. • 438.406(b)(2)(ii): Special arrangements An MCO's process for handling enrollee grievances and appeals of adverse benefit determinations. - C3 has updated their Grievance policy to ensure they are clear about the process of clinical oversight of clinically related grievances. This process has been implemented in policy and practice. • Section 6.18(B): Material Subcontracts/ Subcontractors. Material Subcontract. - C3 drafted language to include in all Material Subcontractor contracts which states their responsibilities more clearly regarding the EOHHS ACO contract. However, not all contracts have been amended to reflect these changes. All contracts will be updated in Q1 of 2023 to ensure all Material Subcontractors comply with the applicable requirements of the EOHHS ACO contract. • Section 6.18(C): Material Subcontracts/ Subcontractors. Monitoring and Reporting on Material Subcontractors. – C3 developed a policy to ensure monitoring and oversight of Material Subcontractors is officially documented and managed in a structured way across the organization. 	<p>Partially addressed</p>

Recommendation for C3 PC ACO	C3 PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
	<ul style="list-style-type: none"> SECTION 7.Data Management and Confidentiality. - This finding related to a lack of consistent tracking of required trainings. Since then, C3 has implemented a Learning Management System (LMS) which tracks completion of the required trainings. Not all trainings have been incorporated into the system, but C3 plans to ensure company-wide adoption of the LMS by Q1 of 2023. 	

¹ 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. PC ACO: primary care accountable care organization; MCP: managed care plan; EQR: external quality review; Q: quarter; EOHHS: Executive Office of Health and Human Services; ACO: accountable care organization; PCP: primary care provider.

MGB ACO Response to Previous EQR Recommendations

Table 15 displays the PC ACO’s progress related to the *PC ACOs External Quality Review CY 2021*, as well as IPRO’s assessment of the PC ACO’s response.

Table 15: MGB PC ACO Response to Previous EQR Recommendations

Recommendation for MGB PC ACO	MGB PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>Compliance 1: MGB needs to revise and/or implement policies and procedures to address the deficient areas to bring the PC ACO into full compliance with federal and state contract requirements.</p>	<p>As the MGB ACO moves into a new contract with MGB Health Plan, policies and procedures will be updated to ensure the ACO is fully compliant with federal and state contract requirements. By waiting until the new ACO launch, we will ensure that the coming together of our two groups will follow compliance standards.</p>	<p>Partially addressed</p>
<p>Compliance 2: MGB should revise its contract language or include information in a provider manual that ensures that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.</p>	<p>As the MGB ACO moves into a new contract with MGB Health Plan, contract language and the provider manual will be updated for the April 1st start date to reflect language that highlights that providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid FFS populations.</p>	<p>Partially addressed</p>

Recommendation for MGB PC ACO	MGB PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>Compliance 3: MGB needs to create and implement a subcontractor monitoring policy and procedure, including information on who has responsibility for oversight, the oversight functions, who has decision-making authority regarding contractual issues, and CAPs.</p>	<p>As the MGB ACO moves into a new contract with MGB Health Plan the list of subcontractors will change. The ACO will implement new policy and procedures to monitor subcontractors.</p>	<p>Partially addressed</p>
<p>Compliance 4: MGB needs to include information about the ombudsperson in its member handbook or as part of its new enrollee information materials.</p>	<p>As the MGB ACO moves into the new contract with MGB Health Plan, the member handbook language will be updated to reflect information about the ombudsperson. Updates will be in place by the contract launch date of April 1st.</p>	<p>Partially addressed</p>
<p>Compliance 5: MGB needs to revise its directory to indicate whether the provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.</p>	<p>As the MGB ACO moves into the new contract with MGB Health Plan, the directory will be updated to provide additional information on accommodations at provider's offices and facilities. Updates will be in place by the contract launch date of April 1st.</p>	<p>Partially addressed</p>
<p>Compliance 6: MGB needs to revise its processes to ensure that all expressions of dissatisfaction are counted and reported as grievances even if they are resolved during a single phone call or are categorized internally as a compliant</p>	<p>The ACO has met with our call center to discuss updates to the process to ensure all expressions of dissatisfaction are counted. An updated policy and procedure will be reflected in the upcoming ACO launch in April of 2023.</p>	<p>Partially addressed</p>

Recommendation for MGB PC ACO	MGB PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
Compliance 7: MGB needs to work with its delegate to create and implement a PC ACO-branded Babel card to be included with grievance correspondence.	As the MGB ACO moves into the new contract with MGB Health Plan, the Babel card will be updated to correctly reflect the ACO's name. This will be ready for ACO launch in April 2023.	Partially addressed
Compliance 8: MGB needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its CAP with MassHealth.	The ACO will address all partially met findings as identified in the 2021 compliance review. The ACO did not have any 'not met' findings in the compliance review. Items has been addressed and will be incorporated into official policies and procedures during the new ACO launch in April of 2023.	Partially addressed

¹ 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. PC ACO: primary care accountable care organization; MCP: managed care plan; EQR: external quality review; ACO: accountable care organization; FFS: fee-for-service; CAP: corrective action plan.

Steward ACO Response to Previous EQR Recommendations

Table 16 displays the PC ACO's progress related to the *PC ACO External Quality Review CY 2021*, as well as IPRO's assessment of the PC ACO's response.

Table 16: Steward PC ACO Response to Previous EQR Recommendations

Recommendation for Steward PC ACO	Steward PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
Compliance 1: Steward needs to revise and/or implement policies and procedures to address the deficient areas to bring the PC ACO into full compliance with federal and state contract requirements.	Steward's Compliance Committee is required by policy to approve all operational policies/procedures that have compliance, contractual or regulatory implications. Following Compliance Committee review, such policies/procedures are approved by voting members of the Committee. All such policies/procedures undergo annual review, editing and approval. Steward's operational areas such as Clinical Operations, Quality and the Contact Center also require written policies/procedures for all key functions. Review and approval processes vary by department and include, at a minimum, sign-off by the areas' executive leadership. As the External Quality Review (EQR) revealed no opportunities to improve either SMCN's policy/procedure format or its review, approval, and implementation processes, these will be maintained. Approved SMCN policies/procedures and associated workflows are subject to business area monitoring of effectiveness. Monitoring methods include but are not limited to review of relevant department metrics and annual review of	Addressed

Recommendation for Steward PC ACO	Steward PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
	policy/procedure content against current supporting contractual and regulatory requirements.	
<p>Compliance 2: Steward needs to develop a mechanism to demonstrate the offering of at least two appropriate primary care providers with open panels across its service areas.</p>	<p>Without significant collaboration from the Executive Office of Health and Human Services (EOHHS), Steward finds that it does not have ability to improve this observation. At issue is the fact that some geographical areas are underserved by PCPs, and the required exclusivity of PCPs to a given ACO. SMCN has communicated to EOHHS its shared commitment to network adequacy and its willingness to collaborate on this opportunity. Steward has evaluated which geographies are underserved and has offered physician recruitment opportunities where possible. Other interventions and monitoring actions to be determined, pending input from EOHHS.</p>	Partially addressed
<p>Compliance 3: Steward should revise its contract language or include information in a manual that ensures that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.</p>	<p>Steward does not have a provider manual but does have other avenues for increasing transparency around provider office hours (e.g., annual training materials). As part of its readiness review activities for implementation of the new PC ACO contract, Steward is updating its provider education materials. Steward will update provider education materials with all requirements that contracted providers will have to meet to participate in the next PC ACO contract. An interdisciplinary work group is engaging in successive meetings at which all deliverables affecting the provider network are identified and extent of completion is tracked. Steward will continue to track provider attendance at all chapter meetings in which education materials are presented.</p>	Partially addressed
<p>Compliance 4: Steward needs to modify its member handbook to include information on how to report fraud or abuse to the PC ACO.</p>	<p>This modification was made in Q1 2022. The responsible Steward business area created Member Handbook content in accordance with requirements. Content was reviewed by Steward Compliance and by executive leadership. The revised Member Handbook was posted on Steward publicly facing website. Print copies are mailed to members upon request. The Member Handbook available online and in print incorporates fraud/waste/abuse reporting mechanisms. Steward Compliance monitors the Steward's website quarterly and validates that fraud/waste/abuse reporting information is present.</p>	Addressed
<p>Compliance 5: Steward needs to implement and document an ongoing monitoring and formal annual review process of material subcontractors on business-related performance measures and requirements, including how CAPs would be initiated and overseen, internal reporting, and decision-making requirements.</p>	<p>Provisions for ongoing monitoring and formal annual review of Material Subcontractor compliance and performance will be incorporated into Steward's existing policy/procedure for Material Subcontractor oversight. Business owners of areas responsible for Material Subcontractor performance will collaborate on creation of a Material Subcontractor performance summary report. The report format will include a standardized corrective action plan (CAP) which the business owner will utilize to address opportunities for improvement with applicable Material Subcontractors. Each area will complete reports for its Material Subcontractors and will present them to the Steward's Compliance Committee (or a related subcommittee) on a quarterly basis. The Compliance Committee or subcommittee will make recommendations for performance improvement as appropriate. Steward's Compliance will function as lead on monitoring of corrective action plans and will facilitate presentation of quarterly status updates to the Compliance</p>	Partially addressed

Recommendation for Steward PC ACO	Steward PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
	<p>Committee. The Material Subcontractor oversight policy will be updated to include a process for formal annual review of all Material Subcontractors by Steward’s Compliance.</p> <p>The Material Subcontractor oversight policy/procedure will be updated as noted above and will be presented to the Compliance Committee for review and approval. Associated workflows and report templates will be created in accordance with the policy/procedure. The Steward Compliance Committee will incorporate review of Material Subcontractor compliance and performance as a standing agenda item in its quarterly meetings. Results of Material Subcontractor annual reviews will be presented at the Compliance Committee meetings throughout the year.</p>	
<p>Compliance 6: Steward should continue to develop communication and education strategies to keep its broad network informed and supported in the PC ACO model.</p>	<p>Steward will update its provider education infrastructure in accordance with deliverables identified by EOHHS in its readiness review materials for ACOs entering the new PC ACO contract in 2023. Through local chapter team and pod meetings, providers have been educated about new requirements they will be expected to meet as part of network tiering. Written documentation of resources to prepare practices for tiering requirements is being distributed. Providers are currently attesting to the tier level they aspire to an extent to which they comply with associated requirements. Regular updates will be given to Steward’s central Governance Committees and Subcommittees (Operations, Quality and Medical Management, Governing Board, Performance and Distribution). Although EOHHS will audit provider tier requirement adherence directly, Steward will continue to collaborate with EOHHS on development of best practices for internal monitoring with the objective of successful tiering audits by EOHHS.</p>	Partially addressed
<p>Compliance 7: Steward should continue to explore strategies to integrate care management within primary care and develop relationships with community partners.</p>	<p>Primary care/ACO integration is being implemented via Steward’s Community Partners program and two partnering PCP practices. An Integrated Care Manager was granted real time access to provider progress notes. The Integrated Care Manager has established multidisciplinary case conferencing that includes the PCP and the Community Partner. Member-centric needs are identified in real time and incorporated into each agency’s/discipline’s plans of care. The PCP electronic health record is used to update interventions planned during case conferencing. The presence of alerts signaling needed interventions in member records can be monitored to evaluate the extent to which the integrated care team has created iterative multidisciplinary plans of care.</p>	Partially addressed
<p>Compliance 8: Steward needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its CAP with MassHealth.</p>	<p>Steward received zero “not met” findings. Steward received some “partially met” findings related to its policies/procedures and member materials related to grievance processing; speed of the provider network termination process; and enforcement of Community Partner assignment turnaround times.</p> <p>The Steward’s Member Handbook was updated with contact information for the MassHealth Ombudsman. Member-facing grievance letters were updated with information on how to utilize the MassHealth Ombudsman. Community Partner Documented Processes</p>	Addressed

Recommendation for Steward PC ACO	Steward PC ACO Response/Actions Taken	IPRO Assessment of MCP Response ¹
	<p>were revised to include clearer expectations about timeframes for member assignment. A new process and tracking system to support timely provider network terminations was developed. All documents and workflows described above were implemented and continue in production. The grievance process is monitored via internal reporting on grievance outcomes and processing times. The Steward’s Member Handbook undergoes annual review and update. An internal workgroup reviews outstanding the provider network terminations tracker against other internal sources of provider network information to ensure terminations are processed completely and timely.</p>	

¹ 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. PC ACO: primary care accountable care organization; MCP: managed care plan; EQR: external quality review; PCP: primary care provider; ACO: accountable care organization; Q: quarter.

VII. MCP Strengths, Opportunities for Improvement, and EQR Recommendations

Table 17 highlights each PC ACO’s performance strengths, opportunities for improvement, and this year’s recommendations based on the aggregated results of CY 2022 EQR activities as they relate to **quality, timeliness, and access**.

Table 17: Strengths, Opportunities for Improvement, and EQR Recommendations for All PC ACOs

PC ACO	Strengths	Weaknesses	Recommendations	Standards
Performance measures				
C3				
NCQA measures	C3 demonstrated compliance with IS standards. No issues were identified. Three HEDIS rates were above the 90 th percentile when compared to the New England regional NCQA Quality Compass benchmark. Those measures were: CIS, IMA, and APM.	Three HEDIS rates were below the 25 th percentile when compared to the New England regional NCQA Quality Compass benchmark. Those measures were: CBP, IET Initiation and Engagement.	C3 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
State-specific measures	Six out of 18 measures rates were above the state benchmark.	Nine out of 18 measures rates were below the statewide benchmark.	Same as above.	Quality, Timeliness, Access
MGB				
NCQA measures	MGB demonstrated compliance with IS standards. No issues were identified. The CBP rate was above the 90 th percentile when compared to the New England regional NCQA Quality Compass benchmark.	While there was no impact to the overall rates, some concerns were identified with chart abstraction for MGB. Four HEDIS rates were below the 25 th percentile when compared to the New England regional NCQA Quality Compass benchmark. Those measures were: PPC, AMR, IET Initiation and Engagement.	MGB 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
State-specific measures	Five rates were above the state benchmark.	Ten rates were below the statewide benchmark.	Same as above.	Quality, Timeliness, Access

PC ACO	Strengths	Weaknesses	Recommendations	Standards
Steward				
NCQA measures	<p>Steward demonstrated compliance with IS standards. No issues were identified.</p> <p>The APM rate was above the 90th percentile when compared to the New England regional NCQA Quality Compass benchmark.</p>	<p>Three HEDIS rates were below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark. Those measures were: AMR, IET Initiation and Engagement.</p>	<p>Steward 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.</p>	<p>Quality, Timeliness, Access</p>
State-specific measures	<p>Six rates were above the state benchmark.</p>	<p>Nine rates were below the statewide benchmark.</p>	<p>Same as above.</p>	<p>Quality, Timeliness, Access</p>
Compliance review				
C3	<p>C3 demonstrated compliance with most of the federal and state contractual standards for the 2021 compliance review across review areas. The review identified many achievements that have taken place since the C3 ACO began operations in 2017. C3 serves members statewide through its unique model of partnering federally qualified health centers (FQHCs) and community health centers (CHCs). Each FQHC and CHC entering the cooperative is established as a corporate member, and C3 is managed by a board of directors. C3 lends support and expertise to its corporate members related to practice transformation while all interactions take place at the health centers, which is a fundamental aspect of this model.</p> <p>The greatest strength noted from the review is C3's model that capitalizes on existing FQHCs and CHCs that have well-</p>	<p>The 2021 review was the first external compliance audit for C3 as a PC ACO. While the PC ACO was found to demonstrate strength in its ability to provide care and services to its members, it had challenges meeting some of the technical aspects of the review such as ensuring formal policies and procedures that meet all federal and state requirements. This included policies and procedures related to:</p> <ul style="list-style-type: none"> • Formal training on member protections to referral circles and employees, • Assistance to American Indian enrollees who elect an Indian Health Services care provider, • Grievance policy revisions related to ensuring clinical expertise in review of grievances of a clinical nature, • Tracking and monitoring mechanisms to ensure confidentiality trainings are completed by staff at hire and at least annually thereafter. <p>The audit found that C3 lacked processes to monitor performance more formally among its FQHC and CHC partners. This included activities</p>	<p>Recommendation 1: C3 needs to revise and/or implement policies and procedures to address the deficient areas to bring the PC ACO into full compliance with federal and state contract requirements.</p> <p>Recommendation 2: C3 needs to create and implement a formal monitoring and annual performance review process, including processes for initiating corrective action, as appropriate.</p> <p>Recommendation 3: C3 needs to revise its subcontractual</p>	<p>Quality, Timeliness, Access</p>

PC ACO	Strengths	Weaknesses	Recommendations	Standards
	<p>established processes for service delivery, established credibility with providing services in their respective communities, and vast experience with providing care to Medicaid members and diverse populations.</p> <p>Another aspect of C3’s model strength was found in its lean structure that has allowed the PC ACO to be nimble in its start-up, agile to make mid-course corrections, and implement and execute changes effectively.</p> <p>The review found that C3 brought consistency and maturity to some processes across FQHCs, including the evolution of care coordination, to bring consistency and efficiency in its approach for implementing an integrated care model. In addition, C3 has served as a valuable vehicle for collaboration and a forum for best practice sharing among the FQHCs.</p> <p>C3 has improved aspects of continuity and coordination of care, including the centralization of transition of care programs, at each health center and moved care management from a disease-state model to a fully integrated model that takes into consideration physical and behavioral health needs along with social determinants of health.</p> <p>Nearly all the 18 FQHCs and CHCs use the same electronic medical record system, which allows for</p>	<p>such as monitoring health center fulfillment of provider termination notifications as well as having a formalized process for annual reviews.</p> <p>C3’s subcontracts lacked some specific provisions related to the right to audit and inspect records, making premises, facilities, equipment records, systems available for audit, and timeframes for the right to audit.</p>	<p>agreements to add provisions for the right to audit and inspect records, making premises, facilities, equipment records, systems available for audit, and timeframes for the right to audit.</p> <p>Recommendation 4: C3 needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review.</p>	

PC ACO	Strengths	Weaknesses	Recommendations	Standards
	<p>communication across the care teams and care settings. In addition, C3 has helped provide data analytics to the clinical teams, which has provided increased visibility of care outcomes and fosters a culture of improving care.</p>			
MGB	<p>MGB demonstrated compliance with most of the federal and state contractual standards for the 2021 compliance review across review areas.</p> <p>The review identified many achievements that have taken place since the MGB ACO began operations in 2017. The plan serves members statewide through its well-established network of community and specialty hospitals and physician network. MGB established a partnership with AllWays Health Plan to support some of the operational functions of the PCACO, including call center and customer service, a clinical nurse advise line, care needs screening oversight, grievances, and ad-hoc reporting needs. MGB operates the PC ACO using 11 regional service organizations (RSOs), which represent its integrated and affiliated providers. MGB had a well-established service delivery network. It was, therefore, already positioned well to serve as a PC ACO at the inception of the program. This maturity allowed MGB to evaluate its needs and leverage expertise from its partners to be thoughtful about the implementation of the program within the first cycle.</p>	<p>The 2021 review was the first external compliance audit for MGB as a PC ACO. While MGB was found to demonstrate strength in its ability to provide care and services to its members, it had challenges meeting some of the technical aspects of the review such as ensuring formal policies and procedures were in place that meet all federal and state requirements. This included policies and procedures related to:</p> <ul style="list-style-type: none"> • Data-sharing and interoperability to describe its operational practice for real-time notification of events in care such as emergency room and inpatient events. • Ensuring the use of the Child and Adolescent Needs and Strengths (CANS) tool by primary care providers for enrollees under 21 years of age. • Coordinating care for criminal justice-involved enrollees to describe its process for ensuring access to medically necessary services, including behavioral health services and care management and care coordination, as appropriate. • New enrollee information timeframes for fulfilling contractual requirements, state approval of new enrollee information, and identification card mailing and monitoring processes. • Quality of care grievances. • Assistance to American Indian enrollees who elect an Indian Health Services care provider. 	<p>Recommendation 1: MGB needs to revise and/or implement policies and procedures to address the deficient areas to bring the PC ACO into full compliance with federal and state contract requirements.</p> <p>Recommendation 2: MGB should revise its contract language or include information in a provider manual that ensures that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.</p> <p>Recommendation 3: MGB needs to create and implement a subcontractor monitoring policy and procedure, including information on who has</p>	<p>Quality, Timeliness, Access</p>

PC ACO	Strengths	Weaknesses	Recommendations	Standards
	<p>The review found MGB to be highly data-driven, which was supported by all the expertise available to the PC ACO by virtue of its academic model. MGB demonstrated robust analytics and impressive evaluation capabilities, including analysis in terms of cost-savings and utilization management.</p> <p>Nearly all providers with the PC ACO use the same electronic medical record system which allows for communication across the care teams and care settings. In addition, all care management functions are documented in the EMR. This supports all aspects of the PC ACO and provides a critical advantage for care management.</p> <p>Another aspect of MGB’s model strength was found in its engagement of primary care providers to help identify members who would likely benefit from care management. This practice promoted increased buy-in from its primary care providers. This was a unique strength noted from the review across both accountable care partnership plans and PC ACOs.</p> <p>The review found efforts to address social determinants of health using flexible services funds to establish food and housing partners within each RSO.</p>	<ul style="list-style-type: none"> Grievance policy revisions related to ensuring clinical expertise in review of grievances of a clinical nature. Tracking and monitoring mechanisms to ensure confidentiality trainings are completed by staff at hire and at least annually thereafter. <p>While MGB had contractual references that outline specific access standards based on visit type and office hours, the language did not specifically ensure that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.</p> <p>The audit found that MGB lacked processes to formally monitor performance among its RSOs, including a formalized process for annual reviews.</p> <p>MGB’s new enrollee information lacked information regarding the ombudsman process.</p> <p>While MGB indicated that all of its academic medical centers and regional service organizations offer basic accommodations for members with disabilities, the PC ACO did not include this information in its provider directory or on its website.</p> <p>While the PC ACO had a delegate in place to identify and intake grievances from enrollees, the review found that this person did not consider expressions of dissatisfaction that were resolved during a single call as a grievance. This process is inconsistent with the definition of a grievance found in the policy as an expression of dissatisfaction by a member or their representative.</p>	<p>responsibility for oversight, the oversight functions, who has decision-making authority regarding contractual issues, and CAPs.</p> <p>Recommendation 4: MGB needs to include information about the ombudsperson in its member handbook or as part of its new enrollee information materials.</p> <p>Recommendation 5: MGB needs to revise its directory to indicate whether the provider’s office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.</p> <p>Recommendation 6: MGB needs to revise its processes to ensure that all expressions of dissatisfaction are counted and reported as grievances even if they are resolved during a single phone call or are categorized</p>	

PC ACO	Strengths	Weaknesses	Recommendations	Standards
		<p>While the PC ACO had a grievance response process managed by a delegate, the EQRO noted that its resolution letters did not include a Babel card or other information regarding the availability of translation.</p>	<p>internally as a compliant.</p> <p>Recommendation 7: MGB needs to work with its delegate to create and implement a PC ACO-branded Babel card to be included with grievance correspondence.</p> <p>Recommendation 8: MGB needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its CAP with MassHealth.</p>	
Steward	<p>In 2021, Steward demonstrated compliance with most of the federal and state contractual standards.</p> <p>The review identified many achievements that have taken place since the Steward ACO began operations in 2017. The Steward Health Care System is the parent organization and is a large national company. Steward serves members statewide through its established provider network of community-based organizations, community-based hospitals, employed providers and affiliates, as well as small and medium practices. Steward had a mature commercial health plan model and was</p>	<p>The 2021 review was the first external compliance audit for Steward as a PC ACO.</p> <p>While Steward indicated that it has processes in place for monitoring its provider panel sizes, the PC ACO did not have documentation to support its ability to offer at least two appropriate primary care providers with open panels.</p> <p>While Steward had contractual references that outline specific access standards based on visit type and office hours, the language did not specifically ensure that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.</p>	<p>Recommendation 1: Steward needs to develop a mechanism to demonstrate the offering of at least two appropriate primary care providers with open panels across its service areas.</p> <p>Recommendation 2: Steward should revise its contract language or include information in a manual that ensures that its providers offer hours of operation that are no less than those</p>	Quality, Timeliness, Access

PC ACO	Strengths	Weaknesses	Recommendations	Standards
	<p>able to leverage existing relationships for the PC ACO and build upon that network. The review found the Steward team’s prior managed care experience and expertise as being a notable strength. The review also found that Steward has a highly sophisticated structure and thoughtful consideration related to its governance of the PC ACO.</p> <p>Steward had robust and mature oversight and monitoring mechanisms for its material subcontractors. This area is particularly important with the high volume of collaborating organizations.</p> <p>The review found that Steward’s unique attribute of allowing smaller primary care provider practices to participate in the PC ACO was a strength and a contrast to other models. The review found that the PC ACO helps support some of these smaller primary care practices in their care of members with social needs, which can be challenging for smaller primary care practices.</p> <p>Steward was knowledgeable about its member population and noted that roughly 50% of it is pediatric. Steward has a large volume of pediatricians to meet this need.</p> <p>Steward implemented innovative activities, including its Healthy Beginnings program, which uses a doula, a trained non-health care professional who provides</p>	<p>Steward’s new enrollee information lacked information regarding how to report fraud or abuse to the PC ACO.</p> <p>While Steward had a robust monitoring and annual review process of its material subcontractors performed by its compliance team for certain aspects of the contract, there was not a documented process to monitor and annually review the business-related performance of a material subcontractor.</p> <p>Steward subcontracts lacked some specific provisions related to the right to audit and inspect records, making premises, facilities, equipment records, systems available for audit, and timeframes for the right to audit.</p> <p>Although there were no significant compliance-related deficiencies, the audit review noted that, due to the broad nature of Steward’s service delivery network, its efforts to effectively communicate with and educate providers under the PC ACO using a national model may present some challenges related to balancing the centralization of operational functions yet keeping the program with a local feel.</p> <p>While Steward had high technical scores for the compliance aspects, the review found some opportunities related to continuity and coordination of care. The care management structure appeared to be modeled in a traditional managed care organization approach for many of its members with care management occurring apart from the treatment team. Practices into which Steward was able to embed care management within primary care appeared to</p>	<p>offered to commercial enrollees or comparable Medicaid fee-for-service populations.</p> <p>Recommendation 3: Steward needs to implement and document an ongoing monitoring and formal annual review process of material subcontractors on business-related performance measures and requirements, including how CAPs would be initiated and overseen, internal reporting, and decision-making requirements.</p> <p>Recommendation 4: Steward should continue to develop communication and education strategies to keep its broad network informed and supported in the PC ACO model.</p> <p>Recommendation 5: Steward should continue to explore strategies to integrate care management within primary care and</p>	

PC ACO	Strengths	Weaknesses	Recommendations	Standards
	<p>support to a pregnant woman before, during, and after delivery. In addition, Steward provides on-demand non-emergency medical transportation.</p> <p>A demonstration of the Steward care management system noted strong functionality to help track and manage members in its program. In addition, Steward established relationships with organizations using flexible spending services funds to assist with providing rapid housing, home modification, moving assistance, utility assistance, and nutrition services.</p>	<p>provide greater engagement among the primary care providers and members.</p>	<p>develop relationships with community partners.</p>	
Quality-of-care surveys				
C3	<p>C3 scored above the statewide benchmark on 2 out of 10 adult PC MES measures.</p>	<p>C3 scored below the statewide benchmark on 8 out of 10 PC MES adult measures and on all child measures.</p>	<p>C3 should utilize the results of the adult and child CAHPS surveys to drive performance improvement as it relates to member experience. C3 should also utilize complaints and grievances to identify and address trends.</p>	<p>Quality, Timeliness, Access</p>
MGB	<p>MGB scored above the statewide benchmark on all but one PC MES adult measures, and 10 out of 12 child PC MES measures.</p>	<p>MGB scored below the statewide benchmark on one adult and two child PC MES measures.</p>	<p>None.</p>	<p>Quality, Timeliness, Access</p>

PC ACO	Strengths	Weaknesses	Recommendations	Standards
Steward	Steward scored above the statewide benchmark on 5 out of 10 adult and 8 out of 12 child PES MES measures.	Steward scored below the statewide benchmark on 5 out of 10 adult and 4 out of 12 child PC MES measures.	Steward should utilize the results of the adult and child CAHPS surveys to drive performance improvement as it relates to member experience.	Quality, Timeliness, Access

PC ACO: primary care accountable care organization; EQR: external quality review; NCOA: National Committee for Quality Assurance; IS: information standards; HEDIS: Healthcare Effectiveness Data and Information Set; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; PPC: Prenatal and Postpartum Care; ACO: accountable care organization; CAP: corrective action plan; EQRO: external quality review organization; PC MES: Primary Care Member Experience Survey; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CIS: Childhood Immunization Status; IMA: Immunization for Adolescents, APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics; CBP: Controlling High Blood Pressure; AMR: Asthma Medication Ratio.

VIII. 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 the **Table 18**.

Table 18: 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 Appendix B, Table B1 .
<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 each PC ACO are summarized in Section VII. MCP Strengths, Opportunities for Improvement, and EQR Recommendations .
<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 Section VII. MCP Strengths, Opportunities for Improvement, and EQR Recommendations for a chart outlining each PC ACO’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 each PC ACO are included in each EQR activity section (Sections III–V) and in Section VII. MCP Strengths, Opportunities for Improvement, and EQR Recommendations .

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 Section I, High-Level Program Findings and Recommendations , as well as when discussing strengths and weaknesses of a PC ACO or activity and when discussing the basis of performance measures.
<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 all PC ACOs is included across the report in each EQR activity section (Sections III–V) and in Section VII. MCP Strengths, Opportunities for Improvement, and EQR Recommendations .
<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 Section VI. MCP Responses to the Previous EQR Recommendations for the prior year findings and the assessment of each PC ACO'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)(iv)</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 does not include information on the validation of PIPs that were underway during the preceding 12 months because, as a PCCM, PC ACOs did not conduct PIPs.
<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 does not include a description of PIP interventions associated with each state-required PIP topic because, as a PCCM, PC ACOs did not conduct PIPs.
<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 each PC ACO's performance measures; see Section III .
<i>Title 42 CFR § 438.358(b)(1)(iii)</i>	<p>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 <i>Title 42 CFR § 438.330</i>.</p> <p>The technical report must provide MCP results for the 11 Subpart D and QAPI standards.</p>	This report includes information on a review, conducted in 2021, to determine each PC ACO's compliance with the standards set forth in Subpart D and the QAPI requirements described in <i>Title 42 CFR § 438.330</i> ; see Section IV .

IX. Appendix A – MassHealth Quality Goals and Objectives

Table A1: MassHealth Quality Strategy Goals and Objectives

MassHealth Quality Strategy Goals and Objectives	
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
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
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
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
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

X. 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"> • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. 	<ol style="list-style-type: none"> 1. AllWays Health Partners, Inc & Merrimack Valley ACO 2. Boston Medical Center Health Plan & Boston Accountable Care Organization, WellSense Community Alliance ACO 3. Boston Medical Center Health Plan & Mercy Health Accountable Care Organization, WellSense Mercy Alliance ACO 4. Boston Medical Center Health Plan & Signature Healthcare Corporation, WellSense Signature Alliance ACO 5. Boston Medical Center Health Plan & Southcoast Health Network, WellSense Southcoast Alliance ACO 6. Fallon Community Health Plan & Health Collaborative of the Berkshires 7. Fallon Community Health Plan & Reliant Medical Group (Fallon 365 Care) 8. Fallon Community Health Plan & Wellforce 9. Health New England & Baystate Health Care Alliance, Be Healthy Partnership 10. Tufts Health Public Plan & Atrius Health 11. Tufts Health Public Plan & Boston Children's Health Accountable Care Organization 12. Tufts Health Public Plan & Beth Israel Deaconess Care Organization 13. Tufts Health Public Plan & Cambridge Health Alliance
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"> • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. 	<ol style="list-style-type: none"> 1. Community Care Cooperative 2. Mass General Brigham 3. Steward Health Choice

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
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"> Population: Managed care eligible Medicaid members under 65 years of age. Managed Care Authority: 1115 Demonstration Waiver. 	<ol style="list-style-type: none"> Boston Medical Center HealthNet Plan (WellSense) Tufts Health Together
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> <ul style="list-style-type: none"> Population: Managed care eligible Medicaid members under 65 years of age. Managed Care Authority: 1115 Demonstration Waiver. 	Not applicable – MassHealth
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"> 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. Managed Care Authority: 1115 Demonstration Waiver. 	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"> Population: Dual-eligible Medicaid members aged 21–64 years at the time of enrollment with MassHealth and Medicare coverage. 	<ol style="list-style-type: none"> Commonwealth Care Alliance Tufts Health Plan Unify UnitedHealthcare Connected for One Care

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
	<ul style="list-style-type: none"> Managed Care Authority: Financial Alignment Initiative Demonstration. 	
Senior care option (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"> Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age. Managed Care Authority: 1915(a) Waiver/1915(c) Waiver. 	<ol style="list-style-type: none"> Boston Medical Center HealthNet Plan Senior Care Option Commonwealth Care Alliance NaviCare (HMO) Fallon Health Senior Whole Health by Molina Tufts Health Plan Senior Care Option UnitedHealthcare Senior Care Options

XI. 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
EOHHS	N/A	Acute Unplanned Admissions for Individuals with Diabetes	X	X				1.2, 3.1, 5.2
NCQA	AMM	Antidepressant Medication Management – Acute and Continuation			X		X	1.2, 3.4, 5.1, 5.2
NCQA	AMR	Asthma Medication Ratio	X	X				1.1, 1.2, 3.1
EOHHS	BH CP Engagement	Behavioral Health Community Partner Engagement	X	X				1.1, 1.3, 2.3, 3.1, 5.2, 5.3
NCQA	COA	Care for Older Adult – All Submeasures			X			1.1, 3.4, 4.1
NCQA	CIS	Childhood Immunization Status	X	X				1.1, 3.1
NCQA	COL	Colorectal Cancer Screening			X			1.1, 2.2, 3.4
EOHHS	CT	Community Tenure	X	X				1.3, 2.3, 3.1, 5.1, 5.2
NCQA	CDC	Comprehensive Diabetes Care: A1c Poor Control	X	X		X	X	1.1, 1.2, 3.4
NCQA	CBP	Controlling High Blood Pressure	X	X	X	X		1.1, 1.2, 2.2
NCQA	DRR	Depression Remission or Response	X					1.1, 3.1, 5.1
NCQA	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					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				1.2, 3.1, 5.1–5.3
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (30 days)			X		X	3.4, 5.1–5.3
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	X	X			X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (30 days)			X	X	X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (7 days)	X	X	X		X	3.4, 5.1–5.3
NCQA	ADD	Follow-up for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (HEDIS)					X	1.2, 3.4, 5.1, 5.2

Measure Steward	Acronym	Measure Name	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
EOHHS	HRSN	Health-Related Social Needs Screening	X					1.3, 2.1, 2.3, 3.1, 4.1
NCQA	IMA	Immunizations for Adolescents	X	X				1.1, 3.1
NCQA	FVA	Influenza Immunization				X		1.1, 3.4
MA-PD CAHPs	FVO	Influenza Immunization			X			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				1.1, 1.3, 2.3, 3.1, 5.2
NCQA	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	X	X			X	1.2, 3.4, 5.1, 5.2
ADA DQA	OHE	Oral Health Evaluation	X	X				1.1, 3.1
NCQA	OMW	Osteoporosis Management in Women Who Had a Fracture			X			1.2, 3.4, 5.1
NCQA	PBH	Persistence of Beta-Blocker Treatment after Heart Attack			X			1.1, 1.2, 3.4
NCQA	PCE	Pharmacotherapy Management of COPD Exacerbation			X			1.1, 1.2, 3.4
NCQA	PCR	Plan All Cause Readmission	X	X	X	X		1.2, 3.4, 5.1, 5.2
NCQA	DDE	Potentially Harmful Drug – Disease Interactions in Older Adults			X			1.2, 3.4, 5.1
CMS	CDF	Screening for Depression and Follow-Up Plan	X					1.1, 3.1, 5.1, 5.2
NCQA	PPC – Timeliness	Timeliness of Prenatal Care	X	X				1.1, 2.1, 3.1
NCQA	TRC	Transitions of Care – All Submeasures			X			1.2, 3.4, 5.1
NCQA	DAE	Use of High-Risk Medications in the Older Adults			X			1.2, 3.4, 5.1
NCQA	SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD			X			1.2, 3.4