MassHealth 2025
Comprehensive Quality Strategy

Commonwealth of Massachusetts

Executive Office of Health and Human Services

Office of Medicaid

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Introduction

Executive Summary

The Commonwealth of Massachusetts, Executive Office of Health and Human Services Office of Medicaid is pleased to submit its updated Comprehensive Quality Strategy (CQS) to support the mission of the Massachusetts Medicaid program (MassHealth), to improve the health outcomes of its diverse members and their families, by providing access to integrated health care service that sustainably and equitably promote health, well-being, independence and quality of life.

MassHealth administers a program combining Massachusetts Medicaid and the Children's Health Insurance Programs (CHIP) which provides health care coverage for over two million residents in Massachusetts. MassHealth's Comprehensive Quality Strategy has evolved since its initial issue of the 2006 Managed Care Quality Strategy. It is reviewed annually and updated periodically (no less than every three years) to reflect evolving changes in population health priorities, member health needs, programming and federal and state quality requirements. This 2025-2027 CQS is inclusive of updated quality goals and strategies to address and assess the outcomes of our managed care and fee-for-service populations.

2025-2027 MassHealth Quality Goals and Objectives

MassHealth is committed to a value-based healthcare system that promotes healthy outcomes, well-being and independence for our residents in Massachusetts through access to safe, high-quality care and integrated health care services.

This commitment is reflected in the following quality goals:

1. Achieve a healthy population by **improving the quality and safety** of pediatric, preventive, and perinatal care.
2. Focus on **high-impact acute and chronic condition areas** to promote effective, high- quality care and well-being of our populations.
3. Enable **coordinated and efficient care** for all members across the continuum of services and settings of care.
4. Enhance **person-centered care** through elevating member voice and improving member experience and engagement with their health care.
5. Ensure **access to and appropriate utilization** of care and services to members.

Key strategies or activities supporting these goals include:

- Addressing cross-cutting priority conditions and health outcomes across our populations.
- Identifying and assessing meaningful processes of care and outcomes that advance safe, quality care.
- Implementing standard measures and approaches across MassHealth value-based programs and its populations to measure the outcomes and progress of improving care for all our members.
- Utilizing a data driven approach to identify opportunities and interventions to reduce variation in quality outcomes across and within our populations served.
- Modernizing and advancing electronic clinical and quality measurement to support data-driven decisions important to affecting timely response and effective outcomes
- Identifying opportunities for efficiency and impact through utilization and care management

- Engaging our members where their voices are heard to understand their needs and choices to ensure that they are consistently experiencing high quality, compassionate care.

These quality goals aim to align with the national quality strategy, state-level population health priorities with active engagement of our stakeholders inclusive of: CMS, national and state organizations, providers, plans and importantly, our members.

2025 Quality Strategy Stakeholder Feedback and Areas for Consideration

Internal and external stakeholders provide valuable input and feedback in the ongoing development, implementation and monitoring of the comprehensive quality strategy (CQS). The CQS represents a non-static set of policies, strategies, objectives and activities recognizing the need to respond and meet the needs of our population and the ever-changing environment.

This CQS was made available on the MassHealth Quality website for public comment through October 27, 2025. Comments requesting technical clarification within the strategy have been incorporated into this final Quality Strategy document. Comments requesting considerations for specific programs were also received. These comments pertained to programmatic and contractual changes, and while not in the scope of the Quality Strategy, have been shared internally for future consideration.

Section 1: Scope

MassHealth's quality strategy is a **Comprehensive Quality Strategy (CQS)**, aimed to drive improvement in the quality of services and care for all MassHealth members inclusive of our managed care and fee-for-service (FFS) populations. The CQS establishes shared goals and objectives across programs and populations and aligns its quality measurement to assess impact. Its purpose is to promote efficient use of resources while also addressing specific performance objectives and activities tailored to the needs of our distinct populations.

Note: Per 42 CFR 438.340(a) and 42 CFR 457.1240(e), CMS requires state Medicaid and CHIP agencies that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and certain primary care case management (PCCM) entities to develop and maintain a Medicaid and CHIP quality strategy to assess and improve the quality of health care and services provided by Managed Care Plans (MCPs).

Outline of Scope:

The CQS includes the following sections:

Section 1: An outline of the scope of the CQS and contents of the sections of the document

Section 2: Background and overview of MassHealth programs, plans and services

Section 3: The quality management structure at MassHealth, stakeholder and member engagement structure and opportunities, and the process for developing, reviewing, and evaluating the CQS

Section 4: MassHealth's CQS which includes quality goals, and objectives with identified quality measures and performance goals to assess and monitor progress

Section 5: Assessment and appropriateness of care reflected in contract management, data collection and monitoring, quality improvement, and external quality review

Section 6: State standards around access inclusive of availability and coverage of services, coordination and continuity of care, and monitoring and compliance

Section 7: Improvement and interventions, including intermediate sanctions

Appendix: Supporting details referenced throughout the CQS. It includes and is not limited to: Definitions of Acronyms used in the CQS, Participating Plans, MassHealth Quality Goals and Objectives, Quality Measures, Baseline, and Targets, and a Summary of Stakeholder Comments prior to finalizing the CQS.

Section 2: MassHealth Background

2.1 Overview

MassHealth covers more than 2 million individuals, or approximately 30% of Massachusetts residents including low-income adults, seniors and people with disabilities, and over 45% of all children. MassHealth began enrolling adults and children in managed care in 1997 as part of an 1115 Demonstration approved in 1995 to expand Medicaid eligibility. This demonstration expanded coverage to families and through state legislation (Chapter 170) combined the Children's Health Insurance Program (CHIP) with Medicaid. Today, approximately 70% of MassHealth members are enrolled in managed care plans, with the remaining 30% in fee-for-service (FFS).

Since 2018, MassHealth has not only continued its foundational aim to improve access to safe, quality universal care, but implemented significant delivery system reforms through the 1115 Waiver Demonstration to advance:

- Restructuring of the delivery system towards integrated, value-based, accountable care
- Improving the integration of physical health with behavioral health and expanding the access and range of behavioral health services (e.g., urgent behavioral health care, recovery-oriented substance use disorder services)
- Shifting more long-term services and supports to care for members in the community where they live

These reforms established a nationally-leading model of Accountable Care Organizations (ACOs) – provider-led organizations that are accountable for managing total cost of care, and improving member health care outcomes, delivery of care and experience. The ACO model requires establishing and maintaining relationships with Community Partners (CPs) and Health Related Social Needs Providers that support the coordination of care and provision of nutrition and housing support for our high-risk, hard-to reach members.

As part of the current CQS, the extension of the 1115 Demonstration (authorized through June 30, 2027) further advances accountability for organizations to establish relationships and coordinated services with key components of our health system inclusive of hospital care, community behavioral health centers, and primary care practices. These efforts strengthen the connections to provide timely and appropriate care for members through improved follow-up and transitions in care to reduce preventable acute hospitalizations. 100% of Safety Net Hospitals now participate in an ACO.

The overall CQS reflects continued commitment to ensure accountability of quality care for all our MassHealth members inclusive of managed care and fee-for-service populations receiving care and services across providers and settings. This also includes implementing programs for dually eligible members (served by Medicare and Medicaid) that have among the most complex care needs of the populations. Members may be dually eligible because they have a disability, or they are over age 65 and low-income. Many dually eligible members utilize a broad range of health care services, including medical and behavioral health services, as well as long-term services and supports that sustain their ability to live independently in the community or are provided in a nursing facility. Programs serving managed care and fee-for-service members are described in the next section.

2.2 MassHealth Managed Care Programs

Today, MassHealth operates the following managed care programs which cover approximately 70% of its overall membership:[1]

Accountable Care Organization (ACO) Program: A network of primary care providers who work in partnership with hospitals, specialists, behavioral health providers, LTSS providers, and state agencies to coordinate all a member's care. MassHealth has two ACO delivery models where ACOs are accountable for the quality, member experience and cost of care for members through a capitated model.

- **Accountable Care Partnership Plan (ACPP):** ACPPs are groups of primary care providers (PCPs) who work with just one managed care organization to create a full network of care.
- **Primary Care ACO (PCACO):** PCACOs are groups of PCPs that work directly with MassHealth to provide primary care to members and to coordinate the full range of services available to them through MassHealth's network of specialists and hospitals. Members receive behavioral health services through the state's Managed Behavioral Health Vendor.

Managed Care Organization (MCO) Program – A capitated model for managed care eligible members under the age of 65 that have access to a full network of care through one managed care organization.

Primary Care Clinician (PCC) Plan Program – A primary care case management model of managed care for members under age 65 and without any third-party insurance. Members receive behavioral health services through the state's Managed Behavioral Health Vendor.

Managed Behavioral Health Vendor (MBHV) – A capitated behavioral health (BH) model that provides and/or manages behavioral health services to members of the PCC Plan and PCACOs, and other children (e.g., with MassHealth as a secondary insurer).

Integrated Care Programs – Comprehensive managed care programs implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare and Medicaid covered benefits for MassHealth Members who are eligible for both programs at the time of enrollment.

Integrated care program options include:

- **One Care –** A comprehensive care option for members ages 21-64 at the time of enrollment who are eligible for both programs. Services are developed and delivered based on Member's person-centered assessment and care plan.
- **Senior Care Options (SCO)** –A comprehensive care option for eligible Massachusetts individuals ages 65 and older managed by a SCO plan using a person-centered model of care.

Note: SCO and OneCare were reprocured for 2026. The document references reflect the future state through still covers 2025 as required.

[1] All summaries of contract provisions in this document are for information purposes only. Interested parties should refer to the contracts for the contractual terms and conditions that apply. Nothing in this document should be read to alter or amend any contractual obligation. To the extent any discrepancies or conflicts exist between this document and the contract, the language of the contract controls.

Table 1: Managed Care Plans (MCPs) Membership in 2025

The following table provides a summary of the managed care plans, managed and approximate membership, managed care plan type, authority and approximated membership.

Plan Name	MCP Type	Managed Care Authority	Membership (Aug 2025)
Accountable Care Partnership Plan (ACPP)	MCE	1115	826,808
Primary Care ACO (PCACO)	PCCM Entity	1115	263,134
MCO Plan	MCE	1115	43,721
PCC Plan	PCCM	1115	41,993
Managed BH Health Vendor	PIHP	1115	51,279
One Care	MCE	Financial Alignment Initiative Demonstration	39,501
Senior Care Options (SCO)	MCE	1915(a) Starting in 2026/1915(c)	85,517

Note: In accordance with the managed care rule, the Accountable Care Partnership Plan, MCO, One Care and SCO programs are considered MCOs, and for the purposes of this document, will be referred to as managed care entities (MCEs). Primary Care ACOs are considered primary care case management entities (PCCM entities). The PCC Plan is considered a PCCM. MassHealth's Managed Behavioral Health Vendor, which serves members enrolled in the PCC Plan and Primary Care ACOs, and certain other populations is a Prepaid Inpatient Health Plan (PIHP) and is also referred to as Managed BH Vendor in this document. MassHealth does not contract with any Prepaid Ambulatory Health Plans (PAHPs) as defined in 42 CFR 438.2. The CQS under 42 CFR 438.340 relates to (but is not limited to) MCEs, PIHPs, and to PCCM entities as described in 42 CFR 438.310(c)(2).

A complete list of MassHealth managed care plans is provided in **Appendix B.**

2.3 Additional MassHealth Programs – Fee-for-Service and Other Programs

Additional programs, services, and supports provide important care to members.

Fee-for-Service (FFS) Medicaid Program

FFS Medicaid provides care where no entity is charged with coordinating care. FFS includes individuals under age 65 that have employer sponsored insurance to whom MassHealth offers wraparound benefits or those who live in a nursing facility or rehabilitation hospital. Adults (age 65 and over) or disabled with Medicare may also choose to remain in FFS.

Community Partners Program

Community Partners (CPs) collaborate with ACOs and MCOs to provide care coordination and care management support to individuals with significant behavioral health issues needs and/or complex LTSS needs. Members include ACO or MCO members who are adults with complex BH needs or children and adults with complex LTSS needs. PCC Plan and MassHealth's FFS members affiliated with the Department of Mental Health's Adult Community Clinical Supports Program are also eligible for this program.

Acute Hospital and Psychiatric Hospital Programs

MassHealth manages an acute care hospital network and providers to serve its FFS, PCC Plan, and Primary Care ACO populations with inpatient and outpatients services. MassHealth also manages a psychiatric inpatient hospital network and providers. Psychiatric inpatient hospitals provide covered services to MassHealth FFS members eligible to receive those services.

Program of All-Inclusive Care of the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) is an integrated care program for members aged 55 and older who are nursing facility eligible but can live safely in the community. PACE offers a complete range of medical and supportive services to participants via a coordination of care model that operates from a PACE center. Coordinated care is planned and provided by an interdisciplinary team (IDT) of providers (e.g., physicians, nurses, social workers, rehabilitation therapists, health aides). The PACE model is designed to keep frail elders living in the community safely for as long as possible.

Long-Term Services and Supports (LTSS)

MassHealth provides a system of care for members of all ages who require services to enable them to live independently, participate in their communities, and with improved quality of life. LTSS are offered through a variety of delivery systems, including fee-for-service, integrated care plans, and the Program of All-Inclusive Care for the Elderly (PACE).

Services managed by the MassHealth Office of Long-Term Service and Supports (OLTSS) include:

- Community-based LTSS: Adult Day Health, Adult Foster Care, Continuous Skilled Nursing, Day Habilitation, Group Foster Care and Personal Care Attendant Program (PCA).
- Facility-based LTSS: Nursing Facility Services and Chronic Disease and Rehabilitation Hospital (CDRH) Services.
- Other Covered Services: Durable Medical Equipment (DME), Orthotics and Prosthetics, Oxygen and Respiratory Therapy, Hospice Services, Home Health Agency (except Continuous Skilled Nursing), Nursing Facility and CDRH services (for the first 100 days), and Therapies (including Physical Therapy, Occupational Therapy and Speech Therapy).

One Care, SCO, and PACE programs cover all community-based and facility-based LTSS services and Other Covered Services. ACOs and MCOs cover the set of Other Covered Services. LTSS services, including Nursing Facility Services and CDRH services (after the first 100 days), are provided on a fee-for-service (FFS) basis by MassHealth directly to eligible ACO and MCO members.

Section 3: Quality Management at MassHealth

3.1 Quality Management Structure and Processes

Quality management at MassHealth reflects a systematic approach and oversight function of quality processes and activities with the goal of ensuring that members (through their providers and plans) receive safe, effective, patient-centered care that is timely, efficient and appropriate.

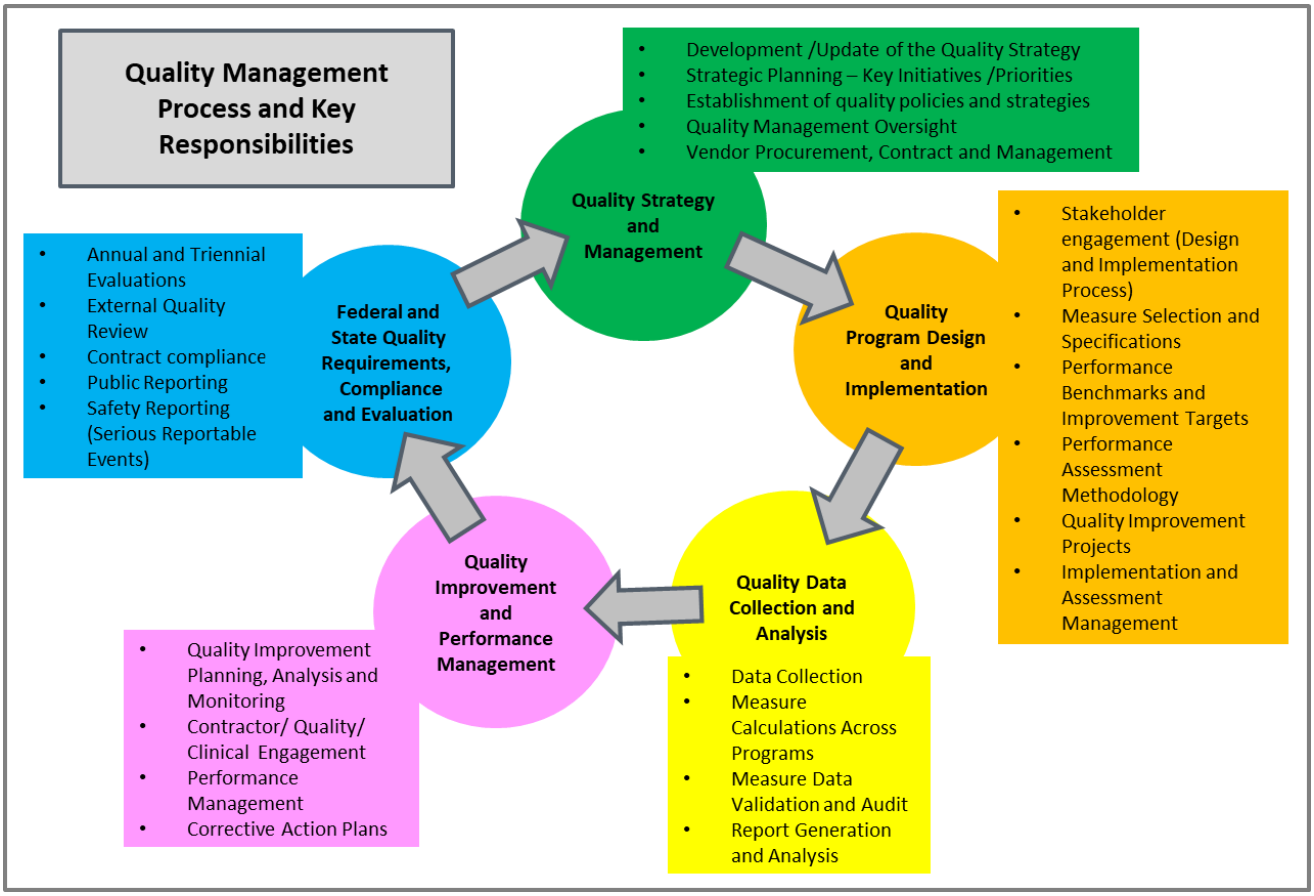
Quality Management Process and Key Responsibilities/ Activities

Key components of quality management at MassHealth include:

- Quality strategy and management
- Program design and implementation
- Data collection and analysis
- Quality improvement and performance management, and
- Federal and state quality requirements management, compliance and evaluation.

Below is a visual of the quality management process with key responsibilities or activities associated with each process component.

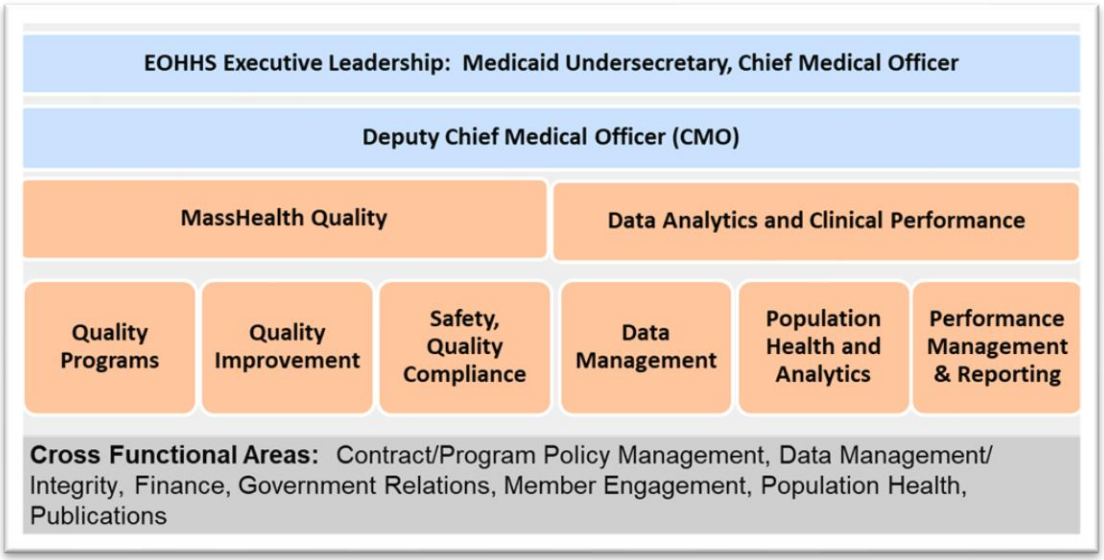
Figure 1:



Quality Management Structure: MassHealth Quality Office (MQO)

The MassHealth Quality Office (MQO) is a centralized unit responsible for overall quality management processes and activities. The MQO works across the organization to develop and implement the overall CQS, quality policies, and plans that aim to improve effective delivery and quality of care to its members and drive healthy outcomes. The Deputy Chief Medical Officer provides clinical oversight to the MQO and to other interdependent department areas core to meeting this aim.

Figure 2:



Other department teams that work closely with the MQO include Data Analytics and Clinical Performance (e.g., population health, clinical engagement and reporting teams. The quality management structure provides a hub for cross-collaboration between the quality department, other departmental and cross-functional teams to:

- Develop and implement provider/plan value-based care and accountability models for quality care for all our populations
- Promote access and integration of a continuum of care and services for members throughout their care journey,
- Identify and assess performance management opportunities and interventions to improve outcomes for populations across and within individual programs.
- Engage with stakeholders (e.g., contracted providers, plans and members) to develop and implement quality programs, improvement and performance management efforts, and,
- Evaluate, report and monitor member outcomes.

MassHealth Quality Strategy and Management Committee

The MassHealth Quality Strategy and Management Committee (QSMC) is an internal forum established to address quality and related topics that inform and drive overall quality strategy/policies, programming, measurement, evaluation, and improvement activities. The committee is chaired and facilitated by the Senior Director of the MassHealth Quality Office. Participants include quality department leaders (program directors and senior managers), medical directors and leaders

representing interrelated areas key to quality (i.e., population health, analytics, clinical performance and reporting).

The objectives of the QSMC include (but are not limited to):

- Aligning quality priorities and policies across the organization
- Synchronizing quality programming and payment reform activities where possible
- Identifying and implementing standards for quality program design inclusive of measurement, performance assessment, reporting and evaluation
- Data and information sharing and collaboration across program and department areas
- Communicating and publicizing quality program activities and results to internal and external stakeholders through transparent and timely engagement and reporting
- Evaluating quality program results and member outcomes to develop actionable plans for performance management, quality improvement and implementation of best practices

3.2 Member and Stakeholder Engagement

MassHealth regularly engages with external -stakeholders through recurring forums (e.g., bi-weekly, bi-monthly or quarterly). These meetings inform quality strategy, program policies, development and implementation. Participants include; MassHealth members and consumer advocates; health care providers such as community health centers, primary care providers, hospitals, behavioral health providers; LTSS providers; community organizations, payers, and associations; and subject matter experts (e.g., clinical areas, quality improvement, measurement, value-based care). *Refer to Appendix D for a summary of stakeholder forums.*
Engagement with members as a core stakeholder is critical to ensuring their voices shape the programs that serve them. A dedicated Member Engagement and Experience (MEE) Team at MassHealth works to strengthen understanding of the member perspective to inform program and policy development.

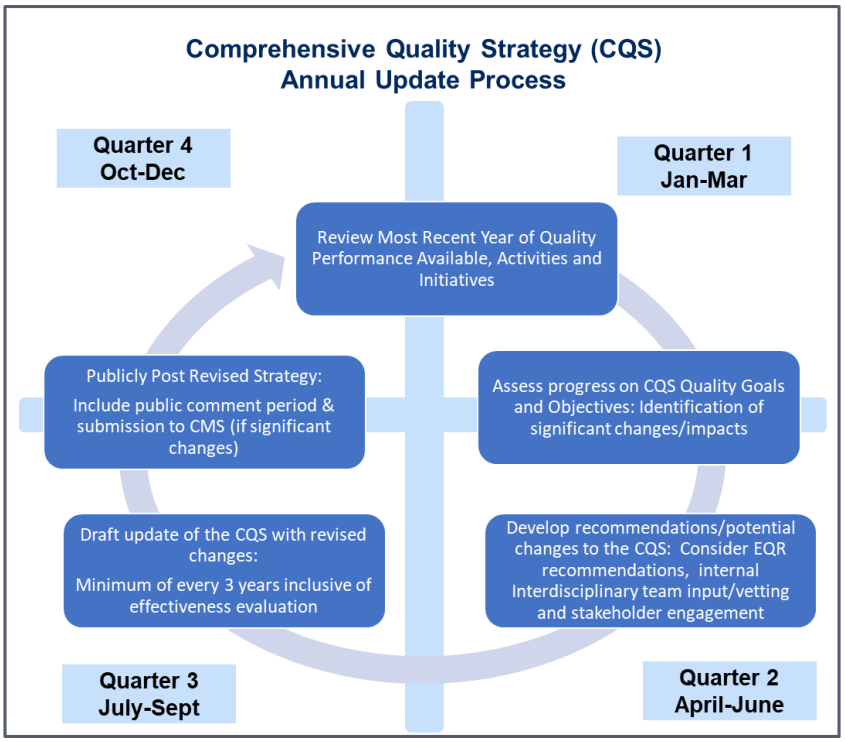
MassHealth also works closely with other Massachusetts Executive Office of Health and Human Services (EOHHS) state agencies on quality initiatives. Examples include developing statewide quality priorities, aligning quality measures, advancing measure collection approaches, data sharing and reporting. These agencies include, but are not limited to:

- Betsy Lehman Center for Patient Safety
- Center for Health Information and Analysis
- Department of Mental Health
- Department of Public Health
- Health Policy Commission

3.3 Quality Strategy Development, Update and Management Process

The CQS has been prepared and updated by the MassHealth Quality Office since its initial 2006 Managed Care Quality Strategy submission. It is a year-long process that is revisited annually. Key components of the process include; annual review of quality performance; assessment of progress on the quality goals and targets; recommendations for any changes to the CQS and drafting and posting updates.

Figure 3:



Quality Strategy Updates

MassHealth reviews the CQS annually and updates it as needed, at least once every three years. The review and revision process involves assessing goals and performance and incorporating guidance from and other internal stakeholders. MassHealth also solicits input from external stakeholders and MassHealth's External Quality Review Organization (EQRO). In the CY24 EQR Annual Technical Report, our EQRO had no recommendations for MassHealth as we addressed all of them in the Quality Strategy Evaluation and Effectiveness Report. MassHealth annually reviews the recommendations for the Quality Strategy from the EQRO, and incorporates those recommendations as needed.

MassHealth works with CMS to ensure that the CQS meets all content requirements set forth in 42 CFR 438.340. MassHealth will continue to comply with the reporting requirements of its approved waivers and submit reports to CMS on waiver implementation and effectiveness, as required by CMS.

In accordance with 42 CFR 438.340(b)(10), states must define what constitutes a "significant change" that would require revising the CQS more frequently than every three years. Factors that constitute a significant change and necessitate revision of the MassHealth CQS include:

- A dramatic restructuring of quality management or substantial initiatives impacting quality within the agency
- Significant changes to the state's Medicaid program including, but not limited to, adding or shifting of populations to the state's different managed care programs
- A significant change in membership demographics or the provider network

- A material change in the measures or targets, number/types of program entities, or timeframes for quality reporting
- Identified patterns of quality deficiencies identified through analysis of the annual reporting or performance data submitted by MCEs
- Changes to quality standards or requirements resulting from regulatory authorities or legislation at the state or federal level

Availability of the CQS for Public Comment

Following final review by the Quality Strategy and Management Committee and internal leadership, the draft CQS is posted to the MassHealth quality webpage for public comment. Feedback is noted in the CQS, with additional consideration and incorporation into future updates of the strategy. Following collection and review of feedback and comments from the internal and external review process, the CQS is reposted publicly and submitted to CMS.

The most current version of the CQS is available on the MassHealth quality reports and resources web page: MassHealth Quality Reports and Resources | Mass.gov

3.4 Evaluation of the Effectiveness of the Quality Strategy

As required under 42 CFR 438.340(c)(2), the state must review and update its quality strategy as needed, but no less than every three years. The state's review of the quality strategy must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years.

Triennially, MassHealth conducts a review and evaluation of CQS effectiveness during the previous three measurement periods (calendar years). The current CQS Evaluation is available on the MassHealth quality reports and resources web page. MassHealth Quality Reports and Resources | Mass.gov

Annually, MassHealth conducts the following activities:

- Review of measure/key indicator performance across all programs to assess progress toward quality goals and objectives.
- Review of EQR reports to assess the effectiveness of managed care programs in providing quality accessible services.

Section 4: MassHealth Quality Strategy

The Comprehensive Quality Strategy (CQS) articulates overarching goals and objectives for improving members' experience and quality and delivery of care. It is grounded in national priorities and guided by agency-wide and population health priorities. The CQS identifies specific measures, and performance goals and promotes focused projects and initiatives to drive performance and quality improvement. It also reflects an ongoing strategic effort to achieve alignment across agency programs and populations balanced with recognizing and meeting the special needs of our varied populations.

4.1 MassHealth Priorities

MassHealth's CQS continues to align with CMS and the National Quality Strategy's commitment to promote the highest quality outcomes and safest care for individuals across their care journey. The CQS strives to improve each individual's experience of care, advance the health of people and their communities, and maintain a strong health care delivery system through innovation and an exceptional provider workforce delivering value-based care. These aims are foundational to the current and previous iterations of the CQS (since its inception in 2012) that guide the goals and strategies of the CQS.

The following high-level priority areas drive population health for MassHealth members and are addressed across the goals, strategies, and activities in the CQS:

- Preventative care for children, family and adults
- Acute and chronic disease management for high-impact populations
- Care coordination and integration for behavioral health populations and individuals with complex care needs,
- Member experience and engagement in their care, and
- Timely access and appropriate utilization of care and services

4.2 MassHealth Quality Goals and Objectives

The following quality goals reflect a commitment and alignment to our national, state and population health priorities.

2025-2027 MassHealth Quality Goals and Objectives

Aligned with the national strategy and overall goals for better health, better outcomes and affordable care, the CQS includes the following goals:

1. Achieve a healthy population by **delivering high-quality** pediatric, preventive, and perinatal care.
2. Advance progress on **high-impact acute and chronic condition areas** to improve safe, effective, high-value care.
3. Enable **coordinated and efficient quality care** for all members across the continuum of services and settings of care.
4. Enhance **person-centered care** through elevating member voice and improving member experience and engagement with their health care.
5. Ensure **access to and appropriate utilization** of care and services to members.

To achieve this vision, the following tables outline overall goals and key objectives core to the CQS, and quality metrics to assess progress. These measures align with CMS' Core Measure Sets, and the Universal Foundation measures where possible, to address population health priorities and minimize unnecessary administrative burden. Quality measurement is an essential tool to assess the health across our populations and to measure accountability of care and services provided. Individual quality programs utilize these and other metrics in value-based programs to further address provider care or services in the specific settings and populations served.

Table 2. Goal 1: Achieve a healthy population, **delivering high-quality** pediatric, preventive, and perinatal care.

ID	Objective	Quality Measure * CMS Universal Foundation and Core Set Measure **CMS Core Measure *** Other national measure	Statewide Performance - Baseline (MY2023)	Performance Target (MY 2027)
1.1	Improve access and quality of care for infants and children	W30-CH: Well-visits first 15/30 months*	51.9% 54.6%	57% 60%

ID	Objective	Quality Measure * CMS Universal Foundation and Core Set Measure **CMS Core Measure *** Other national measure	Statewide Performance - Baseline (MY2023)	Performance Target (MY 2027)
		WCV-CH: Child and adolescent well-visits*		
1.2	Increase utilization and timeliness of preventative services	BCS-AD: Breast cancer screening* COL-AD: Colorectal Cancer Screening*	64.3% 28.8%	70% 32%
1.3	Manage quality and access to maternal health	PPC: Prenatal and Postpartum Care*	48.6% 63.4%	55% 70%

Table 3. Goal 2: Advance progress on **high-impact acute and chronic condition areas** to improve safe, effective, high-value care.

ID	Objective	Quality Measure * CMS Universal Foundation and Core Set Measure **CMS Core Measure *** Other national measure	Statewide Performance - Baseline (MY2023)	Performance Target (MY 2027)
2.1	Improve the health of populations with acute and chronic conditions that are key contributors to co-morbidities	CBP-AD: Controlling High blood pressure GSD-AD: Glycemic Status Assessment for Patients with Diabetes** (poor control where lower is better)	71.7% 25.5%	75% 22%
2.2	Manage populations impacted by mental health and substance use disorders	FUA: Follow-up after emergency department visit for substance use*	7-day: 36.6% 30-day: 49.5%	40% 53%
2.3	Promote member safety	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD / OUD-HH)**	79.2%	82%

Table 4. Goal 3: Enable **coordinated and efficient quality care** for all members across the continuum of services and settings of care.

ID	Objective	Quality Measure * CMS Universal Foundation and Core Set Measure **CMS Core Measure *** Other national measure	Statewide Performance – Baseline (MY2023)	Performance Target (MY 2027)
3.1	Manage timely, smooth transitions in care between inpatient and outpatient settings	FUH: Follow-up after hospitalization for mental illness*	7-day: 38.3% 30-day: 59.5%	45% 64%
3.2	Improve access to and quality of home and community-based services	MLTSS-7***	1.33	1.0
3.3	Reduce unnecessary hospitalizations by Improving coordination and delivery of care in the community	PCR-AD: Plan All-Cause Readmissions*	1.24	1.0

Table 5. Goal 4: Enhance **person-centered care** through elevating member voice and improving member experience and engagement with their health care.

ID	Objective	Quality Measure * CMS Universal Foundation and Core Set Measure **CMS Core Measure *** Other national measure	Statewide Performance - Baseline (MY2024)	Performance Target (MY 2027)
4.1	Improve and maintain a high level of experience for members receiving routine care.	CAHPS Health Plan Survey (Medicaid): Rating of Doctor (9+10)	Adult: 68.56% Child: 79.26% (Medicaid Expansion CHIP and non-CHIP)	71% 82%
	Improve and maintain a high level of experience for members receiving routine care.	CAHPS Health Plan Survey (Medicaid): Rating of Health Care* (9+10)	Adult: 57.05% Child: 80.39% (Medicaid Expansion CHIP and non-CHIP)	60% 82%
4.2	Understand and improve the member experience of populations or members that have complex care needs	Rating of Healthcare Quality SCO and One Care*	SCO: 86% One Care: 87%	88% 89%

Table 6. Goal 5: Ensure **access to and appropriate utilization** of care and services to members.

ID	Objective	Quality Measure * CMS Universal Foundation and Core Set Measure **CMS Core Measure *** Other national measure	Statewide Performance - Baseline (MY2023)	Performance Target (MY 2027)
5.1	Establish and maintain timely access to care and services in the communities where people live	CAHPS member experience: Getting Care Quickly* (A+U)	Adult: 80.27% Child: 85.44% (Medicare Expansion CHIP and non-CHIP)	83% 87%
5.2	Promote provider and service access	FUM: Follow-up after Emergency Department Visit for Mental Illness**	7-day: 68.1% 30-day: 76.8%	72% 80%

MassHealth uses the following levers to support the quality goals and objectives across populations and programs (but are not limited to):

- Member, plan and provider engagement
- Quality oversight and contract standards
- Quality performance incentives (e.g., pay-for-performance, withholds)
- Centralized quality data collection, management and evaluation
- Quality improvement and performance management

4.3 Quality Measurement and Reporting

Quality Measurement

MassHealth employs quality measures to assess and monitor the quality of care provided to its members. The measures support the MassHealth quality goals and objectives and align with statewide, CMS and other national priorities. A data driven approach, informed by national and regional benchmarks (where available), and provider and plan performance, is used to define performance targets for all measures. Measure results are used for evaluation, monitoring and modifications (when needed) to measure performance expectations.

MassHealth selects standardized measures guided by the following criteria:

- Measures aligned where possible, with local and national measure sets or quality programs (e.g., Massachusetts Statewide Aligned Quality Measure Set, CMS Core Measure Sets, CMS Universal Foundation Set, CMS MIPS, CMS Star Ratings)
- Nationally endorsed and/or validated measures (e.g., HEDIS, Joint Commission, AHRQ, CDC measures) wherever possible
- Patient-reported measures and outcome measures where possible (e.g., CAHPS surveys)
- Adapted or non-standard measures, only as an exception when there is a clear measurement gap to assess progress for a critical population or innovative program priority

Table 7: MassHealth quality measures used across programs fall into the following categories.

Type of Measures
Process Measures: Assesses the effectiveness of provider processes in delivering care

Type of Measures
Outcome Measures: Assesses the results of the members' health status
Patient Reported Measures: Assesses process or outcome measures from the members' perspective
Structural Measures: Utilized to assess capacity or readiness for priority initiatives (Usually time-limited)

Public Reporting

Measures by managed care programs are outlined in **Appendix C** and are subject to public reporting requirements pursuant to 42 CFR 438.340(b)(3)(i).

1) At a statewide level, MassHealth collects, monitors, and reports on the CMS Medicaid Adult and Medicaid /CHIP Child Core Measure Sets for the MassHealth population (inclusive of managed care and fee-for-service members). The most recently available results may be found on the CMS State Profiles website (Massachusetts | Medicaid.gov).

2) In accordance with 42 CFR 438.340, MassHealth annually publishes the results of managed care quality performance of its contracted organizations (Managed Care Plan Quality Performance Report). Outcomes are reported for each contracted MCE and the PCC Plan. In addition to reported plan-level rates, MassHealth calculates a MassHealth Weighted Mean (MHWM), which is a weighted average and reflects an overall performance rate for all the plans reporting data for that measure. These rates are compared to national benchmarks (i.e., HEDIS). Annual reporting of these measures may be found on the MassHealth quality website.

3) No less than triennially, the MassHealth Evaluation Report is published per public reporting requirements, measures are reported at the program contract level employing performance measures identified in managed care contracts.

   The most recent reports are available on the MassHealth quality website. (MassHealth Quality Reports and Resources | Mass.gov).

4.4 Quality Performance

MassHealth identifies program-specific measure slates for plan and provider quality performance and accountability, with various performance requirements (e.g., pay-for-performance (P4P), quality withholds). The quality measures reflected in the slates address quality goals and objectives with identified baselines and targets for performance or improvement. MassHealth aligns these measures across national, state, or MassHealth programs wherever possible to promote shared goals, priorities, and comparability across populations. In addition, alignment of performance measures promote parsimony, recognizing provider burden and resources to effectively address quality performance and improvement.

Additional quality measures may be monitored by MassHealth. Monitoring measures may be novel measures reflecting potentially emerging priorities to be incorporated for future performance measurement. Older high performing measures may be monitored for continued high quality performance. Other measures may be used to conduct longitudinal measurement over time.

Identifying Performance Targets

To establish performance targets for managed care programs, plan-level performance or baselines are determined and may be compared to national or regional benchmarks (e.g., NCQA HEDIS measures). For example, MassHealth typically uses the national Medicaid 90th percentile as the primary goal benchmark against which state and individual plan performance is compared. The Medicaid 75th percentile is used to reflect a threshold goal for performance. Additionally, MassHealth regularly compares its performance on the CMS Adult and Child Core Measure Sets with other states (e.g., state median) as part of CMS publicly reported state profiles.

At a program level, MassHealth may establish additional approaches to developing performance targets. For example, these targets may include other nationally established benchmarks, such as Medicare Star ratings, or regional benchmarks that often exceed national performance. A baseline may be established with annual gap-to-goal targets for improvement to reach a goal benchmark over time. Targets are also informed by initial baseline performance, relative peer performance, or improvement over time, especially when benchmarks may not be available.

Please see **Appendix C** for CQS overarching quality goals, associated measures tracking progress on these goals, baseline performance and approach for establishing targets by program.

4.5 Performance Measurement and Value-Based Care

MassHealth operates value-based quality programs for both managed care and non-managed care populations to ensure accountability across populations and settings of care. Opportunities for increased coordination and integration of care is a goal for the evolving CQS to address shared population health priorities, coordination, and follow-up of care for members across settings.

ACO and MCO Programs

The ACO and MCO programs focus on delivering high quality care, positive member experience and coordination of services. The ACO/MCO payment model includes financial incentives for ACO/MCOs to provide strong performance on cost and quality. Ongoing measurement is central to holding ACOs and MCOs accountable for providing sustainable, high-value care across several metrics. In addition, the ACO entities engage in performance improvement projects designed to achieve improvements in clinical care and non-clinical care processes, outcomes, and member experience.

ACO and MCO members with complex BH and LTSS needs may also participate in the Community Partners (CP) Program. Similar to the ACO and MCO programs, the CP program includes financial incentives for quality performance. CPs also participate in performance measurement, to further support improvements to address the care and needs of the population.

Massachusetts also directs MCOs, ACOs and the MBHV to adopt payment mechanisms under 42 CFR 438.6(c), which include, but not limited to, performance-based quality incentive programs for hospitals, CBHCs, minimum or maximum fee schedules, and a uniform dollar or percentage increases for certain network providers (i.e., hospitals) that provide specified services under the contract.

Hospital Programs

MassHealth contracts with acute, psychiatric, and substance abuse treatment hospitals that provide inpatient and outpatient services to MassHealth members. MassHealth manages and implements value-based quality programs with these hospitals.

The acute hospital Clinical Quality Incentive (CQI) program serves members accessing care in the inpatient setting. The acute hospital program aligns with the priorities and goals for quality measurement performance with particular focus and priority on maternal and newborn health, patient

safety, care coordination, behavioral health, and member experience. For more detailed information on the hospital quality measures and other resources, please refer to: EOHHS Technical Specifications Manuals | Mass.gov.

Similarly, the inpatient free-standing psychiatric hospital program also incorporates a quality incentive program focused on a subset of hospital measures that address the special needs of its population.

Efforts are made to align the MassHealth hospital quality reporting standards with guidelines for hospital measurement and reporting systems the Center for Medicare and Medicaid Services (CMS) and other national stakeholder groups developing hospital inpatient quality measures support. Examples of measures include nationally reported patient safety, member experience, and clinical quality measures (e.g., AHRQ, HCAHPS, CMS and The Joint Commission). The program also is increasingly adopting the use of electronic clinical quality measurement aligned with current national requirements.

Long-Term Services and Supports: Integrated Care and Fee-For-Service programs

MassHealth integrated care plans (One Care and SCO) deliver and coordinate all Medicare and Medicaid covered benefits including managed long-term services and supports to enrolled MassHealth members eligible for both programs. Services are developed and delivered based on an Enrollee's person-centered assessment and care plan.

Like other MassHealth managed care plans, One Care and SCO plans are held accountable to a set of performance measures defined by MassHealth as part of their comprehensive Quality Assurance and Performance Improvement (QAPI) program and, beginning in CY 2026, part of a quality withhold program. Measures were identified with input from OLTSS clinical leadership and integrated care program leadership and align with quality measurement efforts across MassHealth while addressing the unique needs of the aging and disabled populations. In addition, the integrated care measure slates (Appendix C) demonstrate performance in key LTSS domains including rebalancing and community integration through use of measures such as Minimizing Facility Length of Stay and All Cause Readmission. As the One Care plans transition to Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) and new One Care and SCO contracts begin (January 1, 2026), MassHealth is planning how to expand measurement in these key LTSS domains for our managed LTSS services.

Because the majority of MassHealth LTSS services are provided through a Fee for Service mechanism MassHealth is developing quality monitoring for FFS LTSS services. This emerging approach seeks to assess a broad range of areas including the LTSS provider's engagement in the member's care in the community and inpatient setting, access to services and supports, the quality of services delivered, as well as qualitative methods to understand the member's and caregiver's experience of care.

Section 5: Quality Assessment and Appropriateness of Care

The Comprehensive Quality Strategy (CQS) is designed to reflect standards associated with quality assessment and how the Commonwealth evaluates the quality of health care and services furnished by managed care plans.

Quality assessment in MassHealth occurs through at least three mechanisms:

- **Contract management requirements** – Manage care plan contracts typically include requirements for measure reporting, performance, and improvement. MassHealth contract

managers and quality staff review submissions and evaluate whether the plan has satisfactorily met the contract requirements.

- **State-level data collection and monitoring** - MassHealth routinely collects HEDIS and other performance measure data from its managed care plans.
- **Quality improvement performance programs** - Each MCE and the Managed BH Vendor is required to complete two performance improvement projects annually in accordance with 42 CFR 438.330(d).

5.1 Contract management

Assessing Health Care Needs

Each managed care entity (MCE) is required to have systems in place to assess members identified as having special health care needs. MCEs are required to identify members at increased risk to have complex or chronic medical needs requiring specialized health care services, including persons with multiple chronic conditions, co-morbidities, and/or co-existing functional impairments, and including persons with physical, mental/substance use, and/or developmental disabilities, such as persons with cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities.

Further, plans are required to assess the quality and appropriateness of care furnished to members with special health care needs by developing individualized care plans, ensuring timely and coordinated care, and ensuring the development of clinical protocols and approaches to the provision of care that are appropriate for the members' needs. MCEs may also rely on information shared by the Commonwealth. This includes Categories of Assistance, such as Supplemental Security Income (SSI), to which MassHealth assigns members.

Members' disability status may be further identified through screening individuals at the point of service (need for accommodation or special assistance) or via survey (e.g., utilizing the standard HHS question set for identifying disability status related to disability type (e.g., cognitive, hearing, mobility, vision, self-care, and independent living).

Behavioral Health Screening Among Children

Since 2007, EOHHS has required primary care providers to use standardized behavioral health screening tools when administering the BH screening component of the well-child visit to all MassHealth enrolled children under the age of 21 pursuant to the Commonwealth's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical Protocol and Periodicity Schedule.

MassHealth routinely conducts clinical reviews and updates its menu of BH screening tools. The update is informed by current research and identification of evidence-based tools that are considered standards and adopted by nationally recognized child and behavioral health organizations (e.g., Bright Horizons).

Addressing Performance Variation in Health Outcomes

The following activities support addressing differences in health outcomes through; identification of member populations where there are differences in quality performance; understanding the barriers to receiving optimal care and implementing opportunities to improve care processes or outcomes.

- Data Collection: Identification of members' voluntary self-reported data about themselves (e.g., demographic data) are captured through enrollment data. Health plans may receive these data when available, through transmittal of the HIPAA 834 file. The data can be analyzed with claims data to identify the quality of care for various populations and support quality improvement planning. Data are supplemented further through other sources including health plans and

providers that collect and provide these data (e.g., as part of the required HEDIS measure submissions data). Other state data sources are also available and shared through data use agreements (e.g., Department of Public Health, Center for Healthcare Information and Analysis).

- Member Experience Surveys: Federal requirements (i.e., Core Measure reporting), contracted plan and program quality requirements include conducting member surveys. The surveys include collection of voluntary self-reported member information (e.g., demographics, chronic conditions, disability status) to enable subgroup analyses. These data provide opportunities to detect and implement improvement opportunities where there are barriers to the experience of care for sub-populations and whether their needs are being met.

- Member Engagement: Member councils are required (e.g., through Hospital Patient Family Advisory Councils, ACO Consumer Advisory Councils and other EOHHS and contractor requirements) to ensure patient-level engagement to further understand the needs and specific opportunities to address and implement sub- populations opportunities for improvement at the programming and contractor level.

- Member Communications: All health plans are required to ensure the provision of appropriate communications so that member needs are understood and met. This includes identifying and addressing barriers associated with health care system navigation, and communications between healthcare providers and members to support integration of care and access to a continuum of services inclusive of links to community resources. Member communications efforts contribute to addressing the specific needs for improving member engagement in their care and their outcomes.
- Behavioral Health Support for at-risk populations: MassHealth offers the Community Support Program (CSP). This program offers intensive case management services to individuals considered “at risk” in their communities. Members can engage in their care, use treatment services, and adhere to their clinical treatment plans. It increases independence for members to manage their own behavioral health and medical services, supporting self-empowerment, recovery and wellness.
- Support for non-medical services: MassHealth’s Health Related Social Needs Services provides evidence-based supports for ACO members to address factors that can impact their well-being. Services are linked to assessment of needs, care and treatment plans of members and can include services such as housing support and nutritional programs.

5.2 State-level Data Collection and Monitoring

HEDIS Quality Measures and CAHPS Member Experience

MassHealth collects and uses the results of HEDIS quality measures and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as part of its reporting and quality incentive programs to: 1) assess performance and program accountability for member experience performance 2) identify opportunities for improvement, and 3) support required core measure reporting and reporting of plan-level measure rates. MassHealth currently monitors submissions of HEDIS data from several of its managed care plans, including MCEs, SCO and One Care plans.

MassHealth currently monitors plan-level submissions of CAHPS member experience surveys submitted for the MCO, SCO, and One Care programs. MassHealth also administers the Primary Care, BH, LTSS, One Care Experience Survey, and One Care Quality of Life surveys.

Table 8: Patient experience surveys

Survey Tool	Program(s)	Population	Survey Level
CAHPS 5.1H	N/A	Adults and Children	Entire MassHealth membership
CAHPS 5.1H	MCO	Adults and Children	Plan
Medicare Advantage-PDP CAHPS	SCO, One Care	Dual eligible members enrolled in MassHealth and Medicare	Plan
Primary Care Survey Clinician Group (CG) CAHPS	ACO, MCO, PCCM	Adults and Children	ACO, MCO, PCCM
Hospital (HCAHPS)	Acute Hospital	Adults Only	Acute Hospital
MassHealth LTSS Survey	LTSS Community Partners (CP)	Adults and Children	LTSS CPs
MassHealth Behavioral Health Survey	BH Community Partners (CP)	Adults Only	BH CPs
PIHP (Behavioral Health Vendor) Member Experience Survey	PIHP	Adults and Children	PIHP
One Care Experience Survey	One Care	Dual eligible adults 18-65 enrolled in MassHealth and Medicare	Plan
One Care Quality of Life Survey	One Care	Dual eligible adults 18-65 enrolled in MassHealth and Medicare	Plan

5.3 Quality Improvement Performance Projects

MassHealth requires MCEs and the Managed BH Vendor to conduct performance improvement projects (PIPs) annually, in compliance with federal requirements. MCEs and the Managed BH Vendor are required to develop PIP topics in priority areas MassHealth selects to align with the CQS goals and strategies.

Through identification of opportunities for improvement, implementing, testing, and evaluating interventions at the contract level, PIPs are intended to improve the care and services provided to MassHealth members. Below are the current program PIP topic areas for which they are required.

TABLE 9: Current EQR PIP Topics, by Program

EXTERNAL QUALITY REVIEW – 2024 PERFORMANCE IMPROVEMENT PROJECT TOPICS

Plan	Topic 1	Topic 2	Topic 3	Topic 4
MCO	Prenatal and Postpartum Care **Intervention example:** Offer members access to the Ovia app, which provides support and education throughout pregnancy, postpartum and throughout the childcare journey.	Follow Up After Hospitalization for Mental Illness **Intervention example:** Partner with a virtual BH provider group so members have access to more providers.	HbA1c Poor Control **Intervention example:** Members that identify transportation being a barrier getting to and from appointments will be allowed to call and set up transportation for each appointment.	--
ACPP	Controlling High Blood Pressure **Intervention example:** Population Health Managers outreach members who are non-compliant with BP control. Outreach includes a comprehensive assessment related to HTN monitoring and compliance.	Screening for Depression and Follow Up Plan **Intervention example:** Add screening requirements to additional visits and add depression screening to list of screenings performed by the Mobile Health Unit.	HbA1c Poor Control **Intervention example:** Offer mail order home A1c test kits and/or Quest home lab draws to members with no A1c test on file.	--
SCO	Transitions of Care **Intervention example:** Develop an educational checklist for members addressing complicated aspects of medication reconciliation that providers will share with members.	Colorectal Cancer Screening **Intervention example:** Collect refusal reasons of noncompliant members through gaps in care outreach. Using this information to guide further interventions.	Use of High-Risk Medications in Older Adults **Intervention example:** Clinical Quality Program Manager will educate providers on use of resources when prescribing medications to patients over the age of 67.	Controlling high blood pressure **Intervention example:** Partner with providers who have members with uncontrolled blood pressure where members have not had a PCP appointment to increase availability and outreach for member appointments for

Plan	Topic 1	Topic 2	Topic 3	Topic 4
				managing hypertension.
One Care	Initiation and Engagement of Substance Use Disorder Treatment **Intervention example:** Develop a list of active community substance use resources to be provided to members	Plan- All Cause Readmission **Intervention example:** Develop and create comprehensive training for internal providers on the GOLD standards specific to COPD.	Follow Up After Hospitalization for Mental Illness **Intervention example:** Support members with substance use disorder by offering them enrollment in a peer support program.	HbA1c Poor Control **Intervention example:** Offer nutritious food to all members with diabetes. FarmboxRX is a vendor that will deliver healthy food choices to the members' residence.
MBHP	Pharmacotherapy for Opioid Use Disorder **Intervention example:** Share Performance Data by identifying high volume/low performing index providers and outreach with POD-M performance data.	Follow-Up Care for Children Prescribed ADHD Medication **Intervention example:** Develop educational materials for providers on medication titration best practices and distribute to lower performers.	--	--

Note: Plans are not conducting a PIP in each of the above identified topics, this is a summary of PIP work across MassHealth.

PIPs conducted across MassHealth typically run on a 3-year cycle: one baseline and two remeasurement periods. MassHealth may modify the PIP cycle to address immediate or emerging priorities, including but not limited to public health emergencies or implementation of new contracts or plans.

The current cycle of PIPs began in 2024, results from the first remeasurement period will be reported on in the CY25 EQR Annual Technical Reports. Prior cycle PIPs and details may be found in the annual EQR Technical Reports found on the MassHealth Reports and Resources web page: MassHealth Quality Reports and Resources | Mass.gov

5.4 External Quality Review

MassHealth monitors compliance with contractual and federal requirements in multiple ways. **Appendix D** lists the specific reports MassHealth uses to ensure compliance. The External Quality Review Organization (EQRO) also provides valuable compliance review functions.

External Quality Review

Massachusetts contracts with a qualified External Quality Review Organization (EQRO) in accordance with 42 CFR 438.354. Massachusetts currently contracts with Island Peer Review Organization (IPRO) to complete external quality review functions for all MCOs, Accountable Care Partnership Plans, Primary Care ACOs, the Managed BH Vendor, One Care Plans, and SCOs.

The current EQRO contract has been in effect over the last 3 years and will end on 12/31/2026. There are two optional one-year renewals available. EQR Technical Reports are reviewed with particular attention paid to areas of low performance. EQRO findings and recommendations inform the development of and monitor progress towards meeting quality strategy goals and objectives.

Mandatory Activities

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

1. Annual validation of performance measures reported to EOHHS, as directed or calculated by EOHHS.
2. Annual validation of performance improvement projects required by EOHHS.
3. At least once every three years, review of compliance with standards mandated by 42 CFR 438, Subpart E and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to members.
4. Validation of MassHealth-developed network adequacy and availability of services standards required under 42 CFR 438.68 and 438.206. More information may be found in the annual EQR Technical Reports on the MassHealth Reports and Resources web page: MassHealth Quality Reports and Resources | Mass.gov

Covered Entities

All managed care entities will participate in an EQRO review. MassHealth has determined that the most efficient mechanism for quality oversight of these entities will be the EQRO.

Review Cycle

Annually, following each project year, the EQRO produces a full technical report for MassHealth review and approval. Once finalized, the report is posted to the MassHealth website and submitted to CMS prior to April 30th each year. The technical reports cover all mandatory EQR activities, and any other optional activities requested by MassHealth.

Managed Care Entity Responsibilities

Each MCE is required through their contracts to take all steps necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS to conduct External Quality Review (EQR) Activities identified above, in accordance with 42 CFR 438.358. Additional information on MassHealth contracts may be accessed at: MassHealth Health Plan Contracts | Mass.gov.

For additional information on EQR and access to the annual EQR Technical Reports, please visit the MassHealth Reports and Resources web page: MassHealth Quality Reports and Resources | Mass.gov.

Non-Duplication Provisions

MassHealth encourages the EQRO to use the NCQA Managed Care Toolkit to reduce duplication of effort of review when possible. Many MassHealth MCEs are NCQA-accredited and/or certified and the

opportunity exists to leverage documents which are produced for accreditation and other purposes to fulfill EQR requirements.

When applicable and upon MassHealth approval, MassHealth requires information from a review of an MCE or Managed BH Vendor performed by a Medicare or private accrediting entity contributes to the EQRO's findings related to reporting of mandatory activities. The use of reports from HEDIS audits and NCQA health plan accreditations are used to fulfill aspects of performance measure validation and compliance activities, minimizing duplication of effort and significantly reducing administrative burden.

Section 6: State Access Standards

All MassHealth managed care entities (MCEs) and Managed BH Vendor are required to maintain standards for access to care including availability of services, care coordination and continuity of care, and coverage and authorization of services required by 42 CFR 438.206-438.210; however, coverage and authorization of service requirements do not apply to PCACOs.

Standards described in this section are detailed further in plan contracts available on-line. MassHealth Health Plan Contracts | Mass.gov

6.1 Accessibility and Availability of Services

In accordance with the standards in 42 CFR 438.206, MassHealth ensures that services covered under contracts are accessible and available to members in a timely manner. Each plan must maintain and monitor a network of providers that is supported by written agreements and sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each plan considers, but is not limited to the following areas:

- Anticipated MassHealth enrollment
- Expected use of services by members, considering the characteristics and health care needs of specific MassHealth member populations
- Types of providers (in terms of training, experience, and specialization) required to furnish contracted services
- Geographic location of providers and MassHealth managed care members, considering distance, travel time, and modes of transportation MassHealth managed care members typically use, and whether the location provides physical access for MassHealth members with disabilities

MassHealth requires its MCEs and the Managed BH Vendor to credential network providers as required by 42 CFR 438.214. MassHealth also requires its MCEs to ensure that its network includes sufficient family planning providers to ensure timely access to covered services.

Beginning in 2024 MassHealth, in conjunction with its EQRO, implemented protocol 4, Network Adequacy Validation. The EQRO validates the MCEs' analyses of their network time and distance and provider ratio standards. As an additional form of validation, the EQRO conducts their own assessment of MCE time and distance and provider ratio standards and compares those findings to the findings produced by the MCEs. In 2024, MassHealth's EQRO also launched a secret shopper survey to assess provider directory accuracy and appointment wait times.

For information on the process and findings, please see the 2024 EQR Technical Reports on the MassHealth Reports and Resources web page: MassHealth Quality Reports and Resources | Mass.gov.

Cultural Considerations

- MassHealth requires that medical and behavioral health (BH) services and care are delivered in a culturally competent manner and address any barriers to access. MassHealth participates in efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural backgrounds. All MCEs are required to ensure availability of multi-lingual providers and skilled medical interpreters for the commonly used languages in each community.

Written information is available to members in prevalent languages, as the Commonwealth determines. Prevalent languages are those spoken by 5% or more of MassHealth members. Through analyses of MassHealth data (both state-wide and EOHHS regional (Boston, Metro West, Central MA, Western MA, Northeastern MA, and Southeastern MA)), EOHHS has currently defined Spanish and English as the prevalent languages in which written information must be made available.

- At the time of enrollment, MCEs must identify members' needs for culturally and linguistically appropriate services, which must include accommodations for individuals who are Deaf or Hard of Hearing, with vision impairments, and/or have language preferences. MassHealth plans make available, free of charge, oral interpretation services in all non-English languages to assist members with interpretation of all written materials provided to members. Informational materials distributed to members via mail are accompanied by a card that indicates that the enclosed materials are important and should be translated immediately. The card also provides information on how the member may obtain help with getting the materials translated.

- In addition, all plans are required, to the degree possible, to complete population profiles that describe geographic location, settings, and socio-demographics of the member population. These activities are part of an overall community needs assessment that informs how plans can develop goals and activities that engage members and their communities toward health improvements.

6.2 Access and Availability

All MCEs and the Managed BH Vendor are required to maintain a provider network that, at a minimum, provides members access to all Medically Necessary Medical and Behavioral Health Covered Services according to contracted standards.

MCEs and the Managed BH Vendor are required to ensure adequate access to covered services for all members and facilitate access to non-covered services. All services need to be accessible and available to members in a timely manner. Accessibility is defined as the extent to which members can obtain services at the time they are needed. Availability is defined as the extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership. Travel time and distance standards vary depending on the provider type and managed care plan. For details on time and distance standards, and degree of MCEs' compliance with those standards, please see the EQR Annual Technical Reports: MassHealth Quality Reports and Resources | Mass.gov. Please also see the Annual Technical Reports for provider ratio standards.

Overall, MCEs and Managed BH Vendor must assure their capacity to serve members in accordance with the access and availability standards MassHealth specifies by submitting reports on an annual basis, and whenever there is a significant change to the operations of the provider network or the provider network itself that would affect the adequacy and capacity of services.

Standards also include ensuring access to covered services in accordance with state and federal laws for persons with disabilities by ensuring that network providers are aware of and comply with such laws so that physical and communication barriers do not inhibit members from obtaining services.

In accordance with 42 CFR 438.206(c)(1)(iii), MCEs and Managed BH Vendor must make covered services available 24 hours a day, seven days a week when medically necessary.

Requirements for Physical Health Services:

- Emergency Services that are available immediately upon presentation at the service delivery site, including non-network and out-of-area facilities; and in accordance with 42 U.S.C. §1396u-2(b)(2) and 42

CFR 434.30, provide coverage for Emergency Services to Enrollees 24-hours a day and seven days a week without regard to prior authorization or the Emergency Service Provider's relationship to the MCEs and Managed BH Vendor.

- Primary Care services that are available:
    - ACOs and MCOs
        - Within 48 hours of the Enrollee's request for Urgent Care;
        - Within 10 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and
        - Within 45 calendar days of the Enrollee's request for Non-Symptomatic Care, unless an appointment is required more quickly to ensure the provision of screenings in accordance with the schedule established by the EPSDT Periodicity Schedule
    - One Care (Effective changes 2026)
        - Within 48 hours of the Enrollee's request for Urgent Care;
        - Within 10 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care;
        - Within 45 calendar days of the Enrollee's request for Non-Symptomatic Care
    - SCO (Effective changes 2026)
        - Within 48 hours of the Enrollee's request for Urgent Care;
        - Within 10 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care;
        - Within 45 calendar days of the Enrollee's request for Non-Symptomatic Care

- Primary Care or Urgent Care during extended hours to reduce avoidable inpatient admissions and emergency department visits

- Specialty Care that is available:
    - ACOs and MCOs
        - Within 48 hours of the Enrollee's request for Urgent Care;
        - Within 30 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and
        - Within 60 calendar days for Non-Symptomatic Care.
    - One Care
        - Within 48 hours of the Enrollee's request for Urgent Care
        - Within 30 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care;
        - Within 60 calendar days of the Enrollee's request for Non-Symptomatic Care
    - SCO
        - Within 48 hours of the Enrollee's request for Urgent Care;
        - Within 30 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care;
        - Within 60 calendar days of the Enrollee's request for Non-Symptomatic Care

Requirements for members newly placed in the care or custody of DCF:

- Within 7 calendar days of receiving a request from a DCF caseworker, a DCF Health Care Screening shall be offered at a reasonable time and place. DCF Health Care Screening shall attempt to detect life

threatening conditions, communicable diseases, and/or serious injuries, or indication of physical or sexual abuse; and

- Within 30 calendar days of receiving a request from a DCF caseworker, a comprehensive medical examination, including all age-appropriate screenings according to the EPSDT Periodicity Schedule shall be offered at a reasonable time and place.

Requirements for Receiving Behavioral Health Services:

- Emergency Services immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present at any qualified Provider, whether a Network Provider or a non-Network provider.
- Emergency Services Program Services immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present for such services.
- Urgent Care within 48 hours for services that are not Emergency Services or routine services.
- All Other Behavioral Health Services within 14 calendar days.

Requirements for Receiving Services Described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:

- Non-24-Hour Diversionary Services – within two calendar days of discharge;
- Medication Management – within 14 calendar days of discharge;
- Other Outpatient Services – within seven calendar days of discharge; and
- Intensive Care Coordination Services – within the time frame directed by EOHHS.
- The Contractor shall ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or MassHealth Fee-For-Service, as applicable.

Pharmacy services must be provided in accordance with usual and customary community standards; members must receive access to pharmacy services in a timely manner,

For all other services, members must receive access in accordance with usual and customary community standards.

MCEs and the Managed BH Vendor may request an exception to the contracted access standards by submitting a written request to MassHealth. The request must include alternative standards that are equal to or exceed the usual and customary community standards for accessing care.

MCEs and the Managed BH Vendor are required to monitor and document access and appointment scheduling and use statistically valid sampling methods to monitor compliance with the appointment/access standards. Prompt action will be taken to address any access deficiencies, including but not limited to taking corrective action. Additional details regarding access and availability standards are available through individual contracts and EQRO reports.

For more information and details please visit: [MassHealth Health Plan Contracts | Mass.gov]

6.3 Coordination and Continuity of Care

MassHealth plans must support coordinated care by ensuring that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care delivered to the member. All members receive timely and coordinated access to all medically necessary services, including BH and specialty services. Plans are required to link staff in other

agencies and/or community service organizations if the agency/organization is already involved in meeting the member's needs, or if the agency/organization is identified as helpful in meeting such needs.

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

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

A. Continuity of Care

To ensure that members successfully transition to their new health plans and continue to have access to all the services they need, MassHealth requires that contracted MCEs provide appropriate continuity of care (CoC). The CoC period for MassHealth ranges from 30 days for most ACO, MCO, and PCC Plan members to up to 90 days for One Care and SCO members

- MCO, ACPP, and PCACO: New members that enroll from another MassHealth MCP, FFS, or commercial carrier are provided with 30-day continuity of care period. The CoC period may be extended for ACO, MCO, and PCC members up to 90 days for members receiving Applied Behavior Analysis (ABA) services and members whose PCP moves to a new MassHealth plan.
- Managed BH Vendor: Requires development of CoC plans for special populations including children in the care and/or custody of the Commonwealth who change providers due to changes in their foster care arrangements or for other reasons, and participants who transfer from the Integrated Care Management Program (ICMP) to Practice Based Care Management (PBCM) and/or pilot ACO care management programs.
- One Care and SCO: requires a CoC for all members enrolling from FFS or members changing One Care Plans. The aim of these policies and procedures is to minimize disruption of care and ensure uninterrupted access to Medically Necessary Services. The One Care CoC period is completed when members sign their care plan – usually within 90 days but the CoC must be extended until the care plan is complete.
- SCO (in 2025): MassHealth requires that SCOs provide a 90-day CoC period for members that are passively enrolled into a SCO plan.

Detailed CoC requirements are included in all MCP contracts, and these policies and procedures cover a full range of services. Examples of these services include: durable medical equipment; prosthetics, orthotics and supplies; physical therapy, occupational therapy or speech therapy; scheduled surgeries; out-of-area specialty services; nursing home admissions; honoring of prior authorizations and prior approvals for services for the duration of such prior authorizations and prior approval; access emergency services at any emergency room, including from out-of-network providers; honoring of existing prescriptions for covered drugs; and accepting and utilizing medical records, claims histories, and prior authorizations from an member's previous MCP.

In addition, MCPs have specific policies and procedures for members who, at the time of their transition, are pregnant or have special or significant health care needs, including behavior health or substance use needs and complex medical conditions (e.g., terminal illness, receiving inpatient care at time of enrollment) that may require a longer CoC period. In certain cases, CoC for these individuals may be extended beyond the 30- or 90-day period.

B. Program-Specific Requirements for Care Coordination

Generally, all MCPs must maintain care management programs for any member (adults and children) who needs assistance coordinating physical and BH services and benefits to maintain optimal levels of health, though some programs require care management services for all members.

Some of the programs have additional program-specific requirements for care coordination. The following are example activities by MassHealth MCPs, but do not represent the totality of requirements.

1. **ACO and MCO Programs**

Initial Care Needs Screening

Like the other MCPs, the MCO and ACO Programs must identify members' health and functional needs. They must develop, implement, and maintain procedures for completing an initial care needs screening for each and complete the screening within 90 days of the member's Effective Date of enrollment.

In addition to other requirements, the survey instrument MCOs and ACOs use to conduct the initial care needs screening must include questions on member demographics, and health history, including chronic illness, current treatment, and self-perceived health status. It must also include questions to identify members with special health care needs, members that need culturally and linguistically appropriate services, and members requiring medical and diagnostic equipment, as well as members' health concerns/goals and children's care needs, including evaluating characteristics of the members' families and homes. Furthermore, like the other MCPs, the MCO and ACO program care needs screening also evaluates member needs for behavioral-health-related services, as well as any LTSS-related services. These evaluations must include an assessment of members' current use of such services, as well as any unmet needs.

Transitional Care Management Program

Per their contracts, MCOs and ACOs must develop and implement transitional care protocols with all network or affiliated hospitals to ensure follow-up with a member within 72 hours of discharge from any type of hospital inpatient stay or emergency department visit, a home visit, an in-office appointment, a telehealth visit, or phone conversation, as appropriate. MCOs and ACOs are required to ensure that post-discharge plans are appropriate based on the needs of the member and identify the need for follow-up services. These protocols must be developed in partnership with CPs as applicable and integrate other care management activities and personnel such as care coordinators or clinical care managers.

2. **Senior Care Options**

Comprehensive Assessment

Comprehensive assessments for members enrolled in the Senior Care Organizations (SCOs) are conducted every six months, when there is a change in health status, and quarterly for any member with a Complex Care Need. A Complex Care Need is defined as any condition or situation that demonstrates the member's need for expert coordination of multiple services, including, but not limited to clinical

eligibility for institutional long-term care and medical illness, psychiatric illness, or cognitive impairment that requires skilled nursing to manage essential unskilled services and care.

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

3. **One Care**

Comprehensive Assessments

One Care plans must complete Comprehensive Assessments for each new member within 90 days of the member's effective enrollment date, annually, and whenever the member experiences a major change that is not temporary, affects their health status, and/or requires review or revision of their Individualized Care Plan. Comprehensive Assessments are documented in the Centralized Member Record and include domain areas the Commonwealth specifies. Domain areas include health status, medications, functional status, personal goals, housing status, social supports, and more. Results of the Comprehensive Assessments are used to inform the Individualized Care Plan.

Long-term Supports (LTS) Coordinator

MassHealth requires each One Care plan to offer members an LTS Coordinator to participate as part of the member's care team. The LTS Coordinator brings expertise in community supports to the member and assists with the coordination of their LTSS as applicable. The LTS Coordinator's primary responsibilities are to: ensure person-centered care, counsel potential members; provide communication and support needs; and act as an independent facilitator and liaison between the member, the One Care plan, and their service providers. LTS Coordinators help members identify and understand their needs and the kind of help and supports they want from the One Care plan, including:

- Identification of community services and resources
- Development of an Individualized Care Plan that includes services that will support members' health, safety, independence, and/or recovery
- Connection to the services in members' Individualized Care Plan
- Helping members understand and protect their rights as a One Care member

Member needs for LTSS and BH should be identified through the Comprehensive Assessment. The member's care plan should reflect their goals and preferences for addressing their LTSS and BH needs. In addition, the Comprehensive Assessment would also identify any functional limitations an individual may have and need assistance in addressing.

4. **PCC Plan**

Integrated Care Management Program (ICMP) and Practice-Based Care Management (PBCM)

In collaboration with the Managed BH Vendor, the PCC Plan provides increased support and coordination of care for members who have complex medical and/or BH care needs and whose overall health care may benefit from the assistance of a care manager and increased support for the providers that regularly manage their care. In addition, select PCC Plan service locations may contract with the Managed BH Vendor to conduct their own Practice-Based Care Management (PBCM) programs that mirror the standards of the plan-based CMP.

6.4 Coverage and Authorization of Services

In accordance with 42 CFR 438.210, each MassHealth MCE and the Managed BH Vendor must specify the amount, duration, and scope of each covered service. Services may be no less than the amount, duration, and scope for the same services furnished to beneficiaries under MassHealth FFS, may not be comprised solely because of diagnosis, type of illness, or condition of a member, and must be rendered in accordance with the medical necessity standard. All MCEs operate under the same definition of medical necessity as MassHealth fee-for-service.

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

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

All MCEs are required to follow grievance procedures related to adverse action decisions as detailed in their contracts.

6.5 Additional Monitoring and Compliance

A. Health Information Systems

MCEs and the Managed BH Vendor must maintain a health information system (or systems) that collects, analyzes, integrates, and reports data in accordance with 42 CFR 438.242 and that supports all aspects of the quality management programs. The system must collect data on member and provider characteristics and on services furnished to members. Contracted plans including the Managed BH Vendor, ensure that data received from providers is accurate and complete by:

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

MassHealth requires MCEs and the Managed BH Vendor to certify that information, data, and documentation in all reports are true, accurate, and complete.

B. Clinical Practice Guidelines

MCEs implement evidence-based practice through dissemination and use of practice guidelines. The guidelines must stem from recognized organizations that develop evidence-based clinical practice guidelines with involvement from board-certified providers from appropriate specialties. Prior to adoption, guidelines must be reviewed by the plan's Medical Director, as well as other practitioners and network providers, as appropriate. Guidelines must consider the needs of members and be reviewed and updated, as appropriate, at least every two years. Plans are required to disseminate guidelines to all new network providers and, upon request, to all members or potential members.

Guidelines must be available on the plan's web site. In addition**,** plans must develop explicit processes for monitoring adherence to guidelines, including ensuring that decisions regarding utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. MCEs also must establish processes for reviewing and updating guidelines.

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

- MassHealth All Provider Manual –Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical and Dental Protocol and Periodicity Schedule, Appendix W
- Massachusetts Health Quality Partners Guidelines for Adult and Pediatric Preventive Care
- Massachusetts Health Quality Partners Guidelines for Perinatal Care
- Massachusetts Department of Public Health Immunization Schedules and Guidelines

Section 7: Improvement and Interventions

7.1: Improvement and Interventions

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

MassHealth convenes internal and external committees as well as workgroups to ensure stakeholders have opportunities to advise, share best practices, and contribute to inform quality measurement, quality program design, monitoring of results, and development of improvement projects and program services. Examples of these committees include the Delivery System Technical Advisory Committee (DSTAC), Program Office Hours (e.g., with ACO/MCO, CP, Hospital, and CBHCs), SCO Advisory Committee, One Care Implementation Council, and the EOHHS Quality Measure Alignment Taskforce. Please refer to Appendix D for a full list.

Improvement strategies described throughout this document are designed to advance the quality-of-care MCEs deliver, including periodic review and use of standard practice guidelines, ongoing measurement, evaluation, and interventions. Targeted interventions are developed through the formal PIPs process and are not limited to participation in other performance management or quality improvement collaboration opportunities (e.g., corrective action plans, affinity groups, pilot measurement, or improvement activities).

7.2: Intermediate Sanctions

EOHHS monitors compliance through routine reporting requirements, regular meetings with entities, and ongoing communications as appropriate and necessary.

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

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

MCE contracts identify additional circumstances under which sanctions may be imposed, including, but not limited to:

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

- Failure to comply with the contract

A list of additional plan sanctions, as per 42 CFR 438.702, includes, but is not limited to:

- Suspension of payment for members enrolled after the effective date of the sanction
- Appointment of temporary management to oversee the operation of the plan in those circumstances set forth in 42 USC §1396 u-2(e)(2)(B) and 42 CFR 438.706
- Notification to affected members of their right to disenroll
- Suspension of enrollment or disenrollment of members
- Termination of the contract
- Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance

Appendices

Appendix A: Acronyms

Acronym	Definition
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plan
AHRQ	Agency for Healthcare Research and Quality
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CDRH	Chronic Disease Rehabilitation Hospital
CHIP	Children's Health Insurance Program
CMP	Care Management Program
CMS	Centers for Medicare and Medicaid Services
CoC	Continuity of Care
CP	Community Partner
CQS	Comprehensive Quality Strategy
DME	Durable Medical Equipment
ED	Emergency Department
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-for-Service
HEDIS	Healthcare Effectiveness Data and Information Set
LTS	Long Term Supports
LTSS	Long Term Services and Supports
MCE	Managed Care Entity
MCO	Managed Care Organization
MCP	Managed Care Plan
NCQA	National Committee for Quality Assurance
OLTSS	Office of Long-Term Services and Supports
PACE	Program of All-Inclusive Care for the Elderly
PCC	Primary Care Clinician (Plan)
PCCM	Primary Care Case Management
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
SCO	Senior Care Options or Senior Care Organizations
SSI	Supplemental Security Income

Appendix B: MassHealth Managed Care Plans (MCPs)

Program	MCP Type	Managed Care Authority	Name of Plan
Accountable Care Partnership Plan (ACPP)	MCE	1115	• Be Healthy Partnership • Berkshire Fallon Health Collaborative • WellSense Community Alliance • WellSense Mercy Alliance • WellSense Signature Alliance • WellSense Southcoast Alliance • WellSense Care Alliance • Fallon 365 Care • Fallon Health with Atrius Health • WellSense Beth Israel Lahey Health Performance Network ACO • WellSense with Boston Children's ACO • Tufts Health Together with Cambridge Health Alliance • Tufts Health Together with UMass Memorial • East Boston Neighborhood Health WellSense Alliance • Mass General Brigham Health Plan with Mass General Brigham ACO
Primary Care Accountable Care Organization (PCACO)	PCCM entity	1115	• Community Care Cooperative (C3) • Revere Medical
Managed Care Organization (MCO)	MCE	1115	• WellSense Essential • Tufts Health Together[2]
Senior Care Options (SCO)	MCE	1915(a)/1915(c)	• Commonwealth Care Alliance • Fallon Health • Senior Whole Health • Point32Health • United HealthCare • WellSense SCO[2] • Mass General Brigham Health Plan[4]
One Care	MCE	Financial Alignment	• Commonwealth Care Alliance • Tufts Health One Care • United HealthCare Connected • Molina Healthcare[4]

[2] Will no longer be a plan in 2026
[4] Will become a plan in 2026

Program	MCP Type	Managed Care Authority	Name of Plan
		Initiative Demonstration[3]	• Mass General Brigham Health Plan[4]
PCC Plan	PCCM	1115	NA (MassHealth)
Behavioral Health Plan	PIHP	1115	• Massachusetts Behavioral Health Partnership (MBHP)

[3] The One Care Program will become a FIDE-SNP in 2026

Appendix C: Quality Program Measures

Reference: Program Measures in the following appendices are associated with at least one MassHealth Quality Goal and Objective. Program measures may support multiple goals and objectives.

	Quality Goals and Objectives: Improve health care delivery, experience, and outcomes
1.	Achieve a healthy population, **delivering high-quality** pediatric, preventive, and perinatal care.
1.1	Improve access and quality of care for infants and children
1.2	Increase utilization and timeliness of preventative services
1.3	Manage quality and access to maternal health
2.	Advance progress on **high-impact acute and chronic condition areas** to improve safe, effective, high-value care.
2.1	Improve the health of populations with acute and chronic conditions that are key contributors to co-morbidities
2.2	Manage populations impacted by mental health and substance use disorders
2.3	Promote member safety
3.	Enable **coordinated and efficient quality care** for all members across the continuum of services and settings of care.
3.1	Manage timely, smooth transitions in care between inpatient and outpatient settings
3.2	Improve access to and quality of home and community-based services
3.3	Reduce unnecessary hospitalizations by Improving coordination and delivery of care in the community
4.	Enhance **person-centered care** through elevating member voice and improving member experience and engagement with their health care.
4.1	Improve and maintain a high level of experience for members receiving routine care.
4.2	Understand and improve the member experience of populations or members that have complex care needs
5.	Ensure **access to and appropriate utilization** of care and services to members.
5.1	Establish and maintain timely access to care and services in the communities where people live
5.2	Promote appropriate provider care and access to services

C-1: Quality Goals and Objectives and Statewide Measures (Managed Care Plans: MCEs, PCC Plan)

Statewide Performance Target: Statewide measures reflect metrics for which progress on CQS goals and objectives are evaluated. Targets are typically based on or informed by the national HEDIS Medicaid 75th and 90th percentile with which statewide plan performance is compared. The Medicaid 75th percentile may reflect a minimum or threshold standard for performance. The Medicaid 90th performance may reflect a goal target for performance. Performance targets may change as benchmarks are updated annually at a national level and reviewed with state performance.

Measure ID	**Quality Measure** * CMS Universal Foundation and Core Set Measure **CMS Core Measure *** Other national measure	**Statewide Performance - Baseline (MY2023)**	**MassHealth Goal/ Objective**
W30-CH WCV-CH:	Well-visits first 15/30 months* Child and adolescent well-visits*	51.9% 54.6%	1.1
BCS-AD COL-AD	Breast cancer screening* Colorectal Cancer Screening*	64.3% 28.8%	1.2
PPC	Prenatal Care Postpartum Care*	48.6% 63.4%	1.3
CBP-AD GSD-AD:	Controlling High blood pressure; poor control* Glycemic Status Assessment for Patients with Diabetes**	71.7% 25.5%	2.1
FUA	Follow-up after emergency department visit for substance use*	7-day: 36.6% 30-day: 49.5%	2.2
	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD / OUD-HH)**	79.2%	2.3
FUH	Follow-up after hospitalization for mental illness*	7-day: 38.3% 30-day: 59.5%	3.1
MLTSS-7	Minimizing Facility Length of Stay	1.33	3.2
PCR-AD	Plan All-Cause Readmissions*	1.24	3.3
CAHPS	CAHPS Health Plan Survey (Medicaid): Rating of Doctor and Rating of Health Care*	Adult: 68.56% CHIP: 74.15% Adult: 57.05% CHIP: 68.38%	4.1
CAHPS	Rating of Healthcare Quality SCO and One Care*	SCO: 86% One Care: 87%	4.2
CAHPS	CAHPS member experience: Getting Care Quickly*	Adult: 80.27% CHIP: 83.54%	5.1
FUM	Follow-up after Emergency Department Visit for Mental Illness**	7-day: 68.1% 30-day: 76.8%	5.2

Appendix C-2: ACO and MCO Program Measures

ACO and MCO Performance Targets: Targets for HEDIS measures are typically based on or informed by the national or regional HEDIS Medicaid 25th and 90th percentile targets for which ACO and MCO plan performance is compared. The Medicaid 25th percentile is used to inform a minimum or threshold standard for performance. The Medicaid 90th performance is used to inform a goal target for performance. The baselines were based on CY2019-2023 data where possible.

For measures that are not HEDIS measures, and are absent of external benchmarks, MassHealth employs an approach that assesses initial baseline performance of the ACOs (e.g., 2023). Fixed targets are determined in review of average, median and individual ACO performance to determine reasonable threshold and goal percentiles. Performance targets may change as benchmarks are updated annually at a national or regional level and reviewed with program performance.

Measure ID	Quality Measure *(+ not included in MCO program)*	ACO Baseline 2023	MCO Baseline 2023	MassHealth Goal/ Objective
NCQA--CIS	Childhood Immunization Status (combo 10)	NA	NA	1.1
NCQA-PPC	Timeliness of Prenatal Care	92.4%	91.0%	1.3
NCQA-PPC	Postpartum Care	86.5%	82.5%	1.3
NCQA- IMA	Immunization for Adolescents (combo 2)	NA	NA	1.1
TFL	Topical Fluoride for Children	18.9%	NA	1.1
NCQA-CBP	Controlling High Blood Pressure	NA	NA	2.1
NCQA- AMR	Asthma Medication Ratio	NA	NA	2.1
GSD	Glycemic Status Assessment for Patients with Diabetes HbA1c >9%	NA	NA	2.1
NCQA-APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NA	+	2.2
CG-CAHPS	Willingness to Recommend+	(Adult)87.5% (Child)91.3%	(Adult)87.5% (Child)91.3%	4.1
CG-CAHPS	Communication+	(Adult)92.9% (Child)95.7%	(Adult)92.9% (Child)95.7%	4.1
CG-CAHPS	Integration of Care+	(Adult)85.1% (Child)85.2%	(Adult)85.1% (Child)85.2%	4.1
CG-CAHPS	Knowledge of Patient+	(Adult)86.5% (Child)89.4%	(Adult)86.5% (Child)89.4%	4.1
NCQA- FUH-7	Follow-Up After Hospitalization for Mental Illness (7 days)	46.4%	45.1%	3.1
NCQA-FUM-7	Follow-up After Emergency Department Visit for Mental Illness (7 days)	73.0%	70.9%	3.1
NCQA- IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	47.6%	48.7%	2.2
NCQA- IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	19.5%	21.8%	2.2

Measure ID	Quality Measure *(+ not included in MCO program)*	ACO Baseline 2023	MCO Baseline 2023	MassHealth Goal/ Objective
NCQA-CDF	Screening for Depression and Follow-Up Plan+	47.2%	+	1.2
DEV	Developmental Screening in the First Three Years of Life	21.5%	NA	1.1
NCQA-FUA-7	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	36.8%	43.0%	3.1

Appendix C-3: Managed Behavioral Health Vendor Program Measures

Managed BH Vendor Performance Targets: Measure targets are based on or informed by the national HEDIS Medicaid 75th and 90th percentile as the primary benchmarks or targets with which plan performance is compared. The Medicaid 75th percentile may be used to reflect a minimum or threshold standard for performance. The Medicaid 90th performance may be used to reflect a goal target for performance. Performance targets may change as benchmarks are updated annually at a national level and reviewed with program performance.

Measure ID	Quality Measure	Baseline 2023	MassHealth Goals/Objectives
FUM-7	Follow-Up After Emergency Department Visit for Mental Illness (7 day)	74.3%	5.2
FUH-7	Follow-Up After Hospitalization for Mental Illness (7 day)	41.3%	3.1
POD	Pharmacotherapy for Opioid Use Disorder	46.0%	2.2
IPF	Thirty-day All Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	23.0%	3.3
OUD	Use of Pharmacotherapy for Opioid Use Disorder	86.0%	2.3

Appendix C-4 Senior Care Option Program Measures

SCO Performance Targets: Measure targets (attainment threshold and goal benchmark) for each Quality Measure are based on or informed by historical MassHealth data and where applicable regional or national HEDIS Medicare data. The 10th and 75th percentiles may serve as the primary benchmarks or targets against which plan performance is compared. The 10th percentile may be used to reflect a minimum or threshold standard for performance. The 75th percentile may be used to reflect a goal target for performance. Performance targets remain stable over the course of a 3–5-year period.

Measure ID	Quality Measure	Baseline 2023	MassHealth Goals/ Objectives
NCQA-COL	Colorectal Cancer Screening	65.6%	1.2
NCQA-TRC	Transitions of Care: Medication Reconciliation Post-Discharge	77.8%	3.1
NCQA-CBP	Controlling High Blood Pressure	77.1%	2.1
NCQA-PCE-C	Pharmacotherapy Management of COPD Exacerbation Corticosteroids	76.1%	2.1
NCQA-PCE-B	Pharmacotherapy Management of COPD Exacerbation Bronchodilators	89.5%	2.1
NCQA-DAE	Use of High-Risk Medications in the Elderly - Total	21.6%	2.3
NCQA-FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	60.5%	3.1
NCQA PCR	Plan All-Cause Readmission (Observed/Expected Ratio)	1.12	3.3
MLTSS-7	Minimizing Facility Length of Stay	1.17	3.2
COA	Care for Older Adults: Functional Status Assessment	96.2%	4.2
CAHPS	Rating of Health Care Quality	86.0%	4.1
CAHPS	Rating of Health Plan	88.0%	4.1
CAHPS	Getting needed care	78.0%	4.1
CAHPS	Getting appointments and care quickly	81.0%	4.1

Appendix C-5: One Care Program Measures

One Care Performance Targets: Measure targets (attainment threshold and goal benchmark) for each Quality Measure are based on or informed by historical MassHealth data and where applicable regional or national HEDIS Medicaid data. The 10th and 75th percentiles may serve as the primary benchmarks or targets against which plan performance is compared. The 10th percentile may be used to reflect a minimum or threshold standard for performance. The 75th percentile may be used to reflect a goal target for performance. Performance targets remain stable over the course for a 3–5-year period.

Measure ID	Quality Measure	Baseline 2023	MassHealth Goals/Objectives
NCQA-CBP	Controlling High Blood Pressure	76.2%	2.1
NCQA-GSD	Glycemic Status Assessment for Patients with Diabetes HbA1c >9%	24.0%	2.1
NCQA-FUH-30	Follow-Up After Hospitalization for Mental Illness (30 days)	65.4%	3.1
NCQA-IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	40.7%	2.2
NCQA-IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	10.0%	2.2
NCQA-PCR (<65)	Plan All-Cause Readmission (observed/expected ratio) (18-64 years)	1.43	3.3
BCS	Breast Cancer Screening	71.2%	1.2
MLTSS-7	Minimizing Facility Length of Stay	1.61	3.2
COL	Colorectal Cancer Screening	58.2%	1.2
CAHPS	Getting Care and Appointments Quickly	81.0%	4.1
CAHPS	Getting Needed Care	79.0%	4.1
CAHPS	Rating of Health Plan	87.0%	4.1
CAHPS	Rating of Health Care Quality	87.0%	4.1
TRC	Transitions of Care: med reconciliation	56.3%	3.1

Appendix C-6: Acute Hospital Program Measures

Quality Domain	Measure ID	Measure Steward: Measure Name	MassHealth Goals/Objectives
Care Coordination / Integration	CCI-1	CHIA: Adult Readmission Measure	3.3
Care Coordination / Integration	PED-1	Center of Excellence for Pediatric Quality Measurement: Pediatric All-Condition Readmission Measure	3.3
Care Coordination / Integration	CCI-2	NCQA FUM: Follow-up After ED Visit for Mental Illness (7-Day and 30-Day) - *Treated as 1 measure which includes 2 sub-measures*	5.1
Care Coordination / Integration	CCI-3	NCQA FUA: Follow-up After ED Visit for Substance Use (7-Day and 30-Day)- *Treated as 1 measure which includes 2 sub-measures*	2.2
Care Coordination / Integration	CCI-4	NCQA FUH: Follow-up After Hospitalization for Mental Illness (7 and 30 day) - *Treated as 1 measure which includes 2 sub-measures*	3.1
Care for Acute and Chronic Conditions	SUB-2	TJC SUB-2: Alcohol Use – Brief Intervention Provided or Offered	2.2
Care for Acute and Chronic Conditions	SUB-3	TJC SUB-3: Alcohol & Other Drug Use Disorder – Treatment provided/offered at Discharge	2.2
Care for Acute and Chronic Conditions	OP-1e	CMS 506v5: Safe Use of Opioids – Concurrent Prescribing	2.3
Care for Acute and Chronic Conditions	PED-2	NCQA: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	5.2
Patient Safety	HAI-1	CDC: Central Line-Associated Bloodstream Infection (CLABSI)	2.3
Patient Safety	HAI-2	CDC: Catheter-Associated Urinary Tract Infection (CAUTI)	2.3
Patient Safety	HAI-3	CDC: Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA)	2.3
Patient Safety	HAI-4	CDC: Clostridium Difficile Infection (CDI)	2.3
Patient Safety	HAI-5	CDC: Surgical Site Infections: Colon and abdominal hysterectomy surgeries (SSI)	2.3
Patient Experience	HCAHPS	AHRQ: Hospital Consumer Assessment of Healthcare Provider Systems Survey (HCAHPS) This measure includes 7 survey dimensions: 1) nurse communication, 2) doctor communication, 3) responsiveness of Hospital staff, 4) communication about medicines, 5) discharge information, 6) overall rating and 7) three item care transition.	4.1
Perinatal Care	MAT-4	TJC PC-02: Cesarean Birth, NTSV	1.3

Quality Domain	Measure ID	Measure Steward: Measure Name	MassHealth Goals/Objectives
Perinatal Care	NEWB-3	TJC PC-06: Unexpected Newborn Complications in Term Infants	1.1
Perinatal Care	SOC	TJC PC-07: Severe Obstetric Complications	1.3
Behavioral Health Care	BHC-2	CMS IPFQR: Medication Continuation Following Inpatient Psychiatric Discharge	2.2
Behavioral Health Care	BHC-3	CMS IPFQR: Screening for Metabolic Disorders	2.2

Appendix D: Summary of External Stakeholder Forums

1. Member/Community Advocate Focused Engagement

Stakeholder/Member Forums	General Activity
• MassHealth Member Advisory Committee (MAC) - Fulfills requirement for a Beneficiary Advisory Council (BAC) under 42 CFR 431.12(e).	• Member focused engagement to improve experience, quality of services and access to care for MassHealth members and their families.
• Hospital and Health Plans - Consumer Advisory Councils/Patient Family Advisory Councils - Health Quality and Equity Committees	• MassHealth requirement for contracted health plans and hospitals to establish and engage members through their own organizational forums to support and strengthen program implementation.

2. Multi-Stakeholder Engagement (including members, their families, consumer advocates, payers and providers)

Stakeholder/Member Forums	General Activity
• Eligibility and Disability Advocates • MassHealth Program Advisory Council (MPAC) • One Care Implementation Council • SCO Advisory Council (SCO-AC)	• Advocate and community-stakeholder focused engagement to inform needs and experiences, some related to specific program, services and populations
• ABI/MFP/TBI Waiver Stakeholder Advisory Group - Membership includes HCBS waiver participants, family members and providers • OLTSS/HCBS stakeholder groups: Home Health, Adult Foster Care, and Durable Medical Equipment	• Provides input to improve the quality of waiver services. • Provides input to improve quality and access to specified long-term services and supports, including HH and DME
• EOHHS Quality Measure Alignment Taskforce (QMAT): State agencies, providers, payers, measurement experts, consumer advocates	• Engagement in aligning population health priorities and measurement standards • Statewide annua review and alignment of quality measures for use in global payment contracts • Collaboration on developing statewide population health, quality priorities
• Delivery System Technical Advisory Committee (DSTAC) - DSTAC addresses CMS requirement for a Hospital Quality and Equity Initiative Advisory Committee, as directed in STC 14.23.	• Advisement and monitoring of progress of MassHealth's delivery system reform efforts for 2022-2027 Demonstration programs

3. Provider and Plan Engagement

Stakeholder/Member Forums	General Activity
• Quality Program Office Hours for: - ACO/MCO Quality Programs - BH and LTSS Community Partners Program - Hospital Programs (Acute, psychiatric hospitals) - Community Behavioral Health Centers	• Providers and plan engagement to support specific contracted quality program design, implementation and monitoring. • Implementation guidance and feedback sessions

Stakeholder/Member Forums	General Activity
- Medical Directors' Forums	• Clinical provider engagement (ACO, hosp., BH, etc.) to support quality and performance improvement.