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

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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I. Executive Summary

Managed Care Organizations

External quality review (EQR) is the evaluation and validation of information about quality, timeliness, and access to health care services furnished to Medicaid enrollees. The objective of the EQR is to improve states' ability to oversee managed care plans (MCPs) and to help MCPs to improve their performance. This annual technical report (ATR) describes the results of the EQR for managed care organizations (MCOs) that furnish health care services to Medicaid enrollees in Massachusetts.

Massachusetts's Medicaid program, administered by the Massachusetts Executive Office of Health and Human Services (EOHHS, known as "MassHealth"), contracted with two MCOs during the 2022 calendar year (CY). MCOs are health plans run by health insurance companies. The state contracts with MCOs to manage enrollees' care and connect members with regular preventative care and with additional supports like interpreter services. In addition, MCOs manage member outreach and education, as well as the financing of care. The state pays MCOs a fixed monthly payment for care management, and MCOs pay providers at reduced cost for health care services provided to members. MCOs contract with providers and have their own provider network. MassHealth's MCOs are listed in **Table 1**.

Table 1: MassHealth's MCOs – CY 2022

MCO Name	Abbreviation Used in the Report	Members as of December 31, 2022	Percent of Total MCO Population
Boston Medical Center HealthNet Plan	BMCHP WellSense MCO	46,399	39.56%
Tufts Health Together	Tufts MCO	70,894	60.44%

The **Boston Medical Center HealthNet Plan** (**BMCHP WellSense MCO**) is a nonprofit health insurance company that serves 46,399 MassHealth enrollees across all 14 counties in the state of Massachusetts. BMCHP WellSense MCO was founded in 1997 by the Boston Medical Center,[1] a private, nonprofit academic medical center that is the largest safety-net hospital in New England (NE).[2] BMCHP WellSense MCO received a rating of 4 out of 5 stars from the National Committee on Quality Assurance (NCQA) and is NCQA-accredited.

The **Tufts Health Together MCO** (**Tufts MCO**) is a nonprofit health plan that serves 70,894 MassHealth enrollees across 10 counties in the state of Massachusetts. The Barnstable, Bristol, Dukes, and Nantucket counties are not part of the Tufts MCO service area. Tufts MCO was founded in 1979 and is headquartered in Canton, Massachusetts.[3] Tufts MCO received a rating of 4.5 out of 5 stars from NCQA and is NCQA-accredited.

Purpose of Report

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

[1] WellSense Health Plan | Boston Medical Center (bmc.org)
[2] About Us | WellSense Health Plan
[3] About Tufts Health Plan | About Us | Visitor | Tufts Health Plan

Scope of External Quality Review Activities

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

(i) ***CMS Mandatory Protocol 1: Validation of Performance Improvement Projects (PIPs) –*** This activity validates that MCOs' performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.

(ii) ***CMS Mandatory Protocol 2: Validation of Performance Measures –*** This activity assesses the accuracy of performance measures (PMs) reported by each MCO and determines the extent to which the rates calculated by the MCOs follow state specifications and reporting requirements.

(iii) ***CMS Mandatory Protocol 3: Review of Compliance with Medicaid and CHIP[4] Managed Care Regulations –*** This activity determines MCOs' compliance with its contract and with state and federal regulations.

(iv) ***CMS Mandatory Protocol 4: Validation of Network Adequacy –*** This activity assesses MCOs' adherence to state standards for travel time and distance to specific provider types, as well as each MCO's ability to provide an adequate provider network to its Medicaid population.

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

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

All four mandatory EQR activities were conducted in accordance with CMS EQR protocols. CMS defined *validation* in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis." It should be noted that validation of network adequacy was conducted at the state's discretion, as activity protocols were not included in the *CMS External Quality Review (EQR) Protocols* published in October 2019.

High-Level Program Findings

The EQR activities conducted in CY 2022 demonstrated that MassHealth and the MCOs share a commitment to improvement in providing high-quality, timely, and accessible care for members.

IPRO used the analyses and evaluations of CY 2022 EQR activity findings to assess the performance of MassHealth's MCOs in providing quality, timely, and accessible health care services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the **quality**, **access**, and **timeliness** domains, and results were compared to previous years for trending when possible. These plan-level findings and recommendations for each MCO are discussed in each EQR activity section, as well as in the **MCP Strengths, Opportunities for Improvement, and EQR Recommendations** section.

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

[4] Children's Health Insurance Program.

MassHealth Medicaid Comprehensive Quality Strategy

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

Strengths:

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

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

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

Opportunities for improvement:

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

For example, to assess if MassHealth achieved measurable reductions in health care inequities (goal 2), the state could look at the core set measures stratified by race/ethnicity; to assess if MassHealth made care more value-based (goal 3), the state could look at the number of enrollees in value-based arrangements. The state may decide to continue with or revise its five strategic goals based on the evaluation.

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

Performance Improvement Projects

State agencies must require that contracted MCPs conduct PIPs that focus on both clinical and non-clinical areas, as established in *Title 42 CFR § 438.330(d)*.

Strengths:

MassHealth selected topics for its PIPs in alignment with the quality strategy goals and objectives.

MassHealth requires that within each project there is at least one intervention focused on health equity, which supports MassHealth's strategic goal to promote equitable care.

During CY 2022, each MCO conducted two baseline PIPs, which were validated by MassHealth's previous EQRO. PIPs were conducted in compliance with federal requirements and were designed to drive improvement on measures that support specific strategic goals; however, they also presented opportunities for improvement.

Opportunities for improvement:

PIPs did not have effective aim statements that would define a clear objective for the improvement project. An effective aim statement should be short, specific, and measurable. PIPs also lacked effective measures to track the success of specific changes that were put in place to overcome barriers that prevent improvement.

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

Performance Measure Validation

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

Strengths:

The use of quality metrics is one of the key elements of MassHealth's quality strategy.

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

MCOs are evaluated on a set of Healthcare Effectiveness Data and Information Set (HEDIS®) and non-HEDIS measures. HEDIS rates are calculated by each MCO and reported to the state. Non-HEDIS measures (i.e., measures that are not reported to NCQA via the Interactive Data Submission System [IDSS]) are calculated by MassHealth's vendor Telligen®.

IPRO conducted performance measure validation (PMV) to assess the accuracy of MCOs' performance measures and to determine the extent to which all performance measures follow MassHealth's specifications and reporting requirements. IPRO also reviewed MCOs' Final Audit Reports (FARs) issued by independent HEDIS auditors. IPRO found that both MCOs were fully compliant with appliable NCQA information system standards. No issues were identified.

Opportunities for improvement:

For HEDIS measures calculated by plans, MassHealth extracted rates for MCO-only members (i.e., the members of each health plan who were not enrolled in any accountable care organization [ACO]). The MCO-only rates were not validated as part of the HEDIS Compliance Audit™ or the PMV but were reported because they are the most meaningful comparative information about MCOs' quality performance.

When IPRO compared the statewide averages for MCO-only members to the NCQA Quality Compass, almost all rates were below the New England regional 25th percentiles, except for the Immunization for Adolescents Combo 2 rate, which was below the 50th percentile, and the Plan All-Cause Readmissions rate, which was below the 75th percentile. The 75th percentile is used by MassHealth to reflect a minimum (threshold) standard for performance.

For the non-HEDIS measures calculated by Telligen, IPRO compared the statewide averages to goal benchmarks determined by MassHealth. The statewide averages for all non-HEDIS measures were below the goal benchmarks.

PMV findings are provided in Section IV of this report.

Compliance

The compliance of MCOs with Medicaid and CHIP managed care regulations was evaluated by MassHealth's previous EQRO. The most current review was conducted in 2021 for the 2020 contract year. IPRO summarized the 2021 compliance results and followed up with each plan on recommendations made by the previous EQRO.

IPRO's assessment of whether MCOs effectively addressed the recommendations is included in Section VIII of this report. The compliance validation process is conducted triennially, and the next comprehensive review will be conducted in contract year 2024.

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

Network

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

Strengths:

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

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

Travel time and distance standards and availability standards are defined in the MCOs' contracts with MassHealth.

Opportunities for improvement:

IPRO evaluated each MCO's provider network to determine compliance with the time and distance standards established by MassHealth; however, the exceptions for the Nantucket and Dukes Counties were not included in template standards used for analysis.

Network deficiencies were calculated on a county level, where 100% of health plan members residing in a county had to have access within the required travel time or distance standards. However, MCO contracts and associated network standards are based on MassHealth service areas and not counties. Therefore, to assess network adequacy, ZIP codes were used to identify covered areas and then mapped to counties for each plan. As such, county level results reflect only mapped ZIP codes.

Access was assessed for a total of 64 provider types. The BMCHP WellSense MCO demonstrated adequate networks for 36 provider types in all 14 counties. The Tufts MCO demonstrated adequate networks for 41 provider types in all 10 counties.

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

Member Experience of Care Survey

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

Strengths:

MassHealth requires contracted MCOs to administer and submit annually to MassHealth the results from the Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medicaid Health Plan survey.

MassHealth monitors MCOs' submissions of CAHPS surveys and uses the results to identify opportunities for improvement and inform quality improvement work.

Each MassHealth MCO independently contracted with a certified CAHPS vendor to administer the CAHPS 5.1H Adult Medicaid Health Plan Survey for measurement year (MY) 2021. In addition, the BMCHP WellSense MCO contracted with a certified CAHPS vendor to administer the CAHPS 5.1H Child Medicaid Health Plan Survey.

Opportunities for improvement:
IPRO compared MCOs' top-box scores to national Medicaid performance reported in the Quality Compass 2022 (MY 2021). The MassHealth statewide averages were below the 75th percentile for all adult CAHPS measures, except for the Rating of All Health Care and the Rating of Health Plan measures, which both scored between the 75th and 90th percentiles.

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

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

Recommendations

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

EQR Recommendations for MassHealth

- *Recommendation towards achieving the goals of the Medicaid quality strategy* – MassHealth should assess whether the state met or made progress on the five strategic goals and objectives described in the quality strategy. This assessment should describe whether the state successfully promoted better care for MassHealth members (goal 1), achieved measurable reductions in health care inequities (goal 2), made care more value-based (goal 3), successfully promoted person- and family-centered care (goal 4), and improved care through better integration, communication, and coordination (goal 5). The state may decide to continue with or revise its five strategic goals and objectives based on the evaluation.[5]
- *Recommendation towards accelerating the effectiveness of PIPs* – IPRO recommends that MassHealth's PIPs have an effective aim statement and include intervention tracking measures to better track the success of specific changes that were put in place to overcome barriers that prevent improvement.
- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and CAHPS Health Plan Survey data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.

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

- *Recommendation towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access. MassHealth should also work with EQRO and MCPs to identify consistent network adequacy indicators.
- *Recommendation towards sharing information about member experiences with health care* – IPRO recommends that MassHealth publish summary results from member experience surveys on the MassHealth Quality Reports and Resources website and make the results available to MassHealth enrollees.

EQR Recommendations for the MCOs

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

II. Massachusetts Medicaid Managed Care Program

Managed Care in Massachusetts

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

MassHealth's mission is to improve the health outcomes of its members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life. MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.[6]

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

MassHealth Medicaid Quality Strategy

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

MassHealth has implemented a comprehensive Medicaid quality strategy to improve the quality of health care for its members. The quality strategy is comprehensive, as it guides quality improvement of services delivered to all MassHealth members, including managed care and fee-for-service populations. MassHealth's strategic goals are listed in Table 2.

Table 2: MassHealth's Strategic Goals

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

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

[6] MassHealth 2022 Comprehensive Quality Strategy (mass.gov)

MassHealth Managed Care Programs

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

1. The **Accountable Care Partnership Plans** (ACPPs) are health plans consisting of groups of primary care providers who partner with one managed care organization to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As accountable care organizations, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high quality care to MassHealth enrollees. To select an Accountable Care Partnership Plan, a MassHealth enrollee must live in the plan's service area and must use the plan's provider network.
2. The **Primary Care Accountable Care Organizations** (PCACOs) are health plans consisting of groups of primary care providers who contract directly with MassHealth to provide integrated and coordinated care. A PCACO functions as an accountable care organization and a primary care case management arrangement. In contrast to ACPPs, a PCACO does not partner with just one managed care organization. Instead, PCACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. **Managed Care Organizations** (MCOs) are health plans run by health insurance companies with their own provider network that includes primary care providers, specialists, behavioral health providers, and hospitals.
4. **Primary Care Clinician Plan** (PCCP) is a primary care case management arrangement, where Medicaid enrollees select or are assigned to a primary care provider, called a Primary Care Clinician (PCC). The PCC provides services to enrollees including the location, coordination, and monitoring of primary care health services. PCCP uses the MassHealth network of primary care providers, specialists, and hospitals as well as the Massachusetts Behavioral Health Partnership's network of behavioral health providers.
5. **Massachusetts Behavioral Health Partnership** is a health plan that manages behavioral health care for MassHealth's Primary Care Accountable Care Organizations and the Primary Care Clinician Plan. MBHP also serves children in state custody, not otherwise enrolled in managed care and certain children enrolled in MassHealth who have commercial insurance as their primary insurance.[7]
6. **One Care** Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services as well as long-term services and support. This plan is for enrollees between 21 and 64 years old who are dually enrolled in Medicaid and Medicare.[8]
7. **Senior Care Options** (SCO) plans are coordinated health plans that cover services paid by Medicare and Medicaid. This plan is for MassHealth enrollees 65 or older and it offers services to help seniors stay independently at home by combining healthcare services with social supports.[9]

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

Quality Metrics

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

[7] Massachusetts Behavioral Health Partnership. Available at: https://www.masspartnership.com/index.aspx
[8] One Care Facts and Features. Available at: https://www.mass.gov/doc/one-care-facts-and-features-brochure/download
[9] Senior Care Options (SCO) Overview. Available at: https://www.mass.gov/service-details/senior-care-options-sco-overview

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

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

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

Performance Improvement Projects

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

Member Experience of Care Surveys

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

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

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

MassHealth Initiatives

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

1115 Demonstration Waiver

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

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

Roadmap for Behavioral Health

Another MassHealth initiative that supports the goals of the quality strategy is the five-year roadmap for behavioral health reform that was released in 2021. Key components of implementing this initiative include the following: behavioral health integration in primary care, community-based alternatives to emergency department for crisis interventions, and the creation of the 24-7 Behavioral Health Help Line that will become available in 2023.

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

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

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

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

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

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

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

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

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

III. Validation of Performance Improvement Projects

Objectives

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

Section 2.13.C.1.e. of the Fourth and Restated MassHealth MCO Contract and Appendix B to the MassHealth MCO Contract require the MCOs to perform PIPs annually in compliance with federal regulations. MCOs are required to develop PIP topics in priority areas selected by MassHealth in alignment with its quality strategy goals. For the CY 2022, each MCO conducted two PIPs in one of the following priority areas: health equity, prevention and wellness, and access to care. All 2022 MCO PIPs were baseline projects. Specific MCO PIP topics are displayed in Table 3.

Table 3: MCO PIP Topics – CY 2022

MCO	PIP Topics
BMCHP WellSense MCO	PIP 1: IET – Baseline Report Improving BMCHP WellSense member initiation and engagement of alcohol and other drug abuse or dependence treatment (IET)
	PIP 2: CDC – Baseline Report Increasing the rate of HbA1c control for BMCHP WellSense MCO members with diabetes, with a focus on health equity
Tufts MCO	PIP 1: IET – Baseline Report Improving outcomes in initiating and engaging treatment for alcohol, opioid, or other drug dependence in Tufts Health Public Plan members
	PIP 2: PPC – Baseline Report Improving prenatal and postpartum care outcomes in Tufts Health Public Plan members

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. PIPs that were underway in 2022 were validated by MassHealth's previous EQRO. This section of the report summarizes their 2022 PIP validation results.

Technical Methods of Data Collection and Analysis

MCOs submitted two PIP reports in 2022. In May 2022, the MCOs submitted a Baseline Project Plan Report in which they described project goals, planned stakeholder involvement, anticipated barriers, proposed interventions, a plan for intervention effectiveness analysis, and performance indicators. In September 2022, the MCOs reported project updates and baseline data in the Baseline Performance Final Report.

Validation was performed by the previous EQRO's Technical Reviewers with support from the Clinical Director. PIPs were validated in accordance with *Title 42 CFR § 438.330(b)(i)*. The previous EQRO provided PIP report templates to each MCO for the submission of the project plan and the final baseline report. Each review was a four-step process:

1) ***PIP Project Report.*** MCPs submit a project report for each PIP to the EQRO Microsoft® Teams® site. This report is specific to the stage of the project. All 2022 PIPs were baseline projects.
2) ***Desktop Review.*** A desktop review is performed for each PIP. The Technical Reviewer and Medical Director review the project report and any supporting documentation submitted by the plan. Working collaboratively, they identify project strengths, issues requiring clarification, and opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the project. The Medical Director's focus is on clinical integrity and interventions.

3) ***Conference with the Plan.*** The Technical Reviewer and Medical Director meet virtually with plan representatives to obtain clarification on identified issues as well as to offer recommendations for improvement. When it is not possible to assign a validation rating to a project due to incomplete or missing information, the plan is required to remediate the report and resubmit it within 10 calendar days. In all cases, the plan is offered the opportunity to resubmit the report to address feedback received from the EQRO although it is not required to do so.
4) ***Final Report.*** A PIP Validation Worksheet based on CMS EQR Protocol Number 1 is completed by the Technical Reviewer. The inter-rater reliability was conducted to ensure consistency between reviewers. Reports submitted in Fall 2022 were scored by the reviewers. Individual standards are scored either: 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. The Medical Director documents his or her findings, and in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report. A determination is made by the Technical Reviewers as to the validity of the project.

Description of Data Obtained

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

Conclusions and Comparative Findings

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. Validation rating was assessed on the following scale: high confidence, moderate confidence, low confidence, and no confidence.

Table 4: MCO PIP Validation Rating – CY 2022

MCO	PIP 1	PIP 2
BMCHP WellSense MCO	IET: Moderate Confidence	CDC: Moderate Confidence
Tufts MCO	IET: High Confidence	PPC: High Confidence

MCO: managed care organization; CY: calendar year; PIP: performance improvement project; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; PPC: Prenatal and Postpartum Care; CDC: Comprehensive Diabetes Care.

PIP validation results are reported as rating averages in Tables 5–6 for each MCO. A rating average is a percent value calculated by dividing the number of scored points by the total number of available points.

Table 5: BMCHP WellSense MCO PIP Validation Results

Summary Results of Validation Ratings	PIP 1: IET – Rating Averages	PIP 2: CDC – Rating Averages
Updates to Project Descriptions and Goals	100%	100%
Update to Stakeholder Involvement	92%	92%
Intervention Activities Updates	100%	100%
Performance Indicator Data Collection	100%	100%
Capacity for Indicator Data Analysis	67%	100%
Performance Indicator Parameters	100%	100%
Baseline Performance Indicator Rates	100%	100%
Conclusions and Planning for Next Cycle	67%	100%
Overall Validation Rating Score	**96%**	**99%**

Table 6: Tufts MCO PIP Validation Results

Summary Results of Validation Ratings	PIP 1: IET – Rating Averages	PIP 2: PPC – Rating Averages
Updates to Project Descriptions and Goals	100%	100%
Update to Stakeholder Involvement	100%	100%
Intervention Activities Updates	97%	100%
Performance Indicator Data Collection	100%	100%
Capacity for Indicator Data Analysis	100%	100%
Performance Indicator Parameters	100%	100%
Baseline Performance Indicator Rates	100%	100%
Conclusions and Planning for Next Cycle	100%	100%
Overall Validation Rating Score	**98%**	**100%**

BMCHP WellSense MCO PIPs

BMCHP WellSense MCO PIP summaries, including aim, interventions, and results (indicators), are reported in Tables 7–9.

Table 7: BMCHP WellSense MCO PIP Summaries, 2022

BMCHP WellSense MCO PIP Summaries,
PIP 1: Improving BMCHP member initiation and engagement of alcohol and other drug abuse or dependence treatment (IET) Validation Summary: Moderate confidence.
Aim The HEDIS/NCQA IET metric assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other substance use who received the following: Initiation of Treatment: Adolescents and adults who initiated treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of diagnosis. Engagement of Treatment: Adolescents and adults who initiated treatment and had two or more additional services or MAT within 34 days of the initiation visit. In 2020, over 20 million Americans 13 years of age and older were classified as having a substance use disorder (SUD) involving treatment for alcohol and/or other substance use. This treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD mortality, improve health, productivity and social outcomes as well as reduce health care spending. Despite strong evidence, less than 20% of individuals with SUDs receive treatment.

Providing comprehensive care for members, as it relates to SUD issues, is a priority for BMCHP. This is especially true as the opioid crisis continues to significantly impact communities. The purpose of this PIP is to engage in and maintain interventions that will improve the IET HEDIS score year over year, demonstrating a higher number of BMCHP members seeking treatment and engaging in it. This will be achieved by interventions with identified SUD providers in the network.

In 2021, BMCHP scored above the 75th percentile of HEDIS benchmarks for both initiation and engagement in the IET metric. That said, neither of these 2021 metrics hit the 90th percentile of HEDIS benchmarks for IET. The overarching goal of this PIP is to get both of these IET metrics at or above the 90th percentile by the end of 2023 (90th percentile for initiation ≥ 54%; 90th percentile for engagement ≥ 24%).

While this PIP involves working with all possible SUD providers in Massachusetts, it also includes a targeted goal for a disparate population. With the intent of reducing health inequities where identified, it does appear the BMCHP members with a primary alcohol SUD diagnosis in Essex County have a notably lower IET score (initiation 37.8% and engagement 9.2%, based on 2021 data). Consequently, this subpopulation is being targeted initially in terms of the plan's work with SUD providers. BMCHP Provider Quality Managers (PQMs) will work directly with the Lahey system, the only ASAM 3.7 provider in Essex County, to maximize their work with BMCHP members (e.g., increase their IET score). The MCO also plans to strategically partner available Recovery Coach (RC), Recovery Support Navigator (RSN), and Community Support Program (CSP) contracted providers with the Lahey system.

Interventions in 2022

- SUD strategic provider focused quality program.
- Increase utilization of SUD community support services by BMCHP members.

Performance Improvement Summary

Not applicable until the remeasurement results are available in CY 2023 for the MY 2022.

PIP 2: Increasing the rate of HbA1c control for BMCHP MassHealth MCO members with diabetes, with a focus on health equity

Validation Summary: Moderate confidence.

Aim

The scope of this project will be improving comprehensive diabetes care for BMCHP MassHealth MCO members by implementing interventions targeting social determinants of health (SDoH) and racial disparity. The BMCHP population analysis identified that members living in the Southeast region were more likely to be noncompliant with the Hba1c testing measure when compared to the overall BMCHP MassHealth MCO population. The MCO hopes that by addressing SDoH and racial disparity identified and removing unfair barriers to health equity for members living in the Southeast region, the plan will improve its comprehensive diabetes care and specifically its compliance with HbA1c testing and control.

BMCHP aspires to accomplish the following goals over the multi-year project cycle:

- Identify disparities and barriers to compliance to HbA1c testing and HbA1c control.
- Examine and understand the history of the communities in the Southeast region and what barriers they may face to health equity.
- Solicit feedback from community members on barriers to comprehensive diabetes care and develop interventions that are most applicable to their needs.
- Increase the rates of HbA1c testing and control by implementing interventions targeting groups with lower compliance and addressing the SDoH and racial disparity they face.
- Improve health equity in diabetes care.

Interventions in 2022

- Text messaging campaign to provide members with educational information about the importance of HbA1c testing and control, exercise, and healthy eating. A quick survey will be included at the end of the texting campaign

to solicit feedback and additional barriers related to HbA1c testing and control among members from the Southeast region.

Performance Improvement Summary

Not applicable until the remeasurement results are available in 2023 for the MY 2022.

Table 8: BMCHP WellSense MCO PIP Results – PIP 1

Improving BMC WellSense Member initiation and engagement of alcohol and other drug abuse or dependence treatment (IET; 2022–2023) – Indicators and Reporting Year	BMCHP WellSense MCO
Indicator 1: Initiation	
2022 (baseline, MY 2021 data)	51.5%
2023 (remeasurement year 1)	Not Applicable
Indicator 2: Engagement	
2022 (baseline, MY 2021 data)	19.5%
2023 (remeasurement year 1)	Not Applicable
Indicator 3: Survey	
2022 (baseline, MY 2021 data)	83.9%
2023 (remeasurement year 1)	Not Applicable

Table 9: BMCHP WellSense MCO PIP Results – PIP 2

Increasing the rate of HbA1c control for BMC WellSense MCO members with diabetes, with a focus on health equity (2022–2023) – Indicators and Reporting Year	BMCHP WellSense MCO
Indicator 1: HbA1c Testing	
2022 (baseline, MY 2021 data)	83.45%
2023 (remeasurement year 1)	Not Applicable
Indicator 2: HbA1c < 8.0%	
2022 (baseline, MY 2021 data)	50.82%
2023 (remeasurement year 1)	Not Applicable

Recommendations

1. Recommendation for PIP 1: WellSense Provider Quality Managers (PQMs) are engaging well with the SUD strategic facility providers, who are also invested in seeing an improvement in their IET scores. SUD community providers (i.e., RC, RSN, and CSP providers), have been responsive to the plan's survey and outreach. The previous EQRO recommended further exploration on strengths and challenges in order to address challenges that may arise.
2. Recommendation for PIP 1: WellSense plan for the continuous quality improvement is to stay engaged in its interventions. The previous EQRO recommended this plan to be further developed.
3. Recommendation for PIP 2: The previous EQRO recommended that the plan develop other methods of receiving provider input into this initiative outside of the formal survey process which would delay valuable input that could lead to changes.

Tufts MCO PIPs

Tufts MCO PIP summaries, including aim, interventions, and results (indicators), are reported in Tables 10–12.

Table 10: Tufts MCO PIP Summaries, 2022

Tufts MCO PIP Summaries
PIP 1: Improving outcomes in initiating and engaging treatment for alcohol, opioid, or other drug dependence in Tufts Health Public Plan Members Validation Summary: High confidence. There were no validation findings that indicate that the credibility is at risk for the PIP results.
Aim The goal of the PIP is to improve outcomes related to the HEDIS Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) measure amongst Tufts Health Public Plan (THPP) MCO members. The measure includes two phases: • Initiation of AOD Treatment (IET-I): Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of diagnosis. • Engagement of AOD Treatment (IET-E): Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. The goal is to improve performance in both IET- I and IET- E phases as listed below: • Improve HEDIS Initiation of Alcohol, Opioid or Other Drug Abuse or Dependence Treatment (IET-I) score by 2.68 percentage points (50.20%) by 12/31/2022. • Improve Engagement of Alcohol, Opioid or Other Drug Abuse or Dependence Treatment (IET-E) score by 1.48 percentage points (23.80%) by 12/31/2022. MCO members can include high-risk individuals who have numerous complexities due to a multitude of factors that can be exacerbated by social determinants of health (SDoH) including alcohol or other drug dependence (AOD). The plan will focus on addressing health disparities related to Race and SDoH among other factors including geographic region, age, and gender. The interventions in this PIP are aimed at meeting members' individual needs and engaging with members to increase the rate in which they obtain treatment. Member goals are focused on member education and support and helping members to recover from and seek treatment for alcohol, opioid or other drug dependence. The plan utilizes the Addiction Recovery Care Managers (ARCMs), who are licensed BH practitioners and plan employees, provide high-intensity, community-based transition of care support, decreasing relapse and SUD related emergency department use to thereby increase member days in the community. The ARCMs currently use aggregate data from daily reports to conduct outreach to acute treatment facilities to assist with discharge planning. MCO provider interventions are another key focus of this PIP. Sharing IET best practices and member gap in care information with providers will improve HEDIS performance, member outcomes, and also promote collaboration to ensure provider billing and coding best practices. **Interventions in 2022** ▪ Utilize ARCM Program to provide member education and support discharge planning with the facility. ▪ ARCM to assess and address member needs during the transitions of care process from the facility back to the community. ▪ Increase provider education. **Performance Improvement Summary** Not applicable until the remeasurement results are available in 2023 for the MY 2022.

Tufts MCO PIP Summaries
PIP 2: Improving prenatal and postpartum care outcomes in Tufts Health Public Plan Members Validation Summary: High confidence. There were no validation findings that indicate that the credibility is at risk for the PIP results.

Aim

The goal of the PIP over a multi-year project cycle is to increase prenatal and postpartum care outcomes and reduce racial and ethnic health disparities around prenatal and postpartum care. Tufts Health Public Plans (THPP) will be implementing both member and provider focused activities (described below) to achieve project goals in increasing outcomes as related to prenatal and postpartum care with focus on the diversity of the plan MCO population. The interventions in this PIP are aimed at meeting members' individual needs.

The goal is focused on member education and support. The plan has contracted with Accompany Doula Care, who provides doula support to MCO members in Massachusetts. Through the Doula Program members receive support from high quality, culturally competent doulas who are specially trained for antepartum, birth and postpartum support as a no cost benefit. The doulas coach pregnant members to ensure healthier pregnancies and deliveries by providing education on maternal and infant health. Doulas can help with everything from scheduling prenatal appointments to teaching how to breastfeed, coaching members for delivery day, and showing how to take care of an infant. Additionally, the MCO plans to target interventions to provide culturally appropriate care to the Black/African American sub-population. Further, as the White sub-population has the lowest rates of prenatal and postpartum appointments, the MCO plans to expand intervention efforts to include identification of SDoH barriers that may impact White members seeking and receiving timely prenatal and postpartum care.

Provider goals are centered on provider engagement and education which include plans for collaborating with providers to strategize on actionable interventions to further engage with pregnant members and to increase the rate of prenatal and postpartum care. Additionally, provider educational materials will be published on the MCO provider website around the importance of encouraging members to engage in prenatal and postpartum care. The plan will collaborate directly with high volume low performing provider groups to share best practices for engaging and educating pregnant members on the importance of attending prenatal and postpartum care appointments. Member care gap data, based on claims analysis, will be shared with OB/GYN and PCP providers which will initiate conversations about best practices for prenatal and postpartum care within the MCO population. Given these provider focused activities, HEDIS Prenatal and Postpartum Care (PPC) rates may improve.

Interventions in 2022

- Prenatal and Postpartum Care: member focused supports.
- Enhancing member education and engagement around prenatal and postpartum care services available.
- Enhancing provider education around prenatal and postpartum care outcomes.

Performance Improvement Summary

Not applicable until the remeasurement results are available in 2023 for the MY 2022.

Table 11: Tufts MCO PIP Results – PIP 1

Improving outcomes in initiating and engaging treatment for alcohol, opioid, or other drug dependence in Tufts Health Public Plan members (2022–2023) – Indicators and Reporting Year	Tufts MCO
Indicator 1: Initiation	
2022 (baseline, MY 2021 data)	50.00%
2023 (remeasurement year 1)	Not Applicable
Indicator 2: Engagement	
2022 (baseline, MY 2021 data)	19.46%
2023 (remeasurement year 1)	Not Applicable

Table 12: Tufts MCO PIP Results – PIP 2

Improving outcomes in initiating and engaging treatment for alcohol, opioid, or other drug dependence in Tufts Health Public Plan members (2022–2023) – Indicators and Reporting Year	Tufts MCO
Indicator 1: Prenatal Care	
2022 (baseline, MY 2021 data)	95.38%
2023 (remeasurement year 1)	Not Applicable
Indicator 2: Postpartum Care	
2022 (baseline, MY 2021 data)	85.15%
2023 (remeasurement year 1)	Not Applicable

Recommendations

None.

IV. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

MassHealth evaluates MCOs' performance on HEDIS health plan measures. MCOs calculate HEDIS measure rates and are required to have the rates audited by a certified HEDIS compliance auditor before providing them to the state on an annual basis, as stated in Section 2.14.G.6 of the Fourth and Restated MassHealth MCO Contract.

MassHealth also evaluates MCO performance on a number of non-HEDIS measures (i.e., measures that are not reported to NCQA via IDSS). MCO non-HEDIS rates are calculated by MassHealth's vendor, Telligen. Telligen subcontracted with SS&C Health (SS&C), an NCQA-certified vendor, to produce the non-HEDIS measures rates for all MCOs.

MassHealth contracted with IPRO to conduct PMV. IPRO assessed the accuracy of both HEDIS and non-HEDIS PMs.

For HEDIS measures, IPRO performed an independent evaluation of the MY 2021 HEDIS Compliance Audit FARs, which contained findings related to the information systems standards. An EQRO may review an assessment of the MCP's information systems conducted by another party in lieu of conducting a full Information Systems Capabilities Assessment (ISCA).[10] Since the MCOs' HEDIS rates were audited by an independent NCQA-licensed HEDIS compliance audit organization, both plans received a full ISCA as part of the audit. Onsite (virtual) audits were therefore not necessary to validate reported measures.

For non-HEIDS measures, IPRO conducted a source code review with SS&C to ensure compliance with the measure specifications when calculating measures rates.

Description of Data Obtained

The following information was obtained from each MCO: Completed NCQA Record of Administration, Data Management, and Processes (Roadmap) from the current year HEDIS Compliance Audit, as well as associated supplemental documentation, IDSS files, and the FAR.

Validation Findings

- Information Systems Capabilities Assessment (ISCA): The ISCA is conducted to confirm that the MCOs' information systems (IS) were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, and provider data systems. IPRO reviewed MCOs' HEDIS Final Audit Reports issued by the MCOs' independent NCQA-Certified HEDIS compliance auditors. No issues were identified.
- Source Code Validation: Source code review is conducted to ensure compliance with the measure specifications when calculating measure rates. NCQA measure certification for HEDIS measures was accepted in lieu of source code review. The review of each MCOs FAR confirmed that the MCOs used NCQA

[10] The *CMS External Quality Review (EQR) Protocols,* published in October 2019, states that the ISCA is a required component of the mandatory EQR activities as part of Protocols 1, 2, 3, and 4. CMS clarified that the systems reviews that are conducted as part of NCQA HEDIS Compliance Audit may be substituted for an ISCA. The results of HEDIS compliance audits are presented in the HEDIS FARs issued by each MCO's independent auditor.

certified measure vendors to produce the HEDIS rates. Source code review was conducted for MCO non-HEDIS measure rates. No issues were identified.

- Medical Record Validation: Medical record review validation is conducted to confirm that the MCO followed appropriate processes to report rates using the hybrid methodology. The review of each MCOs FAR confirmed that the MCOs passed medical record review validation. No issues were identified.
- Primary Source Validation (PSV): PSV is conducted to confirm that the information from the primary source matches the output information used for measure reporting. The review of each MCOs FAR confirmed that the MCOs passed primary source verification. No issues were identified.
- Data Collection and Integration Validation: This includes a review of the processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately. The review of each MCOs FAR confirmed that the MCOs met all requirements related to data collection and integration. No issues were identified.
- Rate Validation: Rate validation is conducted to evaluate measure results and compare rates to industry standard benchmarks. No issues were identified. All required measures were reportable.

Based on a review of the MCOs' HEDIS FARs issued by the MCOs' independent NCQA-certified HEDIS compliance auditor, IPRO found that the MCOs were fully compliant with all seven of the applicable NCQA information system standards. Findings from IPRO's review of the MCOs' HEDIS FARs are displayed in Table 13.

Table 13: MCO Compliance with Information System Standards – MY 2021

IS Standard	BMCHP WellSense MCO	Tufts MCO
1.0 Medical Services Data	Compliant	Compliant
2.0 Enrollment Data	Compliant	Compliant
3.0 Practitioner Data	Compliant	Compliant
4.0 Medical Record Review Processes	Compliant	Compliant
5.0 Supplemental Data	Compliant	Compliant
6.0 Data Preproduction Processing	Compliant	Compliant
7.0 Data Integration and Reporting	Compliant	Compliant

MCO: managed care organization; IS: information system; MY: measurement year.

Conclusions and Comparative Findings

IPRO aggregated the MCO rates to provide methodologically appropriate, comparative information for all MCOs consistent with guidance included in the EQR protocols issued in accordance with *Title 42 CFR § 438.352(e)*. HEDIS rates produced by the MCOs were audited and reported to the NCQA.

However, HEDIS rates reported to NCQA were produced for the entire population of MCO members, including members enrolled in MassHealth's ACOs. To evaluate the quality of care provided to MCO-only members (i.e., the members of the health plan who are not enrolled in any ACOs), MassHealth extracted rates for MCO-only members. The MCO-only rates were not approved as part of the HEDIS Compliance Audit and the PMV but are reported here because they are most reflective of MCO quality performance.

IPRO compared the MCO-only rates and the weighted statewide averages to the NCQA HEDIS MY 2021 Quality Compass New England (NE) regional percentiles for Medicaid health maintenance organizations (HMOs) for all measures where available. MassHealth's benchmarks for MCO rates are the 75th and the 90th Quality Compass New England regional percentile. The regional percentiles are color coded to compare to the MCO rates, as explained in Table 14.

Table 14: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2021 Quality Compass NE Regional Percentiles

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

When compared to the MY 2021 Quality Compass New England (NE) regional percentiles, all BMCHP WellSense MCO HEDIS rates were below the 25th percentile, except for the Follow-up After Emergency Department Visit for Mental Illness rate, which was below the 75th percentile. For Tufts MCO, 7 out of 12 HEDIS rates were below the 25th percentile; however, the Follow-up After Emergency Department Visit for Mental Illness rate was above the 75th percentile, while the Timeliness of Prenatal Care (PPC) rate was above the NE regional 90th percentile. Table 15 displays the MCO-only HEDIS PMs for MY 2021 for both MCOs and the weighted statewide averages.

Table 15: MCO-only HEDIS Performance Measures – MY 2021

Measure Steward/ Acronym	HEDIS Measure	BMCHP WellSense MCO	Tufts MCO	Weighted Statewide Average
NCQA CIS	Childhood Immunization Status (combo 10)	35.71%	42.11%	40.35%
NCQA PPC	Timeliness of Prenatal Care	63.64%	94.38%	82.66%
NCQA IMA	Immunization for Adolescents (combo 2)	22.92%	36.21%	32.96%
NCQA CBP	Controlling High Blood Pressure	52.17%	57.85%	55.77%
NCQA AMR	Asthma Medication Ratio	54.36%	52.09%	52.77%
NCQA CDC	Comprehensive Diabetes Care: A1c Poor Control[1] LOWER IS BETTER	53.33%	49.15%	50.67%
NCQA APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	31.91%	26.97%	28.14%
NCQA FUH7	Follow-Up After Hospitalization for Mental Illness (7 days)	40.47%	42.36%	41.54%
NCQA FUM7	Follow-up After Emergency Department Visit for Mental Illness (7 days)	74.08%	79.26%	77.15%
NCQA PCR	Plan All-Cause Readmissions[1,2]- LOWER IS BETTER	11.96%	12.10%	12.05%
NCQA IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	52.42%	51.89%	52.13%
NCQA IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	20.35%	20.43%	20.39%

[1] A lower rate indicates better performance.

[2] Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age. No benchmark available in the NCQA Quality Compass.

MCO: managed care organization; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; NCQA: National Committee for Quality Assurance.

For the non-HEDIS measures calculated by Telligen, IPRO compared the rates to the goal benchmarks determined by MassHealth. MassHealth goal benchmarks for MCOs were fixed targets calculated without COVID-based adjustments. **Table 16** shows the color key for state-specific PM comparison to the state benchmark.

Table 16: Color Key for State Performance Measure Comparison to the State Benchmark

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

When compared to the state benchmark, Tufts MCO's LTSS Community Partner Engagement rate was the only Tufts MCO measure above the goal benchmark. None of the BMCHP MCO non-HEDIS rates were above the goal benchmark. **Table 17** shows non-HEDIS PMs for MY 2021 for all MCOs and the weighted stateside average.

Table 17: MCO State-Specific Performance Measures – MY 2021

Measure Steward	State Performance Measure	BMCHP MCO	Tufts MCO	Weighted Statewide Average	Goal Benchmark
ADA	Oral Health Evaluation	46.86%	49.75%	48.81%	60.00%
EOHHS	Acute Unplanned Admissions for Individuals with Diabetes (Adult; Observed/Expected Ratio)	18.185	14.987	N/A	N/A
EOHHS	Community Tenure (CT) – Bipolar, Schizophrenia or Psychosis (Observed/Expected Ratio)	1.208	0.314	0.728	TBD
EOHHS	Community Tenure (CT) – LTSS and Non-BSP (Observed/Expected Ratio)	1.095	0.510	0.812	TBD
EOHHS	Risk-Adjusted Ratio (Observed/Expected) of ED Visits for Members Aged 18–65 Years Identified with a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions (lower is better)	0.805	0.797	0.801	0.88
EOHHS	Behavioral Health Community Partner Engagement	4.51%	5.33%	4.82%	12.20%
EOHHS	LTSS Community Partner Engagement	3.69%	9.35%	6.70%	9.20%

MY: measurement year; ADA: American Dental Association; EOHHS: Executive Office of Health and Human Services; LTSS: long-term services and supports; BSP: bipolar, schizophrenia or psychosis; ED: emergency department; MY: measurement year; N/A: not applicable; TBD: to be determined.

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

Objectives

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

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

Technical Methods of Data Collection and Analysis

Compliance reviews were divided into 11 standards consistent with the CMS October 2021 EQR protocols:

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

Scoring Methodology

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by total possible points. A three-point scoring system was used: Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points. For each standard identified as Partially Met or Not Met, the MCO was required to submit a corrective action plan (CAP) in a format agreeable to MassHealth. The scoring definitions are outlined in Table 18.

Table 18: Scoring Definitions

Scoring	Definition
Met = 1 point	Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and MCO staff interviews provided information consistent with documentation provided.
Partially Met = 0.5 points	Any one of the following may be applicable: • Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. MCO staff interviews, however, provided information that was not consistent with documentation provided. • Documentation to substantiate compliance with some but not all the regulatory or contractual provision was provided, although MCO staff interviews provided information consistent with compliance with all requirements. • Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided, and MCO staff interviews provided information inconsistent with compliance with all requirements.
Not Met = 0 points	There was an absence of documentation to substantiate compliance with any of the regulatory or contractual requirements and MCO staff did not provide information to support compliance with requirements.

Description of Data Obtained

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

Nonduplication of Mandatory Activities

Per *Title 42 CFR 438.360*, Nonduplication of Mandatory Activities, the EQRO accepted NCQA accreditation findings to avoid duplicative work. To implement the deeming option, the EQRO obtained the most current NCQA accreditation standards and reviewed them against the federal regulations. Where the accreditation standard was at least as stringent as the federal regulation, the EQRO flagged the review element as eligible for deeming. For a review standard to be deemed, the EQRO evaluated each MCO's most current accreditation review and scored the review element as "Met" if the MCO scored 100% on the accreditation review element.

Conclusions and Comparative Findings

MCOs were compliant with many of the Medicaid and CHIP managed care regulations and standards. However, Tufts performed below 90% on the Availability of Services standard, and BMCHP WellSense performed below 70% on the Enrollment and Disenrollment standard. Both MCOs achieved compliance scores of 100% in the following domains:

- Assurances of Adequate Capacity and Services;
- Confidentiality;
- Practice Guidelines; and
- Health Information Technology.

Each MCO's scores are displayed in Table 19.

Table 19: CFR Standards to State Contract Crosswalk – 2021 Compliance Validation Results

CFR Standard Name[1]	CFR Citation	BMCHP WellSense MCO	Tufts MCO
Overall compliance score		**96.0%**	**97.2%**
Availability of Services	**438.206**	94.7%	84.0%
Enrollee Rights and Protections	**438.10**	100%	92.9%
Enrollment and Disenrollment	**438.56**	61.1%	100%
Enrollee Information	**438.10**	100%	96.2%
Assurances of Adequate Capacity and Services	**438.207**	100%	100%
Coordination and Continuity of Care	**438.208**	100%	98.4%
Coverage and Authorization of Services	**438.210**	98.4%	97.5%
Provider Selection	**438.214**	94.4%	97.2%
Confidentiality	**438.224**	100%	100%
Grievance and Appeal Systems	**438.228**	97.5%	98.3%
Subcontractual Relationships and Delegation	**438.230**	98.8%	97.6%
Practice Guidelines	**438.236**	100%	100%
Health Information Systems	**438.242**	100%	100%
QAPI	**438.330**	98.4%	98.4%

1 The following compliance validation results were conducted by MassHealth's previous external quality review organization.
CFR: Code of Federal Regulations; QAPI: Quality Assurance and Performance Improvement.

VI. Validation of Network Adequacy

Objectives

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

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

MassHealth's access and availability standards are described in Section 2.9 of the Fourth and Restated MassHealth MCO Contract. MCOs are contractually required to meet accessibility standards (i.e., standards for the duration of time between enrollee's request and the provision of services) and availability standards (i.e., travel time and distance standards and, when needed, threshold member to provider ratios).

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. However, the most current CMS protocols published in October 2019 did not include network adequacy protocols for the EQRO to follow. To meet federal regulations, MassHealth contracted with IPRO, an EQRO, to perform the validation of network adequacy for MassHealth MCOs.

Technical Methods of Data Collection and Analysis

For 2022, IPRO evaluated each MCO's provider network to determine compliance with the time and distance standards established by MassHealth. MassHealth's accessibility standards are displayed in Table 20 and the travel time and distance standards are displayed in Table 21.

Table 20 displays MassHealth's Medicaid accessibility standards for emergency services, primary and specialty care, pharmacy, behavioral health services, and services in the inpatient or 24-hour diversionary services discharge plan, as well as services for enrollees newly placed in the care or custody of the Department of Children and Families (DCF). Access to all other MCO covered services must be consistent with usual and customary community standards, as stated in the MassHealth MCO contracts.

Table 20: MCO Network Accessibility Standards - Duration of Time Between a Request and a Provision of Services

MassHealth Network Accessibility Standards
Emergency Services
Immediately upon enrollee presentation, including non-network and out-of-area facilities.
Twenty four hours a day and seven days a week without regard to prior authorization or the emergency service provider's contractual relationship with the MCO.
Primary Care
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, unless an appointment is required more quickly to assure the provision of screening in accordance with the schedule established by the EPSDT Periodicity Schedule.

MassHealth Network Accessibility Standards
Specialty 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 for non-symptomatic care.
Pharmacy
In accordance with usual and customary community standards; in a timely manner, including, but not limited to, by using delivery, courier, or other comparable service as needed to ensure such timely access.
Enrollees 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.
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.
Behavioral Health Services – Emergency Services
Immediately, on a 24-hour basis, seven days a week, with unrestricted access to enrollees who present at any qualified provider, whether a network provider or a non-network provider.
Behavioral Health Services – ESP Services
Immediately, on a 24-hour basis, seven days a week, with unrestricted access to enrollees who present for such services.
Behavioral Health Services – Urgent Care
Within 48 hours for services that are not emergency services or routine services.
Behavioral Health Services – All Other
Within 14 calendar days.
Services in the Inpatient or 24-Hour Diversionary Services Discharge Plan
Non-24-hour diversionary services – within 2 calendar days of discharge.
Medication management – within 14 calendar days of discharge.
Other outpatient services – within 7 calendar days of discharge.
Intensive care coordination services – within the timeframe directed by MassHealth.

MCO: managed care organization; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; DCF: Department of Children and Families; ESP: Emergency Services Program.

Table 21 displays MassHealth availability standards for PCPs, physical health services, specialists (including ob/gyn), behavioral health services, and pharmacy, as described in Section 2.9.C of the Fourth and Restated MassHealth MCO Contract. MCOs are required to meet the travel time or the distance standard but are not required to meet both.

Table 21: MCO Network Availability Standards – Travel Time or Distance, and Member-to-Provider Ratios

MassHealth Network Availability Standards
Primary Care Providers (PCPs)
Each enrollee must have a choice of at least two PCPs with open panels located within 15 miles or 30-minute travel time from the enrollee's residence and 40 miles or 40-minute travel time for those enrollees who live in the Oak Bluffs and Nantucket service areas.
One adult PCP for every 200 adult enrollees and one pediatric PCP for every 200 pediatric enrollees throughout the region.
Physical Health Services
Acute inpatient services: within 20 miles or 40-minute travel time from enrollee's residence, except for Martha's Vineyard and Nantucket Islands where the standard can be met by any hospital located on these islands that provide acute inpatient services or the closest hospital located off each island that provide acute inpatient services.
Rehabilitation hospital services: within 30 miles or 60-minute travel time from an enrollee's residence.
Urgent care services: within 15 miles or 30-minute travel time from the enrollee's residence.
Other physical health services: in accordance with the usual and customary community standards for accessing care.

MassHealth Network Availability Standards
Specialists
All other specialists: 20 miles or 40-minute travel time from the enrollee's residence and 40 miles or 40-minute travel time for those enrollees who live in the Oak Bluffs and Nantucket service areas.
An obstetrician/gynecologist to female enrollees (aged 10 and older) ratio of one to 500, throughout the region. When feasible, enrollees shall have a choice of two obstetrician/gynecologists.
Behavioral Health Services
Inpatient services: within 60 miles or 60-minute travel time from the enrollee's residence.
ESP services: in accordance with the geographic distribution provided by the state.
Community Service Agencies: in accordance with the geographic distribution provided by the state.
Outpatient services: within 30 miles or 30-minute travel time from the enrollee's residence.
Pharmacy
At least one retail pharmacy available within 15 miles or 30-minute travel time from the enrollee's residence.
A network of retail pharmacies that ensures prescription drug coverage and availability seven days a week.

MCO: managed care organization; PCP: primary care provider; ESP: Emergency Services Program.

In addition to the accessibility and availability standards, as noted in Section 2.9 of the MassHealth MCO Contracts and compliant with *Title 42 CFR 438.206*, each MassHealth MCO is required to make covered services available 24 hours a day, seven days a week when medically necessary; and ensure that non-English speaking enrollees have a choice of at least two PCPs and at least two behavioral health providers in the prevalent language in each region. MCOs are also required to have a mechanism in place to allow enrollees direct access to a specialist (e.g., through a standing referral or an approved number of visits).

IPRO entered into an agreement with Quest Analytics™ to use the Quest Enterprise System (QES) to validate that MCOs' provider networks meet MassHealth's availability standards. Reports were generated by combining the following files together: data on all providers and service locations contracted to participate in plans' networks, census data, service area information provided by MassHealth, and network adequacy template standards.

The network adequacy template standards were created in 2021 through a series of meetings with Quest Analytics, the previous EQRO, and MassHealth. The standards were supplied by MassHealth. Once the standards were entered into a template format, the templates were approved by MassHealth. All template information was then programmatically loaded and tested in the QES environment before processing the MassHealth network adequacy data. These same template standards were used to conduct the analysis for the CY 2022 because the network adequacy standards did not change. Table 22 shows the travel time and distance standards used for analysis.

Table 22: MassHealth MCO Travel Time or Distance Standards Used for Analysis

Provider Type	Standard
Primary Care Provider (PCP)	
Adult PCP Pediatric PCP	100% of members have access to 2 providers within 15 miles or 30 minutes. And the provider-to-member ratio must be 1:200 in any given county.
Specialists	
Allergy and Immunology Anesthesiology Audiology Cardiology Cardiothoracic Surgery	100% of members have access to 1 provider within 20 miles or 40 minutes. And for ob/gyn, the provider-to-member ratio must be 1:500 in any given county.

Provider Type	Standard
Chiropractor Dermatology ENT/Otolaryngology Emergency Medicine Endocrinology Gastroenterology General Surgery Hematology Infectious Diseases Nephrology Neurology Neurosurgery Nuclear Medicine Ob/Gyn Oncology – Medical, Surgical Oncology Radiation/Radiation Oncology Ophthalmology Oral Surgery Orthopedic Surgery Pathology Physiatry, Rehabilitative Medicine Plastic Surgery Podiatry Psych APN (PCNS or CNP) Psychiatry Psychology Pulmonology Radiology Rheumatology Urology Vascular Surgery	
BH Diversionary	
CBAT-ICBAT-TCU Clinical Support Services for SUD (Level 3.5) Community Support Program Intensive Outpatient Program Monitored Inpatient (Level 3.7) Partial Hospitalization Program Program of Assertive Community Treatment Psychiatric Day Treatment Recovery Coaching Recovery Support Navigators Residential Rehabilitation Services for SUD (Level 3.1) Structured Outpatient Addiction Program	100% of members have access to 2 providers within 30 miles or 30 minutes.
BH Inpatient	
Managed Inpatient (Level 4) Psych Inpatient Adolescent, Adult, and Child	100% of members have access to 2 providers within 60 miles or 60 minutes.
BH Intensive Community Treatment	
In-Home Behavioral Services In-Home Therapy Services Therapeutic Mentoring Services	100% of members have access to 2 providers within 30 miles or 30 minutes.
BH Outpatient	

Provider Type	Standard
Applied Behavior Analysis BH Outpatient Opioid Treatment Programs	100% of members have access to 2 providers within 30 miles or 30 minutes.
Medical Facility	
Acute Inpatient Hospital Rehabilitation Hospital Urgent Care Services	100% of members have access to 1 provider within 20 miles or 40 minutes.
Pharmacy	
Retail Pharmacies	100% of members have access to 1 provider within 15 miles or 30 minutes.

MCO: managed care organization; ENT: ear, nose, and throat; ob/gyn: obstetrics and gynecology; Psych APN: psychiatric advanced nurse; PCNS: psychiatric clinical nurse specialist; CNP: certified nurse practitioner; CBAT-ICBAT-TCU: community-based acute treatment – intensive community-based acute treatment – transition care unit; SUD: substance use disorder; BH: behavioral health.

Because QES analysis is county-based while MassHealth-defined standards are region-based, counties were assigned on a Zone Improvement Plan (ZIP) code basis. The analysis shows whether an MCO has a sufficient network of providers for all members residing in the same county. The results reflect only mapped ZIP codes. While the analysis is conducted for members who live in the same county, providers do not have to practice in that county; a provider must be available within a specified travel time or distance from the member's residence, as defined in Table 22.

IPRO aggregated the results to identify MCOs with adequate provider networks, as well as counties with deficient networks. When an MCO appeared to have network deficiencies in a particular county, IPRO reported the percent of MCO members in that county who had access. When possible, IPRO also reported when there were available providers with whom an MCO could potentially contract to bring member access to or above the access requirement. The list of potential providers is based on publicly available data sources such as the National Plan & Provider Enumeration System (NPPES) Registry and CMS's Physician Compare.

Description of Data Obtained

Validation of network adequacy for CY 2022 was performed using network data submitted by MCOs to IPRO. IPRO requested a complete provider list which included facility/provider name, address, phone number, and the national provider identifier (NPI) for the following provider types: primary care, ob/gyn, hospitals, rehabilitation, urgent care, specialists, behavioral health, and pharmacy.

Conclusions and Comparative Findings

IPRO reviewed the aggregated results to assess the adequacy of the MCO networks by provider type. Access was assessed for a total of 64 provider types. The BMCHP WellSense MCO demonstrated adequate networks for 36 provider types in all its 14 counties. The Tufts MCO demonstrated adequate networks for 41 provider types in all its 10 counties. Table 23 shows the number of counties with an adequate network of providers by provider type. 'Met' means that an MCO has an adequate network of that provider type in all counties in which it operates. For a detailed analysis of network deficiencies in specific counties and provider types, see plan-level results in Table 24 and Table 25.

Table 23: MCOs Adherence to Provider Time or Distance Standards

The number of counties where MCOs had an adequate network, per provider type. "Met" means that an MCO had an adequate network of that provider type in all counties it is in.

Provider Type	Standard – 100% of Members Have Access	BMCHP WellSense MCO	Tufts MCO
Total Number of Counties		**14**	**10**
Primary Care Provider (PCP)			
Adult PCP	2 providers within 15 miles or 30 minutes.	12	Met
Pediatric PCP	2 providers within 15 miles or 30 minutes.	12	Met
Specialists			
Allergy and Immunology	1 provider within 20 miles or 40 minutes.	13	Met
Anesthesiology	1 provider within 20 miles or 40 minutes.	Met	Met
Audiology	1 provider within 20 miles or 40 minutes.	13	Met
Cardiology	1 provider within 20 miles or 40 minutes.	Met	Met
Cardiothoracic Surgery	1 provider within 20 miles or 40 minutes.	11	9
Chiropractor	1 provider within 20 miles or 40 minutes.	Met	Met
Dermatology	1 provider within 20 miles or 40 minutes.	Met	Met
ENT/Otolaryngology	1 provider within 20 miles or 40 minutes.	Met	Met
Emergency Medicine	1 provider within 20 miles or 40 minutes.	Met	Met
Endocrinology	1 provider within 20 miles or 40 minutes.	Met	Met
Gastroenterology	1 provider within 20 miles or 40 minutes.	Met	Met
General Surgery	1 provider within 20 miles or 40 minutes.	Met	Met
Hematology	1 provider within 20 miles or 40 minutes.	Met	Met
Infectious Diseases	1 provider within 20 miles or 40 minutes.	13	Met
Nephrology	1 provider within 20 miles or 40 minutes.	Met	Met
Neurology	1 provider within 20 miles or 40 minutes.	Met	Met
Neurosurgery	1 provider within 20 miles or 40 minutes.	12	9
Nuclear Medicine	1 provider within 20 miles or 40 minutes.	8	9
Ob/Gyn	1 provider within 15 miles or 30 minutes.	Met	Met
Oncology – Medical, Surgical	1 provider within 20 miles or 40 minutes.	Met	Met
Oncology Radiation/Radiation Oncology	1 provider within 20 miles or 40 minutes.	12	Met
Ophthalmology	1 provider within 20 miles or 40 minutes.	Met	Met
Oral Surgery	1 provider within 20 miles or 40 minutes.	9	Met
Orthopedic Surgery	1 provider within 20 miles or 40 minutes.	Met	Met
Pathology	1 provider within 20 miles or 40 minutes.	12	Met
Physiatry, Rehabilitative Medicine	1 provider within 20 miles or 40 minutes.	Met	Met
Plastic Surgery	1 provider within 20 miles or 40 minutes.	11	9
Podiatry	1 provider within 20 miles or 40 minutes.	Met	9
Psych APN (PCNS or CNP)	1 provider within 20 miles or 40 minutes.	Met	Met
Psychiatry	1 provider within 20 miles or 40 minutes.	Met	Met
Psychology	1 provider within 20 miles or 40 minutes.	Met	Met
Pulmonology	1 provider within 20 miles or 40 minutes.	Met	Met
Radiology	1 provider within 20 miles or 40 minutes.	Met	9
Rheumatology	1 provider within 20 miles or 40 minutes.	Met	Met
Urology	1 provider within 20 miles or 40 minutes.	Met	Met
Vascular Surgery	1 provider within 20 miles or 40 minutes.	12	Met
BH Diversionary			
CBAT-ICBAT-TCU	2 providers within 30 miles or 30 minutes.	10	9
Clinical Support Services for SUD (Level 3.5)	2 providers within 30 miles or 30 minutes.	12	9
Community Support Program	2 providers within 30 miles or 30 minutes.	Met	9

Provider Type	Standard – 100% of Members Have Access	BMCHP WellSense MCO	Tufts MCO
Intensive Outpatient Program	2 providers within 30 miles or 30 minutes.	11	7
Monitored Inpatient (Level 3.7)	2 providers within 30 miles or 30 minutes.	12	9
Partial Hospitalization Program	2 providers within 30 miles or 30 minutes.	12	8
Program of Assertive Community Treatment	2 providers within 30 miles or 30 minutes.	5	8
Psychiatric Day Treatment	2 providers within 30 miles or 30 minutes.	Met	9
Recovery Coaching	2 providers within 30 miles or 30 minutes.	Met	5
Recovery Support Navigators	2 providers within 30 miles or 30 minutes.	Met	5
Residential Rehabilitation Services for SUD (Level 3.1)	2 providers within 30 miles or 30 minutes.	10	6
Structured Outpatient Addiction Program	2 providers within 30 miles or 30 minutes.	12	Met
BH Inpatient			
Managed Inpatient (Level 4)	2 providers within 60 miles or 60 minutes.	13	6
Psych Inpatient Adolescent	2 providers within 60 miles or 60 minutes.	13	Met
Psych Inpatient Adult	2 providers within 60 miles or 60 minutes.	Met	Met
Psych Inpatient Child	2 providers within 60 miles or 60 minutes.	13	6
BH Intensive Community Treatment			
In-Home Behavioral Services	2 providers within 30 miles or 30 minutes.	13	Met
In-Home Therapy Services	2 providers within 30 miles or 30 minutes.	Met	Met
Therapeutic Mentoring Services	2 providers within 30 miles or 30 minutes.	13	Met
BH Outpatient			
Applied Behavior Analysis	2 providers within 30 miles or 30 minutes.	13	6
BH Outpatient	2 providers within 30 miles or 30 minutes.	Met	Met
Opioid Treatment Programs	2 providers within 30 miles or 30 minutes.	13	7
Medical Facility			
Acute Inpatient Hospital	1 provider within 20 miles or 40 minutes.	Met	Met
Rehabilitation Hospital	1 provider within 30 miles or 60 minutes.	13	9
Urgent Care Services	1 provider within 15 miles or 30 minutes.	10	3
Pharmacy			
Retail Pharmacies	1 provider within 15 miles or 30 minutes.	Met	Met

MCO: managed care organization; ENT: ear, nose, and throat; ob/gyn: obstetrics and gynecology; Psych APN: psychiatric advanced nurse; PCNS: psychiatric clinical nurse specialist; CNP: certified nurse practitioner; CBAT-ICBAT-TCU: community-based acute treatment - intensive community-based acute treatment - transition care unit; SUD: substance use disorder; BH: behavioral health.

BMCHP WellSense MCO

The BMCHP WellSense MCO's members reside in 14 counties. If 100% of MCO members in one county have adequate access, then the network availability standard is met. But if there is even one member in that county who does not have access to providers within a specified travel time or distance, then the network is deficient. Table 24 shows counties with deficient networks and whether the network deficiency can be potentially filled by an available provider. "Yes" represents an available provider that, when combined with the existing network, would allow the MCO to pass an access requirement. "Increase" represents an available provider that would increase access, but an MCO would continue to remain below the access requirement.

Table 24: BMCHP WellSense MCO Counties with Network Deficiencies by Provider Type

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That County	Standard – 100% of Members Have Access	Deficiency Fillable by an Available Provider?
Primary Care				
Adult PCP	Berkshire	98.4%	2 providers within 15 miles or 30 minutes	No
	Nantucket	52.7%	2 providers within 15 miles or 30 minutes	No
Pediatric PCP	Berkshire	74.0%	2 providers within 15 miles or 30 minutes	Increase
	Barnstable	97.7%	2 providers within 15 miles or 30 minutes	Yes
Specialists				
Allergy and Immunology	Nantucket	90.9%	1 provider within 20 miles or 40 minutes	No
Audiology	Worcester	99.9%	1 provider within 20 miles or 40 minutes	Yes
Cardiothoracic Surgery	Berkshire	61.1%	1 provider within 20 miles or 40 minutes	Increase
	Franklin	99.5%	1 provider within 20 miles or 40 minutes	Yes
	Nantucket	81.8%	1 provider within 20 miles or 40 minutes	No
Infectious Diseases	Nantucket	80.0%	1 provider within 20 miles or 40 minutes	Yes
Neurosurgery	Franklin	98.8%	1 provider within 20 miles or 40 minutes	Yes
	Nantucket	80.0%	1 provider within 20 miles or 40 minutes	No
Nuclear Medicine	Barnstable	65.7%	1 provider within 20 miles or 40 minutes	Yes
	Berkshire	25.6%	1 provider within 20 miles or 40 minutes	Increase
	Dukes	75.6%	1 provider within 20 miles or 40 minutes	Increase
	Franklin	72.2%	1 provider within 20 miles or 40 minutes	Yes
	Nantucket	0%	1 provider within 20 miles or 40 minutes	Increase
	Worcester	99.9%	1 provider within 20 miles or 40 minutes	Yes
Oncology Radiation/ Radiation Oncology	Franklin	99.85	1 provider within 20 miles or 40 minutes	Yes
	Nantucket	80.0%	1 provider within 20 miles or 40 minutes	No
Oral Surgery	Berkshire	27.3%	1 provider within 20 miles or 40 minutes	Yes
	Bristol	85.8%	1 provider within 20 miles or 40 minutes	Yes
	Hampden	99.8%	1 provider within 20 miles or 40 minutes	Yes
	Hampshire	99.8%	1 provider within 20 miles or 40 minutes	Yes
	Nantucket	80.0%	1 provider within 20 miles or 40 minutes	Yes
Pathology	Dukes	87.5%	1 provider within 20 miles or 40 minutes	Yes
	Nantucket	80.0%	1 provider within 20 miles or 40 minutes	No
Plastic Surgery	Franklin	98.3%	1 provider within 20 miles or 40 minutes	Yes
	Nantucket	90.9%	1 provider within 20 miles or 40 minutes	Yes
	Worcester	98.4%	1 provider within 20 miles or 40 minutes	Yes
Vascular Surgery	Franklin	98.8%	1 provider within 20 miles or 40 minutes	Yes
	Nantucket	90.9%	1 provider within 20 miles or 40 minutes	No
BH Diversionary				
CBAT-ICBAT-TCU	Barnstable	99.9%	2 providers within 30 miles or 30 minutes	No
	Berkshire	99.6%	2 providers within 30 miles or 30 minutes	No
	Dukes	98.1%	2 providers within 30 miles or 30 minutes	No
	Nantucket	3.6%	2 providers within 30 miles or 30 minutes	No
Clinical Support Services for SUD (Level 3.5)	Berkshire	99.6%	2 providers within 30 miles or 30 minutes	Increase
	Nantucket	0%	2 providers within 30 miles or 30 minutes	Yes

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That County	Standard – 100% of Members Have Access	Deficiency Fillable by an Available Provider?
Residential Rehabilitation Services for SUD (Level 3.1)	Barnstable	45.0%	2 providers within 30 miles or 30 minutes	Increase
	Berkshire	99.6%	2 providers within 30 miles or 30 minutes	Increase
	Dukes	66.9%	2 providers within 30 miles or 30 minutes	Yes
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
Intensive Outpatient Program	Berkshire	6.9%	2 providers within 30 miles or 30 minutes	No
	Franklin	98.3%	2 providers within 30 miles or 30 minutes	No
	Nantucket	7.3%	2 providers within 30 miles or 30 minutes	No
Monitored Inpatient (Level 3.7)	Berkshire	99.6%	2 providers within 30 miles or 30 minutes	Increase
	Nantucket	0%	2 providers within 30 miles or 30 minutes	Yes
Partial Hospitalization Program	Berkshire	99.6%	2 providers within 30 miles or 30 minutes	No
	Nantucket	7.3%	2 providers within 30 miles or 30 minutes	No
Program of Assertive Community Treatment	Barnstable	44.9%	2 providers within 30 miles or 30 minutes	No
	Berkshire	20.7%	2 providers within 30 miles or 30 minutes	No
	Bristol	99.8%	2 providers within 30 miles or 30 minutes	No
	Dukes	38.8%	2 providers within 30 miles or 30 minutes	No
	Hampden	99.9%	2 providers within 30 miles or 30 minutes	No
	Hampshire	99.6%	2 providers within 30 miles or 30 minutes	No
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
	Plymouth	96.8%	2 providers within 30 miles or 30 minutes	No
	Worcester	98.6%	2 providers within 30 miles or 30 minutes	No
Residential Rehabilitation Services for SUD (Level 3.1)	Barnstable	45.0%	2 providers within 30 miles or 30 minutes	Increase
	Berkshire	99.6%	2 providers within 30 miles or 30 minutes	Increase
	Dukes	66.9%	2 providers within 30 miles or 30 minutes	Yes
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
Structured Outpatient Addiction Program	Berkshire	99.7%	2 providers within 30 miles or 30 minutes	No
	Nantucket	3.6%	2 providers within 30 miles or 30 minutes	No
BH Inpatient				
Managed Inpatient (Level 4)	Nantucket	0%	2 providers within 60 miles or 60 minutes	No
Psych Inpatient Adolescent	Nantucket	94.5%	2 providers within 60 miles or 60 minutes	Yes
Psych Inpatient Child	Nantucket	94.5%	2 providers within 60 miles or 60 minutes	Yes
BH Intensive Community Treatment				
In-Home Behavioral Services	Barnstable	99.9%	2 providers within 30 miles or 30 minutes	No
Therapeutic Mentoring Services	Barnstable	99.9%	2 providers within 30 miles or 30 minutes	No

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That County	Standard – 100% of Members Have Access	Deficiency Fillable by an Available Provider?
BH Outpatient				
Applied Behavior Analysis,	Nantucket	23.6%	2 providers within 30 miles or 30 minutes	Yes
Opioid Treatment Programs	Nantucket	90.9%	2 providers within 30 miles or 30 minutes	No
Medical Facility				
Rehabilitation Hospital	Franklin	88.0%	1 provider within 30 miles or 60 minutes	Yes
Urgent Care Services	Berkshire	96.1%	1 provider within 15 miles or 30 minutes	Increase
	Franklin	96.7%	1 provider within 15 miles or 30 minutes	Yes
	Nantucket	0%	1 provider within 15 miles or 30 minutes	No
	Worcester	99.9%	1 provider within 15 miles or 30 minutes	Yes

PCP: primary care provider; CBAT-ICBAT-TCU: community-based acute treatment - intensive community-based acute treatment - transition care unit; SUD: substance use disorder; BH: behavioral health.

Recommendations

- IPRO recommends that BMCHP WellSense expands its network when a deficiency can be closed by an available, single provider for the provider types and counties identified in Table 24.
- IPRO recommends that BMCHP WellSense expands its network when member's access can be increased by available providers for the provider types and counties identified in Table 24.

Tufts MCO

The Tufts MCO members reside in 10 counties. If 100% of MCO members in one county have adequate access, then the network availability standard is met. But if there is even one member in that county who does not have access to providers within a specified travel time or distance, then the network is deficient. Table 25 shows counties with deficient networks and whether the network deficiency can be potentially filled by an available provider. "Yes" represents an available provider that, when combined with the existing network, would allow the MCO to pass an access requirement. "Increase" represents an available provider that would increase access, but an MCO would continue to remain below the access requirement.

Table 25: Tufts MCO Counties with Network Deficiencies by Provider Type

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That County	Standard – 100% of Members Have Access	Deficiency Fillable by a Single Provider?
Specialists				
Cardiothoracic Surgery	Franklin	99.5%	1 provider within 20 miles or 40 minutes	Yes
Neurosurgery	Franklin	99.3%	1 provider within 20 miles or 40 minutes	Yes
Nuclear Medicine	Berkshire	74.4%	1 provider within 20 miles or 40 minutes	Increase
Plastic Surgery	Worcester	98.2%	1 provider within 20 miles or 40 minutes	Yes
Podiatry	Berkshire	93.9%	1 provider within 20 miles or 40 minutes	Yes
Radiology	Berkshire	80.9%	1 provider within 20 miles or 40 minutes	Yes
BH Diversionary				
CBAT-ICBAT-TCU	Berkshire	22.3%	2 providers within 30 miles or 30 minutes	No
Clinical Support Services for SUD (Level 3.5)	Berkshire	99.0%	2 providers within 30 miles or 30 minutes	Yes

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That County	Standard – 100% of Members Have Access	Deficiency Fillable by a Single Provider?
Residential Rehabilitation Services for SUD (Level 3.1)	Berkshire	0%	2 providers within 30 miles or 30 minutes	No
	Hampden	19.8%	2 providers within 30 miles or 30 minutes	No
	Hampshire	96.6%	2 providers within 30 miles or 30 minutes	No
	Franklin	97.2%	2 providers within 30 miles or 30 minutes	No
Community Support Program	Berkshire	99.7%	2 providers within 30 miles or 30 minutes	No
Intensive Outpatient Program	Berkshire	98.9%	2 providers within 30 miles or 30 minutes	No
	Franklin	98.3%	2 providers within 30 miles or 30 minutes	No
	Worcester	99.9%	2 providers within 30 miles or 30 minutes	No
Monitored Inpatient (Level 3.7)	Berkshire	99.8%	2 providers within 30 miles or 30 minutes	Yes
Partial Hospitalization Program	Berkshire	22.3%	2 providers within 30 miles or 30 minutes	No
	Worcester	99.9%	2 providers within 30 miles or 30 minutes	No
Program of Assertive Community Treatment	Berkshire	31.7%	2 providers within 30 miles or 30 minutes	No
	Essex	99.8%	2 providers within 30 miles or 30 minutes	No
Psychiatric Day Treatment	Berkshire	25.3%	2 providers within 30 miles or 30 minutes	No
Recovery Coaching	Berkshire	1.7%	2 providers within 30 miles or 30 minutes	No
	Franklin	12.1%	2 providers within 30 miles or 30 minutes	No
	Hampden	49.1%	2 providers within 30 miles or 30 minutes	No
	Hampshire	13.1%	2 providers within 30 miles or 30 minutes	No
	Worcester	99.9%	2 providers within 30 miles or 30 minutes	No
Recovery Support Navigators	Berkshire	1.7%	2 providers within 30 miles or 30 minutes	No
	Franklin	12.1%	2 providers within 30 miles or 30 minutes	No
	Hampden	49.1%	2 providers within 30 miles or 30 minutes	No
	Hampshire	13.1%	2 providers within 30 miles or 30 minutes	No
	Worcester	99.9%	2 providers within 30 miles or 30 minutes	No
BH Inpatient				
Managed Inpatient (Level 4)	Berkshire	0%	2 providers within 60 miles or 60 minutes	Increase
	Franklin	93.3%	2 providers within 60 miles or 60 minutes	Yes
	Hampden	99.2%	2 providers within 60 miles or 60 minutes	Yes
	Hampshire	98.2%	2 providers within 60 miles or 60 minutes	Yes
Psych Inpatient Child	Berkshire	0%	2 providers within 60 miles or 60 minutes	Yes
	Franklin	70.3%	2 providers within 60 miles or 60 minutes	Yes
	Hampden	87.4%	2 providers within 60 miles or 60 minutes	Yes
	Hampshire	91.4%	2 providers within 60 miles or 60 minutes	Yes
BH Outpatient				
Applied Behavior Analysis	Berkshire	3.7%	2 providers within 30 miles or 30 minutes	Increase
	Franklin	34.1%	2 providers within 30 miles or 30 minutes	Increase
	Hampshire	98.5%	2 providers within 30 miles or 30 minutes	Yes
	Worcester	99.7%	2 providers within 30 miles or 30 minutes	Increase

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That County	Standard – 100% of Members Have Access	Deficiency Fillable by a Single Provider?
Opioid Treatment Programs	Berkshire	98.9%	2 providers within 30 miles or 30 minutes	No
	Franklin	91.9%	2 providers within 30 miles or 30 minutes	No
	Worcester	98.2%	2 providers within 30 miles or 30 minutes	No
Medical Facility				
Rehabilitation Hospital	Berkshire	75.5%	1 provider within 30 miles or 60 minutes	Yes
Urgent Care Services	Berkshire	0.3%	1 provider within 15 miles or 30 minutes	Increase
	Essex	99.5%	1 provider within 15 miles or 30 minutes	Yes
	Franklin	91.9%	1 provider within 15 miles or 30 minutes	Yes
	Hampden	91.9%	1 provider within 15 miles or 30 minutes	Increase
	Hampshire	99.8%	1 provider within 15 miles or 30 minutes	Yes
	Middlesex	99.6%	1 provider within 15 miles or 30 minutes	Yes
	Worcester	85.1%	1 provider within 15 miles or 30 minutes	Increase

CBAT-ICBAT-TCU: community-based acute treatment - intensive community-based acute treatment - transition care unit; SUD: substance use disorder; BH: behavioral health.

Recommendations

- IPRO recommends that Tufts expands its network when a network deficiency can be closed by an available, single provider for the provider types and counties identified in Table 25.
- IPRO recommends that Tufts expands its network when member's access can be increased by available providers for the provider types and counties identified in Table 25.

VII. Validation of Quality-of-Care Surveys – CAHPS Member Experience Survey

Objectives

The overall objective of the CAHPS survey is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

Section 2.13.C.1.c.3 of the Fourth and Restated MassHealth MCO Contract requires contracted MCOs to administer and submit annually to MassHealth the results from the CAHPS Medicaid Health Plan survey that the MCOs submit to NCQA as part of their accreditation process. The CAHPS tool is a standardized questionnaire that asks enrollees to report on their satisfaction with care and services from the MCO, the providers, and their staff.

Each MassHealth MCO independently contracted with a certified CAHPS vendor to administer the adult survey for MY 2021. In addition, the BMCHP WellSense MCO contracted with a certified CAHPS vendor to administer the child survey. MassHealth monitors MCOs' submissions of CAHPS surveys and uses the results to identify opportunities for improvement and inform MassHealth's quality management work.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected for the MassHealth MCOs were the CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child Medicaid Health Plan Survey. The CAHPS Medicaid questionnaire set includes separate versions for the adult and child populations. The Tufts MCO did not administer the child CAHPS survey.

HEDIS specifications require that the MCOs provide a list of all eligible members for the sampling frame. Following HEDIS requirements, the MCOs included members in the sample frame who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2021, who were continuously enrolled for at least five of the last six months of MY 2021, and who are enrolled in the MCO. Table 26 provides a summary of the technical methods of data collection by MCO.

Table 26: CAHPS – Technical Methods of Data Collection by MCO, MY 2021

CAHPS – Technical Methods of Data Collection	BMCHP WellSense MCO	Tufts MCO
Adult CAHPS survey		
Survey vendor	SPH Analytics Press Ganey	SPH Analytics Press Ganey
Survey tool	CAHPS 5.1H	CAHPS 5.1H
Survey timeframe	March–May, 2022	February – May, 2022
Method of collection	Mail, telephone, and email	Mail and telephone
Sample size	2,835	2,295
Response rate	10.8%	9.1%
Child CAHPS survey		
Survey vendor	SPH Analytics Press Ganey	N/A
Survey tool	CAHPS 5.1H	N/A
Survey timeframe	March–May, 2022	N/A
Method of collection	Mail, telephone, and email	N/A
Sample size	3,630	N/A
Response rate	7.4%	N/A

For the global ratings, composite measures, composite items, and individual item measures, the scores were calculated using a 100-point scale. Responses were classified into response categories. Table 27 displays these categories and the measures for which these response categories are used.

Table 27: CAHPS Response Categories, MY 2021

Measures	Response Categories
• Rating of Health Plan • Rating of All Health Care • Rating of Personal Doctor • Rating of Specialist	• 0 to 4 (Dissatisfied) • 5 to 7 (Neutral) • 9 or 10 (Satisfied)
• Getting Needed Care • Getting Care Quickly • How Well Doctors Communicate • Customer Service composite measures • Coordination of Care individual item measures • Ease of Filling out Forms individual item measures	• Never (Dissatisfied) • Sometimes (Neutral) • Usually or Always (Satisfied)

To assess MCO performance, IPRO compared MCOs' top-box scores to national Medicaid performance reported in the Quality Compass 2022 (MY 2021) for all lines of business that reported MY 2021 CAHPS data to NCQA. The top-box scores are the survey results for the highest possible response category.

Description of Data Obtained

For each MCO, IPRO received a copy of the final MY 2021 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as MCO-level results and analyses.

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across both MCOs, IPRO compared the MCO results and CAHPS statewide averages for adults and children to the national Medicaid benchmarks presented in the Quality Compass 2022. Measures performing at or above the 90th percentile were considered strengths; measures performing at or above the 75th percentile but below the 90th percentile were considered above the threshold standard for performance; and measures performing below the 75th percentile were identified as opportunities for improvement, as explained in Table 28.

Table 28: Key for CAHPS Performance Measure Comparison to NCQA HEDIS MY 2021 Quality Compass Medicaid National Percentiles.

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

When compared to the available national Medicaid benchmarks, the Tufts MCO achieved two adult CAHPS scores for MY 2021 that exceeded the national Medicaid 90th percentile. The Tufts MCO also achieved two adult CAHPS scores that exceeded the national Medicaid 75th percentile. The BMCHP MCO scored below the national 75th percentile for all adult and child CAHPS measures.

Table 29 displays the top-box scores of the 2022 CAHPS Adult Medicaid Survey for MY 2021, and Table 30 displays the top-box scores of the 2022 CAHPS Child Medicaid Survey for MY 2021.

Table 29: CAHPS Performance – Adult Member, MY 2021

CAHPS Measure	BMCHP WellSense MCO	Tufts MCO	Statewide Average
Getting Needed Care	77.0%	80.6%	79.7%
Getting Care Quickly	70.2%	85.7%	79.1%
How Well Doctors Communicate	89.3%	92.2%	91.7%
Customer Service	88.6%	86.0%	87.6%
Coordination of Care	81.5%	86.8%	84.8%
Ease of Filling Out Forms	92.3%	98.0%	94.4%
Rating of All Health Care (9 or 10)	52.1%	65.6%	60.1%
Rating of Personal Doctor (9 or 10)	61.5%	64.3%	65.7%
Rating of Specialist Seen Most Often (9 or 10)	66.9%	63.8%	67.1%
Rating of Health Plan (9 or 10)	62.4%	69.8%	67.5%

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year.

Table 30: CAHPS Performance – Child Member, MY 2021

CAHPS Measure	BMCHP WellSense MCO	Tufts MCO
Getting Needed Care	79.1%	N/A
Getting Care Quickly	81.5%	N/A
How Well Doctors Communicate	92.3%	N/A
Customer Service	87.1%	N/A
Coordination of Care	83.1%	N/A
Ease of Filling Out Forms	93.1%	N/A
Rating of All Health Care	61.1%	N/A
Rating of Personal Doctor	74.1%	N/A
Rating of Specialist Seen Most Often	65.6%	N/A
Rating of Health Plan	64.7%	N/A

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; N/A: not applicable.

VIII. MCP Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results(a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP,[11] PAHP,[12] or PCCM entity has effectively addressed the recommendations for QI[13] made by the EQRO during the previous year's EQR." **Tables 32–33** display the MCOs' responses to the recommendations for QI made during the previous EQR, as well as IPRO's assessment of these responses.

BMCHP WellSense MCO Response to Previous EQR Recommendations

Table 31 displays the MCO's progress related to the *Managed Care Organizations External Quality Review CY 2021*, as well as IPRO's assessment of the MCO's response.

Table 31: BMCHP MCO Response to Previous EQR Recommendations

Recommendation for BMCHP MCO	BMCHP MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PIP 1 Vaccination Access-Related: Kepro recommends tailoring text messages for specific populations. Quality-Related: Kepro recommends the development of additional interventions.	In February 2022, the MCO was notified by Kepro that the PIP topics for the 2022 reporting cycle will be modified considering a CMS requirement. As a result, the MCO discontinued the COVID-19 and Telehealth Access projects and started 2 new projects on improving CDC and IET with an equity focus.	Not applicable
PIP 2 Telehealth Access Access-Related: BMCHP reported that targeting the high-volume provider groups within the Asian and Hispanic communities will ensure the approach will be culturally and linguistically appropriate. Kepro recommends that BMCHP gather additional information from other sources to ensure cultural barriers are addressed.	In February 2022, the MCO was notified by Kepro that the PIP topics for the 2022 reporting cycle will be modified considering a CMS requirement. As a result, the MCO discontinued the COVID-19 and Telehealth Access projects and started 2 new projects on improving CDC and IET with an equity focus.	Not applicable
PMV 1: Quality-Related: Continue quality improvement initiatives for the Asthma Medication Ratio measure, which ranks below the 25th percentile compared to the NCQA Medicaid Quality Compass MY 2020 data.	MCO described several interventions aimed to support the goal of improving Asthma Medication Ratio (AMR). However, the MY 2021 AMR rate remained below the New England Regional Quality Compass 25th percentile.	Partially addressed
Compliance 1: BMCHP WellSense needs to ensure annual review and approval of its policies and procedures against the most recent federal and state contract requirements to ensure continued compliance with all federal and MassHealth standards.	BMCHP implemented a new policy and procedure management tool, PolicyTech. This allows for an automated annual review process.	Addressed

[11] Prepaid inpatient health plan.
[12] Prepaid ambulatory health plan.
[13] Quality improvement.

Recommendation for BMCHP MCO	BMCHP MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Compliance 2: BMCHP WellSense needs to create and implement a medical record review process to monitor network provider compliance with policies and procedures and specifications and appropriateness of care.	MCO described efforts to ensure provider engagement and compliance with policies and procedures, specifications, and appropriateness of care.	Addressed
Compliance 3: BMC WellSense should revise the language used in denial and appeals letters to convey decision rationale in a manner that is easily understood.	The Plan UM department has added additional tools and resources and has provided additional staff training to convert physician denial rationales into easily understandable language. All denial letters are reviewed by a clinician and edited, if necessary, prior to being sent. In addition, UM recently conducted a denial file audit, including review of denial letters, to identify any opportunity for continued improvement. Additionally, staff in our Member Appeals continually strive to ensure communication to our members are conveyed in a clear, consistent, and easily understood manner.	Addressed
Compliance 4: BMC WellSense needs to work towards compliance with accessibility standards to meet MassHealth requirements. In addition, BMC WELLSENSE needs to develop a mechanism to evaluate non-English speaking enrollees' choice of primary and behavioral health providers in prevalent languages.	BMCHP will review with the Providers, on an annual basis, any language needs prevalent in their area. BMCHP will survey the providers and work with their administration and affiliated hospitals to identify the needs of the community.	Partially addressed
Compliance 5: BMC WellSense needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its Corrective Action Plan to MassHealth.	Upon receipt of the audit report, BMCHP implemented corrective actions to address each partial or not met finding, all of which have been successfully implemented and validated by the Compliance team.	Addressed
Network 1: Kepro recommends that BMCHP expand its network of Primary Care Providers (Adult and Pediatric) in Barnstable County.	BMCHP continues to recruit specialists to expand access for our members.	Partially addressed
Network 2: Network development in Barnstable, Berkshire, Dukes, and Nantucket Counties represents an opportunity for improvement for BMCHP.	BMCHP continues to recruit specialists to expand access for our members.	Partially addressed
Network 3: Kepro recommends contracting with additional providers as available to close other network gaps.	BMCHP regularly assesses it network and continues to recruit PCPs and specialists to expand access for our members.	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined. **Not applicable**: PIP discontinued. MCO: managed care organization; MCP: managed care plan; EQR: external quality review; CMS: Centers for Medicare and Medicaid Services; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; CDC: Comprehensive Diabetes Care; COVID-19: 2019 novel coronavirus; NCQA: National Committee for Quality Assurance; MY: measurement year; UM: utilization management; PCP: primary care provider.

Tufts MCO Response to Previous EQR Recommendations

Table 32 displays the MCO's progress related to the *Managed Care Organizations External Quality Review CY 2021,* as well as IPRO's assessment of the MCO's response.

Table 32: Tufts MCO Response to Previous EQR Recommendations

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PIP 1 Vaccination: Quality-Related: Kepro recommends that, for its own project management purposes, Tufts construct a more detailed workplan with a greater breakdown of sub-activities and timelines.	Discontinued	Not applicable
PIP 2 Telehealth Access Quality-Related: Tufts' workplans are marginally acceptable but could be strengthened by listing additional detail on sub-activities.	Discontinued	Not applicable
PMV 1: Quality-Related: Continue to develop and initiate quality improvement initiatives for the Asthma Medication Ratio measure. This measure ranks between the 25th and 33rd percentiles compared to the NCQA 2021 Medicaid Quality Compass	The MCO works collaboratively with its Accountable Care Organization (ACO) partners to improve the Asthma Medication Ratio (AMR). However, the MY 2021 AMR rate was below the New England Regional Quality Compass 25th percentile.	Partially addressed
Compliance 1: Tufts should implement an internal quality review process for compliance review preparation to ensure representation of all necessary functional areas and to ensure review elements were documented to demonstrate full compliance.	Tufts has implemented new oversight and processes to create a more robust quality review process for future compliance review preparation. In addition, all of the necessary functional areas are being engaged as early as possible in the process to help review elements to ensure documents demonstrate full compliance.	Addressed
Compliance 2: Tufts needs to continue to work towards compliance with accessibility standards to meet MassHealth requirements. In addition, Tufts needs to develop a mechanism to evaluate non-English speaking enrollees' choice of primary and behavioral health providers in prevalent languages. Furthermore, Tufts needs to develop more formal policies and procedures to address behavioral health requirements.	As part of the 2020 EQRO Compliance Audit this was identified and remediated for all SCO, Together and Unify.	Addressed
Compliance 3: Tufts should revise its member handbook to address the specific contractual provisions related to timelines, parties to an internal appeal, and Board of Hearing liaison training attendance.	This was identified as a CAP and has since been remediated.	Addressed
Compliance 4: Tufts needs to revise its grievance and appeals policy related to timelines, parties to an internal appeal, and Board of Hearing liaison training attendance.	This was identified as a CAP and has since been remediated.	Addressed

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Compliance 5: Tufts needs to integrate all required components into its QI Program Description including medical record review, medical interrater reliability review (IRR), fidelity report, and the ICC and IHT medical record review. In addition, Tufts needs to activate its Family and Enrollee Advisory Council.	This was identified as a CAP and has since been remediated.	Addressed
Compliance 6: Tufts should revise the language used in denial and appeals letters to covey decision rationale in a manner that is easily understood.	This was identified as a CAP and has since been remediated.	Addressed
Compliance 7: Tufts needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its Corrective Action Plan to MassHealth.	The MCO responded by updating policies and procedures, process documents, Member Handbook, Provider Manual, and other documents to address 30 CAPs.	Addressed
Network 1: Kepro recommends that Tufts fill network gaps as identified.	Through this most recent NA reporting exercise we discovered that last year's Network Adequacy files for MCO and ACO did not represent the networks accurately. Tufts Health Plan uses tools such as Quest and Zelis to identify providers that may not be contracted with Tufts Health Plans MCO in order to fill any gaps.	Partially addressed
Network 2: Kepro suggests that Tufts focus network development efforts on Berkshire, Franklin, and Worcester Counties.	Tufts Health Plans' MCO contains cities and towns in Region 5, Western, Service Area. Tufts Health Plans' MCO is an open network and is consistently evaluating opportunities to grow its network. Tufts Health Plan uses tools such as Quest and Zelis to identify providers that may not yet be contracted with Tufts Health Plans MCO in order to grow its MCO Network.	Partially addressed
Network 3: Tufts' behavioral health service network presents multiple opportunities for improvement.	The MCP is consistently evaluating opportunities to grow its behavioral health network. Many of the gaps identified in 2021 for behavioral health and substance use disorder facilities have been closed.	Partially addressed
Network 4: Kepro suggests that Tufts prioritize behavioral health network development in Berkshire and Hampden Counties.	The Western part of MA is a priority area for behavioral health provider network expansion. There are a limited number of providers in each county and there are even less that accept Medicaid products.	Partially addressed
Network 5: Kepro recommends that Tufts contract with additional Child and Adolescent Inpatient Psychiatric Facilities, as available, in Western Massachusetts.	The Western part of MA is a priority area for behavioral health provider network expansion. There are a limited number of providers in each county and there are even less that accept Medicaid products.	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined.
MCO: managed care organization; MCP: managed care plan; EQR: external quality review; NCQA: National Committee for Quality Assurance; MY: measurement year; EQRO: external quality review organization; SCO: senior care option; CAP: corrective action plan; NA: network adequacy; MA: Massachusetts.

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

Table 33 highlights each MCO's performance strengths, opportunities for improvement, and this year's recommendations based on the aggregated results of CY 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 33: Strengths, Opportunities for Improvement, and EQR Recommendations for All MCOs

MCO	Strengths	Weaknesses	Recommendations	Standards
Performance improvement projects				
BMCHP				
PIP 1: IET	Provider Quality Managers (PQMs) engaged well with the SUD strategic facility providers, who were also invested in seeing an improvement in their IET scores. SUD community providers (i.e., RC, RSN, and CSP providers) have been responsive to the plan's survey and outreach.	The plan's evaluation of the PIP strengths (what is going well) and challenges (barriers encountered) was not comprehensive. No challenges were identified. The plan did not describe plans for the continuous quality improvement; instead, the plan stated that the intervention will continue until the end of 2023.	The previous EQRO recommended further exploration on PIP strengths and challenges. The previous EQRO also recommended that continuous quality improvement be further developed.	Quality, Timeliness
PIP 2: CDC	Texting program allows the flexibility to send variable scripts to members.	The provider feedback was not available by the end of 2022.	The previous EQRO recommended that the plan develop other methods of receiving provider input into this initiative outside of the formal survey process, which would delay valuable input that could lead to changes.	Quality
Tufts				
PIP1: IET	The Addiction Recovery Care Managers (ARCMs) program offering individualized comprehensive care for members in recovery.	There were no weaknesses identified.	None.	Quality, Timeliness
PIP 2: PPC	Through the Doula Program members receive support from culturally competent doulas trained for antepartum, birth	There were no weaknesses identified.	None.	Quality, Timeliness, Access

MCO	Strengths	Weaknesses	Recommendations	Standards
	and postpartum support as a no cost benefit.			
Performance measures				
BMCHP				
HEDIS measures	MCO demonstrated compliance with IS standards. No issues were identified.	All HEDIS measures were below the 25th percentile, except for the FUM-7 Days which was below the 75th percentile.	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access
Non-HEDIS measures	None.	For the four measures with an available benchmark, BMCHP scored below the benchmark.	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access
Tufts				
HEDIS measures	MCO demonstrated compliance with IS standards. No issues were identified. The Timeliness of Prenatal Care (PPC) rate was above the regional 90th percentile.	Seven out of 12 HEDIS measures were below the 25th Quality Compass New England regional percentile.	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access
Non-HEDIS measures	The LTSS Community Partner Engagement measure was above the goal benchmark.	For the additional three measures with an available benchmark, Tufts scored below the benchmark.	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access
Compliance review				
BMCHP	MCO demonstrated compliance with most of the federal and state contractual standards and demonstrated strong investment in system solutions and technology. MCO addressed opportunities for improvement from the prior compliance review.	BMCHP did not meet all MassHealth-required time and distance standards.	Work towards compliance with accessibility standards to meet MassHealth requirements. In addition, develop a mechanism to evaluate non-English speaking enrollees' choice of primary and behavioral health providers in prevalent languages.	Quality, Timeliness, Access
Tufts	MCO demonstrated compliance with most of the federal and state contractual	Prior recommendations were addressed.	None.	Quality, Timeliness, Access

MCO	Strengths	Weaknesses	Recommendations	Standards
	standards, addressed opportunities for improvement from the prior compliance review, made enhancements to its care management approach with a large focus to better integrate behavioral health into its integrated team. Grievance resolution letters were found to be very thorough and detailed, and the credentialing manual was identified as a best practice.			
Network adequacy				
BMCHP	MCO demonstrated adequate networks for 36 provider types in all its 14 counties.	MCO had deficient networks in one or more counties for 28 provider types.	MCO should expand network when members' access can be improved and when network deficiencies can be closed by available providers.	Access, Timeliness
Tufts	MCO demonstrated adequate networks for 41 provider types in all its 10 counties.	MCO had deficient networks in one or more counties for 23 provider types.	MCO should expand network when members' access can be improved and when network deficiencies can be closed by available providers.	Access, Timeliness
Quality-of-care surveys				
BMCHP	MCO conducted both adult and child CAHPS surveys.	MCO scored below the national 75th percentile on all adult and child HP CAHPS measures.	MCO should utilize the results of the adult and child CAHPS surveys to drive performance improvement as it relates to member experience. MCO should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access
Tufts	MCO achieved two adult CAHPS scores for MY 2021 that exceeded the national Medicaid 90th percentile, and two adult CAHPS scores that exceeded the national Medicaid 75th percentile.	MCO scored below the national 75th percentile on six adult HP CAHPS measures. MCO did not conduct the child HP CAHPS survey.	MCO should utilize the results of the adult HP CAHPS surveys to drive performance improvement as it relates to member experience. MCO should also consider conducting the child HP CAHPS survey.	Quality, Timeliness, Access

EQR: external quality review; MCO: managed care organization; PIP: performance improvement project; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; PPC: Prenatal and Postpartum Care; CDC: Comprehensive Diabetes Care; SUD: substance abuse disorder; EQRO: external quality review organization; HEDIS: Healthcare Effectiveness Data and Information Set; IS: information systems; LTSS: long-term services and support; CAHPS: Consumer Assessment of Healthcare Providers and Systems; HP: health plan.

X. Required Elements in EQR Technical Report

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

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

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

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

Elements required in EQR technical report, including the requirements for the PIP validation, PMV, and review of compliance activities, are listed in the Table 34.

Table 34: Required Elements in EQR Technical Report

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

Regulatory Reference	Requirement	Location in the EQR Technical Report
Title 42 CFR § 438.364(a)(4)	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy, under *Title 42 CFR § 438.340*, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP beneficiaries.	Recommendations for how the state can target goals and objectives in the quality strategy are included in **Section I, High-Level Program Findings and Recommendations**, as well as when discussing strengths and weaknesses of an MCO or activity and when discussing the basis of performance measures or PIPs.
Title 42 CFR § 438.364(a)(5)	The technical report must include methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities.	Methodologically appropriate, comparative information about all MCOs is included across the report, in each EQR activity section (**Sections III–VII**) and in **Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations**.
Title 42 CFR § 438.364(a)(6)	The technical report must include an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	See **Section VIII. MCP Responses to the Previous EQR Recommendations** for the prior year findings and the assessment of each MCO's approach to addressing the recommendations issued by the EQRO in the previous year's technical report.
Title 42 CFR § 438.364(d)	The information included in the technical report must not disclose the identity or other protected health information of any patient.	The information included in this technical report does not disclose the identity or other PHI of any patient.
Title 42 CFR § 438.364 (a)(2)(iiv)	The technical report must include the following for each of the mandatory activities: objectives, technical methods of data collection and analysis, description of data obtained including validated performance measurement data for each PIP, and conclusions drawn from the data.	Each EQR activity section describes the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.
Title 42 CFR § 438.358(b)(1)(i)	The technical report must include information on the validation of PIPs that were underway during the preceding 12 months.	This report includes information on the validation of PIPs that were underway during the preceding 12 months; see **Section III**.
Title 42 CFR § 438.330(d)	The technical report must include a description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle.	The report includes a description of PIP interventions associated with each state-required PIP topic; see **Section III**.
Title 42 CFR § 438.358(b)(1)(ii)	The technical report must include information on the validation of each MCO's, PIHP's, PAHP's, or PCCM entity's performance measures for each MCO, PIHP, PAHP, and PCCM entity performance measure calculated by the state during the preceding 12 months.	This report includes information on the validation of each MCO's performance measures; see **Section IV**.
Title 42 CFR § 438.358(b)(1)(iii)	Technical report must include information on a review, conducted within the previous three-year period, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in *Title 42 CFR § 438.330*. The technical report must provide MCP results for the 11 Subpart D and QAPI standards.	This report includes information on a review, conducted in 2021, to determine each MCO's compliance with the standards set forth in Subpart D and the QAPI requirements described in *Title 42 CFR § 438.330*; see **Section V**.

XI. Appendix A – MassHealth Quality Goals and Objectives

Table A1: MassHealth Quality Strategy Goals and Objectives

MassHealth Quality Strategy Goals and Objectives	
Goal 1	**Promote better care:** Promote safe and high-quality care for MassHealth members
1.1	Focus on timely preventative, primary care services with access to integrated care and community-based services and supports
1.2	Promote effective prevention and treatment to address acute and chronic conditions in at-risk populations
1.3	Strengthen access, accommodations, and experience for members with disabilities, including enhanced identification and screening, and improvements to coordinated care
Goal 2	**Promote equitable care**: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience
2.1	Improve data collection and completeness of social risk factors (SRF), which include race, ethnicity, language, disability (RELD) and sexual orientation and gender identity (SOGI) data
2.2	Assess and prioritize opportunities to reduce health disparities through stratification of quality measures by SRFs, and assessment of member health-related social needs
2.3	Implement strategies to address disparities for at-risk populations including mothers and newborns, justice-involved individuals, and members with disabilities
Goal 3	**Make care more value-based:** Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care
3.1	Advance design of value-based care focused on primary care provider participation, behavioral health access, and integration and coordination of care
3.2	Develop accountability and performance expectations for measuring and closing significant gaps on health disparities
3.3	Align or integrate other population, provider, or facility-based programs (e.g., hospital, integrated care programs)
3.4	Implement robust quality reporting, performance and improvement, and evaluation processes
Goal 4	**Promote person and family-centered care**: Strengthen member and family-centered approaches to care and focus on engaging members in their health
4.1	Promote requirements and activities that engage providers and members in their care decisions through communications that are clear, timely, accessible, and culturally and linguistically appropriate
4.2	Capture member experience across our populations for members receiving acute care, primary care, behavioral health, and long-term services and supports
4.3	Utilize member engagement processes to systematically receive feedback to drive program and care improvement
Goal 5	**Improve care through better integration**, communication, and coordination across the care continuum and across care teams for our members
5.1	Invest in systems and interventions to improve verbal, written, and electronic communications among caregivers to reduce harm or avoidable hospitalizations and ensure safe and seamless care for members
5.2	Proactively engage members with high and rising risk to streamline care coordination and ensure members have an identified single accountable point of contact
5.3	Streamline and centralize behavioral health care to increase timely access and coordination of appropriate care options and reduce mental health and SUD emergencies

XII. Appendix B – MassHealth Managed Care Programs and Plans

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

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Accountable care partnership plan (ACPP)	Groups of primary care providers working with one managed care organization to create a full network of providers. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. AllWays Health Partners, Inc & Merrimack Valley ACO 2. Boston Medical Center Health Plan & Boston Accountable Care Organization, WellSense Community Alliance ACO 3. Boston Medical Center Health Plan & Mercy Health Accountable Care Organization, WellSense Mercy Alliance ACO 4. Boston Medical Center Health Plan & Signature Healthcare Corporation, WellSense Signature Alliance ACO 5. Boston Medical Center Health Plan & Southcoast Health Network, WellSense Southcoast Alliance ACO 6. Fallon Community Health Plan & Health Collaborative of the Berkshires 7. Fallon Community Health Plan & Reliant Medical Group (Fallon 365 Care) 8. Fallon Community Health Plan & Wellforce 9. Health New England & Baystate Health Care Alliance, Be Healthy Partnership 10. Tufts Health Public Plan & Atrius Health 11. Tufts Health Public Plan & Boston Children's Health Accountable Care Organization 12. Tufts Health Public Plan & Beth Israel Deaconess Care Organization 13. Tufts Health Public Plan & Cambridge Health Alliance
Primary care accountable care organization (PC ACO)	Groups of primary care providers forming an ACO that works directly with MassHealth's network of specialists and hospitals for care and coordination of care. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Community Care Cooperative 2. Mass General Brigham 3. Steward Health Choice

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Managed care organization (MCO)	Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Boston Medical Center HealthNet Plan (WellSense) 2. Tufts Health Together
Primary Care Clinician Plan (PCCP)	Members select or are assigned a primary care clinician (PCC) from a network of MassHealth hospitals, specialists, and the Massachusetts Behavioral Health Partnership (MBHP). • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	Not applicable – MassHealth
Massachusetts Behavioral Health Partnership (MBHP)	Capitated behavioral health model providing or managing behavioral health services, including visits to a licensed therapist, crisis counseling and emergency services, SUD and detox services, care management, and community support services. • Population: Medicaid members under 65 years of age who are enrolled in the PCCP or a PC ACO (which are the two PCCM programs), as well as children in state custody not otherwise enrolled in managed care. • Managed Care Authority: 1115 Demonstration Waiver.	MBHP (or managed behavioral health vendor: Beacon Health Options)
One Care Plan	Integrated care option for persons with disabilities in which members receive all medical and behavioral health services and long-term services and support through integrated care. Effective January 1, 2026, the One Care Plan program will shift from a Medicare-Medicaid Plan (MMP) demonstration to a Medicare Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) with a companion Medicaid managed care plan. • Population: Dual-eligible Medicaid members aged 21–64 years at the time of enrollment with MassHealth and Medicare coverage.	1. Commonwealth Care Alliance 2. Tufts Health Plan Unify 3. UnitedHealthcare Connected for One Care

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
	• Managed Care Authority: Financial Alignment Initiative Demonstration.	
Senior care option (SCO)	Medicare Fully Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs) with companion Medicaid managed care plans providing medical, behavioral health, and long-term, social, and geriatric support services, as well as respite care. • Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age. • Managed Care Authority: 1915(a) Waiver/1915(c) Waiver.	1. Boston Medical Center HealthNet Plan Senior Care Option 2. Commonwealth Care Alliance 3. NaviCare (HMO) Fallon Health 4. Senior Whole Health by Molina 5. Tufts Health Plan Senior Care Option 6. UnitedHealthcare Senior Care Options

XIII. Appendix C – MassHealth Quality Measures

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

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

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