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External Quality Review Massachusetts Behavioral Health Partnership Annual Technical Report, Calendar Year 2022



Commonwealth of Massachusetts
Executive Office of Health and
Human Services

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I. Executive Summary

Massachusetts Behavioral Health Partnership

External quality review (EQR) is the evaluation and validation of information about quality, 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 the Massachusetts Behavioral Health Partnership (MBHP) that manages behavioral health care for MassHealth's members enrolled in the primary care accountable care organizations (PC ACOs) and the Primary Care Clinician Plan (PCCP).

Massachusetts's Medicaid program, administered by the Massachusetts Executive Office of Health and Human Services (EOHHS, known as "MassHealth"), contracted with Beacon Health Options, Inc. to provide behavioral health care for PC ACO and PCCP members during the 2022 calendar year (CY). MBHP is a network of behavioral health providers who manage behavioral health care for MassHealth's PC ACOs and PCCP. MBHP also serves children in state custody who are not otherwise enrolled in managed care, as well as certain children enrolled in MassHealth who have commercial insurance as their primary insurance. MBHP served 692,118 MassHealth members during the CY 2022.

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 MBHP met the state standards and whether the state met the federal standards as defined in the CFR.

Scope of External Quality Review Activities

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

- (i) **CMS Mandatory Protocol 1: Validation of Performance Improvement Projects (PIPs)** – This activity validates that MBHP performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- (ii) **CMS Mandatory Protocol 2: Validation of Performance Measures** – This activity assesses the accuracy of performance measures (PMs) reported by MBHP and determines the extent to which the rates calculated by the MBHP follow state specifications and reporting requirements.
- (iii) **CMS Mandatory Protocol 3: Review of Compliance with Medicaid and CHIP¹ Managed Care Regulations** – This activity determines MBHP's compliance with its contract and with state and federal regulations.
- (iv) **CMS Mandatory Protocol 4: Validation of Network Adequacy** – This activity assesses MBHP's adherence to state standards for travel time and distance to specific provider types, as well as the MBHP's ability to provide an adequate provider network to its Medicaid population.

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

- technical methods of data collection and analysis,
- description of obtained data,
- comparative findings, and

¹ Children's Health Insurance Program.

- where applicable, the MBHP’s 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 MBHP 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 MBHP in providing quality, timely, and accessible health care services to Medicaid members. MBHP evaluated against state and national benchmarks for measures related to the **quality, access, and timeliness** domains, and results were compared to previous years for trending when possible. These plan-level findings and recommendations are discussed in each EQR activity section, as well as in the **MCP Strengths, Opportunities for Improvement, and EQR Recommendations** section.

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

MassHealth Medicaid Comprehensive Quality Strategy

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

Strengths:

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

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

Consequently, MassHealth programs and initiatives reflect the priorities articulated in the strategy and include specific measures. 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, MBHP conducted two PIPs: the first focused on increasing follow-up care for alcohol and other drug use disorder after emergency department visit and the second focused on improving access to telehealth services. Both PIPs 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.

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

Performance Measure Validation

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

Strengths:

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

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

The MBHP is evaluated on the Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are calculated by MBHP and reported to the MassHealth.

IPRO conducted performance measure validation (PMV) to assess the accuracy of HEDIS PMs and to determine the extent to which HEDIS performance measures follow MassHealth's specifications and reporting requirements. IPRO conducted a full Information Systems Capabilities Assessment (ISCA), a primary source

validation (PSV), and a check on the processes used to collect, calculate, and report the PMs. The results showed that the data and processes used to produce HEDIS rates by the MBHP were fully compliant with information system standards.

When IPRO compared MBHP's HEDIS rates to the National Committee for Quality Assurance (NCQA) Quality Compass[®], MBHP's rates were above the national Medicaid 90th percentile on the 7-day and 30-day Follow-Up After Emergency Department Visit for Mental Illness and the Continuation of Antidepressant Medication Management measures. Specifically, 77.16% of MBHP members with a diagnosis of mental illness or intentional self-harm received a follow-up visit for mental illness within 7 days of an emergency department visits, and 83.01% received a follow up visit within 30 days. In addition, 56.94% of adults with a diagnosis of depression remained on a new antidepressant medication for at least six months.

Opportunities for improvement:

MBHP's Initiation and Continuation of Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication rates were below the 25th national Medicaid percentile. Only 33.16% of children who were diagnosed with ADHD had one follow-up visit with a practitioner with prescribing authority; only 36.03% of children who had a prescription remained on the medication for at least 210 days and had at least two follow-up visits with a practitioner.

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

Compliance

MBHP's compliance with Medicaid and CHIP managed care regulations was evaluated by MassHealth's previous EQRO. The most current review was conducted in 2020 for the 2019 contract year. IPRO summarized the 2020 compliance results and followed up with the plan on recommendations made by the previous EQRO. IPRO's assessment of whether MBHP 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 2023.

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

Opportunities for improvement:

IPRO evaluated MBHP provider network to determine compliance with the time and distance standards established by MassHealth. Access was assessed for a total of 25 provider types. MBHP demonstrated adequate networks for only 11 out of 25 provider types across all 14 counties. MBHP had network deficiencies for 14 provider types.

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

Member Experience of Care Survey

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

Strengths:

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

When IPRO compared MBHP's survey results to the benchmark goals set by MassHealth, MBHP scored above the benchmark for the measure related to appointment availability, as well as five measures in the Acceptability of MBHP Practitioners category, four measures in the Scope of Service category, and one measure in the Experience of Care category.

Opportunities for improvement:

IPRO compared MBHP's survey results to benchmark goals set by MBHP. The benchmark goals were available for 25 measures, and 14 of the measures were below the benchmarks.

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

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

Recommendations

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

EQR Recommendations for MassHealth

- *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.²

- *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 members experience of care survey data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.
- *Recommendation towards 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 MBHP

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

² 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](#).

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.³

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

MassHealth Medicaid Quality Strategy

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

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

Table 1: MassHealth's Strategic Goals

Strategic Goal	Description
1. 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**.

³ [MassHealth 2022 Comprehensive Quality Strategy \(mass.gov\)](https://www.mass.gov/info-details/masshealth-2022-comprehensive-quality-strategy)

MassHealth Managed Care Programs

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

1. The **Accountable Care Partnership Plans** (ACPPs) are health plans consisting of groups of primary care providers who partner with one managed care organization to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As accountable care organizations, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high quality care to MassHealth enrollees. To select an Accountable Care Partnership Plan, a MassHealth enrollee must live in the plan's service area and must use the plan's provider network.
2. The **Primary Care Accountable Care Organizations** (PC ACOs) are health plans consisting of groups of primary care providers who contract directly with MassHealth to provide integrated and coordinated care. A PC ACO functions as an accountable care organization and a primary care case management arrangement. In contrast to ACPPs, a PC ACO does not partner with just one managed care organization. Instead, PC ACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. **Managed Care Organizations** (MCOs) are health plans run by health insurance companies with their own provider network that includes primary care providers, specialists, behavioral health providers, and hospitals.
4. **Primary Care Clinician Plan** (PCCP) is a primary care case management arrangement, where Medicaid enrollees select or are assigned to a primary care provider, called a Primary Care Clinician (PCC). The PCC provides services to enrollees including the 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.⁴
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.⁵
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.⁶

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.

⁴ Massachusetts Behavioral Health Partnership. Available at: <https://www.masspartnership.com/index.aspx>

⁵ One Care Facts and Features. Available at: <https://www.mass.gov/doc/one-care-facts-and-features-brochure/download>

⁶ 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 Consumer Assessment of Healthcare Providers and Systems (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 8.2.D.2 of MBHP's contract with MassHealth requires MBHP to develop PIPs designed to achieve significant improvements in clinical care and non-clinical care processes that are expected to improve health outcomes, as well as satisfaction of covered individuals, network providers, and primary care clinicians (PCCs), as MBHP provides services to members of the MassHealth PCC plan. MassHealth requires that within each PIP, there is at least one intervention focused on health equity. MassHealth can also modify the PIP cycle to address immediate priorities.

For the CY 2022, MBHP was required to develop two PIPs in the following priority areas selected by MassHealth in alignment with its quality strategy goals:

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

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

Table 2: MBHP PIP Topics – CY 2022

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

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 the previous EQRO's 2022 PIP validation results.

Technical Methods of Data Collection and Analysis

MBHP submitted two PIP reports in 2022 for each PIP. Both PIPs were remeasurement projects. In May 2022, MBHP submitted Remeasurement Reports in which it described project goals, stakeholder involvement, interventions, and performance indicators. In September 2022, the plan reported project updates and remeasurement data in the Remeasurement 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 for the submission of the project plan, the final baseline report, and the remeasurement report where appropriate. 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.

- 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

“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. The external reviewers were highly confident that the Telehealth PIP adhered to methodology for all phases of the projects, whereas the confidence in the FUA PIP was rated as low.

After the review to determine whether the PIP met the quality validation criteria established by CMS and MassHealth, the external reviewers rated each PIP and assigned an overall validation rating score based on rating averages across all requirements. The FUA PIP was scored at 84%, while the Telehealth PIP was scored at 100%. PIP validation results are reported in **Table 3**.

Table 3: MBHP PIP Validation Results

Summary Results of Validation Ratings	PIP 1: FUA – Rating Averages	PIP 2: Telehealth – Rating Averages
Updates to Project Descriptions and Goals	100%	100%
Update to Stakeholder Involvement	100%	100%
Intervention Activities Updates	33%	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	33%	100%
Overall Validation Rating Score	84%	100%

MBHP PIPs

MBHP PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 4–6**.

Table 4: MBHP PIP Summaries, 2022

MBHP PIP Summaries
<p>PIP 1: Improving rates of follow-up for alcohol and other drug use disorder after ED discharge (HEDIS FUA and measure) and the percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) use or dependence who received the following: initiation of AOD treatment, engagement of AOD treatment (IET)</p> <p>Validation Summary: Low confidence.</p> <p>Aim</p> <p>To increase the percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) use or dependence who received initiation of AOD treatment and engagement of AOD treatment (IET). In addition, the scope of this project is also to improve care coordination and successful engagement in treatment for members who enter the emergency department (ED) with a primary diagnosis of alcohol and other drug use disorder or dependence (AOD), also commonly referred to as substance use disorder (SUD).</p> <p>Interventions in 2022</p> <ul style="list-style-type: none"> ▪ Creation of a Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) predictive model. ▪ Expand the use of community support personnel (RC, RSN and CSP) for members in the IET cohort as a way of increasing rates of initiation and engagement in treatment. ▪ Initiation of a case manager follow-up with MBHP members who frequently use the ED (HEDIS FUA). <p>Performance Improvement Summary</p> <p>Conclusions cannot be drawn at this time due to the addition of new indicators in 2022.</p>
<p>PIP 2: Improving follow-up after inpatient discharge by improving access to telehealth services</p> <p>Validation Summary: High confidence. There were no validation findings that indicate that the credibility is at risk for the PIP results.</p> <p>Aim</p> <p>To increase the utilization of telehealth as a modality for outpatient treatment within the context of the HEDIS FUH measure, which captures the rate of follow up visits within 7 and 30 days for outpatient mental health care following discharge from inpatient mental health care.</p> <p>Interventions in 2022</p> <ul style="list-style-type: none"> ▪ Modify discharge form to allow inpatient (IP) providers to report telehealth as a type of appointment, including that telehealth capability was assessed with the member. ▪ MBHP Provider Quality Managers (PQMs) to implement collaborative strategic plans for IP providers who, based on comparative performance data, may be candidates for increasing the percentage of aftercare appointments scheduled as telehealth appointments.

MBHP PIP Summaries

- Recruit additional OP providers, who are proficient with the use of telehealth, to offer open access (timely same day appointments), to be listed on the Massachusetts Behavioral Health Access (MABHA) website.
- Educate outpatient providers to include telehealth coding on claims.

Performance Improvement Summary

Telehealth utilization rates per visit improved dramatically between 2020–2021. However, because the rates are claims-based and rely on proper claims coding, it is hard to know whether the increase is a result of improved coding practices, or if members are increasing their rate of utilization. Nonetheless, the outcomes analysis indicates that each of the interventions undertaken are having a positive effect or at least coincide with increases seen in the indicator rates for this project (rates of telehealth for FUH 7- and 30-day visits). Toward this end, MBHP plans to continue the interventions into 2023. It may be that moving forward, MBHP will see less of an increase in telehealth utilization compared to in-person, as the Covid pandemic subsides, and more people return to their preference of in-person therapy. The data that MBHP presented for intervention 1 certainly shows that given the choice, a significant cohort of members are still choosing “in-person” for follow-up after hospitalization and that follow-up rates are also higher for this cohort compared to those who initially choose telehealth. MBHP will continue to work with inpatient providers through discharge planning process to ensure members are equipped to experience successful follow-up whether the member’s choice is telehealth or in-person.

Table 5: MBHP PIP Results – PIP 1

Improving rates of follow-up for alcohol and other drug use disorder after ED discharge (HEDIS FUA and measure) and the percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) use or dependence who received the following: initiation of AOD treatment, engagement of AOD treatment (IET; 2022–2023) – Indicators and Reporting Year	MBHP
Indicator 1: FUA – 7 days	
2022 (baseline, MY 2022 data)	18.10%
2023 (remeasurement year 1)	Not Applicable
Indicator 2: FUA – 30 days	
2022 (baseline, MY 2022 data)	27.48%
2023 (remeasurement year 1)	Not Applicable
Indicator 3: Initiation	
2022 (baseline, MY 2022 data)	90.60%
2023 (remeasurement year 1)	Not Applicable
Indicator 4: Engagement	
2022 (baseline, MY 2022 data)	35.34%
2023 (remeasurement year 1)	Not Applicable
Indicator 5: Utilization of Community Support for IET Population Discharged from ATS Inpatient Stay	
2022 (baseline, MY 2022 data)	15.03%
2023 (remeasurement year 1)	Not Applicable
Indicator 6: FUA – 7 days	
2022 (baseline, MY 2022 data)	18.10%
2023 (remeasurement year 1)	Not Applicable
Indicator 7: FUA – 30 days	
2022 (baseline, MY 2022 data)	27.48%
2023 (remeasurement year 1)	Not Applicable

Table 6: MBHP PIP Results – PIP 2

Improving follow-up after inpatient discharge by improving access to telehealth services (2021–2023) – Indicators and Reporting Year		MBHP
Indicator 1: Percentage of completed post-discharge (7-day) follow-up visits conducted via telehealth (coded as telehealth-modifier 02)		
2021 (baseline, MY 2021 data)		38.05%
2022 (remeasurement year 1)		52.03%
2023 (remeasurement year 2)		Not Applicable
Indicator 2: Percentage of completed post-discharge (30-day) follow-up visits conducted via telehealth (coded as telehealth-modifier 02)		
2021 (baseline, MY 2021 data)		41.70%
2022 (remeasurement year 1)		54.59%
2023 (remeasurement year 2)		Not Applicable

Recommendations

- PIP 2: The plan has identified that members prefer in-person visits. The plan should look at the in-person follow-up visit rate as well as telehealth rate.

IV. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

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

MassHealth evaluates MBHP quality performance on a slate of HEDIS measures. MBHP was not required to report any non-HEDIS measures for MY 2021. All MBHP PMs were calculated by Inovalon®, an NCQA-certified vendor, to produce HEDIS measure rates.

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

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

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

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

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

Description of Data Obtained

The following information was obtained from the MBHP:

- A completed ISCA tool.
- Denominator and numerator compliant lists for the following two measures:
 - Follow-Up After Hospitalization for Mental Illness (FUH), and
 - Follow-Up Care for Children Prescribed ADHD Medication (ADD).
- Rates for HEDIS measures for MY 2021.
- NCQA Measure Certification report for HEDIS measures.

Validation Results

- *Information Systems Capabilities Assessment (ISCA)*: The ISCA is conducted to confirm that the MBHP's information systems (IS) were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, provider data systems. No issues were identified.

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

IPRO found that the data and processes used to produce HEDIS rates by the MBHP were fully compliant with information system standards. Findings from IPRO's review are displayed in **Table 7**.

Table 7: MBHP Compliance with Information System Standards – MY 2021

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

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

Conclusions

IPRO compared the MBHP rates to the NCQA HEDIS MY 2021 Quality Compass national Medicaid percentiles where available. MassHealth's benchmarks for MBHP rates are the 75th and the 90th Quality Compass national percentile. The Quality Compass percentiles are color-coded to compare to the MBHP rates, as explained in **Table 8**.

Table 8: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2021 Quality Compass National Medicaid Percentiles.

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

When IPRO compared MBHP's HEDIS rates to the NCQA Quality Compass, MBHP's rates were above the national Medicaid 90th percentile on the 7-day and 30-day Follow-Up After Emergency Department Visit for Mental Illness and the Continuation of Antidepressant Medication Management measures. MBHP also scored above the 75th percentile on an additional five measures, where MassHealth uses the Medicaid 75th percentile to reflect a minimum standard of performance. The remaining six measures rates were below the 75th percentile. The Initiation and Continuation of Follow-Up Care for Children Prescribed ADHD Medication rates were below the 25th national Medicaid percentile. **Table 9** displays the HEDIS PMs for MY 2021 for MBHP.

Table 9: MBHP HEDIS Performance Measures – MY 2021

HEDIS Measure	MBHP
Follow-Up Care for Children Prescribed ADHD Medication (Initiation)	33.16%
Follow-Up Care for Children Prescribed ADHD Medication (Continuation)	36.03%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	37.62%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.79%
Follow-Up After Emergency Department Visit for Mental Illness (7 days)	77.16%
Follow-Up After Emergency Department Visit for Mental Illness (30 days)	83.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	20.43%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	28.74%
Follow-Up After Hospitalization for Mental Illness (7 days)	48.80%
Follow-Up After Hospitalization for Mental Illness (30 days)	69.31%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (7 days)	44.59%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (30 days)	16.04%
Antidepressant Medication Management (Acute)	70.73%
Antidepressant Medication Management (Continuation)	56.94%

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

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

Objectives

The objective of the compliance 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).

MBHP's compliance with Medicaid and CHIP managed care regulations was evaluated by MassHealth's previous EQRO. The most current review was conducted in 2020 for contract year 2019. This section of the report summarizes the 2020 compliance results. The next comprehensive review will be conducted in 2023, 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 2019 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, MBHP was required to submit a corrective action plan (CAP) in a format agreeable to MassHealth. The scoring definitions are outlined in **Table 10**.

Table 10: Scoring Definitions

Scoring	Definition
Met = 1 point	Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and MBHP staff interviews provided information consistent with documentation provided.
Partially Met = 0.5 points	Any one of the following may be applicable: <ul style="list-style-type: none">• Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. MBHP 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 MBHP staff interviews provided information consistent with compliance with all requirements.

Scoring	Definition
	<ul style="list-style-type: none"> Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided, and MBHP 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 MBHP 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. MBHP was 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 MBHP 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 MBHP's most current accreditation review and scored the review element as "Met" if MBHP scored 100% on the accreditation review element.

Conclusions

The previous MassHealth's EQRO reviewed all documents that were submitted in support of the compliance validation process and conducted a virtual review on September 22–23, 2020. MBHP was compliant with many of the Medicaid and CHIP managed care regulations and standards. However, MBHP performed below 90% on the standards for Subcontractual Relationships and Delegation. MBHP's scores are displayed in **Table 11**.

Table 11: CFR Standards to State Contract Crosswalk – MBHP 2020 Compliance Validation Results

CFR Standard Name ¹	CFR Citation	MBHP
Overall compliance score		98.0%
Availability of Services	438.206	98.0%
Enrollee Rights and Protections	438.10	100%
Enrollment and Disenrollment	438.56	100%
Enrollee Information	438.10	96.0%
Assurances of Adequate Capacity and Services	438.207	100%
Coordination and Continuity of Care	438.208	100%
Coverage and Authorization of Services	438.210	96.8%
Provider Selection	438.214	100%
Confidentiality	438.224	100%
Grievance and Appeal Systems	438.228	93.4%
Subcontractual Relationships and Delegation	438.230	88.5%
Practice Guidelines	438.236	100%
Health Information Systems	438.242	100%
QAPI	438.330	98.4%

¹ The following compliance validation results were conducted by MassHealth's previous external quality review organization.

MBHP: Massachusetts Behavioral Health Partnership; CFR: Code of Federal Regulations; QAPI: Quality Assurance and Performance Improvement.

VI. Validation of Network Adequacy

Objectives

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

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

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

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. 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 MBHP's provider network.

Technical Methods of Data Collection and Analysis

IPRO evaluated MBHP's provider network to determine compliance with the travel time and distance standards established by MassHealth. MassHealth's standards for the duration of time between a request and a provision of services are displayed in **Table 12**, and the travel time and distance standards are displayed in **Table 13**.

Table 12 displays MassHealth's access standards for emergency services, Emergency Services Program (ESP), and urgent care services. These standards clarify the expected duration of time between a request and a provision of services based on the degree of urgency.

Table 12: MBHP Network Standards Consistent with the Degree of Urgency - Duration of Time Between a Request and a Provision of Services

MassHealth Network Standards – Duration of Time
Emergency Services
Immediately (respond to call with a live voice; face-to-face within 60 minutes) on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present for such services at any qualified provider, whether a network provider or a non-network provider.
Behavioral Health Services – Emergency Services Program Services
Immediately on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present for such services, including covered individuals, uninsured individuals and persons covered by Medicare only.
Behavioral Health Services – Urgent Care
Within 48 hours.
Behavioral Health Services – All Other
Within 14 calendar days, in accordance with usual and customary community standards.

MBHP: Massachusetts Behavioral Health Partnership

Table 13 displays MassHealth’s time travel and distance standards for inpatient services, ESP services, intensive care coordination and family support and training services, and other intensive home and community-based services. MBHP must ensure that at a minimum 90% of enrollees have access to these services within a specific travel time or a specific distance.

Table 13: MBHP Network Availability Standards – Travel Time or Distance Standards

MassHealth Network Standards – Travel Time or Distance
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.
All other BH covered services: within 30 miles or 30-minute travel time from the enrollee’s residence, whichever requires less travel time.

MBHP: Massachusetts Behavioral Health Partnership; ESP: Emergency Services Program; BH: behavioral health.

IPRO entered into an agreement with Quest Analytics™ to use the Quest Enterprise System (QES) to validate that MBHP’s provider network meets MassHealth’s standards. Network adequacy 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 template was 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 14** shows the travel time or distance standards used for analysis.

Table 14: MBHP Travel Time or Distance Standards Used for Analysis

Provider Type	Standard
Specialists	
Psych APN (PCNS or CNP) Psychiatry Psychology	90% of members have access to 2 providers within 30 miles or 30 minutes.
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	90% of members have access to 2 providers within 30 miles or 30 minutes.

Provider Type	Standard
BH Inpatient	
Managed Inpatient (Level 4) Psych Inpatient Adolescent, Adult, and Child	90% 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	90% of members have access to 2 providers within 30 miles or 30 minutes.
BH Outpatient	
Applied Behavior Analysis BH Outpatient Opioid Treatment Programs	90% of members have access to 2 providers within 30 miles or 30 minutes.

MBHP: Massachusetts Behavioral Health Partnership; Psych APN: psychiatric advanced nurse; PCNS: psychiatric clinical nurse specialist; CNP: certified nurse practitioner; CBAT-ICBAT-TCU: community-based acute treatment – intensive community-based acute treatment – transition care unit; SUD: substance use disorder; BH: behavioral health.

The analysis shows whether MBHP has a sufficient network of providers for all members residing in the same county. While the analysis is conducted for members who live in the same county, providers do not have to practice in that county; a provider must be available within a specified travel time or distance from the member’s residence, as defined in **Table 14**.

IPRO aggregated the results to identify counties with deficient networks. When MBHP appeared to have network deficiencies in a particular county, IPRO reported the percent of covered members in that county who did not have adequate access. When possible, IPRO also reported when there were available providers with whom MBHP 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 MBHP to IPRO. IPRO requested a complete specialists and behavioral health providers list which included facility/provider name, address, phone number, and the national provider identifier (NPI).

Conclusions

MBHP members reside in 14 counties. MBHP had adequate networks of 11 different provider types in all 14 counties. **Table 15** shows the number of counties with an adequate network of providers by provider type. ‘Met’ means that MBHP had an adequate network of that provider type in all counties.

Table 15: MBHP Adherence to Provider Time or Distance Standards

The number of counties where MBHP had an adequate network, per provider type. “Met” means that MBHP had an adequate network of that provider type in all 14 counties.

Provider Type	Standard – 90% of Members Have Access	MBHP
Total Number of Counties		14
Specialists		
Psych APN (PCNS or CNP)	2 providers within 30 miles or 30 minutes	13
Psychiatry	2 providers within 30 miles or 30 minutes	12
Psychology	2 providers within 30 miles or 30 minutes	Met
BH Diversionary		
CBAT-ICBAT-TCU	2 providers within 30 miles or 30 minutes	4
Clinical Support Services for SUD (Level 3.5)	2 providers within 30 miles or 30 minutes	5
Community Support Program	2 providers within 30 miles or 30 minutes	Met
Intensive Outpatient Program	2 providers within 30 miles or 30 minutes	12
Monitored Inpatient Level 3.7	2 providers within 30 miles or 30 minutes	6
Partial Hospitalization Program	2 providers within 30 miles or 30 minutes	11
Program of Assertive Community Treatment	2 providers within 30 miles or 30 minutes	6
Psychiatric Day Treatment	2 providers within 30 miles or 30 minutes	4
Recovery Coaching	2 providers within 30 miles or 30 minutes	Met
Recovery Support Navigators	2 providers within 30 miles or 30 minutes	Met
Residential Rehabilitation Services for SUD (Level 3.1)	2 providers within 30 miles or 30 minutes	12
Structured Outpatient Addiction Program	2 providers within 30 miles or 30 minutes	11
BH Inpatient		
Managed Inpatient (Level 4)	2 providers within 60 miles or 60 minutes	6
Psych Inpatient Adolescent	2 providers within 60 miles or 60 minutes	Met
Psych Inpatient Adult	2 providers within 60 miles or 60 minutes	Met
Psych Inpatient Child	2 providers within 60 miles or 60 minutes	Met
BH Intensive Community Treatment		
In-Home Behavioral Services	2 providers within 30 miles or 30 minutes	12
In-Home Therapy Services	2 providers within 30 miles or 30 minutes	Met
Therapeutic Mentoring Services	2 providers within 30 miles or 30 minutes	Met
BH Outpatient		
Applied Behavior Analysis	2 providers within 30 miles or 30 minutes	12
BH Outpatient	2 providers within 30 miles or 30 minutes	Met
Opioid Treatment Programs	2 providers within 30 miles or 30 minutes	Met

MBHP: Massachusetts Behavioral Health Partnership; 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.

A detailed analysis of network deficiencies is presented in **Table 16**. If at least 90% of MBHP members in one county had adequate access, then the network availability standard was met. But if less than 90% of members in one county had adequate access, then the network was deficient. **Table 16** 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 MBHP to pass an access requirement. “Increase” represents an available provider that would increase access, but MBHP would continue to remain below the access requirement.

Table 16: MBHP Counties with Network Deficiencies by Provider Type

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access	Deficiency Fillable by an Available Provider?
Specialists				
Psych APN (PCNS or CNP)	Nantucket	0%	2 providers within 30 miles or 30 minutes	Increase
Psychiatry	Berkshire	82.8%	2 providers within 30 miles or 30 minutes	Yes
	Nantucket	0%	2 providers within 30 miles or 30 minutes	Increase
BH Diversionary				
CBAT-ICBAT-TCU	Barnstable	17.1%	2 providers within 30 miles or 30 minutes	No
	Berkshire	0%	2 providers within 30 miles or 30 minutes	No
	Dukes	0.6%	2 providers within 30 miles or 30 minutes	No
	Essex	47%	2 providers within 30 miles or 30 minutes	No
	Franklin	0%	2 providers within 30 miles or 30 minutes	No
	Hampden	0%	2 providers within 30 miles or 30 minutes	No
	Hampshire	0%	2 providers within 30 miles or 30 minutes	No
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
	Plymouth	76.9%	2 providers within 30 miles or 30 minutes	No
	Worcester	61.9%	2 providers within 30 miles or 30 minutes	No
Clinical Support Services for SUD (Level 3.5)	Barnstable	62.8%	2 providers within 30 miles or 30 minutes	Increase
	Berkshire	0%	2 providers within 30 miles or 30 minutes	Increase
	Essex	61.5%	2 providers within 30 miles or 30 minutes	Yes
	Franklin	0%	2 providers within 30 miles or 30 minutes	Increase
	Hampden	4.2%	2 providers within 30 miles or 30 minutes	Yes
	Hampshire	11.5%	2 providers within 30 miles or 30 minutes	Yes
	Middlesex	89.2%	2 providers within 30 miles or 30 minutes	Yes
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
	Worcester	85.7%	2 providers within 30 miles or 30 minutes	No
Intensive Outpatient Program	Dukes	76.2%	2 providers within 30 miles or 30 minutes	No
	Nantucket	3.6%	2 providers within 30 miles or 30 minutes	No
Monitored Inpatient (Level 3.7)	Barnstable	8.1%	2 providers within 30 miles or 30 minutes	Increase
	Berkshire	0%	2 providers within 30 miles or 30 minutes	Increase
	Dukes	0.6%	2 providers within 30 miles or 30 minutes	Yes
	Franklin	0%	2 providers within 30 miles or 30 minutes	Increase
	Hampden	4.2%	2 providers within 30 miles or 30 minutes	Yes
	Hampshire	11.5%	2 providers within 30 miles or 30 minutes	Yes
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
	Worcester	84.2%	2 providers within 30 miles or 30 minutes	No
Partial Hospitalization Program	Berkshire	5.5%	2 providers within 30 miles or 30 minutes	No
	Dukes	22.5%	2 providers within 30 miles or 30 minutes	No
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access	Deficiency Fillable by an Available Provider?
Program of Assertive Community Treatment	Berkshire	0.1%	2 providers within 30 miles or 30 minutes	No
	Bristol	41.7%	2 providers within 30 miles or 30 minutes	No
	Dukes	0.6%	2 providers within 30 miles or 30 minutes	No
	Essex	86.2%	2 providers within 30 miles or 30 minutes	No
	Hampden	17.5%	2 providers within 30 miles or 30 minutes	No
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
	Norfolk	89.8%	2 providers within 30 miles or 30 minutes	No
	Worcester	87.5%	2 providers within 30 miles or 30 minutes	No
Psychiatric Day Treatment	Barnstable	16.1%	2 providers within 30 miles or 30 minutes	No
	Berkshire	0%	2 providers within 30 miles or 30 minutes	No
	Bristol	68.5%	2 providers within 30 miles or 30 minutes	No
	Dukes	0.6%	2 providers within 30 miles or 30 minutes	No
	Franklin	0%	2 providers within 30 miles or 30 minutes	No
	Hampden	0%	2 providers within 30 miles or 30 minutes	No
	Hampshire	0%	2 providers within 30 miles or 30 minutes	No
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
	Plymouth	82.2%	2 providers within 30 miles or 30 minutes	No
	Worcester	47.9%	2 providers within 30 miles or 30 minutes	No
Residential Rehabilitation Services for SUD (Level 3.1)	Barnstable	73.8%	2 providers within 30 miles or 30 minutes	Increase
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
Structured Outpatient Addiction Program	Barnstable	88.7%	2 providers within 30 miles or 30 minutes	No
	Berkshire	23.2%	2 providers within 30 miles or 30 minutes	No
	Nantucket	0%	2 providers within 30 miles or 30 minutes	No
BH Inpatient				
Managed Inpatient (Level 4)	Barnstable	11.8%	2 providers within 60 miles or 60 minutes	Increase
	Berkshire	0%	2 providers within 60 miles or 60 minutes	No
	Dukes	0%	2 providers within 60 miles or 60 minutes	Increase
	Essex	88.4%	2 providers within 60 miles or 60 minutes	No
	Franklin	10.9%	2 providers within 60 miles or 60 minutes	No
	Hampden	17.5%	2 providers within 60 miles or 60 minutes	No
	Hampshire	47.7%	2 providers within 60 miles or 60 minutes	No
	Nantucket	0%	2 providers within 60 miles or 60 minutes	No
BH Intensive Community Treatment				
In-Home Behavioral Services	Dukes	12.5%	2 providers within 30 miles or 30 minutes	No
	Nantucket	3.6%	2 providers within 30 miles or 30 minutes	No
BH Outpatient				
Applied Behavior Analysis	Berkshire	82.2%	2 providers within 30 miles or 30 minutes	Increase
	Nantucket	0%	2 providers within 30 miles or 30 minutes	Increase

MBHP: Massachusetts Behavioral Health Partnership; 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.

Recommendations

- IPRO recommends that MBHP expands its network when a deficiency can be closed by an available, single provider for the provider types and counties identified in **Table 17**.
- IPRO recommends that MBHP expands its network when member's access can be increased by available providers for the provider types and counties identified in **Table 17**.
- When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those counties.

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

Objectives

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

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

Technical Methods of Data Collection and Analysis

MBHP contracted with SPH Analytics to administer the survey. The standardized survey tool assesses member experience with specialty behavioral health care, including mental health and chemical dependency services. MBHP designed the survey tool, which was redesigned in 2019 and 2020 to enhance its readability. For MY 2021, MBHP included additional questions about members' telehealth experience. The survey is organized across six different categories. **Table 17** provides a list of all six survey categories.

Table 17: MBHP Member Satisfaction Survey Categories

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

The sample frame included members randomly selected from MBHP's outpatient population. SPH Analytics selected a random sample of 7,000 members who had a claim between the third quarter of 2020 through the end of the second quarter of 2021. Members receive a mail packet including a cover letter, mail survey, and business return envelope. Three weeks after the initial mailing, SHP reached out to nonrespondents by phone. Language line assistance was provided when requested. **Table 18** provides a summary of the technical methods of data collection.

Table 18: MBHP Member Satisfaction Survey – Technical Methods of Data Collection, MY 2021

MBHP Member Satisfaction Survey – Technical Methods of Data Collection	
Survey vendor	SPH Analytics
Survey tool	MBHP's Member Satisfaction Survey
Survey timeframe	November 2021 through January 2022
Method of collection	Mail and telephone
Sample size	7,000
Response rate	5.7%

Description of Data Obtained

IPRO received a copy of the MY 2021 *MBHP Member Experience Annual Report* produced for Beacon Health Options. The report included descriptions of the project objectives and methodology, as well as survey results and analyses.

Conclusions

To determine MBHP's strengths and opportunities for improvement, IPRO compared the survey results to the benchmark goals set by MBHP. Measures performing above the goal were considered strengths; measures performing at the same level as the goal were considered average; and measures performing below the goal were identified as opportunities for improvement, as explained in **Table 19**.

Table 19: Color Key for MBHP Member Satisfaction Performance Measure Comparison to the Benchmark Goal

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

Table 20 displays the results of the 2022 MBHP Member Experience Survey for MY 2021. In the Appointment Access category, all results were below the benchmark goal. In the Appointment Availability category, the one measure in this category exceeded the goal. In the Acceptability of MBHP Practitioners category, five measures exceeded the goal. In the Acceptability of Telehealth Services category, goals were not identified. In the Scope of Service category, four measures exceeded the goal. And in the Experience of Care category, one measure exceeded the goal.

Table 20: MBHP Member Satisfaction Survey Performance, MY 2021

Member Experience MBHP Measure	MBHP	Benchmark Goal
Appointment Access		
When you needed non-life-threatening Emergency Care, did you have to wait? (Answer key: less than 6 hours)	68.10%	≥ 85%
When you needed Urgent Care, when was the earliest appointment that was offered to you? (Answer key: an appointment within 24 hours or an appointment between 25 to 48 hours)	84.90%	≥ 85%
When you had a first-time appointment, when was the earliest appointment that was offered to you? (Answer key: an appointment within 10 business days)	60.80%	≥ 85%
Appointment Availability		
In the last 12 months, how often were treatment locations close enough for you? (Answer key: always or usually)	86.50%	≥ 80%
Acceptability of MBHP Practitioners		
In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas?		
1. Language? (Answer key: always or usually)	91.90%	≥ 85%
2. Communication? (Answer key: always or usually)	91.00%	≥ 85%
3. Religious? (Answer key: usually or always)	69.50%	≥ 85%
4. Cultural? (Answer key: usually or always)	73.30%	≥ 85%
In the last 12 months, how often were those you saw for counseling or treatment just right for your needs? (Answer key: always or usually)	84.80%	≥ 85%
How satisfied are you with all your counseling or treatment in the last 12 months? (Answer key: very satisfied or somewhat satisfied)	91.00%	≥ 85%
In the last 12 months, have you stayed overnight in a hospital or facility for any mental health or substance use services? (Answer key: yes)	88.20%	≥ 85%
Do you feel the number of days approved for your stay was enough? (Answer key: yes)	76.50%	≥ 80%

Member Experience MBHP Measure	MBHP	Benchmark Goal
How satisfied are you with the ease of getting needed mental health or substance use care in the last 12 months? (Answer key: very satisfied or somewhat satisfied)	88.30%	≥ 85%
Acceptability of Telehealth Services		
In the last 12 months, have you had any services via telehealth? (Answer key: yes)	80.90%	N/A
1. Existing provider (previously providing in-person service)	75.30%	N/A
2. New provider	17.20%	N/A
3. MD Live	1.30%	N/A
4. Other	6.30%	N/A
How did you receive the telehealth service?		
1. Video/Audio (by smartphone or tablet/computer)	50.00%	N/A
2. Audio only (landline or cell phone)	50.00%	N/A
How satisfied are you with the following? (Answer key: very satisfied or somewhat satisfied)		
1. Overall satisfaction with telehealth	94.40%	N/A
2. Scheduling your telehealth visit	96.00%	N/A
3. Help you were given in preparing for your telehealth visit	95.80%	N/A
4. Session length	93.50%	N/A
5. Call quality	91.00%	N/A
6. Effectiveness of telehealth compared to in-person services	86.80%	N/A
7. Usefulness of telehealth	94.40%	N/A
8. Communication about next steps following telehealth visit and/or treatment plan	95.00%	N/A
Which of the following apply to your experience? (Select all that apply)		
1. I did not have a hard time using telehealth	86.00%	N/A
2. Not having access to needed technology to participate	4.20%	N/A
3. Not having access to internet/WI-FI connection	3.80%	N/A
4. Unable to get needed services in preferred language	0.00%	N/A
5. Other reasons it was not easy using telehealth services	6.00%	N/A
How would you like to receive future services?		
1. In-person	22.10%	N/A
2. Telehealth	23.00%	N/A
3. Combination of in-person and telehealth	48.80%	N/A
4. No opinion/Not applicable	6.20%	N/A
How likely are you to recommend telehealth to a friend? (Answer key: 6 to 10)	87.50%	N/A
Scope of Service		
In the last 12 months, have you called MBHP for any reason? (Answer key: yes)	24.00%	N/A
How many calls to a MBHP staff member did it take to get all the information you needed? (Answer key: one or two)	73.90%	≥ 80%
How often were MBHP staff member(s) as polite and respectful as you thought they should be? (Answer key: always or usually)	90.40%	≥ 85%
How often did MBHP staff member(s) give you all the information or help you needed? (Answer key: always or usually)	80.90%	≥ 85%
How satisfied are you with the quality of services you got from MBHP staff member(s)? (Answer key: very satisfied or somewhat satisfied)	91.20%	≥ 85%

Member Experience MBHP Measure	MBHP	Benchmark Goal
Did you need help from MBHP to speak or write in your preferred language? (Answer key: yes)	6.40%	N/A
Did MBHP give you that help? (Answer key: yes)	80.00%	≥ 85%
In the last 12 months, did you call MBHP to find a provider such as a therapist, counselor, or psychiatrist? (Answer key: yes)	53.90%	N/A
When you called to find a provider, was it a life-threatening emergency? (Answer key: yes)	8.20%	N/A
After you called MBHP, did you have a hard time finding a provider for any of the following reasons? Select all that apply.		
1. Outdated provider listings	10.60%	N/A
2. Provider no longer takes your insurance	10.60%	N/A
3. Provider is not close enough to where you live or work	7.60%	N/A
4. Provider is not taking new patients	15.20%	N/A
5. Providers' office hours do not work for your schedule	4.50%	N/A
6. Provider is not a good fit for your needs	3.00%	N/A
7. Provider does not speak my language	0%	N/A
8. Other reasons it was hard to find a provider: please specify	12.10%	N/A
9. I did not have a hard time finding a provider	36.40%	N/A
How satisfied are you with the quality of service you got when you called MBHP to find a provider? (Answer key: very satisfied or somewhat satisfied)	83.30%	≥ 85%
How satisfied are you with services you get from MBHP? (Answer key: very satisfied or somewhat satisfied)	92.90%	≥ 85%
How likely would you be to recommend MBHP to your family and friends? (Answer key: very likely or somewhat likely)	93.80%	≥ 85%
Experience of Care		
In the last 12 months, did you get counseling, treatment, or medicine for any of these reasons? (Answer key: yes)	76.70%	N/A
In the last 12 months, did you take any medicine as part of your treatment? (Answer key: yes)	84.70%	N/A
Did those you saw for counseling or treatment tell you what side effects of those medicines to watch for? (Answer key: yes)	82.70%	≥ 85%
Compared to 12 months ago, how would you rate your problems or symptoms? (Answer key: much better or a little better)	73.00%	N/A
In the last 12 months, how much were you helped by the counseling or treatment you had? (Answer key: a lot or somewhat)	91.30%	≥ 85%
A personal doctor is a doctor you see for your physical health. In the last 12 months, how often did your personal doctor seem to know about the counseling or treatment you had? (Answer key: always or usually)	77.10%	≥ 80%
In the last 12 months, how often did those you have seen for counseling and treatment seem to know about the care you had from medical doctors? (Answer key: always or usually)	76.10%	≥ 80%

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,⁷ PAHP,⁸ or PCCM entity has effectively addressed the recommendations for QI⁹ made by the EQRO during the previous year’s EQR.” Table 21 display the MBHP’s responses to the recommendations for QI made during the previous EQR, as well as IPRO’s assessment of these responses.

Table 21: MBHP Response to Previous EQR Recommendations

Recommendation for MBHP	MBHP Response/Actions Taken	I PRO Assessment of MCP Response ¹
PIP 1 Access-Related: To track differences in subpopulation management, MBHP’s member racial and ethnic background will be included in reports to guide prioritization of interventions by subpopulations. Kepro recommends developing population-specific strategies for outreach to increase follow up for SUD after ED visits. Access-Related: Kepro recommends including other socioeconomic factors that might have significant impact on ED utilization and follow-up visit attendance such as housing/homelessness, poverty, lack of transportation, and access to technology for virtual visits such as phones or tablets. Speaking a language other than English should also be included.	MBHP has initiated a comprehensive approach to capture additional socioeconomic factors in its operations. Specifically, in 2023 MBHP has a goal of capturing 80% of all MBHP Member’s race and ethnicity. In addition, the clinical team has adopted a new module to capture additional socioeconomic factors such as Member’s economic background, housing status, past experiences with treatment and ability to utilize telemedicine to better manage aspects of their specific recovery plan. Because of this additional information available to the Quality Department, it will be possible to create specific interventions to focus on specific member populations.	Addressed
PIP 2 Access-Related: Kepro notes that, in this PIP, MBHP is focusing on just 0.7% (N=4,649) of its total member population (N=609,409). Stated differently, MBHP is not taking any action in this PIP to support its other 604,760 members with respect to accessing behavioral health services through telehealth platforms. With respect to improving telehealth access, MBHP’s executive committee should consider options for broadening this PIP to engage a broader portion of its membership.	MBHP clarified the scope of this initiative in subsequent meetings with Kepro. As noted in the description of the PIP, MassHealth formulated the telehealth initiative in the context of Member discharges from inpatient psychiatric care, specifically the HEDIS FUH measure, which captures the rate of successful 7-day and 30-day follow-up after psychiatric inpatient discharge. The aim of the initiative is to increase the percentage of successful visits conducted via telehealth. The number 4,649 only represents the baseline denominator for the indicator, specifically those Members who accomplished a successful visit following their acute psychiatric inpatient stay. However, the primary intervention being implemented (inpatient staff reporting on whether a follow-up outpatient telehealth appointment has been scheduled) is being applied to all	Partially addressed

⁷ Prepaid inpatient health plan.

⁸ Prepaid ambulatory health plan.

⁹ Quality improvement.

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response ¹
	inpatient discharges (>10,000 Members annually). Further, MBHP implemented an intervention to increase telehealth capacity in the outpatient setting. Specifically, MBHP added four providers who were able to offer Open Access (same day appointments) via telehealth, representing 16,311 telehealth visits during Q1, 2022.	
Compliance 1: MBHP should review and update its policies and procedures to ensure compliance with all federal and MassHealth standards that were identified as deficient as part of the review.	MBHP provided updates about 14 policies. All policies and processes were updated.	Addressed
Compliance 2: MBHP should review its member letter templates and ensure that the templates and customized language is well-written and in a manner that is easily understood.	In regards to Policy CM 1: Medical Necessity Determinations and Policy CM 21: Internal Member Appeals and Board of Hearing Appeals, it was cited that an enrollee did not always easily understand the notice of action (NOA). MBHP now ensures that NOAs meet the language and format requirements that an enrollee will easily understand. In addition, MBHP has developed a process to ensure NOAs meet the language and format requirements that the enrollee easily understands. In addition, MBHP performs monthly audits on the process to ensure that it is meeting the needs of the enrollees.	Addressed
Compliance 3: MBHP needs to improve its grievance process to ensure timely acknowledgement of the grievance, action, and resolution as related to non-quality of care issues.	In regards to CM21- Member Appeals and QM 309- Grievances, in which it was cited that while MBHP had a policy and procedure for handing grievance and appeals, including the process to provide written notice of the reason for a delay in grievance or appeal resolution; however, the policy lacked inclusion of the 2-calendar day timeframe. MBHP responds that it has revised its policies and procedures to include the 2-calendar day timeframe for written notice when a grievance or appeal extension is taken to notify the Enrollee of the delay.	Addressed
Compliance 4: MBHP needs to revise its geo-access reporting to meet MassHealth standards for accessibility.	Massachusetts Behavioral Health Partnership, (MBHP), assesses its provider network to ensure there is adequate availability of practitioners and providers based on membership. An analysis is conducted to identify network gaps, and based on those gaps, recruitment plans may be implemented. Two types of measures are used to evaluate accessibility: <ul style="list-style-type: none"> Geographic accessibility of practitioners/organizational providers-to-members, specifically Urban: 1 provider within 15 miles or 15 minutes of residence, Suburban: 1 provider within 25 miles or 25 minutes of residence and Rural: 1 provider within 45 miles or 45 minutes of residence. 	Partially addressed

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response ¹
	<ul style="list-style-type: none"> o Numeric ratio of practitioners/organizational providers-to-members, specifically 1 provider for every 1,000 – 10,000 members (depending on the specialty.) 	
<p>Network 1: Kepro recommends that MBHP contract with additional providers in Nantucket County, as available, for those services not meeting requirements including, but not limited to In-Home Behavioral Services, Psychiatric Day Treatment, and both physician- and advanced practice nurse-level Psychiatry.</p>	<p>In regards to the recommendation, that MBHP contract with additional providers in Nantucket county, as available, MBHP responds that we contract with services that are available in Nantucket which are limited. This continues to be an issue but are hindered by the actual availability of providers on the island. What we feel has greatly increased the ability of MBHP members to receive services is the expansion of Telehealth. Specifically, the use of telehealth as the type of visit that accounted for timely 7 and 30-day follow-up, increased by 35.24% (7 day) and 33.002% (30) between 2020 and 2021. In addition, Members who used telehealth for their appointment within 7 days of discharge from inpatient service increased from 38.05 percent in 2020 to 51.56 percent in 2021. This represents a 35.24 percent increase in utilization of telehealth as a modality for follow-up care within 7 days. Members who used telehealth for their appointment within 30 days of discharge from inpatient service increased from 41.70 percent in 2020 to 55.47 percent in 2021. This represents a 33.02 percent increase in utilization of telehealth as a modality for follow-up care within 30 days.</p>	Partially addressed
<p>Network 2: Specific to substance use disorder services, Kepro recommends that MBHP expand its geographic coverage of substance use disorder (SUD) Residential Rehabilitation Services, SUD Clinical Support Services, Monitored Inpatient Level 3.7 providers, and Managed Inpatient Level 4 services.</p>	<p>In 2021, specific to substance use disorder services, MBHP successfully expanded its geographic coverage of substance use disorder (SUD) Residential Rehabilitation Services, SUD Clinical Support Services, Monitored Inpatient Level 3.7 providers, and Managed Inpatient Level 4 services.</p> <p>For the entire state of Massachusetts, each cited SUD provider type mentioned in the network adequacy validation met MBHP's internal goal of 95% for geographic availability as well as successfully meeting MBHP's internal goal of 100% for numeric density.</p>	Partially addressed
<p>Network 3: Kepro recommends that MBHP fill other network gaps as identified where possible.</p>	<p>In 2021, 736 additional providers were recruited to the MBHP network to close network gaps and improve accessibility. Furthermore, MBHP recruited prescribers, psychiatrists, and other providers based on specific specialty, cultural/linguistic, and geographic needs. Specific recruitment in 2021 included:</p> <ul style="list-style-type: none"> • 45 MD/DO/Prescribers • 15 PhD Services • 138 Master Level Clinicians • 2 Inpatient Mental Health • 18 Inpatient Substance Abuse 	Partially addressed

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response ¹
	<ul style="list-style-type: none"> • 2 Residential • 39 Partial Hospital Mental Health • 39 Partial Hospital Substance Abuse • 20 IOP Mental Health • 22 IOP Substance Abuse • 41 Outpatient Mental Health 	

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. MBHP: Massachusetts Behavioral Health Partnership; MCP: managed care plan; EQR: external quality review; SUD: substance use disorder; ED: emergency department; N: number; PIP: performance improvement project; HEDIS: Health Effectiveness Data and Information Set; Q: quarter; CM: care management; QM: quality management; FUH: Follow-Up After Hospitalization for Mental Illness.

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

Table 22 highlight MBHP's performance strengths, opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of CY 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 22: MBHP Strengths, Opportunities for Improvement, and EQR Recommendations

MBHP	Strengths	Weaknesses	Recommendations	Standards
Performance improvement projects				
PIP 1: FUA	No strengths were identified.	No weaknesses were identified.	None.	Quality, Timeliness, Access
PIP 2: Telehealth	Telehealth utilization rates improved between 2020 and 2021. Interventions coincide with increases in the FUH 7 and 30 days measures.	It is hard to know whether the increase is a result of improved coding practices or utilization. A significant cohort of members prefer 'in-person' for follow-up after hospitalization.	The plan has identified that members prefer in-person visits. The plan should look at the in-person follow-up visit rate as well as telehealth rate.	Quality, Timeliness
Performance measures				
NCQA measures	<p>MBHP demonstrated compliance with IS standards. No issues were identified.</p> <p>MBHP HEDIS rates were above the 90th national Medicaid percentile of the NCQA Quality Compass on the following measures:</p> <ul style="list-style-type: none"> Follow-Up After Emergency Department Visit for Mental Illness (7 day) Follow-Up After Emergency Department Visit for Mental Illness (30 day) 	<p>MBHP HEDIS rates were below the 25th percentile for the following measures:</p> <ul style="list-style-type: none"> Follow-Up Care for Children Prescribed ADHD Medication (initiation) Follow-Up Care for Children Prescribed ADHD Medication (continuation) 	MBHP should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access

MBHP	Strengths	Weaknesses	Recommendations	Standards
	<ul style="list-style-type: none"> Antidepressant Medication Management (continuation) 			
Compliance review				
	<p>Overall, MBHP demonstrated compliance with most of the federal and State contractual standards. MBHP performed best in areas that related to the quality of care and services.</p> <p>The EQRO found this model to be a best practice for the integration of physical and behavioral health services. This was a consistent finding from the prior review period.</p> <p>Overall, MBHP's quality program was comprehensive and had good alignment with many of MassHealth's quality strategy aims.</p> <p>MBHP made a system enhancement in 2019 to use InterQual criteria for its coverage and authorization decisions. The transition was well-received from the provider community and supports services being provided consistent with medical necessity criteria. In addition, MBHP's use of peer-to-peer consultation and documentation was noted as a</p>	<p>While MBHP performed provider access analysis, the review showed that its analysis did not meet MassHealth's requirement to ensure a choice of at least two behavioral health providers. Therefore, the EQRO was not able to fully access network accessibility.</p>	<p>MBHP needs to revise its geo-access reporting to meet MassHealth standards for accessibility.</p>	<p>Timeliness, Access</p>

MBHP	Strengths	Weaknesses	Recommendations	Standards
	<p>strength. This process appears to support a more collaborative decision between MBHP and treating providers related to coverage decisions and appropriate level-of-care.</p> <p>MBHP demonstrated ongoing efforts related to care coordination with emphasis on transitions of care. In general, the EQRO found that MBHP addressed opportunities for improvement from the prior compliance review.</p>			
Network adequacy				
	<p>MBHP provides services across all 14 counties in Massachusetts. MBHP demonstrated adequate networks for 11 out of 25 provider types in all its counties.</p>	<p>Access was assessed for a total of 25 provider types. MBHP had deficient networks for 14 provider types:</p> <ul style="list-style-type: none"> • Psych APN (PCNS or CNP) • Psychiatry • CBAT-ICBAT-TCU • Clinical Support Services for SUD (Level 3.5) • Intensive Outpatient Program • Monitored Inpatient (Level 3.7) • Partial Hospitalization Program • Program of Assertive Community Treatment • Psychiatric Day Treatment • RRS for SUD (Level 3.1) • Structured Outpatient Addiction Program • Managed Inpatient (Level 4) • In-Home Behavioral Services • Applied Behavior Analysis 	<p>MBHP should expand its network when members' access can be improved and when network deficiencies can be closed by available providers.</p> <p>When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those counties.</p>	<p>Access, Timeliness</p>

MBHP	Strengths	Weaknesses	Recommendations	Standards
Quality-of-care surveys				
	<p>MBHP scored above the benchmark goal set by MassHealth on the 11 following measures:</p> <p>Appointment Availability</p> <ul style="list-style-type: none"> In the last 12 months, how often were treatment locations close enough for you? (Answer key: always or usually) <p>Acceptability of MBHP practitioners</p> <ul style="list-style-type: none"> In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? Language? (Answer key: always or usually) In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? Communication? (Answer key: always or usually) How satisfied are you with all your counseling or treatment in the last 12 months? (Answer key: very satisfied or somewhat satisfied) In the last 12 months, have you stayed overnight in a hospital or facility for any 	<p>MBHP scored below the benchmark goal set by MassHealth on the 14 following measures:</p> <p>Appointment Access</p> <ul style="list-style-type: none"> When you needed non-life-threatening Emergency Care, did you have to wait? (Answer key: less than 6 hours) When you needed Urgent Care, when was the earliest appointment that was offered to you? (Answer key: an appointment within 24 hours or an appointment between 25 to 48 hours) When you had a first-time appointment, when was the earliest appointment that was offered to you? (Answer key: an appointment within 10 business days) <p>Acceptability of MBHP practitioners</p> <ul style="list-style-type: none"> In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? c. Religious? (Answer key: usually or always) In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? d. Cultural? (Answer key: usually or always) 	<p>MBHP should utilize the results of the Member Satisfaction Survey to drive performance improvement as it relates to member experience.</p>	<p>Quality, Timeliness, Access</p>

MBHP	Strengths	Weaknesses	Recommendations	Standards
	<p>mental health or substance use services? (Answer key: yes)</p> <ul style="list-style-type: none"> How satisfied are you with the ease of getting needed mental health or substance use care in the last 12 months? (Answer key: very satisfied or somewhat satisfied) <p>Scope of Service</p> <ul style="list-style-type: none"> How often were MBHP staff member(s) as polite and respectful as you thought they should be? (Answer key: always or usually) How satisfied are you with the quality of services you got from MBHP staff member(s)? (Answer key: very satisfied or somewhat satisfied) How satisfied are you with services you get from MBHP? (Answer key: very satisfied or somewhat satisfied) How likely would you be to recommend MBHP to your family and friends? (Answer key: very likely or somewhat likely) <p>Experience of Care</p> <ul style="list-style-type: none"> In the last 12 months, how much were you helped by 	<ul style="list-style-type: none"> In the last 12 months, how often were those you saw for counseling or treatment just right for your needs? (Answer key: always or usually) Do you feel the number of days approved for your stay was enough? (Answer key: yes) <p>Scope of Service</p> <ul style="list-style-type: none"> How many calls to a MBHP staff member did it take to get all the information you needed? (Answer key: one or two) How often did MBHP staff member(s) give you all the information or help you needed? (Answer key: always or usually) Did MBHP give you that help? (Answer key: yes) How satisfied are you with the quality of service you got when you called MBHP to find a provider? (Answer key: very satisfied or somewhat satisfied) <p>Experience of Care</p> <ul style="list-style-type: none"> Did those you saw for counseling or treatment tell you what side effects of those medicines to watch for? (Answer key: yes) A personal doctor is a doctor you see for your physical 		

MBHP	Strengths	Weaknesses	Recommendations	Standards
	the counseling or treatment you had? (Answer key: always or usually)	<p>health. In the last 12 months, how often did your personal doctor seem to know about the counseling or treatment you had? (Answer key: always or usually)</p> <ul style="list-style-type: none"> In the last 12 months, how often did those you have seen for counseling and treatment seem to know about the care you had from medical doctors? (Answer key: always or usually) 		

MBHP: Massachusetts Behavioral Health Partnership; EQR: external quality review; PIP: performance improvement project; IS: Information systems; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; ADHD: attention deficit hyperactivity disorder; EQRO: external quality review organization; Psych APN: psychiatric advanced nurse; PCNS: psychiatric clinical nurse specialist; CNP: certified nurse practitioner; CBAT-ICBAT-TCU: community-based acute treatment - intensive community-based acute treatment - transition care unit; SUD: substance use disorder; RRS for SUD: Residential Rehabilitation Services for Substance Use Disorder; FUH: Follow-Up After Hospitalization for Mental Illness. FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.

X. Required Elements in EQR Technical Report

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

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

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

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

Elements required in EQR technical report, including the requirements for the PIP validation, PMV, and review of compliance activities, are listed in the **Table 23**.

Table 23: Required Elements in EQR Technical Report

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

Regulatory Reference	Requirement	Location in the EQR Technical Report
<i>Title 42 CFR § 438.364(a)(4)</i>	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy, under <i>Title 42 CFR § 438.340</i> , to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP beneficiaries.	Recommendations for how the state can target goals and objectives in the quality strategy are included in Section I, High-Level Program Findings and Recommendations , as well as when discussing strengths and weaknesses of the MBHP or activity and when discussing the basis of performance measures or PIPs.
<i>Title 42 CFR § 438.364(a)(5)</i>	The technical report must include methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities.	Methodologically appropriate, comparative information about the MBHP is included across the report in each EQR activity section (Sections III–VII) and in Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations .
<i>Title 42 CFR § 438.364(a)(6)</i>	The technical report must include an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	See Section VIII. MCP Responses to the Previous EQR Recommendations for the prior year findings and the assessment of MBHP's approach to addressing the recommendations issued by the EQRO in the previous year's technical report.
<i>Title 42 CFR § 438.364(d)</i>	The information included in the technical report must not disclose the identity or other protected health information of any patient.	The information included in this technical report does not disclose the identity or other PHI of any patient.
<i>Title 42 CFR § 438.364(a)(2)(iiv)</i>	The technical report must include the following for each of the mandatory activities: objectives, technical methods of data collection and analysis, description of data obtained including validated performance measurement data for each PIP, and conclusions drawn from the data.	Each EQR activity section describes the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.
<i>Title 42 CFR § 438.358(b)(1)(i)</i>	The technical report must include information on the validation of PIPs that were underway during the preceding 12 months.	This report includes information on the validation of PIPs that were underway during the preceding 12 months; see Section III .
<i>Title 42 CFR § 438.330(d)</i>	The technical report must include a description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle.	The report includes a description of PIP interventions associated with each state-required PIP topic; see Section III .
<i>Title 42 CFR § 438.358(b)(1)(ii)</i>	The technical report must include information on the validation of each MCO's, PIHP's, PAHP's, or PCCM entity's performance measures for each MCO, PIHP, PAHP, and PCCM entity performance measure calculated by the state during the preceding 12 months.	This report includes information on the validation of MBHP's performance measures; see Section IV .
<i>Title 42 CFR § 438.358(b)(1)(iii)</i>	Technical report must include information on a review, conducted within the previous three-year period, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in Title 42 CFR § 438.330. The technical report must provide MCP results for the 11 Subpart D and QAPI standards.	This report includes information on a review, conducted in 2020, to determine MBHP's compliance with the standards set forth in Subpart D and the QAPI requirements described in <i>Title 42 CFR § 438.330</i> ; see 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)	<p>Groups of primary care providers working with one managed care organization to create a full network of providers.</p> <ul style="list-style-type: none"> Population: Managed care eligible Medicaid members under 65 years of age. Managed Care Authority: 1115 Demonstration Waiver. 	<ol style="list-style-type: none"> AllWays Health Partners, Inc & Merrimack Valley ACO Boston Medical Center Health Plan & Boston Accountable Care Organization, WellSense Community Alliance ACO Boston Medical Center Health Plan & Mercy Health Accountable Care Organization, WellSense Mercy Alliance ACO Boston Medical Center Health Plan & Signature Healthcare Corporation, WellSense Signature Alliance ACO Boston Medical Center Health Plan & Southcoast Health Network, WellSense Southcoast Alliance ACO Fallon Community Health Plan & Health Collaborative of the Berkshires Fallon Community Health Plan & Reliant Medical Group (Fallon 365 Care) Fallon Community Health Plan & Wellforce Health New England & Baystate Health Care Alliance, Be Healthy Partnership Tufts Health Public Plan & Atrius Health Tufts Health Public Plan & Boston Children's Health Accountable Care Organization Tufts Health Public Plan & Beth Israel Deaconess Care Organization Tufts Health Public Plan & Cambridge Health Alliance
Primary care accountable care organization (PC ACO)	<p>Groups of primary care providers forming an ACO that works directly with MassHealth's network of specialists and hospitals for care and coordination of care.</p> <ul style="list-style-type: none"> Population: Managed care eligible Medicaid members under 65 years of age. Managed Care Authority: 1115 Demonstration Waiver. 	<ol style="list-style-type: none"> Community Care Cooperative Mass General Brigham Steward Health Choice

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Managed care organization (MCO)	<p>Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals.</p> <ul style="list-style-type: none"> Population: Managed care eligible Medicaid members under 65 years of age. Managed Care Authority: 1115 Demonstration Waiver. 	<ol style="list-style-type: none"> 1. Boston Medical Center HealthNet Plan (WellSense) 2. Tufts Health Together
Primary Care Clinician Plan (PCCP)	<p>Members select or are assigned a primary care clinician (PCC) from a network of MassHealth hospitals, specialists, and the Massachusetts Behavioral Health Partnership (MBHP).</p> <ul style="list-style-type: none"> Population: Managed care eligible Medicaid members under 65 years of age. Managed Care Authority: 1115 Demonstration Waiver. 	Not applicable – MassHealth
Massachusetts Behavioral Health Partnership (MBHP)	<p>Capitated behavioral health model providing or managing behavioral health services, including visits to a licensed therapist, crisis counseling and emergency services, SUD and detox services, care management, and community support services.</p> <ul style="list-style-type: none"> Population: Medicaid members under 65 years of age who are enrolled in the PCCP or a PC ACO (which are the two PCCM programs), as well as children in state custody not otherwise enrolled in managed care. Managed Care Authority: 1115 Demonstration Waiver. 	MBHP (or managed behavioral health vendor: Beacon Health Options)
One Care Plan	<p>Integrated care option for persons with disabilities in which members receive all medical and behavioral health services and long-term services and support through integrated care. Effective January 1, 2026, the One Care Plan program will shift from a Medicare-Medicaid Plan (MMP) demonstration to a Medicare Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) with a companion Medicaid managed care plan.</p> <ul style="list-style-type: none"> Population: Dual-eligible Medicaid members aged 21–64 years at the time of enrollment with MassHealth and Medicare coverage. 	<ol style="list-style-type: none"> 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
	<ul style="list-style-type: none"> Managed Care Authority: Financial Alignment Initiative Demonstration. 	
Senior care option (SCO)	<p>Medicare Fully Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs) with companion Medicaid managed care plans providing medical, behavioral health, and long-term, social, and geriatric support services, as well as respite care.</p> <ul style="list-style-type: none"> Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age. Managed Care Authority: 1915(a) Waiver/1915(c) Waiver. 	<ol style="list-style-type: none"> 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