



External Quality Review Massachusetts Behavioral Health Partnership Annual Technical Report, Calendar Year 2025



Commonwealth of Massachusetts
Executive Office of Health and
Human Services

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Per *Title 42 CFR § 438.364(a)(7)*, no managed care plan was exempt from the external quality review activities conducted in CY 2025.

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I. Executive Summary

Massachusetts Behavioral Health Partnership

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

Massachusetts's Medicaid program (known as "MassHealth"), administered by the Massachusetts Executive Office of Health and Human Services (EOHHS), contracted with MBHP to provide behavioral health care for PC ACO and PCCP members during the 2025 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. As of December 27, 2025, MBHP served 357,243 MassHealth members during CY 2025.

Purpose of Report

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

Scope of EQR 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** – 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 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.

¹ Children's Health Insurance Program.

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

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

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

High-Level Program Findings

The EQR activities conducted in CY 2025 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 the CY 2025 EQR activity findings to assess the performance of MBHP in providing quality, timely, and accessible health care services to Medicaid members. MBHP evaluated against state and national benchmarks for measures related to the **quality**, **access**, and **timeliness** domains. These plan-level findings and recommendations are discussed in each EQR activity section, as well as in the **MCP Strengths, Opportunities for Improvement, and EQR Recommendations** section.

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

MassHealth Medicaid Comprehensive Quality Strategy

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

Strengths:

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

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

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

MassHealth reviews and evaluates the effectiveness of its quality strategy every 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.

The most recent Comprehensive Quality Strategy was published in October 2025. It defines goals and plans to improve the quality of care for the managed care and fee-for-service populations through 2027. The document was made available for public comment via the MassHealth quality website. Comments have been incorporated and shared for consideration if pertaining to specific programs or contracts.

Opportunities for Improvement:

Not applicable.

General Recommendations for MassHealth:

None at this time.

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)*. MBHP is currently working on two performance improvement projects: one focused on improving the percentage of pharmacotherapy treatments for members with opioid use disorder; and the second focused on improving rates of follow-up care and medication compliance for members ages 6–12 years who were newly prescribed medication for ADHD.

Strengths:

IPRO found that both PIP Remeasurement Reports follow an acceptable methodology in determining PIP aims, identifying barriers, and proposing interventions to address them. In terms of producing significant evidence of improvement, PIP 1 received high confidence rating, but PIP 2 received low confidence rating because several interventions were delayed, and there was no evidence of improvement in the performance indicator rates. No validation findings suggest that the credibility of the PIPs results is at risk.

Opportunities for Improvement:

Not applicable.

General Recommendations for MassHealth:

None at this time.

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.

MBHP is evaluated on the Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are calculated by MBHP and reported to MassHealth. IPRO conducted performance measure validation to assess the accuracy of HEDIS measure rates and to determine the extent to which MBHP followed measure specifications and reporting requirements. IPRO conducted a full Information Systems Capabilities Assessment (ISCA), a primary source validation, and a check on the processes used to collect, calculate, and report the performance measures. 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 HEDIS rates were above the 90th percentile of the NCQA Quality Compass on the following measures:

- Follow-up After Emergency Department Visit for Mental Illness (7 days)
- Follow-up After Emergency Department Visit for Mental Illness (30 days)
- Pharmacotherapy for Opioid Use Disorder

Opportunities for Improvement:

Source code review revealed that MBHP did not use the most current measure specifications to calculate the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility measure. MBHP was provided guidance to use the most current measure specifications going forward.

MBHP requested a late clarification from MassHealth to approve the mapping of the federally qualified health center (FQHC) codes to NCQA codes, as well as a clarification regarding a removal of members with third party liability or other insurance, but not members in state-custody that are discharged to residential facilities. The recalculated rates were not provided during the performance measure validation process. The rates provided as part of the initial performance measure validation submission were used for the performance measure validation activity. MBHP was provided guidance to seek clarification sooner.

Rates for the following measures were at or below the 25th percentile:

- Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (Initiation)
- Follow-up Care for Children Prescribed ADHD Medication (Continuation)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

General Recommendations for MassHealth:

- *Recommendation towards using the most current measure specifications* – MassHealth should ensure that MBHP receives guidance on the specifications and versions that should be used for measure rate calculation and reporting.
- *Recommendation towards obtaining timely clarifications* – MassHealth should continue to provide MBHP with timely clarifications on eligible populations to be included in measure calculations.
- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.

Performance measure validation findings are provided in **Section IV** of this report.

Compliance Review

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

Strengths:

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

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

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

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

Opportunities for Improvement:

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

General EQR Recommendations for MassHealth:

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

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

Network Adequacy Validation

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

Strengths:

Network adequacy is an integral part of MassHealth's strategic goals. One of MassHealth's quality strategy goals is to promote timely preventive primary care services with access to integrated care and community-based services and supports. Additionally, MassHealth aims to improve access for members with disabilities, increase timely access to behavioral health care, and reduce mental health and substance use disorder (SUD) emergencies.

MassHealth has established 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 SUD), adult and pediatric specialists, hospitals, pharmacy services, and long-term services and supports (LTSS). However, MassHealth did not develop standards for pediatric dental services, as these services are carved out from managed care.

Travel time and distance standards, availability standards, are clearly defined in the MBHPs' contracts with MassHealth. MCPs are required to submit in-network provider lists and the results of their GeoAccess analysis on an annual and ad hoc basis. This analysis evaluates provider locations relative to members' place of residence.

IPRO reviewed the results of MBHP's GeoAccess analysis and generated network adequacy validation ratings, reflecting overall confidence in the methodology used for design, data collection, analysis, and interpretation of each network adequacy indicator.

A high confidence rating indicates that no issues were found with the underlying information systems, the MBHP's provider data were clean, the correct MassHealth standards were applied, and the MBHP's results matched the time and distance calculations independently verified by IPRO.

In 2025, MBHP's network adequacy was calculated on a MassHealth-service area level, where 90% of health plan members residing in a service area had to have access within the required travel time and/or distance standards, depending on the type of provider.

Opportunities for Improvement:

Although no issues were found with the underlying information systems, MBHP did not apply the correct MassHealth standards for analysis, and/or their provider data contained numerous duplicate records. If multiple issues were identified in the network provider data submitted by MBHP, a moderate or low confidence rating was assigned. A low confidence rating was given for Psychiatric Inpatient Adult, Psychiatry, and Partial Hospitalization services. A moderate confidence rating was given for all other provider type services GeoAccess analysis.

After resolving data issues and removing duplicate records, IPRO assessed MBHPs' provider network for compliance with MassHealth's time and distance standards. Access was evaluated for all provider types identified by MassHealth. MBHP had deficiencies in 10 out of 14 of its provider networks.

Additionally, IPRO conducted provider directory audit, verifying Community Mental Health Centers (CMHCs) telephone numbers, addresses, specialties, MCP participation, and panel status. The accuracy of provider directory information varied widely, and no provider directory accuracy thresholds were established. IPRO informed MBHP about errors identified in directory data.

The average wait times for an appointment was 7 calendar days for community mental health centers. The results are based on small samples and should be interpreted with caution. Appointment availability was often not disclosed unless eligibility or insurance information was provided, preventing IPRO from assessing wait times and creating unnecessary barriers to patient access.

General Recommendations for MassHealth:

- *Recommendation towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access.

- *Recommendations towards better access* – MassHealth should work with health plans to explore ways that providers could disclose appointment availability to members without requiring eligibility verification, reducing barriers to access and enabling information care decisions.

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 MassHealth at least biennially. MBHP contracted with Press Ganey® 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 on two measures in the Appointment Access category, three measures in the Acceptability of MBHP Practitioners category, two measures in the Scope of Service category, and one measure in the Experience of Care category.

Opportunities for Improvement:

Twenty-two MBHP measures had scores below the benchmark goal. Additionally, 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.

General Recommendations for MassHealth:

- *Recommendation towards sharing information about member experiences* – IPRO recommends that MassHealth publish summary results from member experience surveys on the MassHealth Quality Reports and Resources website and make the results available to MassHealth enrollees.

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

Recommendations

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

EQR Recommendations for MassHealth

- *Recommendation towards using the most current measure specifications* – MassHealth should ensure that MBHP receives guidance on the specifications and versions that should be used for measure rate calculation and reporting.
- *Recommendation towards obtaining timely clarifications* – MassHealth should continue to provide MBHP with timely clarifications on eligible populations to be included in measure calculations.
- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.

- *Recommendation towards better policy documentation* – The state should direct MBHP to thoroughly review its policies and procedures, integrating all Massachusetts contract requirements into relevant policies.
- *Recommendation towards addressing gaps identified through the compliance review* – To effectively address the areas of non-compliance, MassHealth should establish direct communication with MBHP to discuss the identified issues. MBHP should ensure alignment of policy requirements with the contract terms to guarantee comprehensive coverage and ensure timely submission of all required reports to MassHealth, maintaining the evidence of transmittal. MBHP should also amend existing contracts to require 10 years of record retention and ensure that future contracts comply with this requirement.
- *Recommendation towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access.
- *Recommendations towards better access* – MassHealth should work with health plans to ensure providers disclose appointment availability to members without requiring eligibility verification, reducing barriers to access and enabling information care decisions.
- *Recommendation towards sharing information about member experiences* – IPRO recommends that MassHealth publish summary results from member experience surveys on the MassHealth Quality Reports and Resources website and make the results available to MassHealth enrollees.

EQR Recommendations for MBHP

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

II. Massachusetts Medicaid Managed Care Program

Managed Care in Massachusetts

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

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

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, pregnant women, and children.

MassHealth Medicaid Quality Strategy

Titles 42 CFR § 438.340(a) and 42 CFR § 457.1240(e) establish 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 has reviewed and updated its quality strategy since the initial issue produced in 2006. MassHealth reviews its quality strategy annually and updates it at least once every three years. The most recent Comprehensive Quality Strategy was published in October 2025. It defines goals and plans to improve the quality of care for the managed care and fee-for-service populations through 2027. The document was made available for public comment via the MassHealth quality website. Comments have been incorporated and shared for consideration if pertaining to specific programs or contracts.

2025–2027 Strategic Goals

Compared to its 2022 predecessor, the 2025 Comprehensive Quality Strategy includes goals with explicit objectives and associated quality measures. Progress will be assessed based on MassHealth's ability to achieve clearly stated 2027 targets which were set based on statewide performance during a baseline period. The baseline period represents either MY 2023 or MY 2024. MassHealth's strategic goals are listed in **Table 1**. For the full list of MassHealth's quality goals, objectives, quality measures, baseline performance, and 2027 targets, see **Appendix A, Tables A1–A5**.

² [MassHealth 2025 Comprehensive Quality Strategy](https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download). Also available at: <https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download>.

Table 1: MassHealth’s Strategic Goals

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

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

1. The **Accountable Care Partnership Plans** (ACPPs) are ACOs consisting of groups of PCPs who partner with one health plan to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As ACOs, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high quality care to MassHealth enrollees. To select an ACPP, 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 ACOs consisting of groups of PCPs who contract directly with MassHealth to provide integrated and coordinated care. PC ACOs function as an ACO but are considered primary care case management (PCCM) entities. In contrast to ACPPs, a PC ACO does not partner with a health plan. 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 PCPs, specialists, behavioral health providers, and hospitals.
4. **Primary Care Clinician Plan** (PCCP) is a PCCM arrangement, where Medicaid enrollees select or are assigned to a PCPs, called a primary care clinician (PCC). The PCC provides services, including care coordination, to enrollees under age 65 years and without any third-party insurance. PCCP uses the MassHealth network of PCPs, specialists, and hospitals, as well as the MBHP’s network of behavioral health providers.
5. **Massachusetts Behavioral Health Partnership** (MBHP) is a health plan that manages behavioral health care for MassHealth’s PC ACOs and the PCCP. 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.

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 LTSS. This Plan is for Enrollees ages 21 to 64 years who are dually enrolled in Medicaid and Medicare.³
7. **Senior Care Options (SCO)** Plans are also integrated health plans that cover services paid for by Medicare and Medicaid. SCO Plans are for MassHealth Enrollees ages 65 years and older, and they offer services to help seniors stay independently at home by combining health care with social supports.⁴ SCO Plans coordinate all Medicare and Medicaid benefits, and Enrollees must be eligible for both programs at the time of enrollment.

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 populations served.

MassHealth Additional Programs

MassHealth manages other programs beyond MCPs.

Fee-for-service (FFS) Medicaid Program

Fee-for-service is a traditional payment model where healthcare providers are paid directly for each service without a capitated payment and care coordination. According to the MassHealth Comprehensive Quality Strategy, 30% of MassHealth members are enrolled in fee-for-service, which includes individuals who live in nursing facilities or rehabilitation hospitals, individuals under age 65 years who have employer-sponsored insurance for whom MassHealth offers wraparound benefits, and individuals over age 65 years or who are disabled with Medicare and choose to remain in fee-for-service.⁵

Long-term Services and Supports (LTSS)

LTSS includes assistance with daily activities like bathing, dressing, and eating provided both in nursing homes and in private residences. Covered services include personal care services, as well as durable medical equipment, oxygen and respiratory therapy, and orthotics and prosthetics, among others. Eligibility is based on needing help with specific daily activities to enable people to live independently and participate in their communities. MassHealth offers LTSS in fee-for-service, SCO and One Care integrated Plans, and the Program of All-Inclusive Care of the Elderly. MassHealth has implemented quality monitoring for managed care LTSS through the requirements established for the integrated care plans and is planning to develop quality monitoring for fee-for-service LTSS services.

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

Members who are over 55 years of age and nursing-home-eligible can benefit from the Program of All-Inclusive Care of the Elderly to live safely at home. In this model, an interdisciplinary team of providers (clinicians, social workers, therapists, and health aids) provide coordinated services to help the elderly live in the community for as long as possible.

Community Partners Program

Members with complex LTSS and behavioral health needs may also participate in the Community Partners Program. Community Partners collaborate with ACOs and MCOs to provide care coordination and care management support and are eligible for financial incentives for quality performance. Community Partners also support the PCCP and MassHealth's fee-for-service members affiliated with the Department of Mental Health's Adult Community Clinical Supports Program.

³ [One Care Facts and Features](https://www.mass.gov/doc/one-care-facts-and-features-brochure/download). Also available at: <https://www.mass.gov/doc/one-care-facts-and-features-brochure/download>.

⁴ [Senior Care Options \(SCO\) Overview](https://www.mass.gov/service-details/senior-care-options-sco-overview). Also available at: <https://www.mass.gov/service-details/senior-care-options-sco-overview>.

⁵ [MassHealth 2025 Comprehensive Quality Strategy](https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download). Also available at: <https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download>.

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.

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, ACPPs, MCOs, SCOs, One Care Plans, and MBHP calculate HEDIS rates and are required to report on these metrics on a regular basis. MassHealth’s vendor Telligen® 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, where the 90th percentile is used to inform a goal target. The MBHP 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 PCCP, all health plans and ACPPs are required to develop PIPs.

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, an MCO, a PC ACO, and the PCCP, MassHealth conducts an annual survey adapted from the CAHPS Clinician & Group Survey (CG-CAHPS) that assesses members experience 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 MBHP’s Member Satisfaction Survey that MBHP conducts annually.

MassHealth Access Standards

MassHealth standards for access to care and availability of services as well as coverage and authorization of services are detailed in the contracts with all managed care entities and MBHP. The coverage and authorization of service requirements do not apply to PC ACOs. Travel time and distance standards vary by provider type and MCP standards. The wait time for appointments standards are listed in the quality strategy document. Managed care entity compliance with access standards is validated during the annual EQR process.

State's Evaluation of the Effectiveness of the 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 updates to the quality strategy must take EQR recommendations into account.

The most recent evaluation of MassHealth's 2022 Quality Strategy was conducted in 2024. Overall, MassHealth achieved goals 1 and 5 and made progress toward goals 2, 3, and 4. Based on the evaluation, the state revised several quality strategy goals to better align with evolving agency priorities. MassHealth will evaluate the effectiveness of the 2025 Comprehensive Quality Strategy in 2028; however, the progress towards quality strategy measures and key performance indicators across all programs will be reviewed annually.

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

MassHealth published a revised Comprehensive Quality Strategy in 2025. The revised strategy articulates five clearly defined goals with clearly defined objectives, quality measures, baseline performance, and 2027 targets.

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

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. Standards for adult dental services were developed for SCO and One Care Plans.

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 performance measure validation and compliance activities when plans received a full assessment as part of a HEDIS Compliance Audit or NCQA accreditation and worked with a certified vendor. 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 most recent evaluation of MassHealth's Quality Strategy was conducted in 2024. Overall, MassHealth achieved goals 1 and 5 and made progress toward goals 2, 3, and 4. Based on the evaluation, the state plans to maintain and revise several quality strategy goals to better align with evolving agency priorities.

Overall, MassHealth's quality strategy is designed to improve the quality of health care for Medicaid members.

III. Validation of Performance Improvement Projects

Objectives

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

Section 2.13.C 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 PCCs, as MBHP provides services to members of the MassHealth PCCP. MassHealth can modify the PIP cycle to address immediate priorities. In CY 2025, MBHP was required to submit two PIP baseline reports. Specific MBHP PIP topics are displayed in **Table 2**.

Table 2: MBHP PIP Topics – CY 2025

MCP	PIP Topics
MBHP	PIP 1: POD-M – Remeasurement 1 Report Improving the percentage of pharmacotherapy treatments for members with opioid use disorder. PIP 2: ADD – Remeasurement 1 Report Improving rates of follow-up care and medication compliance for members ages 6–12 years who were newly prescribed medication for ADHD.

MBHP: Massachusetts Behavioral Health Partnership; PIP: performance improvement project; CY: calendar year; ADHD: attention-deficit/hyperactivity disorder.

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. To meet federal regulations, MassHealth contracted with IPRO, an EQRO, to perform the validation of PIPs conducted by MBHP during CY 2025.

Technical Methods of Data Collection and Analysis

MBHP submitted its initial PIP proposals to IPRO in December 2023 reporting the 2022 performance measurement baseline rates. The report template and validation tool were developed by IPRO. The initial proposals were reviewed between January and March 2024. In July 2024, MBHP submitted baseline update reports once the 2023 baseline performance measurement rates became available. The first remeasurement reports were submitted in July 2025.

In the first remeasurement report, MBHP described project goals, performance indicators’ rates, anticipated barriers, interventions, and intervention tracking measures’ rates. MBHP completed these reports electronically and submitted them to IPRO through a web-based project management and collaboration platform.

The analysis of the collected information focused on several key aspects, including the appropriateness of the topic, an assessment of the aim statement, population, quality of the data, barrier analysis, and appropriateness of the interventions as well as the progress of the interventions and initial evidence of improvement. It aimed to evaluate an alignment between the interventions and project goals and whether reported improvements could be maintained over time.

Description of Data Obtained

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

Conclusions and Comparative Findings

IPRO assigns two validation ratings. The first rating assessed IPRO's overall confidence in the PIP's adherence to acceptable methodology throughout all project phases, including the design, data collection, data analysis, and interpretation of the results. The second rating evaluates IPRO's overall confidence in the PIP's ability to produce significant evidence of improvement. Both ratings use the following scale: high confidence, moderate confidence, low confidence, and no confidence.

Rating 1: Adherence to Acceptable Methodology - Validation Results Summary

The first PIP received a high confidence rating, whereas the second PIP received a moderate confidence rating for adherence to acceptable methodology.

Rating 2: Evidence of Improvement - Validation Results Summary

In terms of producing significant evidence of improvement, the PIP 1 received high confidence rating but PIP 2 received low confidence rating because several interventions were delayed, and there was no evidence of improvement in the performance indicator rates.

PIP validation results are reported in **Table 3** for MBHP.

Table 3: MBHP PIP Validation Confidence Ratings – CY 2025

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: POD-M	High Confidence	High Confidence
PIP 2: ADD	Moderate Confidence	Low Confidence

MBHP: Massachusetts Behavioral Health Partnership; CY: calendar year; PIP: performance improvement project.

MBHP PIPs

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

Table 4: MBHP PIP 1 Summary, 2025

MBHP PIP 1: Improving the percentage of pharmacotherapy treatments for members with opioid use disorder.
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence

MBHP: Massachusetts Behavioral Health Partnership; MY: measurement year; PIP: performance improvement project; OUD: opioid use disorder.

Aim

By the end of 2025, the Plan aims to increase the percentage of Members who initiated with MOUD (medications for opioid use disorder) treatment within 30 days of a new diagnosis by 3 percentage points compared to the MY 2023 baseline rate.

Interventions in 2024

- Identify and collaborate with high-volume/low-performing index providers to improve time to MOUD following a diagnosis of OUD.
- Increase utilization of community support personnel (Recovery Coaches and Recovery Support Navigators) through outreach.
- Increase the number of Substance Use Disorder Open Access sites.

Performance Improvement Summary

Performance indicators, ITMs, appendices, and discussion provided evidence of continuous intervention monitoring, evaluation, and adaptation.

Table 5: MBHP PIP 1 Performance Measures and Results

Indicator	Reporting Year	Rate
Indicator 1: POD-M	2024 (baseline, MY 2023 data)	63.33%
Indicator 1: POD-M	2025 (remeasurement 1, MY 2024 data)	63.34%

MBHP: Massachusetts Behavioral Health Partnership; MY: measurement year.

Table 6: MBHP PIP 2 Summary, 2025

MBHP PIP 2: Improving rates of follow-up care and medication compliance for members ages 6–12 years who were newly prescribed medication for ADHD.
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – Moderate Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – Low Confidence

MBHP: Massachusetts Behavioral Health Partnership; PIP: performance improvement project; ADHD: attention-deficit/hyperactivity disorder.

Aim

By the end of 2025 MBHP aims to increase the percentage of Members aged 6-12 who have been initiated on ADHD medication and who have had a follow-up visit with a practitioner with prescribing authority within 30 days of initiation by 3 percentage points. We also aim to increase by 3 percentage points those Members aged 6-12 who (1) remain on their ADHD medication for at least 210 days and (2) had at least two additional follow-up visits with a practitioner within 270 days (9 months) of the Initiation Phase.

Interventions in 2024

- Perform targeted outreach to prescribers with low initiation and continuation rates.
- Develop educational materials for providers on medication best practices.
- Promotion of the Massachusetts Child Psychiatry Access Program (McPAP) to providers that prescribe ADD medication.
- Develop educational material for members and families related to medication continuation and follow ups.

Performance Improvement Summary

Several interventions were delayed, and there was no evidence of improvement in the performance indicator rates throughout the PIP.

Table 7: MBHP PIP 2 Performance Measures and Results

Indicator	Reporting Year	Rate
Indicator 1: Percentage of children ages 6–12 years with newly prescribed ADHD medication who had a follow-up visit with a prescribing practitioner within 30 days of the initial prescription start date.	2024 (baseline, MY 2023 data)	40.35%
Indicator 1: Percentage of children ages 6–12 years with newly prescribed ADHD medication who had a follow-up visit with a prescribing practitioner within 30 days of the initial prescription start date.	2025 (remeasurement 1, MY 2024 data)	36.51%
Indicator 2: Percentage of children ages 6–12 years who remained on ADHD medication for 210 days and who had at least one visit with a prescribing practitioner during the Initiation Phase, and at least two additional follow-up visits with a practitioner within 270 days after the Initiation Phase ended.	2024 (baseline, MY 2023 data)	40.96%
Indicator 2: Percentage of children ages 6–12 years who remained on ADHD medication for 210 days and who had at least one visit with a prescribing practitioner during the Initiation Phase, and at least two additional follow-up visits with a practitioner within 270 days after the Initiation Phase ended.	2025 (remeasurement 1, MY 2024 data)	36.95%

MBHP: Massachusetts Behavioral Health Partnership; MY: measurement year; ADHD: attention-deficit/hyperactivity disorder.

Recommendations

- *Recommendation for PIP 2:* MBHP should implement the provider and member outreach interventions as soon as possible to produce improvement in the performance indicator rates.

IV. Validation of Performance Measures

Objectives

The purpose of performance measure validation is to assess the accuracy of performance measures and to determine the extent to which performance measures follow state specifications and reporting requirements.

Technical Methods of Data Collection and Analysis

MassHealth contracted with IPRO to conduct performance measure validation to assess the data collection and reporting processes used to calculate the MBHP performance measure rates.

MassHealth evaluates MBHP quality performance on a slate of HEDIS measures and a few non-HEDIS measures. All MBHP HEDIS performance measures were calculated by Inovalon®, an NCQA-certified vendor, to produce HEDIS measure rates. One non-HEDIS CMS Adult Core Set measure, Use of Pharmacotherapy for Opioid Use Disorder, and one additional non-HEDIS CMS measure, 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility, were also calculated by Inovalon.

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

IPRO conducted a full Information Systems Capabilities Assessment 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 Information Systems Capabilities Assessment tool and underwent a virtual site review.

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

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

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

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

Description of Data Obtained

The following information was obtained from the MBHP:

- a completed Information Systems Capabilities Assessment tool;
- denominator and numerator compliant lists for the following two measures:
 - Follow-up After Emergency Department Visit for Mental Illness (FUM) – 7 days,
 - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD);
- rates for HEDIS measures for MY 2024;

- NCQA Measure Certification report for HEDIS measures; and
- Rates for non-HEDIS measures for MY 2024.

Conclusions and Comparative Findings

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

Table 8: MBHP Compliance with Information System Standards – MY 2024

Information System 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; MY: measurement year; N/A: not applicable.

Validation Results

- **Information Systems Capabilities Assessment:** The Information Systems Capabilities Assessment is conducted to confirm that MBHP’s information systems were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, and provider data systems. No issues were identified.
- **Source Code Validation:** Source code review is conducted to ensure compliance with the measure specifications when calculating measure rates. NCQA measure certification for HEDIS measures was accepted in lieu of source code review. Source code review was conducted for the non-HEDIS measures. MBHP was provided guidance to use the most current measure specifications to calculate the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility measure. No other issues were identified.
- **Medical Record Validation:** No measures were reported using a hybrid methodology. Therefore, medical record review validation was not required.
- **Primary Source Validation:** Primary source validation 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. MBHP requested clarification from MassHealth with regards to the mapping of the federally qualified health center (FQHC) codes to NCQA codes, as well as the removal of members with third party liability or other insurance and removal of members in state-custody that are discharged to residential facilities. MassHealth approved the mapping of the FQHC codes to NCQA codes, as well as the removal of members with third party liability or other insurance but not the removal of members in state-custody that are discharged to residential facilities. The recalculated rates were not provided during the performance measure validation process. The rates provided as part of the initial performance measure validation submission were used for the performance measure validation activity. No other issues were identified.

- **Rate Validation:** Rate validation is conducted to evaluate measure results and compare rates to industry standard benchmarks. No rate comparison was conducted for the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility measure since this was the first year that the MBHP calculated the measure using the updated calculation methodology. No issues were identified. All required measures were reportable.

Recommendations

- MBHP should ensure that timely clarification is obtained from MassHealth on eligible populations to be included in measure calculations.
- MBHP should ensure that clarification is obtained from MassHealth on the specifications and versions that should be used for measure rate calculation and reporting.

Comparative Findings

IPRO compared the MBHP rates to the NCQA HEDIS MY 2024 Quality Compass national Medicaid percentiles. 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 9**. **Table 10** displays the HEDIS performance for MY 2024 for MBHP.

Best Performance (rates above the 90th percentile):

- Follow-up After Emergency Department Visit for Mental Illness (7 days)
- Follow-up After Emergency Department Visit for Mental Illness (30 days)
- Pharmacotherapy for Opioid Use Disorder

Needs Improvement (rates below 25th percentile):

- Follow-up Care for Children Prescribed ADHD Medication (Initiation)
- Follow-up Care for Children Prescribed ADHD Medication (Continuation)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Table 9: Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2024 Quality Compass National Medicaid Percentiles

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

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

Table 10: MBHP HEDIS Performance Measures – MY 2024

HEDIS Measure	MBHP
Follow-up Care for Children Prescribed ADHD Medication (Initiation)	35.14% (< 25th)
Follow-up Care for Children Prescribed ADHD Medication (Continuation)	37.43% (< 25th)
Metabolic Monitoring for Children and Adolescents on Antipsychotics	34.73% (≥ 25th but < 50th)

HEDIS Measure	MBHP
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.91% (< 25th)
Follow-up After Emergency Department Visit for Mental Illness (7 days)	74.91% (≥ 90th)
Follow-up After Emergency Department Visit for Mental Illness (30 days)	80.99% (≥ 90th)
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	39.04% (≥ 75th but < 90th)
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	51.65% (≥ 75th but < 90th)
Follow-up After Hospitalization for Mental Illness (7 days)	39.88% (≥ 25th but < 50th)
Follow-up After Hospitalization for Mental Illness (30 days)	60.14% (≥ 25th but < 50th)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Initiation)	48.97% (≥ 50th but < 75th)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Engagement)	19.94% (≥ 75th but < 90th)
Antidepressant Medication Management (Acute)	73.41% (≥ 75th but < 90th)
Antidepressant Medication Management (Continuation)	57.98% (≥ 75th but < 90th)
Pharmacotherapy for Opioid Use Disorder	45.10% (≥ 90th)
Use of Pharmacotherapy for Opioid Use Disorder	84.9% (N/A)
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility [CMS IPFQR Measure]	28.76% (N/A)

MBHP: Massachusetts Behavioral Health Partnership; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; ADHD: attention deficit hyperactivity disorder; CMS: Centers for Medicare and Medicaid Services; IPFQR: Inpatient Psychiatric Facility Quality Reporting; N/A: not applicable.

V. Review of Compliance with Medicaid Managed Care Regulations

Objectives

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Pre-interview Documentation Review

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

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

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

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

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

Remote Interviews

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

Post-interview Report Preparation

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

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

For each standard identified as Partially Met or Not Met, the MCP was required to provide a timeline and high-level plan to implement the correction. MBHP is expected to provide an update on the status of the

implementation of the corrections when IPRO requests an update on the status of the annual technical report recommendations, which is part of the annual EQR process.

Scoring Methodology

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

Table 11: Scoring Definitions

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

MCP: managed care plan.

Description of Data Obtained

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

Conclusions and Comparative Findings

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

- Disenrollment requirements and limitations
- Emergency and post-stabilization services
- Assurances of adequate capacity and services
- Confidentiality
- Grievance and appeal systems
- Practice guidelines
- QAPI

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

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

Table 12 presents MBHP’s compliance scores for each of the 14 review domains. Red text indicates opportunity for improvement (less than 90%).

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

CFR Standard Name (Review Domain)	CFR Citation	MBHP
Overall compliance score	N/A	94.6%
Disenrollment Requirements and Limitations	438.56	100.0%
Enrollee Rights Requirements	438.100	92.3%
Emergency and Post-stabilization Services	438.114	100.0%
Availability of Services	438.206	90.0%
Assurances of Adequate Capacity and Services	438.207	100.0%
Coordination and Continuity of Care	438.208	87.9%
Coverage and Authorization of Services	438.210	98.1%
Provider Selection	438.214	87.1%
Confidentiality	438.224	100.0%
Grievance and Appeal Systems	438.228	100.0%
Subcontractual Relationships and Delegation	438.230	75.0%
Practice Guidelines	438.236	100.0%
Health Information Systems	438.242	94.4%
QAPI	438.330	100.0%

MBHP: Massachusetts Behavioral Health Partnership; CFR: Code of Federal Regulations; QAPI: Quality Assurance and Performance Improvement; N/A: not applicable.

VI. Validation of Network Adequacy

Objectives

Validation of network adequacy is a process to verify the network adequacy analyses conducted by MCPs. This includes validating data to determine whether the network standards, as defined by the state, were met. This also includes assessing the underlying information systems and provider data sets that MCPs maintain to monitor their networks' adequacy. Network adequacy validation is a mandatory EQR activity that applies to MCOs, prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs).

The state of Massachusetts has developed access and availability standards based on the requirements outlined in *Title 42 CFR § 438.68(c)*. One of the goals of MassHealth's quality strategy is to promote timely preventive 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.

IPRO used MassHealth's access and availability standards as they were described in Section 2.9 of the Behavioral Health Vendor Contract with MassHealth. 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 2.9.C of the MBHP contract. MBHP is also required to make covered services available 24 hours a day, seven days a week when medically necessary.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet federal regulations, MassHealth contracted with IPRO, an EQRO, to perform the validation of network adequacy for MBHP. IPRO evaluated MBHP's processes for collecting and storing network data, and provider networks' compliance with MassHealth's GeoAccess requirements.

The methodology used to conduct each of these activities and the results are discussed in more detail in this report. If any weaknesses were identified, this report offers recommendations for improvement. The results from each one of these activities were aggregated into ratings of the overall confidence that the MBHP used an acceptable methodology or met MassHealth standards for each network adequacy monitoring activity. To clarify the findings, IPRO shared the preliminary results with MBHP and conducted an interview to supplement our understanding of MBHP's network information systems and processes.

Technical Methods of Data Collection and Analysis

This section explains the methodology behind both elements of network adequacy validation: validation of the underlying information systems and validation of compliance with MassHealth's travel time and distance standards.

Network Information Systems Validation Methodology

The Information System Capacity Assessment is a component of the performance measure validation activity that MBHP completes during external quality review. To complement the already existing assessment, IPRO evaluated the integrity of the systems MBHP uses to collect, store, and process provider network data. IPRO developed a survey in Research Electronic Data Capture (REDCap®) to support this effort. The survey questions addressed topics such as the systems used to collect and store provider data for network analysis; methods of data entry; the roles of staff involved in collecting, storing, and analyzing data; the frequency of data collection and updates; the extent of missing data; and the quality assurance measures in place to prevent and correct errors.

The survey was distributed on April 4, 2025, and closed on May 27, 2025. IPRO also scheduled an individual interview session with MBHP to supplement our understanding of MBHP’s information systems and processes.

Provider Directory and Availability of Appointments Methodology

The accuracy of provider directories and availability of appointments were assessed using secret shopper surveys. In a secret shopper survey, callers act as members and attempted to schedule an appointment, documenting the date of the next available appointment or barriers to making the appointment. The audited specialties are listed in **Table 13**.

Table 13: Audited Specialties

Reporting Group	Specialty
Outpatient mental health and substance use disorder providers	Community Mental Health Centers (CMHCs)

IPRO filtered MBHP online provider directory⁶ for outpatient clinic and mental health centers that were accepting new patients and then used a browser-based web scraping tool to scrape the data, creating a database of providers. The sample size was determined based on the population size using a 95% confidence level and a 7% margin of error to ensure a statistically valid methodology. The records in the random samples were reviewed for overlaps to create a “calling sample size” and to ensure that the same providers were not contacted multiple times. The records in the calling samples were manually checked for accuracy against the online provider directory, ensuring that all records in the calling samples were correct.

To validate the accuracy of the information published in the provider directories, surveyors contacted a random sample of Community Mental Health Centers to confirm the telephone number, address, and open panel status as well as participation with the Medicaid MCP. IPRO reported the percentage of Community Mental Health Centers in the sample with verified and correct information.

IPRO also inquired about the wait times for the next available intake session and/or individual therapy appointment. Callers were provided with scenarios to use when attempting to schedule appointments. Each script was designed to address telehealth and in-person appointments and differentiate between a billable clinical intake session vs administrative screening. A telehealth appointment was counted towards the average appointment wait times only if the provider also offered in-person appointments.

MassHealth’s appointment availability standards for MBHP are detailed in **Table 14**. Standards highlighted in gray are for emergency and urgent care services that were not included in this survey.

Table 14: Availability Standards

Provider Type	Urgency Level	Standard
Emergency services ¹	Emergency	Immediately
Urgent care ¹	Urgent/Symptomatic	48 hours
Behavioral health (BH) services ¹	Nonurgent BH services	14 calendar days

¹ Gray cells: provider types not included in the survey.
PCP: primary care provider; ob/gyn: obstetrics/gynecology.

⁶ MBHP. [Find a Behavioral Health Provider](https://www.masspartnership.com/member/FindBHProvider.aspx). Also available at: providers.masspartnership.com/member/FindBHProvider.aspx.

Travel Time and Distance Validation Methodology

For 2025, IPRO evaluated each MCP's provider network to determine compliance with network GeoAccess standards established by MassHealth. According to the MBHP contract, at least 90% of health plan members in each service area must have access to medically necessary behavioral health covered services according to travel time or distance standards defined in the contract.

IPRO reviewed MassHealth GeoAccess standards and worked together with the state to define network adequacy indicators. IPRO calculated the travel time and distance from Covered Individuals' residence. MBHP network adequacy standards and indicators are listed in **Appendix D (Tables D1–D2)**.

IPRO requested in-network provider data on April 4, 2025, with a submission due date of May 16, 2025. MBHP submitted data to IPRO following templates developed by MassHealth and utilized by MCOs and ACPPs to report provider lists to MassHealth on an annual basis. The submitted data went through a careful and significant data cleanup and deduplication process. If IPRO identified missing or incorrect data, the plans were contacted and asked to resubmit. Duplicative records were identified and removed before the analysis.

IPRO worked with a subvendor to develop MBHP's GeoAccess reports. IPRO analyzed the results to identify adequate provider networks, as well as service areas with deficient networks. When MBHP appeared to have network deficiencies in a particular service area, IPRO reported the percentage of Covered Individuals in that service area who had adequate access.

To validate the MBHP's results, IPRO compared the outcomes of the time and distance analysis that IPRO conducted to the results submitted by MBHP. The first step in this process was to verify that MBHP correctly applied MassHealth's time and distance standards for the analysis. The second step involved identifying duplicative records from the provider lists submitted by MBHP to IPRO. If IPRO identified significant discrepancies, such as the use of incorrect standards or inconsistencies in provider datasets (e.g., duplicate records), no further comparison could be conducted.

Description of Data Obtained

All data necessary for analysis were obtained from MassHealth and MBHP between April 4 and October 1, 2025. Before requesting data from MBHP, IPRO consulted with MassHealth and confirmed the variables necessary for the network adequacy validation, agreed on the format of the files, and reviewed the information systems survey form.

Network Information Systems Capacity Assessment Data

MBHP received a unique URL link via email to a REDCap survey. The survey was open from April 4, 2025, until May 16, 2025.

Provider Directory and Availability of Appointment Data

Data was obtained directly for MBHP online provider directory⁷ using a browser-based web scraping tool. The data was obtained on October 27, 2025. The Community Mental Health Centers were contacted in January and February 2026.

Travel Time and Distance Data

Validation of network adequacy for CY 2025 was performed using network data submitted by MBHP to IPRO. IPRO requested a complete provider list which included facility/provider name, address, phone number, and the national provider identifier for the following provider types: behavioral health inpatient services, diversionary services, and standard outpatient services as well as intensive home or community-based

⁷ MBHP. [Find a Behavioral Health Provider](#). Also available at: providers.masspartnership.com/member/FindBHPProvider.aspx.

services. IPRO received a complete list of Medicaid Covered Individuals and their residence information from MBHP.

Provider and member enrollment data as of April 1, 2025, were submitted to IPRO via IPRO's secure file transfer protocol site. MBHP also submitted the results of its time and distance analysis to IPRO.

GeoAccess reports were generated by combining the following files: data on all providers and service locations contracted to participate in MBHP networks, member enrollment data, service area information provided by MassHealth, and network adequacy standards and indicators.

Conclusions and Findings

After assessing the reliability and validity of MBHP's network adequacy data, processes, and methods used by MBHP to assess network adequacy and calculate each network adequacy indicator, IPRO determined whether the data, processes, and methods used by MBHP to monitor network adequacy were accurate and current. IPRO also validated network adequacy results submitted by MBHP and compared them to the results calculated by IPRO to assess whether MBHP's results were valid, accurate, and reliable, as well as if MBHP's interpretation of data was accurate.

Taking all of the above into account, IPRO generated network adequacy validation ratings that reflect IPRO's overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. The network adequacy validation rating includes IPRO's assessment of the data collection procedures, methods used to calculate the indicator, and confidence that the results calculated by MBHP are valid, accurate, and reliable.

The network adequacy validation rating is based on the following scale: high, moderate, low, and no confidence. **High confidence** indicates that no issues were found with the underlying information systems, the MCP's provider data were clean, the MCP applied the correct MassHealth standards for analysis, and the results calculated by MBHP matched the time and distance results calculated by IPRO. A lack of one of these requirements resulted in **moderate confidence**. A lack of two requirements resulted in **low confidence**, while issues with three or more requirements resulted in a rating of **no confidence**.

The network adequacy validation rating for each indicator is reported in **Table 15**.

Table 15: MBHP Network Adequacy Validation Ratings – CY 2025

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating	Comments
Behavioral Health Inpatient Services	<ul style="list-style-type: none"> • 90% of covered individuals have access to 2 inpatient service providers within 60 miles or 60 minutes within a covered individual's ZIP code of residence. 	Addressed	Low confidence: Psychiatric Inpatient Adult	<p>No issues were found with the underlying information systems; however, the MCP did not apply the correct MassHealth standards, and the MCP’s provider data had some duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>IPRO’s analysis of the network revealed that the Psych Inpatient Adult GeoAccess standard was met in all service areas.</p>
Behavioral Health Standard Outpatient Services	<ul style="list-style-type: none"> • 90% of covered individuals have access to 2 BH service providers within 30 miles or 30 minutes within the covered individual's ZIP code of residence. • 90% of covered individuals have access to 1 Partial Hospitalization Program providers within 60 miles or 60 minutes within the covered individual's ZIP code of residence. • 90% of covered individuals have access to 1 Psychiatry providers within 20 miles or 40 minutes within the covered individual's ZIP code of residence. 	Addressed	<p>Low confidence: Psychiatry and Partial Hospitalization Programs</p> <p>Moderate confidence: all other provider types</p>	<p>For Psychiatry and Partial Hospitalization Programs: No issues were found with the underlying information systems; however, the MCP did not apply the correct MassHealth standards, and the MCP’s provider data had some duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>For all other provider types: No issues were found with the underlying information systems and the MCP applied the correct MassHealth standards; however, the MCP’s provider data had some duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>IPRO’s analysis of the network revealed that the Partial Hospitalization Program, Behavioral Health Outpatient, and Psychiatry GeoAccess standards were met in all service areas, but other provider networks had gaps in at least one service area.</p>

¹ “Addressed” means that the indicator was required to be reported to the state and the managed care plan (MCP) submitted the report to the state. “Missing” means that the indicator was either not required or required but not reported.

MBHP: Massachusetts Behavioral Health Partnership; MCP: Managed Care Plan.

Information Systems and Quality of Provider Data

The analysis of the information systems assessment showed the following:

- Information Systems Capabilities Assessment: The Information Systems Capabilities Assessment is conducted to confirm that MBHP's information systems were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, and provider data systems. No issues were identified.
- IPRO assessed the reliability and validity of MBHP's network adequacy data.
 - MBHP reported that its system controls do not allow duplicate providers and that duplicate processes are in place to review and resolve, if any, duplicate records. IPRO determined that the data used by the MBHP to monitor network adequacy were mostly accurate and current, except for duplicative provider records. MBHP should clean and deduplicate its provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
 - IPRO determined that the membership data used by the MCP to monitor network adequacy were mostly accurate, with the exception of a higher membership count compared to the MassHealth membership count for the same period.
 - IPRO determined that 41 providers had deactivated national provider identifiers, while two providers had more than 10 different locations listed per provider.
- IPRO reviewed the MBHP's process for updating data (i.e., provider and beneficiary information). Providers' name, address, and phone numbers are validated during annual directory audit surveys. Providers' national provider identifiers, credentials, taxonomy codes, and provider types are validated during the credentialing process when the provider joins the network and then every three years. Providers are required to attest their data quarterly. Provider data are imported from the provider database into the provider directory. IPRO concluded that the MBHP's process for updating data should include a method for assessing the accuracy of provider information published in the online provider directory.
- IPRO assessed changes in the MBHP's data systems that might affect the accuracy or completeness of network adequacy monitoring data (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs). No significant changes were reported; systems appear stable.

Provider Directory

IPRO validated the accuracy of provider directories for a random sample of Community Mental Health Centers. The most frequent reason why the directory information was not correct was due to some type of contact failure, which can include a number of reasons e.g., the phone number was not in service, the phone number was wrong, call was disconnected before contact was made, constant busy signal, no answer, the surveyor was put on hold for more than 5 minutes or was connected to an automated answering machine and an answering service. The last three reasons would have to occur three consecutive times in order to be considered a contact failure.

Table 16 shows the percentage of Community Mental Health Centers in the MBHP directory with verified telephone number, address, and Medicaid participation information. An accuracy goal for the provider directory activity was not established. The percentage of CMHCs with correct information means the percentage of CMHCs for which all of the following is correct: the CMHC offers outpatient therapy; the address is correct; the phone number is correct; the CMHC is accepting new patients; and the CMHC is accepting this health plan. The percentage of CMHCs for whom health plan info could not be confirmed means that the staff member did not know whether the provider accepts this health plan or not.

Table 16: Provider Directory Accuracy – Community Mental Health Centers (CMHCs)

CMHC Directory Accuracy	MBHP
% CMHCs with correct information	21.56% (36)
% CMHCs for whom health plan info could not be confirmed	9.58% (16)
Total CMHCs called	167

Note: The sample is representative of the population with a 90% confidence interval and +/- 7% margin of error.
 MBHP: Massachusetts Behavioral Health Partnership.

Table 17 shows the most common reasons for inaccuracies or unverified information regarding Community Mental Health Centers in the directories. The “contact fails” category includes several circumstances: the phone number was not in service; the telephone number was wrong; the call was disconnected before a contact was made; callers encountered a constant busy signal; no answer; callers were placed on hold for more than five minutes; there was an automated answering machine; or the caller was redirected to an answering service. Callers made up to three attempts to reach a live staff person at each practice to complete the survey. If a phone number was not in service, wrong, disconnected, or resulted in a constant busy signal, an additional call was made to verify the outcome. The phrase “CMHC does not offer outpatient services” indicates that the CMHC provides only group services; program-specific services (e.g., intensive outpatient program, partial hospitalization, addiction recovery groups, crisis stabilization); has insufficient clinical staffing (no licensed therapists or open vacancies); or offers other types of services (e.g., residential treatment).

Table 17: Directory Inaccuracy/Provider Verification Challenges – Community Mental Health Centers (CMHCs)

Directory Inaccuracy Reasons	MBHP
Contact Fails	48
CMHC does not offer outpatient services	47
Address is NOT correct	34
Telephone number is NOT correct	4
CMHC does NOT accept this health plan	1
CMHC is NOT accepting new patients	0
Total Inaccuracies per Plan	134

MBHP: Massachusetts Behavioral Health Partnership.

Wait Time for Appointment

The results of the wait time for appointment survey are listed below. For the Community Mental Health Centers that shared the appointment date, the average wait time for an appointment was 7 calendar days, ranging from same-day appointments to a 28 calendar day waiting period. 86.4% of contacted CMHCs, who shared an appointment date, met the MassHealth appointment wait time standard of 14 calendar days.

Table 18 shows the wait time for appointment results for Community Mental Health Centers.

Table 18: Average Appointment Wait Time – Community Mental Health Centers (CMHCs)

MassHealth Behavioral Health Wait Time Standards	MBHP
Average calendar days to appointment (min, max) ¹	7.0 (0, 28)
% CMHC meeting 14-day standard	86.4% (19)
CMHC with appointment date (N)	22
CMHC reached	119

¹ Range (min, max) indicates the span between the shortest wait time recorded and the longest wait time recorded in calendar days. N = Total CMHC reached, which is calculated as the number of CMHC for which contact was made and an appointment date was collected.

Note: The appointment date was requested only when the contacted CMHC offered outpatient therapy and accepted the health plan.

MBHP: Massachusetts Behavioral Health Partnership.

Appointment availability information was repeatedly withheld unless the patient’s eligibility could be verified and met preventing IPRO from assessing wait time but also restricting patients’ access. A patient deciding where to seek care should be able to assess how long the wait is without needing to register with the center and without an administrative intake appointment. The barriers include requiring eligibility verification before discussing schedules, requiring patient registration to disclose availability, and refusing to share the next appointment date without an insurance ID, etc. **Table 19** shows the most frequent reasons why appointment dates were not collected.

Table 19: Reasons Not Able to Get an Appointment Date – Community Mental Health Centers (CMHCs)

Reasons Appointment Date Was Not Collected	MBHP
Administrative intake must be conducted first	20
Patients are placed on a waiting list	11
Other ¹	7
Patient's ID or personal info must be presented first	7
Patient must be registered with the clinic first	4
CMHC is not accepting new patients.	0
Medical records must be submitted first	0
Staff member refused to participate	0
Staff member requested a callback	0
Total	49

¹ Other includes any additional response where an appointment date was not shared, instead the caller was told, for example, that the appointment time will be provided later via a callback after and the administrative intake process is completed.

MBHP: Massachusetts Behavioral Health Partnership.

Time and Distance Standards

Following the comparative results, this next section focuses on an analysis of provider network gaps. These results, derived from IPRO’s calculations, aim to identify specific service areas where the network may not meet MassHealth’s adequacy standards.

Tables 20–21 provide a summary of the network adequacy results for healthcare providers subject to travel time and distance standards defined in the MBHP’s contract with MassHealth.

Table 20: Service Areas with Adequate Network of Behavioral Health Inpatient Service Providers

Provider Type	Standard – 90% of Covered Individuals in a Service Area Have Access	MBHP
Psych Inpatient Adult	2 providers within 60 miles or 60 minutes	38 out of 38 (Met)

MBHP: Massachusetts Behavioral Health Partnership.

Table 21: Service Areas with Adequate Network of Behavioral Health Outpatient Services

Provider Type	Standard – 90% of Covered Individuals in a Service Area Have Access	MBHP
Youth Community Crisis Stabilization (YCCS)	2 providers within 30 miles or 30 minutes	3 out of 38 (Partially Met)
Monitored inpatient Acute Treatment Services (ATS) Level 3.7	2 providers within 30 miles or 30 minutes	30 out of 38 (Partially Met)
Clinical Stabilization Services (CSS) Level 3.5	2 providers within 30 miles or 30 minutes	31 out of 38 (Partially Met)
Partial Hospitalization Program (PHP)	1 provider within 60 miles or 60 minutes	38 out of 38 (Met)
Structured Outpatient Addiction Program (SOAP)	2 providers within 30 miles or 30 minutes	34 out of 38 (Partially Met)
Behavioral Health Outpatient (including psychology and psych APN)	2 providers within 30 miles or 30 minutes	38 out of 38 (Met)
Psychiatry (MDs)	1 provider within 20 miles or 40 minutes	38 out of 38 (Met)
Opioid Treatment Programs (OTP)	2 providers within 30 miles or 30 minutes	33 out of 38 (Partially Met)
Applied Behavior Analysis	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)
In-home Behavioral Services	2 providers within 30 miles or 30 minutes	34 out of 38 (Partially Met)
In-home Therapy Services	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)
Therapeutic Mentoring Services	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)
Intensive Care Coordination (ICC)	2 providers within 30 miles or 30 minutes	32 out of 38 (Partially Met)

Massachusetts Behavioral Health Partnership; APN: advanced practice nurse; MD: medical doctor.

After analyzing the network adequacy results for all provider types, IPRO identified service areas with network deficiencies. If 90% of MBHP Covered Individuals in one service area had adequate access, then the network availability standard was met. However, if less than 90% of Covered Individuals in that service area had access to providers within a specified travel time or distance, then the network was deficient. **Table 22** shows service areas with deficient networks for MBHP. IPRO also determined that 41 providers had deactivated national provider identifiers, while two providers had more than 10 different locations listed per provider.

Table 22: MBHP Service Areas with Network Deficiencies – Behavioral Health Outpatient Services

Provider Type	Service Area with Network Deficiencies	Percent of Covered Individuals with Access in That Service Area	Standard – 90% of Covered Individuals Who Have Access
Youth Community Crisis Stabilization (YCCS)	Adams	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Athol	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Attleboro	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Barnstable	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Beverly	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Boston - Primary	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Brockton	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Fall River	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Falmouth	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Framingham	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Gardner-Fitchburg	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Gloucester	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Greenfield	3.2%	2 providers within 30 miles or 30 minutes
YCCS	Haverhill	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Lawrence	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Lowell	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Lynn	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Malden	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
YCCS	New Bedford	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Northampton	89.4%	2 providers within 30 miles or 30 minutes
YCCS	Oak Bluffs	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Orleans	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Pittsfield	1.9%	2 providers within 30 miles or 30 minutes
YCCS	Plymouth	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Quincy	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Revere	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Salem	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Somerville	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Southbridge	6.8%	2 providers within 30 miles or 30 minutes
YCCS	Taunton	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Waltham	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Wareham	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Woburn	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Worcester	0.0%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Acute Treatment Services (ATS) Level 3.7	Adams	75.3%	2 providers within 30 miles or 30 minutes
ATS	Greenfield	19.2%	2 providers within 30 miles or 30 minutes
ATS	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
ATS	Oak Bluffs	47.7%	2 providers within 30 miles or 30 minutes
ATS	Orleans	4.2%	2 providers within 30 miles or 30 minutes
ATS	Pittsfield	3.5%	2 providers within 30 miles or 30 minutes
ATS	Springfield	8.2%	2 providers within 30 miles or 30 minutes
ATS	Westfield	2.2%	2 providers within 30 miles or 30 minutes

Provider Type	Service Area with Network Deficiencies	Percent of Covered Individuals with Access in That Service Area	Standard – 90% of Covered Individuals Who Have Access
Clinical Stabilization Services (CSS) Level 3.5	Adams	75.3%	2 providers within 30 miles or 30 minutes
CSS	Greenfield	19.4%	2 providers within 30 miles or 30 minutes
CSS	Oak Bluffs	47.7%	2 providers within 30 miles or 30 minutes
CSS	Orleans	47.1%	2 providers within 30 miles or 30 minutes
CSS	Pittsfield	2.8%	2 providers within 30 miles or 30 minutes
CSS	Springfield	8.2%	2 providers within 30 miles or 30 minutes
CSS	Westfield	2.2%	2 providers within 30 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	Adams	75.1%	2 providers within 30 miles or 30 minutes
SOAP	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
SOAP	Orleans	22.5%	2 providers within 30 miles or 30 minutes
SOAP	Pittsfield	8.5%	2 providers within 30 miles or 30 minutes
Opioid Treatment Programs (OTP)	Adams	86.1%	2 providers within 30 miles or 30 minutes
OTP	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
OTP	Oak Bluffs	67.1%	2 providers within 30 miles or 30 minutes
OTP	Orleans	35.0%	2 providers within 30 miles or 30 minutes
OTP	Pittsfield	89.2%	2 providers within 30 miles or 30 minutes
Applied Behavior Analysis	Nantucket	8.1%	2 providers within 30 miles or 30 minutes
In-home Behavioral Services	Barnstable	25.4%	2 providers within 30 miles or 30 minutes
In-home Behavioral Services	Nantucket	0.9%	2 providers within 30 miles or 30 minutes
In-home Behavioral Services	Oak Bluffs	4.9%	2 providers within 30 miles or 30 minutes
In-home Behavioral Services	Orleans	22.3%	2 providers within 30 miles or 30 minutes
In-home Therapy Services	Nantucket	1.3%	2 providers within 30 miles or 30 minutes
Therapeutic Mentoring Services	Nantucket	1.3%	2 providers within 30 miles or 30 minutes
Intensive Care Coordination (ICC)	Adams	75.1%	2 providers within 30 miles or 30 minutes
ICC	Barnstable	23.2%	2 providers within 30 miles or 30 minutes
ICC	Nantucket	0.9%	2 providers within 30 miles or 30 minutes
ICC	Oak Bluffs	1.7%	2 providers within 30 miles or 30 minutes
ICC	Orleans	28.5%	2 providers within 30 miles or 30 minutes
ICC	Pittsfield	10.4%	2 providers within 30 miles or 30 minutes

MBHP: Massachusetts Behavioral Health Partnership.

Recommendations

- MBHP should clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- MBHP should submit for the analysis only the providers that are considered acceptable by MassHealth for certain behavioral health provider types.
- MBHP should use the correct standards and clean (deduplicated) data for the GeoAccess analysis for all provider types.
- MBHP should expand the network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the plan should explain what actions are being taken to provide adequate access for members residing in those counties.

VII. Quality-of-care Surveys – Member Satisfaction Survey

Objectives

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

Section 2.13.A.5 of the MassHealth MBHP contract requires MBHP to conduct satisfaction surveys of covered individuals at least biennially 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. In 2024, children were surveyed for the first time.

Technical Methods of Data Collection and Analysis

MBHP contracted with Press Ganey to administer the survey. The standardized survey tool assesses member experience with specialty behavioral health care, including mental health and chemical dependency services. For 2024, a child version of the survey (to be completed by a parent or guardian) was fielded for the first time. There were minimal changes to the survey for 2024. The survey is organized across six different categories.

Table 23 provides a list of all six survey categories.

Table 23: MBHP Member Satisfaction Survey Categories

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

MBHP: Massachusetts Behavioral Health Partnership.

The sample frame included members randomly selected from MBHP’s outpatient population. Press Ganey selected a random sample of members who had a behavioral health claim between the third quarter of 2023 through the end of the second quarter of 2024. Members receive a mail packet including a cover letter, mail survey, and business return envelope. After the initial mailing, Press Ganey reached out to nonrespondents by phone. Language line assistance was provided when requested. Members also had the option to complete the survey digitally. **Table 24** provides a summary of the technical methods of data collection.

Table 24: MBHP Member Satisfaction Survey – Technical Methods of Data Collection, MY 2024

Technical Methods of Data Collection	MBHP
Survey vendor	Press Ganey
Survey tool	MBHP’s Member Satisfaction Survey
Survey timeframe	Initial mailing began 9/24/2024 Phone collection began 10/23/2024 Data collection closed 12/9/2024
Method of collection	Mail, telephone, digital
Sample size	20,257
Response rate	3.1%

MBHP: Massachusetts Behavioral Health Partnership; MY: measurement year.

Description of Data Obtained

IPRO received a copy of the MY 2024 MBHP Member Experience Annual Report. The report included descriptions of the project objectives and methodology, as well as survey results and analyses.

Conclusions

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

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

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

MBHP: Massachusetts Behavioral Health Partnership.

Tables 26–29 show the results of the 2024 MBHP Member Experience Survey. In the Appointment Access and Availability categories, two measure rates exceeded the goal. In the Acceptability of MBHP Practitioners category, two measures exceeded the goal. In the Scope of Service category, three measures exceeded the goal. In the Experience of Care category, one measure exceeded the goal.

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

Member Experience MBHP Measure	MBHP	Benchmark Goal
When you needed non-life-threatening Emergency Care, did you have to wait? (Answer key: less than 6 hours)	69.8% (< Goal)	≥ 79.1% 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)	85.1% (> Goal)	≥ 83.5% within 48 hours
When you had a first-time appointment, when was the earliest appointment that was offered to you? (Answer key: an appointment within 10 business days)	61.7% (> Goal)	≥ 60.2%
In the last 12 months, how often were treatment locations close enough for you? (Answer key: always or usually)	78.4% (< Goal)	≥ 85.0%

MBHP: Massachusetts Behavioral Health Partnership.

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

Member Experience MBHP Measure	MBHP	Benchmark Goal
In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? A. Language? (Answer key: always or usually)	89.8% (> Goal)	≥ 85.0%
In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? B. Communication? (Answer key: always or usually)	87.8% (> Goal)	≥ 85.0%
In the last 12 months, how often did counseling or treatment meet your needs concerning the following areas? C. Religious? (Answer key: usually or always)	68.9% (< Goal)	≥ 76.2%
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)	75.2% (< Goal)	≥ 77.9%

Member Experience MBHP Measure	MBHP	Benchmark Goal
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)	82.1% (< Goal)	≥ 85.0%
How satisfied are you with all your counseling or treatment in the last 12 months? (Answer key: very satisfied or somewhat satisfied)	86.5% (> Goal)	≥ 85.0%
In the last 12 months, have you stayed overnight in a hospital or facility for any mental health or substance use services? IF YES: how satisfied are you with the treatment you got from this facility?	77.2% (< Goal)	≥ 85.0%
Do you feel the number of days approved for your stay was enough? (Answer key: yes)	78.6% (< Goal)	≥ 85.0%
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)	82.5% (< Goal)	≥ 85.0%

MBHP: Massachusetts Behavioral Health Partnership.

Table 28: MBHP Member Satisfaction Survey Performance – Scope of Service

Member Experience MBHP Measure	MBHP	Benchmark Goal
In the last 12 months, have you called MBHP for any reason? IF YES: how many calls to an MBHP staff member did it take to get all the information you needed?	25.0%	N/A
How often did MBHP staff member(s) treat you with courtesy and respect? (Answer key: always or usually)	90.2% (> Goal)	≥ 85.0%
How often did MBHP staff member(s) give you all the information or help you needed? (Answer key: always or usually)	79.9% (< Goal)	≥ 85.0%
How satisfied are you with the quality of services you got from MBHP staff member(s)? (Answer key: very or somewhat satisfied)	79.1% (< Goal)	≥ 85.0%
Overall satisfaction with language assistance (Answer key: very or somewhat satisfied)	81.8% (< Goal)	≥ 85.0%
Accuracy of language assistance (Answer key: very or somewhat satisfied)	78.3% (< Goal)	≥ 85.0%
Ease of getting language assistance (Answer key: very or somewhat satisfied)	77.3% (< Goal)	≥ 85.0%
Timeliness of getting language assistance (Answer key: very or somewhat satisfied)	77.3% (< Goal)	≥ 85.0%
How satisfied are you with the quality of service you got when you called MBHP to find a provider? (Answer key: very or somewhat satisfied)	76.5% (< Goal)	≥ 78.1%
How satisfied are you with the services you get from MBHP? (Answer key: very or somewhat satisfied)	82.1% (< Goal)	≥ 85.0%
How likely would you be to recommend MBHP to your family and friends? (Answer key: very or somewhat satisfied)	88.4% (> Goal)	≥ 85.0%

MBHP: Massachusetts Behavioral Health Partnership; N/A: not applicable.

Table 29: MBHP Member Satisfaction Survey Performance – Experience of Care

Member Experience MBHP Measure	MBHP	Benchmark Goal
Did those you saw for counseling or treatment tell you what side effects of those medicines to watch for? (Answer key: yes)	85.3% (> Goal)	≥ 79.9%
In the last 12 months, how much were you helped by the counseling or treatment you had? (Answer key: a lot or somewhat)	81.9% (< Goal)	≥ 85.0%
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)	70.0% (< Goal)	≥ 73.0%
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)	74.2% (< Goal)	≥ 77.7%

MBHP: Massachusetts Behavioral Health Partnership.

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, PAHP, or PCCM entity has effectively addressed the recommendations for QI⁸ made by the EQRO during the previous year’s EQR.” **Table 30** displays MBHP’s responses to the recommendations for QI made during CY 2024 as well as IPRO’s assessment of these responses. The table also includes IPRO’s assessment of these responses.

Table 30: MBHP Response to Previous EQR Recommendations

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>PMV: Currently, the membership data available to MBHP have race and ethnicity data in one single field and are not consistently available. MBHP is using a mapping methodology to report rates that require race and ethnicity stratification that is acceptable.</p> <p>It was noted that the measure specifications used to calculate the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility measure were not current. However, since the most current version of the specifications did not have any changes from the prior version besides the updated value set, the measure rates are considered reportable. Rates for the following measures were at or below the 25th percentile:</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) 	<p>Recommendation 1: MBHP should implement processes to obtain distinct and complete race and ethnicity data so that measures that require race and ethnicity stratification can be reported.</p> <p>Response: MBHP receives race and ethnicity data from MassHealth. We are able to effectively stratify rates by race and ethnicity. Additionally, self-reported demographic data is collected from Members via our Member Needs Assessment. Stratified rates have been submitted to MassHealth for MY 2023 and MY 2024.</p> <p>Recommendation 2: MBHP should ensure that clarification is obtained from MassHealth on the specifications and versions that should be used for measure rate calculation and reporting.</p> <p>Response: MBHP has identified that new specifications are released in June of each year. Upon release of the updated specifications, MBHP will review and confirm updated specs with MassHealth to ensure that the correct are implemented. Once confirmed, the updated specifications will be shared with the vendor for implementation. Rates will be calculated with the confirmed and updated specifications. We will create an SOP to monitor effectiveness.</p> <p>Recommendation 3: 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.</p> <p>Response: MBHP is currently working on a 3-year PIP related to the ADHD measures. We have done root cause analysis and designed quality improvement activities to address. Collaborative work with provider quality, primary care, member input, clinical and other stakeholders is currently in progress. We expect to see an increase in both ADHD measures. We will monitor the impact of the interventions, measure impact on HEDIS rates and modify the plan as needed.</p>	<p>Addressed</p>

⁸ Quality improvement.

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response ¹
	Language was added to provider communications to remind prescribers that telehealth can be used to complete required ADHD follow-up visits. Provider Quality Managers also reinforced the telehealth option during direct outreach activities, such as phone calls, site visits, and email communication. These efforts are intended to reduce access barriers and support improved member compliance with 30-day and continuation phase follow-up requirements.	
<p>Network – Time and Distance (Recommendation from CY 2023): Access was assessed for a total of 26 provider types. MBHP had deficient networks of all provider types except for two.</p> <p>MBHP should expand its network when members’ access can be improved and when network deficiencies can be closed by available providers.</p> <p>When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those counties.</p>	<p>MBHP is actively working to address network adequacy gaps by expanding access through targeted recruitment and contracting efforts. For counties where additional providers are available, MBHP is prioritizing outreach to close identified gaps. In areas where provider availability remains limited, MBHP is leveraging alternative strategies to support member access, such as utilizing telehealth when appropriate.</p> <p>MBHP will continue to monitor the network based on the existing geo-access reports and will appropriately address any needs in the network based on the results of these geo-access reports if any deficient areas are identified. In the event that we receive notification of a large provider termination or departure, MBHP will identify any access to care issues at that time. MBHP’s clinical department is also involved in this process to ensure continuity of care for members. The Network department will be sure to identify any service gaps in coverage and recruit key providers to maintain adequate network availability.</p>	Addressed
<p>Network – Information Systems and Quality of Provider Data – Duplicates: MBHP submitted many duplicates for facility providers due to variations in the facility names, such as including individual providers name, including suite names in the address, submitting departments, and facility name variations. IPRO removed a total of 945 duplicate providers from MBHP’s provider lists prior to conducting the analysis. MBHP should clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.</p>	<p>MBHP updated the code for our data to exclude duplicate records between first & second submission attempts. Going forward submissions will reflect this code. Provider data deduplication will be incorporated into the final quality check process and monitored by the team responsible for submitting the data to the auditors. We anticipate improved data accuracy on future submissions.</p>	Addressed

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>Network – Time and Distance Analysis – MCP’s Methodology: MBHP had duplicative records for many behavioral health diversionary services, all standard outpatient services, and all intensive home and community-based services. Because of the quality of the provider data, IPRO was not able to compare MBHP’s results for those provider types.</p> <p>MBHP should use clean (deduplicated) data for the GeoAccess analysis for all provider types.</p>	<p>MBHP updated the code for our data to exclude duplicate records between first & second submission attempts. Going forward submissions will reflect this code. Provider data deduplication will be incorporated into the final quality check process and monitored by the team responsible for submitting the data to the auditors. We anticipate improved data accuracy on future submissions.</p>	<p>Addressed</p>
<p>Network - Time and Distance Analysis – Gaps in Provider Networks: Other MBHP provider networks had gaps in at least one county. IPRO’s analysis revealed network gaps for all intensive home and community-based services.</p> <p>MBHP should expand the network when members’ access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the plan should explain what actions are being taken to provide adequate access for members residing in those counties.</p>	<p>MBHP continues to actively recruit all specialties to fill identified gaps. Where provider specialties are limited within the state. We continue to recruit additional providers to fill identified gaps in our network. We also work with members to ensure they have access to care. Effectiveness through our routine and ongoing geo access reports.</p>	<p>Partially Addressed</p>
<p>Quality-of-Care Surveys: Seventeen MBHP measures scored below the benchmark goal.</p> <p>MBHP should utilize the results of the Member Satisfaction Survey to drive performance improvement as it relates to member experience. Considering the high scores and some measures reaching 100% satisfaction, MBHP should also utilize complaints and</p>	<p>Each year MBHP implements quality improvement initiatives aimed to improve Member satisfaction with specific measures on the Member Experience survey, which are outlined in the Member survey report. With respect to the recommendation to utilize complaints and grievances (C&G) to identify new questions for the survey, MBHP analyzed 2024 aggregate results to find that out of the six categories of C&G (Attitude, Quality of Care/Clinical Practice Issues, Access to Care, Billing/Finance, Quality of Practitioner Office Site, and Other Issues) there were only eight substantiated C&Gs, all attributed to Quality of Care/Clinical Practice Issues). MBHP determined that the specific issues raised did not warrant revised or additional questions to be introduced to the administration of the Member survey in 2025, however,</p>	<p>Partially Addressed</p>

Recommendation for MBHP	MBHP Response/Actions Taken	IPRO Assessment of MCP Response ¹
grievances to identify new questions, expand the survey, and gain deeper insights.	MBHP will continue to monitor C&Gs in order to determine if there are opportunities for adding related questions to future survey administrations.	

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.

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

Table 31 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 2025 EQR activities as they relate to **quality, timeliness, and access**.

Table 31: MBHP Strengths, Opportunities for Improvement, and EQR Recommendations

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: POD	There is high confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is high confidence that the PIP produced evidence of improvement.	N/A	N/A	Quality, Timeliness, Access
PIP 2: ADD	There is moderate confidence that the PIP Baseline Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers.	There is low confidence that the PIP produced evidence of improvement. Several interventions were delayed, and there was no evidence of improvement in the performance indicator rates throughout the PIP. The plan noted delays in the creation and approval of both the provider and member outreach/education letters (noting this passive approach may not address deeper barriers), and the delay in receiving member-level data for members starting ADD medication.	MBHP should implement the provider and member outreach interventions as soon as possible to produce improvement in the performance indicator rates.	Quality, Timeliness, Access

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
<p>Performance Measure Validation: NCQA measures</p>	<p>MBHP demonstrated compliance with information system standards. No issues were identified. 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 days) Follow-up After Emergency Department Visit for Mental Illness (30 days) Pharmacotherapy for Opioid Use Disorder 	<p>MBHP did not use the most current measure specifications to calculate the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility measure.</p> <p>MBHP requested clarification from MassHealth with regards to the mapping of the FQHC codes to NCQA codes, removal of members with third party liability (TPL) or other insurance and removal of members in state-custody that are discharged to residential facilities. MassHealth approved the mapping of the FQHC codes to NCQA codes, removal of members with third party liability (TPL) or other insurance but not the removal of members in state-custody that are discharged to residential facilities. The recalculated rates were not provided during the performance measure validation process. The rates provided as part of the initial performance measure validation submission were used for the performance measure validation activity.</p> <p>Rates for the following measures were at or below the 25th percentile:</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) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications 	<p>Recommendation 1: MBHP should ensure that timely clarification is obtained from MassHealth on eligible populations to be included in measure calculations.</p> <p>Recommendation 2: MBHP should ensure that clarification is obtained from MassHealth on the specifications and versions that should be used for measure rate calculation and reporting.</p> <p>Recommendation 3: 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.</p>	<p>Quality, Timeliness, Access</p>
<p>Network Adequacy: Information Systems and Quality of Provider Data – Duplicates</p>	<p>Data used by MBHP to monitor network adequacy were mostly accurate and current, except for duplicative provider records.</p>	<p>MBHP submitted many duplicates for facility providers due to variations in the facility names, such as including individual providers name, submitting departments, and facility name variations. IPRO removed a total of 1,326 duplicate providers from MBHP's provider lists prior to conducting the analysis.</p>	<p>MBHP should clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.</p>	<p>Quality, Access, Timeliness</p>

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Information Systems and Quality of Provider Data Behavioral Health Providers	Data used by the MCP to monitor network adequacy were mostly accurate and current, except for duplicative provider records and incorrect provider directory information.	MBHP submitted additional behavioral health providers for Clinical Stabilization Services (Level 3.5), Psychiatric Inpatient Adult, Structured Outpatient Addiction Programs (SOAP), and Opioid Treatment Programs that were not on the approved list provided by MassHealth. IPRO removed a total of 721 additional providers from the MBHP behavioral health data prior to conducting the analysis.	MBHP should submit for the analysis only the providers that are considered acceptable by MassHealth for certain behavioral health provider types.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – MCP’s Methodology	MBHP used the correct MassHealth standards for all provider types except for Psychiatry, Partial Hospitalization Programs (PHP), and some service areas for Psychiatric Inpatient Adult services.	MBHP used incorrect MassHealth standards for Psychiatry, Partial Hospitalization Programs (PHP), and some service areas for Psychiatric Inpatient Adult services. MBHP had duplicative records for all provider types. Because of the quality of the provider data, IPRO was not able to compare MBHP’s results for those provider types.	MBHP should use the correct standards and clean (deduplicated) data for the GeoAccess analysis for all provider types.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	MBHP demonstrated adequate networks for Psychiatric Inpatient Adult, Partial Hospitalization Programs, Behavioral Health Outpatient, and Psychiatry in all service areas.	Other MBHP provider networks had gaps in at least one service area.	MBHP should expand the network when members’ access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the plan should explain what actions are being taken to provide adequate access for members residing in those counties.	Access, Timeliness
Quality-of-care Surveys	MBHP exceeded its benchmark goal on eight measures.	Twenty-two MBHP measures scored below the benchmark goal.	MBHP should utilize the results of the Member Satisfaction Survey to drive performance improvement as it relates to member experience. MBHP should also utilize complaints and grievances to identify new questions, expand the survey, and gain deeper insights.	Quality, Timeliness, Access

MBHP: Massachusetts Behavioral Health Partnership; EQR: external quality review; PIP: performance improvement project; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; ADHD: attention-deficit/hyperactivity disorder; MCP: managed care plan; N/A: not applicable.

X. Required Elements in EQR Technical Report

The Balanced Budget Act of 1997 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, performance measure validation, and review of compliance activities, are listed in **Table 32**.

Table 32: 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 .

Regulatory Reference	Requirement	Location in the EQR Technical Report
<p><i>Title 42 CFR § 438.358(b)(1)(iii)</i></p>	<p>Technical report must include information on a review, conducted within the previous three-year period, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in Title 42 CFR § 438.330.</p> <p>The technical report must provide MCP results for the 11 Subpart D and QAPI standards.</p>	<p>This report includes information on a review, conducted in 2023, to determine MBHP's compliance with the standards set forth in Subpart D and the QAPI requirements described in <i>Title 42 CFR § 438.330</i>; see Section V.</p>

EQR: external quality review; CFR: Code of Federal Regulations; §: section; CHIP: Children's Health Insurance Program; MCP: managed care plan; MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan; PCCM: primary care case management; PIP: performance improvement project; EQRO: external quality review organization; PHI: protected health information; QAPI: quality assurance and performance improvement.

XI. Appendix A – MassHealth Quality Goals and Objectives

Table A1: Goal 1 – Achieve a healthy population, delivering high-quality pediatric, preventive, and perinatal care.

Goal	Objective	Quality Measure	Baseline (MY 2023)	Target (MY 2027)
1.1	Improve access and quality of care for infants and children	W30-CH: Well-visits First 15/30 Months ¹ WCV-CH: Child and Adolescent Well-visits ¹	51.9% 54.6%	57% 60%
1.2	Increase utilization and timeliness of preventative services	BCS-AD: Breast Cancer Screening ¹ COL-AD: Colorectal Cancer Screening ¹	64.3% 28.8%	70% 32%
1.3	Manage quality and access to maternal health	PPC: Prenatal Care ¹ PPC: Postpartum Care ¹	48.6% 63.4%	55% 70%

¹ CMS Universal Foundation and Core Set Measure.

CH: Child; AD: Adult; PPC: Prenatal and Postpartum Care; MY: measurement year.

Table A2: Goal 2 – Advance progress on high-impact acute and chronic condition areas to improve safe, effective, high-value care.

Goal	Objective	Quality Measure	Baseline (MY 2023)	Target (MY 2027)
2.1	Improve the health of populations with acute and chronic conditions that are key contributors to co-morbidities	CBP-AD: Controlling High Blood Pressure GSD-AD: Glycemic Status Assessment for Patients with Diabetes (poor control; lower is better) ¹	71.7% 25.5%	75% 22%
2.2	Manage populations impacted by mental health and substance use disorders	FUA: Follow-up after Emergency Department Visit for Substance Use ²	7-day: 36.6% 30-day: 49.5%	40% 53%
2.3	Promote member safety	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD/OUD-HH) ¹	79.2%	82%

¹ CMS Core Measure.

² CMS Universal Foundation and Core Set Measure.

AD: Adult; HH: Health Home; MY: measurement year.

Table A3: Goal 3 – Enable coordinated and efficient quality care for all members across the continuum of services and settings of care.

Goal	Objective	Quality Measure	Baseline (MY 2023)	Target (MY 2027)
3.1	Manage timely, smooth transitions in care between inpatient and outpatient settings	FUH: Follow-up After Hospitalization for Mental Illness ¹	7-day: 38.3% 30-day: 59.5%	45% 64%
3.2	Improve access to and quality of home and community-based services	MLTSS-7: Managed LTSS Minimizing Facility Length of Stay ²	1.33	1.0
3.3	Reduce unnecessary hospitalizations by Improving coordination and delivery of care in the community	PCR-AD: Plan All-Cause Readmissions ¹	1.24	1.0

¹ CMS Universal Foundation and Core Set Measure.

² Other national measure.

LTSS: Long-Term Services and Support; AD: Adult; MY: measurement year.

Table A4: Goal 4 – Enhance person-centered care through elevating member voice and improving member experience and engagement with their health care.

Goal	Objective	Quality Measure	Baseline (MY 2024)	Target (MY 2027)
4.1	Improve and maintain a high level of experience for members receiving routine care.	CAHPS Health Plan Survey (Medicaid): Rating of Doctor (9 + 10) ¹ CAHPS Health Plan Survey (Medicaid): Rating of Health Care* (9 + 10) ¹	Adult: 68.56% Child: 79.26% ² Adult: 57.05% Child: 80.39% ²	71% 82% 60% 82%
4.2	Understand and improve the member experience of populations or members that have complex care needs	Rating of Healthcare Quality SCO and One Care ¹	SCO: 86% One Care: 87%	88% 89%

¹ CMS Universal Foundation and Core Set Measure.

² Medicaid Expansion CHIP and non-CHIP.

CAHPS: Consumer Assessment of Healthcare Providers and Systems; SCO: Senior Care Options; MY: measurement year.

Table A5: Goal 5 – Ensure access to and appropriate utilization of care and services to members.

Goal	Objective	Quality Measure	Baseline (MY 2023)	Target (MY 2027)
5.1	Establish and maintain timely access to care and services in the communities where people live	CAHPS member experience: Getting Care Quickly ¹	Adult: 80.27% Child: 85.44% ²	83% 87%
5.2	Promote provider and service access	FUM: Follow-up after Emergency Department Visit for Mental Illness ³	7-day: 68.1% 30-day: 76.8%	72% 80%

¹ CMS Universal Foundation and Core Set Measure.

² Medicaid Expansion CHIP and non-CHIP.

³ CMS Core Measure.

MY: measurement year.

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. • Type: MCE. 	<ol style="list-style-type: none"> 1. BeHealthy Partnership Plan 2. Berkshire Fallon Health Collaborative 3. East Boston Neighborhood Health WellSense Alliance 4. Fallon 365 Care 5. Fallon Health – Atrius Health Care Collaborative 6. Mass General Brigham Health Plan with Mass General Brigham ACO 7. Tufts Health Together with Cambridge Health Alliance (CHA) 8. Tufts Health Together with UMass Memorial Health 9. WellSense Beth Israel Lahey Health (BILH) Performance Network ACO 10. WellSense Boston Children’s ACO 11. WellSense Care Alliance 12. WellSense Community Alliance 13. WellSense Mercy Alliance 14. WellSense Signature Alliance 15. WellSense Southcoast 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. • Type: PCCM Entity. 	<ol style="list-style-type: none"> 1. Community Care Cooperative 2. Revere Medical
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. • Type: MCE. 	<ol style="list-style-type: none"> 1. WellSense Essential 2. Tufts Health Together (will no longer be a plan in 2026)

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
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. • Type: PCCM. 	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. • Type: PIHP. 	MBHP
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 ages 21–64 years at the time of enrollment with MassHealth and Medicare coverage. • Managed Care Authority: Financial Alignment Initiative Demonstration. • Type: MCE. 	<ol style="list-style-type: none"> 1. Commonwealth Care Alliance 2. Tufts Health Plan Unify 3. UnitedHealthcare Connected

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Senior Care Options (SCO)	<p>Medicare 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) Waivers. • Type: MCE. 	<ol style="list-style-type: none"> 1. Commonwealth Care Alliance 2. NaviCare Fallon Health 3. Senior Whole Health by Molina 4. Tufts Health Plan Senior Care Option 5. UnitedHealthcare Senior Care Options 6. WellSense Senior Care Option (will no longer be a plan in 2026)

ACO: accountable care organization; PCP: primary care provider; MCE: managed care entity; PCCM: primary care case management; PIHP: prepaid inpatient health plan.

XIII. Appendix C – MassHealth Quality Measures

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

Measure Steward	Acronym	Measure Name	Core Set	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/ Objectives
NCQA	AMM	Antidepressant Medication Management – Acute and Continuation	X	N/A	N/A	X	N/A	X	2.2
NCQA	AMR	Asthma Medication Ratio	X	X	X	N/A	N/A	N/A	2.1
NCQA	BCS	Breast Cancer Screening	X	N/A	N/A	N/A	X	N/A	1.2
NCQA	COA	Care for Older Adults: Functional Status Assessment	N/A	N/A	N/A	X	N/A	N/A	4.2
NCQA	WCV	Child and Adolescent Well-Care Visits	X	N/A	N/A	N/A	N/A	N/A	1.1
NCQA	CIS	Childhood Immunization Status (Combo 10)	X	X	X	N/A	N/A	N/A	1.1
NCQA	COL	Colorectal Cancer Screening	X	N/A	N/A	X	X	N/A	1.2
NCQA	CBP	Controlling High Blood Pressure	X	X	X	X	X	N/A	2.1
OHSU	DEV	Developmental Screening in the First Three Years of Life	X	X	X	N/A	N/A	N/A	1.2
NCQA	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	X	N/A	N/A	N/A	N/A	X	2.1
NCQA	FUM	Follow-up After Emergency Department Visit for Mental Illness (30 days)	X	N/A	N/A	X	N/A	X	5.1
NCQA	FUM	Follow-up After Emergency Department Visit for Mental Illness (7 days)	X	X	X	N/A	X	X	5.2
NCQA	FUH	Follow-up After Hospitalization for Mental Illness (30 days)	X	N/A	N/A	X	X	X	3.1
NCQA	FUH	Follow-up After Hospitalization for Mental Illness (7 days)	X	X	X	N/A	N/A	X	3.1
NCQA	FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	X	N/A	N/A	N/A	N/A	X	3.1
NCQA	FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	X	X	X	N/A	N/A	X	3.1
NCQA	ADD	Follow-up for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (HEDIS)	X	N/A	N/A	N/A	N/A	X	1.1

Measure Steward	Acronym	Measure Name	Core Set	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/ Objectives
NCQA	GSD	Glycemic Status Assessment for Patients with Diabetes Hemoglobin A1c > 9%	X	X	X	N/A	X	N/A	2.1
NCQA	IMA	Immunizations for Adolescents	X	X	X	N/A	N/A	N/A	1.1
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	X	2.2
CMS	MLTSS-7	Managed Long-term Services and Supports Minimizing Facility Length of Stay	N/A	N/A	N/A	X	X	N/A	3.2
NCQA	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	X	X	X	N/A	N/A	X	2.2
NCQA	OMW	Osteoporosis Management in Women Who Had a Fracture	N/A	N/A	N/A	X	N/A	N/A	2.1
NCQA	PBH	Persistence of Beta-Blocker Treatment after Heart Attack	N/A	N/A	N/A	X	N/A	N/A	2.1
NCQA	PCE	Pharmacotherapy Management of COPD Exacerbation	N/A	N/A	N/A	X	N/A	N/A	2.1
NCQA	POD	Pharmacotherapy for Opioid Use Disorder	N/A	N/A	N/A	N/A	N/A	X	2.2
NCQA	PCR	Plan All-Cause Readmission	X	N/A	N/A	X	X	N/A	3.3
NCQA	DDE	Potentially Harmful Drug – Disease Interactions in Older Adults	N/A	N/A	N/A	X	N/A	N/A	2.1
CMS	CDF	Screening for Depression and Follow-up Plan	X	X	X	N/A	N/A	N/A	1.2
CMS	IPF	30-day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	N/A	N/A	N/A	N/A	N/A	X	3.3
NCQA	PPC	Timeliness of Prenatal Care	X	X	X	N/A	N/A	N/A	1.3
NCQA	PPC	Postpartum Care	X	X	X	N/A	N/A	N/A	1.3
NCQA	TRC	Transitions of Care – All Submeasures	N/A	N/A	N/A	X	X	N/A	3.1
DQA (ADA)	TFL	Topical Fluoride for Children	X	X	X	N/A	N/A	N/A	1.1
NCQA	DAE	Use of High-risk Medications in the Older Adults	N/A	N/A	N/A	X	N/A	N/A	2.3
SAMHSA	OUD	Use of Pharmacotherapy for Opioid Use Disorder	X	N/A	N/A	N/A	N/A	X	2.3

NCQA: National Committee for Quality Assurance; EOHS: Massachusetts Executive Office of Health and Human Services; DQA (ADA): Dental Quality Alliance (American Dental Association); CMS: Centers for Medicare and Medicaid Services; COPD: chronic obstructive pulmonary disease; SAMHSA: Substance Abuse and Mental Health Services Administration; OHSU: Oregon Health and Science University; N/A: not applicable; ACPP: accountable care partnership plan; PC ACO: primary care accountable care organization; MCO: managed care organization; SCO: Senior Care Options; MBHP: Massachusetts Behavioral Health Partnership.

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

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

Network Adequacy Standards Source: Appendix P of MBHP Contract Amendment 7/1/25	Indicator	Definition of the Indicator
<p>Inpatient Service Provider Types:</p> <ul style="list-style-type: none"> Psychiatric Inpatient Adult <p>Covered individuals must have access to 2 inpatient service providers within 60 miles or 60 minutes of their residence.</p> <p>MBHP must ensure that, at a minimum, 90% of covered individuals have access to all Medically Necessary BH Services.</p>	<p>Inpatient Service Providers:</p> <p>90% of covered individuals have access to 2 inpatient service providers within 60 miles or 60 minutes within a covered individual's residence.</p>	<p>Psychiatric inpatient adult Geo-Access:</p> <p>Numerator: number of members in a Service Area for which one of the following is true:</p> <ul style="list-style-type: none"> Two unique in-network providers are a 60-minute drive or less from a member residence; OR Two unique in-network providers are 60 miles or less from a member residence. <p>Denominator: all members in a Service Area</p> <p><i>*For the Nantucket and Oak Bluffs Service Areas only, the Contractor may meet this requirement by including in its Provider Network the two closest Providers that provide Psychiatric Inpatient Adult services.</i></p>

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

Network Adequacy Standards Source: Appendix P of MBHP Contract Amendment 7/1/25	Indicator	Definition of the Indicator
<ul style="list-style-type: none"> • Monitored inpatient Acute Treatment Services (ATS) Level 3.7 • Clinical Stabilization Services (CSS) Level 3.5 • Partial Hospitalization Program (PHP) • Structured Outpatient Addiction Program (SOAP) • Youth Community Crisis Stabilization (YCCS) • BH Outpatient (including psychology and psych APN) • Psychiatry (MDs) • Opioid Treatment Programs (OTP) • In-Home Behavioral Services (IHBS) • In-Home Therapy (IHT) Providers • Therapeutic Mentoring (TM) Services • Applied Behavioral Analysis (ABA) • Intensive Care Coordination (ICC) <p>Covered Individuals must have access to 2 providers for all other BH Covered Services within 30 miles or 30 minutes of their residence.</p> <p>MBHP must ensure that, at a minimum, 90% of covered individuals have access to all Medically Necessary BH Services.</p>	<p>Partial Hospitalization (PHP): 90% of covered individuals have access to 1 BH service providers within 60 miles or 60 minutes within the covered individual's residence.</p> <p>Psychiatry: 90% of covered individuals have access to 1 BH service provider within 20 miles or 40 minutes within the covered individual's residence.</p> <p>All other provider types: 90% of covered individuals have access to 2 BH service providers within 30 miles or 30 minutes within the covered individual's residence.</p>	<p>Partial Hospitalization Geo-Access: Numerator: number of members in a Service Area for which one of the following is true:</p> <ul style="list-style-type: none"> • One unique in-network providers are a 60-minute drive or less from a member residence; OR • One unique in-network providers are 60 miles or less from a member residence. <p>Denominator: all members in a Service Area</p> <p>Psychiatry Geo-Access: Numerator: number of members in a Service Area for which one of the following is true:</p> <ul style="list-style-type: none"> • One unique in-network providers are a 40-minute drive or less from a member residence; OR • One unique in-network providers are 20 miles or less from a member residence. <p>Denominator: all members in a Service Area</p> <p>Other Behavioral Health Services Geo-Access: Numerator: number of members in a Service Area for which one of the following is true:</p> <ul style="list-style-type: none"> • Two unique in-network providers are a 30-minute drive or less from a member residence; OR • Two unique in-network providers are 30 miles or less from a member residence. <p>Denominator: all members in a Service Area</p> <p><i>*For the Nantucket Service Area only, the Contractor may meet this requirement by including in its Provider Network the four closest Providers that provide CSS level 3.5 services.</i></p>