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External Quality Review
Primary Care Accountable Care Organizations
Annual Technical Report, Calendar Year 2023

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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I. Executive Summary

Primary Care Accountable Care Organizations

External quality review (EQR) is the evaluation and validation of information about quality 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 to improve their performance. This annual technical report (ATR) describes the results of the EQR for primary care accountable care organizations (PC ACOs) that furnish health care services to Medicaid enrollees in Massachusetts.

In March 2023, Massachusetts's Medicaid program (known as "MassHealth") and administered by the Massachusetts Executive Office of Health and Human Services (EOHHS), initiated a re-procurement of the ACO program, leading to the discontinuation of one PC ACO plan. Effective April 1, 2023, MassHealth contracted with two PC ACO plans.

PC ACOs are health plans consisting of groups of primary care providers who contract directly with MassHealth to provide integrated and coordinated care. A PC ACO functions as an ACO and a primary care case management (PCCM) arrangement. In contrast to Accountable Care Partnership Plans (ACPPs), a PC ACO does not partner with just one managed care organization (MCO). Instead, PC ACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP). MassHealth's PC ACOs are listed in **Table 1**.

Table 1: MassHealth's PC ACOs – Effective April 1, 2023

Primary Care Accountable Care Organization (PC ACO) Name	Abbreviation Used in the Report	Members as of December 31, 2023	Percent of Total PC ACO Population
Community Care Cooperative	C3 ACO	211,942	65.31%
Steward Health Choice	Steward ACO	112,557	34.69%
All PC ACOs	Total	324,499	100.00%

The **Community Care Cooperative** (**C3 ACO**) is an ACO that serves 211,942 MassHealth enrollees. C3 ACO was formed in 2016 by leaders from nine federally qualified health centers (FQHCs). It is the only ACO in Massachusetts founded by and governed by FQHCs. C3 ACO serves diverse and underserved populations across the entire state. [1]

The **Steward Health Choice** (**Steward**) is an ACO that serves 112,557 MassHealth enrollees. Steward is a part of the Steward Health Care System. Steward's network includes hospitals, urgent care centers, and skilled nursing facilities. Steward serves a diverse population of members, including children and adults with disabilities.[2]

Purpose of Report

The purpose of this ATR 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 PC ACOs met the state standards and whether the state met the federal standards as defined in the CFR.

[1] MassHealth Community Care Cooperative, Inc. Available at Community Care Cooperative, Inc. | Mass.gov Accessed on 1.28.2024
[2] MassHealth Steward Medicaid Care Network, Inc. Available at Steward Medicaid Care Network, Inc. | Mass.gov Accessed on 1.28.2024

Scope of External Quality Review Activities

MassHealth contracted with IPRO, an external quality review organization (EQRO), to conduct mandatory EQR activities for its PC ACOs. As a type of a PCCM arrangement, PC ACOs are subject to two mandatory EQR activities. As set forth in *Title 42 CFR § 438.358 Activities related to external quality review(b)(1)*, these activities are:

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

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

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

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

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

High-Level Program Findings

The EQR activities conducted during the 2023 calendar year (CY) demonstrated that MassHealth and the PC ACOs share a commitment to improvement in providing high-quality, timely, and accessible care for members.

IPRO used the analyses and evaluations of CY 2023 EQR activity findings to assess the performance of MassHealth's PC ACOs in providing quality, timely, and accessible health care services to Medicaid members. The individual PC ACOs were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible. These plan-level findings and recommendations for each PC ACO are discussed in each EQR activity section, as well as in the MCP Strengths, Opportunities for Improvement, and EQR Recommendations section.

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

MassHealth Medicaid Comprehensive Quality Strategy

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

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.

[3] Children's Health Insurance Program.

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

MassHealth reviews and evaluates the effectiveness of its quality strategy every 3 years. In addition to the triennial review, MassHealth also conducts an annual review of measures and key performance indicators to assess progress toward strategic goals. MassHealth relies on the annual EQR process to assess the managed care programs' effectiveness in providing high-quality, accessible services.

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

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

General Recommendations for MassHealth:

- *Recommendation towards achieving the goals of the Medicaid quality strategy* – MassHealth should assess whether the state met or made progress on the five strategic goals and objectives described in the quality strategy. This assessment should describe whether the state successfully promoted better care for MassHealth members (goal 1), achieved measurable reductions in healthcare inequities (goal 2), made care more value-based (goal 3), successfully promoted person- and family-centered care (goal 4), and improved care through better integration, communication, and coordination (goal 5). The state may decide to continue with or revise its five strategic goals and objectives based on the evaluation.[4]

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

Performance Improvement Projects

MassHealth selected topics for its performance improvement projects (PIPs) in alignment with the quality strategy goals and objectives. As a type of a PCCM arrangement, PC ACOs were not subject to the validation of PIPs, and PC ACOs did not conduct any PIPs during CY 2023. Starting in 2024, PC ACOs will start implementing their first PIP as part of MassHealth's Quality and Equity Incentive Programs.

Performance Measure Validation

IPRO validated the accuracy of PMs and evaluated the state of health care quality in the PC ACO program. PC ACOs are evaluated on a set of Healthcare Effectiveness Data and Information Set (HEDIS®) measures and state-specific measures. Quality measures rates are calculated by MassHealth's vendor Telligen®.

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

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.

IPRO conducted performance measure validation (PMV) to assess the accuracy of PC ACO performance measures and to determine the extent to which all performance measures follow MassHealth's specifications and reporting requirements. IPRO found that the data and processes used to produce HEDIS and state-specific rates for the PC ACOs were fully compliant with all seven of the applicable NCQA information system standards.

IPRO aggregated PC ACOs measure rates to provide comparative information for all plans. When compared to the MY2022 Quality Compass® New England regional percentile, performance varied across plans. When compared to the MassHealth goal benchmark, the following measures scored above the goal:

- Oral Health Evaluation: All PC ACOs were above the state benchmark goal and the weighted statewide mean was also above the state benchmark goal.
- Risk-Adjusted Ratio (Observed/Expected) of ED Visits for Members Aged 18–65 Years Identified with a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions: All PC ACOs and the weighted statewide mean were above the state benchmark goal.

Opportunities for Improvement:
When IPRO compared the HEDIS measures rates to the NCQA Quality Compass and state-specific measures rates to the state's goal benchmark, the performance varied across measures with the opportunities for improvement in the following areas:

- Hemoglobin A1c Control; HbA1c poor control (>9.0%): All entities were below the 25th percentile, indicating a need for improvement.
- Follow-Up After Hospitalization for Mental Illness (7 days): All entities were at or above the 25th percentile, but below the 50th percentile, indicating a need for improvement.
- Asthma Medication Ratio: Both MGB and Steward were at or above 25th percentile, but below the 50th percentile, and C3 was at or above 75, but below 90, while the statewide weighted mean was at or above 25th, but below the 50th percentile, suggesting an area for improvement.
- Plan All-Cause Readmissions (Observed/Expected Ratio) – C3 ACO was below the 25th percentile, MGB was at or above the 25th percentile but below the 50th percentile, and Steward was at or above the median but below the 75th percentile. The PC ACO statewide weighted average was below the 25th percentile compared to the Quality Compass.
- Timeliness of Prenatal Care – MGB was below the 25th percentile, Steward was at or above the 50th percentile, but below the 75th percentile, and C3 was at or above the 75th percentile, but below the 90th percentile, while the PC ACO statewide weighted mean was below the 50th percentile.
- Depression Remission or Response: All PC ACOs were below the goal benchmark, indicating a need for improvement.
- Behavioral Health Community Partner Engagement: All PC ACOs were below the goal benchmark, indicating a need for improvement.

General Recommendations for MassHealth:

- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the quality measures data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions.

PMV findings are provided in Section III of this report.

Compliance Review

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

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

Member Experience of Care Survey

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

Strengths:

MassHealth surveys ACO members about their experiences with PCPs using the Primary Care Member Experience Survey (PC MES), developed based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician & Group Survey (CG-CAHPS). Similar to CG-CAHPS, the PC MES survey asks members to report on their experiences with providers and staff in physician practices and groups.

MassHealth is contractually allowed to administer patient experience survey to evaluate PC ACOs enrollees' experience with PCP providers participating in the MassHealth's ACO program.

MassHealth uses the survey results to assess ACOs performance. Four adult and four child member experience measures (Communication, Willingness to Recommend, Integration of Care, and Knowledge of Patient) are included in the calculation of the ACOs' quality score impacting a portion of the savings that ACOs earn.

Opportunities for Improvement:

Goal benchmarks have been established for only the four member experience measures that are tied to value-based payment. Without benchmarks, it becomes challenging to assess an ACO's performance and identify areas that need improvement. IPRO compared PC ACO adult and child PC MES results to statewide scores calculated for all ACOs, including ACPPs and PC ACOs. However, while comparing ACOs' scores to the statewide score offers some insights, it is not enough for a comprehensive evaluation.

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.

The PC MES survey does not adhere to CMS technical specifications for the mandatory reporting of the CAHPS Health Plan Survey 5.1H Child Version (CPC-CH) measure. To adhere to Medicaid Child Core Set reporting guidance issued by CMS, MassHealth would need to follow the HEDIS protocol and ensure that all measure-eligible Medicaid and CHIP beneficiaries are included in the state reporting of the child CAHPS Health Plan survey measure. This includes children enrolled in multiple delivery systems, like managed care, primary care

case management, and fee for service.[5] Child Core Set reporting is mandatory beginning with FFY 2024 reporting.

General Recommendations for MassHealth:

- *Recommendation towards an effective evaluation of ACO's performance on member experience measures* – IPRO recommends establishing benchmarks for all member experience measures to enhance the effectiveness of performance evaluation and support continuous quality improvement.
- *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.
- *Recommendation towards adhering to CMS Child Core Set reporting guidance* – To adhere to Medicaid Child Core Set reporting guidance issued by CMS, MassHealth would need to follow the HEDIS protocol and ensure that all measure-eligible Medicaid and CHIP beneficiaries are included in the state reporting of the child CAHPS Health Plan survey measure. This includes children enrolled in multiple delivery systems, like managed care, primary care case management, and fee for service.

PC ACO-specific results for member experience of care surveys are provided in Section V of this report.

Recommendations

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

EQR Recommendations for MassHealth

Here is a summary of all recommendations for MassHealth:

- *Recommendation towards achieving the goals of the Medicaid quality strategy* – MassHealth should assess whether the state met or made progress on the five strategic goals and objectives described in the quality strategy.
- *Recommendation towards accelerating the effectiveness of PIPs* – While regulations do not require PCCM entities to conduct PIPs as a part of their quality assurance and performance improvement (QAPI) programs, states may choose to require their PCCM entities to do so. States that require PCCM entities to conduct PIPs should consider validating those PIPs.[6] PC ACOs serve a large portion of MassHealth's enrollees. IPRO recommends that MassHealth require PC ACOs to validate PIPs.
- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the quality measures data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions.
- *Recommendation towards an effective evaluation of ACO's performance on member experience measures* – IPRO recommends establishing benchmarks for all member experience measures to enhance the effectiveness of performance evaluation and support continuous quality improvement.

[5] Child Core Set. Technical Specifications and Resource Manual for FFY 2024 Reporting. January 2024. Appendix E: Guidance for Conducting the Child CAHPS Health Plan Survey 5.1H (page E-4). Available at: Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2024 Reporting. Accessed on 1.28.2024.

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

- *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.
- *Recommendation towards adhering to CMS Child Core Set reporting guidance* – To adhere to Medicaid Child Core Set reporting guidance issued by CMS, MassHealth would need to follow the HEDIS protocol and ensure that all measure-eligible Medicaid and CHIP beneficiaries are included in the state reporting of the child CAHPS Health Plan survey measure. This includes children enrolled in multiple delivery systems, like managed care, primary care case management, and fee for service.

EQR Recommendations for PC ACO Plans

PC ACO-specific recommendations related to quality of, timeliness of, and access to care are provided in Section VII 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. Massachusetts's Medicaid 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. MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.[7]

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

MassHealth Medicaid Quality Strategy

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

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

Table 2: MassHealth's Strategic Goals

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

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

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

MassHealth Managed Care Programs

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

1. The Accountable Care Partnership Plans (ACPPs) are health plans consisting of groups of primary care providers who partner with one managed care organization to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As accountable care organizations, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high quality care to MassHealth enrollees. To select an Accountable Care Partnership Plan, a MassHealth enrollee must live in the plan's service area and must use the plan's provider network.
2. The Primary Care Accountable Care Organizations (PC ACOs) are health plans consisting of groups of primary care providers who contract directly with MassHealth to provide integrated and coordinated care. A PC ACO functions as an accountable care organization and a primary care case management arrangement. In contrast to ACPPs, a PC ACO does not partner with just one managed care organization. Instead, PC ACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. Managed Care Organizations (MCOs) are health plans run by health insurance companies with their own provider network that includes primary care providers, specialists, behavioral health providers, and hospitals.
4. Primary Care Clinician Plan (PCCP) is a primary care case management arrangement, where Medicaid enrollees select or are assigned to a primary care provider, called a Primary Care Clinician (PCC). The PCC provides services to enrollees including the coordination, and monitoring of primary care health services. PCCP uses the MassHealth network of primary care providers, specialists, and hospitals as well as the Massachusetts Behavioral Health Partnership's network of behavioral health providers.
5. Massachusetts Behavioral Health Partnership is a health plan that manages behavioral health care for MassHealth's Primary Care Accountable Care Organizations and the Primary Care Clinician Plan. MBHP also serves children in state custody, not otherwise enrolled in managed care and certain children enrolled in MassHealth who have commercial insurance as their primary insurance.[8]
6. One Care Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services as well as long-term services and support. This plan is for enrollees between 21 and 64 years old who are dually enrolled in Medicaid and Medicare.[9]
7. Senior Care Options (SCO) plans are coordinated health plans that cover services paid by Medicare and Medicaid. This plan is for MassHealth enrollees 65 or older and it offers services to help seniors stay independently at home by combining healthcare services with social supports.[10]

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

Quality Metrics

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

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

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

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

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

Performance Improvement Projects

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

Member Experience of Care Surveys

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

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

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

MassHealth Initiatives

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

1115 Demonstration Waiver

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

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

Quality and Equity Incentive Programs

Quality and Equity Incentive Programs are initiatives coordinated between MassHealth's Accountable Care Organizations and acute hospitals with an overarching goal to improve quality of care and advance health equity. Health equity is defined as the opportunity for everyone to attain their full health potential regardless of their social position or socially assigned circumstance. ACOs quality and equity performance is incentivized through programs implemented under managed care authority. Hospitals quality performance is incentivized through the "Clinical Quality Incentive Program" implemented under State Plan Authority, while hospitals equity performance is incentivized through the "Hospital Quality and Equity Initiative" authorized under the 1115 Demonstration Waiver. Under the "Hospital Quality and Equity Initiative," private acute hospitals and the Commonwealth's only non-state-owned public hospital, Cambridge Health Alliance, are assessed on the completeness of social needs data (domain 1), performance on quality metrics and associated reductions in disparities (domain 2), and improvements in provider and workforce capacity and collaboration between health system partners (domain 3). MassHealth's ACOs and hospitals work towards coordinated deliverables aligned in support of the common goals of the incentive programs.[11] For example, in 2023, ACOs and hospitals partnered to work together on equity-focused performance improvement projects.

Roadmap for Behavioral Health

Another MassHealth initiative that supports the goals of the quality strategy is the five-year roadmap for behavioral health reform that was released in 2021. Key components of implementing this initiative include the integration of behavioral health in primary care, community-based alternatives to emergency department for crisis interventions, and the creation of the 24-7 Behavioral Health Help Line (BHHL) that became available in 2023. The Behavioral Health Help Line is free and available to all Massachusetts residents.[12]

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

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

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

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

[11] MassHealth QEIP Deliverables Timelines. Available at: download (mass.gov). Accessed on 12.29.2023.
[12] Behavioral Health Help Line FAQ. Available at: Behavioral Health Help Line (BHHL) FAQ | Mass.gov. Accessed on 12.29.2023.

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

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

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

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

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

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

III. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

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

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

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

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

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

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

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

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

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

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

Description of Data Obtained

The following information was obtained from MassHealth:

- A completed ISCA tool.
- Denominator and numerator compliant lists for the following two measures:
  - Follow-Up After Hospitalization for Mental Illness (FUH): Within 7 days.
  - Initiation and Engagement of Substance Use Disorder Treatment (IET): Initiation of SUD Treatment.
- Rates for HEDIS and non-HEDIS measures.
- Screenshots from the data warehouse for PSV.
- Lists of numerator records that were compliant by medical record abstraction for the following:
  - Childhood Immunization Status (CIS)
  - Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care (PPC-Prenatal).

The following information was obtained from the PC ACOs:

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

Conclusions and Comparative Findings

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

Table 3: PC ACO Compliance with Information System Standards – MY 2022

IS Standard	C3 ACO	MGB ACO	Steward ACO
1.0 Medical Services Data	Compliant	Compliant	Compliant
2.0 Enrollment Data	Compliant	Compliant	Compliant
3.0 Practitioner Data	Compliant	Compliant	Compliant
4.0 Medical Record Review Processes	Compliant	Compliant	Compliant
5.0 Supplemental Data	Compliant	Compliant	Compliant
6.0 Data Preproduction Processing	Compliant	Compliant	Compliant
7.0 Data Integration and Reporting	Compliant	Compliant	Compliant

Validation Findings

- Information Systems Capabilities Assessment (ISCA): There were no concerns with encounter data received for members enrolled in the PC ACOs. No issues were identified.
- Source Code Validation: Source code review was conducted with SS&C for the PC ACO's non-HEDIS measure rates. No issues were identified.
- Medical Record Validation: All PC ACOs met the 80% threshold for the selected sample charts appropriately abstracted. No other issues were identified.
- Primary Source Validation (PSV): PSV is conducted to confirm that the information from the primary source matches the output information used for measure reporting. MassHealth provided screenshots from the data warehouse of the selected records for PSV. All records passed validation. No issues were identified.
- Data Collection and Integration Validation: This includes a review of the processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and

algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately. No issues were identified.

- Rate Validation: Rate validation is conducted to evaluate measure results and compare rates to industry standard benchmarks. All required measures were reportable.

Comparative Findings

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

IPRO compared the PC ACOs measures rates and the weighted statewide means to the NCQA HEDIS MY 2022 Quality Compass New England (NE) regional percentiles for Medicaid health maintenance organizations (HMOs) for all measures where available. The weighted statewide means were calculated across all MassHealth's ACOs, including ACPPs and PC ACOs.

The performance varied across measures, with opportunities for improvement in several areas. According to the MassHealth Quality Strategy, MassHealth's benchmarks for ACPP measures rates are the 75th and the 90th Quality Compass New England regional percentiles. Improvement strategies may need to focus on areas where rates were below the 25th percentile.

Varied Performance:

- Childhood Immunization Status (combo 10): C3 was above the 90th percentile, but MGB, Steward, and the statewide weighted mean were all below the 75th percentile.
- Controlling High Blood Pressure: Steward was above the 90th percentile but MGB was below the 25th percentile. C3 and the ACO statewide mean were below the 75th percentile.
- Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement): C3 was above the 90th percentile, but all other entities were below the 75th percentile.
- Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation): C3 was above the 90th percentile, but MGB was below the 50th percentile and Steward and the ASO statewide benchmark were below the 87th percentile.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: C3 was above the 90th percentile, but all other entities were below the 75th percentile.
- Follow-up After Emergency Department Visit for Mental Illness (7 days) – MGB was at or above the 75th percentile but below the 90th and all other entities were below the 75th percentile.
- Immunization for Adolescents (combo 2) – While C3 ACO was above the 90th percentile, MGB and Steward were at or above 25th percentile but below the 50th percentile, and the ACO statewide weighted mean was also below the 50th percentile.

Needs Improvement:

- Hemoglobin A1c Control; HbA1c control (>9.0%) (Lower is better): All entities were below the 25th percentile, indicating a need for improvement.
- Follow-Up After Hospitalization for Mental Illness (7 days): All entities were at or above the 25th percentile but below the 50th percentile, indicating a need for improvement.
- Asthma Medication Ratio: Both MGB and Steward were at or above 25th percentile but below the 50th percentile and C3 was at or above 75 but below 90, while the statewide weighted mean was at or above 25th but below the 50th percentile, suggesting an area for improvement.
- Plan All-Cause Readmissions (Observed/Expected Ratio) – C3 ACO was below the 25th percentile, MGB was at or above the 25th percentile but below the 50th percentile, and Steward was at or above the

median but below the 75th percentile. The ACO statewide weighted average was below the 25th percentile compared to the Quality Compass.

- Timeliness of Prenatal Care – MGB was below the 25th percentile, Steward was at or above the 50th percentile but below the 75th percentile, and C3 was at or above the 75th percentile but below the 90th percentile, while the ACO statewide weighted mean was below the 50th percentile.

Table 4: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2022 Quality Compass New England (NE) Regional Percentiles.

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

Table 5: PC ACO HEDIS Performance Measures – MY 2022

HEDIS Measure	C3 ACO	MGB ACO	Steward ACO	ACO Statewide Mean
Childhood Immunization Status (combo 10)	58.16% (≥90th)	54.55% (≥50th but <75th)	48.29% (≥50th but <75th)	52.47% (≥50th but <75th)
Timeliness of Prenatal Care	92.45% (≥75th but <90th)	75% (<25th)	90.7% (≥50th but <75th)	86.76% (≥25th but <50th)
Immunization for Adolescents (combo 2)	56.44% (≥90th)	36.74% (≥25th but <50th)	42.34% (≥25th but <50th)	49.06% (≥50th but <75th)
Controlling High Blood Pressure	67.9% (≥50th but <75th)	60.93% (<25th)	73.47% (≥90th)	67.23% (≥50th but <75th)
Asthma Medication Ratio	63.38% (≥75th but <90th)	58.46% (≥25th but <50th)	57.97% (≥25th but <50th)	60.65% (≥25th but <50th)
Hemoglobin A1c Control; HbA1c control (>9.0%) LOWER IS BETTER	36.96% (<25th)	43.29% (<25th)	36.23% (<25th)	34.07% (≥50th but <75th)
Metabolic Monitoring for Children and Adolescents on Antipsychotics	57.25% (≥90th)	33.81% (≥50th but <75th)	43.58% (≥50th but <75th)	41.78% (≥50th but <75th)
Follow-Up After Hospitalization for Mental Illness (7 days)	45.32% (≥25th but <50th)	48.43% (≥25th but <50th)	41.99% (≥25th but <50th)	46.43% (≥25th but <50th)
Follow-up After Emergency Department Visit for Mental Illness (7 days)	68.71% (≥50th but <75th)	75.24% (≥75th but <90th)	72.69% (≥50th but <75th)	74.65% (≥50th but <75th)
Plan All-Cause Readmissions (Observed/Expected Ratio) LOWER IS BETTER	1.19 (<25th)	1.09 (≥25th but <50th)	1.02 (≥50th but <75th)	1.20 (<25th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	56.21% (≥90th)	44.6% (≥25th but <50th)	46.78% (≥50th but <75th)	50.94% (≥50th but <75th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	32.82% (≥90th)	18.29% (≥50th but <75th)	22.55% (≥50th but <75th)	22.91% (≥50th but <75th)

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

For the state-specific measures, IPRO compared the rates to the goal benchmarks determined by MassHealth. Goal benchmarks for PC ACOs were fixed targets calculated with COVID-based adjustments. The state did not establish goal benchmarks for both of the Community Tenure measures.

Best Performance:

- Oral Health Evaluation: All PC ACOs were above the state benchmark goal and the Weighted Statewide Mean was also above the state benchmark goal.
- Risk-Adjusted Ratio (Observed/Expected) of ED Visits for Members Aged 18–65 Years Identified with a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions LOWER IS BETTER: All PC ACOs and the Weighted Statewide Mean were above the state benchmark goal.

Varied Performance:

- Health-Related Social Needs Screening: C3, MGB, and the state benchmark were above the goal but the Steward ACO was below the goal, indicating moderate performance.
- LTSS Community Partner Engagement: All entities except C3 were below the goal benchmark.
- Screening for Depression and Follow-Up Plan: All entities except C3 were below the goal benchmark.

Needs Improvement:

- Depression Remission or Response: All PC ACOs were below the goal benchmark, indicating a need for improvement.
- Behavioral Health Community Partner Engagement: All PC ACOs were below the goal benchmark, indicating a need for improvement.

Table 6 shows the color key for state-specific PM comparison to the state benchmark.

Table 7 shows state-specific PMs for MY 2022 for all PC ACOs and ACO Weighted Statewide Mean. Primary Care Member Experience Survey (PC MES) measures were not included in the performance measure validation.

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

Color Key	How Rate Compares to the State Benchmark
< Goal	Below the state benchmark
= Goal	At the state benchmark.
> Goal	Above the state benchmark.
N/A	Not applicable (N/A).

Table 7: PC ACO State-Specific Performance Measures – MY 2022

Measure	C3 ACO	MGB ACO	Steward ACO	ACO Statewide Mean	State Benchmark
Oral Health Evaluation	53.7% (>Goal)	55.98% (>Goal)	50.66% (>Goal)	53.26% (>Goal)	43.28% (N/A)
Community Tenure (CT) – Bipolar, Schizophrenia or Psychosis (BSP; Observed/Expected Ratio)	1.13 (N/A)	1.18 (N/A)	1.17 (N/A)	0.82 (N/A)	TBD
Community Tenure (CT) – Non-BSP (Observed/Expected Ratio)	1.86 (N/A)	1.57 (N/A)	1.71 (N/A)	1.13 (N/A)	TBD
Health-Related Social Needs Screening	28.71% (>Goal)	34.06% (>Goal)	8.76% (<Goal)	29.47% (>Goal)	23.50% (N/A)
Risk-Adjusted Ratio (Observed/Expected) ED Visits for Members Aged 18–65 Years Identified with a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions (lower is better)	1.03% (>Goal)	0.83% (>Goal)	1.00% (>Goal)	0.87% (>Goal)	1.28 (N/A)
Behavioral Health Community Partner Engagement	8.14% (<Goal)	10.04% (<Goal)	8.45% (<Goal)	10.57% (<Goal)	12.20% (N/A)
LTSS Community Partner Engagement	10.07% (<Goal)	7.43% (<Goal)	4.53% (<Goal)	7.51% (<Goal)	9.20% (N/A)
PC MES Willingness to Recommend+ Adult	79.87 (< Goal)	87.95 (< Goal)	85.08 (< Goal)	84.48 (< Goal)	90.40 (N/A)
PC MES Willingness to Recommend+ Child	86.75 (< Goal)	90.84 (< Goal)	90.51 (< Goal)	89.2 (< Goal)	91.30 (N/A)
PC MES Communication+ Adult	84.46 (< Goal)	89.92 (< Goal)	88.30 (< Goal)	96.72 (> Goal)	90.20 (N/A)
PC MES Communication+ Child	88.96 (< Goal)	91.80 (> Goal)	90.94 (> Goal)	90.4 (< Goal)	90.80 (N/A)
PC MES Integration of Care+ Adult	72.70 (< Goal)	80.24 (< Goal)	77.60 (< Goal)	78.11 (< Goal)	82.90 (N/A)
PC MES Integration of Care+ Child	73.03 (< Goal)	78.35 (< Goal)	79.31 (< Goal)	78.6 (< Goal)	89.10 (N/A)

Measure	C3 ACO	MGB ACO	Steward ACO	ACO Statewide Mean	State Benchmark
PC MES Knowledge of Patient+ Adult	78.36 (< Goal)	84.70 (> Goal)	82.85 (< Goal)	81.50 (< Goal)	83.30 (N/A)
PC MES Knowledge of Patient+ Child	84.30 (< Goal)	87.84 (< Goal)	87.33 (< Goal)	86.2 (< Goal)	89.10 (N/A)
Screening for Depression and Follow-Up Plan	51.88% (>Goal)	41.85% (<Goal)	40.41% (<Goal)	46.19% (<Goal)	49.32 (N/A)
Depression Remission or Response	7.87% (<Goal)	2.43% (<Goal)	2.47% (<Goal)	6.56% (<Goal)	9.20 (N/A)

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

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

Objectives

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

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

Technical Methods of Data Collection and Analysis

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

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

Scoring Methodology

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

Table 8: Scoring Definitions

Scoring	Definition
Met = 1 point	Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and PC ACO staff interviews provided information consistent with documentation provided.
Partially Met = 0.5 points	Any one of the following may be applicable: • Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. PC ACO staff interviews, however, provided information that was not consistent with documentation provided.

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

Description of Data Obtained

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

Conclusions and Comparative Findings

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

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

CFR Standard Name[1]	CFR Citation	C3 ACO	MGB ACO	Steward
Overall compliance score	**N/A**	**89.4%**	**94.5%**	**96.4%**
Availability of Services	**438.206**	92.3%	92.6%	91.1%
Enrollee Rights and Protections	**438.10**	90.0%	100.0%	100.0%
Enrollment and Disenrollment	**438.56**	N/A	N/A	N/A
Enrollee Information	**438.10**	98.9%	94.6%	97.8%
Assurances of Adequate Capacity and Services	**438.207**	N/A	N/A	N/A
Coordination and Continuity of Care	**438.208**	100.0%	99.1%	100.0%
Coverage and Authorization of Services	**438.210**	N/A	N/A	N/A
Provider Selection	**438.214**	N/A	N/A	N/A
Confidentiality	**438.224**	50.0%	100.0%	100.0%
Grievance and Appeal Systems	**438.228**	96.9%	84.4%	87.5%
Subcontractual Relationships and Delegation	**438.230**	86.8%	97.4%	94.7%
Practice Guidelines	**438.236**	N/A	N/A	N/A
Health Information Systems	**438.242**	N/A	N/A	N/A
QAPI	**438.330**	100.0%	87.5%	100.0%

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

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

Objectives

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

Section 3.2.A. and Appendix B of the PC ACO Contract with MassHealth states that MassHealth will administer patient experience survey to evaluate the enrollee experience with PCP providers participating in the MassHealth's ACO program.

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

MassHealth's PC MES is based on the CG-CAHPS survey, which asks members to report on their experiences with providers and staff in physician practices and groups. CG-CAHPS survey results can be used to monitor the performance of physician practices and groups and to reward for high-quality care.[13] The level of analysis for the PC MES surveys was medical group and ACO, where ACOs assign practices to medical groups and medical groups roll up to ACOs.[14]

Technical Methods of Data Collection and Analysis

The program year (PY) 2022 PC MES was administered between May and August 2023 by the Center for the Study of Services (CSS), an independent survey research organization and MHQP's subcontractor.

The Adult and Child PC MES survey instruments were based on the CG-CAHPS 3.0 surveys developed by the Agency for Health Care Research and Quality (AHRQ) and the NCQA. The PY 2022 PC MES adult and child surveys included Patient-Centered Medical Home (PCMH) survey items and the Coordination of Care supplemental items.

Seventeen ACOs participated in the PY 2022 survey, including 13 ACPPs, 3 PC ACOs, and the Lahey ACO. Across the 17 ACOs, MassHealth members were attributed to ACO practices that were grouped into 35 medical groups. This report provides the results for the PC ACOs.

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

The sample frame included members 18 years of age or older for the adult survey or 17 years of age or younger for the child survey, who had at least one primary care visit at one of the ACO's practices during the measurement year (January 1 –December 31, 2022), and who were enrolled in one of the ACOs on the anchor date (December 31, 2022). Tables 10 and 11 provide a summary of the technical methods of data collection.

[13] AHRQ. CAHPS Clinician & Group Survey. Available at: CAHPS Clinician & Group Survey | Agency for Healthcare Research and Quality (ahrq.gov). Accessed on 1.27.2024.

[14] Year 5-MassHealth Member Experience of Primary Care, Behavioral Health, and Long-Term Services and Supports Surveys: Based on the 2022 Program Year (Fielded in 2023). Technical Report. MHQP. September 26, 2023.

Table 10: Adult PC MES – Technical Methods of Data Collection for PC ACO, MY 2022

Technical Methods of Data Collection	PC ACO
Survey vendor	MHQP
Survey tool	MassHealth PC MES, based on the CG-CAHPS 3.0 survey instrument
Survey timeframe	May–August 2023
Method of collection	Mailings and emails
Sample size – all ACOs	121,352
Response rate	8.5%

Table 11: Child PC MES – Technical Methods of Data Collection for PC ACO, MY 2022

Technical Methods of Data Collection	PC ACO
Survey vendor	MHQP
Survey tool	MassHealth PC MES, based on the CG-CAHPS 3.0 survey instrument
Survey timeframe	May–August 2023
Method of collection	Mailings and emails
Sample size – all ACOs	165,760
Response rate	4.2%

To assess ACPP performance, IPRO aggregated and reported ACPPs' and ACO statewide scores calculated as the cumulative top-box survey results across all MassHealth's ACOs. Top-box scores are the survey results for the highest possible response category.

Description of Data Obtained

IPRO received copies of the final PY 2022 technical and analysis reports produced by MHQP. These reports included comprehensive descriptions of the project technical methods and survey results. IPRO also received separate files with the PC ACO-level results and statewide averages.

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all PC ACOs, IPRO compared each PC ACO's results to the ACO statewide scores for the Adult and Child PC MES surveys. The ACO statewide scores are the cumulative top-box survey results for MassHealth enrollees attributed to all MassHealth ACOs. Measures performing above the statewide score were considered strengths; measures performing at the statewide score were considered average; and measures performing below the statewide score were identified as opportunities for improvement, as explained in Table 12.

Table 13 shows the results of the PC MES adult Medicaid survey for PY 2022. The MGB ACO exceeded the statewide score on all adult PC MES measures. Steward ACO exceeded the statewide score on six measures and C3 ACO exceeded the statewide score only on one measure.

Table 14 shows the results of the PC MES child Medicaid survey for PY 2022. The C3 ACO scored below the statewide score for the majority of child PC MES measures, except the Self-Management Support measure. The MGB ACO exceeded the statewide score on almost all measures except for the Integration of Care measures. Steward ACO exceeded the statewide score on seven out of 11 measures.

Table 12: Color Key for PC MES Performance Measure Comparison Score

Color Key	How Rate Compares to the ACO Statewide Average
< Goal	Below the statewide score.
= Goal	At the statewide score.
> Goal	Above the statewide score.
N/A	Statewide score.

Table 13: PC MES Performance – Adult Member, PY 2022

PC MES Measure	C3 ACO	MGB ACO	Steward ACO	ACO Statewide Score
Adult Behavioral Health	66.62 (> Goal)	73.98 (> Goal)	64.88 (< Goal)	66.6
Communication	84.46 (< Goal)	89.92 (> Goal)	88.30 (> Goal)	86.9
Integration of Care	72.70 (< Goal)	80.24 (> Goal)	77.60 (< Goal)	78.1
Knowledge of Patient	78.36 (< Goal)	84.70 (> Goal)	82.85 (> Goal)	81.5
Office Staff	81.00 (< Goal)	86.70 (> Goal)	84.66 (> Goal)	84.0
Organizational Access	68.80 (< Goal)	78.42 (> Goal)	78.16 (> Goal)	75.6
Overall Provider Rating	82.54 (< Goal)	89.65 (> Goal)	87.04 (> Goal)	86.4
Self-Management Support	61.23 (< Goal)	65.76 (> Goal)	60.50 (< Goal)	61.6
Willingness to Recommend	79.87 (< Goal)	87.95 (> Goal)	85.08 (> Goal)	84.5

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

Table 14: PC MES Performance – Child Member, PY 2022

PC MES Measure	C3 ACO	MGB ACO	Steward ACO	ACO Statewide Score
Communication	88.96 (< Goal)	91.80 (> Goal)	90.94 (> Goal)	90.4
Integration of Care	73.03 (< Goal)	78.35 (< Goal)	79.31 (> Goal)	78.6
Knowledge of Patient	84.30 (< Goal)	87.84 (> Goal)	87.33 (> Goal)	86.2
Office Staff	80.92 (< Goal)	87.15 (> Goal)	87.33 (> Goal)	85.0
Organizational Access	73.06 (< Goal)	83.25 (> Goal)	84.63 (> Goal)	80.9
Overall Provider Rating	87.75 (< Goal)	90.96 (> Goal)	90.27 (> Goal)	89.8
Self-Management Support	55.45 (> Goal)	58.40 (> Goal)	51.85 (< Goal)	55.3
Willingness to Recommend	86.75 (< Goal)	90.84 (> Goal)	90.51 (> Goal)	89.2

PC MES Measure	C3 ACO	MGB ACO	Steward ACO	ACO Statewide Score
Child Development	66.63 (< Goal)	71.02 (> Goal)	69.81 (< Goal)	69.8
Child Provider Communication	93.85 (< Goal)	95.21 (> Goal)	94.64 (< Goal)	94.7
Pediatric Prevention	63.08 (< Goal)	67.85 (> Goal)	64.25 (< Goal)	65.8

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

VI. MCP Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results(a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP,[15] PAHP,[16] or PCCM entity has effectively addressed the recommendations for QI[17] made by the EQRO during the previous year's EQR." **Tables 15 and 16** display the PC ACOs' responses to the recommendations for QI made during the previous EQR, as well as IPRO's assessment of these responses. Effective April 1, 2023, MGB PC ACO was discontinued due to re-procurement.

C3 ACO Response to Previous EQR Recommendations

Table 15 displays the PC ACO's progress related to the *PC ACO External Quality Review CY 2022,* as well as IPRO's assessment of the PC ACO's response.

Table 15: C3 PC ACO Response to Previous EQR Recommendations

Recommendation for C3 PC ACO	C3 PC ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV 1: NCQA Measures: C3 should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	C3 participated in the MassHealth Performance Remediation Plan (PRP) for the IET quality measure for the performance period of November 2021-June 2022. C3 identified the root causes of lower performance and developed reporting capabilities that were not available before the PRP. The root causes included limited performance reporting and a limited understanding of best practices among FQHCs. C3 will continue with root cause analysis (RCA) for IET as the measure moves back into pay-for-performance in 2024. In early 2023, we completed an initial root cause RCA for CBP. Based on the initial RCA, a workgroup was formed to begin identifying, implementing, and evaluating improvement efforts. For each QI Plan, there is an identified improvement goal, which will be tracked against the implemented actions. All actions/efforts are tracked in detail with process and outcome measures defined, when available. A measure run chart will be maintained, to track improvement over time, with start dates for efforts/activities overlayed.	Addressed.
PMV 2: State-Specific Measures: C3 should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	The C3 Quality Team will conduct a root cause analysis of underperforming MES measures and establish a QI plan. In addition, the Team aims to increase survey responses from members for future MES. In Q4 2023, as part of annual quality planning, the team will partner with stakeholders to conduct an RCA and identify contributing factors to low performance. Based on the RCA, a QI plan will be drafted, and a workgroup(s) will be formed. In Q1 2024, the Quality Team will review the MHQP pre-notification toolkit and outline a communication plan to increase response rates. The expected outcome of the actions includes 1) a completed QI Plan (A3) with implementation in 2024, and 2) implementation of a survey communication plan, to increase member response. For RCA and improvement, all actions/efforts are tracked in detail. As MES data is delayed, the team will need to identify process measures as a proxy for outcomes. For the MES response increase, the team will document the process steps.	Addressed.

[15] Prepaid inpatient health plan.
[16] Prepaid ambulatory health plan.
[17] Quality improvement.

Recommendation for C3 PC ACO	C3 PC ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Compliance 1: C3 needs to revise and/or implement policies and procedures to address the deficient areas to bring the PC ACO into full compliance with federal and state contract requirements.	C3 has updated policies and procedures applicable to the findings during the EQR process. Those policies include Material Subcontract Oversight, Member Education, Orientation, and Informational Materials, Member Protection – Grievances, and Provider Terminations. All policies and documented processes are reviewed annually. The P&P Committee reviews all policies, and all new or updated policies are signed off on by Executive Leadership.	Addressed.
Compliance 2: C3 needs to create and implement a formal monitoring and annual performance review process, including processes for initiating corrective action, as appropriate.	C3 created a new Material Subcontractor oversight policy that addresses all areas of concern. This policy was submitted to, and approved by, EOHHS during the Readiness Review process. Before contracting with a Material Subcontractor, C3 evaluates the prospective Material Subcontractor's ability to perform the activities to be subcontracted.	Addressed.
Compliance 3: C3 needs to revise its subcontractual agreements to add provisions for the right to audit and inspect records, making premises, facilities, equipment records, systems available for audit, and timeframes for the right to audit.	Material Subcontractor contracts now state their responsibilities more clearly regarding the EOHHS ACO contract. Our Material Subcontractors will gain a better understanding of the EOHHS contractual requirements and make themselves amenable to any audit requirements. C3 will continue to monitor the activities of Material Subcontractors to ensure they are adhering to their agreements appropriately.	Addressed.
Compliance 4: C3 needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review.	C3 updated the policy to adhere to the recommendation and incorporated the appropriate language into the Member Handbook. Member Rights are communicated to all Health Centers via our Provider Handbook, the Compliance Workgroup (compliance leads from all C3-affiliated Health Centers), and the Member Handbook. All appropriate health center staff have access to, and are educated on, Member Rights. C3 created a form to streamline the reporting of relevant information regarding the notification to Members/patients of "provider terminations" (i.e., PCPs leaving practices). This form was designed to capture all relevant information from each organization to ensure compliance. C3 incorporated all applicable training into its Learning Management System (LMS). Through the LMS, C3 tracks the completion of the required training to ensure compliance.	Addressed.
Quality-of-Care Surveys: C3 should utilize the results of the adult and child CAHPS surveys to drive performance improvement as it relates to member experience. C3 should also utilize complaints and grievances	The C3 Quality Team plans to create and aggregate practice-level summaries of CY 2021 MES findings to distribute internally as well as individual practices. The performance summary will include suggestions for improvement, including C3-program-level efforts (e.g., telehealth, social health, member operations, and practice transformation) as well as practice-level efforts (e.g., staff awareness and training, clinical best practice, and workflows). Analysis summaries were planned to be distributed in November 2023, to provide C3 program areas and provider practices the opportunity to include suggested improvement efforts in 2024 improvement work plans. The goal is to ensure MES performance	Partially Addressed.

Recommendation for C3 PC ACO	C3 PC ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
to identify and address trends.	gaps are understood across C3 and provider groups and to support the inclusion of MES measures in improvement work plans.	

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined. PC ACO: primary care accountable care organization; MCP: managed care plan; EQR: external quality review; EOHHS: Executive Office of Health and Human Services; NCQA: National Committee for Quality Assurance; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PCP: primary care provider.

Steward ACO Response to Previous EQR Recommendations

Table 16 displays the PC ACO's progress related to the *PC ACO External Quality Review CY 2022,* as well as IPRO's assessment of the PC ACO's response.

Table 16: Steward PC ACO Response to Previous EQR Recommendations

Recommendation for Steward PC ACO	Steward PC ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV 1: NCQA Measures: NCQA Measures: Three HEDIS rates were below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark. Those measures were: AMR, IET Initiation, and Engagement. Steward should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Steward does not routinely use root cause analysis to address opportunities for improvement but instead focuses on improving practice workflows and reviewing patient lists with practices to determine the next steps for each patient not meeting the measure. Real-time specific interventions directed to each member seeking care from our providers are the preferred methods of supporting our continuous quality improvement approach.	Partially Addressed.
PMV 2: State-Specific Measures: Nine rates were below the statewide benchmark. Steward should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates	Ditto	Partially Addressed.

Recommendation for Steward PC ACO	Steward PC ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
and to improve members' appropriate access to the services evaluated by these measures.		
Compliance 2: Steward should revise its contract language or include information in a manual that ensures that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.	SMCN does not have a provider manual but does have other avenues for increasing transparency around provider office hours (e.g., annual training materials). As part of its readiness review activities for implementation of the new PCACO contract (effective April 1, 2023), SMCN updated its provider education materials with all requirements that contracted providers were expected to meet to participate in the current PCACO contract that was executed effective April 1, 2023. During the readiness review, EOHHS assessed SMCN's provider network as being ready for contract implementation. An interdisciplinary work group engaged in successive meetings at which all deliverables affecting the provider network were identified and the extent of deliverable completion was tracked. SMCN monitored provider attendance at all chapter meetings in which education materials were presented. The final measure of deliverables completion was the timely execution of provider participation agreements for all network providers.	Addressed
Compliance 3: Steward needs to implement and document an ongoing monitoring and formal annual review process of material subcontractors on business-related performance measures and requirements, including how CAPs would be initiated and overseen, internal reporting, and decision-making requirements.	Provisions for ongoing monitoring and formal annual review of Material Subcontractor compliance and performance were incorporated into SMCN's existing policy/procedure for Material Subcontractor oversight.	Addressed
Compliance 5: Steward should continue to explore strategies to integrate care management within primary care and develop relationships with community partners.	Primary care/ACO integration is being implemented via SMCN's Community Partners program and three partnering PCP practices. An Integrated Care Manager was granted real-time access to provider progress notes. The Integrated Care Manager has established multidisciplinary case conferencing that includes the PCP and the Community Partner. Member-centric needs are identified in real-time and incorporated into each agency's/discipline's plans of care. The PCP electronic health record is used to update interventions planned during case conferencing. The presence of alerts signaling needed interventions in member records can be monitored to evaluate the extent to which the integrated care team has created iterative multi-disciplinary plans of care.	Addressed

Recommendation for Steward PC ACO	Steward PC ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Quality-of-Care Surveys: Steward scored below the statewide benchmark on 5 out of 10 adult and 4 out of 12 child PC MES measures. Steward should utilize the results of the adult and child PC MES surveys to drive performance improvement as it relates to member experience.	Steward uses Press Ganey to survey member experience in real-time following each encounter.	Partially Addressed.

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined.
PC ACO: primary care accountable care organization; MCP: managed care plan; EQR: external quality review; EOHHS: Executive Office of Health and Human Services; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; PCP: primary care provider.

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

Table 17–19 highlight each PC ACO's performance strengths, opportunities for improvement, and this year's recommendations based on the aggregated results of CY 2023 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 17: Strengths, Opportunities for Improvement, and EQR Recommendations for C3 ACO

Activity	Strengths	Weaknesses	Recommendations	Standards
PMV: NCQA measures	C3 demonstrated compliance with IS standards. No issues were identified. Five HEDIS rates were above the 90th percentile when compared to the New England regional NCQA Quality Compass benchmark. Those measures were: CIS, IMA, APM, IET Initiation and IET Engagement.	Two HEDIS rates were below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark. Those measures were: HBD, and PCR.	C3 should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access
PMV: State-specific measures	Five out of 17 measures rates were above the state benchmark.	10 out of 17 measures rates were below the statewide benchmark.	Same as above.	Quality, Timeliness, Access
Quality-of-care surveys	C3 scored above the statewide benchmark on 1 adult and 1 child PC MES measures.	C3 scored below the statewide benchmark on the majority of adult and child PC MES measures.	C3 should utilize the results of the adult and child PC MES surveys to drive performance improvement as it relates to member experience. C3 should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access

ACO: accountable care organization; EQR: external quality review; NCQA: National Committee for Quality Assurance; IS: information standards; HEDIS: Healthcare Effectiveness Data and Information Set; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; PC MES: Primary Care Member Experience Survey; CIS: Childhood Immunization Status; IMA: Immunization for Adolescents, APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics.

Table 18: Strengths, Opportunities for Improvement, and EQR Recommendations for MGB

Activity	Strengths	Weaknesses	Recommendations	Standards
PMV: NCQA measures	MGB demonstrated compliance with IS standards. No issues were identified. MGB did not score above the 90th percentile on any NCQA measures.	Three HEDIS rates were below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark. Those measures were: PPC, CBD, and HBD.	MGB PC ACO was discontinued. No recommendations were made.	Quality, Timeliness, Access
PMV: State-specific measures	Five rates were above the state benchmark.	Ten rates were below the statewide benchmark.	Same as above.	Quality, Timeliness, Access
Quality-of-care surveys	MGB scored above the statewide benchmark on all adult and almost all child PC MES measures.	MGB scored below the statewide benchmark on one child PC MES measure: Integration of Care.	None.	Quality, Timeliness, Access

PC ACO: primary care accountable care organization; EQR: external quality review; NCQA: National Committee for Quality Assurance; IS: information standards; HEDIS: Healthcare Effectiveness Data and Information Set; PPC: Prenatal and Postpartum Care; PC MES: Primary Care Member Experience Survey.

Table 19: Strengths, Opportunities for Improvement, and EQR Recommendations for Steward

Activity	Strengths	Weaknesses	Recommendations	Standards
PMV: NCQA measures	Steward demonstrated compliance with IS standards. No issues were identified. The CBP rate was above the 90th percentile when compared to the New England regional NCQA Quality Compass benchmark.	HBD rate was below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark.	Steward should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access
PMV: State-specific measures	Three rates were above the state benchmark.	The majority of measures were below the statewide benchmark.	Same as above.	Quality, Timeliness, Access
Quality-of-care surveys	Steward scored above the statewide benchmark on 6 adult and 7 child PES MES measures.	Steward scored below the statewide benchmark on 3 adult and 4 child PC MES measures.	Steward should utilize the results of the adult and child PC MES surveys to drive performance improvement as it relates to member experience.	Quality, Timeliness, Access

EQR: external quality review; NCQA: National Committee for Quality Assurance; IS: information standards; PC MES: Primary Care Member Experience Survey; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

VIII. Required Elements in EQR Technical Report

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

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

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

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

Elements required in EQR technical report, including the requirements for the PIP validation, PMV, and review of compliance activities, are listed in **Table 20**.

Table 20: Required Elements in EQR Technical Report

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

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

IX. Appendix A – MassHealth Quality Goals and Objectives

Table A1: MassHealth Quality Strategy Goals and Objectives – Goal 1

Goal 1	**Promote better care:** Promote safe and high-quality care for MassHealth members
1.1	Focus on timely preventative, primary care services with access to integrated care and community-based services and supports
1.2	Promote effective prevention and treatment to address acute and chronic conditions in at-risk populations
1.3	Strengthen access, accommodations, and experience for members with disabilities, including enhanced identification and screening, and improvements to coordinated care

Table A2: MassHealth Quality Strategy Goals and Objectives – Goal 2

Goal 2	**Promote equitable care**: Achieve measurable reductions in health and healthcare quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience
2.1	Improve data collection and completeness of social risk factors (SRF), which include race, ethnicity, language, disability (RELD) and sexual orientation and gender identity (SOGI) data
2.2	Assess and prioritize opportunities to reduce health disparities through stratification of quality measures by SRFs, and assessment of member health-related social needs
2.3	Implement strategies to address disparities for at-risk populations including mothers and newborns, justice-involved individuals, and members with disabilities

Table A3: MassHealth Quality Strategy Goals and Objectives – Goal 3

Goal 3	**Make care more value-based:** Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care
3.1	Advance design of value-based care focused on primary care provider participation, behavioral health access, and integration and coordination of care
3.2	Develop accountability and performance expectations for measuring and closing significant gaps on health disparities
3.3	Align or integrate other population, provider, or facility-based programs (e.g., hospital, integrated care programs)
3.4	Implement robust quality reporting, performance and improvement, and evaluation processes

Table A4: MassHealth Quality Strategy Goals and Objectives – Goal 4

Goal 4	**Promote person and family-centered care**: Strengthen member and family-centered approaches to care and focus on engaging members in their health
4.1	Promote requirements and activities that engage providers and members in their care decisions through communications that are clear, timely, accessible, and culturally and linguistically appropriate
4.2	Capture member experience across our populations for members receiving acute care, primary care, behavioral health, and long-term services and supports
4.3	Utilize member engagement processes to systematically receive feedback to drive program and care improvement

Table A5: MassHealth Quality Strategy Goals and Objectives – Goal 5

Goal 5	**Improve care through better integration**, communication, and coordination across the care continuum and across care teams for our members
5.1	Invest in systems and interventions to improve verbal, written, and electronic communications among caregivers to reduce harm or avoidable hospitalizations and ensure safe and seamless care for members
5.2	Proactively engage members with high and rising risk to streamline care coordination and ensure members have an identified single accountable point of contact
5.3	Streamline and centralize behavioral health care to increase timely access and coordination of appropriate care options and reduce mental health and SUD emergencies

X. Appendix B – MassHealth Managed Care Programs and Plans

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

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Accountable Care Partnership Plan (ACPP)	Groups of primary care providers working with one managed care organization to create a full network of providers. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. 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)	Groups of primary care providers forming an ACO that works directly with MassHealth's network of specialists and hospitals for care and coordination of care. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Community Care Cooperative 2. Steward Health Choice
Managed Care Organization (MCO)	Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Boston Medical Center HealthNet Plan WellSense 2. Tufts Health Together
Primary Care Clinician Plan (PCCP)	Members select or are assigned a primary care clinician (PCC) from a network of MassHealth hospitals, specialists, and the Massachusetts Behavioral Health Partnership (MBHP).	Not applicable – MassHealth

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
	• Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	
Massachusetts Behavioral Health Partnership (MBHP)	Capitated behavioral health model providing or managing behavioral health services, including visits to a licensed therapist, crisis counseling and emergency services, SUD and detox services, care management, and community support services. • Population: Medicaid members under 65 years of age who are enrolled in the PCCP or a PC ACO (which are the two PCCM programs), as well as children in state custody not otherwise enrolled in managed care. • Managed Care Authority: 1115 Demonstration Waiver.	MBHP (or managed behavioral health vendor: Beacon Health Options)
One Care Plan	Integrated care option for persons with disabilities in which members receive all medical and behavioral health services and long-term services and support through integrated care. Effective January 1, 2026, the One Care Plan program will shift from a Medicare-Medicaid Plan (MMP) demonstration to a Medicare Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) with a companion Medicaid managed care plan. • Population: Dual-eligible Medicaid members aged 21–64 years at the time of enrollment with MassHealth and Medicare coverage. • Managed Care Authority: Financial Alignment Initiative Demonstration.	1. Commonwealth Care Alliance 2. Tufts Health Plan Unify 3. UnitedHealthcare Connected for One Care
Senior Care Options (SCO)	Medicare Fully Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs) with companion Medicaid managed care plans providing medical, behavioral health, and long-term, social, and geriatric support services, as well as respite care. • Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age. • Managed Care Authority: 1915(a) Waiver/1915(c) Waiver.	1. WellSense Senior Care Option 2. Commonwealth Care Alliance 3. NaviCare Fallon Health 4. Senior Whole Health by Molina 5. Tufts Health Plan Senior Care Option 6. UnitedHealthcare Senior Care Options

XI. Appendix C – MassHealth Quality Measures

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

Measure Steward	Acronym	Measure Name	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	AMM	Antidepressant Medication Management – Acute and Continuation	N/A	N/A	X	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	AMR	Asthma Medication Ratio	X	X	N/A	N/A	N/A	1.1, 1.2, 3.1
EOHHS	BH CP Engagement	Behavioral Health Community Partner Engagement	X	X	N/A	N/A	N/A	1.1, 1.3, 2.3, 3.1, 5.2, 5.3
NCQA	COA	Care for Older Adult – All Submeasures	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.1
NCQA	ACP	Advance Care Planning	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.1
NCQA	CIS	Childhood Immunization Status	X	X	N/A	N/A	N/A	1.1, 3.1
NCQA	COL	Colorectal Cancer Screening	N/A	N/A	X	N/A	N/A	1.1., 2.2, 3.4
EOHHS	CT	Community Tenure	X	X	N/A	N/A	N/A	1.3, 2.3, 3.1, 5.1, 5.2
NCQA	HBD	Hemoglobin A1c Control; HbA1c control (>9.0%) Poor Control	X	X	N/A	X	X	1.1, 1.2, 3.4
NCQA	CBP	Controlling High Blood Pressure	X	X	X	X	N/A	1.1, 1.2, 2.2
NCQA	DRR	Depression Remission or Response	X	N/A	N/A	N/A	N/A	1.1, 3.1, 5.1
NCQA	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
EOHHS	ED SMI	Emergency Department Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions	X	X	N/A	N/A	N/A	1.2, 3.1, 5.1–5.3
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (30 days)	N/A	N/A	X	N/A	X	3.4, 5.1–5.3
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	X	X	N/A	N/A	X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (30 days)	N/A	N/A	X	X	X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (7 days)	X	X	X	N/A	X	3.4, 5.1–5.3
NCQA	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	N/A	N/A	N/A	N/A	X	3.4, 5.1–5.3

Measure Steward	Acronym	Measure Name	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	N/A	N/A	N/A	N/A	X	3.4, 5.1–5.3
NCQA	ADD	Follow-up for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (HEDIS)	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
EOHHS	HRSN	Health-Related Social Needs Screening	X	N/A	N/A	N/A	N/A	1.3, 2.1, 2.3, 3.1, 4.1
NCQA	IMA	Immunizations for Adolescents	X	X	N/A	N/A	N/A	1.1, 3.1
NCQA	FVA	Influenza Immunization	N/A	N/A	N/A	X	N/A	1.1, 3.4
MA-PD CAHPs	FVO	Influenza Immunization	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.2
NCQA	IET – Initiation/Engagement	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment – Initiation and Engagement Total	X	X	X	X	X	1.2, 3.4, 5.1–5.3
EOHHS	LTSS CP Engagement	Long-Term Services and Supports Community Partner Engagement	X	X	N/A	N/A	N/A	1.1, 1.3, 2.3, 3.1, 5.2
NCQA	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	X	X	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
ADA DQA	OHE	Oral Health Evaluation	X	X	N/A	N/A	N/A	1.1, 3.1
NCQA	OMW	Osteoporosis Management in Women Who Had a Fracture	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
NCQA	PBH	Persistence of Beta-Blocker Treatment after Heart Attack	N/A	N/A	X	N/A	N/A	1.1, 1.2, 3.4
NCQA	PCE	Pharmacotherapy Management of COPD Exacerbation	N/A	N/A	X	N/A	N/A	1.1, 1.2, 3.4
NCQA	PCR	Plan All Cause Readmission	X	X	X	X	N/A	1.2, 3.4, 5.1, 5.2
NCQA	DDE	Potentially Harmful Drug – Disease Interactions in Older Adults	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
CMS	CDF	Screening for Depression and Follow-Up Plan	X	N/A	N/A	N/A	N/A	1.1, 3.1, 5.1, 5.2
NCQA	PPC – Timeliness	Timeliness of Prenatal Care	X	X	N/A	N/A	N/A	1.1, 2.1, 3.1
NCQA	TRC	Transitions of Care – All Submeasures	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
NCQA	DAE	Use of High-Risk Medications in the Older Adults	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
NCQA	SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	N/A	N/A	X	N/A	N/A	1.2, 3.4