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External Quality Review
Primary Care Accountable Care Organizations
Annual Technical Report, Calendar Year 2025

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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

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I. Executive Summary

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 improve their performance. This annual technical report describes the results of the EQR for primary care accountable care organizations (PC ACOs) that furnish health care services to Medicaid enrollees in Massachusetts.

During calendar year (CY) 2025, Massachusetts's Medicaid program (known as "MassHealth"), administered by the Massachusetts Executive Office of Health and Human Services (EOHHS), contracted with two PC ACO plans. PC ACOs are health plans consisting of groups of primary care providers (PCPs) 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) entity. In contrast to accountable care partnership plans (ACPPs), a PC ACO does not partner with just one health plan. Instead, PC ACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP). MassHealth's PC ACOs are listed in **Table 1**.

Table 1: MassHealth's PC ACOs

PC ACO	Abbreviation Used in the Report	Members as of December 27, 2025	Percent of Total PC ACO Population
Community Care Cooperative	C3 ACO	185,105	70.71%
Revere Medical	Revere ACO	76,670	29.29%
All PC ACOs	Total	261,775	100.00%

PC ACO: primary care accountable care organization.

The **Community Care Cooperative** (**C3 ACO**) is an ACO that serves 185,105 MassHealth enrollees. C3 ACO was formed in 2016 by leaders from nine federally qualified health centers. Today, the PC ACO is comprised of 15 federally qualified health centers and is the only ACO in Massachusetts founded by and governed by federally qualified health centers. C3 ACO serves diverse and underserved populations across the entire state.[1]

The **Revere Medical** (**Revere ACO**) is an ACO that serves 76,670 MassHealth enrollees. Revere Medical was previously known as Steward Health Choice but changed names following the sale of the Steward Health Care physician network to Rural Healthcare Group in 2024.

Purpose of Report

The purpose of this annual technical report is to present the results of EQR activities conducted to assess the quality of, timeliness of, and access to health care services furnished to Medicaid enrollees, in accordance with the following federal managed care regulations: *Title 42 Code of Federal Regulations (CFR) Section (§) 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*. EQR activities validate two levels of compliance to assert whether 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. Also available at Community Care Cooperative, Inc. | Mass.gov.

Scope of EQR 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 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[2] Managed Care Regulations –*** This activity determines PC ACOs' compliance with their 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 Centers for Medicare and Medicaid Services (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 CY 2025 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 the CY 2025 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.

[2] 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. Measure targets are explained in the quality strategy by each managed care program.

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

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

Opportunities for Improvement:
Not applicable.

General Recommendations for MassHealth:
None at this time.

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

Performance Improvement Projects

MassHealth selected topics for its performance improvement projects (PIPs) in alignment with the quality strategy goals and objectives. As a PCCM entity, PC ACOs were not subject to the validation of PIPs.

Performance Measure Validation

IPRO validated the accuracy of performance measure rates 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. All PC ACO performance measures were calculated by MassHealth's vendor Telligen®. During measurement year (MY) 2024, the slate of state-specific measures included measures of members' experiences with care, which were collected via the Primary Care Member Experience Survey (PC MES) conducted by MassHealth, and three clinical measures of which two were new: Topical Fluoride for Children Ages 1–5 Years and Developmental Screening in the Frist 3 Years of Life.

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 to assess the accuracy of PC ACO performance measures and to determine the extent to which all performance measure rates 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 applicable National Committee for Quality Assurance (NCQA) information system standards.

IPRO aggregated the PC ACO measure rates to provide comparative information for all PC ACOs. When compared to the MY 2024 Quality Compass® New England regional percentiles, the best performance was found for the following measures:

- Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment: statewide, 59.14% (≥ 90th percentile)
- Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment: statewide, 34.38% (≥ 90th percentile)
- Immunization for Adolescents (Combo 2): C3 ACO, 57.91% (≥ 90th percentile)

Opportunities for Improvement:
Although it is encouraging that both PC ACOs exceeded the goal benchmark for the two newly introduced non-HEDIS measures (i.e., Topical Fluoride for Children and Developmental Screening in the First 3 Years of Life), this result suggests that the goal benchmark is set too low to meaningfully drive continued quality improvement.

It was identified that MassHealth's sampling methodology did not include sufficient oversample of members to replace members that met exclusion criteria for the Screening for Depression and Follow-up Plan measure. Caution should be used when comparing the rates of the two PC ACOs for the Screening for Depression and Follow-up Plan measure since they both have different sample sizes.

When IPRO compared the HEDIS measure rates to the NCQA Quality Compass New England regional percentiles, performance varied across measures, with the opportunities for improvement in the following areas:

- Follow-up After Hospitalization for Mental Illness (7 days): Both PC ACOs and the statewide weighted mean were below the 25th percentile, signaling an area for improvement.
- Controlling High Blood Pressure: C3 ACO, 67.64% (< 25th).

When compared to the goal benchmark, the statewide scores were below the goal for the following measures:

- Willingness to Recommend Adult: 88.75% (< Goal)
- Integration of Care Child: 86.17% (< Goal)
- Screening for Depression and Follow-up Plan: 56.94% (< Goal)

General Recommendations for MassHealth:

- *Recommendation towards benchmarks that support continuous quality improvement* – Both PC ACOs exceeded the current goal benchmark for the newly introduced state-specific measures: Topical Fluoride for Children and Developmental Screening in the First 3 Years of Life. To continue driving meaningful quality improvement and prevent performance from plateauing, IPRO recommends increasing the benchmark to a more ambitious target.
- *Recommendation towards better hybrid measure sampling methodology* – MassHealth should update the hybrid measure sampling methodology to include a larger oversample of members to account for members that are removed from the hybrid sample for exclusions.
- *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.

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

Compliance Review

IPRO evaluated the compliance of PC ACOs with Medicaid and CHIP managed care regulations, as well as with the MassHealth contract.

Strengths:

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

MassHealth established contractual requirements that encompass nine compliance review domains consistent with CMS regulations. This includes regulations that ensure enrollee rights and protections and coordination and continuity of care, as well as address grievances and monitor the quality of healthcare services provided by MCPs. MassHealth collaborates with MCPs to identify areas for improvement, and MCPs actively engage in performance improvement initiatives.

MassHealth monitors MCP's compliance with contractual obligations via regular audits, reviews, and reporting requirements. PC ACOs undergo compliance reviews every three years. The next compliance review will be conducted in contract year 2027.

The CY 2024 validation of PC ACOs highlighted their commitment to members as well as strong operations. Of the nine areas of review, both C3 and Revere ACOs achieved 100% compliance in the following areas: Disenrollment Requirements and Limitations, Enrollee Rights and Protections, Confidentiality, and Subcontractual Relationships and Delegation.

Opportunities for Improvement:

Gaps were identified in the areas of Quality Assurance and Performance Improvement (QAPI) program (Revere ACO: 84% compliance, C3 ACO: 96% compliance), Health Information Systems (C3 ACO: 96% compliance), and Grievance and Appeal Systems (Revere ACO: 92% compliance).

PC ACOs were not always able to identify policy documentation and provide evidence that all requirements are being implemented. The absence of policies can result in inconsistent practices and lead to variations in the quality of services provided.

Additionally, the PC ACO requirements have recently been updated, and it appears that the plans may not fully understand all of their obligations under these new guidelines. Establishing ongoing technical assistance could help ensure that all plans are well-informed and compliant.

General Recommendations for MassHealth:

- *Recommendation towards better policy documentation* – To encourage consistent practices and compliance with MassHealth standards, MassHealth should require MCPs to establish and maintain well-defined policies and procedures. Additionally, establishing ongoing technical assistance could help ensure that all plans are well-informed and compliant.

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 and managed care organizations (MCO) members about their experiences with PCPs using the 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 required to administer patient experience surveys to evaluate PC ACOs enrollees' experience with PCP providers participating in MassHealth's ACO program. MassHealth uses the survey results to assess ACO and MCOs 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 and MCOs earn.

To adhere to Medicaid Child Core Set mandatory reporting guidance issued by CMS, MassHealth contracted with Massachusetts Health Quality Partners (MHQP) who worked with a HEDIS-certified subcontractor to administer the CAHPS Health Plan 5.1H Child Version (CPC-CH) survey to eligible Medicaid and CHIP beneficiaries, per HEDIS guidelines.

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 or MCO performance and identify areas that need improvement. IPRO compared PC ACO adult and child PC MES results to statewide scores calculated for all ACOs and MCOs. However, while comparing individual ACO or MCO performance to statewide scores 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.

General Recommendations for MassHealth:

- *Recommendation towards an effective evaluation of 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.

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 benchmarks that support continuous quality improvement* – Both PC ACOs exceeded the current goal benchmark for the newly introduced state-specific measures: Topical Fluoride for Children and Developmental Screening in the First 3 Years of Life. To continue driving meaningful quality improvement and prevent performance from plateauing, IPRO recommends increasing the benchmark to a more ambitious target.
- *Recommendation towards better hybrid measure sampling methodology* – MassHealth should update the hybrid measure sampling methodology to include a larger oversample of members to account for members that are removed from the hybrid sample for exclusions.
- *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 better policy documentation* – To encourage consistent practices and compliance with MassHealth standards, MassHealth should require MCPs to establish and maintain well-defined policies and procedures. Additionally, establishing ongoing technical assistance could help ensure that all plans are well-informed and compliant.
- *Recommendation towards an effective evaluation of 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.
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EQR Recommendations for PC ACOs

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. The program is funded by both the state and federal government, and it is administered by the Massachusetts EOHHS.

MassHealth's mission is to improve the health outcomes of its "members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life."[3] MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.

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

MassHealth Medicaid Quality Strategy

Titles 42 CFR § 438.340(a) and *42 CFR § 457.1240(e)* establish that state agencies must draft and implement a written quality strategy for assessing and improving the quality of health care services furnished by the managed care programs with which the state is contracted. MassHealth has implemented a comprehensive Medicaid quality strategy to improve the quality of health care for its members. The quality strategy is comprehensive, as it guides quality improvement of services delivered to all MassHealth members, including managed care and fee-for-service populations.

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

2025–2027 Strategic Goals

Compared to its 2022 predecessor, the 2025 Comprehensive Quality Strategy includes goals with explicit objectives and associated quality measures. Progress will be assessed based on MassHealth's ability to achieve clearly stated 2027 targets, which were set based on statewide performance during a baseline period. The baseline period represents either MY 2023 or MY 2024. MassHealth's strategic goals are listed in **Table 2**. For the full list of MassHealth's quality goals, objectives, quality measures, baseline performance, and 2027 targets, see **Appendix A**, **Tables A1–A5**.

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

Table 2: MassHealth's Strategic Goals

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

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

MassHealth Managed Care Programs

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

1. The **Accountable Care Partnership Plans** (ACPPs) are ACOs consisting of groups of PCPs who partner with one health plan to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As ACOs, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high-quality care to MassHealth enrollees. To select an ACPP, a MassHealth enrollee must live in the plan's service area and must use the plan's provider network.
2. The **Primary Care Accountable Care Organizations** (PC ACOs) are ACOs consisting of groups of PCPs who contract directly with MassHealth to provide integrated and coordinated care. PC ACOs function as an ACO but are considered PCCM entities. In contrast to ACPPs, a PC ACO does not partner with a health plan. Instead, PC ACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. **Managed Care Organizations** (MCOs) are health plans run by health insurance companies with their own provider network that includes PCPs, specialists, behavioral health providers, and hospitals.
4. **Primary Care Clinician Plan** (PCCP) is a PCCM arrangement, where Medicaid enrollees select or are assigned to a PCPs, called a primary care clinician (PCC). The PCC provides services, including care coordination, to enrollees under age 65 years and without any third-party insurance. PCCP uses the MassHealth network of PCPs, specialists, and hospitals, as well as the MBHP's network of behavioral health providers.
5. **Massachusetts Behavioral Health Partnership** (MBHP) is a health plan that manages behavioral health care for MassHealth's PC ACOs and the PCCP. MBHP also serves children in state custody not otherwise enrolled in managed care and certain children enrolled in MassHealth who have commercial insurance as their primary insurance.

6. **One Care** Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services, as well as LTSS. This Plan is for Enrollees ages 21 to 64 years who are dually enrolled in Medicaid and Medicare.[4]
7. **Senior Care Options** (SCO) Plans are also integrated health plans that cover services paid for by Medicare and Medicaid. SCO Plans are for MassHealth Enrollees ages 65 years and older, and they offer services to help seniors stay independently at home by combining health care with social supports.[5] SCO Plans coordinate all Medicare and Medicaid benefits, and Enrollees must be eligible for both programs at the time of enrollment.

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

MassHealth Additional Programs

MassHealth manages other programs beyond MCPs.

Fee-for-service (FFS) Medicaid Program

Fee-for-service is a traditional payment model where healthcare providers are paid directly for each service without a capitated payment and care coordination. According to the MassHealth Comprehensive Quality Strategy, 30% of MassHealth members are enrolled in fee-for-service, which includes individuals who live in nursing facilities or rehabilitation hospitals, individuals under age 65 years who have employer-sponsored insurance for whom MassHealth offers wraparound benefits, and individuals over age 65 years or who are disabled with Medicare and choose to remain in fee-for-service.[6]

Long-term Services and Supports (LTSS)

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

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

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

Community Partners Program

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

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[4] One Care Facts and Features. Also available at: https://www.mass.gov/doc/one-care-facts-and-features-brochure/download.
[5] Senior Care Options (SCO) Overview. Also available at: https://www.mass.gov/service-details/senior-care-options-sco-overview.
[6] MassHealth 2025 Comprehensive Quality Strategy. Also available at: https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download.

Quality Metrics

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

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

Under each managed care program, health plans are either required to calculate quality measure rates, or the state calculates measure rates for the plans. Specifically, ACPPs, MCOs, SCOs, One Care Plans, and MBHP calculate HEDIS rates and are required to report on these metrics on a regular basis, whereas PC ACOs' 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, where the 90th percentile is used to inform a goal target. The MBHP targets are the national HEDIS Medicaid 75th and 90th percentiles, whereas the SCO and One Care Plan targets are the national HEDIS Medicare and Medicaid 75th and 90th percentiles. The 75th percentile is a minimum or threshold standard for performance, and the 90th performance reflects a goal target for performance. For non-HEDIS measures, fixed targets are determined based on prior performance.

Performance Improvement Projects

MassHealth selects topics for its PIPs in alignment with the quality strategy goals and objectives, as well as in alignment with the CMS National Quality Strategy. , all health plans and ACPPs are required to develop PIPs.

Member Experience of Care Surveys

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

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

Individuals covered by MBHP are asked about their experience with specialty behavioral health care via MBHP's Member Satisfaction Survey that MBHP conducts annually.

MassHealth Access Standards

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

State's Evaluation of the Effectiveness of the Quality Strategy

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

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

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

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

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

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

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

The quality strategy was posted to the MassHealth quality webpage for public comment, feedback was reviewed, and then the strategy was shared with CMS for review before it was published as final.

MassHealth evaluates the effectiveness of its quality strategy and conducts a review of measures and key performance indicators to assess progress toward strategic goals.

The most recent evaluation of MassHealth's Quality Strategy was conducted in 2024. Overall, MassHealth achieved goals 1 and 5 and made progress toward goals 2, 3, and 4. Based on the evaluation, the state plans to maintain and revise several quality strategy goals to better align with evolving agency priorities.

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

III. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

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

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

MassHealth adjudicates claims for the PC ACOs and receives encounter data from a behavioral health vendor (MBHP) for members enrolled in the PC ACOs. MassHealth provided Telligen with PC ACOs' claims and encounter data files every quarter through a comprehensive data file extract referred to as the mega-data extract. Telligen extracted and transformed the data elements necessary for the measure rate calculation.

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

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

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

Primary source validation was conducted on MassHealth systems to confirm that the information from the primary source matched the output 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 performance measures. The data collection validation included accurate numerator and denominator identification and algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately.

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

Description of Data Obtained

The following information was obtained from MassHealth:

- a completed Information Systems Capabilities Assessment tool;
- denominator and numerator compliant lists for the following two measures:
  - Developmental Screening in the First 3 Years of Life (DEV),
  - Asthma Medication Ratio (AMR);
- rates for HEDIS and non-HEDIS measures;
- screenshots from the data warehouse for primary source validation; and
- lists of numerator records that were compliant by medical record abstraction were obtained for the Screening for Depression and Follow-up Plan measure.

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 non-HEDIS rates for the PC ACOs were fully compliant with all applicable information system standards. Findings from IPRO's review are displayed in **Table 3**.

Table 3: PC ACO Compliance with Information System Standards – MY 2024

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

MY: measurement year; PC ACO: primary care accountable care organization.

Validation Findings

- **Information Systems Capabilities Assessment:** The Information Systems Capabilities Assessment is conducted to confirm that MassHealth's information systems were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, provider data systems, and encounter data systems. There were no concerns with any other data received for members enrolled in the PC ACOs. No issues were identified.
- **Source Code Validation:** Source code review is conducted to ensure compliance with the measure specifications when calculating measure rates. NCQA measure certification for HEDIS measures was accepted in lieu of source code review. MassHealth's vendor Telligen subcontracted with SS&C Health, an NCQA-certified vendor, to produce the HEDIS measures rates for the PC ACOs. Source code review was conducted with SS&C Health for the PC ACOs' non-HEDIS measure rates. No issues were identified.

- **Medical Record Validation:** Medical record review validation is conducted to confirm that MassHealth followed appropriate processes to report rates using the hybrid methodology. The PC ACOs provided charts for sample records for medical record review validation. All records passed review. It was identified that MassHealth's sampling methodology did not include sufficient oversample of members to replace members that met exclusion criteria for the Screening for Depression and Follow-up Plan measure. Caution should be used when comparing the rates of the two PC ACOs for the Screening for Depression and Follow-up Plan measure since they both have different sample sizes. No other issues were identified.
- **Primary Source Validation:** Primary source validation is conducted to confirm that the information from the primary source matches the output information used for measure reporting. MassHealth provided screenshots from the data warehouse of the selected records for primary source validation. 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 other 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.

Recommendations

- MassHealth should update the hybrid measure sampling methodology to include a larger oversample of members to account for members that are removed from the hybrid sample for exclusions.

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 2024 Quality Compass New England regional percentiles for Medicaid health maintenance organizations 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 PC ACO measure 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.

Best Performance:

- **Controlling High Blood Pressure**
  - Revere ACO: 79.81% (≥ 75th percentile but < 90th percentile)
- **Immunization for Adolescents (Combo 2)**
  - C3 ACO: 57.91% (≥ 90th percentile)
- **Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)**
  - Revere ACO: 25.61% (≥ 75th percentile but < 90th percentile)
  - C3 ACO: 38.17% (≥ 90th percentile)

- **Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)**
  - C3 ACO: 62.56% (≥ 90th percentile)

Needs Improvement:

- **Controlling High Blood Pressure**
  - C3 ACO: 67.64% (< 25th percentile)
- **Follow-up After Hospitalization for Mental Illness (7 days)**
  - Revere ACO: 47.21% (< 25th percentile)
  - C3 ACO: 48.91% (< 25th percentile)

As explained in **Table 4**, the regional percentiles are color coded to compare to the PC ACO rates.

Table 5 displays the HEDIS performance measures for MY 2024 for the PC ACOs.

Table 4: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2024 Quality Compass New England Regional Percentiles

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

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

Table 5: PC ACO HEDIS Performance Measures – MY 2024

HEDIS Measure	C3 ACO	Revere ACO	ACO Statewide Mean
Timeliness of Prenatal Care	91.24% (≥ 50th but < 75th)	90.75% (≥ 50th but < 75th)	91.15% (≥ 50th but < 75th)
Postpartum Care	83.45% (≥ 25th but < 50th)	84.67% (≥ 25th but < 50th)	83.69% (≥ 25th but < 50th)
Follow-up After Hospitalization for Mental Illness (7 days)	48.91% (< 25th)	47.21% (< 25th)	48.41% (< 25th)
Follow-up After Emergency Department Visit for Mental Illness (7 days)	71.40% (≥ 50th but < 75th)	72.69% (≥ 50th but < 75th)	71.81% (≥ 50th but < 75th)
Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	62.56% (≥ 90th)	51.22% (≥ 50th but < 75th)	59.14% (≥ 90th)
Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	38.17% (≥ 90th)	25.61% (≥ 75th but < 90th)	34.38% (≥ 90th)
Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	42.41% (≥ 50th but < 75th)	39.10% (≥ 25th but < 50th)	41.5% (≥ 50th but < 75th)
Asthma Medication Ratio	59.16% (≥ 50th but < 75th)	57.44% (≥ 25th but < 50th)	58.49% (≥ 50th but < 75th)
Controlling High Blood Pressure	67.64% (< 25th)	79.81% (≥ 75th but < 90th)	71.68% (≥ 25th but < 50th)
Glycemic Status Assessment for Patients with Diabetes (> 9.0%; lower is better)	30.41% (≥ 25th but < 50th)	32.60% (≥ 25th but < 50th)	31.08% (≥ 25th but < 50th)
Childhood Immunization Status (Combo 10)	45.74% (≥ 50th but < 75th)	40.15% (≥ 25th but < 50th)	43.55% (≥ 50th but < 75th)

HEDIS Measure	C3 ACO	Revere ACO	ACO Statewide Mean
Immunization for Adolescents (Combo 2)	57.91% (≥ 90th)	35.77% (≥ 25th but < 50th)	49.31% (≥ 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. **Table 6** shows the color key for state-specific performance measure comparison to the state benchmark. **Table 7** shows state-specific performance measures for MY 2024 for all PC ACOs and the ACO weighted statewide mean. PC MES measures were not included in the performance measure validation. The PC MES survey results were fielded in 2025, for the 2024 program year.

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

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 2024

Measure	C3 ACO	Revere ACO	ACO Statewide Mean	State Benchmark
PC MES Willingness to Recommend+ Adult	86.55% (< Goal)	88.86% (< Goal)	88.75% (< Goal)	92% (N/A)
PC MES Willingness to Recommend+ Child	89.74% (< Goal)	93.63% (> Goal)	92.48% (> Goal)	92% (N/A)
PC MES Communication+ Adult	92.56% (> Goal)	92.71% (> Goal)	93.40% (> Goal)	92% (N/A)
PC MES Communication+ Child	94.29% (> Goal)	96.39% (> Goal)	96.11% (> Goal)	92% (N/A)
PC MES Integration of Care+ Adult	83.77% (< Goal)	85.74% (> Goal)	86.26% (> Goal)	85% (N/A)
PC MES Integration of Care+ Child	84.12% (< Goal)	88.35% (< Goal)	86.17% (< Goal)	90% (N/A)

Measure	C3 ACO	Revere ACO	ACO Statewide Mean	State Benchmark
PC MES Knowledge of Patient+ Adult	85.36% (> Goal)	86.82% (> Goal)	87.75% (> Goal)	85% (N/A)
PC MES Knowledge of Patient+ Child	87.3% (< Goal)	90.36% (> Goal)	90.11% (> Goal)	90% (N/A)
Screening for Depression and Follow-up Plan	55.99% (< Goal)	50.7% (< Goal)	56.94% (< Goal)	58% (N/A)
Topical Fluoride for Children, Dental or Oral Health Services (Ages 1–5 Years)	38.54% (> Goal)	39.86% (> Goal)	38.03% (> Goal)	24% (N/A)
Developmental Screening in the First 3 Years of Life	72.65% (> Goal)	71.36% (> Goal)	74.01% (> Goal)	60% (N/A)

PC ACO: primary care accountable care organization PC MES: Primary Care Member Experience Survey; MY: measurement year; N/A: not applicable.

IV. Review of Compliance with Medicaid Managed Care Regulations

Objectives

The objective of the compliance review process is to determine the extent to which Medicaid managed care entities comply with federal quality standards mandated by the Balanced Budget Act of 1997. The purpose of this compliance review was to assess PC ACOs compliance with federal and state regulations regarding structure and operations; grievance policies; availability of services; quality measurement; and coordination and continuity of care. This section of the report summarizes the 2024 compliance results. The next comprehensive review will be conducted in 2027, as the compliance validation process is conducted triennially.

Technical Methods of Data Collection and Analysis

IPRO's review of compliance with state and federal regulations was conducted in accordance with Protocol 3 of the CMS EQR protocols. 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. Consequently, the following areas were not applicable to the PC ACO review:

- Emergency and post-stabilization services (*Title 42 CFR § 438.114*)
- Assurances of adequate capacity and services (*Title 42 CFR § 438.207*)
- Coverage and authorization of services (*Title 42 CFR § 438.210*)
- Provider selection (*Title 42 CFR § 438.214*)
- Practice guidelines (*Title 42 CFR § 438.236*)

PC ACO compliance reviews were divided into nine standards consistent with the CMS February 2023 EQR protocols:

- Disenrollment requirements and limitations (*Title 42 CFR § 438.56*)
- Enrollee rights requirements (*Title 42 CFR § 438.100*)
- Availability of services (*Title 42 CFR § 438.206*)
- Coordination and continuity of care (*Title 42 CFR § 438.208*)
- Confidentiality (*Title 42 CFR § 438.224*)
- Grievance and appeal systems (*Title 42 CFR § 438.228*)
- Subcontractual relationships and delegation (*Title 42 CFR § 438.230*)
- Health information systems (*Title 42 CFR § 438.242*)
- QAPI (*Title 42 CFR § 438.330*)

The 2024 annual compliance review consisted of three phases: 1) pre-interview desk review of PC ACOs documentation and case file review, 2) remote interviews, and 3) post-interview report preparation.

Pre-interview Documentation Review

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

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

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

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

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

Remote Interviews

The remote interview with PC ACOs were conducted between September 30 and October 18, 2024. Interviews with relevant plan staff allow the EQRO to assess whether the plan indeed understands the requirements, the internal processes, and procedures to deliver the required services to members and providers; can articulate in their own words; and draws the relationship between the policies and the implementation of those policies. Interviews discussed elements in each of the review tools that were considered less than fully compliant based upon initial review. Interviews were used to further explore the written documentation and to allow PC ACOs to provide additional documentation, if available. PC ACO staff was given two days from the close of the onsite review to provide any further documentation.

Post-interview Report Preparation

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

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

For each standard identified as Partially Met or Not Met, the PC ACO was required to provide a timeline and high-level plan to implement the correction. PC ACOs are expected to provide an update on the status of the implementation of the corrections when IPRO requests an update on the status of the annual technical report recommendations, which is part of the annual EQR process.

Scoring Methodology

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by the total possible points. A three-point scoring system was used: Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points. For each standard identified as Partially Met or Not Met, the PC ACO was required to clarify how and when the issue will be resolved. 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 MCP 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. MCP staff interviews, however, provided information that was not consistent with the documentation provided. • Documentation to substantiate compliance with some but not all of the regulatory or contractual provisions was provided, although MCP staff interviews provided information consistent with compliance with all requirements. • Documentation to substantiate compliance with some but not all of the regulatory or contractual provisions was provided, and MCP staff interviews provided information inconsistent with compliance with all requirements.
Not Met = 0 points	There was an absence of documentation to substantiate compliance with any of the regulatory or contractual requirements, and MCP staff did not provide information to support compliance with requirements.
Not applicable	The requirement was not applicable to the MCP. Not applicable elements are removed from the denominator

MCP: managed care plan.

Description of Data Obtained

Compliance review tools included detailed regulatory and contractual requirements in each standard area. The 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. Both C3 and Revere ACOs performed exceptionally well in several compliance domains, achieving 100% in Disenrollment Requirements and Limitations, Enrollee Rights and Protections, Confidentiality, and Subcontractual Relationships and Delegation.

However, there are areas needing improvement:

- **C3 ACO** needs to improve in Health Information Systems (96%) and QAPI (96%).
- **Revere ACO** should focus on improving Grievance and Appeal Systems (92%) and QAPI (84%).

At the time of writing this report, IPRO has yet to determine PC ACOs performance in **Coordination and Continuity of Care.**

Table 9 presents compliance scores for each of the nine domains for both PC ACOs. Red text: indicates opportunity for improvement (less than 90%).

Table 9: PC ACO Performance by Review Domain – 2024 Compliance Validation Results

CFR Standard Name	CFR Citation	C3 ACO	Revere ACO
Overall Compliance Score	**N/A**	**95%**	**90%**
Disenrollment Requirements and Limitations	**438.56**	100%	100%
Enrollee Rights and Protections	**438.100**	100%	100%
Availability of Services	**438.206**	100%	99%
Coordination and Continuity of Care	**438.208**	67%	41%
Confidentiality	**438.224**	100%	100%
Grievance and Appeal Systems	**438.228**	100%	92%
Subcontractual Relationships and Delegation	**438.230**	100%	100%
Health Information Systems	**438.242**	96%	100%
QAPI	**438.330**	96%	84%

PC ACO: primary care accountable care organization; CFR: Code of Federal Regulations; QAPI: Quality Assurance and Performance Improvement.

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 second amended and restated PC ACO Contract with MassHealth states that MassHealth will administer patient experience surveys to evaluate the enrollee experience with PCP providers participating in the MassHealth's ACO program.

MassHealth worked with Massachusetts Health Quality Partners (MHQP), an independent nonprofit measurement and reporting organization, to survey adult and pediatric ACO and MCO members about their experiences with PCPs using the 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 high-quality care.[7] The level of analysis for the PC MES surveys was individual ACO-MCO.

Technical Methods of Data Collection and Analysis

The measurement year 2024 PC MES was fielded between May and August 2025, by MHQP. The adult and child PC MES survey instruments were adapted from the CG-CAHPS 4.0 (beta) surveys developed by the Agency for Health Care Research and Quality and the NCQA. The measurement year 2024 PC MES adult and child surveys included Patient-Centered Medical Home survey items, as well as the Health Promotion & Education supplemental survey items in the adult survey, and the Coordination of Care supplemental survey items in the child survey.

Nineteen MCPs participated in the measurement year 2024 survey, including 15 ACPPs, two PC ACOs, and two MCOs. 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, Khmer, and Arabic (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. Email invitations were sent to members with email addresses on file. The mailed survey and email invitations included a link to an online version of the survey. The survey fielding protocol includes up to 5 emails and up to 3 mailings..

The sample frame included members who had at least one in-person primary care visit during the measurement year and who were enrolled in one of the ACOs or MCOs. Patients' age on the anchor date (December 31, 2024) was used to assign respondents for the adult or child survey. **Tables 10–11** provide a summary of the technical methods of data collection.

[7] AHRQ. CAHPS Clinician & Group Survey. Also available at: CAHPS Clinician & Group Survey | Agency for Healthcare Research and Quality (ahrq.gov).

Table 10: Adult PC MES – Technical Methods of Data Collection, MY 2024

Technical Methods of Data Collection	ACO
Survey vendor	Massachusetts Health Quality Partners
Survey tool	MassHealth PC MES, adapted from the CG-CAHPS 4.0 (beta) survey instrument
Survey fielding timeline	May–August 2025
Method of collection	Mailings and emails
Sample size – all ACOs and MCOs	97,344
Response rate	9.9%

PC MES: Primary Care Member Experience Survey; ACO: accountable care organization; MCO: managed care organization; MY: measurement year; CG-CAHPS: Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey.

Table 11: Child PC MES – Technical Methods of Data Collection, MY 2024

Technical Methods of Data Collection	ACO
Survey vendor	Massachusetts Health Quality Partners
Survey tool	MassHealth PC MES, adapted from the CG-CAHPS 4.0 (beta) survey instrument
Survey fielding timeline	May –August 2025
Method of collection	Mailings and emails
Sample size – all ACOs and MCOs	144,423
Response rate	4.5%

PC MES: Primary Care Member Experience Survey; ACO: accountable care organization; MCO: managed care organization; MY: measurement year; CG-CAHPS: Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey.

To assess PC ACO performance, IPRO reported PC MES statewide scores calculated across all ACOs and MCOs.

Description of Data Obtained

IPRO received copies of the final program year 2024 technical and analysis reports produced by MHQP. These reports included 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 both PC ACOs, IPRO compared each PC ACO's results to the ACO-MCO statewide scores for the adult and child PC MES surveys. 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 program year 2024 (fielded in 2025). Revere ACO exceeded the statewide score on two adult PC MES measures. C3 ACO exceeded the statewide score only on one measure.

Table 14 shows the results of the PC MES child Medicaid survey for program year 2024 (fielded in 2025). Revere ACO exceeded the statewide score on seven measures, while C3 ACO exceeded the statewide score on only one child PC MES measure.

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

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.

PC MES: Primary Care Member Experience Survey; ACO: accountable care organization.

Table 13: PC MES Performance – Adult Member, Program Year 2024

PC MES Measure	C3 ACO	Revere ACO	Statewide Score (ACOs and MCOs)
Adult Behavioral Health	66.97 (< Goal)	60.50 (< Goal)	67.1
Communication	92.56 (< Goal)	92.71 (< Goal)	93.4
Integration of Care	83.77 (< Goal)	85.74 (< Goal)	86.3
Knowledge of Patient	85.36 (< Goal)	86.82 (< Goal)	87.8
Office Staff	92.52 (< Goal)	93.91 (> Goal)	93.8
Organizational Access	75.01 (< Goal)	79.53 (< Goal)	79.8
Overall Provider Rating	86.46 (< Goal)	88.50 (< Goal)	88.7
Self-Management Support	64.85 (> Goal)	61.08 (< Goal)	64.5
Willingness to Recommend	86.55 (< Goal)	88.86 (> Goal)	88.7

PC MES: Primary Care Member Experience Survey; ACO: accountable care organization.

Table 14: PC MES Performance – Child Member, Program Year 2024

PC MES Measure	C3 ACO	Revere ACO	Statewide Score (ACOs and MCOs)
Communication	94.29 (< Goal)	96.39 (> Goal)	96.1
Integration of Care	84.12 (< Goal)	88.35 (> Goal)	86.2
Knowledge of Patient	87.30 (< Goal)	90.36 (> Goal)	90.1
Office Staff	92.55 (< Goal)	95.23 (> Goal)	94.5
Organizational Access	71.93 (< Goal)	88.06 (> Goal)	83.4
Overall Provider Rating	89.22 (< Goal)	92.02 (> Goal)	91.4
Self-Management Support	52.56 (> Goal)	49.13 (< Goal)	52.4
Willingness to Recommend	89.74 (< Goal)	93.63 (> Goal)	92.5
Child Development	62.83 (< Goal)	64.85 (< Goal)	66.4
Child Provider Communication	94.48 (< Goal)	96.03 (< Goal)	96.0
Pediatric Prevention	60.76 (< Goal)	60.11 (< Goal)	62.6

PC MES: Primary Care Member Experience Survey; ACO: accountable care organization.

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,[8] PAHP,[9] or PCCM entity has effectively addressed the recommendations for QI[10] made by the EQRO during the previous year's EQR." **Tables 15–16** 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 reprocurement.

C3 ACO Response to Previous EQR Recommendations

Table 15 displays the PC ACO's progress related to the *PC ACO External Quality Review CY 2024,* as well as IPRO's assessment of the PC ACO's response.

Table 15: C3 ACO Response to Previous EQR Recommendations

Recommendation for C3 ACO	C3 ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV 1: The following HEDIS rates were below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark: • Timeliness of Prenatal Care: 82.73% • Postpartum Care: 79.56% • Follow-up After Hospitalization for Mental Illness (7 days): 35.6% C3 ACO 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 addressed the Postpartum Care (PPC) and Follow-up After Hospitalization for Mental Illness (FUM) measures through MassHealth Performance Improvement Plans (PIPs) that target barriers to care and improve coordination between hospitals and FQHCs. Specific interventions include providing blood pressure cuffs to eligible Hispanic members, creating workflows for follow-up care, and sharing data with FQHCs to support outreach for high-utilizer patients. For Timeliness of Prenatal Care, C3 implemented a maternity registry accessible to providers and offered training and CMO-led forums to enhance early engagement and care coordination.	Addressed

[8] Prepaid inpatient health plan.
[9] Prepaid ambulatory health plan.
[10] Quality improvement.

Recommendation for C3 ACO	C3 ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV 2: Six out of nine measures rates were below the statewide benchmark. C3 ACO 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.	See below for PC MES measures, i.e., the last row of this table.	Partially Addressed

Compliance: Lack of compliance with 28 requirements in the following domains:
• Care coordination (27)
• QAPI (1)
 	
Partial compliance with 132 requirements in the following domains:
• Care coordination (126)
• Health information systems (3)
• QAPI (3)
 	
MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation
	<u>Care coordination (Lack of compliance)</u>:
	• The compliance review found lack of compliance with care coordination elements related to care delivery, including screening, assessments, care plans, and follow-up; baseline care coordination; risk stratification; and enhanced care coordination.
	  ○ Initially, 27 care coordination-related requirements were not compliant. Of these, 11 were fully addressed and resulted in demonstrated improvement, while 16 were partially addressed but did not yet show improvement. The details of these findings were shared with the MCP and MassHealth.
	<u>Care coordination (Partial compliance)</u>:
	• The compliance review found partial compliance with care coordination elements related to care delivery, including screening, assessments, care plans, and follow-up; transitional care management and discharge planning; baseline care coordination; risk stratification; and enhanced care coordination.
	  ○ Initially, 126 care coordination-related requirements were only partially compliant. Of these, 73 were fully addressed and resulted in demonstrated improvement, while 53 were partially addressed but did not yet show improvement. The details of these findings were shared with the MCP and MassHealth.
	<u>Health information systems (Partial compliance):</u>
	• C3 should either update existing policies or procedures, or create a new document that addresses a process to obtain and capture all of the required enrollee characteristics within their data systems.
	  ○ An SOP has been developed and finalized. The SOP captures the processes followed to ensure C3 captures enrollee's characteristics within our data systems so they can be reported to MassHealth monthly in the Member Data Reports.
		Addressed (3 Health information systems elements, 84 Care coordination elements, 4 QAPI elements)
		
		Partially addressed (69 Care coordination elements)

Recommendation for C3 ACO	C3 ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	• C3 should engage with the MassHealth exchange services to meet this requirement (increase connectivity to Mass Hiway). ○ After C3 held direct discussions with CTC staff, C3 sent surveys to affiliated providers' IT contacts at non CTC sites; surveys were returned October 15th. The surveys confirm health center connectivity, and reliance on data delivered via MassHIway. They also depend largely on EHR vendor-specific data sharing (e.g., Epic Care Everywhere and Athena One Patient Record Sharing) and the national interop infrastructures (Commonwell and CareQuality). <u>QAPI (Initial Lack of Compliance)</u>: IPRO recommended that C3 include representatives from parents or guardians of Enrollees under the age of 21 among PFAC members. C3 reported that a caregiver of a member under 21 is presently a member of the PFAC. <u>QAPI (Initial Partial Compliance)</u>: IPRO recommended that PFAC should provide regular feedback to the Governing Board on issues of enrollee care and services. As of April 24, 2025, the PFAC Report became a standing agenda item at each Governing Board meeting, and two reports have already been delivered and documented in meeting minutes. IPRO recommended that PFAC members should be involved in the development and updating of cultural and linguistic policy and procedure decisions, The PFAC has been actively involved in cultural competency and has weighed in several quality improvement initiatives. IPRO recommended that C3 publicize the opportunity for joining the PFAC such that any Enrollee (or their family member as applicable) may have the opportunity to apply to participate or otherwise join. C3 developed and deployed new PFAC recruitment materials in 2025, including flyers approved by MassHealth, a social media strategy, and a dedicated section on the C3 website.	
Quality-of-Care Surveys: C3 ACO scored below the statewide benchmark on six adult and all child PC MES measures. C3 ACO should utilize the results of the adult and child PC MES surveys to drive performance improvement as it relates to member experience. C3 ACO should also utilize complaints and grievances to identify and address trends.	C3 has undertaken various paths to address this recommendation including providing Quality Improvement (QI) and Trauma Informed Care (TIC) Trainings to Affiliated Providers' staff. These training sessions were a mix of virtual and in-person. In addition, nine virtual coaching sessions were offered, beginning in November of 2024 and continuing through June 2025. We believe these training sessions helped both internal and Affiliated Providers' staff improve patient care and experience. Further, C3 has provided resources to Affiliated Providers to prepare them for the MES surveys such as pre-notification information and sharing the MassHealth tool kits with them. These resources are intended to remind Affiliated Providers and members that the surveys are upcoming increase the response rate. Sharing the flyers in multiple languages has also helped increase access and likelihood of completion. We are monitoring performance by tracking if there is an increase in member completion after receipt and distribution of these resources. Further, as noted above, C3 provides a breakdown of member	Partially Addressed

Recommendation for C3 ACO	C3 ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	experience surveys by race, ethnicity, and language for FQHCs. Even though the data is shielded to each Affiliated Provider by member level, we still apply these strategies across the ACO front. Further, we believe the survey being available electronically and in multiple languages will positively impact member completion rates. As a part of future planning, C3 plans to compare previous MES results to scope areas for improvement. C3 plans to continue implementation initiatives started in PY2024 into PY 2025.	

[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.
ACO: accountable care organization; MCP: managed care plan; EQR: external quality review; MH: MassHealth.

Revere ACO Response to Previous EQR Recommendations

Table 16 displays the PC ACO's progress related to the *PC ACO External Quality Review CY 2024,* as well as IPRO's assessment of the PC ACO's response.

Table 16: Revere ACO Response to Previous EQR Recommendations

Recommendation for Revere ACO	Revere ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV 1: The following rate was below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark: • Follow-up After Hospitalization for Mental Illness (7 days): 42.58% Revere 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.	Based on the Quality benchmarks published by EOHHS which are based on regional Medicaid ACO performance, RHG Medicaid ACO performed slightly below the midpoint of the goal and attainment benchmarks. Mass Health has set the attainment benchmark at 39% and the goal at 55% in 2023. Although our performance is exceeding the EOHHS attainment benchmark, we still believe there is room to improve and starting in 2023, Revere Medical partnered with 7 hospitals to address the performance opportunities in the Follow Up After Hospitalization for Mental Illness. The partnership was later reduced to 2 hospitals due to closure and sale of the hospital partners but so far has produced strong results. NCQA Quality Compass benchmarks are applicable to health plans. RHG Medicaid ACO is a Model B program and does not meet the guidelines to report HEDIS measure performance to NCQA.	Partially Addressed

Recommendation for Revere ACO	Revere ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV 2: State-specific Measures: Six measures were below the statewide benchmark. Revere 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.	RHG Medicaid ACO performance is above the EOHHS attainment benchmark (minimum performance level) in all measures in 2023 and met or exceeded the goal benchmark in 5 measures. RHG Medicaid ACO has implemented a comprehensive reporting suite to track performance in each quality measure month over month, maintains clinical support operations to drive quality performance, integrates quality measure requirements into all applicable clinical care delivery workflows and conducts outreach to patients to schedule appointments with their primary care provider so that quality gaps in care can be addressed.	Partially Addressed

Compliance: Lack of compliance with 109 requirements in the following domains:
• Care coordination (107)
• QAPI (2)
 	
Partial compliance with 128 requirements in the following domains:
• Availability of services (1)
• Care coordination (107)
• Grievances and appeals (3)
• QAPI (17)
 	
MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation
	<u>Availability of services (Partial compliance)</u>:
	• Update the Maintenance and Monitoring of Participating Provider Agreements policy and has provided a draft edit including the seven days.
	  ○ The policy/procedure as updated and approved in January 2025 remains in force.
	<u>Care coordination (Lack of compliance)</u>:
	• The compliance review found lack of compliance with 107 care coordination elements related to care delivery, including screening, assessments, care plans, and follow-up; clinical advice and support line; baseline care coordination; risk stratification; and enhanced care coordination, including transitions of care plans and medication review.
	  ○ IPRO found that Revere addressed all care coordination-related elements that were initially out of compliance, demonstrating improvement. The details of these findings were shared with MassHealth.
	<u>Care coordination (Partial compliance)</u>:
	• The compliance review found partial compliance with 107 care coordination elements related to care delivery, including screening, assessments, care plans, and follow-up; transitional care management and discharge planning; clinical advice and support line; baseline care coordination; risk stratification; and enhanced care coordination, including transitions of care plans and medication review.
	  ○ IPRO found that Revere addressed all care coordination-related elements that were initially only partially compliant, demonstrating improvement. The details of these findings were shared with MassHealth.
	<u>Grievances and appeals (Partial compliance)</u>:
	• IPRO recommends that Revere update the most recent Member Grievances Policy #6.02 to reflect the State contract requirements of notifying enrollees of the receipt.
		Addressed (1 Availability of services, 214 Care coordination, 3 Grievances and appeals, 1 QAPI)
		
		Partially Addressed (17 QAPI)
		
		Remains an opportunity for improvement: QAPI (1)

Recommendation for Revere ACO	Revere ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	○ The policy/procedure as updated and approved in January 2025 remains in force. Monitoring done as of September 2025 shows that timeframe for enrollee notification RE receipt of all grievances continues to be met 100%. • IPRO recommends that Revere Medical regularly reviews and revises policies based on State contract requirements and best practices. ○ The policy/procedure as updated and approved in January 2025 remains in force. ○ The grievance oversight procedure included in Community Partner oversight continues in place. <u>QAPI (Initial Lack of Compliance)</u>: • IPRO recommends that Revere conduct an annual evaluation of the results of QM/QI initiatives and submit the results of the evaluation to MassHealth. The evaluation of the QM/QI program should include the results of activities that demonstrate the Contractor's assessment of the clinical quality of care rendered, initiatives focusing on Health Equity and Health Related Social Needs, as well as accomplishments and compliance and/or deficiencies in meeting the previous year's QM/QI Strategic Work Plan. ○ RHG Network ACO has begun documenting the annual plan in a different template that is expected to better meet the auditor's requirements. – **<u>Remains an Opportunity for Improvement:</u>** The response indicates that Revere has begun using a new template to document the annual plan. However, it does not confirm that an evaluation was conducted during the review period, nor does it provide evidence of assessing outcomes, leaving the recommendation unaddressed. • PFAC should include representatives from parents or guardians of Enrollees under the age of 21. IPRO suggests that the meeting minutes should clearly identify which of the meeting participants are PFAC members/Revere enrollees, including representatives from parents or guardians of enrollees under the age of 21. ○ Eight new consumer PFAC members were identified/recruited in 2025, comprised of both adult members and guardians of children. – **<u>Addressed</u>** <u>QAPI (Initial Partial Compliance)</u>: • The QM/QI program should be communicated in a manner that is accessible and understandable. Revere should maintain a comprehensive QI program description, including a clear description of its QI Program structure, with specific details on how CQI principles are applied to all aspects of its service delivery. The QI Program description should, at a minimum, include the QI Program staff structure and the QI Program committee structure describing the QM/QI roles and responsibilities. Steward should develop an annual QI work plan outlining the specific steps for	

Recommendation for Revere ACO	Revere ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	quality improvement for that year. Revere should annually evaluate the effectiveness of its QI program's processes and changes implemented to improve outcomes. Revere should also evaluate and monitor its effectiveness in engaging members and providers in designing these changes. Revere should develop and maintain policies and procedures demonstrating internal processes established to support its QM/QI program. ○ RHG Medicaid ACO continues to maintain and update documentation of a robust QM/QI program and has made additional modifications to make it easier for the EOHHS vendor who conducts the audits to understand. • The health plan should establish a clearly defined set of QM/QI functions and responsibilities, outlining them in an organizational chart that includes descriptions of key leadership roles, such as the Vice President of Quality and the National Performance Operations Manager. This structure should be documented in official materials, like the QI Program Description, to ensure clarity. All official documents should be current to the review period, accurately reflecting the responsibilities and functions during that time. ○ RHG Medicaid ACO continues to maintain and update documentation of a robust QM/QI program. All organizational chart information provided to the auditor in the Model of Care was accurate during the review period. RHG Medicaid ACO will continue to update the organizational charts to reflect any changes applicable to the review period. • To meet this requirement, the health plan should first establish a clearly defined set of QM/QI functions and responsibilities, adequate for the planned number of QI initiatives. Then, they should provide additional documentation, such as staff resumes, to demonstrate that qualified individuals held these positions during the review period. ○ RHG Medicaid ACO has clearly defined and documented the operational functions that drive quality performance. RHG Medicaid ACO has provided resumes for the roles that are specifically identified as being in scope for the audit review by the CFR and/or the contract. RHG Medicaid ACO Human Resources team ensures that all staff meet the requirements for the positions. RHG Medicaid ACO Leadership also performs regular evaluations of job performance. • IPRO recommends that the health plan develop a detailed QI Program description to describe the structure, goals, and objectives of its QM/QI Program and QI initiatives. The QI Program description should include a clearly defined set of QM/QI functions and responsibilities, a comprehensive quality program structure, and at minimum, the elements outlined on lines 17 through 20 and line 41 of this tool.	

Recommendation for Revere ACO	Revere ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	○ RHG Medicaid ACO has integrated quality of care into clinical operations and continues to monitor performance, identify operational opportunities and rectify those opportunities as they arise. • IPRO recommends that Revere develop its QI Program description to address all aspects of health care quality improvement (such as patient safety, access, timeliness, patient-centered care, provider and member satisfaction), including Health Related Social Needs, and Health Equity as well as behavioral health aspects (or include the behavioral health aspects in a separate QI Plan referenced in the QI Program Description). ○ RHG Medicaid ACO continues to maintain and update documentation of a robust QM/QI program and has made additional modifications to make it easier for the EOHHS vendor who conducts the audits to understand. The QM/QI program specifically addresses Health Related Social Needs Assessments, Health Equity and Behavioral Health quality metrics. The RHG Medicaid ACO recently was surveyed by NCQA as part of the Health Equity Accreditation and was granted a continuation of its accreditation. • IPRO recommends that Revere develop its QI Program description to explain mechanisms for the collection and submission of performance measurement data. ○ RHG Medicaid ACO continues to completely and accurately collect and submit all medical record documentation required by EOHHS's vendor. • IPRO recommends that Revere develop its QI Program description to help the reader better understand resources dedicated to the QM/QI program, including staff, data resources, and analytic programs or IT systems. ○ RHG Medicaid ACO continues to maintain and update documentation of a robust QM/QI program. All organizational chart information provided to the auditor in the Model of Care was accurate during the review period. RHG Medicaid ACO will continue to update the organizational charts to reflect any changes applicable to the review period. The QM/QI program teams are end-users of Health Information Systems that are designed, maintained and provided by the RHG Medicaid ACO technology team so are best and most accurately described in the IT Systems and Analytics section of the EQR audit. • IPRO recommends that Revere develop its QI Program description to include evaluations of QI or QM initiatives conducted over the previous year. ○ RHG Medicaid ACO has implemented this recommendation. • IPRO recommends that Revere develop and maintain an annual QM/QI Work Plan that broadly describes the annual QI activities under the QI program as well as the components outlined on lines 22 through 27. A QM/QI Work Plan should be approved by the quality committee at the beginning of each year. The work plan	

Recommendation for Revere ACO	Revere ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	should be used throughout the year to track the progress of each initiative. It should also be used as the foundation for the quality program evaluation conducted at the end of the year. ○ RHG Network ACO has begun documenting the annual plan in a different template that is expected to better meet the auditor's requirements. • IPRO recommends that Revere develop and maintain an annual QM/QI Work Plan that includes clinical and non-clinical initiatives planned for that year. The task of developing the QI Work Plan should be listed among non-clinical initiatives, identifying the individual responsible for maintaining the work plan. ○ RHG Network ACO has begun documenting the annual plan in a different template that is expected to better meet the auditor's requirements. • IPRO recommends that Revere develop and maintain an annual QM/QI Work Plan that includes the objectives of each initiative planned for that year. ○ RHG Network ACO has begun documenting the annual plan in a different template that is expected to better meet the auditor's requirements. • IPRO recommends that Revere develop and maintain an annual QM/QI Work Plan that includes a time frame for the completion of each initiative planned for that year. ○ RHG Network ACO has begun documenting the annual plan in a different template that is expected to better meet the auditor's requirements. • IPRO recommends that Revere develop and maintain an annual QM/QI Work Plan that includes the individual(s) responsible for each initiative planned for that year. ○ RHG Network ACO has begun documenting the annual plan in a different template that is expected to better meet the auditor's requirements. • IPRO recommends that Revere develop and maintain an annual QM/QI Work Plan that includes quality issues identified by Revere, MassHealth, enrollees, and providers. The work plan should be used to track how those issues are resolved over time. meet the auditor's requirements. ○ This recommendation is out of scope for the QM/QI plan but is addressed through the grievance workflow that RHG Medicaid ACO has implemented. • IPRO recommends that Revere develop and maintain an annual QM/QI Work Plan that includes the evaluation of clinical and non-clinical initiatives. ○ RHG Network ACO has begun documenting the annual plan in a different template that is expected to better meet the auditor's requirements. • IPRO recommends that Revere describe the mechanisms for assessing both the underutilization and overutilization of services in its QM/QI Program description. ○ RHG Network ACO has begun documenting the annual plan in a different template that is expected to better meet the auditor's requirements.	

Recommendation for Revere ACO	Revere ACO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	• PFAC should provide regular feedback to the Governing Board on issues of enrollee care and services. Revere should be able to demonstrate that PFAC feedback is shared with the Governing Board. Such evidence can include, for example, Board minutes demonstrating that the PFAC feedback was shared. ○ Actions reported for 2024 remain in force currently.	
Quality-of-Care Surveys: Revere scored below the statewide benchmark on three adult and two child PC MES measures. Revere should utilize the results of the adult and child PC MES surveys to drive performance improvement as it relates to member experience.	RHG remains committed to continuing to improve patient experience and has invested in a survey vendor who conducts off-cycle surveys which allows almost all RHG Medicaid ACO providers to get near real-time feedback from their patients on patient experience. RHG conducts quarterly provider training and provides monthly patient experience communications on how to improve patient experience.	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.
ACO: accountable care organization; MCP: managed care plan; EQR: external quality review.

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

Table 17–18 highlight each PC ACO's performance strengths, opportunities for improvement, and this year's recommendations based on the aggregated results of CY 2025 EQR activities as they relate to **quality**, **timeliness**, and **access**.

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

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: NCQA measures	C3 ACO demonstrated compliance with information system standards. No issues were identified. The following rates were above the 90th percentile: • Immunization for Adolescents (Combo 2): 57.91% (≥ 90th percentile) • Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement): 38.17% (≥ 90th percentile) • Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment: 62.56% (≥ 90th percentile)	The following HEDIS rates were below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark: • Controlling High Blood Pressure: 67.64% (< 25th percentile) • Follow-up After Hospitalization for Mental Illness (7 days): 48.91% (< 25th percentile)	C3 ACO 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
Performance Measure Validation: State-specific measures	The following measures were above the goal benchmark: • PC MES Communication+ Adult • PC MES Communication+ Child • PC MES Knowledge of Patient+ Adult • Topical Fluoride for Children, Dental or Oral Health Services (Age 1–5 Years) • Developmental Screening in the First 3 Years of Life	The following measures rates were below the goal benchmark: • PC MES Willingness to Recommend+ Adult • PC MES Willingness to Recommend+ Child • PC MES Integration of Care+ Adult • PC MES Integration of Care+ Child • PC MES Knowledge of Patient+ Child • Screening for Depression and Follow-up Plan	Same as above.	Quality, Timeliness, Access

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Compliance Review	Based on the review of the most recent responses to IPRO's recommendations, C3 ACO demonstrated compliance with most of the federal and state contractual standards. MCP addressed the following opportunities for improvement from the prior compliance review: • Health information systems (3) • Care coordination (84) • QAPI (4)	Partial compliance remains with the requirements in the following domains: • Care coordination (69)	MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 2/4/2025. IPRO will monitor the status of all recommendations as part of the EQR processes and follow up with the MCP before the end of CY 2026.	Quality, Timeliness, Access
Quality-of-care Surveys	C3 ACO scored above the statewide benchmark on one adult and one child PC MES measures.	C3 ACO scored below the statewide benchmark on eight adult and ten child PC MES measures.	C3 ACO should utilize the results of the adult and child PC MES surveys to drive performance improvement as it relates to member experience. C3 ACO 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; HEDIS: Healthcare Effectiveness Data and Information Set; CY: calendar year; MCP: managed care plan; PC MES: Primary Care Member Experience Survey; QAPI: quality assurance and performance improvement.

Table 18: Strengths, Opportunities for Improvement, and EQR Recommendations for Revere ACO

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: NCQA measures	Revere ACO demonstrated compliance with information system standards. No issues were identified.	The following rate was below the 25th percentile when compared to the New England regional NCQA Quality Compass benchmark: • Follow-up After Hospitalization for Mental Illness (7 days): 47.21%	Revere 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

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: State-specific measures	The following measures were above the goal benchmark: • PC MES Willingness to Recommend+ Child • PC MES Communication+ Adult • PC MES Communication+ Child • PC MES Integration of Care+ Adult • PC MES Knowledge of Patient+ Adult • PC MES Knowledge of Patient+ Child • Topical Fluoride for Children, Dental or Oral Health Services (Age 1−5 Years) • Developmental Screening in the First 3 Years of Life	The following measures rates were below the goal benchmark: • PC MES Willingness to Recommend+ Adult • PC MES Integration of Care+ Child • Screening for Depression and Follow-Up Plan	Same as above.	Quality, Timeliness, Access
Compliance Review	Based on the review of the most recent responses to IPRO's recommendations, the MCP demonstrated compliance with most of the federal and state contractual standards. MCP addressed the following opportunities for improvement from the prior compliance review: • Availability of Services (1) • Care coordination (214) • Grievances and appeals (3) • QAPI (1)	Partial compliance remains with the requirements in the following domains: • QAPI (17) Remains an opportunity for improvement: • QAPI (1)	MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 2/4/2025. IPRO will monitor the status of all recommendations as part of the EQR processes and follow up with the MCP before the end of CY 2026.	Quality, Timeliness, Access
Quality-of-care Surveys	Revere ACO scored above the statewide benchmark on two adult and seven child PC MES measures.	Revere ACO scored below the statewide benchmark on seven adult and four child PC MES measures.	Revere ACO 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

ACO: accountable care organization; EQR: external quality review; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; CY: calendar year; MCP: managed care plan; PC MES: Primary Care Member Experience Survey; QAPI: quality assurance and performance improvement.

VIII. Required Elements in EQR Technical Report

The Balanced Budget Act of 1997 established that state agencies contracting with MCPs provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCP. The federal requirements for the annual EQR of contracted MCPs are set forth in *Title 42 CFR § 438.350 External quality review (a)* through *(f).*

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

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

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

Elements required in EQR technical report, including the requirements for the PIP validation, performance measure validation, and review of compliance activities, are listed in **Table 19**.

Table 19: 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**.

Regulatory Reference	Requirement	Location in the EQR Technical Report
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 2024, 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**.

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

IX. Appendix A – MassHealth Quality Goals and Objectives

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

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

[1] CMS Universal Foundation and Core Set Measure.
CH: Child; AD: Adult; PPC: Prenatal and Postpartum Care; MY: measurement year.

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

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

[1] CMS Core Measure.
[2] CMS Universal Foundation and Core Set Measure.
AD: Adult; HH: Health Home; MY: measurement year.

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

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

[1] CMS Universal Foundation and Core Set Measure.
[2] Other national measure.
LTSS: Long-Term Services and Support; AD: Adult; MY: measurement year.

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

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

[1] CMS Universal Foundation and Core Set Measure.

[2] Medicaid Expansion CHIP and non-CHIP.

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

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

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

[1] CMS Universal Foundation and Core Set Measure.

[2] Medicaid Expansion CHIP and non-CHIP.

[3] CMS Core Measure.

MY: measurement year.

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. • Type: MCE.	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. • Type: PCCM Entity.	1. Community Care Cooperative 2. Revere Medical
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. • Type: MCE.	1. WellSense Essential 2. Tufts Health Together (will no longer be a plan in 2026)

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Primary Care Clinician Plan (PCCP)	Members select or are assigned a primary care clinician (PCC) from a network of MassHealth hospitals, specialists, and the Massachusetts Behavioral Health Partnership (MBHP). • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. • Type: PCCM.	Not applicable – MassHealth
Massachusetts Behavioral Health Partnership (MBHP)	Capitated behavioral health model providing or managing behavioral health services, including visits to a licensed therapist, crisis counseling and emergency services, SUD and detox services, care management, and community support services. • Population: Medicaid members under 65 years of age who are enrolled in the PCCP or a PC ACO (which are the two PCCM programs), as well as children in state custody not otherwise enrolled in managed care. • Managed Care Authority: 1115 Demonstration Waiver. • Type: PIHP.	MBHP
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 ages 21−64 years at the time of enrollment with MassHealth and Medicare coverage. • Managed Care Authority: Financial Alignment Initiative Demonstration. • Type: MCE.	1. Commonwealth Care Alliance 2. Tufts Health Plan Unify 3. UnitedHealthcare Connected

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Senior Care Options (SCO)	Medicare FIDE-SNPs with companion Medicaid managed care plans providing medical, behavioral health, and long-term, social, and geriatric support services, as well as respite care. • Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age. • Managed Care Authority: 1915(a) Waiver/1915(c) Waivers. • Type: MCE.	1. Commonwealth Care Alliance 2. NaviCare Fallon Health 3. Senior Whole Health by Molina 4. Tufts Health Plan Senior Care Option 5. UnitedHealthcare Senior Care Options 6. WellSense Senior Care Option (will no longer be a plan in 2026)

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

XI. Appendix C – MassHealth Quality Measures

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

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

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

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