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

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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I. Executive Summary

Managed Care Organizations

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

Massachusetts's Medicaid program (known as "MassHealth"), administered by the Massachusetts Executive Office of Health and Human Services (EOHHS), contracted with two MCOs during the 2023 calendar year (CY). MCOs are health plans run by health insurance companies. The state contracts with MCOs to coordinate enrollees' care and connect members with additional support like interpreter services. The state pays MCOs a fixed monthly payment for care management, and MCOs pay providers for health care services provided to members. MCOs contract with providers and have their own provider network. MassHealth's MCOs are listed in Table 1.

Table 1: MassHealth's MCOs – CY 2023

MCO Name	Abbreviation Used in the Report	Members as of December 31, 2023	Percent of Total MCO Population
Boston Medical Center HealthNet Plan	WellSense MCO	28,623	43.32%
Tufts Health Together	Tufts MCO	37,450	56.68%

The Boston Medical Center HealthNet Plan (WellSense MCO) is a nonprofit health insurance company that serves 28,623 MassHealth enrollees residing across five MCO regions in the state of Massachusetts. WellSense health plan was founded in 1997 by the Boston Medical Center,[1] a private, nonprofit academic medical center that is the largest safety-net hospital in New England (NE).[2] WellSense MCO received a rating of 4 out of 5 stars from the National Committee on Quality Assurance (NCQA) and is NCQA-accredited.

The Tufts Health Together MCO (Tufts MCO) is a nonprofit health plan that serves 37,450 MassHealth enrollees residing across four MCO regions in the state of Massachusetts. Tufts MCO was founded in 1979 and is headquartered in Canton, Massachusetts.[3] Tufts MCO received a rating of 4.5 out of 5 stars from NCQA and is NCQA-accredited.

Purpose of Report

The purpose of this ATR is to present the results of EQR activities conducted to assess the quality 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 the MCOs met the state standards and whether the state met the federal standards as defined in the CFR.

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

Scope of External Quality Review Activities

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

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

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

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

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

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

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

All four mandatory EQR activities were conducted in accordance with CMS EQR 2023 protocols. CMS defined *validation* in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

High-Level Program Findings

The EQR activities conducted in CY 2023 demonstrated that MassHealth and the MCOs share a commitment to improvement in providing high-quality, timely, and accessible care for members.

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

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

[4] Children's Health Insurance Program.

MassHealth Medicaid Comprehensive Quality Strategy

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

Strengths:

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

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

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

Opportunities for Improvement:

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

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

General Recommendations for MassHealth:

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

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

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

Performance Improvement Projects

State agencies must require that contracted MCPs conduct PIPs that focus on both clinical and non-clinical areas, as established in *Title 42 CFR § 438.330(d)*. Due to the re-procurement, effective April 1, 2023, each MCO had to conclude its PIPs by the end of March 2023 and plan for new PIPs starting in CY 2024. The new PIPs will be validated by IPRO during CY 2024 and the validation results will be reported in the next ATR. The validation of MCOs' PIPs conducted in CY 2023 demonstrated the following strengths and weaknesses.

Strengths:

MassHealth selected topics for its PIPs in alignment with the quality strategy goals and objectives. MassHealth requires that, within each project, there is at least one intervention focused on health equity, which supports MassHealth's strategic goal to promote equitable care.

During CY 2023, each MCO conducted two PIPs in one of the following priority areas: health equity, prevention and wellness, and access to care. All 2023 MCO PIPs were remeasurement year 1 projects. PIPs were conducted in compliance with federal requirements and were designed to drive improvement on measures that support specific strategic goals; however, they also presented opportunities for improvement.

Opportunities for Improvement:

The PIP processes in place prior to IPRO becoming the EQRO of record for Massachusetts had several limitations that impacted and were reflected in MCOs' PIPs, including the following weaknesses observed across all Plans:

- Lack of clearly defined aims and interventions.
- Lack of formal barrier analysis to assess factors underlying suboptimal performance on performance indicators at baseline and inform the development of interventions tailored to the unique needs and characteristics of the member population.
- Limited/absent use of process measures to track progress with respect to intervention implementation.
- Modifications made to interventions throughout the PIP cycle were generally not evident and where evident, were not documented uniformly.
- Efforts to promote sustainability and spread were not clearly and/or uniformly documented across interventions.

General Recommendations for MassHealth:

Recommendation for MassHealth relevant to both MCOs towards accelerating the effectiveness of PIPs:

- Standardized structure and reporting requirements should be established to define and describe PIP aims and interventions.
- All Plans should be required to conduct an initial barrier analysis at the outset of every PIP and document it in PIP proposal submission. Additionally, Plans should be required/expected to conduct additional analyses throughout the process as additional barriers are discovered.
- For each PIP intervention, Plans should be required to track implementation progress with at least one intervention-specific process measure. Rates should be tracked/reported on at least a quarterly basis throughout the PIP cycle.
- Plans should be required to document modifications made to interventions throughout the PIP cycle in a uniform fashion within the PIP template.
- Plans should be required to document efforts to promote sustainability and spread in a standardized manner across all interventions (and PIPs) in the final PIP report.

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

Performance Measure Validation

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

Strengths:

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

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

IPRO aggregated the MCO measure rates to provide comparative information for all MCOs. When compared to the MY2022 Quality Compass® New England regional percentile, the best performance was found for the following measures:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Tufts MCO and the weighted statewide mean were above the 90th percentile, while WellSense MCO was above the 75th percentile, indicating a relatively strong performance.
- Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation): WellSense MCO and the weighted statewide mean were above the 90th percentile, while Tufts MCO was above the 75th percentile, indicating a relatively strong performance.
- Risk-Adjusted Ratio (Observed/Expected) of ED Visits for Members Aged 18–65 Years Identified with a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions: Both MCOs and the weighted statewide mean were above the state benchmark goal.

Opportunities for Improvement:

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

- Childhood Immunization Status (combo 10): All entities were below the 25th percentile, indicating a need for improvement.
- Immunization for Adolescents (combo 2): WellSense MCO was below the 25th percentile, while Tufts MCO and the weighted statewide means were at or above the 25th percentile but below the 50th percentile, indicating a need for improvement.
- Controlling High Blood Pressure: Tufts MCO was below the 25th percentile, and even though WellSense MCO was at or above the 50th percentile, the weighted statewide mean was at or above the 25th percentile but below the 50th percentile, suggesting an area for improvement.
- Asthma Medication Ratio: Both Tufts MCO and the weighted statewide mean were below the 25th percentile, suggesting an area for improvement. WellSense MCO was at or above the 25th percentile, but below the 50th percentile.

- Hemoglobin A1c Control; HbA1c poor control (>9.0%): Tufts MCO was below the 25th percentile, and even though WellSense MCO was at or above the 50th percentile, the weighted statewide mean was at or above the 25th percentile, but below the 50th percentile, suggesting an area for improvement.
- Follow-Up After Hospitalization for Mental Illness (7 days): All entities were at or above the 25th percentile but below the 50th percentile, so there is room for improvement.
- Timeliness of Prenatal Care: Tufts MCO was at or above the 50th percentile, but below the 75th percentile, while WellSense MCO and the weighted statewide mean were at or above the 25th, but below the 50th percentile, signaling an area for improvement.
- Oral Health Evaluation: All MCOs were below the state benchmark goal, suggesting an area for improvement.
- Behavioral Health Community Partner Engagement: All MCOs were below the state benchmark goal, suggesting an area for improvement.

General Recommendations for MassHealth:

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

PMV findings are provided in Section IV of this report.

Compliance Review

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

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

Network Adequacy Validation

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

Strengths:

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

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

Travel time and distance standards, including provider to member ratios, and availability standards are well defined in the MCOs' contracts with MassHealth. MassHealth requires MCPs to submit in-network provider lists to the state on an annual and ad-hoc basis. Both MCOs met the provider to member standards defined by MassHealth.

Opportunities for Improvement:
Although the travel time and distance standards are defined in the MCO contracts with MassHealth, the definitions of the network adequacy indicators have not been shared with the MCPs. Network adequacy indicators are metrics used to measure adherence to network adequacy standards.[6] The definitions of the network adequacy indictors as agreed upon for the purpose of this EQR are included in Appendix D.

IPRO found that the format of the report templates utilized to request in-network providers lists may cause duplication of records submitted for the time and distance analysis. IPRO used the same templates to request data from the MCPs. Duplicate records were removed before the analysis was conducted. IPRO also identified and corrected several issues with network provider data submitted by MCPs.

After data issues were resolved and duplicate records were removed, IPRO evaluated each MCO's provider network to determine compliance with the time and distance standards established by MassHealth. Access was assessed for a total of 55 provider types. The WellSense MCO had network deficiencies for 21 provider types in one or more service areas. The Tufts MCO had network deficiencies for 10 provider types in one or more service areas.

Finally, IPRO conducted provider directory audits and calculated the percentage of providers with verified telephone number, address, and specialty information as well as providers' participation in Medicaid and panel status. The accuracy of information varied widely. Provider directory accuracy thresholds were not established.

General Recommendations for MassHealth:
- *Recommendations towards network data integrity* - The format of the submission templates should be adjusted to improve data submission accuracy and reduce duplications of the data.
- *Recommendations towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access. MassHealth should share with MCPs the definitions of the network adequacy indicators that were identified for the purpose of this EQR (Appendix D).
- *Recommendations towards better provider directories* – The findings from the *2023 Provider Directory Audit* should be used to improve and develop further network adequacy activities.

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

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

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

[6] CMS External Quality Review (EQR) Protocols, February 2023. Available at: CMS External Quality Review (EQR) Protocols (medicaid.gov) Accessed on 1/21/2024.

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

Each MassHealth MCO was independently contracted with a certified CAHPS vendor to administer the CAHPS 5.1H Adult Medicaid Health Plan Survey for measurement year (MY) 2022.

Opportunities for Improvement:
IPRO compared MCOs' top-box scores to national Medicaid performance reported in the MY 2022 Quality Compass. The MassHealth statewide weighted means were below the 75th percentile for the following adult CAHPS measures:

- Getting Needed Care
- Getting Care Quickly
- Coordination of Care
- Ease of Filling Out Forms
- Rating of All Health Care (9 or 10)
- Rating of Personal Doctor (9 or 10)
- Rating of Specialist Seen Most Often (9 or 10)

Only WellSense MCO contracted with a certified CAHPS vendor to administer the CAHPS 5.1H Child Medicaid Health Plan Survey. Reporting of the CAHPS Health Plan Child Survey 5.1H is mandatory for Child Core Set beginning with federal fiscal year (FFY) 2024 reporting. WellSense MCO scored below the 75th percentile on all Child CAHPS measures leaving room for improvement.

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

General Recommendations for MassHealth:

- *Recommendation towards better performance on CAHPS measures* – MassHealth should continue to utilize CAHPS data to evaluate MCOs' performance and to support the development of major initiatives, and quality improvement strategies, accordingly.
- *Recommendation towards adhering to CMS Child Core Set reporting guidance* – To adhere to Medicaid Child Core Set reporting guidance issued by CMS, all measure-eligible Medicaid and CHIP beneficiaries would have to be included in the state reporting of the child CAHPS Health Plan survey measure. This includes children enrolled in multiple delivery systems, like managed care, primary care case management, and fee for service. [7]
- *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.

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

Recommendations

Per *Title 42 CFR § 438.364 External quality review results(a)(4)*, this report is required to include recommendations for improving the quality of health care services furnished by the MCOs and

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

recommendations on how MassHealth can target the goals and the objectives outlined in the state's quality strategy to better support improvement in the quality of, timeliness of, and access to health care services furnished to Medicaid managed care enrollees.

EQR Recommendations for MassHealth

Here is a summary of all recommendations for MassHealth:

- *Recommendation towards achieving the goals of the Medicaid quality strategy* – MassHealth should assess whether the state met or made progress on the five strategic goals and objectives described in the quality strategy.
- *Recommendation for MassHealth relevant to both MCOs towards accelerating the effectiveness of PIPs*:
  - Standardized structure and reporting requirements should be established to define and describe PIP aims and interventions.
  - All Plans should be required to conduct an initial barrier analysis at the outset of every PIP and document it in PIP proposal submission. Additionally, Plans should be required/expected to conduct additional analyses throughout the process as additional barriers are discovered.
  - For each PIP intervention, Plans should be required to track implementation progress with at least one intervention-specific process measure. Rates should be tracked/reported on at least a quarterly basis throughout the PIP cycle.
  - Plans should be required to document modifications made to interventions throughout the PIP cycle in a uniform fashion within the PIP template.
  - Plans should be required to document efforts to promote sustainability and spread in a standardized manner across all interventions (and PIPs) in the final PIP report.
- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.
- *Recommendations towards network data integrity* - The format of the submission templates should be adjusted to improve data submission accuracy and reduce duplications of the data.
- *Recommendations towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access. MassHealth should share with MCPs the definitions of the network adequacy indicators that were identified for the purpose of this EQR (Appendix D).
- *Recommendations towards better provider directories* – The findings from the *2023 Provider Directory Audit* should be used to improve and develop further network adequacy activities.
- *Recommendation towards better performance on CAHPS measures* – MassHealth should continue to utilize CAHPS data to evaluate MCOs' performance and to support the development of major initiatives, and quality improvement strategies, accordingly.
- *Recommendation towards adhering to CMS Child Core Set reporting guidance* – To adhere to Medicaid Child Core Set reporting guidance issued by CMS, all measure-eligible Medicaid and CHIP beneficiaries would have to be included in the state reporting of the child CAHPS Health Plan survey measure. This includes children enrolled in multiple delivery systems, like managed care, primary care case management, and fee for service. [8]

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

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

EQR Recommendations for the MCOs

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

II. Massachusetts Medicaid Managed Care Program

Managed Care in Massachusetts

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

MassHealth's mission is to improve the health outcomes of its members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life. MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.[9]

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

MassHealth Medicaid Quality Strategy

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

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

Table 2: MassHealth's Strategic Goals

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

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

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

MassHealth Managed Care Programs

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

1. The Accountable Care Partnership Plans (ACPPs) are health plans consisting of groups of primary care providers who partner with one managed care organization to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As accountable care organizations, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high quality care to MassHealth enrollees. To select an Accountable Care Partnership Plan, a MassHealth enrollee must live in the plan's service area and must use the plan's provider network.
2. The Primary Care Accountable Care Organizations (PCACOs) are health plans consisting of groups of primary care providers who contract directly with MassHealth to provide integrated and coordinated care. A PCACO functions as an accountable care organization and a primary care case management arrangement. In contrast to ACPPs, a PCACO does not partner with just one managed care organization. Instead, PCACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. Managed Care Organizations (MCOs) are health plans run by health insurance companies with their own provider network that includes primary care providers, specialists, behavioral health providers, and hospitals.
4. Primary Care Clinician Plan (PCCP) is a primary care case management arrangement, where Medicaid enrollees select or are assigned to a primary care provider, called a Primary Care Clinician (PCC). The PCC provides services to enrollees including the coordination, and monitoring of primary care health services. PCCP uses the MassHealth network of primary care providers, specialists, and hospitals as well as the Massachusetts Behavioral Health Partnership's network of behavioral health providers.
5. Massachusetts Behavioral Health Partnership is a health plan that manages behavioral health care for MassHealth's Primary Care Accountable Care Organizations and the Primary Care Clinician Plan. MBHP also serves children in state custody, not otherwise enrolled in managed care and certain children enrolled in MassHealth who have commercial insurance as their primary insurance.[10]
6. One Care Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services as well as long-term services and support. This plan is for enrollees between 21 and 64 years old who are dually enrolled in Medicaid and Medicare.[11]
7. Senior Care Options (SCO) plans are coordinated health plans that cover services paid by Medicare and Medicaid. This plan is for MassHealth enrollees 65 or older and it offers services to help seniors stay independently at home by combining healthcare services with social supports.[12]

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

Quality Metrics

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

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

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

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

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

Performance Improvement Projects

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

Member Experience of Care Surveys

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

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

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

MassHealth Initiatives

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

1115 Demonstration Waiver

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

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

Quality and Equity Incentive Programs

Quality and Equity Incentive Programs are initiatives coordinated between MassHealth's Accountable Care Organizations and acute hospitals with an overarching goal to improve quality of care and advance health equity. Health equity is defined as the opportunity for everyone to attain their full health potential regardless of their social position or socially assigned circumstance. ACOs quality and equity performance is incentivized through programs implemented under managed care authority. Hospitals quality performance is incentivized through the "Clinical Quality Incentive Program" implemented under State Plan Authority, while hospitals equity performance is incentivized through the "Hospital Quality and Equity Initiative" authorized under the 1115 Demonstration Waiver. Under the "Hospital Quality and Equity Initiative," private acute hospitals and the Commonwealth's only non-state-owned public hospital, Cambridge Health Alliance, are assessed on the completeness of social needs data (domain 1), performance on quality metrics and associated reductions in disparities (domain 2), and improvements in provider and workforce capacity and collaboration between health system partners (domain 3). MassHealth's ACOs and hospitals work towards coordinated deliverables aligned in support of the common goals of the incentive programs.[13] For example, in 2023, ACOs and hospitals partnered to work together on equity-focused performance improvement projects.

Roadmap for Behavioral Health

Another MassHealth initiative that supports the goals of the quality strategy is the five-year roadmap for behavioral health reform that was released in 2021. Key components of implementing this initiative include the integration of behavioral health in primary care, community-based alternatives to emergency department for crisis interventions, and the creation of the 24-7 Behavioral Health Help Line (BHHL) that became available in 2023. The Behavioral Health Help Line is free and available to all Massachusetts residents.[14]

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

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

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

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

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

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

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

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

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

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

III. Validation of Performance Improvement Projects

Objectives

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

Section 2.14.C.1.e. of the Fifth Amended and Restated MassHealth MCO Contract and Appendix B to the MassHealth MCO Contract require the MCOs to perform PIPs annually in compliance with federal regulations. MCOs are required to develop PIP topics in priority areas selected by MassHealth in alignment with its quality strategy goals. Each MCO conducted two PIPs in one of the following priority areas: health equity, prevention and wellness, and access to care. Due to the re-procurement, effective April 1, 2023, each MCO had to conclude its PIPs by the end of March 2023. All 2023 MCO PIPs were remeasurement year one projects. Specific MCO PIP topics are displayed in Table 3.

Table 3: MCO PIP Topics – CY 2023

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

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an External Quality Review Organization (EQRO) to perform the annual validation of PIPs. To meet federal regulations, MassHealth contracted with IPRO, an EQRO, to perform the validation of PIPs conducted by MassHealth MCOs during the 2023 CY.

Technical Methods of Data Collection and Analysis

MCOs had concluded their PIPs in March of 2023 and submitted closeout reports to IPRO in July and August of the same year. The report template and validation tool were developed by IPRO by merging a template that had been in use by health plans since the inception of their projects, with IPRO's standardized template. This integration allowed IPRO to enhance the original template report and include questions about intervention tracking measures.

In the closeout reports, MCOs described project goals, anticipated barriers, interventions, performance measures, and their evaluation of the effectiveness of the project. MCOs completed these reports electronically and submitted them to IPRO through a web-based project management and collaboration platform. No additional interviews were conducted.

The analysis of the collected information focused on several key aspects, including an assessment of the quality of the data, appropriateness of the interventions, and interpretation of the results. It aimed to evaluate an alignment between the interventions and project goals and whether reported improvements could be

maintained over time. The analysis of other PIP elements, such as the appropriateness of the topic, aim statement, population, sampling methods, and the variables, was conducted during the baseline and remeasurement years.

Description of Data Obtained

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

Conclusions and Comparative Findings

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

Rating 1: Adherence to Acceptable Methodology - Validation results summary

The ratings for PIP adherence to acceptable methodology vary, with three PIPs receiving high confidence, and one PIP receiving moderate confidence.

Rating 2: Evidence of Improvement - Validation results summary

The ratings for PIPs in terms of producing significant evidence of improvement show that all four PIPs gained high confidence.

PIP validation results are reported in **Tables 4 and 5** for each MCO.

Table 4: WellSense MCO PIP Validation Ratings – CY 2023

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: IET	High Confidence	High Confidence
PIP 2: CDC	Moderate Confidence	High Confidence

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

Table 5: Tufts MCO PIP Validation Ratings – CY 2023

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: IET	High Confidence	High Confidence
PIP 2: PPC	High Confidence	High Confidence

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

A description of each validated PIP is provided in the MCO-specific subsections below.

WellSense MCO PIPs

WellSense MCO PIP summaries, including aim, interventions, and results (indicators), are reported in Tables 6–9.

Table 6: WellSense MCO PIP 1 Summary, 2023

WellSense MCO PIP 1: Improving member initiation and engagement of alcohol and other drug abuse or dependence treatment (IET)
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence
Aim Improving WellSense Member Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). This project was initiated to address the below benchmark IET HEDIS scores measured in Massachusetts (2021). The objective was to utilize our MA Substance Use Disorder (SUD) Provider Quality Managers, who meet quarterly with strategic SUD providers, by adding a provider goal to improve their individual IET HEDIS by 2% (2021 to 2022). **Interventions in 2023** ▪ SUD strategic provider focused quality program. ▪ Increase utilization of SUD community support services by WellSense members. **Performance Improvement Summary** ▪ **Performance Indicator Results Summary:** Indicator 1 improved. ▪ **Summary of factors associated with success:** Provider engagement in PIP. ▪ **Summary of challenges/barriers faced during the PIP:** The Covid-19 pandemic presented challenges. ▪ **Summary of how entities will use the PIP findings:** WellSense originally had PQMs focused on inpatient mental health facilities and the HEDIS scores they were focused on. But in the last few years, WellSense has expanded the PQM program to include inpatient SUD facilities. These PIP results are the latest indication that this is important and effective work to improve SUD service outcomes.

Table 7: WellSense MCO PIP 1 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: Initiation	2022 (baseline, MY 2021 data)	51.5%
Indicator 1: Initiation	2023 (remeasurement year 1)	54.38%
Indicator 2: Engagement	2022 (baseline, MY 2021 data)	19.5%
Indicator 2: Engagement	2023 (remeasurement year 1)	23.32%
Indicator 3: Survey	2022 (baseline, MY 2021 data)	83.9%
Indicator 3: Survey	2023 (remeasurement year 1)	Not available at time of reporting

Table 8: WellSense MCO PIP 2 Summary, 2023

WellSense MCO PIP 2: Increasing the rate of HbA1c control for MassHealth MCO members with diabetes, with a focus on health equity
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – Moderate Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence
Aim Increasing the rate of HbA1c control for WellSense MassHealth MCO members with diabetes, with a focus on health equity. Decreasing the health disparity gap for the HA1c by empowering members to self-manage their diabetes through care management programs. Doing this will address the factors that can influence health such as healthy food access. Identifying and removing social and environmental factors that reduce the member's ability to manage their health will improve overall outcomes for the diabetic patients. Diabetes PIP has the potential to improve chronic disease management, health promotion, and disease prevention. **Interventions in 2023** ▪ Interventions included a texting campaign to provide members with educational information about the importance of HbA1c testing and control, exercise and healthy eating and a member survey to solicit feedback and additional barriers related to HbA1c testing and control among members from the Southeast region. **Performance Improvement Summary** ▪ **Performance Indicator Results Summary**: Indicator 1 improved, but IPRO is unable to assess Indicator 2. ▪ **Summary of factors associated with success:** Correct member contact information was on file which allowed a successful texting campaign roll-out. ▪ **Summary of challenges/barriers faced during the PIP:** Plan encountered barriers that were critical to improvement of the intervention outcomes, including the inability to contact members due to inaccurate or outdated contact data. Improvement options include cross-team collaboration with provider services and call centers, and ensuring that the organization makes updating demographic information a top priority when interacting with members. ▪ **Summary of how entities will use the PIP findings:** Develop a disease management team to focus on diagnosis relevant with high-risk members.

Table 9: WellSense MCO PIP 2 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: HbA1c Testing	2022 (baseline, MY 2021 data)	88.64%*
Indicator 1: HbA1c Testing	2023 (remeasurement year 1)	88.12%
Indicator 2: HbA1c < 8.0%	2022 (baseline, MY 2021 data)	9.78%*
Indicator 2: HbA1c < 8.0%	2023 (remeasurement year 1)	9.73%

*WellSense MCO reported different baseline rates in the previous reporting period. Indicator 1's Baseline rate in MY 2021 was 83.45%, and Indicator 2's Baseline rate in MY 2021 was 50.82%.

Recommendations

- Recommendation for PIP 2: IPRO recommends using detailed vendor data when available to evaluate these interventions and assess which interventions can be sustainable outside of the scope of the PIP.

Tufts MCO PIPs

Tufts MCO PIP summaries, including aim, interventions, and results (indicators), are reported in Tables 10–13.

Table 10: Tufts MCO PIP 1 Summary, 2023

Tufts MCO PIP 1: Improving outcomes in initiating and engaging treatment for alcohol, opioid, or other drug dependence in Tufts Health Public Plan Members
Validation Summary: Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence
Aim This project aims to identify disparities within the MCO population and to understand if the support of an Addiction Recovery Care Manager (ARCM) improves rates of initiation and engagement of treatment for alcohol or drug use. The goals this of project include increasing member engagement in AOD treatment by supporting the member's AOD recovery process and encouraging them to continue treatment by ensuring the initial follow-up appointment is attended within 14 days of the AOD diagnosis episode and reinforcing the member's AOD recovery process by engaging further AOD treatment through ensuring two additional follow-up visits are attended with an appropriate BH provider within 34 days of the initiation visit. The provider focused goal is to improve the HEDIS initiation and engagement rates evidenced by enhanced communication, collaboration and sharing of information with providers. Interventions in 2023 ▪ Utilize the Addiction Recovery Care Management (ARCM) Program to provide member education, support treatment facility discharge planning, and coordinate and encourage member's engagement in and attendance of follow-up visits and care for those diagnosed with alcohol and/or drug dependence; Ensure members assessed with social determinants of health needs are provided resources to help mitigate or eliminate gaps and disparities. ▪ Develop and disseminate education for providers on how to correctly code for IET and provide effective resources to help support members seeking treatment for alcohol and/or drug dependence. Performance Improvement Summary ▪ Performance Indicator Results Summary: Demonstrated improvement. IET initiation and engagement rates improved from baseline. The IET-initiation indicator did not meet the entity goal, but IET-engagement indicator met the entity goal, and both showed an increase from baseline. Members within the cohort that engaged with the ARCM program (intervention 1) showed a higher propensity to complete initiation & engagement visits relative to members that were not linked with the program. ▪ Summary of factors associated with success: ARCMs' support of members who were discharged with AOD-related diagnoses bolstered attendance of the initiation & engagement treatment visits. ▪ Summary of challenges/barriers faced during the PIP: Challenges exist related to the specifications of HEDIS IET measure. Members can be excluded from the measure when the initial AOD diagnosis code is not the same as the primary diagnosis code used in the initiation or the engagement visits. Another challenge described was the lack of feedback received on educational tip sheets distributed to providers. Tufts Health Public Plan also shared that outdated contact information and unsigned release forms prior to discharge can make follow-up after discharge more difficult, and how staff turnover can result in limiting engagement between facilities and programs like ARCM. ▪ Summary of how entities will use the PIP findings: Tufts Health Public Plan will disseminate findings to members via a quarterly MCO member panel and to Providers through MCO Medical Director meetings. THPP is adding the ARCM program to other lines of business & continues to build relationships with provider groups. Behavioral health care management is working toward standardizing an enterprise care model to include ARCM.

Table 11: Tufts MCO PIP 1 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: Initiation	2022 (baseline, MY 2021 data)	50.00%
Indicator 1: Initiation	2023 (remeasurement year 1)	51.06%
Indicator 2: Engagement	2022 (baseline, MY 2021 data)	19.46%
Indicator 2: Engagement	2023 (remeasurement year 1)	21.12%

Table 12: Tufts MCO PIP 2 Summary, 2023

Tufts MCO PIP 2: Improving prenatal and postpartum care outcomes in Tufts Health Public Plan Members

Validation Summary

Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence

Aim

Tufts Health Plan Public Plan's (THPP) goal of this PIP is to improve prenatal and postpartum care outcomes and reduce racial and ethnic health disparities around prenatal and postpartum care through member and provider focused activities. The project asks if doula supports improve rates of prenatal and postpartum care. The member goals of this PIP are to provide educational information to members about the importance of prenatal and postpartum care and to increase awareness around covered prenatal and postpartum services evidenced by prenatal and postpartum care rates and to address barriers members face related to racial and Social Determinant of Health (SDoH) related disparities which impact access to quality maternal care evidenced by Doula Program support. The provider focused goals are to increase knowledge about the importance of members' scheduling prenatal and postpartum care appointments evidenced by sharing informational gap reports and educational materials and to improve provider engagement and ability to address member barriers evidenced by working with high volume, and low performing provider groups to discuss best practices for engaging with pregnant members. The HEDIS Timeliness of Prenatal Care baseline (MY2021) rates were 94.38% with a goal to increase by 1 percentage point to 95.38%. The HEDIS Postpartum Care baseline (MY2021) rates were 83.15% with a goal to increase the rate by 2 percentage points to 85.15%.

Interventions in 2023

- Prenatal and Postpartum Care; Member Focused supports; Partner with Accompany Doula to enhance member experience and better-meet the diverse cultural and linguistic needs of MCO members seeking maternal health care.
- Enhance member knowledge and engagement with prenatal and post-partum care services through events and promotion of culturally and linguistically supportive educational resources.
- Enhance Provider education on prenatal and post-partum care outcomes through tip sheets, educational materials, training, and gap-in-care reports.

Performance Improvement Summary

- **Performance Indicator Results Summary:** Demonstrated improvement. Although the THPP HEDIS Prenatal Care indicator decreased from baseline, the Postpartum Care indicator showed an increase. Additionally, enhancements were made to infrastructure and supportive services (maternal health dashboard, partnership with Accompany doula, making educational materials available to pregnant members and training materials for Providers)
- **Summary of factors associated with success:** Plan reported satisfaction with the doula program and the comprehensive educational materials and community events that are available to pregnant members.
- **Summary of challenges/barriers faced during the PIP:**
  - Data and resource limitations in tracking the doula-engaged member outcomes and subsequent lack of visibility to disparity figures.
  - Difficulty in identifying pregnant members for outreach and offer of support.
  - Low rate of provider feedback on educational materials
  - Difficulty in gaining visibility to provider groups who most often provide prenatal or post-partum care to MCO patients and provider groups with low performance on HEDIS PPC measures.
  - Difficulty generating maternal 'gap-in-care' reports for provider groups.

Tufts MCO PIP 2: Improving prenatal and postpartum care outcomes in Tufts Health Public Plan Members
▪ **Summary of how entities will use the PIP findings:** THPP presented the interventions of this PIP to the MCO member panel and feedback was given that education materials for the support person of the pregnant member would be helpful. THPP found that members could desire more education on the prenatal/postpartum benefits available to them such as the doula program, and that that members valued the ability to partner with a doula of their same cultural background. THPP would like to find out more about provider preferences, explore additional ways to track and measure intervention effectiveness, and assess and reduce disparities among member populations. Additionally, THPP plans to use the findings of this PIP in an enterprise maternal health workgroup aimed at improving maternal health equity.

Table 13: Tufts MCO PIP 2 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: Prenatal Care	2022 (baseline, MY 2021 data)	94.38%
Indicator 1: Prenatal Care	2023 (remeasurement year 1)	90.16%
Indicator 2: Postpartum Care	2022 (baseline, MY 2021 data)	83.15%
Indicator 2: Postpartum Care	2023 (remeasurement year 1)	85.25%

Recommendations

- Recommendation for PIP 2: In future PIP reporting, IPRO will request that plans note 'Not Applicable' ('N/A') for calculated fields or rate fields in which a denominator is zero.

IV. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

MassHealth evaluates MCOs' performance on HEDIS health plan measures. MCOs calculate HEDIS measure rates and are required to have the rates audited by a Certified HEDIS Compliance Auditor before providing them to the state on an annual basis, as stated in Section 2.15.G.6 of the Fifth Amended and Restated MassHealth MCO Contract.

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

MassHealth contracted with IPRO to conduct performance measure validation. IPRO assessed the accuracy of both HEDIS and non-HEDIS performance measures. For HEDIS measures, IPRO performed an independent evaluation of the MY 2022 HEDIS Compliance Audit Final Audit Reports (FARs), which contained findings related to the information systems standards. An EQRO may review an assessment of the MCP's information systems conducted by another party in lieu of conducting a full Information Systems Capabilities Assessment (ISCA).[15] Since the MCOs' HEDIS rates were audited by an independent NCQA-licensed HEDIS compliance audit organization, both plans received a full ISCA as part of the audit. Onsite (virtual) audits were therefore not necessary to validate reported measures.

A separate request was made to the MCOs to provide a detailed summary of how "MCO-only" HEDIS measure rates (administrative and hybrid) were calculated. The MCO-only rates are rates extracted for MCO-only Medicaid members, as opposed to rates which include the ACO-attributed population. The rates approved as part of the HEDIS Compliance audit process and submitted to the NCQA via IDSS, included both the MCO-only members and the MCO's ACO-attributed population, ergo IPRO validated the MCO-only HEDIS measure rates separately.

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

Description of Data Obtained

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

[15] The *CMS External Quality Review (EQR) Protocols,* published in February 2023, states that the ISCA is a required component of the mandatory EQR activities as part of Protocols 1, 2, 3, and 4. CMS clarified that the systems reviews that are conducted as part of NCQA HEDIS Compliance Audit may be substituted for an ISCA. The results of HEDIS compliance audits are presented in the HEDIS FARs issued by each MCO's independent auditor.

Conclusions and Comparative Findings

Based on a review of the MCOs' HEDIS FARs issued by the MCOs' independent NCQA-certified HEDIS compliance auditor, IPRO found that the MCOs were fully compliant with all seven of the applicable NCQA information system standards. Findings from IPRO's review of the MCOs' HEDIS FARs are displayed in Table 14.

Table 14: MCO Compliance with Information System Standards – MY 2022

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

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

Validation Findings

- Information Systems Capabilities Assessment (ISCA): The ISCA is conducted to confirm that the MCOs' information systems (IS) were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, and provider data systems. IPRO reviewed MCOs' HEDIS Final Audit Reports issued by the MCOs' independent NCQA-Certified HEDIS compliance auditors and the explanation of the production of the Medicaid only rates. No issues were identified.
- Source Code Validation: Source code review is conducted to ensure compliance with the measure specifications when calculating measure rates. NCQA measure certification for HEDIS measures was accepted in lieu of source code review. The review of each MCOs FAR confirmed that the MCOs used NCQA certified measure vendors to produce the HEDIS rates. Source code review was conducted for MCO non-HEDIS measure rates. No issues were identified.
- Medical Record Validation: Medical record review validation is conducted to confirm that the MCO followed appropriate processes to report rates using the hybrid methodology. The review of each MCOs FAR confirmed that the MCOs passed medical record review validation. No issues were identified.
- Primary Source Validation (PSV): PSV is conducted to confirm that the information from the primary source matches the output information used for measure reporting. The review of each MCOs FAR confirmed that the MCOs passed primary source verification. No issues were identified.
- Data Collection and Integration Validation: This includes a review of the processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately. The review of each MCOs FAR confirmed that the MCOs met all requirements related to data collection and integration. No issues were identified.
- Rate Validation: Rate validation is conducted to evaluate measure results and compare rates to industry standard benchmarks. No issues were identified. All required measures were reportable.

Comparative Findings

IPRO aggregated the MCO-only measure rates to provide methodologically appropriate, comparative information for all MCOs consistent with guidance included in the EQR protocols issued in accordance with *Title 42 CFR § 438.352(e)*. IPRO compared the MCO-only rates and the weighted statewide means to the NCQA HEDIS MY 2022 Quality Compass New England (NE) regional percentiles for Medicaid health maintenance organizations (HMOs) for all measures where available.

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

Best Performance:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Tufts MCO and the Weighted Statewide Mean were above the 90th percentile while WellSense MCO was above the 75th percentile, indicating a relatively strong performance.
- Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation): WellSense MCO and the Weighted Statewide Mean were above the 90th percentile while Tufts MCO was above the 75th percentile, indicating a relatively strong performance.

Varied Performance:

- Follow-up After Emergency Department Visit for Mental Illness (7 days): Both MCOs and the Weighted Statewide Mean were at or above the 50th percentile but below the 75th percentile, indicating a moderate performance.
- Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement): Both MCOs and the Weighted Statewide Mean were at or above the 50th percentile but below the 75th percentile, indicating a moderate performance.

Needs Improvement:

- Childhood Immunization Status (combo 10): All entities were below the 25th percentile, indicating a need for improvement.
- Immunization for Adolescents (combo 2): WellSense MCO was below the 25th percentile, while Tufts MCO and the Weighted Statewide Means were at or above the 25th percentile but below the 50th percentile, indicating a need for improvement.
- Controlling High Blood Pressure: Tufts MCO was below the 25th percentile, and even though WellSense MCO was at or above the 50th percentile, the Weighted Statewide Mean was at or above the 25th percentile but below the 50th percentile, suggesting an area for improvement.
- Asthma Medication Ratio: Both Tufts MCO and the Weighted Statewide Mean were below the 25th percentile, suggesting an area for improvement. WellSense MCO was at or above the 25th percentile but below the 50th percentile.
- Hemoglobin A1c Control; HbA1c control (>9.0%) LOWER IS BETTER: Tufts MCO was below the 25th percentile, and even though WellSense MCO was at or above the 50th percentile, the Weighted Statewide Mean was at or above the 25th percentile but below the 50th percentile, suggesting an area for improvement.
- Follow-Up After Hospitalization for Mental Illness (7 days): All entities were at or above the 25th percentile but below the 50th percentile, so there is room for improvement.
- Timeliness of Prenatal Care: Tufts MCO was at or above the 50th percentile but below the 75th percentile, while WellSense MCO and the Weighted Statewide Mean were at or above the 25th but below the 50th percentile signaling an area for improvement.

As explained in Table 15, the regional percentiles are color coded to compare to the MCO-only rates.

Table 16 displays the MCO-only HEDIS performance measures for MY 2022 for both MCOs and the Weighted Statewide Means.

Table 15: Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2022 Quality Compass NE Regional Percentiles

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

Table 16: MCO-only HEDIS Performance Measures – MY 2022

Measure Steward/ Acronym	HEDIS Measure	WellSense MCO	Tufts MCO	Weighted Statewide Mean
NCQA CIS	Childhood Immunization Status (combo 10)	32.61% (<25th)	32.76% (<25th)	32.71% (<25th)
NCQA PPC	Timeliness of Prenatal Care	84.62% (≥25th but <50th)	90.16% (≥50th but <75th)	87.71% (≥25th but <50th)
NCQA IMA	Immunization for Adolescents (combo 2)	21.62% (<25th)	38.98% (≥25th but <50th)	34.33% (≥25th but <50th)
NCQA CBP	Controlling High Blood Pressure	67.39% (≥50th but <75th)	58.02% (<25th)	61.67% (≥25th but <50th)
NCQA AMR	Asthma Medication Ratio	61.37% (≥25th but <50th)	50.87% (<25th)	54.31% (<25th)
NCQA CDC	HBD: Hemoglobin A1c Control; HbA1c control (>9.0%) LOWER IS BETTER	32.50% (≥50th but <75th)	37.50% (<25th)	35.55% (≥25th but <50th)
NCQA APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	49.02% (≥75th but <90th)	54.55% (≥90th)	52.91% (≥90th)
NCQA FUH7	Follow-Up After Hospitalization for Mental Illness (7 days)	41.06% (≥25th but <50th)	40.46% (≥25th but <50th)	40.7% (≥25th but <50th)
NCQA FUM7	Follow-up After Emergency Department Visit for Mental Illness (7 days)	72.70% (≥50th but <75th)	74.44% (≥50th but <75th)	73.59% (≥50th but <75th)
NCQA PCR	Plan All-Cause Readmissions[1] LOWER IS BETTER	12.51% N/A	10.79% N/A	11.45% N/A
NCQA IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	55.66% (≥90th)	53.09% (≥75th but <90th)	54.18% (≥90th)
NCQA IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	23.52% (≥50th but <75th)	22.71% (≥50th but <75th)	23.05% (≥50th but <75th)

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

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

For the non-HEDIS measures calculated by Telligen, IPRO compared the rates to the goal benchmarks determined by MassHealth. MassHealth goal benchmarks for MCOs were fixed targets calculated without COVID-based adjustments. The goal benchmarks were not established for both Community Tenure measures.

Best Performance:

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

Varied Performance:

- **LTSS Community Partner Engagement:** Tufts MCO was above the state benchmark goal, but WellSense MCO and the Weighted Statewide Mean were below the goal, indicating a moderate performance.

Needs Improvement:

- **Oral Health Evaluation:** All entities were below the state benchmark goal, suggesting an area for improvement.
- **Behavioral Health Community Partner Engagement:** All entities were below the state benchmark goal, suggesting an area for improvement.

Table 17 shows the color key for state-specific performance measures in comparison to the state benchmark.

Table 18 shows non-HEDIS PMs for MY 2022 for all MCOs and the weighted stateside average.

Table 17: Key for State 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 18: MCO State-Specific Performance Measures – MY 2022

Measure Steward	State Performance Measure	WellSense MCO	Tufts MCO	Weighted Statewide Mean	Goal Benchmark
ADA	Oral Health Evaluation	48.37% (<Goal)	50.92% (<Goal)	50.10% (<Goal)	60.00%
EOHHS	Community Tenure (CT) – Bipolar, Schizophrenia or Psychosis (Observed/Expected Ratio)	1.13 (N/A)	0.53 (N/A)	0.78 (N/A)	TBD
EOHHS	Community Tenure (CT) – LTSS and Non-BSP (Observed/Expected Ratio)	1.01 (N/A)	0.82 (N/A)	0.92 (N/A)	TBD
EOHHS	Risk-Adjusted Ratio (Observed/Expected) of ED Visits for Members Aged 18–65 Years Identified with a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions LOWER IS BETTER	0.78 (>Goal)	0.75 (>Goal)	0.77 (>Goal)	0.88
EOHHS	Behavioral Health Community Partner Engagement	4.34% (<Goal)	3.66% (<Goal)	4.00% (<Goal)	12.20%
EOHHS	LTSS Community Partner Engagement	4.51% (<Goal)	11.48% (>Goal)	8.40% (<Goal)	9.20%

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

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

Objectives

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

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

Technical Methods of Data Collection and Analysis

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

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

Scoring Methodology

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by total possible points. A three-point scoring system was used: Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points. For each standard identified as Partially Met or Not Met, the MCO was required to submit a corrective action plan (CAP) in a format agreeable to MassHealth. The scoring definitions are outlined in Table 19.

Table 19: Scoring Definitions

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

Description of Data Obtained

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

Nonduplication of Mandatory Activities

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

Conclusions and Comparative Findings

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

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

Each MCO's scores are displayed in Table 20.

Table 20: CFR Standards to State Contract Crosswalk – 2021 Compliance Validation Results

CFR Standard Name[1]	CFR Citation	WellSense MCO	Tufts MCO
Overall compliance score	**N/A**	**96.0%**	**97.2%**
Availability of Services	**438.206**	94.7%	84.0%
Enrollee Rights and Protections	**438.10**	100.0%	92.9%
Enrollment and Disenrollment	**438.56**	61.1%	100.0%
Enrollee Information	**438.10**	100.0%	96.2%
Assurances of Adequate Capacity and Services	**438.207**	100.0%	100.0%
Coordination and Continuity of Care	**438.208**	100.0%	98.4%
Coverage and Authorization of Services	**438.210**	98.4%	97.5%
Provider Selection	**438.214**	94.4%	97.2%
Confidentiality	**438.224**	100.0%	100.0%
Grievance and Appeal Systems	**438.228**	97.5%	98.3%
Subcontractual Relationships and Delegation	**438.230**	98.8%	97.6%
Practice Guidelines	**438.236**	100.0%	100.0%
Health Information Systems	**438.242**	100.0%	100.0%
QAPI	**438.330**	98.4%	98.4%

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

VI. Validation of Network Adequacy

Objectives

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

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

MassHealth's access and availability standards are described in Section 2.10 of the Fifth Amended and Restated MassHealth MCO Contract and in Appendix N to the same contract. MCOs are contractually required to meet accessibility standards (i.e., standards for the duration of time between enrollee's request and the provision of services) and availability standards (i.e., travel time and distance standards and, when needed, threshold member to provider ratios).

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet federal regulations, MassHealth contracted with IPRO, an EQRO, to perform the validation of network adequacy for MassHealth MCOs. IPRO evaluated MCO's provider networks compliance with MassHealth's geo-access requirements as well as the accuracy of the information presented in MCO's online provider directories.

Technical Methods of Data Collection and Analysis

For 2023, IPRO evaluated each MCO's provider network to determine compliance with geo-access requirements established by MassHealth. According to the MCOs' contracts, at least 90% of health plan members in each MCO Service Area must have access to in-network providers in accordance with the time-OR-distance standards defined in the contract.

IPRO reviewed MassHealth network availability standards and worked together with the state to define network adequacy indicators. Network adequacy indicators were defined through a series of meetings with IPRO and MassHealth that took place between April and August 2023. MCO network adequacy standards and indicators are listed in Appendix D (Tables D1 to D6).

IPRO requested in-network providers data on August 1, 2023, with a submission due date of August 29, 2023. MCPs submitted data to IPRO following templates developed by MassHealth and utilized by MCOs and ACPPs to report providers lists to MassHealth on an annual basis. The submitted data went through a careful and significant data clean up and deduplication process. If IPRO identified missing or incorrect data, the plans were contacted and asked to resubmit. Duplicative records were identified and removed before the analysis.

IPRO entered into an agreement with Quest Analytics™ to develop MCOs' geo-access reports. IPRO analyzed the results to identify MCOs with adequate provider networks, as well as Service Areas with deficient networks. When an MCO appeared to have network deficiencies in a particular Service Area, IPRO reported the percentage of MCO members in that Service Area who had adequate access.

In addition to geo-access reports, IPRO also calculated the provider-to-member ratios. MCO Contracts define required provider-to-member ratios for primary care and OB/GYN providers as defined in Table 21.

Table 21: Provider-to-member ratios

Provider Type	Goal	Provider-to-member ratio definition
Adult PCP	1:750	The number of all in-network adult primary care providers (i.e., internal medicine and family medicine) against the number of all members ages 21 to 64. Calculate for all providers (i.e., providers with open and closed panels altogether).
Pediatrics PCP	1:750	The number of all in-network pediatric primary care providers (i.e., pediatricians and family medicine) against the number of all members ages 0 to 20. Calculate for all providers (i.e., providers with open and closed panels altogether).
OB/GYN	1:500	The number of all in-network OB/GYN providers against the number of all female members ages 10+. Calculate for all providers (i.e., providers with open and closed panels altogether).
Specialists	N/A	The number of all in-network providers against the number of all members. There are no predefined ratios that need to be achieved.
Physical Health Services	N/A	Provider-to-member ratio not required. Did not calculate.
Behavioral Health Services	N/A	Provider-to-member ratio not required. Did not calculate.
Pharmacy	N/A	Provider-to-member ratio not required. Did not calculate.

N/A: not applicable.

Finally, using the MCOs' online provider directories, IPRO validated the accuracy of the information published in the provider directories. Between August and December 2023, IPRO reviewers contacted a sample of practice sites to confirm providers' participation with the Medicaid managed care plan, open panel status for listed specialty, specialty, telephone number, and address. IPRO reported the percentage of providers in the sample with verified and correct information. The validation of provider directories included the following provider types:

- Family Medicine
- Internal Medicine
- Pediatrics
- OB/GYN
- Infectious Disease
- Neurology, Child, and Adult
- Autism (ABA)
- Psychiatry
- Psychiatry Inpatient Adolescent/Child
- ATS/Detox Level 3.7
- Clinical Stabilization Services Level 3.5
- Opioid/Alcohol Medical Treatment
- Outpatient Behavioral Health/Substance Use Facilities
- Urgent Care

Description of Data Obtained

Validation of network adequacy for CY 2023 was performed using network data submitted by MCOs to IPRO. IPRO requested a complete provider list which included facility/provider name, address, phone number, and the national provider identifier (NPI) for the following provider types: primary care, ob/gyn, hospitals, rehabilitation, urgent care, specialists, behavioral health, and pharmacy. For PCPs, IPRO also requested the open and closed

panels as well as providers' second language information. IPRO also received a complete list of MassHealth enrollees from the state. IPRO also requested aggregated enrollment data from MassHealth. The requested enrollment data included information about member demographics (age and gender) and address of residence.

Geo-access reports were generated by combining the following files together: data on all providers and service locations contracted to participate in plans' networks, member enrollment data, service area information provided by MassHealth, and network adequacy standards and indicators. Whereas provider-to-member ratios were generated using the data on all in-network providers and the enrollment file.

For the provider directories validation, provider directory web addresses were reported to IPRO by the managed care plans, and are presented in Appendix E.

Conclusions and Comparative Findings

MassHealth divided the state into 38 service areas and 5 regions. Medicaid members can enroll in a health plan available in their area. A service area is a group of cities and towns that a health plan serves. Table 22 shows the number of service areas that each MCO covers.

Table 22: MCOs and Number of Service Areas and Regions

Number	WellSense MCO*	Tufts MCO
Number of Service Areas	38	26
Number of Regions	5	4

*The WellSense MCO has members residing in the Oak Bluffs and Nantucket Service Areas, which have unique standards for PCPs, OB/GYN, specialists, and acute inpatient hospitals.

Time and Distance Standards

Tables 23 through 27 provide a summary of the network adequacy results for healthcare providers subject to travel time and distance standards defined in the MCOs' contracts with MassHealth.

- For Primary Care Providers, Tufts MCO's PCP network met access standards; however, the WellSense MCO's Pediatric PCP network was deficient in four service areas.
- For Pharmacy, both MCOs met the pharmacy access standards.
- For Physical Health Services, both MCOs had deficient urgent care networks. In addition, WellSense MCO had deficiencies in its rehabilitation hospital network.
- For Specialty Providers, both MCOs met the specialty providers' access except for the WellSense MCO whose audiology network was deficient in the Gardner Fitchburg service area.
- For allergy providers, oral surgeons, plastic surgeons, and vascular surgeons no time-OR-distance standards were specified. Instead, the MCOs must have had at least one provider in their network. Both MCOs met the requirements for those provider types.
- For Behavioral Health Providers, both MCOs demonstrated mixed results, with some networks of behavioral health provider types meeting the standards while others showing only partial compliance.

Please note that the analysis conducted did not include exemptions for MassHealth service areas where there are known provider gaps. Therefore, in some circumstances, results may reflect market issues rather than network deficiencies. In future analysis, MassHealth will provide exemptions for service areas with known provider gaps.

Table 23: Service Areas with Adequate Network of PCPs, OB/GYN, and Pharmacy

Provider Type	Standard – 90% of Members Have Access	WellSense MCO	Tufts MCO
Adult PCP (Open Panel Only)	2 providers within 15 miles or 30 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Pediatric PCP (Open Panel Only)	2 providers within 15 miles or 30 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	34 out of 38 (Partially Met)	26 out of 26 (Met)
OBGYN (Open Panel Only)	2 providers within 15 miles or 30 minutes	N/A*	26 out of 26 (Met)
Pharmacy	1 pharmacy within 15 miles or 30 minutes.	38 out of 38 (Met)	26 out of 26 (Met)

*WellSense MCO's OB-GYN network data was not included in this report due to a data submission issue that was investigated but could not be resolved before publication given the time constraints.

Table 24: Service Areas with Adequate Network of Physical Health Services Providers

Provider Type	Standard – 90% of Members Have Access	WellSense MCO	Tufts MCO
Acute Inpatient Hospital	1 hospital within 20 miles or 40 minutes, and, for members residing in Oak Bluffs and Nantucket, any hospital located in the Oak Bluffs and Nantucket Service Areas, or the closest hospital located outside of these service areas.	38 out of 38 (Met)	26 out of 26 (Met)
Rehabilitation Hospital	1 rehabilitation hospital within 30 miles or 60 minutes	34 out of 38 (Partially Met)	26 out of 26 (Met)
Urgent Care Services	1 urgent care within 15 miles or 30 minutes	37 out of 38 (Partially Met)	23 out of 26 (Partially Met)

Table 25: Service Areas with Adequate Network of Specialist Providers

Provider Type	Standard – 90% of Members Have Access	WellSense MCO	Tufts MCO
Anesthesiology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Audiology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	37 out of 38 (Partially Met)	26 out of 26 (Met)
Cardiology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Dermatology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Emergency Medicine	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Endocrinology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Gastroenterology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)

Provider Type	Standard – 90% of Members Have Access	WellSense MCO	Tufts MCO
General Surgery	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Hematology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Infectious Diseases	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Medical Oncology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Nephrology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Neurology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Ophthalmology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Orthopedic Surgery	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Otolaryngology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Physiatry	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Podiatry	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Psychiatry	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Pulmonology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Rheumatology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)
Urology	1 provider within 20 miles or 40 minutes, and 40 miles or 40 minutes for members residing in the Oak Bluffs and Nantucket Service Areas.	38 out of 38 (Met)	26 out of 26 (Met)

Table 26: MCOs with Adequate Network of Allergy Providers, and Oral/Plastic/Vascular Surgeons

Provider Type	Standard*	WellSense MCO	Tufts MCO
Allergy	At least 1 provider in the network.	(Met)	(Met)
Oral Surgery	At least 1 provider in the network.	(Met)	(Met)
Plastic Surgery	At least 1 provider in the network.	(Met)	(Met)
Vascular Surgery	At least 1 provider in the network.	(Met)	(Met)

*There are no time-OR-distance standards for allergy providers, oral surgeons, plastic surgeons, and vascular surgeons. The Contractor must show that they have at least one allergy provider, oral surgeon, plastic surgeon, vascular surgeon in their network.

Table 27: Service Areas with Adequate Network of Behavioral Health Providers

Provider Type	Standard – 90% of Members Have Access	WellSense MCO	Tufts MCO
Psychiatric Inpatient Adult	2 providers within 60 miles or 60 minutes.	37 out of 38 (Partially Met)	21 out of 26 (Partially Met)
Psychiatric Inpatient Adolescent	2 providers within 60 miles or 60 minutes.	37 out of 38 (Partially Met)	21 out of 26 (Partially Met)
Psychiatric Inpatient Child	2 providers within 60 miles or 60 minutes.	32 out of 38 (Partially Met)	21 out of 26 (Partially Met)
Managed Inpatient Level 4	2 providers within 60 miles or 60 minutes.	37 out of 38 (Partially Met)	14 out of 26 (Partially Met)
Monitored Inpatient Level 3.7	2 providers within 30 miles or 30 minutes.	24 out of 38 (Partially Met)	26 out of 26 (Met)
Clinical Stabilization Service Level 3.5	2 providers within 30 miles or 30 minutes.	24 out of 38 (Partially Met)	26 out of 26 (Met)
CBAT-ICBAT-TCU	2 providers within 30 miles or 30 minutes.	15 out of 38 (Partially Met)	26 out of 26 (Met)
Partial Hospitalization Program (PHP)	2 providers within 30 miles or 30 minutes.	28 out of 38 (Partially Met)	23 out of 26 (Partially Met)
Intensive Outpatient Program (IOP)	2 providers within 30 miles or 30 minutes.	34 out of 38 (Partially Met)	25 out of 26 (Partially Met)
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	2 providers within 30 miles or 30 minutes.	32 out of 38 (Partially Met)	22 out of 26 (Partially Met)
Intensive Care Coordination (ICC)	2 providers within 30 miles or 30 minutes.	38 out of 38 (Met)	26 out of 26 (Met)
Applied Behavior Analysis (ABA)	2 providers within 30 miles or 30 minutes.	37 out of 38 (Partially Met)	26 out of 26 (Met)
In-Home Behavioral Services	2 providers within 30 miles or 30 minutes.	38 out of 38 (Met)	26 out of 26 (Met)
In-Home Therapy Services	2 providers within 30 miles or 30 minutes.	37 out of 38 (Partially Met)	26 out of 26 (Met)
Therapeutic Mentoring Services	2 providers within 30 miles or 30 minutes.	37 out of 38 (Partially Met)	26 out of 26 (Met)
Community Crisis Stabilization	2 providers within 30 miles or 30 minutes.	31 out of 38 (Partially Met)	26 out of 26 (Met)
Structured Outpatient Addiction Program (SOAP)	2 providers within 30 miles or 30 minutes.	34 out of 38 (Partially Met)	26 out of 26 (Met)
BH outpatient (including psychology and psych APN)	2 providers within 30 miles or 30 minutes.	38 out of 38 (Met)	26 out of 26 (Met)
Community Support Program (CSP)	2 providers within 30 miles or 30 minutes.	38 out of 38 (Met)	26 out of 26 (Met)

Provider Type	Standard – 90% of Members Have Access	WellSense MCO	Tufts MCO
Recovery Support Navigators	2 providers within 30 miles or 30 minutes.	38 out of 38 (Met)	17 out of 26 (Partially Met)
Recovery Coaching	2 providers within 30 miles or 30 minutes.	38 out of 38 (Met)	21 out of 26 (Partially Met)
Opioid Treatment Programs (OTP)	2 providers within 30 miles or 30 minutes.	37 out of 38 (Partially Met)	26 out of 26 (Met)

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

Provider to Member Ratios

IPRO calculated the provider to member ratios for Adult PCP, Pediatrics PCP, and OB/GYN providers and compared the results to the predefined goals. The calculations were conducted for all providers i.e., providers with open and closed panels altogether. A lower provider to member ratio is considered better. For example, ratio of 1:90 is better compared to the goal of 1:750, as it indicates that there is a lower number of members for each provider. Both MCOs met the provider to member standards defined by MassHealth (**Tables 28 and 29**).

Table 28: MCO Provider to Member Ratios for PCPs and OB/GYN – Lower is Better

Provider Type	Goal	WellSense MCO	Tufts MCO
Adult PCP	1:750	1: 68 (Met)	1: 23 (Met)
Pediatrics PCP	1:750	1: 33 (Met)	1: 20 (Met)
OB/GYN	1:500	1: 14 (Met)	1: 15 (Met)

Although there are no predefined provider to member ratios that need to be achieved for specialists, IPRO calculated and reported the specialists' provider to member ratios per MassHealth request.

Table 29: MCO Provider to Member Ratios for Specialists – Lower is Better

Provider Type	Goal	WellSense MCO	Tufts MCO
Allergy*	N/A	1: 218	1: 232
Anesthesiology	N/A	1: 20	1: 25
Audiology	N/A	1: 215	1: 202
Cardiology	N/A	1: 34	1: 38
Dermatology	N/A	1: 90	1: 103
Emergency Medicine	N/A	1: 21	1: 25
Endocrinology	N/A	1: 77	1: 95
Gastroenterology	N/A	1: 55	1: 64
General Surgery	N/A	1: 48	1: 45
Hematology	N/A	1: 67	1: 69
Infectious Diseases	N/A	1: 84	1: 90
Medical Oncology	N/A	1: 60	1: 61
Nephrology	N/A	1: 105	1: 117
Neurology	N/A	1: 39	1: 48
Ophthalmology	N/A	1: 61	1: 68
Oral Surgery*	N/A	1: 588	1: 552
Orthopedic Surgery	N/A	1: 51	1: 58
Otolaryngology	N/A	1: 125	1: 138

Provider Type	Goal	WellSense MCO	Tufts MCO
Physiatry	N/A	1: 146	1: 123
Plastic Surgery*	N/A	1: 240	1: 232
Podiatry	N/A	1: 162	1: 148
Psychiatry	N/A	1: 12	1: 27
Pulmonology	N/A	1: 68	1: 69
Rheumatology	N/A	1: 157	1: 178
Urology	N/A	1: 113	1: 131
Vascular Surgery*	N/A	1: 3726	1: 265

Provider Directory Validation

IPRO validated the accuracy of provider directories for a sample of providers. Provider types were selected by MassHealth. **Tables 30–32** show the percent of providers in the directory with verified telephone number, address, specialty information, Medicaid participation, and panel status. **Tables 33 and 34** show the most frequent reasons why information in the directories was incorrect or could not be validated.

Table 30: Provider Directory Accuracy – Primary Care Providers

Provider Type	Goal	WellSense MCO	Tufts MCO
Family Medicine	Not Defined	23.3%	33.3%
Internal Medicine	Not Defined	30.0%	13.3%
OB/GYN	Not Defined	33.3%	26.7%
Pediatric	Not Defined	46.7%	26.7%
All PCPs	Not Defined	33.3%	25.0%

Table 31: Provider Directory Accuracy – Specialists

Provider Type	Goal	WellSense MCO	Tufts MCO
Infectious Disease	Not Defined	30.00%	30.00%
Neurology Adult	Not Defined	36.67%	30.00%
Neurology Youth	Not Defined	46.15%*	26.32%*
Autism Services**	Not Defined	6.67%	13.33%
All Specialists	Not Defined	27.18%	27.77%

*Sample size less than 30, interpret with caution.

**The Autism Services Provider Type includes the following services: Autism Services: Applied Behavior Analyst, Autism Services: Counselor, Autism Services: Psychiatrist, Autism Services: Psychologist, and Autism Services: Social Worker.

Table 32: Provider Directory Accuracy – Urgent Care Providers

Provider Type	Goal	WellSense MCO	Tufts MCO
Urgent Care Providers	Not Defined	66.67%	50.00%*

*Sample size less than 30, interpret with caution.

Table 33: Frequency of Failure Types - Primary Care Providers

Type of Failure	MCO Total	WellSense MCO	Tufts MCO
Provider not at the site	**65**	25	40
Provider not accepting new patients	**46**	28	18
Contact Fails*	**31**	13	18
Provider does not accept the health plan	**26**	14	12
Provider reported a different specialty	**6**	1	5

*The "Contact Fails" category includes the following reasons: answering machine/voicemail (3 calls), answering service (3 calls), constant busy signal (3 calls), disconnected telephone number (1 call), no answer (3 calls), put on hold for more than 5 minutes (3 calls), wrong telephone number (1 call).

Table 34: Frequency of Failure Types - Specialists

Type of Failure	MCO Total	WellSense MCO	Tufts MCO
Provider not at the site	69	31	38
Contact Fails*	62	28	34
Provider does not accept the health plan	16	11	5
Provider reported a different specialty	5	2	3
Provider not accepting new patients	3	2	1

*The "Contact Fails" category includes the following reasons: answering machine/voicemail (3 calls), answering service (3 calls), constant busy signal (3 calls), disconnected telephone number (1 call), no answer (3 calls), put on hold for more than 5 minutes (3 calls), wrong telephone number (1 call).

WellSense MCO

After analyzing the network adequacy results for all provider types, IPRO identified service areas with network deficiencies. If 90% of MCO members in one service area had adequate access, then the network availability standard was met. But if less than 90% of members in that service area had access to providers within a specified travel time or distance, then the network was deficient. Tables 35–38 show service areas with deficient networks for WellSense MCO.

Table 35: WellSense MCO Service Areas with Network Deficiencies – PCPs and OB/GYN

Provider Type	Service Area with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Pediatric PCP (Open Panel Only)	ATTLEBORO	27.0%	2 providers within 15 miles or 30 minutes
Pediatric PCP (Open Panel Only)	FALL RIVER	54.2%	2 providers within 15 miles or 30 minutes
Pediatric PCP (Open Panel Only)	PITTSFIELD	85.0%	2 providers within 15 miles or 30 minutes
Pediatric PCP (Open Panel Only)	TAUNTON	68.1%	2 providers within 15 miles or 30 minutes

Table 36: WellSense MCO Service Areas with Network Deficiencies – Physical Health Services Providers

Provider Type	Service Area with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Rehabilitation Hospital	ADAMS	0.5%	1 provider within 30 miles or 60 minutes
Rehabilitation Hospital	NANTUCKET	0.0%	1 provider within 30 miles or 60 minutes
Rehabilitation Hospital	ORLEANS	72.8%	1 provider within 30 miles or 60 minutes
Rehabilitation Hospital	PITTSFIELD	14.4%	1 provider within 30 miles or 60 minutes
Urgent Care Services	NANTUCKET	0.0%	1 provider within 15 miles or 30 minutes

Table 37: WellSense MCO Service Areas with Network Deficiencies – Specialists

Provider Type	Service Area with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Audiology	GARDNER-FITCHBURG	84.9%	1 provider within 20 miles or 40 minutes

Table 38: WellSense MCO Service Areas with Network Deficiencies – Behavioral Health Providers

Provider Type	Service Area with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Psychiatric Inpatient Adult	NANTUCKET	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adolescent	NANTUCKET	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	BARNSTABLE	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	FALMOUTH	26.6%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	NANTUCKET	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	OAK BLUFFS	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	ORLEANS	13.1%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	PITTSFIELD	86.6%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	NANTUCKET	0.0%	2 providers within 60 miles or 60 minutes
Monitored Inpatient Level 3.7	ADAMS	0.0%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	ATHOL	9.1%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	FALL RIVER	83.9%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	GARDNER-FITCHBURG	83.3%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	GREENFIELD	1.4%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	HOLYOKE	0.0%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	NANTUCKET	0.0%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	NORTHAMPTON	5.0%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	OAK BLUFFS	2.0%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	ORLEANS	12.9%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	PITTSFIELD	2.1%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	SOUTHBRIDGE	42.7%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	SPRINGFIELD	2.8%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Level 3.7	WESTFIELD	1.2%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	ADAMS	67.5%	2 providers within 30 miles or 30 minutes

Provider Type	Service Area with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Clinical Stabilization Service Level 3.5	BARNSTABLE	0.0%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	FALL RIVER	89.3%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	FALMOUTH	20.4%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	GARDNER-FITCHBURG	89.0%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	GLOUCESTER	89.3%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	NANTUCKET	0.0%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	OAK BLUFFS	0.0%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	ORLEANS	0.0%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	PITTSFIELD	1.0%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	PLYMOUTH	87.4%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	SOUTHBRIDGE	54.0%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	SPRINGFIELD	8.4%	2 providers within 30 miles or 30 minutes
Clinical Stabilization Service Level 3.5	WESTFIELD	1.2%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	ADAMS	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	ATHOL	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	BARNSTABLE	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	BEVERLY	87.3%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	FALL RIVER	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	FALMOUTH	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	GARDNER-FITCHBURG	21.6%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	GLOUCESTER	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	GREENFIELD	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	HAVERHILL	19.8%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	HOLYOKE	0.5%	2 providers within 30 miles or 30 minutes

Provider Type	Service Area with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
CBAT-ICBAT-TCU	NANTUCKET	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	NEW BEDFORD	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	NORTHAMPTON	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	OAK BLUFFS	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	ORLEANS	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	PITTSFIELD	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	PLYMOUTH	12.4%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	SOUTHBRIDGE	54.9%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	SPRINGFIELD	4.1%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	TAUNTON	48.7%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	WAREHAM	0.0%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	WESTFIELD	0.0%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	ADAMS	0.0%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	BARNSTABLE	0.0%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	FALMOUTH	30.2%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	GLOUCESTER	85.3%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	GREENFIELD	39.2%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	HAVERHILL	84.2%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	NANTUCKET	0.0%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	OAK BLUFFS	0.0%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	ORLEANS	0.0%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	PITTSFIELD	2.1%	2 providers within 30 miles or 30 minutes
Intensive Outpatient Program (IOP)	ADAMS	0.0%	2 providers within 30 miles or 30 minutes
Intensive Outpatient Program (IOP)	GREENFIELD	84.5%	2 providers within 30 miles or 30 minutes

Provider Type	Service Area with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Intensive Outpatient Program (IOP)	NANTUCKET	0.0%	2 providers within 30 miles or 30 minutes
Intensive Outpatient Program (IOP)	PITTSFIELD	6.2%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	ADAMS	68.4%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	BARNSTABLE	21.9%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	NANTUCKET	0.0%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	OAK BLUFFS	74.5%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	ORLEANS	0.0%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	PITTSFIELD	6.2%	2 providers within 30 miles or 30 minutes
Applied Behavior Analysis (ABA)	NANTUCKET	5.9%	2 providers within 30 miles or 30 minutes
In-Home Therapy Services	NANTUCKET	82.4%	2 providers within 30 miles or 30 minutes
Therapeutic Mentoring Services	NANTUCKET	82.4%	2 providers within 30 miles or 30 minutes
Community Crisis Stabilization	ADAMS	66.5%	2 providers within 30 miles or 30 minutes
Community Crisis Stabilization	ATHOL	26.8%	2 providers within 30 miles or 30 minutes
Community Crisis Stabilization	BARNSTABLE	15.4%	2 providers within 30 miles or 30 minutes
Community Crisis Stabilization	NANTUCKET	0.0%	2 providers within 30 miles or 30 minutes
Community Crisis Stabilization	OAK BLUFFS	2.0%	2 providers within 30 miles or 30 minutes
Community Crisis Stabilization	ORLEANS	0.0%	2 providers within 30 miles or 30 minutes
Community Crisis Stabilization	PITTSFIELD	8.2%	2 providers within 30 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	ADAMS	67.5%	2 providers within 30 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	GARDNER-FITCHBURG	87.7%	2 providers within 30 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	NANTUCKET	5.9%	2 providers within 30 miles or 30 minutes

Provider Type	Service Area with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Structured Outpatient Addiction Program (SOAP)	PITTSFIELD	6.2%	2 providers within 30 miles or 30 minutes
Opioid Treatment Programs (OTP)	NANTUCKET	64.7%	2 providers within 30 miles or 30 minutes

CBAT-ICBAT-TCU: community-based acute treatment for children and adolescents-intensive community-based acute treatment for children and adolescents-transitional care unit; SUD: substance use disorder; BH: behavioral health.

Recommendations

- *Network Adequacy Data Integrity Recommendation*: IPRO identified and corrected a number of issues with submitted network provider data. IPRO recommends that for future network adequacy analysis, WellSense MCO review and deduplicate in-network provider data before data files are submitted for analysis.
- *Network Adequacy Time/Distance Standards Recommendation*: IPRO recommends that WellSense expands its network when a deficiency is identified. When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those service areas.
- *Network Adequacy Provider Directory Recommendation*: MCP should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory. MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans.

Tufts MCO

After analyzing the network adequacy results for all provider types, IPRO identified service areas with network deficiencies. If 90% of MCO members in one service area had adequate access, then the network availability standard was met. But if less than 90% of members in that service area had access to providers within a specified travel time or distance, then the network was deficient. Tables 39 and 40 show service areas with deficient networks for Tufts MCO.

Table 39: Tufts MCO Service Areas with Network Deficiencies – Physical Health Services Providers

Provider Type	Service Areas with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Urgent Care Services	ADAMS	0.0%	1 provider within 15 miles or 30 minutes
Urgent Care Services	GLOUCESTER	85.0%	1 provider within 15 miles or 30 minutes
Urgent Care Services	PITTSFIELD	0.2%	1 provider within 15 miles or 30 minutes

Table 40: Tufts MCO Service Areas with Network Deficiencies – Behavioral Health Providers

Provider Type	Service Areas with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Psychiatric Inpatient Adult	ADAMS	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adult	GREENFIELD	88.8%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adult	NORTHAMPTON	88.5%	2 providers within 60 miles or 60 minutes

Provider Type	Service Areas with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Psychiatric Inpatient Adult	PITTSFIELD	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adult	WESTFIELD	71.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adolescent	ADAMS	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adolescent	GREENFIELD	88.8%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adolescent	NORTHAMPTON	88.5%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adolescent	PITTSFIELD	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Adolescent	WESTFIELD	71.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	ADAMS	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	GREENFIELD	88.8%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	NORTHAMPTON	88.5%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	PITTSFIELD	0.0%	2 providers within 60 miles or 60 minutes
Psychiatric Inpatient Child	WESTFIELD	71.0%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	ADAMS	0.0%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	ATHOL	2.5%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	GARDNER-FITCHBURG	79.1%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	GLOUCESTER	81.4%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	GREENFIELD	0.0%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	HAVERHILL	76.6%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	HOLYOKE	0.0%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	NORTHAMPTON	0.0%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	PITTSFIELD	0.0%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	SOUTHBRIDGE	89.4%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	SPRINGFIELD	0.0%	2 providers within 60 miles or 60 minutes
Managed Inpatient Level 4	WESTFIELD	0.0%	2 providers within 60 miles or 60 minutes

Provider Type	Service Areas with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Partial Hospitalization Program (PHP)	ADAMS	0.0%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	GREENFIELD	81.7%	2 providers within 30 miles or 30 minutes
Partial Hospitalization Program (PHP)	PITTSFIELD	2.4%	2 providers within 30 miles or 30 minutes
Intensive Outpatient Program (IOP)	GREENFIELD	72.1%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	ADAMS	0.0%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	GREENFIELD	48.2%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	NORTHAMPTON	88.5%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	PITTSFIELD	1.2%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	ADAMS	0.0%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	ATHOL	14.2%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	GARDNER-FITCHBURG	89.5%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	GLOUCESTER	28.7%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	GREENFIELD	17.8%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	HAVERHILL	80.6%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	NORTHAMPTON	87.7%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	PITTSFIELD	0.6%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators	SOUTHBRIDGE	60.9%	2 providers within 30 miles or 30 minutes
Recovery Coaching	ADAMS	0.0%	2 providers within 30 miles or 30 minutes
Recovery Coaching	GREENFIELD	50.3%	2 providers within 30 miles or 30 minutes
Recovery Coaching	NORTHAMPTON	88.5%	2 providers within 30 miles or 30 minutes

Provider Type	Service Areas with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Recovery Coaching	PITTSFIELD	0.6%	2 providers within 30 miles or 30 minutes
Recovery Coaching	SOUTHBRIDGE	60.9%	2 providers within 30 miles or 30 minutes

SUD: substance use disorder; BH: behavioral health.

Recommendations

- *Network Adequacy Data Integrity Recommendations*: None
- *Network Adequacy Time/Distance Recommendations*: IPRO recommends that Tufts expands its network when a deficiency is identified. When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those service areas.
- *Network Adequacy Provider Directory Recommendation*: MCP should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory. MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans.

VII. Quality-of-Care Surveys – Health Plan CAHPS

Objectives

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

Section 2.14.C.1.c. of the Fifth Amended and Restated MassHealth MCO Contract requires contracted MCOs to administer and submit annually to MassHealth the results from the CAHPS Medicaid Health Plan surveys (Adult and Child) that the MCOs submit to NCQA as part of their accreditation process. The CAHPS tool is a standardized questionnaire that asks enrollees to report on their satisfaction with care and services from the MCO, the providers, and their staff.

Each MassHealth MCO independently contracted with a certified CAHPS vendor to administer the adult survey for MY 2022. In addition, the WellSense MCO contracted with a certified CAHPS vendor to administer the child survey. MassHealth monitors MCOs' submissions of CAHPS surveys and uses the results to identify opportunities for improvement and inform MassHealth's quality management work.

Technical Methods of Data Collection and Analysis

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

HEDIS specifications require that the MCOs provide a list of all eligible members for the sampling frame. Following HEDIS requirements, the MCOs included members in the sample frame who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2022, who were continuously enrolled for at least five of the last six months of MY 2022, and who are enrolled in the MCO. Tables 41 and 42 provides a summary of the technical methods of data collection by MCO.

Table 41: Adult CAHPS – Technical Methods of Data Collection by MCO, MY 2022

CAHPS – Technical Methods of Data Collection	WellSense MCO	Tufts MCO
Survey vendor	SPH Analytics Press Ganey	SPH Analytics Press Ganey
Survey tool	CAHPS 5.1H	CAHPS 5.1H
Survey timeframe	March–May, 2023	February – May, 2023
Method of collection	Mail, telephone, and internet*	Mail and telephone
Sample size	2,970	2,295
Response rate	6.8%	7.0%

*Internet modes of data collection include QR codes, email, and URL.

Table 42: Child CAHPS – Technical Methods of Data Collection by MCO, MY 2022

CAHPS – Technical Methods of Data Collection	WellSense MCO	Tufts MCO
Survey vendor	SPH Analytics Press Ganey	N/A
Survey tool	CAHPS 5.1H	N/A
Survey timeframe	March–May, 2023	N/A
Method of collection	Mail, telephone, and internet*	N/A
Sample size	5775	N/A
Response rate	5.1%	N/A

*Internet modes of data collection include QR codes, email, and URL.

For the global ratings, composite measures, composite items, and individual item measures, the scores were calculated using a 100-point scale. Responses were classified into response categories. Table 43 displays these categories and the measures for which these response categories are used.

Table 43: CAHPS Response Categories, MY 2022

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

To assess MCO performance, IPRO compared MCOs' top-box scores to national Medicaid performance reported in the Quality Compass 2023 (MY 2022) for all lines of business that reported MY 2022 CAHPS data to NCQA. The top-box scores are the survey results for the highest possible response category.

Description of Data Obtained

For each MCO, IPRO received a copy of the final MY 2022 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as MCO-level results and analyses.

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across both MCOs, IPRO compared the MCO results and CAHPS weighted mean (calculated for WellSense and Tufts MCOs) to the national Medicaid benchmarks presented in the Quality Compass MY 2022. Measures performing at or above the 90th percentile were considered strengths; measures performing at or above the 75th percentile but below the 90th percentile were considered above the threshold standard for performance; and measures performing below the 75th percentile were identified as opportunities for improvement, as explained in Table 44.

Table 44: Key for CAHPS Performance Measure Comparison to NCQA HEDIS MY 2022 Quality Compass Medicaid National Percentiles.

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

When compared to the available national Medicaid benchmarks, the Tufts MCO's Adult CAHPS scores for how well doctors communicate, coordination of care, overall rating of healthcare, rating of specialists, and overall rating of the health plan exceeded the national Medicaid 90th percentile. WellSense's Adult CAHPS score for customer service also exceeded the 90th percentile. However, both health plans scored below the national 75th percentile on all other Adult CAHPS measures. WellSense MCO scored below the 75th percentile on all Child CAHPS measures, leaving room for improvement.

Table 45 displays the top-box scores of the 2023 CAHPS Adult Medicaid Survey for MY 2022, and Table 46 displays the top-box scores of the 2023 CAHPS Child Medicaid Survey for MY 2022.

Table 45: CAHPS Performance – Adult Member, MY 2022

CAHPS Measure	WellSense MCO	Tufts MCO	Weighted Mean
Getting Care Quickly	80.8% (< 75th)	78.5% (< 75th)	79.8% (< 75th)
Getting Needed Care	81.4% (< 75th)	80.8% (< 75th)	81.1% (< 75th)
How Well Doctors Communicate	93.1% (< 75th)	96.3% (≥ 90th)	94.6% (≥ 75th)
Customer Service	92.2% (≥ 90th)	90.4% (< 75th)	91.4% (≥ 75th)
Coordination of Care	84.8% (< 75th)	90.0% (≥ 90th)	87.1% (< 75th)
Ease of Filling Out Forms	94.4% (< 75th)	94.5% (< 75th)	94.4% (< 75th)
Rating of All Health Care (9 or 10)	56.5% (< 75th)	68.4% (≥ 90th)	61.9% (≥ 75th)
Rating of Personal Doctor (9 or 10)	61.5% (< 75th)	71.6% (< 75th)	66.1% (< 75th)
Rating of Specialist Seen Most Often (9 or 10)	61.3% (< 75th)	75.0% (≥ 90th)	67.5% (< 75th)
Rating of Health Plan (9 or 10)	53.8% (< 75th)	69.8% (≥ 90th)	61.0% (< 75th)

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

Table 46: CAHPS Performance – Child Member, MY 2022

CAHPS Measure	WellSense MCO	Tufts MCO
Getting Care Quickly	81.0% (< 75th)	N/A
Getting Needed Care	78.3% (< 75th)	N/A
How Well Doctors Communicate	92.9% (< 75th)	N/A
Customer Service	78.0% (< 75th)	N/A
Coordination of Care	84.2% (< 75th)	N/A
Ease of Filling Out Forms	92.6% (< 75th)	N/A
Rating of All Health Care (9 or 10)	59.6% (< 75th)	N/A
Rating of Personal Doctor (9 or 10)	74.0% (< 75th)	N/A
Rating of Specialist Seen Most Often (9 or 10)	67.6% (< 75th)	N/A
Rating of Health Plan (9 or 10)	61.9% (< 75th)	N/A

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

VIII. MCP Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results(a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP,[16] PAHP,[17] or PCCM entity has effectively addressed the recommendations for QI[18] made by the EQRO during the previous year's EQR." **Tables 47 and 48** display the MCOs' responses to the recommendations for QI made during the previous EQR, as well as IPRO's assessment of these responses.

WellSense MCO Response to Previous EQR Recommendations

Table 47 displays the MCO's progress related to the *Managed Care Organizations External Quality Review CY 2022*, as well as IPRO's assessment of the MCO's response.

Table 47: WellSense MCO Response to Previous EQR Recommendations

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PIP 1 IET Quality-Related: The previous EQRO recommended further exploration of PIP strengths and challenges. Quality-Related: The previous EQRO also recommended that continuous quality improvement be further developed	WellSense continues to work with Carelon Behavioral Health on the SUD Transition of Care program. This program includes a Carelon clinician on-site at 4 ATS facilities (Community Health Link, Washburn House, Spectrum Westborough, and Adcare). A clinician engages members presents available resources to support recovery and collaborates with the treatment team to make referrals and assist with access to care issues. WellSense continues to monitor our rates monthly during our data refresh, while also monitoring daily census of hospital and ED admissions.	Addressed
PIP 2 CDC Quality-Related: The previous EQRO recommended that the plan develop other methods of receiving provider input into this initiative outside of the formal survey process, which would delay valuable input that could lead to changes.	WellSense plans to leverage more detailed reporting as education and intel for PCPs to consider the next steps in the member journey (for example: the member may need an Endocrine referral or member may need to change the class of medications, etc.).	Addressed
PMV 1: Quality-Related: HEDIS Measures: MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by the measures for which WellSense scored below the 25th percentile.	WellSense has activated direct member outreach for multiple measures, outside of what is being done in care management. WellSense RNs personally outreach to members who continue to show non-compliance, provide education, and support member to receive appropriate level of care for compliance. Additionally, WellSense has continued to enhance its maternal care management program and is working to connect to each expecting mother through their journey. WellSense quality has routine data reviews, measure level workgroups, and multiple cross-functional partnerships to impact measure performance from multiple channels.	Partially addressed

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

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV: Non-HEDIS Measures: MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by the measures for which WellSense scored below the 25th percentile.	Regarding oral health evaluation, quality is currently partnering with network team to assess the market and build quality partnerships with dental providers in an effort to support and facilitate patient scheduling of routine care. Additionally, WellSense is exploring dental education packets that would be sent to the members. Through continuous monitoring of leading indicators, we will be able to evaluate progress month-over-month. WellSense has increased the number of members both identified and enrolled in the Community Partners program by: • Enhancing the claims-based algorithm used to identify members who might benefit from programming • Partnering more closely with the CP provider network to identify and mitigate operational inefficiencies • Developing new reporting to better monitor the target enrollment rate in the CP program by ACO partner Since 4/1/23, enrollment rates for legacy ACO partners remain at target, and for new partners, have been rising month-over-month as new providers become more familiar with the CP program and additional claims experience helps to fuel improved algorithmic identification.	Addressed
Compliance: WellSense needs to work towards compliance with accessibility standards to meet MassHealth requirements. In addition, WellSense needs to develop a mechanism to evaluate non-English speaking enrollees' choice of primary and behavioral health providers in prevalent languages.	WellSense response: WellSense contracts with providers state-wide and in all areas, to include all languages. WellSense obtains additional languages spoken by providers and captures languages spoken in its provider directory. Carelon has updated its policies to formally document the mechanism for ensuring that non-English speaking Enrollees have a choice of at least Behavioral Health Providers within each behavioral health covered service category, in the Prevalent Language as part of the standard network oversight procedures. Further, to monitor and ensure appropriate access levels to providers that speak prevalent languages within each service area, Carelon will run a report customized for this metric on a quarterly basis which will be reviewed by the Carelon Network team with ongoing reporting and action items shared with the Plans.	Addressed
Network: MCO should expand network when members' access can be improved and when network deficiencies can be closed by available providers.	The WellSense Network Management team continuously works to recruit providers into the Network for all Plan products. Recent provider and practice terminations were noted in our oral surgery network; available providers are being identified for	Addressed

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	immediate recruitment. Carelon's Contracting and Provider Relations staff identifies and establishes recruitment needs for providers and facilities in the specific geographic area(s), as well as expanding the network to accommodate intermediate care levels by creating custom network development strategies designed to recruit specific or specialty providers.	
Quality-of-Care Surveys: MCO should utilize the results of the adult and child CAHPS surveys to drive performance improvement as it relates to member experience. MCO should also utilize complaints and grievances to identify and address trends	WellSense took the following actions to improve its performance on the MY2021 MassHealth CAHPS Adult and Child survey measures, all of which scored below the State's performance goal set at the national 75th Medicaid Quality Compass percentile: Convened a CAHPS Improvement Subcommittee meeting with leaders from Care Management, Member and Provider Service, Network Management and Product in October 2022 to review the MY2021 MassHealth Medicaid adult and child CAHPS survey results. The subcommittee identified the following prioritized interventions to act upon: implemented a member experience Performance Remediation Plan (PRP) with four ACOs (BACO Community Alliance, Mercy Alliance, Signature Alliance, and Southcoast Alliance) between July and December 2022. On a monthly basis, lists of members having no PCP visits in a year and identified by WellSense's predictive analytics software as being likely to report negative response to access related CAHPS items were shared with ACO partners who targeted members for outreach to assist them in scheduling a PCP visit. Utilized a data-driven approach to identify MassHealth adult and child members with open care gaps and likely to report negative response to access related CAHPS items. Examined calendar year 2022 MassHealth member appeals and grievances in July 2023 for any possible trends.	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined. **Not applicable**: PIP discontinued. MCO: managed care organization; MCP: managed care plan; EQR: external quality review; PIP: performance improvement project; HEDIS: Healthcare Effectiveness Data and Information Set; PCP: primary care provider; CAHPS: Consumer Assessment of Healthcare Providers and Systems; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; CDC: Comprehensive Diabetes Care; MY: measurement year.

Tufts MCO Response to Previous EQR Recommendations

Table 48 displays the MCO's progress related to the *Managed Care Organizations External Quality Review CY 2022,* as well as IPRO's assessment of the MCO's response.

Table 48: Tufts MCO Response to Previous EQR Recommendations

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV: HEDIS Measures: MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Tufts Health Public Plans (THPP) chose to address the following HEDIS measures for the MCO product (Tufts Health Together) during CY 2022: Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment (IET), Follow-up After Hospitalization for Mental Illness -7 Days (FUH), Follow-up after Emergency Department Visits for Mental Illness -7 Days (FUM), and Asthma Medication Ratio (AMR). Activities included: expanded access to behavioral health providers, promotion of telehealth visits and early outreach to identified members (IET), leveraging internal admission reports for early identification of members admitted to the emergency department or hospital, improved communications with discharge planners (FUH and FUM) and increased provider communication, follow-up with members in the emergency department with an asthma diagnosis, and collaboration with pharmacy resources (AMR). The MCO AMR rate was also subject to an unfavorable variance in the CY 2021. It was discovered through root cause analysis that AMR was impacted by an increase in denied claims as a result of the implementation of the Unified Pharmacy Product List with MassHealth. As NCQA specifications require health plans to include denied claims in HEDIS measure calculations, these claims adversely impacted the rate. In April 2022, THPP was able to correct the issue for MY2021 and all reporting for AMR going forward.	Addressed
PMV: Non-HEDIS Measures: MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	These measures are calculated by EOHHS, and the data is provided to them through separate channels and varied sources independent of the health plan. Thus, the MCO does not have access to the relevant data needed to calculate iterative performance or conduct root cause analyses for these measures.	Partially addressed
Network: MCO should expand network when members' access can be improved and when network deficiencies can be closed by available providers.	The Network Services & Compliance department conducts quarterly monitoring of the MCO network to track all specialties in all counties to identify any deficiencies. In the event a new gap is identified, the MCO can proactively work to close the gap. Gaps in Recovery Coaching and Oral Surgery have been closed; a gap in Urgent Care Centers remains. For some gaps, the MCO is utilizing the QuestCloud tool to identify available providers to aid in outreach and contracting efforts.	Addressed

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Quality-of-Care Surveys: MCO should utilize the results of the adult HP CAHPS surveys to drive performance improvement as it relates to member experience. MCO should also consider conducting the child HP CAHPS survey.	The MCO utilizes CAHPS surveys to drive performance improvement by working collaboratively to complete analysis of the CAHPS results. Through the analysis lower performing areas are identified, and based on the areas for improvement, a specific action plan is developed. The action plans outline strategies for addressing the identified issues. Action plans are executed systematically through quality improvement workgroups and the implementation of CAHPS improvement activities are monitored and evaluated to ensure impact. At least annually, CAHPS is brought to a MCO Member Advisory Committee to obtain member feedback; feedback is about CAHPS results as well as CAHPS improvement efforts. The MCO completes a CAHPS overview which provides department specific presentations of the CAHPS data. These department specific presentations ensure that relevant stakeholders are involved in the CAHPS process while also ensuring that business areas understand the importance of CAHPS scores and their role in improving them. The MCO continuously monitors CAHPS scores and the impact on CAHPS improvement efforts. This CAHPS quality improvement approach is enterprise wide. The MCO is completing a Child CAHPS with CCC in 2024.	Addressed

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

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

Tables 49 and 50 highlight each MCO's performance strengths, opportunities for improvement, and this year's recommendations based on the aggregated results of CY 2023 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 49: Strengths, Opportunities for Improvement, and EQR Recommendations for WellSense MCO

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: IET	The plan reported provider engagement in the PIP as a strength.	There were no weaknesses identified.	None.	Quality, Timeliness, Access
PIP 2: CDC	The plan noted that correct member contact information was on file which allowed a successful texting campaign roll-out.	Issues related to data collection and reporting limited IPRO's ability to assess progress with respect to indicator 2 (The percentage of members 18–64 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% during the measurement year). Results must be interpreted with some caution due to the large difference in the denominator between baseline year and remeasurement years for Indicator 2.	**Recommendation for PIP 2:** IPRO recommends using the comprehensive vendor data file when available to evaluate these interventions and assess which interventions can be sustainable outside of the scope of the PIP. Please see the general recommendations to MassHealth for additional recommendations relevant to all plans.	Quality, Timeliness, Access
PMV: HEDIS measures	MCO demonstrated compliance with IS standards. No issues were identified. The Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment was above the 90th percentile.	The following HEDIS measures rates were below the 25th percentile: • Childhood Immunization Status (combo 10) • Immunization for Adolescents (combo 2)	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access
PMV: Non-HEDIS measures	No issues were identified. The Risk-Adjusted Ratio (Observed/Expected) of ED Visits for Members Aged 18–65 Years Identified with	The following measures rates were below the goal benchmark: • Oral Health Evaluation • Behavioral Health Community Partner Engagement	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
	a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions measure rate was above the goal benchmark.	• LTSS Community Partner Engagement		
Compliance Review	MCO demonstrated compliance with most of the federal and state contractual standards and demonstrated strong investment in system solutions and technology. MCO addressed opportunities for improvement from the prior compliance review.	WellSense MCO did not meet all MassHealth-required time and distance standards.	Work towards compliance with accessibility standards to meet MassHealth requirements. In addition, develop a mechanism to evaluate non-English speaking enrollees' choice of primary and behavioral health providers in prevalent languages.	Quality, Timeliness, Access
Network Adequacy: Data Integrity	WellSense MCO submitted all requested in-network providers' data.	Individual provider names were submitted where facilities were requested and listed under the same NPI and address as the facility. Duplicated data was submitted, showing slight variations in the facility names, listed under the same NPI and address. Facility departments were submitted in the data, in addition to the facility name, under the facility's NPI and address. Duplicated data was submitted in the facility tabs, both the NPI Registered Name and DBA Name were submitted in the data.	<u>Recommendation</u> IPRO recommends that, for future network adequacy analysis, WellSense MCO review and deduplicate in-network provider data before data files are submitted for analysis.	Access, Timeliness
Network Adequacy: Time/Distance Standards	MCO demonstrated adequate networks for 34 out of the total of 55 provider types in all its 38 service areas.	MCO had deficient networks in one or more service areas for 20 provider types: • Pediatric PCP • Rehabilitation Hospital • Urgent Care Services	<u>Recommendation</u> MCO should expand the network when members' access can be improved and when network deficiencies can be closed by available providers.	Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
		• Audiology • 16 out of 22 Behavioral Health Providers	When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those service areas.	
Network Adequacy: Provider Directory	WellSense MCO's highest accuracy rate was 66.67% for the Urgent Care Providers directory.	WellSense MCO's accuracy rate was below 20% for the following provider type: • Autism Services (6.67%)	<u>Recommendations</u> MCP should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory.	Access, Timeliness
Quality-of-care Surveys	MCO conducted both adult and child CAHPS surveys. WellSense scored above the 90th percentile on the customer service adult CAHPS measure.	Except for the customer service adult CAHPS measure, MCO scored below the national 75th percentile on the remaining adult and all child HP CAHPS measures.	WellSense's CAHPS results have not improved from the previous year. The actions taken by WellSense during the 2023 CY to improve members satisfaction seemed to be mostly focused on scheduling PCP visits. In addition, WellSense should conduct a root cause analysis to understand why members are not satisfied. WellSense should also continue to analyze complaints and grievances to identify and address trends.	Quality, Timeliness, Access

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

Table 50: Strengths, Opportunities for Improvement, and EQR Recommendations for Tufts MCO

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: IET	The plan reported ARCMs' support of members who were discharged with AOD-related diagnoses bolstered attendance of the initiation & engagement treatment visits as a strength. There is evidence of continued assessment of barriers and subsequent adjustments to infrastructure aimed at improving the effectiveness, scope and sustainability of interventions.	There were no weaknesses identified.	None.	Quality, Timeliness, Access
PIP 2: PPC	Enhancements were made to infrastructure and supportive services, such as the Comprehensive education materials and community events available to pregnant members. The plan reported member satisfaction with the doula program.	The plan struggled with data collection and tracking of target populations and provider groups but took steps in setting the foundation for improved measurement, tracking, outreach and member and provider support moving forward.	**Recommendation for PIP 2:** In future PIP reporting, IPRO will request that plans note 'Not Applicable' ('N/A') for calculated fields or rate fields in which a denominator is zero. Please see the general recommendations to MassHealth for additional recommendations relevant to all plans.	Quality, Timeliness, Access
PMV: HEDIS measures	MCO demonstrated compliance with IS standards. No issues were identified. The Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate was above the 90th percentile.	The following HEDIS measures rates were below the 25th percentile: • Childhood Immunization Status (combo 10) • Controlling High Blood Pressure • Asthma Medication Ratio • HBD: Hemoglobin A1c Control; HbA1c control (>9.0%) (Lower is better)	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
PMV: Non-HEDIS measures	No issues were identified. The following measures rates were above the goal benchmark: • Risk-Adjusted Ratio (Observed/Expected) of ED Visits for Members Aged 18–65 Years Identified with a Diagnosis of Serious Mental Illness, Substance Addiction, or Co-occurring Conditions • the LTSS Community Partner Engagement	The following measures rates were below the goal benchmark: • Oral Health Evaluation • Behavioral Health Community Partner Engagement	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access
Compliance Review	MCO demonstrated compliance with most of the federal and state contractual standards, addressed opportunities for improvement from the prior compliance review, made enhancements to its care management approach with a large focus to better integrate behavioral health into its integrated team. Grievance resolution letters were found to be very thorough and detailed, and the credentialing manual was identified as a best practice.	Prior recommendations were addressed.	None.	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
Network Adequacy: Time/Distance Standards	Tufts MCO demonstrated adequate networks for all PCP, OB/GYN, pharmacy, and all specialty providers in 26 of its service areas.	Tufts MCO had a deficient urgent care network in three service areas. The MCO also had deficient networks in one or more service areas for 9 out of 22 behavioral health provider types.	<u>Recommendation</u> MCO should expand the network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those service areas.	Access, Timeliness
Network Adequacy: Provider Directory	Tufts MCO's highest accuracy rate was 50.00% for the Urgent Care Providers directory.	Tufts MCO's accuracy rate was below 20% for the following provider types: • Internal Medicine (13.3%) • Autism Services (13.33%)	<u>Recommendations</u> MCP should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory. MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans.	Access, Timeliness
Quality of Care Surveys	MCO achieved five adult CAHPS scores for MY 2021 that exceeded the national Medicaid 90th percentile.	MCO scored below the national 75th percentile on five adult HP CAHPS measures. MCO did not conduct the child HP CAHPS survey. The measures below the 75th percentile were: • Getting Care Quickly • Getting Needed Care • Customer Service • Ease of Filling Out Forms • Rating of Personal Doctor	Tufts should continue developing and implementing action plans to address the five lower performing areas of the CAHPS survey in order to drive performance improvement in those specific areas. MCO should also consider conducting the child HP CAHPS survey.	Quality, Timeliness, Access

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

X. Required Elements in EQR Technical Report

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

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

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

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

Elements required in EQR technical report, including the requirements for the PIP validation, PMV, and review of compliance activities, are listed in **Table 51**.

Table 51: Required Elements in EQR Technical Report

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

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

XI. Appendix A – MassHealth Quality Goals and Objectives

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

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

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

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

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

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

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

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

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

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

XII. Appendix B – MassHealth Managed Care Programs and Plans

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

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Accountable Care Partnership Plan (ACPP)	Groups of primary care providers working with one managed care organization to create a full network of providers. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. BeHealthy Partnership Plan 2. Berkshire Fallon Health Collaborative 3. East Boston Neighborhood Health WellSense Alliance 4. Fallon 365 Care 5. Fallon Health – Atrius Health Care Collaborative 6. Mass General Brigham Health Plan with Mass General Brigham ACO 7. Tufts Health Together with Cambridge Health Alliance (CHA) 8. Tufts Health Together with UMass Memorial Health 9. WellSense Beth Israel Lahey Health (BILH) Performance Network ACO 10. WellSense Boston Children's ACO 11. WellSense Care Alliance 12. WellSense Community Alliance 13. WellSense Mercy Alliance 14. WellSense Signature Alliance 15. WellSense Southcoast Alliance
Primary Care Accountable Care Organization (PC ACO)	Groups of primary care providers forming an ACO that works directly with MassHealth's network of specialists and hospitals for care and coordination of care. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Community Care Cooperative 2. Steward Health Choice
Managed Care Organization (MCO)	Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Boston Medical Center HealthNet Plan WellSense 2. Tufts Health Together
Primary Care Clinician Plan (PCCP)	Members select or are assigned a primary care clinician (PCC) from a network of MassHealth hospitals, specialists, and the Massachusetts Behavioral Health Partnership (MBHP). • Population: Managed care eligible Medicaid members	Not applicable – MassHealth

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

XIII. Appendix C – MassHealth Quality Measures

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

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

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

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

Table D1: MCO Network Adequacy Standards and Indicators – Primary Care Providers

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
Applicable Provider Types: • Adult PCP; • Family PCP (applies to all ages, adults and children) • Pediatric PCP Sec. 2.10.C.1 Primary Care Providers a. The Contractor shall develop and maintain a network of Primary Care Providers that ensures PCP coverage and availability throughout the region 24 hours a day, seven days a week. b. The Contractor shall maintain a sufficient number of PCPs, defined as one adult PCP for every 750 adult Enrollees and one pediatric PCP for every 750 pediatric Enrollees throughout all of the Contractor's regions set forth in Appendix F. EOHHS may approve a waiver of the above ratios in accordance with federal law. c. The Contractor shall include in its Network a sufficient number of appropriate PCPs to meet the time and distance requirements set forth in Appendix N. An appropriate PCP is defined as a PCP who: 1) Is open at least 20 hours per week; 2) Has qualifications and expertise commensurate with the health care needs of the Enrollee; and 3) Has the ability to communicate with the Enrollee in a linguistically	Primary Care Providers: • At least 90% of Enrollees in each of the Contractor's Service Areas must have access to at least 2 Providers in accordance with the time-OR- distance standards defined in Appendix N, including exceptions for the Oak Bluff and Nantucket Service Areas. • The Contractor shall take into account only Providers with open panels and shall consider both walking and public transportation. • The provider-to-member ratio must be 1:750	ADULT Primary Care Providers Geo-Access: Numerator: number of plan members ages 21 to 64 in a Service Area for which one of the following is true: • Two unique in-network adult PCP providers with open panels (i.e., internal medicine and family medicine) are a 30-minute drive or less from a member residence; and 40-minute drive or less from a member residence for members in the Oak Bluffs and Nantucket Service Areas; OR • Two unique in-network adult PCP providers with open panels (i.e., internal medicine and family medicine) are 15 miles or less from a member residence, and 40 miles from the member's residence for members in the Oak Bluffs and Nantucket Service Areas. Denominator: all plan members ages 21 to 64 in a Service Area ADULT Primary Care Provider-to-Member ratio: the number of all in-network adult primary care providers (i.e., internal medicine and family medicine) against the number of all members ages 21 to 64. Calculate for all providers (i.e., providers with open and closed panels altogether). PEDIATRIC Primary Care Providers Geo-Access: Numerator: number of plan members ages 0 to 20 in a Service Area for which one of the following is true: • Two unique in-network pediatric PCP providers with open panels (i.e., pediatricians and family medicine) are a 30-minute drive or less from a member residence; and 40-minute drive or less from a member residence for members in the Oak Bluffs and Nantucket Service Areas; OR • Two unique in-network pediatric PCP providers with open panels (i.e., pediatricians and family medicine) are 15 miles or less from a member residence, and 40 miles from the member's residence for members in the Oak Bluffs and Nantucket Service Areas. Denominator: all plan members ages 0 to 20 in a Service Area Pediatric Primary Care Provider-to-Member ratio: the number of all in-

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
appropriate and culturally sensitive manner.		network pediatric primary care providers (i.e., pediatricians and family medicine) against the number of all members ages 0 to 20. Calculate for all providers (i.e., providers with open and closed panels altogether).

Table D2: MCO Network Adequacy Standards and Indicators – Obstetrician and Gynecologists

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
Sec. 2.10.C.3.c Obstetrician/Gynecologists 1) In addition to the requirements set forth at Appendix N, the Contractor shall maintain an Obstetrician/Gynecologist ratio, throughout the region, of one to 500 Enrollees who may need such care, including but not limited to female Enrollees aged 10 and older and other transgender and gender diverse individuals who need Obstetric and/or Gynecologic care. EOHHS may approve a waiver of such ratio in accordance with federal law. 2) When feasible, Enrollees shall have a choice of two Obstetrician/Gynecologists.	OB/GYN • At least 90% of Enrollees in each of the Contractor's Service Areas must have access to at least 2 Providers in accordance with the time-OR- distance standards defined in Appendix N. • The Contractor shall take into account only Providers with open panels and shall consider both walking and public transportation. • The provider-to-member ratio must be 1:500	OB/GYN Geo-Access: Numerator: number of female members ages 10+ in a Service Area for which one of the following is true: • Two unique in-network OB/GYN providers with open panels are a 30-minute drive or less from a member residence; OR • Two unique in-network OB/GYN providers with open panels are 15 miles or less from a member residence. Denominator: all female members ages 10+ in a Service Area OB/GYN Provider-to-Member ratio: the number of all in-network OB/GYN providers against the number of all female members ages 10+. Calculate for all providers (i.e., providers with open and closed panels altogether).

Table D3: MCO Network Adequacy Standards and Indicators – Physical Health Services

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
Physical Health Services: • Acute Inpatient Hospital • Rehabilitation hospital • Urgent care services Only in Appendix N - Physical Health Services are not listed in Sec. 2.10.C	Physical Health Services • At least 90% of Enrollees in each of the Contractor's Service Areas must have access to at least 1 Provider in accordance with the time-OR- distance standards defined in Appendix N, including the exception for acute inpatient hospitals in Oak Bluff and Nantucket Service Areas. • Provider-to-member ratio not required. Do not calculate.	Hospitals Geo-Access: Numerator: number of members in a Service Area for which one of the following is true: • One in-network hospital is a 40-minute drive or less from a member residence; OR • One in-network hospital is 20 miles or less from a member residence. Denominator: all members in a Service Area. **For the Oak Bluff and Nantucket Service Areas, the Contractor may meet this requirement by including in its Provider Network any hospitals located in these Service Areas that provide acute inpatient services or the closest hospital located outside these Service Areas that provide acute inpatient services. **Cape Cod Hospital in Barnstable is closest to Nantucket, and Falmouth Hospital is closest to Oak Bluffs.* Urgent Care Geo-Access: Numerator: number of members in a Service Area for which one of the following is true: • One in-network urgent care facility is a 30-minute drive or less from a member residence; OR • One in-network urgent care facility is 15 miles or less from a member residence. Denominator: all members in a Service Area. Rehabilitation Hospital Geo-Access: Numerator: number of members in a Service Area for which one of the following is true: • One in-network rehabilitation hospital is a 60-minute drive or less from a member residence; OR • One in-network rehabilitation hospital is 30 miles or less from a member residence. Denominator: all members in a Service Area.

Table D4: MCO Network Adequacy Standards and Indicators – Specialists

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
Specialists Allergy* Anesthesiology Audiology Cardiology Dermatology Emergency Medicine Endocrinology Gastroenterology General Surgery Hematology Infectious Disease Medical Oncology Nephrology Neurology Ophthalmology Oral Surgery* Orthopedic Surgery Otolaryngology Physiatry Plastic Surgery* Podiatry Psychiatry Pulmonology Rheumatology Urology Vascular Surgery* Sec. 2.10.C.3. a and b. Other Physical Health Specialty Providers a. The Contractor shall include in its Network a sufficient number of specialty Providers to meet the time and distance requirements set forth in Appendix N. b. For all other specialty provider types	Specialists: • At least 90% of Enrollees in each of the Contractor's Service Areas must have access to at least 1 Provider in accordance with the time-OR- distance standards defined in Appendix N, including the exceptions in Oak Bluff and Nantucket Service Areas. • Contractor is required to report provider-to-member ratios, but there are no predefined ratios that need to be achieved. • There are no time-OR-distance standards for allergy providers, oral surgeons, plastic surgeons, and vascular surgeons. The Contractor must show that they have at least one allergy provider, oral surgeon, plastic surgeon, vascular surgeon in their network.	Specialists Geo-Access: Numerator: number of plan members in a Service Area for which one of the following is true: • One in-network Specialist provider is a 40-minute drive or less from a member residence; and 40-minute drive or less from a member residence for members in the Oak Bluffs and Nantucket Service Areas; OR • One in-network Specialist provider is 20 miles or less from a member residence, and 40 miles from the member's residence for members in the Oak Bluffs and Nantucket Service Areas. Denominator: all plan members in a Service Area Provider-to-Member ratio: the number of all in-network providers against the number of all members. There are no predefined ratios that need to be achieved. ** There are no time-OR-distance standards for allergy providers, oral surgeons, plastic surgeons, and vascular surgeons. The Contractor must show that they have at least one allergy provider, oral surgeon, plastic surgeon, vascular surgeon in their network.*

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
not listed in Appendix N, the Contractor shall include in its Network a sufficient number of Providers to ensure access in accordance with the usual and customary community standards for accessing care. Usual and customary community standards shall be equal to or better than such access in the Primary Care Clinician Plan		

Table D5: MCO Network Adequacy Standards and Indicators – Behavioral Health Services

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
Behavioral Health Services: Psychiatric inpatient adult Psychiatric inpatient adolescent Psychiatric inpatient child Managed inpatient level 4 Monitored inpatient level 3.7 Clinical Stabilization Services level 3.5 CBAT- ICBAT- TCU Partial Hospitalization (PHP) Intensive Outpatient Program (IOP) Residential Rehabilitation Services level 3.1 Intensive Care Coordination (ICC) Applied Behavioral Analysis (ABA) In-Home Behavioral Services In-Home Therapy Therapeutic Mentoring Services Community Crisis Stabilization Structured Outpatient Addiction Program (SOAP) BH outpatient (including psychology and psych APN) Community Support Program (CSP)	Behavioral Health Services • At least 90% of Enrollees in each of the Contractor's Service Areas must have access to at least 2 Providers in accordance with the time-OR-distance standards defined in Appendix N. • Provider-to-member ratio not required. Do not calculate.	Psychiatric inpatient adult, adolescent, and child; & Managed Inpatient Level 4 Geo-Access: Numerator: number of members in a Service Area for which one of the following is true: • Two unique in-network providers are a 60-minute drive or less from a member residence; OR • Two unique in-network providers are 60 miles or less from a member residence. Denominator: all members in a Service Area Other Behavioral Health Services Geo-Access: Numerator: number of members in a Service Area for which one of the following is true: • Two unique in-network providers are a 30-minute drive or less from a member residence; OR • Two unique in-network providers are 30 miles or less from a member residence. Denominator: all members in a Service Area

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
Recovery Support Navigators Recovery Coaching Opioid Treatment Program (OTP) Sec. 2.10.C.5 5. Behavioral Health Services (as listed in Appendix C) a. The Contractor shall include in its Network a sufficient number of Behavioral Health Providers to meet the time and distance requirements set forth in Appendix N to the extent qualified, willing providers are available. b. In addition to the Availability requirements set forth in Appendix N, the Contractor shall include in its Network: 1) At least one Network Provider of each Behavioral Health Covered Service set forth in Appendix C in every region of the state served by the Contractor or, as determined by EOHHS, to the extent that qualified, interested Providers are available; and 2) Providers set forth in Appendix G, Exhibit 1 in accordance with the geographic distribution set forth in such appendix, as updated by EOHHS from time to time, including but not limited to providers of ESP Services;		

CBAT-ICBAT-TCU: community-based acute treatment for children and adolescents-intensive community-based acute treatment for children and adolescents-transitional care unit

Table D6: MCO Network Adequacy Standards and Indicators – Pharmacy

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N of the MCO Contracts	Indicator	Definition of the Indicator
Sec. 2.10.C.2.Pharmacy a. The Contractor shall develop and maintain a network of retail pharmacies that ensure prescription drug coverage and availability throughout the region seven days a week. b. The Contractor shall include in its Network a sufficient number of pharmacies to meet the time and distance requirements set forth in Appendix N.	Pharmacy • At least 90% of Enrollees in each of the Contractor's Service Areas must have access to at least 1 pharmacy in accordance with the time-OR-distance standards defined in Appendix N. • Provider-to-member ratio not required. Do not calculate.	Pharmacy Geo-Access: Numerator: number of members in a Service Area for which one of the following is true: • One pharmacy is a 30-minute drive or less from a member residence; OR • One pharmacy is 15 miles or less from a member residence. Denominator: all members in a Service Area

XV. Appendix E – MassHealth MCO Provider Directory Web Addresses

Table E1: MCO Provider Directory Web Addresses

Managed Care Plan	Web Addresses Reported by Managed Care Plan
WellSense MCO	https://www.wellsense.org/members/ma/masshealth#find-a-provider
Tufts MCO	https://www.tuftsmedicarepreferred.org/tufts-health-plan-doctor-search