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External Quality Review
Managed Care Organizations
Annual Technical Report, Calendar Year 2024

Commonwealth of Massachusetts
Executive Office of Health and Human Services

Per *Title 42 CFR § 438.364(a)(7)*, no managed care plan was exempt from the external quality review activities conducted in CY2024

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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 improve their performance. This annual technical report 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 2024 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 supports 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 2024

MCO Name	Abbreviation Used in the Report	Members as of December 30, 2024	Percent of Total MCO Population
Boston Medical Center HealthNet Plan	WellSense MCO	19,752	40.14%
Tufts Health Together	Tufts MCO	29,460	59.86%
Total MCO	NA	49,212	100.00%

MCO: managed care organization; CY: calendar year; NA: not applicable.

The Boston Medical Center HealthNet Plan (WellSense MCO) is a nonprofit health insurance company that serves 19,752 MassHealth enrollees residing across five MCO regions in the state of Massachusetts. WellSense health plan was founded in 1997 by the Boston Medical Center, a private, nonprofit, and equity-led academic medical center that is the largest safety-net hospital in New England.[1,2] WellSense MCO received a rating of 4 out of 5 stars from the National Committee on Quality Assurance (NCQA).

The Tufts Health Together MCO (Tufts MCO) is a nonprofit health plan that serves 29,460 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 annual technical report is to present the results of EQR activities conducted to assess the quality of, timeliness of, and access to health care services furnished to Medicaid enrollees, in accordance with the following federal managed care regulations: *Title 42 Code of Federal Regulations (CFR) Section (§) 438.364 External review results* (*a*) through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*. EQR activities validate two levels of compliance to assert whether 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 EQR 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 –*** 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 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 the 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 2024 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 the CY 2024 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 three years. In addition to the triennial review, MassHealth also conducts an annual review of measures and key performance indicators to assess progress toward strategic goals. MassHealth relies on the annual EQR process to assess the managed care programs' effectiveness in providing high quality accessible services.

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

Opportunities for Improvement:

Not applicable.

General Recommendations for MassHealth:

None at this time

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

Performance Improvement Projects

State agencies must require that contracted MCPs conduct PIPs that focus on both clinical and non-clinical areas, as established in *Title 42 CFR § 438.330(d)*. Both WellSense and Tufts MCOs proposed PIPs to improve prenatal and postpartum care outcomes. In addition, WellSense MCO proposed a project focused on increasing the rate of hemoglobin A1c control for members with diabetes, and Tufts MCO proposed a project focused on improving rates of follow-up visits within 7 days after hospitalization for mental illness.

Strengths:

IPRO found that all four PIP Baseline Reports follow an acceptable methodology in determining PIP aims, identifying barriers, and proposing interventions to address them. No validation findings suggest that the credibility of the PIPs results is at risk.

Opportunities for Improvement:

Not applicable.

General Recommendations for MassHealth:

None at this point.

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

Performance Measure Validation

IPRO validated the accuracy of performance measures 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. During the 2023 measurement year (MY), the slate of non-HEDIS measures included only measures of members' experiences with care, which were collected via the Primary Care Member Experience Survey (PC MES) conducted by MassHealth.

Strengths:

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

IPRO conducted performance measure validation to assess the accuracy of 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 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 MY 2023 Quality Compass® New England regional percentile, the best performance was found for the following measures:

- Timeliness of Prenatal Care: WellSense MCO 94.58% (≥ 90th percentile)
- Follow-up After Emergency Department Visit for Mental Illness (7 days): WellSense MCO 72.74% (≥ 90th percentile).

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:

- Follow-up After Hospitalization for Mental Illness (7 days): Both MCOs were at or above the 25th percentile but below the 50th percentile, so there is room for improvement.
- Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment: Tufts MCO 17.56% (≥ 25th but < 50th)
- PC MES Integration of Care+ Child: WellSense MCO: 82.08% (< Goal); Tufts MCO: 82.35% (< Goal)
- PC MES Willingness to Recommend+ Adult: WellSense MCO: 85.77% (< Goal); Tufts MCO: 85.46% (< Goal)

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.

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

Compliance Review

IPRO evaluated the compliance of MCOs with Medicaid managed care regulations.

Strengths:

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

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

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

The validation of MCOs conducted in CY 2024 demonstrated MCOs' commitment to their members and providers, as well as strong operations. Both WellSense and Tufts MCOs performed exceptionally well in several compliance domains, achieving 100% in the following areas: Enrollee Rights and Protections, Emergency and Post-stabilization Services, Assurances of Adequate Capacity and Services, Coverage and Authorization of Services, Provider Selection, Confidentiality, and Subcontractual Relationships and Delegation.

Opportunities for Improvement:

Gaps were identified in the areas of Health Information Systems (WellSense: 70%), Availability of Services (WellSense: 91%; Tufts: 93%), Quality Assurance and Performance Improvement (QAPI; WellSense: 94%), and Disenrollment Requirements and Limitations (Tufts: 95%). MCOs were not always able to describe established policies or identify policy documentation and provide evidence that all requirements are being implemented. The absence of policies can result in inconsistent practices and lead to variations in the quality of services provided.

General Recommendations for MassHealth:

- *Recommendation towards better policy documentation* – To encourage consistent practices and compliance with MassHealth standards, MassHealth should require MCPs to establish and maintain well-defined policies and procedures.

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:

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

MassHealth has established time and distance standards for adult and pediatric primary care providers (PCPs), obstetrics/gynecology (OB/GYN) providers, adult and pediatric behavioral health providers (for mental health and SUD), adult and pediatric specialists, hospitals, pharmacy services, and long-term services and supports

(LTSS). However, MassHealth did not develop standards for pediatric dental services, as these services are carved out from managed care.

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

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

A high confidence rating indicates that no issues were found with the underlying information systems, the MCP's provider data were clean, the correct MassHealth standards were applied, and the MCP's results matched the time and distance calculations independently verified by IPRO. Both MCOs received a high confidence rating for Pharmacy GeoAccess calculations and provider-to-member ratios, with no identified issues in the underlying information systems.

Opportunities for Improvement:

Although no issues were found with the underlying information systems, some MCPs did not apply the correct MassHealth standards for analysis, and/or their provider data contained numerous duplicate records. If multiple issues were identified in the network provider data submitted by MCPs, a moderate or low confidence rating was assigned. A moderate confidence rating was given for the PCP, specialist, and behavioral health services GeoAccess analysis.

After resolving data issues and removing duplicate records, IPRO assessed each MCO's provider network for compliance with MassHealth's time and distance standards. Access was evaluated for all provider types identified by MassHealth. The WellSense MCO had network deficiencies for 17 provider types in one or more service areas, while the Tufts MCO had deficiencies for six provider types in one or more service areas.

Additionally, IPRO conducted provider directory audits, verifying providers' telephone numbers, addresses, specialties, Medicaid participation, and panel status. The accuracy of provider directory information varied widely, and no provider directory accuracy thresholds were established. IPRO informed MCPs about errors identified in directory data.

The average wait times for an appointment were: 84 days for a PCP, 85 days for an OB/GYN, and 79 days for a cardiologist. However, these results are based on small samples and should be interpreted with caution.

General Recommendations for MassHealth:

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

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. 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 MY 2023. In addition, adult and pediatric MCO members were surveyed by MassHealth about their experiences with PCPs using the PC MES tool adapted from the CAHPS Clinician and Group Survey (CG-CAHPS) that assesses members experiences with providers and staff in physician practices and groups.

Opportunities for Improvement:

IPRO compared MCOs' top-box scores to national Medicaid performance reported in the MY 2023 Quality Compass. The MassHealth statewide weighted means were below the 75th percentile for most of adult and child CAHPS measures.

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 and PC MES data to evaluate MCOs' performance and to support the development of major initiatives and quality improvement strategies, accordingly.
- *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 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 better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.
- *Recommendation towards better policy documentation* – To encourage consistent practices and compliance with MassHealth standards, MassHealth should require MCPs to establish and maintain well-defined policies and procedures.
- *Recommendations towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access.
- *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 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.[5]

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.

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

MassHealth Managed Care Programs

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

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

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.

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**.

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

Under each managed care program, health plans are either required to calculate quality measure rates or the state calculates measure rates for the plans. Specifically, ACPPs, MCOs, SCOs, One Care Plans, and MBHP calculate HEDIS rates and are required to report on these metrics on a regular basis, whereas PC ACOs' 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 PCCP, all health plans and ACOs are required to develop at least two PIPs.

Member Experience of Care Surveys

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

For members enrolled in an ACPP, an MCO, a PCACO, and the PCCP, MassHealth conducts an annual survey adapted from the CAHPS Clinician and Group Survey (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 MBHP's Member Satisfaction Survey that MBHP conducts annually.

MassHealth Initiatives

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

1115 Demonstration Waiver

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

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

Roadmap for Behavioral Health

Another MassHealth initiative that supports the goals of the quality strategy is the five-year roadmap for behavioral health reform that was released in 2021. Key components of implementing this initiative include the 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 that became available in 2023. The Behavioral Health Help Line is free and available to all Massachusetts residents.[9]

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

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

Evaluation Process

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

The most recent evaluation of MassHealth's Quality Strategy was conducted in 2024, with results published on the MassHealth website in 2025.

Findings

The state assessed progress on each quality strategy goal and objective. Overall, MassHealth achieved goals 1 and 5 and made progress toward goals 2, 3, and 4. Areas for continued improvement include:

- Strengthening access to and engagement with coordinated LTSS and behavioral health services,
- Improving initiation and engagement in treatment for alcohol, opioid, and other substance use disorders,
- Reducing plan all-cause readmissions,
- Enhancing follow-up care for children prescribed ADHD medication,
- Addressing gaps in member experience, communication, and safety domains.

If a goal was not met or could not be measured, the state provided an explanation. For example, efforts toward goal 2 have focused on building capacity to reduce healthcare inequities. Now that these foundational processes are in place, MassHealth will modify its approach with the expectation of measuring progress on goal 2 more effectively in the future. Based on the evaluation, the state plans to maintain and revise several quality strategy goals to better align with evolving agency priorities.

Methodology

A goal was considered achieved if the established benchmark or Gap-to-Goal improvement target was met. MassHealth compared its MY 2022 aggregate measure rate (i.e., weighted mean across plans) to national and program-specific benchmarks. If the MY 2022 aggregate performance was below benchmarks, MassHealth applied the Gap-to-Goal methodology, as defined by CMS for the Medicare-Medicaid Quality Withholds (available at MMP Quality Withhold Technical Notes for DY 2 through 12). This methodology assessed changes in measure rates from MY 2020 (the baseline year) to MY 2022 (the comparison year).

If a quantifiable metric was not available to meaningfully evaluate progress on a specific goal, MassHealth provided a narrative response explaining that it is still developing an appropriate evaluation methodology.

[9] Behavioral Health Help Line FAQ. Available at: Behavioral Health Help Line (BHHL) FAQ | Mass.gov.

MassHealth monitors adult and child core set measures annually to track performance over time. In addition to MY 2022 findings, low performance was identified in the following MY 2023 child and adult core set measures:

- Low-Risk Cesarean Delivery
- Asthma Medication Ratio
- Plan All-Cause Readmission
- COPD or Asthma in Older Adults Admission Rate
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
- Use of Opioids at High Dosage in Persons Without Cancer
- Child & Adult CAHPS Measures

EQR Recommendations

The state addressed all EQR recommendations in its quality strategy evaluation, outlining the steps taken to implement improvements based on these recommendations.

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

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

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

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

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

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

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

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

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 of the Sixth 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 new PIPs in one of the following priority areas: health equity, prevention and wellness, and access to care. Specific MCO PIP topics are displayed in Table 3.

Table 3: MCO PIP Topics – CY 2024

MCO	PIP Topics
WellSense MCO	**PIP 1: PPC – Baseline Report** Improving prenatal and postpartum care outcomes in WellSense MCO members **PIP 2: HBD – Baseline Report** Increasing the rate of HbA1c control for WellSense MCO members with diabetes
Tufts MCO	**PIP 1: PPC – Baseline Report** Improving prenatal and postpartum care outcomes in Tufts Health Public Plan members **PIP 2: FUH – Baseline Report** Improving rates of follow-up visits within 7 days of a mental health discharge among Tufts Health Public Plan members

MCO: managed care organization; PIP: performance improvement project; CY: calendar year; PPC: Prenatal and Postpartum Care; HBD: Hemoglobin A1c Control for Patients with Diabetes; FUH: Follow-up After Hospitalization for Mental Illness.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet federal regulations, MassHealth contracted with IPRO, an EQRO, to perform the validation of PIPs conducted by MassHealth MCOs during CY 2024.

Technical Methods of Data Collection and Analysis

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

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

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

The projects started in January, and after the initial baseline reports were approved, IPRO conducted progress calls with all MCOs between October and December 2024.

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 assigns two validation ratings. The first rating assessed IPRO's overall confidence in the PIP's adherence to acceptable methodology throughout all project phases, including the design, data collection, data analysis, and interpretation of the results. The second rating evaluates IPRO's overall confidence in the PIP's ability to produce significant evidence of improvement and could not be assessed this year due to the fact that all projects started in 2024. Both ratings use the following scale: high confidence, moderate confidence, low confidence, and no confidence.

Rating 1: Adherence to Acceptable Methodology - Validation results summary

All four PIPs received a high confidence rating for adherence to acceptable methodology.

Rating 2: Evidence of Improvement - Validation results summary

The ratings for PIPs in terms of producing significant evidence of improvement was not applicable this year because the MCOs started their interventions during this review period.

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

Table 4: WellSense MCO PIP Validation Ratings – CY 2024

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: PPC	High Confidence	N/A
PIP 2: HBD	High Confidence	N/A

MCO: managed care organization; CY: calendar year; PIP: performance improvement project; PPC: Prenatal and Postpartum Care; HBD: Hemoglobin A1c Control for Patients with Diabetes; N/A: not applicable.

Table 5: Tufts MCO PIP Validation Ratings – CY 2024

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: PPC	High Confidence	N/A
PIP 2: FUH	High Confidence	N/A

MCO: managed care organization; CY: calendar year; PIP: performance improvement project; PPC: Prenatal and Postpartum Care; FUH: Follow-up After Hospitalization for Mental Illness; N/A: not applicable.

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

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, 2024

WellSense MCO PIP 1: Improving prenatal and postpartum care outcomes in WellSense MCO members
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – N/A
Aim Indicator 1: By the end of 2025, WellSense aims to increase the percentage of members who receive a recommended postpartum visit, after a live birth delivery between 10/8/PY and 10/7/MY by 5 percentage points compared to the MY 2023 baseline rate for eligible MassHealth MCO population. Indicator 2: By the end of 2025, WellSense aims to increase the percentage of members who receive a prenatal care visit in the first trimester, occurring on or before the enrollment start date or within 42 days of enrollment in the organization, between 10/8/PY and 10/7/MY by 5 percentage points compared to the MY 2023 baseline rate for eligible MassHealth MCO population. **Interventions in 2024** ▪ Outreach members with recent delivery to encourage follow up visits ▪ Email members educational materials related to pregnancy and postpartum care ▪ Develop a Prenatal Outreach program to focus on prenatal care education **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

MCO: managed care organization; PIP: performance improvement project; PY: performance year; MY: measurement year; CY: calendar year; N/A: not applicable.

Table 7: WellSense MCO PIP 1 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: Prenatal Care Visit	2024 (baseline, MY 2023 data)	82.86%
Indicator 2: Postpartum Visit	2024 (baseline, MY 2023 data)	71.43%

MCO: managed care organization; PIP: performance improvement project; MY: measurement year.

Table 8: WellSense MCO PIP 2 Summary, 2024

WellSense MCO PIP 2: Increasing the rate of HbA1c control for MassHealth MCO members with diabetes
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – N/A
Aim Indicator 1: By the end of 2025, WellSense aims to increase the percentage of members with a diagnosis of diabetes and whose most recent HbA1c result was adequately controlled (<8%) by six percent points compared to the MY 2023 baseline rate for the MassHealth MCO population. Indicator 2: By the end of 2025, WellSense aims to decrease the percentage of members with a diagnosis of diabetes and whose most recent HbA1c result was poorly controlled (>9%) by six percent points compared to the MY 2023 baseline rate for the MassHealth MCO population. **Interventions in 2023** ▪ Connect members to transportation services for appointments ▪ Implement a text campaign to encourage members to have their HbA1c tested regularly ▪ Conduct outreach calls to members with HbA1c >9% **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

MCO: managed care organization; PIP: performance improvement project; HbA1c: hemoglobin A1c; MY: measurement year; CY: calendar year; N/A: not applicable.

Table 9: WellSense MCO PIP 2 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: HbA1c < 8.0%	2024 (baseline, MY 2023 data)	62.96%
Indicator 2: HbA1c > 9.0%	2024 (baseline, MY 2023 data)	25.93%

MCO: managed care organization; PIP: performance improvement project; HbA1c: hemoglobin A1c.

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, 2024

Tufts MCO PIP 1: 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 – N/A
Aim Indicator 1: By the end of 2025 THP MCO aims to improve the rate of members who had timely prenatal care by 5 percentage points from the baseline rate of 60.58% to 65.58%. Indicator 2: By the end of 2025, THP MCO aims to increase the rate of members who had timely postpartum care by 5 percentage points from 70.32% to 75.32%. Indicator 3: By the end of 2025, THP MCO aims to maintain or reduce the percentage of members with diabetes and/or hypertension who had a hospital admission within 60 days of delivery. The goal is to keep the rate at 3.53% or less. Indicator 4: By the end of 2025 THP MCO aims to improve the rate of Black/African American members who had timely prenatal care by 5 percentage points from the baseline rate of 66.67% to 71.67%. Indicator 5: By the end of 2025, THP MCO aims to increase the rate of black/ African American members who had timely postpartum care by 5 percentage points from 83.00% to 88.00%. **Interventions in 2024** ▪ Connect high risk members to Obstetrical Care Management ▪ Offer members the Ovia app to provide support and education throughout pregnancy and postpartum ▪ Expand use of the maternal health dashboard to identify pregnant members **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

MCO: managed care organization; PIP: performance improvement project; THP: Tufts Health Plan; CY: calendar year; MY: measurement year; N/A: not applicable.

Table 11: Tufts MCO PIP 1 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: Prenatal Care Visit	2024 (baseline, MY 2023 data)	60.58%
Indicator 2: Postpartum Visit	2024 (baseline, MY 2023 data)	70.32%
Indicator 3: Postpartum admissions among members with diabetes, hypertension, or preeclampsia	2024 (baseline, MY 2023 data)	0.78%
Indicator 4: Timeliness of prenatal care for Black/African American members	2024 (baseline, MY 2023 data)	66.67%
Indicator 5: Timeliness of postpartum care for Black/African American members	2024 (baseline, MY 2023 data)	71.67%

MCO: managed care organization; PIP: performance improvement project; MY: measurement year.

Table 12: Tufts MCO PIP 2 Summary, 2024

Tufts MCO PIP 2: Improving rates of follow-up visits within 7 days of a mental health discharge among 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 – N/A
Aim By the end of 2025 THP MCO aims to increase the percentage of members who had a follow up visit within 7 days of mental health discharge by 5 percentage points compared to the MY 2023 baseline rate of 46.97% to 51.97%. **Interventions in 2024** ▪ Utilize the community partners program to outreach and assist members in scheduling follow up visits ▪ Utilize the service navigator program to connect members with behavioral health providers ▪ Partner with Valera Health, a virtual behavioral health group, to increase access to providers for follow up. **Performance Improvement Summary** ▪ Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

MCO: managed care organization; PIP: performance improvement project; THP: Tufts Health Plan; CY: calendar year; MY: measurement year; N/A: not applicable.

Table 13: Tufts MCO PIP 2 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: Follow-up After Hospitalization for Mental Illness within 7 days	2024 (baseline, MY 2023 data)	46.97%

MCO: managed care organization; PIP: performance improvement project; MY: measurement year.

IV. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

MassHealth 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 2.14.C.6 of the Sixth and Restated MassHealth MCO Contract.

For performance year (PY) 2023, MCOs were also required to report select HEDIS measures using allowable adjustments for the "Medicaid only" population. The measurement period for PY 2023 was April 1, 2023, through December 31, 2023.

In the prior years, MassHealth also evaluated MCO performance on a number of non-HEDIS measures (i.e., measures that are not reported to NCQA via the Interactive Data Submission System). However, for PY 2023, no non-HEDIS measures were in scope for reporting or validation.

MassHealth contracted with IPRO to conduct performance measure validation. IPRO assessed the accuracy of both HEDIS measures as reported via the Interactive Data Submission System and selected HEDIS measures with allowable adjustments for "Medicaid only" for PY 2023 from April 1, 2023, through December 31, 2023.

For HEDIS measures submitted through the Interactive Data Submission System, IPRO performed an independent evaluation of the MY 2023 HEDIS Compliance Audit Final Audit Reports, 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.[10] Since the MCOs' HEDIS rates submitted via the Interactive Data Submission System were audited by an independent NCQA-licensed HEDIS compliance audit organization, both plans received a full Information Systems Capabilities Assessment 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 with allowable adjustments for PY 2023 between April 1, 2023 and December 31, 2023. IPRO validated the "MCO only" PY 2023 HEDIS measure rates with allowable adjustments separately because the rates approved as part of the HEDIS Compliance Audit process and submitted to the NCQA via the Interactive Data Submission System, included both the MCO and ACO members.

For the HEDIS measures with allowable adjustments for PY 2023, IPRO conducted source code review to ensure compliance with the measure specifications, and NCQA allowed adjustments when calculating measures rates with allowable adjustments.

[10] The *CMS External Quality Review (EQR) Protocols,* published in February 2023, state that the Information Systems Capabilities Assessment 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 Information Systems Capabilities Assessment. The results of HEDIS compliance audits are presented in the HEDIS Final Audit Reports issued by each MCO's independent auditor.

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, Interactive Data Submission System files, the Final Audit Report, the Medicaid MCO only adjusted rates for PY 2023 rates, and the explanation for how the Medicaid only adjusted rates were calculated for PY 2023.

Conclusions and Comparative Findings

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

Table 14: MCO Compliance with Information System Standards – MY 2023

IS Standard	WellSense MCO	Tufts MCO
IS R Data Management and Reporting (formerly IS 6.0, IS 7.0)	Compliant	Compliant
IS C Clinical and Care Delivery Data (formerly IS 5.0)	Compliant	Compliant
IS M Medical Record Review Processes (formerly IS 4.0)	Compliant	Compliant
IS A Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)	Compliant	Compliant

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

Validation Findings

- Information Systems Capabilities Assessment: The Information Systems Capabilities Assessment is conducted to confirm that the MCOs' information systems were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, and provider data systems. 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 PY 2023 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 Final Audit Report confirmed that the MCOs used NCQA-certified measure vendors to produce the HEDIS rates. Source code review was conducted for each MCO's Medicaid only adjusted HEDIS measure rates for PY 2023. 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 Final Audit Report confirmed that the MCOs passed medical record review validation. No issues were identified.
- Primary Source Validation: Primary source validation is conducted to confirm that the information from the primary source matches the output information used for measure reporting. The review of each MCOs Final Audit Report 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 MCO's Final Audit Report 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 2023 Quality Compass New England regional percentiles for Medicaid health maintenance organizations.

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. No rates were below the 25th percentile.

Best Performance:

- Timeliness of Prenatal Care
  - WellSense MCO 94.58% (≥ 90th percentile)
- Follow-up After Emergency Department Visit for Mental Illness (7 days)
  - WellSense MCO 72.74% (≥ 90th percentile)

Needs 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.
- Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment
  - Tufts MCO 17.56% (≥ 25th but < 50th)

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 2023 for both MCOs and the weighted statewide means.

Table 15: Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2023 Quality Compass New England Regional Percentiles

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

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

Table 16: MCO-only HEDIS Performance Measures – MY 2023

Measure Steward/Acronym	HEDIS Measure	WellSense MCO	Tufts MCO	Weighted Statewide Mean
NCQA PPC	Timeliness of Prenatal Care	94.58% (≥ 90th)	89.13% (≥ 25th but < 50th)	92.78% (≥ 75th but < 90th)
NCQA PPC	Postpartum Care	86.25% (≥ 50th but < 75th)	85.87% (≥ 50th but < 75th)	86.12% (≥ 50th but < 75th)
NCQA FUH7	Follow-Up After Hospitalization for Mental Illness (7 days)	46.51% (≥ 25th but < 50th)	47.29% (≥ 25th but < 50th)	46.75% (≥ 25th but < 50th)
NCQA FUM7	Follow-up After Emergency Department Visit for Mental Illness (7 days)	72.74% (≥ 90th)	69.67% (≥ 50th but < 75th)	71.84% (≥ 75th but < 90th)
NCQA IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	52.02% (≥ 75th but < 90th)	43.08% (≥ 25th but < 50th)	48.92% (≥ 50th but < 75th)
NCQA IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	20.49% (≥ 50th but < 75th)	17.56% (≥ 25th but < 50th)	19.48% (≥ 50th but < 75th)
NCQA FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	39.03% (≥ 50th but < 75th)	41.61% (≥ 50th but < 75th)	39.61% (≥ 50th but < 75th)

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, IPRO compared the rates to the goal benchmarks determined by MassHealth. MassHealth goal benchmarks for MCOs were fixed targets.

Best Performance:

- PC MES Communication+ Child:
  - WellSense MCO: 96.39% (> Goal)
  - Tufts MCO: 93.20% (> Goal)
- PC MES Knowledge of Patient+ Adult:
  - WellSense MCO: 86.27% (> Goal)
  - Tufts MCO: 85.59% (> Goal)

Needs Improvement:

- PC MES Integration of Care+ Child:
  - WellSense MCO: 82.08% (< Goal)
  - Tufts MCO: 82.35% (< Goal)
- PC MES Willingness to Recommend+ Adult:
  - WellSense MCO: 85.77% (< Goal)
  - Tufts MCO: 85.46% (< Goal)

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

Table 18 shows non-HEDIS performance measures for MY 2023 for all MCOs and the weighted statewide mean. The PC MES survey results were fielded in 2024, for the 2023 program year.

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.
Not applicable (N/A)	N/A.

Table 18: MCO State-Specific Performance Measures – MY 2023

Measure Steward[1]	State Performance Measure	WellSense MCO	Tufts MCO	Weighted Statewide Mean	Goal Benchmark
EOHHS	PC MES Willingness to Recommend+ Adult	85.77% (< Goal)	85.46% (< Goal)	87.45% (< Goal)	92%
EOHHS	PC MES Willingness to Recommend+ Child	92.04% (> Goal)	90.45% (< Goal)	91.26% (< Goal)	92%
EOHHS	PC MES Communication+ Adult	91.85% (< Goal)	91.83% (< Goal)	92.87% (> Goal)	92%
EOHHS	PC MES Communication+ Child	96.39% (> Goal)	93.20% (> Goal)	95.65% (> Goal)	92%
EOHHS	PC MES Integration of Care+ Adult	83.12% (< Goal)	83.36% (< Goal)	85.09% (> Goal)	85%
EOHHS	PC MES Integration of Care+ Child	82.08% (< Goal)	82.35% (< Goal)	85.24% (< Goal)	90%
EOHHS	PC MES Knowledge of Patient+ Adult	86.27% (> Goal)	85.59% (> Goal)	86.45% (> Goal)	85%
EOHHS	PC MES Knowledge of Patient+ Child	90.71% (> Goal)	89.19% (< Goal)	89.40% (< Goal)	90%

[1] Survey results based on the 2023 program year, fielded in 2024.

MCO: managed care organization; MY: measurement year; EOHHS: Executive Office of Health and Human Services; Primary Care Member Experience Survey.

V. Review of Compliance with Medicaid Managed Care Regulations

Objectives

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Pre-interview Documentation Review

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

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

To facilitate the review process, IPRO provided MCOs with examples of documents that they could furnish to validate compliance with the regulations. Instructions regarding the file review component of the audit were

also provided, along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO randomly selected a sample of cases for the MCOs to provide in each area, which were reviewed remotely.

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

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

Remote Interviews

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

Post-interview Report Preparation

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

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

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

Scoring Methodology

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

MCP: managed care plan.

Description of Data Obtained

Compliance review tools included detailed regulatory and contractual requirements in each standard area. The 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.

Conclusions and Comparative Findings

MCO plans were compliant with many of the Medicaid and CHIP managed care regulations and standards. Both WellSense and Tufts MCOs performed exceptionally well in several compliance domains, achieving 100% in areas such as Enrollee Rights and Protections, Emergency and Post-stabilization Services, Assurances of Adequate Capacity and Services, Coverage and Authorization of Services, Provider Selection, Confidentiality, and Subcontractual Relationships and Delegation.

However, there are areas needing improvement:

- WellSense: Needs to work on Health Information Systems (70%), QAPI (94%), and Availability of Services (91%).
- Tufts: Should focus on improving Disenrollment Requirements and Limitations (95%) and Availability of Services (93%).

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

Table 20 presents compliance scores for each of the 14 domains for both MCOs.

Table 20: MCO Performance by Review Domain – 2024 Compliance Validation Results

CFR Standard Name	CFR Citation	WellSense MCO	Tufts MCO
Overall Compliance Score	N/A	96%	98%
Disenrollment Requirements and Limitations	438.56	100%	95%
Enrollee Rights and Protections	438.100	100%	100%
Emergency and Post-stabilization Services	438.114	100%	100%
Availability of Services	438.206	91%	93%
Assurances of Adequate Capacity and Services	438.207	100%	100%
Coordination and Continuity of Care	438.208	89%[1]	89%[1]
Coverage and Authorization of Services	438.210	100%	99.5%
Provider Selection	438.214	100%	100%
Confidentiality	438.224	100%	100%
Grievance and Appeal Systems	438.228	98%	98%
Subcontractual Relationships and Delegation	438.230	100%	100%
Practice Guidelines	438.236	95%	100%
Health Information Systems	438.242	70%[1]	99%
QAPI	438.330	94%	97%

[1] Red text: indicates opportunity for improvement (less than 90%).
CFR: Code of Federal Regulations; TBD: to be determined; QAPI: Quality Assurance and Performance Improvement.

VI. Validation of Network Adequacy

Objectives

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

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

MassHealth's access and availability standards are described in Section 2.10 and Appendix N of *the Sixth Amended and Restated MassHealth MCO Contract*. MassHealth's requirements pertaining to provider directories are described in Section 2.8.E of the same contract. The state requires MCOs to report changes to the provider network monthly and update provider directories no later than 30 calendar days after being made aware of any change in information. MCOs are contractually required to meet the standards for appointment availability (i.e., standards for the duration of time between an enrollee's request for an appointment and the provision of services), GeoAccess standards (i.e., travel time and distance standards), and the 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 MCOs' processes for collecting and storing network data, provider networks' compliance with MassHealth's GeoAccess requirements, the accuracy of the information presented in MCOs' online provider directories, and compliance with the standards for appointment wait times.

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

Technical Methods of Data Collection and Analysis

This section explains the methodology behind each one of the three elements of network adequacy validation: validation of the underlying information systems, validation of compliance with MassHealth's travel time and distance standards, and the validation of compliance with MassHealth's standards for appointment wait times.

Network Information Systems Validation Methodology

The Information System Capacity Assessment is a component of the performance measure validation EQR activity, during which MCPs submit the results of their HEDIS audits for deeming. To complement the already existing assessments, IPRO evaluated the integrity of the systems used to collect, store, and process provider network data.

IPRO developed a survey in Research Electronic Data Capture (REDCap®) to support this effort. The survey questions addressed topics such as the systems used to collect and store provider data for network analysis; methods of data entry; the roles of staff involved in collecting, storing, and analyzing data; the frequency of data collection and updates; the extent of missing data; and the quality assurance measures in place to prevent and correct errors.

The survey was distributed to MCPs on July 8, 2024, and closed on August 23, 2024. IPRO will also schedule individual interview sessions with each MCP to supplement understanding of the MCP's information systems and processes.

Provider Directory and Availability of Appointments Methodology

The accuracy of provider directories and availability of appointments were assessed using secret shopper surveys. In a secret shopper survey, callers acted as members and attempted to schedule an appointment, documenting the date of the next available appointment or barriers to making the appointment. The audited specialties are listed in Table 21.

Table 21: Audited Specialties

Reporting Group	Specialty
Primary care	Family medicine Internal medicine Pediatrics
Specialists	Obstetrics/Gynecology (Ob/Gyn) Cardiology

Using the MCO online provider directories, PDF versions of the plan directories were downloaded, and computer code was used to scrape the data, creating a database of providers. Due to inherent variations in provider directory layouts this process may have resulted in a small percentage of errors. The findings should be interpreted with caution.

To ensure a statistically sound methodology, random and statistically significant samples were selected for each plan and provider type. The samples were reviewed for overlaps to create a "calling sample size" and to ensure that the same providers were not contacted multiple times.

To validate the accuracy of the information published in the provider directories, surveyors contacted a sample of practice sites to confirm providers' participation with the Medicaid MCP, telephone number, and address, as well as record the open panel status for listed specialty. IPRO reported the percentage of providers in the sample with verified and correct information.

IPRO also inquired about the wait times for the next available sick and routine appointments. Callers were provided with scenarios to use when attempting to schedule appointments. Each scenario was designed to address both the routine and sick visit standards, allowing responses to be captured in a single call.

MassHealth's appointment availability standards for MCOs are detailed in Table 22. Standards highlighted in gray are for provider types not included in the survey.

Table 22: Availability Standards

Provider Type	Urgency Level	MCO/ACPP Sec. 2.10.B
Emergency services[1]	Emergency	Immediately
Urgent care[1]	Urgent/Symptomatic	48 hours
MCO/ACPP PCP: internal medicine, family medicine, pediatrics	Nonurgent symptomatic: sick visit	10 calendar days
MCO/ACPP PCP: internal medicine, family medicine, pediatrics	Nonsymptomatic: routine visit	45 calendar days
MCO/ACPP specialty provider: ob/gyn, cardiology	Nonurgent symptomatic: sick visit	30 calendar days
MCO/ACPP specialty provider: ob/gyn, cardiology	Nonsymptomatic: routine visit	60 calendar days
Behavioral health (BH) services[1]	Nonurgent BH services	14 calendar days

[1] Gray cells: provider types not included in the survey.
MCO: managed care organization; ACPP: accountable care partnership plan; PCP: primary care provider; ob/gyn: obstetrics/gynecology.

Travel Time and Distance Validation Methodology

For 2024, IPRO evaluated each MCP's provider network to determine compliance with network GeoAccess standards established by MassHealth. According to the MCO contracts, at least 90% of health plan members in each MCO service area must have access to in-network providers following the time or distance standards defined in the contract.

IPRO reviewed MassHealth GeoAccess standards and worked together with the state to define network adequacy indicators. Network adequacy indicators were updated to reflect all changes to the contract requirements for CY 2024. MCO network adequacy standards and indicators are listed in Appendix D (Tables D1–D6).

IPRO requested in-network provider data on July 8, 2024, with a submission due date of August 23, 2024. MCPs submitted data to IPRO following templates developed by MassHealth and utilized by MCOs and ACPPs to report provider lists to MassHealth on an annual basis. The submitted data went through a careful and significant data cleanup and deduplication process. If IPRO identified missing or incorrect data, the plans were contacted and asked to resubmit. Duplicative records were identified and removed before the analysis.

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

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

In addition to GeoAccess reports, IPRO calculated the provider-to-member ratios. MCO contracts define required provider-to-member ratios for PCPs and ob/gyn providers, as defined in Table 23.

Table 23: Provider-to-Member Ratios

Provider Type	Goal	Provider-to-member ratio definition
Adult primary care provider (PCP)	1:750	The number of all in-network adult PCPs (i.e., internal medicine and family medicine) against the number of all members ages 21 to 64 years. Calculated for all providers (i.e., providers with open and closed panels).
Pediatric PCP	1:750	The number of all in-network pediatric PCPs (i.e., pediatricians and family medicine) against the number of all members ages 0 to 20 years. Calculated for all providers (i.e., providers with open and closed panels).
Obstetricians/Gynecologists (Ob/Gyns)	1:500	The number of all in-network ob/gyns against the number of all female members ages 10+ years. Calculated for all providers (i.e., providers with open and closed panels).
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 providers	N/A	Provider-to-member ratio not required. Did not calculate.

N/A: not applicable.

Description of Data Obtained

All data necessary for analysis were obtained from MassHealth and the MCPs between July 8 and December 31, 2024. Before requesting data from the MCPs, IPRO consulted with MassHealth and confirmed the variables necessary for the network adequacy validation, agreed on the format of the files, and reviewed the information systems survey form.

Network Information Systems Capacity Assessment Data

Each MCP received a unique URL link via email to a REDCap survey. The survey was open from July 8, 2024, until August 3, 2024.

Provider Directory and Availability of Appointment Data

For the provider directory validation, provider directory web addresses were reported to IPRO by the MCPs and are presented in Appendix E. The practice sites were contacted between October and December 2024.

Travel Time and Distance Data

Validation of network adequacy for CY 2024 was performed using network data submitted by MCPs to IPRO. IPRO requested a complete provider list which included facility/provider name, address, phone number, and the national provider identifier for the following provider types: primary care, ob/gyn, hospitals, rehabilitation, urgent care, specialists, behavioral health, and pharmacy. For PCPs, panel status and providers' non-English language information were also requested. IPRO received a complete list of Medicaid enrollees from each MCP. Provider and member enrollment data as of July 1, 2024, were submitted to IPRO via IPRO's secure file transfer protocol site. MCPs also submitted the results of their time and distance analysis to IPRO.

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

Conclusions and Findings

After assessing the reliability and validity of the MCP's network adequacy data, processes, and methods used by the MCP to assess network adequacy and calculate each network adequacy indicator, IPRO determined

whether the data, processes, and methods used by the MCP to monitor network adequacy were accurate and current.

IPRO also validated network adequacy results submitted by the MCPs and compared them to the results calculated by IPRO to assess whether the MCP's results were valid, accurate, and reliable, as well as if the MCP's interpretation of data was accurate.

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

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

For a few indicators, namely provider-to-member ratios, the accuracy of provider directories, and appointment wait times, IPRO did not assess MCP methods of calculating the indicator but instead calculated the indicator itself. In those instances, the network adequacy validation rating reflects IPRO's confidence that the MCP's network meets MassHealth's standards and expectations.

The network adequacy validation rating for each indicator is reported in **Table 24**. Detailed descriptions for each plan's validation ratings can be found in the plan-specific results sections below.

Table 24: MCOs Network Adequacy Validation Ratings – CY 2024

Network Adequacy Indicator	WellSense MCO Validation Rating	Tufts MCO Validation Rating
PCP GeoAccess	Moderate confidence	Moderate confidence
Ob/Gyn GeoAccess	Low confidence	Moderate confidence
Physical Health Services GeoAccess	Moderate confidence	High confidence
Specialists GeoAccess	Moderate confidence	Moderate confidence
Behavioral Health Services GeoAccess	Moderate confidence	Moderate confidence
Pharmacy GeoAccess	High confidence	High confidence
Provider-to-Member Ratios[1]	High confidence	High confidence
Accuracy of Directories[1]	Moderate confidence	Moderate confidence

Network Adequacy Indicator	WellSense MCO Validation Rating	Tufts MCO Validation Rating
Wait Time for Appointment[2]	Not Reportable	Not Reportable

[1] IPRO did not assess the MCP's methods of calculating the indicator but instead calculated the indicator itself. The network adequacy validation rating reflects IPRO's confidence that the MCP's network meets MassHealth's standards and expectations.
[2] Fewer than 30 providers were able to be contacted. There is not enough information to draw plan-level conclusions; only program-level results are reported.
MCO: managed care organization; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; TBD: to be determined; MCP: managed care plan.

Network Information Systems Survey

The analysis of the information systems assessment showed the following:

- The Information Systems Capabilities Assessment was conducted to confirm that the MCOs' information systems were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This included a review of the claims processing systems, enrollment systems, and provider data systems. IPRO reviewed MCO HEDIS Final Audit Reports issued by the MCOs' independent NCQA-certified HEDIS compliance auditors. No issues were identified.
- IPRO assessed the reliability and validity of MCP network adequacy data. IPRO determined that the data used by the MCP to monitor network adequacy were mostly accurate and current except for duplicative provider records and incorrect provider directory information, which was shared with the MCP via email.
- IPRO reviewed the MPC's process for updating data (i.e., provider and beneficiary information) and concluded that the MCP process for updating data should include a method for assessing the accuracy of provider information published in the online provider directory.
- IPRO assessed changes in the MCP's data systems that might affect the accuracy or completeness of network adequacy monitoring data (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs). No issues were identified.

Provider Directory

IPRO validated the accuracy of provider directories for a sample of provider types chosen by MassHealth. Tables 25–27 show the percentage of providers in the directory with verified telephone number, address, specialty, and Medicaid participation. MassHealth did not establish a goal for the provider directory activity.

Table 25: Provider Directory Accuracy – Primary Care Providers

Provider Directory Accuracy	WellSense MCO % (n)[2]	Tufts MCO % (n)[2]
Primary care providers (PCPs)[1]	47.86% (67)	7.37% (16)
Total PCPs called	140	217

[1] Primary care providers (PCPs) include family medicine, internal medicine, and pediatric providers.
[2] (n) is the number of providers in the sample for whom the contact information was correct.
Note: The sample is representative of the population with a 95% confidence interval and +/- 5% margin of error.
MCO: managed care organization.

Table 26: Provider Directory Accuracy – Obstetrics/Gynecology

Provider Directory Accuracy	WellSense MCO % (n)[1]	Tufts MCO % (n)[1]
Ob/Gyn	27.18% (28)	19.05% (8)
Total ob/gyns called	103	42

[1] (n) is the number of providers in the sample for whom the contact information was correct.
Note: The sample is representative of the population with a 90% confidence interval and +/- 7% margin of error.
MCO: managed care organization; Ob/Gyn: obstetricians/gynecologists.

Table 27: Provider Directory Accuracy – Cardiologists

Provider Directory Accuracy	WellSense MCO % (n)[1]	Tufts MCO % (n)[1]
Cardiologists	43.40% (46)	38.46% (40)
Total cardiologists called	106	104

[1] (n) is the number of providers in the sample for whom the contact information was correct.
Note: The sample is representative of the population with a 90% confidence interval and +/- 7% margin of error.
MCO: managed care organization.

Tables 28–30 show the most frequent reasons why information in the directories was incorrect or could not be validated.

Table 28: Directory Inaccuracy/Provider Verification Challenges – Primary Care Providers

Type of Failure	MCO Total	WellSense MCO	Tufts MCO
Contact fails[1]	159	41	118
Provider not at the site[2]	91	18	73
Provider reported a different specialty[3]	4	2	2
Provider does not accept Medicaid	4	2	2
Provider is retired	2	1	1
Refused to participate (e.g., hung up)	1	0	1
Wrong address	11	9	2
Total	272	73	199

[1] Contact fails = wrong telephone number, no answer, disconnected phone number, constant busy signal, put on hold for more than five minutes, answering service.
[2] Provider not at the site = provider left group or was never part of group.
[3] Provider reported a different specialty = provider is a hospitalist; urgent care facility/nursing home facility.
MCO: managed care organization.

Table 29: Directory Inaccuracy/Provider Verification Challenges – Obstetrics/Gynecology

Type of Failure	MCO Total	WellSense MCO	Tufts MCO
Contact fails[1]	45	32	13
Provider not at the site[2]	31	23	8
Wrong address	26	18	8
Provider reported a different specialty[3]	3	1	2
Provider does not accept Medicaid	3	1	2
Provider is retired	0	0	0
Refused to participate (e.g., hung up)	0	0	0
Total	108	75	33

[1] Contact fails = wrong telephone number, no answer, disconnected phone number, constant busy signal, put on hold for more than five minutes, answering service .
[2] Provider not at the site = provider left group or was never part of group.
[3] Provider reported a different specialty = provider is a hospitalist; urgent care facility/nursing home facility.
MCO: managed care organization.

Table 30: Directory Inaccuracy/Provider Verification Challenges – Cardiologists

Type of Failure	MCO Total	WellSense MCO	Tufts MCO
Contact fails[1]	66	36	30
Wrong address	28	16	12
Provider not at the site[2]	24	7	17
Provider is retired	2	0	2
Provider does not accept Medicaid	2	1	1
Provider reported a different specialty[3]	1	0	1
Refused to participate (e.g., hung up)	1	0	1
Total	124	60	64

[1] Contact fails = wrong telephone number, no answer, disconnected phone number, constant busy signal, put on hold for more than five minutes, answering service.
[2] Provider not at the site = provider left group or was never part of group.
[3] Provider reported a different specialty = provider is a hospitalist; urgent care facility/nursing home facility.
MCO: managed care organization.

Wait Time for Appointment

The results of the wait time for appointment survey are listed below. **Tables 31-33** show the wait time for appointment results for PCPs.

Table 31: Average Appointment Wait Time – PCPs

MassHealth Wait Time Standards	MCO Average Calendar Days to Appt. (Min-Max)
Timely Routine Appt Rate (non-symptomatic): 45 Calendar Days Timely Sick Appt Rate (non-urgent, symptomatic): 10 Calendar Days	84 (7-364)
Total Providers Reached (N)	27

Range (Min-Max) indicates the span between the shortest wait time recorded and the longest wait time recorded in calendar days.
N = Total Providers Reached, which is calculated as the number of providers for whom the survey was successfully completed and the secrete shopper was ABLE to get an appointment date.

Table 32: Reasons Not Able to Get an Appointment Date – PCPs

Reasons Not Able to Get an Appointment Date	MCO Total
Medicaid ID required[1]	12
Others[2]	10
Provider not accepting new patients	47
Contact Fails[3]	159
Provider not at the site[4]	91
Provider reported a different specialty[5]	4
Provider does not accept Medicaid	4
Provider is retired	2
Refused to Participate (e.g. Hung up)	1
Total	330

[1] Medicaid ID required = Medicaid ID required to schedule an appt date, need to be registered to make an appt, etc.
[2] Others = New patient waitlist, booking out 6 months, accepting new patients but no availability for that provider, etc.
[3] Contact fails = wrong telephone number, no answer, disconnected phone number, constant busy signal, put on hold for more than five minutes, answering service.
[4] Provider not at the site = provider left group or was never part of group.
[5] Provider reported a different specialty = provider is a hospitalist; urgent care facility/nursing home facility.

Table 33: Appointment Wait Time Standards Met – PCPs

MassHealth Wait Time Standards	MCO Providers Meeting the Standard % (n)
Timely Routine Appt Rate (non-symptomatic): 45 Calendar Days	33.33% (9)
Timely Sick Appt Rate (non-urgent, symptomatic): 10 Calendar Days	7.41% (2)
Total Providers Reached (N)	27

N = Total Providers Reached, which is calculated as the number of providers for whom the survey was successfully completed an d the secrete shopper was ABLE to get an appointment date.

Tables 34- 36 show the wait time for appointment results for Obstetrics/Gynecology.

Table 34: Average Appointment Wait Time – Obstetrics/Gynecology

MassHealth Wait Time Standards	MCO Average Calendar Days to Appt. (Min-Max)
Timely Routine Appt Rate (non-symptomatic): 45 Calendar Days Timely Sick Appt Rate (non-urgent, symptomatic): 10 Calendar Days	85 (14-209)
Total Providers Reached (N)	20

Range (Min-Max) indicates the span between the shortest wait time recorded and the longest wait time recorded in calendar days.
N = Total Providers Reached, which is calculated as the number of providers for whom the survey was successfully completed an d the secrete shopper was ABLE to get an appointment date.

Table 35: Reasons Not Able to Get an Appointment Date – Obstetrics/Gynecology

Reasons Not Able to Get an Appointment Date	MCO Total
Medicaid ID required[1]	11
Others[2]	21
Provider not accepting new patients	11
Contact Fails[3]	45

Provider not at the site[4]	31
Provider reported a different specialty[5]	3
Provider does not accept Medicaid	3
Provider is retired	0
Refused to Participate (e.g. Hung up)	0
Total	125

[1] Medicaid ID required = Medicaid ID required to schedule an appt date, need to be registered to make an appt, etc.
[2] Others = New patient waitlist, booking out 6 months, accepting new patients but no availability for that provider, etc.
[3] Contact fails = wrong telephone number, no answer, disconnected phone number, constant busy signal, put on hold for more than five minutes, answering service.
[4] Provider not at the site = provider left group or was never part of group.
[5] Provider reported a different specialty = provider is a hospitalist; urgent care facility/nursing home facility.

Table 36: Appointment Wait Time Standards Met – Obstetrics/Gynecology

MassHealth Wait Time Standards	MCO Providers Meeting the Standard % (n)
Timely Routine Appt Rate (non-symptomatic): 60 Calendar Days	40.00% (8)
Timely Sick Appt Rate (non-urgent, symptomatic): 30 Calendar Days	10.00% (2)
Total Providers Reached (N)	20

N = Total Providers Reached, which is calculated as the number of providers for whom the survey was successfully completed and the secrete shopper was ABLE to get an appointment date.

Tables 37- 39 show the wait time for appointment results for Cardiology.

Table 37: Average Appointment Wait Time – Cardiologists

MassHealth Wait Time Standards	MCO Average Calendar Days to Appt. (Min-Max)
Timely Routine Appt Rate (non-symptomatic): 60 Calendar Days Timely Sick Appt Rate (non-urgent, symptomatic): 30 Calendar Days	79 (8-186)
Total Providers Reached (N)	18

Range (Min-Max) indicates the span between the shortest wait time recorded and the longest wait time recorded in calendar days.
N = Total Providers Reached, which is calculated as the number of providers for whom the survey was successfully completed and the secrete shopper was ABLE to get an appointment date.

Table 38: Reasons Not Able to Get an Appointment Date – Cardiologists

Reasons Not Able to Get an Appointment Date	MCO Total
Medicaid ID required[1]	14
Others[2]	74
Provider not accepting new patients	8
Contact Fails[3]	66
Provider not at the site[4]	24
Provider is retired	2
Provider does not accept Medicaid	2
Provider reported a different specialty[5]	1
Refused to Participate (e.g. Hung up)	1
Total	192

[1] Medicaid ID required = Medicaid ID required to schedule an appt date, need to be registered to make an appt, etc.
[2] Others = New patient waitlist, booking out 6 months, accepting new patients but no availability for that provider, etc.
[3] Contact fails = wrong telephone number, no answer, disconnected phone number, constant busy signal, put on hold for more than five minutes, answering service.
[4] Provider not at the site = provider left group or was never part of group.
[5] Provider reported a different specialty = provider is a hospitalist; urgent care facility/nursing home facility.

Table 39: Appointment Wait Time Standards Met – Cardiologists

MassHealth Wait Time Standards	MCO Providers Meeting the Standard % (n)
Timely Routine Appt Rate (non-symptomatic): 60 Calendar Days	38.89% (7)
Timely Sick Appt Rate (non-urgent, symptomatic): 30 Calendar Days	5.56% (1)
Total Providers Reached (N)	18

N = Total Providers Reached, which is calculated as the number of providers for whom the survey was successfully completed an d the secrete shopper was ABLE to get an appointment date.

Travel Time and Distance

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

MassHealth divided the state into 38 service areas and five 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 40 shows the number of service areas that each MCO covers.

Table 40: Number of Service Areas and Regions

Number	WellSense MCO[1]	Tufts MCO
Number of service areas	38	26
Number of regions	5	4

[1] WellSense MCO has members residing in the Oak Bluffs and Nantucket service areas, which have unique standards for primary care providers, obstetricians/gynecologists, specialists, and acute inpatient hospitals.
MCO: managed care organization.

Tables 41–45 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.

Table 41: Service Areas with Adequate Network of PCPs, Ob/Gyns, and Pharmacy Providers

Provider Type[1]	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	35 out of 38 (Partially Met)	26 out of 26 (Met)
Ob/Gyn	2 providers within 15 miles or 30 minutes	37 out of 38 (Partially Met)	26 out of 26 (Met)
Pharmacy providers	1 pharmacy within 15 miles or 30 minutes	38 out of 38 (Met)	26 out of 26 (Met)

[1] Black text indicates Met; red text indicates Partially Met.

PCP: primary care provider; ob/gyn: obstetrician/gynecologist; MCO: managed care organization.

Table 42: Service Areas with Adequate Network of Physical Health Services Providers

Provider Type[1]	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	37 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)

[1] Black text indicates Met; red text indicates Partially Met.
MCO: managed care organization.

Table 43: Service Areas with Adequate Network of Specialist Providers

Provider Type[1]	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)
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)

Provider Type[1]	Standard – 90% of Members Have Access	WellSense MCO	Tufts MCO
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)

[1] Black text indicates met; red text indicates partially met.
MCO: managed care organization.

Table 44: MCOs with Adequate Network of Allergy Providers and Oral/Plastic/Vascular Surgeons

Provider Type[1]	Standard[1]	WellSense MCO	Tufts MCO
Allergy medicine	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)

[1] There are no time-or-distance standards for allergy providers, oral surgeons, plastic surgeons, and vascular surgeons. The managed care organization (MCO) must show that they have at least one allergy provider, oral surgeon, plastic surgeon, vascular surgeon in their network.

Table 45: Service Areas with Adequate Network of Behavioral Health Providers

Provider Type[1]	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)	26 out of 26 (Met)

Provider Type[1]	Standard – 90% of Members Have Access	WellSense MCO	Tufts MCO
Psychiatric inpatient adolescent	2 providers within 60 miles or 60 minutes	37 out of 38 (Partially Met)	26 out of 26 (Met)
Managed inpatient level 4	2 providers within 60 miles or 60 minutes	25 out of 38 (Partially Met)	18 out of 26 (Partially Met)
Monitored inpatient level 3.7	2 providers within 30 miles or 30 minutes	24 out of 38 (Partially Met)	22 out of 26 (Partially Met)
Clinical stabilization service level 3.5	2 providers within 30 miles or 30 minutes	25 out of 38 (Partially Met)	21 out of 26 (Partially Met)
CBAT-ICBAT-TCU	2 providers within 30 miles or 30 minutes	17 out of 38 (Partially Met)	26 out of 26 (Met)
Partial hospitalization program (PHP)	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)	23 out of 26 (Partially Met)
Residential rehabilitation services for substance use disorders level 3.1	2 providers within 30 miles or 30 minutes	31 out of 38 (Partially Met)	26 out of 26 (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	38 out of 38 (Met)	26 out of 26 (Met)
Therapeutic mentoring services	2 providers within 30 miles or 30 minutes	38 out of 38 (Met)	26 out of 26 (Met)
Community crisis stabilization	2 providers within 30 miles or 30 minutes	38 out of 38 (Met)	26 out of 26 (Met)
Structured outpatient addiction program (SOAP)	2 providers within 30 miles or 30 minutes	33 out of 38 (Partially Met)	26 out of 26 (Met)
BH outpatient (including psychology and psychiatric 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)
Recovery support navigators	2 providers within 30 miles or 30 minutes	35 out of 38 (Partially Met)	26 out of 26 (Met)
Recovery coaching	2 providers within 30 miles or 30 minutes	38 out of 38 (Met)	26 out of 26 (Met)
Opioid treatment programs (OTP)	2 providers within 30 miles or 30 minutes	36 out of 38 (Partially Met)	16 out of 26 (Partially Met)

[1] Black text indicates met; red text indicates partially met.

MCO: managed care organization; CBAT: community-based acute treatment; ICBAT: intensive community-based acute treatment; TCU: transitional care unit; BH: behavioral health; APN: advanced practice nurse.

Provider-to-Member Ratios

IPRO calculated the provider-to-member ratios for adult PCP, pediatric 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, the ratio of 1:90 (1 provider per 90 members) is better compared to the goal of 1:750 (1 provider per 750

members), as it indicates that there are fewer members for each provider. Both MCOs met the provider-to-member standards defined by MassHealth (Tables 46–47).

Table 46: MCO Provider-to-Member Ratios for PCPs and Ob/Gyns

Provider Type[1]	Goal	WellSense MCO	Tufts MCO
Adult PCP	1:750	1:68 (Met)	1:23 (Met)
Pediatric PCP	1:750	1:33 (Met)	1:20 (Met)
Ob/Gyn	1:500	1:14 (Met)	1:15 (Met)

[1] A lower provider-to-member ratio is better.
MCO: managed care organization; PCP: primary care provider; ob/gyn: obstetrician/gynecologist.

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

Table 47: MCO Provider to Member Ratios for Specialists

Provider Type[1]	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
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	1:3,726	1:265

[1] A lower provider-to-member ratio is better.
MCO: managed care organization; N/A: not applicable.

WellSense MCO

More information about WellSense MCO's network adequacy validation rating is provided in Table 48.

Table 48: WellSense MCO Network Adequacy Validation Ratings – CY 2024

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating WellSense MCO	Comments
PCP GeoAccess	• 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP applied the correct MassHealth standards for analysis for pediatric PCPs; however, the MCP's provider data had some duplicative records. IPRO compared the pediatric PCP results and found that IPRO and WellSense MCO had identical results in all but three service areas. IPRO's analysis of the network revealed that the GeoAccess standard was met in all service areas except for pediatric PCPs in three service areas.
Ob/Gyn GeoAccess	• 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.	Addressed	Low confidence	No issues were found with the underlying information systems; however, the MCP did not apply the correct MassHealth standards for analysis, and the MCP's provider data had many duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standard was met in all service areas except Orleans.
Physical Health Services GeoAccess	• 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems; however, the MCP's provider data were clean except for one duplicative record for acute inpatient hospitals and three records for urgent care services. The MCP applied the incorrect MassHealth standards for rehabilitation hospitals. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed gaps in the urgent care network and rehabilitation hospital network in one service area.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating WellSense MCO	Comments
Specialists GeoAccess	• 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. • 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP applied the correct MassHealth standards for analysis; however, the MCP's provider data had many duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standards were met in all service areas except for audiology in the Adams service area.
Behavioral Health Services GeoAccess	• 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems; however, the MCP did not apply the correct MassHealth standards for analysis for Nantucket and Oak Bluffs, and the MCP's provider data had many duplicative records. IPRO could only compare results for the Monitored Inpatient Level 3.7 and Psychiatric Inpatient Adolescent networks. IPRO's analysis of the network revealed gaps for 12 provider types in multiple service areas.
Pharmacy GeoAccess	• 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.	Addressed	High confidence	No issues were found with the underlying information systems. The MCP's provider data were clean, the MCP applied the correct MassHealth standards for analysis, and the results calculated by the MCP matched the time-and-distance results calculated by IPRO. IPRO's analysis of the network revealed that the GeoAccess standards were met in all service areas.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating WellSense MCO	Comments
Provider-to-Member Ratios[2]	• Adult PCP Ratio: 1:750 • Pediatric PCP Ratio: 1:750 • Ob/Gyn Ratio: 1:500	Addressed	High confidence	IPRO's analysis showed that the MCP's network meets the provider-to-member standards.
Accuracy of Directories[2]	• Percent of providers in the directory with correct information	Missing[3]	Moderate confidence	IPRO's analysis showed that the information in the PCP, ob/gyn, and cardiology providers directories is not entirely accurate.

[1] "Addressed" means that the indicator was required to be reported to the state and the managed care plan (MCP) submitted the report to the state. "Missing" means that the indicator was either not required or required but not reported.
[2] IPRO did not assess the MCP's methods of calculating the indicator but instead calculated the indicator itself. The network adequacy validation rating reflects IPRO's confidence that the MCP's network meets MassHealth's standards and expectations.
[3] Although the state requires MCPs to report changes to the provider network and update their directories no later than 30 calendar days after being made aware of any changes in information, the MCPs are not required to report what percentage of the directory information is accurate.
MCO: managed care organization; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; TBD: to be determined.

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. However, 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 49–52 show service areas with deficient networks for WellSense MCO.

Table 49: WellSense MCO Service Areas with Network Deficiencies – PCPs, Ob/Gyn, and Pharmacy

Provider Type	Service Areas with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Pediatric PCP (Open Panel Only)	Attleboro	66.0%	2 providers within 15 miles or 30 minutes
Pediatric PCP (Open Panel Only)	Oak Bluffs	0.0%[1]	2 providers within 40 miles or 40 minutes
Pediatric PCP (Open Panel Only)	Pittsfield	88.2%	2 providers within 15 miles or 30 minutes
Ob/Gyn (Open Closed Panel)	Orleans	84.1%	2 providers within 15 miles or 30 minutes

[1] WellSense MCO services Oak Bluffs, but there are no pediatric members residing there.
MCO: managed care organization. PCP: primary care provider; Ob/Gyn: obstetrician/gynecologists.

Table 50: WellSense 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
Rehabilitation Hospital	Adams	84.4%	1 provider within 30 miles or 60 minutes
Urgent Care Services	Nantucket[1]	0.0%	1 provider within 15 miles or 30 minutes

[1] In lieu of Urgent Care Services on Nantucket, plans are allowed to substitute for Emergency Departments (EDs). However, WellSense did not include Emergency Departments in their data submissions, therefore EDs were not included in the analysis. As a result, WellSense is likely meeting the standard despite appearances.
MCO: managed care organization.

Table 51: WellSense MCO Service Areas with Network Deficiencies – Specialty Providers

Provider Type	Service Areas with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Audiology	Gardner-Fitchburg	86.8%	1 provider within 20 miles or 40 minutes

MCO: managed care organization.

Table 52: WellSense 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	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
Managed inpatient level 4 (MIL4)	Adams	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Athol	79.9%	2 providers within 60 miles or 60 minutes
MIL4	Barnstable	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
MIL4	Falmouth	16.5%	2 providers within 60 miles or 60 minutes
MIL4	Greenfield	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Holyoke	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Nantucket	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Northampton	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Oak Bluffs	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Orleans	11.3%	2 providers within 60 miles or 60 minutes
MIL4	Pittsfield	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Springfield	2.6%	2 providers within 60 miles or 60 minutes
MIL4	Westfield	0.0%	2 providers within 60 miles or 60 minutes
Monitored inpatient level 3.7 (MIL3.7)	Adams	0.0%	2 providers within 30 miles or 30 minutes
MIL3.7	Athol	9.8%	2 providers within 30 miles or 30 minutes
MIL3.7	Gardner-Fitchburg	78.0%	2 providers within 30 miles or 30 minutes
MIL3.7	Gloucester	88.0%	2 providers within 30 miles or 30 minutes
MIL3.7	Greenfield	0.0%	2 providers within 30 miles or 30 minutes
MIL3.7	Haverhill	89.4%	2 providers within 30 miles or 30 minutes
MIL3.7	Holyoke	2.5%	2 providers within 30 miles or 30 minutes
MIL3.7	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
MIL3.7	Northampton	2.4%	2 providers within 30 miles or 30 minutes
MIL3.7	Oak Bluffs	58.3%	2 providers within 30 miles or 30 minutes
MIL3.7	Orleans	4.5%	2 providers within 30 miles or 30 minutes
MIL3.7	Pittsfield	5.8%	2 providers within 30 miles or 30 minutes
MIL3.7	Springfield	5.4%	2 providers within 30 miles or 30 minutes
MIL3.7	Westfield	1.0%	2 providers within 30 miles or 30 minutes
Clinical stabilization service level 3.5 (CSSL3.5)	Adams	0.0%	2 providers within 30 miles or 30 minutes
CSSL3.5	Athol	10.8%	2 providers within 30 miles or 30 minutes
CSSL3.5	Barnstable	22.5%	2 providers within 30 miles or 30 minutes
CSSL3.5	Gardner-Fitchburg	57.9%	2 providers within 30 miles or 30 minutes
CSSL3.5	Gloucester	88.0%	2 providers within 30 miles or 30 minutes
CSSL3.5	Greenfield	9.6%	2 providers within 30 miles or 30 minutes
CSSL3.5	Haverhill	89.4%	2 providers within 30 miles or 30 minutes
CSSL3.5	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
CSSL3.5	Oak Bluffs	58.3%	2 providers within 30 miles or 30 minutes
CSSL3.5	Orleans	0.0%	2 providers within 30 miles or 30 minutes
CSSL3.5	Pittsfield	0.0%	2 providers within 30 miles or 30 minutes
CSSL3.5	Springfield	10.7%	2 providers within 30 miles or 30 minutes
CSSL3.5	Westfield	0.0%	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	0.7%	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	74.6%	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	21.3%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	Gloucester	0.6%	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
CBAT-ICBAT-TCU	Greenfield	8.5%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	Haverhill	25.2%	2 providers within 30 miles or 30 minutes
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	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	13.5%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	Southbridge	55.5%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	Springfield	9.3%	2 providers within 30 miles or 30 minutes
CBAT-ICBAT-TCU	Taunton	49.2%	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)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
Residential Rehabilitation Services for Substance Use Disorders Level 3.1 (RRS3.1)	Adams	23.8%	2 providers within 30 miles or 30 minutes
RRS3.1	Barnstable	0.0%	2 providers within 30 miles or 30 minutes
RRS3.1	Falmouth	17.3%	2 providers within 30 miles or 30 minutes
RRS3.1	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
RRS3.1	Oak Bluffs	0.0%	2 providers within 30 miles or 30 minutes
RRS3.1	Orleans	0.0%	2 providers within 30 miles or 30 minutes
RRS3.1	Pittsfield	7.7%	2 providers within 30 miles or 30 minutes
Applied Behavior Analysis (ABA)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	Adams	61.3%	2 providers within 30 miles or 30 minutes
SOAP	Gardner-Fitchburg	88.6%	2 providers within 30 miles or 30 minutes
SOAP	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
SOAP	Orleans	16.8%	2 providers within 30 miles or 30 minutes
Recovery Support Navigators (RSN)	Pittsfield	7.7%	2 providers within 30 miles or 30 minutes
RSN	Adams	62.5%	2 providers within 30 miles or 30 minutes
RSN	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
Opioid Treatment Programs (OTP)	Pittsfield	11.5%	2 providers within 30 miles or 30 minutes
OTP	Nantucket	0.0%	2 providers within 30 miles or 30 minutes

MCO: managed care organization.

Recommendations

- WellSense MCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- WellSense MCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- WellSense 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 explain what actions are being taken to provide adequate access for members residing in those service areas.
- WellSense MCO should design quality improvement interventions to enhance the accuracy of all three directories.

Tufts MCO

More information about Tufts MCO's network adequacy validation rating is provided in Table 53.

Table 53: Tufts MCO Network Adequacy Validation Ratings – CY 2024

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts MCO	Comments
PCP GeoAccess	• 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP applied the correct MassHealth standards for analysis; however, the MCP's provider data had some duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standard was met in all service areas.
Ob/Gyn GeoAccess	• 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP applied the correct MassHealth standards for analysis; however, the MCP's provider data had many duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standard was met in all service areas.
Physical Health Services GeoAccess	• 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.	Addressed	High confidence	No issues were found with the underlying information systems. The MCP's provider data were clean except for one duplicative record for one urgent care facility, the MCP applied the correct MassHealth standards for analysis, and the results calculated by the MCP matched the time and distance results calculated by IPRO. IPRO's analysis of the network revealed gaps in the urgent care network in three service areas.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts MCO	Comments
Specialists GeoAccess	• 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. • 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP applied the correct MassHealth standards for analysis; however, the MCP's provider data had duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standards were met in all service areas.
Behavioral Health Services GeoAccess	• 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP applied the correct MassHealth standards for analysis; however, the MCP's provider data had many duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed gaps for five provider types in multiple service areas.
Pharmacy GeoAccess	• 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.	Addressed	High confidence	No issues were found with the underlying information systems. The MCP's provider data were clean, the MCP applied the correct MassHealth standards for analysis, and the results calculated by the MCP matched the time-and-distance results calculated by IPRO. IPRO's analysis of the network revealed that the GeoAccess standards were met in all service areas.
Provider-to-Member Ratios[2]	• Adult PCP Ratio: 1:750 • Pediatric PCP Ratio: 1:750 • Ob/Gyn Ratio: 1:500	Addressed	High confidence	IPRO's analysis showed that the MCP's network meets the provider-to-member standards.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts MCO	Comments
Accuracy of Directories[2]	• Percent of providers in the directory with correct information	Missing[3]	Moderate confidence	IPRO's analysis showed that the information in the PCP, ob/gyn, and cardiology providers directories is not entirely accurate.

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

[2] IPRO did not assess the MCP's methods of calculating the indicator, but instead calculated the indicator itself. The network adequacy validation rating reflects IPRO's confidence that the MCP's network meets MassHealth's standards and expectations.

[3] Although the state requires MCPs to report changes to the provider network and update their directories no later than 30 calendar days after being made aware of any changes, the MCPs are not required to report what percentage of the directory information is accurate.

MCO: managed care organization; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; TBD: to be determined.

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. However, 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 54–55 shows service areas with deficient networks for Tufts MCO.

Table 54: 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	80.6%	1 provider within 15 miles or 30 minutes
Urgent Care Services	Pittsfield	0.3%	1 provider within 15 miles or 30 minutes

MCO: managed care organization.

Table 55: 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
Managed inpatient level 4 (MIL4)	Adams	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Athol	45.3%	2 providers within 60 miles or 60 minutes
MIL4	Greenfield	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Holyoke	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Northampton	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Pittsfield	0.0%	2 providers within 60 miles or 60 minutes
MIL4	Springfield	3.8%	2 providers within 60 miles or 60 minutes
MIL4	Westfield	0.0%	2 providers within 60 miles or 60 minutes
Monitored inpatient level 3.7 (MIL3.7)	Greenfield	84.3%	2 providers within 30 miles or 30 minutes
MIL3.7	Holyoke	35.1%	2 providers within 30 miles or 30 minutes
MIL3.7	Springfield	8.8%	2 providers within 30 miles or 30 minutes
MIL3.7	Westfield	43.3%	2 providers within 30 miles or 30 minutes
Clinical stabilization service level 3.5 (CSSL3.5)	Adams	69.2%	2 providers within 30 miles or 30 minutes
CSSL3.5	Greenfield	85.5%	2 providers within 30 miles or 30 minutes
CSSL3.5	Pittsfield	0.9%	2 providers within 30 miles or 30 minutes
CSSL3.5	Springfield	14.0%	2 providers within 30 miles or 30 minutes
CSSL3.5	Westfield	0.7%	2 providers within 30 miles or 30 minutes
Partial hospitalization program (PHP)	Adams	0.0%	2 providers within 30 miles or 30 minutes
PHP	Greenfield	83.1%	2 providers within 30 miles or 30 minutes
PHP	Pittsfield	2.0%	2 providers within 30 miles or 30 minutes
PHP	Adams	0.0%	2 providers within 30 miles or 30 minutes
Opioid treatment programs (OTP)	Athol	11.7%	2 providers within 30 miles or 30 minutes
OTP	Gardner-Fitchburg	82.0%	2 providers within 30 miles or 30 minutes
OTP	Gloucester	32.2%	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
OTP	Greenfield	0.0%	2 providers within 30 miles or 30 minutes
OTP	Holyoke	5.1%	2 providers within 30 miles or 30 minutes
OTP	Northampton	0.0%	2 providers within 30 miles or 30 minutes
OTP	Pittsfield	1.7%	2 providers within 30 miles or 30 minutes
OTP	Springfield	84.6%	2 providers within 30 miles or 30 minutes
OTP	Westfield	4.7%	2 providers within 30 miles or 30 minutes

MCO: managed care organization.

Recommendations

- Tufts MCO should clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- Tufts MCO should submit for the analysis only the providers that are considered acceptable by MassHealth for certain behavioral health provider types.
- Tufts MCO should clean data for the GeoAccess analysis for all provider types.
- Tufts MCO should expand 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.
- Tufts MCO should design quality improvement interventions to enhance the accuracy of all three directories.

VII. Quality-of-Care Surveys – Member Experience Surveys

Objectives

Section 2.14.C.1.c. of the Sixth Amended and Restated MassHealth MCO Contract requires contracted MCOs to participate in all MassHealth member experience survey activities and 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.

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.

Each MassHealth MCO independently contracted with a certified CAHPS vendor to administer the adult and child survey for MY 2023. MassHealth monitors MCOs' submissions of CAHPS surveys and uses the results to identify opportunities for improvement and inform MassHealth's quality management work.

In addition, adult and pediatric MCO members were surveyed by MassHealth about their experiences with PCP using the PC MES. MassHealthworked with Massachusetts Health Quality Partners (MHQP), an independent non-profit measurement and reporting organization, to conduct the PC MES.MCO members were surveyed for the first time in 2024. MassHealth's PC MES is based on the CG-CAHPS survey, which asks members to report on their experiences with providers and staff in physician practices and groups. MassHealth's PC MES is based on the CG-CAHPS survey, which asks members to report on their experiences with providers and staff in physician practices and groups. The CG-CAHPS survey results can be used to monitor the performance of physician practices and groups and to reward high-quality care.[9] The level of analysis for the PC MES surveys was statewide and individual ACO-MCO.

Technical Methods of Data Collection and Analysis

Health Plan CAHPS

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.

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, 2023, who were continuously enrolled for at least five of the last six months of MY 2023, and who are enrolled in the MCO.

Tables 56–57 provides a summary of the technical methods of data collection by MCO.

Table 56: Adult CAHPS – Technical Methods of Data Collection by MCO, MY 2023

CAHPS – Technical Methods of Data Collection	WellSense MCO	Tufts MCO
Survey vendor	Press Ganey	Press Ganey
Survey tool	CAHPS 5.1H	CAHPS 5.1H
Survey timeframe	March–May, 2024	March–May, 2024
Method of collection	Mail, telephone, and internet[1]	Mail and telephone
Sample size	4,388	3,983

CAHPS – Technical Methods of Data Collection	WellSense MCO	Tufts MCO
Response rate	7.6%	10.2%

[1] Internet modes of data collection include QR codes, email, and URL.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MCO: managed care organization; MY: measurement year.

Table 57: Child CAHPS – Technical Methods of Data Collection by MCO, MY 2023

CAHPS – Technical Methods of Data Collection	WellSense MCO	Tufts MCO
Survey vendor	Press Ganey	Press Ganey
Survey tool	CAHPS 5.1H	CAHPS 5.1H
Survey timeframe	March–May, 2024	March–May, 2024
Method of collection	Mail, telephone, and internet[1]	Mail and telephone
Sample size	6,600	1,650
Response rate	5.5%	6.1%

[1] Internet modes of data collection include QR codes, email, and URL.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MCO: managed care organization; MY: measurement year.

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 58** displays these categories and the measures for which these response categories are used.

Table 58: CAHPS Response Categories, MY 2023

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

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

To assess MCO performance, IPRO compared MCOs' top-box scores to national Medicaid performance reported in the Quality Compass 2024 (MY 2023) for all lines of business that reported MY 2023 CAHPS data to NCQA. The top-box scores are the survey results for the highest possible response category.

PC MES

The program year 2023 PC MES was administered between April and July 2024, by MHQP.. The adult and child PC MES survey instruments were adapted from the CG-CAHPS 4.0 (beta) surveys developed by the Agency for Health Care Research and Quality and the NCQA. The program year 2023 PC MES adult and child surveys included Patient-Centered Medical Home survey items and the Coordination of Care supplemental items.

Nineteen MCPs participated in the program year 2023 survey, including 15 ACPPs, two PC ACOs, and two MCOs. For the PC MES adult and child surveys, respondents could complete surveys in English or Spanish (in paper or on the web), or in Portuguese, Chinese, Vietnamese, Haitian Creole, Arabic, Russian, or Khmer (on the web only). All members received an English paper survey in mailings, and members on file as Spanish-speaking also received a Spanish paper survey in mailings. The mail only protocol involved receiving up to three mailings. The email protocol involved receiving up to five emails and up to three mailings.

The sample frame included members who had at least one primary care visit during the MY (April 1–December 31, 2023) and who were enrolled in one of the ACOs or MCOs on the anchor date (December 31, 2023). **Tables 59–60** provide a summary of the technical methods of data collection.

Table 59: Adult PC MES – Technical Methods of Data Collection for MCO, MY 2023

Technical Methods of Data Collection	MCO
Survey vendor	Massachusetts Health Quality Partners
Survey tool	MassHealth PC MES, adapted from the CG-CAHPS 4.0 (beta) survey instrument
Survey timeframe	April–July 2024
Method of collection	Mailings and emails
Sample size – all MCOs	114,276
Response rate	10.5%

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

Table 60: Child PC MES – Technical Methods of Data Collection for MCO, MY 2023

Technical Methods of Data Collection	MCO
Survey vendor	Massachusetts Health Quality Partners
Survey tool	MassHealth PC MES, adapted from the CG-CAHPS 4.0 (beta) survey instrument
Survey timeframe	April–July 2024
Method of collection	Mailings and emails
Sample size – all MCOs	144,920
Response rate	4.8%

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

To assess MCO performance, IPRO aggregated and reported MCOs' statewide scores.

Description of Data Obtained

For each MCO, IPRO received a copy of the final MY 2023 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.

For PC MES, IPRO received copies of the final program year 2023 technical and analysis reports produced by MHQP. These reports included descriptions of the project technical methods and survey results. IPRO also received separate files with the MCO-level results and statewide scores calculated across all ACOs and MCOs.

Conclusions and Comparative Findings

Health Plan CAHPS

To determine common strengths and opportunities for improvement across both MCOs, IPRO compared the MCO results and CAHPS weighted mean (calculated for all health plans) to the national Medicaid benchmarks presented in the Quality Compass MY 2023. 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 61**.

Table 61: Color Key for CAHPS Performance Measure Comparison to NCQA HEDIS MY 2023 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).

CAHPS: Consumer Assessment of Healthcare Providers and Systems; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year.

When compared to the available national Medicaid benchmarks, except for coordination of care and rating of all health care, all adult measures were below the 75th percentile, leaving room for improvement. For child CAHPS results, care coordination was above the 90th percentile, the rating of all health care and rating of personal doctor scored at or above the 75th percentile, and all other measures were below the 75th percentile.

Table 62 displays the top-box scores of the 2024 CAHPS Adult Medicaid Survey for MY 2023, and Table 63 displays the top-box scores of the 2024 CAHPS Child Medicaid Survey for MY 2023.

Table 62: CAHPS Performance – Adult Member, MY 2023

CAHPS Measure	WellSense MCO	Tufts MCO	Weighted Mean (All Health Plans)
Getting Care Quickly	77.70% (< 75th)	78.10% (< 75th)	78.83% (< 75th)
Getting Needed Care	83.10% (< 75th)	79.80% (< 75th)	81.96% (< 75th)
How Well Doctors Communicate	92.40% (< 75th)	92.60% (< 75th)	92.76% (< 75th)
Customer Service	86.50% (< 75th)	86.90% (< 75th)	88.22% (< 75th)
Coordination of Care	89.80% (≥ 75th)	90.10% (≥ 75th)	89.72% (≥ 75th)
Ease of Filling Out Forms	94.40% (< 75th)	92.30% (< 75th)	94.00% (< 75th)
Rating of All Health Care (9 or 10)	81.00% (≥ 75th)	75.50% (< 75th)	79.46% (≥ 75th)
Rating of Personal Doctor (9 or 10)	84.40% (< 75th)	84.00% (< 75th)	83.73% (< 75th)
Rating of Specialist Seen Most Often (9 or 10)	81.20% (< 75th)	83.80% (< 75th)	81.16% (< 75th)
Rating of Health Plan (9 or 10)	79.30% (< 75th)	78.10% (< 75th)	79.33% (< 75th)

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MCO: managed care organization.

Table 63: CAHPS Performance – Child Member, MY 2023

CAHPS Measure	WellSense MCO	Tufts MCO	Weighted Mean (All Health Plans)
Getting Care Quickly	87.30% (< 75th)	78.30% (< 75th)	85.13% (< 75th)
Getting Needed Care	84.60% (< 75th)	76.90% (< 75th)	83.69% (< 75th)

CAHPS Measure	WellSense MCO	Tufts MCO	Weighted Mean (All Health Plans)
How Well Doctors Communicate	93.20% (< 75th)	95.90% (≥ 75th)	93.45% (< 75th)
Customer Service	88.70% (< 75th)	84.80% (< 75th)	87.64% (< 75th)
Coordination of Care	89.50% (≥ 90th)	80.00% (< 75th)	89.39% (≥ 90th)
Ease of Filling Out Forms	95.20% (< 75th)	91.60% (< 75th)	95.00% (< 75th)
Rating of All Health Care (9 or 10)	90.50% (≥ 75th)	90.70% (≥ 75th)	89.39% (≥ 75th)
Rating of Personal Doctor (9 or 10)	92.20% (≥ 75th)	92.30% (≥ 75th)	91.89% (≥ 75th)
Rating of Specialist Seen Most Often (9 or 10)	86.70% (< 75th)	82.40% (< 75th)	85.63% (< 75th)
Rating of Health Plan (9 or 10)	85.10% (< 75th)	80.00% (< 75th)	85.13% (< 75th)

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MCO: managed care organization.

PC MES

To determine common strengths and opportunities for improvement across both MCOs, IPRO compared each MCO's results to the ACO-MCO statewide scores for the adult and child PC MES surveys. . Measures performing above the statewide score were considered strengths; measures performing at the statewide score were considered average; and measures performing below the statewide score were identified as opportunities for improvement, as explained in Table 64.

Table 65 shows the results of the PC MES adult Medicaid survey for program year 2023 (fielded in 2024). Both MCOs were above the statewide score of the Organizational Access measures but below the statewide score for all remaining adult PC MES measures.

Table 66 shows the results of the PC MES child Medicaid survey for program year 2023 (fielded in 2024). WellSense MCO scored above the statewide score for the majority of PC MES child measures, whereas Tufts MCO scored above the statewide score for two PC MES child measures only: Organizational Access and Pediatric Preventive Care.

Table 64: Color Key for PC MES Performance Measure Comparison Score

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

PC MES: Primary Care Member Experience Survey; MCO: managed care organization.

Table 65: PC MES Performance – Adult Member, Program Year 2023

PC MES Measure	WellSense MCO	Tufts MCO	Statewide Score
Adult Behavioral Health	61.99% (< Goal)	61.02% (< Goal)	65.94%
Communication	91.85% (< Goal)	91.83% (< Goal)	92.87%
Integration of Care	83.12% (< Goal)	83.36% (< Goal)	85.09%
Knowledge of Patient	86.27% (< Goal)	85.59% (< Goal)	86.45%
Office Staff	92.32% (< Goal)	93.08% (< Goal)	93.11%
Organizational Access	80.03% (> Goal)	79.75% (> Goal)	77.49%
Overall Provider Rating	86.45% (< Goal)	85.97% (< Goal)	87.38%
Self-Management Support	63.59% (< Goal)	59.56% (< Goal)	63.60%
Willingness to Recommend	85.77% (< Goal)	85.46% (< Goal)	87.45%

PC MES: Primary Care Member Experience Survey.

Table 66: PC MES Performance – Child Member, Program Year 2023

PC MES Measure	WellSense MCO	Tufts MCO	MCO Statewide Score
Communication	96.39% (> Goal)	93.20% (< Goal)	95.65%
Integration of Care	82.08% (< Goal)	82.35% (< Goal)	85.24%
Knowledge of Patient	90.71% (> Goal)	89.19% (< Goal)	89.40%
Office Staff	94.80% (> Goal)	92.58% (< Goal)	93.89%
Organizational Access	86.45% (> Goal)	85.52% (> Goal)	82.14%
Overall Provider Rating	91.44% (> Goal)	89.52% (< Goal)	90.37%
Self-Management Support	48.80% (< Goal)	46.50% (< Goal)	52.44%
Willingness to Recommend	92.04% (> Goal)	90.45% (< Goal)	91.26%
Child Development	69.53% (> Goal)	64.47% (< Goal)	65.66%
Child Provider Communication	94.70% (< Goal)	92.86% (< Goal)	95.31%
Pediatric Prevention	59.45% (< Goal)	61.76% (> Goal)	61.72%

PC MES: Primary Care Member Experience Survey.

VIII. MCP Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results(a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI[11] made by the EQRO during the previous year's EQR." Tables 58–59 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 67 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 67: WellSense MCO Response to Previous EQR Recommendations

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PIP 2 CDC: 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.	WellSense has recently transitioned to a certified HEDIS software platform which is the official audit-approved source for the data collection of all WellSense quality measures. In addition, WellSense continues to utilize the comprehensive data to implement sustainable interventions to improve outcomes for all members with diabetes.	Addressed
PMV: HEDIS Measures: 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.	WellSense has enhanced its information systems capabilities by implementing new non-standard SDS sources to receive data from the Massachusetts Immunization Information System (MIIS) as of July 2024. Additionally, the organization plans to develop a non-standard supplemental interface to collect immunization data from medical records, which will be incorporated into HEDIS NCQA and state submissions by October 2024.	Partially Addressed

[11] Quality improvement.

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV: Non-HEDIS Measures: The following measures rates were below the goal benchmark: • Oral Health Evaluation • Behavioral Health Community Partner Engagement • LTSS 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	WellSense has enhanced performance oversight by holding monthly meetings with Care Providers (CPs) to review key metrics using MassHealth reports from Mathematica. To further improve data timeliness, WellSense will introduce an internal report card that leverages monthly claims data from MassHealth through ACOs and MCOs. This will provide CPs with more current information, enabling them to quickly identify and address performance barriers. The initiative aims to drive improvements in both LTSS Community Partner and Behavioral Health Engagement metrics. Additionally, for BH providers, when additional providers are not available, Carelon typically takes several actions to ensure adequate access for members. These actions may include: • Telehealth Services: Expanding access to telehealth services to allow members to consult with healthcare providers remotely. • Out-of-Network Coverage: Providing coverage for out-of-network providers to ensure members can still receive necessary care • Recruitment and Retention Programs: Implementing programs to recruit and retain healthcare providers in underserved areas.	Partially Addressed
Network Adequacy: Data Integrity: IPRO recommends that, for future network adequacy analysis, WellSense MCO review and deduplicate in-network provider data before data files are submitted for analysis.	WellSense is implementing stricter validation rules in our data processing pipeline to prevent data integrity issues. We will add internal review steps prior to reports submission to deduplicate the data and to ensure that Credentials for PCP and Specialists, State, Zip code, and NPI information are all populated and in correct format. For missing information like Credentials and NPI we will work with Provider Data Integrity and IT teams to ensure information is populated in our source data.	Addressed

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network Adequacy: Time/Distance Standards: WellSense MCO had deficient networks in one or more service areas for 20 provider types: • Pediatric PCP • Rehabilitation Hospital • Urgent Care Services • Audiology • 16 out of 22 Behavioral Health Providers WellSense 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.	WellSense was unable to replicate IPRO's findings for the Rehabilitation Hospital and Audiology provider types. However, we have confirmed network gaps in Urgent Care services in Nantucket and Pediatric Primary Care Providers (PCPs) in Pittsfield. To address these gaps, WellSense will leverage its newly acquired enhanced network adequacy reporting tools to identify and recruit providers in the affected service areas. While we have not encountered any cases where members were unable to access needed services, we are fully prepared to establish single case agreements with available providers if necessary.	Addressed
Network Adequacy: Provider Directory: WellSense MCO's accuracy rate was below 20% for the following provider type: • Autism Services (6.67%) WellSense MCO should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory.	To maintain accurate records and keep provider directory current Carelon requires providers to regularly review their practice information and promptly notify us of any changes. Carelon utilizes CAQH, our provider portal and National Provider Service Line as methods of provider information updates. Regular audits and updates are essential to maintaining the accuracy of our provider directory.	Remains an Opportunity for Improvement

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Quality-of-Care Surveys: 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.	WellSense convened an internal CAHPS Work Group that met monthly from July through December 2023 to review the MY2022 CAHPS Medicaid Adult survey results collected in 2023, identify key drivers, prioritize interventions, and monitor progress of initiative implementation. WellSense added supplemental questions to the CAHPS MA Adult and Child surveys regarding the number of days waiting to get an urgent or routine care appointment, as well as questions about telehealth usage and prescription medication, to assist root cause analysis, which supports WellSense's continued efforts of telephonic outreach targeting members lacking a PCP visit in the last 12 months during Q4 2023 to help then engage with a primary care provider to help coordinate their care. In Q4 2023, WellSense began exploring expanding its Nurse Advice Line to include telehealth capacity to expand access for members. A root cause analysis revealed prominent subgroup differences among Black/African American survey respondents. In addition to continuing targeted phone outreach to members with care gaps or lacking a recent PCP visit and at-risk of access issues, the CAHPS Work Group recommended and the Quality Improvement Committee approved the following prioritized interventions to improve member experience: identify potential racial or ethnic disparities using predictive models to better target member subpopulations at higher risk for experiencing access barriers; promote urgent care access options in materials and make it easier to find urgent care centers in the online provider directory; and implement a process within Member Services that identifies providers accepting new patients and helps members schedule appointments. An analysis of MY2023 MA Medicaid member appeals and grievances found Access-related prescription appeals continued to account for the highest volume appeals category and possible impact of increased prescription appeals may be found in survey results: parents of MA child members who take prescription medications reported a substantially lower Rating of Health Care compared to MA children who do not take prescription medications. Beginning in 2024, WellSense transitioned from using the CAHPS Medicaid Child survey to using the CAHPS Medicaid Child survey with the Chronic Conditions supplement as required by MassHealth.	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.

Tufts MCO Response to Previous EQR Recommendations

Table 68 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 68: Tufts MCO Response to Previous EQR Recommendations

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PIP 2 PPC: 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.	The MCP updates the template of this PIP yearly when new data is available. In future iterations of this PIP the MCP will input 'Not Applicable' ('N/A') for calculated fields or rate fields in which a denominator is zero.	Addressed
PMV: HEDIS Measures: 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.	The CIS Combo 10 measure increased from 32.76% in MY2022 to 46.79% in MY2023. The Health Plan is receiving immunization data from the Massachusetts Immunization Information System (MIIS registry) beginning in 2023 which enhances our data capture. -There is a reminder mailing to the parents on their child's 3rd, 5th, 8th, 11th and 14th months of age about the age appropriate vaccines for their child. HBD: Hemoglobin A1c Control; HbA1c control (>9.0%) rates improved in MY2023 when compared to NCQA QC NE Medicaid benchmarks Sample sizes for Hemoglobin A1c Control (HBD) and Controlling High Blood Pressure (CBP) for MY 2022 and MY2023 are small which makes root cause analysis challenging to conduct. As CBP and the HBD/GSD measure moves to pay-for-performance for the MassHealth ACO/MCO program, sample sizes increase and dedicated samples for just the MCO product will provide additional data for root cause analysis and the ability to track response rates just for this product's sample. We will continue to evaluate opportunities for supplemental data capture & quality improvement initiatives. We have created provider tip sheets with best practices to educate providers and increase rates. https://www.point32health.org/provider/hedis-tip-sheets/ Asthma Medication Ratio (AMR)- Rates for this measure continue to be challenged by formulary changes where we see multiple denied meds on the same day as a fill. While we only include the final version of each pharmacy claim, these denials come in as separate claims - and therefore are included in the measurement and can affect the ratio of controller to reliever. Since AMR is in the Effective of Care Domain we are required to include all claims, whether paid or denied. We are conducting another analysis at the end of 2024 and into 2025 to see if there are any opportunities to improve this rate.	Addressed

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV: Non-HEDIS Measures: 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	Regarding the Oral Health measure, dental benefits are a wrap benefit for the Medicaid population. These benefits are not administered by the health plan and while some dental claims are provided by EOHHS, the limited data has not provided enough insight into performance. Furthermore, this measure is one, over which the health plan has limited influence for its MCO members. Regarding the Behavioral Health Community Partner Engagement measure, Point32Health has implemented several interventions to increase the percentage of Behavioral Health Community Partner engagement. Clinical case conferences now occur on a monthly basis with the organization's BH CP providers where high-risk members are discussed, as well as hard to reach members. The BH CPs are also receiving robust supplemental data that includes information such as the last provider with whom the member had a visit, the provider who prescribed anti-depressant medications is applicable, and medication dispensing dates. The supplemental information is an additional source of data that can be leveraged to help locate hard to reach members, which is a barrier to engagement. Point32Health has also created a weekly report to distribute to BH CPs that identifies which of their members are in MCO Care Management. This is meant to facilitate increased care collaboration on dually involved members as well as the sharing the most recent contract information. These interventions began in CY 2023 and are ongoing. The goals are to increase the BH CP engagement rate with member-signed care plans by 5% through targeting hard to reach members and co-managing shared cases with the organization's care managers. The Community Partner Program Manager will continue to monitor performance through the evaluation of monthly status outreach reports (MSO) provided by the BH CPs to calculate and trend engagement rates.	Partially Addressed

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network: Time/Distance Standards: 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. 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.	The MCP has a quarterly monitoring process where the Tufts Health Together Network is evaluated using standards set forth in the contract between THPP and EOHHS. When a gap or deficiency is identified, the appropriate contracting teams are made aware of the issue. Research is also done using an analytics market availability tool to determine if there are providers available for contracting. Some of the gaps identified for the BH provider types have been closed via system data clean-up efforts over the last year and by recruitment efforts to bring additional providers into the Together MCO Network. Investigation is being conducted on the Urgent Care deficiencies to determine if there is a real gap in coverage or if there is additional provider data clean up needed. The Together Provider Directory does list at least 1 Urgent Care Facility within 15 miles for Adams, Pittsfield, and Gloucester. Our most current Quarterly Monitoring reports only identifies 3 current deficiencies in the BH provider types: BH18 - Managed Inpatient Level 4, Partial Hospitalization, and Psychiatric Inpatient Adult. All 3 deficiencies are in the Adams, Greenfield, Pittsfield service areas. The only facility available who provides those BH services is Berkshire Medical Center, which does participate in the Together Network. Tufts Health Together will continue to monitor the network and look for opportunities to bring in additional providers within those service areas into the network when they become available.	Addressed
Network: Provider Directory: Tufts MCO's accuracy rate was below 20% for the following provider types: • Internal Medicine (13.3%) • Autism Services (13.33%) 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 Health Plan conducted a root cause analysis to understand the issues identified from the provider directory audit results. During an extensive review of the results of the audit, the Provider Operations team identified several interventions to improve the accuracy of provider and facility directory information, as well as to increase provider engagement in maintaining updated and correct directory information.	Addressed

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Quality-of-Care Surveys: 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 to drive performance improvement in those specific areas. MCO should also consider conducting the child HP CAHPS survey.	Point32Health utilizes CAHPS results (including HP Child CAHPS in 2024) to track and trend performance across a continuum of key member satisfaction performance indicators to inform opportunities for improvement. Barrier analyses are conducted to identify common themes, issues, and areas of member dissatisfaction that appear in multiple data sources. When appropriate, the organization also leverages internal data sources such as Appeals and Grievance data, member experience gleaned from its members through the organization's Member Advisory Councils as well as additional satisfaction surveys administered by the health plan. Identified opportunities are prioritized based on areas of greatest dissatisfaction for members balanced with the organization's ability to successfully intervene. With a focus on indicators with the largest variance from organizational goals, internal brainstorming sessions and the results of barrier analyses inform the strategy for improvement. After trending member experience results across multiple products and committing to improving member experience overall, Point32Health has chosen to implement a new Member Experience Governance structure that will oversee multidisciplinary teams that are responsible for the execution of targeted initiatives.	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. MCO: managed care organization; MCP: managed care plan; EQR: external quality review.

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

Tables 69–70 highlight each MCO's performance strengths, opportunities for improvement, and this year's recommendations based on the aggregated results of CY 2024 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 69: Strengths, Opportunities for Improvement, and EQR Recommendations for WellSense MCO

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: PPC	There is high confidence that the PIP Baseline Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access
PIP 2: HBD	There is high confidence that the PIP Baseline Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access
Performance Measure Validation: HEDIS measures	MCO demonstrated compliance with information system standards. No issues were identified. Timeliness of Prenatal Care and Follow-up After Emergency Department Visit for Mental Illness (7 days) rates were above the 90th percentile.	N/A	N/A	Quality, Timeliness, Access
Performance Measure Validation: Non-HEDIS measures	No issues were identified. PC MES Willingness to Recommend Child, Communication Child, PC MES Knowledge of Patient Adult, PC MES Knowledge of Patient Child measures were above the goal benchmark.	The following measures rates were below the goal benchmark: • PC MES Willingness to Recommend+ Adult • PC MES Communication+ Adult • PC MES Integration of Care+ Adult • PC MES Integration of Care+ Child	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
Compliance Review	WellSense MCO demonstrated compliance with most of the federal and state contractual standards. MCP addressed opportunities for improvement from the prior compliance review.	Lack of compliance with eight requirements in the following domains: • Availability of services (4) • Health information systems (4) Partial compliance with 29 requirements in the following domains: • Availability of services (1) • Grievances and appeals (2) • Practice guidelines (1) • Health information systems (16) • QAPI (9)	MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 1/31/2025. IPRO will monitor the status of all recommendations as part of the EQR processes and follow up with the MCP before the end of CY 2025.	Quality, Timeliness, Access
Network Adequacy: Information Systems and Quality of Provider Data – Duplicates	Data used by the MCP to monitor network adequacy were mostly accurate and current except for duplicative provider records and incorrect provider directory information.	WellSense MCO submitted many duplicates for individual and facility providers due to variations in the facility names, such as including the suite name or address information, submitting departments in addition to the facilities, or including DBA titles. IPRO removed a total of 2,558 duplicate providers from the WellSense MCO data prior to conducting the analysis.	WellSense MCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – MCP's Methodology	WellSense MCO used the correct MassHealth standards for most of the provider types. IPRO compared WellSense MCO's results for Monitored Inpatient Level 3.7, Pediatric PCP, Pharmacy, and Psychiatric Inpatient Adolescent. The comparison showed that IPRO and WellSense MCO had identical results for Monitored Inpatient Level 3.7 providers in almost half of the services, for Pediatric PCPs in all but three service areas, for Pharmacy providers in all service areas, and for Psychiatric Inpatient Adolescent providers in all service areas but Adams. IPRO concluded that the results reported for those four provider types were valid, accurate, and reliable.	WellSense MCO used incorrect time OR distance standards for behavioral health provider types in Nantucket and Oak Bluff service areas, as well as ob/gyn and rehabilitation hospitals in all service areas. Because of the quality of the provider data, IPRO was able to compare WellSense MCO's results for only four provider types: Monitored Inpatient Level 3.7, Pediatric PCP, Pharmacy, and Psychiatric Inpatient Adolescent.	WellSense MCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.	Quality, Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	WellSense MCO demonstrated adequate networks for adult PCP, pharmacy, acute inpatient hospitals, and all specialty providers except one service area for audiology.	WellSense MCO had a deficient pediatric PCP network in three service areas and a deficient ob/gyn network in two service areas. The MCO also had deficient networks in one or more service areas for 12 out of 20 behavioral health provider types, rehabilitation hospitals, and urgent care services.	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 explain what actions are being taken to provide adequate access for members residing in those service areas.	Access, Timeliness
Network Adequacy: Accuracy of Provider Directory	None.	WellSense MCO achieved only a 47.86% accuracy rate in its PCP directory, a 27.18% accuracy rate in its ob/gyn directory, and only 43.40% in its cardiology directory.	WellSense MCO should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness
Quality-of-care Surveys: HP CAHPS	MCO conducted both adult and child CAHPS surveys. WellSense MCO scored above the 90th percentile on the coordination of care measure.	WellSense MCO scored below the national 75th percentile on the majority of HP CAHPS measures.	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; PPC: Prenatal and Postpartum Care; N/A: not applicable; HBD: Hemoglobin A1c Control for Patients with Diabetes; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; HP: health plan; PC MES: Primary Care Member Experience Survey; MCP: managed care plan; QAPI: quality assurance and performance improvement; CY: calendar year; DBA: doing business as; PCP: primary care provider; ob/gyn: obstetrics/gynecology.

Table 70: Strengths, Opportunities for Improvement, and EQR Recommendations for Tufts MCO

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: PPC	There is high confidence that the PIP Baseline Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access
PIP 2: FUH	There is high confidence that the PIP Baseline Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access
Performance Measure Validation: HEDIS measures	MCO demonstrated compliance with information system standards. No issues were identified.	N/A	N/A	Quality, Timeliness, Access
Performance Measure Validation: Non-HEDIS measures	No issues were identified. The following measures rates were above the goal benchmark: • PC MES Communication Child • PC MES Knowledge of Patient Adult	The following measures rates were below the goal benchmark: • PC MES Willingness to Recommend+ Adult • PC MES Willingness to Recommend+ Child • PC MES Communication+ Adult • PC MES Integration of Care+ Adult • PC MES Integration of Care+ Child • PC MES Knowledge of Patient+ Child	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
Compliance Review	Tufts MCO demonstrated compliance with most of the federal and state contractual standards. MCP addressed opportunities for improvement from the prior compliance review.	Lack of compliance with two requirements in the following domains: • Disenrollment requirements and limitations (1) • Availability of services (1) Partial compliance with 14 requirements in the following domains: • Availability of services (4) • Coverage and authorization of services (1) • Grievances and appeals (3) • Health information systems (1) • QAPI (5)	MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 1/31/2025. IPRO will monitor the status of all recommendations as part of the EQR processes and follow up with the MCP before the end of CY 2025.	Quality, Timeliness, Access
Network Adequacy: Information Systems and Quality of Provider Data – Duplicates	Data used by the MCP to monitor network adequacy were mostly accurate and current except for duplicative provider records and incorrect provider directory information.	Tufts MCO submitted many duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address. IPRO removed a total of 2,396 duplicate providers from the Tufts MCO data prior to conducting the analysis.	Tufts MCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.	Quality, Access, Timeliness
Network Adequacy: Information Systems and Quality of Provider Data Behavioral Health Providers	Data used by the MCP to monitor network adequacy were mostly accurate and current except for duplicative provider records and incorrect provider directory information.	Tufts MCO submitted additional behavioral health providers for Clinical Stabilization Services (level 3.5), Managed Inpatient (level 4), Monitored Inpatient (level 3.7), and Opioid Treatment Programs that were not on the approved list provided by MassHealth. IPRO removed a total of 315 duplicate providers from the Tufts MCO behavioral health data prior to conducting the analysis.	Tufts MCO should submit for the analysis only the providers that are considered acceptable by MassHealth for certain behavioral health provider types.	Quality, Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – MCP's Methodology	Tufts MCO used the correct MassHealth standards for all provider types. When IPRO compared Tuft MCO's results for Acute Inpatient Hospital, Pharmacy, Psychiatric Inpatient Adult, and Psychiatric Inpatient Adolescent, the comparison showed that IPRO and Tufts MCO had identical results for all four provider types in all service areas except for Psychiatric Inpatient Adolescent in the Adams service area. IPRO concluded that the results reported for those four provider types were valid, accurate, and reliable.	Because of the quality of the provider data, IPRO was able to compare Tuft MCO's results for only four provider types: Acute Inpatient Hospital, Pharmacy, Psychiatric Inpatient Adult, and Psychiatric Inpatient Adolescent	Tufts MCO should clean data for the GeoAccess analysis for all provider types.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	Tufts MCO demonstrated adequate networks for all PCP, ob/gyn, pharmacy, and all specialty providers in all 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 5 out of 20 behavioral health provider types.	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 explain what actions are being taken to provide adequate access for members residing in those service areas.	Access, Timeliness
Network Adequacy: Accuracy of Provider Directory	None.	Tufts MCO achieved only a 7.37% accuracy rate in its PCP directory, a 19.00% accuracy rate in its ob/gyn provider directory, and only a 38.46% accuracy rate in its cardiology directory.	Tufts MCO should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
Quality-of-care Surveys: HP CAHPS	MCO conducted both adult and child CAHPS surveys.	MCO scored below the national 75th percentile on most HP CAHPS measures.	Tufts should continue developing and implementing action plans to address the lower performing areas of the CAHPS survey in order to drive performance improvement in those specific areas.	Quality, Timeliness, Access

EQR: external quality review; MCO: managed care organization; PIP: performance improvement project; PPC: Prenatal and Postpartum Care; N/A: not applicable; FUH: Follow-up After Hospitalization for Mental Illness; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; HP: health plan; PCMES: Primary Care Member Experience Survey; MCP: managed care plan; QAPI: quality assurance and performance improvement; CY: calendar year; PCP: primary care provider; ob/gyn: obstetrics/gynecology.

X. Required Elements in EQR Technical Report

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

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

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

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

Elements required in EQR technical report, including the requirements for the PIP validation, performance measure validation, and review of compliance activities, are listed in **Table 71**.

Table 71: 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.

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

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

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

XI. Appendix A – MassHealth Quality Goals and Objectives

Table A1: 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. Revere Medical
Managed Care Organization (MCO)	Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Boston Medical Center HealthNet Plan WellSense 2. Tufts Health Together

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

ACO: accountable care organization; PCP: primary care provider; PCCM: primary care case management.

XIII. Appendix C – MassHealth Quality Measures

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

Measure Steward	Acronym	Measure Name	Core Set	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	SAA	Adherence to Antipsychotics for Individuals with Schizophrenia	X	N/A	N/A	N/A	N/A	N/A	1.2, 3.1, 5.1, 5.2
NCQA	AMM	Antidepressant Medication Management – Acute and Continuation	X	N/A	N/A	X	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	AMR	Asthma Medication Ratio	X	N/A	N/A	N/A	N/A	N/A	1.1, 1.2, 3.1
NCQA	AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis	X	N/A	N/A	N/A	N/A	N/A	1.1., 2.2, 3.4
EOHHS	BH CP Engagement	Behavioral Health Community Partner Engagement	N/A	X	X	N/A	N/A	N/A	1.1, 1.3, 2.3, 3.1, 5.2, 5.3
NCQA	BCS	Breast Cancer Screening	X	N/A	N/A	N/A	N/A	N/A	1.1., 2.2, 3.4
NCQA	CCS	Cervical Cancer Screening	X	N/A	N/A	N/A	N/A	N/A	1.1., 2.2, 3.4
NCQA	ACP	Advance Care Planning	N/A	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.1
NCQA	WCV	Child and Adolescent Well-Care Visits	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
NCQA	CIS	Childhood Immunization Status	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
NCQA	CHL	Chlamydia Screening	X	N/A	N/A	N/A	N/A	N/A	1.1., 2.2, 3.4
NCQA	COL	Colorectal Cancer Screening	X	N/A	N/A	X	N/A	N/A	1.1., 2.2, 3.4
PQA	COB	Concurrent Use of Opioids and Benzodiazepines	X	N/A	N/A	N/A	N/A	N/A	1.2, 3.1, 5.1, 5.2
NCQA	CBP	Controlling High Blood Pressure	X	N/A	N/A	X	X	N/A	1.1, 1.2, 2.2
NCQA	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	X	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (30 days)	X	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	X	N/A	X	X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (30 days)	X	N/A	N/A	N/A	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	X	3.4, 5.1–5.3

Measure Steward	Acronym	Measure Name	Core Set	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	X	N/A	N/A	N/A	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 (7 days)	X	N/A	N/A	N/A	N/A	X	3.4, 5.1–5.3
NCQA	ADD	Follow-up for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (HEDIS)	X	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	HBD	Hemoglobin A1c Control; HbA1c control (> 9.0%) Poor Control	X	N/A	N/A	N/A	X	N/A	1.1, 1.2, 3.4
NCQA	IMA	Immunizations for Adolescents	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
NCQA	FVA	Influenza Immunization	N/A	N/A	N/A	N/A	X	N/A	1.1, 3.4
MA-PD CAHPs	FVO	Influenza Immunization	N/A	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	X	1.2, 3.4, 5.1–5.3
NCQA	LSC	Lead Screening in Children	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
CMS	MLTSS-7	Managed Long Term Services and Supports Minimizing Facility Length of Stay	N/A	N/A	N/A	X	N/A	N/A	4.1, 5
NCQA	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	X	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	OMW	Osteoporosis Management in Women Who Had a Fracture	N/A	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	N/A	X	N/A	N/A	1.1, 1.2, 3.4
NCQA	PCE	Pharmacotherapy Management of COPD Exacerbation	N/A	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	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	N/A	X	N/A	N/A	1.2, 3.4, 5.1
CMS	CDF	Screening for Depression and Follow-Up Plan	X	X	N/A	N/A	N/A	N/A	1.1, 3.1, 5.1, 5.2

Measure Steward	Acronym	Measure Name	Core Set	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	PPC	Timeliness of Prenatal Care	X	N/A	N/A	N/A	N/A	N/A	1.1, 2.1, 3.1
NCQA	TRC	Transitions of Care – All Submeasures	N/A	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
NCQA	APP	Use of First-Line Psychosocial Care for Children and Adolescents	X	N/A	N/A	N/A	N/A	N/A	1.2, 3.1, 5.1, 5.2
NCQA	DAE	Use of High-Risk Medications in the Older Adults	N/A	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
PQA	OHD	Use of Opioids at High Dosage in Persons Without Cancer	X	N/A	N/A	N/A	N/A	N/A	1.2, 3.1, 5.1, 5.2
SAMHSA	OUD	Use of Pharmacotherapy for Opioid Use Disorder	X	N/A	N/A	N/A	N/A	N/A	1.2, 3.1, 5.1, 5.2
NCQA	SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	N/A	N/A	N/A	X	N/A	N/A	1.2, 3.4
NCQA	W30	Well-Child Visits in the First 30 Months	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
NCQA	WCC	Weight Assessment and Counseling for Children	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1

NCQA: National Committee for Quality Assurance; EOHHS: Massachusetts Executive Office of Health and Human Services; MA-PD CAHPS: Medicare Advantage and Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems; ADA DQA: American Dental Association Dental Quality Alliance; CMS: Centers for Medicare and Medicaid Services; COPD: chronic obstructive pulmonary disease; PQA: Pharmacy Quality Alliance; SAMHSA: Substance Abuse and Mental Health Services Administration.

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	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 appropriate and culturally sensitive manner.	**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 GeoAccess:** **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 GeoAccess**: **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 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 – Obstetricians and Gynecologists

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N	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 provider-to-member ratio must be 1:500	OB/GYN GeoAccess: **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 are a 30-minute drive or less from a member residence; OR • Two unique in-network OB/GYN providers 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+.

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

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N	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 GeoAccess:** **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 GeoAccess:** **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. **For the Nantucket Service Area only, the Contractor may substitute Emergency Departments for Urgent Care sites to meet this requirement.* **Rehabilitation Hospital GeoAccess:** **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	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 not listed in Appendix N, the Contractor shall	**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 GeoAccess:** **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	Indicator	Definition of the Indicator
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	Indicator	Definition of the Indicator
Behavioral Health Services: Psychiatric inpatient adult Psychiatric inpatient adolescent Managed inpatient level 4 Monitored inpatient level 3.7 Clinical Stabilization Services level 3.5 CBAT- ICBAT- TCU Partial Hospitalization (PHP) 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 psychiatric APN) Community Support Program (CSP) Recovery Support Navigators Recovery Coaching Opioid Treatment Program (OTP)	**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 GeoAccess:** **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 **For the Nantucket Service Area only, the Contractor may meet this requirement by including in its Provider Network the two closest Providers that provide managed inpatient level 4 services.* **Other Behavioral Health Services GeoAccess:** **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 **For the Nantucket Service Area only, the Contractor may meet this requirement by including in its Provider Network the four closest Providers that provide CSS level 3.5 services.*

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N	Indicator	Definition of the Indicator
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;		

Table D6: ACPP/MCO Network Adequacy Standards and Indicators – Pharmacy

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N	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 GeoAccess:** **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://tuftshealthplan.com/find-a-doctor#

MCO: managed care organization.