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

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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

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I. Executive Summary

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 2025 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 2025

MCO Name	Abbreviation Used in the Report	Members as of December 27, 2025	Percent of Total MCO Population
Boston Medical Center HealthNet Plan	WellSense MCO	17,313	45.84%
Tufts Health Together	Tufts MCO	20,457	54.16%
Total MCO	N/A	37,770	100%

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 17,313 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 20,457 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 their 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 2025 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 2025 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. Measure targets are explained in the quality strategy by each managed care program.

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

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

Opportunities for Improvement:
Not applicable.

General Recommendations for MassHealth:
None at this time.

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

Performance Improvement Projects

State agencies must require that contracted MCPs conduct PIPs that focus on both clinical and non-clinical areas, as established in *Title 42 CFR § 438.330(d)*. In CY 2024, both WellSense and Tufts MCOs started PIPs to improve prenatal and postpartum care outcomes. In addition, WellSense MCO is implementing a project focused on increasing the rate of hemoglobin A1c control for members with diabetes, and Tufts MCO is implementing 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 remeasurement reports follow an acceptable methodology in determining PIP aims, identifying barriers, and proposing interventions to address them. In terms of producing significant evidence of improvement, three PIPs received high ratings, and one PIP received a moderate confidence rating. No validation findings suggest that the credibility of the PIPs results is at risk.

Opportunities for Improvement:
Not applicable.

General Recommendations for MassHealth:
None at this time.

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

Performance Measure Validation

IPRO validated the accuracy of performance measure rates 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 2024 measurement year (MY), the slate of non-HEDIS measures included measures of members' experiences with care, which were collected via the Primary Care Member Experience Survey (PC MES) conducted by MassHealth, as well as two new measures: Topical Fluoride for Children (ages 1–5 years), and Developmental Screening in the First 3 Years of Life.

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

IPRO conducted performance measure validation to assess the accuracy of MCOs' performance measure rates 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 2024 Quality Compass® New England regional percentiles, the best performance was found for the following measures:

- Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment: statewide, 58.36% (≥ 90th percentile)
- Postpartum Care: Tufts MCO, 89.57% (≥ 90th percentile)

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

- PC MES Willingness to Recommend+ Child: 92.48% (> Goal)
- PC MES Communication+ Adult: 93.40% (> Goal)
- PC MES Communication+ Child: 96.11% (> Goal)
- PC MES Integration of Care+ Adult: 86.26% (> Goal)
- PC MES Knowledge of Patient+ Adult: 87.75% (> Goal)
- PC MES Knowledge of Patient+ Child: 90.11% (> Goal)
- Topical Fluoride for Children, Dental or Oral Health Services (Age 1–5 Years): 38.03% (> Goal)
- Developmental Screening in the First 3 Years of Life: 74.01% (> Goal)

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

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 opportunities for improvement in the following areas:

- Asthma Medication Ratio: statewide weighted mean, 53.65% (< 25th)
- Controlling High Blood Pressure: statewide weighted mean, 62.15% (< 25th)
- Childhood Immunization Status (Combo10): statewide weighted mean, 29.54% (< 25th)
- PC MES Willingness to Recommend+ Adult: statewide weighted mean, 88.75% (< Goal)
- PC MES Integration of Care+ Child: statewide weighted mean, 86.17% (< Goal)

General Recommendations for MassHealth:

- *Recommendation towards benchmarks that support continuous quality improvement* – Both MCOs exceeded the current goal benchmark for the newly introduced state-specific measures: Topical Fluoride for Children and Developmental Screening in the First 3 Years of Life. To continue driving meaningful quality improvement and prevent performance from plateauing, IPRO recommends increasing the benchmark to a more ambitious target.
- *Recommendation towards better 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, and monitor the quality of healthcare services provided by MCPs. MassHealth collaborates with MCPs to identify areas for improvement, and MCPs actively engage in performance improvement initiatives.

MassHealth monitors 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 Physical Health Services and 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 to Tufts MCO for the PCP, some specialist, and some behavioral health services GeoAccess analysis. WellSense MCO received moderate confidence for the ob/gyn, some specialists, some 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 11 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, MCP 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 routine appointments were: 70.8 calendar days for a PCPs, 84.5 calendar days for an ob/gyn, and 5.7 calendar days for community mental health centers. These results are based on small samples and should be interpreted with caution. Appointment availability was often not disclosed unless eligibility or insurance information was provided, preventing IPRO from assessing wait times and creating unnecessary barriers to patient access.

General Recommendations for MassHealth:
- *Recommendations towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access.
- *Recommendations towards better access* – MassHealth should work with health plans to ensure providers disclose appointment availability to members without requiring eligibility verification, reducing barriers to access and enabling informed care decisions.

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 2024. 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 & 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 MY 2024 Quality Compass. The MassHealth statewide weighted means were below the 75th percentile for all 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 benchmarks that support continuous quality improvement* – Both MCOs exceeded the current goal benchmark for the newly introduced state-specific measures: Topical Fluoride for Children and Developmental Screening in the First 3 Years of Life. To continue driving meaningful quality improvement and prevent performance from plateauing, IPRO recommends increasing the benchmark to a more ambitious target.
- *Recommendation towards better 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.
- *Recommendations towards better access* – MassHealth should work with health plans to ensure providers disclose appointment availability to members without requiring eligibility verification, reducing barriers to access and enabling informed care decisions.
- *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.

EQR Recommendations for the MCOs

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

II. Massachusetts Medicaid Managed Care Program

Managed Care in Massachusetts

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

MassHealth's mission is to improve the health outcomes of its "members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life."[5] MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.

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

MassHealth Medicaid Quality Strategy

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

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

2025–2027 Strategic Goals

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

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

Table 2: MassHealth's Strategic Goals

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

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

MassHealth Managed Care Programs

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

1. The **Accountable Care Partnership Plans** (ACPPs) are ACOs consisting of groups of PCPs who partner with one health plan to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As ACOs, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high-quality care to MassHealth enrollees. To select an ACPP, a MassHealth enrollee must live in the plan's service area and must use the plan's provider network.
2. The **Primary Care Accountable Care Organizations** (PC ACOs) are ACOs consisting of groups of PCPs who contract directly with MassHealth to provide integrated and coordinated care. PC ACOs function as an ACO but are considered primary care case management (PCCM) entities. In contrast to ACPPs, a PC ACO does not partner with a health plan. Instead, PC ACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. **Managed Care Organizations** (MCOs) are health plans run by health insurance companies with their own provider network that includes PCPs, specialists, behavioral health providers, and hospitals.
4. **Primary Care Clinician Plan** (PCCP) is a PCCM arrangement, where Medicaid enrollees select or are assigned to a PCPs, called a primary care clinician (PCC). The PCC provides services, including care coordination, to enrollees under age 65 years and without any third-party insurance. PCCP uses the MassHealth network of PCPs, specialists, and hospitals, as well as the MBHP's network of behavioral health providers.
5. **Massachusetts Behavioral Health Partnership** (MBHP) is a health plan that manages behavioral health care for MassHealth's PC ACOs and the PCCP. MBHP also serves children in state custody not otherwise enrolled in managed care and certain children enrolled in MassHealth who have commercial insurance as their primary insurance.
6. **One Care** Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services, as well as LTSS. This Plan is for Enrollees ages 21 to 64 years who are dually enrolled in Medicaid and Medicare.[6]

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

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

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

MassHealth Additional Programs

MassHealth manages other programs beyond MCPs.

Fee-for-service (FFS) Medicaid Program

Fee-for-service is a traditional payment model where healthcare providers are paid directly for each service without a capitated payment and care coordination. According to the MassHealth Comprehensive Quality Strategy, 30% of MassHealth members are enrolled in fee-for-service, which includes individuals who live in nursing facilities or rehabilitation hospitals, individuals under age 65 years who have employer-sponsored insurance for whom MassHealth offers wraparound benefits, and individuals over age 65 years or who are disabled with Medicare and choose to remain in fee-for-service.[8]

Long-term Services and Supports (LTSS)

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

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

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

Community Partners Program

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

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.

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[7] Senior Care Options (SCO) Overview. Also available at: https://www.mass.gov/service-details/senior-care-options-sco-overview.
[8] MassHealth 2025 Comprehensive Quality Strategy. Also available at: https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download.

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

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

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

Performance Improvement Projects

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

Member Experience of Care Surveys

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

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

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

MassHealth Access Standards

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

State's Evaluation of the Effectiveness of the Quality Strategy

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

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

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

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

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

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

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

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

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

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

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

III. Validation of Performance 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 Seventh Amended and Restated MassHealth MCO Contract and Appendix B to the MassHealth MCO Contract require the MCOs to perform PIPs annually in compliance with federal regulations. MCOs are required to develop PIP topics in priority areas selected by MassHealth in alignment with its quality strategy goals. Each MCO conducted two PIPs in one of the following priority areas: health equity, prevention and wellness, and access to care. Specific MCO PIP topics are displayed in **Table 3.**

Table 3: MCO PIP Topics – CY 2025

MCO	PIP Topics
WellSense MCO	**PIP 1: PPC – Remeasurement 1 Report** Improving prenatal and postpartum care outcomes in WellSense MCO members. **PIP 2: HBD – Remeasurement 1 Report** Increasing the rate of HbA1c control for WellSense MCO members with diabetes.
Tufts MCO	**PIP 1: PPC – Remeasurement 1 Report** Improving prenatal and postpartum care outcomes in Tufts Health Public Plan members. **PIP 2: FUH – Remeasurement 1 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 2025.

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 March 2025, IPRO offered optional progress calls and met with the Tufts MCO to discuss their performance improvement projects before the remeasurement one submission deadline. The first remeasurement report was submitted in July 2025 by both MCOs.

In the first remeasurement report, MCOs described project goals, performance indicators' rates, anticipated barriers, interventions, and intervention tracking measures' rates. 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 as well as the progress of the interventions and initial evidence of

improvement. It aimed to evaluate an alignment between the interventions and project goals and whether reported improvements could be maintained over time.

Description of Data Obtained

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

Conclusions and Comparative Findings

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

Rating 1: Adherence to Acceptable Methodology - Validation Results Summary

Two PIPs received a high confidence rating, and two PIPs received a moderate confidence rating for adherence to acceptable methodology.

Rating 2: Evidence of Improvement - Validation Results Summary

In terms of producing significant evidence of improvement, three PIPs received high ratings, and one PIP received a moderate confidence rating.

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

Table 4: WellSense MCO PIP Validation Ratings – CY 2025

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

MCO: managed care organization; CY: calendar year; PIP: performance improvement project; PPC: Prenatal and Postpartum Care; HBD: Hemoglobin A1c Control for Patients with Diabetes.

Table 5: Tufts MCO PIP Validation Ratings – CY 2025

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

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

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, 2025

WellSense MCO PIP 1: Improving prenatal and postpartum care outcomes in WellSense MCO members.
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – Moderate Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence

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

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 2025

- 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

The validation findings generally indicate that the credibility of the PIP results is not at risk. Intervention tracking measure data continue to improve quarter after quarter. However, the methodology is inconsistent throughout the PIP. The baseline and benchmark data have been revised to be administrative data for the full population.

Table 7: WellSense MCO PIP 1 Performance Measures and Results

Indicator	Reporting Year	Results
Indicator 1: Prenatal Care Visit	2024 (baseline, MY 2023 data)	48.83%
Indicator 1: Prenatal Care Visit	2025 (remeasurement 1, MY 2024 data)	43.00%
Indicator 2: Postpartum Visit	2024 (baseline, MY 2023 data)	62.43%
Indicator 2: Postpartum Visit	2025 (remeasurement 1, MY 2024 data)	48.00%

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

Recommendations

- *Recommendation for PIP 1*: In future reports, the health plan should ensure a consistent methodology throughout the report. Admin rates should be reported for the performance indicator for consistency with the baseline, benchmark, and goal rates.

Table 8: WellSense MCO PIP 2 Summary, 2025

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 – High Confidence

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

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 2024

- 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

There were no validation findings that indicate that the credibility of the PIP results is at risk. There was sustained performance indicator rate improvement throughout PIP with continuous intervention monitoring and adaptation.

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 1: HbA1c < 8.0%	2025 (remeasurement 1, MY 2024 data)	66.67%
Indicator 2: HbA1c > 9.0%	2024 (baseline, MY 2023 data)	25.93%
Indicator 2: HbA1c > 9.0%	2025 (remeasurement 1, MY 2024 data)	75.00%

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

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, 2025

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 – High Confidence

MCO: managed care organization; PIP: performance improvement project.

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

Tufts MCO reached their goal rates in the first year of the PIP. The plan continued to implement interventions despite the overall membership decreasing.

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 1: Prenatal Care Visit	2025 (remeasurement 1, MY 2024 data)	74.94%
Indicator 2: Postpartum Visit	2024 (baseline, MY 2023 data)	70.32%
Indicator 2: Postpartum Visit	2025 (remeasurement 1, MY 2024 data)	84.67%
Indicator 3: Postpartum admissions among members with diabetes, hypertension, or preeclampsia	2024 (baseline, MY 2023 data)	0.78%
Indicator 3: Ditto	2025 (remeasurement 1, MY 2024 data)	4.00%
Indicator 4: Timeliness of prenatal care for Black/African American members	2024 (baseline, MY 2023 data)	66.67%
Indicator 4: Ditto	2025 (remeasurement 1, MY 2024 data)	75.00%

Indicator	Reporting Year	Results
Indicator 5: Timeliness of postpartum care for Black/African American members	2024 (baseline, MY 2023 data)	71.67%
Indicator 5: Ditto	2025 (remeasurement 1, MY 2024 data)	91.67%

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

Table 12: Tufts MCO PIP 2 Summary, 2025

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 – Moderate Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence

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

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

Tufts MCO did not demonstrate proactive efforts to resolve some data issues, although it did discuss these limitations. The PIP produced evidence of improvement based on Tufts MCO's modifications of two interventions and the increase in the performance indicator.

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%
Indicator 1: Follow-up After Hospitalization for Mental Illness within 7 days	2025 (remeasurement 1, MY 2024 data)	48.98%

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 and non-HEDIS health plan measures. MCOs calculate HEDIS measure rates and are required to contribute to all HEDIS-related processes before providing them to the state on an annual basis, as stated in Section 2.14.C.6 of the Seventh Amended and Restated MassHealth MCO Contract.

For performance year (PY) 2024, MCOs were also required to report selected HEDIS measures, using allowable adjustments, for the "Medicaid only" population. The measurement period for PY 2024 was January 1, 2024, through December 31, 2024.

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 2024 from January 1, 2024, through December 31, 2024.

For HEDIS measures submitted through the Interactive Data Submission System, IPRO performed an independent evaluation of the MY 2024 HEDIS Compliance Audit Final Audit Report, 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.[9] 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 "Medicaid only" HEDIS measure rates (administrative and hybrid) were calculated with allowable adjustments for PY 2024 between January 1, 2024, and December 31, 2024, as well as measures with a look-back period to incorporate data from April 1, 2023, and December 31, 2023. IPRO validated the "Medicaid only" PY 2024 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 Interactive Data Submission System included both the MCO's Medicaid-only members and the MCO's ACO members.

For the HEDIS measures with allowable adjustments for PY 2024, IPRO conducted a source code review to ensure compliance with the measure specifications, and NCQA allowed adjustments when calculating measure rates with allowable adjustments.

MassHealth's vendor Telligen calculated two non-HEDIS measures in scope for the MCOs. Telligen subcontracted with SS&C Health to produce the non-HEDIS measure rates for the MCOs.

[9] The *CMS External Quality Review (EQR) Protocols,* published in February 2023, states 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 the 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.

MassHealth received claims and encounter data from the MCOs. MassHealth then provided Telligen with MCO claims and encounter data files on a quarterly basis through a comprehensive data file extract referred to as the mega-data extract. Telligen extracted and transformed the data elements necessary for the measure rate calculation. Additionally, Telligen collected and transformed supplemental data received from individual MCOs to support rate calculation.

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

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

Primary source validation was conducted on MassHealth systems for one of the non-HEDIS measures to confirm that the information from the primary source matched the output information used for measure reporting. To this end, MassHealth provided screenshots from the data warehouse for the selected records.

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

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

Description of Data Obtained

The following information was obtained from each MCO: Completed NCQA Record of Administration, Data Management, and Processes (Roadmap) from the current year HEDIS Compliance Audit, as well as associated supplemental documentation, Interactive Data Submission System files, the Final Audit Report, the Medicaid MCO-only adjusted rates for PY 2024 rates, and the explanation for how the Medicaid-only adjusted rates were calculated for PY 2024.

The following information was obtained from MassHealth:

- a completed Information Systems Capabilities Assessment tool;
- denominator and numerator compliant lists for the Topical Fluoride for Children, Dental or Oral Health Services measure for the MCOs;
- rates for the Topical Fluoride for Children, Dental or Oral Health Services measure and Developmental Screening in the First 3 Years of Life measure for the MCOs; and
- screenshots from the data warehouse for primary source validation for the Topical Fluoride for Children, Dental or Oral Health Services measure for the MCOs.

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 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 2024

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 2024 rates. IPRO also conducted an Information Systems Capabilities Assessment review with MassHealth for the non-HEDIS measures. 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 MCO's 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 2024. Source code review was conducted with SS&C Health for the MCO's non-HEDIS measure rates. No issues were identified.
- **Medical Record Validation**: Medical record review validation is conducted to confirm that the MCO followed appropriate processes to report rates using the hybrid methodology. The review of each MCO's Final Audit Report confirmed that the MCOs passed medical record review validation. The two non-HEDIS measures calculated by MassHealth/SS&C Health did not use hybrid methodology; therefore, additional medical record review validation was not required. 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 MCO's Final Audit Report confirmed that the MCOs passed primary source verification for the HEDIS measures. MassHealth provided screenshots from the data warehouse for the selected records for primary source validation for the Topical Fluoride for Children, Dental or Oral Health Services measure. All records passed validation. No issues were identified.
- **Data Collection and Integration Validation**: This includes a review of the processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately. The review of each MCO's Final Audit Report confirmed that the MCOs met all requirements related to data collection and integration. MassHealth also met these requirements. 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 2024 Quality Compass New England regional percentiles for Medicaid health maintenance organizations. According to the MassHealth Quality Strategy, MassHealth's benchmarks for MCO rates are the 75th and the 90th Quality Compass New England regional percentile. The performance varied across measures, with opportunities for improvement in several areas.

Best Performance:

- **Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)**
  - Tufts: 58.92% (≥ 90th percentile)
  - WellSense: 57.41% (≥ 90th percentile)
- **Postpartum Care**
  - Tufts: 89.57% (≥ 90th percentile)
- **Timeliness of Prenatal Care**
  - WellSense: 93.70% (≥ 75th percentile but < 90th percentile)
- **Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)**
  - WellSense: 44.08% (≥ 75th percentile but < 90th percentile)
- **Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)**
  - Tufts: 21.94% (≥ 75th percentile but < 90th percentile)
  - WellSense: 22.66% (≥ 75th percentile but < 90th percentile)

Needs Improvement:

- **Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment**
  - Tufts: 17.56% (≥ 25th but < 50th)
- **Asthma Medication Ratio**
  - WellSense: 54.98% (< 25th percentile)
  - Tufts: 52.86% (< 25th percentile)
- **Childhood Immunization Status (Combo 10)**
  - Tufts: 28.15% (< 25th percentile)
  - WellSense: 31.43% (< 25th percentile)
- **Controlling High Blood Pressure**
  - WellSense: 60.83% (< 25th percentile)
  - Tufts: 62.56% (< 25th percentile)
- **Follow-up After Hospitalization for Mental Illness (7 days)**
  - Tufts: 48.88% (< 25th percentile)
- **Glycemic Status Assessment for Patients with Diabetes (> 9.0%; lower is better)**
  - WellSense: 37.47% (< 25th percentile)
- **Immunization for Adolescents (Combo 2)**
  - WellSense: 25.47% (< 25th percentile)

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

Table 16 displays the MCO-only HEDIS performance measures for MY 2024 for both MCOs and the weighted statewide means.

Table 15: Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2024 Quality Compass New England Regional Percentiles

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

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

Table 16: MCO-only HEDIS Performance Measures – MY 2024

Measure Steward/ Acronym	HEDIS Measure	WellSense MCO	Tufts MCO	Weighted Statewide Mean
NCQA PPC	Timeliness of Prenatal Care	93.7% (≥ 75th but < 90th)	92.37% (≥ 50th but < 75th)	92.77% (≥ 50th but < 75th)
NCQA PPC	Postpartum Care	82.96% (≥ 25th but < 50th)	89.57% (≥ 90th)	87.59% (≥ 50th but < 75th)
NCQA FUH7	Follow-up After Hospitalization for Mental Illness (7 days)	53.61% (≥ 50th but < 75th)	48.88% (< 25th)	50.64% (≥ 25th but < 50th)
NCQA FUM7	Follow-up After Emergency Department Visit for Mental Illness (7 days)	72.03% (≥ 50th but < 75th)	71.36% (≥ 50th but < 75th)	71.64% (≥ 50th but < 75th)
NCQA IET-I	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	57.41% (≥ 90th)	58.92% (≥ 90th)	58.36% (≥ 90th)
NCQA IET-E	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	22.66% (≥ 75th but < 90th)	21.94% (≥ 75th but < 90th)	22.21% (≥ 75th but < 90th)
NCQA FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	44.08% (≥ 75th but < 90th)	43.53% (≥ 50th but < 75th)	43.72% (≥ 75th but < 90th)
NCQA AMR	Asthma Medication Ratio	54.98% (< 25th)	52.86% (< 25th)	53.65% (< 25th)
NCQA CBP	Controlling High Blood Pressure	60.83% (< 25th)	62.56% (< 25th)	62.15% (< 25th)
NCQA GSD	Glycemic Status Assessment for Patients with Diabetes (> 9.0%; lower is better)	37.47% (< 25th)	31.5% (≥ 25th but < 50th)	33.13% (≥ 25th but < 50th)
NCQA CIS	Childhood Immunization Status (Combo 10)	31.43% (< 25th)	28.15% (< 25th)	29.54% (< 25th)
NCQA IMA	Immunization for Adolescents (Combo 2)	25.47% (< 25th)	41.98% (≥ 25th but < 50th)	34.67% (≥ 25th but < 50th)

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.

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 2024 for all MCOs and the weighted statewide mean. The PC MES survey results were fielded in 2025, for the 2024 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 2024

Measure Steward	State Performance Measure	WellSense MCO	Tufts MCO	Weighted Statewide Mean	Goal Benchmark
EOHHS	PC MES Willingness to Recommend+ Adult	85% (< Goal)	89.17% (< Goal)	88.75% (< Goal)	92%
EOHHS	PC MES Willingness to Recommend+ Child	94.68% (> Goal)	93.61% (> Goal)	92.48% (> Goal)	92%
EOHHS	PC MES Communication+ Adult	91.68% (< Goal)	93.61% (> Goal)	93.4% (> Goal)	92%
EOHHS	PC MES Communication+ Child	97.4% (> Goal)	96.27% (> Goal)	96.11% (> Goal)	92%
EOHHS	PC MES Integration of Care+ Adult	83.05% (< Goal)	85.39% (> Goal)	86.26% (> Goal)	85%
EOHHS	PC MES Integration of Care+ Child	81.52% (< Goal)	84.73% (< Goal)	86.17% (< Goal)	90%
EOHHS	PC MES Knowledge of Patient+ Adult	85.46% (> Goal)	88.85% (> Goal)	87.75% (> Goal)	85%
EOHHS	PC MES Knowledge of Patient+ Child	93.05% (> Goal)	91.52% (> Goal)	90.11% (> Goal)	90%
DQA (ADA)	Topic Fluoride for Children (Ages 1–5 years)	24.88% (> Goal)	29.15% (> Goal)	38.03% (> Goal)	24%
OHSU	Developmental Screening in the First 3 Years of Life	66.67% (> Goal)	60.96% (> Goal)	74.01% (> Goal)	60%

MCO: managed care organization; MY: measurement year; EOHHS: Executive Office of Health and Human Services; Primary Care Member Experience Survey; DQA (ADA): Dental Quality Alliance (American Dental Association); OHSU: Oregon Health and Science University.

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*)
- QAPI (*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 EQRO to assess whether the plan indeed understands the requirements, the internal processes, and procedures to deliver the required services to members and providers; can articulate in their own words; and draws the relationship between the policies and the implementation of those policies. Interviews discussed elements in each of the review tools that were considered less than fully compliant based upon initial review. Interviews were used to further explore the written documentation and to allow 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, the 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 MCO needs to work on Health Information Systems (70%), QAPI (94%), and Availability of Services (91%).
- Tufts MCO 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. Red text indicates opportunity for improvement (less than 90%).

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%	89%
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%	99%
QAPI	**438.330**	94%	97%

CFR: Code of Federal Regulations; QAPI: Quality Assurance and Performance Improvement; N/A: not applicable.

VI. Validation of Network Adequacy

Objectives

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

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

MassHealth's access and availability standards are described in Section 2.10 and Appendix N of *the Seventh 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 April 4, 2025, and closed on May 27, 2025. IPRO also scheduled 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. Tufts MCO was excluded from the secret shopper activity because it ended operations at the end of CY 2025. The audited specialties are listed in **Table 21**.

Table 21: Audited Specialties

Reporting Group	Specialty/Facility
Primary care	Family medicine, Internal medicine, Pediatrics
Specialists	Obstetrics/Gynecology (Ob/Gyn)
Outpatient mental health and substance use disorder providers	Community Mental Health Centers (CMHCs)

IPRO filtered WellSense MCO online provider directory for primary care, obstetrics/gynecology providers as well as Community Mental Health Centers (CMHCs) that were accepting new patients and then used a browser-based web scraping tool to scrape the data, creating a database of providers. The sample size was determined based on the population size using a 95% confidence level and a 7% margin of error to ensure a statistically valid methodology. The records in the random samples were reviewed for overlaps to create a "calling samples" and to ensure that the same providers were not contacted multiple times. The records in the calling samples were manually checked for accuracy against the online provider directory, ensuring that all records in the calling samples were correct.

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

IPRO also inquired about the wait times for the next available routine and sick appointments for primary care and ob/gyn providers as well as the next available intake session and/or individual therapy appointment at the CMHCs. Callers were provided with scenarios to use when attempting to collect the appointment dates. Each CMHCs calling script was designed to address telehealth and in-person appointments and differentiate between a billable clinical intake session vs administrative screening. A telehealth appointment was counted towards the average appointment wait times only if the behavioral health provider also offered in-person appointments.

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	Nonurgent symptomatic: sick visit	30 calendar days
MCO/ACPP specialty provider: ob/gyn	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 2025, 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 2025. MCO network adequacy standards and indicators are listed in **Appendix D** (**Tables D1–D6**).

IPRO requested in-network provider data on April 4, 2025, with a submission due date of May 16, 2025. 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 April 4 and October 1, 2025. 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 April 4, 2025, until May 16, 2025.

Provider Directory and Availability of Appointment Data

For the provider directory validation, WellSense MCO provider directory web address were reported to IPRO by the MCPs and is presented in **Appendix E**. Data was obtained directly from WellSense MCO online provider directory using a browser-based web scraping tool. The PCP data was obtained on August 25, 2025; the ob/gyn data was obtained on September 9, 2025; and the CMHC data was obtained on September 3, 2025. The PCP and ob/gyn practice sites were contacted between October and November 2025. The CMHCs were contacted between January and February 2026. Tufts MCO was excluded from the secret shopper activity because it ended operations at the end of CY 2025.

Travel Time and Distance Data

Validation of network adequacy for CY 2025 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 April 1, 2025, 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 2025

Network Adequacy Indicator	WellSense MCO Validation Rating	Tufts MCO Validation Rating
PCP GeoAccess	High confidence	Moderate confidence
Ob/Gyn GeoAccess	Moderate confidence	High confidence
Physical Health Services GeoAccess	High confidence	High confidence
Specialists GeoAccess	Moderate confidence: Emergency Medicine, Gastroenterology, Infectious Diseases, Psychiatry, and Urology High confidence: all other provider types	Moderate confidence: Ophthalmology, Podiatry, Psychiatry, and Urology High confidence: all other specialist provider types

Network Adequacy Indicator	WellSense MCO Validation Rating	Tufts MCO Validation Rating
Behavioral Health Services GeoAccess	High confidence: Psychiatric Inpatient Adult Moderate confidence: all other provider types	Moderate confidence: Behavioral Health Outpatient, Monitored Inpatient Acute Treatment Services (ATS) Level 3.7, Opioid Treatment Programs (OTP), Psychiatric Inpatient Adult, Structured Outpatient Addiction Program (SOAP) High confidence: all other Behavioral Health provider types
Pharmacy GeoAccess	High confidence	High confidence
Provider-to-member Ratios[1]	High confidence	High confidence
Accuracy of Directories[1]	Moderate confidence	N/A

[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.
MCO: managed care organization; CY: calendar year; PCP: primary care provider; ob/gyn: obstetrics/gynecology; MCP: managed care plan; N/A: not applicable, Tufts MCO was excluded from the secret shopper activity because it ended operations at the end of CY 2025.

Network Information Systems Survey

The analysis of the information systems assessment showed the following:

- 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 2024 rates. IPRO also conducted an Information Systems Capabilities Assessment review with MassHealth for the non-HEDIS measures. 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, incorrect provider directory information, and different membership counts compared to the MassHealth membership count for the same period. These findings were shared with the MCP via email.
- IPRO reviewed the MCP's process for updating data (i.e., provider and beneficiary information) and concluded that while the MCP process for updating provider data includes daily updates and validation routines, it should also 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 significant system changes were reported.

Provider Directory

IPRO validated the accuracy of provider directories for a random sample of provider types chosen by MassHealth. **Table 25**, **Table 27**, and **Table 29** show the percentage of providers in the directory with verified telephone number, address, specialty, and Medicaid participation. An accuracy goal for the provider directory

activity was not established. Tufts MCO was excluded from the secret shopper activity because it ended operations at the end of CY 2025.

Table 25: Provider Directory Accuracy – Primary Care Providers

Provider Directory Accuracy	WellSense MCO
% Providers with correct information[1]	23.5% (32)
Total providers called	136

[1] Providers with correct information = Provider is at the site; address is correct; phone number is correct; provider is accepting new patients; provider is a primary care provider; provider is participating in this health plan.
Note: The sample is representative of the population with a 95% confidence interval and +/- 7% margin of error.
MCO: managed care organization.

Table 26 shows the most frequent reasons why PCP information in the directories was incorrect or could not be validated.

Table 26: Directory Inaccuracy/Provider Verification Challenges – Primary Care Providers

Directory Inaccuracy Reasons	WellSense MCO
Provider is NOT accepting new patients	31
Contact fails[1]	36
Provider is not at site[2]	20
Address is NOT correct	11
Telephone number is NOT correct	8
Provider is NOT a primary care provider	11
Provider is NOT participating in this health plan	10
Total inaccuracies per plan[3]	127

[1] Contact fails = Phone number is not in service; wrong telephone number; the call was disconnected before contact was made; constant busy signal; no answer; put on hold for more than 5 minutes; automated answering machine; answering service.
[2] Provider is not at the site = Provider is retired; provider is no longer at the site; and provider was never part of the group.
[3] Total inaccuracies per plan = Total number of inaccuracies. They will not equal provider counts.
MCO: managed care organization.

Table 27 shows the percentage of ob/gyn providers with accurate provider directory information.

Table 27: Provider Directory Accuracy – Obstetrics/Gynecology

Provider Directory Accuracy	WellSense MCO
% Providers with correct information[1]	19.50% (31)
% Providers for whom health plan info could not be confirmed[2]	16.35% (26)
Total providers called	159

[1] Providers with correct information = Provider is at the site; address is correct; phone number is correct; provider is accepting new patients; provider is an ob/gyn; provider is participating in this health plan.
[2] Providers for whom health plan info could not be confirmed = the staff member did not know whether the provider accepts this health plan or not.
Note: The sample is representative of the population with a 90% confidence interval and +/- 7% margin of error.
MCO: managed care organization.

Table 28 shows the most frequent reasons why ob/gyn information in the directories was incorrect or could not be validated.

Table 28: Directory Inaccuracy/Provider Verification Challenges – Obstetrics/Gynecology

Directory Inaccuracy Reasons	WellSense MCO
Provider is not at site[1]	39
Contact Fails[2]	36
Provider is NOT accepting new patients	20
Address is NOT correct	14
Provider is NOT an ob/gyn	12
Telephone number is NOT correct	8
Provider is NOT participating in this health plan	6
Total Inaccuracies per Plan	135

[1] Provider is not at the site = Provider is retired; provider is no longer at the site; and provider was never part of the group.
[2] Contact fails = Phone number is not in service; wrong telephone number; the call was disconnected before contact was made; constant busy signal; no answer; put on hold for more than 5 minutes; automated answering machine; answering service.
MCO: managed care organization; ob/gyn: obstetrician/gynecologist.

Table 29 shows the percentage of Community Mental Health Centers with accurate online directory information. The percentage of CMHCs with correct information means the percentage of CMHCs for which all of the following is correct: the CMHC offers outpatient therapy; the address is correct; the phone number is correct; the CMHC is accepting new patients; and the CMHC is accepting this health plan. The percentage of CMHCs for whom health plan info could not be confirmed means that the staff member did not know whether the provider accepts this health plan or not.

Table 29: Provider Directory Accuracy – Community Mental Health Centers (CMHCs)

CMHC Directory Accuracy	WellSense MCO
% CMHCs with correct information	3.2% (4)
% CMHCs for whom health plan info could not be confirmed	10.40% (13)
Total CMHCs called	125

Note: The sample is representative of the population with a 90% confidence interval and +/- 7% margin of error.
MCO: managed care organization.

Table 30 shows the most common reasons for inaccuracies or unverified information regarding Community Mental Health Centers in the directories. The “contact fails” category includes several circumstances: the phone number was not in service; the telephone number was wrong; the call was disconnected before a contact was made; callers encountered a constant busy signal; no answer; callers were placed on hold for more than five minutes; there was an automated answering machine; or the caller was redirected to an answering service. Callers made up to three attempts to reach a live staff person at each practice to complete the survey. If a phone number was not in service, wrong, disconnected, or resulted in a constant busy signal, an additional call was made to verify the outcome. The phrase “CMHC does not offer outpatient services” indicates that the CMHC provides only group services; program-specific services (e.g., intensive outpatient program, partial hospitalization, addiction recovery groups, crisis stabilization); has insufficient clinical staffing (no licensed therapists or open vacancies); or offers other types of services (e.g., residential treatment).

Table 30: Directory Inaccuracy/Provider Verification Challenges – Community Mental Health Centers (CMHCs)

Directory Inaccuracy Reasons	WellSense MCO
CMHC does not offer outpatient services	37
Contact Fails	35
Address is NOT correct	16

Directory Inaccuracy Reasons	WellSense MCO
CMHC does NOT accept this health plan	16
CMHC is NOT accepting new patients	2
Telephone number is NOT correct	2
Total Inaccuracies per Plan	108

MCO: managed care organization.

Wait Time for Appointment

The results of the wait time for appointment survey are listed below. **Tables 31–32** show the wait time for appointment results for PCPs.

Table 31: Average Appointment Wait Time – PCPs

MassHealth Routine Wait Time Standards[1]	WellSense MCO
Average calendar days to routine appointment (min, max)	70.8 (3, 396)
% providers meeting 45-day standard	41.7% (15)
Providers with routine appointment date (N)	36
Providers reached	100

[1] 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 contact was made and an appointment date was collected.

PCP: primary care provider; MCO: managed care organization.

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

Reasons Routine Appointment Date Was Not Collected	WellSense MCO
Provider is not accepting new patients	9
Patient must be registered with the clinic first	2
Other[1]	9
Patients are placed on a waiting list.	0
Patient's ID or personal info must be presented first	3
Medical records must be submitted first	1
Staff member refused to participate	0
Staff member requested a callback	0
Total	24

[1] Other includes reasons related to role limitations, care-setting restrictions, telehealth-only coverage, or a closed/transitioning patient panel. For example, the provider is telehealth-only and serves as coverage for other clinicians, so routing in-person of new patient appointments cannot be scheduled. PCP: primary care provider; MCO: managed care organization.

Tables 33–34 show the wait time for appointment results for obstetrics/gynecology.

Table 33: Average Appointment Wait Time – Obstetrics/Gynecology

MassHealth Routine Wait Time Standards[1]	WellSense MCO
Average calendar days to routine appointment (min, max)	84.5 (1, 180)
% providers meeting 60-day standard	27.3% (9)
Providers with routine appointment date (N)	33
Providers reached	123

[1] 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 contact was made and an appointment date was collected.

MCO: managed care organization.

Table 34: Reasons Not Able to Get an Appointment Date – Obstetrics/Gynecology

Reasons Routine Appointment Date Was Not Collected	WellSense MCO
Other[1]	13
Provider is not accepting new patients.	6
Patient must be registered with the clinic first	3
Patient's ID or personal info must be presented first	3
Medical records must be submitted first	3
Staff member requested a callback	3
Patients are placed on a waiting list	1
Staff member refused to participate	1
Caller was instructed to seek an Urgent Care Facility	0
Total	33

[1] Other reasons due to specialty only care, referral requirements, inpatient-only services, or lack of near-term appointment availably that were not accounted for in the preidentified categories. For example, the provider is a Gynecology surgeon who only accepts in-network referrals and has a waitlist extending into early 2026. MCO: managed care organization.

For the Community Mental Health Centers that shared the appointment date, the average wait time for appointment was 5.7 calendar days, ranging from a one calendar day to a 15 calendar day waiting period. 85.7% of contacted CMHCs, who shared an appointment date, met the MassHealth appointment wait time standard of 14 calendar days. **Tables 35–36** show the wait time for appointment results for Community Mental Health Centers in the WellSense MCO network.

Table 35: Average Appointment Wait Time – Community Mental Health Centers (CMHCs)

MassHealth Behavioral Health Wait Time Standards	WellSense MCO
Average calendar days to appointment (min, max)	5.7 (1, 15)
% CMHC meeting 14-day standard	85.7% (6)
CMHC with appointment date (N)	7
CMHC reached	90

[1] Range (min, max) indicates the span between the shortest wait time recorded and the longest wait time recorded in calendar days. N = total CMHC reached, which is calculated as the number of CMHC for which contact was made and an appointment date was collected. Note: The appointment date was requested only when the contacted CMHC offered outpatient therapy and accepted the health plan.
MCO: managed care organization.

Appointment availability information was repeatedly withheld unless the patient's eligibility could be verified and met preventing IPRO from assessing wait time but also restricting patients' access. A patient deciding where to seek care should be able to assess how long the wait is without needing to register with the center and without an administrative intake appointment. The barriers include requiring eligibility verification before discussing schedules, requiring patient registration to disclose availability, and refusing to share the next appointment date without an insurance ID, etc. **Table 36** shows the most frequent reasons why appointment dates were not collected.

Table 36: Reasons Not Able to Get an Appointment Date – Community Mental Health Centers (CMHCs)

Reasons Appointment Date Was Not Collected	WellSense MCO
Administrative intake must be conducted first	20
Patient must be registered with the clinic first	10
Patients are placed on a waiting list	6
Other[1]	5

Reasons Appointment Date Was Not Collected	WellSense MCO
Patient's ID or personal info must be presented first	5
CMHC is not accepting new patients.	0
Medical records must be submitted first	0
Staff member refused to participate	0
Staff member requested a callback	0
Total	46

[1] Other includes reasons related to intake or outpatient staff being unreachable or unable to provide dates until prerequisite steps were completed. For example, when the caller was transferred from the front desk to central intake to obtain an appointment date, the call went to voicemail. MCO: managed care organization.

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 37** shows the number of service areas that each MCO covers.

Table 37: 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 38–42 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 38: 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	37 out of 38 (Partially Met)	26 out of 26 (Met)
Ob/Gyn	2 providers within 15 miles or 30 minutes	38 out of 38 (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)

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

Table 39: 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	38 out of 38 (Met)	26 out of 26 (Met)
Urgent care services	1 urgent care within 15 miles or 30 minutes	38 out of 38 (Met)	24 out of 26 (Partially Met)

MCO: managed care organization.

Table 40: 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	38 out of 38 (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)

MCO: managed care organization.

Table 41: 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 it has at least one allergy provider, oral surgeon, plastic surgeon, vascular surgeon in its network.

Table 42: 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, and, for members residing in Oak Bluffs and Nantucket, any hospital located in the Oak Bluffs and Nantucket Service Areas, or the two closest hospitals located outside of these service areas	38 out of 38 (Met)	26 out of 26 (Met)
Clinical Stabilization Service (CSS) Level 3.5	2 providers within 30 miles or 30 minutes, and, for members residing in Oak Bluffs and Nantucket, any hospital located in the Oak Bluffs and Nantucket Service Areas, or the four closest hospitals located outside of these service areas	26 out of 38 (Partially Met)	24 out of 26 (Partially Met)
Youth Community Crisis Stabilization (YCCS)	2 providers within 30 miles or 30 minutes	32 out of 38 (Partially Met)	26 out of 26 (Met)
Monitored Inpatient Acute Treatment Services (ATS) Level 3.7	2 providers within 30 miles or 30 minutes	24 out of 38 (Partially Met)	20 out of 26 (Partially Met)
Partial Hospitalization Program (PHP)	1 provider within 60 miles or 60 minutes	38 out of 38 (Met)	26 out of 26 (Met)
Structured Outpatient Addiction Program (SOAP)	2 providers within 30 miles or 30 minutes	32 out of 38 (Partially Met)	22 out of 26 (Partially Met)
Intensive Care Coordination (ICC)	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)	26 out of 26 (Met)
BH outpatient (including psychology and psych APN)	2 providers within 30 miles or 30 minutes	38 out of 38 (Met)	26 out of 26 (Met)
Opioid Treatment Programs (OTP)	2 providers within 30 miles or 30 minutes	34 out of 38 (Partially Met)	25 out of 26 (Partially Met)
Applied Behavior Analysis (ABA)	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)	23 out of 26 (Partially Met)
In-home Behavioral Services	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)	26 out of 26 (Met)
In-home Therapy Services	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)	26 out of 26 (Met)
Therapeutic Mentoring Services	2 providers within 30 miles or 30 minutes	37 out of 38 (Partially Met)	26 out of 26 (Met)

MCO: managed care organization; 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 43–44**).

Table 43: MCO Provider-to-member Ratios for PCPs and Ob/Gyns

Provider Type[1]	Goal	WellSense MCO	Tufts MCO
Adult PCP	1:750	1:14 (Met)	1:24 (Met)
Pediatric PCP	1:750	1:11 (Met)	1:17 (Met)
Ob/Gyn	1:500	1:7 (Met)	1:10 (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 44: MCO Provider-to-member Ratios for Specialists

Provider Type[1]	Goal	WellSense MCO	Tufts MCO
Allergy	N/A	1:112	1:188
Anesthesiology	N/A	1:12	1:16
Audiology	N/A	1:114	1:118
Cardiology	N/A	1:17	1:27
Dermatology	N/A	1:43	1:68
Emergency medicine	N/A	1:11	1:18
Endocrinology	N/A	1:40	1:65
Gastroenterology	N/A	1:30	1:43
General surgery	N/A	1:22	1:31
Hematology	N/A	1:21	1:64
Infectious diseases	N/A	1:43	1:64
Medical oncology	N/A	1:20	1:45
Nephrology	N/A	1:50	1:79
Neurology	N/A	1:22	1:32
Ophthalmology	N/A	1:35	1:46
Oral surgery	N/A	1:375	1:450
Orthopedic surgery	N/A	1:26	1:41
Otolaryngology	N/A	1:66	1:90
Physiatry	N/A	1:67	1:88
Plastic surgery	N/A	1:118	1:157
Podiatry	N/A	1:89	1:104
Psychiatry	N/A	1:7	1:17
Pulmonology	N/A	1:30	1:47
Rheumatology	N/A	1:77	1:119
Urology	N/A	1:65	1:95
Vascular surgery	N/A	1:144	1:185

[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 45**.

Table 45: WellSense MCO Network Adequacy Validation Ratings – CY 2025

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating WellSense MCO	Comments
Primary Care Providers' 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	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.
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 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.
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; 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
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: Emergency Medicine, Gastroenterology, Infectious Diseases, Psychiatry, and Urology High confidence: all other provider types	For Emergency Medicine, Gastroenterology, Infectious Diseases, Psychiatry, and Urology: 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. For all other provider types: 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.
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	High confidence: Psychiatric Inpatient Adult Moderate confidence: all other provider types	For Psychiatric Inpatient Adult: 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. For Clinical Stabilization Service (CSS) Level 3.5, Monitored inpatient Acute Treatment Services (ATS) Level 3.7, and Youth Community Crisis Stabilization (YCCS): No issues were found with the underlying information systems; the MCP's provider data were clean; and the MCP applied the correct MassHealth standards for analysis; however, the results calculated by the MCP did not match the time-and-distance results calculated by IPRO for some service areas. For all other provider types: 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 gaps for 10 provider types in multiple service areas.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating WellSense MCO	Comments
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.
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 CMHC 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.

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 46–47** show service areas with deficient networks for WellSense MCO. IPRO also determined that 222 providers submitted for the analysis had deactivated national provider identifiers, while four providers had more than 25 different locations listed per provider.

Table 46: WellSense MCO Service Areas with Network Deficiencies – PCPs, Ob/Gyn, and Pharmacy

Provider Type[1]	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)	Oak Bluffs	0.0%	2 providers within 40 miles or 40 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 47: 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
Clinical Stabilization Service (CSS) Level 3.5	Adams	0.0%	2 providers within 30 miles or 30 minutes
CSS	Athol	12.5%	2 providers within 30 miles or 30 minutes
CSS	Barnstable	22.9%	2 providers within 30 miles or 30 minutes
CSS	Gardner-Fitchburg	57.8%	2 providers within 30 miles or 30 minutes
CSS	Gloucester	88.4%	2 providers within 30 miles or 30 minutes
CSS	Greenfield	14.6%	2 providers within 30 miles or 30 minutes
CSS	Haverhill	88.3%	2 providers within 30 miles or 30 minutes
CSS	Oak Bluffs	50.0%	2 providers within 30 miles or 30 minutes, or the 4 closest providers to Oak Bluffs
CSS	Orleans	0.0%	2 providers within 30 miles or 30 minutes
CSS	Pittsfield	0.0%	2 providers within 30 miles or 30 minutes
CSS	Springfield	9.6%	2 providers within 30 miles or 30 minutes
CSS	Westfield	0.0%	2 providers within 30 miles or 30 minutes
Youth Community Crisis Stabilization (YCCS)	Adams	57.9%	2 providers within 30 miles or 30 minutes
YCCS	Barnstable	34.1%	2 providers within 30 miles or 30 minutes
YCCS	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
YCCS	Oak Bluffs	30.0%	2 providers within 30 miles or 30 minutes
YCCS	Orleans	33.9%	2 providers within 30 miles or 30 minutes
YCCS	Pittsfield	19.5%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Acute Treatment Services (ATS) Level 3.7	Adams	0.0%	2 providers within 30 miles or 30 minutes
ATS	Athol	11.1%	2 providers within 30 miles or 30 minutes
ATS	Gardner-Fitchburg	80.1%	2 providers within 30 miles or 30 minutes
ATS	Gloucester	88.4%	2 providers within 30 miles or 30 minutes
ATS	Greenfield	1.4%	2 providers within 30 miles or 30 minutes
ATS	Haverhill	88.3%	2 providers within 30 miles or 30 minutes
ATS	Holyoke	2.7%	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
ATS	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
ATS	Northampton	3.2%	2 providers within 30 miles or 30 minutes
ATS	Oak Bluffs	50.0%	2 providers within 30 miles or 30 minutes
ATS	Orleans	5.7%	2 providers within 30 miles or 30 minutes
ATS	Pittsfield	4.9%	2 providers within 30 miles or 30 minutes
ATS	Springfield	5.1%	2 providers within 30 miles or 30 minutes
ATS	Westfield	0.7%	2 providers within 30 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	Adams	57.9%	2 providers within 30 miles or 30 minutes
SOAP	Gardner-Fitchburg	89.9%	2 providers within 30 miles or 30 minutes
SOAP	Greenfield	89.5%	2 providers within 30 miles or 30 minutes
SOAP	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
SOAP	Orleans	16.3%	2 providers within 30 miles or 30 minutes
SOAP	Pittsfield	17.1%	2 providers within 30 miles or 30 minutes
Intensive Care Coordination (ICC)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
Opioid Treatment Programs (OTP)	Adams	62.9%	2 providers within 30 miles or 30 minutes
OTP	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
OTP	Oak Bluffs	70.0%	2 providers within 30 miles or 30 minutes
OTP	Orleans	35.7%	2 providers within 30 miles or 30 minutes
Applied Behavior Analysis (ABA)	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
In-home Behavioral Services	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
In-home Therapy Services	Nantucket	0.0%	2 providers within 30 miles or 30 minutes
Therapeutic Mentoring Services	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 submit for the analysis only the providers that are considered acceptable by MassHealth for certain behavioral health provider types.
- WellSense MCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- WellSense MCO should revisit the GeoAccess results that differed from IPRO's analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.
- 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 48**.

Table 48: Tufts MCO Network Adequacy Validation Ratings – CY 2025

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts MCO	Comments
Primary Care Providers' 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	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.
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; 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 two 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: Ophthalmology, Podiatry, Psychiatry, and Urology High confidence: all other specialist provider types	For Ophthalmology, Podiatry, Psychiatry, and Urology: 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. For all other provider types: 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.
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: Behavioral Health Outpatient, Monitored Inpatient Acute Treatment Services (ATS) Level 3.7, Opioid Treatment Programs (OTP), Psychiatric Inpatient Adult, Structured Outpatient Addiction Program (SOAP) High confidence: all other behavioral health provider types	For Behavioral Health Outpatient, Monitored Inpatient Acute Treatment Services (ATS) Level 3.7, Opioid Treatment Programs (OTP), Psychiatric Inpatient Adult, Structured Outpatient Addiction Program (SOAP): 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. For all other provider types: 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 gaps for five provider types in multiple service areas.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts MCO	Comments
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.
Accuracy of Directories[2]	• Percent of providers in the directory with correct information	Missing[3]	N/A	N/A

[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; N/A: not applicable, Tufts MCO was excluded from the secret shopper activity because it ended operations at the end of CY 2025.

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 49–50** shows service areas with deficient networks for Tufts MCO. IPRO also determined that 32 providers had deactivated national provider identifiers, while 20 providers had more than 25 different locations listed per provider.

Table 49: 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	Athol	29.5%	1 provider within 15 miles or 30 minutes
Urgent Care Services	Gardner-Fitchburg	51.8%	1 provider within 15 miles or 30 minutes

MCO: managed care organization.

Table 50: 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
Clinical Stabilization Service (CSS) Level 3.5	Springfield	15.2%	2 providers within 30 miles or 30 minutes
CSS	Westfield	46.1%	2 providers within 30 miles or 30 minutes
Monitored Inpatient Acute Treatment Services (ATS) Level 3.7	Athol	12.5%	2 providers within 30 miles or 30 minutes
ATS	Gardner-Fitchburg	87.6%	2 providers within 30 miles or 30 minutes
ATS	Greenfield	83.2%	2 providers within 30 miles or 30 minutes
ATS	Holyoke	34.7%	2 providers within 30 miles or 30 minutes
ATS	Springfield	9.5%	2 providers within 30 miles or 30 minutes
ATS	Westfield	46.1%	2 providers within 30 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	Adams	72.0%	2 providers within 30 miles or 30 minutes
SOAP	Athol	30.6%	2 providers within 30 miles or 30 minutes
SOAP	Gardner-Fitchburg	88.9%	2 providers within 30 miles or 30 minutes
SOAP	Pittsfield	5.8%	2 providers within 30 miles or 30 minutes
Opioid Treatment Programs (OTP)	Adams	84.0%	2 providers within 30 miles or 30 minutes
Applied Behavior Analysis (ABA)	Adams	0.8%	2 providers within 30 miles or 30 minutes
ABA	Greenfield	87.0%	2 providers within 30 miles or 30 minutes
ABA	Pittsfield	6.5%	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 revisit the GeoAccess results that differed from IPRO's analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.
- 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.

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

Objectives

Section 2.14.C.1.c. of the Second 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 members 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 care provided.

Each MassHealth MCO independently contracted with a certified CAHPS vendor to administer the adult and child survey for MY 2024. 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 in primary care using the Primary Care Member Experience Survey (PC MES). MassHealth worked with Massachusetts Health Quality Partners, an independent nonprofit measurement and reporting organization, to conduct the PC MES.. MassHealth's PC MES is based on the CG-CAHPS survey, which asks members to report on their experiences with providers and staff in physician practices and groups. The CG-CAHPS survey results can be used to monitor the performance of physician practices and groups and to reward high-quality care.[10] The level of analysis for the PC MES surveys was individual ACO-MCO.

Technical Methods of Data Collection and Analysis

Health Plan CAHPS

The standardized survey instruments were the CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child Medicaid Health Plan Survey.

Following HEDIS requirements, the MCOs' plans prepared sample frames per HEDIS sample frame specifications.

Tables 51–52 provide a summary of the technical methods of data collection by MCO.

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

Table 51: Adult CAHPS – Technical Methods of Data Collection by MCO, MY 2024

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, 2025	February–May, 2025
Method of collection	Mail, telephone, and internet[1]	Mail and telephone
Sample size	4,388	3,983
Response rate	10.5%	10.0%

[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 52: Child CAHPS – Technical Methods of Data Collection by MCO, MY 2024

CAHPS – Technical Methods of Data Collection	WellSense MCO	Tufts MCO
Survey vendor	Press Ganey	Press Ganey
Survey tool	CAHPS 5.1H with CCC	CAHPS 5.1H with CCC
Survey timeframe	March–May, 2025	February–May, 2025
Method of collection	Mail, telephone, and internet[1]	Mail and telephone
Sample size	6,600	1,650
Response rate	7.0%	6.7%

[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; CCC: Children with Chronic Conditions.

Responses were classified into response categories. **Table 53** displays these categories and the measures for which these response categories are used.

Table 53: CAHPS Response Categories, MY 2024

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 • 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 in NCQA Quality Compass 2025 (Measurement Year 2024) for health plans that reported measurement year 2024 CAHPS data to NCQA. The top-box scores are the survey results for the highest possible response category.

PC MES

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

Nineteen MCPs participated in the measurement year 2024 survey, including 15 ACPPs, two PC ACOs, and two MCOs. For the PC MES adult and child surveys, respondents could complete surveys in English or Spanish (in paper or on the web), or in Portuguese, Chinese, Vietnamese, Haitian Creole, Arabic, Russian, Khmer, and Arabic (on the web only). All members received an English paper survey in mailings, and members on file as Spanish-speaking also received a Spanish paper survey in mailings. Email invitations were sent to members with emails on file. The mailed survey and email invitations included a link to the online version of the survey. The survey fielding protocol includes up to 5 emails and up to 3 mailings.

The sample frame included members who had at least one in-person primary care visit during the MY and who were enrolled in one of the ACOs or MCOs. Patients' age on the anchor date (December 31, 2024) was used to assign respondents for the adult or child survey. **Tables 54–55** provide a summary of the technical methods of data collection.

Table 54: Adult PC MES – Technical Methods of Data Collection for MCO, MY 2024

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 fielding timeline	May–August 2025
Method of collection	Mailings and emails
Sample size – all ACOs and MCOs	97,344
Response rate	9.9%

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

Table 55: Child PC MES – Technical Methods of Data Collection for MCO, MY 2024

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 fielding timeline	May–August 2025
Method of collection	Mailings and emails
Sample size – all ACOs and MCOs	144,423
Response rate	4.5%

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

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

Description of Data Obtained

Health Plan CAHPS

For each MCO, IPRO received a copy of the final MY 2024 study reports produced by the plan's certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as results and analyses. IPRO also received weighted means (performance at the all-plans level) calculated by EOHHS.

PC MES

For PC MES, IPRO received copies of the final program year 2024 technical and analysis reports produced by Massachusetts Health Quality Partners. These reports included descriptions of the project's 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 CAHPS results and CAHPS weighted mean (calculated for all health plans) to the national Medicaid benchmarks presented in NCQA Quality Compass MY 2024. 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 56**.

Table 56: Color Key for CAHPS Performance Measure Comparison to NCQA HEDIS MY 2024 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 ratings of all health care, health plan, and a specialist, all adult measures were below the 75th percentile, leaving room for improvement. For child CAHPS results, all measures were below the 75th percentile, except the coordination of care measure.

Table 57 displays the top-box scores of the 2025 CAHPS Adult Medicaid Survey for MY 2024, and **Table 58** displays the top-box scores of the 2025 CAHPS Child Medicaid Survey for MY 2024.

Table 57: CAHPS Performance – Adult Member, MY 2024

CAHPS Measure	WellSense MCO	Tufts MCO	Weighted Mean (All Health Plans)
Getting Care Quickly (always + usually)	74.60% (< 75th)	80.90% (< 75th)	77.35% (< 75th)
Getting Needed Care (always + usually)	77.10% (< 75th)	79.80% (< 75th)	78.18% (< 75th)
How Well Doctors Communicate (always + usually)	91.90% (< 75th)	90.70% (< 75th)	92.33% (< 75th)

CAHPS Measure	WellSense MCO	Tufts MCO	Weighted Mean (All Health Plans)
Customer Service (always + usually)	83.30% (< 75th)	87.60% (< 75th)	86.75% (< 75th)
Coordination of Care (always + usually)	83.10% (< 75th)	80.30% (< 75th)	84.11% (< 75th)
Ease of Filling Out Forms (always + usually)	93.30% (< 75th)	95.60% (< 75th)	93.73% (< 75th)
Rating of All Health Care (9 + 10)	52.10% (< 75th)	60.70% (≥ 75th)	55.04% (< 75th)
Rating of Personal Doctor (9 + 10)	63.10% (< 75th)	69.30% (< 75th)	66.38% (< 75th)
Rating of Specialist Seen Most Often (9 + 10)	71.80% (≥ 75th)	69.80% (< 75th)	69.34% (< 75th)
Rating of Health Plan (9 + 10)	61.00% (< 75th)	65.70% (≥ 75th)	62.58% (< 75th)

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

Table 58: CAHPS Performance – Child Member, MY 2024

CAHPS Measure	WellSense MCO	Tufts MCO	Weighted Mean (All Health Plans)
Getting Care Quickly(always + usually)	86.20% (< 75th)	65.80% (< 75th)	84.93% (< 75th)
Getting Needed Care(always + usually)	80.50% (< 75th)	71.30% (< 75th)	80.13% (< 75th)
How Well Doctors Communicate(always + usually)	94.60% (< 75th)	89.70% (< 75th)	93.81% (< 75th)
Customer Service(always + usually)	89.60% (< 75th)	74.60% (< 75th)	88.59% (< 75th)
Coordination of Care(always + usually)	89.10% (≥ 75th)	85.20% (< 75th)	88.21% (< 75th)
Ease of Filling Out Forms(always + usually)	92.70% (< 75th)	93.00% (< 75th)	93.38% (< 75th)
Rating of All Health Care (9 + 10)	68.50% (< 75th)	68.90% (< 75th)	70.16% (< 75th)
Rating of Personal Doctor (9 + 10)	76.80% (< 75th)	72.50% (< 75th)	77.28% (< 75th)
Rating of Specialist Seen Most Often (9 +10)	74.00% (< 75th)	64.50% (< 75th)	72.87% (< 75th)
Rating of Health Plan (9 + 10)	69.70% (< 75th)	69.80% (< 75th)	70.56% (< 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 59**.

Table 60 shows the results of the PC MES adult Medicaid survey for program year 2024 (fielded in 2025). WellSense MCO scored below the statewide score on all adult PC MES measures, except the Organizational Access measure, which was above the statewide score. Tufts MCO scored below the statewide score on the following three measures: Adult Behavioral Health, Integration of Care, and Self-Management Support.

Table 61 shows the results of the PC MES child Medicaid survey for program year 2024 (fielded in 2025). Tufts MCO scored above the statewide score for the majority of PC MES child measures, whereas WellSense MCO scored above the statewide score on seven PC MES child measures.

Table 59: Color Key for PC MES Performance Measure Comparison Score

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 60: PC MES Performance – Adult Member, Program Year 2024

PC MES Measure	WellSense MCO	Tufts MCO	Statewide Score (ACOs and MCOs)
Adult Behavioral Health	57.37 (< Goal)	64.18 (< Goal)	67.1
Communication	91.68 (< Goal)	93.61 (> Goal)	93.4
Integration of Care	83.05 (< Goal)	85.39 (< Goal)	86.3
Knowledge of Patient	85.46 (< Goal)	88.85 (> Goal)	87.8
Office Staff	93.45 (< Goal)	94.83 (> Goal)	93.8
Organizational Access	80.19 (> Goal)	84.43 (> Goal)	79.8
Overall Provider Rating	86.58 (< Goal)	89.68 (> Goal)	88.7
Self-Management Support	62.64 (< Goal)	62.61 (< Goal)	64.5
Willingness to Recommend	85.00 (< Goal)	89.17 (> Goal)	88.7

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

Table 61: PC MES Performance – Child Member, Program Year 2024

PC MES Measure	WellSense MCO	Tufts MCO	MCO Statewide Score (ACOs and MCOs)
Communication	97.40 (> Goal)	96.27 (> Goal)	96.1
Integration of Care	81.52 (< Goal)	84.73 (< Goal)	86.2
Knowledge of Patient	93.05 (> Goal)	91.52 (> Goal)	90.1

PC MES Measure	WellSense MCO	Tufts MCO	MCO Statewide Score (ACOs and MCOs)
Office Staff	97.31 (> Goal)	95.36 (> Goal)	94.5
Organizational Access	91.63 (> Goal)	88.60 (> Goal)	83.4
Overall Provider Rating	93.55 (> Goal)	91.49 (> Goal)	91.4
Self-Management Support	47.40 (< Goal)	54.40 (> Goal)	52.4
Willingness to Recommend	94.68 (> Goal)	93.61 (> Goal)	92.5
Child Development	66.23 (< Goal)	71.76 (> Goal)	66.4
Child Provider Communication	97.88 (> Goal)	95.68 (< Goal)	96.0
Pediatric Prevention	58.12 (< Goal)	65.38 (> Goal)	62.6

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

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 62–63** 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 62 displays the MCO's progress related to the *Managed Care Organizations External Quality Review CY 2024*, as well as IPRO's assessment of the MCO's response.

Table 62: WellSense MCO Response to Previous EQR Recommendations

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: • 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	WellSense analyzed 2023 MHQP patient experience survey results and identified "Integration of Care" and trust as key areas for improvement. In response, they hosted a Patient Experience ACO Collaboration session focused on building trust through empathetic communication and service recovery strategies. Additionally, they engaged with MassHealth through quality meetings and provided feedback on the member experience survey in 2024.	Partially Addressed
Compliance Review: Lack of compliance with 14 requirements in the following domains: • Availability of services (4) • Care coordination (6) • Health information systems (4) Partial compliance with 78 requirements in the following domains:	<u>Availability of services (Lack of compliance)</u>: • The WellSense MCO should create a formal document for this position (disability access coordinator) and its associated job responsibilities. ○ We are in the process of drafting a comprehensive position description for this role and will begin recruitment process; we are targeting completion and an individual in place not later than the end of Q2'2025. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; dedicated WellSense resource in place.	<u>Addressed</u>: Availability of services (5), Care coordination (9), Grievances and appeals (2), Practice guidelines (1), Health information systems (16), QAPI (9)

[11] Quality improvement.

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]

• Availability of services (1)
• Care coordination (49)
• 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 recommends reviewing the policy annually for any updates, as this is a new practice in 2024.
	  ○ Revision of the Coordination of Care policy is complete. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence.
	<u>Availability of services (Partial compliance)</u>:
	• The WellSense MCO should adopt a formal policy or procedure for identifying and addressing any wait lists for behavioral health services.
	  • Currently, there is not a specific protocol for managing waitlists though Carelon BH will be looking at this at large. A defined processed and written policy and procedure will be in place by 4/30/25. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. Note: WellSense is in-sourcing BH activities as of 1/1/2026; Carelon contract has been terminated as of 12/31/2025.
	<u>Care coordination (Lack of compliance)</u>:
	• The compliance review found lack of compliance with care coordination elements related to care delivery, including HRSN screening and care plans, and enhanced care coordination.
	  ○ Initially, six care coordination-related requirements were not compliant. Of these, three were fully addressed and resulted in demonstrated improvement, while three were partially addressed but did not yet show improvement. The details of these findings were shared with the MCP and MassHealth.
	<u>Care coordination (Partial compliance)</u>:
	• The compliance review found partial compliance with care coordination elements related to care delivery, including care plans, transitional care management and discharge planning; enhanced care coordination; and special kids special care.
	  ○ Initially, 49 care coordination-related requirements were only partially compliant. Of these, six were fully addressed and resulted in demonstrated improvement, while 43 were partially addressed but did not yet show improvement. The details of these findings were shared with the MCP and MassHealth.
	<u>Grievances and appeals (Partial compliance)</u>:
	• IPRO recommends that WellSense continue its efforts to ensure adherence to the contract requirement of a written acknowledgment of receipt of each grievance and appeal within one business day.
	  ○ Workflows are current regarding this requirement and team reminded about the importance of compliance with this requirement on September 26, 2024. New report created to monitor compliance with this requirement
		<u>Partially Addressed</u>: Care coordination (46)

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	around the same time. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. • WellSense should ensure that upon the decision to deny an enrollee's request for an expedited resolution for an internal appeal, a prompt oral notice advising the enrollee and appeal representative of the denial and decision to reduce to a standard internal appeal, should be initiated. The verbal outreach should be documented in the electronic tracking system; written notice should follow within two calendar days per state contract requirements advising of the expedited denial and transfer to the 30-day standard resolution. Written notification of denial from expedited to standard is separate from the one-business-day acknowledgment letter. ○ Member Appeals process was updated to clarify this requirement in our workflows on September 26, 2024 and team has been trained on this requirement. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. <u>Health information systems (Lack of compliance)</u>: • WellSense should complete their policy and procedure that is in development to address making all data collected available to MassHealth and/or CMS upon request. ○ WellSense will update existing policies or create new policies to incorporate the recommendations by end of Q2 2025. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. • WellSense should complete their policy and procedure that is in development to address interoperability and HEI requirements. ○ WellSense will update existing policies or create new policies to incorporate the recommendations by end of Q2 2025. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. • WellSense should develop their process for ascertaining provider adoption of electronic health records and implement their process, including an action plan on bringing participating up to the required threshold, if performance does not meet the benchmark rate of 75%. ○ We now have a policy and process to adhere to. We are on track for an end of Q3 completion date. Process includes steps that are now allowing for: 1) Adoption of Certified EHR: The Plan is required to ensure that at least 75% of our EHR-eligible clinicians adopt and integrate Electronic Health	

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	Record systems that have been certified by the Office of the National Coordinator (ONC). The certification must be in accordance with the 2015 Certification Edition and any subsequent updates as mandated by the 21st Century Cures Act. 2) Interoperability Standards: All EHR systems adopted must support full interoperability, enabling the seamless exchange of health information across different healthcare platforms to ensure coordinated and continuous care. 3) Monitoring and Compliance: The Plan's Provider Relations Department will monitor compliance in the following manner: The total number of EHR-eligible clinicians within the organization; The number and percentage of clinicians who have adopted certified EHR systems; Details on the EHR system used (including ONC certification number and version). 4) Auditing: The Plan may conduct annual audits to validate provider participation in EHR-eligible systems. Above 75% The Plan may require an attestation to verify continued compliance with this requirement. Below 75% The Plan will require, at a minimum, an annual attestation process until 75% compliance is achieved. 5) Self-Reporting Mechanism: The Plan will use a self-reported attestations through an online platform and/or a standardized form. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. • WellSense should complete their policy and procedure that is in development to address QM/QI requirements. ○ WellSense will update existing policies or create new policies to incorporate the recommendations by end of Q2 2025. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. <u>Health information systems (Partial compliance)</u>: • WellSense should finalize and publish the Information Systems – Core Operational Platforms policy that became effective 6/1/2024. ○ WellSense will update existing policies or create new policies to incorporate the recommendations by end of Q2 2025. October 2025: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. • WellSense should complete their policy and procedure that is in development to address verification of data accuracy. ○ WellSense will update existing policies or create new policies to incorporate the recommendations by end of Q2 2025. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported	

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. • Create claims processing policies that specifically address all data elements required in claims files, as well as transfer modes and timeframes and error corrections. ○ WellSense will update existing policies or create new policies to incorporate the recommendations by end of Q2 2025. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines, are complete; ongoing monitoring activities in place to prevent recurrence. <u>Practice guidelines (Partial compliance)</u>: • IPRO recommends adding additional details to the Clinical Practice Guidelines (CPG) policy outlining the process and involvement of the Marketing department in the dissemination of CPGs upon adoption, revision, and approval. This should include elements of timely notification to all affected providers as well as any requests by enrollees and potential enrollees, posting CPGs on the website, and advisement in provider newsletters and any other communication avenues. IPRO would like to note that the admitted deficiency lies in the dissemination of the CPGs and WellSense has taken proactive measures to rectify the discrepancy. ○ An updated CGP policy adding the following language to close the gaps identified will be brought to QIC in March 2025 for approval. Language will be added to #4 of the procedure section of the policy identifying the Marketing Team as managing the notifications after QIC approval. The Marketing team's notifications of newly approved CGPs sent to providers via provider newsletters and/or other mailings as well as an updated website will include a timeframe of within 3 months of QIC approval so that providers, members and prospective members can have access. The cadence of CGPs review and updates will remain at least annually or when deemed necessary. October 2025 update: Internal remediation activities, based on IPRO recommendations and WellSense-reported timelines and action plans, are complete; ongoing monitoring activities in place to prevent recurrence. <u>QAPI (Initial Partial Compliance)</u>: WellSense has enhanced its processes involved in collecting demographic data, utilizing quality measures data to inform the design of QI activities, conducting medical record reviews, and monitoring Intensive Care Coordination (ICC) according to Wraparound standards. For example, WellSense created standardized policies to collect Race, Ethnicity, and Language data, linked both HEDIS and non-HEDIS measures to QI activities for health equity, and enhanced monitoring of medical record reviews and ICC services. WellSense has also developed and implemented a policy that outlines how HEDIS and non-HEDIS quality measures are used to guide QI activities, as well as a standardized process	

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	for collecting race, ethnicity, language, and other demographic data to support stratification of quality measures and identify disparities.	
Network Adequacy: Provider Directory (Recommendation from CY2023): 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.	As of January 1, 2026 WellSense will bring Behavioral Health (BH) services in-house and will leverage its established outreach methodology to support ongoing demographic accuracy. This includes quarterly outreach to providers for demographic validation, during which providers are expected to identify and submit any necessary updates to ensure the directory remains current.	Addressed
Network Adequacy: Information Systems and Quality of Provider Data – Duplicates: 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.	We acknowledge that duplicate provider records were present in submission. Since the CY2024 submission, we have implemented a new duplication process that is expected to significantly reduce the number of duplicated provider records in submissions after 2024. However, some complex cases still require manual identification and removal. To address this, we plan to conduct a manual data review following the completion of our programming evaluations to eliminate the remaining duplicates and further improve data quality. Carelon Behavioral Health has implemented into their QA processes steps to identify and remove duplicate data prior to submission. Please note: WellSense will have Behavioral Health services insourced as of 1/1/2026.	Addressed
Network Adequacy: Time and Distance Analysis – MCP's Methodology: WellSense MCO used incorrect time OR distance standards for behavioral health provider types in	The correct time and distance standard was configured within the Quest GeoAccess system; however, an incorrect standard was mistakenly copied and dragged down from another provider category, leading to discrepancies in the reported results. To prevent such issues, we have implemented validation checks to ensure that the correct standards are consistently applied in the final output.	Addressed

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
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.	Carelon Behavioral Health has implemented into their QA processes steps to identify and remove duplicate data prior to submission. Please note: WellSense will have Behavioral Health services insourced as of 1/1/2026.	
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks: 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.	As of the 2025 reporting period, WellSense MCO has successfully closed all previously identified gaps in the pediatric PCP network across the three affected service areas and the ob/gyn network in the two impacted service areas. Additionally, deficiencies in rehabilitation hospitals and urgent care services have been resolved. We continue to monitor behavioral health provider access and are actively working to address remaining deficiencies where provider availability permits. In service areas where additional providers are not currently available, WellSense is implementing alternative strategies to ensure members have adequate access to care, including expanded telehealth services, transportation support, and enhanced care coordination. Notably, WellSense is in the process of bringing the behavioral health provider network in-house, which may result in different outcomes and improved access as the transition progresses.	Addressed

Recommendation for WellSense MCO	WellSense MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network Adequacy: Accuracy of Provider Directory: 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.	The Provider Relations team conducted outreach to PCPs, OB/GYNs, and Cardiology providers who were flagged for demographic discrepancies. Providers were asked to review and update their demographic information. When updates were identified, the Provider Relations team submitted the changes to the health plan, and the directory was updated accordingly. It is important to note that auditors observed a limitation in the outreach process: the individuals making the calls did not consistently account for providers with multiple practice locations. For example, if a provider was already listed correctly at a secondary location, that entry was not reviewed and was instead marked as an error. This oversight impacted the accuracy of the audit findings, as many providers practice at multiple sites with varying schedules. To support ongoing accuracy, the Provider Relations team will continue outreach to providers on a quarterly basis to review and validate demographic information and encourage providers to review and submit any necessary changes to ensure the provider directory remains current.	Addressed
Quality-of-Care Surveys: 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.	Consumer Insights leads an internal CAHPS Work Group that met seven times in 2024 to review the CAHPS member experience survey results, identify key drivers and opportunities for improvement, prioritize interventions, and monitor progress of initiative implementation. Barriers to members' access to needed care include challenges exacerbated by increasing emergency department wait times and the abrupt Compass Medical office closures in May 2023 that sent thousands of patients scrambling to find other providers in southeastern Massachusetts. The analysis revealed disparities in member experience across racial and age subgroups, and complaints and appeals data highlighted concerns with provider service and access to care. Initiatives approved by the WellSense Quality Improvement Committee to improve MassHealth member experience include: continuing the pre-CAHPS member outreach to remind members of their Plan benefits and to schedule annual checkups with a PCP; aiding members calling WellSense Member Services to request help finding a new PCP via the PCP Search Group; designing blast text messaging campaigns to targeted member groups to encourage member engagement in Care Management programs; enhancing online member materials about preventive health and managing chronic health conditions; and launching the new system of collecting member communication preferences.	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 63 displays the MCO's progress related to the *Managed Care Organizations External Quality Review CY 2024,* as well as IPRO's assessment of the MCO's response.

Table 63: Tufts MCO Response to Previous EQR Recommendations

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: • 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	The Tufts MCO Plan will be discontinued after 12/31/25.	N/A
Compliance Review: Lack of compliance with 13 requirements in the following domains: • Availability of services (1) • Care coordination (11) • Disenrollment requirements and limitations (1) Partial compliance with 51 requirements in the following domains: • Availability of services (4) • Care coordination (37) • Coverage and authorization of services (1)	<u>Availability of services (Lack of compliance)</u>: • The Tufts MCO should create and implement a robust policy for providers to address any barriers to care based on accessibility or specific accommodations for care. ○ In July 2025, the MCP published updates to the online Provider to reflect the contractual requirement. The Provider Manual serves as the most current and comprehensive resource for policies, procedures, products, and programs. It is designed as a reference tool for network physicians, facilities, and office staff who serve our members. Per the MCP's contracts, network providers are required to comply with the policies outlined in the Provider Manual. <u>Availability of services (Partial compliance)</u>: • The Tufts MCO should include specific language in its member handbook that the out-of-network care approved and provided is obtained from a provider that is qualified with the appropriate training and experience.	<u>Addressed</u>: Availability of services (5), Care coordination (18), Coverage and authorization of services (1), Grievances and appeals (3), Health information systems (1), QAPI (5) <u>Partially Addressed</u>: Care coordination (30), Disenrollment

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[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.	○ In March 2025, the MCP updated the Member Handbook and the Medical Necessity Guidelines (MNGs) to clarify this contractual requirement as recommended. • The Tufts MCO should include specific language in its member handbook that enrollees will not be charged additional costs when receiving care out-of-network. ○ Upon review of the updated recommendation and the Member Handbook, the MCP did not take additional action. The Tufts Health Plan Member Handbook currently states "According to state and federal regulations and Tufts Health Together's contract with MassHealth, Your Provider is not allowed to bill you for any Covered Service. " It also states "Do Not pay an Out-of-Network Provider if they bill you for your Covered Services. The Provider should bill Tufts Health Plan directly." It is the responsibility of the member to know and read that language. • The Tufts MCO should create and implement a robust policy for ensuring that Enrollees have access to 2 providers in their prevalent language. ○ To ensure members receive services in their preferred language, the MCP developed and implemented a policy approved in July 2025. Effectiveness will be monitored through triannual reviews of provider and member language data, along with annual policy oversight. • The Tufts MCO should adopt a formal policy to monitor and ensure that providers are offering culturally and linguistically appropriate care to enrollees, such as through formal required trainings. ○ To promote culturally responsive care and reduce health disparities, the MCP developed a CLAS (Culturally and Linguistically Appropriate Services) policy in May 2025. The policy includes monitoring provider completion of CLAS training, with effectiveness assessed through training completion rates and relevant quality metrics. <u>Care coordination (Lack of compliance)</u>: • The compliance review found lack of compliance with care coordination elements related to care needs screening, care plans, transitional care management and discharge planning, risk stratification, and enhanced care coordination. ○ Initially, 11 care coordination-related requirements were not compliant. Of these, ten were fully addressed and resulted in demonstrated improvement, while one was partially addressed but did not yet show improvement. The details of these findings were shared with the MCP and MassHealth. <u>Care coordination (Partial compliance)</u>: • The compliance review found partial compliance with care coordination elements related to care needs screening, care plans, transitional care management and discharge planning, risk stratification, and enhanced care coordination.	requirements and limitations (1)

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	○ Initially, 37 care coordination-related requirements were only partially compliant. Of these, eight were fully addressed and resulted in demonstrated improvement, while 29 were partially addressed but did not yet show improvement. The details of these findings were shared with the MCP and MassHealth. <u>Coverage and authorization of services (Partial compliance)</u>: • The MCP should add a section for the effective date and date of changes with notes about what was altered. ○ In response to IPRO's recommendations, the MCP updated its CBHI workflow in October 2024 to ensure review dates and changes are included. <u>Disenrollment requirements and limitations (Lack of compliance)</u>: • Tufts should create a policy or procedure to address the requirement to notify MassHealth of a change in conditions impacting eligibility such as entering an intermediate care facility for persons with intellectual disability, a state psychiatric hospital, or a locked DYS facility. ○ In response to IPRO's recommendation, the MCP sought clarification from MassHealth. In September 2025, the MCP received guidance on report submission details to a designated EOHHS contact. By end of 2025, the MCP is targeting to complete development of an automated report to address this contractual requirement and be submitted to EOHHS minimally every 10 days to EOHHS. <u>Grievances and appeals (Partial compliance)</u>: • IPRO recommends that Tufts review and correct the language in the documents provided (Tufts MCO Member Handbook, Notice Letter Insert, and Tufts Health Plan UM Policy Manual) to ensure they consistently reflect the contract language for this requirement which states 'the contractor shall not require the enrollee to submit a written signed Internal Appeal form subsequent to the Enrollee's oral request for an appeal. ○ Although the MCP standardly accepts appeals both orally and in writing, with no requirement for written follow-up after an oral submission, the MCP removed language from the appeal insert, Member Handbook and Utilization Management (UM) Policy as recommended by IPRO for clarity in April 2025. • IPRO recommends that Tufts continue to improve its processes in the acknowledgment of the receipt of each Grievance within the one-business-day requirement timeframe. ○ In response to IPRO's recommendations, the MCP automated a report to track open grievances with a daily distribution to management for oversight starting in September 2024. • IPRO recommends that Tufts correct the language in their documents to reflect the contract requirements which state, 'The Contractor shall treat an oral request seeking to appeal an Adverse Action as an Internal Appeal in order to establish the earliest possible filing date for Internal Appeals and shall not	

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
	require the Enrollee or an Appeal Representative to confirm such oral requests in writing.' This language should be consistently stated per State contract requirements in all staff, and member and provider-facing materials. ○ Although the MCP standardly accepted both oral and written appeals without requiring written follow-up for oral submissions, the MCP removed language from the appeal insert, Member Handbook and Utilization Management (UM) Policy as recommended by IPRO for clarity in April 2025. <u>Health information systems (Partial compliance)</u>: • Tufts should develop a method to track the adoption rate of EHRs among their providers in order to report the adoption rate to MassHealth. ○ The MCP completed its exploration of capabilities in 2025 and plans to enhance its data collection approach by incorporating EHR certification tracking into its provider intake form. <u>QAPI (Initial Partial Compliance)</u>: In March 2025, Tufts developed and implemented formal policy and procedure establishing processes for utilizing quality measure data in Quality Management (QM) and Quality Improvement (QI) activities. Tufts also developed a policy to ensure the use of HEDIS and non-HEDIS quality measure results in designing QI activities targeting health equity. Effectiveness will be monitored through an annual policy review and triannual assessments of data utilization. Tufts also established a standardized medical record review process and completed the CY2024 review in September 2025, indicating that the process is operational. Tufts launched a Quality Improvement Workplan in July 2025 that integrated provider satisfaction data and profiling activities with clinical and non-clinical metrics.	
Network: Information Systems and Quality of Provider Data – Duplicates: 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	The MCP has implemented enhanced quality control measures to identify and remove duplicate provider addresses prior to data submission. This includes the use of Excel de-duplication logic and conditional formatting to compare address data across multiple fields. The effectiveness of these measures is reflected in the reduced number of duplicate addresses identified in the 2025 audit.	Addressed.

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
analyses or submitting provider data for the EQR analysis.		
Network: Information Systems and Quality of Provider Data – Behavioral Health Providers: 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.	The MCP established a standardized process to validate behavioral health provider data against the MassHealth-approved list prior to submission. This process has been consistently followed throughout 2025. Staff have received training to prevent recurrence of issues, and quality control checks will be applied to all future submissions. Annual and as-needed re-education will be conducted to maintain ongoing effectiveness.	Addressed
Network: Time and Distance Analysis – MCP's Methodology: 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.	The MCP is actively enhancing provider data quality including establishing clear oversight of vendor data to eliminate duplicates where applicable. For all other provider data, ongoing reviews are being conducted to address integrity issues. Notable improvements in data quality and a reduction in duplicates have been observed from 2023 to 2024, with continued progress anticipated.	Partially Addressed

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network: Time and Distance Analysis – Gaps in Provider Networks: 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.	The MCP monitors its provider network quarterly against applicable standards. When licensed providers are available to address access gaps, the MCP initiates internal coordination to begin outreach. If no providers are available, recruitment is not feasible; in such cases, the MCP will leverage its care management resources to support members in accessing care across geographies.	Remains an Opportunity for Improvement
Network: Accuracy of Provider Directory: 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.	Following the audit, The MCP reviewed and corrected each of the provider directory. Tufts also established a dedicated provider directory auditing team to proactively identify and correct inaccuracies. Complaints related to directory accuracy are being tracked to uncover root causes. A consistent month-over-month decline in complaint volume indicates meaningful improvements in data quality.	Addressed
Quality-of-Care 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	The Tufts MCO Plan will be discontinued after 12/31/25.	N/A

Recommendation for Tufts MCO	Tufts MCO Response/Actions Taken	IPRO Assessment of MCP Response[1]
CAHPS survey in order to drive performance improvement in those specific areas.		

[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; N/A: not applicable.

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

Tables 64–65 highlight each MCO's performance strengths, opportunities for improvement, and this year's recommendations based on the aggregated results of CY 2025 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 64: Strengths, Opportunities for Improvement, and EQR Recommendations for WellSense MCO

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: PPC	There is moderate confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is moderate confidence that the PIP produced evidence of improvement.	Hybrid and admin rates were used interchangeably throughout the PIP, causing inconsistencies between the performance indicators and the baselines, benchmark, and goal rates.	In future reports, the health plan should ensure a consistent methodology throughout the report. Admin rates should be reported for the performance indicator for consistency with the baseline, benchmark, and goal rates.	Quality, Timeliness, Access
PIP 2: HBD	There is high confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is high confidence that the PIP produced evidence of improvement.	N/A	N/A	Quality, Timeliness, Access
Performance Measure Validation: HEDIS measures	MCO demonstrated compliance with information system standards. No issues were identified. The following rates were above the 90th percentile: • Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment • Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment • Timeliness of Prenatal Care • Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	The following measures were below the 25th percentile: • Asthma Medication Ratio • Childhood Immunization Status (Combo 10) • Immunization for Adolescents (Combo 2) • Controlling High Blood Pressure • Glycemic Status Assessment for Patients with Diabetes (> 9.0%; lower is better)	MCO should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: Non-HEDIS measures	No issues were identified. The following measures were above the goal benchmark: • PC MES Willingness to Recommend Child • PC MES Communication Child • PC MES Knowledge of Patient Adult • PC MES Knowledge of Patient Child • Topical Fluoride for Children (Ages 1−5 Years) • Developmental Screening in the First 3 Years of Life	The following measures rates were below the goal benchmark: • PC MES Willingness to Recommend+ Adult • PC MES 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
Compliance Review	Based on the review of the most recent responses to IPRO's recommendations, WellSense MCO demonstrated compliance with most of the federal and state contractual standards. MCP addressed the following opportunities for improvement from the prior compliance review: • Availability of services (5) • Care coordination (9) • Grievances and appeals (2) • Practice guidelines (1) • Health information systems (16) • QAPI (9)	Partial compliance remains with the requirements in the following domains: • Care coordination (46)	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 2026.	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 variations in the address. IPRO removed a total of 315 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

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Information Systems and Quality of Provider Data Behavioral Health Providers	Data used by the MCP to monitor network adequacy were mostly accurate and current, except for duplicative provider records and incorrect provider directory information.	WellSense MCO submitted additional behavioral health providers for Structured Outpatient Addiction Programs (SOAP) that were not on the approved list provided by MassHealth. IPRO removed a total of three additional providers from the WellSense MCO behavioral health data prior to conducting the analysis.	WellSense MCO should submit for the analysis only the providers that are considered acceptable by MassHealth for certain behavioral health provider types.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – MCP's Methodology	WellSense MCO used the correct MassHealth standards for all provider types except for Pediatric PCPs in the Nantucket service area. IPRO compared WellSense MCO's results for PCPs, 17 specialist provider types, rehabilitation hospitals, Psychiatric Inpatient Adult, urgent care, and pharmacies. The comparison showed that IPRO and WellSense MCO had similar or identical results for these provider types. IPRO concluded that the results reported were valid, accurate, and reliable.	WellSense MCO used incorrect time OR distance standards for Pediatric PCPs in the Nantucket service area. IPRO compared WellSense MCO's results for Acute Inpatient Hospitals and three behavioral health provider types. The comparison showed that IPRO and WellSense MCO had different results for these provider types.	WellSense MCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types. WellSense MCO should also revisit the GeoAccess results that differed from IPRO's analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	WellSense MCO demonstrated adequate networks for Adult PCP, ob/gyn, pharmacy, physical health providers, and all specialty providers.	WellSense MCO had a deficient pediatric PCP network in Oak Bluffs service area. The MCO also had deficient networks in one or more service areas for 10 out of 13 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

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Quality-of-care Surveys: HP CAHPS	MCO conducted both adult and child CAHPS surveys. WellSense MCO scored above the statewide score on one adult and seven child PC MES measures.	WellSense MCO scored below the national 75th percentile on the majority of adult and child HP CAHPS measures. WellSense MCO scored below the statewide score on the majority (eight) adult and four child PC MES measures.	WellSense should conduct a root cause analysis to understand why members are not satisfied. WellSense MCO 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; PCP: primary care provider; ob/gyn: obstetrics/gynecology.

Table 65: Strengths, Opportunities for Improvement, and EQR Recommendations for Tufts MCO

Activity[1]	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: PPC	There is high confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is high confidence that the PIP produced evidence of improvement.	N/A	N/A	Quality, Timeliness, Access
PIP 2: FUH	There is moderate confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is high confidence that the PIP produced evidence of improvement.	N/A	N/A	Quality, Timeliness, Access

Activity[1]	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: HEDIS measures	MCO demonstrated compliance with information system standards. No issues were identified. The following measures were above the 90th percentile: • Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment • Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment • Postpartum Care	The following measures were below the 25th percentile: • Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment • Asthma Medication Ratio • Childhood Immunization Status (Combo 10) • Controlling High Blood Pressure • Follow-up After Hospitalization for Mental Illness (7 days)	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
Performance Measure Validation: Non-HEDIS measures	No issues were identified. The following measures rates were above the goal benchmark: • PC MES Willingness to Recommend+ Child • PC MES Communication+ Adult • PC MES Communication Child • PC MES Knowledge of Patient Adult • PC MES Integration of Care+ Adult • PC MES Knowledge of Patient+ Child • Topical Fluoride for Children (Ages 1-5 Years) • Developmental Screening in the First 3 Years of Life	The following measures rates were below the goal benchmark: • PC MES Willingness to Recommend+ Adult • PC MES Integration of Care+ Child	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[1]	Strengths	Opportunities for Improvement	Recommendations	Standards
Compliance Review	Based on the review of the most recent responses to IPRO's recommendations, Tufts MCO demonstrated compliance with most of the federal and state contractual standards. MCP addressed the following opportunities for improvement from the prior compliance review: • Availability of services (4) • Care coordination (18) • Coverage and authorization of services (1) • Grievances and appeals (3) • Health information systems (1) • QAPI (5)	Partial compliance remains with the requirements in the following domains: • Care coordination (30), • Disenrollment requirements and limitations (1)	MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 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 2026.	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 some duplicates for individual and facility providers due to submitting identical records for the analysis. IPRO removed a total of 16 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 Monitored Inpatient Acute Treatment Services (ATS) Level 3.7, Psychiatric Inpatient Adult, Structured Outpatient Addiction Programs (SOAP), and Opioid Treatment Programs that were not on the approved list provided by MassHealth. IPRO removed a total of 18 additional 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[1]	Strengths	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – MCP's Methodology	Tufts MCO used the correct MassHealth standards for all provider types. IPRO compared Tufts MCO's results for ob/gyns, pharmacies, acute inpatient and rehabilitation hospitals, urgent care services, seven behavioral health provider types, and all but four specialist provider types. The comparison showed that IPRO and Tufts MCO had similar or identical results. IPRO concluded that the results reported for those provider types were valid, accurate, and reliable.	IPRO compared Tufts MCO's results for Applied Behavioral Analysis. The comparison showed that IPRO and Tufts MCO had different results for the Adams and Pittsfield service areas.	Tufts MCO should revisit the GeoAccess results that differed from IPRO's analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	Tufts MCO demonstrated adequate networks for PCPs, ob/gyn, pharmacy, acute inpatient and rehabilitation hospitals, and all specialty providers.	Tufts MCO had a deficient urgent care network in two service areas and deficient networks in one or more service areas for five out of 13 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
Quality-of-care Surveys: HP CAHPS	MCO conducted both adult and child CAHPS surveys. Tufts MCO scored above the statewide score on six adult and nine child PC MES measures.	MCO scored below the national 75th percentile on eight adult and all child HP CAHPS measures. Tufts MCO scored below the statewide score on three adult and two child PC MES 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

[1] The Tufts MCO plan will be discontinued after 12/31/25.

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; PC MES: 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 66**.

Table 66: 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: Goal 1 – Achieve a healthy population, delivering high-quality pediatric, preventive, and perinatal care.

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

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

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

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

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

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

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

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

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

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

[1] CMS Universal Foundation and Core Set Measure.

[2] Medicaid Expansion CHIP and non-CHIP.

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

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

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

[1] CMS Universal Foundation and Core Set Measure.

[2] Medicaid Expansion CHIP and non-CHIP.

[3] CMS Core Measure.

MY: measurement year.

XII. Appendix B – MassHealth Managed Care Programs and Plans

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

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Accountable Care Partnership Plan (ACPP)	Groups of primary care providers working with one managed care organization to create a full network of providers. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. • Type: MCE.	1. BeHealthy Partnership Plan 2. Berkshire Fallon Health Collaborative 3. East Boston Neighborhood Health WellSense Alliance 4. Fallon 365 Care 5. Fallon Health – Atrius Health Care Collaborative 6. Mass General Brigham Health Plan with Mass General Brigham ACO 7. Tufts Health Together with Cambridge Health Alliance (CHA) 8. Tufts Health Together with UMass Memorial Health 9. WellSense Beth Israel Lahey Health (BILH) Performance Network ACO 10. WellSense Boston Children's ACO 11. WellSense Care Alliance 12. WellSense Community Alliance 13. WellSense Mercy Alliance 14. WellSense Signature Alliance 15. WellSense Southcoast Alliance
Primary Care Accountable Care Organization (PC ACO)	Groups of primary care providers forming an ACO that works directly with MassHealth's network of specialists and hospitals for care and coordination of care. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. • Type: PCCM Entity.	1. Community Care Cooperative 2. Revere Medical
Managed Care Organization (MCO)	Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. • Type: MCE.	1. WellSense Essential 2. Tufts Health Together (will no longer be a plan in 2026)

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

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

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

XIII. Appendix C – MassHealth Quality Measures

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

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

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

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

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; • 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 with open panels 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 – including both open and closed panels	**ADULT Primary Care Providers Geo-Access:** **Numerator**: number of plan members ages 21 to 64 in a Service Area for which one of the following is true: • Two unique in-network adult PCP providers with open panels (i.e., internal medicine and family medicine) are a 30-minute drive or less from a member residence; and 40-minute drive or less from a member residence for members in the Oak Bluffs and Nantucket Service Areas; OR • Two unique in-network adult PCP providers with open panels (i.e., internal medicine and family medicine) are 15 miles or less from a member residence, and 40 miles from the member's residence for members in the Oak Bluffs and Nantucket Service Areas. **Denominator**: all plan members ages 21 to 64 in a Service Area **ADULT Primary Care Provider-to-Member ratio**: the number of all in-network adult primary care providers (i.e., internal medicine and family medicine) against the number of all members ages 21 to 64. Calculate for all providers (i.e., providers with open and closed panels altogether). **PEDIATRIC Primary Care Providers Geo-Access**: **Numerator**: number of plan members ages 0 to 20 in a Service Area for which one of the following is true: • Two unique in-network pediatric PCP providers with open panels (i.e., pediatricians and family medicine) are a 30-minute drive or less from a member residence; and 40-minute drive or less from a member residence for members in the Oak Bluffs and Nantucket Service Areas; OR • Two unique in-network pediatric PCP providers with open panels (i.e., pediatricians and family medicine) are 15 miles or less from a member residence, and 40 miles from the member's residence for members in the Oak Bluffs and Nantucket Service Areas. **Denominator**: all plan members ages 0 to 20 in a Service Area **Pediatric Primary Care Provider-to-Member ratio**: the number of all in-network 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 Geo-Access:** **Numerator**: number of female members ages 10+ in a Service Area for which one of the following is true: • Two unique in-network OB/GYN providers 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.	**Acute Inpatient Hospitals Geo-Access:** **Numerator**: number of members in a Service Area for which one of the following is true: • One in-network hospital is a 40-minute drive or less from a member residence; OR • One in-network hospital is 20 miles or less from a member residence. **Denominator**: all members in a Service Area. **For the Oak Bluff, Orleans, and Nantucket Service Areas, the Contractor may meet this requirement by including in its Provider Network any hospitals located in these Service Areas that provide acute inpatient services or the closest hospital located outside these Service Areas that provide acute inpatient services. **Cape Cod Hospital in Barnstable is closest to Nantucket, and Falmouth Hospital is closest to Oak Bluffs.* **Urgent Care Geo-Access:** **Numerator**: number of members in a Service Area for which one of the following is true: • One in-network urgent care facility is a 30-minute drive or less from a member residence; OR • One in-network urgent care facility is 15 miles or less from a member residence. **Denominator**: all members in a Service Area. **For the Nantucket Service Area only, the Contractor may substitute Emergency Departments for Urgent Care sites to meet this requirement.* **Rehabilitation Hospital Geo-Access:** **Numerator**: number of members in a Service Area for which one of the following is true: • One in-network rehabilitation hospital is a 60-minute drive or less from a member residence; OR • One in-network rehabilitation hospital is 30 miles or less from a member residence. **Denominator**: all members in a Service Area.

Table D4: MCO Network Adequacy Standards and Indicators – Specialists

Network Adequacy Standards Source: Sec. 2.10.C and Appendix N	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 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	**Specialists**: • At least 90% of Enrollees in each of the Contractor's Service Areas must have access to at least 1 Provider in accordance with the time-OR- distance standards defined in Appendix N, including the exceptions in Oak Bluff and Nantucket Service Areas. • Contractor is required to report provider-to-member ratios, but there are no predefined ratios that need to be achieved. • There are no time-OR-distance standards for allergy providers, oral surgeons, plastic surgeons, and vascular surgeons. The Contractor must show that they have at least one allergy provider, oral surgeon, plastic surgeon, vascular surgeon in their network.	**Specialists Geo-Access:** **Numerator**: number of plan members in a Service Area for which one of the following is true: • One in-network Specialist provider is a 40-minute drive or less from a member residence; and 40-minute drive or less from a member residence for members in the Oak Bluffs and Nantucket Service Areas; OR • One in-network Specialist provider is 20 miles or less from a member residence, and 40 miles from the member's residence for members in the Oak Bluffs and Nantucket Service Areas. **Denominator**: all plan members in a Service Area **Provider-to-Member ratio:** the number of all in-network providers against the number of all members. There are no predefined ratios that need to be achieved. ** There are no time-OR-distance standards for allergy providers, oral surgeons, plastic surgeons, and vascular surgeons. The Contractor must show that they have at least one allergy provider, oral surgeon, plastic surgeon, vascular surgeon in their network.*

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 Monitored inpatient Acute Treatment Services (ATS) level 3.7 Clinical Stabilization Services (CSS) level 3.5 Partial Hospitalization (PHP) Intensive Care Coordination (ICC) Applied Behavioral Analysis (ABA) In-Home Behavioral Services In-Home Therapy Therapeutic Mentoring Services Youth Community Crisis Stabilization (YCCS) Structured Outpatient Addiction Program (SOAP) BH outpatient (including psychology and psych APN) Opioid Treatment Program (OTP) **Sec. 2.10.C.5 5. Behavioral Health Services (as listed in Appendix C)** a. The Contractor shall include in its Network a sufficient number of Behavioral Health Providers to meet the time and distance requirements set forth in Appendix N to the extent qualified, willing providers are available. b. In addition to the Availability requirements set forth in Appendix N, the Contractor shall include in its Network: 1) At least one Network Provider of each Behavioral Health Covered Service set forth in Appendix C in every region of the state served by the Contractor or, as determined by EOHHS, to the extent that qualified, interested Providers are available; and 2) Providers set forth in Appendix G, Exhibit 1 in accordance with the geographic distribution set forth in such appendix, as updated by EOHHS from time to time, including but not limited to providers of ESP Services;	**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 Geo-Access:** **Numerator:** number of members in a Service Area for which one of the following is true: • Two unique in-network providers are a 60-minute drive or less from a member residence; OR • Two unique in-network providers are 60 miles or less from a member residence. **Denominator:** all members in a Service Area **For the Nantucket and Oak Bluffs Service Areas only, the Contractor may meet this requirement by including in its Provider Network the two closest Providers that provide Psychiatric Inpatient Adult services.* **Partial Hospitalization Geo-Access:** **Numerator:** number of members in a Service Area for which one of the following is true: • One unique in-network providers are a 60-minute drive or less from a member residence; OR • One unique in-network providers are 60 miles or less from a member residence. **Denominator:** all members in a Service Area **Other Behavioral Health Services Geo-Access:** **Numerator:** number of members in a Service Area for which one of the following is true: • Two unique in-network providers are a 30-minute drive or less from a member residence; OR • Two unique in-network providers are 30 miles or less from a member residence. **Denominator:** all members in a Service Area **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.*

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 Geo-Access:** **Numerator**: number of members in a Service Area for which one of the following is true: • One pharmacy is a 30-minute drive or less from a member residence; OR • One pharmacy is 15 miles or less from a member residence. **Denominator**: all members in a Service Area

XV. Appendix E – MassHealth MCO Provider Directory Web Addresses

Table E1: MCO Provider Directory Web Addresses

Managed Care Plan	Web Addresses Reported by Managed Care Plan
WellSense MCO	https://www.wellsense.org/members/ma/masshealth#find-a-provider
Tufts MCO	N/A

MCO: managed care organization; N/A: not applicable, Tufts MCO was excluded from the secret shopper activity because it ended operations at the end of CY 2025.