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External Quality Review
One Care Plans
Annual Technical Report, Calendar Year 2023

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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I. Executive Summary

One Care Plans

External quality review (EQR) is the evaluation and validation of information about quality of, timeliness of, and access to health care services furnished to Medicaid Enrollees. The objective of the EQR is to improve states' ability to oversee managed care plans (MCPs) and to help MCPs to improve their performance. This annual technical report (ATR) describes the results of the EQR for One Care Plans that furnish health care services to Medicaid Enrollees in Massachusetts (i.e., Medicare-Medicaid dual eligible population).

Massachusetts's Medicaid program (known as "MassHealth"), administered by the Massachusetts Executive Office of Health and Human Services (EOHHS), contracted with three One Care Plans during the 2023 calendar year (CY). 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, Enrollees receive all medical and behavioral health services, as well as long-term services and support (LTSS). One Care Plans are for Enrollees between 21–64 years old, at enrollment, who are dually enrolled in Medicaid and Medicare. Enrollees can stay in the One Care program after the age of 65 if they continue to be eligible for MassHealth Standard or MassHealth CommonHealth. MassHealth's One Care Plans are listed in **Table 1**.

Table 1: MassHealth's One Care Plans – CY 2023

One Care Plan Name	Abbreviation Used in the Report	Members as of December 31, 2023	Percent of Total One Care Plan Population
Commonwealth Care Alliance	CCA One Care	31,372	71%
Tufts Health Plan Unify	Tufts -One Care	7,747	18%
UnitedHealthcare Connected for One Care	UHC One Care	4,955	11%
One Care All Plans (Total)	N/A	44,074	100%

The **Commonwealth Care Alliance** (**CCA One Care**) is a nonprofit integrated health system that serves 31,372 MassHealth Enrollees. CCA One Care is available to Enrollees who live in Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties.[1]

The **Tufts Health Plan Unify** (**Tufts One Care**) is a nonprofit health plan that serves 7,747 MassHealth Enrollees across eight counties in the state of Massachusetts: Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester. Tufts Health Unify is part of the Point32Health health system.[2]

The **UnitedHealthcare Connected for One Care** (**UHC One Care**) serves 4,955 MassHealth Enrollees across 10 counties in the state of Massachusetts. UHC Connected is available to Enrollees who live in Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties.[3]

Purpose of Report

The purpose of this ATR is to present the results of EQR activities conducted to assess the quality of, timeliness of, and access to health care services furnished to Medicaid Enrollees, in accordance with the following federal managed care regulations: *Title 42 Code of Federal Regulations (CFR) Section (§) 438.364 External review results (a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*. EQR activities validate

[1] One Care | Commonwealth Care Alliance MA
[2] Tufts Health Unify | Member | Tufts Health Plan
[3] UnitedHealthcare Connected® for One Care (Medicare-Medicaid Plan) | UnitedHealthcare Community Plan: Medicare & Medicaid Health Plans (uhccommunityplan.com)

two levels of compliance to assert whether the One Care Plans met the state standards and whether the state met the federal standards as defined in the CFR.

Scope of External Quality Review Activities

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

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

(ii) ***CMS Mandatory Protocol 2: Validation of Performance Measures –*** This activity assesses the accuracy of performance measures (PMs) reported by each One Care Plan and determines the extent to which the rates calculated by the One Care Plans 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 One Care Plans' compliance with its contract and with state and federal regulations.

(iv) ***CMS Mandatory Protocol 4: Validation of Network Adequacy –*** This activity assesses One Care Plans' adherence to state standards for travel time and distance to specific provider types, as well as each One Care Plan'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 One Care Plans' performance strengths and opportunities for improvement.

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

High-Level Program Findings

The EQR activities conducted in CY 2023 demonstrated that MassHealth and the One Care Plans share a commitment to improvement in providing high-quality, timely, and accessible care for members. IPRO used the analyses and evaluations of CY 2023 EQR findings to assess the performance of MassHealth's One Care Plans in providing quality, timely, and accessible health care services to Medicaid Enrollees. Each One Care Plan was evaluated against state and national benchmarks for measures related to the **quality**, **access**, and **timeliness** domains. The plan-level findings and recommendations for each One Care Plan 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 One Care 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 One Care 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 3 years. In addition to the triennial review, MassHealth also conducts an annual review of measures and key performance indicators to assess progress toward strategic goals. MassHealth relies on the annual EQR process to assess the managed care programs' effectiveness in providing high-quality, accessible services.

Opportunities for Improvement:

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

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

General Recommendations for MassHealth:

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

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

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

Performance Improvement Projects

State agencies must require that contracted MCPs conduct PIPs that focus on both clinical and non-clinical areas, as established in *Title 42 CFR § 438.330(d)*. The validation of One Care Plan PIPs conducted in CY 2023 demonstrated the following strengths and weaknesses.

Strengths:

The Plans developed and implemented multi-level interventions that focused on member, provider, and health plan levels.

During CY 2023, each CCA and Tufts One Care plans conducted two PIPs in one of the following priority areas: care coordination and prevention/wellness, primarily for flu vaccination improvement. UHC One Care conducted one PIP focused on flu vaccination improvement. PIPs were conducted in compliance with federal requirements and were designed to drive improvement on measures that support specific strategic goals; however, they also presented opportunities for improvement.

Opportunities for Improvement:

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

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

General PIP Recommendations for MassHealth:

Recommendation for MassHealth relevant to all One Care Plans towards accelerating the effectiveness of PIPs:

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

One Care Plan-specific PIP validation results are described in **Section III** of this report.

Performance Measure Validation

IPRO validated the accuracy of PMs and evaluated the state of health care quality in the One Care program.

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.

One Care Plans are evaluated on a set of Healthcare Effectiveness Data and Information Set (HEDIS®) and non-HEDIS measures (i.e., measures that are not reported to the National Committee for Quality Assurance [NCQA] via the Interactive Data Submission System [IDSS]). HEDIS rates are calculated by each One Care Plan and reported to the state. Non-HEDIS measures were not available at the time of writing this report.

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

IPRO compared One Care Plans' and MassHealth's weighted statewide average HEDIS rates to both the Medicaid and Medicare national Quality Compass® percentiles. When compared to the national Quality Compass rates, the Controlling Blood Pressure weighted statewide mean was above the national Medicaid 90th percentile, while the Engagement in Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment weighted statewide mean rate was above the 90th Medicare percentile.

IPRO also reported One Care measurement year (MY) 2022 non-HEDIS rates calculated by CMS's vendor for the CMS financial alignment demonstration. Compared to the quality withhold benchmarks established by CMS in collaboration with MassHealth, all three One Care Plans scored above the Documentation of Care Plan Goals measure benchmark.

Opportunities for Improvement:

When compared to the MY 2022 Quality Compass national Medicaid percentiles, MassHealth's weighted state means were below the 25th percentile for the Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment measure and the Plan All-Cause Readmissions Ratio. When compared to the MY 2022 Quality Compass national Medicare percentiles, MassHealth's weighted state means were below the 25th percentile for the Hemoglobin A1c Poor Control measure and the Plan All-Cause Readmissions Ratio.

Compared to the quality withhold benchmarks for the non-HEDIS measures, all three One Care plans scored below CMS's Tracking of Demographic Information measure benchmark. The Tracking of Demographic Information measure is the percentage of members whose demographic data are collected and maintained in the Centralized Enrollee Record, including information about race, ethnicity, primary language, homelessness, disability type, and LGBTQ identity.

General Recommendations for MassHealth:

- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major

initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.

PMV findings are provided in Section IV of this report.

Compliance Review

IPRO evaluated the compliance of One Care Plans with Medicaid and CHIP 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 compliance review domains consistent with CMS regulations. This includes regulations that ensure access, address grievances and appeals, enforce beneficiary rights and protections, as well as monitor the quality of healthcare services provided by MCPs. MassHealth collaborates with MCPs to identify areas for improvement, and MCPs actively engage in performance improvement initiatives.

MassHealth monitors MCPs compliance with contractual obligations via regular audits, reviews, and reporting requirements. One Care Plans undergo compliance reviews every 3 years. The next compliance review will be conducted in CY 2026.

The validation of One Care Plans conducted in CY 2023 demonstrated One Care Plans' commitment to their members and providers, as well as strong operations. Of the 14 areas of review, Tufts One Care scored 100% in 8 and 90% or more in 4 domains; UHC One Care scored 100% in 7 and 90% or more in another 7 domains; and CCA One Care scored 100% in 6 and 90% or more in different 6 domains.

Opportunities for Improvement:

Gaps were identified in the areas of Enrollee Rights and Requirements, Emergency and Post-stabilization Services,[6] Coordination and Continuity of Care, as well as Coverage and Authorization of Services. One Care Plans were not always able to identify policy documentation and provide evidence that all requirements are being implemented. The absence of policies can result in inconsistent practices and lead to variations in the quality of provided services.

Some contractual requirements were written in complex language that left room for interpretation that could impede implementation. For example, the proximity access requirements in Section 2.8.2 lacked clarity in terms of network adequacy standards, indicators, and provider types. Some requirements remained in the contract even though they were retired or postponed. Too complex regulations or out of date requirements may hinder the implantation and a broader understanding of contractual obligations leading to inefficiencies and non-compliance.

[6] *Emergency and Post Stabilization Services* domain consists of seven regulations embedded in the 438.210 Coverage and Authorization Tool and extracted in the scorecard for presentation.

General EQR 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.
- *Recommendation towards using plain language in contractual requirements* – To improve clarity, accessibility, and compliance, MassHealth should use plain language and express contractual requirements in straightforward terms that can be easily understood by a broader audience.
- *Recommendation towards addressing gaps identified through the compliance review* – To effectively address the areas of non-compliance, MassHealth should establish direct communication with the MCP to discuss the identified issue, provide the MCP with a detailed explanation of the requirements that were not being met, and collaborate to develop a resolution strategy.

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

Network Adequacy Validation

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

Strengths:

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

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

Travel time and distance standards and availability standards are defined in the One Care contracts with MassHealth. Network adequacy was calculated on a county level, where 90% of health plan members residing in a county had to have access within the required travel time and/or distance standards, depending on a provider type.

All One Care Plans had adequate networks of adult primary care, specialist providers, and behavioral health outpatient providers.

Opportunities for Improvement:

Although the travel time and distance standards are defined in the One Care contracts with MassHealth, the definitions of the network adequacy indicators have not been shared with the MCPs. Network adequacy indicators are metrics used to measure adherence to network adequacy standards.[7] The definitions of the network adequacy indictors as agreed upon for the purpose of this EQR are included in Appendix D.

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

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

After data issues were resolved and duplicate records were removed, IPRO evaluated each One Care provider network to determine compliance with the time and distance standards established by MassHealth. Access was assessed for a total of 56 provider types. The results show that all One Care Plans had some type of hospital, LTSS providers, and behavioral health diversionary services network deficiency. UHC One Care had network deficiencies for 25 provider types, Tufts One Care for 15 and CCA One Care for 13 provider types.

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

General Recommendations for MassHealth:

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

One Care Plan-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 One Care Plans to conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey using an approved CAHPS vendor and report CAHPS data to MassHealth. Each One Care Plan independently contracted with a CMS-approved survey vendor to administer the MA-PD CAHPS surveys.

CMS uses information from MA-PD CAHPS to further evaluate health plans' part D operations; MassHealth monitors One Care Plans' submissions of CAHPS surveys and uses the results to identify opportunities for improvement and inform MassHealth's quality management work.

One Care weighted mean scores exceeded the Getting Appointments and Care Quickly, Customer Service, and Rating of Health Plan CAHPS measures benchmarks. The benchmarks were the Medicare Advantage fee-for-service (FFS) mean scores.

Opportunities for Improvement:

The MassHealth weighted means scored below the Getting Needed Care, Care Coordination, and the Annual Flu Vaccine benchmarks. All One Care Plans scored below the Annual Flu Vaccine benchmark.

Summarized information about health plans' performance is not available on the MassHealth website. Making survey reports publicly available could help inform consumers' choices when selecting a One Care Plan.

General Recommendations for MassHealth:

- *Recommendation towards better performance on CAHPS measures* – MassHealth should continue to utilize CAHPS data to evaluate One Care Plans' 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.

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

EQR Recommendations for MassHealth

Here is a summary of all recommendations for MassHealth:

- *Recommendation towards achieving the goals of the Medicaid quality strategy* – MassHealth should assess whether the state met or made progress on the five strategic goals and objectives described in the quality strategy.
- *Recommendation for MassHealth relevant to all One Care Plans towards accelerating the effectiveness of PIPs*:
  - Standardized structure and reporting requirements should be established to define and describe PIP aims and interventions.
  - All Plans should be required to conduct an initial barrier analysis at the outset of every PIP, this should be documented in the PIP proposal submission. Additionally, Plans should be required/expected to conduct additional analyses throughout the process if additional barriers are discovered.
  - For each PIP intervention, Plans should be required to track implementation progress with at least one intervention-specific process measure. Rates should be tracked/reported on a quarterly basis at minimum, or more frequently if possible, throughout the PIP cycle.
  - Plans should be required to document modifications made to interventions throughout the PIP cycle in a standardized manner on the PIP template.
  - Plans should be required to document efforts to promote sustainability and spread in a standardized manner across all interventions (and PIPs) in the final PIP report.
- *Recommendation towards better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.

- *Recommendation towards better policy documentation* – To encourage consistent practices and compliance with MassHealth standards, MassHealth should require MCPs to establish,maintain and publish well-defined policies and procedures.
- *Recommendation towards using plain language in contractual requirements* – To improve clarity, accessibility, and compliance, MassHealth should use plain language and express contractual requirements in straightforward terms that can be easily understood by a broad audience.
- *Recommendation towards addressing gaps identified through the compliance review* – To effectively address the areas of non-compliance, MassHealth should establish direct communication with the MCP to discuss the identified issue, provide the MCP with a detailed explanation of the requirements that were not met, and collaborate to develop a resolution strategy.
- *Recommendations towards network data integrity* – The format of the submission templates should be adjusted to improve data submission accuracy and reduce duplications of the data.
- *Recommendations towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access. MassHealth should share with MCPs the definitions of the network adequacy indicators that were identified for the purpose of this EQR (Appendix D).
- *Recommendations towards better provider directories* – The findings from the *2023 Provider Directory Audit* should be used to improve and develop further network adequacy activities.
- *Recommendation towards better performance on CAHPS measures* – MassHealth should continue to utilize CAHPS data to evaluate One Care Plans' performance and to support the development of major initiatives, and quality improvement strategies.
- *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 One Care Plans

One Care Plan-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. Massachusetts's Medicaid program is funded by both the state and federal government, and it is administered by the Massachusetts EOHHS.

MassHealth's mission is to improve the health outcomes of its members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life. MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.[8]

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

MassHealth Medicaid Quality Strategy

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

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

Table 2: MassHealth's Strategic Goals

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

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

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

MassHealth Managed Care Programs

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

1. The Accountable Care Partnership Plans (ACPPs) are health plans consisting of groups of primary care providers who partner with one managed care organization to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As accountable care organizations, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high quality care to MassHealth Enrollees. To select an Accountable Care Partnership Plan, a MassHealth Enrollee must live in the Plan's service area and must use the Plan's provider network.
2. The Primary Care Accountable Care Organizations (PCACOs) are health plans consisting of groups of primary care providers who contract directly with MassHealth to provide integrated and coordinated care. A PCACO functions as an accountable care organization and a primary care case management arrangement. In contrast to ACPPs, a PCACO does not partner with just one managed care organization. Instead, PCACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. Managed Care Organizations (MCOs) are health plans run by health insurance companies with their own provider network that includes primary care providers, specialists, behavioral health providers, and hospitals.
4. Primary Care Clinician Plan (PCCP) is a primary care case management arrangement, where Medicaid Enrollees select or are assigned to a primary care provider, called a Primary Care Clinician (PCC). The PCC provides services to Enrollees including the coordination, and monitoring of primary care health services. PCCP uses the MassHealth network of primary care providers, specialists, and hospitals as well as the Massachusetts Behavioral Health Partnership's network of behavioral health providers.
5. Massachusetts Behavioral Health Partnership is a health plan that manages behavioral health care for MassHealth's Primary Care Accountable Care Organizations and the Primary Care Clinician Plan. MBHP also serves children in state custody, not otherwise enrolled in managed care and certain children enrolled in MassHealth who have commercial insurance as their primary insurance.[9]
6. One Care Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services, as well as, long-term services and support (LTSS). This plan is for Enrollees between 21 and 64 years old, at enrollment, who are dually enrolled in Medicaid and Medicare.[10]
7. Senior Care Options (SCO) plans are coordinated health plans that cover services paid by Medicare and Medicaid. This plan is for MassHealth Enrollees 65 or older and it offers services to help seniors stay independently at home by combining healthcare services with social supports.[11]

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

Quality Metrics

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

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

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

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

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

Performance Improvement Projects

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

Member Experience of Care Surveys

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

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

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

MassHealth Initiatives

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

Quality and Equity Incentive Programs

Quality and Equity Incentive Programs are initiatives coordinated between MassHealth's Accountable Care Organizations and acute hospitals with an overarching goal to improve quality of care and advance health equity. Health equity is defined as the opportunity for everyone to attain their full health potential regardless of their social position or socially assigned circumstance. ACOs quality and equity performance is incentivized through programs implemented under managed care authority. Hospitals quality performance is incentivized

through the "Clinical Quality Incentive Program" implemented under State Plan Authority, while hospitals equity performance is incentivized through the "Hospital Quality and Equity Initiative" authorized under the 1115 Demonstration Waiver. Under the "Hospital Quality and Equity Initiative," private acute hospitals and the Commonwealth's only non-state-owned public hospital, Cambridge Health Alliance, are assessed on the completeness of social needs data (domain 1), performance on quality metrics and associated reductions in disparities (domain 2), and improvements in provider and workforce capacity and collaboration between health system partners (domain 3). MassHealth's ACOs and hospitals work towards coordinated deliverables aligned in support of the common goals of the incentive programs.[12] For example, in 2023, ACOs and hospitals partnered to work together on equity-focused performance improvement projects.

Roadmap for Behavioral Health

Another MassHealth initiative that supports the goals of the quality strategy is the five-year roadmap for behavioral health reform that was released in 2021. Key components of implementing this initiative include the integration of behavioral health in primary care, community-based alternatives to emergency department for crisis interventions, and the creation of the 24-7 Behavioral Health Help Line (BHHL) that became available in 2023. The Behavioral Health Help Line is free and available to all Massachusetts residents.[13]

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

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

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

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

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

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

MassHealth's quality strategy describes MassHealth's standards for network adequacy and service availability, care coordination and continuity of care, coverage, and authorization of services, as well as standards for

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

dissemination and use of evidence-based practice guidelines. MassHealth's strategic goals include promoting timely preventative primary care services with access to integrated care and community-based services and supports. MassHealth's strategic goals also include improving access for members with disabilities, as well as increasing timely access to behavioral health care and reducing mental health and SUD emergencies.

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

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

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted Managed Care Plans (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 2.13 of the MassHealth One Care Three-Way Contract requires One Care Plans to annually develop PIPs designed to achieve significant improvements in clinical care and non-clinical care processes, outcomes, and Enrollee experience. MassHealth requires that within each PIP, there is at least one intervention focused on health equity. MassHealth can also modify the PIP cycle to address immediate priorities.

For the CY 2023, One Care Plans were required to close both of their PIPs because the State was transitioning all MassHealth managed care programs to a new reporting cycle. The 2023 closeout PIPs were focused on the following priority areas selected by MassHealth in alignment with its quality strategy goals: care coordination/planning and prevention and wellness, primarily for flu vaccination improvement. Specific One Care PIP topics are displayed in Table 3.

Table 3: One Care PIP Topics – CY 2023

One Care Plan	PIP Topics
CCA One Care	**PIP 1: Care Planning – Year 1 Remeasurement Report** Improving rates of connecting with unreachable/disconnected One Care members **PIP 2: Flu– Year 2 Remeasurement Report** Flu vaccine improvement – One Care
Tufts One Care	**PIP 1: FUH – Year 1 Remeasurement Report** Care coordination and planning following a behavioral health hospital discharge within 7 days in Tufts Health Plan's One Care population **PIP 2: Flu – Year 2 Remeasurement Report** Improving flu immunization in Tufts Health Public Plan's One Care population
UHC One Care	**PIP 1: Flu – Year 1 Remeasurement Report** Improving flu vaccination rates for UnitedHealthcare One Care Community Plan members

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

Technical Methods of Data Collection and Analysis

IPRO conducted individual progress calls with One Care Plans to review the progress of the PIP in April and May 2023. One Care Plans concluded their PIPs in June of 2023 and submitted closeout reports to IPRO in September of the same year. The report template and validation tool were developed by IPRO by merging a template that had been in use by health plans since the inception of their projects, with IPRO's standardized template. This integration allowed IPRO to enhance the original template report and include additional questions about successes and challenges encountered during the PIP and sustainability efforts.

In the closeout reports, One Care Plans described project goals, anticipated barriers, interventions, performance measures, and their evaluation of the effectiveness of the project. One Care Plans completed these reports electronically and submitted them to IPRO through a web-based project management and

collaboration platform. IPRO was available for individual health plan questions and ad hoc calls related to the PIP throughout this process.

The analysis of the collected information focused on several key aspects, including an assessment of the quality of the data, appropriateness of the interventions, and interpretation of the results. It aimed to evaluate an alignment between the interventions and project goals and whether reported improvements could be maintained over time. The analysis of other PIP elements, such as the appropriateness of the topic, aim statement, population, sampling methods, and the variables, was conducted during the baseline and previous remeasurement years.

Description of Data Obtained

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

Conclusions and Comparative Findings

IPRO assigned two validation ratings. The first rating assessed IPRO's overall confidence in the PIP's adherence to acceptable methodology throughout all project phases, including the design, data collection, data analysis, and interpretation of the results. The second rating evaluated IPRO's overall confidence in the PIP's ability to produce significant evidence of improvement. Evidence of improvement was assessed in multiple activities throughout the PIP cycle, including identification of barriers, intervention selection and implementation, data informed modifications to interventions, and improvement of performance indicator rates. Both ratings used the following scale: high confidence, moderate confidence, low confidence, and no confidence.

Rating 1: Adherence to Acceptable Methodology - Validation results summary

The ratings for PIP adherence to acceptable methodology were high with all 5 PIPs receiving high confidence.

Rating 2: Evidence of Improvement - Validation results summary

The ratings for PIPs in terms of producing significant evidence of improvement were also high with 4 PIPs receiving high confidence and 1 PIP receiving moderate confidence.

PIP validation results are reported in Tables 4–6 for each One Care plan.

Table 4: CCA One Care PIP Validation Confidence Ratings – CY 2023

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: Care Planning	High Confidence	High Confidence
PIP 2: Flu	High Confidence	High Confidence

Table 5: Tufts Health Unify PIP Validation Confidence Ratings – CY 2023

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

Table 6: UHC Connected PIP Validation Confidence Ratings – CY 2023

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

CCA One Care PIPs

CCA One Care PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 7–10**.

Table 7: CCA One Care PIP 1 Summary, 2023

CCA One Care PIP 1: Improving rates of connecting with unreachable/disconnected One Care members
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence
Aim To connect with the female "unreachable"/disconnected (unengaged) members and integrate preventative wellness care gap closure for them when completing assessments and care plans resulting in improved One Care member clinical outcomes. Based upon population analysis for "unreachable"/disconnected (unengaged) One Care members, CCA has decided to focus efforts for female population specific to breast and cervical cancer screenings education documentation. CCA One Care strives to close gaps by collaborating with practitioners to help members close gaps in care. This project scope includes members from diverse cultures, with limited English proficiency and health disparities. **Interventions in 2023** ▪ Engage One Care female members in discussions of care goals to address preventive care gap closure care (although not limited to) for breast and cervical cancer screening when completing a comprehensive assessment and individualized member care plan. ▪ Implement CCA operational interventions to support the Member Engagement Assessment Unit (MEAU), On-boarding Specialist and Care Teams in connecting with the "unreachable"/disconnected (unengaged) members. Interventions include operational process changes/workflows specific to provider stakeholders, and data analytic tools to clearly delineate member population by race, ethnicity, language, and member status (male and female "unreachable"/disconnected [unengaged]). **Performance Improvement Summary** ▪ **Demonstrated improvement-** Indicator 1: CCA Male and Female One Care 'unreachable' & disconnected /(unengaged) members now connected with documented evidence of a completed initial comprehensive assessment or a reassessment. The remeasurement rate was 5.57% which exceeded the baseline goal rate of 5.0% ▪ **Performance declined -** Indicator 2: Female member breast cancer screening education documentation. The remeasurement year rate was 40.07% which was a decrease of 7.19% from the baseline year and 12.19% below the remeasurement year goal. Indicator 3: Female Member cervical cancer screening education documentation. The remeasurement year rate was 30.45% which was a decrease of 9.96% from the baseline year and 14.96% below the remeasurement year goal. ▪ **Summary of factors associated with success:** The Plan mentioned that system-level process changes/improvements were successful. Performance improvement activities included hiring and onboarding of new outreach staff, new staff training regarding a codified workflow, the development and implementation of a UM standard operating procedure, and assigning male and female unreachable members to the MEAU team for outreach. ▪ **Summary of challenges/barriers faced during the PIP:** Barriers included delays in cultural competency education, knowledge deficit related to priorities and roles related to interventions, lack of time management skills due to several competing priorities, and lack of buy-in amongst staff regarding the significance of recommended member goals being equally important to agreed-upon goals during care plan development. The Plan also mentioned that there was a one to two-month delay in obtaining monthly data. ▪ **Summary of how entities will use the PIP findings:** A new workgroup has been implemented by the Plan's organizational leadership team for the development of a unified strategy that the Plan will utilize to locate and

CCA One Care PIP 1: Improving rates of connecting with unreachable/disconnected One Care members
engage members. The Plan's chief experience officer has implemented a system-wide member engagement initiative. ▪ **Summary of weaknesses:** There were minor rounding errors in the Results Table Year 1 results. The Plan's discussion regarding the impact of interventions on performance indicator rates was not robust. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans.

Table 8: CCA One Care PIP 1 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: CCA Male and Female One Care 'unreachable' & disconnected (unengaged) members now connected with documented evidence of a completed initial comprehensive assessment or a reassessment.[1]	2022 (baseline, MY 2021 data)	0%
Indicator 1: CCA Male and Female One Care 'unreachable' & disconnected (unengaged) members now connected with documented evidence of a completed initial comprehensive assessment or a reassessment.[1]	2023 (remeasurement year 1)	5.57%
Indicator 2: Female member Breast Cancer Screening education documentation	2022 (baseline, MY 2021 data)	47.26%
Indicator 2: Female member Breast Cancer Screening education documentation	2023 (remeasurement year 1)	40.12%
Indicator 3: Female member Cervical Cancer Screening education documentation	2022 (baseline, MY 2021 data)	40.41%
Indicator 3: Female member Cervical Cancer Screening education documentation	2023 (remeasurement year 1)	30.47%

[1] The 2021 baseline data were established, and system changes put in place to track male and female 'unreachable' and disconnected (unengaged) members were connected; therefore, the numerator was unknown for this baseline submission.

Table 9: CCA One Care PIP 2 Summary, 2023

CCA One Care PIP 2: Flu vaccine improvement – One Care
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence
Aim To improve the CCA One Care influenza vaccination rates with a particular focus on population subgroups identified by the CCA One Care population analysis as having historically lower vaccination rates compared to the overall One Care population vaccination rates and/or compared to the One Care population subgroups with the highest vaccination rates. Subgroup analyses included examination of vaccination rates by race/ethnicity, age, primary language, the presence of certain chronic conditions, prior vaccination history, primary care engagement, and primary care location. **Interventions in 2023** ▪ The vaccine task force design and implementation of operational standards and practices for vaccine administration at CCA. ▪ CCA and Network Primary Care Provider Vaccine Education and Collaboration ▪ CCA Member Vaccine Education. **Performance Improvement Summary** ▪ **Demonstrated improvement** - Indicator 1: CCA Primary Care (One Care only) patients who have received an annual influenza vaccination demonstrated a 3.49% increase in performance from Measurement Year 1 (61.31%) to Measurement Year 2 (64.80%).

CCA One Care PIP 2: Flu vaccine improvement – One Care

▪ **Performance declined** - Indicator 2: CCA One Care members who have received an annual flu vaccination demonstrated a 5.79% decrease in performance from Measurement Year 1 (52.72%) to Measurement Year 2 (46.93%).
▪ **Summary of factors associated with success:**
  ▪ Plan described that the dedication and commitment of the CCA Primary Care practice's leadership and clinician staff related to flu vaccinations increased vaccination rates among members.
  ▪ Postcard mailing reminders to members who skipped vaccination during the last flu season but have a prior history of receiving the vaccine in years past.
▪ **Summary of challenges/barriers faced during the PIP:**
  ▪ Member confusion regarding vaccine safety and efficacy related to false messaging.
  ▪ Mild flu outbreaks during the last flu season led to less member urgency to get vaccinated.
  ▪ PCP office staffing shortages resulting in less-than-optimal flu immunization programs.
  ▪ Planned vaccine video messaging intervention was postponed.
▪ **Summary of how entities will use the PIP findings:**
  ▪ Utilize the project's key findings in the design and implementation of the 2023/2024 flu vaccination improvement strategies.
  ▪ Provide member education regarding flu vaccination through member newsletters and reminder mailings.
  ▪ Send PCP practices flu vaccination performance data and education material.
  ▪ Share findings with clinical and care management leadership at the CCA Clinical Quality Subcommittee
▪ **Summary of weaknesses:** PIP submission contained minor rounding errors. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans.

Table 10: CCA One Care PIP 2 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: Annual influenza vaccination rate – CCA One Care Primary Care patients	2021 (baseline, 2020–2021 flu season)	60.6%
Indicator 1: Annual influenza vaccination rate – CCA One Care Primary Care patients	2022 (remeasurement year 1)	61.3%
Indicator 1: Annual influenza vaccination rate – CCA One Care Primary Care patients	2023 (remeasurement year 2)	64.8%
Indicator 2: Annual influenza vaccination rate – All CCA One Care members	2021 (baseline, 2020–2021 flu season)	52.6%
Indicator 2: Annual influenza vaccination rate – All CCA One Care members	2022 (remeasurement year 1)	52.3%
Indicator 2: Annual influenza vaccination rate – All CCA One Care members	2023 (remeasurement year 2)	46.9%

Recommendations

- *Recommendation for PIP 1*: Please review future PIP submissions for accuracy. IPRO recommends that, for future PIP submissions, the Plan describe in more detail how the interventions correlate with the success of performance outcomes. Where possible, conclusions should be supported by plan data regarding

implementation and/or utilization of individual interventions. Please see general recommendations for additional recommendations relevant to all Plans.

- *Recommendation for PIP 2*: Please review future PIP submissions for accuracy. Please see general recommendations for additional recommendations relevant to all Plans.

Tufts Health Unify PIPs

Tufts Health Unify PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 11–14**.

Table 11: Tufts Health Unify PIP 1 Summary, 2023

Tufts Health Unify PIP 1: Care coordination and planning following a behavioral health hospital discharge within 7 days in Tufts Health Plan's One Care population.
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence
Aim To increase the number of follow-up appointments within 7-days of discharge following a behavioral health inpatient discharge. By ensuring members are seen within 7 days following a hospital discharge, members will be equipped with resources and tactics to avoid future unnecessary hospitalizations by utilizing Cityblock Health (CBH) services available to them. Tufts Health Unify One Care has implemented both member and provider focused activities to improve 7-day follow-up visit rates with a focus on the diversity of the Tufts One Care population. **Interventions in 2023** ▪ Member support post hospitalization. ▪ Collaboration with inpatient and acute care facilities. ▪ Care navigator program at UMASS. **Performance Improvement Summary** ▪ **Performance Indicator Results Summary:** Demonstrated improvement. The rate of follow-up appointments within 7-days of discharge following a behavioral health inpatient discharge increased from 48.5% to 54.4% from MY 2021 to MY 2022. ▪ **Summary of factors associated with success:** Collaboration with hospitals and provider groups to build better communication during an admission and post-discharge process. This allowed care managers to contact members and schedule a follow-up visit on time. ▪ **Summary of challenges/barriers faced during the PIP:** Engaging with members prior to discharge due to an inability to contact the facility as well as maintaining correct and current member contact information. ▪ **Summary of how entities will use the PIP findings:** The findings of this PIP will be shared with other THP and CBH areas that are focused on improving care coordination and transition of care. CBH will share best practices related to this PIP with provider groups during leadership meetings. ▪ **Summary of weaknesses:** No plan-specific weaknesses. Please see the section on general weaknesses for additional information regarding weaknesses observed across plans.

Table 12: Tufts Health Unify PIP 1 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: Follow-up After Hospitalization for Mental Illness	2022 (baseline, MY 2021 data)	48.50%
Indicator 1: Follow-up After Hospitalization for Mental Illness	2023 (remeasurement year 1)	54.4%

Table 13: Tufts Health Unify PIP 2 Summary, 2023

Tufts Health Unify PIP 2: Improving flu immunization in Tufts Health Public Plan's One Care population
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence
Aim To increase flu immunization rates and reduce racial, and ethnic health disparities related to flu vaccination. Tufts continues to work with Cityblock Health (CBH), which provides care management services for the entire membership. CBH renders individualized and comprehensive care and assists members in receiving their flu vaccine. CBH has the capability to provide care in the home to the most at-risk members. Additionally, CBH has ongoing efforts to collaborate with providers and other community organizations to meet the varied needs of the One Care membership which include collaborative efforts to address and increase the flu vaccination rates among the One Care population. This high touch approach brings members the resources they need to receive their flu vaccine such as connecting them with vaccine clinics or bringing the vaccine to their home in certain cases. **Interventions in 2023** ▪ Member education. ▪ Cityblock health member outreach. ▪ Cityblock health community paramedicine program. ▪ Provider education and outreach. **Performance Improvement Summary** ▪ **Performance Indicator Results Summary:** Performance level was maintained. The flu vaccination rate increased from 29.57% in MY 2021 to 37.8% in MY 2022. The 2023 MY rate remained higher than the baseline rate. ▪ **Summary of factors associated with success:** Individualized member support of individual member barriers, community paramedicine program offering flu vaccines in members' homes, and sending education materials to members on the importance of flu vaccines. ▪ **Summary of challenges/barriers faced during the PIP:** Vaccine hesitancy and medical misinformation due to misinformation about COVID vaccine. Other barriers included vaccine fatigue, staffing availability to make outreach calls to provider groups, and members not engaging in care management. ▪ **Summary of how entities will use the PIP findings:** PIP findings will be used to improve the member experience. The Plan is working to build relationships with large provider groups and facilities so that information can be shared, and care team can work together seamlessly. ▪ **Summary of weaknesses:** No plan-specific weaknesses. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans.

Table 14: Tufts Health Unify PIP 2 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: Flu vaccination rate among members	2021 (baseline, 2020–2021 flu season)	29.57%
Indicator 1: Flu vaccination rate among members	2022 (remeasurement year 1)	37.8%
Indicator 1: Flu vaccination rate among members	2023 (remeasurement year 2)	36.37%

Recommendations

- *Recommendation for PIP 1*: No plan-specific recommendations. Please see general recommendations for additional recommendations relevant to all Plans.
- *Recommendation for PIP 2*: No plan-specific recommendations. Please see general recommendations for additional recommendations relevant to all Plans.

UHC Connected PIPs

UHC Connected PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 15 and 16**.

Table 15: UHC Connected PIP 1 Summary, 2023

UHC Connected PIP 1: Improving flu vaccination rates for UnitedHealthcare One Care Community Plan members
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence
Aim This performance improvement project (PIP) is focused on improving Flu vaccination rates for One Care members enrolled in the UnitedHealthcare (UHC) One Care Plan. The baseline for this PIP is based on the 79 members who met the criterion to be continuously enrolled in the One Care Plan for six months. Instead of using the baseline vaccination rate of 28% for the flu 2021/2022 season for the 79 members in its baseline population, UHC will base the PIP goal on the national adult flu vaccination rate. The health plan will achieve an increase in the One Care members' vaccination rate by using two interventions. **Interventions in 2023** ▪ Improve Care Coordinators Member Outreach with Vaccination Education and trust-Building Conversations. ▪ Primary care providers incentives. **Performance Improvement Summary** ▪ **Performance Indicator Results Summary:** Demonstrated improvement - The Flu vaccination rate for One Care Members improved from a baseline rate (8/2021-3/2022) of 28% (22/79) to a remeasurement rate (8/2022/ 3/2023) of 40% (607/1,516). UHC's vaccination rate increased 12 percentage points but missed the goal of 50.6% by 10 percentage points. It is important to note that the UHC One Care Flu denominator population increased from 79 to 1,516 from baseline to remeasurement. ▪ **Summary of factors associated with success:** The Care Coordinators who outreached to members and provided the member education regarding flu vaccination often speak the same language as the member and may come from the same culture of the member. ▪ **Summary of challenges/barriers faced during the PIP:** The administrative processes to implement the provider incentive took longer than anticipated. The practices received the letter describing the incentive the first week of February 2023, which only gave them 7.5 weeks to complete the task by the end of the Flu season, March 31, 2023. In addition, UHC Clinical Practice Consultants who routinely meet with providers did not have relationships with some of these practices. Care Coordinators report that long-held myths about the flu vaccine are difficult to change despite education. Although outreach to members was conducted, data collection of members contacted was absent, and UHC was unable to measure the effectiveness of the care coordination conversations intervention on members obtaining vaccinations. ▪ **Summary of how entities will use the PIP findings:** Findings were disseminated in August 2023 at UHC's Provider Advisory Committee meeting and Quality Management Committee meeting. The findings will be shared in September with the Flu Work Group, clinical leadership, executive leadership, and the State. ▪ **Summary of weaknesses:** No plan-specific weaknesses. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans.

Table 16: UHC Connected PIP 1 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: Flu vaccination rate for One Care members	2022 (baseline, MY 2022 data)	28%
Indicator 1: Flu vaccination rate for One Care members	2023 (remeasurement year 1)	40%

Recommendations

- *Recommendation for PIP 1*: IPRO supports UHC's recommendations for initiating vaccination incentive programs earlier in the season for future programs and continuing with trust-building conversations and education to reduce vaccine hesitancy. In future projects, UHC may consider applying intervention tracking measures to gain insights on intervention effectiveness while the PIP is in process. Please see general recommendations for additional recommendations relevant to all Plans.

IV. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

MassHealth contracted with IPRO to conduct PMV to assess the data collection and reporting processes used to calculate the PM rates by the One Care Plans.

MassHealth evaluates One Care Plans' performance on HEDIS measures. One Care Plans are required to calculate and report HEDIS measures rates to MassHealth, as stated in Sections 2.13.3 and 2.16.2 of the Amended and Restated Three-Way One Care Contract between MassHealth, CMS, and each One Care Plan.

For HEDIS measures, IPRO performed an independent evaluation of the MY 2022 HEDIS Compliance Audit FARs, which contained findings related to the information systems standards. An EQRO may review an assessment of the MCP's information systems conducted by another party in lieu of conducting a full Information Systems Capabilities Assessment (ISCA).[14] Since the One Care Plans' HEDIS rates were audited by an independent NCQA-licensed HEDIS compliance audit organization, all plans received a full ISCA as part of the audit. Onsite (virtual) audits were therefore not necessary to validate reported measures.

MassHealth also evaluates One Care Plans' performance on Medicare-Medicaid plan-specific non-HEDIS measures, some of which are calculated by CMS and were not validated by IPRO. These four measures are required as part of the One Care Plans through their participation in the CMS Financial Alignment Initiative (FAI) demonstration project and are calculated by CMS' vendor, the National Opinion Research Center (NORC). Data is submitted by plans on a quarterly basis through either the CMS Health Plan Management System (HPMS) or the NORC FAI data collection systems. CMS contracts with Health Services Advisory Group (HSAG) to conduct an annual performance measure validation process for two of the four measures: Timely Assessment and Documentation of Care Plan goals. This performance measure validation process includes a virtual site visit, document review, and primary source verification. The other two measures, Access to LTS Coordinator and Tracking of Demographic Information, are closely monitored by CMS and data are reviewed at the point of submission.

Description of Data Obtained

The following information was obtained from each One Care Plan: Completed NCQA Record of Administration, Data Management, and Processes (Roadmap) from the current year MY 2022 HEDIS Compliance Audit, as well as associated supplemental documentation, IDSS files, and the Final Audit Report.

Conclusions and Comparative Findings

Based on a review of the One Care Plans' HEDIS FARs issued by their independent NCQA-certified HEDIS compliance auditors, IPRO found that all One Care Plans were fully compliant with all seven of the applicable NCQA information system standards. Findings from IPRO's review of the One Care Plans' HEDIS FARs are displayed in Table 17.

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

Table 17: One Care Plan Compliance with Information System Standards – MY 2022

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

IS: information system; MY: measurement year.

Validation Findings

- **Information Systems Capabilities Assessment (ISCA):** The ISCA was conducted to confirm that the One Care Plan's information systems (IS) were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, provider data systems. IPRO reviewed the One Care Plans' HEDIS FARs issued by their independent NCQA-certified HEDIS compliance auditors. 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 One Care Plan's FAR confirmed that the One Care Plans used NCQA-certified measure vendors to produce the HEDIS rates. No issues were identified.
- **Medical Record Validation:** Medical record review validation is conducted to confirm that the One Care Plans followed appropriate processes to report rates using the hybrid methodology. The review of each One Care Plan's FAR confirmed that the One Care Plans passed medical record review validation. No issues were identified.
- **Primary Source Validation (PSV):** PSV is conducted to confirm that the information from the primary source matches the output information used for measure reporting. The review of each One Care Plan's FAR confirmed that the One Care Plans passed the PSV. 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 Once Care Plan's FAR confirmed that the One Care Plans met all requirements related to data collection and integration. No issues were identified.
- **Rate Validation:** Rate validation is conducted to evaluate measure results and compare rates to industry standard benchmarks. No issues were identified. All required measures were reportable.

Comparative Findings

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

When IPRO compared the rates to the NCQA HEDIS MY 2022 Quality Compass national Medicaid percentiles, the performance varied across measures, with opportunities for improvement in several areas. MassHealth's benchmarks for One Care Plan rates are the 75th and the 90th Quality Compass national percentile. Improvement strategies may need to focus on areas where rates were below the 25th percentile.

Best Performance:

- Controlling High Blood Pressure (CCA and the Weighted Statewide Mean)
- HBD: Hemoglobin A1c Control; HbA1c control; >9.0% (Tufts)
- Follow-Up After Hospitalization for Mental Illness, 7 days (Tufts)

Needs Improvement:

- Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Tufts, CCA, and the Weighted Statewide Mean)
- Engagement in Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Tufts, CCA, and the Weighted Statewide Mean)
- Plan All-Cause Readmission Ratio (CCA and the Weighted Statewide Mean)

The Medicaid Quality Compass percentiles were color-coded to compare to the One Care Plan rates, as explained in Table 18.

Table 18: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2022 Quality Compass Medicaid National Percentiles.

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass National Medicaid Percentiles
<25th	Below the national Medicaid 25th percentile.
≥25thbut <50th	At or above the national Medicaid 25th percentile but below the 50th percentile.
≥50thbut <75th	At or above the national Medicaid 50th percentile but below the 75th percentile.
≥75thbut <90th	At or above the national Medicaid 75th percentile but below the 90th percentile.
≥90th	At or above the national Medicaid 90th percentile.
N/A	No national benchmarks available for this measure or measure not applicable (N/A).

Table 19 displays the HEDIS PMs for MY 2022 for all One Care Plans and the weighted statewide mean as compared to the Quality Compass Medicaid national percentiles. The CAHPS Influenza Vaccination measure was not included in the performance measure validation. The Influenza Vaccination measure was compared to the Medicare Advantage 2022 FFS Mean Score, instead of the Medicaid Quality Compass. UHC One Care started as a One Care Plan on January 1st, 2022, and could not report on several measures due to continuous enrollment and look back periods for the measures.

Table 19: OneCare HEDIS Performance Measures – MY 2022 as compared to Medicaid Quality Compass

HEDIS Measure	CCA One Care	Tufts One Care	UHC One Care	Weighted Statewide Mean
Influenza Vaccination*	69% (< Goal)	67% (< Goal)	67% (< Goal)	69% (< Goal)
Controlling High Blood Pressure	73.22% (≥90th)	67.25% (≥50thbut <75th)	N/A	72.6% (≥90th)
HBD: Hemoglobin A1c Control; HbA1c control (>9.0%) LOWER IS BETTER	36.25% (≥50thbut <75th)	29.20% (≥90th)	N/A	35.7% (≥50thbut <75th)
Follow-Up After Hospitalization for Mental Illness (7 days)	41.23% (≥50thbut <75th)	54.40% (≥90th)	29.07% (≥25thbut <50th)	42% (≥50thbut <75th)
Follow-Up After Hospitalization for Mental Illness (30 days)	62.15% (≥50thbut <75th)	69.95% (≥75thbut <90th)	45.35% (<25th)	62.2% (≥50thbut <75th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	38.90% (<25th)	38.16% (<25th)	N/A	38.7% (<25th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	10.64% (≥25thbut <50th)	11.05% (≥25thbut <50th)	N/A	10.7% (≥25thbut <50th)
Plan All-Cause Readmission (Observed/Expected Ratio) (18–64 years) LOWER IS BETTER	1.3778 (>25th)	0.9360 (≥50thbut <75th)	N/A	1.341 (>25th)

*The CAHPS Influenza Vaccination measure was compared to the Medicare Advantage 2022 FFS Mean Score, instead of the Medicaid Quality Compass.
HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: if eligible population/denominator less than 30, marked as N/A; NR: plan chose to not report.

IPRO also compared the One Care Plan rates to the NCQA HEDIS MY 2022 Quality Compass national Medicare percentiles. MassHealth's benchmarks for One Care rates are the 75th and the 90th Quality Compass national percentiles. Improvement strategies may need to focus on areas where rates were below the 25th percentile.

Best Performance:

- Follow-Up After Hospitalization for Mental Illness, 7 days (Tufts)
- Follow-Up After Hospitalization for Mental Illness, 30 days (Tufts)
- Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Tufts and the Weighted Statewide Mean)

Needs Improvement:

- HBD: Hemoglobin A1c Control; HbA1c control; >9.0% (Tufts and the Weighted Statewide Mean)
- Plan All-Cause Readmission Ratio (CCA and the Weighted Statewide Mean)

Table 20 provides the color key for the comparison to the Quality Compass Medicare benchmarks.

Table 21 displays the HEDIS performance measures for MY 2022 for all One Care Plans and the statewide average as compared to the Quality Compass national Medicare percentiles. The Influenza Vaccination measure was not included in the performance measure validation.

Table 20: Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2022 Quality Compass Medicare National Percentiles.

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass Medicare National Percentiles
<25th	Below the national Medicare 25th percentile.
≥25thbut <50th	At or above the national Medicare 25th percentile, but below the 50th percentile.
≥50thbut <75th	At or above the national Medicare 50th percentile, but below the 75th percentile.
≥75thbut <90th	At or above the national Medicare 75th percentile, but below the 90th percentile.
≥90th	At or above the national Medicare 90th percentile.
N/A	No national Medicare benchmarks available for this measure or measure not applicable (N/A).

Table 21: One Care HEDIS Performance Measures – MY 2022 as compared to Medicare Quality Compass

HEDIS Measure ID	CCA One Care	Tufts One Care	UHC One Care	Weighted Statewide Mean
Influenza Vaccination*	69% (< Goal)	67% (< Goal)	67% (< Goal)	69% (< Goal)
Controlling High Blood Pressure	73.22% (≥25th but <50th)	67.25% (≥25th but <50th)	N/A	72.6% (≥25th but <50th)
HBD: Hemoglobin A1c Control; HbA1c control (>9.0%) LOWER IS BETTER	N/A	29.20% (<25th)	N/A	35.7% (<25th)
Follow-Up After Hospitalization for Mental Illness (7 days)	41.23% (≥75th but <90th)	54.40% (≥90th)	29.07% (≥50th but <75th)	42% (≥75th but <90th)
Follow-Up After Hospitalization for Mental Illness (30 days)	62.15% (≥75th but <90th)	69.95% (≥90th)	45.35% (≥25th but <50th)	62.2% (≥75th but <90th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	N/A	38.16% (≥50th but <75th)	N/A	38.7% (≥50th but <75th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	N/A	11.05% (≥90th)	N/A	10.7% (≥90th)

HEDIS Measure ID	CCA One Care	Tufts One Care	UHC One Care	Weighted Statewide Mean
Plan All-Cause Readmission (Observed/Expected Ratio) (18–64 years) LOWER IS BETTER	1.3778 (>25th)	0.9360 (≥50thbut <75th)	N/A	1.341% (>25th)

*The CAHPS Influenza Vaccination measure was compared to the Medicare Advantage 2022 FFS Mean Score, instead of the Medicaid Quality Compass.
HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: if eligible population/denominator less than 30, marked as N/A; NR: plan chose to not report.

Finally, in Table 23, IPRO reported MY 2022 rates for the four non-HEDIS measures calculated by CMS's vendor for the CMS financial alignment demonstration. MassHealth weighted means are a weighted average calculated across the three participating Plans and account for the impact of the size of each Plan's population on the average. The rates and weighted statewide means are compared to quality withhold benchmarks established by CMS in collaboration with MassHealth. The quality withhold benchmarks are calculated considering past Plan performance, as well as performance across demonstration participants. Table 22 provides the color key for the comparison to the quality withhold benchmarks.

Table 22: Key for One Care non-HEDIS Performance Measures Comparison to the Quality Withhold Benchmarks.

Color Key	How Rate Compares to the Medicare Advantage 2022 FFS Mean Score
< Goal	Below the quality withhold benchmarks.
= Goal	The same as the quality withhold benchmarks.
> Goal	Above the quality withhold benchmarks score.
N/A	Measure not applicable (N/A).

Table 23: One Care non-HEDIS Performance Measures – MY 2022 as compared to the quality withhold benchmarks.

HEDIS Measure	CCA One Care	Tufts One Care	UHC One Care	Weighted Statewide Mean	Benchmark
Access to LTS Coordinator: Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment	99.9% > Goal	71.4% < Goal	33.7% < Goal	68.9% < Goal	95% N/A
Tracking of Demographic Information: Percent of members whose demographic data are collected and maintained in the Centralized Enrollee Record (race/ethnicity/ primary language/homelessness/disability type/LGBTQ identity).	75.5% < Goal	69.9% < Goal	61% < Goal	73.3% < Goal	85% N/A
Documentation of Care Plan Goals: Percent of members with documented discussions of care goals.	100% > Goal	97.6% > Goal	98.3% > Goal	99% > Goal	95% N/A
Timely Assessment: Percent of members with an initial assessment completed within 90 days of enrollment	91.1% > Goal	96.2% > Goal	51.1% < Goal	81.4% < Goal	90% N/A

V. Review of Compliance with Medicaid and CHIP 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 (BBA).

The purpose of this compliance review was to assess One Care Plans 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 (UM).

This section of the report summarizes the 2023 compliance results. The next comprehensive review will be conducted in 2026, 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 (42 CFR 438.56)
- Enrollee rights requirements (42 CFR 438.100)
- Emergency and post-stabilization services (42 CFR 438.114)
- Availability of services (42 CFR 438.206)
- Assurances of adequate capacity and services (42 CFR 438.207)
- Coordination and continuity of care (42 CFR 438.208)
- Coverage and authorization of services (42 CFR 438.210)
- Provider selection (42 CFR 438.214)
- Confidentiality (42 CFR 438.224)
- Grievance and appeal systems (42 CFR 438.228)
- Subcontractual relationships and delegation (42 CFR 438.230)
- Practice guidelines (42 CFR 438.236)
- Health information systems (42 CFR 438.242)
- Quality assessment and performance improvement program (42 CFR 438.330)

The 2023 annual compliance audit consisted of three phases: 1) pre-onsite documentation review, 2) remote interviews, and 3) post-onsite report preparation.

Pre-onsite 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 on MassHealth's suggestions, some tools were revised and issued as final. These final tools were then submitted to MassHealth in advance of the remote review.

Once MassHealth approved the methodology, IPRO sent One Care Plans a packet that included the review tools, along with a request for documentation and a guide to help One Care Plan staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure File Transfer Protocol (FTP) site.

To facilitate the review process, IPRO provided One Care Plans with examples of documents they could furnish to validate its 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 plans to provide in each area, which were reviewed remotely.

Prior to the review, One Care Plans submitted written policies, procedures, and other relevant documentation to support its adherence to state and federal requirements. One Care Plans were given a period of approximately four weeks to submit documentation to IPRO. To further assist One Care Plans' staff in understanding the requirements of the audit 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 One Care Plans' staff.

After One Care Plans submitted the required documentation, a team of IPRO reviewers was convened to review policies, procedures, and materials, and to assess One Care Plans' adherence 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 interviews for all the MCPs were conducted between August 21 and September 19, 2023. Interviews with relevant plan staff allow the EQR to assess whether the Plan indeed understands the requirements, can articulate in their own words, the internal processes, and procedures to deliver the required services to members and providers and to draw 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 One Care Plans to provide additional documentation, if available. One Care Plans' staff was given 2 days from the close of the onsite review to provide any further documentation.

Post-onsite Report Preparation

Following the remote interviews, draft reports were prepared. These draft reports included an initial review determination for each element reviewed and identify what specific evidence was used to assess that a One Care Plan was compliant with the standard or a rationale for why a One Care Plan 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 the One Care Plan to consider in order for them to attain full compliance.

Each draft report underwent a second level of review by IPRO staff members who were not involved in the first level of review. Once completed, the draft reports were shared with MassHealth staff for review. Any updates or revisions requested by MassHealth were considered and if appropriate, edits were made to the draft reports. Upon MassHealth approval, the draft reports were sent to One Care Plans with a request to provide responses for all elements that were determined to be less than fully compliant. Each One Care Plan was given 9 days to respond to the issues noted on the draft reports. If a One Care plan agreed with the findings, the Plan was asked to indicate its agreement. If a One Care Plan disagreed with the findings, the Plan was asked to reference already provided documentation, within which the Plan believed sufficient evidence of compliance could be found, for IPRO to re-review. After receiving One Care Plans' response, IPRO re-reviewed each element for which a One Care Plan provided a citation. As necessary, review scores and recommendations were updated based on the response from the One Care Plan.

Scoring Methodology

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by total possible points. A three-point scoring system was used: Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points. For each standard identified as Partially Met or Not Met, the MCP was required to clarify how and when the issue will be resolved. The scoring definitions are outlined in **Table 24**.

Table 24: 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 documentation provided. • Documentation to substantiate compliance with some but not all the regulatory or contractual provision 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 provision 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. N/A elements are removed from the denominator

Description of Data Obtained

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

One Care Plans were compliant with many of the Medicaid and CHIP managed care regulations and standards. The average total compliance rate among all One Care Plans was 95.7%. UHC One Care had the highest total compliance rate at 97.2%, while CCA One Care had the lowest at 92.8%.

Areas that require improvement:

- UHC One Care performed below 90% in the Emergency and Post-stabilization Services domain, which consist of 7 regulations embedded in the 438.210 Coverage and Authorization Tool.
- Tufts One Care performed below 90% in the Coordination and Continuity of Care and in the Coverage and Authorization of Services domain.
- CCA One Care performed below 90% in the Enrollee Rights Requirements domain and the Emergency and Post-stabilization services domain.

Table 25 presents compliance scores for each of the 14 domains across all three One Care Plans.

Table 25: One Care Performance by Review Domain – 2023 Compliance Validation Results

CFR Standard Name (Review Domain)	CFR Citation	CCA One Care	Tufts One Care	UHC One Care	One Care Average
Overall compliance score	**N/A**	**92.8%**	**97.0%**	**97.2%**	**95.7%**
Disenrollment requirements and limitations	**438.56**	100.0%	100.0%	91.7%	97.2%
Enrollee rights requirements*	**438.100**	85.3%	97.1%	94.2%	92.2%
Emergency and post-stabilization services**	**438.114**	50.0%	100.0%	100.0%	83.3%
Availability of services	**438.206**	91.7%	92.5%	97.5%	93.9%
Assurances of adequate capacity and services	**438.207**	100.0%	100.0%	93.5%	97.8%
Coordination and continuity of care	**438.208**	93.2%	89.6%	94.0%	92.3%
Coverage and authorization of services	**438.210**	97.3%	83.5%	98.7%	93.2%
Provider selection	**438.214**	100.0%	100.0%	100.0%	100.0%
Confidentiality	**438.224**	100.0%	100.0%	100.0%	100.0%
Grievance and appeal systems	**438.228**	99.2%	99.2%	100.0%	99.5%
Subcontractual relationships and delegation	**438.230**	100.0%	100.0%	100.0%	100.0%
Practice guidelines	**438.236**	90.0%	100.0%	100.0%	96.7%
Health information systems	**438.242**	92.5%	100.0%	90.0%	94.2%
QAPI	**438.330**	100.0%	96.4%	100.0%	98.8%

**Enrollee Rights & Protections Total* is the sum of regulations in the 438.10 Information Requirements Tool and the 438.100 Enrollee Rights & Protections Tool.

***Emergency and Post Stabilization Services* is 7 regulations embedded in the 438.210 Coverage and Authorization Tool and extracted in the scorecard for presentation.

CFR: Code of Federal Regulations; QAPI: Quality Assurance and Performance Improvement.

VI. Validation of Network Adequacy

Objectives

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

The state of Massachusetts has developed access and availability standards based on the requirements outlined in *Title 42 CFR § 438.68(c)*. One of the goals of MassHealth's quality strategy is to promote timely preventative primary care services with access to integrated care and community-based services and supports. MassHealth's strategic goals also include improving access for Enrollees 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 Sections 2.8 and 2.9 of the Amended and Restated Three-Way One Care Contract between MassHealth, CMS, and each One Care Plan. One Care Plans are contractually required to meet proximity access requirements (i.e., the travel time and distance standards) and provider availability standards (i.e., standards for the duration of time between Enrollee's request and the provision of services).

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 One Care Plans. IPRO evaluated compliance of One Care Plans' provider networks with MassHealth's geo-access requirements as well as the accuracy of the information presented in One Care Plans' online provider directories.

Technical Methods of Data Collection and Analysis

IPRO evaluated One Care Plans' provider networks to determine compliance with the time and distance requirements. IPRO reviewed MassHealth network availability standards and worked together with the state to define network adequacy indicators. Network adequacy indicators were defined through a series of meetings with IPRO and MassHealth that took place between April and August 2023. One Care network adequacy standards and indicators are listed in Appendix D (Tables D1 to D8).

One Care network adequacy standards are a combination of CMS' network adequacy standards for Medicare and Medicaid Plans (MMPs) and MassHealth-developed standards defined in the contract between One Care Plans and MassHealth. Consequently, some One Care provider types must meet both the time and the distance standard as defined by CMS, whereas other provider types must meet either the time or the distance standard but not both, as defined by MassHealth and explained in Table 26.

Table 26: Provider Type Standards – Travel Time AND Distance vs. Travel Time OR Distance

CMS Travel time AND distance	MassHealth Travel time OR distance
• Primary Care • Specialists • LTSS Providers: Nursing Facility • Acute Inpatient Hospital	• Emergency Services Program (ESP) Providers • Behavioral Health (BH) Diversionary Providers • Behavioral Health Outpatient Services • LTSS Providers: Adult Day Health, Adult Foster Care, Day Rehabilitation, Day Services, Group Adult Foster Care, Hospice, Occupational Therapy, Oxygen and Respiratory Equipment, Personal Care Assistant, Physical Therapy, and Speech Therapy • Hospital Rehabilitation

LTSS: long-term services and supports.

For certain One Care provider types, MassHealth has a special rule that applies when only one provider is located within a county. According to this rule, One Care Enrollees must have a choice of two providers within the applicable time and distance standards; however, if only one provider is located within a county, then the second provider may be within a 50-mile radius of the Enrollee's Zone Improvement Plan (ZIP) code. According to One Care contracts, the 50-mile radius rule applies to hospitals and nursing facilities.

The CMS' travel time and distance standards vary by provider type, as well as by CMS' County designation. Different time and distance standards apply when certain provider types render services to members who reside in metro vs. large metro counties. Massachusetts' county designation is listed in Table 27.

Table 27: County Designation in Massachusetts – Metro vs. Large Metro

Metro Counties	Large Metro Counties
Barnstable	Essex
Berkshire	Middlesex
Bristol	Norfolk
Franklin	Suffolk
Hampden	
Hampshire	
Plymouth	
Worcester	

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

IPRO entered into an agreement with Quest Analytics™ to validate One Care Plans' provider networks. Geo-access reports were generated by combining the following files together: data provided by One Care Plans on all providers and service locations contracted to participate in plans' networks, enrollment data provided by MassHealth, service area information provided by MassHealth, network adequacy template standards and indicators provided by IPRO and MassHealth, and network adequacy standards for MMPs downloaded on December 20, 2023, from the CMS' MMPs Application and Annul Requirements website.

IPRO analyzed the results to identify One Care Plans with adequate provider networks, as well as counties with deficient networks. When a One Care Plan appeared to have network deficiencies in a particular county, IPRO reported the county and the percentage of One Care Plan's members in that county who had adequate access.

Finally, using the One Care Plans' online provider directories, IPRO validated the accuracy of the information published in the provider directories. Between August and December 2023, IPRO reviewers contacted a sample of practice sites to confirm providers' participation with the One Care plan, open panel status, specialty, telephone number, and address. IPRO reported the percentage of providers in the sample with verified and correct information. The validation of provider directories included primary care and Long-term Services and Supports (LTSS) provider types listed below.

Primary Care Provider Types:

- Family Medicine
- Internal Medicine
- OB/GYN

LTSS Provider Types:

- Physical Therapist
- Speech Therapist
- Occupational Therapist
- Durable Medical Equipment
- Home Health Care Agencies
- Hospice
- Nursing Facility
- Adult Day Health
- Adult Foster care
- Day Habilitation
- Group Adult Foster Care

Description of Data Obtained

Validation of network adequacy for CY 2022 was performed using network data submitted by One Care Plans to IPRO. IPRO requested a complete provider lists which included facility/provider name, address, phone number, and the national provider identifier (NPI) for the following provider types: primary care, ob/gyn, hospitals, rehabilitation, urgent care, specialists, behavioral health, and LTSS. IPRO also requested aggregated enrollment data from MassHealth. The requested enrollment data included information about Enrollees' demographics (age and gender) and ZIP code of residence.

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

Conclusions and Comparative Findings

Medicaid members who meet One Care enrollment criteria, can enroll in a One Care health plan available in their county. One Care Plans cover large metro and metro counties as defined in Table 28.

Table 28: One Care Plans and Number of Counties

County Type	CCA One Care	Tufts Unify	UHC Connected
Number of Large Metro Counties	4	4	4
Number of Metro Counties	8	4	6
Total Number of Counties	12	8	10

Time and Distance Standards

IPRO reviewed the aggregated results to assess the adequacy of the One Care networks by provider type. The summary tables (Tables 29 and 35) show the number of counties with an adequate network of providers by provider type. 'Met' means that a One Care Plan had an adequate network of that provider type in all counties in which it operates.

- For Primary Care (Table 29), all One Care Plans met the Adult PCP network adequacy standards.
- For Specialist Providers (Table 30), most One Care Plans met the access standards. However, the CCA One Care OB/GYN network was deficient in Berkshire County, and the Tufts One Care Neurosurgery network was deficient in Essex County.
- For Hospitals and Emergency Support Services (Table 31), most One Care Plans met the access standards. However, the CCA One Care Rehabilitation Hospital services network was deficient in Franklin County; the Tufts One Care acute inpatient hospital network was deficient in the Middlesex and Norfolk Counties and its rehabilitation hospital network was deficient in the Barnstable and Worcester Counties. The UHC One Care acute inpatient hospital network was deficient in Middlesex County, its rehabilitation hospital services network was deficient in Hampden and Worcester Counties, and its emergency support services network was deficient in Bristol, Plymouth, and Worcester Counties.
- For LTSS providers (Table 32), most services across different provider types and county classifications generally met the access standards. There were instances, however, of partial compliance, especially in the metro areas, for services like occupational therapy, speech therapy, adult day health, adult foster care, day services, group adult foster care, oxygen and respiratory equipment services, and personal care assistants.
- For pharmacies (Table 33), CCA One Care did not meet the pharmacy standard in Berkshire and Franklin counties, and UHC One Care in Franklin County.
- For Behavioral Health (BH) Outpatient providers (Table 34), all One Care Plans met the network adequacy standards.
- For BH Diversionary services (Table 35), CCA One Care generally met access standards for most services in both Large Metro and Metro areas. Tufts One Care also generally met the standards but showed partial compliance in certain metro areas for services like Monitored Inpatient Level 3.7, PHP, Program of Assertive Community Treatment, Psychiatric Day Treatment, Recovery Coaching, and SOAP. UHC One Care demonstrated mixed results, with some services meeting the standards while others, particularly in metro areas, showed partial compliance.

For a detailed analysis of network deficiencies in specific counties and provider types, see plan-level results.

Table 29: Number of Counties with an Adequate Network of Primary Care Providers

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Adult PCP	Large Metro	2 providers within 5 miles and 10 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Adult PCP	Metro	2 providers within 10 miles and 15 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)

Table 30: Number of Counties with an Adequate Network of Specialist Providers

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Allergy and Immunology	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Allergy and Immunology	Metro	1 provider within 35 miles and 53 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Cardiology	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Cardiology	Metro	1 provider within 25 miles and 38 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Cardiothoracic Surgery	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Cardiothoracic Surgery	Metro	1 provider within 40 miles and 60 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Chiropractor	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Chiropractor	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Dermatology	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Dermatology	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Endocrinology	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Endocrinology	Metro	1 provider within 50 miles and 75 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
ENT/Otolaryngology	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
ENT/Otolaryngology	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Gastroenterology	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Gastroenterology	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
General Surgery	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
General Surgery	Metro	1 provider within 20 miles and 30 minutes, and 25 miles and 30 minutes for Enrollees residing in Berkshire County.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Gynecology, OB/GYN	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Gynecology, OB/GYN	Metro	1 provider within 30 miles and 45 minutes.	7 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Infectious Diseases	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Infectious Diseases	Metro	1 provider within 50 miles and 75 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Nephrology	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Nephrology	Metro	1 provider within 35 miles and 53 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Neurology	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Neurology	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Neurosurgery	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Neurosurgery	Metro	1 provider within 40 miles and 60 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Oncology - Medical, Surgical	Large Metro	1 provider within 10 miles and 20 minutes, and 15 miles and 20 minutes for Enrollees residing in Essex County.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Oncology - Medical, Surgical	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Oncology - Radiation/Radiation Oncology	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Oncology - Radiation/Radiation Oncology	Metro	1 provider within 40 miles and 60 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Ophthalmology	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Ophthalmology	Metro	1 provider within 25 miles and 38 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Orthopedic Surgery	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Orthopedic Surgery	Metro	1 provider within 25 miles and 38 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Physiatry, Rehabilitative Medicine	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Physiatry, Rehabilitative Medicine	Metro	1 provider within 35 miles and 53 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Plastic Surgery	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Plastic Surgery	Metro	1 provider within 50 miles and 75 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Podiatry	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Podiatry	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Psychiatry	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Psychiatry	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Pulmonology	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Pulmonology	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Rheumatology	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Rheumatology	Metro	1 provider within 40 miles and 60 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Urology	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Urology	Metro	1 provider within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Vascular Surgery	Large Metro	1 provider within 15 miles and 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Vascular Surgery	Metro	1 provider within 50 miles and 75 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)

Table 31: Number of Counties with an Adequate Network of Hospital and emergency Support Services

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Acute Inpatient Hospital	Large Metro	2 providers within 10 miles and 20 minutes.	4 out of 4 (Met)	2 out of 4 (Partially Met)	3 out of 4 (Partially Met)
Acute Inpatient Hospital	Metro	2 providers within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Acute Inpatient Hospital_50	Large Metro	2 providers within 50 miles.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Acute Inpatient Hospital_50	Metro	2 providers within 50 miles.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Rehabilitation Hospital Services	Large Metro	1 provider within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Rehabilitation Hospital Services	Metro	1 provider within 15 miles or 30 minutes.	7 out of 8 (Partially Met)	2 out of 4 (Partially Met)	4 out of 6 (Partially Met)
Emergency Support Services	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Emergency Support Services	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	3 out of 6 (Partially Met)

Table 32: Number of Counties with an Adequate Network of LTSS Providers

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Nursing Facility	Large Metro	2 providers within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Nursing Facility	Metro	2 providers within 20 miles and 35 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Nursing Facility_50	Large Metro	2 providers within 50 miles.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Nursing Facility_50	Metro	2 providers within 50 miles.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Occupational Therapy	Large Metro	2 providers within 10 miles and 20 minutes.	4 out of 4 (Met)	2 out of 4 (Partially Met)	1 out of 4 (Partially Met)
Occupational Therapy	Metro	2 providers within 25 miles and 40 minutes.	8 out of 8 (Met)	3 out of 4 (Partially Met)	4 out of 6 (Partially Met)
Orthotics and Prosthetics	Large Metro	2 providers within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	1 out of 4 (Partially Met)
Orthotics and Prosthetics	Metro	2 providers within 25 miles and 40 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	4 out of 6 (Partially Met)
Physical Therapy	Large Metro	2 providers within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Physical Therapy	Metro	2 providers within 25 miles and 40 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Speech Therapy	Large Metro	2 providers within 10 miles and 20 minutes.	4 out of 4 (Met)	2 out of 4 (Partially Met)	0 out of 4 (Not Met)
Speech Therapy	Metro	2 providers within 25 miles and 40 minutes.	8 out of 8 (Met)	3 out of 4 (Partially Met)	0 out of 6 (Not Met)
Adult Day Health	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Adult Day Health	Metro	2 providers within 15 miles or 30 minutes.	6 out of 8 (Partially Met)	4 out of 4 (Met)	4 out of 6 (Partially Met)
Adult Foster Care	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Adult Foster Care	Metro	2 providers within 15 miles or 30 minutes.	7 out of 8 (Partially Met)	4 out of 4 (Met)	4 out of 6 (Partially Met)
Day Habilitation	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	3 out of 4 (Partially Met)
Day Habilitation	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	3 out of 6 (Partially Met)
Day Services	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	2 out of 4 (Partially Met)
Day Services	Metro	2 providers within 15 miles or 30 minutes.	6 out of 8 (Partially Met)	4 out of 4 (Met)	1 out of 6 (Partially Met)
Group Adult Foster Care	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Group Adult Foster Care	Metro	2 providers within 15 miles or 30 minutes.	6 out of 8 (Partially Met)	3 out of 4 (Partially Met)	5 out of 6 (Partially Met)
Hospice	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	0 out of 4 (Not Met)
Hospice	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	0 out of 6 (Not Met)
Oxygen and Respiratory Equipment	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Oxygen and Respiratory Equipment	Metro	2 providers within 15 miles or 30 minutes.	3 out of 8 (Partially Met)	4 out of 4 (Met)	5 out of 6 (Partially Met)
Personal Care Assistant	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Personal Care Assistant	Metro	2 providers within 15 miles or 30 minutes.	5 out of 8 (Partially Met)	4 out of 4 (Met)	3 out of 6 (Partially Met)

Table 33: Number of Counties with an Adequate Network of Pharmacies

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Pharmacy	Large Metro	1 provider within 2 miles.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Pharmacy	Metro	1 provider within 5 miles.	6 out of 8 (Partially Met)	4 out of 4 (Met)	5 out of 6 (Partially Met)

Table 34: Number of Counties with an Adequate Network of Behavioral Health Outpatient

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
BH Outpatient Providers	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
BH Outpatient Providers	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)

Table 35: Number of Counties with an Adequate Network of Behavioral Health Diversionary Services

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Clinical Support Services for Substance Use Disorders (Level 3.5)	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Clinical Support Services for Substance Use Disorders (Level 3.5)	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	3 out of 4 (Partially Met)	4 out of 6 (Partially Met)
Community Crisis Stabilization	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	3 out of 4 (Partially Met)
Community Crisis Stabilization	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	2 out of 6 (Partially Met)
Community Support Program (CSP)	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Community Support Program (CSP)	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Intensive Outpatient Program (IOP)	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Intensive Outpatient Program (IOP)	Metro	2 providers within 15 miles or 30 minutes.	7 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Monitored Inpatient Level 3.7	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County who Have Access	CCA One Care	Tufts One Care	UHC One Care
Monitored Inpatient Level 3.7	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	3 out of 4 (Partially Met)	3 out of 6 (Partially Met)
Partial Hospitalization Program (PHP)	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Partial Hospitalization Program (PHP)	Metro	2 providers within 15 miles or 30 minutes.	7 out of 8 (Partially Met)	3 out of 4 (Partially Met)	5 out of 6 (Partially Met)
Program of Assertive Community Treatment	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	3 out of 4 (Partially Met)	3 out of 4 (Partially Met)
Program of Assertive Community Treatment	Metro	2 providers within 15 miles or 30 minutes.	7 out of 8 (Partially Met)	3 out of 4 (Partially Met)	0 out of 6 (Not Met)
Psychiatric Day Treatment	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	2 out of 4 (Partially Met)
Psychiatric Day Treatment	Metro	2 providers within 15 miles or 30 minutes.	6 out of 8 (Partially Met)	3 out of 4 (Partially Met)	1 out of 6 (Partially Met)
Recovery Coaching	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Recovery Coaching	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	1 out of 4 (Partially Met)	6 out of 6 (Met)
Recovery Support Navigators	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Recovery Support Navigators	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	1 out of 4 (Partially Met)	6 out of 6 (Met)
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	3 out of 4 (Partially Met)	6 out of 6 (Met)
Structured Outpatient Addiction Program (SOAP)	Large Metro	2 providers within 15 miles or 30 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Structured Outpatient Addiction Program (SOAP)	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (Met)	3 out of 4 (Partially Met)	5 out of 6 (Partially Met)

Provider Directory Validation

IPRO validated the accuracy of provider directories for a sample of provider types chosen by MassHealth. **Tables 36 and 37** show the percent of providers in the directory with verified telephone number, address, specialty, One Care Plan participation, and panel status. **Tables 38 and 39** show the most frequent reasons why information in the directories was incorrect or could not be validated.

Table 36: Provider Directory Accuracy – Primary Care Providers

Provider Type	Goal	CCA One Care	Tufts One Care	UHC One Care
Family Medicine	Not Defined	36.7%	20.0%	13.3%
Internal Medicine	Not Defined	26.7%	33.3%	23.3%
OB/GYN	Not Defined	16.7%	30.0%	33.3%
All PCPs	Not Defined	26.7%	27.8%	23.3%

Table 37: Provider Directory Accuracy – Long-term Services and Supports (LTSS)

Provider Type	Goal	CCA One Care	Tufts One Care	UHC One Care
All Home and Community-Based Services*	Not Defined	50.00%	33.33%	46.67%

* All Home and Community-Based Services include Adult Day Health, Adult Foster Care, Occupational Therapist, Nursing Facility, Durable Medical Equipment, Physical Therapist, Speech Therapist, Hospice, Home Health Care Agency, Day Habilitation

Table 38: Frequency of Failure Types - Primary Care Providers

Type of Failure	One Care Total	CCA One Care	Tufts One Care	UHC One Care
Provider not at the site	**66**	27	18	21
Contact Fails*	**46**	17	16	13
Provider not accepting new patients	**41**	12	12	17
Provider does not accept the health plan	**33**	2	16	15
Provider reported a different specialty	**13**	8	3	2

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

Table 39: Frequency of Failure Types - Long-term Services and Supports (LTSS)

Type of Failure	One Care Total	CCA One Care	Tufts One Care	UHC One Care
Contact Fails*	**37**	10	14	13
Provider not at the site	**6**	3	2	1
Provider does not accept the health plan	**5**	1	2	2
Provider reported a different specialty	**2**	1	1	0
Provider not accepting new patients	**1**	0	1	0

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

CCA One Care

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of CCA One Care members in one county had adequate access, then the network availability standard was met. But if less than 90% of members in one county had adequate access, then the network was deficient. Tables 40–44 show counties with deficient networks.

Table 40: CCA One Care Counties with Network Deficiencies of Specialist Providers

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Gynecology, OB/GYN	Berkshire	27.9%	1 provider within 30 miles and 45 minutes.

Table 41: CCA One Care Counties with Network Deficiencies of Hospitals and Emergency Support Services

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Rehabilitation Hospital Services	Franklin	9.7%	1 provider within 15 miles or 30 minutes.

Table 42: CCA One Care Counties with Network Deficiencies of LTSS Providers

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Adult Day Health	Barnstable	32.8%	2 providers within 15 miles or 30 minutes.
Adult Day Health	Berkshire	7.2%	2 providers within 15 miles or 30 minutes.
Adult Foster Care	Franklin	63.9%	2 providers within 15 miles or 30 minutes.
Day Services	Berkshire	12.4%	2 providers within 15 miles or 30 minutes.
Day Services	Worcester	86.7%	2 providers within 15 miles or 30 minutes.
Group Adult Foster Care	Berkshire	1.7%	2 providers within 15 miles or 30 minutes.
Group Adult Foster Care	Franklin	52.9%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Barnstable	87.5%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Berkshire	0.3%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Franklin	0.0%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Hampden	0.1%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Hampshire	14.2%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Barnstable	1.3%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Berkshire	17.2%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Plymouth	88.3%	2 providers within 15 miles or 30 minutes.

Table 43: CCA One Care Counties with Network Deficiencies of Pharmacy

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Pharmacy	Berkshire	82.9%	1 provider within 5 miles.
Pharmacy	Franklin	78.9%	1 provider within 5 miles.

Table 44: CCA One Care Counties with Network Deficiencies of BH Diversionary Services

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Intensive Outpatient Program (IOP)	Barnstable	37.6%	2 providers within 15 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Berkshire	13.5%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Berkshire	12.5%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Barnstable	32.6%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Berkshire	14.0%	2 providers within 15 miles or 30 minutes.

Recommendations

- *Network Adequacy Data Integrity Recommendation*: IPRO identified and corrected several issues with submitted network provider data. IPRO recommends that the One Care Plan review and deduplicate in-network provider data before data files are submitted for future network adequacy analysis.
- *Network Adequacy Time/Distance Standards Recommendation*: IPRO recommends that the One Care Plan expands its network when a deficiency is identified in any given county. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those counties.
- *Network Adequacy Provider Directory Recommendation*: MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans. MCP should educate network providers about the importance of reporting changes to the health plan promptly. MCP should regularly monitor member complaints and grievances to assess if the provider directory is perceived as a barrier to accessing care.

Tufts One Care

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of Tufts One Care members in one county had adequate access, then the network availability standard was met. But if less than 90% of members in one county had adequate access, then the network was deficient. Tables 45–48 show counties with deficient networks.

Table 45: Tufts One Care Counties with Network Deficiencies of Specialist Providers

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Neurosurgery	Essex	89.0%	1 provider within 15 miles and 30 minutes.

Table 46: Tufts One Care Counties with Network Deficiencies of Hospital and Emergency Support Services

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Acute Inpatient Hospital	Middlesex	70.7%	2 providers within 10 miles and 20 minutes.
Acute Inpatient Hospital	Norfolk	88.4%	2 providers within 10 miles and 20 minutes.
Rehabilitation Hospital Services	Barnstable	9.2%	1 provider within 15 miles or 30 minutes.
Rehabilitation Hospital Services	Worcester	68.8%	1 provider within 15 miles or 30 minutes.

Table 47: Tufts One Care Counties with Network Deficiencies of LTSS Providers

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Occupational Therapy	Middlesex	37.2%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Norfolk	88.0%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Worcester	80.7%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Barnstable	49.4%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Essex	66.3%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Middlesex	46.6%	2 providers within 10 miles and 20 minutes.
Group Adult Foster Care	Worcester	74.8%	2 providers within 15 miles or 30 minutes.

Table 48: Tufts One Care Counties with Network Deficiencies of BH Diversionary Services

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Clinical Support Services for Substance Use Disorders (Level 3.5)	Barnstable	50.4%	2 providers within 15 miles or 30 minutes.
Monitored Inpatient Level 3.7	Barnstable	50.4%	2 providers within 15 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Worcester	81.6%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Barnstable	88.9%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Essex	84.1%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Barnstable	23.4%	2 providers within 15 miles or 30 minutes.
Recovery Coaching	Barnstable	13.0%	2 providers within 15 miles or 30 minutes.
Recovery Coaching	Plymouth	87.3%	2 providers within 15 miles or 30 minutes.
Recovery Coaching	Worcester	56.9%	2 providers within 15 miles or 30 minutes.
Recovery Support Navigators	Barnstable	0.0%	2 providers within 15 miles or 30 minutes.
Recovery Support Navigators	Essex	45.3%	2 providers within 15 miles or 30 minutes.
Recovery Support Navigators	Plymouth	82.0%	2 providers within 15 miles or 30 minutes.
Recovery Support Navigators	Worcester	51.2%	2 providers within 15 miles or 30 minutes.

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	Barnstable	72.5%	2 providers within 15 miles or 30 minutes.
Structured Outpatient Addiction Program (SOAP)	Barnstable	50.4%	2 providers within 15 miles or 30 minutes.

Recommendations

- *Network Adequacy Data Integrity Recommendation*: IPRO identified and corrected several issues with submitted network provider data. IPRO recommends that the One Care Plan review and deduplicate in-network provider data before data files are submitted for future network adequacy analysis.
- *Network Adequacy Time/Distance Standards Recommendation*: IPRO recommends that the One Care Plan expands its network when a deficiency is identified in any given county. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those counties.
- *Network Adequacy Provider Directory Recommendation*: MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans. MCP should educate network providers about the importance of reporting changes to the health plan promptly. MCP should regularly monitor member complaints and grievances to assess if the provider directory is perceived as a barrier to accessing care.

UHC One Care

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of UHC Connected members in one county had adequate access, then the network availability standard was met. But if less than 90% of members in one county had adequate access, then the network was deficient. Tables 49–52 show counties with deficient networks.

Table 49: UHC One Care Counties with Network Deficiencies of Hospitals and Emergency Support Services

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Acute Inpatient Hospital	Middlesex	88.4%	2 providers within 10 miles and 20 minutes.
Rehabilitation Hospital Services	Hampden	78.4%	1 provider within 15 miles or 30 minutes.
Rehabilitation Hospital Services	Worcester	61.9%	1 provider within 15 miles or 30 minutes.
Emergency Support Services	Bristol	40.9%	2 providers within 15 miles or 30 minutes.
Emergency Support Services	Plymouth	75.0%	2 providers within 15 miles or 30 minutes.
Emergency Support Services	Worcester	67.7%	2 providers within 15 miles or 30 minutes.

Table 50: UHC One Care Counties with Network Deficiencies of LTSS Providers

Provider Type	County with a Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Occupational Therapy	Essex	2.8%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Franklin	34.8%	2 providers within 25 miles and 40 minutes.
Occupational Therapy	Middlesex	55.4%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Norfolk	83.9%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Plymouth	88.4%	2 providers within 25 miles and 40 minutes.
Orthotics and Prosthetics	Essex	3.9%	2 providers within 10 miles and 20 minutes.
Orthotics and Prosthetics	Middlesex	61.4%	2 providers within 10 miles and 20 minutes.
Orthotics and Prosthetics	Norfolk	82.8%	2 providers within 10 miles and 20 minutes.
Orthotics and Prosthetics	Plymouth	81.9%	2 providers within 25 miles and 40 minutes.
Orthotics and Prosthetics	Worcester	60.7%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Bristol	81.5%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Essex	31.5%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Franklin	0.0%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Hampden	10.5%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Hampshire	9.5%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Middlesex	39.1%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Norfolk	79.4%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Plymouth	85.0%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Suffolk	87.2%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Worcester	79.0%	2 providers within 25 miles and 40 minutes.
Adult Day Health	Franklin	10.9%	2 providers within 15 miles or 30 minutes.
Adult Day Health	Worcester	88.3%	2 providers within 15 miles or 30 minutes.
Adult Foster Care	Franklin	67.4%	2 providers within 15 miles or 30 minutes.
Adult Foster Care	Worcester	83.7%	2 providers within 15 miles or 30 minutes.
Day Habilitation	Bristol	40.5%	2 providers within 15 miles or 30 minutes.
Day Habilitation	Essex	50.2%	2 providers within 15 miles or 30 minutes.
Day Habilitation	Franklin	65.2%	2 providers within 15 miles or 30 minutes.
Day Habilitation	Plymouth	79.3%	2 providers within 15 miles or 30 minutes.
Day Services	Bristol	86.1%	2 providers within 15 miles or 30 minutes.
Day Services	Essex	42.7%	2 providers within 15 miles or 30 minutes.
Day Services	Franklin	0.0%	2 providers within 15 miles or 30 minutes.
Day Services	Hampshire	89.2%	2 providers within 15 miles or 30 minutes.
Day Services	Middlesex	79.9%	2 providers within 15 miles or 30 minutes.
Day Services	Plymouth	84.8%	2 providers within 15 miles or 30 minutes.
Day Services	Worcester	89.9%	2 providers within 15 miles or 30 minutes.
Group Adult Foster Care	Franklin	65.2%	2 providers within 15 miles or 30 minutes.
Hospice	Bristol	25.8%	2 providers within 15 miles or 30 minutes.
Hospice	Essex	3.2%	2 providers within 15 miles or 30 minutes.
Hospice	Franklin	34.8%	2 providers within 15 miles or 30 minutes.
Hospice	Hampden	1.0%	2 providers within 15 miles or 30 minutes.
Hospice	Hampshire	85.1%	2 providers within 15 miles or 30 minutes.
Hospice	Middlesex	10.0%	2 providers within 15 miles or 30 minutes.
Hospice	Norfolk	30.6%	2 providers within 15 miles or 30 minutes.
Hospice	Plymouth	0.0%	2 providers within 15 miles or 30 minutes.
Hospice	Suffolk	1.1%	2 providers within 15 miles or 30 minutes.
Hospice	Worcester	59.1%	2 providers within 15 miles or 30 minutes.

Provider Type	County with a Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Oxygen and Respiratory Equipment	Franklin	67.4%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Bristol	81.8%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Franklin	4.3%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Worcester	77.8%	2 providers within 15 miles or 30 minutes.

Table 51: UHC One Care Counties with Network Deficiencies of Pharmacy

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Pharmacy	Franklin	80.4%	1 provider within 5 miles.

Table 52: UHC One Care Counties with Network Deficiencies of BH Diversionary Services

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Clinical Support Services for Substance Use Disorders (Level 3.5)	Franklin	87.0%	2 providers within 15 miles or 30 minutes.
Clinical Support Services for Substance Use Disorders (Level 3.5)	Worcester	74.7%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Bristol	55.9%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Essex	83.0%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Franklin	69.6%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Plymouth	63.2%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Worcester	69.6%	2 providers within 15 miles or 30 minutes.
Monitored Inpatient Level 3.7	Franklin	4.3%	2 providers within 15 miles or 30 minutes.
Monitored Inpatient Level 3.7	Hampshire	89.2%	2 providers within 15 miles or 30 minutes.
Monitored Inpatient Level 3.7	Worcester	67.7%	2 providers within 15 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Franklin	87.0%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Bristol	39.7%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Franklin	0.0%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Hampden	0.0%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Hampshire	0.0%	2 providers within 15 miles or 30 minutes.

Provider Type	County with Deficient Network	Percent of Enrollees with Access in that County	Standard – 90% of Enrollees in a County who Have Access
Program of Assertive Community Treatment	Middlesex	89.4%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Plymouth	65.0%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Worcester	76.7%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Bristol	83.1%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Essex	85.4%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Franklin	0.0%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Hampshire	79.7%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Middlesex	84.2%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Plymouth	88.0%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Worcester	11.3%	2 providers within 15 miles or 30 minutes.
Structured Outpatient Addiction Program (SOAP)	Worcester	83.3%	2 providers within 15 miles or 30 minutes.

Recommendations

- *Network Adequacy Data Integrity Recommendation*: IPRO identified and corrected several issues with submitted network provider data. IPRO recommends that the One Care Plan review and deduplicate in-network provider data before data files are submitted for future network adequacy analysis.
- *Network Adequacy Time/Distance Standards Recommendation*: IPRO recommends that the One Care Plan expands its network when a deficiency is identified in any given county. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those counties.
- *Network Adequacy Provider Directory Recommendation*: MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans. MCP should educate network providers about the importance of reporting changes to the health plan promptly. MCP should regularly monitor member complaints and grievances to assess if the provider directory is perceived as a barrier to accessing care.

VII. Quality-of-Care Surveys – MA-PD CAHPS Member Experience Survey

Objectives

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

Section 2.13.3.2.2 of the One Care Three-way Contract requires One Care Plans to conduct an annual CAHPS survey using an approved CAHPS vendor and report CAHPS data to MassHealth. The CAHPS tool is a standardized questionnaire that asks Enrollees to report on their satisfaction with care and services from the plans, the providers, and their staff.

Because One Care Plans serve dually eligible members with MassHealth and Medicare coverage, the Plans are required to participate in the annual Medicare Advantage Prescription Drugs (MA-PD) CAHPS survey mandated by the CMS. MassHealth monitors plans' submissions of CAHPS surveys and uses the results to identify opportunities for improvement and inform MassHealth's quality management work. Each One Care Plan independently contracted with a CMS-approved survey vendor to administer the MA-PD CAHPS surveys.

Technical Methods of Data Collection and Analysis

The 2023 MA-PD CAHPS survey was conducted in the first half of 2023 and measured members' experiences with their MA-PD plan over the previous six months. The MA-PD CAHPS survey is administered to members dually eligible for Medicaid and Medicare using a random sample of members selected by CMS. CMS requires all MA-PD plans with at least 600 members to contract with approved survey vendors to collect and report CAHPS survey data following a specific timeline and protocols established by CMS. The MassHealth One Care Plans used the 2023 MA-PD CAHPS standardized survey instrument. The MA-PD survey tool contains 68 questions, organized into seven sections, as explained in Table 53.

Table 53: MA-PD CAHPS Survey Sections

Section	Number of Questions
Introductory section	2 questions
Your Health Care in the Last 6 Months	8 questions
Your Personal Doctor	16 questions
Getting Health Care from Specialists	6 questions
Your Health Plan	8 questions
Your Prescription Drug Plan	7 questions
About You	21 questions

The CMS data collection protocol included mailing of prenotification letters, up to two mailings of paper surveys, and telephone surveys with non-responders. The mail and telephone surveys were available in English, Spanish, Chinese, Vietnamese, Korean, or Tagalog-language versions. The survey was conducted using a random sample of members selected by CMS. The sample frame included One Care Enrollees who were 18 years or older, continuously enrolled in the contract for at least six months at the time of sample draw in January 2023, and who were not institutionalized. Table 54 provides a summary of the technical methods of data collection by One Care Plans.

Table 54: Adult MA-PD CAHPS – Technical Methods of Data Collection by One Care Plan, 2023 MA-PD CAHPS

MA-PD CAHPS – Technical Methods of Data Collection	CCA One Care	Tufts One Care	UHC One Care
Survey vendor	SPH Analytics	SPH Analytics	SPH Analytics
Survey tool	2023 MA-PD CAHPS	2023 MA-PD CAHPS	2023 MA-PD CAHPS
Survey timeframe	March–May, 2023	March–May, 2023	March–May, 2023
Method of collection	Mail and telephone	Mail and telephone	Mail and telephone
Response rate	22.0%	16.8%	12.5%

For the global ratings and composite measures, the mean scores were calculated using a 100-point scale. For the Annual Flu Vaccine individual item measure, the reported value was the percentage of survey responders who said yes. Responses were classified into response categories. Table 55 displays these categories and the measures for which these response categories are used.

Table 55: MA-PD CAHPS Response Categories

Measures	Response Categories
• Rating of Health Plan • Rating of All Health Care Quality • Rating of Personal Doctor • Rating of Specialist • Rating of Prescription Drug Plan	• 0 to 4 (Dissatisfied) • 5 to 7 (Neutral) • 9 or 10 (Satisfied)
• Getting Needed Care • Getting Appointments and Care Quickly • Doctors Who Communicate Well • Customer Service • Care Coordination • Getting Needed Prescription Drugs composite measures	• Never (Dissatisfied) • Sometimes (Neutral) • Usually or Always (Satisfied)
• Annual Flu Vaccine individual item measures	• Yes or No

To assess One Care Plans performance, IPRO compared plans' top-box scores to the Medicare Advantage FFS mean score. The top-box scores are the survey results for the highest possible response category.

Description of Data Obtained

For each One Care Plan, IPRO received a copy of the final 2023 MA-PD CAHPS Results report produced by CMS. These reports included descriptions of the project objectives and methodology, as well as plan-level results and analyses.

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all One Care Plans, IPRO compared the plan-level MA-PD CAHPS results and MassHealth Weighted means to the Medicare Advantage FFS mean score. Measures performing above the national benchmarks were considered strengths; measures performing at the mean were considered average; and measures performing below the national benchmark were identified as opportunities for improvement, as explained in Table 56.

Table 56: Key for MA-PD CAHPS Performance Measure Comparison to the Medicare Advantage FFS Mean Score.

Color Key	How Rate Compares to the Medicare Advantage FFS Mean Score
< Goal	Below the Medicare Advantage FFS mean score.
= Goal	The same as the Medicare Advantage FFS mean score.
> Goal	Above the Medicare Advantage FFS mean score.
N/A	Measure not applicable (N/A).

When compared to the Medicare Advantage FFS mean score, the CCA One Care plan's scores exceeded the national benchmark on three CAHPS measures, whereas the Tufts One Care scores exceeded the national benchmark on one CAHPS measure. All three One Care Plans scored below the benchmark on the Annual Flu Vaccine measure. **Table 57** displays the top-box scores of the 2023 MA-PD CAHPS survey.

Table 57: MA-PD CAHPS Performance – MassHealth One Care Plans, 2023 MA-PD CAHPS

CAHPS Measure	CCA One Care	Tufts One Care	UHC One Care	MassHealth Weighted Mean	Medicare Advantage FFS Mean Score
Getting Needed Care (Composite)	79 (< Goal)	75 (< Goal)	N/A	78 (< Goal)	80
Getting Appointments and Care Quickly (Composite)	76 (> Goal)	N/A	N/A	76 (> Goal)	75
Customer Service (Composite)	90 (> Goal)	N/A	N/A	90 (> Goal)	87
Care Coordination (Composite)	84 (< Goal)	N/A	N/A	84 (< Goal)	85
Getting Needed Prescription Drugs (Composite)	90	N/A	N/A	90	N/A
Annual Flu Vaccine	69% (< Goal)	67% (< Goal)	67% (< Goal)	69% (< Goal)	77%
Rating of Prescription Drug Plan	90	85	N/A	89	N/A
Rating of Health Care Quality	N/A	N/A	N/A	N/A	N/A
Rating of Health Plan	90 (> Goal)	86 (> Goal)	N/A	89 (> Goal)	83
Pneumonia Vaccine	52%	44%	49%	51%	N/A

MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; FFS: fee-for-service; N/A: not applicable.

VIII. MCP Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results(a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP,[15] PAHP,[16] or PCCM entity has effectively addressed the recommendations for QI[17] made by the EQRO during the previous year's EQR." **Tables 58–60** display the One Care Plans' responses to the recommendations for QI made during the previous EQR, as well as IPRO's assessment of these responses.

CCA One Care Response to Previous EQR Recommendations

Table 58 displays the One Care Plan's progress related to the *One Care Plans External Quality Review CY 2023,* as well as IPRO's assessment of plan's response.

Table 58: CCA One Care Response to Previous EQR Recommendations

Recommendation for CCA One Care	CCA One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
PIP 1 Flu Vaccination The EQRO also noted that CCA's population analysis, which was extensive and multidimensional, was presented in one PDF file that was difficult to read. In future reporting, the EQRO recommended that CCA reports its population analysis on a Microsoft® Excel® spreadsheet.	Population analysis was submitted in an MS Excel format.	Addressed
PIP 2 Care Planning Other than staff training in cultural competency and staff diversity, CCA presented no strategies for assisting members who resist cancer screening due to cultural or linguistic barriers. The EQRO recommended that CCA develop coaching scripts for care managers (CMs) that specifically anticipate barriers that a member may experience due to cultural or linguistic biases.	Coaching Scripts: Tip sheets were developed and placed on the CCA intranet for care team access to support their conversations with female Members for breast cancer screening.	Addressed
PMV: HEDIS Measures: CCA One Care 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.	CCA One Care follows QI workplan using the Plan, Do, Act, check process, focusing on One Care Withold Measures and key HEDIS measures. In 2022, they met the 100% withhold threshold, with only one measure not meeting the target. The Plan uses tools like root cause analysis and data reviews to assess progress and make corrections.	Addressed
Network 1: CCA One Care should expand its network when members' access can be improved and when network deficiencies can be closed by available providers.	CCA is exploring new opportunities and new methodologies for closing network deficiencies to ensure comprehensive and complete coverage for its members resulting in optimal quality of member care and services.	Partially addressed.

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

Recommendation for CCA One Care	CCA One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network 2: 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 counties.	In addition, CCA allows for out-of-network authorization when and if the need arises. Care partners assist in getting members out-of-network services with appropriate authorizations while CCA looks to cure any deficiencies.	Addressed.
Quality-of-Care Surveys: CCA One Care should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience.	The results are analyzed to identify trends that focus on three areas of greatest importance to CCA's members including getting needed care, getting appointments and care quickly, and care coordination. A cross-functional CAHPS Strategy Lead team and Steering committee was formed to identify and prioritize top issues that created dissatisfaction among members. CCA continues to leverage data from new surveys to better understand member concerns in these areas and implement improvements.	Addressed.

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined. **Not applicable**: PIP was discontinued. CCA: Commonwealth Care Alliance; MCP: managed care plan; EQR: external quality review; PIP: performance improvement project; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

Tufts One Care Response to Previous EQR Recommendations

Table 59 displays the One Care Plan's progress related to the *One Care Plans External Quality Review CY 2023,* as well as IPRO's assessment of plan's response.

Table 59: Tufts One Care Response to Previous EQR Recommendations

Recommendation for Tufts One Care	Tufts One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
PIP 1 Care Coordination The EQRO recommended that Tufts One Care explain in greater detail the strategies it will use with its community-based provider network to improve providers' responsiveness to members who may not traditionally access professional behavioral health services due to members' negative biases based upon cultural beliefs.	Tufts One Care collaborates with Cityblock Health (CBH), which utilizes a community-based provider network for care management. CBH's coordination of care process involves reaching out to members post-hospital discharge to identify their needs and establish behavioral health services. Discharge planning includes assessing cultural preferences, and efforts are made to connect members with providers of similar cultural backgrounds. CBH has expanded its internal network to be more culturally diverse, offering training to enhance cultural competency among providers and promote equitable services. Regular interactions with members aim to build engagement, and trust, and educate them on the importance of behavioral health services, addressing cultural hesitancies.	Addressed
PIP 1 Care Coordination Tufts One Care listed several strengths and challenges for this PIP, all of which are reasonable given the project goals.	Tufts One Care and CBH meet regularly to discuss the challenges of this PIP and its interventions. CBH is continually outreaching to members and working to engage them at any touchpoints with the	Addressed

Recommendation for Tufts One Care	Tufts One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
The EQRO recommended that Tufts One Care and Cityblock Health (CBH) address the challenges cited in its intervention strategies.	healthcare system, such as inpatient admissions. Tufts One Care and CBH have also created a monthly workgroup to discuss shared data needs between the entities to create streamlined processes (specifically for demographic/REL data sharing). Tufts One Care is continuing this PIP topic in 2024 and will consider if the solutions to these challenges can be incorporated into an intervention.	
PMV: HEDIS Measures: Tufts One Care should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Tufts One Care and Cityblock collaborate closely for Unify members, with the health plan providing monthly reports to track and improve key metrics. Monthly meetings are conducted to discuss and enhance quality performance, focusing on measures like controlling high blood pressure and hemoglobin A1c. An issue with denied claims affecting the Asthma Medication Ratio in MY 2021 was identified and corrected in April 2022, ensuring accurate reporting moving forward.	Addressed.
Network 1: Tufts One Care should expand its network when members' access can be improved and when network deficiencies can be closed by available providers.	As of Q3 2023, Tufts One Care has expanded its provider network and closed a number of gaps in specialties that were deficient in 2022. The following specialties: Rehab Hospitals, Group Adult Foster Care, BH-PACT, BH-Psychiatric Day, Recovery Coaching, RSS, RSN, Cardiac Surgery, and Neurosurgery remain deficient. For some gaps, Tufts One Care utilizes the QuestCloud tool to identify available providers to aid in outreach and contracting efforts.	Addressed.
Network 2: 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 counties.	When there are no additional providers available, Tufts One Care members can see a non-contracted provider at the in-network level of benefits.	Addressed.
Quality-of-Care Surveys: Tufts One Care should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience.	Tufts One Care Unify outlined the general process and approach followed in using the CAHPS survey to improve performance. After analyzing the survey results, the Plan identifies issues and implements an action plan through quality improvement workgroups.	Addressed.

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined. **Not applicable**: PIP was discontinued. MCP: managed care plan; EQR: external quality review; PIP: performance improvement project; BH: behavioral health; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

UHC One Care Response to Previous EQR Recommendations

Table 60 displays the One Care Plan's progress related to the *One Care Plans External Quality Review CY 2023,* as well as IPRO's assessment of plan's response.

Table 60: UHC One Care Response to Previous EQR Recommendations

Recommendation for UHC One Care	UHC One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV: UHC One Care should report rates for all HEDIS measures.	The Technical Report listed six HEDIS measures. UHC One Care respectfully notes that all six of these measures were reported in addition to other measures to the state on July 5, 2023. UHC was a new plan in 2022 with very low denominators in the majority of these HEDIS measures.	Addressed.
Network: Access was assessed for a total of 71 provider types. UHC One Care had deficient networks for 22 provider types: • Psychiatry • Nursing Facility • Acute Inpatient Hospital • Emergency Services Program • Community Crisis Stabilization • Intensive Outpatient Program • Monitored Inpatient (Level 3.7) • Partial Hospitalization Program • Program of Assertive Community Treatment • Psychiatric Day Treatment • RRS for SUD (Level 3.1) • Structured Outpatient Addiction Program • Adult Day Health • Adult Foster Care • Day Habilitation • Day Services • Group Adult Foster Care • Occupational Therapy • Oxygen and Respiratory Equipment • Personal Care Assistant • Speech Therapy • Rehabilitation Hospital UHC One Care should expand its network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those counties.	UHC One Care addresses network gaps by reaching out to nonparticipation hospitals. Efforts include increasing contracting for Adult Day Health, Day Habilitation, Day services, and Person Care Assistant services. UHC's monitoring involves routine reports, quarterly reviews of work plans, and addressing member needs through negotiations and single-case agreements if required.	Addressed.

UHC: UnitedHealthcare; MCP: managed care plan; EQR: external quality review; PIP: performance improvement project; BH: behavioral health; HEDIS: Healthcare Effectiveness Data and Information Set.

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

Table 61–63 highlight each One Care Plan's performance strengths, opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of CY 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**.

CCA One Care Strengths, Opportunities for Improvement, and Recommendations

Table 61: Strengths, Opportunities for Improvement, and EQR Recommendations for CCA One Care

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: Care Planning	Successful system level process changes.	There are minor rounding errors in the Results Table Year 1 results. The Plan's discussion regarding the impact of interventions on performance indicator rates was not robust. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans.	**Recommendation for PIP 1:** Please review future PIP submissions for accuracy. IPRO recommends that, for future PIP submissions, the Plan describe in more detail how the interventions correlate with the success of performance outcomes. Where possible, conclusions should be supported by plan data regarding the implementation and/or utilization of individual interventions. Please see general recommendations for additional recommendations relevant to all Plans.	Quality, Timeliness, Access
PIP 2: Flu	Dedication and commitment of the CCA Primary Care practice's leadership and clinical staff. Successful postcard mailing campaign.	PIP submission contained a minor rounding error. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans.	**Recommendation for PIP 2:** Please review future PIP submissions for accuracy. Please see general recommendations for additional recommendations relevant to all Plans.	Quality, Timeliness, Access
PMV: HEDIS measures	CCA One Care demonstrated compliance with IS standards. No issues were identified. The Controlling High Blood Pressure measure rate was above the 90th national Medicare Quality Compass percentile.	The Plan All-Cause Readmission Ratio was below the 25th national Medicaid Quality Compass percentile and the 25th national Medicare Quality Compass percentile. Rates for 3 of 8 HEDIS measures were not reported.	CCA One Care 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	CCA One Care demonstrated compliance with most of the federal and state contractual standards.	Lack of compliance with 13 requirements in the following domains: • Enrollee rights and protections (4)	MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 2/1/2024. 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 2024.	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
	MCP addressed opportunities for improvement from the prior compliance review.	• Coordination and continuity of care (6) • Coverage and authorization of services (1) • Practice guidelines (1) • Health information systems (1) Partial compliance with 26 requirements in the following domains: • Enrollee Rights and Protections (7) • Emergency and post-stabilization services (7) • Availability of services (3) • Coordination and continuity of care (5) • Coverage and authorization of services (2) • Grievances and appeals (1 element) • Health information systems (1)		
Network Adequacy: Data Integrity	CCA One Care plan submitted all requested in-network providers' data.	Individual provider names were submitted where facilities were requested and listed under the same NPI and address as the facility. Facility departments were submitted in the data, in addition to the facility name, under the facility's NPI and address. Duplicated data was submitted in the facility tabs, both the NPI Registered Name and DBA Name were submitted in the data.	<u>Recommendation</u> IPRO recommends that, for future network adequacy analysis, the CCA One Care plan review and deduplicate in-network provider data before data files are submitted for analysis.	Access, Timeliness
Network adequacy	CCA One Care Enrollees reside in 12 counties. CCA One Care demonstrated adequate networks for 46 out of 59	Access was assessed for a total of 59 provider types. CCA One Care had deficient networks for 13 provider types:	CCA One Care should expand its network when members' access can be improved and when network deficiencies can be closed by available providers.	Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
	provider types in all its counties.	• Gynecology, OB/GYN • Rehabilitation Hospital • Adult Health • Adult Foster Care • Day Services • Group Adult Foster Care • Oxygen and Respiratory Equipment • Personal Care assistant • Pharmacy • Intensive Outpatient Program • Partial Hospitalization Program • Program of Assertive Community Treatment • Psychiatric Day Treatment	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 counties.	
Network Adequacy: Provider Directory	CCA One Care's highest accuracy rate was 50% for All Home and Community-Based Services.	CCA One Care's accuracy rate was below 20% for the following provider type: • OB/GYN (16.70%)	<u>Recommendations</u> CCA One Care should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory. MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans.	Access, Timeliness
Quality-of-care surveys	CCA One Care scores above the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures: • Getting Appointments and Care Quickly • Rating of Health Plan • Customer Service	CCA One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures: • Getting Needed Care • Care Coordination • Annual Flu Vaccine	CCA One Care should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. MCP should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access

EQR: external quality review; PIP: performance improvement project; EQRO: external quality review organization; SDoH: social determinants of health; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; RRS for SUD: Residential Rehabilitation Services for Substance Use Disorder; MA-PD: Medicare Advantage Prescription Drug; FFS: fee-for-service; FUH: Follow-Up After Hospitalization for Mental Illness.

Tufts One Care Strengths, Opportunities for Improvement, and Recommendations

Table 62: Strengths, Opportunities for Improvement, and EQR Recommendations for Tufts One Care

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: FUH	Successful collaboration with hospitals and provider groups to improve communication during admission and post-discharge. Member satisfaction with care management services.	No plan-specific weaknesses. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans.	**Recommendation for PIP 1:** No plan-specific recommendations. Please see general recommendations for additional recommendations relevant to all Plans.	Quality, Timeliness, Access
PIP 2: Flu	Individual approach to overcoming barriers, offering flu vaccines at home via the community paramedic program, and sending education materials to members.	No plan-specific weaknesses. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans	**Recommendation for PIP 2:** No plan-specific recommendations. Please see general recommendations for additional recommendations relevant to all Plans.	Quality, Timeliness, Access
PMV: HEDIS measures	HEDIS rates for the following measures were above the 90th national Medicaid Quality Compass percentile: • HBD: Hemoglobin A1c Control; HbA1c control; >9.0% • Follow-up after Hospitalization for Mental Illness, 7 days HEDIS rates for the following measures were above the 90th national Medicare Quality Compass percentile: • Follow-up after Hospitalization for Mental Illness, 7 days • Follow-up after Hospitalization for Mental Illness, 30 days	The Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment rate was below the 25th national Medicaid Quality Compass percentile. The Hemoglobin A1c Poor Control rate was below the 25th national Medicare Quality Compass percentile.	Tufts One Care should conduct a root cause analysis and design quality improvement interventions to increase quality measures' rates and to improve members' appropriate access to the services evaluated by these measures.	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
	• Engagement in Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment			
Compliance Review	Tufts One Care demonstrated compliance with most of the federal and state contractual standards. MCP addressed opportunities for improvement from the prior compliance review.	Lack of compliance with 15 requirements in the following domains: • Enrollee rights and protections (1) • Coordination and continuity of care (9) • Coverage and authorization of services (5) Partial compliance with 29 requirements in the following domains: • Enrollee Rights and Protections (1) • Availability of services (3) • Coordination and continuity of care (8) • Coverage and authorization of services (12) • Grievances and appeals (1) • QAPI (4)	MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 2/1/2024. 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 2024.	Quality, Timeliness, Access
Network Adequacy: Data Integrity	Tufts One Care plan submitted all requested in-network providers' data.	IPRO found that duplicated data was submitted in the facility tabs, both the NPI Registered Name and DBA Name were submitted in the data. Duplicated data was submitted in the facility tabs, both the NPI Registered Name and DBA Name were submitted in the data.	<u>Recommendation</u> IPRO recommends that, for future network adequacy analysis, the Tufts One Care plan review and deduplicate in-network provider data before data files are submitted for analysis.	Access, Timeliness
Network adequacy	Tufts One Care Enrollees reside in eight counties. Tufts One care demonstrated adequate networks for 44 out of 59 provider types in all its counties.	Access was assessed for a total of 59 provider types. Tufts One Care had deficient networks for 15 provider types: • Neurology • Acute Inpatient Hospital • Rehabilitation Hospital • Occupational Therapy • Speech Therapy • Group Adult Foster Care • "Clinical Support Services for	Tufts One Care should expand its network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those counties.	Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
		Substance Use Disorders (Level 3.5)" • "Monitored Inpatient Level 3.7" • "Partial Hospitalization Program (PHP)" • "Program of Assertive Community Treatment" • Psychiatric Day Treatment • Recovery Coaching • Recovery Support Navigators • "Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)" • "Structured Outpatient Addiction Program (SOAP)"		
Network Adequacy: Provider Directory	Tufts One Care's highest accuracy rate was 33.33% for All Home and Community-Based Services.	Tufts One Care accuracy rate was at 20% for the following provider types: • Family Medicine (20.0%)	<u>Recommendations</u> Tufts One Care should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory. MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans.	Access, Timeliness
Quality-of-care surveys	Tufts One Care scored above the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures: • Rating of Health Plan	Tufts One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures: • Getting Needed Care • Annual Flu Vaccine	Tufts One Care should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. MCP should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access

EQR: external quality review; PIP: performance improvement project; EQRO: external quality review organization; SDoH: social determinants of health; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; RRS for SUD: Residential Rehabilitation Services for Substance Use Disorder; MA-PD: Medicare Advantage Prescription Drug; FFS: fee-for-service; FUH: Follow-Up After Hospitalization for Mental Illness.

UHC One Care Strengths, Opportunities for Improvement, and Recommendations

Table 63: Strengths, Opportunities for Improvement, and EQR Recommendations for UHC One Care

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: Flu	Care Coordinators, who conducted outreach and member education, speak the same language, and share the same cultural background as the members.	No plan-specific weaknesses. Please see the section on general weaknesses for additional information regarding weaknesses observed across Plans.	**Recommendation for PIP 1:** In future projects, UHC may consider applying intervention tracking measures to gain insights on intervention effectiveness while the PIP is in process. IPRO supports UHC's recommendations for initiating vaccination incentive programs earlier in the season for future programs and continuing with trust-building conversations and education to reduce vaccine hesitancy.	Quality, Timeliness, Access
PMV: HEDIS measures	UHC One Care demonstrated compliance with IS standards. No issues were identified.	UHC's Follow-Up After Hospitalization for Mental Illness (30 days) measure rate was below the 25th national Medicaid Quality Compass percentile. Rates for 5 of 8 HEDIS measures were not reported.	UHC One Care 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	UHC One Care demonstrated compliance with most of the federal and state contractual standards. MCP addressed opportunities for improvement from the prior compliance review.	Lack of compliance with 3 requirements in the following domains: • Enrollee rights and protections (1) • Coordination and continuity of care (1) • Health Information Systems (1) Partial compliance with 30 requirements in the following domains: • Disenrollment requirements and limitations (5) • Enrollee rights and protections (4) • Availability of services (1)	MCP is required to address all deficient and partially met requirements based on IPRO's recommendations outlined in the final validation tools sent by IPRO to the MCP on 2/1/2024. 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 2024.	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
		• Assurance of adequate capacity and services (3) • Coordination and continuity of care (13 elements) • Coverage and authorization of services (2 elements) • Health information systems (2)		
Network Adequacy: Data Integrity	UHC One Care plan submitted all requested in-network providers' data.	IPRO found that duplicated data was submitted, showing slight variations in the facility names, listed under the same NPI and address. IPRO found that duplicated data was submitted in the facility tabs, both the NPI Registered Name and DBA Name were submitted in the data.	<u>Recommendation</u> IPRO recommends that, for future network adequacy analysis, the UHC One Care plan review and deduplicate in-network provider data before data files are submitted for analysis.	Access, Timeliness
Network adequacy: Time/Distance Standards	UHC One Care Enrollees reside in 10 counties. UHC One Care demonstrated adequate networks for 36 out of 59 provider types in all its counties.	Access was assessed for a total of 59 provider types. UHC Connected had deficient networks for 25 provider types: • Acute Inpatient Hospital • Rehabilitation Hospital • Emergency Support Services • Occupational Therapy • Orthotics and Prosthetics • Speech Therapy • Adult Day Health • Adult Foster Care • Day Habilitation • Day Services • Group Adult Foster Care • Hospice • "Oxygen and Respiratory • Equipment" • Personal Care Assistant • Pharmacy	UHC One Care should expand its network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those counties.	Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
		• "Clinical Support Services for Substance Use Disorders (Level 3.5)" • "Community Crisis Stabilization" • "Monitored Inpatient Level 3.7" • "Partial Hospitalization Program (PHP)" • "Program of Assertive Community Treatment" • Psychiatric Day Treatment • "Structured Outpatient Addiction Program (SOAP)"		
Network Adequacy: Provider Directory	UHC One Care's highest accuracy rate was 46.67% for All Home and Community-Based Services.	UHC Connected accuracy rate was below 20% for the following provider type: • Family Medicine (13.3%)	<u>Recommendations</u> UHC One Care should conduct a root cause analysis and design quality improvement interventions to increase the accuracy of its provider directory. MCP should incorporate results from the 2023 Provider Directory Audit into the development of annual quality assurance improvement programs and network development plans.	Access, Timeliness
Quality-of-care surveys	None	UHC One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measure: • Annual Flu Vaccine	UHC One Care should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. MCP should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access

EQR: external quality review; PIP: performance improvement project; EQRO: external quality review organization; SDoH: social determinants of health; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; RRS for SUD: Residential Rehabilitation Services for Substance Use Disorder; MA-PD: Medicare Advantage Prescription Drug; FFS: fee-for-service; FUH: Follow-Up After Hospitalization for Mental Illness.

X. Required Elements in EQR Technical Report

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

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

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

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

Elements required in EQR technical report, including the requirements for the PIP validation, PMV, and review of compliance activities, are listed in **Table 64**.

Table 64: 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 One Care Plan 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 One Care Plan's strengths and weaknesses for each EQR activity and as they relate to quality, timeliness, and access.
Title 42 CFR § 438.364(a)(4)	The technical report must include recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity.	Recommendations for improving the quality of health care services furnished by each One Care Plan are included in each EQR activity section (**Sections III–VII**) and in **Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations**.

Regulatory Reference	Requirement	Location in the EQR Technical Report
Title 42 CFR § 438.364(a)(4)	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy, under *Title 42 CFR § 438.340*, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP beneficiaries.	Recommendations for how the state can target goals and objectives in the quality strategy are included in **Section I, High-Level Program Findings and Recommendations**, as well as when discussing strengths and weaknesses of a One Care Plan 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 One Care Plans 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 One Care Plan's approach to addressing the recommendations issued by the EQRO in the previous year's technical report.
Title 42 CFR § 438.364(d)	The information included in the technical report must not disclose the identity or other protected health information of any patient.	The information included in this technical report does not disclose the identity or other PHI of any patient.
Title 42 CFR § 438.364(a)(2)(iiv)	The technical report must include the following for each of the mandatory activities: objectives, technical methods of data collection and analysis, description of data obtained including validated performance measurement data for each PIP, and conclusions drawn from the data.	Each EQR activity section describes the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.
Title 42 CFR § 438.358 (b)(1)(i)	The technical report must include information on the validation of PIPs that were underway during the preceding 12 months.	This report includes information on the validation of PIPs that were underway during the preceding 12 months; see **Section III**.
Title 42 CFR § 438.330(d)	The technical report must include a description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle.	The report includes a description of PIP interventions associated with each state-required PIP topic; see **Section III**.
Title 42 CFR § 438.358(b)(1)(ii)	The technical report must include information on the validation of each MCO's, PIHP's, PAHP's, or PCCM entity's performance measures for each MCO, PIHP, PAHP, and PCCM entity performance measure calculated by the state during the preceding 12 months.	This report includes information on the validation of each One Care Plan'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 2023, to determine each MCPs compliance with the standards set forth in Subpart D and the QAPI requirements described in *Title 42 CFR § 438.330*; see **Section V**.

XI. Appendix A – MassHealth Quality Goals and Objectives

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

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

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

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

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

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

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

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

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

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

XII. Appendix B – MassHealth Managed Care Programs and Plans

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

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

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

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
	• Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age. • Managed Care Authority: 1915(a) Waiver/1915(c) Waiver.	

XIII. Appendix C – MassHealth Quality Measures

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

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

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

XIV. Appendix D – MassHealth One Care Network Adequacy Standards and Indicators

CMS' network adequacy standards for Medicare and Medicaid Plans (MMPs) were downloaded on 12.20.2023 from the following CMS website: Medicare-Medicaid Plan (MMP) Application & Annual Requirements | CMS

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

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Primary care Providers: • General Practice • Family Practice • Internal Medicine Contract Language: For non-pharmacy Medicare medical providers and facilities: Primary Care Providers: at least two (2) PCPs within CMS' standards	Primary Care Providers: 90% of Enrollees in a county have access to at least 2 PCP providers within a specific drive (defined in minutes) and distance (defined in miles) from Enrollee's ZIP code of residence. *Note*: Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type. Apply provider-to-enrollee ratio defined by CMS. Apply CMS standards of the minimum number of PCP providers in each county.	Primary Care Providers: Numerator: number of Enrollees in a county for which both of the following is true: •Two unique in-network providers are within a specific drive (defined in minutes) or less from Enrollee's ZIP code of residence; AND •Two unique in-network providers are within a specific distance (defined in miles) or less from Enrollee's ZIP code of residence. *Note*: Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type. Denominator: all plan Enrollees in a county. Minimum Provider Ratios: the number of all in-network providers in a county against the number of all Enrollees in that county. Minimum Number of Providers: apply the minimum number of providers as defined by CMS per county designation.

Table D2: One Care Network Adequacy Standards and Indicators – Hospital and Nursing Facilities

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Hospitals/Medical Facilities: • Acute Inpatient Hospital • Skilled Nursing Facilities	Hospitals/Medical Facilities: • 90% of Enrollees in a county have access to 2 facilities within a designated time and distance standards from Enrollee's ZIP code of residence.	Hospitals/Medical Facilities: Numerator: number of plan Enrollees in a county for which both of the following are true:

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Contract Language: 3. For non-pharmacy Medicare medical providers and facilities: • Hospital Services: at least two (2) hospitals within CMS' standards; except that if only one (1) hospital is located within a County, the second hospital may be within a fifty (50) mile radius of the Enrollee's ZIP code of residence. • Nursing Facilities: at least two (2) nursing facilities within CMS' standards; except that if only one (1) nursing facility is located within a County, the second nursing facility may be within a fifty (50) mile radius of the Enrollee's ZIP code of residence.	• The actual time and distance vary by provider type and the micro-metro-large metro geographic type. • Apply provider-to-enrollee ratio defined by CMS. • Apply the minimum number of providers defined by CMS, which vary by county.	• Two unique in-network facilities are within a specific-minute drive or less from Enrollee's ZIP code of residence; AND • Two unique in-network facilities are within a specific distance or less from Enrollee's ZIP code of residence. • The actual time and distance vary by provider type and the micro-metro-large metro geographic type. Denominator: all plan Enrollees in a county. Minimum Provider Ratios: the number of all in-network facilities in a county against the number of all Enrollees in that county per each provider type. Minimum Number of Providers: apply the minimum number of facilities as defined by CMS per county designation for each provider types.

Table D3: One Care Network Adequacy Standards and Indicators – Specialists

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Specialists CMS standards: Allergy and Immunology Cardiology Cardiothoracic Surgery Chiropractor Dermatology Endocrinology ENT/Otolaryngology Gastroenterology General Surgery Gynecology, OB/GYN Infectious Diseases	Specialists: • 90% of Enrollees in a county have access to 1 provider within a designated time and distance standards from Enrollee's ZIP code of residence. • The actual time and distance differ by provider type and the micro-metro-large metro geographic type. • Apply provider-to-enrollee ratio defined by CMS.	Specialists: Numerator: number of plan Enrollees in a county for which both of the following are true: • One unique in-network provider is within a specific-minute drive or less from Enrollee's ZIP code of residence; AND • One unique in-network provider is within a specific distance or less from Enrollee's ZIP code of residence. • The actual time and distance differ by provider type and the micro-metro-large metro geographic type.

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Nephrology Neurology Neurosurgery Oncology – Medical, Surgical Oncology – Radiation/Radiation Oncology Ophthalmology Orthopedic Surgery Physiatry, Rehabilitative Medicine Plastic Surgery Podiatry Psychiatry Pulmonology Rheumatology Urology Vascular Surgery Contract Language: For Medicare medical providers and facilities, time, distance, and minimum number of providers and facilities standards updated by CMS: https://www.cms.gov/files/document/mmphsdcriteriareftablecy2023.xlsx (Source: Medicare-Medicaid Plan (MMP) Application & Annual Requirements | CMS)	• Apply the minimum number of providers defined by CMS, which vary by county.	Denominator: all plan Enrollees in a county. Minimum Provider Ratios: the number of all in-network providers in a county against the number of all Enrollees in that county for each provider type. Minimum Number of Providers: apply the minimum number of providers as defined by CMS per county designation for each provider type.

Table D4: One Care Network Adequacy Standards and Indicators – Outpatient and Diversionary Behavioral Health Services

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Outpatient Behavioral Health Provider Types: • BH Outpatient BH Diversionary services – State's standards: • Clinical Support Services for Substance Use Disorders (Level 3.5) • Community Crisis Stabilization	BH Outpatient, Diversionary, and LTSS – State's standards • 90% of members in a county have access to at least 2 in-network providers within 15 miles or 30 minutes from	BH Outpatient, Diversionary, and LTSS – State's standards Numerator: number of plan members in a county for whom one of the following is true: • Two unique in-network providers are a 30-minute drive or less from a member's ZIP code of residence; OR • Two unique in-network providers are 15 miles or less

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
• Community Support Program • Intensive Outpatient Program • Monitored Inpatient Level 3.7 • Partial Hospitalization Program • Program of Assertive Community Treatment • Psychiatric Day Treatment • Recovery Coaching • Recovery Support Navigators • Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) • Structured Outpatient Addiction Program Contract Language: 4.The provider network must have sufficient providers to ensure that each Enrollee has a choice of at least: • two (2) outpatient and diversionary BH providers AND • two (2) community LTSS providers that are either within 15 miles or 30 minutes from the Enrollee's ZIP code of residence, except that with EOHHS prior approval, Contractor may offer Enrollee only one community LTSS provider per Covered Service. (Covered Services: referenced in Appendix A and defined in Appendix B of the One Care Contract)	Enrollee's ZIP code of residence.	from a member's ZIP code of residence. Denominator: all plan members in a county.

Table D5: One Care Network Adequacy Standards and Indicators – Pharmacy

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Provider Type: • Pharmacy Contract Language: For Medicare pharmacy providers, time, distance and minimum number	Pharmacy •90% of beneficiaries in Large Metro counties (urban areas) must be within 2 miles of a retail pharmacy; •90% of beneficiaries in Metro counties (suburban areas) must be within 5 miles of a retail pharmacy;	Pharmacy: Numerator: number of plan Enrollees in a county for which the following is true: •Large Metro: A retail pharmacy is within 2 miles or less from Enrollee's ZIP code of residence.

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
standards as required in Appendix F, Article II, Sec. I; and 42 C.F.R. §423.120.	•70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.	•Metro: A retail pharmacy is within 5 miles or less from Enrollee's ZIP code of residence. •Micro: A retail pharmacy is within 15 miles or less from Enrollee's ZIP code of residence. Denominator: all plan Enrollees in a county.

Table D6: One Care Network Adequacy Standards and Indicators – LTSS Providers

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
LTSS Providers – State's standards: • Adult Day Health • Adult Foster Care • Day Habilitation • Day Services • Group Adult Foster Care • Hospice • Oxygen and Respiratory Equipment • Personal Care Assistant Contract Language: 4.The provider network must have sufficient providers to ensure that each Enrollee has a choice of at least: • two (2) outpatient and diversionary BH providers AND • two (2) community LTSS providers that are either within 15 miles or 30 minutes from the Enrollee's ZIP code of residence, except that with EOHHS prior approval, Contractor may offer Enrollee only one community LTSS provider per Covered Service. (Covered Services: referenced in Appendix A and defined in Appendix B of the One Care Contract)	BH Outpatient, Diversionary, and LTSS – State's standards • 90% of members in a county have access to at least 2 in-network providers within 15 miles or 30 minutes from Enrollee's ZIP code of residence.	BH Outpatient, Diversionary, and LTSS – State's standards Numerator: number of plan members in a county for whom one of the following is true: • Two unique in-network providers are a 30-minute drive or less from a member's ZIP code of residence; OR • Two unique in-network providers are 15 miles or less from a member's ZIP code of residence. Denominator: all plan members in a county.
LTSS Providers – CMS standards: • Physical Therapy • Occupational Therapy • Speech Therapy	LTSS provider services – CMS standards: • 90% of members in a county have access to at least 2 Physical, Occupational, and Speech Therapy providers within a specific	LTSS provider services – CMS standards: Numerator: number of Enrollees in a

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
• Orthotics and Prosthetics Contract Language: For Medicare medical providers and facilities, time, distance, and minimum number of providers and facilities standards updated by CMS: https://www.cms.gov/files/document/mmphsdcriteriareftablecy2023.xlsx (Source: Medicare-Medicaid Plan (MMP) Application & Annual Requirements | CMS)	drive (defined in minutes) and distance (defined in miles) from Enrollee's ZIP code of residence. Note: Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type. • CMS standards specify a minimum number of Physical, Occupational, and Speed Therapy provider in each county, but not the minimum provider ratios • CMS standards do not specify ratio and minimum number of facilities for Orthotics and Prosthetics.	county for which both of the following is true: •Two unique in-network providers are within a specific drive (defined in minutes) or less from Enrollee's ZIP code of residence; AND •Two unique in-network providers are within a specific distance (defined in miles) or less from Enrollee's ZIP code of residence. Note: Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type. Denominator: all plan Enrollees in a county. Minimum Number of Providers: apply the minimum number of Physical, Occupational, and Speed Therapy provider as defined by CMS per county designation.

Table D7: One Care Network Adequacy Standards and Indicators – Other Provider Types

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Emergency support services Contract does not explicitly state a time and distance standard for Emergency support services. Included per MassHealth's request.	Emergency services program 90% of Enrollees in a county have access to at least 2 ESP services within 15 miles or 30 minutes from Enrollee's ZIP code of residence.	Emergency services program Numerator: number of plan Enrollees in a county for whom one of the following is true: • Two unique in-network ESP providers are a 30-minute drive or less from Enrollee's ZIP code of residence; OR • Two unique in-network ESP providers are 15 miles or less from Enrollee's ZIP code of residence. Denominator: all plan Enrollees in a county.

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated OneCare Three-way Contract	Indicator	Definition of the Indicator
Rehabilitation Hospital services Contract does not explicitly state a time and distance standard for Rehabilitation Hospital services. Included per MassHealth's request.	Hospital rehabilitation services/Medical Facility 90% of Enrollees in a county have access to 1 rehabilitation hospital within 15 miles or 30 minutes from Enrollee's ZIP code of residence.	Hospital rehabilitation services/Medical Facility **Numerator:** number of plan Enrollees in a county for whom one of the following is true: • An in-network rehabilitation hospital is a 30-minute drive or less from Enrollee's ZIP code of residence; **OR** • An in-network rehabilitation hospital is 15 miles or less from Enrollee's ZIP code of residence. **Denominator:** all plan Enrollees in a county.

XV. Appendix E – MassHealth One Care Plans Provider Directory Web Addresses

Table E1: One Care provider Directory Web Addresses

Managed Care Plan	Web Addresses Reported by Managed Care Plan
CCA One Care	https://www.commonwealthcarealliance.org/ma/members/find-a-provider/
Tufts Health Unify	https://tuftshealthplan.com/find-a-doctor#
UHC Connected	https://www.uhccommunityplan.com/find-a-provider