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External Quality Review
One Care Plans
Annual Technical Report, Calendar Year 2024

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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

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I. Executive Summary

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 improve their performance. This annual technical report 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 2024 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 of age at enrollment who are dually enrolled in Medicaid and Medicare. Enrollees can stay in the One Care program after the age of 65 years 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 2024

One Care Plan Name	Abbreviation Used in the Report	Members as of December 31, 2024	Percent of Total One Care Plan Population
Commonwealth Care Alliance	CCA One Care	29,352	71.11%
Tufts Health One Care	Tufts One Care	7,258	17.58%
UnitedHealthcare Connected for One Care	UHC One Care	4,668	11.31%
One Care Plans (Total)	N/A	41,278	100%

The **Commonwealth Care Alliance** (**CCA One Care**) is a nonprofit integrated health system that serves 29,352 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 One Care** (**Tufts One Care**) is a nonprofit health plan that serves 7,258 MassHealth Enrollees across eight (8)counties in the state of Massachusetts: Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester. Tufts One Care is part of the Point32Health health system.[2]

The **UnitedHealthcare Connected for One Care** (**UHC One Care**) serves 4,668 MassHealth Enrollees across ten (10) counties in the state of Massachusetts. UHC One Care 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 annual technical report is to present the results of EQR activities conducted to assess the quality of, timeliness of, and access to health care services furnished to Medicaid Enrollees, in accordance with the following federal managed care regulations: *Title 42 Code of Federal Regulations (CFR) Section (§) 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*.

[1] Commonwealth Care Alliance | Home

[2] https://tuftshealthplan.com/member/tufts-health-one-care

[3] UnitedHealthcare Connected® for One Care (Medicare-Medicaid Plan) | UnitedHealthcare Community Plan: Medicare & Medicaid Health Plans (uhccommunityplan.com)

EQR activities validate 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 EQR Activities

MassHealth contracted with IPRO, an external quality review organization (EQRO), to conduct four mandatory EQR activities, as outlined by the Centers for Medicare and Medicaid Services (CMS), for its 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 –*** 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 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 the CMS EQR 2023 protocols. CMS defined *validation* in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

High-Level Program Findings

The EQR activities conducted in CY 2024 demonstrated that MassHealth and the 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 2024 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 three years. In addition to the triennial review, MassHealth also conducts an annual review of measures and key performance indicators to assess progress toward strategic goals. MassHealth relies on the annual EQR process to assess the managed care programs' effectiveness in providing high-quality, accessible services.

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

Opportunities for Improvement:

Not applicable.

General Recommendations for MassHealth:

None at this time.

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

Performance Improvement Projects

State agencies must require that contracted MCPs conduct PIPs that focus on both clinical and non-clinical areas, as established in *Title 42 CFR § 438.330(d)*.

Strengths:

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

Opportunities for Improvement:

Not applicable.

General Recommendations for MassHealth:

None at this point.

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). HEDIS rates are calculated by each One Care Plan and reported to the state.

IPRO conducted performance measure validation 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 also reviewed One Care Plans' Final Audit Reports 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, Hemoglobin A1c Control, and Breast Cancer Screening weighted statewide means were 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) 2023 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, the weighted statewide mean scored above the Documentation of Care Plan Goals and Minimizing Facility Length of Stay measures benchmarks.

Opportunities for Improvement:

When compared to the MY 2023 Quality Compass national Medicaid percentiles, MassHealth's weighted state means were below the 25th percentile for the Plan All-Cause Readmissions Ratio. When compared to the MY 2023 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, MassHealth's weighted state mean was 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, sexual orientation and genderidentity. The following weighted state means were also below CMS's benchmarks: Access to LTS Coordinator (percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment) and Timely Assessment (percent of members with an initial assessment completed within 90 days of enrollment).

General Recommendations for MassHealth:

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

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

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

Compliance Review

IPRO evaluated the compliance of 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 three 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 eight and 90% or more in four domains; UHC One Care scored 100% in seven and 90% or more in another seven domains; and CCA One Care scored 100% in six and 90% or more in another six domains.

Opportunities for Improvement:

Gaps were identified in the areas of Enrollee Rights and Requirements, Emergency and Post-stabilization Services,[5] and 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 implementation and a broader understanding of contractual obligations, leading to inefficiencies and non-compliance.

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.

[5] 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.

- *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:

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

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

Travel time and distance standards and wait time for appointment standards are clearly defined in the One Care Plans' contracts with MassHealth. MCPs are required to submit in-network provider lists and the results of their GeoAccess analysis on an annual and ad hoc basis. This analysis evaluates provider locations relative to members' ZIP code of residence.

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

A high confidence rating indicates that no issues were found with the underlying information systems, the MCP's provider data were clean, the correct MassHealth standards were applied, and the MCP's results matched the time and distance calculations independently verified by IPRO. UHC received a rating of high confidence for behavioral health diversionary services, pharmacy, as well as oxygen and respiratory equipment services and rehabilitation hospital services. Tufts One Care plan received a rating of high confidence for pharmacy in large metro counties.

In addition to generating network adequacy validation ratings, IPRO produced GeoAccess reports to identify counties 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 percentage of members in that county who had adequate access. IPRO's analysis showed that all One Care Plans had adequate networks of adult primary care and behavioral health outpatient providers.

Opportunities for Improvement:

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

After resolving data issues and removing duplicate records, IPRO assessed each One Care Plans' provider network for compliance with MassHealth's time and distance standards. Access was evaluated for all provider types identified by MassHealth. Most One Care Plans had deficiencies in their behavioral health providers and dental services networks.

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

The average wait times for an appointment were: 90 calendar days for a PCP, 95 calendar days for an OB/GYN, and 25 calendar days for a dentist. However, these results are based on small samples and should be interpreted with caution.

General Recommendations for MassHealth:

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

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 to report CAHPS data to MassHealth. Each One Care Plan independently contracted with a CMS-approved survey vendor to administer the Medicare Advantage and Prescription Drug (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 Customer Service, Rating of Health Care Quality, 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 Medicare Adventage FFS mean score on the following measures: Getting Needed Care, Getting Appointments and Care Quickly, Care Coordination, and Annual Flu Vaccine. Similar to last year, 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 better performance on quality measures* – MassHealth should continue to leverage the HEDIS and non-HEDIS data and report findings to support the development of relevant major initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities.
- *Recommendation towards better policy documentation* – To encourage consistent practices and compliance with MassHealth standards, MassHealth should require MCPs to establish and maintain well-defined policies and procedures.
- *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.
- *Recommendations towards measurable network adequacy standards* – MassHealth should continue to monitor network adequacy across MCPs and leverage the results to improve access.
- *Recommendation towards better performance on CAHPS measures* – MassHealth should continue to utilize CAHPS data to evaluate 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.

EQR Recommendations for One Care Plans

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

II. Massachusetts Medicaid Managed Care Program

Managed Care in Massachusetts

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

MassHealth's mission is to improve the health outcomes of its members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life. MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.[6]

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.

[6] 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 following seven distinct managed care programs:

1. The Accountable Care Partnership Plans (ACPPs) are ACOs consisting of groups of PCPs who partner with one health plan to provide coordinated care and create a full network of providers, including specialists, behavioral health providers, and hospitals. As ACOs, ACPPs are rewarded for spending Medicaid dollars more wisely while providing high quality care to MassHealth Enrollees. To select an ACPP, a MassHealth Enrollee must live in the plan's service area and must use the plan's provider network.
2. The Primary Care Accountable Care Organizations (PC ACOs) are ACOs consisting of groups of PCPs who contract directly with MassHealth to provide integrated and coordinated care. A PC ACO functions as an ACO and a primary care case management (PCCM) entity. In contrast to ACPPs, a PC ACO does not partner with a health plan. Instead, PC ACOs use the MassHealth network of specialists and hospitals. Behavioral health services are provided by the Massachusetts Behavioral Health Partnership (MBHP).
3. Managed Care Organizations (MCOs) are health plans run by health insurance companies with their own provider network that includes PCPs, specialists, behavioral health providers, and hospitals.
4. Primary Care Clinician Plan (PCCP) is a PCCM arrangement, where Medicaid Enrollees select or are assigned to a PCP, called a primary care clinician (PCC). The PCC provides services to enrollees, including the coordination and monitoring of primary care health services. PCCP uses the MassHealth network of PCPs, specialists, and hospitals, as well as the MBHP's network of behavioral health providers.
5. Massachusetts Behavioral Health Partnership (MBHP) is a health plan that manages behavioral health care for MassHealth's PC ACOs and the PCCP. MBHP also serves children in state custody not otherwise enrolled in managed care and certain children enrolled in MassHealth who have commercial insurance as their primary insurance.[7]
6. One Care Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services, as well as LTSS. This plan is for Enrollees between 21 and 64 years of age at enrollment who are dually enrolled in Medicaid and Medicare.[8]
7. Senior Care Options (SCO) Plans are coordinated health plans that cover services paid by Medicare and Medicaid. This Plan is for MassHealth Enrollees 65 years of age or older, and it offers services to help seniors stay independently at home by combining healthcare services with social supports.[9]

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

Quality Metrics

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

At a statewide level, MassHealth monitors the Medicaid program's performance on the CMS Medicaid Adult and Child Core Sets measures. On a program level, each managed care program has a distinctive slate of measures. Quality measures selected for each program reflect MassHealth quality strategy goals and objectives.

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

For the alignment between MassHealth's quality measures with strategic goals and objectives, see Appendix C, Table C1.

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

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

Performance Improvement Projects

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

Member Experience of Care Surveys

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

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

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

MassHealth Initiatives

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

1115 Demonstration Waiver

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

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

Roadmap for Behavioral Health

Another MassHealth initiative that supports the goals of the quality strategy is the five-year roadmap for behavioral health reform that was released in 2021. Key components of implementing this initiative include the integration of behavioral health in primary care, community-based alternatives to emergency department for crisis interventions, and the creation of the 24-7 Behavioral Health Help Line that became available in 2023. The Behavioral Health Help Line is free and available to all Massachusetts residents.[10]

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

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

Evaluation Process

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

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

Findings

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

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

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

Methodology

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

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

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

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

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

EQR Recommendations

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

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

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

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

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

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

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

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

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

III. Validation of Performance Improvement Projects

Objectives

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

Section 2.13 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 can also modify the PIP cycle to address immediate priorities. In CY 2024, each One Care Plan started two new PIPs. Specific One Care PIP topics are displayed in Table 3.

Table 3: One Care PIP Topics – CY 2024

One Care Plan	PIP Topics
CCA One Care	**PIP 1: PCR – Baseline Report** Decreasing the rate of readmissions following an adult acute inpatient stay with a focus on COPD **PIP 2: IET – Baseline Report** Improving rates of initiation and engagement of treatment for substance use disorder
Tufts One Care	**PIP 1: FUH – Baseline Report** Increasing the percent of members who received follow-up care after an inpatient discharge for mental illness **PIP 2: IET – Baseline Report** Improving rates of initiation and engagement of treatment for substance use disorder
UHC One Care	**PIP 1: FUH – Baseline Report** Increasing the percent of members who received follow-up care after an inpatient discharge for mental illness within 30 days **PIP 2: HBD – Baseline Report** Improving the rate of members 18–75 years of age with diabetes whose HbA1c was controlled

PIP: performance improvement project; CY: calendar year; COPD: chronic obstructive pulmonary disease; HbA1c: hemoglobin A1c.

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Description of Data Obtained

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

Conclusions and Comparative Findings

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

Rating 1: Adherence to Acceptable Methodology - Validation results summary

The ratings for PIP adherence to acceptable methodology were high for almost all PIPs, except for the Tufts One Care IET PIP, which was rated moderate. It was recommended that the Tufts One Care clarify process measures used to track the success of its IET-focused interventions.

Rating 2: Evidence of Improvement - Validation results summary

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

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

Table 4: CCA One Care PIP Validation Confidence Ratings – CY 2024

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

PIP: performance improvement project; CY: calendar year; N/A: not applicable.

Table 5: Tufts One Care PIP Validation Confidence Ratings – CY 2024

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

PIP: performance improvement project; CY: calendar year; N/A: not applicable.

Table 6: UHC One Care PIP Validation Confidence Ratings – CY 2024

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

PIP: performance improvement project; CY: calendar year; N/A: not applicable.

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, 2024

CCA One Care PIP 1: Decreasing the rate of readmissions following an adult acute inpatient stay with a focus on COPD
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – N/A
Aim Indicator 1: By the end of 2025 CCA aims to decrease all cause readmissions and achieve the MY 2022 Massachusetts average readmission rate observed/expected compared to the MY 2023 baseline rate. Indicator 2: By the end of 2025 CCA aims to decrease the number of ICO COPD readmissions for members discharged from an acute care setting with an index diagnosis of COPD by 2.75%-point decrease compared to the MY 2023 baseline rate. Indicator 3: By the end of 2025 CCA aims to increase the number of ICO members with systemic corticosteroid pharmacotherapy management of COPD exacerbation to achieve a 2.5% -point increase compared to the CCA MY 2023 baseline rate. Indicator 4: By the end of 2025 CCA aims to increase the number of ICO members with bronchodilator pharmacotherapy management of COPD exacerbation to achieve the MY 2022 Massachusetts average rate as compared to the CCA MY 2023 baseline rate. **Interventions in 2024** ▪ Provide educational materials upon discharge to members with an index admission for COPD ▪ Develop training for providers on the GOLD standard specific to COPD ▪ Provide educational videos and material relating to COPD on CCA website for member use **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

PIP: performance improvement project; N/A: not appliable; CY: calendar year; MY: measurement year; COPD: chronic obstructive pulmonary disease.

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

Indicators	Reporting Year	Rate
Indicator 1: Plan All-Cause Readmissions (Ratio)	2024 (baseline, MY 2023 data)	1.42
Indicator 2: Modified PCR Specific to COPD	2024 (baseline, MY 2023 data)	19.12%
Indicator 3: Pharmacotherapy Management of COPD Exacerbation (PCE) Systemic Corticosteroids	2024 (baseline, MY 2023 data)	87.50%
Indicator 4: Pharmacotherapy Management of COPD Exacerbation (PCE) Bronchodilators	2024 (baseline, MY 2023 data)	68.00%

PIP: performance measure; MY: measurement year; COPD: chronic obstructive pulmonary disease.

Table 9: CCA One Care PIP 2 Summary, 2024

CCA One Care PIP 2: Improving rates of initiation and engagement of treatment for substance use disorder
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – N/A
Aim Indicator 1: By the end of 2025 CCA aims to increase the SUD treatment initiation rate of One Care members with a substance use disorder by 3 percentage points compared to the 2023 MY baseline rate. Indicator 2: By the end of 2025 CCA aims to increase the SUD treatment engagement rate of One Care members with a substance use disorder by 3 percentage points compared to the 2023 MY baseline rate **Interventions in 2024** ▪ Provide information about community resources to Spanish speaking members ▪ Collaborate with local emergency departments ▪ Perform Screening, Brief Intervention, and Referral to treatment for substance use at the time of a status change **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

PIP: performance improvement project; N/A: not appliable; CY: calendar year; MY: measurement year; SUD: substance use disorder.

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

Indicators	Reporting Year	Rate
Indicator 1: Initiation of SUD Treatment	2024 (baseline, 2023 MY date)	41.09%
Indicator 2: Engagement of SUD Treatment	2024 (baseline, 2023 MY date)	10.50%

PIP: performance improvement project; MY: measurement year; SUD: substance use disorder.

Tufts One Care PIPs

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

Table 11: Tufts One Care PIP 1 Summary, 2024

Tufts Health PIP 1: Increasing the percent of members who received follow-up care after an inpatient discharge for mental illness
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – N/A
Aim FUH 7-day: By the end of 2025 Tufts Health One Care aims to increase the percentage of members who had a follow-up appointment with a mental health provider within 7 days after discharge from a psychiatric admission by 6.25 percentage points compared to the MY2023 baseline rate of 46.65%. FUH 30-day: By the end of 2025 Tufts Health One Care aims to increase the percentage of members who had a follow-up appointment with a mental health provider within 30 days after discharge from a psychiatric admission by 3.54 percentage points compared to the MY2023 baseline rate of 71.46%. **Interventions in 2024** ▪ Initiate care coordination upon notification of member's admission ▪ Increase care management opportunities between nurse liaisons and members ▪ Increase engagement in care management **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

PIP: performance improvement project; N/A: not appliable; CY: calendar year; MY: measurement year.

Table 12: Tufts One Care PIP 1 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: Follow-up After Hospitalization for Mental Illness 7-day	2024 (baseline, MY 2023 data)	46.65%
Indicator 1: Follow-up After Hospitalization for Mental Illness 30-day	2024 (baseline, MY 2023 data)	71.46%

PIP: performance improvement project; MY: measurement year.

Table 13: Tufts One Care PIP 2 Summary, 2024

Tufts Health One Care PIP 2: Improving rates of initiation and engagement of treatment for substance use disorder
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – Moderate Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – N/A
Aim Indicator 1: By the end of 2025, Tufts Health One Care aims to increase the percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days of diagnosis by 7.53 percentage points compared to the MY2023 baseline rate of 34.39%. Indicator 2: By the end of 2025, Tufts Health One Care aims to increase the percentage of new SUD episodes in which the member initiated treatment and had two or more additional SUD services or medication treatment within 34 days of the initiation visit by 4.95 percentage points compared to the MY2023 baseline rate of 8.92%. **Interventions in 2024** ▪ Develop and share reporting of emergency departments SUD diagnosis information with Community Behavioral Health ▪ Introduced focused member education on SUD and chronic disease ▪ Increase member self-reports of SUD diagnosis or treatment to support initiation and engagement **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

PIP: performance improvement project; N/A: not appliable; CY: calendar year; MY: measurement year; SUD: substance use disorder.

Table 14: Tufts One Care PIP 2 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: Initiation of SUD Treatment	2024 (baseline, MY 2023 data)	34.39%
Indicator 1: Engagement of SUD Treatment	2024 (baseline, MY 2023 data)	8.92%

PIP: performance improvement project; MY: measurement year; SUD: substance use disorder.

Recommendations

- *Recommendation for PIP 2*: Continue refining intervention tracking measures to accurately assess improvement.

UHC One Care PIPs

UHC One Care PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 15–18**.

Table 15: UHC One Care PIP 1 Summary, 2024

UHC One Care PIP 1: Increasing the percent of members who received follow-up care after an inpatient discharge for mental illness within 30 days
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – N/A
Aim By the end of 2025, UnitedHealthcare aims to improve the FUH-30-day HEDIS measure rate for One Care members by three percentage points from 58.33% in MY2023 to 61.33%. **Interventions in 2024** ▪ Outreach members needing follow up appointment with a mental health provider ▪ Utilize the Optum Behavioral Health Peer Support Program for members with a mental health or SUD diagnosis ▪ Create pilot program for 30 day follow up **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

PIP: performance improvement project; N/A: not appliable; CY: calendar year; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Table 16: UHC One Care PIP 1 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: FUH 30-day	2024 (baseline, MY 2023 data)	58.33%

PIP: performance improvement project; MY: measurement year.

Table 17: UHC One Care PIP 2 Summary, 2024

UHC One Care PIP 2: Improving the rate of members 18–75 years of age with diabetes whose HbA1c was controlled
Validation Summary Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence Confidence Rating 2: PIP Produced Evidence of Improvement – N/A
Aim By the end of 2025, UnitedHealthcare One Care members with adequately controlled diabetes (HBD <8%) will increase from 58.88% in MY2023 to 68.88%%. **Interventions in 2024** ▪ Provide members with diabetes home delivered food services ▪ Partner with Evans Medical Foundation to provide members access to the American Diabetes Association (ADA) Project Power program ▪ Initiate pilot program for in home phlebotomy services **Performance Improvement Summary** Not applicable until the remeasurement results are available in CY 2025 for the MY 2024.

PIP: performance improvement project; N/A: not appliable; CY: calendar year; MY: measurement year.

Table 18: UHC One Care PIP 2 Performance Measures and Results

Indicators	Reporting Year	Rate
Indicator 1: HBD	2024 (baseline, MY 2023 data)	58.88%

PIP: performance improvement project; MY: measurement year.

IV. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

MassHealth contracted with IPRO to conduct performance measure validation to assess the data collection and reporting processes used to calculate the performance measure 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. There were no non-HEDIS measures required for reporting or in scope of the performance measure validation for MY 2023.

For HEDIS measures, IPRO performed an independent evaluation of the MY 2023 HEDIS Compliance Audit Final Audit Reports, which contained findings related to the information systems standards. An EQRO may review an assessment of the MCP's information systems conducted by another party in lieu of conducting a full Information Systems Capabilities Assessment.[11] Since the One Care Plans' HEDIS rates were audited by an independent NCQA-licensed HEDIS compliance audit organization, all Plans received a full Information Systems Capabilities Assessment 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 demonstration project and are calculated by CMS's vendor, the National Opinion Research Center. Data are submitted by Plans on a quarterly basis through either the CMS Health Plan Management System or the National Opinion Research Center Financial Alignment Initiative data collection systems. CMS contracts with Health Services Advisory Group 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 2023 HEDIS Compliance Audit, as well as associated supplemental documentation, Interactive Data Submission System files, and the Final Audit Report.

[11] 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 Information Systems Capabilities Assessment. The results of HEDIS compliance audits are presented in the HEDIS Final Audit Reports issued by each One Care Plan's independent auditor.

Conclusions and Comparative Findings

Based on a review of the One Care Plans' HEDIS Final Audit Reports issued by their independent NCQA-certified HEDIS compliance auditors, IPRO found that all One Care Plans were fully compliant with all four of the applicable NCQA information system standards. Findings from IPRO's review of the One Care Plans' HEDIS FARs are displayed in Table 19.

Table 19: One Care Plan Compliance with Information System Standards – MY 2023

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

MY: measurement year.

Validation Findings

- Information Systems Capabilities Assessment (ISCA): The Information Systems Capabilities Assessment is conducted to confirm that the One Care Plan's information systems were appropriately capable of meeting regulatory requirements for managed care quality assessment and reporting. This includes a review of the claims processing systems, enrollment systems, and provider data systems. IPRO reviewed the One Care Plans' HEDIS Final Audit Reports 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 Final Audit Report 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 Final Audit Report confirmed that the One Care Plans passed medical record review validation. No issues were identified.
- Primary Source Validation: Primary source validation is conducted to confirm that the information from the primary source matches the output information used for measure reporting. The review of each One Care Plan's Final Audit Report confirmed that the One Care Plans passed primary source validation. No issues were identified.
- Data Collection and Integration Validation: This includes a review of the processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately. The review of each One Care Plan's Final Audit Report 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 2023 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: 78.66%; Tufts: 73.22%; UHC: 76.89%; Statewide: 77.89%
- HBD: Hemoglobin A1c Control – CCA: 22.83%; Statewide: 23.95%
- Breast Cancer Screening – CCA: 71.6%; Tufts: 67.49%; Statewide: 71.22%

Needs Improvement

- Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment – CCA: 34.39%
- Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment – Tufts: 7.22%
- Plan All-Cause Readmission (Observed/Expected Ratio) – CCA: 1.4255; Tufts: 1.3312; UHC: 1.8401; Statewide: 1.4326

The Medicaid Quality Compass percentiles were color-coded to compare to the One Care Plan rates, as explained in Table 20.

Table 20: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2023 Quality Compass Medicaid National Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2023 Quality Compass National Medicaid Percentiles
< 25th	Below the national Medicaid 25th percentile.
≥ 25th but < 50th	At or above the national Medicaid 25th percentile but below the 50th percentile.
≥ 50th but < 75th	At or above the national Medicaid 50th percentile but below the 75th percentile.
≥ 75th but < 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).

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

Table 21 displays the HEDIS performance measures for MY 2023 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.

Table 21: One Care HEDIS Performance Measures – MY 2023 as Compared to Medicaid Quality Compass

HEDIS Measure	CCA One Care	Tufts One Care	UHC One Care	Weighted Statewide Mean
Influenza Vaccination[1]	64 (< Goal)	71 (< Goal)	58 (< Goal)	65 (< Goal)
Controlling High Blood Pressure	78.66% (≥ 90th)	73.22% (≥ 90th)	76.89% (≥ 90th)	77.89% (≥ 90th)
HBD: Hemoglobin A1c Control; HbA1c control (> 9.0%) LOWER IS BETTER	22.83% (≥ 90th)	27.41% (≥ 75th but < 90th)	32.36% (≥ 50th but < 75th)	23.95% (≥ 90th)
Follow-up After Hospitalization for Mental Illness (7 days)	44.55% (≥ 50th but < 75th)	46.65% (≥ 50th but < 75th)	31.35% (≥ 25th but < 50th)	43.55% (≥ 50th but < 75th)
Follow-up After Hospitalization for Mental Illness (30 days)	65.02% (≥ 50th but < 75th)	71.46% (≥ 75th but < 90th)	58.33% (≥ 25th but < 50th)	65.39% (≥ 50th but < 75th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	41.88% (≥ 25th but < 50th)	34.39% (< 25th)	43.33% (≥ 25th but < 50th)	40.65% (≥ 25th but < 50th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	10.50% (≥ 25th but < 50th)	8.92% (≥ 25th but < 50th)	7.22% (< 25th)	10.03% (≥ 25th but < 50th)
Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years) LOWER IS BETTER	1.4255 (< 25th)	1.3312 (< 25th)	1.8401 (< 25th)	1.4326 (< 25th)
Breast Cancer Screening	71.6% (≥ 90th)	67.49% (≥ 90th)	N/A	71.22% (≥ 90th)

[1] The CAHPS Influenza Vaccination measure was compared to the Medicare Advantage 2023 FFS Mean Score, instead of the Medicaid Quality Compass.

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: not applicable, if eligible population/denominator less than 30, marked as N/A; CAHPS: Consumer Assessment of Healthcare Providers and Systems; FFS: fee-for-service; HbA1c; hemoglobin A1c.

IPRO also compared the One Care Plan rates to the NCQA HEDIS MY 2023 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: 46.65%
- Follow-up After Hospitalization for Mental Illness (30 days) – Tufts: 71.46%
- Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment – CCA: 10.5%; Weighted Statewide Mean: 10.03%

Needs Improvement:

- Hemoglobin A1c Control (HbA1c > 9.0%; lower is better) – CCA: 22.83%; Tufts: 27.41%; UHC: 32.36%; Weighted Statewide Mean: 23.95%
- Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years) – CCA: 1.4255; Tufts: 1.3312; UHC: 1.8401; Weighted Statewide Mean: 1.4326

Table 22 provides the color key for the comparison to the Quality Compass Medicare benchmarks.

Table 23 displays the HEDIS performance measures for MY 2023 for all One Care Plans and the weighted statewide mean as compared to the Quality Compass national Medicare percentiles. The Influenza Vaccination measure was not included in the performance measure validation.

Table 22: Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2023 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.
≥ 25th but < 50th	At or above the national Medicare 25th percentile, but below the 50th percentile.
≥ 50th but < 75th	At or above the national Medicare 50th percentile, but below the 75th percentile.
≥ 75th but < 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 23: One Care HEDIS Performance Measures – MY 2023 as Compared to Medicare Quality Compass

HEDIS Measure	CCA One Care	Tufts One Care	UHC One Care	Weighted Statewide Mean
Influenza Vaccination[1]	64 (< Goal)	71 (< Goal)	58 (< Goal)	65 (< Goal)
Controlling High Blood Pressure	78.66% (≥ 50th but < 75th)	73.22% (≥ 25th but < 50th)	76.89% (≥ 50th but < 75th)	77.89% (≥ 50th but < 75th)
HBD: Hemoglobin A1c Control; HbA1c control (> 9.0%) LOWER IS BETTER	22.83% (< 25th)	27.41% (< 25th)	32.36% (< 25th)	23.95% (< 25th)
Follow-Up After Hospitalization for Mental Illness (7 days)	44.55% (≥ 75th but < 90th)	46.65% (≥ 90th)	31.35% (≥ 50th but < 75th)	43.55% (≥ 75th but < 90th)
Follow-Up After Hospitalization for Mental Illness (30 days)	65.02% (≥ 75th but < 90th)	71.46% (≥ 90th)	58.33% (≥ 50th but < 75th)	65.39% (≥ 75th but < 90th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation)	41.88% (≥ 50th but < 75th)	34.39% (≥ 25th but < 50th)	43.33% (≥ 75th but < 90th)	40.65% (≥ 50th but < 75th)
Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement)	10.50% (≥ 90th)	8.92% (≥ 75th but < 90th)	7.22% (≥ 75th but < 90th)	10.03% (≥ 90th)
Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years) LOWER IS BETTER	1.4255 (< 25th)	1.3312 (< 25th)	1.8401 (< 25th)	1.4326 (< 25th)
Breast Cancer Screening	71.6% (≥ 25th but < 50th)	67.49% (≥ 25th but < 50th)	N/A	71.22% (≥ 25th but < 50th)

[1] The CAHPS Influenza Vaccination measure was compared to the Medicare Advantage 2023 FFS Mean Score, instead of the Medicaid Quality Compass.

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: not applicable, if eligible population/denominator less than 30, marked as N/A; CAHPS: Consumer Assessment of Healthcare Providers and Systems; FFS: fee-for-service; HbA1c; hemoglobin A1c.

Finally, in **Table 25**, IPRO reported MY 2023 rates for the five 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 24** provides the color key for the comparison to the quality withhold benchmarks.

Table 24: Key for One Care Non-HEDIS Performance Measures Comparison to the Quality Withhold Benchmarks

Color Key	How Rate Compares to the Medicare Advantage 2023 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).

HEDIS: Healthcare Effectiveness Data and Information Set; FFS: fee-for-service.

Table 25: One Care Non-HEDIS Performance Measures – MY 2023 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.	99.80% (> Goal)	98.44% (> Goal)	35.47% (< Goal)	79.64% (< Goal)	95.00 (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).	86.20% (> Goal)	68.48% (< Goal)	84.89% (< Goal)	82.94% (< Goal)	85.00 (N/A)
Documentation of Care Plan Goals: Percent of members with documented discussions of care goals.	100.00% (> Goal)	93.54% (< Goal)	98.08% (> Goal)	99.20% (> Goal)	95.00 (N/A)
Timely Assessment: Percent of members with an initial assessment completed within 90 days of enrollment.	91.96% (> Goal)	95.33% (> Goal)	64.65% (< Goal)	88% (< Goal)	90.00 (N/A)
Minimizing Facility Length of Stay	1.72 (> Goal)	1.62 (> Goal)	1.07 (> Goal)	1.61 (> Goal)	1.00 (N/A)

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; LTSS: long-term services and supports.

V. Review of Compliance with Medicaid Managed Care Regulations

Objectives

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

The purpose of this compliance review was to assess 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.

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

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

Pre-interview Documentation Review

To ensure a complete and meaningful assessment of MassHealth's policies and procedures, IPRO prepared 14 review tools to reflect the areas for review. These 14 tools were submitted to MassHealth for approval at the outset of the review process. The tools included review elements drawn from the state and federal regulations. Based 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 site.

To facilitate the review process, IPRO provided One Care Plans with examples of documents they could furnish to validate compliance with the regulations. Instructions regarding the file review component of the audit were also provided, along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO randomly selected a sample of cases for the 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, the internal processes, and procedures to deliver the required services to members and providers; can articulate in their own words; and draws the relationship between the policies and the implementation of those policies. Interviews discussed elements in each of the review tools that were considered less than fully compliant based upon initial review. Interviews were used to further explore the written documentation and to allow One Care Plans to provide additional documentation, if available. One Care Plans' staff was given two days from the close of the onsite review to provide any further documentation.

Post-interview Report Preparation

Following the remote interviews, 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 nine 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 the total possible points. A three-point scoring system was used: Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points. For each standard identified as Partially Met or Not Met, the MCP was required to clarify how and when the issue will be resolved. The scoring definitions are outlined in Table 26.

Table 26: 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. Not applicable elements are removed from the denominator.

MCP: managed care plan.

Description of Data Obtained

Compliance review tools included detailed regulatory and contractual requirements in each standard area. The 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 seven 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 27 presents compliance scores for each of the 14 domains across all three One Care Plans.

Table 27: 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[1]	438.100	85.3%[3]	97.1%	94.2%	92.2%
Emergency and post-stabilization services[2]	438.114	50.0%[3]	100.0%	100.0%	83.3%[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%[3]	94.0%	92.3%
Coverage and authorization of services	438.210	97.3%	83.5%[3]	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%

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

[2] Emergency and Post-stabilization Services is seven regulations embedded in the 438.210 Coverage and Authorization Tool and extracted in the scorecard for presentation.

[3] Red text: indicates opportunity for improvement (less than 90%).

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

VI. Validation of Network Adequacy

Objectives

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

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

MassHealth's access and availability standards are described in 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, referred to as GeoAccess standards in this report, (i.e., the travel time and distance standards) and provider appointment 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 One Care Plans' processes for collecting and storing network data, provider networks' compliance with MassHealth's GeoAccess requirements, the accuracy of the information presented in One Care Plans' online provider directories, and compliance with the standards for appointment wait times.

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

Technical Methods of Data Collection and Analysis

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

Network Information Systems Validation Methodology

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

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

data collection and updates; the extent of missing data; and the quality assurance measures in place to prevent and correct errors.

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

Provider Directory and Availability of Appointments Methodology

The accuracy of provider directories and availability of appointments were assessed using secret shopper surveys. In a secret shopper survey, callers acted as members and attempted to schedule an appointment, documenting the date of the next available appointment or barriers to making the appointment. The audited specialties are listed in Table 28.

Table 28: Audited Specialties

Reporting Group	Specialty
Primary care	Family medicine Internal medicine
Specialists	Obstetrics/Gynecology (Ob/Gyn) General Dental Services

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

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

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

IPRO also inquired about the wait times for the next available sick and routine appointments. Callers were provided with scenarios to use when attempting to schedule appointments. Each scenario was designed to address both the routine and sick visit standards, allowing responses to be captured in a single call. MassHealth's appointment availability standards for One Care Plans are detailed in Table 29. Standards highlighted in gray are for provider types not included in the survey.

Table 29: Availability Standards

Provider Type	Urgency Level	One Care Sec. 2.9.2.8
Emergency services[1]	Emergency	Immediately
Urgent care[1]	Urgent/Symptomatic	48 hours
One Care PCP: internal medicine, family medicine	Nonurgent symptomatic: sick visit	10 calendar days
One Care PCP: internal medicine, family medicine	Nonsymptomatic: routine visit	30 calendar days
One Care specialty provider: ob/gyn, general dental	Nonurgent symptomatic: sick visit	30 calendar days

Provider Type	Urgency Level	One Care Sec. 2.9.2.8
One Care specialty provider: ob/gyn, general dental	Nonsymptomatic: routine visit	30 calendar days
Behavioral health (BH) services[1]	Nonurgent BH services	14 calendar days

1 Gray cell: indicates provider types not included in the survey.
PCP: primary care provider; ob/gyn: obstetrics/gynecology.

Travel Time and Distance Validation Methodology

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

One Care network adequacy standards are a combination of CMS's network adequacy standards for Medicare and Medicaid Plans 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 30.

Table 30: Provider Type Standards – Travel Time AND Distance Versus Travel Time OR Distance

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

CMS: Centers for Medicare and Medicaid Services; 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 ZIP code. According to One Care contracts, the 50-mile radius rule applies to hospitals and nursing facilities.

The CMS's travel time and distance standards vary by provider type, as well as by CMS's county designation. Different time and distance standards apply when certain provider types render services to members who reside in metro versus large metro counties. Massachusetts' county designation is listed in Table 31.

Table 31: County Designation in Massachusetts – Metro Versus Large Metro

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

IPRO reviewed MassHealth GeoAccess standards and worked together with the state to define network adequacy indicators. Network adequacy indicators were updated to reflect all changes to the contract requirements for CY 2024. One Care GeoAccess network adequacy standards and indicators are listed in Appendix D (Tables D1–D8).

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

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

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

Description of Data Obtained

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

Network Information Systems Capacity Assessment Data

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

Provider Directory and Availability of Appointment Data

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

Travel Time and Distance Data

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

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

Conclusions and Findings

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

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

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

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

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

The network adequacy validation rating for each indicator is reported in Table 32.

Table 32: One Care Network Adequacy Validation Ratings – CY 2024

Network Adequacy Indicator	CCA One Care Validation Rating	Tufts One Care Validation Rating	UHC One Care Validation Rating
PCP GeoAccess	Low confidence	Low confidence	Low confidence
Hospital and Nursing Facilities GeoAccess	Low confidence	Moderate confidence	Moderate confidence
Specialists GeoAccess	Low confidence	Moderate confidence	Low confidence
Outpatient and Diversionary Behavioral Health Services GeoAccess	Low confidence	Moderate confidence	High confidence: Behavioral Health Diversionary Services Moderate confidence: Behavioral Health Outpatient
Pharmacy GeoAccess	Moderate confidence	High confidence: large metro counties Moderate confidence: metro counties	High confidence
LTSS Providers GeoAccess	Moderate confidence: Day Services and Group Adult Foster Care Low confidence: the remaining LTSS provider types	Moderate confidence: most LTSS provider types Low confidence: Physical and Speech Therapy	Moderate confidence
Other Provider Types GeoAccess	Moderate confidence: Rehabilitation Hospital Services Low confidence: Emergency Support Services	Moderate confidence	High Confidence: Oxygen and Respiratory Equipment Services and Rehabilitation Hospital Services Not enough information to validate: Emergency Support Services
Dental Services GeoAccess[1]	Low confidence	Moderate confidence	Moderate confidence
Accuracy of Directories[2,3]	Moderate confidence	Moderate confidence	Moderate confidence
Wait Time for Appointment[4]	Not Reportable	Not Reportable	Not Reportable

[1] Not required to report to MassHealth during the review period.

[2] Managed care plans (MCPs) are not required to report what percentage of the directory information is accurate.

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

[4]Fewer than 30 providers were able to be contacted. There is not enough information to draw plan-level conclusions; only program-level results are reported.

CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; TBD: to be determined; LTSS: long-term services and supports.

Network Information Systems and Quality of Provider Data

The analysis of the information systems assessment showed the following:

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

Provider Directory

IPRO validated the accuracy of provider directories for a sample of provider types chosen by MassHealth. Tables 33- 35 show the percentage of providers in the directory with verified telephone number, address, specialty, and Medicaid participation. MassHealth did not establish a goal for the provider directory activity.

Table 33: Provider Directory Accuracy – PCPs

Provider Directory Accuracy	CCA One Care % (n)[2]	Tufts One Care % (n)[2]	UHC One Care % (n)[2]
PCPs[1]	21.82% (79)	44.60% (157)	36.36% (48)
Total PCPs called	362	352	132

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

Table 34: Provider Directory Accuracy – Obstetrics/Gynecology

Provider Directory Accuracy	CCA One Care % (n)[1]	Tufts One Care % (n)[1]	UHC One Care % (n)[1]
Obstetrics/Gynecology (Ob/Gyn)	29.66% (35)	37.50% (12)	36.63% (37)
Total ob/gyns called	118	32	101

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

Table 35: Provider Directory Accuracy – General Dental Services

Provider Directory Accuracy	CCA One Care % (n)[1]	Tufts One Care % (n)[1]	UHC One Care % (n)[1]
Dentists	43.33% (13)	53.33% (16)	60.00% (18)
Total dentists called	30	30	30

[1] (n) is the number of providers in the sample for whom the contact information was correct.
Note: The sample a random sample of 30 providers.

Tables 36-38 show the most frequent reasons why information in the directories was incorrect or could not be validated.

Table 36: Directory Inaccuracy/Provider Verification Challenges– Primary Care Providers

Directory Inaccuracy/Provider verification challenges	One Care Total	CCA One Care	Tufts One Care	UHC One Care
Contact fails[1]	252	129	80	43
Provider not at the site[2]	151	62	66	23
Provider reported a different specialty[3]	92	70	15	7
Wrong address	50	18	22	10
Provider does not accept Medicaid	10	1	8	1
Provider is retired	6	3	3	0
Refused to participate (e.g., hung up)	1	0	1	0
Total	562	283	195	84

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

Table 37: Directory Inaccuracy/Provider Verification Challenges– Obstetrics/Gynecology

Directory Inaccuracy/Provider verification challenges	One Care Total	CCA One Care	Tufts One Care	UHC One Care
Contact fails[1]	97	49	10	38
Provider not at the site[2]	51	23	5	23
Wrong address	13	10	3	0
Provider does not accept Medicaid	3	1	1	1
Provider reported a different specialty[3]	1	0	1	0
Provider is retired	0	0	0	0
Refused to participate (e.g., hung up)	0	0	0	0
Total	165	83	20	62

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

Table 38: Directory Inaccuracy/Provider Verification Challenges– General Dental Services

Directory Inaccuracy/Provider verification challenges	One Care Total	CCA One Care	Tufts One Care	UHC One Care
Contact fails[1]	21	7	7	7
Provider not at the site[2]	12	4	6	2
Provider does not accept Medicaid	8	4	1	3
Wrong address	3	3	0	0
Provider is retired	0	0	0	0
Provider reported a different specialty[3]	0	0	0	0
Refused to participate (e.g., hung up)	0	0	0	0
Total	44	18	14	12

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

Wait Time for Appointment

The results of the wait time for appointment survey are listed below. **Tables 39-41** show the wait time for appointment results for PCPs.

Table 39: Average Appointment Wait Time – PCPs

MassHealth Wait Time Standards	One Care Average Calendar Days to Appt. (Min-Max)
Timely Routine Appt Rate (non-symptomatic): 30 Calendar Days Timely Sick Appt Rate (non-urgent, symptomatic): 10 Calendar Days	90 (3-365)
Total Providers Reached (N)	62

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

Table 40: Reasons Not Able to Get an Appointment Date – PCPs

Reasons Not Able to Get an Appointment Date	One Care Total
Medicaid ID required[1]	37
Others[2]	32
Provider not accepting new patients	203
Contact Fails[3]	252
Provider not at the site[4]	151
Provider reported a different specialty[5]	92
Provider does not accept Medicaid	10
Provider is retired	6
Refused to Participate (e.g. Hung up)	1
Total	784

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

Table 41: Appointment Wait Time Standards Met – PCPs

MassHealth Wait Time Standards	One Care Providers Meeting the Standard % (n)
Timely Routine Appt Rate (non-symptomatic): 45 Calendar Days	19.35% (12)
Timely Sick Appt Rate (non-urgent, symptomatic): 10 Calendar Days	6.45% (4)
Total Providers Reached (N)	62

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

Tables 42- 44 show the wait time for appointment results for Obstetrics/Gynecology.

Table 42: Average Appointment Wait Time – Obstetrics/Gynecology

MassHealth Wait Time Standards	One Care Average Calendar Days to Appt. (Min-Max)
Timely Routine Appt Rate (non-symptomatic): 30 Calendar Days Timely Sick Appt Rate (non-urgent, symptomatic): 30 Calendar Days	95 (42-159)
Total Providers Reached (N)	23

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

Table 43: Reasons Not Able to Get an Appointment Date – Obstetrics/Gynecology

Reasons Not Able to Get an Appointment Date	One Care Total
Medicaid ID required[1]	22
Others[2]	36
Provider not accepting new patients	18
Contact Fails[3]	97
Provider not at the site[4]	51
Provider does not accept Medicaid	3
Provider reported a different specialty[5]	1
Provider is retired	0
Refused to Participate (e.g. Hung up)	0
Total	228

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

Table 44: Appointment Wait Time Standards Met – Obstetrics/Gynecology

MassHealth Wait Time Standards	One Care Providers Meeting the Standard % (n)
Timely Routine Appt Rate (non-symptomatic): 30 Calendar Days	0.00% (0)
Timely Sick Appt Rate (non-urgent, symptomatic): 30 Calendar Days	0.00% (0)
Total Providers Reached (N)	23

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

Tables 45- 47 show the wait time for appointment results for General Dental Services.

Table 45: Average Appointment Wait Time – General Dental Services

MassHealth Wait Time Standards	One Care Average Calendar Days to Appt. (Min-Max)
Timely Routine Appt Rate (non-symptomatic): 30 Calendar Days Timely Sick Appt Rate (non-urgent, symptomatic): 30 Calendar Days	25 (1-175)
Total Providers Reached (N)	23

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

Table 46: Reasons Not Able to Get an Appointment Date – General Dental Services

Reasons Not Able to Get an Appointment Date	One Care Total
Medicaid ID required[1]	19
Others[2]	4
Provider not accepting new patients	3
Contact Fails[3]	21
Provider not at the site[4]	12
Provider does not accept Medicaid	8
Provider is retired	0
Provider reported a different specialty[5]	0
Refused to Participate (e.g. Hung up)	0
Total	67

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

Table 47: Appointment Wait Time Standards Met – General Dental Services

MassHealth Wait Time Standards	One Care Providers Meeting the Standard % (n)
Timely Routine Appt Rate (non-symptomatic): 30 Calendar Days	86.96% (20)
Timely Sick Appt Rate (non-urgent, symptomatic): 30 Calendar Days	86.96% (20)
Total Providers Reached (N)	23

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

Time and Distance Standards

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

For a detailed analysis of network deficiencies in specific counties and provider types, see Plan-level results. The state of Massachusetts has 14 counties. Medicaid members who meet One Care enrollment criteria can enroll in a One Care Plan available in their county. One Care Plans cover large metro and metro counties, as defined in Table 48.

Table 48: One Care Plans and Number of Counties

County Type	CCA One Care	Tufts One Care	UHC One Care
Number of large metro counties	4	4	4
Number of Metro Counties	8	4	6
Total number of counties	12	8	10

Tables 49–56 provide a summary of the network adequacy results for healthcare providers subject to travel time and distance standards defined in the One Care contracts with MassHealth.

Table 49: Service Areas with Adequate Network of Primary Care Providers

Provider Type[1]	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)

[1] Black text indicates met; red text indicates partially met.
PCP: primary care provider.

Table 50: Service Areas with Adequate Network of Specialist Providers

Provider Type[1]	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.	2 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Allergy and Immunology	Metro	1 provider within 35 miles and 53 minutes.	5 out of 8 (Partially 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.	7 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Cardiothoracic Surgery	Large Metro	1 provider within 15 miles and 30 minutes.	2 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Cardiothoracic Surgery	Metro	1 provider within 40 miles and 60 minutes.	4 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Chiropractor	Large Metro	1 provider within 15 miles and 30 minutes.	2 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Chiropractor	Metro	1 provider within 30 miles and 45 minutes.	2 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Dermatology	Large Metro	1 provider within 10 miles and 20 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Dermatology	Metro	1 provider within 30 miles and 45 minutes.	3 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Endocrinology	Large Metro	1 provider within 15 miles and 30 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Endocrinology	Metro	1 provider within 50 miles and 75 minutes.	7 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
ENT/Otolaryngology	Large Metro	1 provider within 15 miles and 30 minutes.	2 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)

Provider Type[1]	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
ENT/Otolaryngology	Metro	1 provider within 30 miles and 45 minutes.	2 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Gastroenterology	Large Metro	1 provider within 10 miles and 20 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Gastroenterology	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)
General Surgery	Large Metro	1 provider within 10 miles and 20 minutes.	4 out of 4 (Met)	4 out of 4 (Met)	3 out of 4 (Partially Met)
General Surgery	Metro	1 provider within 20 miles and 30 minutes.	3 out of 8 (Partially Met)	4 out of 4 (Met)	4 out of 6 (Partially 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.	3 out of 4 (Partially 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.	6 out of 8 (Partially 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)
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.	2 out of 4 (Partially Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Neurosurgery	Metro	1 provider within 40 miles and 60 minutes.	4 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Oncology – Medical, Surgical	Large Metro	1 provider within 10 miles and 20 minutes.	1 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Oncology – Medical, Surgical	Metro	1 provider within 30 miles and 45 minutes.	5 out of 8 (Partially 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.	1 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)

Provider Type[1]	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
Oncology – Radiation/Radiation Oncology	Metro	1 provider within 40 miles and 60 minutes.	4 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Ophthalmology	Large Metro	1 provider within 10 miles and 20 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Ophthalmology	Metro	1 provider within 25 miles and 38 minutes.	5 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Orthopedic Surgery	Large Metro	1 provider within 10 miles and 20 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Orthopedic Surgery	Metro	1 provider within 25 miles and 38 minutes.	6 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Physiatry, Rehabilitative Medicine	Large Metro	1 provider within 15 miles and 30 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Physiatry, Rehabilitative Medicine	Metro	1 provider within 35 miles and 53 minutes.	5 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Plastic Surgery	Large Metro	1 provider within 15 miles and 30 minutes.	1 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Plastic Surgery	Metro	1 provider within 50 miles and 75 minutes.	6 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Podiatry	Large Metro	1 provider within 10 miles and 20 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Podiatry	Metro	1 provider within 30 miles and 45 minutes.	5 out of 8 (Partially 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.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Pulmonology	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)
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.	5 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Urology	Large Metro	1 provider within 10 miles and 20 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)

Provider Type[1]	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
Urology	Metro	1 provider within 30 miles and 45 minutes.	2 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Vascular Surgery	Large Metro	1 provider within 15 miles and 30 minutes.	2 out of 4 (Partially 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)

[1] Black text indicates met; red text indicates partially met.
ENT: ear, nose, and throat; ob/gyn: obstetrics/gynecology.

Table 51: Service Areas with Adequate Network of Hospitals and Emergency Support Services

Provider Type[1]	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)	4 out of 4 (Met)	4 out of 4 (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.	6 out of 8 (Partially Met)	2 out of 4 (Partially Met)	6 out of 6 (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)	6 out of 6 (Met)

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

Table 52: One Care Plans with 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)	1 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)	4 out of 4 (Met)	6 out of 6 (Met)
Orthotics and Prosthetics	Large Metro	2 providers within 15 miles and 30 minutes.	4 out of 4 (Met)	3 out of 4 (Partially Met)	1 out of 4 (Partially Met)
Orthotics and Prosthetics	Metro	2 providers within 30 miles and 45 minutes.	8 out of 8 (Met)	4 out of 4 (Met)	3 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)
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)	1 out of 4 (Partially Met)	2 out of 4 (Partially Met)
Speech Therapy	Metro	2 providers within 25 miles and 40 minutes.	8 out of 8 (Met)	2 out of 4 (Partially Met)	6 out of 6 (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)	5 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)	5 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)	4 out of 4 (Met)
Day Habilitation	Metro	2 providers within 15 miles or 30 minutes.	8 out of 8 (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
Day 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)
Day Services	Metro	2 providers within 15 miles or 30 minutes.	6 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (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[2]	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[2]	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[2]	Large Metro	2 providers within 15 miles or 30 minutes.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Oxygen and Respiratory Equipment[2]	Metro	2 providers within 15 miles or 30 minutes.	2 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.	3 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)

[1] Black text indicates met; red text indicates partially met or not met.

[2] Managed Care Plans utilize statewide vendors to deliver services in individuals' homes for certain LTSS categories, which is not adequately represented in the GeoAccess analysis.

LTSS: long-term services and supports.

Table 53: Number of Counties with an Adequate Network of Pharmacies

Provider Type[1]	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.	1 out of 4 (Partially Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Pharmacy	Metro	1 provider within 5 miles.	1 out of 8 (Partially Met)	4 out of 4 (Met)	5 out of 6 (Partially Met)

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

Table 54: Number of Counties with an Adequate Network of Behavioral Health Outpatient

Provider Type[1]	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)

[1] Black text indicates met; red text indicates partially met.
BH: behavioral health

Table 55: Number of Counties with an Adequate Network of Behavioral Health Diversionary Services

Provider Type[1]	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.	7 out of 8 (Partially Met)	3 out of 4 (Partially Met)	5 out of 6 (Partially Met)
Community Crisis Stabilization	Large Metro	2 providers within 15 miles or 30 minutes.	1 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Community Crisis Stabilization	Metro	2 providers within 15 miles or 30 minutes.	1 out of 8 (Partially Met)	4 out of 4 (Met)	4 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.	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
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)	5 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)	4 out of 4 (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)	4 out of 4 (Met)	4 out of 4 (Met)

Provider Type[1]	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
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)	5 out of 6 (Partially Met)
Psychiatric Day Treatment	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)
Psychiatric Day Treatment	Metro	2 providers within 15 miles or 30 minutes.	6 out of 8 (Partially Met)	3 out of 4 (Partially Met)	3 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)	4 out of 4 (Met)	6 out of 6 (Met)
Recovery Support Navigators	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 Support Navigators	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)
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)	4 out of 4 (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)	4 out of 4 (Met)	6 out of 6 (Met)

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

Table 56: Number of Counties with an Adequate Network of Dental Services

Provider Type[1]	County Class	Standard – 95% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
General Dentists	Large Metro	2 providers within 10 minutes.	0 out of 4 (Not Met)	0 out of 4 (Not Met)	1 out of 4 (Partially Met)
General Dentists	Metro	2 providers within 10 minutes.	0 out of 8 (Not Met)	0 out of 4 (Not Met)	0 out of 6 (Not Met)
Orthodontist	Large Metro	1 provider within 30 minutes.	2 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Orthodontist	Metro	1 provider within 30 minutes.	4 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)
Oral Surgeon	Large Metro	1 provider within 30 minutes.	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Oral Surgeon	Metro	1 provider within 30 minutes.	7 out of 8 (Partially Met)	0 out of 4 (Not Met)	5 out of 6 (Partially Met)

[1] Black text indicates met; red text indicates partially met or not met.

CCA One Care

More information about CCA One Care network adequacy validation rating is provided in Table 57.

Table 57: CCA One Care Network Adequacy Validation Ratings – CY 2024

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating CCA One Care	Comments
PCP GeoAccess	• 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 CMS standards of the minimum number of PCP providers in each county.	Addressed	Low confidence	No issues were found with the underlying information systems; however, the MCP's provider data had some duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standard was met in all counties.
Hospital and Nursing Facilities GeoAccess	• 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. • The actual time and distance vary by provider type and the micro-metro-large metro geographic type. • Apply the minimum number of providers defined by CMS, which vary by county.	Addressed	Low confidence	No issues were found with the underlying information systems; however, the MCP's provider data had some duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standard was met in all counties.
Specialists GeoAccess	• 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 the minimum number of providers defined by CMS, which vary by county.	Addressed	Low confidence	No issues were found with the underlying information systems; however, the MCP's provider data had some duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis revealed gaps in many specialists' networks.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating CCA One Care	Comments
Outpatient and Diversionary Behavioral Health Services GeoAccess	• 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.	Addressed	Low confidence	No issues were found with the underlying information systems; however, the MCP's provider data had some duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the Outpatient BH GeoAccess standards were met in all counties; however, the Diversionary BH Services GeoAccess standards had gaps.
Pharmacy GeoAccess	• 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; • 70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP's provider data had no duplicative records; however, the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis revealed gaps in the pharmacy network.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating CCA One Care	Comments
LTSS Providers GeoAccess	• **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. **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 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 • CMS standards do not specify minimum number of facilities for Orthotics and Prosthetics.	Addressed	Moderate confidence: Day Services and Group Adult Foster Care Low confidence: the remaining LTSS provider types	No issues were found with the underlying information systems; however, the MCP's provider data had some duplicative records, and the MCP did not consistently apply the correct MassHealth standards for the majority or LTSS provider types, with the exception of LTSS Day Services and Group Adult Foster Care. For LTSS Day Services and Group Adult Foster Care, the MCP's provider data were clean, and the MCP applied the correct MassHealth standards for analysis, so the results were comparable; however the results calculated by the MCP did not always match the time-and-distance results calculated by IPRO. IPRO's analysis revealed gaps in six LTSS provider networks.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating CCA One Care	Comments
Other Provider Types GeoAccess	• **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. • **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.	Addressed	Moderate confidence: Rehabilitation Hospital Services Low confidence: Emergency Support Services	No issues were found with the underlying information systems; however, the MCP's provider data had some duplicative records, and the MCP did not consistently apply the correct MassHealth standards for Emergency Support Services. For Rehabilitation Hospital Services, the MCP's provider data were clean, and the MCP applied the correct MassHealth standards for analysis, so the results were comparable; however, the results calculated by the MCP did not always match the time-and-distance results calculated by IPRO. IPRO's analysis of the network revealed that Emergency Support Services GeoAccess standards were met in all counties, while there were some deficiencies in the Rehabilitation Hospital network.
Dental Services GeoAccess	• General Dentists: 95% of Members have access to 2 General Dentists within 10 minutes of their home • Orthodontist: 95% of Members have access to 1 Orthodontist within 30 minutes of their home •Oral Surgeon: 95% have access to 1 Oral Surgeon within 30 minutes of their home	Missing[3]	Low confidence	No issues were found with the underlying information systems; however, the MCP's provider data had some duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis revealed gaps in the dental network.
Accuracy of Directories[2]	• Percent of providers in the directory with correct information	Missing[4]	Moderate confidence	IPRO's analysis showed that the information in the PCP, ob/gyn, and general dental providers directories is not entirely accurate.

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

[2] IPRO did not assess the MCP's methods of calculating the indicator, but instead calculated the indicator itself. The network adequacy validation (NAV) rating reflects IPRO's confidence that the MCP's network meets MassHealth's standards and expectations.
[3] Not required to report to MassHealth during the review period.
[4] MCPs are not required to report what percentage of the directory information is accurate.
CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; CMS: Centers for Medicare and Medicaid Services; LTSS: long-term services and supports; BH: behavioral health; TBD: to be determined.

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of CCA One Care's 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 58–63 show counties with deficient networks for CCA One Care.

Table 58: CCA One Care Counties with Network Deficiencies of Specialist 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
Allergy and Immunology	Barnstable	0.0%	1 provider within 35 miles and 53 minutes.
Allergy and Immunology	Bristol	32.2%	1 provider within 35 miles and 53 minutes.
Allergy and Immunology	Essex	65.7%	1 provider within 15 miles and 30 minutes.
Allergy and Immunology	Norfolk	72.6%	1 provider within 15 miles and 30 minutes.
Allergy and Immunology	Plymouth	76.8%	1 provider within 35 miles and 53 minutes.
Cardiology	Berkshire	1.2%	1 provider within 25 miles and 38 minutes.
Cardiothoracic Surgery	Barnstable	0.0%	1 provider within 40 miles and 60 minutes.
Cardiothoracic Surgery	Berkshire	73.0%	1 provider within 40 miles and 60 minutes.
Cardiothoracic Surgery	Bristol	34.9%	1 provider within 40 miles and 60 minutes.
Cardiothoracic Surgery	Essex	62.5%	1 provider within 15 miles and 30 minutes.
Cardiothoracic Surgery	Norfolk	77.4%	1 provider within 15 miles and 30 minutes.
Cardiothoracic Surgery	Plymouth	83.7%	1 provider within 40 miles and 60 minutes.
Chiropractor	Barnstable	32.3%	1 provider within 30 miles and 45 minutes.
Chiropractor	Berkshire	0.0%	1 provider within 30 miles and 45 minutes.
Chiropractor	Essex	59.3%	1 provider within 15 miles and 30 minutes.
Chiropractor	Franklin	0.6%	1 provider within 30 miles and 45 minutes.
Chiropractor	Hampden	0.0%	1 provider within 30 miles and 45 minutes.
Chiropractor	Hampshire	0.1%	1 provider within 30 miles and 45 minutes.
Chiropractor	Middlesex	75.7%	1 provider within 15 miles and 30 minutes.
Chiropractor	Worcester	86.8%	1 provider within 30 miles and 45 minutes.
Dermatology	Barnstable	14.7%	1 provider within 30 miles and 45 minutes.
Dermatology	Berkshire	4.0%	1 provider within 30 miles and 45 minutes.
Dermatology	Bristol	34.9%	1 provider within 30 miles and 45 minutes.
Dermatology	Essex	54.8%	1 provider within 10 miles and 20 minutes.
Dermatology	Franklin	79.3%	1 provider within 30 miles and 45 minutes.
Dermatology	Plymouth	81.4%	1 provider within 30 miles and 45 minutes.
Endocrinology	Berkshire	61.3%	1 provider within 50 miles and 75 minutes.
Endocrinology	Essex	74.5%	1 provider within 15 miles and 30 minutes.
ENT/Otolaryngology	Barnstable	0.0%	1 provider within 30 miles and 45 minutes.
ENT/Otolaryngology	Bristol	31.9%	1 provider within 30 miles and 45 minutes.
ENT/Otolaryngology	Essex	58.3%	1 provider within 15 miles and 30 minutes.
ENT/Otolaryngology	Franklin	2.4%	1 provider within 30 miles and 45 minutes.
ENT/Otolaryngology	Hampden	1.1%	1 provider within 30 miles and 45 minutes.
ENT/Otolaryngology	Hampshire	16.3%	1 provider within 30 miles and 45 minutes.
ENT/Otolaryngology	Middlesex	83.3%	1 provider within 15 miles and 30 minutes.
ENT/Otolaryngology	Plymouth	81.4%	1 provider within 30 miles and 45 minutes.
Gastroenterology	Berkshire	30.1%	1 provider within 30 miles and 45 minutes.
Gastroenterology	Essex	54.4%	1 provider within 10 miles and 20 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
General Surgery	Barnstable	0.0%	1 provider within 20 miles and 30 minutes.
General Surgery	Berkshire	1.1%	1 provider within 22 miles and 30 minutes.
General Surgery	Bristol	41.5%	1 provider within 20 miles and 30 minutes.
General Surgery	Plymouth	85.6%	1 provider within 20 miles and 30 minutes.
General Surgery	Worcester	77.3%	1 provider within 20 miles and 30 minutes.
Gynecology, Ob/Gyn	Berkshire	29.2%	1 provider within 30 miles and 45 minutes.
Infectious Diseases	Essex	66.1%	1 provider within 15 miles and 30 minutes.
Nephrology	Barnstable	79.8%	1 provider within 35 miles and 53 minutes.
Nephrology	Berkshire	48.1%	1 provider within 35 miles and 53 minutes.
Neurosurgery	Barnstable	0.0%	1 provider within 40 miles and 60 minutes.
Neurosurgery	Berkshire	6.1%	1 provider within 40 miles and 60 minutes.
Neurosurgery	Bristol	34.9%	1 provider within 40 miles and 60 minutes.
Neurosurgery	Essex	58.3%	1 provider within 15 miles and 30 minutes.
Neurosurgery	Norfolk	72.1%	1 provider within 15 miles and 30 minutes.
Neurosurgery	Plymouth	83.4%	1 provider within 40 miles and 60 minutes.
Oncology - Medical, Surgical	Berkshire	4.6%	1 provider within 30 miles and 45 minutes.
Oncology - Medical, Surgical	Bristol	28.7%	1 provider within 30 miles and 45 minutes.
Oncology - Medical, Surgical	Essex	60.4%	1 provider within 13 miles and 20 minutes.
Oncology - Medical, Surgical	Middlesex	50.1%	1 provider within 10 miles and 20 minutes.
Oncology - Medical, Surgical	Norfolk	35.3%	1 provider within 10 miles and 20 minutes.
Oncology - Medical, Surgical	Plymouth	78.5%	1 provider within 30 miles and 45 minutes.
Oncology - Radiation/Radiation Oncology	Berkshire	0.0%	1 provider within 40 miles and 60 minutes.
Oncology - Radiation/Radiation Oncology	Bristol	75.1%	1 provider within 40 miles and 60 minutes.
Oncology - Radiation/Radiation Oncology	Essex	62.5%	1 provider within 15 miles and 30 minutes.
Oncology - Radiation/Radiation Oncology	Franklin	1.9%	1 provider within 40 miles and 60 minutes.
Oncology - Radiation/Radiation Oncology	Hampshire	60.8%	1 provider within 40 miles and 60 minutes.
Oncology - Radiation/Radiation Oncology	Middlesex	78.9%	1 provider within 15 miles and 30 minutes.
Oncology - Radiation/Radiation Oncology	Norfolk	79.4%	1 provider within 15 miles and 30 minutes.
Ophthalmology	Berkshire	0.0%	1 provider within 25 miles and 38 minutes.
Ophthalmology	Franklin	0.4%	1 provider within 25 miles and 38 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
Ophthalmology	Middlesex	80.7%	1 provider within 10 miles and 20 minutes.
Ophthalmology	Worcester	88.5%	1 provider within 25 miles and 38 minutes.
Orthopedic Surgery	Barnstable	59.8%	1 provider within 25 miles and 38 minutes.
Orthopedic Surgery	Berkshire	2.7%	1 provider within 25 miles and 38 minutes.
Orthopedic Surgery	Essex	81.3%	1 provider within 10 miles and 20 minutes.
Physiatry, Rehabilitative Medicine	Barnstable	18.5%	1 provider within 35 miles and 53 minutes.
Physiatry, Rehabilitative Medicine	Berkshire	2.5%	1 provider within 35 miles and 53 minutes.
Physiatry, Rehabilitative Medicine	Essex	54.3%	1 provider within 15 miles and 30 minutes.
Physiatry, Rehabilitative Medicine	Franklin	74.4%	1 provider within 35 miles and 53 minutes.
Plastic Surgery	Barnstable	0.0%	1 provider within 50 miles and 75 minutes.
Plastic Surgery	Bristol	48.8%	1 provider within 50 miles and 75 minutes.
Plastic Surgery	Essex	65.4%	1 provider within 15 miles and 30 minutes.
Plastic Surgery	Middlesex	74.9%	1 provider within 15 miles and 30 minutes.
Plastic Surgery	Norfolk	67.4%	1 provider within 15 miles and 30 minutes.
Podiatry	Barnstable	67.9%	1 provider within 30 miles and 45 minutes.
Podiatry	Berkshire	2.2%	1 provider within 30 miles and 45 minutes.
Podiatry	Essex	2.0%	1 provider within 10 miles and 20 minutes.
Podiatry	Franklin	22.1%	1 provider within 30 miles and 45 minutes.
Pulmonology	Berkshire	5.8%	1 provider within 30 miles and 45 minutes.
Pulmonology	Norfolk	59.4%	1 provider within 10 miles and 20 minutes.
Rheumatology	Barnstable	0.9%	1 provider within 40 miles and 60 minutes.
Rheumatology	Berkshire	6.9%	1 provider within 40 miles and 60 minutes.
Rheumatology	Bristol	73.6%	1 provider within 40 miles and 60 minutes.
Urology	Barnstable	0.0%	1 provider within 30 miles and 45 minutes.
Urology	Berkshire	0.0%	1 provider within 30 miles and 45 minutes.
Urology	Bristol	77.2%	1 provider within 30 miles and 45 minutes.
Urology	Essex	80.9%	1 provider within 10 miles and 20 minutes.
Urology	Franklin	1.3%	1 provider within 30 miles and 45 minutes.
Urology	Hampden	0.9%	1 provider within 30 miles and 45 minutes.
Urology	Hampshire	13.1%	1 provider within 30 miles and 45 minutes.
Vascular Surgery	Essex	56.6%	1 provider within 15 miles and 30 minutes.
Vascular Surgery	Middlesex	65.2%	1 provider within 15 miles and 30 minutes.

ENT: ear, nose, and throat; ob/gyn: obstetricians/gynecology.

Table 59: CCA One Care Counties with Network Deficiencies of Hospitals and Emergency Supports

Provider Type	County with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Rehabilitation Hospital Services	Franklin	8.2%	1 provider within 15 miles or 30 minutes.
Rehabilitation Hospital Services	Worcester	79.6%	1 provider within 15 miles or 30 minutes.

Table 60: CCA One Care Counties with Network Deficiencies of LTSS Providers

Provider Type	County with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Adult Day Health	Barnstable	34.3%	2 providers within 15 miles or 30 minutes.
Adult Day Health	Berkshire	8.1%	2 providers within 15 miles or 30 minutes.
Adult Foster Care	Franklin	32.3%	2 providers within 15 miles or 30 minutes.
Day Services	Berkshire	10.7%	2 providers within 15 miles or 30 minutes.
Day Services	Worcester	83.5%	2 providers within 15 miles or 30 minutes.
Group Adult Foster Care	Berkshire	1.1%	2 providers within 15 miles or 30 minutes.
Group Adult Foster Care	Franklin	8.2%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Barnstable	29.4%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Berkshire	88.9%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Essex	50.1%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Franklin	1.0%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Hampden	0.0%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Hampshire	0.9%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Worcester	81.1%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Barnstable	27.7%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Berkshire	14.7%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Bristol	89.5%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Plymouth	54.0%	2 providers within 15 miles or 30 minutes.
Personal Care Assistant	Worcester	82.8%	2 providers within 15 miles or 30 minutes.

LTSS: long-term services and supports.

Table 61: CCA One Care Counties with Network Deficiencies of Pharmacies

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Pharmacy	Barnstable	2.1%	1 provider within 5 miles.
Pharmacy	Berkshire	0.0%	1 provider within 5 miles.
Pharmacy	Bristol	1.9%	1 provider within 5 miles.
Pharmacy	Essex	62.9%	1 provider within 2 miles.
Pharmacy	Franklin	19.1%	1 provider within 5 miles.
Pharmacy	Hampshire	60.7%	1 provider within 5 miles.
Pharmacy	Middlesex	67.7%	1 provider within 2 miles.
Pharmacy	Norfolk	63.7%	1 provider within 2 miles.
Pharmacy	Plymouth	82.7%	1 provider within 5 miles.
Pharmacy	Worcester	69.1%	1 provider within 5 miles.

Table 62: CCA One Care Counties with Network Deficiencies of Behavioral Health Diversionary Services

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Clinical Support Services for Substance Use Disorders (Level 3.5)	Barnstable	74.7%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Barnstable	0.0%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Berkshire	0.9%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Bristol	0.0%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Essex	3.6%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Franklin	0.6%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Hampshire	84.3%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Middlesex	50.8%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Norfolk	63.0%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Plymouth	2.0%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Worcester	0.1%	2 providers within 15 miles or 30 minutes.
Intensive Outpatient Program (IOP)	Barnstable	72.1%	2 providers within 15 miles or 30 minutes.
Monitored Inpatient Level 3.7	Middlesex	87.0%	2 providers within 15 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Berkshire	11.2%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Berkshire	10.0%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Barnstable	24.0%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Berkshire	14.5%	2 providers within 15 miles or 30 minutes.

Table 63: CCA One Care Counties with Network Deficiencies of Dental Services

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 95% of Members Have Access
General Dentists	Barnstable	0.0%	2 providers within 10 minutes.
General Dentists	Berkshire	0.0%	2 providers within 10 minutes.
General Dentists	Bristol	0.0%	2 providers within 10 minutes.
General Dentists	Essex	0.0%	2 providers within 10 minutes.
General Dentists	Franklin	0.0%	2 providers within 10 minutes.
General Dentists	Hampden	0.0%	2 providers within 10 minutes.
General Dentists	Hampshire	0.3%	2 providers within 10 minutes.
General Dentists	Middlesex	36.8%	2 providers within 10 minutes.
General Dentists	Norfolk	11.1%	2 providers within 10 minutes.

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 95% of Members Have Access
General Dentists	Plymouth	0.0%	2 providers within 10 minutes.
General Dentists	Suffolk	79.9%	2 providers within 10 minutes.
General Dentists	Worcester	27.0%	2 providers within 10 minutes.
Orthodontist	Barnstable	0.0%	1 provider within 30 minutes.
Orthodontist	Berkshire	17.9%	1 provider within 30 minutes.
Orthodontist	Bristol	1.9%	1 provider within 30 minutes.
Orthodontist	Essex	85.1%	1 provider within 30 minutes.
Orthodontist	Norfolk	90.2%	1 provider within 30 minutes.
Orthodontist	Plymouth	2.9%	1 provider within 30 minutes.
Oral Surgeon	Barnstable	93.0%	1 provider within 30 minutes.

Recommendations

- CCA One Care should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- CCA One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- CCA One Care should expand its network when a deficiency is identified. When additional providers are not available, the Plan should provide an explanation of what actions are being taken to provide adequate access for members residing in those service areas.
- CCA One Care should design quality improvement interventions to enhance the accuracy of all three directories.

Tufts One Care

More information about Tufts One Care network adequacy validation rating is provided in **Table 64.**

Table 64: Tufts One Care Network Adequacy Validation Ratings – CY 2024

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts One Care	Comments
PCP GeoAccess	• 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 CMS standards of the minimum number of PCP providers in each county.	Addressed	Low confidence	No issues were found with the underlying information systems; however, the MCP's provider data had duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standards were met in all counties.
Hospital and Nursing Facilities GeoAccess	• 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. • The actual time and distance vary by provider type and the micro-metro-large metro geographic type. • Apply the minimum number of providers defined by CMS, which vary by county.	Addressed	Moderate confidence	No issues with the underlying data systems. Acute Hospitals had clean data but used incorrect standards, and the results were not comparable. Skilled Nursing Facilities had some duplicative records that had to be removed from analysis but used the correct standard, yet because of duplicative records, the results were not comparable. IPRO's analysis of the network revealed that the GeoAccess standards were met in all counties.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts One Care	Comments
Specialists GeoAccess	• 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 the minimum number of providers defined by CMS, which vary by county.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards; however, the MCP's provider data had duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the networks revealed that the GeoAccess standards were met for the majority of provider types, except for a gap in the Neurosurgery provider network in a large metro county.
Outpatient and Diversionary Behavioral Health Services GeoAccess	• 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.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards; however, the MCP's provider data had duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the networks revealed that the GeoAccess standards were met for BH Outpatient, but some BH Diversionary provider types had gaps in their networks.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts One Care	Comments
Pharmacy GeoAccess	• 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; • 70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.	Addressed	High confidence: Large metro counties Moderate confidence: Metro counties	Large metro counties: No issues were found with the underlying information systems, provider data had no duplicative records, MassHealth standards were applied correctly, and the comparison yielded very close results. Metro counties: No issues were found with the underlying information systems, and the MCP's provider data had no duplicative records; however, in metro counties, the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results for the metro counties were not comparable for further analysis. IPRO's analysis of the networks revealed that the Pharmacy GeoAccess standards were met in metro counties but identified pharmacy network gaps in large metro counties.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts One Care	Comments
LTSS Providers GeoAccess	• **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. **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 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 • CMS standards do not specify minimum number of facilities for Orthotics and Prosthetics.	Addressed	Moderate confidence: most LTSS provider types Low confidence: Physical and Speech Therapy	Most LTSS providers: No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards; however, the MCP's provider data had duplicative records, except for Occupational Therapy, which did not have any duplicative records but applied incorrect standards. The MCP's results were not comparable for further analysis. For Physical and Speech Therapy: No issues were found with the underlying information systems; however, the MCP's provider data had duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed gaps in some LTSS providers' networks.
Other Provider Types GeoAccess	• **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. • **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.	Addressed	Moderate confidence	No issues were found with the underlying information systems, but MCP's provider data had duplicative records (Emergency Support Services) or the MCP either applied incorrect standards (Rehabilitation Hospital Services). The MCP's results were not comparable for further analysis. IPRO's analysis of the networks revealed that the Emergency Support Services GeoAccess standards were met but identified Rehabilitation Hospital Services network gaps in two large metro counties.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating Tufts One Care	Comments
Dental Services GeoAccess	• General Dentists: 95% of Members have access to 2 General Dentists within 10 minutes of their home • Orthodontist: 95% of Members have access to 1 Orthodontist within 30 minutes of their home •Oral Surgeon: 95% have access to 1 Oral Surgeon within 30 minutes of their home	Missing[3]	Moderate confidence	No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards; however, the MCP's provider data had duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the networks revealed that the Orthodontist GeoAccess standards were met, but the analysis also identified General Dentists and Oral Surgeon network gaps in all counties.
Accuracy of Directories[2]	• Percent of providers in the directory with correct information	Missing[4]	Moderate confidence	IPRO's analysis showed that the information in the PCP, ob/gyn, and general dental providers directories is not entirely accurate.

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

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

[3] Not required to report to MassHealth during the review period.

[4] MCPs are not required to report what percentage of the directory information is accurate.

CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; CMS: Centers for Medicare and Medicaid Services; LTSS: long-term services and supports; BH: behavioral health; TBD: to be determined.

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of Tufts One Care's 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 65–70 show counties with deficient networks.

Table 65: Tufts One Care Counties with Network Deficiencies of Specialist Providers

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Neurosurgery	Essex	86.0%	1 provider within 15 miles and 30 minutes.

Table 66: Tufts One Care Counties with Network Deficiencies of Hospitals and Emergency Support Services

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Rehabilitation Hospital Services	Barnstable	18.0%	1 provider within 15 miles or 30 minutes.
Rehabilitation Hospital Services	Worcester	88.0%	1 provider within 15 miles or 30 minutes.

Table 67: Tufts One Care Counties with Network Deficiencies of LTSS Providers

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Occupational Therapy	Essex	61.0%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Middlesex	41.0%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Norfolk	85.0%	2 providers within 10 miles and 20 minutes.
Orthotics and Prosthetics	Essex	87.0%	2 providers within 15 miles and 30 minutes.
Speech Therapy	Barnstable	35.0%	2 providers within 25 miles and 40 minutes.
Speech Therapy	Essex	36.0%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Middlesex	37.0%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Norfolk	81.0%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Worcester	82.0%	2 providers within 25 miles and 40 minutes.
Group Adult Foster Care	Worcester	83.0%	2 providers within 15 miles or 30 minutes.

LTSS: long-term services and supports.

Table 68: Tufts One Care Counties with Network Deficiencies of Pharmacies

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Pharmacy	Essex	90.0%	1 provider within 2 miles.

Table 69: Tufts One Care Counties with Network Deficiencies of Behavioral Health Diversionary Services

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Clinical Support Services for Substance Use Disorders (Level 3.5)	Barnstable	50.0%	2 providers within 15 miles or 30 minutes.
Monitored Inpatient Level 3.7	Barnstable	50.0%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Barnstable	85.0%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Barnstable	35.0%	2 providers within 15 miles or 30 minutes.
Recovery Support Navigators	Barnstable	50.0%	2 providers within 15 miles or 30 minutes.

Table 70: Tufts One Care Counties with Network Deficiencies of Dental Services

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 95% of Members Have Access
General Dentists	Barnstable	80.0%	2 providers within 10 minutes.
General Dentists	Bristol	93.0%	2 providers within 10 minutes.
General Dentists	Essex	67.0%	2 providers within 10 minutes.
General Dentists	Middlesex	80.0%	2 providers within 10 minutes.
General Dentists	Norfolk	53.0%	2 providers within 10 minutes.
General Dentists	Plymouth	44.0%	2 providers within 10 minutes.
General Dentists	Suffolk	84.0%	2 providers within 10 minutes.
General Dentists	Worcester	59.0%	2 providers within 10 minutes.
Oral Surgeon	Barnstable	93.0%	1 provider within 30 minutes.
Oral Surgeon	Bristol	28.0%	1 provider within 30 minutes.
Oral Surgeon	Norfolk	92.0%	1 provider within 30 minutes.
Oral Surgeon	Plymouth	72.0%	1 provider within 30 minutes.
Oral Surgeon	Worcester	71.0%	1 provider within 30 minutes.

Recommendations

- Tufts One Care should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- Tufts One Care should submit specific providers for the Adult Day Health, Day Services, Group Adult Foster Care, and Personal Care Assistant networks.
- Tufts One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- Tufts One Care should expand the network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those service areas.
- Tufts One Care should design quality improvement interventions to enhance the accuracy of all three directories.

UHC One Care

More information about UHC One Care network adequacy validation rating is provided in Table 71.

Table 71: UHC One Care Network Adequacy Validation Ratings – CY 2024

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating UHC One Care	Comments
PCP GeoAccess	• 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 CMS standards of the minimum number of PCP providers in each county.	Addressed	Low confidence	No issues were found with the underlying information systems, but the MCP's provider data had duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standards were met in all counties.
Hospital and Nursing Facilities GeoAccess	• 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. • The actual time and distance vary by provider type and the micro-metro-large metro geographic type. • Apply the minimum number of providers defined by CMS, which vary by county.	Addressed	Moderate confidence	No issues were found with the underlying information systems, and the MCP's provider data had no duplicative records; however, the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standards were met in all counties.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating UHC One Care	Comments
Specialists GeoAccess	• 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 the minimum number of providers defined by CMS, which vary by county.	Addressed	Low confidence	No issues were found with the underlying information systems, but the MCP's provider data had duplicative records, and the MCP did not consistently apply the correct MassHealth standards for analysis. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the GeoAccess standards were met in all counties for most specialty provider types, except General Surgery.
Outpatient and Diversionary Behavioral Health Services GeoAccess	• 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.	Addressed	High confidence: Behavioral Health Diversionary Services Moderate Confidence: Behavioral Health Outpatient	For Behavioral Health Diversionary Services: No issues were found with the underlying information systems, provider data had no duplicative records, MassHealth standards were applied correctly, and the comparison yielded very close results. For Behavioral Health Outpatient: No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards; however, the MCP's provider data had duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the Outpatient Behavioral Health GeoAccess standards were met in all counties; however, some Diversionary Behavioral Health Services provider networks had gaps.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating UHC One Care	Comments
Pharmacy GeoAccess	• 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; • 70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.	Addressed	High confidence	No issues were found with the underlying information systems, provider data had no duplicative records, MassHealth standards were applied correctly, and the comparison yielded very close results. IPRO's analysis of the network revealed that Pharmacy GeoAccess standards were met in large metro counties but were not met in metro counties.
LTSS Providers GeoAccess	• **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. **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 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 • CMS standards do not specify minimum number of facilities for Orthotics and Prosthetics.	Addressed	Moderate confidence	No issues were found with the underlying information systems, some provider data had duplicative records, MassHealth LTSS standards were applied correctly, but CMS LTSS standards were not applied correctly. Some MCP's results were compared to IPRO's results, and the comparison yielded very similar results. IPRO's analysis of the network revealed that the GeoAccess standard was not met for some LTSS provider types.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating UHC One Care	Comments
Other Provider Types GeoAccess	• **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. • **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.	Addressed	High confidence: Oxygen and Respiratory Equipment Services and Rehabilitation Hospital Services Not enough information to validate: Emergency Support Services	Oxygen and Respiratory Equipment Services and Rehabilitation Hospital Services: No issues were found with the underlying information systems, provider data had no duplicative records, MassHealth standards were applied correctly, and the comparison yielded close results. Emergency Support Services: No issues were found with the underlying information systems, and provider data had no duplicative records; however, the MCP did not provide complete standards when submitting their analysis. IPRO did not have enough information to conduct the validation. IPRO's analysis of the network revealed a gap in the Oxygen and Respiratory Equipment network in Franklin County.
Dental Services GeoAccess	• General Dentists: 95% of Members have access to 2 General Dentists within 10 minutes of their home • Orthodontist: 95% of Members have access to 1 Orthodontist within 30 minutes of their home •Oral Surgeon: 95% have access to 1 Oral Surgeon within 30 minutes of their home	Missing[3]	Moderate confidence	No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards; however, the MCP's provider data had duplicative records. The MCP's results were not comparable for further analysis. IPRO's analysis of the network revealed that the Orthodontist standards were met in large and metro counties and that Oral Surgeon GeoAccess standards were met in large metro Counties; however, General Dentistry standards were not met in either large or metro counties, and Oral Surgeon standards were not met in metro Counties.

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring?[1]	Validation Rating UHC One Care	Comments
Accuracy of Directories[2]	• Percent of providers in the directory with correct information	Missing[4]	Moderate confidence	IPRO's analysis showed that the information in the PCP, ob/gyn, and general dental providers directories is not entirely accurate.

[1] "Addressed" means that the indicator was required to be reported to the state and the managed care plan (MCP) submitted the report to the state. "Missing" means that the indicator was either not required or required but not reported.
[2] IPRO did not assess the MCP's methods of calculating the indicator but instead calculated the indicator itself. The network adequacy validation rating reflects IPRO's confidence that the MCP's network meets MassHealth's standards and expectations.
[3] Not required to report to MassHealth during the review period.
[4] MCPs are not required to report what percentage of the directory information is accurate.
CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; CMS: Centers for Medicare and Medicaid Services; LTSS: long-term services and supports; BH: behavioral health; TBD: to be determined.

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of UHC One Care's 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 72–76 show counties with deficient networks.

Table 72: UHC One Care Counties with Network Deficiencies of Specialist Providers

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
General Surgery	Franklin	80.8%	1 provider within 20 miles and 30 minutes.
General Surgery	Middlesex	75.8%	1 provider within 10 miles and 20 minutes.
General Surgery	Worcester	58.7%	1 provider within 20 miles and 30 minutes.

Table 73: UHC One Care Counties with Network Deficiencies of LTSS Providers

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Occupational Therapy	Essex	82.4%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Middlesex	87.6%	2 providers within 10 miles and 20 minutes.
Occupational Therapy	Norfolk	89.3%	2 providers within 10 miles and 20 minutes.
Orthotics and Prosthetics	Essex	0.4%	2 providers within 15 miles and 30 minutes.
Orthotics and Prosthetics	Franklin	60.3%	2 providers within 30 miles and 45 minutes.
Orthotics and Prosthetics	Middlesex	42.6%	2 providers within 15 miles and 30 minutes.
Orthotics and Prosthetics	Norfolk	71.8%	2 providers within 15 miles and 30 minutes.
Orthotics and Prosthetics	Plymouth	68.2%	2 providers within 30 miles and 45 minutes.
Orthotics and Prosthetics	Worcester	13.0%	2 providers within 30 miles and 45 minutes.
Speech Therapy	Middlesex	83.1%	2 providers within 10 miles and 20 minutes.
Speech Therapy	Norfolk	89.3%	2 providers within 10 miles and 20 minutes.
Adult Day Health	Franklin	5.1%	2 providers within 15 miles or 30 minutes.
Adult Foster Care	Franklin	25.6%	2 providers within 15 miles or 30 minutes.
Day Habilitation	Bristol	47.2%	2 providers within 15 miles or 30 minutes.
Day Habilitation	Franklin	88.5%	2 providers within 15 miles or 30 minutes.
Group Adult Foster Care	Franklin	5.1%	2 providers within 15 miles or 30 minutes.
Hospice	Bristol	55.5%	2 providers within 15 miles or 30 minutes.
Hospice	Essex	0.0%	2 providers within 15 miles or 30 minutes.
Hospice	Franklin	0.0%	2 providers within 15 miles or 30 minutes.
Hospice	Hampden	0.0%	2 providers within 15 miles or 30 minutes.
Hospice	Hampshire	0.0%	2 providers within 15 miles or 30 minutes.
Hospice	Middlesex	1.2%	2 providers within 15 miles or 30 minutes.
Hospice	Norfolk	46.1%	2 providers within 15 miles or 30 minutes.
Hospice	Plymouth	7.7%	2 providers within 15 miles or 30 minutes.
Hospice	Suffolk	0.0%	2 providers within 15 miles or 30 minutes.
Hospice	Worcester	5.8%	2 providers within 15 miles or 30 minutes.
Oxygen and Respiratory Equipment	Franklin	65.4%	2 providers within 15 miles or 30 minutes.

LTSS: long-term services and supports.

Table 74: UHC One Care Counties with Network Deficiencies of Pharmacies

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Pharmacy	Franklin	82.1%	1 provider within 5 miles.

Table 75: UHC One Care Counties with Network Deficiencies of Behavioral Health Divisionary Services

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Clinical Support Services for Substance Use Disorders (Level 3.5)	Franklin	89.7%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Bristol	76.6%	2 providers within 15 miles or 30 minutes.
Community Crisis Stabilization	Plymouth	79.2%	2 providers within 15 miles or 30 minutes.
Monitored Inpatient Level 3.7	Franklin	5.1%	2 providers within 15 miles or 30 minutes.
Partial Hospitalization Program (PHP)	Franklin	89.7%	2 providers within 15 miles or 30 minutes.
Program of Assertive Community Treatment	Bristol	41.3%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Bristol	83.7%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Franklin	5.1%	2 providers within 15 miles or 30 minutes.
Psychiatric Day Treatment	Worcester	38.9%	2 providers within 15 miles or 30 minutes.

Table 76: UHC One Care Counties with Network Deficiencies of Dental Services

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 95% of Members Have Access
General Dentists	Bristol	93.3%	2 providers within 10 minutes.
General Dentists	Essex	87.2%	2 providers within 10 minutes.
General Dentists	Franklin	53.8%	2 providers within 10 minutes.
General Dentists	Hampden	88.0%	2 providers within 10 minutes.
General Dentists	Hampshire	51.6%	2 providers within 10 minutes.
General Dentists	Middlesex	89.0%	2 providers within 10 minutes.
General Dentists	Plymouth	51.3%	2 providers within 10 minutes.
General Dentists	Suffolk	89.0%	2 providers within 10 minutes.
General Dentists	Worcester	69.2%	2 providers within 10 minutes.
Oral Surgeon	Plymouth	91.9%	1 provider within 30 minutes.

Recommendations

- UHC One Care should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- UHC One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- UHC One Care should expand the network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those service areas.
- UHC One Care should design quality improvement interventions to enhance the accuracy of all three directories.

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 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 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 2024 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.[12] The MassHealth One Care Plans used the 2024 MA-PD CAHPS standardized survey instrument. The MA-PD survey tool contains 69 questions, organized into seven sections, as explained in Table 77.

Table 77: 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	22 questions

MA-PD CAHPS: Medicare Advantage and Prescription Drug Consumer Assessment of Healthcare Providers and Systems.

The CMS data collection protocol included mailing of prenotification letters, invitations to complete the survey via web, 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 of age or older, who were continuously enrolled in the contract for at least six months at the time of sample draw in January 2024, and who were not institutionalized. If identified during data collection, institutionalized Enrollees were excluded from the analysis. Table 78 provides a summary of the technical methods of data collection by One Care Plans.

[12] Medicare Advantage and Prescription Drug Plan CAHPS® Survey. Available at: https://www.ma-pdpcahps.org/.

Table 78: 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	2024 MA-PD CAHPS	2024 MA-PD CAHPS	2024 MA-PD CAHPS
Survey timeframe	February and June 2024	February and June 2024	February and June 2024
Method of collection	Mail and telephone	Mail and telephone	Mail and telephone
Response rate	19.2%	11.0%	11.6%

MA-PD CAHPS: Medicare Advantage and Prescription Drug Consumer Assessment of Healthcare Providers and Systems.

For the global ratings and composite measures, the mean scores were calculated using a 100-point scale. For the Annual Flu Vaccine and Pneumonia Vaccine individual item measures, the reported value was the percentage of survey responders who said yes. Responses were classified into response categories. Table 79 displays these categories and the measures for which these response categories are used.

Table 79: 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 measure • Pneumonia Vaccine individual item measure	• Yes or No

MA-PD CAHPS: Medicare Advantage and Prescription Drug Consumer Assessment of Healthcare Providers and Systems.

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 2024 Medicare-Medicaid Plan 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 80.

Table 80: 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).

MA-PD CAHPS: Medicare Advantage and Prescription Drug Consumer Assessment of Healthcare Providers and Systems; FFS: fee-for-service.

When compared to the Medicare Advantage FFS mean score, the following measures exceeded the national benchmark:

- Customer Service (Composite)
- Rating of Health Care Quality
- Rating of Health Plan

The following measures scored below the benchmark:

- Getting Needed Care (Composite)
- Getting Appointments and Care Quickly (Composite)
- Care Coordination (Composite)
- Annual Flu Vaccine

Many of the Tufts One Care measures did not meet reporting criteria for sample size or reliability.

Table 81 displays the top-box scores of the 2024 MA-PD CAHPS survey.

Table 81: MA-PD CAHPS Performance – MassHealth One Care Plans, 2024 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)	N/A	78 (< Goal)	79 (< Goal)	80
Getting Appointments and Care Quickly (Composite)	81 (< Goal)	N/A	80 (< Goal)	81 (< Goal)	82
Customer Service (Composite)	90 (> Goal)	N/A	88 (> Goal)	90 (> Goal)	87
Care Coordination (Composite)	83 (< Goal)	N/A	85 (< Goal)	83 (< Goal)	86
Getting Needed Prescription Drugs (Composite)	90	N/A	86	89	N/A
Annual Flu Vaccine	64 (< Goal)	71 (< Goal)	58 (< Goal)	65 (< Goal)	73
Rating of Prescription Drug Plan	90	N/A	86	89	N/A
Rating of Health Care Quality	87 (> Goal)	N/A	86 (> Goal)	87 (> Goal)	85
Rating of Health Plan	88 (> Goal)	N/A	83 (= Goal)	87 (> Goal)	83
Pneumonia Vaccine	53	52	45	52	N/A

MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems; 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, PAHP, or PCCM entity has effectively addressed the recommendations for QI[13] made by the EQRO during the previous year's EQR." **Tables 82–84** 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 82 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 82: 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 Care Planning: 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.	CCA is committed to maintaining high confidence by implementing acceptable methodology and evidence of improvement when engaging in performance improvement projects (PIPs). Future PIPs will include a robust barrier analysis and the implementation of individual interventions, which are Member, system and or provider focused, which link back to the barriers identified. Each intervention will include a description and a tracking measure to determine intervention effectiveness. Quarterly data for each intervention will be analyzed for value towards improving the overall indicator(s). PIP conclusions will be better informed using these described improvements and regularly leveraging data for individual measurable interventions.	Addressed
PIP 2 Flu: Please review future PIP submissions for accuracy.	CCA is committed to ensuring data accuracy when engaging in performance improvement projects (PIPs). For future PIPs, a consistent approach to data will be uniformly throughout the PIP. This includes consistency when discussing data within the project narrative, and when displaying those same rates within tables. Consistency to the required decimal will be validated prior to submission. For PIPs, CCA will continue to leverage HEDIS and when appropriate non-HEDIS data to support the development of interventions and monitoring.	Addressed

[13] Quality improvement.

Recommendation for CCA One Care	CCA One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
PMV: HEDIS Measures: 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.	Internal CCA analysis of the Plan All-Cause Readmissions has shown that often Member readmissions are not related to their index admission. CCA's Member population is medically complex, with chronic conditions such as Diabetes, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, which are frequently accompanied by behavioral health and substance use disorders driving Member readmissions. CCA has implemented several performance improvement projects /initiatives with a medical and behavioral health approach, and with the intent to positively impact this ratio: 1. Interventions for ICO members with index diagnoses specific to COPD to prevent exacerbation /readmission (s), 2. Health Plan Chronic Kidney Management & High-Risk Discharge Program with a population focus of Members with cardiovascular-kidney metabolic syndrome with the most acute complex risk stratification. 3. A High Intensity Care Management Program for ICO Members with concurrent diagnoses of CHF, Chronic Kidney Disease and Diabetes. 4. Clinical pathways implemented decrease readmissions by completion of discharge Member follow-up, a Member discharge visit and completion of a discharge medication reconciliation. 5. Multi-disciplinary steering committee oversight to support improvement by monitoring interventions using data and conducting root cause analysis when appropriate to support improvement. This committee plans to begin in the Fall 2024.	Addressed

Recommendation for CCA One Care	CCA One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Compliance: 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. Lack of compliance with 13 requirements in the following domains: • Enrollee rights and protections (4) • 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)	CCA implemented CAPs for all One Care Partially Met and Not Met findings identified during the 2023 EQR Compliance Validation as outlined in the Compliance Review Tools. CAPs were tracked through implementation and staff validated that completed CAPs had sufficient evidence of successful remediation (for example, updated policies) to confirm closure. All One Care CAPs from the 2023 EQR Compliance Validation have been successfully implemented, validated, and closed as of October 2024.	Addressed
Network – Data Integrity: 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.	CCA is implementing new processes for all network adequacy analysis, including submissions to external review organizations. This includes improvements to the base source data as well as the file integration in downstream systems, and is part of our larger Provider Data transformation work beginning in 2024 and finishing in 2025, with the implementation of a new core provider data technology stack.	Addressed

Recommendation for CCA One Care	CCA One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network – Time and Distance: Access was assessed for a total of 59 provider types. CCA One Care had deficient networks for 13 provider types: • 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 CCA 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.	CCA continuously monitors our network adequacy for any deficiencies and takes immediate action to close gaps if any are identified. In most of the cases noted above, the gap is a result of no providers available that close the gap. In this case, our care teams work with members residing in these areas to access the services in different ways, such as telehealth if applicable, accessing CCA's transportation benefit to contracted providers, services provided by CCA's clinical organizations in the home, and if necessary single case agreements with out-of-network providers.	Addressed
Network – Provider Directory: CCA One Care's accuracy rate was below 20% for the following provider type: • OB/GYN (16.70%) 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.	CCA has conducted a root cause analysis of the various issues driving provider directory inaccuracies as part of scoping our provider data transformation work described above. The remediation work includes updating our policies, procedures, and workflows to minimize preventable errors in the system. Beginning in 2024 with a targeted go-live of September 2025, CCA will be converting to new platforms to upgrade our existing Provider Data, Credentialing, and Directory systems. These systems will enable greater automation with CAQH and other outside entities to verify accuracy of provider data and validate how the data is being displayed.	Addressed

Recommendation for CCA One Care	CCA One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Quality-of-Care Surveys: 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.	CCA is working on a variety of performance improvement metrics relative to member experience. Specific to getting needed care and care coordination: CCA is developing workflows to create better escalation pathways when members are unable to obtain appointments with providers, is reviewing telehealth solutions that may be able to better increase access to Behavioral Health resources, and is developing communication materials to send to members on provider data accuracy. Specific to the flu vaccine: CCA has added information to the member newsletter highlighting the importance of getting an annual flu vaccine and is working with Provider, Quality, and Network teams to develop provider education materials relative to reminding members to get an annual flu vaccine.	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.
MCP: managed care plan; EQR: external quality review.

Tufts One Care Response to Previous EQR Recommendations

Table 83 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 83: 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]
PMV: HEDIS Measures: 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.	Point32Health monitors rates monthly starting in February each year and collaborates with Cityblock (CBH) on quality improvement interventions. This collaboration has been aligned even further the last few years through our monthly HEDIS review meetings. - Cityblock conducts a review of their data for members included in the HEDIS samples and sends any relevant medical record information to Point32Health for abstraction as appropriate - The Hemoglobin A1c Poor control indicator is included in monthly Gap in Care (GIC) and Rate reports sent to CBH each month; - CBH uses the Gap in Care file to research non-compliant members and determine necessary interventions such as re-check the member's A1C; or refer to CBH pharmacist for a focused intervention to optimize medications and self-management - Point32Health also recently developed a HEDIS tip sheet for the revised GSD measure - tip sheets are posted on our website and communicated to providers in our Provider newsletters. <u>Initiation and Engagement of Substance Use Disorder Treatment (IET):</u> Tufts Health Plan One Care is working closely with Cityblock (CBH) to support members with a new diagnosis of SUD. CBH is planning to use a new report (ED visits with a SUD diagnosis) to contact members to help them find care. Additionally, CBH is expanding their care management approach to substance use, which will include new member education and scripting as well as new targeted questions during care management assessments.	Partially Addressed

Recommendation for Tufts One Care	Tufts One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Compliance: 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. 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)	All deficiencies and "partially met" requirements have been addressed through the corrective action process.	Addressed
Network – Data Integrity: 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.	The MCP uses the geocoding tool in Quest Analytics Suite to ensure we are using valid addresses. Additionally, we will use the standardized addresses that geocoding produces to identify duplicate records and improve the quality of our submissions in the future.	Addressed

Recommendation for Tufts One Care	Tufts One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network – Time and Distance: 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 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)" 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.	The MCP has a quarterly monitoring process where the Tufts Health One Care Network is evaluated using both CMS Time/Distance standards and EOHHS standards as specified in the One Care Contract. When a gap or deficiency is identified, the appropriate contracting teams are made aware of the issue. Research is also done using the MA/MMP Supply files and an analytics market availability tool to determine if there are providers available for contracting. Some of the deficiencies listed above are for Counties that are part of One Care's expansion efforts, not in Counties that we currently sell business in. These counties are Berkshire, Franklin, Hampden, and Hampshire. Although we are not yet currently in these counties, we do include them as part of our regular quarterly monitoring process. Other gaps identified above have been closed via system data clean-up efforts over the last year and by recruitment efforts to bring additional providers into the One Care network. Tufts Health One Care makes all attempts to service the member via an in network LTSS provider via our ASAP (Aging Service Access Points) relationships.	Addressed
Network – Provider Directory: Tufts One Care accuracy rate was at 20% for the following provider type: • Family Medicine (20.0%). 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.	Tufts Health Plan conducted a root cause analysis to understand the issues identified from the provider directory audit results. During an extensive review of the results of the audit, the Provider Operations team identified several interventions to improve the accuracy of provider and facility directory information, as well as to increase provider engagement in maintaining updated and correct directory information.	Addressed

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

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined.
MCP: managed care plan; EQR: external quality review.

UHC One Care Response to Previous EQR Recommendations

Table 84 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 84: 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]
PIP 1 Flu: 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.	UnitedHealthcare Community Plan of Massachusetts (UnitedHealthcare) internally tracked interventions as part of the normal Performance Improvement Project (PIP) intervention analysis process, and Intervention Tracking Measures (ITMs) are now included in all IPRO Performance Improvement Project templates submitted. During the PIP, Flu data was discussed during collaborative meetings with data analysts. Data was analyzed against the goals. UnitedHealthcare acknowledges that the vaccination incentive program was not aligned with the flu season. However, the following flu season (2023-2024) the incentive program was announced to providers in October 2023, which allowed providers to be aware of the incentive at the start of the flu season. UnitedHealthcare reviewed flu vaccination rates for the entire One Care population, specific practices included in the provider incentive and gained insight from the Provider Advisory Committee.	Addressed
PMV: HEDIS Measures: 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.	UnitedHealthcare conducted a root cause analysis and held quality meetings where input was obtained to identify barriers impacting members. UnitedHealthcare created interventions to address identified barriers and improve the measure. UnitedHealthcare engaged with a vendor who is telephonically outreaching to members and actively scheduling follow-up appointments while they have the member on the phone. UnitedHealthcare is also referring members to the Optum Peer Support program which assigns the member a Peer Support Specialist (PSS). The Peer Support Specialist is not a clinician but someone who has a lived experience similar to the members' and can help provide guidance, assist with scheduling follow-up appointments, and align the member with community resources. UnitedHealthcare's Care Coordinators assess to see if their member needs a follow-up appointment and refer members to a mental health provider if needed. The Plan Do Study Act (PDSA) cycle is followed for each intervention. The Clinical Quality Data Analyst generates reports and data is analyzed for trends and rates. These reports are drilled down to the member level. Monthly reports are pulled to review staff compliance with assisting members with scheduling follow-up appointments, and this information is relayed to the clinical leadership team.	Addressed

Recommendation for UHC One Care	UHC One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Compliance: 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. 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) • 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)	UnitedHealthcare has formally responded to the IPRO recommendations outlined in the final validation tool.	Addressed
Network – Data Integrity: 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.	UnitedHealthcare successfully advocated with IPRO to use only National Provider Identification instead of Tax Identification Number, significantly reducing duplicate records. They encouraged the creation of the Technical Manual for MassHealth Managed Care Plans, which included a helpful data dictionary. UnitedHealthcare developed a new internal Policy and Procedure (P&P) for state and third-party audits, such as the IPRO Survey. Improved communications between UnitedHealthcare and the Commonwealth audit team (IPRO) clarified key information ahead of data submission, ensuring deliverables met state requirements. The internal review now includes a multi-layered quality assurance process and can produce information that is de-duplicated. UnitedHealthcare monitor's the network by evaluating the data produced year over year.	Addressed

Recommendation for UHC One Care	UHC One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network – Time and Distance: 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 • "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)" 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.	UnitedHealthcare has resolved deficiencies where possible by contracting with additional providers, engaging and building agreements with networks in deficient areas and monitoring network adequacy reports to address gaps. UnitedHealthcare is actively working to identify additional providers and reaching out to non-participating providers to close gaps. UnitedHealthcare continues targeted recruitment through community outreach, internet searches, emails, and phone calls to eligible providers. The goal is to resolve network deficiencies by the end of Q2 2025.	Addressed

Recommendation for UHC One Care	UHC One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Network – Provider Directory: UHC Connected accuracy rate was below 20% for the following provider type: • Family Medicine (13.3%) 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.	UnitedHealthcare has various initiatives in place to increase data accuracy. These initiatives are carefully reviewed monthly and maintained or changed as evidenced by results. Our Provider Quality Assurance team performs an accuracy review each month. Defects are validated through the Total Quality Management (TQM) Audit Liaison roles as a support for the operations business partners and any appeals are managed through that team to assure accurate measurement systems and results. Additionally, validated defects are 100% root caused and trended to determine key opportunities for improvements. Internal quality reviews are additionally conducted via phone call campaigns to practitioner offices (Secret Shopper), defects from which an additional outreach validation is prompted to determine if system updates and/or corrective actions should be taken in UnitedHealthcare source systems; if so, updates are made to the applicable elements or practitioners are removed from directory display. Data Controls and Proactive Business Rule Detections have also been established for updates to be made. Additionally, multiple intake channels were created with the intent of allowing practitioners an opportunity to validate, or attest, to the demographic data on file with UnitedHealthcare every 90 days. Providers may also be contacted via phone or email to validate demographic data. Attestation data is tracked across all channels within an internal database and is archived for physician and facility. UnitedHealthcare does not solely rely on providers to share demographic changes but seeks additional opportunities to improve directory accuracy. UnitedHealthcare operational and technology teams work continuously to increase data updates via automated tools and processes for enhanced data capture.	Addressed

Recommendation for UHC One Care	UHC One Care Response/Actions Taken	IPRO Assessment of MCP Response[1]
Quality-of-care surveys: 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.	The UnitedHealthcare Quality Team has reviewed the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) data and relayed it to the One Care team. Together the teams have devised ways to address the Annual Flu Vaccine rate. Several interventions have been created including: collaborating with community partners to host flu clinics; member outreach and education about obtaining flu vaccines; developed talking points for staff about how to address vaccine hesitancy; Fall campaigns in English and Spanish with reminders and information about flu vaccine; flu vaccine portal with resources and flu vaccination for home bound members. The UnitedHealthcare team will track flu vaccination rates and trend against prior month and year rates. The UnitedHealthcare Team has reviewed the complaints and grievances and identified a trend with members complaining about transportation. Members have unlimited rides for medical appointments, and One Care members have an additional benefit: 8 Value Add Benefits (VAB) trips. This includes 8 one-way trips per/month for non-medical appointments, which offer members the option to schedule rides by calling the call center, using a mobile application, or working with their Care Management team to coordinate. There is a newly established transportation workgroup that meets quarterly and includes teams from Compliance, Sales, Member Advocacy, Operations, and Legal. This group reviews quarterly reports from Modivcare, diving into top trip denials, grievances, and driver performance to identify areas for improvement.	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.
MCP: managed care plan; EQR: external quality review.

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

Table 85–87 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 2024 EQR activities as they relate to **quality**, **timeliness**, and **access**.

CCA One Care Strengths, Opportunities for Improvement, and EQR Recommendations

Table 85: Strengths, Opportunities for Improvement, and EQR Recommendations for CCA One Care

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: PCR	There is high confidence that the PIP Baseline Update Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access
PIP 2: IET	There is high confidence that the PIP Baseline Update Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
Performance Measure Validation: HEDIS measures	CCA One Care demonstrated compliance with information system standards. No issues were identified. HEDIS rates for the following measures were above the 90th national Medicaid Quality Compass percentile: • Controlling High Blood Pressure: 78.66% • Hemoglobin A1c Control (HbA1c > 9.0%; lower is better): 22.83% • Breast Cancer Screening: 71.6% HEDIS rates for the following measures were above the 90th national Medicare Quality Compass percentile: • Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement): 10.5%	The HEDIS rate for the following measure was below the 25th national Medicaid Quality Compass percentile: • Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years): 1.4255 HEDIS rates for the following measures were below the 25th national Medicare Quality Compass percentile: • Hemoglobin A1c Control (HbA1c > 9.0%; lower is better): 22.83% • Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years): 1.4255	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. MCP addressed opportunities for improvement from the prior compliance review.	Lack of compliance with 13 requirements in the following domains: • Enrollee rights and protections (4) • 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) • Health information systems (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
Network Adequacy: Information Systems and Quality of Provider Data – Duplicates	Data used by the MCP to monitor network adequacy was mostly accurate and current except for duplicative provider records and incorrect provider directory information.	CCA One Care submitted many duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address, and facility name variations such as submitting departments or DBA names. IPRO removed a total of 3,861 duplicate providers from the CCA One Care data prior to conducting the analysis.	CCA One Care should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – MCP's Methodology	CCA One Care used the correct MassHealth standards for many LTSS providers and behavioral health services.	CCA One Care used incorrect standards for PCP, Acute Inpatient Hospitals, some LTSS provider types, and many of the specialist providers, specifically for the provider types that follow the CMS standards. CCA One Care also used incorrect standards for some behavioral health providers, pharmacy, and dental services. Because of the quality of the provider data, IPRO was able to compare CCA One Care's results for only three provider types: Day Services, Group Adult Foster Care, and Rehabilitation Hospitals. The comparison found many discrepancies.	CCA One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	CCA One Care demonstrated adequate networks for PCP, acute inpatient hospitals, emergency support services, and behavioral health outpatient services in all 12 counties it services.	CCA One Care had had deficient networks in one or more counties for 24 out of 26 specialty types; rehabilitation hospitals; 6 out of 13 LTSS provider types; pharmacy; 7 out of 12 behavioral health diversionary provider types; and all three dental provider types.	The One Care Plan should expand the network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those service areas.	Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
Network Adequacy: Accuracy of Provider Directory	None.	CCA One Care achieved only a 21.82% accuracy rate in its PCP provider directory, a 29.66% accuracy rate in its ob/gyn directory, and only a 43.33% accuracy rate in its dental directory.	CCA One Care should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness
Quality-of-care Surveys	CCA One Care scores above the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures: • Customer Service • Rating of Health Care Quality • Rating of Health Plan	CCA One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures: • Getting Needed Care • Getting Appointments and Care Quickly • 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; N/A: not applicable; HEDIS: Healthcare Effectiveness Data and Information Set; MCP: managed care plan; CY: calendar year; DBA: doing business as; LTSS: long-term services and supports; CMS: Centers for Medicare and Medicaid Services; PCP: primary care provider; ob/gyn: obstetrics/gynecology; TBD: to be determined; MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems; FFS: fee-for-service.

Tufts One Care Strengths, Opportunities for Improvement, and EQR Recommendations

Table 86: Strengths, Opportunities for Improvement, and EQR Recommendations for Tufts One Care

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: FUH	There is high confidence that the PIP Baseline Update Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access
PIP 2: IET	There is moderate confidence that the PIP Baseline Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address	Results must be interpreted with some caution due to several Intervention Tracking Measures being somewhat unclear.	The Plan should continue to work on the intervention tracking measures mentioned and include the revisions in the report.	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
	the barriers. The validation findings generally indicate that the credibility of the PIP results is not at risk.			
Performance Measure Validation: HEDIS measures	HEDIS rates for the following measures were above the 90th national Medicaid Quality Compass percentile: • Controlling High Blood Pressure: 73.22% • Breast Cancer Screening: 67.49% 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 • Engagement in Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	HEDIS rates for the following measures were below the 25th national Medicaid Quality Compass percentile: • Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation): 34.39% • Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years): 1.3312 HEDIS rates for the following measures were below the 25th national Medicare Quality Compass percentile: • Hemoglobin A1c Control (HbA1c > 9.0%; lower is better): 22.83% • Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years): 1.4255	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
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: Information Systems and Quality of Provider Data – Duplicates	Data used by the MCP to monitor network adequacy was mostly accurate and current except for duplicative provider records and incorrect provider directory information.	Tufts One Care submitted many duplicates for individual and facility providers due to variations in the names of facilities and submitting Aging Service Access Point (ASAP) providers. IPRO removed a total of 3,053 duplicate providers from the Tufts One Care data prior to conducting the analysis.	Tufts One Care should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.	Quality, Access, Timeliness
Network Adequacy: Information Systems and Quality of Provider Data LTSS Providers	Data used by the MCP to monitor network adequacy was mostly accurate and current except for duplicative provider records and incorrect provider directory information.	Tufts One Care submitted ASAP providers for the Adult Day Health, Day Services, Group Adult Foster Care, and Personal Care Assistant networks rather than the specific providers that offer these services, creating many duplicates in the provider data.	Tufts One Care should submit specific providers for the Adult Day Health, Day Services, Group Adult Foster Care, and Personal Care Assistant networks.	Quality, Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – MCP's Methodology	Tufts One Care used the correct MassHealth standards for most provider types.	Tufts One used incorrect standards for Adult PCP, Acute Inpatient Hospital, Rehabilitation Hospitals, General Dentists and Oral Surgeons, and Occupational, Physical, and Speech Therapy networks. Because of the quality of the provider data, IPRO was able to compare Tuft One Care's results for only the Pharmacy network. When IPRO compared Tuft One Care's results for the large metro counties in the Pharmacy network, the comparison showed that IPRO and Tufts One Care did not have identical results.	Tufts One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	Tufts One Care demonstrated adequate networks for adult PCP, ob/gyn, behavioral health outpatient, and all specialty providers except one county for Neurosurgery and Orthodontists, in all eight counties.	Tufts One Care had a deficient rehabilitation hospital network in two counties. The MCP also had deficient networks in one or more service areas for 4 out of 13 LTSS provider types, one county for the pharmacy network, 4 out of 12 behavioral health diversionary networks, and 2 out of 3 dental service networks.	The One Care Plan should expand the network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those service areas.	Access, Timeliness
Network Adequacy: Accuracy of Provider Directory	None.	Tufts One Care achieved only a 44.60% accuracy rate in its PCP provider directory, a 37.50% accuracy rate in its Ob/Gyn directory, and only a 53.33% accuracy rate in its dental directory.	Tufts One Care should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
Quality-of-care Surveys	N/A	Many of the Tufts One Care measures did not meet reporting criteria for sample size or reliability. Tufts One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures: • Annual Flu Vaccine	To increase sample size, strengthen member engagement strategies and increase outreach before the next survey period. 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; N/A: not applicable; HEDIS: Healthcare Effectiveness Data and Information Set; MCP: managed care plan; CY: calendar year; DBA: doing business as; LTSS: long-term services and supports; CMS: Centers for Medicare and Medicaid Services; PCP: primary care provider; ob/gyn: obstetrics/gynecology; TBD: to be determined; QAPI: quality assurance and performance improvement; MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems; FFS: fee-for-service.

UHC One Care Strengths, Opportunities for Improvement, and EQR Recommendations

Table 87: Strengths, Opportunities for Improvement, and EQR Recommendations for UHC One Care

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 1: FUH	There is high confidence that the PIP Baseline Update Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access

Activity	Strengths	Weaknesses	Recommendations	Standards
PIP 2: HBD	There is high confidence that the PIP Baseline Update Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There were no validation findings that indicate that the credibility of the PIP results is at risk.	N/A	N/A	Quality, Timeliness, Access
PMV: HEDIS measures	UHC One Care demonstrated compliance with IS standards. No issues were identified. HEDIS rates for the following measures were above the 90th national Medicaid Quality Compass percentile: • Controlling High Blood Pressure: 76.89%	HEDIS rates for the following measures were below the 25th national Medicaid Quality Compass percentile: • Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Initiation): 34.39% • Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years): 1.3312 HEDIS rates for the following measures were below the 25th national Medicare Quality Compass percentile: • Hemoglobin A1c Control (HbA1c > 9.0%; lower is better): 32.36% • Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years): 1.8401	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

Activity	Strengths	Weaknesses	Recommendations	Standards
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 three 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) • Assurance of adequate capacity and services (3) • Coordination and continuity of care (13) • Coverage and authorization of services (2) • Health information systems (2)	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: Information Systems and Quality of Provider Data – Duplicates	Data used by the MCP to monitor network adequacy was mostly accurate and current except for duplicative provider records and incorrect provider directory information.	UHC One Care submitted many duplicates for individual and facility providers due to variations in the facility names. IPRO removed a total of 691 duplicate providers from the UHC One Care data prior to conducting the analysis.	UHC One Care should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – MCP's Methodology	UHC One Care used the correct MassHealth standards for many provider types, specifically for those outlined by MassHealth.	UHC One Care used incorrect standards for PCP, Acute Inpatient Hospitals, some LTSS provider types, and many of the specialist providers, specifically for the provider types that follow the CMS standards. Because of the quality of the provider data, IPRO was able to compare UHC One Care's results for most behavioral health provider networks, rehabilitation hospital, pharmacy, and four LTSS provider types. IPRO found many discrepancies in this comparison analysis.	UHC One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.	Quality, Access, Timeliness

Activity	Strengths	Weaknesses	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	UHC One Care demonstrated adequate networks for PCP, ob/gyn, hospitals and emergency support services, behavioral health outpatient, and all specialty providers except General Surgery, in all 10 counties it services.	UHC One Care had a deficient pharmacy network in one county. The MCP also had deficient networks in one or more counties for 9 out of 13 LTSS provider types, one or more counties for all three dental service provider types, and one or more counties for 6 out of 12 behavioral health diversionary provider types.	One Care Plan should expand the network when members' access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those service areas.	Access, Timeliness
Network Adequacy: Accuracy of Provider Directory	None.	UHC One Care achieved only a 36.36% accuracy rate in its PCP provider directory, a 36.63% accuracy rate in its ob/gyn directory, and only a 60.00% accuracy rate in its dental directory.	UHC One Care should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness
Quality-of-care Surveys	UHC One Care scores above the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures: • Customer Service • Rating of Health Care Quality	UHC One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measure: • Getting Needed Care • Getting Appointments and Care Quickly • Care Coordination • 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; N/A: not applicable; HEDIS: Healthcare Effectiveness Data and Information Set; MCP: managed care plan; CY: calendar year; DBA: doing business as; LTSS: long-term services and supports; CMS: Centers for Medicare and Medicaid Services; PCP: primary care provider; ob/gyn: obstetrics/gynecology; TBD: to be determined; MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems; FFS: fee-for-service.

X. Required Elements in EQR Technical Report

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

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

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

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

Elements required in EQR technical report, including the requirements for the PIP validation, performance measure validation, and review of compliance activities, are listed in **Table 88**.

Table 88: 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**.

Regulatory Reference	Requirement	Location in the EQR Technical Report
Title 42 CFR § 438.358(b)(1)(iii)	Technical report must include information on a review, conducted within the previous three-year period, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in *Title 42 CFR § 438.330*. The technical report must provide MCP results for the 11 Subpart D and QAPI standards.	This report includes information on a review, conducted in 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.

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

XI. Appendix A – MassHealth Quality Goals and Objectives

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

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

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

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

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

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

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

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

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

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

XII. Appendix B – MassHealth Managed Care Programs and Plans

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

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Accountable Care Partnership Plan (ACPP)	Groups of primary care providers working with one managed care organization to create a full network of providers. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. BeHealthy Partnership Plan 2. Berkshire Fallon Health Collaborative 3. East Boston Neighborhood Health WellSense Alliance 4. Fallon 365 Care 5. Fallon Health – Atrius Health Care Collaborative 6. Mass General Brigham Health Plan with Mass General Brigham ACO 7. Tufts Health Together with Cambridge Health Alliance (CHA) 8. Tufts Health Together with UMass Memorial Health 9. WellSense Beth Israel Lahey Health (BILH) Performance Network ACO 10. WellSense Boston Children's ACO 11. WellSense Care Alliance 12. WellSense Community Alliance 13. WellSense Mercy Alliance 14. WellSense Signature Alliance 15. WellSense Southcoast Alliance
Primary Care Accountable Care Organization (PC ACO)	Groups of primary care providers forming an ACO that works directly with MassHealth's network of specialists and hospitals for care and coordination of care. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Community Care Cooperative 2. Revere Medical
Managed Care Organization (MCO)	Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals. • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver.	1. Boston Medical Center HealthNet Plan WellSense 2. Tufts Health Together

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

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

XIII. Appendix C – MassHealth Quality Measures

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

Measure Steward	Acronym	Measure Name	Core Set	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	SAA	Adherence to Antipsychotics for Individuals with Schizophrenia	X	N/A	N/A	N/A	N/A	N/A	1.2, 3.1, 5.1, 5.2
NCQA	AMM	Antidepressant Medication Management – Acute and Continuation	X	N/A	N/A	X	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	AMR	Asthma Medication Ratio	X	N/A	N/A	N/A	N/A	N/A	1.1, 1.2, 3.1
NCQA	AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis	X	N/A	N/A	N/A	N/A	N/A	1.1., 2.2, 3.4
EOHHS	BH CP Engagement	Behavioral Health Community Partner Engagement	N/A	X	X	N/A	N/A	N/A	1.1, 1.3, 2.3, 3.1, 5.2, 5.3
NCQA	BCS	Breast Cancer Screening	X	N/A	N/A	N/A	N/A	N/A	1.1., 2.2, 3.4
NCQA	CCS	Cervical Cancer Screening	X	N/A	N/A	N/A	N/A	N/A	1.1., 2.2, 3.4
NCQA	ACP	Advance Care Planning	N/A	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.1
NCQA	WCV	Child and Adolescent Well-Care Visits	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
NCQA	CIS	Childhood Immunization Status	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
NCQA	CHL	Chlamydia Screening	X	N/A	N/A	N/A	N/A	N/A	1.1., 2.2, 3.4
NCQA	COL	Colorectal Cancer Screening	X	N/A	N/A	X	N/A	N/A	1.1., 2.2, 3.4
PQA	COB	Concurrent Use of Opioids and Benzodiazepines	X	N/A	N/A	N/A	N/A	N/A	1.2, 3.1, 5.1, 5.2
NCQA	CBP	Controlling High Blood Pressure	X	N/A	N/A	X	X	N/A	1.1, 1.2, 2.2
NCQA	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	X	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (30 days)	X	N/A	N/A	X	N/A	X	3.4, 5.1–5.3
NCQA	FUM	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	X	X	X	N/A	X	X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (30 days)	X	N/A	N/A	N/A	X	X	3.4, 5.1–5.3
NCQA	FUH	Follow-Up After Hospitalization for Mental Illness (7 days)	X	X	X	N/A	X	X	3.4, 5.1–5.3

Measure Steward	Acronym	Measure Name	Core Set	ACPP/ PC ACO	MCO	SCO	One Care	MBHP	MassHealth Goals/Objectives
NCQA	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)	X	N/A	N/A	N/A	N/A	X	3.4, 5.1–5.3
NCQA	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	X	N/A	N/A	N/A	N/A	X	3.4, 5.1–5.3
NCQA	ADD	Follow-up for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (HEDIS)	X	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	HBD	Hemoglobin A1c Control; HbA1c control (> 9.0%) Poor Control	X	N/A	N/A	N/A	X	N/A	1.1, 1.2, 3.4
NCQA	IMA	Immunizations for Adolescents	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
NCQA	FVA	Influenza Immunization	N/A	N/A	N/A	N/A	X	N/A	1.1, 3.4
MA-PD CAHPs	FVO	Influenza Immunization	N/A	N/A	N/A	X	N/A	N/A	1.1, 3.4, 4.2
NCQA	IET – Initiation/ Engagement	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment – Initiation and Engagement Total	X	X	X	X	X	X	1.2, 3.4, 5.1–5.3
NCQA	LSC	Lead Screening in Children	X	N/A	N/A	N/A	N/A	N/A	1.1, 3.1
CMS	MLTSS-7	Managed Long Term Services and Supports Minimizing Facility Length of Stay	N/A	N/A	N/A	X	N/A	N/A	4.1, 5
NCQA	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	X	N/A	N/A	N/A	N/A	X	1.2, 3.4, 5.1, 5.2
NCQA	OMW	Osteoporosis Management in Women Who Had a Fracture	N/A	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
NCQA	PBH	Persistence of Beta-Blocker Treatment after Heart Attack	N/A	N/A	N/A	X	N/A	N/A	1.1, 1.2, 3.4
NCQA	PCE	Pharmacotherapy Management of COPD Exacerbation	N/A	N/A	N/A	X	N/A	N/A	1.1, 1.2, 3.4
NCQA	PCR	Plan All Cause Readmission	X	X	X	X	X	N/A	1.2, 3.4, 5.1, 5.2
NCQA	DDE	Potentially Harmful Drug – Disease Interactions in Older Adults	N/A	N/A	N/A	X	N/A	N/A	1.2, 3.4, 5.1
CMS	CDF	Screening for Depression and Follow-Up Plan	X	X	N/A	N/A	N/A	N/A	1.1, 3.1, 5.1, 5.2

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

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

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

CMS's network adequacy standards for Medicare and Medicaid Plans were downloaded on 08/28/24 from the following CMS website: https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-application-annual-requirements

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 One Care 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 – Hospitals and Nursing Facilities

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated One Care Three-Way Contract	Indicator	Definition of the Indicator
Hospitals/Medical Facilities: • Acute Inpatient Hospital • Skilled Nursing Facilities **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.	**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. • 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.	**Hospitals/Medical Facilities:** **Numerator:** number of plan Enrollees in a county for which both of the following are true: • 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 One Care 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 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/medicare/medicaid-coordination/plans/mmp-application-annual-requirements	**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. Apply the minimum number of providers defined by CMS, which vary by county.	**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. **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 One Care 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 • 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)	**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.

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 One Care Three-Way Contract	Indicator	Definition of the Indicator
Provider Type: • Pharmacy **Contract Language:** For Medicare pharmacy providers, time, distance and minimum number standards as required in Appendix F, Article II, Sec. I; and 42 C.F.R. §423.120.	**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; •70% of beneficiaries in Micro counties (rural areas) must be within 15 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. •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 One Care 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.

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated One Care Three-Way Contract	Indicator	Definition of the Indicator
LTSS Providers – CMS standards: • Physical Therapy • Occupational Therapy • Speech Therapy • 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/medicare/medicaid-coordination/plans/mmp-application-annual-requirements	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 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.	LTSS provider services – CMS standards: 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 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 One Care 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.
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.

Table D8: One Care Network Adequacy Standards and Indicators – Dental Services

Network Adequacy Standards Source: Sec. 2.8.2 ("Proximity Access Requirements") in the Amended and Restated One Care Three-Way Contract	Indicator	Definition of the Indicator
1. Access: Contractor shall meet the Access Standards (as defined below), Travel Times (as defined below), Appointment Accessibility Standards (as defined below), and Wait Times (as defined below) for general, periodontics orthodontic and oral surgery practitioners by the Contract Implementation Date and thereafter throughout the life of the Contract, except for the Travel Times related to periodontics , orthodontists and oral surgeons for Members residing on Nantucket Island, Hampshire, Hampden, Franklin, Barnstable, Dukes and Berkshire counties; related to general practitioners and periodontics for Members residing in Barnstable; Nantucket Island, Berkshire, Hampden, Hampshire, Franklin and Dukes counties; related to orthodontists for Members residing in Berkshire County; and related to oral surgeons for Members residing in Hampden, Hampshire, Franklin, Berkshire, Barnstable and Dukes counties and on Nantucket Island.	**General Dentists** •95% of Members have access to 2 General Dentists within 10 minutes of their home •Apply provider-to-enrollee ratio of 1: 1,500 **Orthodontist** •95% of Members have access to 1 Orthodontist within 30 minutes of their home •Apply provider-to-enrollee ratio of 1: 15,000 **Oral Surgeon** •95% have access to 1 Oral Surgeon within 30 minutes of their home •Apply provider-to-enrollee ratio of 1: 20,000	**General Dentists:** **Numerator:** number of plan enrollees in a county for which two unique in-network providers are within a 10-minute drive or less from Enrollee's ZIP code of residence. **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. **Orthodontists:** **Numerator:** number of plan enrollees in a county for which one unique in-network provider is within a 30-minute drive or less from Enrollee's ZIP code of residence. **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. **Oral Surgeons:** **Numerator:** number of plan enrollees in a county for which one unique in-network provider is within a 30-minute drive or less from Enrollee's ZIP code of residence. **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.

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
Tufts One Care	PCP and Dental: https://tuftshealthplan.com/find-a-doctor#
CCA One Care	PCP: https://www.commonwealthcarealliance.org/ma/members/find-a-provider/ Dental: Search - Provider Directory (commonwealthcarealliance.org)
UHC One Care	PCP and Dental: Find a Provider | UnitedHealthcare Community Plan: Medicare & Medicaid Health Plans (uhccommunityplan.com)

PCP: primary care provider.