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External Quality Review One Care Plans Annual Technical Report, Calendar Year 2025



Commonwealth of Massachusetts
Executive Office of Health and
Human Services

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

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I. Executive Summary

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 provide 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 2025 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. Effective January 1, 2026, the One Care Plan program will shift from a Medicare-Medicaid Plan (MMP) demonstration to a type of Medicare Advantage Plan, a Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) with a companion Medicaid managed care plan. MassHealth's One Care Plans are listed in **Table 1**.

Table 1: MassHealth's One Care Plans – CY 2025

One Care Plan Name	Abbreviation Used in the Report	Members as of December 27, 2025	Percent of Total One Care Plan Population
Commonwealth Care Alliance	CCA One Care	27,593	71.61%
Tufts Health One Care	Tufts One Care	6,734	17.48%
UnitedHealthcare Connected for One Care	UHC One Care	4,208	10.91%
One Care Plans (Total)	N/A	38,535	100.00%

CY: calendar year; N/A: not applicable.

The **Commonwealth Care Alliance (CCA One Care)** is a nonprofit integrated health system that serves 27,593 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 6,734 MassHealth Enrollees across eight 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 4,208 MassHealth Enrollees across 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

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 \(uhccommunityplan.com\)](#).

Purpose of Report

The purpose of this annual technical report is to present the results of EQR activities conducted to assess the quality of, timeliness of, and access to health care services furnished to Medicaid Enrollees, in accordance with the following federal managed care regulations: *Title 42 Code of Federal Regulations (CFR) Section (§) 438.364 External review results (a) through (d)* and *Title 42 CFR § 438.358 Activities related to external quality review*. EQR activities validate two levels of compliance to assert whether the 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 CHIP⁴ Managed Care Regulations** – This activity determines One Care Plans’ compliance with their 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 2025 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 the CY 2025 EQR activity 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

⁴ Children’s Health Insurance Program.

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.

MassHealth Medicaid Comprehensive Quality Strategy

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

Strengths:

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

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

Consequently, MassHealth programs and initiatives reflect the priorities articulated in the strategy and include specific measures. Measure targets are explained in the quality strategy by each managed care program.

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

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

Opportunities for Improvement:

Not applicable.

General Recommendations for MassHealth:

None at this time.

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

Performance Improvement Projects

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

Strengths:

IPRO found that the majority of PIP remeasurement reports follow an acceptable methodology in determining PIP aims, identifying barriers, and proposing interventions to address them. In terms of producing significant evidence of improvement, three PIPs received high ratings, and three PIPs received moderate confidence ratings. No validation findings suggest that the credibility of the PIPs results is at risk.

Opportunities for Improvement:

Not applicable.

General Recommendations for MassHealth:

None at this time.

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, weighted statewide mean rates were above the 90th Medicaid percentile for the following measures:

- Controlling Blood Pressure: 83.96% (≥ 90th)
- Glycemic Status Assessment for Patients with Diabetes (> 9.0%; lower is better): 20.83% (≥ 90th)
- Breast Cancer Screening: 71.67% (≥ 90th)

When compared to the measurement year (MY) 2024 Quality Compass national Medicare percentiles, MassHealth’s weighted state means was above the 90th percentile for the Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment measure.

IPRO also reported One Care MY 2024 non-HEDIS rates calculated by CMS’s vendor for the CMS Financial Alignment Initiative (FAI). Compared to the quality withhold benchmarks established by CMS in collaboration with MassHealth, the weighted statewide mean scored above benchmark for the following measures:

- Tracking of Demographic Information: percent of members whose demographic data are collected and maintained in the Centralized Enrollee Record: 87.7% (> Goal)
- Documentation of Care Plan Goals: percent of members with documented discussions of care goals: 99.1% (> Goal)
- Minimizing Facility Length of Stay: 1.66 (> Goal)

Opportunities for Improvement:

When compared to the MY 2024 Quality Compass national Medicaid percentiles, MassHealth’s weighted state means were below the 25th percentile for the following measures:

- Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment: 39.99% (< 25th)
- Plan All-Cause Readmissions Observed/Expected Ratio: 1.3609 (< 25th)

When compared to the MY 2024 Quality Compass national Medicare percentiles, MassHealth’s weighted state means were below the 25th percentile for following measures:

- Glycemic Status Assessment for Patients with Diabetes (> 9.0%; lower is better): 20.83% (< 25th)
- Plan All-Cause Readmission Observed/Expected Ratio: 1.3609 (< 25th)

Compared to the quality withhold benchmarks for the non-HEDIS measures, the following weighted state means were 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: 85.5% (< Goal)
- Timely Assessment: percent of members with an initial assessment completed within 90 days of enrollment: 92.9% (< Goal)

General Recommendations for MassHealth:

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

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

Compliance Review

IPRO evaluated the compliance of 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, and monitor the quality of healthcare services provided by MCPs. MassHealth collaborates with MCPs to identify areas for improvement, and MCPs actively engage in performance improvement initiatives.

MassHealth monitors MCPs compliance with contractual obligations via regular audits, reviews, and reporting requirements. 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 domains and 90% or more in four domains; UHC One Care scored 100% in seven domains and 90% or more in seven domains; and CCA One Care scored 100% in six domains and 90% or more in 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, and 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 and 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.
- *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 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

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.

of their GeoAccess analysis on an annual and ad hoc basis. This analysis evaluates provider locations relative to members' ZIP code of residence.

I PRO 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 I PRO. UHC One Care received a rating of high confidence for acute inpatient hospitals, pharmacy, and some of the LTSS and specialist services. Tufts One Care Plan received a rating of high confidence for acute inpatient hospitals and specialists in large metro counties, as well as for rehabilitation hospitals, pharmacy, and most of the behavioral health diversionary services.

In addition to generating network adequacy validation ratings, I PRO 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, I PRO reported the percentage of members in that county who had adequate access. I PRO's analysis showed that all One Care Plans had adequate networks of behavioral health outpatient and most of the specialist services.

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. CCA One Care was given low confidence ratings for primary care, acute inpatient hospitals, specialist services in metro counties, some of the LTSS provider types, and dental services. UHC One Care received a low confidence rating for some specialist services, recovery coaching, structured outpatient addiction programs, and behavioral health outpatient services.

After resolving data issues and removing duplicate records, I PRO 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 hospital, LTSS, and behavioral health diversionary, and dental services networks.

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

The average wait times for routine appointments were: 78.4 calendar days for a PCPs, 66.36 calendar days for an ob/gyn, and 8 calendar days for community mental health centers. These results are based on small samples and should be interpreted with caution. Appointment availability was often not disclosed unless eligibility or insurance information was provided, preventing I PRO from assessing wait times and creating unnecessary barriers to patient access.

General Recommendations for MassHealth:

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

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.

CMS requires all Medicare Advantage contracts with at least 600 enrollees to contract with approved survey vendors to collect and report CAHPS survey data following a timeline and protocols established by CMS. The Medicare Advantage and Prescription Drug (MA-PD) CAHPS surveys is administered by a CMS-approved survey vendor. CMS uses information from MA-PD CAHPS to further evaluate health plans' Part D operations.

MassHealth monitors One Care Plans' submissions of MA-PD CAHPS surveys and uses the results to identify opportunities for improvement and inform MassHealth's quality management work.

Strengths:

When compared to the Medicare Advantage Fee-for-service mean score, One Care weighted means for the following measures exceeded the national benchmark:

- Customer Service
- Rating of Health Care Quality
- Rating of Health Plan

Opportunities for Improvement:

When compared to the Medicare Advantage Fee-for-service mean score, One Care weighted means for the following measures scored below the benchmark:

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

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 experience* – 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 members.

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.
- *Recommendations towards better access* – MassHealth should work with health plans to ensure providers disclose appointment availability to members without requiring eligibility verification, reducing barriers to access and enabling informed care decisions.
- *Recommendation towards better performance on CAHPS measures* – MassHealth should continue to utilize CAHPS 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."⁶ MassHealth covers over 2 million residents in Massachusetts, approximately 30% of the state's population.

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

MassHealth Medicaid Quality Strategy

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

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

2025–2027 Strategic Goals

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

⁶ [MassHealth 2025 Comprehensive Quality Strategy](https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download). Also available at: <https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download>.

Table 2: MassHealth’s Strategic Goals

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

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

MassHealth Managed Care Programs

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

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

6. **One Care** Plans are integrated health plans for people with disabilities that cover the full set of services provided by both Medicare and Medicaid. Through integrated care, members receive all medical and behavioral health services, as well as LTSS. This Plan is for Enrollees ages 21 to 64 years who are dually enrolled in Medicaid and Medicare.⁷
7. **Senior Care Options (SCO)** Plans are also integrated health plans that cover services paid for by Medicare and Medicaid. SCO Plans are for MassHealth Enrollees ages 65 years and older, and they offer services to help seniors stay independently at home by combining health care with social supports.⁸ SCO Plans coordinate all Medicare and Medicaid benefits, and Enrollees must be eligible for both programs at the time of enrollment.

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

MassHealth Additional Programs

MassHealth manages other programs beyond MCPs.

Fee-for-service (FFS) Medicaid Program

Fee-for-service is a traditional payment model where healthcare providers are paid directly for each service without a capitated payment and care coordination. According to the MassHealth Comprehensive Quality Strategy, 30% of MassHealth members are enrolled in fee-for-service, which includes individuals who live in nursing facilities or rehabilitation hospitals, individuals under age 65 years who have employer-sponsored insurance for whom MassHealth offers wraparound benefits, and individuals over age 65 years or who are disabled with Medicare and choose to remain in fee-for-service.⁹

Long-term Services and Supports (LTSS)

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

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

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

Community Partners Program

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

⁷ [One Care Facts and Features](https://www.mass.gov/doc/one-care-facts-and-features-brochure/download). Also available at: <https://www.mass.gov/doc/one-care-facts-and-features-brochure/download>.

⁸ [Senior Care Options \(SCO\) Overview](https://www.mass.gov/service-details/senior-care-options-sco-overview). Also available at: <https://www.mass.gov/service-details/senior-care-options-sco-overview>.

⁹ [MassHealth 2025 Comprehensive Quality Strategy](https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download). Also available at: <https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download>.

Quality Metrics

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

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

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

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

Performance Improvement Projects

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

Member Experience of Care Surveys

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

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

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

MassHealth Access Standards

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

State's Evaluation of the Effectiveness of the Quality Strategy

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

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

IPRO's Assessment of the Massachusetts Medicaid Quality Strategy

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

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

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

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

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

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

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

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

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

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

III. Validation of Performance Improvement Projects

Objectives

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

Section 2.13 of the MassHealth One Care Three-Way Contract requires One Care Plans to develop and maintain 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, which continued to be implemented during CY 2025. Specific One Care PIP topics are displayed in **Table 3**.

Table 3: One Care PIP Topics – CY 2025

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

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 CY 2025.

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 March 2025, IPRO offered optional progress calls and met with two One Care Plans. The first remeasurement report was submitted in July 2025 by all One Care Plans.

In the first remeasurement report, One Care Plans described project goals, performance indicators’ rates, anticipated barriers, interventions, and intervention tracking measures’ rates. 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 as well as the progress of the interventions and initial evidence of improvement. It aimed to evaluate an alignment between the interventions and project goals and whether reported improvements could be maintained over time.

Description of Data Obtained

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

Conclusions and Comparative Findings

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

Rating 1: Adherence to Acceptable Methodology - Validation Results Summary

The ratings for PIP adherence to acceptable methodology were high for almost all PIPs, except for the CCA 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

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

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

Table 4: CCA One Care PIP Validation Confidence Ratings – CY 2025

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

PIP: performance improvement project; CY: calendar year.

Table 5: Tufts One Care PIP Validation Confidence Ratings – CY 2025

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

PIP: performance improvement project; CY: calendar year.

Table 6: UHC One Care PIP Validation Confidence Ratings – CY 2025

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

PIP: performance improvement project; CY: calendar year.

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, 2025

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 – High Confidence

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

Aim

Indicator 1: By the end of 2025 CCA aims to decrease plan 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 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 2025

- 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

All four performance indicators have demonstrated improvement from baseline to the first remeasurement period. Additional interventions and intervention tracking measures have been added to increase effectiveness.

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 1: Plan All-Cause Readmissions (Ratio)	2025 (remeasurement 1, MY 2024 data)	1.39
Indicator 2: Modified PCR Specific to COPD	2024 (baseline, MY 2023 data)	19.12%
Indicator 2: Modified PCR Specific to COPD	2025 (remeasurement 1, MY 2024 data)	17.03%
Indicator 3: Pharmacotherapy Management of COPD Exacerbation (PCE) Systemic Corticosteroids	2024 (baseline, MY 2023 data)	87.50%
Indicator 3: Pharmacotherapy Management of COPD Exacerbation (PCE) Systemic Corticosteroids	2025 (remeasurement 1, MY 2024 data)	91.19%

Indicators	Reporting Year	Rate
Indicator 4: Pharmacotherapy Management of COPD Exacerbation (PCE) Bronchodilators	2024 (baseline, MY 2023 data)	68.00%
Indicator 4: Pharmacotherapy Management of COPD Exacerbation (PCE) Bronchodilators	2025 (remeasurement 1, MY 2024 data)	79.26%

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

Table 9: CCA One Care PIP 2 Summary, 2025

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

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

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 2025

- 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

Although both indicator rates experienced substantial improvement from the baseline rate for the interim year comparison, most interventions were implemented late 2024/early 2025, leaving it difficult to assess whether the interventions were effectively improving performance outcomes

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 data)	41.90%
Indicator 1: Initiation of SUD Treatment	2025 (remeasurement 1, 2024 MY data)	44.23%
Indicator 2: Engagement of SUD Treatment	2024 (baseline, 2023 MY data)	10.50%
Indicator 2: Engagement of SUD Treatment	2025 (remeasurement 1, 2024 MY data)	12.25%

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

Recommendations

- *Recommendation for PIP 2:* For future report submissions or future PIP cycles, CCA One Care should ensure that attempts are made to replace those interventions that have significant issues resulting in significant delays in implementation.

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, 2025

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 – Moderate Confidence

PIP: performance improvement project; MY: measurement year.

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 2025

- 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

Although both indicator rates improved from the baseline to interim period, several intervention tracking measures corresponding to the interventions included several low denominators and rates, leaving it difficult to assess the effectiveness of the interventions that were implemented during the MY. Tufts One Care is encouraged to continue interventions while monitoring the associated intervention tracking measure data for performance improvement. The Plan is also encouraged to modify/include new interventions based on intervention/intervention tracking measure performance outcomes.

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 7-day	2025 (remeasurement 1, MY 2024 data)	56.45%
Indicator 1: Follow-up After Hospitalization for Mental Illness 30-day	2024 (baseline, MY 2023 data)	71.46%
Indicator 1: Follow-up After Hospitalization for Mental Illness 30-day	2025 (remeasurement 1, MY 2024 data)	79.03%

PIP: performance improvement project; MY: measurement year.

Table 13: Tufts One Care PIP 2 Summary, 2025

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 – High Confidence

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

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

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 2025

- 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

Although both indicator rates improved from the baseline to interim period, several intervention tracking measures corresponding to the interventions included several low denominators and rates, leaving it difficult to assess effectiveness of the interventions that were implemented during the measurement year.

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: Initiation of SUD Treatment	2025 (remeasurement 1, MY 2024 data)	37.62%
Indicator 1: Engagement of SUD Treatment	2024 (baseline, MY 2023 data)	8.92%
Indicator 1: Engagement of SUD Treatment	2025 (remeasurement 1, MY 2024 data)	10.10%

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

Recommendations

- *Recommendation for PIP 1 and 2:* Tufts One Care is encouraged to continue interventions while monitoring the associated intervention tracking measure data for performance improvement. The Plan is also encouraged to modify/include new interventions based on intervention/intervention tracking measure performance outcomes.

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, 2025

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 – High Confidence

PIP: performance improvement project; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

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

The indicator of focus has demonstrated improvement from baseline to the first remeasurement report period despite a late start to some interventions and intervention tracking measures.

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%
Indicator 1: FUH 30-day	2025 (remeasurement 1, MY 2024 data)	61.20%

PIP: performance improvement project; MY: measurement year.

Table 17: UHC One Care PIP 2 Summary, 2025

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 – High Confidence

PIP: performance improvement project; MY: measurement year; HbA1c: hemoglobin A1c.

Aim

By the end of 2025, UnitedHealthcare One Care members with adequately controlled diabetes (HbA1c <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

The indicator of focus has demonstrated improvement from baseline to the first remeasurement report period despite a late start to some interventions and intervention tracking measures.

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%
Indicator 1: HBD	2025 (remeasurement 1, MY 2024 data)	67.89%

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 measure 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 four non-HEDIS measures required for reporting, but all four were calculated and validated by CMS, so they were out of scope for the EQR validation for MY 2024.

For HEDIS measures, IPRO performed an independent evaluation of the MY 2024 HEDIS Compliance Audit Final Audit Reports, which contained findings related to the information systems standards. An EQRO may review an assessment of the MCP's information systems conducted by another party in lieu of conducting a full Information Systems Capabilities Assessment.¹⁰ Since the 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.

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 2024 HEDIS Compliance Audit, as well as associated supplemental documentation, Interactive Data Submission System files, and the Final Audit Reports.

Conclusions and Comparative Findings

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

Table 19: One Care Plan Compliance with Information System Standards – MY 2024

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; IS: information systems.

¹⁰ The *CMS External Quality Review (EQR) Protocols*, published in February 2023, states that the Information Systems Capabilities Assessment is a required component of the mandatory EQR activities as part of Protocols 1, 2, 3, and 4. CMS clarified that the systems reviews that are conducted as part of the NCQA HEDIS Compliance Audit may be substituted for an Information Systems Capabilities Assessment. The results of HEDIS compliance audits are presented in the HEDIS Final Audit Reports issued by each One Care Plan's independent auditor.

Validation Findings

- **Information Systems Capabilities Assessment:** 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 2024 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:

- **Breast Cancer Screening**
 - CCA One Care: 72.19% (≥ 90th percentile)
 - Tufts One Care: 70.28% (≥ 90th percentile)
 - UHC One Care: 65.61% (≥ 75th percentile but < 90th percentile)
- **Controlling High Blood Pressure**
 - CCA One Care: 85.57% (≥ 90th percentile)
 - Tufts One Care: 78.05% (≥ 90th percentile)
 - UHC One Care: 81.27% (≥ 90th percentile)

- **Follow-up After Hospitalization for Mental Illness – 30 days (Total)**
 - Tufts One Care: 79.03% (≥ 90th percentile)
- **Follow-up After Hospitalization for Mental Illness – 7 days (Total)**
 - Tufts One Care: 56.45% (≥ 75th percentile but < 90th percentile)
- **Glycemic Status Assessment for Patients With Diabetes – Glycemic Status > 9.0%**
 - CCA One Care: 19.95% (≥ 90th percentile)
 - UHC One Care: 21.41% (≥ 90th percentile)
 - Tufts One Care: 24.81% (≥ 75th percentile but < 90th percentile)

Needs Improvement:

- **Initiation of Substance Use Disorder Treatment**
 - Tufts One Care: 37.62% (< 25th percentile)
 - UHC One Care: 32.57% (< 25th percentile)
- **Engagement of Substance Use Disorder Treatment**
 - Tufts One Care: 10.10% (< 25th percentile)
 - UHC One Care: 8.49% (< 25th percentile)
- **Plan All-Cause Readmissions (Ages 18–64 years)**
 - CCA One Care: 1.3715 (< 25th percentile)
 - Tufts One Care: 1.3516 (< 25th percentile)

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

Table 20: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2024 Quality Compass Medicaid National Percentiles

Key	How Rate Compares to the NCQA HEDIS MY 2024 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 2024 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 2023 Fee-for-service Mean Score, instead of the Medicaid Quality Compass.

Table 21: One Care HEDIS Performance Measures – MY 2024 as Compared to Medicaid Quality Compass

HEDIS Measure	CCA One Care	Tufts One Care	UHC One Care	Weighted Statewide Mean
Influenza Vaccination ¹	45 (< Goal)	43 (< Goal)	54 (> Goal)	46 (N/A)
Controlling High Blood Pressure	85.57% (≥ 90th)	78.05% (≥ 90th)	81.27% (≥ 90th)	83.96% (≥ 90th)
Glycemic Status Assessment for Patients with Diabetes (> 9.0%; lower is better)	19.95% (≥ 90th)	24.81% (≥ 75th but < 90th)	21.41% (≥ 90th)	20.83% (≥ 90th)
Follow-up After Hospitalization for Mental Illness (7 days)	39.85% (≥ 25th but < 50th)	56.45% (≥ 75th but < 90th)	36.4% (≥ 25th but < 50th)	42.33% (≥ 50th but < 75th)
Follow-up After Hospitalization for Mental Illness (30 days)	58.28% (≥ 25th but < 50th)	79.03% (≥ 90th)	61.2% (≥ 25th but < 50th)	62.09% (≥ 50th but < 75th)
Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	42.23% (≥ 25th but < 50th)	37.62% (< 25th)	32.57% (< 25th)	39.99% (< 25th)
Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	11.7% (≥ 25th but < 50th)	10.1% (< 25th)	8.49% (< 25th)	10.94% (≥ 25th but < 50th)
Plan All-Cause Readmission (Observed/Expected Ratio; ages 18–64 years; lower is better)	1.3715 (< 25th)	1.3516 (< 25th)	1.2785 (≥ 25th but < 50th)	1.3609 (< 25th)
Breast Cancer Screening	72.19% (≥ 90th)	70.28% (≥ 90th)	65.61% (≥ 75th but < 90th)	71.67% (≥ 90th)

¹ The CAHPS Influenza Vaccination measure was compared to the MassHealth weighted mean, instead of the Medicaid Quality Compass. The usual benchmark – the Medicare Advantage 2023 Fee-for-Service Mean Score – was not available.

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; CAHPS: Consumer Assessment of Healthcare Providers and Systems; N/A: not available.

IPRO also compared the One Care Plan rates to the NCQA HEDIS MY 2024 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:

- **Controlling High Blood Pressure**
 - CCA One Care: 85.57% (≥ 75th percentile but < 90th percentile)
- **Follow-up After Hospitalization for Mental Illness – 30 days (Total)**
 - Tufts One Care: 79.03% (≥ 90th percentile)
- **Follow-up After Hospitalization for Mental Illness – 7 days (Total)**
 - CCA One Care: 39.85% (≥ 75th percentile but < 90th percentile)
 - Tufts One Care: 56.45% (≥ 90th percentile)

- **Initiation and Engagement of Substance Use Disorder Treatment – Engagement of SUD Treatment (Total)**
 - CCA One Care: 11.70% (≥ 90th percentile)
 - Tufts One Care: 10.10% (≥ 90th percentile)
 - UHC One Care: 8.49% (≥ 75th percentile but < 90th percentile)

Needs Improvement:

- **Breast Cancer Screening**
 - UHC One Care: 65.61% (< 25th percentile)
- **Glycemic Status Assessment for Patients With Diabetes – Glycemic Status > 9.0%**
 - CCA One Care: 19.95% (< 25th percentile)
 - Tufts One Care: 24.81% (< 25th percentile)
 - UHC One Care: 21.41% (< 25th percentile)
- **Plan All-Cause Readmissions (Ages 18–64 Years)**
 - CCA One Care: 1.3715 (< 25th percentile)
 - Tufts One Care: 1.3516 (< 25th percentile)
 - UHC One Care: 1.2785 (< 25th percentile)

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

Table 23 displays the HEDIS performance measures for MY 2024 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 2024 Quality Compass Medicare National Percentiles

Key	How Rate Compares to the NCQA HEDIS MY 2024 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).

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

Table 23: One Care HEDIS Performance Measures – MY 2024 as Compared to Medicare Quality Compass

HEDIS Measure	CCA One Care	Tufts One Care	UHC One Care	Weighted Statewide Mean
Influenza Vaccination ¹	45 (< Goal)	43 (< Goal)	54 (> Goal)	46 (N/A)
Controlling High Blood Pressure	85.57% (≥ 75th but < 90th)	78.05% (≥ 25th but < 50th)	81.27% (≥ 50th but < 75th)	83.96% (≥ 75th but < 90th)
Glycemic Status Assessment for Patients with Diabetes (> 9.0%; lower is better)	19.95% (< 25th)	24.81% (< 25th)	21.41% (< 25th)	20.83% (< 25th)
Follow-up After Hospitalization for Mental Illness (7 days)	39.85% (≥ 75th but < 90th)	56.45% (≥ 90th)	36.4% (≥ 50th but < 75th)	42.33% (≥ 75th but < 90th)
Follow-up After Hospitalization for Mental Illness (30 days)	58.28% (≥ 50th but < 75th)	79.03% (≥ 90th)	61.2% (≥ 50th but < 75th)	62.09% (≥ 75th but < 90th)
Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	42.23% (≥ 50th but < 75th)	37.62% (≥ 50th but < 75th)	32.57% (≥ 25th but < 50th)	39.99% (≥ 50th but < 75th)
Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	11.7% (≥ 90th)	10.1% (≥ 90th)	8.49% (≥ 75th but < 90th)	10.94% (≥ 90th)
Plan All-Cause Readmission (Observed/Expected Ratio; ages 18–64 years; lower is better)	1.3715 (< 25th)	1.3516 (< 25th)	1.2785 (< 25th)	1.3609 (< 25th)
Breast Cancer Screening	72.19% (≥ 25th but < 50th)	70.28% (≥ 25th but < 50th)	65.61% (< 25th)	71.67% (≥ 25th but < 50th)

¹ The CAHPS Influenza Vaccination measure was compared to the MassHealth weighted mean, instead of the Medicaid Quality Compass. The usual benchmark – the Medicare Advantage 2023 Fee-for-Service Mean Score – was not available.

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; CAHPS: Consumer Assessment of Healthcare Providers and Systems; N/A: not available.

Finally, in **Table 25**, IPRO reported MY 2024 rates for the five non-HEDIS measures calculated by CMS’s vendor for the CMS Financial Alignment Initiative . 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

Key	How Rate Compares to the Medicare Advantage 2024 Fee-for-service 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.

Table 25: One Care Non-HEDIS Performance Measures – MY 2024 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.	99.60% (> Goal)	93.30% (< Goal)	59.00% (< Goal)	85.50% (< 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).	90.70% (> Goal)	77.20% (< Goal)	84.50% (< Goal)	87.70% (> Goal)	85.00% (N/A)
Documentation of Care Plan Goals: Percent of members with documented discussions of care goals.	100.00% (> Goal)	99.30% (> Goal)	96.90% (> Goal)	99.10% (> Goal)	95.00% (N/A)
Timely Assessment: Percent of members with an initial assessment completed within 90 days of enrollment.	93.20% (> Goal)	99.10% (> Goal)	82.00% (< Goal)	92.90% (< Goal)	93.00% (N/A)
Minimizing Facility Length of Stay	1.79 (> Goal)	1.87 (> Goal)	1.03 (< Goal)	1.66 (> Goal)	1.25 (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 EQRO to assess whether the Plan indeed understands the requirements, the internal processes, and procedures to deliver the required services to members and providers; can articulate in their own words; and draws the relationship between the policies and the implementation of those policies. Interviews discussed elements in each of the review tools that were considered less than fully compliant based upon initial review. Interviews were used to further explore the written documentation and to allow One Care Plans to provide additional documentation, if available. One Care Plans' staff was given two days from the close of the remote interviews 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: <ul style="list-style-type: none"> 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 domains.
- CCA One Care performed below 90% in the Enrollee Rights Requirements and the Emergency and Post-stabilization Services domains.

Table 27 presents compliance scores for each of the 14 domains across all three One Care Plans. Enrollee Rights & Protections Total is the sum of regulations in the 438.10 Information Requirements Tool and the 438.100 Enrollee Rights & Protections Tool. Emergency and Post-stabilization Services are seven regulations embedded in the 438.210 Coverage and Authorization Tool and extracted in the scorecard for presentation. Red text indicates opportunity for improvement (less than 90%).

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	438.100	85.3%	97.1%	94.2%	92.2%
Emergency and Post-stabilization Services	438.114	50.0%	100.0%	100.0%	83.3%
Availability of Services	438.206	91.7%	92.5%	97.5%	93.9%
Assurances of Adequate Capacity and Services	438.207	100.0%	100.0%	93.5%	97.8%
Coordination and Continuity of Care	438.208	93.2%	89.6%	94.0%	92.3%
Coverage and Authorization of Services	438.210	97.3%	83.5%	98.7%	93.2%
Provider Selection	438.214	100.0%	100.0%	100.0%	100.0%
Confidentiality	438.224	100.0%	100.0%	100.0%	100.0%
Grievance and Appeal Systems	438.228	99.2%	99.2%	100.0%	99.5%
Subcontractual Relationships and Delegation	438.230	100.0%	100.0%	100.0%	100.0%
Practice Guidelines	438.236	90.0%	100.0%	100.0%	96.7%
Health Information Systems	438.242	92.5%	100.0%	90.0%	94.2%
QAPI	438.330	100.0%	96.4%	100.0%	98.8%

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

VI. Validation of Network Adequacy

Objectives

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

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

MassHealth's access and availability standards are described in 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 April 4, 2025, and closed on May 16, 2025. IPRO also scheduled individual interview sessions with each MCP to supplement understanding of the MCP’s information systems and processes.

Provider Directory and Availability of Appointments Methodology

The accuracy of provider directories and availability of appointments were assessed using secret shopper surveys. In a secret shopper survey, callers acted as members and attempted to schedule an appointment, documenting the date of the next available appointment or barriers to making the appointment. 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)
Outpatient mental health and substance use disorder providers	Mental Health Clinics

IPRO filtered One Care Plans online provider directories for Community Mental Health Centers (CMHCs) that were accepting new patients and then used a browser-based web scraping tool to scrape the data, creating a database of providers. Scraping was not feasible for PCP and ob/gyn providers because some directory search tools imposed filter limitations, preventing extraction of the full provider universe. For that reason, IPRO requested the PCP and ob/gyn provider data directly from One Care Plans. The data request included an attestation requirement confirming that the data submitted to IPRO was the same data reflected in the online provider directories.

The sample size was determined based on the population size using a 95% confidence level and a 7% margin of error to ensure a statistically valid methodology. The records in the random samples were reviewed for overlaps to create a “calling samples” and to ensure that the same providers were not contacted multiple times.

The records in the calling samples were manually checked for comparability against the online provider directories. IPRO found that the PCP data submission from Tufts One Care was the most comparable with the online directory information (95% correct) and the CCA One Care was the least comparable with online directory information (80% correct), mainly because the providers in the submitted data were not found in the online directory. To note, the data was submitted to IPRO in December and checked for comparison in January. For ob/gyn, CCA data submission was the most comparable (73.5% correct), while Tufts One Care was the least comparable (23% correct). The ob/gyn check was conducted in February 2026.

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

IPRO also inquired about the wait times for the next available routine and sick appointments for primary care and ob/gyn providers as well as the next available intake session and/or individual therapy appointment at the

CMHCs. Callers were provided with scenarios to use when attempting to collect the appointment dates. Each CMHC’s calling script was designed to address telehealth and in-person appointments and differentiate between a billable clinical intake session vs administrative screening. A telehealth appointment was counted towards the average appointment wait times only if the behavioral health provider also offered in-person appointments.

MassHealth’s appointment availability standards for 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
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 2025, 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 CMS, 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
<ul style="list-style-type: none"> Primary Care Acute Inpatient Hospital Skilled Nursing Facility Specialists LTSS Providers: Physical Therapy, Occupational Therapy, Speech Therapy 	<ul style="list-style-type: none"> Behavioral Health Outpatient Services Behavioral Health Diversionary Providers LTSS Providers: Adult Day Health, Adult Foster Care, Day Habilitation, Day Services, Group Adult Foster Care, Hospice Rehabilitation Hospitals Dental Services: General Dentistry, Orthodontia, and Oral Surgery

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
Suffolk

IPRO reviewed MassHealth GeoAccess standards and worked together with the state to define network adequacy indicators. Network adequacy indicators were updated to reflect all changes to the contract requirements for CY 2025. One Care GeoAccess network adequacy standards and indicators are listed in **Appendix D (Tables D1–D8)**.

IPRO requested in-network provider data on April 4, 2025, with a submission due date of May 16, 2025. MCPs submitted data to IPRO following templates developed by MassHealth and utilized by MCOs and ACPs 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 April 4 and October 1, 2025. Before requesting data from the MCPs, IPRO consulted with MassHealth and confirmed the variables

necessary for the network adequacy validation, agreed on the format of the files, and reviewed the information systems survey form.

Network Information Systems Capacity Assessment Data

Each MCP received a unique URL link via email to a REDCap survey. The survey was open from April 4, 2025, until May 16, 2025.

Provider Directory and Availability of Appointment Data

For the provider directory validation, One Care provider directory web addresses were reported to IPRO by the MCPs and are presented in **Appendix E**. CMHC data was obtained directly from online directories using a browser-based scraping tool. The data was obtained on August 28, 2025. When a browser-based extraction from online directories was not feasible, health plan export files were used instead. IPRO requested the PCP and ob/gyn data from the One Care Plans on October 29 and received the data on December 12, 2025. The PCP and ob/gyn practice sites and CMHCs were contacted between January and February 2026.

Travel Time and Distance Data

Validation of network adequacy for CY 2025 was performed using network data submitted by MCPs to IPRO. IPRO requested a complete provider list which included facility/provider name, address, phone number, and the national provider identifier for the following provider types: primary care, ob/gyn, hospitals, rehabilitation, urgent care, specialists, behavioral health, and pharmacy. For PCPs, panel status and providers' non-English language information were also requested. IPRO received a complete list of Medicaid Enrollees from each MCP. Provider and member enrollment data as of April 1, 2025, were submitted to IPRO via IPRO's secure file transfer protocol site. MCPs also submitted the results of their time and distance analysis to IPRO.

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

Conclusions and Findings

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

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

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

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

For two indicators, namely the accuracy of provider directories, 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 2025

Network Adequacy Indicator	CCA One Care Validation Rating	Tufts One Care Validation Rating	UHC One Care Validation Rating
Primary Care Providers' GeoAccess	Low confidence	High confidence: Adult PCP in Essex and Middlesex Counties Moderate confidence: Adult PCP in Norfolk County and the remaining providers	Moderate confidence
Hospitals and Rehabilitation Hospital Services GeoAccess	Moderate confidence: Rehabilitation Hospital Services Low confidence: Acute Inpatient Hospital Services	High confidence: Acute Inpatient Hospital Services in Large Metro Counties and Rehabilitation Hospital Services in all counties Moderate confidence: Acute Inpatient Hospital Services in Metro Counties	High confidence: Acute Inpatient Hospital Services Moderate confidence: Rehabilitation Hospital Services
Specialists GeoAccess	Moderate confidence: Large Metro Low confidence: Metro Counties	High confidence: Large Metro Counties Moderate confidence: the majority Low confidence: Cardiology in Metro Counties	High confidence: Cardiothoracic Surgery, Chiropractor, Clinical Psychology, Clinical Social Work, Dermatology, ENT, Gastroenterology, General Surgery, Ob/Gyn, Infectious Diseases, Neurology, Oncology, Physiatry, Plastic Surgery, Podiatry, Psychiatry, Pulmonology, Rheumatology, Vascular Surgery Moderate confidence: many in Large Metro Counties Low confidence: Allergy, Cardiology, Endocrinology, Nephrology, Ophthalmology, Orthopedic Surgery

Network Adequacy Indicator	CCA One Care Validation Rating	Tufts One Care Validation Rating	UHC One Care Validation Rating
Outpatient and Diversionary Behavioral Health Services GeoAccess	Low confidence	High confidence: the majority of Behavioral Health Diversionary Services Moderate confidence: Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) Moderate confidence: Behavioral Health Outpatient	Moderate confidence: Behavioral Health Diversionary Services Low confidence: Recovery Coaching and Structural Outpatient Addiction Program Low confidence: Behavioral Health Outpatient
Pharmacy GeoAccess	Moderate confidence	High confidence	High confidence
LTSS Providers GeoAccess	Moderate confidence: Nursing Facility, Group Adult Foster Care, and Adult Day Health and Day Habilitation Low confidence: the remaining provider types	High confidence: Large Metro Counties, with a few exceptions Moderate confidence: Large Metro Counties when the comparison did not yield close results Low confidence: Physical Therapy in Metro Counties	High confidence Moderate confidence: Physical Therapy, Speech Therapy, Adult Day Health, and Group Adult Foster Care
Dental Services GeoAccess ¹	Low confidence	High confidence Moderate confidence: General Dentists	Moderate confidence
Accuracy of Directories ^{2,3}	Moderate confidence	Moderate confidence	Moderate confidence

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; 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 ISCA is conducted to confirm that the One Care Plans' 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.
- IPRO assessed the reliability and validity of MCP network adequacy data. IPRO determined that the data used by the MCPs to monitor network adequacy were mostly accurate and current, except for duplicative provider records, incorrect provider directory information, and different membership counts compared to the MassHealth membership count for the same period. These findings were shared with the MCPs via email.
- IPRO reviewed the MCPs 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 MCPs' data systems that might affect the accuracy or completeness of network adequacy monitoring data (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs). No significant system changes were identified.

Provider Directory

IPRO validated the accuracy of provider directories for a sample of provider types chosen by MassHealth.

Table 33, Table 35, and Table 37 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	Tufts One Care	UHC One Care
% providers with correct information ¹	14.97% (28)	18.23% (33)	11.60% (21)
% providers for whom health plan info could not be confirmed ²	17.11% (32)	22.65% (41)	25.97% (47)
Total providers called	187	181	181

¹ Providers with correct information = provider is at the site; address is correct; phone number is correct; provider is accepting new patients; provider is a primary care provider; provider is participating in this health plan.

² Providers for whom health plan info could not be confirmed = the staff member did not know whether the provider accepts this health plan or not.

Note: The sample is representative of the population with a 95% confidence interval and +/- 7% margin of error.

PCP: primary care provider.

Table 34 shows the most frequent reasons why information in the PCP directories was incorrect or could not be validated.

Table 34: Directory Inaccuracy/Provider Verification Challenges – PCPs

Directory Inaccuracy Reasons	CCA One Care	Tufts One Care	UHC One Care	Total Inaccuracies Across Plans
Provider is NOT accepting new patients	49	41	62	152
Contact Fails ¹	47	52	36	135
Provider is not at site ²	27	23	23	73
Provider is NOT participating in this health plan	23	17	25	65
Provider is NOT a primary care provider	8	4	27	39

Directory Inaccuracy Reasons	CCA One Care	Tufts One Care	UHC One Care	Total Inaccuracies Across Plans
Address is NOT correct	14	6	11	31
Telephone number is NOT correct	12	6	6	24
Total Inaccuracies per Plan	180	149	190	519

¹ Contact fails = phone number is not in service; wrong telephone number; the call was disconnected before contact was made; constant busy signal; no answer; put on hold for more than 5 minutes; automated answering machine; answering service.

² Provider is not at the site = provider is retired; provider is no longer at the site; and provider was never part of the group.
PCP: primary care provider.

Table 35 shows the percentage of ob/gyn providers with accurate provider directory information.

Table 35: Provider Directory Accuracy – Obstetrics/Gynecology

Provider Directory Accuracy	CCA One Care	Tufts One Care	UHC One Care
% providers with correct information ¹	19.28% (32)	27.81% (42)	29.46% (38)
% providers for whom health plan info could not be confirmed ²	7.23% (12)	14.57% (22)	4.65% (6)
Total providers called	166	151	129

¹ Providers with correct information = Provider is at the site; address is correct; phone number is correct; telephone number is correct; provider is accepting new patients; provider is an obstetrician/gynecologist; provider is participating in this health plan.

² Providers for whom health plan info couldn't be confirmed = the staff member did not know whether the provider accepts this health plan or not.

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

Table 36 shows the most frequent reasons why information in the obstetrics/gynecology directories was incorrect or could not be validated.

Table 36: Directory Inaccuracy/Provider Verification Challenges – Obstetrics/Gynecology

Directory Inaccuracy Reasons	CCA One Care	Tufts One Care	UHC One Care	Total Inaccuracies Across Plans
Contact Fails	56	43	42	141
Provider is not at site	37	9	15	61
Provider is NOT accepting new patients	21	24	9	54
Provider is NOT participating in this health plan	14	18	13	45
Provider is NOT an ob/gyn	9	12	5	26
Address is NOT correct	8	7	7	22
Telephone number is NOT correct	9	9	4	22
Total Inaccuracies per Plan	154	122	95	371

¹ Contact fails = phone number is not in service; wrong telephone number; the call was disconnected before contact was made; constant busy signal; no answer; put on hold for more than 5 minutes; automated answering machine; answering service.

² Provider is not at the site = provider is retired; provider is no longer at the site; and provider was never part of the group.

Table 37 shows the percentage of Community Mental Health Centers with accurate online directory information. The percentage of CMHCs with correct information means the percentage of CMHCs for which all of the following is correct: the CMHC offers outpatient therapy; the address is correct; the phone number is correct; the CMHC is accepting new patients; and the CMHC is accepting this health plan. The percentage of CMHCs for whom health plan info could not be confirmed means that the staff member did not know whether the provider accepts this health plan or not.

Table 37: Provider Directory Accuracy – Community Mental Health Centers (CMHCs)

CMHC Directory Accuracy	CCA One Care	Tufts One Care	UHC One Care
% CMHCs with correct information	28.40% (23)	22.22% (12)	0.00% (0)
% CMHCs for whom health plan info could not be confirmed	7.41% (6)	12.96% (7)	0.00% (0)
Total CMHCs called	81	54	2

Table 38 shows the most common reasons for inaccuracies or unverified information regarding Community Mental Health Centers in the directories. The “contact fails” category includes several circumstances: the phone number was not in service; the telephone number was wrong; the call was disconnected before a contact was made; callers encountered a constant busy signal; no answer; callers were placed on hold for more than five minutes; there was an automated answering machine; or the caller was redirected to an answering service. Callers made up to three attempts to reach a live staff person at each practice to complete the survey. If a phone number was not in service, wrong, disconnected, or resulted in a constant busy signal, an additional call was made to verify the outcome. The phrase “CMHC does not offer outpatient services” indicates that the CMHC provides only group services; program-specific services (e.g., intensive outpatient program, partial hospitalization, addiction recovery groups, crisis stabilization); has insufficient clinical staffing (no licensed therapists or open vacancies); or offers other types of services (e.g., residential treatment).

Table 38: Directory Inaccuracy/Provider Verification Challenges – Community Mental Health Centers (CMHCs)

Directory Inaccuracy Reasons	CCA One Care	Tufts One Care	UHC One Care	Total Inaccuracies Across Plans
Contact Fails	19	22	0	41
CMHC does not offer outpatient services	17	7	1	25
Address is NOT correct	12	7	0	19
Telephone number is NOT correct	7	2	0	9
CMHC does NOT accept this health plan	5	2	0	7
CMHC is NOT accepting new patients	1	4	1	6
Total Inaccuracies per Plan	61	44	2	107

Wait Time for Appointment

The results of the wait time for appointment survey are listed below. **Tables 39–40** show the wait time for appointment results for PCPs.

Table 39: Average Appointment Wait Time – PCPs

MassHealth Routine Wait Time Standards ¹	CCA One Care	Tufts One Care	UHC One Care	One Care Average
Average calendar days to routine appointment (min, max)	85.9 (1, 293)	73.9 (0, 373)	75.1 (2, 334)	78.4 (0, 373)
% providers meeting 30-day standard	24.4% (10)	36.2% (17)	41.4% (12)	33.3 (39)
Providers with routine appointment date (N)	41	47	29	117
Providers reached	140	129	145	414

¹ Range (min, max) indicates the span between the shortest wait time recorded and the longest wait time recorded in calendar days. N = total providers reached, which is calculated as the number of providers for whom contact was made and an appointment date was collected.

PCP: primary care provider.

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

Reasons Routine Appointment Date Was Not Collected	CCA One Care	Tufts One Care	UHC One Care	Total Across Plans
Provider is not accepting new patients.	22	17	27	66
Patients are placed on a waiting list.	8	10	11	29
Other	4	7	7	18
Patient must be registered with the clinic first	8	3	2	13
Patient's ID or personal info must be presented first	2	1	0	3
Staff member refused to participate	1	0	1	2
Medical records must be submitted first	0	0	0	0
Staff member requested a callback	0	0	0	0
Total	45	38	48	131

¹Other refers to situations where appointment access is limited due to non-standard practice models, restricted care settings or populations, provider availability constraints. For example, the provider only delivers care to patients living in nursing homes or assisted living facilities. PCP: primary care provider.

Tables 41–42 show the wait time for appointment results for obstetrics/gynecology.

Table 41: Average Appointment Wait Time – Obstetrics/Gynecology

MassHealth Routine Wait Time Standards ¹	CCA One Care	Tufts OneCare	UHC One Care	One Care Average
Average calendar days to routine appointment (min, max)	74.7 (1, 220)	63.7 (1, 208)	61.0 (2, 196)	66.36 (1, 220)
% providers meeting 30-day standard	29.4% (10)	33.3% (13)	29.4% (10)	30.8% (33)
Providers with routine appointment date (N)	34	39	34	107
Providers reached	110	108	87	305

¹ Range (min, max) indicates the span between the shortest wait time recorded and the longest wait time recorded in calendar days. N = total providers reached, which is calculated as the number of providers for whom contact was made and an appointment date was collected.

Table 42: Reasons Not Able to Get an Appointment Date – Obstetrics/Gynecology

Reasons Routine Appointment Date Was Not Collected	CCA One Care	Tufts One Care	UHC One Care	Total Across Plans
Patient must be registered with the clinic first	8	14	8	30
Patient's ID or personal info must be presented first	1	10	1	12
Patients are placed on a waiting list	4	0	7	11
Provider is not accepting new patients	3	4	3	10
Other ¹	2	1	1	4
Medical records must be submitted first	0	1	1	2
Staff member refused to participate	0	0	2	2
Staff member requested a callback	0	1	0	1

¹ Other refers to situations where appointment scheduling was contingent on a required referral and could not proceed until that referral was obtained, regardless of provider availability. For example, the office confirmed that a primary care referral is required before and appointment can be booked, and no appointment information could be provided without referral.

For the Community Mental Health Centers that shared the appointment date, the average wait time for appointment was 8 calendar days, ranging from the same day appointment to a 66 calendar day waiting period. 84% of contacted CMHCs, who shared an appointment date, met the MassHealth appointment wait time standard of 14 calendar days. **Tables 43–44** show the wait time for appointment results for Community Mental Health Centers.

Table 43: Average Appointment Wait Time – Community Mental Health Centers (CMHCs)

MassHealth Behavioral Health Wait Time Standards ¹	CCA One Care	Tufts One Care	UHC One Care	One Care Average
Average calendar days to appointment (min, max)	8.4 (0, 66)	5.8 (0, 14)	0 (0, 0)	8 (0, 66)
% CMHC meeting 14-day standard	81.0% (17)	100.0% (4)	0% (0)	84% (21)
CMHC with appointment date (N)	21	4	0	25
CMHC reached	62	32	2	96

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

Appointment availability information was repeatedly withheld unless the patient’s eligibility could be verified and met, preventing IPRO from assessing wait time but also restricting patients’ access. A patient deciding where to seek care should be able to assess how long the wait is without needing to register with the center and without an administrative intake appointment. The barriers include requiring eligibility verification before discussing schedules, requiring patient registration to disclose availability, and refusing to share the next appointment date without an insurance ID, etc. **Table 44** shows the most frequent reasons why appointment dates were not collected.

Table 44: Reasons Not Able to Get an Appointment Date – Community Mental Health Centers (CMHCs)

Reasons Appointment Date Was Not Collected	CCA One Care	Tufts One Care	UHC One Care	Total Across Plans
Patients are placed on a waiting list	10	7	0	17
Other ¹	2	7	0	9
Patient must be registered with the clinic first	3	2	0	5
Administrative intake must be conducted first	3	1	0	4
CMHC is not accepting new patients.	0	1	1	2
Patient's ID or personal info must be presented first	0	2	0	2
Staff member requested a callback	1	0	0	1
Medical records must be submitted first	0	0	0	0
Staff member refused to participate	0	0	0	0
Total	19	20	1	40

¹ Other refers to situation where appointment access was unavailable due to intake workflows, referral submission processes, misdirected contact paths, limited staff availability, or service-eligibility restrictions rather than standard scheduling. For example, the caller was transferred from the front desk to the intake coordinator to obtain appointment date, but the call went directly to voicemail and no appointment information could be provided.

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 45**.

Table 45: 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 46–53 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 46: Service Areas with Adequate Network of Primary Care Providers

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

PCP: primary care provider.

Table 47: Service Areas with Adequate Network of Specialist Providers

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
Allergy and Immunology	Large Metro	1 provider within 15 miles and 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Allergy and Immunology	Metro	1 provider within 35 miles and 53 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Cardiology	Large Metro	1 provider within 10 miles and 20 minutes	4 out of 4 (Met)	4 out of 4 (Met)	3 out of 4 (Partially Met)
Cardiology	Metro	1 provider within 25 miles and 38 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Cardiothoracic Surgery	Large Metro	1 provider within 15 miles and 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Cardiothoracic Surgery	Metro	1 provider within 40 miles and 60 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Chiropractor	Large Metro	1 provider within 15 miles and 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Chiropractor	Metro	1 provider within 30 miles and 45 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Clinical Psychology	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)
Clinical Psychology	Metro	1 provider within 30 miles and 45 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Clinical Social Work	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)
Clinical Social Work	Metro	1 provider within 20 miles and 30 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Dermatology	Large Metro	1 provider within 10 miles and 20 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Dermatology	Metro	1 provider within 30 miles and 45 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Endocrinology	Large Metro	1 provider within 15 miles and 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Endocrinology	Metro	1 provider within 50 miles and 75 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
ENT/Otolaryngology	Large Metro	1 provider within 15 miles and 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
ENT/Otolaryngology	Metro	1 provider within 30 miles and 45 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Gastroenterology	Large Metro	1 provider within 10 miles and 20 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Gastroenterology	Metro	1 provider within 30 miles and 45 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
General Surgery*	Large Metro	1 provider within 10 miles and 20 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
General Surgery*	Metro	1 provider within 20 miles and 30 minutes	8 out of 8 (Met)	4 out of 4 (Met)	5 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	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Infectious Diseases	Large Metro	1 provider within 15 miles and 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Infectious Diseases	Metro	1 provider within 50 miles and 75 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)

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

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

*For members in Berkshire County, 1 provider within 22 miles and 30 minutes.

**For members in Essex County, 1 provider within 13 miles and 20 minutes.

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

Table 48: Service Areas with Adequate Network of Hospitals and Emergency Support Services

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
Acute Inpatient Hospital	Large Metro	2 providers within 10 miles and 20 minutes	3 out of 4 (Partially Met)	2 out of 4 (Partially Met)	2 out of 4 (Partially Met)
Acute Inpatient Hospital	Metro	2 providers within 30 miles and 45 minutes	8 out of 8 (Met)	3 out of 4 (Partially 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)

Table 49: One Care Plans with Adequate Network of LTSS 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
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	7 out of 8 (Partially 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)	3 out of 4 (Partially Met)	3 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)
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)	2 out of 4 (Partially Met)	3 out of 4 (Partially 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
Speech Therapy	Metro	2 providers within 25 miles and 40 minutes	8 out of 8 (Met)	3 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	8 out of 8 (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)	6 out of 6 (Met)
Day Services	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Day Services	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)
Group Adult Foster Care	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Group Adult Foster Care	Metro	2 providers within 15 miles or 30 minutes	5 out of 8 (Partially Met)	3 out of 4 (Partially Met)	6 out of 6 (Met)
Hospice	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	2 out of 4 (Partially Met)	0 out of 4 (Not Met)
Hospice	Metro	2 providers within 15 miles or 30 minutes	8 out of 8 (Met)	3 out of 4 (Partially Met)	0 out of 6 (Not Met)

¹ 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 50: Number of Counties with an Adequate Network of Pharmacies

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
Pharmacy	Large Metro	1 provider within 2 miles	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Pharmacy	Metro	1 provider within 5 miles	7 out of 8 (Partially Met)	4 out of 4 (Met)	5 out of 6 (Partially Met)

Table 51: Number of Counties with an Adequate Network of Behavioral Health Outpatient

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

Table 52: Number of Counties with an Adequate Network of Behavioral Health Diversionary Services

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
Clinical Stabilization Services for Substance Use Disorders (ASAM 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 Stabilization Services for Substance Use Disorders (ASAM 3.5)	Metro	2 providers within 15 miles or 30 minutes	8 out of 8 (Met)	1 out of 4 (Partially Met)	1 out of 6 (Partially Met)
Adult Community Crisis Stabilization (ACCS)	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 Community Crisis Stabilization (ACCS)	Metro	2 providers within 15 miles or 30 minutes	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Adult Mobile Crisis Intervention (AMCI)	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Adult Mobile Crisis Intervention (AMCI)	Metro	2 providers within 15 miles or 30 minutes	8 out of 8 (Met)	4 out of 4 (Met)	5 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	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)
Medically Monitored Intensive Services – Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	3 out of 4 (Partially Met)
Medically Monitored Intensive Services – Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Metro	2 providers within 15 miles or 30 minutes	8 out of 8 (Met)	1 out of 4 (Partially Met)	2 out of 6 (Partially Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA One Care	Tufts One Care	UHC One Care
Partial Hospitalization Program (PHP)	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	3 out of 4 (Partially Met)
Partial Hospitalization Program (PHP)	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)
Program of Assertive Community Treatment	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	2 out of 4 (Partially Met)	4 out of 4 (Met)
Program of Assertive Community Treatment	Metro	2 providers within 15 miles or 30 minutes	7 out of 8 (Partially Met)	1 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)	2 out of 4 (Partially Met)	4 out of 4 (Met)
Psychiatric Day Treatment	Metro	2 providers within 15 miles or 30 minutes	7 out of 8 (Partially Met)	1 out of 4 (Partially Met)	6 out of 6 (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 (RSN)	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 (RSN)	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)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	Metro	2 providers within 15 miles or 30 minutes	8 out of 8 (Met)	3 out of 4 (Partially Met)	6 out of 6 (Met)
Structured Outpatient Addiction Program	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	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)

Table 53: Number of Counties with an Adequate Network of Dental Services

Provider Type	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)	0 out of 4 (Not 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	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Orthodontist	Metro	1 provider within 30 minutes	8 out of 8 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Oral Surgeon	Metro	1 provider within 30 minutes	6 out of 8 (Partially Met)	4 out of 4 (Met)	3 out of 6 (Partially Met)

CCA One Care

More information about CCA One Care network adequacy validation rating is provided in **Table 54**.

Table 54: CCA One Care Network Adequacy Validation Ratings – CY 2025

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating CCA One Care	Comments
Primary Care Providers' GeoAccess	<ul style="list-style-type: none"> • 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. <p><i>Note:</i> Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <ul style="list-style-type: none"> • Apply CMS standards of the minimum number of PCP providers in each county. 	Addressed	Low confidence	<p>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.</p> <p>IPRO's analysis of the network revealed that the GeoAccess standard was met in all counties.</p>
Hospitals and Rehabilitation Hospital Services GeoAccess	<p>Acute Inpatient Hospitals:</p> <ul style="list-style-type: none"> • 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. <p>Hospital Rehabilitation Services:</p> <p>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.</p>	Addressed	<p>Moderate confidence: Rehabilitation Hospital Services</p> <p>Low confidence: Acute Inpatient Hospital Services</p>	<p>Moderate confidence for Rehabilitation Hospital Services: 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.</p> <p>Low confidence for Acute Inpatient Hospital 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 analysis. The MCP's results were not comparable for further analysis.</p> <p>IPRO's analysis revealed gaps in the Acute Hospital Services network in Essex County and in the Rehabilitation Hospital Services Network in Franklin and Worcester counties. Other than that, the standards were met in all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating CCA One Care	Comments
Specialists GeoAccess	<ul style="list-style-type: none"> • 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	<p>Moderate confidence: Large Metro</p> <p>Low confidence: Metro Counties</p>	<p>Moderate confidence in Large Metro Counties: No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards for analysis; however, the MCP’s provider data had duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>Low confidence in Metro Counties: 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.</p> <p>IPRO’s analysis of the network revealed that the GeoAccess standard was met in all counties.</p>
Outpatient and Diversionary Behavioral Health Services GeoAccess	<ul style="list-style-type: none"> • 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	<p>Low confidence for Behavioral Health Diversionary 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 analysis. The MCP’s results were not comparable for further analysis.</p> <p>IPRO’s analysis revealed gaps in the PHP network in Berkshire County, the Program of Assertive Community Treatment also in Berkshire County, and Psychiatric Day Treatment in Barnstable County, as well as gaps in the ASAM Level 3.1 network in seven counties.</p> <p>Low confidence for Behavioral Health Outpatient: 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.</p> <p>IPRO’s analysis of the network revealed that the GeoAccess standard was met in all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating CCA One Care	Comments
Pharmacy GeoAccess	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>IPRO’s analysis revealed gaps in the pharmacy network in Franklin County only.</p>
LTSS Providers GeoAccess	<ul style="list-style-type: none"> • 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. <p>Note: Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <ul style="list-style-type: none"> • 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	<p>Moderate confidence: Nursing Facility, Group Adult Foster Care, and Adult Day Health and Day Habilitation</p> <p>Low confidence: remaining provider types</p>	<p>Moderate confidence for Nursing Facility and Group Adult Foster Care: 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.</p> <p>Moderate confidence for Adult Day Health and Day Habilitation: No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards for analysis; however, the MCP’s provider data had duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>Low confidence for the remaining 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 analysis. The MCP’s results were not comparable for further analysis.</p> <p>IPRO’s analysis revealed gaps in the Nursing Facility network in Barnstable County, in the Adult Day Health Network in Barnstable and Berkshire counties, in the Day Services network in Berkshire County, and in the Group Adult Foster Care network in Berkshire, Franklin, and Worcester counties. Other than that, the standards were met in all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating CCA One Care	Comments
Dental Services GeoAccess	<ul style="list-style-type: none"> • 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 	Addressed	Low confidence	<p>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.</p> <p>I PRO’s analysis revealed gaps in the General Dentists network in Large Metro and Metro counties, as well as in the oral surgeons’ network in metro counties.</p>
Accuracy of Directories ²	<ul style="list-style-type: none"> • Percent of providers in the directory with correct information 	Missing ³	Moderate confidence	I PRO’s analysis showed that the information in the PCP, Ob/Gyn, and CMHC providers directories is not entirely accurate.

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

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

³ 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.

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 55–59** show counties with deficient networks for CCA One Care. IPRO also determined that 14 providers had deactivated national provider identifiers, while one provider had more than 25 different locations listed per provider.

Table 55: CCA One Care Counties with Network Deficiencies of Hospitals

Provider Type	County with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Acute Inpatient Hospital Services	Essex	88.3%	2 providers within 10 miles and 20 minutes
Rehabilitation Hospital Services	Franklin	8.4%	1 provider within 15 miles or 30 minutes
Rehabilitation Hospital Services	Worcester	79.7%	1 provider within 15 miles or 30 minutes

Table 56: 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
Nursing Facility	Barnstable	83.8%	2 providers within 20 miles and 35 minutes
Adult Day Health	Barnstable	35.4%	2 providers within 15 miles or 30 minutes
Adult Day Health	Berkshire	6.7%	2 providers within 15 miles or 30 minutes
Day Services	Berkshire	0.8%	2 providers within 15 miles or 30 minutes
Group Adult Foster Care	Berkshire	1.0%	2 providers within 15 miles or 30 minutes
Group Adult Foster Care	Franklin	8.8%	2 providers within 15 miles or 30 minutes
Group Adult Foster Care	Worcester	87.4%	2 providers within 15 miles or 30 minutes

LTSS: long-term services and supports.

Table 57: 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	Franklin	83.9%	1 provider within 5 miles

Table 58: 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
Partial Hospitalization Program (PHP)	Berkshire	11.6%	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	56.2%	2 providers within 15 miles or 30 minutes

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Transitional Support Services (TSS) for Substance Use Disorders (ASAM Level 3.1)	Barnstable	0.0%	2 providers within 15 miles or 30 minutes
TSS	Bristol	11.7%	2 providers within 15 miles or 30 minutes
TSS	Franklin	9.9%	2 providers within 15 miles or 30 minutes
TSS	Hampden	0.7%	2 providers within 15 miles or 30 minutes
TSS	Hampshire	11.2%	2 providers within 15 miles or 30 minutes
TSS	Plymouth	80.2%	2 providers within 15 miles or 30 minutes
TSS	Worcester	80.3%	2 providers within 15 miles or 30 minutes

Table 59: 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	62.2%	2 providers within 10 minutes
General Dentists	Berkshire	57.9%	2 providers within 10 minutes
General Dentists	Bristol	89.7%	2 providers within 10 minutes
General Dentists	Essex	78.1%	2 providers within 10 minutes
General Dentists	Franklin	68.2%	2 providers within 10 minutes
General Dentists	Hampden	56.6%	2 providers within 10 minutes
General Dentists	Hampshire	54.0%	2 providers within 10 minutes
General Dentists	Middlesex	94.9%	2 providers within 10 minutes
General Dentists	Norfolk	91.9%	2 providers within 10 minutes
General Dentists	Plymouth	85.1%	2 providers within 10 minutes
General Dentists	Suffolk	93.5%	2 providers within 10 minutes
General Dentists	Worcester	54.0%	2 providers within 10 minutes
Oral Surgeon	Barnstable	93.5%	1 provider within 30 minutes
Oral Surgeon	Plymouth	94.3%	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 60**.

Table 60: Tufts One Care Network Adequacy Validation Ratings – CY 2025

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating Tufts One Care	Comments
Primary Care Providers' GeoAccess	<ul style="list-style-type: none"> • 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. <p><i>Note:</i> Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <ul style="list-style-type: none"> • Apply CMS standards of the minimum number of PCP providers in each county. 	Addressed	<p>High confidence: Adult PCP in Essex and Middlesex Counties</p> <p>Moderate confidence: Adult PCP in Norfolk County and the remaining providers</p>	<p>High confidence for Adult PCP in Essex and Middlesex 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.</p> <p>Moderate confidence for Adult PCP in Norfolk County: No issues were found with the underlying information systems, provider data had no duplicative records, and MassHealth standards were applied correctly; however, the comparison did not yield the same results.</p> <p>Moderate confidence for the remaining provider types: 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.</p> <p>IPRO’s analysis of the network revealed that the GeoAccess standard was met in all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating Tufts One Care	Comments
Hospitals and Rehabilitation Hospital Services GeoAccess	<ul style="list-style-type: none"> • 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. <p>Hospital Rehabilitation Services: 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.</p>	Addressed	<p>High confidence: Acute Inpatient Hospital Services in Large Metro Counties and Rehabilitation Hospital Services in all counties</p> <p>Moderate confidence: Acute Inpatient Hospital Services in Metro Counties</p>	<p>High confidence for Acute Inpatient Hospital Services in Large Metro Counties and Rehabilitation Hospital Services in all 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.</p> <p>Moderate confidence for Acute Inpatient Hospital Services in Metro Counties: 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.</p> <p>I PRO’s analysis of the network revealed gaps in the acute inpatient hospital network and rehabilitation hospital services network in metro counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating Tufts One Care	Comments
Specialists GeoAccess	<ul style="list-style-type: none"> • 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	<p>High confidence: Large Metro Counties</p> <p>Moderate confidence: the majority</p> <p>Low confidence: Cardiology in Metro Counties</p>	<p>High confidence in 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.</p> <p>Moderate confidence for the majority of provider types: No issues were found with the underlying information systems; however, the MCP either did not apply the correct MassHealth standards for analysis, or the provider data had duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>Low confidence for Cardiology in Metro Counties: 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.</p> <p>I PRO’s analysis of the network revealed that the GeoAccess standard was met in all counties, with the exception of gaps found in the Neurosurgery network in Essex County.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating Tufts One Care	Comments
Outpatient and Diversionary Behavioral Health Services GeoAccess	<ul style="list-style-type: none"> • 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	<p>High confidence: the majority of Behavioral Health Diversionary Services</p> <p>Moderate confidence: Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)</p> <p>Moderate confidence: Behavioral Health Outpatient</p>	<p>High confidence for the majority of 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.</p> <p>Moderate confidence for Residential Rehabilitation Services for Substance Use Disorders (Level 3.1): No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards for analysis; however, the MCP’s provider data had duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>Moderate confidence Behavioral Health Outpatient: No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards for analysis; however, the MCP’s provider data had duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>I PRO’s analysis revealed gaps in networks for nine Behavioral Health Diversionary Services provider types.</p> <p>I PRO’s analysis of the network revealed that the Behavioral Health Outpatient standards were met in all counties, except for ASAM, AMCI, ATS, Program of Assertive Community Treatment, RSN, RRS, and Structured Outpatient Addiction Program.</p>
Pharmacy GeoAccess	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>I PRO’s analysis revealed potential gaps in the pharmacy network in Essex County.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating Tufts One Care	Comments
LTSS Providers GeoAccess	<ul style="list-style-type: none"> • 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. <p>Note: Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <ul style="list-style-type: none"> • 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	<p>High confidence: Large Metro Counties, with a few exceptions</p> <p>Moderate confidence: Large Metro Counties when the comparison did not yield close results</p> <p>Low confidence: Physical Therapy in Metro Counties</p>	<p>High confidence in Large Metro Counties, with a few exceptions: 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.</p> <p>Moderate confidence in Large Metro Counties when the comparison did not yield close results: No issues were found with the underlying information systems, provider data had no duplicative records, and MassHealth standards were applied correctly; however, the comparison did not yield the same results for the Occupational Therapy in Essex County, Speech Therapy in Essex and Norfolk counties, and Hospice in Essex, Middlesex, and Worcester counties.</p> <p>Moderate confidence in the Majority of Metro Counties: 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.</p> <p>Low confidence for Physical Therapy in Metro Counties: 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.</p> <p>I PRO’s analysis revealed gaps for Essex County in the Occupational Therapy, Speech Therapy, Day Services, Group Adult Foster Care, and Hospice network, as well as for Worcester County in the Speech Therapy, Group Adult Foster Care, and Hospice network; gaps were also found in the Speech Therapy network in Norfolk and in Hospice in Middlesex County.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating Tufts One Care	Comments
Dental Services GeoAccess	<ul style="list-style-type: none"> • 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. 	Addressed	High confidence Moderate confidence: General Dentists	High confidence for the majority: 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. Moderate confidence for General Dentists: No issues were found with the underlying information systems, provider data had no duplicative records, MassHealth standards were applied correctly; however, the comparison did not yield the same results. IPRO's analysis revealed gaps in the General Dentists network.
Accuracy of Directories ²	<ul style="list-style-type: none"> • Percent of providers in the directory with correct information. 	Missing ³	Moderate confidence	IPRO's analysis showed that the information in the PCP, Ob/Gyn, and CMHC providers directories is not entirely accurate.

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

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

³ 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.

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 61–66** show counties with deficient networks. IPRO also determined that 27 providers had deactivated national provider identifiers, while 13 providers had more than 25 different locations listed per provider.

Table 61: 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	89.1%	1 provider within 15 miles and 30 minutes

Table 62: Tufts One Care Counties with Network Deficiencies of Hospitals

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Acute Inpatient Hospital Services	Barnstable	84.7%	2 providers within 30 miles and 45 minutes
Acute Inpatient Hospital Services	Essex	83.7%	2 providers within 10 miles and 20 minutes
Acute Inpatient Hospital Services	Norfolk	68.2%	2 providers within 10 miles and 20 minutes
Rehabilitation Hospital Services	Barnstable	10.3%	1 provider within 15 miles or 30 minutes
Rehabilitation Hospital Services	Worcester	69.5%	1 provider within 15 miles or 30 minutes

Table 63: 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	85.4%	2 providers within 10 miles and 20 minutes
Speech Therapy	Essex	64.3%	2 providers within 10 miles and 20 minutes
Speech Therapy	Norfolk	74.5%	2 providers within 10 miles and 20 minutes
Speech Therapy	Worcester	85.6%	2 providers within 25 miles and 40 minutes
Day Services	Essex	85.6%	2 providers within 15 miles or 30 minutes
Group Adult Foster Care	Essex	87.1%	2 providers within 15 miles or 30 minutes
Group Adult Foster Care	Worcester	73.0%	2 providers within 15 miles or 30 minutes
Hospice	Essex	29.0%	2 providers within 15 miles or 30 minutes
Hospice	Middlesex	58.7%	2 providers within 15 miles or 30 minutes
Hospice	Worcester	74.1%	2 providers within 15 miles or 30 minutes

LTSS: long-term services and supports.

Table 64: 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	89.8%	1 provider within 2 miles

Table 65: 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 Stabilization Services (CSS) for Substance Use Disorders (ASAM Level 3.5)	Barnstable	46.6%	2 providers within 15 miles or 30 minutes
CSS	Bristol	84.1%	2 providers within 15 miles or 30 minutes
CSS	Worcester	69.2%	2 providers within 15 miles or 30 minutes
Adult Mobile Crisis Intervention (AMCI)	Essex	88.6%	2 providers within 15 miles or 30 minutes
Medically Monitored Intensive Services – Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Barnstable	45.7%	2 providers within 15 miles or 30 minutes
ATS	Bristol	86.6%	2 providers within 15 miles or 30 minutes
ATS	Worcester	66.2%	2 providers within 15 miles or 30 minutes
Program of Assertive Community Treatment (PACT)	Barnstable	17.4%	2 providers within 15 miles or 30 minutes
PACT	Bristol	63.3%	2 providers within 15 miles or 30 minutes
PACT	Essex	84.6%	2 providers within 15 miles or 30 minutes
PACT	Norfolk	86.5%	2 providers within 15 miles or 30 minutes
PACT	Worcester	66.6%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Barnstable	14.9%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Bristol	35.5%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Essex	20.9%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Middlesex	39.1%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Worcester	58.4%	2 providers within 15 miles or 30 minutes
Recovery Support Navigators (RSN)	Barnstable	29.9%	2 providers within 15 miles or 30 minutes
Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)	Barnstable	12.2%	2 providers within 15 miles or 30 minutes
RRS	Essex	84.8%	2 providers within 15 miles or 30 minutes
Structured Outpatient Addiction Program	Bristol	52.6%	2 providers within 15 miles or 30 minutes
Transitional Support Services (TSS) for Substance Use Disorders (ASAM Level 3.1)	Barnstable	0.0%	2 providers within 15 miles or 30 minutes
TSS	Bristol	0.0%	2 providers within 15 miles or 30 minutes
TSS	Essex	18.7%	2 providers within 15 miles or 30 minutes
TSS	Middlesex	29.0%	2 providers within 15 miles or 30 minutes
TSS	Norfolk	5.2%	2 providers within 15 miles or 30 minutes
TSS	Plymouth	1.9%	2 providers within 15 miles or 30 minutes

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
TSS	Suffolk	31.7%	2 providers within 15 miles or 30 minutes
TSS	Worcester	0.2%	2 providers within 15 miles or 30 minutes

Table 66: 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	78.5%	2 providers within 10 minutes
General Dentists	Bristol	93.8%	2 providers within 10 minutes
General Dentists	Essex	67.8%	2 providers within 10 minutes
General Dentists	Middlesex	79.6%	2 providers within 10 minutes
General Dentists	Norfolk	49.1%	2 providers within 10 minutes
General Dentists	Plymouth	43.8%	2 providers within 10 minutes
General Dentists	Suffolk	86.4%	2 providers within 10 minutes
General Dentists	Worcester	57.6%	2 providers within 10 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 use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- Tufts OneCare should review GeoAccess results that differ from IPRO’s analysis to verify its methodology and determine causes of discrepancies.
- 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 67**.

Table 67: UHC One Care Network Adequacy Validation Ratings – CY 2025

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating UHC One Care	Comments
Primary Care Providers' GeoAccess	<ul style="list-style-type: none"> 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. <p><i>Note:</i> Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <ul style="list-style-type: none"> Apply CMS standards of the minimum number of PCP providers in each county. 	Addressed	Moderate confidence	<p>Moderate confidence: No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards for analysis; however, the MCP's provider data had duplicative records. The MCP's results were not comparable for further analysis.</p> <p>IPRO's analysis of the network revealed that the GeoAccess standards were met in most counties, except for Franklin County.</p>
Hospitals and Rehabilitation Hospital Service GeoAccess	<ul style="list-style-type: none"> 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. <p>Hospital Rehabilitation Services: 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.</p>	Addressed	<p>High confidence: Acute Inpatient Hospital Services</p> <p>Moderate confidence: Rehabilitation Hospital Services</p>	<p>High confidence for Acute Inpatient 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 very close results.</p> <p>Moderate confidence for Rehabilitation Hospital Services: 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.</p> <p>IPRO's analysis revealed gaps in the Acute Inpatient Hospital Services network in Middlesex and Norfolk counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating UHC One Care	Comments
Specialists GeoAccess	<ul style="list-style-type: none"> • 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	<p>High confidence: Cardiothoracic Surgery, Chiropractor, Clinical Psychology, Clinical Social Work, Dermatology, ENT, Gastroenterology, General Surgery, Ob/Gyn, Infectious Diseases, Neurology, Oncology, Physiatry, Plastic Surgery, Podiatry, Psychiatry, Pulmonology, Rheumatology, Vascular Surgery</p> <p>Moderate confidence: many in Large Metro Counties</p> <p>Low confidence: Allergy, Cardiology, Endocrinology, Nephrology, Ophthalmology, Orthopedic Surgery</p>	<p>High confidence for many provider types: 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.</p> <p>Moderate confidence for many provider types: No issues were found with the underlying information systems; however, the MCP did not apply the correct MassHealth standards for analysis, or the data had duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>Low confidence for some 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 analysis. The MCP’s results were not comparable for further analysis.</p> <p>I PRO’s analysis of the network revealed that the GeoAccess standards were met in most counties, except for gaps in the Cardiology network in Middlesex, the General Surgery network in Franklin, and the Oncology network in Middlesex.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating UHC One Care	Comments
Outpatient and Diversionary Behavioral Health Services GeoAccess	<ul style="list-style-type: none"> • 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	<p>Moderate confidence: Behavioral Health Diversionary Services</p> <p>Low confidence: Recovery Coaching and Structural Outpatient Addiction Program</p> <p>Low confidence: Behavioral Health Outpatient</p>	<p>For Behavioral Health Diversionary Services, moderate confidence for the majority: 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.</p> <p>Low confidence for Recovery Coaching and Structural Outpatient Addiction Program: 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.</p> <p>For Behavioral Health Outpatient, 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.</p> <p>I PRO’s analysis revealed gaps in the following networks: Clinical Stabilization Services for SUD, ATS for SUD, TSS for SUD, Adult Mobile Crisis Intervention, Partial Hospitalization Program, and Program of Assertive Community Treatment, while the Behavioral Health Outpatient standards were met in all counties.</p>
Pharmacy GeoAccess	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>I PRO’s analysis revealed gaps in the pharmacy network in Franklin County.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? ¹	Validation Rating UHC One Care	Comments
LTSS Providers GeoAccess	<ul style="list-style-type: none"> • BH Outpatient, Diversionary, and LTSS – State’s standards: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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	<p>High confidence</p> <p>Moderate confidence: Physical Therapy, Speech Therapy, Adult Day Health, and Group Adult Foster Care</p>	<p>High confidence for the majority: 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.</p> <p>Moderate confidence for Physical Therapy, Speech Therapy, Adult Day Health, and Group Adult Foster Care: No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards for analysis; however, the MCP’s provider data had duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>IPRO’s analysis revealed gaps in the Occupational and Speech Therapy networks in Middlesex, Adult Day Health and Adult Foster Care networks in Franklin, as well as in the Hospice network overall.</p>
Dental Services GeoAccess	<ul style="list-style-type: none"> • 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 	Addressed	Moderate confidence	<p>Moderate confidence: No issues were found with the underlying information systems, and the MCP consistently applied the correct MassHealth standards for analysis; however, the MCP’s provider data had duplicative records. The MCP’s results were not comparable for further analysis.</p> <p>IPRO’s analysis revealed gaps in the General Dentists network, as well as in the Orthodontist network in Franklin and Worcester counties.</p>
Accuracy of Directories ²	<ul style="list-style-type: none"> • Percent of providers in the directory with correct information 	Missing ³	Moderate confidence	<p>IPRO’s analysis showed that the information in the PCP, Ob/Gyn, and CMHC providers directories is not entirely accurate.</p>

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 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.

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 68–74** show counties with deficient networks. IPRO also determined that 47 providers had deactivated national provider identifiers, while one provider had more than 25 different locations listed per provider.

Table 68: UHC One Care Counties with Network Deficiencies of Primary Providers

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Adult PCP	Franklin	89.2%	2 providers within 10 miles and 15 minutes

Table 69: 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
Cardiology	Middlesex	79.2%	1 provider within 10 miles and 20 minutes
General Surgery	Franklin	83.1%	1 provider within 20 miles and 30 minutes
Oncology – Medical, Surgical	Middlesex	73.5%	1 provider within 10 miles and 20 minutes

Table 70: UHC One Care Counties with Network Deficiencies of Hospitals

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Acute Inpatient Hospital Services	Middlesex	82.6%	2 providers within 10 miles and 20 minutes
Acute Inpatient Hospital Services	Norfolk	69.5%	2 providers within 10 miles and 20 minutes

Table 71: 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	Middlesex	83.5%	2 providers within 10 miles and 20 minutes
Speech Therapy	Middlesex	83.0%	2 providers within 10 miles and 20 minutes
Adult Day Health	Franklin	41.5%	2 providers within 15 miles or 30 minutes
Adult Foster Care	Franklin	4.6%	2 providers within 15 miles or 30 minutes
Hospice	Bristol	34.3%	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	0.0%	2 providers within 15 miles or 30 minutes
Hospice	Norfolk	15.1%	2 providers within 15 miles or 30 minutes
Hospice	Plymouth	0.2%	2 providers within 15 miles or 30 minutes
Hospice	Suffolk	0.0%	2 providers within 15 miles or 30 minutes

Provider Type	Counties with Network Deficiencies	Percent of Members with Access in That Service Area	Standard – 90% of Members Have Access
Hospice	Worcester	0.0%	2 providers within 15 miles or 30 minutes

LTSS: long-term services and supports.

Table 72: 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	83.1%	1 provider within 5 miles

Table 73: 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 Stabilization Services (CSS) for Substance Use Disorders (ASAM Level 3.5)	Bristol	84.5%	2 providers within 15 miles or 30 minutes
CSS	Franklin	0.0%	2 providers within 15 miles or 30 minutes
CSS	Hampden	0.0%	2 providers within 15 miles or 30 minutes
CSS	Hampshire	69.4%	2 providers within 15 miles or 30 minutes
CSS	Worcester	67.9%	2 providers within 15 miles or 30 minutes
Adult Mobile Crisis Intervention (AMCI)	Worcester	63.3%	2 providers within 15 miles or 30 minutes
Medically Monitored Intensive Services – Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Bristol	85.2%	2 providers within 15 miles or 30 minutes
ATS	Franklin	0.0%	2 providers within 15 miles or 30 minutes
ATS	Hampshire	77.6%	2 providers within 15 miles or 30 minutes
ATS	Norfolk	89.9%	2 providers within 15 miles or 30 minutes
ATS	Worcester	67.9%	2 providers within 15 miles or 30 minutes
Partial Hospitalization Program (PHP)	Essex	88.2%	2 providers within 15 miles or 30 minutes
Program of Assertive Community Treatment	Franklin	53.8%	2 providers within 15 miles or 30 minutes
Transitional Support Services (TSS) for Substance Use Disorders (ASAM Level 3.1)	Franklin	0.0%	2 providers within 15 miles or 30 minutes
TSS	Hampden	0.0%	2 providers within 15 miles or 30 minutes
TSS	Hampshire	0.0%	2 providers within 15 miles or 30 minutes
TSS	Worcester	17.9%	2 providers within 15 miles or 30 minutes

Table 74: 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	47.2%	2 providers within 10 minutes
General Dentists	Essex	80.6%	2 providers within 10 minutes
General Dentists	Franklin	0.0%	2 providers within 10 minutes
General Dentists	Hampden	79.8%	2 providers within 10 minutes
General Dentists	Hampshire	16.3%	2 providers within 10 minutes
General Dentists	Middlesex	71.2%	2 providers within 10 minutes
General Dentists	Norfolk	61.2%	2 providers within 10 minutes
General Dentists	Plymouth	50.4%	2 providers within 10 minutes
General Dentists	Suffolk	88.7%	2 providers within 10 minutes
General Dentists	Worcester	48.5%	2 providers within 10 minutes
Oral Surgeon	Franklin	3.1%	1 provider within 30 minutes
Oral Surgeon	Plymouth	90.0%	1 provider within 30 minutes
Oral Surgeon	Worcester	82.1%	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 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 2025 MA-PD CAHPS survey was conducted in the first half of 2025 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.¹¹ The MassHealth One Care Plans used the 2025 MA-PD CAHPS standardized survey instrument. The MA-PD survey tool contains 66 questions, organized into seven sections, as explained in **Table 75**.

Table 75: MA-PD CAHPS Survey Sections

Section	Number of Questions
Introductory section	2 questions
Your Health Care in the Last 6 Months	7 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	20 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 2025, and who were not institutionalized. If identified during data collection, institutionalized Enrollees were excluded from the analysis. **Table 76** provides a summary of the technical methods of data collection by One Care Plans.

¹¹ [Medicare Advantage and Prescription Drug Plan CAHPS Survey](https://www.ma-pdcahps.org/). Also available at: <https://www.ma-pdcahps.org/>.

Table 76: Adult MA-PD CAHPS – Technical Methods of Data Collection by One Care Plan, 2025 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	2025 MA-PD CAHPS	2025 MA-PD CAHPS	2025 MA-PD CAHPS
Survey timeframe	February and June 2025	February and June 2025	February and June 2025
Method of collection	Mail, web, telephone	Mail, web, telephone	Mail, web, telephone
Response rate	19.9%	14.6%	15.8%

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

Table 77: MA-PD CAHPS Response Categories

Measures	Response Categories
<ul style="list-style-type: none"> • Rating of Health Plan • Rating of All Health Care Quality • Rating of Personal Doctor • Rating of Specialist • Rating of Prescription Drug Plan 	<ul style="list-style-type: none"> • 0 to 4 (Dissatisfied) • 5 to 7 (Neutral) • 9 or 10 (Satisfied)
<ul style="list-style-type: none"> • Getting Needed Care • Getting Appointments and Care Quickly • Doctors Who Communicate Well • Customer Service • Care Coordination • Getting Needed Prescription Drugs composite measures 	<ul style="list-style-type: none"> • Never (Dissatisfied) • Sometimes (Neutral) • Usually or Always (Satisfied)
<ul style="list-style-type: none"> • Annual Flu Vaccine individual item measure • Pneumonia Vaccine individual item measure 	<ul style="list-style-type: none"> • 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 Fee-for-Service 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 2025 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 Fee-for-Service 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 78**.

Table 78: Key for MA-PD CAHPS Performance Measure Comparison to the Medicare Advantage Fee-for-Service Mean Score

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

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

When compared to the Medicare Advantage Fee-for-service mean score, One Care Plans exceeded the goal benchmark for the following measures:

- Getting Appointments and Care Quickly (Composite): UHC One Care
- Customer Service (Composite): CCA One Care
- Annual Flu Vaccine: UHC One Care
- Rating of Health Care Quality: CCA One Care and Tufts One Care
- Rating of Health Plan: CCA One Care and Tufts One Care

When compared to the Medicare Advantage Fee-for-service mean score, One Care Plans scored below the Medicare Advantage national mean score for the following measures:

- Getting Needed Care: Tufts One Care
- Getting Appointments and Care Quickly: CCA One Care
- Care Coordination: CCA One Care and Tufts One Care
- Annual Flu Vaccine: CCA One Care and Tufts One Care

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

Table 79 displays the top-box scores of the 2025 MA-PD CAHPS survey.

Table 79: MA-PD CAHPS Performance – MassHealth One Care Plans, 2025 MA-PD CAHPS

CAHPS Measure	CCA One Care	Tufts One Care	UHC One Care	MassHealth Weighted Mean	Medicare Advantage Fee-for-service Mean Score
Getting Needed Care (Composite)	81 (= Goal)	78 (< Goal)	N/A	80 (< Goal)	81
Getting Appointments and Care Quickly (Composite)	81 (< Goal)	83 (= Goal)	88 (> Goal)	82 (< Goal)	83
Customer Service (Composite)	89 (> Goal)	87 (= Goal)	N/A	89 (> Goal)	87
Care Coordination (Composite)	85 (< Goal)	86 (< Goal)	N/A	85 (< Goal)	87
Getting Needed Prescription Drugs (Composite)	91	91	N/A	91	N/A
Annual Flu Vaccine	62 (< Goal)	55 (< Goal)	70 (> Goal)	62 (< Goal)	69
Rating of Prescription Drug Plan	92	88	88	91	N/A
Rating of Health Care Quality	88 (> Goal)	87 (> Goal)	N/A	88 (> Goal)	86
Rating of Health Plan	91 (> Goal)	86 (> Goal)	84 (= Goal)	89 (> Goal)	84
Pneumonia Vaccine	45	43	54	46	N/A

MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems; N/A: not applicable, the measure does not meet reporting criteria for sample size or reliability.

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 QI¹² made by the EQRO during the previous year’s EQR.” **Tables 80–82** 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 80 displays the One Care Plan’s progress related to the *One Care Plans External Quality Review CY 2024*, as well as IPRO’s assessment of Plan’s response.

Table 80: 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
<p>PMV: HEDIS Measures: The HEDIS rate for the following measure was below the 25th national Medicaid Quality Compass percentile:</p> <ul style="list-style-type: none"> Plan All-Cause Readmission (Observed/Expected Ratio; 18–64 years): 1.4255 <p>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.</p>	<p>CCA implemented quality improvement strategy to address underperformance in Plan All-Cause Readmissions and Hemoglobin A1c control, including root cause analyses, targeted provider and member interventions, and enhanced data collection. Early results show measurable improvements in both metrics.</p>	<p>Addressed</p>
<p>Network – Information Systems and Quality of Provider Data – Duplicates: 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.</p> <p>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..</p>	<p>CCA underwent an effort to clean up the duplication issue in how files were generated for the IPRO analysis to better replicate the process CCA uses directly with Quest. This was taken on mid-year 2025 and resulted in an almost 70% decrease in the number of duplicates year-over-year. As part of our continued monitoring, CCA is partnering with Quest to identify additional duplicate causes that can be remediated prior to next year’s report development for IPRO. Of note, when CCA analyzes network adequacy results internally, we are leveraging a similar deduplication methodology inside Quest that IPRO uses. In 2026 CCA will be converting our provider data systems over to CareSource’s (our new parent company) platforms. As part of this work there is an intensive project focused on provider data cleanup ahead of transferring into the new system, inclusive of back end data clean up as well as increased provider outreach across the network for updated information.</p>	<p>Addressed</p>

¹² Quality improvement.

Recommendation for CCA One Care	CCA One Care Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>Network – Time and Distance Analysis – MCP’s Methodology: 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.</p> <p>CCA One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</p>	<p>This issue persisted in 2025, however the root cause was identified as an issue of the manual translation of the requirements into the IPRO file submission. For future audits, this will be corrected and validated ahead of time with IPRO to ensure it is not repeated for 2026. For CCA’s internal monitoring, our Quest software is set up to measure against the correct MassHealth standards. This was an issue with the submission to IPRO that will be addressed going forward.</p>	<p>Addressed</p>
<p>Network – Time and Distance Analysis – Gaps in Provider Networks: 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.</p> <p>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.</p>	<p>CCA determined that some of the deficiencies listed were due to data errors in network adequacy reporting as well as possible true deficiencies. Between our data improvement efforts and more than 200 new provider contracts signed late 2024 into 2025, the number of deficiencies identified reduced dramatically. Outstanding deficiencies are routinely monitored for improvement opportunities and reviewed against member impact via review of Appeals and Grievance data and care manager feedback, as well as out-of-network requests and utilization. For the deficiencies listed, some will never be closed as there are no available providers, e.g. CCA has now contracted with every acute care hospital in our service area for One Care but still shows a deficiency in Essex County. For LTSS providers, these deficiencies often relate to service area coverage vs. provider address. CCA’s network team constantly monitors our network access and availability for these services in collaboration with the care management team and our ASAP and ILC partner organizations. We also routinely monitor the MassHealth approved provider list for these specialties to identify new providers to recruit to the network. As CCA continues to improve our data monitoring capabilities in converting to a new system, we expect accuracy of network adequacy analysis to improve and further enable our efforts.</p>	<p>Addressed</p>

Recommendation for CCA One Care	CCA One Care Response/Actions Taken	IPRO Assessment of MCP Response ¹
	<p>The provider contracting teams are continuing to build the network focusing on geographic and specialty areas where members and teams have reported access and availability challenges. Of the ~200 contracts signed in 2025, nearly 40% of those were behavioral health providers, which is the area most often reported as challenging to access care.</p>	
<p>Network – Accuracy of Provider Directory: 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.</p> <p>CCA One Care should design quality improvement interventions to enhance the accuracy of all three directories.</p>	<p>CCA secured a new Provider Data Management system with capabilities to automate CAQH provider data updates directly to our system. Implementation efforts launched in January 2025, however mid-year acquisition of CCA disrupted the new system implementation. Decision was made to integrate with the CareSource (acquiring entity) systems, which is ongoing through mid-year 2026. As an interim solution CCA has begun designing a manual data ingestion process to pull CAQH data updates into our Provider Data Management system, which feeds our provider directories. CCA made enhancements to our online provider directory to make it easier for members to identify when a provider is participating with CCA as a PCP. The enhancement was to add the “Type of Provider” field to indicate whether the provider is participating as a PCP, Specialist, or PCP/Specialist at each location. CCA also began including a reminder in our monthly Provider Newsletter to prompt providers to comply with their requirement to share regular data updates with CCA.</p>	Partially Addressed
<p>Quality-of-Care Surveys: CCA One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> • Getting Needed Care • Getting Appointments and Care Quickly • Care Coordination • Annual Flu Vaccine <p>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.</p>	<p>CCA contracts with Press Ganey to administer the survey and with Decision Point to improve member satisfaction. CCA One Care implemented a strategy to improve member satisfaction, including predictive analytics, targeted outreach campaigns, provider engagement, and contact center enhancements. For care coordination, CCA focused on empowering members, educating providers, and planning future scorecard to track performance. To increase flu vaccination rates, CCA launched culturally tailored communications, partnered with CVS for onsite clinics, and provided stratified data and educational materials to providers.</p>	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 81 displays the One Care Plan’s progress related to the *One Care Plans External Quality Review CY 2024*, as well as IPRO’s assessment of Plan’s response.

Table 81: 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
<p>PIPs: PIP 2 - IET: 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.</p>	<p>To meet PIP requirements and improve IET rates for the One Care population through targeted quality improvement activities, the MCP and CityBlock made necessary updates to intervention tracking measures in September 2025. Effectiveness will be monitored in alignment with MassHealth/EOHHS timelines, with the next remeasurement report including evaluation scheduled for July 2026 using MY2025 data.</p>	<p>Addressed</p>
<p>PMV: HEDIS Measures: HEDIS rates for the following measures were below the 25th national Medicaid Quality Compass percentile:</p> <ul style="list-style-type: none"> 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 <p>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.</p>	<p>To identify quality improvement interventions that can improve IET measure rate and any new possible interventions for PCR, the MCP and CityBlock plan to complete a root cause analysis for IET and PCR by December 2025. Effectiveness will continue to be monitored through monthly quality meetings with CityBlock including sharing results of root cause analysis and tracking any new interventions.</p>	<p>Partially Addressed</p>
<p>Network – Information Systems and Quality of Provider Data – Duplicates: 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.</p>	<p>The MCP has implemented enhanced quality control measures to identify and remove duplicate provider addresses prior to data submission. This includes the use of Excel de-duplication logic and conditional formatting to compare address data across multiple fields. The effectiveness of these measures is reflected in the reduced number of duplicate addresses identified in the 2025 audit.</p>	<p>Addressed</p>

Recommendation for Tufts One Care	Tufts One Care Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>Network – Information Systems and Quality of Provider Data - LTSS Providers: 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.</p>	<p>Tufts One Care has addressed this recommendation, as evidenced by the 2025 network adequacy validation activity and corresponding data submissions.</p>	<p>Addressed</p>
<p>Network – Time and Distance Analysis – MCP’s Methodology: 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.</p> <p>Tufts One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</p>	<p>In 2025, the MCP obtained and documented clarification of time and distance standards. Staff have been educated on PNA instructions, with updates incorporated into standard operating procedures. A quality review process has been implemented to ensure standards are met prior to submission. Re-education will be conducted.</p>	<p>Addressed</p>
<p>Network – Time and Distance Analysis – Gaps in Provider Networks: 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.</p>	<p>The MCP monitors its provider network quarterly against applicable standards. When licensed providers are available to address access gaps, the MCP initiates internal coordination to begin outreach. If no providers are available, recruitment is not feasible; in such cases, the MCP will leverage its care management resources to support members in accessing care across geographies.</p>	<p>Addressed</p>

Recommendation for Tufts One Care	Tufts One Care Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>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.</p>		
<p>Network – Provider Directory: 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.</p> <p>Tufts One Care should design quality improvement interventions to enhance the accuracy of all three directories.</p>	<p>The MCP monitors its provider network quarterly against applicable standards. When licensed providers are available to address access gaps, the MCP initiates internal coordination to begin outreach. If no providers are available, recruitment is not feasible; in such cases, the MCP will leverage its care management resources to support members in accessing care across geographies.</p>	<p>Remains an Opportunity for Improvement</p>
<p>Quality-of-Care Surveys: Many of the Tufts One Care measures did not meet reporting criteria for sample size or reliability.</p> <p>Tufts One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> Annual Flu Vaccine <p>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.</p>	<p>To maintain a strong survey response and improve all MA-PD CAHPS scores, the MCP has been utilizing MA-PD CAHPS survey results to inform and guide targeted member experience improvement initiatives. In 2025, the MCP implemented a new customer experience structure including a dedicated lead overseeing the experience measurement program. Improvements that were rolled out include oversampling One Care's MA-PD CAHPS survey by 100% increasing our response by 4.6% and execution of high-touch outbound campaigns aimed at removing barriers for members with gaps in care. Effectiveness is monitored through survey and claim analysis, grievance trend reviews and other performance data.</p>	<p>Partially Addressed</p>

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 82 displays the One Care Plan’s progress related to the *One Care Plans External Quality Review CY 2024*, as well as IPRO’s assessment of Plan’s response.

Table 82: 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
<p>PMV: HEDIS Measures: HEDIS rates for the following measures were below the 25th national Medicaid Quality Compass percentile:</p> <ul style="list-style-type: none"> 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 <p>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.</p>	<p>UnitedHealthcare One Care conducted root cause analyses and implemented targeted quality improvement interventions for all three underperforming HEDIS measures. These improvements were monitored through a structured Plan-Do-Study-Act cycle and regular data analysis, demonstrating both implementation and measurable improvement.</p>	<p>Addressed</p>
<p>Network – Information Systems and Quality of Provider Data – Duplicates: 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’s data prior to conducting any network analyses or submitting provider data for the EQR analysis.</p>	<p>Elements of this Policy and Procedure (P&P) include procedures for pulling appropriate data, de-duping data, and ensuring files transmitted have the most accurate information. UnitedHealthcare continues to follow our internal Policy and Procedure (P&P) and has seen significant improvement based on the Preliminary 2025 Network Adequacy Validation Report (NAV). UnitedHealthcare continues to ensure that our goals are aligned with meeting MassHealth requirements. Our internal review now includes a multi-layer quality assurance process and can produce information that is deduped. UnitedHealthcare will monitor by evaluating the data produced year over year in accordance with UnitedHealthcare’s Policies and Procedures. As noted above, UnitedHealthcare implemented process improvements based on CY2023 recommendations, which significantly reduced duplicate records identified by IPRO, and we are continually refining our policies and procedures to maintain provider record integrity.</p>	<p>Addressed</p>
<p>Network – Time and Distance Analysis – MCPs Methodology: UHC One Care used the correct MassHealth standards for many provider types, specifically for</p>	<p>UnitedHealthcare applied the appropriate standards, as listed in the 2024 IPRO Technical Manual. It is UnitedHealthcare’s belief that IPRO may have taken our Minimum Servicing Providers column and applied that</p>	<p>Addressed</p>

Recommendation for UHC One Care	UHC One Care Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>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.</p>	<p>to the number of providers required for the time and distance standard specified for the provider types listed above. The data in the Minimum Servicing Providers column does not represent the time and distance standard but illustrates the results of applying the time and distance standard to the CMS ratio. UnitedHealthcare will continue to follow the standards established within IPRO’s technical manual. UnitedHealthcare continues to ensure that our goals are aligned with meeting MassHealth requirements. UnitedHealthcare’s Policy and Procedure (P&P) includes language that addresses procedures to ensure that the appropriate time and distance standards as outlined in IPRO’s technical manual.</p>	
<p>Network – Time and Distance Analysis – Gaps in Provider Networks: 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.</p> <p>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</p>	<p>UnitedHealthcare recognizes the pharmacy gap in Franklin County for rural members. There are now 12 pharmacies in the county, and all are currently part of our network. UnitedHealthcare monitors its pharmacy network to add new pharmacies as they open. UnitedHealthcare has initiated a multi-pronged strategy to address network adequacy deficiencies across Orthotics and Prosthetics, Occupational Therapy, and Speech Therapy services in Essex, Franklin, Middlesex, Norfolk, Plymouth, and Worcester counties. Key actions include aligning network participation across Senior Care Options (SCO) and One Care to ensure congruency, actively recruiting non-participating providers to close identified gaps, and leveraging commercial provider relationships to expand One Care participation. UnitedHealthcare has taken targeted steps to address network adequacy deficiencies across the HCBS provider Types, Hospice, Psychiatric Day Treatment, and Partial Hospitalization Programs. For Clinical Support Services for Substance Use Disorders (Level 3.5), no providers currently exist per the State Licensing Program and Bed Report. UnitedHealthcare is documenting efforts and has shared feedback with MassHealth during the establishment and Maintenance of Network presentation to MassHealth in March of 2025. For Community Crisis Stabilization and Program of Assertive Community Treatment, UnitedHealthcare has made contacts with all available providers is open to additional provider information from MassHealth for further outreach. UnitedHealthcare has committed to completing these initiatives by the end of Q2 2026. UnitedHealthcare will</p>	<p>Addressed</p>

Recommendation for UHC One Care	UHC One Care Response/Actions Taken	IPRO Assessment of MCP Response ¹
	<p>work towards meeting the minimum network adequacy standards across all service categories and counties. UnitedHealthcare will analyze quarterly network adequacy reports to track contracted provider counts and geographic coverage and conduct periodic reviews to assess progress and identify persistent gaps. UnitedHealthcare is actively recruiting providers through community outreach, internet and competitor directory searches and Behavioral Health Help Line treatment connection tools. The goal is to resolve all network deficiencies by end of Q2 2026. UnitedHealthcare will document all outreach efforts and, where applicable, submission of Exception Narratives to MassHealth if time and distance standards cannot be met.</p>	
<p>Network – Provider Directory: 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.</p> <p>UHC One Care should design quality improvement interventions to enhance the accuracy of all three directories.</p>	<p>UnitedHealthcare has in place multiple initiatives to ensure provider data accuracy. These include recurring auditing and monitoring processes, data controls, business rules, and quality reviews. UnitedHealthcare has also developed platforms such as My Practice Profile (MPP), CAQH Provider Data Portal, and roster processing tools. Additionally, programs like High-Risk Suppression and Trust Evaluator have been introduced to proactively manage and verify provider data. These initiatives are ongoing and executed through monthly accuracy reviews, quarterly auto-dialer checks, and continuous data ingestion and verification processes. Updates are made via multiple intake channels including MPP, CAQH, and roster submissions. The High-Risk Suppression Program and Trust Evaluator operate on regular schedules to identify and suppress inaccurate data. The primary goals are to maintain accurate provider directories, ensure compliance with regulatory standards, and improve the member experience. Expected outcomes include reduced defects, timely updates to provider data, and enhanced directory accuracy. UnitedHealthcare monitors effectiveness through its Quality Audit Program, which includes monthly sampling of provider data, phone call campaigns, and attestation tracking. Defects are root causes and trends for improvement opportunities. Internal quality reviews and feedback loops are used to continuously assess and refine processes.</p>	Addressed

Recommendation for UHC One Care	UHC One Care Response/Actions Taken	IPRO Assessment of MCP Response ¹
<p>Quality-of-care surveys: UHC One Care scored below the Medicare Advantage FFS mean score on the following MA-PD CAHPS measure:</p> <ul style="list-style-type: none"> • Getting Needed Care • Getting Appointments and Care Quickly • Care Coordination • Annual Flu Vaccine <p>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</p>	<p>UnitedHealthcare One Care conducted root cause analyses and implemented a wide range of targeted interventions to improve performance on all four underperforming MA-PD CAHPS measures. These efforts are supported by clear goals, performance tracking, and ongoing monitoring through dashboards, data analysis, and quality improvement cycles.</p>	<p>Addressed</p>

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 83–85 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 2025 EQR activities as they relate to **quality, timeliness, and access**.

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

Table 83: Strengths, Opportunities for Improvement, and EQR Recommendations for CCA One Care

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: PCR	There is high confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is high confidence that the PIP produced evidence of improvement.	N/A	N/A	Quality, Timeliness, Access
PIP 2: IET	There is moderate confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. Interventions were added to address program barriers. There is moderate confidence that the PIP produced evidence of improvement.	The implementation of additional barriers causes significant delays in implementation and data collections, making it difficult to assess whether the associated performance indicator rate increases were a direct result of the interventions that were implemented.	CCA One Care should ensure that attempts are made to replace those interventions that have significant issues resulting in significant delays in implementation.	Quality, Timeliness, Access

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: HEDIS measures	<p>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:</p> <ul style="list-style-type: none"> Breast Cancer Screening: 72.19% Controlling High Blood Pressure: 85.57% Glycemic Status Assessment for Patients With Diabetes – Glycemic Status > 9.0%: 19.95% <p>HEDIS rates for the following measures were above the 90th national Medicare Quality Compass percentile:</p> <ul style="list-style-type: none"> Engagement of Substance Use Disorder Treatment: 11.7% 	<p>The HEDIS rate for the following measure was below the 25th national Medicaid Quality Compass percentile:</p> <ul style="list-style-type: none"> Plan All-Cause Readmissions (18-64): 1.3715 <p>HEDIS rates for the following measures were below the 25th national Medicare Quality Compass percentile:</p> <ul style="list-style-type: none"> Glycemic Status Assessment for Patients With Diabetes – Glycemic Status > 9.0%: 19.95% Plan All-Cause Readmissions (18-64): 1.3715 	<p>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.</p>	<p>Quality, Timeliness, Access</p>
Network Adequacy: Information Systems and Quality of Provider Data – Duplicates	<p>Data used by the MCP to monitor network adequacy were mostly accurate and current, except for duplicative provider records and incorrect provider directory information.</p>	<p>CCA One Care submitted many duplicates for individual and facility providers due to variations in the facility names and in the provider addresses. IPRO removed a total of 1,278 duplicate providers from the CCA One Care data prior to conducting the analysis.</p>	<p>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.</p>	<p>Quality, Access, Timeliness</p>
Network Adequacy: Time and Distance Analysis – MCP's Methodology	<p>CCA One Care used the correct MassHealth standards for some specialists and LTSS providers.</p>	<p>CCA One Care used incorrect standards for PCP, specialists, acute inpatient hospitals, rehabilitation hospital services, some LTSS provider types, pharmacies, behavioral health outpatient providers, behavioral health diversionary services, and oral surgeons. because of the quality of the provider data, IPRO could not compare CCA One Care's results for any provider types.</p>	<p>CCA One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</p>	<p>Quality, Access, Timeliness</p>

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	CCA One Care demonstrated adequate networks for PCP, specialists, acute hospitals in metro counties, rehabilitation hospitals services in large metro counties, most LTSS providers, pharmacies in large metro, behavioral health outpatient providers, and most behavioral health diversionary services providers.	CCA One Care had a deficient acute hospital network in a large metro county, rehabilitation hospital services in metro counties, nursing facility in a metro county, adult day health in metro counties, day services and group adult foster care in metro counties, pharmacy in a metro county, and behavioral health diversionary services such as the Partial Hospitalization Program, Program of Assertive Community Treatment, and psychiatric day treatment. There were also deficiencies in the general dentists’ network and the oral surgeon network in metro counties.	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.	CCA One Care achieved only a 14.97% accuracy rate in its PCP provider directory, a 19.28% accuracy rate in its ob/gyn directory, and only a 28.40% accuracy rate in its CMHCs 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 Fee-for-service mean score on the following MA-PD CAHPS measures: <ul style="list-style-type: none"> • Customer Service • Rating of Health Care Quality • Rating of Health Plan 	CCA One Care scored below the Medicare Advantage Fee-for-service mean score on the following MA-PD CAHPS measures: <ul style="list-style-type: none"> • 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; LTSS: long-term services and supports; PCP: primary care provider; ob/gyn: obstetrics/gynecology; MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems.

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

Table 84: Strengths, Opportunities for Improvement, and EQR Recommendations for Tufts One Care

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: FUH	<p>There is high confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is moderate confidence that the PIP produced evidence of improvement.</p>	<p>Several intervention tracking measures corresponding to the interventions included several low denominators and rates, leaving it difficult to assess effectiveness of the interventions that were implemented during the measurement year.</p>	<p>Tufts One Care should continue interventions while monitoring associated intervention tracking measure data for performance improvement and modify/include new interventions based intervention/intervention tracking measure performance outcomes.</p>	<p>Quality, Timeliness, Access</p>
PIP 2: IET	<p>There is high confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is moderate confidence that the PIP produced evidence of improvement.</p>	<p>Several intervention tracking measures corresponding to the interventions included several low denominators and rates, leaving it difficult to assess effectiveness of the interventions that were implemented during the measurement year.</p>	<p>Tufts One Care should continue interventions while monitoring associated intervention tracking measure data for performance improvement and modify/include new interventions based intervention/intervention tracking measure performance outcomes.</p>	<p>Quality, Timeliness, Access</p>

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: HEDIS measures	<p>HEDIS rates for the following measures were above the 90th national Medicaid Quality Compass percentile:</p> <ul style="list-style-type: none"> Breast Cancer Screening: 70.28% Controlling High Blood Pressure: 78.05% Follow-up After Hospitalization for Mental Illness - 30 days (Total): 79.03% <p>HEDIS rates for the following measures were above the 90th national Medicare Quality Compass percentile:</p> <ul style="list-style-type: none"> Follow-up After Hospitalization for Mental Illness – 30 days: 79.03% Follow-up After Hospitalization for Mental Illness – 7 days: 56.45% Engagement of Substance Use Disorder Treatment: 10.1% 	<p>HEDIS rates for the following measures were below the 25th national Medicaid Quality Compass percentile:</p> <ul style="list-style-type: none"> Initiation of Substance Use Disorder Treatment: 37.62% Engagement of Substance Use Disorder Treatment: 10.1% Plan All-Cause Readmissions (18-64): 1.3516 <p>HEDIS rates for the following measures were below the 25th national Medicare Quality Compass percentile:</p> <ul style="list-style-type: none"> Glycemic Status Assessment for Patients With Diabetes – Glycemic Status > 9.0%: 24.81% Plan All-Cause Readmissions (18-64): 1.3516 	<p>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.</p>	<p>Quality, Timeliness, Access</p>
Network Adequacy: Information Systems and Quality of Provider Data – Duplicates	<p>Data used by the MCP to monitor network adequacy were mostly accurate and current, except for duplicative provider records and incorrect provider directory information.</p>	<p>Tufts One Care submitted many duplicates for individual and facility providers due to variations in the facility names. IPRO removed a total of 150 duplicate providers from the Tufts One Care data prior to conducting the analysis.</p>	<p>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.</p>	<p>Quality, Access, Timeliness</p>
Network Adequacy: Time and Distance Analysis – MCP's Methodology	<p>Tufts One Care used the correct MassHealth standards for many provider types.</p>	<p>Tufts One Care used incorrect standards for PCP, some specialists, acute inpatient hospitals, and some LTSS provider types. Because of the quality of the provider data, IPRO was able to compare Tufts One Care's results to IPRO's results but found many discrepancies in this comparison analysis.</p>	<p>Tufts One Care should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</p> <p>Tufts One Care should review GeoAccess results that differ from IPRO's analysis to verify its methodology and determine causes of discrepancies.</p>	<p>Quality, Access, Timeliness</p>

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	Tufts One Care demonstrated adequate networks for PCP, specialists, some LTSS providers, pharmacies in metro counties, behavioral health outpatient services, most behavioral health diversionary services, orthodontists, and oral surgeons.	Tufts One Care had a deficient neurosurgery network in a large metro county, acute hospitals’ network, a rehabilitation hospital services network in two counties, occupational and speech therapy networks, day services, group adult foster care, and hospice, as well as a deficient pharmacy network in one county and deficiencies among behavioral health diversionary services providers. There were also gaps in the general dentists’ network in both large metro and metro counties.	Tufts 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 an 18.23% accuracy rate in its PCP provider directory, a 27.81% accuracy rate in its ob/gyn directory, and only a 22.22% accuracy rate in its CMHCs directory.	Tufts One Care should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness
Quality-of-care Surveys	<p>Tufts One Care scored above the Medicare Advantage Fee-for-service mean score on the following measures:</p> <ul style="list-style-type: none"> • Rating of Health Care Quality • Rating of Health Plan 	<p>Tufts One Care scored below the Medicare Advantage Fee-for-service mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> • Getting Needed Care • Care Coordination • Annual Flu Vaccine 	Tufts One Care should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. MCP should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access

EQR: external quality review; PIP: performance improvement project; N/A: not applicable; HEDIS: Healthcare Effectiveness Data and Information Set; MCP: managed care plan; LTSS: long-term services and supports; PCP: primary care provider; ob/gyn: obstetrics/gynecology; MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems.

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

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

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: FUH	There is high confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is high confidence that the PIP produced evidence of improvement.	N/A	N/A	Quality, Timeliness, Access
PIP 2: HBD	There is high confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is high confidence that the PIP produced evidence of improvement.	N/A	N/A	Quality, Timeliness, Access
Performance Measure Validation: HEDIS measures	UHC One Care demonstrated compliance with information systems standards. No issues were identified. HEDIS rates for the following measures were above the 90th national Medicaid Quality Compass percentile: <ul style="list-style-type: none"> Controlling High Blood Pressure: 81.27% Glycemic Status Assessment for Patients With Diabetes – Glycemic Status > 9.0%: 21.41% 	<p>HEDIS rates for the following measures were below the 25th national Medicaid Quality Compass percentile:</p> <ul style="list-style-type: none"> Initiation of Substance Use Disorder Treatment: 32.57% Engagement of Substance Use Disorder Treatment: 8.49% <p>HEDIS rates for the following measures were below the 25th national Medicare Quality Compass percentile:</p> <ul style="list-style-type: none"> Breast Cancer Screening: 65.61% Glycemic Status Assessment for Patients With Diabetes – Glycemic Status > 9.0%: 21.41% Plan All-Cause Readmissions (18-64): 1.2785 	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	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Information Systems and Quality of Provider Data – Duplicates	Data used by the MCP to monitor network adequacy were mostly accurate and current, except for duplicative provider records and incorrect provider directory information.	UHC One Care submitted many duplicates for individual and facility providers due to variations in the facility names. IPRO removed a total of 66 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, including primary care providers, specialists, acute hospitals, LTSS providers, pharmacies, and dental services.	UHC One Care used incorrect standards for some specialists, rehabilitation hospital services, behavioral health outpatient, and behavioral health diversionary services. Because of the quality of the provider data, IPRO was able to compare UHC One Care’s results for most specialists, acute hospitals, LTSS providers (nursing facility, occupational therapy, adult foster care, day habilitation, day services, hospice), and pharmacies. 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
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	UHC One Care demonstrated adequate networks for PCP in large metro counties, most specialists' hospitals, acute inpatient hospitals in metro counties, rehabilitation hospital services, most LTSS providers, pharmacies in large metro counties, behavioral health outpatient providers, and most behavioral health diversionary services, orthodontists, as well as oral surgeons in large metro counties.	UHC One Care had a deficient PCP network in a metro county, cardiology in a large metro county, oncology in a large metro county, acute inpatient hospitals in large metro counties, LTSS providers such as occupational and speech therapy in large metro counties, adult day health and adult foster care, and hospice and pharmacy networks in metro counties. UHC One Care also appears to have an inadequate clinical stabilization services network, adult mobile crisis intervention, medically monitored intensive services for SUD, a partial hospitalization program, a program of assertive community treatment, and pharmacy network in one county. UHC One Care also had an inadequate general dentists’ network.	UHC 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	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Accuracy of Provider Directory	None.	UHC One Care achieved only a 11.60% accuracy rate in its PCP provider directory, a 29.46% accuracy rate in its ob/gyn directory, and only a 0% accuracy rate in its CMHCs 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 Fee-for-service mean score on the following MA-PD CAHPS measures: <ul style="list-style-type: none"> • Getting Appointments and Care Quickly • Annual Flu Vaccine 	Many of the UHC One Care measures did not meet reporting criteria for sample size or reliability.	To increase sample size, UHC One Care should strengthen member engagement strategies and increase outreach before the next survey period.	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; LTSS: long-term services and supports; PCP: primary care provider; ob/gyn: obstetrics/gynecology; MA-PD CAHPS: Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems.

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 86: Required Elements in EQR Technical Report

Regulatory Reference	Requirement	Location in the EQR Technical Report
<i>Title 42 CFR § 438.364(a)</i>	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 .
<i>Title 42 CFR § 438.364(a)(1)</i>	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 .
<i>Title 42 CFR § 438.364(a)(3)</i>	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.
<i>Title 42 CFR § 438.364(a)(4)</i>	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
<i>Title 42 CFR § 438.364(a)(4)</i>	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy, under <i>Title 42 CFR § 438.340</i> , 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.
<i>Title 42 CFR § 438.364(a)(5)</i>	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
<i>Title 42 CFR § 438.364(a)(6)</i>	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.
<i>Title 42 CFR § 438.364(d)</i>	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.
<i>Title 42 CFR § 438.364(a)(2)(iiv)</i>	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.
<i>Title 42 CFR § 438.358 (b)(1)(i)</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 .
<i>Title 42 CFR § 438.330(d)</i>	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 .
<i>Title 42 CFR § 438.358(b)(1)(ii)</i>	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
<i>Title 42 CFR § 438.358(b)(1)(iii)</i>	<p>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 <i>Title 42 CFR § 438.330</i>.</p> <p>The technical report must provide MCP results for the 11 Subpart D and QAPI standards.</p>	<p>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 <i>Title 42 CFR § 438.330</i>; see Section V.</p>

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

XI. Appendix A – MassHealth Quality Goals and Objectives

Table A1: Goal 1 – Achieve a healthy population, delivering high-quality pediatric, preventive, and perinatal care.

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

¹ CMS Universal Foundation and Core Set Measure.

CH: Child; AD: Adult; PPC: Prenatal and Postpartum Care; MY: measurement year.

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

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

¹ CMS Core Measure.

² CMS Universal Foundation and Core Set Measure.

AD: Adult; HH: Health Home; MY: measurement year.

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

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

¹ CMS Universal Foundation and Core Set Measure.

² Other national measure.

LTSS: Long-Term Services and Support; AD: Adult; MY: measurement year.

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

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

¹ CMS Universal Foundation and Core Set Measure.

² Medicaid Expansion CHIP and non-CHIP.

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

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

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

¹ CMS Universal Foundation and Core Set Measure.

² Medicaid Expansion CHIP and non-CHIP.

³ CMS Core Measure.

MY: measurement year.

XII. Appendix B – MassHealth Managed Care Programs and Plans

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

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Accountable Care Partnership Plan (ACPP)	<p>Groups of primary care providers working with one managed care organization to create a full network of providers.</p> <ul style="list-style-type: none"> • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. • Type: MCE. 	<ol style="list-style-type: none"> 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)	<p>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.</p> <ul style="list-style-type: none"> • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. • Type: PCCM Entity. 	<ol style="list-style-type: none"> 1. Community Care Cooperative 2. Revere Medical
Managed Care Organization (MCO)	<p>Capitated model for services delivery in which care is offered through a closed network of PCPs, specialists, behavioral health providers, and hospitals.</p> <ul style="list-style-type: none"> • Population: Managed care eligible Medicaid members under 65 years of age. • Managed Care Authority: 1115 Demonstration Waiver. • Type: MCE. 	<ol style="list-style-type: none"> 1. WellSense Essential 2. Tufts Health Together (will no longer be a plan in 2026)

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Primary Care Clinician Plan (PCCP)	<p>Members select or are assigned a primary care clinician (PCC) from a network of MassHealth hospitals, specialists, and the Massachusetts Behavioral Health Partnership (MBHP).</p> <ul style="list-style-type: none"> Population: Managed care eligible Medicaid members under 65 years of age. Managed Care Authority: 1115 Demonstration Waiver. Type: PCCM. 	Not applicable – MassHealth
Massachusetts Behavioral Health Partnership (MBHP)	<p>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.</p> <ul style="list-style-type: none"> Population: Medicaid members under 65 years of age who are enrolled in the PCCP or a PC ACO (which are the two PCCM programs), as well as children in state custody not otherwise enrolled in managed care. Managed Care Authority: 1115 Demonstration Waiver. Type: PIHP. 	MBHP
One Care Plan	<p>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.</p> <ul style="list-style-type: none"> Population: Dual-eligible Medicaid members ages 21–64 years at the time of enrollment with MassHealth and Medicare coverage. Managed Care Authority: Financial Alignment Initiative Demonstration. Type: MCE. 	<ol style="list-style-type: none"> Commonwealth Care Alliance Tufts Health Plan Unify UnitedHealthcare Connected

Managed Care Program	Basic Overview and Populations Served	Managed Care Plans (MCPs) – Health Plan
Senior Care Options (SCO)	<p>Medicare FIDE-SNPs with companion Medicaid managed care plans providing medical, behavioral health, and long-term, social, and geriatric support services, as well as respite care.</p> <ul style="list-style-type: none"> • Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age. • Managed Care Authority: 1915(a) Waiver/1915(c) Waivers. • Type: MCE. 	<ol style="list-style-type: none"> 1. Commonwealth Care Alliance 2. NaviCare Fallon Health 3. Senior Whole Health by Molina 4. Tufts Health Plan Senior Care Option 5. UnitedHealthcare Senior Care Options 6. WellSense Senior Care Option (will no longer be a plan in 2026)

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

XIII. Appendix C – MassHealth Quality Measures

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

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

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

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

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

CMS’s network adequacy standards for Medicare and Medicaid Plans were provided by MassHealth on 02/19/2025.

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
<p>Primary care Providers:</p> <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine <p>Contract Language: For non-pharmacy Medicare medical providers and facilities: Primary Care Providers: at least two (2) PCPs within CMS’ standards</p> <p>https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-application-annual-requirements (Source: Medicare-Medicaid Plan (MMP) Application & Annual Requirements CMS)</p>	<p>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. <i>Note:</i> Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <p>Apply provider-to-enrollee ratio defined by CMS.</p> <p>Apply CMS standards of the minimum number of PCP providers in each county.</p>	<p>Primary Care Providers: Numerator: number of Enrollees in a county for which both of the following is true:</p> <ul style="list-style-type: none"> •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. <p><i>Note:</i> Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <p>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.</p>

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
<p>Hospitals/Medical Facilities:</p> <ul style="list-style-type: none"> Acute Inpatient Hospital Nursing Facilities <p>Contract Language:</p> <p>3. For non-pharmacy Medicare medical providers and facilities:</p> <ul style="list-style-type: none"> 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. <p>https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-application-annual-requirements</p> <ul style="list-style-type: none"> (Source: Medicare-Medicaid Plan (MMP) Application & Annual Requirements CMS) 	<p>Hospitals/Medical Facilities:</p> <ul style="list-style-type: none"> 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. <p>Apply the minimum number of providers defined by CMS, which vary by county.</p>	<p>Hospitals/Medical Facilities:</p> <p>Numerator: number of plan Enrollees in a county for which both of the following are true:</p> <ul style="list-style-type: none"> 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. <p>Denominator: all plan Enrollees in a county.</p> <p>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.</p> <p>Minimum Number of Providers: apply the minimum number of facilities as defined by CMS per county designation for each provider types.</p>

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
<p>Specialists CMS standards:</p> <p>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 Clinical Psychology Clinical Social Work</p> <p>Contract Language: For Medicare medical providers and facilities, time, distance, and minimum number of providers and facilities standards updated by CMS:</p>	<p>Specialists:</p> <ul style="list-style-type: none"> 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. <p>Apply the minimum number of providers defined by CMS, which vary by county.</p>	<p>Specialists:</p> <p>Numerator: number of plan Enrollees in a county for which both of the following are true:</p> <ul style="list-style-type: none"> 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. <p>Denominator: all plan Enrollees in a county.</p> <p>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.</p> <p>Minimum Number of Providers: apply the minimum number of providers as defined by CMS per county designation for each provider type.</p>

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
https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-application-annual-requirements (Source: Medicare-Medicaid Plan (MMP) Application & Annual Requirements CMS)		

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
<p>Outpatient Behavioral Health Provider Types:</p> <ul style="list-style-type: none"> • BH Outpatient <p>BH Diversionary services – State’s standards:</p> <ul style="list-style-type: none"> • Clinical Stabilization Services for Substance Use Disorders (ASAM Level 3.5) • Adult Community Crisis Stabilization (ACCS) • Community Support Program (CSP) • Intensive Outpatient Program (IOP) • Medically Monitored Intensive Services - Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7) • Partial Hospitalization Program (PHP) • Program of Assertive Community Treatment • Psychiatric Day Treatment • Recovery Coaching • Recovery Support Navigators (RSN) • Transitional Support Services (TSS) for Substance Use Disorders (ASAM Level 3.1) • Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) • Structured Outpatient Addiction Program • Adult Mobile Crisis Intervention (AMCI) <p>Contract Language:</p> <p>4.The provider network must have sufficient providers to ensure that each Enrollee has a choice of at least:</p> <ul style="list-style-type: none"> • 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 	<p>BH Outpatient, Diversionary, and LTSS – State’s standards</p> <ul style="list-style-type: none"> • 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. 	<p>BH Outpatient, Diversionary, and LTSS – State’s standards</p> <p>Numerator: number of plan members in a county for whom one of the following is true:</p> <ul style="list-style-type: none"> • 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. <p>Denominator: all plan members in a county.</p>

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
per Covered Service. (Covered Services: referenced in Appendix A and defined in Appendix B of the One Care Contract)		

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
<p>Provider Type:</p> <ul style="list-style-type: none"> Pharmacy <p>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.</p>	<p>Pharmacy</p> <ul style="list-style-type: none"> 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. 	<p>Pharmacy:</p> <p>Numerator: number of plan Enrollees in a county for which the following is true:</p> <ul style="list-style-type: none"> 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. <p>Denominator: all plan Enrollees in a county.</p>

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

<p>Network Adequacy Standards Source: Sec. 2.8.2 (“Proximity Access Requirements”) in the Amended and Restated One Care Three-Way Contract</p>	<p>Indicator</p>	<p>Definition of the Indicator</p>
<p>LTSS Providers – State’s standards:</p> <ul style="list-style-type: none"> • Adult Day Health • Adult Foster Care • Day Habilitation • Day Services • Group Adult Foster Care • Hospice <p>Contract Language: 4.The provider network must have sufficient providers to ensure that each Enrollee has a choice of at least:</p> <ul style="list-style-type: none"> • 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) 	<p>BH Outpatient, Diversionary, and LTSS – State’s standards</p> <ul style="list-style-type: none"> • 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. 	<p>BH Outpatient, Diversionary, and LTSS – State’s standards</p> <p>Numerator: number of plan members in a county for whom one of the following is true:</p> <ul style="list-style-type: none"> • 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. <p>Denominator: all plan members in a county.</p>
<p>LTSS Providers – CMS standards:</p> <ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy • Speech Therapy <p>Contract Language: For Medicare medical providers and facilities, time, distance, and minimum number of providers and facilities standards updated by CMS:</p>	<p>LTSS provider services – CMS standards:</p> <ul style="list-style-type: none"> • 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. <p>Note: Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p>	<p>LTSS provider services – CMS standards:</p> <p>Numerator: number of Enrollees in a county for which both of the following is true:</p> <ul style="list-style-type: none"> •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. <p>Note: Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p>

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
<p>https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-application-annual-requirements (Source: Medicare-Medicaid Plan (MMP) Application & Annual Requirements CMS)</p>	<ul style="list-style-type: none"> • 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. 	<p>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.</p>

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
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: <ul style="list-style-type: none"> • 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

<p>Network Adequacy Standards Source: Sec. 2.8.2 (“Proximity Access Requirements”) in the Amended and Restated One Care Three-Way Contract</p>	<p>Indicator</p>	<p>Definition of the Indicator</p>
<p>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, pedodontic, 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 pedodontists, orthodontists and oral surgeons for Members residing on Nantucket Island, Hampshire, Hampden, Franklin, Barnstable, Dukes and Berkshire counties; related to general practitioners and pedodontists 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.</p>	<p>General Dentists</p> <ul style="list-style-type: none"> •95% of Members have access to 2 General Dentists within 10 minutes of their home •Apply provider-to-enrollee ratio of 1: 1,500 <p>Orthodontist</p> <ul style="list-style-type: none"> •95% of Members have access to 1 Orthodontist within 30 minutes of their home •Apply provider-to-enrollee ratio of 1: 15,000 <p>Oral Surgeon</p> <ul style="list-style-type: none"> •95% have access to 1 Oral Surgeon within 30 minutes of their home •Apply provider-to-enrollee ratio of 1: 20,000 	<p>General Dentists:</p> <p>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.</p> <p>Denominator: all plan enrollees in a county.</p> <p>Minimum Provider Ratios: the number of all in-network providers in a county against the number of all enrollees in that county.</p> <p>Orthodontists:</p> <p>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.</p> <p>Denominator: all plan enrollees in a county.</p> <p>Minimum Provider Ratios: the number of all in-network providers in a county against the number of all enrollees in that county.</p> <p>Oral Surgeons:</p> <p>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.</p> <p>Denominator: all plan enrollees in a county.</p> <p>Minimum Provider Ratios: the number of all in-network providers in a county against the number of all enrollees in that county.</p>

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

Table E1: One Care Provider Directory Web Addresses for the Behavioral Health Survey

Managed Care Plan	Web Addresses Reported by Managed Care Plan
Tufts One Care	Find Care - Tufts Health Plan (healthsparq.com)
CCA One Care	Find a Provider or Pharmacy (commonwealthcarealliance.org)
UHC One Care	https://connect.werally.com/behavioralProvider/root?showBackButton=true