



# External Quality Review Senior Care Options 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

## Senior Care Options 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 Senior Care Options (SCO) Plans that furnish health care services to Medicaid Enrollees in Massachusetts (i.e., the Medicare-Medicaid eligible population, which includes Enrollees who are Medicaid only).

Massachusetts's Medicaid program (known as "MassHealth"), administered by the Massachusetts Executive Office of Health and Human Services (EOHHS), contracted with six SCO Plans during the 2025 calendar year (CY). SCOs are health plans for MassHealth Enrollees ages 65 years and older and dual-eligible members ages 65 years and older. SCO Plans include all MassHealth and Medicare benefits, together with prescription drug coverage.<sup>1</sup> They cover medical, behavioral health, and long-term services and supports (LTSS) and provide care coordination for members with chronic conditions. In addition to care coordination, SCOs also offer social and geriatric support services to help seniors stay independently at home as long as possible. MassHealth's SCOs are listed in **Table 1**.

**Table 1: MassHealth's SCOs – CY 2025**

SCO Name	Abbreviation Used in the Report	Members as of December 27, 2025	Percent of Total SCO Population
WellSense Health Plan Senior Care Option	WellSense SCO	648	0.77%
Commonwealth Care Alliance	CCA SCO	18,468	21.88%
NaviCare (HMO) Fallon Health	Fallon SCO	10,820	12.82%
Senior Whole Health by Molina	SWH SCO	11,600	13.74%
Tufts Health Plan Senior Care Option	Tufts SCO	16,868	19.99%
UnitedHealthcare Senior Care Option	UHC SCO	25,994	30.80%
All SCO Plans (Total)	N/A	84,398	100.00%

SCO: Senior Care Options; CY: calendar year; N/A: not applicable.

The **WellSense Health Plan SCO (WellSense SCO)** is a nonprofit health plan that serves 648 MassHealth Enrollees who live in Barnstable, Bristol, Hampden, Plymouth, or Suffolk counties. Its corporate parent is Boston Medical Center Health System, Inc. More information about WellSense SCO is available here: [Senior Care Options | WellSense Health Plan](#).

The **Commonwealth Care Alliance SCO (CCA SCO)** is a nonprofit health plan that serves 18,468 MassHealth Enrollees who live in Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. CCA SCO is an integrated care system based in Boston. More information about CCA SCO is available here: [CCA Senior Care Options | Commonwealth Care Alliance MA](#).

The **NaviCare Fallon Health (Fallon SCO)** is a nonprofit health plan that serves 10,820 MassHealth Enrollees across 12 counties in the state of Massachusetts. The Dukes and Nantucket counties are not part of the Fallon SCO service area. More information about Fallon SCO is available here: [FCHP - NaviCare \(fallonhealth.org\)](#).

<sup>1</sup> [Senior Care Options \(SCO\) | Mass.gov](#).

The **Senior Whole Health by Molina (SWH SCO)** serves 11,600 MassHealth Enrollees who live in Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. SWH SCO's corporate parent is Molina Healthcare. More information about SWH SCO is available here: [Senior Whole Health by Molina Healthcare](#).

The **Tufts Health Plan Senior Care Options (Tufts SCO)** is a nonprofit health plan that serves 16,868 MassHealth Enrollees who live in Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. More information about Tufts SCO is available here: [2025 Tufts Health Plan Senior Care Options \(HMO-SNP\) | Tufts Health Plan Medicare Preferred \(tuftsmedicarepreferred.org\)](#).

The **UnitedHealthcare Senior Care Options (UHC SCO)** serves 25,994 MassHealth Enrollees who live in Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. More information about UHC SCO is available here: [Massachusetts Health Plans | UnitedHealthcare Community Plan: Medicare & Medicaid Health Plans \(uhcommunityplan.com\)](#).

## 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 SCO 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 six SCO 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 SCOs' 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 SCO and determines the extent to which the rates calculated by the SCOs follow state specifications and reporting requirements.
- (iii) **CMS Mandatory Protocol 3: Review of Compliance with Medicaid and CHIP<sup>2</sup> Managed Care Regulations** – This activity determines SCOs' compliance with their contract and with state and federal regulations.
- (iv) **CMS Mandatory Protocol 4: Validation of Network Adequacy** – This activity assesses SCOs' adherence to state standards for travel time and distance to specific provider types, as well as each SCO'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 SCOs' performance strengths and opportunities for improvement.

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<sup>2</sup> Children's Health Insurance Program.

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

### **High-Level Program Findings**

The EQR activities conducted in CY 2025 demonstrated that MassHealth and the SCO 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 SCOs in providing quality, timely, and accessible health care services to Medicaid members. The individual SCOs were evaluated against state and national benchmarks for measures related to the **quality**, **access**, and **timeliness** domains. These Plan-level findings and recommendations for each SCO 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 SCO 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 SCO 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)*. All SCO plans started PIPs in 2024. Each of the six SCO plans has one project focused on the transitions of care; the remaining projects aim to improve specific health outcomes by focusing on key areas such as medication management in older adults (three PIPs), colorectal cancer screening (two PIPs), and controlling high blood pressure (one PIP). The validation of SCO PIPs conducted in CY 2025<sup>4</sup> demonstrated the following strengths and opportunities for improvement.

**Strengths:**

IPRO found that the majority of PIP remeasurement 1 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, five PIPs received high ratings, and six PIPs received moderate confidence ratings. Although one of Tufts SCO's PIPs received a low confidence rating for evidence of improvement, no validation findings suggest that the credibility of the PIP results is at risk.

**Opportunities for Improvement:**

Not applicable.

**General Recommendations for MassHealth:**

None at this time.

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

**Performance Measure Validation**

IPRO validated the accuracy of performance measures and evaluated the state of health care quality in the SCO 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.

SCOs are evaluated on a set of Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS rates are calculated by each SCO and reported to the state.

IPRO conducted performance measure validation to assess the accuracy of HEDIS performance measure rates and to determine the extent to which HEDIS measure rates follow MassHealth's specifications and reporting requirements. IPRO reviewed SCOs' Final Audit Reports issued by independent HEDIS auditors. IPRO found that SCOs were fully compliant with applicable National Committee for Quality Assurance (NCQA) information system standards. No issues were identified.

IPRO aggregated the SCO measure rates to provide comparative information for all SCO Plans. When compared to the measurement year (MY) 2024 NCQA Quality Compass® national Medicare percentiles, the best performance statewide was reported for the following measures:

- Advance Care Planning: statewide, 67.36% (≥ 75th but < 90th national Medicare percentile)
- Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation Bronchodilators: statewide, 88.73% (≥ 75th but < 90th national Medicare percentile)
- Follow-up After Hospitalization for Mental Illness (7 days): statewide, 40.00% (≥ 75th but < 90th national Medicare percentile)

#### **Opportunities for Improvement:**

The performance varied across measures with the opportunities for improvement in the following areas:

- Use of High-risk Medications in the Elderly (Total): statewide, 21.77% (< 25th national Medicare percentile)
- Plan All-Cause Readmission (Observed/Expected Ratio) 65+: statewide, 1.1114 (< 25th national Medicare percentile)
- Osteoporosis Management in Women Who Had a Fracture: statewide, 31.54% (< 25th national Medicare percentile)

#### **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 SCO Plans' compliance 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. SCO Plans undergo compliance reviews every three years. The next compliance review will be conducted in contract year 2026.

The validation of SCO Plans conducted in CY 2023 demonstrated SCO Plans' commitment to their members and providers, as well as strong operations. Of the 14 areas of review, Tufts SCO and SWH SCO scored 100% in 10 domains; WellSense SCO and Fallon SCO scored 100% in eight domains; and CCA SCO and UHC SCO scored 100% in seven domains.

### **Opportunities for Improvement:**

Significant gaps were identified in the following areas:

- Disenrollment requirements and limitations (Tufts SCO)
- Enrollee rights and protections (WellSense SCO and Fallon SCO)
- Emergency and post-stabilization services (CCA SCO)
- Coordination and continuity of care (WellSense SCO, CCA SCO, Fallon SCO, SWH SCO, and Tufts SCO)
- Subcontractual relationships and delegation (UHC SCO)

SCO Plans were not always able to identify policy documentation and provide evidence that all requirements were being implemented. The absence of policies can result in inconsistent practices and lead to variations in the quality of services provided.

Some contractual requirements were written in complex language that left room for interpretation and could impede implementation. For example, the Enrollee Access to Services requirement in Section 2.6 lacked clarity in terms of network adequacy standards, indicators, and provider types. Some requirements remained in the contract even though they were retired, postponed, or did not apply to the SCO population. Overly complex regulations or out-of-date requirements may hinder implementation and a broader understanding of contractual obligations leading to inefficiencies and non-compliance.

### **General Recommendations for MassHealth:**

- *Recommendation towards better policy documentation* – To encourage consistent practices and compliance with MassHealth standards, MassHealth should require MCPs to establish and maintain well-defined policies and procedures.
- *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.
- *Suggestion towards addressing program-wide weakness in Care Coordination* – MassHealth could consider addressing the gap in compliance related to care coordination, specifically in the area of care management process (ensuring timely assessments are completed, care plans are developed and updated per requirements, discharge planning is completed) and care plan documentation (assessments, care plans, member sign-off, etc.). While there were minor gaps in policy documentation across the MCPs, the key driver of lower compliance scores in this domain is found in the area of care management file reviews.

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

### **Network Adequacy Validation**

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

### **Strengths:**

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

MassHealth has established time and distance standards for adult and pediatric primary care providers (PCPs), obstetrics/gynecology (ob/gyn) providers, adult and pediatric behavioral health providers (for mental health and SUD), adult and pediatric specialists, hospitals, pharmacy services, and LTSS. However, MassHealth did not develop standards for pediatric dental services, as these services are carved out from managed care.

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

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. Each SCO Plan received a high confidence rating for at least one provider type.

I PRO's analysis showed that all SCOs had adequate networks of most specialty services and behavioral health outpatient providers.

**Opportunities for Improvement:**

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

After resolving data issues and removing duplicate records, I PRO assessed each SCOs' provider network for compliance with MassHealth's time and distance standards. Access was evaluated for all provider types identified by MassHealth. Most SCOs had deficiencies in their provider networks, with the exception of the behavioral health outpatient providers and most specialists.

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 a routine appointment were: 92.2 calendar days for a PCPs, 63.68 calendar days for an ob/gyn, and 7.3 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.

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

### **Strengths:**

The Rating of Health Plan and the Annual Flu Vaccine SCO weighted mean scores exceeded the Medicare Advantage national mean score.

### **Opportunities for Improvement:**

The MassHealth SCO weighted mean was below the Medicare Advantage national mean score for the following measures:

- Getting Needed Care
- Getting Appointments and Care Quickly
- Care Coordination
- Getting Needed Prescription Drugs

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 SCO Plan.

### **General Recommendations for MassHealth:**

- *Recommendation towards better performance on CAHPS measures* – MassHealth should continue to utilize CAHPS data to evaluate SCO 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 Enrollees.

SCO-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 SCOs 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.
- *Suggestion towards addressing program-wide weakness in Care Coordination* – MassHealth could consider addressing the gap in compliance related to care coordination, specifically in the area of care management process (ensuring timely assessments are completed, care plans are developed and updated per requirements, discharge planning is completed) and care plan documentation (assessments, care plans, member sign-off, etc.). While there were minor gaps in policy documentation across the MCPs, the key driver of lower compliance scores in this domain is found in the area of care management file reviews.
- *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 SCO 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 Enrollees.

### *EQR Recommendations for SCO Plans*

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

## II. Massachusetts Medicaid Managed Care Program

### Managed Care in Massachusetts

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

MassHealth's mission is to improve the health outcomes of its "members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life."<sup>3</sup> 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**.

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<sup>3</sup> [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
<b>Goal 1: High-quality care</b>	Achieve a healthy population by delivering high-quality pediatric, preventive, and perinatal care.
<b>Goal 2: High-impact acute and chronic conditions</b>	Advance progress on high-impact acute and chronic condition areas to improve safe, effective, high-value care.
<b>Goal 3: Coordinated and efficient quality care</b>	Enable coordinated and efficient quality care for all members across the continuum of services and settings of care.
<b>Goal 4: Person-centered care</b>	Enhance person-centered care through elevating member voice and improving member experience and engagement with their health care.
<b>Goal 5: Access to and appropriate utilization</b>	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.<sup>4</sup>
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.<sup>5</sup> 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.<sup>6</sup>

#### **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.

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<sup>4</sup> [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>.

<sup>5</sup> [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>.

<sup>6</sup> [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 ACPPs are required to develop PIPs.

## ***Member Experience of Care Surveys***

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

For members enrolled in an ACPP, an MCO, a PC ACO, and the PCCP, MassHealth conducts an annual survey adapted from the 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 2.9.C of the Third Amended and Restated MassHealth SCO Contract and Appendix L to the MassHealth SCO Contract require the SCOs to annually implement at least two PIPs in the areas care coordination and planning, and quality performance. MassHealth can modify the PIP cycle to address immediate priorities. In CY 2024, each SCO Plan started two new PIPs, which continued to be implemented during CY 2025. Specific SCO PIP topics are displayed in **Table 3**.

**Table 3: SCO PIP Topics – CY 2025**

SCO	PIP Topics
WellSense SCO	<p><b>PIP 1: Transitions of Care (TRC) – Closure Report</b> Improving the transitions of care rate for all WellSense SCO members.</p> <p><b>PIP 2: Colorectal Cancer Screening (COL) – Closure Report</b> Increasing the rate of colorectal screenings in members ages 50-75.</p>
CCA SCO	<p><b>PIP 1: Medication Management in Older Adults (DAE) – Remeasurement 1 Report</b> Decreasing the total percentage of CCA SCO members who use a high-risk medication.</p> <p><b>PIP 2: Transitions of Care (TRC) – Remeasurement 1 Report</b> Improving the transitions of care rate for all CCA SCO members.</p>
Fallon SCO	<p><b>PIP 1: Transitions of Care (TRC) – Remeasurement 1 Report</b> Improving the transitions of care rate for all Fallon SCO members.</p> <p><b>PIP 2: Colorectal Cancer Screening (COL) – Remeasurement 1 Report</b> Increasing the rate of colorectal screenings in members ages 50-75 with a focus on Haitian/Creole speaking members.</p>
SWH SCO	<p><b>PIP 1: Controlling High Blood Pressure (CBP) – Remeasurement 1 Report</b> Improving the percentage of members 18-85 with a diagnosis of hypertension and whose blood pressure was controlled.</p> <p><b>PIP 2: Transitions of Care (TRC) – Remeasurement 1 Report</b> Improving the transitions of care rate for all Senior Whole Health SCO members.</p>
Tufts SCO	<p><b>PIP 1: Medication Management in Older Adults (DAE) – Remeasurement 1 Report</b> Decreasing the total percentage of Tufts SCO members who use a high-risk medication.</p> <p><b>PIP 2: Transitions of Care (TRC) – Remeasurement 1 Report</b> Improving the transitions of care rate for all Tufts SCO members.</p>
UHC SCO	<p><b>PIP 1: Medication Management in Older Adults (DAE) – Remeasurement 1 Report</b> Decreasing the total percentage of UHC SCO members who use a high-risk medication.</p> <p><b>PIP 2: Transitions of Care (TRC) – Remeasurement 1 Report</b> Improving the transitions of care rate for all UHC SCO members.</p>

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year.

*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 SCO Plans during CY 2025.

## Technical Methods of Data Collection and Analysis

SCO 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 SCOs submitted baseline update reports once the 2023 baseline performance measurement rates became available. The projects started in January 2024, and after the initial baseline reports were approved, IPRO conducted progress calls with all SCOs between October and December 2024. In March 2025, IPRO offered optional progress calls and met with four SCO plans. The first remeasurement report was submitted in July 2025 by all SCO plans except WellSense SCO because WellSense will no longer be operating a SCO plan beyond CY2025. This SCO plan submitted its PIP closure report in October 2025.

In the first remeasurement report, SCOs described project goals, performance indicators' rates, anticipated barriers, interventions, and intervention tracking measures' rates. SCOs 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

Overall, the ratings for PIP adherence to acceptable methodology were high, with nine PIPs receiving high confidence and three PIPs receiving moderate confidence.

### Rating 2: Evidence of Improvement - Validation Results Summary

In terms of producing significant evidence of improvement, five PIPs received high ratings, and six PIPs received moderate confidence ratings. Tufts SCO Medication Management in Older Adults PIP received ratings of low confidence.

PIP validation results are reported in **Tables 4–9** for each SCO.

**Table 4: WellSense SCO PIP Validation Confidence Ratings – CY 2025**

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: Transitions of Care (TRC)	High Confidence	Moderate Confidence
PIP 2: Colorectal Cancer Screening (COL)	High Confidence	Moderate Confidence

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year.

**Table 5: CCA SCO PIP Validation Confidence Ratings – CY 2025**

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: Medication Management in Older Adults (DAE)	High Confidence	Moderate Confidence
PIP 2: Transitions of Care (TRC)	High Confidence	High Confidence

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year.

**Table 6: Fallon SCO PIP Validation Confidence Ratings – CY 2025**

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: Transitions of Care (TRC)	High Confidence	High Confidence
PIP 2: Colorectal Cancer Screening (COL)	High Confidence	High Confidence

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year.

**Table 7: SWH SCO PIP Validation Confidence Ratings – CY 2025**

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: Controlling High Blood Pressure (CBP)	High Confidence	High Confidence
PIP 2: Transitions of Care (TRC)	Moderate Confidence	Moderate Confidence

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year.

**Table 8: Tufts SCO PIP Validation Confidence Ratings – CY 2025**

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: Medication Management in Older Adults (DAE)	Moderate Confidence	Low Confidence
PIP 2: Transitions of Care (TRC)	Moderate Confidence	High Confidence

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year.

**Table 9: UHC SCO PIP Validation Confidence Ratings – CY 2025**

PIP	Rating 1: PIP Adhered to Acceptable Methodology	Rating 2: PIP Produced Evidence of Improvement
PIP 1: Medication Management in Older Adults (DAE)	High Confidence	Moderate Confidence
PIP 2: Transitions of Care (TRC)	High Confidence	Moderate Confidence

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year.

### **WellSense SCO PIPs**

WellSense SCO PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 10–13**.

**Table 10: WellSense SCO PIP 1 Summary, 2025**

<b>WellSense SCO PIP 1: Improving the transitions of care rate for all WellSense SCO members.</b>
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

## Aim

By the end of 2025, WellSense aims to improve rate for Notification of Inpatient Admission by 5% above baseline rate of 56.17% for our SCO population. This would be a quality compass rate increase from the 75th to the 90th percentile by 12/31/2025.

By the end of 2025, WellSense aims to improve rate for Receipt of Discharge Information by 5% above baseline rate of 64.48% for our SCO population. This would be a quality compass rate continued performance within the 90th percentile by 12/31/2025.

By the end of 2025, WellSense aims to improve rate for Patient Engagement after Inpatient Discharge by 5% above baseline rate of 86.90% for our SCO population. This would be a quality compass rate increase from the 50th to the 75th percentile by 12/31/2025.

By the end of 2025, WellSense aims to improve Medication Reconciliation Post-Discharge average by 5% above baseline rate of 82.11% for our SCO population. This would be a quality compass rate increase from the 75th to the 90th percentile by 12/31/2025.

## Interventions in 2024

- Provide culturally appropriate outreach to members related to post-discharge best practices
- Conduct the Transition to Home (TTH) assessment to identify barriers to attending follow up visits
- Use a supplemental data interface in inpatient facilities to store data for reporting

## Performance Improvement Summary

Results must be interpreted with some caution due to each of the five submeasures not showing improvement in performance, with each indicator scoring at least 9% below the baseline rate. However, several interventions were revised mid-year of the first MY year but did not yield increased performance. Also, the PIP did not continue through two MYs, leaving it difficult to assess overall performance over an extended period of time.

**Table 11: WellSense SCO PIP 1 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Notification of Inpatient Admissions	2024 (baseline, MY 2023 data)	48.90%
Indicator 1: Notification of Inpatient Admissions	2025 (closure, MY 2024 data)	40.80%
Indicator 2: Receipt of Discharge Information	2024 (baseline, MY 2023 data)	63.30%
Indicator 2: Receipt of Discharge Information	2025 (closure, MY 2024 data)	49.75%
Indicator 3: Patient Engagement After Inpatient Discharge	2024 (baseline, MY 2023 data)	90.20%
Indicator 3: Patient Engagement After Inpatient Discharge	2025 (closure, MY 2024 data)	83.08%
Indicator 4: Medication Reconciliation Post-Discharge	2024 (baseline, MY 2023 data)	82.97%
Indicator 4: Medication Reconciliation Post-Discharge	2025 (closure, MY 2024 data)	66.67%
Indicator 5: Overall Transitions of Care	2024 (baseline, MY 2023 data)	72.02%
Indicator 5: Overall Transitions of Care	2025 (closure, MY 2024 data)	60.07%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

**Table 12: WellSense SCO PIP 2 Summary, 2025**

**WellSense SCO PIP 2: Increasing the rate of colorectal screenings in members ages 50-75.**

**Validation Summary**

Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence

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

SCO: Senior Care Options; PIP: performance improvement project; HEDIS: Healthcare Effectiveness Data and Information Set; ECDS: electronic clinical data systems; CMS: Centers for Medicare and Medicaid Services; PI: performance improvement; MY: measurement year.

**Aim**

WellSense SCO’s Performance Indicator (PI) is the HEDIS COL measure. For Measurement Year (MY) 2024 this measure will only be referred to as COL-E and will be an electronic measure only. Even though WellSense SCO received a strong 4 star rating for HEDIS 2023 at 78% (77.62), there is some uncertainty related to goals for next season. Currently, in December 2023 (for claims paid through 11/30/23), WellSense SCO is down just over 10% without being able to identify an obvious cause for the drop in rates. WellSense SCO will continue to strive to identify root causes for this decline. Many health plans are concerned about the impact of the ECDS transition but last HEDIS season WellSense only had 3% collected by Medical Records. An additional challenge is the increased CMS Cut Point from > 79% to >80% to achieve a 5 star rating. By the end of 2025 (12/31/25) the Plan expects to reach the PI goal rate of 81.50%.

**Interventions in 2024**

- Collaborate to improve the accuracy of the colorectal screening gap data
- Outreach non-compliant members with information regarding colorectal cancer screenings
- Develop a supplemental data management application to capture HEDIS rate calculation year round

**Performance Improvement Summary**

WellSense SCO did not meet the stated goal of 81.5% for colorectal cancer screening, and the percentage of members with documentation showing timely colorectal cancer screening dropped by a little over 3 percentage points between the baseline update and first remeasurement periods. Organizational and operational changes necessitated reallocation of resources, which impacted effectiveness of some interventions requiring additional outreach

**Table 13: WellSense SCO PIP 2 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Rate of adults ages 50-75 who had an appropriate screening for colorectal cancer	2024 (baseline, 2023 MY data)	74.94%
Indicator 1: Rate of adults ages 50-75 who had an appropriate screening for colorectal cancer	2025 (closure, MY 2024 data)	71.71%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

## CCA SCO PIPs

CCA SCO PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 14–17**.

**Table 14: CCA SCO PIP 1 Summary, 2025**

CCA SCO PIP 1: Decreasing the total percentage of CCA SCO members who use a high-risk medication.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year; N/A: not applicable; YO: years old; MY: measurement year.

### Aim

Indicator 1: By the end of 2025, the Plan aims to reduce the percentage points of elderly members  $\geq 67$  YO who are filling prescriptions for high-risk medications by 1.00 percentage point (95 members) compared to the MY 2023 baseline rate.

Indicator 2: By the end of 2025, the Plan aims to reduce the percentage points of elderly members  $\geq 67$  YO who are filling prescriptions for high-risk medications without an appropriate diagnosis by 0.50 percentage point (48 members) compared to the MY 2023 baseline rate.

Indicator 3: By the end of 2025, the Plan aims to reduce the percentage points of the total number of female members  $\geq 67$  YO who are filling prescriptions for high-risk medications by 1.00 percentage point (65 members) compared to the MY 2023 baseline rate

Indicator 4: By the end of 2025, the Plan aims to reduce the percentage point of the total number of members  $\geq 67$  YO who are filling prescriptions for high-risk medications by 1.50 percentage points (143 members) compared to the MY 2023 baseline rate.

### Interventions in 2024

- Outreach providers who are prescribing high-risk medications to provide information and guidance on deprescribing these medications
- Outreach providers with patient- specific tapering and deprescribing recommendations
- Conduct follow-up calls to members with education regarding the tapering or deprescribing of high-risk medication

### Performance Improvement Summary

There is moderate confidence that the PIP produced evidence of improvement. Although there was evidence of adapting interventions during the PIP process, there was no improvement in any of the four PI rates throughout the PIP.

**Table 15: CCA SCO PIP 1 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Use of High-Risk Medication in Older Adults	2024 (baseline, MY 2023 data)	20.49%
Indicator 1: Use of High-Risk Medication in Older Adults	2025 (remeasurement 1, MY 2024 data)	23.57%
Indicator 2: Use of High-Risk Medication in Older Adults Except for Appropriate Diagnosis	2024 (baseline, MY 2023 data)	7.51%
Indicator 2: Use of High-Risk Medication in Older Adults Except for Appropriate Diagnosis	2025 (remeasurement 1, MY 2024 data)	8.24%

Indicators	Reporting Year	Rate
Indicator 3: Use of High-Risk Medication in Older Female Adults	2024 (baseline, MY 2023 data)	27.80%
Indicator 3: Use of High-Risk Medication in Older Female Adults	2025 (remeasurement 1, MY 2024 data)	31.33%
Indicator 4: Use of High-Risk Medication in Older Adults (total HRM1 and HRM2)	2024 (baseline, MY 2023 data)	25.66%
Indicator 4: Use of High-Risk Medication in Older Adults (total HRM1 and HRM2)	2025 (remeasurement 1, MY 2024 data)	28.89%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year, HRM1: at least two different high-risk medications; and HRM2: the same high-risk medication.

**Table 16: CCA SCO PIP 2 Summary, 2025**

CCA SCO PIP 2: Improving the transitions of care rate for all CCA SCO members.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

### Aim

Indicator 1: By the end of 2025, CCA aims to improve the notification of member admission documentation from the inpatient facilities by 10.77 percentage points compared to the MY 2023 baseline rate.

Indicator 2: By the end of 2025, CCA aims to improve the receipt of member discharge documentation from the inpatient facilities by 9.42 percentage points compared to the MY 2023 baseline rate.

Indicator 3: By the end of 2025, CCA aims to improve member engagement post discharge by 7.58 percentage points compared to the MY 2023 baseline rate.

Indicator 4: By the end of 2025, CCA aims to increase completion of post-discharge medication reconciliation for members by 5.48 percentage points compared to the MY 2023 baseline rate.

Indicator 5: By the end of 2025, CCA aims to increase the completion of post discharge medication reconciliation for members by the contracted network providers by 11.98 percentage points compared to MY 2023 baseline rate.

Indicator 6: By the end of 2025, CCA aims to improve the percentage of members who are numerator compliant with all four TRC Measures by 9.44%.

### Interventions in 2024

- Implement Patient Ping/Bamboo Health technology into facilities for automation of discharge documentation
- Develop quarterly reports to measure network provider completion rates for medication reconciliation post discharge
- Utilize post-discharge scripts to capture member-identified needs related to scheduling post-discharge appointments

## Performance Improvement Summary

There is high confidence that the PIP produced evidence of improvement. All six performance indicators reported demonstrated improvement from the baseline to first remeasurement period. Of those, three indicators have reached the goal rate.

**Table 17: CCA SCO PIP 2 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Notification of Inpatient Admissions	2024 (baseline, MY 2023 data)	79.84%
Indicator 1: Notification of Inpatient Admissions	2025 (remeasurement 1, MY 2024 data)	93.19%
Indicator 2: Receipt of Discharge Information	2024 (baseline, MY 2023 data)	75.58%
Indicator 2: Receipt of Discharge Information	2025 (remeasurement 1, MY 2024 data)	77.40%
Indicator 3: Patient Engagement After Inpatient Discharge	2024 (baseline, MY 2023 data)	89.53%
Indicator 3: Patient Engagement After Inpatient Discharge	2025 (remeasurement 1, MY 2024 data)	98.76%
Indicator 4: Medication Reconciliation Post-Discharge	2024 (baseline, MY 2023 data)	85.27%
Indicator 4: Medication Reconciliation Post-Discharge	2025 (remeasurement 1, MY 2024 data)	94.12%
Indicator 5: Medication Reconciliation Post-Discharge by Contracted Network Providers	2024 (baseline, MY 2023 data)	29.07%
Indicator 5: Medication Reconciliation Post-Discharge by Contracted Network Providers	2025 (remeasurement 1, MY 2024 data)	35.60%
Indicator 6: Numerator Compliance for members in all 4 TRC Measures	2024 (baseline, MY 2023 data)	61.63%
Indicator 6: Numerator Compliance for members in all 4 TRC Measures	2025 (remeasurement 1, MY 2024 data)	70.90%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year; TRC: Transitions of Care.

## Recommendations

- *Recommendation for PIP 1:* CCA SCO should continue looking for ways to improve performance indicator rates.

## Fallon SCO PIPs

Fallon SCO PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 18–21**.

**Table 18: Fallon SCO PIP 1 Summary, 2025**

Fallon SCO PIP 1: Improving the transitions of care rate for all Fallon SCO members.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

## Aim

Indicator 1: By 12/31/2025, Fallon Health aims to increase the percentage of members 65 years and older who had documentation of receipt of notification of inpatient admission on the day of admission through 2 day/s after the admission by 5.40 percentage points from the MY2023 baseline rate of 32.60%.

Indicator 2: By 12/31/2025, Fallon Health aims to increase the percentage of male members 65-74 years of age who had a follow up visit within 30 days of discharge from an inpatient admission by 6.44 percentage points from the MY2023 baseline rate of 83.56%.

## Interventions in 2024

- Provide education on timely notifications of admission to provider relations contacts
- Follow up on member records that have not been received from providers
- Identify reasons for lack of follow-up visits among male members ages 65-74 through the transition of care assessment

## Performance Improvement Summary

There is high confidence that the PIP produced evidence of improvement. The two indicators of focus have demonstrated improvement from baseline to the first remeasurement report period despite a late start to interventions and intervention tracking measures.

**Table 19: Fallon SCO PIP 1 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Notification of Inpatient Admissions	2024 (baseline, MY 2023 data)	32.60%
Indicator 1: Notification of Inpatient Admissions	2025 (remeasurement 1, MY 2024 data)	35.52%
Indicator 2: Receipt of Discharge Information	2024 (baseline, MY 2023 data)	83.56%
Indicator 2: Receipt of Discharge Information	2025 (remeasurement 1, MY 2024 data)	87.84%
Indicator 3: Patient Engagement After Inpatient Discharge	2024 (baseline, MY 2023 data)	21.90%
Indicator 3: Patient Engagement After Inpatient Discharge	2025 (remeasurement 1, MY 2024 data)	22.14%
Indicator 4: Medication Reconciliation Post-Discharge	2024 (baseline, MY 2023 data)	88.08%
Indicator 4: Medication Reconciliation Post-Discharge	2025 (remeasurement 1, MY 2024 data)	90.02%
Indicator 5: Medication Reconciliation Post-Discharge	2024 (baseline, MY 2023 data)	92.70%
Indicator 5: Medication Reconciliation Post-Discharge	2025 (remeasurement 1, MY 2024 data)	90.02%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

**Table 20: Fallon SCO PIP 2 Summary, 2025**

<b>Fallon SCO PIP 2: Increasing the rate of colorectal screenings in members ages 50-75 with a focus on Haitian/Creole speaking members.</b>
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

## Aim

Indicator 1: By 12/31/2025, Fallon Health aims to increase the percentage of members ages 65-75 who had appropriate screening for colorectal cancer by 8.7 percentage points from the MY2023 baseline rate of 58.30%.

Indicator 2: By 12/31/2025, Fallon Health aims to increase the percentage of Haitian/Creole speaking members ages 65-75 who had appropriate colorectal cancer screening by 16.5 percentage points from the MY2023 baseline rate of 37.50%.

## Interventions in 2024

- Improve data completeness by adding a Colorectal Cancer Screening alert to identify members with a gap in care
- Collect refusal reasons for noncompliant members through gaps in care outreach
- Distribute Quest FIT kits to Haitian/Creole members in their translated language

## Performance Improvement Summary

There is high confidence that the PIP produced evidence of improvement. There were significant increases in performance indicator percentages between baseline and remeasurement 1, and initial goals were surpassed.

**Table 21: Fallon SCO PIP 2 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Rate of members 65-75 years of age who had appropriate screening for colorectal cancer	2024 (baseline, MY 2023 data)	58.30%
Indicator 1: Rate of members 65-75 years of age who had appropriate screening for colorectal cancer	2025 (remeasurement 1, MY 2024 data)	67.21%
Indicator 2: Rate of Haitian/Creole speaking members 65-75 years of age who had appropriate screening or colorectal cancer	2024 (baseline, MY 2023 data)	37.50%
Indicator 2: Rate of Haitian/Creole speaking members 65-75 years of age who had appropriate screening or colorectal cancer	2025 (remeasurement 1, MY 2024 data)	58.93%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

## SWH SCO PIPs

SWH SCO PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 22–25**.

**Table 22: SWH SCO PIP 1 Summary, 2025**

SWH SCO PIP 1: Improving the percentage of members 18-85 with a diagnosis of hypertension and whose blood pressure was controlled.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence

SCO: Senior Care Options; PIP: performance improvement project; CY: calendar year; N/A: not applicable; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year.

### Aim

Indicator 1: By the end of 2025, SWH aims to increase the percentage of members with a diagnosis of hypertension and whose most recent blood pressure measurement was adequately controlled less than 140 systolic and 90 diastolic (<140/90 mmHg) by 5 percentage points compared to the updated baseline MY2023 hybrid rate for SWH members in the HEDIS population for Controlling Blood Pressure.

Indicator 2: By the end of 2025, SWH aims to increase the percentage of members with a diagnosis of hypertension and whose most recent blood pressure measurement was adequately controlled less than 140 systolic and 90 diastolic (<140/90 mmHg) by 5 percentage points compared to the updated baseline MY2023 administrative rate for SWH members in the HEDIS population for Controlling Blood Pressure.

Indicator 3: By the end of 2025, SWH aims to increase the percentage of members with a diagnosis of hypertension and whose last documented blood pressure measurement of the year was adequately controlled (<140/90mmHg) by 5 percentage points compared to the updated baseline MY2023 rate for SWH members residing in Suffolk County

## Interventions in 2024

- Increase outreach and care management and provide resources to improve blood pressure control
- Increase availability and outreach for member appointments by partnering with providers who have members with uncontrolled blood pressure
- Provide culturally appropriate training and resources to a variety of member populations in the community

## Performance Improvement Summary

There is high confidence that the PIP produced evidence of improvement. The PIP showed significant increases in performance indicator percentages (and performance across all counties), and goals were proactively re-evaluated and updated by SWH SCO for the remeasurement 1 period.

**Table 23: SWH SCO PIP 1 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Rate of members with a hypertension diagnosis who have controlled blood pressure (hybrid)	2024 (baseline, MY 2023 data)	67.64%
Indicator 1: Rate of members with a hypertension diagnosis who have controlled blood pressure (hybrid)	2025 (remeasurement 1, MY 2024 data)	83.94%
Indicator 2: Rate of members with a hypertension diagnosis who have controlled blood pressure (administrative)	2024 (baseline, MY 2023 data)	52.09%
Indicator 2: Rate of members with a hypertension diagnosis who have controlled blood pressure (administrative)	2025 (remeasurement 1, MY 2024 data)	70.96%
Indicator 3: Rate of members who live in Suffolk County with a hypertension diagnosis who have controlled blood pressure	2024 (baseline, MY 2023 data)	47.78%
Indicator 3: Rate of members who live in Suffolk County with a hypertension diagnosis who have controlled blood pressure	2025 (remeasurement 1, MY 2024 data)	66.67%
Indicator 4: Rate of members who live in Bristol County with a hypertension diagnosis who have controlled blood pressure	2024 (baseline, MY 2023 data)	70.87%
Indicator 4: Rate of members who live in Bristol County with a hypertension diagnosis who have controlled blood pressure	2025 (remeasurement 1, MY 2024 data)	77.99%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

**Table 24: SWH SCO PIP 2 Summary, 2025**

SWH SCO PIP 2: Improving the transitions of care rate for all Senior Whole Health SCO members.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – Moderate Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence

SCO: Senior Care Options; PIP: performance improvement project; HEDIS: Healthcare Effectiveness Data and Information Set; TRC: Transitions of Care; MY: measurement year.

## Aim

Senior Whole Health is working on the overall Transition of Care measure to improve rates of compliance for all SWH members for each of the sub-measures of TRC, as previously mentioned. The goals outlined below are specific to the interventions for medication reconciliation for this PIP cycle.

By the end of 2025, Senior Whole Health aims to increase the percentage of members who discharged from a facility and received a timely medication reconciliation post-discharge per HEDIS specifications by 5 percentage points compared to MY2023 updated baseline hybrid rate.

By the end of 2025, Senior Whole Health aims to increase the percentage of members who discharged from a facility and received a timely medication reconciliation post-discharge per HEDIS specifications by 5 percentage points compared to the MY2023 updated baseline administrative rate. SWH is including administrative rate data as a performance indicator for additional timely and county-specific reporting.

By the end of 2025, Senior Whole Health aims to increase the percentage of members in Suffolk County who discharged from facility and received a timely medication reconciliation post-discharge per HEDIS specifications by 5 percentage points compared to the MY2023 updated baseline rate administrative rates.

By the end of 2025, Senior Whole Health aims to increase the percentage of members in Bristol County who discharged from facility and received a timely medication reconciliation post-discharge per HEDIS specifications by 5 percentage points compared to MY2023 updated baseline rate administrative rates.

### Interventions in 2024

- Outreach members upon discharge to address barriers and increase understanding of follow up care
- Collaborate with providers to improve coordination for members medication reconciliation post discharge
- Collaborate with providers to distribute targeted discharge lists

### Performance Improvement Summary

There is moderate confidence that the PIP produced evidence of improvement. Although indicator rates experienced substantial improvement from the baseline rate (Indicator 1) for the interim year comparison, one of the interventions/intervention tracking measures has no demonstrable rate of improvement and no modification to the intervention, leaving it difficult to assess intervention effectiveness on the goal rates.

**Table 25: SWH SCO PIP 2 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: TRC MRP Rates for all SWH (Hybrid)	2024 (baseline, 2023 MY data)	57.66%
Indicator 1: TRC MRP Rates for all SWH (Hybrid)	2025 (remeasurement 1, 2024 MY data)	78.59%
Indicator 2: TRC MRP rates (Administrative)	2024 (baseline, 2023 MY data)	32.40%
Indicator 2: TRC MRP rates (Administrative)	2025 (remeasurement 1, 2024 MY data)	70.70%
Indicator 3: TRC MRP rates for Suffolk County (Administrative)	2024 (baseline, 2023 MY data)	25.34%
Indicator 3: TRC MRP rates for Suffolk County (Administrative)	2025 (remeasurement 1, 2024 MY data)	67.73%
Indicator 4: TRC MRP rates for Bristol County (Administrative)	2024 (baseline, 2023 MY data)	42.41%
Indicator 4: TRC MRP rates for Bristol County (Administrative)	2025 (remeasurement 1, 2024 MY data)	78.13%
Indicator 5: TRC Notification of Inpatient Admission (Hybrid)	2024 (baseline, 2023 MY data)	13.38%
Indicator 5: TRC Notification of Inpatient Admission (Hybrid)	2025 (remeasurement 1, 2024 MY data)	13.63%
Indicator 6: TRC Receipt of Discharge Information (Hybrid)	2024 (baseline, 2023 MY data)	15.33%
Indicator 6: TRC Receipt of Discharge Information (Hybrid)	2025 (remeasurement 1, 2024 MY data)	15.82%

Indicators	Reporting Year	Rate
Indicator 7: TRC Patient Engagement After Inpatient Discharge (Hybrid)	2024 (baseline, 2023 MY data)	87.59%
Indicator 7: TRC Patient Engagement After Inpatient Discharge (Hybrid)	2025 (remeasurement 1, 2024 MY data)	89.54%

SCO: Senior Care Options; PIP: performance improvement project; TRC: Transitions of Care; MRP: Medication Reconciliation Post-Discharge; MY: measurement year.

## Recommendations

- *Recommendation for PIP 2:* Interventions that showed declining intervention tracking measure rates were not modified. For future report submissions or future PIP cycles, SWH SCO should closely monitor intervention tracking measure data so that declines in intervention tracking measure rates can spur quick course correction (and utilize Plan-Do-Study-Act cycles throughout the PIP to help develop intervention changes).

## Tufts SCO PIPs

Tufts SCO PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 26–29**.

**Table 26: Tufts SCO PIP 1 Summary, 2025**

Tufts SCO PIP 1: Decreasing the total percentage of Tufts SCO members who use a high-risk medication.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – Moderate Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – Low Confidence

SCO: Senior Care Options; PIP: performance improvement project; THP: Tufts Health Plan; MY: measurement year.

## Aim

Indicator 1: By the end of 2025, THP SCO aims to decrease the percentage of members who are at risk of having a potentially harmful drug interaction by 3 percentage points from the MY2023 rate of 33.96% to 30.96%.

Indicator 2: By the end of 2025, THP SCO aims to decrease the percentage of members who have a history of falls and are at risk of having a potentially harmful drug interaction from an Antiepileptics, Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics or Antidepressants (SSRIs, Tricyclic Antidepressants and SNRIs) by 5.29 percentage points from the MY2023 rate of 44.33% to 39.04%.

Indicator 3: By the end of 2025, THP SCO aims to decrease the percentage of members who are at risk of having a potentially harmful drug interaction for members who have dementia and take antipsychotics by 2.5 percentage points from the MY2023 rate of 35.80% to 33.30%.

Indicator 4: By the end of 2025, THP SCO aims to decrease the percentage of members who are at risk of having a potentially harmful drug interaction for members who have chronic kidney disease and take Cox-2 Selective NSAIDs or Non-aspirin NSAIDS by 3.44 percentage points from the MY2023 rate of 12.15% to 8.71%.

## Interventions in 2024

- Consult with prescribers on high-risk medication prescriptions
- Increase utilization of the member care dashboard to guide prescriber outreach
- Automate notifications for pharmacy claims to initiate member outreach

## Performance Improvement Summary

There is low confidence that the PIP produced evidence of improvement. Performance indicators did not improve from the baseline rates. Although the Plan identified barriers during the PIP cycle, intervention tracking measure data showed low reach, with less than 40 members being impacted for each of the three intervention tracking measures for the past two quarters reported.

**Table 27: Tufts SCO PIP 1 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Potentially Harmful Drug Disease Interactions	2024 (baseline, MY 2023 data)	33.96%
Indicator 1: Potentially Harmful Drug Disease Interactions	2025 (remeasurement 1, MY 2024 data)	34.39%
Indicator 2: History of Falls and Antiepileptics, Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics or Antidepressants (SSRIs, Tricyclic Antidepressants and SNRIs)	2024 (baseline, MY 2023 data)	44.33%
Indicator 2: History of Falls and Antiepileptics, Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics or Antidepressants (SSRIs, Tricyclic Antidepressants and SNRIs)	2025 (remeasurement 1, MY 2024 data)	43.20%
Indicator 3: Dementia and Antipsychotics	2024 (baseline, MY 2023 data)	35.80%
Indicator 3: Dementia and Antipsychotics	2025 (remeasurement 1, MY 2024 data)	37.80%
Indicator 4: Chronic Kidney Disease and Cox-2 Selective NSAIDs or Non-aspirin NSAIDs	2024 (baseline, MY 2023 data)	12.15%
Indicator 4: Chronic Kidney Disease and Cox-2 Selective NSAIDs or Non-aspirin NSAIDs	2025 (remeasurement 1, MY 2024 data)	11.74%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

**Table 28: Tufts SCO PIP 2 Summary, 2025**

Tufts SCO PIP 2: Improving the transitions of care rate for all Tufts Health Plan SCO members.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – Moderate Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – High Confidence

SCO: Senior Care Options; PIP: performance improvement project; THP: Tufts Health Plan; TRC: Transitions of Care; MY: measurement year.

## Aim

By the end of 2025, THP SCO aims to increase the percentage of members who had a medication reconciliation within 30 days of discharge from a hospital by 13.5 percentage points compared to the MY 2023 baseline rate 54.50% to 68.00%. By focusing on interventions that address barriers to the medication reconciliation component of the TRC measure THP SCO aims to improve the overall TRC measure.

## Interventions in 2024

- Outreach to provider groups with low rates of follow up visits within 30 days of a discharge
- Complete serial calls to high acuity members
- Complete medication reconciliation at discharge

## Performance Improvement Summary

There is high confidence that the PIP produced evidence of improvement. Three of four indicators saw an increase in performance from baseline to the interim period, with the TRC indicator of focus increasing over 10% and exceeding the goal rate.

**Table 29: Tufts SCO PIP 2 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Notification of Inpatient Admissions	2024 (baseline MY 2023 data)	32.06%
Indicator 1: Notification of Inpatient Admissions	2025 (remeasurement 1, MY 2024 data)	43.81%
Indicator 2: Receipt of Discharge Information	2024 (baseline MY 2023 data)	24.57%
Indicator 2: Receipt of Discharge Information	2025 (remeasurement 1, MY 2024 data)	35.77%
Indicator 3: Patients Engagement After Inpatient Discharge	2024 (baseline MY 2023 data)	91.24%
Indicator 3: Patients Engagement After Inpatient Discharge	2025 (remeasurement 1, MY 2024 data)	87.59%
Indicator 4: Medication Reconciliation Post-Discharge	2024 (baseline MY 2023 data)	54.50%
Indicator 4: Medication Reconciliation Post-Discharge	2025 (remeasurement 1, MY 2024 data)	65.94%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

## Recommendations

- *Recommendation for PIP 1:* Given the lack of improvement in the performance indicators, it is recommended that the Plan utilize barrier analysis to develop intervention tracking measures with a larger reach to impact a larger proportion of the member population.
- *Recommendation for PIP 2:* Tufts SCO should ensure that results are reported consistently throughout various sections of the PIP.

## UHC SCO PIPs

UHC SCO PIP summaries, including aim, interventions, and results (indicators), are reported in **Tables 30–33**.

**Table 30: UHC SCO PIP 1 Summary, 2025**

UHC SCO PIP 1: Decreasing the total percentage of UHC SCO members who use a high-risk medication.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

## Aim

Indicator 1: By the end of 2025, UHC SCO aims to decrease the total percentage of SCO members who fill a high-risk medication two or more times by 2.17 percentage points from 21.23% in MY2023 down to 19.06% in MY2025.

Indicator 2: By the end of 2025, UHC SCO aims to decrease the percentage of SCO members who had at least two dispensing events of Zolpidem by 0.27 percentage points from 2.27% in MY2023 to 2.00% in MY2025.

## Interventions in 2024

- Educate providers on resources for prescribing medication to patients over 67 years of age
- Update and provide care plans to providers when conducting assessments with members prescribed high-risk medications
- Educate members on the risks of taking Zolpidem

### Performance Improvement Summary

There is moderate confidence that the PIP produced evidence of improvement. Although there was evidence of adapting interventions during the PIP process, there was not improvement in performance indicator rates throughout the PIP.

**Table 31: UHC SCO PIP 1 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Use of High-Risk Medications in Older Adults - Total (DAE)	2024 (baseline MY 2023 data)	21.23%
Indicator 1: Use of High-Risk Medications in Older Adults - Total (DAE)	2025 (remeasurement 1, MY 2024 data)	20.48%
Indicator 2: The percentage of SCO members 67 years of age and older in the measurement year who had at least two dispensing events for Zolpidem	2024 (baseline MY 2023 data)	2.27%
Indicator 2: The percentage of SCO members 67 years of age and older in the measurement year who had at least two dispensing events for Zolpidem	2025 (remeasurement 1, MY 2024 data)	3.02%
Indicator 3: The percentage of SCO members 67 years of age and older in the measurement year who had at least two dispensing events for a Benzodiazepine	2025 (remeasurement 1, MY 2024 data)	13.14%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

**Table 32: UHC SCO PIP 2 Summary, 2025**

UHC SCO PIP 2: Improving the transitions of care rate for all UHC SCO members.
<b>Validation Summary</b>
Confidence Rating 1: PIP Adhered to Acceptable Methodology – High Confidence
Confidence Rating 2: PIP Produced Evidence of Improvement – Moderate Confidence

SCO: Senior Care Options; PIP: performance improvement project; N/A: not applicable; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year.

### Aim

UHC aims to improve the transition of care experience of SCO community members by increasing the medication reconciliation post hospital discharge HEDIS rate of SCO community members by 3.86 percentage points, from a rate of 86.37% in MY2023 to a rate of 90.23% by end of MY2025.

### Interventions in 2024

- Educate nurse care managers on documentation requirements for medication reconciliation
- Educate care managers assigned to Spanish speaking members on medication reconciliations requirements
- Provide education to providers on medication reconciliation coding

### Performance Improvement Summary

There is moderate confidence that the PIP produced evidence of improvement. Although two of the four indicator rates improved from the baseline to interim period, the targeted submeasure's (MRP) rate did not change during this timeframe and was identical from baseline to the interim period, leaving it difficult to assess effectiveness of the interventions that were implemented during the MY.

**Table 33: UHC SCO PIP 2 Performance Measures and Results**

Indicators	Reporting Year	Rate
Indicator 1: Notification of Inpatient Admissions	2024 (baseline, 2023 MY data)	18.98%
Indicator 1: Notification of Inpatient Admissions	2025 (remeasurement 1, MY 2024 data)	27.25%
Indicator 2: Receipt of Discharge Information	2024 (baseline, 2023 MY data)	26.52%
Indicator 2: Receipt of Discharge Information	2025 (remeasurement 1, MY 2024 data)	20.92%
Indicator 3: Patient Engagement After Inpatient Discharge	2024 (baseline, 2023 MY data)	95.38%
Indicator 3: Patient Engagement After Inpatient Discharge	2025 (remeasurement 1, MY 2024 data)	96.35%
Indicator 4: Medication Reconciliation Post-Discharge	2024 (baseline, 2023 MY data)	86.37%
Indicator 4: Medication Reconciliation Post-Discharge	2025 (remeasurement 1, MY 2024 data)	86.37%

SCO: Senior Care Options; PIP: performance improvement project; MY: measurement year.

### Recommendations

- *Recommendation for PIP 1:* UHC should continue to identify barriers and adapt interventions to increase the PI rates.
- *Recommendation for PIP 2:* UHC should continue interventions while monitoring associated intervention tracking measure data for performance improvement. UHC should also modify/include new interventions based on intervention/intervention tracking measure performance outcomes.

## IV. Validation of Performance Measures

### Objectives

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

### Technical Methods of Data Collection and Analysis

MassHealth evaluates SCOs' performance on HEDIS special needs plans (SNP) measures. For MY 2024, SCOs were required to calculate HEDIS SNP measure rates for all SCO members in accordance with HEDIS specifications and report to MassHealth on the same time schedule as required by CMS, as outlined in Section 2.13.A of the Third Amended and Restated MassHealth SCO Contract.

MassHealth also evaluates SCO performance on non-HEDIS measures (i.e., measures that are not reported to NCQA via the Interactive Data Submission System). One non-HEDIS measure was in scope for reporting and 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.<sup>7</sup> Since the SCOs' HEDIS rates were audited by an independent NCQA-licensed HEDIS compliance audit organization, all SCO Plans received a full Information Systems Capabilities Assessment as part of the audit. Onsite (virtual) audits were therefore not necessary to validate reported measures.

One non-HEDIS measure was calculated by MassHealth on behalf of the SCOs. MassHealth received claims and encounter data from the SCOs. MassHealth then provided Telligen with the SCO claims and encounter data files through a comprehensive data file extract referred to as the mega-data extract. Telligen extracted and transformed the data elements necessary for measure calculation.

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

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

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

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<sup>7</sup> 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 SCO's independent auditor.

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

### Description of Data Obtained

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

The following information was obtained from MassHealth: a completed Information Systems Capabilities Assessment tool, denominator and numerator compliant list for the non-HEDIS measure MLTSS-7: Managed LTSS Minimizing Facility Length of Stay, rates for the non-HEDIS measure, and screenshots from the data warehouse for primary source validation.

### Conclusions and Comparative Findings

Based on a review of the SCO Plans’ HEDIS Final Audit Reports issued by their independent NCQA-certified HEDIS compliance auditors, IPRO found that the SCO Plans were fully compliant with all the applicable NCQA information system standards. Findings from IPRO’s review of the SCO Plans’ HEDIS Final Audit Reports are displayed in **Table 34**.

**Table 34: SCO Compliance with Information System Standards – MY 2024**

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

SCO: Senior Care Options; MY: measurement year; IS: information systems.

### Validation Findings

- Information Systems Capabilities Assessment:** The Information Systems Capabilities Assessment is conducted to confirm that the SCO 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 SCO Plans’ HEDIS Final Audit Reports issued by their independent NCQA-certified HEDIS compliance auditors. IPRO also conducted an Information Systems Capabilities Assessment review with MassHealth for the non-HEDIS measure. 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 SCO Plan’s Final Audit Report confirmed that the SCO Plans used NCQA-certified measure vendors to produce the HEDIS rates. Source code review was conducted with Telligen for the SCO non-HEDIS measure rates. No issues were identified.

- **Medical Record Validation:** Medical record review validation is conducted to confirm that the SCO Plans followed appropriate processes to report rates using the hybrid methodology. The review of each SCO Plan’s Final Audit Report confirmed that the SCO Plans passed medical record review validation. The one non-HEDIS measure calculated by MassHealth/Telligen did not use hybrid methodology; therefore, additional medical record review validation was not required. No issues were identified.
- **Primary Source Validation:** Primary source validation is conducted to confirm that the information from the primary source matches the output information used for measure reporting. The review of each SCO Plan’s Final Audit Report confirmed that the SCO Plans passed the primary source validation. MassHealth provided screenshots from the data warehouse of the selected records for primary source validation for the non-HEDIS measure. All records passed validation. No issues were identified.
- **Data Collection and Integration Validation:** This includes a review of the processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance to evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately. The review of each SCO Plan’s Final Audit Report confirmed that the SCO Plans met all requirements related to data collection and integration. MassHealth also met 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 SCO Plan rates to provide methodologically appropriate, comparative information for all SCO Plans consistent with guidance included in the EQR protocols issued in accordance with *Title 42 CFR § 438.352(e)*. IPRO also compared the SCO Plan rates and the weighted statewide means to the NCQA HEDIS MY 2024 Quality Compass national Medicare percentiles, where available. MassHealth’s benchmarks for SCO rates are the 75th and the 90th Quality Compass national Medicare percentile.

Best Performance:

- **Advance Care Planning**
  - Fallon SCO: 73.25% (≥ 75th percentile but < 90th percentile)
  - SWH SCO: 81.56% (≥ 90th percentile)
  - UHC SCO: 67.14% (≥ 75th percentile but < 90th percentile)
- **Colorectal Cancer Screening (Total)**
  - UHC SCO: 82.27% (≥ 90th percentile)
- **Controlling High Blood Pressure**
  - CCA SCO: 86.67% (≥ 75th percentile but < 90th percentile)
  - SWH SCO: 83.94% (≥ 75th percentile but < 90th percentile)
- **Follow-up After Hospitalization for Mental Illness – 30 days (Total)**
  - CCA SCO: 68.33% (≥ 75th percentile but < 90th percentile)
  - Tufts SCO: 62.16% (≥ 75th percentile but < 90th percentile)
- **Follow-up After Hospitalization for Mental Illness – 7 days (Total)**
  - CCA SCO: 50.00% (≥ 75th percentile but < 90th percentile)
  - SWH SCO: 42.42% (≥ 75th percentile but < 90th percentile)
- **Osteoporosis Management in Women Who Had a Fracture**
  - Fallon SCO: 72.09% (≥ 90th percentile)
- **Pharmacotherapy Management of COPD Exacerbation – Bronchodilator**
  - CCA SCO: 89.14% (≥ 75th percentile but < 90th percentile)
  - Tufts SCO: 89.36% (≥ 75th percentile but < 90th percentile)
  - UHC SCO: 89.80% (≥ 75th percentile but < 90th percentile)

- WellSense SCO: 92.73% (≥ 90th percentile)
- **Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid**
  - Tufts SCO: 82.98% (≥ 75th percentile but < 90th percentile)
  - WellSense SCO: 85.45% (≥ 90th percentile)
- **Potentially Harmful Drug-Disease Interactions in Older Adults – DDI – Total**
  - WellSense SCO: 27.09% (≥ 75th percentile but < 90th percentile)
- **Transitions of Care – Medication Reconciliation Post-discharge (Total)**
  - CCA SCO: 94.12% (≥ 90th percentile)
  - Fallon SCO: 90.02% (≥ 75th percentile but < 90th percentile)

Needs Improvement:

- **Antidepressant Medication Management – Effective Acute Phase Treatment**
  - Fallon SCO: 76.57% (< 25th percentile)
  - WellSense SCO: 73.33% (< 25th percentile)
- **Controlling High Blood Pressure**
  - WellSense SCO: 72.00% (< 2 5th percentile)
- **Osteoporosis Management in Women Who Had a Fracture**
  - CCA SCO: 20.75% (< 25th percentile)
  - SWH SCO: 25.00% (< 25th percentile)
  - Tufts SCO: 21.74% (< 25th percentile)
  - UHC SCO: 27.17% (< 25th percentile)
- **Plan All-Cause Readmissions (65+)**
  - CCA SCO: 1.2675 (< 25th percentile)
  - Tufts SCO: 1.2167 (< 25th percentile)
  - UHC SCO: 1.0803 (< 25th percentile)
  - WellSense SCO: 1.3462 (< 25th percentile)
- **Use of High-Risk Medications in Older Adults – Total**
  - CCA SCO: 27.33% (< 25th percentile)
  - Fallon SCO: 25.38% (< 25th percentile)
  - Tufts SCO: 20.47% (< 25th percentile)
  - UHC SCO: 20.48% (< 25th percentile)

As shown in **Table 35**, the Quality Compass percentiles are color-coded to compare with the SCO Plan rates.

**Table 35: Color Key for HEDIS Performance Measure Comparison to the NCQA HEDIS MY 2024 Quality Compass National Medicare Percentiles**

Key	How Rate Compares to the NCQA HEDIS MY 2024 Quality Compass National Medicare 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.

Tables 36 displays the HEDIS performance measures for MY 2024 for all SCO Plans and the weighted statewide mean.

**Table 36: SCO HEDIS Performance Measures – MY 2024**

HEDIS Measure	WellSense SCO	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Weighted Statewide Mean
Colorectal Cancer Screening	N/A	75.78% (≥ 50th but < 75th)	67.21% (≥ 25th but < 50th)	75.9% (≥ 50th but < 75th)	72.38% (≥ 50th but < 75th)	82.27% (≥ 90th)	76.36% (≥ 50th but < 75th)
Influenza Immunization (age 65+ years) <sup>1</sup>	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Advance Care Planning	N/A	52.9% (≥ 50th but < 75th)	73.25% (≥ 75th but < 90th)	81.56% (≥ 90th)	N/A	67.14% (≥ 75th but < 90th)	67.36% (≥ 75th but < 90th)
Care for Older Adults: Functional Status Assessment <sup>2</sup>	79.88% (N/A)	N/A	100% (N/A)	N/A	N/A	N/A	96.84% (N/A)
Transitions of Care: Medication Reconciliation Post-discharge	66.67% (≥ 25th but < 50th)	94.12% (≥ 90th)	90.02% (≥ 75th but < 90th)	78.59% (≥ 50th but < 75th)	65.94% (≥ 25th but < 50th)	86.37% (≥ 50th but < 75th)	84.69% (≥ 50th but < 75th)
Persistence of Beta Blocker Treatment After Heart Attack	N/A	N/A	N/A	N/A	N/A	N/A	73.08% (≥ 50th but < 75th)
Controlling High Blood Pressure	72% (< 25th)	86.67% (≥ 75th but < 90th)	79.82% (≥ 50th but < 75th)	83.94% (≥ 75th but < 90th)	78.03% (≥ 25th but < 50th)	81.06% (≥ 50th but < 75th)	81.92% (≥ 50th but < 75th)
Pharmacotherapy Management of COPD Exacerbation: Corticosteroids	85.45% (≥ 90th)	74.72% (≥ 25th but < 50th)	77.68% (≥ 50th but < 75th)	76.4% (≥ 50th but < 75th)	82.98% (≥ 75th but < 90th)	77.65% (≥ 50th but < 75th)	77.38% (≥ 50th but < 75th)
Pharmacotherapy Management of COPD Exacerbation: Bronchodilators	92.73% (≥ 90th)	89.14% (≥ 75th but < 90th)	87.55% (≥ 50th but < 75th)	85.96% (≥ 50th but < 75th)	89.36% (≥ 75th but < 90th)	89.8% (≥ 75th but < 90th)	88.73% (≥ 75th but < 90th)
Use of High-Risk Medications in the Elderly (Total; lower is better)	16.67% (≥ 25th but < 50th)	27.33% (< 25th)	25.38% (< 25th)	17.18% (≥ 25th but < 50th)	20.47% (< 25th)	20.48% (< 25th)	21.77% (< 25th)
Potentially Harmful Drug Disease Interactions in the Elderly (Total; lower is better)	27.09% (≥ 75th but < 90th)	33.67% (≥ 25th but < 50th)	36.5% (≥ 25th but < 50th)	31% (≥ 50th but < 75th)	34.39% (≥ 25th but < 50th)	31.08% (≥ 50th but < 75th)	32.7% (≥ 50th but < 75th)
Follow-Up After Hospitalization for Mental Illness (7 days)	N/A	50% (≥ 75th but < 90th)	27.08% (≥ 25th but < 50th)	42.42% (≥ 75th but < 90th)	35.14% (≥ 50th but < 75th)	35.09% (≥ 50th but < 75th)	40% (≥ 75th but < 90th)
Follow-Up After Hospitalization for Mental Illness (30 days)	N/A	68.33% (≥ 75th but < 90th)	52.08% (≥ 50th but < 75th)	60.61% (≥ 50th but < 75th)	62.16% (≥ 75th but < 90th)	57.89% (≥ 50th but < 75th)	61.33% (≥ 50th but < 75th)
Plan All-Cause Readmission (Observed/Expected Ratio) 65+	1.3462 (< 25th)	1.2675 (< 25th)	0.946 (≥ 50th but < 75th)	1.0093 (≥ 25th but < 50th)	1.2167 (< 25th)	1.0803 (< 25th)	1.1114 (< 25th)
Osteoporosis Management in Women Who Had a Fracture	N/A	20.75% (< 25th)	72.09% (≥ 90th)	25% (< 25th)	21.74% (< 25th)	27.17% (< 25th)	31.54% (< 25th)

HEDIS Measure	WellSense SCO	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Weighted Statewide Mean
Antidepressant Medication Management – Acute	73.33% ( < 25th)	82.22% ( ≥ 25th but < 50th)	76.57% ( < 25th)	80.31% ( ≥ 25th but < 50th)	82.23% ( ≥ 25th but < 50th)	82.41% ( ≥ 25th but < 50th)	80.93% ( ≥ 25th but < 50th)
Antidepressant Medication Management – Continuation	71.11% ( ≥ 50th but < 75th)	68.89% ( ≥ 50th but < 75th)	63.37% ( ≥ 25th but < 50th)	67.57% ( ≥ 50th but < 75th)	67.36% ( ≥ 50th but < 75th)	65.86% ( ≥ 25th but < 50th)	66.79% ( ≥ 25th but < 50th)
Managed Long Term Services and Supports, Minimizing Facility Length of Stay	1.25 (N/A)	1.61 (N/A)	0.86 (N/A)	1.55 (N/A)	1.07 (N/A)	0.77 (N/A)	1.1493 (N/A)

<sup>1</sup> The CAHPS Influenza Immunization measure was compared to the Medicare Advantage national mean score, instead of the Quality Compass.

<sup>2</sup> Quality Compass for Care for Older Adults is not available.

SCO: senior care option; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; COPD: chronic obstructive pulmonary disease; N/A: not applicable, eligible population/denominator less than 30; CAHPS: Consumer Assessment of Healthcare Providers and Services.

## 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 SCO 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 review consisted of three phases: 1) pre-interview documentation review, 2) remote interviews, and 3) post-onsite report preparation.

#### Pre-interview Documentation Review

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

Once MassHealth approved the methodology, IPRO sent each SCO Plan a packet that included the review tools, along with a request for documentation and a guide to help 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 SCO Plans with examples of documents that they could furnish to validate compliance with the regulations. Instructions regarding the file review component of the audit were also provided, along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO randomly selected a sample of cases for the Plans to provide in each area, which were reviewed remotely.

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

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

### **Remote Interviews**

The remote interview with SCO Plans were conducted between August 21 and September 14, 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 SCO Plans to provide additional documentation, if available. SCO staff was given two days from the close of the onsite review to provide any further documentation.

### **Post-interview Report Preparation**

Following the remote interviews, review tools were updated. These post-interview tools included an initial review determination for each element reviewed and identified what specific evidence was used to assess that MCP was compliant with the standard or a rationale for why an MCP 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 MCPs to consider in order to attain full compliance.

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

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

### Scoring Methodology

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by the total possible points. A three-point scoring system was used: Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points. For each standard identified as Partially Met or Not Met, the MCP was required to clarify how and when the issue will be resolved. The scoring definitions are outlined in **Table 37**.

**Table 37: 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"> <li>• Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. MCP staff interviews, however, provided information that was not consistent with the documentation provided.</li> <li>• Documentation to substantiate compliance with some but not all of the regulatory or contractual provisions was provided, although MCP staff interviews provided information consistent with compliance with all requirements.</li> <li>• Documentation to substantiate compliance with some but not all of the regulatory or contractual provisions was provided, and MCP staff interviews provided information inconsistent with compliance with all requirements.</li> </ul>
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

SCO Plans were compliant with many of the Medicaid and CHIP managed care regulations and standards. The average total compliance rate among all SCO Plans was 96.2%. SWH SCO had the highest total compliance rate at 98.1%, while CCA SCO had the lowest at 93.4%.

Areas requiring improvement:

- Disenrollment requirements and limitations (Tufts SCO)
- Enrollee rights and protections (WellSense SCO and Fallon SCO)
- Emergency and post-stabilization services (CCA SCO)
- Coordination and continuity of care (WellSense SCO, CCA SCO, Fallon SCO, SWH SCO, and Tufts SCO)
- Subcontractual relationships and delegation (UHC SCO)

**Table 38** presents SCO Plans' compliance scores for each of the 14 review domains. 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 has seven regulations embedded in the 438.210 Coverage and Authorization Tool and extracted in the scorecard for presentation. Red text: indicates an opportunity for improvement (less than 90%).

**Table 38: SCO Plans Performance by Review Domain – 2023 Compliance Validation Results**

CFR Standard Name (Review Domain)	CFR Citation	WellSense SCO	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Statewide Average
Overall compliance score	N/A	96.6%	93.4%	94.8%	98.1%	97.3%	97.0%	96.2%
Disenrollment Requirements and Limitations	<b>438.56</b>	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	97.2%
Enrollee Rights and Protections total	<b>438.100</b>	86.8%	92.4%	74.7%	98.6%	93.2%	98.0%	90.6%
Emergency and Post-stabilization Services	<b>438.114</b>	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	91.7%
Availability of Services	<b>438.206</b>	95.8%	95.8%	95.8%	100.0%	100.0%	100.0%	97.9%
Assurances of Adequate Capacity and Services	<b>438.207</b>	100.0%	100.0%	100.0%	91.2%	100.0%	97.1%	98.1%
Coordination and Continuity of Care	<b>438.208</b>	79.9%	83.6%	88.3%	85.8%	88.8%	92.5%	86.5%
Coverage and Authorization of Services	<b>438.210</b>	98.6%	100.0%	95.8%	100.0%	100.0%	95.8%	98.4%
Provider Selection	<b>438.214</b>	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	98.6%
Confidentiality	<b>438.224</b>	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Grievance and Appeal Systems	<b>438.228</b>	100.0%	94.4%	100.0%	97.2%	97.2%	100.0%	98.1%
Subcontractual Relationships and Delegation	<b>438.230</b>	100.0%	96.7%	100.0%	100.0%	100.0%	84.4%	96.6%
Practice Guidelines	<b>438.236</b>	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	99.3%
Health Information Systems	<b>438.242</b>	93.8%	100.0%	75.0%	100.0%	100.0%	100.0%	94.8%
QAPI	<b>438.330</b>	97.8%	100.0%	97.8%	100.0%	100.0%	97.8%	98.9%

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

## VI. Validation of Network Adequacy

### Objectives

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

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

MassHealth's access and availability standards are described in Section 2.6 Enrollee Access to Services of the Third Amended and Restated MassHealth SCO Contract. SCO Plans are contractually required to meet the time and distance adequacy standards, as well as the availability of services 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 SCOs. IPRO evaluated SCOs' processes for collecting and storing network data, provider networks' compliance with MassHealth's GeoAccess requirements, the accuracy of the information presented in SCOs' 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.

WellSense SCO excluded from NAV activities because the health plan ended operations in the middle of CY 2025.

### 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 39**.

**Table 39: Audited Specialties**

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

IPRO filtered SCO 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 SCO 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 data submission from Tufts SCO was the most comparable with the online directory information (96.7% correct) and the SWH was the least comparable with online directory information (30.7% 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, Fallon SCO data submission was the most comparable (94.8% correct), while SWH was the least comparable (34.4% 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 CMHCs calling script was designed to address telehealth and in-person appointments and differentiate between a billable clinical intake session vs administrative screening. A telehealth appointment was counted towards the average appointment wait times only if the behavioral health provider also offered in-person appointments.

MassHealth’s appointment availability standards for SCOs are detailed in **Table 40**. Standards highlighted in gray are for provider types not included in the survey.

**Table 40: Availability Standards**

Provider Type	Urgency Level	SCO Standard
Emergency services <sup>1</sup>	Emergency	Immediately
Urgent care <sup>1</sup>	Urgent/Symptomatic	48 hours
SCO Primary Care Providers: Internal, Family, Geriatric	Nonurgent symptomatic: sick visit	14 calendar days
SCO Primary Care Providers: Internal, Family, Geriatric	Nonsymptomatic: routine visit	30 calendar days
SCO specialty provider: ob/gyn	Nonurgent symptomatic: sick visit	14 calendar days
SCO specialty provider: ob/gyn	Nonsymptomatic: routine visit	30 calendar days
Behavioral health (BH) services <sup>1</sup>	Nonurgent BH services	14 calendar days

<sup>1</sup> Gray cells: indicates provider types not included in the survey.

SCO: Senior Care Options; 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 SCO contracts, at least 90% of health plan members in each county must have access to in-network providers following the time or distance standards defined in the contract.

SCO network adequacy standards are a combination of CMS’s network adequacy standards for Medicare Advantage and MassHealth-developed standards defined in the contract between the SCO Plans and MassHealth. Consequently, some SCO 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 41**.

**Table 41: 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"> <li>• Primary Care</li> <li>• Acute Inpatient Hospitals</li> <li>• Skilled Nursing Facilities</li> <li>• Occupational Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Specialists</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral Health Outpatient Services</li> <li>• LTSS Providers: Adult Day Health, Day Habilitation, Hospice</li> <li>• Rehabilitation Hospital</li> <li>• Dental Services: General Dentistry and Oral Surgery</li> </ul>

LTSS: long-term services and supports.

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 42**.

**Table 42: 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. SCO network adequacy standards and indicators are listed in **Appendix D (Tables D1–D9)**.

IPRO requested in-network provider data on April 4, 2025, with a submission due date of May 16, 2025. MCPs submitted data to IPRO following templates developed by MassHealth and utilized by MCOs and ACPPs to report provider lists to MassHealth on an annual basis. The submitted data went through a careful and significant data cleanup and deduplication process. If IPRO identified missing or incorrect data, the Plans were contacted and asked to resubmit. Duplicative records were identified and removed before the analysis.

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

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

### **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, SCO 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 between August 28 and September 2, 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 SCO 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 and appointment wait times, IPRO did not assess MCP methods of calculating the indicator but instead calculated the indicator itself. In those instances, the network adequacy validation rating reflects IPRO's confidence that the MCP's network meets MassHealth's standards and expectations. The network adequacy validation rating for each indicator is reported in **Table 43**.

**Table 43: SCO Network Adequacy Validation Ratings – CY 2025**

Network Adequacy Indicator	CCA SCO Validation Rating	Fallon SCO Validation Rating	SWH SCO Validation Rating	Tufts SCO Validation Rating	UHC SCO Validation Rating
Primary Care Providers' GeoAccess	Low confidence	Moderate confidence	Low confidence	High confidence: large metro counties  Moderate confidence: metro counties	Moderate confidence
Hospitals and Rehabilitation Hospital Services GeoAccess	Moderate confidence: Rehabilitation Hospital Services  Low confidence: Acute Inpatient Hospital	High confidence  Moderate confidence: Acute Inpatient Hospitals in Barnstable, Middlesex, and Norfolk counties	Moderate confidence: Rehabilitation Hospital Services  Low confidence: Acute Inpatient Hospitals	High confidence: Rehabilitation Hospital Services and Acute Inpatient Hospitals in large metro counties  Moderate confidence: Acute Inpatient Hospitals in metro counties	High confidence: Acute Inpatient Hospitals  Moderate confidence: Acute Inpatient Hospitals in Franklin, Middlesex, and Norfolk counties  Moderate confidence: Rehabilitation Hospital Services
Specialists GeoAccess, including Ob/Gyn	Moderate confidence: large metro counties  Low confidence: metro counties	High confidence  Moderate confidence: Allergy, Rheumatology, and Vascular Surgery  Low confidence: Clinical Psychology, Clinical Social Work, and Psychiatry	Moderate confidence  Low confidence: Cardiology, Dermatology, Endocrinology, ENT, Gastroenterology, General Surgery, Ob/Gyn, Infectious Diseases, Nephrology, Oncology, Ophthalmology, Orthopedic Surgery, Psychiatry, Plastic Surgery, Podiatry, Pulmonology, Rheumatology, Urology, and Vascular Surgery	High confidence: large metro counties  Moderate confidence: metro counties  Low confidence: Allergy, Cardiology in metro counties, Clinical Psychology, Clinical Social Work, General Surgery, Ob/Gyn, Neurology, Oncology, Urology, and Chiropractor in Barnstable and Bristol counties	High confidence  Moderate confidence: Allergy, Cardiology, Endocrinology, General Surgery, Nephrology, Neurosurgery, Oncology, Ophthalmology, Orthopedic Surgery, and Ob/Gyn

Network Adequacy Indicator	CCA SCO Validation Rating	Fallon SCO Validation Rating	SWH SCO Validation Rating	Tufts SCO Validation Rating	UHC SCO Validation Rating
Outpatient Behavioral Health GeoAccess	<p>Low confidence: Behavioral Health Outpatient</p> <p>Moderate confidence: Psychiatric Inpatient Adult</p> <p>Low confidence: remaining Behavioral Health Diversionary providers</p>	<p>High confidence: Behavioral Health Outpatient</p> <p>Moderate/Low confidence: Behavioral Health Diversionary Services</p> <p>Low confidence: Adult Community Crisis Stabilization, Adult Residential Rehabilitation for SUD, Clinical Support Services for SUD, Community Support Program, Intensive Outpatient Program, Partial Hospitalization Program, Recovery Coaching, and Recovery Support Navigators</p>	<p>High confidence: Behavioral Health Outpatient</p> <p>High confidence: Clinical Support Services for SUD and Program of Assertive Community Treatment</p> <p>Moderate confidence: the majority of Behavioral Health Diversionary Services</p> <p>Low confidence: Adult Community Crisis Stabilization and Psychiatric Day Treatment</p>	<p>Moderate confidence: Behavioral Health Outpatient</p> <p>High confidence: Acute Treatment Services for SUD, Adult Community Crisis Stabilization, Adult Mobile Crisis Intervention, Adult Residential Rehabilitation Services for SUD, Clinical Support Services for SUD, Community Support Program, Intensive Outpatient Program, Partial Hospitalization Program, Program of Assertive Community Treatment, Psychiatric Day Treatment, Psych Inpatient Adult, and Structured Outpatient Addiction Program</p> <p>Moderate confidence: Recovery Coaching and Recovery Support Navigators</p>	<p>Low confidence: Behavioral Health Outpatient</p> <p>Moderate confidence: Behavioral Health Diversionary Services</p>
Pharmacy GeoAccess	<p>High confidence</p> <p>Moderate confidence: Franklin, Plymouth, Suffolk counties</p>	High confidence	Moderate confidence	High confidence	High confidence

Network Adequacy Indicator	CCA SCO Validation Rating	Fallon SCO Validation Rating	SWH SCO Validation Rating	Tufts SCO Validation Rating	UHC SCO Validation Rating
LTSS Providers GeoAccess, including Skilled Nursing Facility, Occupational, Physical, and Speech Therapy	<p>Moderate confidence: Skilled Nursing Facility</p> <p>Moderate confidence: Adult Day Health and Day Habilitation in metro counties</p> <p>Low confidence: Adult Day Health and Day Habilitation in large metro, as well as Occupational, Physical, and Speech Therapy and Hospice</p>	<p>High confidence</p> <p>Moderate confidence: Day Habilitation in Barnstable County</p>	<p>Moderate confidence</p> <p>Low confidence: Skilled Nursing Facility, Occupational, Physical, and Speech Therapy in large metro counties</p>	<p>High confidence: large metro counties</p> <p>Moderate confidence: metro counties for Skilled Nursing Facility, Occupational, Physical, and Speech Therapy</p>	<p>High confidence: Skilled Nursing Facilities, Occupational Therapy, and Day Habilitation in Essex, Middlesex, Norfolk, and Suffolk, as well as Hospice</p> <p>Moderate confidence: Skilled Nursing Facility, Occupational, Therapy, Speech Therapy, and Adult Day Health</p> <p>Low confidence: Physical and Speech Therapy in Bristol, Franklin, Hampden, Hampshire, Plymouth, and Worcester counties</p>
Dental Services GeoAccess	Low confidence	<p>High confidence: General Dentists in Middlesex and Norfolk</p> <p>Moderate confidence: the remaining General Dentists</p> <p>Moderate confidence: Oral Surgeon</p>	Moderate confidence	Moderate confidence	Moderate confidence
Accuracy of Directories <sup>1</sup>	Moderate confidence	Moderate confidence	Moderate confidence	Moderate confidence	Moderate confidence

<sup>1</sup> 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.

SCO: Senior Care Options; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; SUD: substance use disorder.

### *Network Information Systems and Quality of Provider Data*

The analysis of the information systems assessment showed the following:

- The Information Systems Capabilities Assessment is conducted to confirm that the SCO 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 SCO Plans' HEDIS Final Audit Reports issued by their independent NCQA-certified HEDIS compliance auditors. IPRO also conducted an Information Systems Capabilities Assessment review with MassHealth for the non-HEDIS measure. No issues were identified.
- IPRO assessed the reliability and validity of MCP network adequacy data. IPRO determined that the data used by the MCP to monitor network adequacy were mostly accurate and current except for duplicative provider records, incorrect provider directory information, and different membership counts compared to the MassHealth membership count for the same period. These findings were shared with the MCP via email.
- IPRO reviewed the MCP's process for updating data (i.e., provider and beneficiary information) and concluded that the MCP process for updating data should include a method for assessing the accuracy of provider information published in the online provider directory.
- IPRO assessed changes in the MCP's data systems that might affect the accuracy or completeness of network adequacy monitoring data (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs). No significant system changes were identified.

## Provider Directory

IPRO validated the accuracy of provider directories for a random sample of providers. Provider types were chosen by MassHealth. **Table 44**, **Table 46**, and **Table 48** 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 44: Provider Directory Accuracy – Primary Care Providers**

Provider Directory Accuracy	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
% providers with correct information <sup>1</sup>	13.37% (25)	14.77% (26)	1.59% (3)	16.02% (29)	13.44% (25)
% providers for whom health plan info could not be confirmed <sup>2</sup>	17.11% (32)	17.61% (31)	17.46% (33)	16.57% (30)	25.27% (47)
Total providers called	187	176	189	181	186

<sup>1</sup> 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.

<sup>2</sup> 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.

SCO: Senior Care Options.

**Table 45** shows the most frequent reasons why information in the PCP directories was incorrect or could not be validated.

**Table 45: Directory Inaccuracy/Provider Verification Challenges – Primary Care Providers**

Directory Inaccuracy Reasons	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Total Inaccuracies Across Plans
Contact Fails	47	54	87	44	42	274
Provider is NOT accepting new patients	55	44	25	45	70	239
Provider is not at site	28	15	44	20	22	129
Provider is NOT participating in this health plan	20	21	11	31	20	103
Provider is NOT a primary care provider	11	2	19	4	19	55
Address is NOT correct	13	8	11	7	10	49
Telephone number is NOT correct	13	3	13	3	6	38
Total Inaccuracies per Plan	187	147	210	154	189	887

<sup>1</sup> 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.

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

SCO: Senior Care Options.

**Table 46** shows the percentage of ob/gyn providers with accurate provider directory information.

**Table 46: Provider Directory Accuracy – Obstetrics/Gynecology**

Provider Directory Accuracy	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
% Providers with correct information <sup>1</sup>	17.58% (29)	17.65% (27)	14.38% (21)	22.70% (37)	25.85% (38)
% Providers for whom health plan info could not be confirmed <sup>2</sup>	7.27% (12)	20.92% (32)	17.12% (25)	13.50% (22)	6.12% (9)
Total providers called	165	153	146	163	147

<sup>1</sup> Providers with correct information = provider is at the site; address is correct; phone number is correct; provider is accepting new patients; provider is an ob/gyn; provider is participating in this health plan.

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

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

SCO: Senior Care Options; ob/gyn: obstetrician/gynecologist.

**Table 47** shows the most frequent reasons why information in the ob/gyn directories was incorrect or could not be validated.

**Table 47: Directory Inaccuracy/Provider Verification Challenges – Obstetrics/Gynecology**

Directory Inaccuracy Reasons	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Total Inaccuracies Across Plans
Contact Fails	56	38	45	46	48	233
Provider is not at site	37	27	35	18	19	136
Provider is NOT accepting new patients	20	23	15	24	14	96
Provider is NOT participating in this health plan	16	17	15	22	14	84
Provider is NOT an ob/gyn	9	27	14	10	9	69
Address is NOT correct	8	5	3	9	8	33
Telephone number is NOT correct	9	4	3	9	6	31
Total Inaccuracies per Plan	155	141	130	138	118	682

<sup>1</sup> 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.

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

SCO: Senior Care Options; ob/gyn: obstetrician/gynecologist.

**Table 48** 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 48: Provider Directory Accuracy – Community Mental Health Centers (CMHCs)**

CMHC Directory Accuracy	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
% CMHCs with correct information	32.10% (23)	25.00% (30)	27.78% (5)	12.09% (11)	0.00% (0)
% CMHCs for whom health plan info could not be confirmed	7.41% (6)	6.45% (8)	22.22% (4)	9.89% (9)	0.00% (0)
Total CMHCs called	81	124	18	91	2

SCO: Senior Care Options.

**Table 49** 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 49: Directory Inaccuracy/Provider Verification Challenges – Community Mental Health Centers (CMHCs)**

Directory Inaccuracy Reasons	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Total Inaccuracies Across Plans
Contact Fails	19	32	6	45	0	102
CMHC does not offer outpatient services	17	41	1	14	1	74
Address is NOT correct	12	18	0	13	0	43
Telephone number is NOT correct	7	3	0	3	0	13
CMHC does NOT accept this health plan	6	0	2	3	0	11
CMHC is NOT accepting new patients	1	0	0	2	1	4
Total Inaccuracies per Plan	62	94	9	80	2	247

SCO: Senior Care Options.

## Wait Time for Appointment

The results of the wait time for appointment survey are listed below. **Tables 50–51** show the wait time for appointment results for PCPs.

**Table 50: Average Appointment Wait Time – PCPs**

MassHealth Routine Wait Time Standards <sup>1</sup>	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	SCO Average
Average calendar days to routine appointment (min, max)	71.5 (1, 254)	137.9 (6, 397)	84.7 (7, 341)	100.8 (6, 373)	75.8 (2, 334)	92.2 (1, 397)
% providers meeting 30-day standard	34.1% (14)	17.4% (4)	44.4% (4)	32.5% (13)	34.5% (10)	31.7% (45)
Providers with routine appointment date (N)	41	23	9	40	29	142
Providers reached	140	122	102	137	144	645

<sup>1</sup> Range (min, max) indicates the span between the shortest wait time recorded and the longest wait time recorded in calendar days. N = total providers reached, which is calculated as the number of providers for whom the survey was successfully completed and the secret shopper was ABLE to get an appointment date. PCP: primary care provider; SCO: Senior Care Options.

**Table 51: Reasons Not Able to Get an Appointment Date – PCPs**

Reasons Routine Appointment Date Was Not Collected	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Total Across Plans
Provider is not accepting new patients	23	24	10	21	29	107
Patients are placed on a waiting list	4	14	3	3	15	39
Patient must be registered with the clinic first	7	14	3	8	5	37
Other <sup>1</sup>	6	6	1	7	6	26
Patient's ID or personal info must be presented first	1	3	2	4	1	11
Staff member refused to participate	1	0	0	0	2	3
Medical records must be submitted first	0	0	0	0	0	0
Staff member requested a callback	0	0	0	0	0	0
Total	42	61	19	43	58	223

<sup>1</sup> Other includes reasons related to restricted patient populations, care-setting limitations, specialty scope, administrative prerequisites, or provider availability constraints unrelated to waitlists or registration. For example, the provider only sees patients residing in nursing homes or assisted living facilities and does not offer in-office visits. PCP: primary care provider; SCO: Senior Care Options.

**Tables 52–53** show the wait time for appointment results for ob/gyns.

**Table 52: Average Appointment Wait Time – Obstetrics/Gynecology**

MassHealth Routine Wait Time Standards <sup>1</sup>	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	SCO Average
Average calendar days to routine appointment (min, max)	74.7 (1, 220)	43.5 (4, 87)	78.6 (1, 118)	67.7 (1, 181)	55.1 (1, 196)	63.68 (1, 220)
% providers meeting 30-day standard	29.4% (10)	33.3% (5)	20.0% (1)	25.0% (11)	34.2% (13)	29.41% (40)
Providers with routine appointment date (N)	34	15	5	44	38	136
Providers reached	109	115	101	117	99	541

<sup>1</sup> 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. SCO: Senior Care Options.

**Table 53: Reasons Not Able to Get an Appointment Date – Obstetrics/Gynecology**

Reasons Routine Appointment Date Was Not Collected	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Total Across Plans
Patient must be registered with the clinic first	8	8	12	12	9	49
Provider is not accepting new patients	3	10	7	6	3	29
Patient's ID or personal info must be presented first	1	8	10	6	1	26
Patients are placed on a waiting list	4	0	2	0	7	13
Other <sup>1</sup>	1	3	3	0	1	8
Staff member refused to participate	0	0	0	0	2	2
Medical records must be submitted first	0	0	0	0	1	1
Staff member requested a callback	0	0	0	1	0	1
I was instructed to seek an Urgent Care Facility	0	0	0	0	0	0
Total	17	29	34	25	24	129

<sup>1</sup> Other includes reasons related to provider requiring a referral or additional clinical screening before allowing booking, and scheduling is handled through indirect or call-back processes. For example, the provider requires a referral from a primary care physician before the office will return a call to schedule an appointment.

SCO: Senior Care Options.

For the Community Mental Health Centers that shared the appointment date, the average wait time for appointment was 7.3 calendar days, ranging from the same day appointment to a 66 calendar day waiting period. 84.6% of contacted CMHCs, who shared an appointment date, met the MassHealth appointment wait time standard of 14 calendar days. **Tables 54–55** show the wait time for appointment results for Community Mental Health Centers.

**Table 54: Average Appointment Wait Time – Community Mental Health Centers (CMHCs)**

MassHealth Behavioral Health Wait Time Standards <sup>1</sup>	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	SCO Average
Average calendar days to appointment (min, max)	8.4 (0, 66)	6.7 (1, 15)	7.0 (7, 7)	4.9 (1, 17)	0 (0, 0)	7.3 (0, 66)
% CMHC meeting 14-day standard	81.0% (17)	88.9% (8)	100.0% (1)	87.5% (7)	0% (0)	84.6% (33)
CMHC with appointment date (N)	21	9	1	8	0	39
CMHC reached	62	92	12	46	2	214

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

Note: The appointment date was requested only when the contacted CMHC offered outpatient therapy and accepted the health plan.

SCO: Senior Care Options.

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 55** shows the most frequent reasons why appointment dates were not collected.

**Table 55: Reasons Not Able to Get an Appointment Date – Community Mental Health Centers (CMHCs)**

Reasons Appointment Date Was Not Collected	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	Total Across Plans
Administrative intake must be conducted first	3	19	1	6	0	29
Patients are placed on a waiting list	10	4	2	4	0	20
Patient must be registered with the clinic first	3	8	3	5	0	19
Other	2	5	2	2	0	11
Patient's ID or personal info must be presented first	0	6	0	2	0	8
CMHC is not accepting new patients.	0	0	0	2	1	3
Staff member requested a callback	1	0	0	0	0	1
Medical records must be submitted first	0	0	0	0	0	0
Staff member refused to participate	0	0	0	0	0	0

<sup>1</sup> Other includes reasons related to the intake or another department with scheduling authority was unreachable or required callbacks after voicemail-only transfer. For example, the caller was transferred to the intake department to obtain an appointment date, but the call went directly to voicemail. SCO: Senior Care Options.

### *Time and Distance Standards*

IPRO reviewed the aggregated results to assess the adequacy of the SCO networks by provider type. The summary tables show the number of counties with an adequate network of providers by provider type. “Met” means that an SCO Plan had an adequate network of that provider type in all counties in which it operates.

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.

The state of Massachusetts has 14 counties. Medicaid members who meet SCO enrollment criteria can enroll in an SCO Plan available in their county. SCO Plans cover large metro and metro counties, as defined in **Table 56**.

**Table 56: SCO Plans and Number of Counties**

County Type	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Number of large metro counties	4	4	4	4	4
Number of metro counties	6	8	4	6	6
Total number of counties	10	12	8	10	10

SCO: Senior Care Options.

**Tables 57–64** provide a summary of the network adequacy results for healthcare providers subject to travel time and distance standards defined in the SCOs’ contracts with MassHealth.

**Table 57: Counties with Adequate Network of Primary Care Providers**

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Adult PCP <sup>2</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Adult PCP <sup>2</sup>	Metro	2 providers within 10 miles and 15 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	5 out of 6 (Partially Met)	5 out of 6 (Partially Met)

<sup>2</sup> For members residing in Nantucket County, 2 providers within 40 miles and 55 minutes.

SCO: Senior Care Options.

**Table 58: Counties with Adequate Network of Specialists**

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
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)	4 out of 4 (Met)	4 out of 4 (Met)
Allergy and Immunology	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	7 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Cardiology <sup>2</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Cardiology <sup>2</sup>	Metro	1 provider within 20 miles and 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Cardiothoracic Surgery	Metro	1 provider within 40 miles and 60 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Chiropractor	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Clinical Psychology	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Clinical Social Work	Metro	1 provider within 20 miles and 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
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)	4 out of 4 (Met)	4 out of 4 (Met)
Dermatology	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Endocrinology <sup>3</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Endocrinology <sup>3</sup>	Metro	1 provider within 40 miles and 60 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
ENT/Otolaryngology	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Gastroenterology	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
General Surgery <sup>4</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
General Surgery <sup>4</sup>	Metro	1 provider within 20 miles and 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	5 out of 6 (Partially Met)
Gynecology, Ob/Gyn	Large Metro	2 providers within 15 miles and 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Gynecology, Ob/Gyn	Metro	2 providers within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Infectious Diseases <sup>5</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Infectious Diseases <sup>5</sup>	Metro	1 provider within 40 miles and 60 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Nephrology	Large Metro	1 provider within 15 miles and 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Nephrology	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Neurology	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Neurosurgery <sup>6</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Neurosurgery <sup>6</sup>	Metro	1 provider within 40 miles and 60 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Oncology – Medical, Surgical <sup>7</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Oncology – Medical, Surgical <sup>7</sup>	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Oncology – Radiation/Radiation Oncology <sup>8</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Oncology – Radiation/Radiation Oncology <sup>8</sup>	Metro	1 provider within 40 miles and 60 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Ophthalmology	Metro	1 provider within 20 miles and 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Orthopedic Surgery	Metro	1 provider within 20 miles and 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Physiatry, Rehabilitative Medicine <sup>9</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Physiatry, Rehabilitative Medicine <sup>9</sup>	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Plastic Surgery	Metro	1 provider within 40 miles and 60 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Podiatry	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Psychiatry	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Pulmonology <sup>10</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Pulmonology <sup>10</sup>	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Rheumatology	Metro	1 provider within 40 miles and 60 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Urology <sup>11</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Urology <sup>11</sup>	Metro	1 provider within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Vascular Surgery <sup>12</sup>	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)	4 out of 4 (Met)	4 out of 4 (Met)
Vascular Surgery <sup>12</sup>	Metro	1 provider within 40 miles and 60 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)

<sup>2</sup> For members residing in Nantucket County, 2 providers within 40 miles and 55 minutes.

<sup>3</sup> For members residing in Berkshire County, 1 provider within 45 miles and 70 minutes.

<sup>4</sup> For members residing in Berkshire County, 1 provider within 30 miles and 45 minutes.

<sup>5</sup> For members residing in Berkshire and Barnstable counties, 1 provider within 45 miles and 70 minutes.

<sup>6</sup> For members residing in Berkshire County, 1 provider within 40 miles and 60 minutes. For members residing in Essex County, 1 provider within 20 miles and 40 minutes.

<sup>7</sup> For members residing in Berkshire County, 1 provider within 45 miles and 70 minutes. For members residing in Essex County, 1 provider within 15 miles and 30 minutes.

<sup>8</sup> For members residing in Berkshire and Franklin counties, 1 provider within 50 miles and 75 minutes. For members residing in Barnstable County, 1 provider within 55 miles and 85 minutes. For members residing in Essex County, 1 provider within 20 miles.

<sup>9</sup> For members residing in Franklin County, 1 provider within 35 miles and 55 minutes.

<sup>10</sup> For members residing in Berkshire County, 1 provider within 40 miles and 60 minutes.

<sup>11</sup> For members residing in Berkshire County, 1 provider within 40 miles and 60 minutes.

<sup>12</sup> For members residing in Berkshire County, 1 provider within 40 miles and 70 minutes.

SCO: Senior Care Options.

**Table 59: Counties with Adequate Network of Hospitals and Emergency Support Services**

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Acute Inpatient Hospital	Large Metro	2 providers within 10 miles and 20 minutes	4 out of 4 (Met)	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Acute Inpatient Hospital	Metro	2 providers within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
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)	4 out of 4 (Met)	4 out of 4 (Met)
Rehabilitation Hospital Services	Metro	1 provider within 15 miles or 30 minutes	4 out of 6 (Partially Met)	6 out of 8 (Partially Met)	4 out of 4 (Met)	5 out of 6 (Partially Met)	6 out of 6 (Met)

SCO: Senior Care Options.

**Table 60: Counties with Adequate Network of LTSS Providers**

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Skilled 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)	4 out of 4 (Met)	3 out of 4 (Partially Met)
Skilled Nursing Facility	Metro	2 providers within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	5 out of 6 (Partially Met)
Occupational 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)	4 out of 4 (Met)	4 out of 4 (Met)
Occupational Therapy	Metro	2 providers within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Physical Therapy	Metro	2 providers within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	6 out of 6 (Met)
Speech Therapy	Large Metro	2 providers within 10 miles and 20 minutes	4 out of 4 (Met)	4 out of 4 (Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Speech Therapy	Metro	2 providers within 30 miles and 45 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	6 out of 6 (Met)	5 out of 6 (Partially 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)	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 6 (Met)	6 out of 8 (Partially Met)	4 out of 4 (Met)	5 out of 6 (Partially 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)	3 out of 4 (Partially Met)	0 out of 4 (Not Met)	4 out of 4 (Met)
Day Habilitation	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	4 out of 8 (Partially Met)	2 out of 4 (Partially Met)	1 out of 6 (Partially Met)	5 out of 6 (Partially Met)
Hospice	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Hospice	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	7 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (Met)	3 out of 6 (Partially Met)

SCO: Senior Care Options; LTSS: long-term services and supports.

**Table 61: Counties with Adequate Network of Pharmacies**

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

SCO: senior care options.

**Table 62: Counties with Adequate Network of Behavioral Health Outpatient**

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

SCO: Senior Care Options.

**Table 63: 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 SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
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)	2 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	2 out of 8 (Partially Met)	2 out of 4 (Partially Met)	2 out of 6 (Partially Met)	4 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)	2 out of 4 (Partially 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	6 out of 6 (Met)	6 out of 8 (Partially Met)	3 out of 4 (Partially Met)	4 out of 6 (Partially 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)	4 out of 4 (Met)	0 out of 4 (Not Met)	4 out of 4 (Met)	4 out of 4 (Met)
Adult Mobile Crisis Intervention (AMCI)	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	0 out of 4 (Not Met)	4 out of 6 (Partially Met)	5 out of 6 (Partially Met)
Adult Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	2 out of 4 (Partially Met)	2 out of 4 (Partially Met)	4 out of 4 (Met)
Adult Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	5 out of 8 (Partially Met)	2 out of 4 (Partially Met)	4 out of 6 (Partially Met)	0 out of 6 (Not Met)
Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	1 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Clinical Support Services (CSS) for	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	2 out of 8 (Partially Met)	1 out of 4 (Partially Met)	1 out of 6 (Partially Met)	4 out of 6 (Partially Met)

Provider Type	County Class	Standard – 90% of Enrollees in a County Who Have Access	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Substance Use Disorders (Level 3.5)							
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)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Community Support Program (CSP)	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	5 out of 6 (Partially 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)	2 out of 4 (Partially Met)	4 out of 4 (Met)	4 out of 4 (Met)
Intensive Outpatient Program (IOP)	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	0 out of 4 (Not Met)	5 out of 6 (Partially Met)	5 out of 6 (Partially Met)
Partial Hospitalization Program (PHP)	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)	4 out of 4 (Met)
Partial Hospitalization Program (PHP)	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	2 out of 4 (Partially Met)	5 out of 6 (Partially Met)	6 out of 6 (Met)
Program of Assertive Community Treatment (PACT)	Large Metro	2 providers within 15 miles or 30 minutes	4 out of 4 (Met)	3 out of 4 (Partially Met)	0 out of 4 (Not Met)	4 out of 4 (Met)	4 out of 4 (Met)
Program of Assertive Community Treatment (PACT)	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	3 out of 8 (Partially Met)	0 out of 4 (Not Met)	3 out of 6 (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)	1 out of 4 (Partially Met)	3 out of 4 (Partially Met)	3 out of 4 (Partially Met)	4 out of 4 (Met)
Psychiatric Day Treatment	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	0 out of 8 (Not Met)	1 out of 4 (Partially Met)	3 out of 6 (Partially Met)	6 out of 6 (Met)
Psychiatric Inpatient Adult	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)	4 out of 4 (Met)	4 out of 4 (Met)
Psychiatric Inpatient Adult	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	5 out of 8 (Partially Met)	4 out of 4 (Met)	6 out of 6 (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)	4 out of 4 (Met)	4 out of 4 (Met)
Recovery Coaching	Metro	2 providers within 15 miles or 30 minutes	6 out of 6 (Met)	8 out of 8 (Met)	4 out of 4 (Met)	5 out of 6 (Partially Met)	6 out of 6 (Met)

SCO: Senior Care Options.

**Table 64: Number of Counties with an Adequate Network of Dentists**

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

SCO: Senior Care Options.

**CCA SCO**

More information about CCA SCO network adequacy validation rating is provided in **Table 65**.

**Table 65: CCA SCO Network Adequacy Validation Ratings – CY 2025**

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating CCA SCO	Comments
Primary Care Providers' GeoAccess	<ul style="list-style-type: none"> <li>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.</li> </ul> <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"> <li>Apply CMS standards of the minimum number of PCP providers in each county.</li> </ul>	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 of the network revealed that the GeoAccess standards were met in all counties.</p>
Hospitals and Rehabilitation Hospital Services GeoAccess	<p>Hospitals:</p> <ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee's ZIP code of residence.</li> <li>The actual time and distance vary by provider type and the micro-metro-large metro geographic type.</li> <li>Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Rehabilitation Hospital Services:</p> <ul style="list-style-type: none"> <li>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.</li> </ul>	Addressed	<p>Moderate confidence: Rehabilitation Hospital Services</p> <p>Low confidence: Acute Inpatient Hospital</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: 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 all counties, except for Rehabilitation Hospital Services network gaps in Franklin and Worcester counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating CCA SCO	Comments
Specialists GeoAccess, including Ob/Gyn	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The actual time and distance differ by provider type and the micro-metro-large metro geographic type.</li> <li>• Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> Ob/Gyn: <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least 2 OB/GYN providers within a specific drive (defined in minutes) and distance (defined in miles) from Enrollee’s ZIP code of residence.</li> </ul> <i>Note:</i> CMS time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.	Addressed	Moderate confidence: large metro counties  Low confidence: metro counties	<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 standards for Specialists were met in all counties.</p>
Outpatient Behavioral Health GeoAccess	<ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least two Outpatient Behavioral Health Providers within a 15-mile radius or 30 minutes from the Enrollee’s ZIP code of residence.</li> </ul>	Addressed	Low confidence: Behavioral Health Outpatient  Moderate confidence: Psychiatric Inpatient Adult  Low confidence: remaining Behavioral Health Diversionary providers	<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>For Behavioral Health Diversionary Services, moderate confidence for Psychiatric Inpatient Adult: 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 the remaining Behavioral Health Diversionary 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 of the network revealed that the Behavioral Health Outpatient and Behavioral Health Diversionary standards were met in all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating CCA SCO	Comments
Pharmacy GeoAccess	<ul style="list-style-type: none"> <li>• 90% of beneficiaries in Large Metro counties (urban areas) must be within 2 miles of a retail pharmacy.</li> <li>• 90% of beneficiaries in Metro counties (suburban areas) must be within 5 miles of a retail pharmacy.</li> <li>• 70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.</li> </ul>	Addressed	<p>High confidence</p> <p>Moderate confidence: Franklin, Plymouth, Suffolk counties</p>	<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>Moderate confidence in Franklin: 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.</p> <p>Moderate confidence in Plymouth and Suffolk: 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.</p>
LTSS Providers GeoAccess, including Skilled Nursing Facility, Occupational, Physical, and Speech Therapy	<ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least two LTSS providers within 15 miles or 30 minutes for the Enrollee's ZIP code of residence.</li> </ul> <p>Skilled Nursing Facility, Occupational, Physical, and Speech Therapy:</p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee's ZIP code of residence.</li> </ul>	Addressed	<p>Moderate confidence: Skilled Nursing Facility</p> <p>Moderate confidence: Adult Day Health and Day Habilitation in metro counties</p> <p>Low confidence: Adult Day Health and Day Habilitation in large metro, as well as Occupational, Physical, and Speech Therapy and Hospice</p>	<p>Moderate confidence for Skilled Nursing Facility: 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 in 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 for Adult Day Health and Day Habilitation in large metro: 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>Low confidence for Occupational, Physical, and Speech Therapy and Hospice: 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 standards were met in all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating CCA SCO	Comments
Dental Services GeoAccess	<ul style="list-style-type: none"> <li>• General Dentists: 95% of Members have access to 2 General Dentists within 10 minutes of their home.</li> <li>• Oral Surgeon: 95% have access to 1 Oral Surgeon within 30 minutes of their home.</li> </ul>	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>IPRO’s analysis revealed gaps in the General Dentists network.</p>
Accuracy of Directories <sup>2</sup>	<ul style="list-style-type: none"> <li>• Percent of providers in the directory with correct information.</li> </ul>	Missing <sup>3</sup>	Moderate confidence	IPRO’s analysis showed that the information in the PCP, Ob/Gyn, and CMHC providers directories is not entirely accurate.

<sup>1</sup> “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.

<sup>2</sup> 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.

<sup>3</sup> MCPs are not required to report what percentage of the directory information is accurate.

SCO: Senior Care Options; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; LTSS: long-term services and supports; CMS: Centers for Medicare and Medicaid Services.

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of CCA SCO 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 66–68** show counties with deficient networks for CCA SCO. IPRO also determined that 14 providers had deactivated national provider identifiers, while five providers had more than 25 different locations listed per provider

**Table 66: CCA SCO Counties with Network Deficiencies of Hospitals and Emergency Support Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Rehabilitation Hospital Services	Worcester	84.4%	1 provider within 15 miles or 30 minutes
Rehabilitation Hospital Services	Franklin	7.5%	1 provider within 15 miles or 30 minutes

SCO: Senior Care Options.

**Table 67: CCA SCO Counties with Network Deficiencies of Pharmacies**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Pharmacy	Franklin	84.5%	1 provider within 5 miles

SCO: Senior Care Options.

**Table 68: CCA SCO Counties with Network Deficiencies of Dental Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 95% of Members Have Access
General Dentists	Franklin	76.5%	2 providers within 10 minutes
General Dentists	Norfolk	93.9%	2 providers within 10 minutes
General Dentists	Suffolk	90.8%	2 providers within 10 minutes
General Dentists	Worcester	68.3%	2 providers within 10 minutes
General Dentists	Plymouth	87.3%	2 providers within 10 minutes
General Dentists	Hampshire	68.2%	2 providers within 10 minutes
General Dentists	Hampden	53.7%	2 providers within 10 minutes
General Dentists	Essex	79.7%	2 providers within 10 minutes
General Dentists	Bristol	92.4%	2 providers within 10 minutes

SCO: Senior Care Options.

## Recommendations

- CCA SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- CCA SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- CCA SCO 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.
- CCA SCO should design quality improvement interventions to enhance the accuracy of all three directories.

**Fallon SCO**

More information about Fallon SCO network adequacy validation rating is provided in **Table 69**.

**Table 69: Fallon SCO Network Adequacy Validation Ratings – CY 2025**

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Fallon SCO	Comments
Primary Care Providers' GeoAccess	<ul style="list-style-type: none"> <li>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.</li> </ul> <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"> <li>Apply CMS standards of the minimum number of PCP providers in each county.</li> </ul>	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>I PRO's analysis of the network revealed that the GeoAccess standards were met in all counties.</p>
Hospitals and Rehabilitation Hospital Services GeoAccess	<p>Hospitals:</p> <ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee's ZIP code of residence.</li> <li>The actual time and distance vary by provider type and the micro-metro-large metro geographic type.</li> <li>Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Rehabilitation Hospital Services:</p> <ul style="list-style-type: none"> <li>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.</li> </ul>	Addressed	<p>High confidence</p> <p>Moderate confidence:</p> <p>Acute Inpatient Hospitals in Barnstable, Middlesex, and Norfolk counties</p>	<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>Moderate confidence for Acute Inpatient Hospitals in Barnstable, Middlesex, and Norfolk counties: 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.</p> <p>I PRO's analysis revealed gaps in the Rehabilitation Hospital Services network in Franklin and Worcester counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Fallon SCO	Comments
Specialists GeoAccess, Including Ob/Gyn	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The actual time and distance differ by provider type and the micro-metro-large metro geographic type.</li> <li>• Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Ob/Gyn:</p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least 2 OB/GYN providers within a specific drive (defined in minutes) and distance (defined in miles) from Enrollee’s ZIP code of residence.</li> </ul> <p><i>Note:</i> CMS time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p>	Addressed	<p>High confidence</p> <p>Moderate confidence: Allergy, Rheumatology, and Vascular Surgery</p> <p>Low confidence: Clinical Psychology, Clinical Social Work, and Psychiatry</p>	<p>Mostly 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>Moderate confidence for Allergy, Rheumatology, and Vascular Surgery: 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 Clinical Psychology, Clinical Social Work, and Psychiatry: 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 standards were met in all counties, except one metro county for the Allergy network.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Fallon SCO	Comments
Outpatient Behavioral Health GeoAccess	<ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to at least two Outpatient Behavioral Health Providers within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence.</li> </ul>	Addressed	<p>High confidence: Behavioral Health Outpatient</p> <p>Moderate/Low confidence: Behavioral Health Diversionary Services</p> <p>Low confidence: Adult Community Crisis Stabilization, Adult Residential Rehabilitation for SUD, Clinical Support Services for SUD, Community Support Program, Intensive Outpatient Program, Partial Hospitalization Program, Recovery Coaching, and Recovery Support Navigators</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>For Behavioral Health Diversionary, 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>Low confidence for Adult Community Crisis Stabilization, Adult Residential Rehabilitation for SUD, Clinical Support Services for SUD, Community Support Program, Intensive Outpatient Program, Partial Hospitalization Program, Recovery Coaching, and Recovery Support Navigators: 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 Behavioral Health Outpatient standards were met in all counties; however, it also revealed network gaps for at least eight Behavioral Health Diversionary Services provider types.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Fallon SCO	Comments
Pharmacy GeoAccess	<ul style="list-style-type: none"> <li>• 90% of beneficiaries in Large Metro counties (urban areas) must be within 2 miles of a retail pharmacy.</li> <li>• 90% of beneficiaries in Metro counties (suburban areas) must be within 5 miles of a retail pharmacy.</li> <li>• 70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.</li> </ul>	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>IPRO's analysis of the network revealed that the GeoAccess standards were met in all counties.</p>
LTSS Providers GeoAccess, including Skilled Nursing Facility, Occupational, Physical, and Speech Therapy	<ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least two LTSS providers within 15 miles or 30 minutes for the Enrollee's ZIP code of residence.</li> </ul> <p>Skilled Nursing Facility, Occupational, Physical, and Speech Therapy:</p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee's ZIP code of residence.</li> </ul>	Addressed	<p>High confidence</p> <p>Moderate confidence: Day Habilitation in Barnstable County</p>	<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>Moderate confidence for Day Habilitation in Barnstable County: 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.</p> <p>IPRO's analysis of the network revealed that the GeoAccess standards were met in almost all counties, except for the Adult Day Health network in Barnstable and Berkshire counties, the Day Habilitation network in Berkshire, Franklin, Hampden, and Hampshire, and Hospice in Berkshire County.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Fallon SCO	Comments
Dental Services GeoAccess	<ul style="list-style-type: none"> <li>General Dentists: 95% of Members have access to 2 General Dentists within 10 minutes of their home.</li> <li>Oral Surgeon: 95% have access to 1 Oral Surgeon within 30 minutes of their home.</li> </ul>	Addressed	<p>High confidence: General Dentists in Middlesex and Norfolk</p> <p>Moderate confidence: the remaining General Dentists</p> <p>Moderate confidence: Oral Surgeon</p>	<p>High confidence for General Dentists in Middlesex and Norfolk: 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 remaining 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.</p> <p>Moderate confidence for Oral Surgeon: 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 the General Dentists network and in the oral surgeon network in one metro county.</p>
Accuracy of Directories <sup>2</sup>	<ul style="list-style-type: none"> <li>Percent of providers in the directory with correct information.</li> </ul>	Missing <sup>3</sup>	Moderate confidence	I PRO's analysis showed that the information in the PCP, Ob/Gyn, and CMHC providers directories is not entirely accurate.

<sup>1</sup> "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.

<sup>2</sup> 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.

<sup>4</sup> MCPs are not required to report what percentage of the directory information is accurate.

SCO: senior care options; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; LTSS: long-term services and supports; CMS: Centers for Medicare and Medicaid Services; SUD: substance use disorder.

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of Fallon SCO 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 70–74** show counties with deficient networks. IPRO also determined that 174 providers had deactivated national provider identifiers, while one provider had more than 25 different locations listed per provider.

**Table 70: Fallon SCO Counties with Network Deficiencies of Specialist Providers**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Allergy and Immunology	Franklin	75.0%	1 provider within 30 miles and 45 minutes

SCO: senior care options.

**Table 71: Fallon SCO Counties with Network Deficiencies of Hospitals and Emergency Support Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Rehabilitation Hospital Services	Worcester	86.3%	1 provider within 15 miles or 30 minutes
Rehabilitation Hospital Services	Franklin	5.8%	1 provider within 15 miles or 30 minutes

SCO: Senior Care Options.

**Table 72: Fallon SCO Counties with Network Deficiencies of LTSS Providers**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Adult Day Health	Barnstable	51.9%	2 providers within 15 miles or 30 minutes
Adult Day Health	Berkshire	0.4%	2 providers within 15 miles or 30 minutes
Day Habilitation	Hampden	3.7%	2 providers within 15 miles or 30 minutes
Day Habilitation	Franklin	65.4%	2 providers within 15 miles or 30 minutes
Day Habilitation	Berkshire	0.0%	2 providers within 15 miles or 30 minutes
Day Habilitation	Hampshire	15.3%	2 providers within 15 miles or 30 minutes
Hospice	Berkshire	78.8%	2 providers within 15 miles or 30 minutes

SCO: Senior Care Options; LTSS: long-term services and supports.

**Table 73: Fallon SCO Counties with Network Deficiencies of Behavioral Health Diversionary Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Franklin	0.0%	2 providers within 15 miles or 30 minutes
ATS	Hampshire	0.0%	2 providers within 15 miles or 30 minutes
ATS	Essex	82.8%	2 providers within 15 miles or 30 minutes
ATS	Worcester	82.5%	2 providers within 15 miles or 30 minutes

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
ATS	Middlesex	47.7%	2 providers within 15 miles or 30 minutes
ATS	Berkshire	0.0%	2 providers within 15 miles or 30 minutes
ATS	Barnstable	61.2%	2 providers within 15 miles or 30 minutes
ATS	Hampden	0.0%	2 providers within 15 miles or 30 minutes
Adult Community Crisis Stabilization (ACCS)	Barnstable	41.9%	2 providers within 15 miles or 30 minutes
Adult Community Crisis Stabilization (ACCS)	Berkshire	3.7%	2 providers within 15 miles or 30 minutes
Adult Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)	Berkshire	1.7%	2 providers within 15 miles or 30 minutes
RRS	Barnstable	0.0%	2 providers within 15 miles or 30 minutes
RRS	Plymouth	87.7%	2 providers within 15 miles or 30 minutes
Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)	Hampden	0.1%	2 providers within 15 miles or 30 minutes
CSS	Franklin	65.4%	2 providers within 15 miles or 30 minutes
CSS	Norfolk	88.5%	2 providers within 15 miles or 30 minutes
CSS	Essex	82.3%	2 providers within 15 miles or 30 minutes
CSS	Hampshire	59.3%	2 providers within 15 miles or 30 minutes
CSS	Middlesex	48.9%	2 providers within 15 miles or 30 minutes
CSS	Berkshire	7.5%	2 providers within 15 miles or 30 minutes
CSS	Barnstable	61.2%	2 providers within 15 miles or 30 minutes
CSS	Worcester	86.2%	2 providers within 15 miles or 30 minutes
Program of Assertive Community Treatment (PACT)	Barnstable	34.4%	2 providers within 15 miles or 30 minutes
PACT	Norfolk	85.5%	2 providers within 15 miles or 30 minutes
PACT	Berkshire	6.7%	2 providers within 15 miles or 30 minutes
PACT	Bristol	15.5%	2 providers within 15 miles or 30 minutes
PACT	Hampshire	79.7%	2 providers within 15 miles or 30 minutes
PACT	Worcester	51.3%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Hampden	0.0%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Norfolk	88.1%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Middlesex	18.3%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Essex	22.3%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Barnstable	0.0%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Berkshire	0.0%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Worcester	2.0%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Bristol	11.4%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Plymouth	75.8%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Franklin	0.0%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Hampshire	0.0%	2 providers within 15 miles or 30 minutes
Psychiatric Inpatient Adult	Essex	30.1%	2 providers within 15 miles or 30 minutes
Psychiatric Inpatient Adult	Bristol	78.2%	2 providers within 15 miles or 30 minutes
Psychiatric Inpatient Adult	Middlesex	81.9%	2 providers within 15 miles or 30 minutes
Psychiatric Inpatient Adult	Berkshire	5.4%	2 providers within 15 miles or 30 minutes

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Psychiatric Inpatient Adult	Barnstable	44.4%	2 providers within 15 miles or 30 minutes
Recovery Support Navigators	Berkshire	11.2%	2 providers within 15 miles or 30 minutes

SCO: senior care options.

**Table 74: Fallon SCO Counties with Network Deficiencies of Dental Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 95% of Members Have Access
General Dentists	Hampshire	5.1%	2 providers within 10 minutes
General Dentists	Berkshire	51.3%	2 providers within 10 minutes
General Dentists	Essex	88.5%	2 providers within 10 minutes
General Dentists	Worcester	72.7%	2 providers within 10 minutes
General Dentists	Suffolk	93.5%	2 providers within 10 minutes
General Dentists	Hampden	52.9%	2 providers within 10 minutes
General Dentists	Barnstable	65.0%	2 providers within 10 minutes
General Dentists	Plymouth	83.4%	2 providers within 10 minutes
General Dentists	Franklin	0.0%	2 providers within 10 minutes
General Dentists	Bristol	70.0%	2 providers within 10 minutes
Oral Surgeon	Berkshire	9.6%	1 provider within 30 minutes

SCO: Senior Care Options.

## Recommendations

- Fallon SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- Fallon SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- Fallon SCO should revisit the GeoAccess results that differed from IPRO’s analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.
- Fallon SCO 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.
- Fallon SCO should design quality improvement interventions to enhance the accuracy of all three directories.

**SWH SCO**

More information about SWH SCO network adequacy validation rating is provided in **Table 75**.

**Table 75: SWH SCO Network Adequacy Validation Ratings – CY 2025**

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating SWH SCO	Comments
Primary Care Providers' GeoAccess	<ul style="list-style-type: none"> <li>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.</li> </ul> <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"> <li>Apply CMS standards of the minimum number of PCP providers in each county.</li> </ul>	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>IPRO's analysis of the network revealed that the GeoAccess standards were met in all counties.</p>
Hospitals and Rehabilitation Hospital Services GeoAccess	<p>Hospitals:</p> <ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee's ZIP code of residence.</li> <li>The actual time and distance vary by provider type and the micro-metro-large metro geographic type.</li> <li>Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Rehabilitation Hospital Services:</p> <ul style="list-style-type: none"> <li>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.</li> </ul>	Addressed	<p>Moderate confidence: Rehabilitation Hospital Services</p> <p>Low confidence: Acute Inpatient Hospitals</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 Hospitals: 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 standards were met in almost all counties, except for the Acute Inpatient Hospital network in Middlesex County.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating SWH SCO	Comments
Specialists GeoAccess, including Ob/Gyn	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The actual time and distance differ by provider type and the micro-metro-large metro geographic type.</li> <li>• Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Ob/Gyn:</p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least 2 OB/GYN providers within a specific drive (defined in minutes) and distance (defined in miles) from Enrollee’s ZIP code of residence.</li> </ul> <p><i>Note:</i> CMS time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p>	Addressed	<p>Moderate confidence</p> <p>Low confidence:  Cardiology,  Dermatology,  Endocrinology,  ENT,  Gastroenterology,  General Surgery,  Ob/Gyn,  Infectious Diseases,  Nephrology,  Oncology,  Ophthalmology,  Orthopedic Surgery, Physiatry,  Plastic Surgery,  Podiatry,  Psychiatry,  Pulmonology,  Rheumatology,  Urology, and  Vascular Surgery</p>	<p>Mostly 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>Low confidence for some specialists in large 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 standards were met in almost all counties, except for gaps in the Oncology network in Middlesex County.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating SWH SCO	Comments
Outpatient Behavioral Health GeoAccess	<ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least two Outpatient Behavioral Health Providers within a 15-mile radius or 30 minutes from the Enrollee’s ZIP code of residence.</li> </ul>	Addressed	<p>High confidence: Behavioral Health Outpatient</p> <p>High confidence: Clinical Support Services for SUD and Program of Assertive Community Treatment</p> <p>Moderate confidence: the majority of Behavioral Health Diversionary Services</p> <p>Low confidence: Adult Community Crisis Stabilization and Psychiatric Day Treatment</p>	<p>For Behavioral Health Outpatient, 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>For Behavioral Health Diversionary, high confidence for Clinical Support Services for SUD and Program of Assertive Community Treatment: 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 Behavioral Health Diversionary Services: No issues were found with the underlying information systems; however, the MCP’s provider data had no duplicative records or did not apply the correct MassHealth standards for analysis. The MCP’s results were not comparable for further analysis.</p> <p>Low confidence for Adult Community Crisis Stabilization and Psychiatric Day Treatment: 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 Behavioral Health Outpatient standards were met in all counties; however, it also revealed gaps in at least 11 different Behavioral Health Diversionary provider type networks.</p>
Pharmacy GeoAccess	<ul style="list-style-type: none"> <li>• 90% of beneficiaries in Large Metro counties (urban areas) must be within 2 miles of a retail pharmacy.</li> <li>• 90% of beneficiaries in Metro counties (suburban areas) must be within 5 miles of a retail pharmacy.</li> <li>• 70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.</li> </ul>	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>I PRO’s analysis of the network revealed that the GeoAccess standards were met in all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating SWH SCO	Comments
LTSS Providers GeoAccess, including Skilled Nursing Facility, Occupational, Physical, and Speech Therapy	<ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to at least two LTSS providers within 15 miles or 30 minutes for the Enrollee’s ZIP code of residence.</li> </ul> Skilled Nursing Facility, Occupational, Physical, and Speech Therapy: <ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee’s ZIP code of residence.</li> </ul>	Addressed	Moderate confidence  Low confidence: Skilled Nursing Facility, Occupational, Physical, and Speech Therapy in large metro counties	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.  Low confidence for Skilled Nursing Facility, Occupational, Physical, and Speech Therapy in large 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.  IPRO’s analysis of the network revealed that the GeoAccess standards were met in almost all counties, except for gaps in the Speech Therapy network in Essex County and the Day Habilitation network in Essex, Hampden, and Worcester counties.
Dental Services GeoAccess	<ul style="list-style-type: none"> <li>General Dentists: 95% of Members have access to 2 General Dentists within 10 minutes of their home.</li> <li>Oral Surgeon: 95% have access to 1 Oral Surgeon within 30 minutes of their home.</li> </ul>	Addressed	Moderate confidence	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.  IPRO’s analysis revealed gaps in the General Dentists network.
Accuracy of Directories <sup>2</sup>	<ul style="list-style-type: none"> <li>Percent of providers in the directory with correct information.</li> </ul>	Missing <sup>3</sup>	Moderate confidence	IPRO’s analysis showed that the information in the PCP, Ob/Gyn, and CMHC providers directories is not entirely accurate.

<sup>1</sup> “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.

<sup>2</sup> 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.

<sup>3</sup> MCPs are not required to report what percentage of the directory information is accurate.

SCO: senior care options; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; LTSS: long-term services and supports; CMS: Centers for Medicare and Medicaid Services; SUD: substance use disorder.

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of SWH SCO 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 76–80** show counties with deficient networks. IPRO also determined that 40 providers had deactivated national provider identifiers, while two providers had more than 20 different locations listed per provider.

**Table 76: SWH SCO Counties with Network Deficiencies of Specialist Providers**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Oncology – Medical, Surgical	Middlesex	89.4%	1 provider within 10 miles and 20 minutes.

SCO: senior care options.

**Table 77: SWH SCO Counties with Network Deficiencies of Hospitals**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Acute Inpatient Hospital	Middlesex	81.5%	2 providers within 10 miles and 20 minutes

SCO: Senior Care Options.

**Table 78: SWH SCO Counties with Network Deficiencies of LTSS Providers**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Speech Therapy	Essex	70.3%	2 providers within 10 miles and 20 minutes
Day Habilitation	Essex	89.9%	2 providers within 15 miles or 30 minutes
Day Habilitation	Worcester	54.6%	2 providers within 15 miles or 30 minutes
Day Habilitation	Hampden	0.0%	2 providers within 15 miles or 30 minutes

SCO: Senior Care Options; LTSS: long-term services and supports.

**Table 79: SWH SCO Counties with Network Deficiencies of Behavioral Health Diversionary Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Hampden	3.4%	2 providers within 15 miles or 30 minutes
ATS	Worcester	75.6%	2 providers within 15 miles or 30 minutes
Adult Community Crisis Stabilization (ACCS)	Essex	8.0%	2 providers within 15 miles or 30 minutes
ACCS	Middlesex	78.9%	2 providers within 15 miles or 30 minutes
ACCS	Worcester	27.1%	2 providers within 15 miles or 30 minutes
Adult Mobile Crisis Intervention (AMCI)	Essex	0.0%	2 providers within 15 miles or 30 minutes

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
AMCI	Bristol	0.0%	2 providers within 15 miles or 30 minutes
AMCI	Suffolk	0.0%	2 providers within 15 miles or 30 minutes
AMCI	Norfolk	0.0%	2 providers within 15 miles or 30 minutes
AMCI	Middlesex	0.0%	2 providers within 15 miles or 30 minutes
AMCI	Worcester	0.0%	2 providers within 15 miles or 30 minutes
AMCI	Plymouth	0.0%	2 providers within 15 miles or 30 minutes
AMCI	Hampden	0.0%	2 providers within 15 miles or 30 minutes
Adult Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)	Essex	11.3%	2 providers within 15 miles or 30 minutes
RRS	Worcester	78.4%	2 providers within 15 miles or 30 minutes
RRS	Plymouth	59.0%	2 providers within 15 miles or 30 minutes
RRS	Middlesex	79.4%	2 providers within 15 miles or 30 minutes
Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)	Worcester	0.9%	2 providers within 15 miles or 30 minutes
CSS	Plymouth	14.2%	2 providers within 15 miles or 30 minutes
CSS	Hampden	0.0%	2 providers within 15 miles or 30 minutes
Intensive Outpatient Program (IOP)	Worcester	83.5%	2 providers within 15 miles or 30 minutes
IOP	Plymouth	39.8%	2 providers within 15 miles or 30 minutes
IOP	Hampden	0.0%	2 providers within 15 miles or 30 minutes
IOP	Essex	3.9%	2 providers within 15 miles or 30 minutes
IOP	Bristol	1.8%	2 providers within 15 miles or 30 minutes
IOP	Middlesex	80.8%	2 providers within 15 miles or 30 minutes
Partial Hospitalization Program (PHP)	Worcester	84.1%	2 providers within 15 miles or 30 minutes
PHP	Bristol	19.3%	2 providers within 15 miles or 30 minutes
Program of Assertive Community Treatment (PACT)	Worcester	0.0%	2 providers within 15 miles or 30 minutes
PACT	Suffolk	0.0%	2 providers within 15 miles or 30 minutes
PACT	Bristol	0.0%	2 providers within 15 miles or 30 minutes
PACT	Middlesex	0.0%	2 providers within 15 miles or 30 minutes
PACT	Essex	0.0%	2 providers within 15 miles or 30 minutes
PACT	Plymouth	0.0%	2 providers within 15 miles or 30 minutes
PACT	Hampden	0.0%	2 providers within 15 miles or 30 minutes
PACT	Norfolk	0.0%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Worcester	2.4%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Hampden	0.0%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Essex	62.3%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Bristol	10.8%	2 providers within 15 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	Plymouth	21.3%	2 providers within 15 miles or 30 minutes
SOAP	Hampden	0.0%	2 providers within 15 miles or 30 minutes
SOAP	Essex	72.7%	2 providers within 15 miles or 30 minutes

SCO: Senior Care Options.

**Table 80: SWH SCO Counties with Network Deficiencies of Dental Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 95% of Members Have Access
General Dentists	Essex	87.4%	2 providers within 10 minutes
General Dentists	Norfolk	52.5%	2 providers within 10 minutes
General Dentists	Middlesex	49.8%	2 providers within 10 minutes
General Dentists	Bristol	60.5%	2 providers within 10 minutes
General Dentists	Worcester	78.2%	2 providers within 10 minutes
General Dentists	Plymouth	91.2%	2 providers within 10 minutes

SCO: Senior Care Options.

### Recommendations

- SWH SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- SWH SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- SWH SCO should revisit the GeoAccess results that differed from IPRO’s analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.
- SWH SCO 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.
- SWH SCO should design quality improvement interventions to enhance the accuracy of all three directories.

**Tufts SCO**

More information about Tufts SCO network adequacy validation rating is provided in **Table 81**.

**Table 81: Tufts SCO Network Adequacy Validation Ratings – CY 2025**

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Tufts SCO	Comments
Primary Care Providers' GeoAccess	<ul style="list-style-type: none"> <li>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.</li> </ul> <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"> <li>Apply CMS standards of the minimum number of PCP providers in each county.</li> </ul>	Addressed	<p>High confidence: large metro counties</p> <p>Moderate confidence: 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 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 revealed gaps in the Adult PCP network in Hampshire.</p>
Hospitals and Rehabilitation Hospital Services GeoAccess	<p>Hospitals:</p> <ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee's ZIP code of residence.</li> <li>The actual time and distance vary by provider type and the micro-metro-large metro geographic type.</li> <li>Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Rehabilitation Hospital Services:</p> <ul style="list-style-type: none"> <li>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.</li> </ul>	Addressed	<p>High confidence: Rehabilitation Hospital Services and Acute Inpatient Hospitals in large metro counties</p> <p>Moderate confidence: Acute Inpatient Hospitals in metro counties</p>	<p>High confidence for Rehabilitation Hospital Services and Acute Inpatient Hospital 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 Acute Inpatient Hospital 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 that the GeoAccess standards were met in most counties, except for the gap in the Rehabilitation Hospital Services network in Worcester County.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Tufts SCO	Comments
Specialists GeoAccess, including Ob/Gyn	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The actual time and distance differ by provider type and the micro-metro-large metro geographic type.</li> <li>• Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Ob/Gyn:</p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least 2 OB/GYN providers within a specific drive (defined in minutes) and distance (defined in miles) from Enrollee’s ZIP code of residence.</li> </ul> <p><i>Note:</i> CMS time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p>	Addressed	<p>High confidence: large metro counties</p> <p>Moderate confidence: metro counties</p> <p>Low confidence: Allergy, Cardiology in metro counties, Clinical Psychology, Clinical Social Work, General Surgery, Ob/Gyn, Neurology, Oncology, Urology, and Chiropractor in Barnstable and Bristol 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 in metro counties: No issues were found with the underlying information systems; however, the MCP’s provider data had duplicative records or 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 Allergy, Cardiology in metro counties, Clinical Psychology, Clinical Social Work, General Surgery, Ob/Gyn, Neurology, Oncology, Urology, and Chiropractor in Barnstable and Bristol 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 standards were met in all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Tufts SCO	Comments
Outpatient Behavioral Health GeoAccess	<ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to at least two Outpatient Behavioral Health Providers within a 15-mile radius or 30 minutes from the Enrollee’s ZIP code of residence.</li> </ul>	Addressed	<p>Moderate confidence: Behavioral Health Outpatient</p> <p>High confidence: Acute Treatment Services for SUD, Adult Community Crisis Stabilization, Adult Mobile Crisis Intervention, Adult Residential Rehabilitation Services for SUD, Clinical Support Services for SUD, Community Support Program, Intensive Outpatient Program, Partial Hospitalization Program, Program of Assertive Community Treatment, Psychiatric Day Treatment, Psych Inpatient Adult, and Structured Outpatient Addiction Program</p> <p>Moderate confidence: Recovery Coaching and Recovery Support Navigators</p>	<p>For Behavioral Health Outpatient, 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>For Behavioral Health Diversionary Services, 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>Moderate confidence for Recovery Coaching and Recovery Support Navigators: 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 Behavioral Health Outpatient standards were met in all counties, but it also revealed gaps in the Behavioral Health Diversionary Services networks.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating Tufts SCO	Comments
Pharmacy GeoAccess	<ul style="list-style-type: none"> <li>• 90% of beneficiaries in Large Metro counties (urban areas) must be within 2 miles of a retail pharmacy.</li> <li>• 90% of beneficiaries in Metro counties (suburban areas) must be within 5 miles of a retail pharmacy.</li> <li>• 70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.</li> </ul>	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>IPRO's analysis revealed a possible gap in the pharmacy network in Essex County.</p>
LTSS Providers GeoAccess, including Skilled Nursing Facility, Occupational, Physical, and Speech Therapy	<ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least two LTSS providers within 15 miles or 30 minutes for the Enrollee's ZIP code of residence.</li> </ul> <p>Skilled Nursing Facility, Occupational, Physical, and Speech Therapy:</p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee's ZIP code of residence.</li> </ul>	Addressed	<p>High confidence: large metro counties</p> <p>Moderate confidence: metro counties for Skilled Nursing Facility, Occupational, Physical, and Speech Therapy</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 in metro counties for Skilled Nursing Facility, Occupational, Physical, and Speech Therapy: 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 Adult Day Health network in Barnstable County and the Day Habilitation network.</p>
Dental Services GeoAccess	<ul style="list-style-type: none"> <li>• General Dentists: 95% of Members have access to 2 General Dentists within 10 minutes of their home.</li> <li>• Oral Surgeon: 95% have access to 1 Oral Surgeon within 30 minutes of their home.</li> </ul>	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 and oral surgeon network.</p>
Accuracy of Directories <sup>2</sup>	<ul style="list-style-type: none"> <li>• Percent of providers in the directory with correct information.</li> </ul>	Missing <sup>3</sup>	Moderate confidence	IPRO's analysis showed that the information in the PCP, Ob/Gyn, and CMHC providers directories is not entirely accurate.

<sup>1</sup> "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.

<sup>2</sup> 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.

<sup>3</sup> MCPs are not required to report what percentage of the directory information is accurate.

SCO: senior care options; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; LTSS: long-term services and supports; CMS: Centers for Medicare and Medicaid Services; SUD: substance use disorder.

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of Tufts SCO 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 82–87** show counties with deficient networks. IPRO also determined that 38 providers had deactivated national provider identifiers, while three providers had more than 25 different locations listed per provider

**Table 82: Tufts SCO Counties with Network Deficiencies of Primary Care Providers**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Adult PCP	Hampshire	25.0%	2 providers within 10 miles and 15 minutes

SCO: senior care options; PCP: primary care provider.

**Table 83: Tufts SCO Counties with Network Deficiencies of Hospitals**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Rehabilitation Hospital Services	Worcester	83.4%	1 provider within 15 miles or 30 minutes

SCO: Senior Care Options.

**Table 84: Tufts SCO Counties with Network Deficiencies of LTSS Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Adult Day Health	Barnstable	32.2%	2 providers within 15 miles or 30 minutes
Day Habilitation	Worcester	16.8%	2 providers within 15 miles or 30 minutes
Day Habilitation	Plymouth	16.7%	2 providers within 15 miles or 30 minutes
Day Habilitation	Norfolk	0.0%	2 providers within 15 miles or 30 minutes
Day Habilitation	Middlesex	35.8%	2 providers within 15 miles or 30 minutes
Day Habilitation	Hampshire	0.0%	2 providers within 15 miles or 30 minutes
Day Habilitation	Hampden	0.0%	2 providers within 15 miles or 30 minutes
Day Habilitation	Essex	3.4%	2 providers within 15 miles or 30 minutes
Day Habilitation	Suffolk	0.0%	2 providers within 15 miles or 30 minutes
Day Habilitation	Bristol	47.3%	2 providers within 15 miles or 30 minutes

SCO: Senior Care Options; LTSS: long-term services and supports.

**Table 85: Tufts SCO Counties with Network Deficiencies of Pharmacies**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Pharmacy	Essex	89.3%	1 provider within 2 miles

SCO: Senior Care Options.

**Table 86: Tufts SCO Counties with Network Deficiencies of Behavioral Health Diversionary Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Bristol	89.1%	2 providers within 15 miles or 30 minutes
ATS	Worcester	84.9%	2 providers within 15 miles or 30 minutes
ATS	Hampshire	75.0%	2 providers within 15 miles or 30 minutes
ATS	Barnstable	39.3%	2 providers within 15 miles or 30 minutes
Adult Community Crisis Stabilization (ACCS)	Barnstable	43.2%	2 providers within 15 miles or 30 minutes
ACCS	Worcester	74.3%	2 providers within 15 miles or 30 minutes
ACCS	Bristol	88.6%	2 providers within 15 miles or 30 minutes
ACCS	Worcester	80.6%	2 providers within 15 miles or 30 minutes
Adult Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)	Plymouth	51.7%	2 providers within 15 miles or 30 minutes
RRS	Middlesex	74.8%	2 providers within 15 miles or 30 minutes
RRS	Essex	53.1%	2 providers within 15 miles or 30 minutes
RRS	Barnstable	13.8%	2 providers within 15 miles or 30 minutes
Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)	Worcester	82.3%	2 providers within 15 miles or 30 minutes
CSS	Hampshire	75.0%	2 providers within 15 miles or 30 minutes
CSS	Hampden	0.0%	2 providers within 15 miles or 30 minutes
CSS	Bristol	87.7%	2 providers within 15 miles or 30 minutes
CSS	Barnstable	39.7%	2 providers within 15 miles or 30 minutes
Community Support Program (CSP)	Essex	88.0%	2 providers within 15 miles or 30 minutes
CSP	Barnstable	66.3%	2 providers within 15 miles or 30 minutes
Intensive Outpatient Program (IOP)	Barnstable	63.4%	2 providers within 15 miles or 30 minutes
Partial Hospitalization Program (PHP)	Barnstable	63.4%	2 providers within 15 miles or 30 minutes
Program of Assertive Community Treatment (PACT)	Worcester	81.0%	2 providers within 15 miles or 30 minutes
PACT	Bristol	56.4%	2 providers within 15 miles or 30 minutes
PACT	Barnstable	18.9%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Worcester	80.5%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Essex	86.9%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Bristol	36.5%	2 providers within 15 miles or 30 minutes
Psychiatric Day Treatment	Barnstable	0.0%	2 providers within 15 miles or 30 minutes
Recovery Coaching	Barnstable	14.8%	2 providers within 15 miles or 30 minutes

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Recovery Support Navigators	Barnstable	14.8%	2 providers within 15 miles or 30 minutes
Structured Outpatient Addiction Program (SOAP)	Worcester	84.3%	2 providers within 15 miles or 30 minutes

SCO: Senior Care Options.

**Table 87: Tufts SCO Counties with Network Deficiencies of Dental Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 95% of Members Have Access
General Dentists	Barnstable	75.3%	2 providers within 10 minutes
General Dentists	Plymouth	18.8%	2 providers within 10 minutes
General Dentists	Norfolk	92.9%	2 providers within 10 minutes
General Dentists	Essex	88.8%	2 providers within 10 minutes
General Dentists	Hampshire	25.0%	2 providers within 10 minutes
General Dentists	Hampden	86.5%	2 providers within 10 minutes
General Dentists	Worcester	76.2%	2 providers within 10 minutes
General Dentists	Bristol	66.8%	2 providers within 10 minutes
Oral Surgeon	Essex	93.1%	1 provider within 30 minutes
Oral Surgeon	Barnstable	78.6%	1 provider within 30 minutes

SCO: Senior Care Options.

## Recommendations

- Tufts SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- Tufts SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- Tufts SCO should revisit the GeoAccess results that differed from IPRO’s analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.
- Tufts SCO 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 SCO should design quality improvement interventions to enhance the accuracy of all three directories.

**UHC SCO**

More information about UHC SCO network adequacy validation rating is provided in **Table 88**.

**Table 88: UHC SCO Network Adequacy Validation Ratings – CY 2025**

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating UHC SCO	Comments
Primary Care Providers' GeoAccess	<ul style="list-style-type: none"> <li>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.</li> </ul> <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"> <li>Apply CMS standards of the minimum number of PCP providers in each county.</li> </ul>	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 have been successfully met across all counties, except Franklin County.</p>
Hospitals and Rehabilitation Hospital Services GeoAccess	<p>Hospitals:</p> <ul style="list-style-type: none"> <li>90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee's ZIP code of residence.</li> <li>The actual time and distance vary by provider type and the micro-metro-large metro geographic type.</li> <li>Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Rehabilitation Hospital Services:</p> <ul style="list-style-type: none"> <li>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.</li> </ul>	Addressed	<p>High confidence: Acute Inpatient Hospitals</p> <p>Moderate confidence: Acute Inpatient Hospitals in Franklin, Middlesex, and Norfolk counties</p> <p>Moderate confidence: Rehabilitation Hospital Services</p>	<p>Mostly 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>Moderate confidence: either due to the results not matching (Acute Inpatient Hospitals) or incorrect standards being used for analysis (Rehabilitation Hospital Services).</p> <p>IPRO's analysis of the network revealed that the GeoAccess standards have been successfully met across all counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating UHC SCO	Comments
Specialists GeoAccess, including Ob/Gyn	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The actual time and distance differ by provider type and the micro-metro-large metro geographic type.</li> <li>• Apply the minimum number of providers defined by CMS, which vary by county.</li> </ul> <p>Ob/Gyn:</p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least 2 OB/GYN providers within a specific drive (defined in minutes) and distance (defined in miles) from Enrollee’s ZIP code of residence.</li> </ul> <p>Note: CMS time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p>	Addressed	<p>High confidence</p> <p>Moderate confidence:</p> <p>Allergy, Cardiology, Endocrinology, General Surgery, Nephrology, Neurosurgery, Oncology, Ophthalmology, Orthopedic Surgery, and Ob/Gyn</p>	<p>Mostly 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>Moderate confidence for some of the specialties: 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>Ob/Gyn, 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 of the network revealed that the GeoAccess standards were met in almost all counties, except for gaps in the General Surgery network in Franklin County.</p>
Outpatient Behavioral Health GeoAccess	<ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least two Outpatient Behavioral Health Providers within a 15-mile radius or 30 minutes from the Enrollee’s ZIP code of residence.</li> </ul>	Addressed	<p>Low confidence: Behavioral Health Outpatient</p> <p>Moderate confidence: Behavioral Health Diversionary Services</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>For Behavioral Health Diversionary, 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>Low confidence for Adult Community Crisis Stabilization: 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 outpatient Behavioral Health networks: Acute Treatment Services for SUD, Adult Mobile Crisis Intervention, Adult Residential Rehabilitation Services for SUD, Clinical Support Services for SUD, Intensive Outpatient Program, and Program of Assertive Community Treatment.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating UHC SCO	Comments
Pharmacy GeoAccess	<ul style="list-style-type: none"> <li>• 90% of beneficiaries in Large Metro counties (urban areas) must be within 2 miles of a retail pharmacy.</li> <li>• 90% of beneficiaries in Metro counties (suburban areas) must be within 5 miles of a retail pharmacy.</li> <li>• 70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.</li> </ul>	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 a potential gap in the pharmacy network in Franklin County.</p>
LTSS Providers GeoAccess, including Skilled Nursing Facility, Occupational, Physical, and Speech Therapy	<ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to at least two LTSS providers within 15 miles or 30 minutes for the Enrollee’s ZIP code of residence.</li> </ul> <p>Skilled Nursing Facility, Occupational, Physical, and Speech Therapy:</p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee’s ZIP code of residence.</li> </ul>	Addressed	<p>High confidence: Skilled Nursing Facilities, Occupational Therapy, and Day Habilitation in Essex, Middlesex, Norfolk, and Suffolk, as well as Hospice</p> <p>Moderate confidence: Skilled Nursing Facility, Occupational Therapy, Speech Therapy, and Adult Day Health</p> <p>Low confidence: Physical and Speech Therapy in Bristol, Franklin, Hampden, Hampshire, Plymouth, and Worcester counties</p>	<p>Mostly 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>Some moderate confidence: No issues were found with the underlying information systems; however, the MCP’s provider data had duplicative records or did not apply the correct MassHealth standards for analysis (Skilled Nursing Facility). The MCP’s results were not comparable for further analysis.</p> <p>Low confidence for Physical and Speech Therapy: 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 Skilled Nursing Facility, Speech Therapy, Adult Day Health, and Day Habilitation networks, mostly in Franklin County, as well as a gap in the Hospice network in Franklin, Plymouth, and Worcester counties.</p>

Network Adequacy Indicator	Definition of the Indicator	Indicator in MCP monitoring? <sup>1</sup>	Validation Rating UHC SCO	Comments
Dental Services GeoAccess	<ul style="list-style-type: none"> <li>• General Dentists: 95% of Members have access to 2 General Dentists within 10 minutes of their home.</li> <li>• Oral Surgeon: 95% have access to 1 Oral Surgeon within 30 minutes of their home.</li> </ul>	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 in both large metro and metro counties, as well as Oral Surgeon network in metro counties.</p>
Accuracy of Directories <sup>2</sup>	<ul style="list-style-type: none"> <li>• Percent of providers in the directory with correct information.</li> </ul>	Missing <sup>3</sup>	Moderate confidence	IPRO's analysis showed that the information in the PCP, Ob/Gyn, and CMHC providers directories is not entirely accurate.

<sup>1</sup> "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.

<sup>2</sup> 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.

<sup>3</sup> MCPs are not required to report what percentage of the directory information is accurate.

SCO: senior care options; CY: calendar year; ob/gyn: obstetrics/gynecology; PCP: primary care provider; LTSS: long-term services and supports; CMS: Centers for Medicare and Medicaid Services; SUD: substance use disorder.

After analyzing the network adequacy results for all provider types, IPRO identified counties with network deficiencies. If at least 90% of UHC SCO 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 89–94** show counties with deficient networks. IPRO also determined that 48 providers had deactivated national provider identifiers, while one provider had more than 25 different locations listed per provider

**Table 89: UHC SCO Counties with Network Deficiencies of Primary Care Providers**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Adult PCP	Franklin	83.3%	2 providers within 10 miles and 15 minutes

SCO: senior care options; PCP: primary care provider.

**Table 90: UHC SCO Counties with Network Deficiencies of Specialist Providers**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
General Surgery	Franklin	77.8%	1 provider within 20 miles and 30 minutes

SCO: Senior Care Options.

**Table 91: UHC SCO Counties with Network Deficiencies of LTSS Providers**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Skilled Nursing Facility	Norfolk	83.6%	2 providers within 10 miles and 20 minutes
Skilled Nursing Facility	Franklin	88.9%	2 providers within 30 miles and 45 minutes
Speech Therapy	Franklin	88.9%	2 providers within 30 miles and 45 minutes
Adult Day Health	Franklin	27.8%	2 providers within 15 miles or 30 minutes
Day Habilitation	Franklin	16.7%	2 providers within 15 miles or 30 minutes
Hospice	Worcester	89.0%	2 providers within 15 miles or 30 minutes
Hospice	Plymouth	89.4%	2 providers within 15 miles or 30 minutes
Hospice	Franklin	16.7%	2 providers within 15 miles or 30 minutes

SCO: Senior Care Options; LTSS: long-term services and supports.

**Table 92: UHC SCO Counties with Network Deficiencies of Pharmacies**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Pharmacy	Franklin	83.3%	1 provider within 5 miles

SCO: Senior Care Options.

**Table 93: UHC SCO Counties with Network Deficiencies of Behavioral Health Diversionary Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 90% of Members Have Access
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	Worcester	86.4%	2 providers within 15 miles or 30 minutes
ATS	Franklin	11.1%	2 providers within 15 miles or 30 minutes
Adult Mobile Crisis Intervention (AMCI)	Worcester	40.9%	2 providers within 15 miles or 30 minutes
Adult Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)	Worcester	83.4%	2 providers within 15 miles or 30 minutes
RRS	Plymouth	89.2%	2 providers within 15 miles or 30 minutes.
RRS	Hampshire	0.0%	2 providers within 15 miles or 30 minutes
RRS	Hampden	0.0%	2 providers within 15 miles or 30 minutes
RRS	Franklin	0.0%	2 providers within 15 miles or 30 minutes
RRS	Bristol	70.2%	2 providers within 15 miles or 30 minutes
Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)	Worcester	87.7%	2 providers within 15 miles or 30 minutes
CSS	Franklin	88.9%	2 providers within 15 miles or 30 minutes
Intensive Outpatient Program (IOP)	Franklin	88.9%	2 providers within 15 miles or 30 minutes
Program of Assertive Community Treatment (PACT)	Franklin	38.9%	2 providers within 15 miles or 30 minutes

SCO: Senior Care Options.

**Table 94: UHC SCO Counties with Network Deficiencies of Dental Services**

Provider Type	County with Network Deficiencies	Percent of Members with Access in That County	Standard – 95% of Members Have Access
General Dentists	Norfolk	47.5%	2 providers within 10 minutes
General Dentists	Middlesex	79.9%	2 providers within 10 minutes
General Dentists	Hampshire	23.9%	2 providers within 10 minutes
General Dentists	Hampden	83.8%	2 providers within 10 minutes
General Dentists	Worcester	78.0%	2 providers within 10 minutes
General Dentists	Franklin	0.0%	2 providers within 10 minutes
General Dentists	Essex	87.6%	2 providers within 10 minutes
General Dentists	Suffolk	93.1%	2 providers within 10 minutes
General Dentists	Bristol	47.0%	2 providers within 10 minutes
General Dentists	Plymouth	64.5%	2 providers within 10 minutes
Oral Surgeon	Plymouth	94.4%	1 provider within 30 minutes
Oral Surgeon	Franklin	16.7%	1 provider within 30 minutes

SCO: Senior Care Options.

## Recommendations

- UHC SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.
- UHC SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.
- UHC SCO 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 SCO 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 surveys is to capture accurate and complete information about consumer-reported experiences with health care.

Section 2.9.C.5 of the Third Amended and Restated SCO Contract requires contracted SCOs to conduct an annual SCO-level 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 SCO, the providers, and their staff.

All SCO Plans participated in the CMS’s 2025 Medicare Advantage Prescription Drugs CAHPS survey. Each MassHealth SCO independently contracted with a CMS-approved survey vendor to administer the MA-PD CAHPS survey. CMS uses the CAHPS survey results to assign star ratings to health plans. MassHealth monitors SCOs’ submissions of MA-PD CAHPS surveys and uses the results to identify opportunities for improvement and inform MassHealth’s quality management work.

### 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 SCO Plans’ members using a random sample of members selected by CMS. CMS requires all Medicare Advantage and Prescription Drug Plan contracts with at least 600 Enrollees to contract with approved survey vendors to collect and report CAHPS survey data following a specific timeline and protocols established by CMS.<sup>8</sup> The standardized survey instrument selected for the MassHealth SCO Plans was the 2025 MA-PD CAHPS survey. The MA-PD survey contains 66 questions, organized into seven sections, as explained in **Table 95**.

**Table 95: MA-PD CAHPS Survey Sections**

Section	Number of Questions
Introductory section	2 questions
Your Health Care in the Last 6 Months	8 questions
Your Personal Doctor	16 questions
Getting Health Care from Specialists	6 questions
Your Health Plan	8 questions
Your Prescription Drug Plan	7 questions
About You	22 questions

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

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 web, 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 SCO Plan’s Enrollees who were 18 years or older, who were continuously enrolled in the contract for at least six months at the time the sample was drawn in January 2025, and who were not institutionalized.

**Table 96** provides a summary of the technical methods of data collection by SCO.

<sup>8</sup> [Medicare Advantage and Prescription Drug Plan CAHPS Survey](https://www.ma-pdcahps.org/). Also available at: <https://www.ma-pdcahps.org/>.

**Table 96: Adult MA-PD CAHPS – Technical Methods of Data Collection by SCO, 2025 MA-PD CAHPS**

MA-PD CAHPS – Technical Methods of Data Collection	WellSense SCO	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO
Survey vendor	SPH Analytics	SPH Analytics	SPH Analytics	SPH Analytics	SPH Analytics	SPH Analytics
CAHPS survey tool	MA-PD	MA-PD	MA-PD	MA-PD	MA-PD	MA-PD
Survey timeframe	February to June 2025	February to June 2025	February to June 2025	February to June 2025	February to June 2025	February to June 2025
Method of collection	Mail, web, phone	Mail, web, phone	Mail, web, phone	Mail, web, phone	Mail, web, phone	Mail, web, phone
Response rate	21.2%	30.7%	31.8%	26.6%	30.0%	34.3%

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

Responses were classified into response categories. **Table 97** displays these categories and the measures for which these response categories are used.

**Table 97: MA-PD CAHPS Response Categories**

Measures	Response Categories
<ul style="list-style-type: none"> <li>• Rating of Health Plan</li> <li>• Rating of All Health Care Quality</li> <li>• Rating of Personal Doctor</li> <li>• Rating of Specialist</li> <li>• Rating of Prescription Drug Plan</li> </ul>	<ul style="list-style-type: none"> <li>• 0 to 4 (Dissatisfied)</li> <li>• 5 to 7 (Neutral)</li> <li>• 9 or 10 (Satisfied)</li> </ul>
<ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Appointments and Care Quickly</li> <li>• Doctors Who Communicate Well</li> <li>• Customer Service</li> <li>• Care Coordination</li> <li>• Getting Needed Prescription Drugs composite measures</li> </ul>	<ul style="list-style-type: none"> <li>• Never (Dissatisfied)</li> <li>• Sometimes (Neutral)</li> <li>• Usually or Always (Satisfied)</li> </ul>
<ul style="list-style-type: none"> <li>• Annual Flu Vaccine individual item measure</li> <li>• Pneumonia Vaccine individual item measure</li> </ul>	<ul style="list-style-type: none"> <li>• Yes or No</li> </ul>

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

To assess SCOs performance, IPRO compared SCOs’ top-box scores to the Medicare Advantage national mean score. The top-box scores are the survey results for the highest possible response category. Plan scores represent the mean score converted to a 100-point scale, except for the Annual Flu Vaccine and Pneumonia Vaccine measures. For those questions, the value is the percentage of members responding "Yes."

### Description of Data Obtained

For each SCO, IPRO received a copy of the final 2025 MA-PD CAHPS Results report produced by CMS. These reports included descriptions of the project objectives and methodology, as well as Plan-level results and analyses.

### Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all SCOs, IPRO compared the Plan-level MA-PD CAHPS results and MassHealth weighted means to the Medicare Advantage national 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 98**.

**Table 98: Key for MA-PD CAHPS Performance Measure Comparison to the Medicare Advantage National Mean Score**

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

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

When compared to the Medicare Advantage national mean scores, SCO Plans exceeded the goal benchmark for the following measures:

- Customer Service: Fallon SCO and SWH SCO.
- Annual Flu Vaccine: All SCO Plans scored above, except WellSense SCO.
- Rating of Prescription Drug Plan: CCA SCO and Fallon SCO.
- Rating of Health Care Quality: WellSense SCO, CCA SCO, and Fallon SCO.
- Rating of Health Plan: All SCO Plans scored above the Medicare Advantage national mean score.

When compared to the Medicare Advantage national mean scores, SCO Plans scored below the Medicare Advantage national mean score for the following measures:

- Getting Needed Care: All SCO Plans scored below the Medicare Advantage national mean score.
- Getting Appointments and Care Quickly: All SCO Plans scored below the goal, except UHC SCO.
- Customer Service: Tufts SCO and UHC SCO.
- Care Coordination: CCA SCO, Fallon SCO, and Tufts SCO.
- Getting Needed Prescription Drugs: All SCO Plans scored below the goal, except SWH SCO.
- Rating of Prescription Drug Plan: Tufts SCO.
- Rating of Health Care Quality: Tufts SCO and UHC SCO.

**Table 99** displays the top-box scores of the 2025 MA-PD CAHPS survey.

**Table 99: MA-PD CAHPS Performance – MassHealth SCO Plans, 2025 MA-PD CAHPS**

MA-PD CAHPS Measure	WellSense SCO	CCA SCO	Fallon SCO	SWH SCO	Tufts SCO	UHC SCO	SCO Weighted Mean	Medicare Advantage National Mean Score (Goal)
Getting Needed Care (Composite)	78 ( < Goal)	79 ( < Goal)	78 ( < Goal)	79 ( < Goal)	76 ( < Goal)	80 ( < Goal)	79 ( < Goal)	82
Getting Appointments and Care Quickly (Composite)	N/A	82 ( < Goal)	80 ( < Goal)	83 ( < Goal)	77 ( < Goal)	84 ( = Goal)	82 ( < Goal)	84
Customer Service (Composite)	N/A	90 ( = Goal)	91 ( > Goal)	91 ( > Goal)	89 ( < Goal)	89 ( < Goal)	90 ( = Goal)	90
Care Coordination (Composite)	N/A	84 ( < Goal)	86 ( < Goal)	87 ( = Goal)	84 ( < Goal)	87 ( = Goal)	86 ( < Goal)	87
Getting Needed Prescription Drugs (Composite)	N/A	88 ( < Goal)	88 ( < Goal)	90 ( = Goal)	86 ( < Goal)	88 ( < Goal)	88 ( < Goal)	90
Annual Flu Vaccine	69 ( = Goal)	72 ( > Goal)	77 ( > Goal)	72 ( > Goal)	79 ( > Goal)	75 ( > Goal)	75 ( > Goal)	69
Rating of Prescription Drug Plan	88 ( = Goal)	89 ( > Goal)	90 ( > Goal)	88 ( = Goal)	87 ( < Goal)	88 ( = Goal)	88 ( = Goal)	88
Rating of Health Care Quality	89 ( > Goal)	88 ( > Goal)	88 ( > Goal)	87 ( = Goal)	84 ( < Goal)	86 ( < Goal)	87 ( = Goal)	87
Rating of Health Plan	89 ( > Goal)	89 ( > Goal)	91 ( > Goal)	88 ( > Goal)	89 ( > Goal)	90 ( > Goal)	89 ( > Goal)	87
Pneumonia Vaccine	67	65	78	64	70	71	69	N/A

MA-PD: Medicare Advantage Prescription Drugs; CAHPS: Consumer Assessment of Healthcare Providers and Systems; SCO: Senior Care Option; N/A: not applicable, 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 QI<sup>9</sup> made by the EQRO during the previous year’s EQR.”

Tables 100–105 display the SCOs’ responses to the recommendations for QI made during the previous EQR, as well as IPRO’s assessment of these responses.

### WellSense SCO Response to Previous EQR Recommendations

Table 100 displays the SCO’s progress related to the SCOs External Quality Review CY 2024, as well as IPRO’s assessment of SCO’s response.

**Table 100: WellSense SCO Response to Previous EQR Recommendations**

Recommendation for WellSense SCO	WellSense SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>PIP 1 TRC:</b> WellSense SCO should ensure that all valid data are included in the PIP and that indicator details align with the MY 2023 HEDIS Technical Specifications, as well as clarify interventions including all associated intervention tracking measures.</p>	<p>As the SCO plan is set to close at the end of the 2025 calendar year, we will not be initiating further interventions for this PIP. Instead, we are focused on preparing and submitting a comprehensive PIP Close-Out Report by the October 31, 2025 deadline, which will summarize activities to date, outcomes achieved, and lessons learned. In alignment with your recommendation, we will ensure that all valid data are included, indicator details are aligned with the MY 2023 HEDIS Technical Specifications, and interventions are clearly documented along with their associated tracking measures.</p>	<p>Partially Addressed</p>
<p><b>PMV:</b> HEDIS Measures: WellSense SCO HEDIS rates were below the 25th percentile for the following measure:</p> <ul style="list-style-type: none"> <li>• Advance Care Planning: 6.27%</li> </ul> <p>WellSense SCO 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>From MY 2023 to MY 2024 WellSense went from 6.27% to 17.99% for the Advance Care Planning measure. This almost 12 percentage point gain was attributed to several factors:</p> <ul style="list-style-type: none"> <li>• Clinical didactic sessions covering Advanced Care Planning</li> <li>• Staff training to address Advanced Care Planning during a member assessment</li> <li>• Most notably, in 2024, the state changed the requirement to have the MDS (Minimum Data Set) load directly to their portal (i.e., we now have a mini-assessment data in our supplemental feed that was not present in MY2023). Overall the supplemental data collection process for this measure improved MY over MY.</li> <li>• In addition, in 2025, SCO started working with a vendor, Koda, to assist with Advanced Care Planning</li> </ul>	<p>Addressed</p>

<sup>9</sup> Quality improvement.

Recommendation for WellSense SCO	WellSense SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Network – Information Systems and Quality of Provider Data – Duplicates:</b> WellSense SCO submitted duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address. IPRO removed a total of 977 duplicate providers from the WellSense SCO data prior to conducting the analysis. WellSense SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.</p>	<p>We acknowledge that duplicate provider records were present in submission. Since the CY2024 submission, we have implemented a new duplication process that is expected to significantly reduce the number of duplicated provider records in submissions after 2024. However, some complex cases still require manual identification and removal. To address this, we plan to conduct a manual data review following the completion of our programming evaluations to eliminate the remaining duplicates and further improve data quality.</p> <p>Carelon Behavioral Health has implemented into their QA processes steps to identify and remove duplicate data prior to submission. Please note: WellSense will have Behavioral Health services insourced as of 1/1/2026.</p>	<p>Addressed</p>
<p><b>Network – Time and Distance Analysis – MCP’s Methodology:</b> WellSense SCO used incorrect time and distance standards for pharmacy, LTSS providers, and some behavioral health providers. IPRO was able to compare WellSense SCO results for Rehabilitation Hospital Services but only in five counties. WellSense SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</p>	<p>The correct time and distance standard was configured within the Quest GeoAccess system; however, an incorrect standard was mistakenly copied and dragged down from another provider category, leading to discrepancies in the reported results. To prevent such issues, we have implemented validation checks to ensure that the correct standards are consistently applied in the final output.</p> <p>Carelon Behavioral Health has implemented into their QA processes steps to identify and remove duplicate data prior to submission. Please note: WellSense will have Behavioral Health services insourced as of 1/1/2026.</p>	<p>Addressed</p>
<p><b>Network – Provider Directory:</b> WellSense SCO achieved a 40.22% accuracy rate in its PCP provider directory, a 25.24% accuracy rate in its ob/gyn provider directory, and only 40.00% accuracy rate in its dental directory. WellSense SCO should design quality improvement interventions to enhance the accuracy of all three directories.</p>	<p>The Provider Relations team conducted outreach to PCPs and OBGYNs with identified errors. Providers were asked to review and update their demographic information. When updates were identified, the Provider Relations team submitted the changes to the health plan, and the directory was updated accordingly. It is important to note that auditors observed a limitation in the outreach process: the individuals making the calls did not consistently account for providers with multiple practice locations. For example, if a provider was already listed correctly at a secondary location, that entry was not reviewed and was instead marked as an error. This oversight impacted the accuracy of the audit findings, as many providers practice at multiple sites with varying schedules. To support ongoing accuracy, the Provider Relations team will continue outreach to providers on a quarterly basis to review and validate demographic information and encourage providers to review and submit any necessary changes to ensure the provider directory remains current.</p>	<p>Addressed</p>

Recommendation for WellSense SCO	WellSense SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Quality-of-Care Surveys:</b> WellSense SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Appointments and Care Quickly</li> <li>• Customer Service,</li> <li>• Care Coordination</li> <li>• Getting Needed Prescription Drugs</li> <li>• Rating of Prescription Drug Plan</li> <li>• Rating Of Health Care Quality</li> <li>• Rating of Health Plan</li> </ul> <p>WellSense SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>WellSense SCO conducted a root cause analysis and implemented a broad set of targeted interventions to address underperformance across multiple MA-PD CAHPS measures. Additionally, they reviewed grievances and appeals data, optimized non-emergency medical transportation operations, and approved new 2025 initiatives through the Quality Improvement Committee—demonstrating both a data-informed approach and measurable action to improve member experience.</p>	<p>Addressed</p>

<sup>1</sup> 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.

SCO: Senior Care Plan; MCP: managed care plan; EQR: external quality review.

## CCA SCO Response to Previous EQR Recommendations

Table 101 displays the SCO's progress related to the *SCO External Quality Review CY 2024*, as well as IPRO's assessment of SCO's response.

**Table 101: CCA SCO Response to Previous EQR Recommendations**

Recommendation for CCA SCO	CCA SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>PMV 1:</b> HEDIS Measures: SCO's HEDIS rates were below the 25th percentile for the following measures:</p> <ul style="list-style-type: none"> <li>• Use of High-Risk Medications in the Elderly: 25.63%</li> <li>• Plan All-Cause Readmission (Observed/Expected Ratio) 65+: 1.3583</li> <li>• Osteoporosis Management in Women Who Had a Fracture: 12.07%</li> <li>• Antidepressant Medication Management Acute: 73.71%</li> <li>• Antidepressant Medication Management Continuation: 57.54%</li> </ul> <p>CCA SCO 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 SCO conducted root cause analyses and implemented targeted quality improvement interventions for each of the underperforming HEDIS measures.</p> <ul style="list-style-type: none"> <li>• For Use of High-Risk Medications in the Elderly, CCA launched a deprescribing PIP supported by pharmacist and clinician outreach and expanded internal capacity to improve targeting and engagement.</li> <li>• For Plan All-Cause Readmissions, CCA deployed a High Intensity Case Management program and post-discharge interventions, resulting in a reduced readmission rate (1.2675 in MY2024).</li> <li>• For Osteoporosis Management, CCA contracted with Transtreme to deliver in-home screenings, with early improvements in the measure (20.75% in MY2024).</li> <li>• For Antidepressant Medication Management, they improved both acute and continuation phase rates to the 50th percentile, using pharmacy data analysis, provider engagement, and care management screenings—demonstrating both implementation and measurable improvement across all measures.</li> </ul>	<p>Addressed</p>
<p><b>Network – Information Systems and Quality of Provider Data – Duplicates:</b> CCA SCO submitted many duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address. IPRO removed a total of 2,209 duplicate providers from the CCA SCO data prior to conducting the analysis. CCA SCO 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 30% 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>

Recommendation for CCA SCO	CCA SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Network – Time and Distance Analysis – MCP’s Methodology:</b> CCA SCO used incorrect time and distance standards for PCPs, ob/gyn, hospitals and medical facilities, specialists, behavioral health providers, and LTSS providers. Because of the quality of the provider data, IPRO was able to compare MCP’s results for only one provider type: Group Adult Foster Care. CCA SCO 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.</p> <p>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><b>Network – Time and Distance Analysis – Gaps in Provider Networks:</b> CCA SCO 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>While no true gaps were identified in 2025, CCA continually monitors for access and availability issues reported by members through Appeals and Grievances data, care manager and call center feedback, network partner feedback, and out-of-network requests and utilization. CCA continues to build the provider network, adding nearly 200 new contracted providers, the largest category behavioral health (40%).</p>	<p>Addressed</p>
<p><b>Network – Provider Directory:</b> CCA SCO achieved a 21.82% accuracy rate in its PCP directory, a 21.55% accuracy rate in its ob/gyn provider directory, and only 26.67% accuracy rate in its dental directory. CCA SCO 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.</p> <p>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>	<p>Partially Addressed</p>

Recommendation for CCA SCO	CCA SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Quality-of-Care Surveys:</b> CCA SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Appointments and Care Quickly</li> <li>• Care Coordination</li> <li>• Getting Needed Prescription Drugs</li> </ul> <p>CCA SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>CCA SCO conducted a thorough root cause analysis and implemented a wide range of targeted interventions to improve performance on the underperforming MA-PD CAHPS measures.</p>	<p>Addressed</p>

<sup>1</sup> IPRO assessments are as follows: **addressed:** MCP’s quality improvement (QI) response resulted in demonstrated improvement; **partially addressed:** MCP’s QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement:** MCP’s QI response did not address the recommendation; improvement was not observed, or performance declined.

**Not applicable:** PIP was discontinued.

SCO: Senior Care Option; MCP: managed care plan; EQR: external quality review.

## Fallon SCO Response to Previous EQR Recommendations

Table 102 displays SCO's progress related to the *SCO External Quality Review CY 2024*, as well as IPRO's assessment of SCO's response.

**Table 102: Fallon SCO Response to Previous EQR Recommendations**

Recommendation for Fallon SCO	Fallon SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>PMV:</b> the technical report indicated that the Transitions of Care rate stands at 92.7%, which was above the 90th percentile and was recognized as a strength. However, there were two rates that fell below the 25th percentile: Use of High-Risk Medications in the Elderly, and Potentially Harmful Drug-Disease Interactions in the Elderly.</p>	<p>Fallon Health expanded its provider outreach and case management efforts in 2025 to address high-risk medication use and drug-disease interactions in elderly members, including educational communications and pharmacist-led interventions. In 2026, Fallon plans to enhance its transition of care program by training Nurse Case Managers and Pharmacists to engage members and providers during assessments, and to partner with three large provider groups on a fall risk reduction initiative. The goal is to reduce both HEDIS measures by 5%, with progress monitored through the TruCare system and monthly internal HEDIS reporting.</p>	<p>Addressed</p>
<p><b>Network – Data Integrity (Recommendation from CY2023):</b> IPRO recommends that, for future network adequacy analysis, the SCO Plan review and deduplicate in-network provider data before data files are submitted for analysis.</p>	<p>Fallon Health believes that based on actions implemented subsequent to the 2023 recommendation that the duplicate provider issue has been significantly reduced. Fallon Health created a scrubbed monthly extract file that is sent directly to Quest that cuts down on the number of duplicate providers versus the process that was in place during the referenced validation efforts. This monthly extract and validation process has reduced the number of duplicates submitted for EQR analysis.</p>	<p>Addressed</p>
<p><b>Network – Information Systems and Quality of Provider Data – Duplicates:</b> Fallon NaviCare SCO submitted many duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address. IPRO removed a total of 751 duplicate providers from Fallon NaviCare SCO data prior to conducting the analysis. Fallon NaviCare SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.</p>	<p>Based on the 2024 recommendation, Fallon Health has changed processes with Fallon Health's contracted geo-analysis vendor, Quest. Fallon Health has created a scrubbed monthly extract file that is sent directly to Quest to cut down on the number of duplicate providers versus the process that was in place during the referenced validation efforts. This monthly extract and validation process has reduced the number of duplicates submitted for EQR analysis.</p> <p>Fallon Health Configuration &amp; Information Technology teams have worked to complete a number of clean up tickets surrounding provider data throughout calendar year 2025. These tickets consisted of de-duplication of addresses, products and specialties associated with a provider in Fallon Health's source system. Many of these tickets were included into Fallon's nightly automated processes which cleanses data files to limit providers from having inaccurate data persist in the future.</p>	<p>Addressed</p>

Recommendation for Fallon SCO	Fallon SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Network – Time and Distance Analysis – MCP’s Methodology:</b> Fallon NaviCare SCO used incorrect time and distance standards for primary care, ob/gyn, medical facilities in some counties, and dentists. Because of the quality of the provider data, IPRO was able to compare Fallon NaviCare SCO results for those provider types. Fallon NaviCare SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</p>	<p>Fallon Health was notified in 2025 that Fallon Health used the correct standards for aforementioned provider types (The Medicare Advantage) standards outlined by the Centers for Medicare &amp; Medicaid Services (CMS) in the Quest software tool for this analysis of Fallon Health’s Medicare Advantage SCO network and that the Executive Office of Health and Human Services (EOHHS) used the MMP template. Since this exercise Fallon Health has verified alignment of geo-analysis with EOHHS template standard requirements for 2026 SCO contract readiness review.</p>	<p>Addressed</p>
<p><b>Network – Provider Directory:</b> Fallon NaviCare SCO achieved a 57.14% accuracy rate in its PCP directory, a 44.83% accuracy rate in its ob/gyn directory, and only 33.33% in its dental directory. Fallon NaviCare SCO should design quality improvement interventions to enhance the accuracy of all three directories.</p>	<p>Fallon Health continues to partner with the Council for Affordable Quality HealthCare (CAQH) Direct Assure, along with several other Massachusetts health plans, to have providers/providers’ office staff attest and provide updates to directory data. Fallon Health determined that CAQH would be Fallon Health’s source of truth for provider directory data and has automated the data received from CAQH. Fallon Health expects that with the automation of CAQH data, the directory results will be more accurate as providers/providers’ office staff confirm and attest to their directory data at least every 90 days.</p> <p>Fallon Health has been collaborating closely with our Dental vendor, DentaQuest, to enhance oversight of their provider data. In response to these efforts, DentaQuest developed policies and procedures addressing their online directory and provider network adequacy. Additionally, DentaQuest conducts quarterly secret shopper surveys. Furthermore, DentaQuest supports provider engagement through a variety of initiatives, including training sessions, on-site visits by their Provider Relations team, and ad hoc outreach to address member and provider inquiries. During each of these interactions, the Provider Relations team actively works to validate and update provider information to ensure accuracy and compliance.</p>	<p>Addressed</p>

Recommendation for Fallon SCO	Fallon SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Quality-of-Care Surveys:</b> Fallon NaviCare SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Appointments and Care Quickly</li> <li>• Customer Service</li> <li>• Care Coordination</li> <li>• Getting Needed Prescription Drugs</li> <li>• Rating of Health Plan</li> </ul> <p>Fallon NaviCare SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>Fallon Health has a robust Service Excellence Committee structure (that reports up through the Fallon Health Board) that is responsible for monitoring the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results for improvement opportunity identification and action. As part of this structure is a cross functional CMS 5 Star SWAT that is tasked with developing a CAHPS improvement work plan each calendar year. For Calendar year 2025 (based on 2024 results) Fallon Health tasked business owners with improvement activities around Getting Needed Care, Getting Care Quickly, Care Coordination and Rating of Health Plan. In addition to CAHPS results, the Service Excellence Committee reviews Appeals &amp; Grievances, inbound member call data, and other member satisfaction survey results to identify member pain points highlighted in summary CAHPS results.</p>	<p>Partially Addressed</p>

<sup>1</sup> IPRO assessments are as follows: **addressed:** MCP’s quality improvement (QI) response resulted in demonstrated improvement; **partially addressed:** MCP’s QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement:** MCP’s QI response did not address the recommendation; improvement was not observed, or performance declined.

**Not applicable:** PIP was discontinued.

SCO: Senior Care Option; MCP: managed care plan; EQR: external quality review.

## SWH SCO Response to Previous EQR Recommendations

Table 103 displays the SCO's progress related to the *SCO External Quality Review CY 2024*, as well as IPRO's assessment of SCO's response.

**Table 103: SWH SCO Response to Previous EQR Recommendations**

Recommendation for SWH SCO	SWH SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>PIP 2 TRC:</b> For the Remeasurement 1 Report, the Plan should continue to work on the intervention tracking measures to increase the likelihood of desired performance outcomes.</p>	<p>SWH continues to review data and dashboards for the PIP intervention tracking measures. Manual tracking is utilized to compare dashboards to validate data for the ITM. The internal data tracking and source was revised for ITM tracking in 2025. Manual tracking was initiated for validation purposes and validation is ongoing. SWH is continuing to review and improve dashboard data sources. The overall goal for the project intervention of contacting members post discharge for medication reconciliation continues being met. The ITM was created prior to finalizing the data sources and tracking mechanisms available. SWH utilizes an interdisciplinary PIP team and workgroups for ongoing discussions about interventions and data collection. Data validation occurs on a regular basis and is ongoing.</p>	<p>Partially Addressed</p>
<p><b>PMV:</b> HEDIS Measures: SWH SCO's HEDIS rates were below the 25th percentile for the following measures:</p> <ul style="list-style-type: none"> <li>• Transitions of Care – Medication Reconciliation Post-Discharge: 54.5%</li> <li>• Controlling High Blood Pressure: 67.64%</li> <li>• Use of Spirometry Testing in the Assessment and Diagnosis of COPD: 19.86%</li> <li>• Follow-up After Hospitalization for Mental Illness (30 days): 48.48%</li> <li>• Osteoporosis Management in Women Who Had a Fracture: 27.78%</li> </ul> <p>SWH SCO 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>SWH has assessed measure performance data and implemented several interventions to address barriers to care, documentation, and health literacy. SWH is increasing its access to provider data through supplemental data and electronic medical record data to increase medical chart visibility, administrative HEDIS data, and further identify opportunities to improve member quality of care. SWH is also enhancing provider engagement activities to increase partnership with our providers through comprehensive discussion on medication adherence, provider quality and risk performance, as well as ongoing collaboration to increase data visibility.</p> <ul style="list-style-type: none"> <li>• Transition of Care – Medication Reconciliation Post-Discharge: Senior Whole Health (SWH) will continue to work on our state project focusing on Transition of Care – Medication Reconciliation Post-Discharge measure and member outreach by the SWH nurse case managers. SWH utilizes Point Click Care to receive timely discharge notification allowing for earlier follow up with members and providers to improve care.</li> <li>• Controlling High Blood Pressure: SWH will continue its targeted Controlling High Blood Pressure disease management program in addition to its more general educational campaigns and support programs. SWH nurse case manager will continue to outreach to members regarding their blood pressure results, providing education, and mailing educational material to members. Intervention activities will also continue with the CBP focus workgroups in the community which tie to our state project on CBP. SWH will also collaborate with our larger provider groups to achieve higher performance rates through our provider incentive quality program. The Cityblock partnership will also further layer interventions supporting blood pressure control.</li> </ul>	<p>Addressed</p>

Recommendation for SWH SCO	SWH SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
	<ul style="list-style-type: none"> <li>• Use of Spirometry Testing in the Assessment and Diagnosis of COPD: SWH will continue member education on chronic health conditions and spirometry testing in the assessment and diagnosis of COPD. By increasing access to provider data through electronic medical records, SWH will aim to increase historical test results supporting this measure.</li> <li>• Osteoporosis Management in Women Who Had a Fracture: SWH will continue to closely monitor all members that are in the OMW measure, outreaching to members and their providers. Dedicated staff review quality of care gap list data to inform when members have evidence of a fracture or if a test does not produce a valid result. SWH partners with Care Connections provider that utilizes portable DEXA scan machines for in-home scans.</li> </ul>	
<p><b>Compliance:</b> MCP is required to address all deficient and partially met requirements based on IPRO’s recommendations outlined in the final validation tools sent by IPRO to the MCP on 2/1/2024. IPRO will monitor the status of all recommendations as part of the EQR processes and follow up with the MCP before the end of CY 2024.</p> <p>Lack of compliance with 2 requirements in the following domains:</p> <ul style="list-style-type: none"> <li>• Coordination and continuity of care (1)</li> <li>• Grievance and appeal systems (1)</li> </ul> <p>Partial compliance with 23 requirements in the following domains:</p> <ul style="list-style-type: none"> <li>• Enrollee rights requirements (2)</li> <li>• Assurances of adequate capacity and services (3)</li> <li>• Coordination and continuity of care (17)</li> <li>• Grievance and appeal systems (1)</li> </ul>	<p>All deficiencies and “partially met” requirements have been addressed through the corrective action process.</p>	<p>Addressed</p>

Recommendation for SWH SCO	SWH SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Network – Time and Distance (Recommendation from CY2023):</b> MCP 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>Senior Whole Health has implemented system updates to more accurately report Medicaid provider types for all BH and LTSS services that allow for automated reporting and ongoing auditing. Additionally, Senior Whole Health has worked with vendors to ensure vendor data is included in supplemental submissions to address the pharmacy finding. These system enhancements were finalized in August 2025. Manual data maintenance continued through October 2025 when the plan transitioned all reporting to be automated. The Plan was unable to validate adequacy gaps for medical specialties following additional analysis. All fillable gaps have been closed. Gaps that remain are limited to where there are not enough providers to meet minimum provider counts, time, and/or distance criteria. This is largely focused on behavioral health services in Worcester and Hampden counties. Monitoring follows our internal data management policy, including random sampling audits and ongoing network adequacy analysis and “what if” modeling. The migration from manual service type tracking to system-based reporting was completed in 2025. Manual reporting will remain for select provider types that are not network adequacy requirements but are heavily monitored by the Plan.</p>	<p>Addressed</p>
<p><b>Network – Information Systems and Quality of Provider Data – Duplicates:</b> SWH submitted duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address. IPRO removed a total of 971 duplicate providers from SWH SCO data prior to conducting the analysis. SWH SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.</p>	<p>Senior Whole Health has revised our existing provider data validation policy and implemented additional data quality assurance activities that specifically address the findings in the prior submission, including but not limited to duplicate or near duplicate records. Enhancements to the existing provider data management policy were developed in March 2025. Reporting enhancements to support this were completed in May 2025 and full implementation occurred in June 2025. On a monthly basis, providers who are added or terminated from the network are reviewed for accuracy, including verification of new providers through a random sampling secret shopper exercise. Providers who join the network are also extensively education on provider data management and requirements to notify the Plan of any adds, terminations, or status changes for existing providers that may impact their ability to see our shared patients. Additional data quality assurance activities, including updating SQL queries as recommended by this team, began immediately. No less than quarterly, our data analyst runs a full review of the network by provider type and service area. That review includes a fall out analysis to determine any changes to network composition. The analyst has updated SQL codes to account for duplicate and/or near duplicate records, data submitted by vendors, and data for providers who bill through third parties, as we have found that this can impact the service location reported between the rendering record and pay to record. Outcomes have already been realized through these activities. We complete the above-mentioned monthly data validation and quarterly full network analysis. The quarterly fall out analysis captures any change to the network including inclusion or exclusion of duplicate records. The Plan has implemented further staff training on the importance of data management to support the expanded data management audits.</p>	<p>Addressed</p>

Recommendation for SWH SCO	SWH SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Network – Time and Distance Analysis – MCP’s Methodology:</b> SWH SCO used incorrect time and distance standards for many specialists, Intensive Outpatient Program, and dentists. Because of the incorrect standards and the quality of the provider data, IPRO was able to compare SWH SCO’s results for those provider types. SWH SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</p>	<p>Senior Whole Health confirmed that the time and distance standards used for some provider types were incorrectly applied using the 2026 criteria that was also provided to EOHHS during implementation activities. This has been corrected in internal reporting to run both 2025 and 2026 concurrently. This was corrected in the first run following the recommendation. The refreshed reporting supports 2025 network adequacy and did not identify newly opened gaps. This was a one-time error that has been resolved.</p>	<p>Addressed</p>
<p><b>Network – Provider Directory:</b> SWH SCO achieved only a 14.6% accuracy rate in its PCP directory, a 20.72% accuracy rate in its ob/gyn directory, and a 20.00% accuracy rate in its dental directory. SWH SCO should design quality improvement interventions to enhance the accuracy of all three directories.</p>	<p>Senior Whole Health continues to work with DentaQuest to support the findings related to the dental directory. For PCP and OBGYN directory findings, the Plan has worked with EOHHS on the classification of providers to match their enrollment records to ensure that all providers rendering PCP or OB/GYN services are appropriately flagged. In our reviews, we found a low percentage of providers who were flagged incorrectly. The largest barrier remains providers who are not accepting new patients and timely notification to the health plan on the open/closed panel. We conduct random sampling secret shopper activities for non-delegated providers. We require all delegated provider groups to submit open/closed panel status to us no less than quarterly. Senior Whole Health expects open/closed panel flags to be more accurately representative of the patient experience. Provider education occurs no less than quarterly to request full roster reconciliations, inclusive of provider type and panel status. Actions taken as a result of 2023 findings continue to remain in place and are further expanded through additional staff and provider education.</p>	<p>Addressed</p>

Recommendation for SWH SCO	SWH SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Quality-of-Care Surveys:</b> SWH SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Appointments and Care Quickly</li> <li>• Customer Service</li> <li>• Care Coordination</li> <li>• Getting Needed Prescription Drugs</li> <li>• Rating of Prescription Drug Plan</li> <li>• Rating of Health Care Quality</li> <li>• Rating of Health Plan</li> </ul> <p>SWH SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>For MA-PD CAHPS, SWH will continue to increase campaigns to address dissatisfaction to improve member experience utilizing DecisionPoint, post provider visit surveys, increased provider engagement quality discussions, and internal health plan trainings focusing on member and provider experience.. All activities are underway and have been implemented through in person, telephonic, digital, and mail campaigns through member focus groups, member surveys, provider meetings, etc. SWH has taken a collaborative approach utilizing many departments within the health plan and external partners.</p> <p>SWH expects improved outcomes on the CAHPS survey as a result of the interventions supporting improved member experience.</p> <p>SWH will continue to monitor actions through reports and collaboration efforts partnering with providers and other departments to improve member experience.</p> <p>SWH continues to determine areas of opportunities for improvement by increasing campaigns to address dissatisfaction and to perform continuous monitoring. Since the prior response, SWH has further implemented company-wide required trainings for all staff to address member experience and health plan customer service. SWH has also implemented provider post visit surveys to collect anonymous member feedback on provider and health plan experience to further inform opportunities for improvement. SWH has also enhanced provider engagement for additional structured quality improvement discussions with providers.</p>	<p>Partially Addressed</p>

<sup>1</sup> IPRO assessments are as follows: **addressed:** MCP’s quality improvement (QI) response resulted in demonstrated improvement; **partially addressed:** MCP’s QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement:** MCP’s QI response did not address the recommendation; improvement was not observed, or performance declined.

**Not applicable:** PIP was discontinued.

SCO: Senior Care Option; MCP: managed care plan; EQR: external quality review.

## Tufts SCO Response to Previous EQR Recommendations

Table 104 displays the SCO's progress related to the *SCO External Quality Review CY 2024*, as well as IPRO's assessment of SCO's response.

**Table 104: Tufts SCO Response to Previous EQR Recommendations**

Recommendation for Tufts SCO	Tufts SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>PMV: HEDIS Measures:</b> Tufts SCO's HEDIS rate was below the 25th percentile for the following measure:</p> <ul style="list-style-type: none"> <li>• Use of High-Risk Medications in the Elderly: 20.33%</li> <li>• Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (Engagement): 2.9%</li> </ul> <p>Tufts SCO 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 underperforming provider group or facilities, the MCP will conduct a root cause analysis of DAE and IET rates by December 2025. Effectiveness will be evaluated during quarterly meetings through review of findings and any resulting interventions.</p>	<p>Partially Addressed</p>
<p><b>Network – Information Systems and Quality of Provider Data – Duplicates:</b> Tufts SCO submitted many duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address. IPRO removed a total of 1,063 duplicate providers from the Tufts SCO data prior to conducting the analysis. Tufts SCO 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 SCO	Tufts SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Network – Time and Distance Analysis – MCP’s Methodology:</b> Tufts SCO used incorrect time and distance standards for ob/gyn, Acute Inpatient Hospitals, specialists, behavioral health providers, pharmacies in metro counties, Emergency Support Services, and Rehabilitation Hospital Services, as well as General Dentists. Because of the quality of the provider data and a lack of correct standards, IPRO was unable to compare Tuft SCO’s results for those provider types.</p> <p>Tufts SCO 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><b>Network – Provider Directory:</b> Tufts SCO achieved only a 7.48% accuracy rate in its PCP directory, a 37.7% accuracy rate in its ob/gyn directory, and only a 36.67% accuracy rate in its dental directory. Tufts SCO 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>

Recommendation for Tufts SCO	Tufts SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Quality-of-Care Surveys:</b> Tufts SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Appointments and Care Quickly</li> <li>• Customer Service</li> <li>• Care Coordination</li> <li>• Getting Needed Prescription Drugs</li> <li>• Rating of Health Plan</li> <li>• Rating of Health Care Quality</li> <li>• Rating of Prescription Drug Plan</li> </ul> <p>Tufts SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>To strengthen survey response rates and improve MA-PD CAHPS scores, the MCP uses survey results to guide targeted member experience initiatives. In 2025, a new customer experience structure was introduced, led by a dedicated program lead. Improvements are implemented through structured action plans with enhanced governance. Effectiveness is tracked via survey and claims data, grievance trends, performance metrics and member feedback forums.</p>	<p>Partially Addressed</p>

<sup>1</sup> IPRO assessments are as follows: **addressed:** MCP’s quality improvement (QI) response resulted in demonstrated improvement; **partially addressed:** MCP’s QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement:** MCP’s QI response did not address the recommendation; improvement was not observed, or performance declined.

**Not applicable:** PIP was discontinued.

SCO: Senior Care Option; MCP: managed care plan; EQR: external quality review.

## UHC SCO Response to Previous EQR Recommendations

Table 105 displays the SCO's progress related to the *SCO External Quality Review CY 2024*, as well as IPRO's assessment of SCO's response.

**Table 105: UHC SCO Response to Previous EQR Recommendations**

Recommendation for UHC SCO	UHC SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>PMV: HEDIS SNP Measures:</b> HEDIS Measures: UnitedHealthcare SCO's HEDIS rate was below the 25th percentile for the following measures:</p> <ul style="list-style-type: none"> <li>• Use of Spirometry Testing in the Assessment and Diagnosis of COPD: 23.21%</li> <li>• Use of High-Risk Medications in the Elderly: 21.23%</li> <li>• Plan All-Cause Readmission (Observed/Expected Ratio) 65+: 1.1627</li> </ul> <p>UnitedHealthcare SCO 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>	<ul style="list-style-type: none"> <li>• <b>Use of High-Risk Medications in the Elderly (DAE):</b> UnitedHealthcare implemented a targeted Performance Improvement Project (PIP). The Use of High-Risk Medications in the Elderly (DAE) rate improved from 21.23% in Measurement Year 2023 to 20.48% in Measurement Year 2024, with the current rate further reduced to 17.00%, reflecting meaningful progress. The ongoing Performance Improvement Project (PIP) included pilot interventions that demonstrated modest improvements and have since been integrated into standard SCO Care Management (CM) practices.</li> <li>• <b>Plan All-Cause Readmission (Observed/Expected Ratio) 65+ (PCR):</b> UnitedHealthcare conducted a root cause analysis and held quality meetings where input was obtained to identify barriers impacting members and providers. UnitedHealthcare created interventions and quality activities to address identified barriers and improve the measures. In Measurement Year 2023 the Plan All-Cause Readmission (PCR) rate was 1.1627 which improved to 1.0803 in Measurement Year 2024.</li> <li>• <b>Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR):</b> UnitedHealthcare's Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) rate for Measurement Year 2023 was 23.21% which exceeded the Measurement Year 2023 Quality Compass 25thpercentile (22.19%). For Measurement Year 2024 there is no Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) data. According to National Committee for Quality Assurance (NCQA) HEDIS Measurement Year 2024, volume 2 page 3, the Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) measure was retired on 1/1/2024.</li> </ul>	<p>Addressed</p>

Recommendation for UHC SCO	UHC SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
<p><b>Network – Information Systems and Quality of Provider Data – Duplicates:</b> UnitedHealthcare SCO submitted duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address. IPRO removed a total of 228 duplicate providers from the UnitedHealthcare SCO data prior to conducting the analysis. UnitedHealthcare SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.</p>	<p>Elements of this Policy and Procedure (P&amp;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&amp;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.</p>	<p>Addressed</p>
<p><b>Network – Time and Distance Analysis – MCP’s Methodology:</b> UnitedHealthcare SCO seemed to implement incorrect time and distance standards for primary care, OB/GYN, hospitals and medical facilities. Because of incorrect standards and some duplicative records, IPRO was unable to compare UnitedHealthcare’s results for those provider types. UnitedHealthcare SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</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 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&amp;P) includes language that addresses procedures to ensure that the appropriate time and distance standards as outlined in IPRO’s technical manual.</p>	<p>Addressed</p>
<p><b>Network – Provider Directory:</b> UnitedHealthcare SCO achieved a 38.97% accuracy rate in its PCP directory, a 28.71% accuracy rate in its OB/GYN directory, and only 43.33% accuracy rate in its dental directory. UnitedHealthcare SCO should design quality improvement interventions to enhance the accuracy of all three directories.</p>	<p>UnitedHealthcare (UHC) 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</p>	<p>Addressed</p>

Recommendation for UHC SCO	UHC SCO Response/Actions Taken	IPRO Assessment of MCP Response <sup>1</sup>
	<p>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 caused and trended for improvement opportunities. Internal quality reviews and feedback loops are used to continuously assess and refine processes.</p>	
<p><b>Quality-of-Care Surveys:</b> UHC SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Appointments and Care Quickly</li> <li>• Customer Service</li> <li>• Care Coordination</li> <li>• Getting Needed Prescription Drugs</li> <li>• Rating of Health Care Quality</li> </ul> <p>UnitedHealthcare SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>UnitedHealthcare SCO conducted a root cause analysis and implemented a comprehensive set of targeted interventions to improve performance across all underperforming MA-PD CAHPS measures. The plan demonstrated measurable improvements across multiple CAHPS domains from MY2024 to MY2025 and outlined clear goals and monitoring processes, indicating both implementation and observed improvement.</p>	<p>Addressed</p>

<sup>1</sup> IPRO assessments are as follows: **addressed:** MCP’s quality improvement (QI) response resulted in demonstrated improvement; **partially addressed:** MCP’s QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement:** MCP’s QI response did not address the recommendation; improvement was not observed, or performance declined.

**Not applicable:** PIP was discontinued.

SCO: Senior Care Option; MCP: managed care plan; EQR: external quality review.

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

Tables 106–111 highlight each SCO’s performance strengths, opportunities for improvement, and this year’s recommendations based on the aggregated results of CY 2025 EQR activities as they relate to **quality, timeliness, and access**.

### WellSense SCO Strengths, Opportunities for Improvement, and EQR Recommendations

**Table 106: Strengths, Opportunities for Improvement, and EQR Recommendations for WellSense SCO**

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: TRC	There is high confidence that the PIP Closure 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.	N/A	N/A	Quality, Timeliness, Access
PIP 1: COL	There is high confidence that the PIP Closure 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.	N/A	N/A	Quality, Timeliness, Access

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: HEDIS SNP measures	<p>SCO demonstrated compliance with information system standards. No issues were identified. WellSense SCO HEDIS rates were above the national Medicare 90th percentile of the NCQA Quality Compass on the following measures:</p> <ul style="list-style-type: none"> <li>Pharmacotherapy Management of COPD Exacerbation – Bronchodilator: 92.73%</li> <li>Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid: 85.45%</li> </ul>	<p>WellSense SCO HEDIS rates were below the 25th percentile for the following measures:</p> <ul style="list-style-type: none"> <li>Antidepressant Medication Management – Effective Acute Phase Treatment: 73.33%</li> <li>Controlling High Blood Pressure: 72.00%</li> <li>Plan All-Cause Readmissions (65+): 1.3462</li> </ul>	<p>WellSense SCO 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>
Quality-of-care Surveys	<p>WellSense SCO exceeded the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>Rating of Health Care Quality</li> <li>Rating of Health Plan</li> </ul>	<p>WellSense SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>Getting Needed Care</li> </ul>	<p>WellSense SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>Quality, Timeliness, Access</p>

SCO: Senior Care Option; EQR: external quality review; PIP: performance improvement project; SNP: Special Needs Plan; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; COPD: chronic obstructive pulmonary disease; MA-PD CAHPS: Medicare Advantage Prescription Drugs Consumer Assessment of Healthcare Providers and Systems; N/A: not applicable.

## CCA SCO Strengths, Opportunities for Improvement, and EQR Recommendations

**Table 107: Strengths, Opportunities for Improvement, and EQR Recommendations for CCA SCO**

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: DAE	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.	Although there was evidence of adapting interventions during the PIP process, there was no improvement in any of the four performance indicator rates throughout the PIP.	CCA should continue looking for ways to improve performance indicator rates.	Quality, Timeliness, Access
PIP 2: TRC	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 SNP measures	SCO demonstrated compliance with information system standards. No issues were identified. CCA SCO HEDIS rates were above the national Medicare 90th percentile of the NCQA Quality Compass on the following measure: <ul style="list-style-type: none"> <li>Transitions of Care – Medication Reconciliation Post-discharge (Total): 94.12%</li> </ul>	SCO’s HEDIS rates were below the 25th percentile for the following measures: <ul style="list-style-type: none"> <li>Osteoporosis Management in Women Who Had a Fracture: 20.75%</li> <li>Plan All-Cause Readmissions (65+): 1.2675</li> <li>Use of High-risk Medications in Older Adults – Total: 27.33%</li> </ul>	CCA SCO 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.	CCA SCO submitted duplicates for individual and facility providers due to variations in the facility names and in the provider addresses, such as including the suite name. IPRO removed a total of 1,598 duplicate providers from the CCA SCO data prior to conducting the analysis.	CCA SCO 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	It was possible to compare pharmacy results only. IPRO compared MCP’s pharmacy results and concluded that the results reported for those provider types were valid, accurate, and reliable.	CCA SCO seemed to implement incorrect time and distance standards for primary care, specialists, including ob/gyn, hospitals, and rehabilitation hospital services, LTSS providers, pharmacies, behavioral health services, and oral surgeons. Because of incorrect standards and some duplicative records, IPRO was unable to compare CCA SCO’s results for those provider types. The results for general dentists were not submitted to IPRO.	CCA SCO 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	IPRO’s analysis showed that CCA SCO demonstrated adequate networks for primary care providers, all specialists, including ob/gyn, hospitals and rehabilitation hospital services in large metro counties, specialists, all LTSS providers, pharmacy in large metro counties, and behavioral health outpatient, as well as most behavioral health diversionary services and oral surgeons.	CCA SCO had some gaps in rehabilitation hospital services in metro counties and pharmacies in metro counties. IPRO’s analysis also revealed gaps in the general dentists’ networks in large metro and metro counties.	CCA SCO 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 SCO achieved a 13.37% accuracy rate in its PCP directory, a 17.58% accuracy rate in its ob/gyn provider directory, and only 32.10% accuracy rate in its CMHC directory.	CCA SCO should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Quality-of-care Surveys	<p>CCA SCO exceeded the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Annual Flu Vaccine</li> <li>• Rating of Prescription Drug Plan</li> <li>• Rating of Health Care Quality</li> <li>• Rating of Health Plan</li> </ul>	<p>CCA SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care (Composite)</li> <li>• Getting Appointments and Care Quickly (Composite)</li> <li>• Care Coordination (Composite)</li> <li>• Getting Needed Prescription Drugs (Composite)</li> </ul>	<p>CCA SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>Quality, Timeliness, Access</p>

SCO: Senior Care Option; EQR: external quality review; PIP: performance improvement project; PCP: primary care provider; SNP: Special Needs Plan; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; LTSS: long-term services and support; MA-PD CAHPS: Medicare Advantage Prescription Drugs Consumer Assessment of Healthcare Providers and Systems; MCP: managed care plan; ob/gyn; obstetrics/gynecology; N/A: not applicable.

## Fallon SCO Strengths, Opportunities for Improvement, and EQR Recommendations

**Table 108: Strengths, Opportunities for Improvement, and EQR Recommendations for Fallon SCO**

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: TRC	<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 high confidence that the PIP produced evidence of improvement.</p>	N/A	N/A	Quality, Timeliness, Access
PIP 2: COL	<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 high confidence that the PIP produced evidence of improvement.</p>	N/A	N/A	Quality, Timeliness, Access

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: HEDIS SNP measures	SCO demonstrated compliance with information systems standards. No issues were identified. Fallon SCO HEDIS rates were above the national Medicare 90th percentile of the NCQA Quality Compass on the following measure: <ul style="list-style-type: none"> <li>Osteoporosis Management in Women Who Had a Fracture: 72.09%</li> </ul>	Fallon SCO's HEDIS rates were below the 25th percentile for the following measures: <ul style="list-style-type: none"> <li>Antidepressant Medication Management – Effective Acute Phase Treatment: 76.57%</li> <li>Use of High-risk Medications in Older Adults – Total: 25.38%</li> </ul>	Fallon SCO 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
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.	Fallon SCO submitted duplicates for individual and facility providers due to variations in the facility names and in the provider addresses. IPRO removed a total of 117 duplicate providers from the Fallon SCO data prior to conducting the analysis.	Fallon SCO 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	Fallon SCO used the correct MassHealth standards for many provider types. When it was possible, IPRO compared MCP's results other provider types and concluded that the results reported for those provider types were valid, accurate, and reliable.	Fallon SCO seemed to implement incorrect time and distance standards for clinical psychology, clinical social work, psychiatry, behavioral health outpatient providers, ATS for SUD, ACCS, AMCI, Adult RRS for SUD, CSS for SUD, CSP, IOP, PHP, PACT, Psychiatric Day Treatment, Psychiatric Inpatient Adult, Recovery Coaching, Recovery Support Navigators, and SOAP. Because of incorrect standards and some duplicative records, IPRO was unable to compare Fallon SCO's results for those provider types. Sometimes, IPRO's results showed significant discrepancies when compared to the results submitted by the MCP.	Fallon SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.  Fallon SCO should revisit the GeoAccess results that differed from IPRO's analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.	Quality, Access, Timeliness

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	IPRO’s analysis showed that Fallon SCO demonstrated adequate networks for primary care, most specialists, including ob/gyn, acute inpatient hospitals, and most LTSS providers, pharmacies, and behavioral health outpatient.	Fallon SCO had some gaps in behavioral health diversionary services and some LTSS provider networks. IPRO’s analysis also revealed gaps in the general dentists' networks in large metro and metro counties, as well as oral surgeons in metro counties.	Fallon SCO 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.	Fallon SCO achieved a 14.77% accuracy rate in its PCP directory, a 17.65% accuracy rate in its ob/gyn directory, and only 25.00% in its CMHC directory.	Fallon SCO should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness
Quality-of-care Surveys	Fallon SCO scored above the Medicare Advantage national mean score on the following MA-PD CAHPS measures: <ul style="list-style-type: none"> <li>• Customer Service</li> <li>• Annual Flu Vaccine</li> <li>• Rating of Prescription Drug Plan</li> <li>• Rating of Health Care Quality</li> <li>• Rating of Health Plan</li> </ul>	Fallon SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures: <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Appointments and Care Quickly</li> <li>• Care Coordination</li> <li>• Getting Needed Prescription Drugs</li> </ul>	Fallon SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access

SCO: Senior Care Option; EQR: external quality review; PIP: performance improvement project; PCP: primary care provider; SNP: Special Needs Plan; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; LTSS: long-term services and supports; MA-PD CAHPS: Medicare Advantage Prescription Drugs Consumer Assessment of Healthcare Providers and Systems; MCP: managed care plan; SUD: substance use disorder; ob/gyn; obstetrics/gynecology; N/A: not applicable.

## SWH SCO Strengths, Opportunities for Improvement, and EQR Recommendations

**Table 109: Strengths, Opportunities for Improvement, and EQR Recommendations for SWH SCO**

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: CBP	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: TRC	There is moderate confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is moderate confidence that the PIP produced evidence of improvement.	Some intervention tracking measure rates consistently exhibited no improvement, but the intervention was not strengthened or modified in response to the declining rates.	Interventions that showed declining intervention tracking measure rates were not modified. For future report submissions or future PIP cycles, SWH SCO should closely monitor intervention tracking measure data so that declines in intervention tracking measure rates can spur quick course correction (and utilize Plan-Do-Study-Act cycles throughout the PIP to help develop intervention changes).	Quality, Timeliness, Access
Performance Measure Validation: HEDIS SNP measures	SCO demonstrated compliance with information system standards. No issues were identified. The following measure rate was above the 90th percentile: <ul style="list-style-type: none"> <li>Advance Care Planning: 81.56%</li> </ul>	SWH SCO's HEDIS rates were below the 25th percentile for the following measure: <ul style="list-style-type: none"> <li>Osteoporosis Management in Women Who Had a Fracture: 25.00%</li> </ul>	SWH SCO 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
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.	SWH SCO submitted duplicates for individual and facility providers due to variations in the facility names and in the provider addresses. IPRO removed a total of 1,253 duplicate providers from the SWH SCO prior to conducting the analysis.	SWH SCO should further clean and deduplicate the provider data prior to conducting any network analyses or submitting provider data for the EQR analysis.	Quality, Access, Timeliness

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – MCP’s Methodology	SWH SCO used the correct MassHealth standards for many provider types. When it was possible, IPRO compared MCP’s results other provider types and concluded that the results reported for those provider types were valid, accurate, and reliable.	SWH SCO seemed to implement incorrect time and distance standards for primary care, many specialists, including ob/gyn, hospitals, and rehabilitation hospital services, skilled nursing facility, occupational, physical, and speech therapy, pharmacy, and many behavioral health diversionary providers. Because of incorrect standards and some duplicative records, IPRO was unable to compare SWH SCO’s results for those provider types. Notably, IPRO’s results for Clinical Support Services for Substance Use Disorders in Middlesex and Plymouth counties did not match SWH SCO’s results.	SWH SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.  SWH SCO should revisit the GeoAccess results that differed from IPRO’s analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.	Quality, Access, Timeliness
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	IPRO’s analysis showed that SWH SCO demonstrated adequate networks for primary care providers, most specialists, including ob/gyn, hospitals in metro counties, and rehabilitation hospital services, most LTSS providers, pharmacy, and behavioral health outpatient, as well as oral surgeons.	SWH SCO had some gaps in behavioral health diversionary services and acute hospital in network in a large county, speech therapy, and day habilitation network. IPRO’s analysis also revealed gaps in the general dentists’ networks in large metro and metro counties.	SWH SCO 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.	SWH SCO achieved only a 1.59% accuracy rate in its PCP directory, a 14.38% accuracy rate in its ob/gyn directory, and a 27.78% accuracy rate in its CMHC directory.	SWH SCO should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Quality-of-care surveys	<p>SWH SCO scored above the Medicare Advantage national mean score on the following measures:</p> <ul style="list-style-type: none"> <li>• Customer Service</li> <li>• Annual Flu Vaccine</li> <li>• Rating of Health Plan</li> </ul>	<p>SWH SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Appointments and Care Quickly</li> </ul>	<p>SWH SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.</p>	<p>Quality, Timeliness, Access</p>

SCO: Senior Care Option; EQR: external quality review; PIP: performance improvement project; PCP: primary care provider; SNP: Special Needs Plan; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; COPD: chronic obstructive pulmonary disease; LTSS: long-term services and support; MA-PD CAHPS: Medicare Advantage Prescription Drugs Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; CY: calendar year; MCP: managed care plan; ob/gyn; obstetrics/gynecology; N/A: not applicable; TBD: to be determined.

## Tufts SCO Strengths, Opportunities for Improvement, and EQR Recommendations

**Table 110: Strengths, Opportunities for Improvement, and EQR Recommendations for Tufts SCO**

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: DAE	<p>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.</p>	<p>There is low confidence that the PIP produced evidence of improvement.</p>	<p>Given the lack of improvement in the performance indicators, it is recommended that the Plan utilize barrier analysis to develop intervention tracking measures with a larger reach to impact a larger proportion of the member population.</p>	<p>Quality, Timeliness, Access</p>
PIP 2: TRC	<p>There is moderate confidence that the PIP Remeasurement 1 Report adhered to acceptable methodology for determining the aim and methodology of the PIP, identifying barriers, and proposing interventions that address the barriers. There is high confidence that the PIP produced evidence of improvement.</p>	<p>Rates are reported inconsistently throughout the PIP, leaving it difficult to confirm accuracy.</p>	<p>Tufts SCO should ensure that results are reported consistently throughout various sections of the PIP.</p>	<p>Quality, Timeliness, Access</p>

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Performance Measure Validation: HEDIS SNP measures	SCO demonstrated compliance with information system standards. No issues were identified.	<p>Tufts SCO's HEDIS rate was below the 25th percentile for the following measure:</p> <ul style="list-style-type: none"> <li>• Osteoporosis Management in Women Who Had a Fracture: 21.74%</li> <li>• Plan All-Cause Readmissions (65+): 1.2167</li> <li>• Use of High-risk Medications in Older Adults – Total: 20.47%</li> </ul>	Tufts SCO 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
Network Adequacy: Information Systems and Quality of Provider Data – Duplicates	Data used by the MCP to monitor network adequacy were mostly accurate and current, except for duplicative provider records and incorrect provider directory information.	Tufts SCO submitted duplicates for individual and facility providers due to variations in the addresses, such as including the suite name in the address. IPRO removed a total of 45 duplicate providers from the Tufts SCO prior to conducting the analysis.	Tufts SCO 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	Tufts SCO used the correct MassHealth standards for many provider types. When it was possible, IPRO compared MCP's results for other provider types and concluded that the results reported for those provider types were valid, accurate, and reliable.	Tufts SCO seemed to implement incorrect time and distance standards for primary care in metro counties, some specialists, including ob/gyn, acute hospitals, skilled nursing facilities, as well as occupational, physical, and speech therapy. Because of incorrect standards and some duplicative records, IPRO was unable to compare Tufts SCO's results for those provider types. When the results could have been compared, IPRO identified that the results for ATS SUD, CSS SUD, and SOAP within Hampshire County show significant discrepancies when compared to the results submitted by the MCP.	<p>Tufts SCO should use the correct MassHealth standards and clean data for the GeoAccess analysis for all provider types.</p> <p>Tufts SCO should revisit the GeoAccess results that differed from IPRO's analysis to confirm the accuracy of its own methodology and to identify factors driving the discrepancies.</p>	Quality, Access, Timeliness

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Network Adequacy: Time and Distance Analysis – Gaps in Provider Networks	IPRO’s analysis showed that Tufts SCO demonstrated adequate networks for primary care providers in large metro areas, all specialists, including ob/gyn, acute inpatient hospitals, pharmacy in metro counties, and behavioral outpatient providers, as well as most LTSS provider types.	Tufts SCO had some gaps in the adult PCP network in a metro county, rehabilitation hospital services in a metro county, adult day health, day habilitation, pharmacy in a large metro county, and some behavioral health diversionary services. IPRO’s analysis also revealed gaps in the general dentists’ and oral surgeons’ networks in large metro and metro counties.	Tufts SCO 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 SCO achieved only a 16.02% accuracy rate in its PCP directory, a 22.70% accuracy rate in its ob/gyn directory, and only a 12.09% accuracy rate in its CMHC directory.	Tufts SCO should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness
Quality-of-care Surveys	<p>Tufts SCO scored above the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Annual Flu Vaccine</li> <li>• Rating of Health Plan</li> </ul>	<p>Tufts SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care (Composite)</li> <li>• Getting Appointments and Care Quickly (Composite)</li> <li>• Customer Service (Composite)</li> <li>• Care Coordination (Composite)</li> <li>• Getting Needed Prescription Drugs (Composite)</li> <li>• Rating of Prescription Drug Plan</li> <li>• Rating of Health Care Quality</li> </ul>	Tufts SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access

SCO: Senior Care Option; EQR: external quality review; PIP: performance improvement project; PCP: primary care provider; SNP: Special Needs Plan; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; LTSS: long-term services and supports; MA-PD CAHPS: Medicare Advantage Prescription Drugs Consumer Assessment of Healthcare Providers and Systems; MCP: managed care plan; ob/gyn; obstetrics/gynecology; N/A: not applicable; SUD: substance use disorder.

## UHC SCO Strengths, Opportunities for Improvement, and EQR Recommendations

**Table 111: Strengths and Opportunities for Improvement, and EQR Recommendations for UHC SCO**

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
PIP 1: DAE	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.	There was no significant improvement in the performance indicator rates throughout the PIP.	UHC should continue to identify barriers and adapt interventions to increase the PI rates.	Quality, Timeliness, Access
PIP 2: TRC	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.	The targeted submeasure's (MRP) rate did not change during this timeframe and was identical from baseline to the interim period, leaving it difficult to assess effectiveness of the interventions that were implemented during the measurement year.	UHC should continue interventions while monitoring the associated intervention tracking measure data for performance improvement. UHC should also modify/include new interventions based on intervention/intervention tracking measure performance outcomes.	Quality, Timeliness, Access
Performance Measure Validation: HEDIS SNP measures	SCO demonstrated compliance with information system standards. No issues were identified. UHC SCO HEDIS rates were above the national Medicare 90th percentile of the NCQA Quality Compass on the following measure: <ul style="list-style-type: none"> <li>Colorectal Cancer Screening: 82.27%</li> </ul>	UHC SCO's HEDIS rate was below the 25th percentile for the following measures: <ul style="list-style-type: none"> <li>Osteoporosis Management in Women Who Had a Fracture: 27.17%</li> <li>Plan All-Cause Readmissions (65+): 1.0803</li> <li>Use of High-risk Medications in Older Adults (Total): 20.48%</li> </ul>	UHC SCO 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 SCO submitted duplicates for individual and facility providers due to variations in the facility names and in the provider addresses, such as including the suite name in the address. IPRO removed a total of 86 duplicate providers from the UHC SCO data prior to conducting the analysis.	UHC SCO 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 SCO used correct standards for primary care providers, many specialists, acute inpatient hospitals, many LTSS providers, pharmacies, and dental services. When it was possible, IPRO compared MCP’s results with other provider types and concluded that the results reported for those provider types were valid, accurate, and reliable.	UHC SCO seemed to implement incorrect time and distance standards for ob/gyn, rehabilitation hospital services, skilled nursing facilities, occupational, physical, and speech therapy, and many outpatient behavioral health providers. Because of incorrect standards and some duplicative records, IPRO was unable to compare UHC SCO’s results for those provider types.	UHC SCO 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 SCO demonstrated adequate networks for PCPs in large metro counties, most specialists including ob/gyn, hospitals and medical facilities, and pharmacy in large metro counties, as well as many LTSS provider types and rehabilitation hospital services.	UHC SCO had some gaps in the adult PCP network in a metro county, general surgery in a metro county, skilled nursing facilities, speech therapy, adult day health, day habilitation, and hospice, as well as a pharmacy network in a metro county, several behavioral health diversionary services, and a general dentists’ network and oral surgeon network in a metro county. IPRO’s analysis also revealed gaps in the general dentists’ networks in large metro and metro counties.	UHC SCO should expand the network when members’ access can be improved and when network deficiencies can be closed by available providers. When additional providers are not available, the Plan should explain what actions are being taken to provide adequate access for members residing in those service areas.	Access, Timeliness
Network Adequacy: Accuracy of Provider Directory	None.	UHC SCO achieved a 13.44% accuracy rate in its PCP directory, a 25.85% accuracy rate in its ob/gyn directory, and no accuracy in its CMHC directory.	UHC SCO should design quality improvement interventions to enhance the accuracy of all three directories.	Quality, Access, Timeliness

Activity	Strengths	Opportunities for Improvement	Recommendations	Standards
Quality-of-care surveys	UHC SCO exceeded the Medicare Advantage national mean score on the following MA-PD CAHPS measures: <ul style="list-style-type: none"> <li>• Annual Flu Vaccine</li> <li>• Rating of Health Plan</li> </ul>	UHC SCO scored below the Medicare Advantage national mean score on the following MA-PD CAHPS measures: <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Customer Service</li> <li>• Getting Needed Prescription Drugs</li> <li>• Rating of Health Care Quality</li> </ul>	UHC SCO should utilize the results of the MA-PD CAHPS surveys to drive performance improvement as it relates to member experience. SCO should also utilize complaints and grievances to identify and address trends.	Quality, Timeliness, Access

SCO: Senior Care Option; EQR: external quality review; PIP: performance improvement project; PCP: primary care provider; SNP: Special Needs Plan; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; LTSS: long-term services and support; MA-PD CAHPS: Medicare Advantage Prescription Drugs Consumer Assessment of Healthcare Providers and Systems; MCP: managed care plan; ob/gyn; obstetrics/gynecology; N/A: not applicable.

## 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 112**.

**Table 112: 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 <b>Appendix B, Table B1</b> .
<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 SCO are summarized in <b>Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations</b> .
<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 <b>Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations</b> for a chart outlining each SCO’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 SCO are included in each EQR activity section ( <b>Sections III–VII</b> ) and in <b>Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations</b> .

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 <b>Section I, High-Level Program Findings and Recommendations</b> , as well as when discussing strengths and weaknesses of an SCO 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 SCOs is included across the report in each EQR activity section ( <b>Sections III–VII</b> ) and in <b>Section IX. MCP Strengths, Opportunities for Improvement, and EQR Recommendations</b> .
<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 <b>Section VIII. MCP Responses to the Previous EQR Recommendations</b> for the prior year findings and the assessment of each SCO’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 <b>Section III</b> .
<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 <b>Section III</b> .
<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 SCO’s performance measures; see <b>Section IV</b> .

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 SCO's compliance with the standards set forth in Subpart D and the QAPI requirements described in <i>Title 42 CFR § 438.330</i>; see <b>Section V</b>.</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 <sup>1</sup>	51.9%	57%
		WCV-CH: Child and Adolescent Well-visits <sup>1</sup>	54.6%	60%
1.2	Increase utilization and timeliness of preventative services	BCS-AD: Breast Cancer Screening <sup>1</sup>	64.3%	70%
		COL-AD: Colorectal Cancer Screening <sup>1</sup>	28.8%	32%
1.3	Manage quality and access to maternal health	PPC: Prenatal Care <sup>1</sup>	48.6%	55%
		PPC: Postpartum Care <sup>1</sup>	63.4%	70%

<sup>1</sup> 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	71.7%	75%
		GSD-AD: Glycemic Status Assessment for Patients with Diabetes (poor control; lower is better) <sup>1</sup>	25.5%	22%
2.2	Manage populations impacted by mental health and substance use disorders	FUA: Follow-up after Emergency Department Visit for Substance Use <sup>2</sup>	7-day: 36.6%	40%
			30-day: 49.5%	53%
2.3	Promote member safety	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD/OUD-HH) <sup>1</sup>	79.2%	82%

<sup>1</sup> CMS Core Measure.

<sup>2</sup> 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 <sup>1</sup>	7-day: 38.3%	45%
			30-day: 59.5%	64%
3.2	Improve access to and quality of home and community-based services	MLTSS-7: Managed LTSS Minimizing Facility Length of Stay <sup>2</sup>	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 <sup>1</sup>	1.24	1.0

<sup>1</sup> CMS Universal Foundation and Core Set Measure.

<sup>2</sup> 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) <sup>1</sup> CAHPS Health Plan Survey (Medicaid): Rating of Health Care* (9 + 10) <sup>1</sup>	Adult: 68.56% Child: 79.26% <sup>2</sup> Adult: 57.05% Child: 80.39% <sup>2</sup>	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 <sup>1</sup>	SCO: 86% One Care: 87%	88% 89%

<sup>1</sup> CMS Universal Foundation and Core Set Measure.

<sup>2</sup> 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 <sup>1</sup>	Adult: 80.27% Child: 85.44% <sup>2</sup>	83% 87%
5.2	Promote provider and service access	FUM: Follow-up after Emergency Department Visit for Mental Illness <sup>3</sup>	7-day: 68.1% 30-day: 76.8%	72% 80%

<sup>1</sup> CMS Universal Foundation and Core Set Measure.

<sup>2</sup> Medicaid Expansion CHIP and non-CHIP.

<sup>3</sup> 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"> <li>• Population: Managed care eligible Medicaid members under 65 years of age.</li> <li>• Managed Care Authority: 1115 Demonstration Waiver.</li> <li>• Type: MCE.</li> </ul>	<ol style="list-style-type: none"> <li>1. BeHealthy Partnership Plan</li> <li>2. Berkshire Fallon Health Collaborative</li> <li>3. East Boston Neighborhood Health WellSense Alliance</li> <li>4. Fallon 365 Care</li> <li>5. Fallon Health – Atrius Health Care Collaborative</li> <li>6. Mass General Brigham Health Plan with Mass General Brigham ACO</li> <li>7. Tufts Health Together with Cambridge Health Alliance (CHA)</li> <li>8. Tufts Health Together with UMass Memorial Health</li> <li>9. WellSense Beth Israel Lahey Health (BILH) Performance Network ACO</li> <li>10. WellSense Boston Children’s ACO</li> <li>11. WellSense Care Alliance</li> <li>12. WellSense Community Alliance</li> <li>13. WellSense Mercy Alliance</li> <li>14. WellSense Signature Alliance</li> <li>15. WellSense Southcoast Alliance</li> </ol>
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"> <li>• Population: Managed care eligible Medicaid members under 65 years of age.</li> <li>• Managed Care Authority: 1115 Demonstration Waiver.</li> <li>• Type: PCCM Entity.</li> </ul>	<ol style="list-style-type: none"> <li>1. Community Care Cooperative</li> <li>2. Revere Medical</li> </ol>
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"> <li>• Population: Managed care eligible Medicaid members under 65 years of age.</li> <li>• Managed Care Authority: 1115 Demonstration Waiver.</li> <li>• Type: MCE.</li> </ul>	<ol style="list-style-type: none"> <li>1. WellSense Essential</li> <li>2. Tufts Health Together (will no longer be a plan in 2026)</li> </ol>

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"> <li>Population: Managed care eligible Medicaid members under 65 years of age.</li> <li>Managed Care Authority: 1115 Demonstration Waiver.</li> <li>Type: PCCM.</li> </ul>	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"> <li>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.</li> <li>Managed Care Authority: 1115 Demonstration Waiver.</li> <li>Type: PIHP.</li> </ul>	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"> <li>Population: Dual-eligible Medicaid members ages 21–64 years at the time of enrollment with MassHealth and Medicare coverage.</li> <li>Managed Care Authority: Financial Alignment Initiative Demonstration.</li> <li>Type: MCE.</li> </ul>	<ol style="list-style-type: none"> <li>Commonwealth Care Alliance</li> <li>Tufts Health Plan Unify</li> <li>UnitedHealthcare Connected</li> </ol>

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"> <li>• Population: Medicaid members over 65 years of age and dual-eligible members over 65 years of age.</li> <li>• Managed Care Authority: 1915(a) Waiver/1915(c) Waivers.</li> <li>• Type: MCE.</li> </ul>	<ol style="list-style-type: none"> <li>1. Commonwealth Care Alliance</li> <li>2. NaviCare Fallon Health</li> <li>3. Senior Whole Health by Molina</li> <li>4. Tufts Health Plan Senior Care Option</li> <li>5. UnitedHealthcare Senior Care Options</li> <li>6. WellSense Senior Care Option (will no longer be a plan in 2026)</li> </ol>

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 SCO 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: SCO Network Adequacy Standards and Indicators – Primary Care Providers**

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p><b>Primary care Providers:</b></p> <ul style="list-style-type: none"> <li>• General Practice</li> <li>• Family Practice</li> <li>• Internal Medicine</li> </ul> <p><b>Contract Language:</b> For each of the following Provider types, the Contractor shall adhere to CMS’s most current Medicare Advantage network adequacy criteria, including time and distance standards, that apply to the Contractor’s service area:</p> <ol style="list-style-type: none"> <li>a. Primary Care;</li> <li>b. Obstetrics and Gynecology;</li> <li>c. Specialist Providers;</li> <li>d. Hospital; and</li> <li>e. Pharmacy</li> </ol> <p>CMS Medicare Advantage network adequacy criteria (Source: MassHealth-provided spreadsheet)</p>	<p><b>Primary Care Providers:</b> 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> <p><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><b>Primary Care Providers:</b> <b>Numerator:</b> number of Enrollees in a county for which both of the following is true:</p> <ul style="list-style-type: none"> <li>• Two unique in-network providers are within a specific drive (defined in minutes) or less from Enrollee’s ZIP code of residence; <b>AND</b></li> <li>• Two unique in-network providers are within a specific distance (defined in miles) or less from Enrollee’s ZIP code of residence.</li> </ul> <p><i>Note:</i> Time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <p><b>Denominator:</b> all plan Enrollees in a county.</p> <p><b>Minimum Provider Ratios:</b> the number of all in-network providers in a county against the number of all Enrollees in that county.</p> <p><b>Minimum Number of Providers:</b> apply the minimum number of providers as defined by CMS per county designation.</p>

**Table D2: SCO Network Adequacy Standards and Indicators – Obstetricians and Gynecologists**

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p><b>Provider Type:</b></p> <ul style="list-style-type: none"> <li>OB/GYN</li> </ul> <p><b>Contract Language:</b> For each of the following Provider types, the Contractor shall adhere to CMS’s most current Medicare Advantage network adequacy criteria, including time and distance standards, that apply to the Contractor’s service area:</p> <ol style="list-style-type: none"> <li>Primary Care;</li> <li>Obstetrics and Gynecology;</li> <li>Specialist Providers;</li> <li>Hospital; and</li> <li>Pharmacy</li> </ol> <p>CMS Medicare Advantage network adequacy criteria (Source: MassHealth-provided spreadsheet)</p>	<p><b>OB/GYN Providers:</b> 90% of Enrollees in a county have access to at least 2 OB/GYN providers within a specific drive (defined in minutes) and distance (defined in miles) from Enrollee’s ZIP code of residence.</p> <p><i>Note:</i> CMS 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><b>Primary Care Providers:</b> <b>Numerator:</b> number of Enrollees in a county for which both of the following is true:</p> <ul style="list-style-type: none"> <li>Two unique in-network providers are within a specific drive (defined in minutes) or less from Enrollee’s ZIP code of residence; <b>AND</b></li> <li>Two unique in-network providers are within a specific distance (defined in miles) or less from Enrollee’s ZIP code of residence.</li> </ul> <p><i>Note:</i> CMS time and distance vary by county designation (Large Metro, Metro, and Micro) and provider type.</p> <p><b>Denominator:</b> all plan Enrollees in a county.</p> <p><b>Minimum Provider Ratios:</b> the number of all in-network providers in a county against the number of all Enrollees in that county.</p>

**Table D3: SCO Network Adequacy Standards and Indicators – Hospital and Medical Facilities**

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p><b>Hospitals/Medical Facilities:</b></p> <ul style="list-style-type: none"> <li>• Acute Inpatient Hospital</li> <li>• Skilled Nursing Facilities</li> <li>• Occupational Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> </ul> <p><b>Contract Language:</b> For each of the following Provider types, the Contractor shall adhere to CMS’s most current Medicare Advantage network adequacy criteria, including time and distance standards, that apply to the Contractor’s service area:</p> <ol style="list-style-type: none"> <li>a. Primary Care;</li> <li>b. Obstetrics and Gynecology;</li> <li>c. Specialist Providers;</li> <li>d. Hospital; and</li> <li>e. Pharmacy</li> </ol> <p>CMS Medicare Advantage network adequacy criteria (Source: MassHealth-provided spreadsheet)</p>	<p><b>Hospitals/Medical Facilities:</b></p> <ul style="list-style-type: none"> <li>• 90% of Enrollees in a county have access to 2 providers within a designated time and distance standards from Enrollee’s ZIP code of residence.</li> <li>• The actual time and distance vary by provider type and the micro-metro-large metro geographic type.</li> <li>• Apply provider-to-enrollee ratio defined by CMS.</li> </ul> <p>Apply the minimum number of providers defined by CMS, which vary by county.</p>	<p><b>Hospitals/Medical Facilities:</b></p> <p><b>Numerator:</b> number of plan Enrollees in a county for which both of the following are true:</p> <ul style="list-style-type: none"> <li>• Two unique in-network providers are within a specific-minute drive or less from Enrollee’s ZIP code of residence; AND</li> <li>• Two unique in-network providers are within a specific distance or less from Enrollee’s ZIP code of residence.</li> <li>• The actual time and distance vary by provider type and the micro-metro-large metro geographic type.</li> </ul> <p><b>Denominator:</b> all plan Enrollees in a county.</p> <p><b>Minimum Provider Ratios:</b> the number of all in-network providers in a county against the number of all Enrollees in that county per each provider type.</p> <p><b>Minimum Number of Providers:</b> apply the minimum number of providers as defined by CMS per county designation for each provider types.</p>

**Table D4: SCO Network Adequacy Standards and Indicators – Specialists**

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p><b>Specialists CMS standards:</b>  Allergy and Immunology  Cardiology  Cardiothoracic Surgery  Chiropractor  Dermatology  Endocrinology  ENT/Otolaryngology  Gastroenterology  General Surgery  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><b>Contract Language:</b>  For each of the following Provider types, the Contractor shall adhere to CMS’s most current Medicare Advantage network adequacy criteria, including time and distance standards, that apply to the Contractor’s service area:  a. Primary Care;</p>	<p><b>Specialists:</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>The actual time and distance differ by provider type and the micro-metro-large metro geographic type.</li> <li>Apply provider-to-enrollee ratio defined by CMS.</li> </ul> <p>Apply the minimum number of providers defined by CMS, which vary by county.</p>	<p><b>Specialists:</b>  Numerator: number of plan Enrollees in a county for which both of the following are true:</p> <ul style="list-style-type: none"> <li>One unique in-network provider is within a specific-minute drive or less from Enrollee’s ZIP code of residence; AND</li> <li>One unique in-network provider is within a specific distance or less from Enrollee’s ZIP code of residence.</li> <li>The actual time and distance differ by provider type and the micro-metro-large metro geographic type.</li> </ul> <p><b>Denominator:</b> all plan Enrollees in a county.  <b>Minimum Provider Ratios:</b> the number of all in-network providers in a county against the number of all Enrollees in that county for each provider type.  <b>Minimum Number of Providers:</b> apply the minimum number of providers as defined by CMS per county designation for each provider type.</p>

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
b. Obstetrics and Gynecology; c. Specialist Providers; d. Hospital; and e. Pharmacy  CMS Medicare Advantage network adequacy criteria (Source: MassHealth-provided spreadsheet)		

**Table D5: SCO Network Adequacy Standards and Indicators – Outpatient Behavioral Health**

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p><b>Outpatient Behavioral Health</b>  <b>Provider Types:</b>                      BH Outpatient                      Adult Community Crisis Stabilization (ACCS)                      Community Support Program                      Intensive Outpatient Programs                      Partial Hospitalization Programs                      Program of Assertive Community Treatment (PACT)                      Psychiatric Day Treatment                      Psychiatric Inpatient Adult                      Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)                      Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)                      Recovery Coaching                      Recovery Support Navigators                      Adult Residential Rehabilitation Services (RRS)                      for Substance Use Disorders (Level 3.1)                      Structured Outpatient Addiction Program                      Adult Mobile Crisis Intervention (AMCI)</p> <p><b>Contract Language:</b>                      The Contractor shall adhere to the time and distance standards that follow for each of the following provider types:  <b>a. Outpatient Behavioral Health:</b>                      Each Enrollee must have a choice of at least two Outpatient Behavioral Health Providers within a 15-mile</p>	<p><b>Outpatient Behavioral Health</b>                      90% of Enrollees in a county have access to at least two Outpatient Behavioral Health Providers within a 15-mile radius or 30 minutes from the Enrollee’s ZIP code of residence</p>	<p><b>Outpatient Behavioral Health:</b>  <b>Numerator:</b> number of plan Enrollees in a county for whom one of the following is true:</p> <ul style="list-style-type: none"> <li>• Two unique in-network providers are a 30-minute drive or less from an Enrollee’s ZIP code of residence; OR</li> <li>• Two unique in-network providers are 15 miles or less from an Enrollee’s ZIP code of residence.</li> </ul> <p><b>Denominator:</b> all plan Enrollees in a county.</p>

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p>radius or 30 minutes from the Enrollee's ZIP code of residence.</p> <p><b>b. Mental Health Providers:</b> Each Enrollee must have a choice of at least two Mental Health Providers within twenty (20) miles or forty (40) minutes travel time from the Enrollee's ZIP code of residence.</p> <p><b>c. Substance Use Disorder Providers:</b> Each Enrollee must have a choice of at least two Substance Use Disorder Providers within twenty (20) miles or forty (40) minutes travel time from the Enrollee's ZIP code of residence.</p>		

**Table D6: SCO Network Adequacy Standards and Indicators – Pharmacy**

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p><b>Provider Type:</b></p> <ul style="list-style-type: none"> <li>• <b>Pharmacy</b></li> </ul> <p><b>Contract Language:</b> For each of the following Provider types, the Contractor shall adhere to CMS’s most current Medicare Advantage network adequacy criteria, including time and distance standards, that apply to the Contractor’s service area:</p> <ol style="list-style-type: none"> <li>Primary Care;</li> <li>Obstetrics and Gynecology;</li> <li>Specialist Providers;</li> <li>Hospital; and</li> <li>Pharmacy</li> </ol> <p>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><b>Pharmacy</b></p> <ul style="list-style-type: none"> <li>•90% of beneficiaries in Large Metro counties (urban areas) must be within 2 miles of a retail pharmacy;</li> <li>•90% of beneficiaries in Metro counties (suburban areas) must be within 5 miles of a retail pharmacy;</li> <li>•70% of beneficiaries in Micro counties (rural areas) must be within 15 miles of a retail pharmacy.</li> </ul>	<p><b>Pharmacy:</b></p> <p><b>Numerator:</b> number of plan Enrollees in a county for which the following is true:</p> <ul style="list-style-type: none"> <li>•Large Metro: A retail pharmacy is within 2 miles or less from Enrollee’s ZIP code of residence.</li> <li>•Metro: A retail pharmacy is within 5 miles or less from Enrollee’s ZIP code of residence.</li> <li>•Micro: A retail pharmacy is within 15 miles or less from Enrollee’s ZIP code of residence.</li> </ul> <p><b>Denominator:</b> all plan Enrollees in a county.</p>

**Table D7: SCO Network Adequacy Standards and Indicators – LTSS Providers**

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p><b>LTSS Providers:</b></p> <ul style="list-style-type: none"> <li>• Adult Day Health</li> <li>• Day Habilitation</li> <li>• Hospice</li> </ul> <p><b>Contract Language:</b> Enrollee must have a choice of at least two Providers that are either within a 15-mile radius or 30 minutes from the Enrollee’s ZIP code of residence, except that with prior approval from EOHHS, the Contractor may offer the Enrollee only one such Provider per service.</p> <p>a. Adult Day Health; b. Day Habilitation; c. Hospice; and d. The following services are described in the Frail Elder Waiver: 1) Evidence-Based Education Programs; 2) Respite; and 3) Supportive Day Program</p>	<p><b>LTSS Providers:</b> 90% of Enrollees in a county have access to at least two LTSS providers within 15 miles <u>or</u> 30 minutes for the Enrollee’s ZIP code of residence.</p>	<p><b>LTSS Providers:</b> <b>Numerator:</b> number of plan Enrollees in a county for whom one of the following is true:</p> <ul style="list-style-type: none"> <li>• Two unique in-network providers are a 30-minute drive or less from an Enrollee’s ZIP code of residence; <b>OR</b></li> <li>• Two unique in-network providers are 15 miles or less from a Enrollee’s ZIP code of residence.</li> </ul> <p><b>Denominator:</b> all plan Enrollees in a county.</p>

**Table D8: SCO Network Adequacy Standards and Indicators – Other Provider Types**

Network Adequacy Standards Source: SCO Contract - Section 2.6.B.1-4	Indicator	Definition of the Indicator
<p><b>Rehabilitation Hospital services</b> Contract does not explicitly state a time and distance standard for Rehabilitation Hospital services. Included per MassHealth’s request.</p>	<p><b>Hospital rehabilitation services/Medical Facility</b> 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>	<p><b>Hospital rehabilitation services/Medical Facility</b> <b>Numerator:</b> number of plan Enrollees in a county for whom one of the following is true:  <ul style="list-style-type: none"> <li>• An in-network rehabilitation hospital is a 30-minute drive or less from Enrollee’s ZIP code of residence; <b>OR</b></li> <li>• An in-network rehabilitation hospital is 15 miles or less from Enrollee’s ZIP code of residence.</li> </ul> <b>Denominator:</b> all plan Enrollees in a county.</p>

**Table D9: SCO Network Adequacy Standards and Indicators – Dental Services**

<b>Network Adequacy Standards</b> <b>Source: 2025 SCO Contract (to be integrated into the 2024 network analysis) 3.1.A</b>	<b>Indicator</b>	<b>Definition of the Indicator</b>
<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><b>General Dentists</b></p> <ul style="list-style-type: none"> <li>•95% of Members have access to 2 General Dentists within 10 minutes of their home</li> <li>•Apply provider-to-enrollee ratio of 1: 1,500</li> </ul> <p><b>Oral Surgeon</b></p> <ul style="list-style-type: none"> <li>•95% have access to 1 Oral Surgeon within 30 minutes of their home</li> <li>•Apply provider-to-enrollee ratio of 1: 20,000</li> </ul>	<p><b>General Dentists:</b></p> <p><b>Numerator:</b> 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><b>Denominator:</b> all plan enrollees in a county.</p> <p><b>Minimum Provider Ratios:</b> the number of all in-network providers in a county against the number of all enrollees in that county.</p> <p><b>Oral Surgeons:</b></p> <p><b>Numerator:</b> 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><b>Denominator:</b> all plan enrollees in a county.</p> <p><b>Minimum Provider Ratios:</b> the number of all in-network providers in a county against the number of all enrollees in that county.</p>

## XV. Appendix E – MassHealth SCO Provider Directory Web Addresses

**Table E1: SCO Provider Directory Web Addresses**

Managed Care Plan	Web Addresses Reported by Managed Care Plan
WellSense SCO	<ul style="list-style-type: none"> <li>• PCP: <a href="https://www.wellsense.org/members/ma/senior-care-options#find-a-provider">https://www.wellsense.org/members/ma/senior-care-options#find-a-provider</a></li> <li>• Ob/Gyn: <a href="#">Members   Senior Care Options   WellSense Health Plan</a></li> <li>• Dentists: <a href="https://www.dentaquest.com/en/find-a-dentist">https://www.dentaquest.com/en/find-a-dentist</a></li> </ul>
Fallon SCO	<ul style="list-style-type: none"> <li>• PCP: <a href="https://fallonhealth.org/en/find-insurance/navicare/provider-directory">https://fallonhealth.org/en/find-insurance/navicare/provider-directory</a></li> <li>• Ob/Gyn: <a href="https://fallonhealth.org/en/find-insurance/navicare/provider-directory">https://fallonhealth.org/en/find-insurance/navicare/provider-directory</a></li> <li>• Dentists: <a href="https://www.dentaquest.com/en/find-a-dentist">https://www.dentaquest.com/en/find-a-dentist</a></li> </ul>
Tufts SCO	<ul style="list-style-type: none"> <li>• PCP: <a href="https://www.tuftsmedicarepreferred.org/tufts-health-plan-doctor-search">https://www.tuftsmedicarepreferred.org/tufts-health-plan-doctor-search</a></li> <li>• Ob/Gyn: <a href="https://www.tuftsmedicarepreferred.org/tufts-health-plan-doctor-search">https://www.tuftsmedicarepreferred.org/tufts-health-plan-doctor-search</a></li> <li>• Dentists: <a href="#">Search results - DentaQuest (healthsparq.com)</a><a href="https://dentaquest.healthsparq.com/healthsparq/public/%23/one/city=&amp;state=&amp;postalCode=&amp;country=&amp;insurerCode=DENTAQUEST_1&amp;brandCode=DENTAQUEST/search/filters= SPECIALTY%253AGeneral%2520Dentistry&amp;isPromotionSearch=false&amp;location=Boston%252C%2520MA&amp;page =1&amp;productCode=MA-TUFTSCO&amp;radius=25&amp;searchType=advanced">https://dentaquest.healthsparq.com/healthsparq/public/%23/one/city=&amp;state=&amp;postalCode=&amp;country=&amp;insurerCode=DENTAQUEST_1&amp;brandCode=DENTAQUEST/search/filters= SPECIALTY%253AGeneral%2520Dentistry&amp;isPromotionSearch=false&amp;location=Boston%252C%2520MA&amp;page =1&amp;productCode=MA-TUFTSCO&amp;radius=25&amp;searchType=advanced</a></li> </ul>
CCA SCO	<ul style="list-style-type: none"> <li>• PCP: <a href="https://www.commonwealthcarealliance.org/ma/members/find-a-provider/">https://www.commonwealthcarealliance.org/ma/members/find-a-provider/</a></li> <li>• Ob/Gyn: <a href="https://www.commonwealthcarealliance.org/ma/members/find-a-provider/">https://www.commonwealthcarealliance.org/ma/members/find-a-provider/</a></li> <li>• Dentists: <a href="#">Search - Provider Directory (commonwealthcarealliance.org)</a></li> </ul>
UHC SCO	<ul style="list-style-type: none"> <li>• PCP: <a href="https://connect.werally.com/county-plan-selection/uhc.mnr/plan/25025?zipCode=02109&amp;coverageType=medical">https://connect.werally.com/county-plan-selection/uhc.mnr/plan/25025?zipCode=02109&amp;coverageType=medical</a></li> <li>• Ob/Gyn: <a href="https://connect.werally.com/county-plan-selection/uhc.mnr/plan/25025?zipCode=02109&amp;coverageType=medical">https://connect.werally.com/county-plan-selection/uhc.mnr/plan/25025?zipCode=02109&amp;coverageType=medical</a></li> <li>• Dentists: <a href="https://connect.werally.com/dentalProvider/root?showBack Button=true">https://connect.werally.com/dentalProvider/root?showBack Button=true</a></li> </ul>
SWH SCO	<ul style="list-style-type: none"> <li>• PCP: <a href="https://molina.sapphirethreesixtyfive.com//?ci=ma-molina">https://molina.sapphirethreesixtyfive.com//?ci=ma-molina</a></li> <li>• Ob/Gyn: <a href="https://molina.sapphirethreesixtyfive.com//?ci=ma-molina">https://molina.sapphirethreesixtyfive.com//?ci=ma-molina</a></li> <li>• Dentists: <a href="#">Find Care - DentaQuest (healthsparq.com)</a></li> </ul>

PCP: primary care provider; ob/gyn: obstetrics/gynecology; SCO: Senior Care Plan.