



TECHNICAL REPORT

Massachusetts Behavioral Health Partnership External Quality Review

Calendar Year 2021



MassHealth

Massachusetts Executive Office
of Health & Human Services



This program is supported in full by the
Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid.

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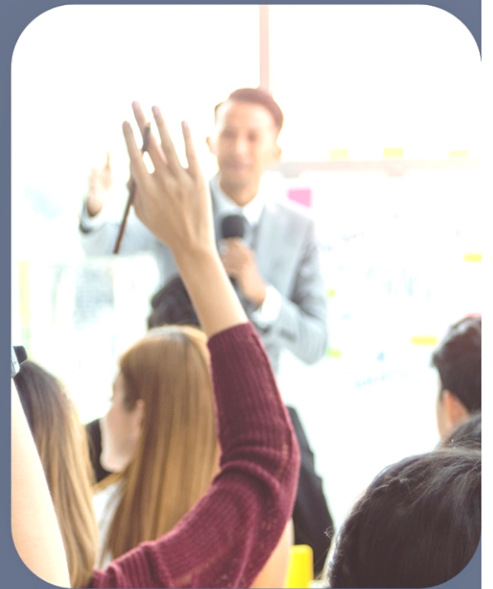
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Section 1.

Introduction



SECTION 1. INTRODUCTION

The Massachusetts Behavioral Health Partnership (MBHP) is a Managed Behavioral Healthcare Organization (MBHO) that provides services to members of the MassHealth Primary Care Clinician Plan, children in state custody, and certain children enrolled in MassHealth who have commercial insurance as their primary insurance. It also manages behavioral health services for members of Community Care Cooperative (C3), Mass General Brigham ACO, Steward Health Choice, BeHealthy Partnership, children in state custody, certain children enrolled in MassHealth who have commercial insurance as their primary insurance, and the managed care organization Health New England. As of December 31, 2021, 638,000 individuals statewide were under the care of the Partnership.

MBHP is a Beacon Health Options company. Headquartered in Boston and servicing the entire state, MBHP has received full NCQA MBHO accreditation. More information is available as www.masspartnership.com

Section 2.

Executive Summary



SECTION 2. EXECUTIVE SUMMARY

INTRODUCTION

The Balanced Budget Act of 1997 was an omnibus legislative package enacted by the U. S. Congress with the intent of balancing the federal budget by 2002. Among its other provisions, this expansive bill authorized states to provide Medicaid benefits (except to special needs children) through managed care entities. Regulations were promulgated, including those related to the quality of care and service provided by managed care entities plans to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the healthcare services that a managed care plan or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth has entered into an agreement with Kepro to perform EQR services for its contracted managed care entities, including MBHP which is the subject of this report. All MassHealth managed care plans participate in external quality review.

As part of its analysis and evaluation activities, the EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services (CMS). The report is also posted to the Medicaid agency website.

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

Kepro conducted the following external quality review activities for MBHP in the calendar year (CY) 2021 review cycle:

- Validation of three performance measures, including an Information Systems Capability Assessment
- Validation of two Performance Improvement Projects (PIPs); and
- Validation of network adequacy.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2021 reflect 2020 quality measurement performance. References to HEDIS® 2021 performance reflect data collected in 2020. Performance Improvement Project reporting is inclusive of activities conducted in CY 2021.

METHODOLOGY FOR PREPARING THE EXTERNAL QUALITY REVIEW TECHNICAL REPORT

To fulfill the requirements of 42 CFR §438.358,1-5, Kepro compiled the overall findings for each EQR activity it conducted. It assessed MBHP's strengths, areas requiring improvement, and opportunities to further strengthen its processes, documentation, and performance outcomes

with respect to the quality and timeliness of, and access to, healthcare services. It also followed up on recommendations made in the previous reporting period.

Data Sources

Kepro used the following data sources to complete its assessment and to prepare this annual EQR technical report:

Performance Measure Validation

- A completed Data Acquisition Questionnaire
- The HEDIS MY 2020 Final HEDIS IDSS file
- NCQA-certified HEDIS vendor MY 2020 report
- The 2021 NCQA Medicaid Quality Compass
- 2020 Performance Measure Validation recommendations

Performance Improvement Project Validation

- The Baseline Project Planning and Baseline Performance Indicator Reports
- Supplemental information as identified by the managed care plan
- Recommendations offered in the previous reporting period

Compliance Validation

- Documentation to substantiate compliance with each requirement during the review period including, but not limited to:
 - Policies and Procedures
 - Standard Operating Procedures
 - Workflows
 - Desk Tools
 - Reports
 - Member Materials
 - Care Management Files
 - Utilization Management Denial Files
 - Appeals Files
 - Grievance Files
 - Credentialing Files
- 42 CFR 438
- Appropriate provisions in the Code of Massachusetts Regulations (CMR)
- Managed care plan agreements with MassHealth
- 2018 Compliance Validation recommendations

Network Adequacy Validation

- Network provider files in an Excel format
- MassHealth provider network adequacy standards
- 2021 recommendations

Data Analysis

For each of the EQR activities, Kepro conducted a thorough review and analysis of the data within the parameters set forth in CMS' EQR Protocols. Reviewers were assigned to EQR activities based on professional experience and credentials. Because the activities varied in terms of types of data collected and used, Kepro designed the methodology for identifying strengths and weaknesses to accommodate the data available for and specific to each activity.

Drawing Conclusions

Kepro's reviewers drew conclusions in response to these and similar questions as pertinent to the scope of the external quality review:

- Did MBHP's methodology for measure calculation comply with HEDIS technical specifications?
- Did MBHP's Performance Improvement Project Report comply with established criteria? Do the interventions show promise for effecting improvement?
- Did MBHP supply documentation evidencing compliance with regulatory and contractual requirements? Did staff interviews demonstrate consistency with compliance?
- Did MBHP's provider network files appear to be complete? Did the analysis show an adequate number of providers and facilities to serve MassHealth members?

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

Exhibit 2.1. Performance Measure Validation Process Overview

Topic	Description
Objectives	To assess the accuracy of performance measures in accordance with 42 CFR § 438.358(b)(ii) reported by MBHP and to determine the extent to which MBHP follows state specifications and reporting requirements.
Technical methods of data collection and analysis	Kepro's Lead Performance Measure Validation Auditor conducted this activity in accordance with 42 CFR § 438.358(b)(ii).
Data obtained	<ul style="list-style-type: none">• A completed Data Acquisition Questionnaire• The HEDIS MY 2020 Final HEDIS IDSS file• NCQA-certified HEDIS vendor MY 2020 report• The 2021 NCQA Medicaid Quality Compass
Conclusions	Kepro's validation review of the selected performance measures indicates that MBHP's measurement and reporting processes were fully compliant with specifications and were methodologically sound.

The Performance Measure Validation process assesses the accuracy of performance measures. In 2021, Kepro conducted Performance Measure Validation in accordance with CMS EQR Protocol 2 on three measures that were selected by MassHealth and Kepro. The measures validated were:

- Antidepressant Medication Management (AMM): Effective Acute Phase Treatment
- Follow-up after ED Visit for Mental Illness (FUM): Seven-Day Follow-Up; and
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of alcohol or other drug (AOD) Treatment.

Kepro also conducted an Information Systems Capability Assessment, the focus of which is on components of plan information systems that contribute to performance measure production. This is to ensure that the system can collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system or other methods. The system must be able to ensure that data received from providers are accurate and complete, and that the accuracy and timeliness of reported data are verified; that the data have been screened for completeness, logic, and consistency; and that service information is collected in standardized formats to the extent feasible and appropriate.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Exhibit 2.2. Performance Improvement Validation Process Overview

Topic	Description
Objectives	To assess overall project methodology as well as the overall validity and reliability of the PIP methodology and findings to determine confidence in the results.
Technical methods of data collection and analysis	Performance Improvement Projects were validated in accordance with § 438.330(b)(i).
Data obtained	MBHP submitted two PIP reports in 2021, Baseline Report: Project Planning (April 2021); and Baseline Report: Performance Indicator Rates (September 2021). It also submitted related supporting documentation.
Conclusions	Based on its review of MBHP's Performance Improvement Projects, Kepro did not discern any issues related to its quality of care or the timeliness of, or access to, care.

Under the terms of its agreement with MassHealth, MBHP is required to conduct performance improvement projects annually that are “designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Covered Individual, Network Provider, and PCC satisfaction.” Two of these projects are validated by MassHealth’s External Quality Review Organization.

The MassHealth Office of Behavioral Health directed MBHP to conduct projects related to:

- 1) Follow-up for alcohol and other drug use disorder after emergency department (ED) discharge; and
- 2) The reduction of barriers to telehealth services.

Kepro evaluates each PIP to determine whether the organization selected, designed, and executed the project in a manner consistent with CMS EQR Protocol 1, *Performance Improvement Project Validation*. The Kepro Technical Reviewer assesses project methodology. The Medical Director evaluates the clinical soundness of the interventions. The review considers the managed care plan's performance in the areas of problem definition, data analysis, measurement, improvement strategies, and outcome. Recommendations are offered to the plan.

Based on its review of MBHP's Performance Improvement Projects, Kepro has high confidence in the validity of the projects' results. Kepro offers three access-related recommendations to MBHP.

- Kepro recommends developing population-specific strategies for outreach to increase follow up for substance use disorders after emergency department visits. Kepro also recommends tracking socioeconomic factors that might have significant impact on emergency department utilization and follow-up visit attendance such as housing status, poverty, lack of transportation, and access to technology for virtual visits such as phones or tablets. Speaking a language other than English should also be included.
- Kepro notes that its PIP focusing on the expansion of access to telehealth services, MBHP is focusing on just 0.7% (N=4,649) of its total member population (N=609,409). Stated differently, MBHP is not taking any action in this PIP to support its other 604,760 members with respect to accessing behavioral health services through telehealth platforms. With respect to improving telehealth access, MBHP's executive committee should consider options for broadening this PIP to engage a broader portion of its membership.

NETWORK ADEQUACY VALIDATION

Exhibit 2.3. Network Adequacy Validation Process Overview

Topic	Description
Objectives	The Network Adequacy Validation process assesses a managed care plan's compliance with the time and distance standards established by MassHealth. CMS has not published a formal protocol for this external quality review activity.
Technical methods of data collection and analysis	Quest Analytics enterprise network adequacy validation solution was used to compile and analyze network information provided by MBHP.
Data obtained	MBHP provided Excel worksheets containing demographic information about its provider network.
Conclusions	On a scale of 1 to 100, MBHP received an overall network adequacy score of 80.5, a decrease of 6 points in comparison to the previous analysis. Rural Dukes and Nantucket counties continue to experience the most gaps in provider network adequacy. The state may want to consider conducting further analysis into these regions to assess whether these counties can meet the standards in their entirety. If not, the state could approve an exception or adjust the standards going forward.

MBHP has opportunities to improve the network for improved access to care for its members. Certain geographical areas seem to struggle more than others, not surprisingly Dukes and Nantucket Counties. Other opportunities for improvement include expanding geographical coverage of services specific to substance use disorders.

MASSHEALTH QUALITY STRATEGY

States operating Medicaid managed care programs under any authority must have a written quality strategy for assessing and improving the quality of healthcare and services furnished by managed care plans. States must also conduct an evaluation of the effectiveness of the quality strategy and update the strategy as needed, but no less than once every three years.

The first MassHealth Quality Strategy was published in 2006. The most recent version was submitted to CMS in November 2018. The 2018 version, the MassHealth Comprehensive Quality Strategy, focused not only on fulfilling managed care quality requirements but on improving the quality of managed care services in Massachusetts. An updated strategy is currently being finalized and is anticipated to be available to the public in early 2022. It will incorporate new behavioral health, health equity, and waiver strategies and will align with the recent CMS toolkit and webinar guidance released in Summer 2021.

SUPPORTING IMPROVEMENT IN THE QUALITY, TIMELINESS, AND ACCESS TO HEALTHCARE SERVICES: RECOMMENDATIONS TO MASSHEALTH

CMS requires that the EQRO offer recommendations for how the State can target goals and objectives in the quality strategy, under § 438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries.

In addition to the managed care plan-specific recommendations made throughout this Technical Report, Kepro respectfully offers the following recommendations to MassHealth.

Provider Network

2021 EQR activities shed a light on the need for both inpatient and outpatient behavioral health services statewide. Kepro strongly recommends that MassHealth work with partners statewide to address workforce and infrastructure solutions to increase the availability of behavioral health and substance abuse services. For example, the Commonwealth might consider lived experience to be an alternate qualification to a professional degree akin to the DMH Peer Support Training and Certification Program. *(Access, Timeliness of Care)*

Kepro recommends that MassHealth leverage Quest Analytics' ability to report on provider non-English language capacity. Additionally, MassHealth should leverage Quest's provider directory verification capabilities as the provider directory is a foundational piece of member information. *(Access, Timeliness of Care)*

MassHealth and the plans both need to increase their oversight of network adequacy, especially as it relates to appointment access. Kepro recommends that MassHealth provide related direction to these plans. Kepro encourages MassHealth to consider the practical feasibility of its network adequacy standards, especially those for the less populated areas of Berkshire, Dukes, and Nantucket counties. The Quest Analytics systems permits the designation of exceptions for individual provider-county combinations. Doing so would allow the system to report a more accurate picture of network adequacy. *(Access, Timeliness of Care)*

Health Equity

To support MassHealth's priority of achieving health equity, it is essential that it improve the quality of its REL data and fix the ever-vexing issue of enrollment updates with no REL data overwriting plan-collected data. *(Access)*

It is Kepro's experience that managed care plans struggled with developing health equity interventions and experience difficulty with the definition of a focal population and culturally sensitive project plans. Kepro strongly encourages MassHealth to consider ways in which technical assistance can be provided to the plans on REL data analysis and the design of associated project interventions. *(Access)*

Performance Improvement Projects

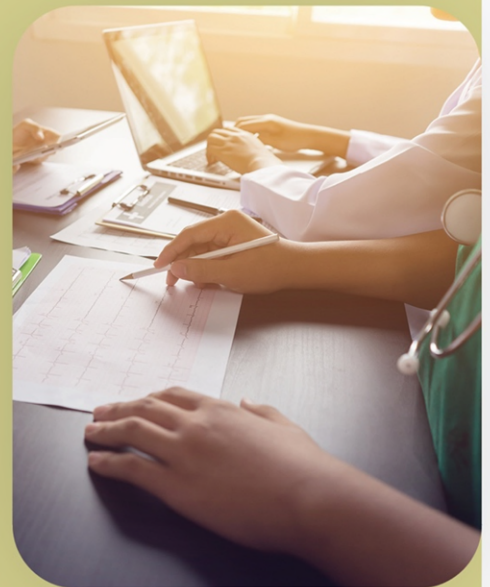
Performance Improvement Projects are resource-intensive undertakings. Kepro believes it is essential that PIP topics focus on priority topics established by MassHealth, topics addressing low-performance areas as identified by performance rates; and topics that address at least 10% or more of the managed care plan's MassHealth population. Kepro recommends that these criteria be applied as part of the Baseline Project Planning reporting process. *(Quality)*

Communication Pathways

Kepro respectfully suggests that MassHealth consider including the External Quality Review Organization, as appropriate, as a contributor to internal agency deliberations regarding managed care plan quality improvement initiatives. With its strong links to plan staff and knowledge of plan quality-related activities, Kepro can offer MassHealth a nuanced understanding of the environment. *(Quality)*

Section 3.

Performance Measure Validation



SECTION 3. PERFORMANCE MEASURE VALIDATION

PERFORMANCE MEASURE VALIDATION METHODOLOGY

The Performance Measure Validation process assesses the accuracy of performance measures reported by the managed care plan. It determines the extent to which the managed care plan follows state specifications and reporting requirements. In addition to validation processes and the reported results, Kepro evaluates performance in comparison to national benchmarks as well as any interventions the plan has in place to improve upon reported rates and health outcomes. Kepro validates three performance measures annually for MBHP.

Conducted in accordance with 42 CFR § 438.358(b)(ii), Kepro's Performance Measure Validation (PMV) audit methodology assesses both the quality of the source data that feed into the measure under review and the accuracy of the calculation. Source data review includes evaluating the plan's data management structure, data sources, and data collection methodology. Measure calculation review includes reviewing the logic and analytic framework for determining the measure numerator, denominator, and exclusion cases, if applicable.

The two-step PMV process consists of a desk review of documentation submitted by the managed care plan. The desk review affords the reviewer an opportunity to become familiar with plan systems and data flows. For plans that do not undergo a formal HEDIS® audit, as is the case with MBHP, an onsite review is conducted. At the onsite review, which is conducted virtually, the reviewer confirms information contained in the Data Acquisition Questionnaire, inspects information systems, and by interviewing staff, obtains clarification about performance measurement and information transfer processes.

The methodology for selecting measures was to identify measures in which MBHP's HEDIS® 2020 performance was either very low, very high, or represented a significant change from HEDIS® 2019 performance. These factors may make it more likely that there is an underlying issue with calculating the rate. The measures selected for review in calendar year 2020 were as follows:

Exhibit 3.1. Performance Measures Validated in 2021

HEDIS Measure Name and Abbreviation	Measure Description
Antidepressant Medication Management (AMM): Effective Acute Phase Treatment <i>Rationale for Selection: Important mental health measure for which to confirm data. Antidepressant medication coverage can be affected by reversed pharmacy claims counting as a unique claim.</i>	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).
Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up <i>Rationale for Selection: Important mental health measure with complicated specifications for counting numerator events.</i>	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within seven days of the ED visit (eight total days).
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD Treatment <i>Rationale for Selection: Important substance abuse measure with complicated specifications for counting initiation events.</i>	The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.

MBHP submitted the documentation that follows in support of the performance measure validation process:

Exhibit 3.2. MBHP Performance Measure Validation Supporting Documentation

Document Reviewed	Purpose of Kepro Review
Data Acquisition Questionnaire (DAQ)	Reviewed to assess managed care plan systems and processes related to performance measure production.
HEDIS MY2020 Final HEDIS IDSS submission file	Reviewed to verify the absence of process issues and to help aid PMV measure selection and for review of the selected PMV measure data.
List of interventions related to performance measures	Reviewed to help explain changes in performance measure rates.
NCQA-certified HEDIS vendor MY2020 report	Reviewed to confirm that the source code for the three selected PMV measures was NCQA-certified for MY 2020.
Follow-up documentation, as requested by the auditor, during the course of PMV review	Plan-specific documentation requested to obtain missing or incomplete information, support and validate plan processes, and verify the completeness and accuracy of information provided in the DAQ or at onsite interviews and systems demonstrations.

TECHNICAL SPECIFICATION COMPLIANCE

The tables that follow contain the HEDIS technical specifications for the measures being validated as well as Kepro's determination as to whether the plans met these criteria. Kepro uses the following ratings for Performance Measure Validation review elements:

- **Met:** MBHP correctly and consistently evidenced review element;
- **Partially met:** MBHP partially or inconsistently evidenced review element; and
- **Not met:** MBHP did not evidence review element or incorrectly evidenced review element.

Antidepressant Medication Management: Effective Acute Phase Treatment

Exhibit 3.3a. AMM Technical Specification Compliance

Category	Element	Rating
Population	MBHP population was appropriately segregated from other product lines.	Met
Population	Population is defined as having an antidepressant medication (Antidepressant Medications List) during the Intake Period (the 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year).	Met
Geographic Area	Includes only those enrollees served in the MBHP's reporting area.	Met
Age & Sex	Members were 18 years of age or older as of April 30 of the measurement year.	Met
Enrollment Calculation	Members must be continuously enrolled from 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD. Members must also be enrolled on the IPSD.	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met
Proper Exclusion Methodology in Administrative Data	Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.	Met
Proper Exclusion Methodology in Administrative Data	Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.	Met

Exhibit 3.3b. AMM Technical Specification Compliance

Administrative Data: Counting Clinical Events	Rating
At least 84 days of treatment with antidepressant medication, beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met

Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Seven-Day Rate

Exhibit 3.4a. FUM Technical Specification Compliance

Category	Element	Rating
Population	MBHP population was appropriately segregated from other product lines.	Met
Population	Members continuously enrolled on or before the date of the ED visit that had a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.	Met
Population	The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period.	Met
Geographic Area	Includes only those Medicaid enrollees served in MBHP's reporting area.	Met
Age & Sex	Members 6 years and older as of the date of the ED visit.	Met
Enrollment Calculation	Members continuously enrolled from the date of the ED visit through 30 days after.	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met
Proper Exclusion Methodology in Administrative Data	Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission.	Met

Exhibit 3.4b. FUM Technical Specification Compliance

Administrative Data: Counting Clinical Events	Rating
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD

Exhibit 3.5a. IET Technical Specification Compliance

Category	Element	Rating
Population	MBHP population was appropriately segregated from other product lines.	Met
Population	Members with intake for a new episode of alcohol abuse or dependence on or between January 1 and November 14 of the measurement year.	Met
Population	Members must have medical, pharmacy and chemical dependency (inpatient and outpatient) benefits.	Met
Geographic Area	Includes only those Medicaid enrollees served in MBHP's reporting area.	Met
Age & Sex	Members 13 years and older as of December 31 of the measurement year.	Met
Enrollment Calculation	Members enrolled 60 days prior to the new episode through 47 days after the new episode.	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met
Proper Exclusion Methodology in Administrative Data	Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication dispensing event during the 60 days before the new episode.	Met

Exhibit 3.5b. IET Technical Specification Compliance

Administrative Data: Counting Clinical Events	Rating
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met

PERFORMANCE MEASURE RESULTS

Exhibit 3.6. MBHP Performance Measure Validation Rates

Measure	Rate	2021 NCQA Medicaid Quality Compass Percentile Range
Antidepressant Medication Management (AMM): Effective Acute Phase Treatment	60.7%	Between the 66th and 75th Percentiles
Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up	76.0%	Above the 95th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of AOD Treatment	45.3%	Between the 50th and 66th Percentiles

Kepro has leveraged the CMS Worksheet 2.14, A Framework for Summarizing Information About Performance Measures, from EQR Protocol 2, to report managed care plan-specific 2021 performance measure validation activities. As is required by CMS, Kepro has identified managed care plan and project strengths as evidenced through the validation process as well as follow up to 2020 recommendations. Kepro's Lead Performance Measure Validation Auditor assigned a validation confidence rating that refers to Kepro's overall confidence that the calculation of the performance measure adhered to acceptable methodology.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Massachusetts Behavioral Health Partnership
Performance measure name: Antidepressant Medication Management (AMM): Effective Acute Phase Treatment
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) Claims and encounter data <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 years of age and older who had a diagnosis of major depression
Definition of numerator (describe): The number of members 18 years of age and older who had a diagnosis of major depression and who remained on an antidepressant medication for at least 84 days (12 weeks)
Program(s) included in the measure: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2020 – December 31, 2020

2. Performance Measure Results

Numerator	6,769
Denominator	11,160
Rate	60.65%

3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

None Identified.

Describe any findings from the Information Systems Capability Analysis (ISCA) or other information systems audit that affected the reliability or validity of the performance measure results.

Claims and Encounter Data. MBHP processed behavioral health claims using its proprietary Claims Adjudication System (CAS). All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Almost all claims were submitted electronically, either using clearinghouses or directly to MBHP. There were adequate monitoring processes in place to monitor electronic claim submissions. Sufficient claims editing processes were initiated on the front-end of claim submissions and additional claims editing checks were in place within CAS. MBHP handled the small volume of paper claim submissions in-house and manually keyed the data into CAS. MBHP received medical encounter files from the PCC Plan on a nightly basis and pharmacy encounter files monthly. There were adequate processes for the receipt and processing of these encounter data files. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

Enrollment Data. MBHP processed Medicaid enrollment data using the CAS system. All necessary enrollment fields were captured for HEDIS reporting. MBHP member enrollment data in an 834 format were received daily from MassHealth and processed by MBHP. The daily file included additions, changes, and terminations. Enrollment data were loaded into CAS. MBHP also received a full monthly refresh file and conducted reconciliation between CAS and the State file. MBHP had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. MBHP performance measures were not calculated using medical record data.

Supplemental Data. MBHP did not use supplemental data sources in the production of the performance measure rates under review.

Data Integration. MBHP's performance measure rates were produced using DST software. Data from the transaction system were loaded to MBHP's enterprise-wide data warehouse nightly. MBHP used an automated process to populate a local data warehouse to facilitate the production of performance measures for the MBHP population. There were adequate processes and validation of data between the enterprise-wide and local data warehouses. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into DST-compliant extracts and loaded into the measure production software monthly. MBHP conducted monthly primary source verification of the data within DST and traced the information to the MBHP source data systems to ensure the software logic was being applied appropriately. MBHP had adequate processes to track completeness and accuracy of data at each transfer point. Data transfers to the DST repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. DST's repository structure was compliant. HEDIS measure report production was managed effectively. The DST software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. MBHP maintains adequate oversight of its vendor, DST. There were no issues identified with data integration processes.

Source Code. MBHP used NCQA-certified DST HEDIS software to produce performance measures. DST received NCQA measure certification to produce the performance measures under the scope of this review. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the performance measure results.

☒ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the performance measure calculation.
None identified.
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of performance measure calculation:
None identified.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Massachusetts Behavioral Health Partnership
Performance measure name: Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) Claims and encounter data <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm.
Definition of numerator (describe): The number of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within seven days of the ED visit (eight total days).
Program(s) included in the measure: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2020 – December 31, 2020

2. Performance Measure Results

Numerator	3,254
Denominator	4,282
Rate	75.99%

3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

None Identified.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.

Claims and Encounter Data. MBHP processed behavioral health claims using its proprietary Claims Adjudication System (CAS). All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Almost all claims were submitted electronically, either using clearinghouses or directly to MBHP. There were adequate monitoring processes in place to monitor electronic claim submissions. Sufficient claims editing processes were initiated on the front-end of claim submissions and additional claims editing checks were in place within CAS. MBHP handled the small volume of paper claim submissions in-house and manually keyed the data into CAS. MBHP received medical encounter files from the PCC Plan on a nightly basis and pharmacy encounter files monthly. There were adequate processes for the receipt and processing of these encounter data files. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

Enrollment Data. MBHP processed Medicaid enrollment data using the CAS system. All necessary enrollment fields were captured for HEDIS reporting. MBHP member enrollment data in an 834 format were received daily from MassHealth and processed by MBHP. The daily file included additions, changes, and terminations. Enrollment data were loaded into CAS. MBHP also received a full monthly refresh file and conducted reconciliation between CAS and the State file. MBHP had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. MBHP performance measures were not calculated using medical record data.

Supplemental Data. MBHP did not use supplemental data sources in the production of the performance measure rates under review.

Data Integration. MBHP's performance measure rates were produced using DST software. Data from the transaction system were loaded to MBHP's enterprise-wide data warehouse nightly. MBHP used an automated process to populate a local data warehouse to facilitate the production of performance measures for the MBHP population. There were adequate processes and validation of data between the enterprise-wide and local data warehouses. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into DST-compliant extracts and loaded into the measure production software monthly. MBHP conducted monthly primary source verification of the data within DST and traced the information to the MBHP source data systems to ensure the software logic was being applied appropriately. MBHP had adequate processes to track completeness and accuracy of data at each transfer point. Data transfers to the DST repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. DST's repository structure was compliant. HEDIS measure report production was managed effectively. The DST software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. MBHP maintains adequate oversight of its vendor, DST. There were no issues identified with data integration processes.

Source Code. MBHP used NCQA-certified DST HEDIS software to produce performance measures. DST received NCQA measure certification to produce the performance measures under the scope of this review. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the performance measure results.
<input checked="" type="checkbox"/> Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation.
None identified.
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of performance measure calculation:
None identified.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Massachusetts Behavioral Health Partnership
Performance measure name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD Treatment
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) Claims and encounter data <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of adolescent and adult members with a new episode of alcohol abuse or dependence.
Definition of numerator (describe): The number of adolescent and adult members with a new episode of alcohol abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
Program(s) included in the measure: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2020 – December 31, 2020

2. Performance Measure Results

Numerator	6,271
Denominator	13,855
Rate	45.26%

3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

None Identified.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.

Claims and Encounter Data. MBHP processed behavioral health claims using its proprietary Claims Adjudication System (CAS). All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Almost all claims were submitted electronically, either using clearinghouses or directly to MBHP. There were adequate monitoring processes in place to monitor electronic claim submissions. Sufficient claims editing processes were initiated on the front-end of claim submissions and additional claims editing checks were in place within CAS. MBHP handled the small volume of paper claim submissions in-house and manually keyed the data into CAS. MBHP received medical encounter files from the PCC Plan on a nightly basis and pharmacy encounter files monthly. There were adequate processes for the receipt and processing of these encounter data files. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

Enrollment Data. MBHP processed Medicaid enrollment data using the CAS system. All necessary enrollment fields were captured for HEDIS reporting. MBHP member enrollment data in an 834 format were received daily from MassHealth and processed by MBHP. The daily file included additions, changes, and terminations. Enrollment data were loaded into CAS. MBHP also received a full monthly refresh file and conducted reconciliation between CAS and the State file. MBHP had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. MBHP performance measures were not calculated using medical record data.

Supplemental Data. MBHP did not use supplemental data sources in the production of the performance measure rates under review.

Data Integration. MBHP's performance measure rates were produced using DST software. Data from the transaction system were loaded to MBHP's enterprise-wide data warehouse nightly. MBHP used an automated process to populate a local data warehouse to facilitate the production of performance measures for the MBHP population. There were adequate processes and validation of data between the enterprise-wide and local data warehouses. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into DST-compliant extracts and loaded into the measure production software monthly. MBHP conducted monthly primary source verification of the data within DST and traced the information to the MBHP source data systems to ensure the software logic was being applied appropriately. MBHP had adequate processes to track completeness and accuracy of data at each transfer point. Data transfers to the DST repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. DST's repository structure was compliant. HEDIS measure report production was managed effectively. The DST software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. MBHP maintains adequate oversight of its vendor, DST. There were no issues identified with data integration processes.

Source Code. MBHP used NCQA-certified DST HEDIS software to produce performance measures. DST received NCQA measure certification to produce the performance measures under the scope of this review. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the performance measure results.
<input checked="" type="checkbox"/> Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation.
None identified.
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of performance measure calculation:
None Identified.

MANAGED CARE PLAN STRENGTHS

- MBHP demonstrated a strong, collaborative relationship with the Primary Care Clinician Plan related to data collection, reporting, and improvement efforts.
- MBHP scored above the NCQA Medicaid Quality Compass 95th percentile for the 7-Day Follow-Up Rate for the HEDIS measure, *Follow-up after ED Visit for Mental Illness (FUM)*.

OPPORTUNITIES FOR IMPROVEMENT

None Identified.

FOLLOW UP TO CALENDAR YEAR 2020 RECOMMENDATIONS

CMS requires that EQROs follow up on recommendations made in the previous year. MBHP's actions related to 2020 recommendations follow.

Exhibit 3.7. Follow Up to 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
Continue quality improvement initiatives for the <i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of AOD – Alcohol Abuse or Dependence</i> measure.	MBHP successfully intervened and improved plan performance on the <i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD Treatment</i> measure.	High
MassHealth does not provide MBHP with Medication Assisted Treatment (MAT) prescription claims data, which could enable MBHP to calculate more accurate pharmacy-related PMV rates	MassHealth now sends MAT claims files to MBHP monthly.	High

CONCLUSIONS

In summary, Kepro's validation review of the selected performance measures indicates that MBHP's measurement and reporting processes were fully compliant with specifications and were methodologically sound.

Section 4.

Performance Improvement Project Validation



SECTION 4. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

INTRODUCTION

As directed by the MassHealth Office of Behavioral Health, MBHP implemented two performance improvement projects:

- Improving Rates of Follow-Up for Alcohol and Other Drug Use Disorder After Emergency Department Discharge; and
- Improving Follow-Up After Inpatient Discharge by Improving Access to Telehealth Services.

OBJECTIVE

The purpose of Performance Improvement Project Validation is to assess overall project methodology as well as the overall validity and reliability of the methods and findings to determine confidence in the results.

DATA OBTAINED

MBHP submitted two PIP reports in 2021. In April 2021, MBHP submitted a Baseline Project Planning Report in which it described project goals, planned stakeholder involvement, anticipated barriers, proposed interventions, a plan for intervention effectiveness analysis, and performance indicators. MBHP also submitted a detailed population analysis. MBHP reported project updates and baseline data in its September 2021 Baseline Performance Indicator Rate reports.

Kepro PIP reviewers, the Kepro Medical Director, and MBHP project staff met virtually after the submission of each report. This afforded an opportunity for Kepro and the project team to engage in a collegial discussion about the project as well as for the team to provide recent project updates. Kepro was able to ask clarifying questions about the project and offer suggestions.

MANAGED CARE PLAN SUPPORT

Kepro provided support to managed care plans in the submission of their project reports.

- Kepro created a library of PIP resources that included recent literature on vaccine hesitancy, health disparities, and best practices for building strong project interventions.
- In addition to instructions embedded in report submission forms, Kepro made a Guidance Manual available to plans, which provides detailed descriptions of the information requested. In many cases, sample responses are offered.
- Kepro made one-on-one technical assistance available to plans.

TECHNICAL METHODS OF DATA COLLECTION AND ANALYSIS

Performance Improvement Projects were validated in accordance with § 438.330(b)(i). Validation was performed by Kepro's Technical Reviewers with support from the Clinical Director. Kepro's lead reviewer, Wayne Stelk, Ph.D., has extensive experience in the implementation of statewide quality improvement projects. Chantal Laperle, MS CPHQ, brings quality management experience from her years at Federally Qualified Health Centers and managed care plans. Bonnie Zell, MD, Medical Director, is a practicing obstetrician and former Institute for Health Improvement fellow.

To permit more real-time review of Performance Improvement Projects, MassHealth has required biannual PIP validation since 2017. Each review is a four-step process:

- 1) **PIP Project Report.** Managed care plans submit a project report for each PIP to the EQRO Teams site. This report is specific to the stage of the project. All 2021 performance improvement projects were baseline projects.
- 2) **Desktop Review.** A desktop review is performed for each PIP. Kepro conducts inter-rater reliability to ensure consistency between reviewers. The Technical Reviewer and Medical Director review the project report and any supporting documentation submitted by the plan. Working collaboratively, they identify project strengths, issues requiring clarification, and opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the project. The Medical Director's focus is on clinical integrity and interventions.
- 3) **Conference with the Plan.** The Technical Reviewer and Medical Director meet virtually with plan representatives to obtain clarification on identified issues as well as to offer recommendations for improvement. When it is not possible to assign a validation rating to a project due to incomplete or missing information, the plan is required to remediate the report and resubmit it within ten calendar days. In all cases, the plan is offered the opportunity to resubmit the report to address feedback received from Kepro, although it is not required to do so.
- 4) **Final Report.** A PIP Validation Worksheet based on CMS EQR Protocol Number 1 is completed by the Technical Reviewer. Individual standards are rated either: 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. The Medical Director documents his or her findings, and in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report. A determination is made by the Technical Reviewers as to the validity of the project.

FINDINGS

Kepro's findings are documented in CMS Worksheet Number 1.11, which follow.

PLAN-SPECIFIC PERFORMANCE IMPROVEMENT PROJECTS

Performance Improvement Project Summaries

As required by CMS, Kepro is providing project-specific summaries using CMS Worksheet Number 1.11 from EQR Protocol Number 1, Validating Performance Improvement Projects. The PIP Aim Statement is taken directly from MBHP's reports to Kepro as are the Improvement Strategies or Interventions. Performance indicator data was taken from this report as well. Kepro validated each of these projects, meaning that it reviewed all parts of each PIP and determined its validity. The PIP Technical Reviewer assigned a validation confidence rating, which refers to Kepro's overall confidence that the PIP adhered to acceptable methodologies for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement or the potential for improvement. Recommendations offered were taken from the Reviewers' rating forms. As is required by CMS, Kepro has identified managed care plan and project strengths as evidenced in the PIP. As both projects are in their first year, there are no updates to 2020 recommendations.

IMPROVING RATES OF FOLLOW-UP FOR ALCOHOL AND OTHER DRUG USE DISORDER AFTER EMERGENCY DEPARTMENT DISCHARGE

1. General PIP Information

Managed Care Plan (MCP) Name: Massachusetts Behavioral Health Partnership (MBHP)
PIP Title: Improving Rates of Follow-Up for Alcohol and other Drug Use Disorder After Emergency Department Discharge (FUA)
<p>PIP Aim Statement:</p> <p>Member-Focused</p> <ul style="list-style-type: none"> • Improve Member retention in substance use disorder (SUD) outpatient treatment by increasing rate of follow up after emergency department services in order for Members to receive intended benefits of services, thereby improving clinical outcomes. • Reduce the prevalence of SUD among Members by increasing engagement in SUD follow-up services, thus assisting in recovery and supporting positive clinical outcomes, including remission. • Reduce ED use for SUD among Members by proactively increasing engagement in SUD outpatient services. • Improve access to SUD outpatient treatment for MBHP Members by increasing availability of appointments, and in turn, improving rates of follow up after ED discharge <p>Provider-Focused</p> <ul style="list-style-type: none"> • Improve care coordination and integration between providers across levels of care by increasing outreach to providers, specifically through the measurable expansion of the provider strategic plan process. • Improve referral pathways to SUD outpatient treatment within and across organizations by increasing the number of alternative sites for SUD intake. • Improve awareness of available SUD services among ED providers by increasing outreach to providers through the expanded use of the strategic plan process and by doing so, help providers to access resources and information related to those SUD outpatient services. • Use provider level performance data to implement Quality Improvement at the ED and outpatient level to increase awareness of performance compared to benchmarks and other sites and, by doing so, increase the use of FUA services. • Use predictive modeling to determine which members are most likely to present to EDs for SUD-related diagnoses and provide this information to providers in order to pre-empt ED utilization through proactive outreach.
<p>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</p> <p><input checked="" type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic)</p> <p><input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases)</p> <p><input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)</p> <p><input type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)</p>
<p>Target age group (check one):</p> <p><input type="checkbox"/> Children only (ages 0-17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children</p> <p>*If PIP uses different age threshold for children, specify age range here:</p>
<p>Target population description, such as duals, LTSS or pregnant women (please specify): All MBHP members</p>
<p>Programs: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP</p>

2. Improvement Strategies or Interventions (Changes tested in the PIP)

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>None identified.</p>

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

MBHP will leverage the results of its predictive modeling (described below) to help clinicians perform proactive outreach as well as to provide targeted follow up to members most at risk of not following up.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

MBHP will develop a methodology for predictive modeling to determine which member populations are most likely to not connect to subsequent treatment after emergency department visits. MBHP will then work with outpatient SUD providers to identify opportunities to improve the referral pathways from the emergency department to outpatient services by identifying opportunities to drive process improvement. Specifically, the intention is to use the predictive modeling and population stratification to understand which populations have the greatest opportunity for effective improvement. The results of the predictive modeling will then be used by clinical staff to target interventions to identified populations. In addition, predictive modeling will serve to facilitate understanding of members most likely to present to EDs for SUD. This information will then be used to pre-empt ED use through proactive interventions.

3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Follow-up after ED for AOD (FUA) in 7 days NCQA NQF #3488	2020	992/4774 20.78%	<input checked="" type="checkbox"/> Not applicable – PIP is in planning or implementation phase, results not available	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Follow-up after ED for AOD (FUA) in 30 days NCQA NQF #3488	2020	1431/4774 29.97%	<input checked="" type="checkbox"/> Not applicable – PIP is in planning or implementation phase, results not available	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):

☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year
☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

EQRO recommendations for improvement of PIP:

Access-Related: To track differences in subpopulation management, MBHP's member racial and ethnic background will be included in reports to guide prioritization of interventions by subpopulations. Kepro recommends developing population-specific strategies for outreach to increase follow up for SUD after ED visits.

Access-Related: Kepro recommends including other socioeconomic factors that might have significant impact on ED utilization and follow-up visit attendance such as housing/homelessness, poverty, lack of transportation, and access to technology for virtual visits such as phones or tablets. Speaking a language other than English should also be included.

Performance Improvement Project Rating

Kepro evaluates performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. MBHP received a rating score of 99% on this Performance Improvement Project.

Exhibit 4.1. Performance Improvement Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	15	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5	15	14	93%
Baseline Performance Indicator Rates	5	15	15	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	28	84	83	99%

Plan & Project Strengths

- **Access-Related:** MBHP is commended for its intention to improve post-ED follow-up services for ethnic groups with historically low rates of SUD post-discharge follow-up services.
- **Quality-Related:** MBHP's intervention effectiveness methodology is well-designed.

Opportunities for Improvement

- **Access-Related:** To track differences in subpopulation management, MBHP's member racial and ethnic background will be included in reports to guide prioritization of interventions by subpopulations. Kepro recommends developing population-specific strategies for outreach to increase follow up for SUD after ED visits.
- **Access-Related:** Kepro recommends including other socioeconomic factors that might have significant impact on ED utilization and follow-up visit attendance such as housing/homelessness, poverty, lack of transportation, and access to technology for virtual visits such as phones or tablets. Speaking a language other than English should also be included.

IMPROVING FOLLOW UP AFTER INPATIENT DISCHARGE BY IMPROVING ACCESS TO TELEHEALTH SERVICES

1. General PIP Information

Managed Care Plan (MCP) Name: Massachusetts Behavioral Health Partnership (MBHP)
PIP Title: Improving Follow Up After Inpatient Discharge by Improving Access to Telehealth Services
<p>PIP Aim Statement</p> <p>Member-Focused</p> <ul style="list-style-type: none"> Members will have an opportunity to assess their own ability for using telehealth technology early in the discharge planning process, measured by the rate at which inpatient providers indicate 'telehealth assessment' has occurred in the discharge form reported on a quarterly basis. Members will experience improved continuity between inpatient and outpatient treatment through using telehealth measured by a year-over-year increase in percentage of 7/30 day follow-up attributed to telehealth. Members who use telehealth will experience clinical outcomes comparable to Members who use in-person treatment measured by year-over-year 90-day readmission rates for both cohorts. <p>Provider-Focused</p> <ul style="list-style-type: none"> Outpatient providers will increase their ability to use technology for providing telehealth service as demonstrated by a year over year increase in the number of providers billing for telehealth and the total number of units billed. Inpatient providers will increase the frequency with which they assess Members for telehealth prior to discharge as documented in the Member's discharge plan. Providers will use newly provided information about the rate of assessments per discharge to measure quarter-over-quarter improvement with rates of assessment. Provider's overall experience with using telehealth will improve year-over-year as measured by the MBHP annual provider satisfaction survey, which now includes questions related to the telehealth modality.
<p>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</p> <p><input checked="" type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic)</p> <p><input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases)</p> <p><input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)</p> <p><input type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)</p>
<p>Target age group (check one):</p> <p><input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children</p> <p>*If PIP uses different age threshold for children, specify age range here:</p>
<p>Target population description, such as duals, LTSS or pregnant women (please specify): All MBHP Members</p>
<p>Programs: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP</p>

2. Improvement Strategies or Interventions (Changes tested in the PIP)

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>None identified.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <ul style="list-style-type: none"> MBHP will modify the inpatient hospital discharge form to require the provider to indicate whether the follow-up appointment is scheduled as telehealth or in-person. If the appointment is to be held by telehealth, the provider will be required to indicate whether the Member was asked about needed support. MBHP will train

providers on completing this section of the form and on the providers' role in supporting the Member in considering telehealth.

- MBHP's Provider Quality Managers will collaborate with providers to implement rapid cycle change processes aimed at supporting the telehealth capability assessment with Members and increasing the rate of telehealth appointments as appropriate. This intervention will have the direct effect of improving internal processes at inpatient sites that will support the increased use of telehealth for aftercare appointments.
- MBHP will recruit additional outpatient providers who are proficient with the use of telehealth to offer Open Access (timely same-day appointments. These appointments will be listed on the Massachusetts Behavioral Health Access (MABHA) website
- MBHP will educate outpatient providers to include telehealth coding on claims.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

MBHP will modify the inpatient hospital discharge form to allow inpatient provider to report telehealth as a type of follow-up appointment, including that telehealth capability was assessed with the Member.

3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of completed post-discharge (7-day) follow-up visits conducted via telehealth (FUH) NCQA NQF #0576	2020	1263/ 3319 38.05%	<input checked="" type="checkbox"/> Not applicable – PIP is in planning or implementation phase, results not available	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Percentage of completed post-discharge (30-day) follow-up visits conducted via telehealth (FUH) NCQA NQF #0576	2020	1939/ 4649 41.70%	<input checked="" type="checkbox"/> Not applicable – PIP is in planning or implementation phase, results not available	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Validation phase (check all that apply): <input type="checkbox"/> PIP submitted for approval <input checked="" type="checkbox"/> Planning phase <input checked="" type="checkbox"/> Implementation phase <input checked="" type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of PIP: Access-Related: Kepro notes that, in this PIP, MBHP is focusing on just 0.7% (N=4,649) of its total member population (N=609,409). Stated differently, MBHP is not taking any action in this PIP to support its other 604,760 members with respect to accessing behavioral health services through telehealth platforms. With respect to improving telehealth access, MBHP's executive committee should consider options for broadening this PIP to engage a broader portion of its membership.

Performance Improvement Project Evaluation

Kepro evaluates performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. MBHP received a rating score of 97% on this Performance Improvement Project.

Exhibit 4.2. Performance Improvement Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5.0	15.0	13.0	88%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5.0	15.0	14.5	97%
Baseline Performance Indicator Rates	5.0	15.0	15.0	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	28	84	81.5	97%

Plan and Project Strengths

- MBHP is commended for engaging its Consumer Advisory and Family Advisory Committees in the design and implementation of this project. MBHP is also commended for modifying its annual Member Experience Survey to include questions about challenges and successes experienced by members using telehealth services.
- Kepro commends MBHP for engaging with members in real time during the discharge preparation to introduce the option of telehealth as a viable vehicle for appointments and to assess their capability to manage this platform.
- MBHP is commended for its Open Access option through which members can call for a telehealth session without a prescheduled appointment time.

Opportunities for Improvement

Access-Related: Kepro notes that, in this PIP, MBHP is focusing on just 0.7% (N=4,649) of its total member population (N=609,409). Stated differently, MBHP is not taking any action in this PIP to support its other 604,760 members with respect to accessing behavioral health services through telehealth platforms. With respect to improving telehealth access, MBHP's executive committee should consider options for broadening this PIP to engage a broader portion of its membership.

Section 5.

Network Adequacy Validation



SECTION 5. NETWORK ADEQUACY VALIDATION

INTRODUCTION

The concept of Network Adequacy revolves around a managed care plan's ability to provide its members with an adequate number of in-network providers located within a reasonable distance from the member's home. Insufficient or inconvenient access points can create gaps in healthcare. To avoid such gaps, MassHealth sets forth contractually required time and distance standards as well as threshold member to provider ratios to ensure access to timely care. In 2021, MassHealth, in conjunction with its External Quality Review Organization, Kepro, evaluated and identified the strengths of the health plan's provider networks, as well as offered recommendations for bridging network gaps. This process of evaluating a plan's network is termed Network Adequacy Validation. While not required by CMS at this time, the MassHealth was strongly encouraged by CMS to incorporate this activity as an annual validation activity as it will be required in the future.

Kepro entered into an agreement with Quest Analytics to use its enterprise system to validate MassHealth managed care plan network adequacy. Quest's system analyzes and reports on network adequacy. The software also reports on National Provider Identifier (NPI) errors and exclusion from participation in CMS programs.

Using Quest, Kepro has analyzed the current performance of the plans based on the time and distance standards that the state requires, while also identifying gaps in coverage by geographic area and specialty. The program also provides information about available providers should network expansion be required. This information is based on a list of all licensed physicians from the Massachusetts Board of Registration in Medicine.

As stated above, the goal of network adequacy analysis is to ensure that every managed care plan offers adequate access to care across the plan's entire service area. When measuring access to care using only existing membership, that dataset may not always be representative of the entire service area. Additionally, measuring only existing membership does not account for future growth or expansion of existing service areas. Therefore, the network adequacy review was performed using a representative set of population points, 3% of the population, distributed throughout the service area based on population patterns. The member file was provided by MassHealth. This methodology allowed MassHealth to ensure each plan was measured consistently against the same population distribution and that the entire service area had adequate access to care within the prescribed time and distance criteria.

REQUEST OF PLAN

Kepro requested a complete provider data set from MBHP, which included the following data points:

- Facility or Provider Name
- Address Information
- Phone Number; and
- NPI Information.

This request applied to the following areas of service:

- Behavioral Health Specialists; and
- Behavioral Health Services.

TIME AND DISTANCE STANDARDS

To ensure that Medicaid members have appropriate access to care for behavioral health services, MassHealth requires MBHP to adhere to certain time and distance standards.

BEHAVIORAL HEALTH DIVERSIONARY SERVICES

MassHealth has established a time and distance standard of 30 miles or 30 minutes for behavioral health diversionary services. These standards apply to all services in the table that follows:

Exhibit 5.1. Behavioral Health Diversionary Service Specialties

BH Diversionary Specialties	
CBAT-ICBAT-TCU	Program of Assertive Community Treatment
Clinical Support Services for Substance Use Disorders (Level 3.5)	Psychiatric Day Treatment
Community Support Program	Recovery Coaching
Intensive Outpatient Program	Recovery Support Navigators
Monitored Inpatient Level 3.7	Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)
Partial Hospitalization Program	Structured Outpatient Addiction Program

BEHAVIORAL HEALTH INPATIENT SERVICES

There are four services in this provider group, i.e., Managed Inpatient Level 4, Adult Psychiatric Inpatient, Adolescent Psychiatric Inpatient, and Child Psychiatric Inpatient. MassHealth has established a 60-mile or 60-minute standard for these services.

BEHAVIORAL HEALTH INTENSIVE COMMUNITY TREATMENT SERVICES

There are three specialties in this provider group, i.e., In-Home Behavioral Services, In-Home Therapy Services, and Therapeutic Monitoring Services. MassHealth has established a 30-mile or 30-minute standard for these services.

BEHAVIORAL HEALTH OUTPATIENT SERVICES

MassHealth has established a 30-mile or 30-minute standard for behavioral health outpatient services. A minimum of two available providers must be located within this geography, i.e., Opioid Treatment Programs, Psychiatrists, Psychiatric Advanced Practice Nurses, and Psychologists.

EVALUATION METHOD AND INTERPRETING RESULTS

The Quest system generates a network adequacy score by combining the following files together:

- Service area zip codes
- Managed care plan provider files
- The time, distance, and minimum provider to member ratios established by MassHealth; and
- A representative membership file

The system assigns a score on a 1 to 100 scale. Scores are assigned at both the specialty and county level. The overall score is derived from the average of all county scores. This report depicts each plan's scores at the county level.

The following text uses an example to describe how to interpret the results.

County	Service
Barnstable	100
Berkshire	70
Bristol	56
Hampden	0
Hampshire	0
Worcester	0*
Overall:	37.6

- Both the access requirement and the servicing provider requirements are met in Barnstable County. Thus, an Adequacy Index Score of 100 is assigned.
- A score of 70 has been assigned to Berkshire County, as the requirement for the number of servicing providers has not been met.
- In Bristol County, the servicing provider requirement is met, but the access requirement is less than what is required (80%), so the Adequacy Index Score is 56, as $70\% \text{ of } 80 = 56$.
- The 0 assigned to Hampden County means that neither the time and distance nor number of servicing provider requirements are met.
- The 0 assigned to Hampshire County means that less than 70% of the membership is within the time and distance standards but the number of servicing provider requirements are met.
- Worcester County shows an asterisk with the zero score, indicating that no provider data were submitted for review by the plan.
- The overall score is an average of the county scores: $(70 + 56 + 100 + 0 + 0 + 0) / 6 = 37.6$

To further assist in the interpretation of results, a county map of Massachusetts follows, as well as a ranked list of county populations.

Exhibit 5.2. Map of Massachusetts County Designations



Exhibit 5.3. Massachusetts County Designations and 2020 Population

County	County Designations	2020 Population ¹
Middlesex	Large Metro	1,632,002
Worcester	Metro	862,111
Essex	Large Metro	809,829
Suffolk	Large Metro	797,936
Norfolk	Large Metro	725,981
Bristol	Metro	579,200
Plymouth	Metro	530,819
Hampden	Metro	465,825
Barnstable	Metro	228,996
Hampshire	Metro	162,308
Berkshire	Metro	129,026
Franklin	Metro	71,029
Dukes	Micro	20,600
Nantucket	Micro	14,255

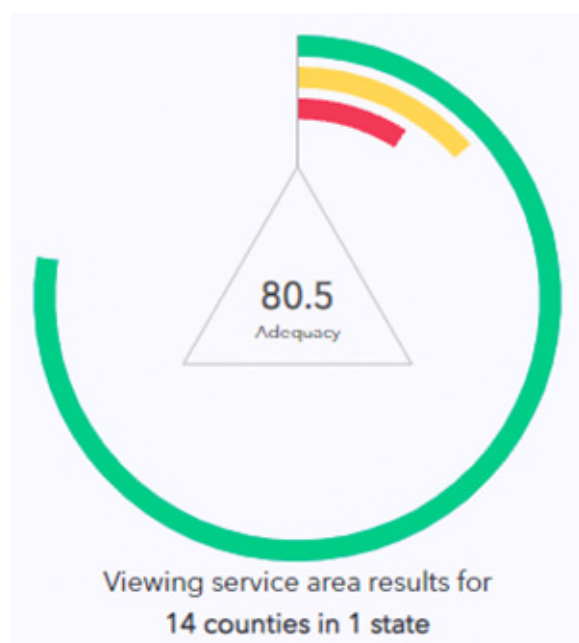
¹ Census.gov, accessed November 10, 2021

RESULTS

MBHP received a network adequacy score of 80.5 out of a possible 100. MBHP's 2020 score was 86.5. The plan has decreased its overall adequacy index score by 6 points in this year's analysis.

This score wheel indicates multiple percentages, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on an average across all specialties.

Exhibit 5.4. MBHP Network Adequacy Score



- The green bar indicates that 77.5% of MBHP's network fully meet the adequacy requirements.
- The yellow bar indicates that 13.4% of MBHP's network meet only the servicing provider requirements.
- The red bar indicates that 9.1% of MBHP's network do not meet either adequacy requirement. Services in which MBHP did not submit data are included in this category.

BEHAVIORAL HEALTH DIVERSIONARY SERVICES

Recovery Coaching Services and Recovery Support Navigators met the minimum network adequacy score.

The tables that follow depict the network adequacy scores for those diversionary services not meeting the minimum network adequacy score.

Exhibit 5.5a. Behavioral Health Diversionary Service Gaps and Corresponding Counties

County	CBAT	Clinical Support Services for SUD	Community Support Program	Intensive Outpatient Programs	Monitored Inpatient Level 3.7
Barnstable	0.0	0.0	100	100	0.0
Berkshire	0.0*	0.0*	100	100	0.0*
Bristol	100	100	100	100	100
Dukes	0.0	0.0	100	51.6	0.0
Essex	0.0	0.0	61.6	100	100
Franklin	0.0*	0.0*	100	100	0.0*
Hampden	0.0	0.0	100	100	0.0
Hampshire	0.0	0.0	100	100	0.0
Middlesex	100	0.0	100	100	100
Nantucket	0.0*	0.0*	100	0.0	0.0*
Norfolk	100	100	100	100	100
Plymouth	54.3	58.4	100	100	62.2
Suffolk	100	100	100	100	100
Worcester	0.0	59.5	100	100	58.6
Overall:	32.5	29.8	97.3	89.4	44.3

* No provider data were submitted by the plan

Exhibit 5.5b. Behavioral Health Diversionary Service Gaps and Corresponding Counties

County	Partial Hospitalization Program	Program of Assertive Community Treatment	Psychiatric Day Treatment	Residential Rehab Services for SUD	Structured Outpatient Addiction Program
Barnstable	100	100	0.0	56.6	62.2
Berkshire	0.0	0.0*	0.0	100	0.0
Bristol	100	0.0	47.9	100	100
Dukes	0.0	0.0	0.0	100	100
Essex	100	60.4	100	100	100
Franklin	100	0.0	0.0	100	100
Hampden	100	0.0	0.0	100	100
Hampshire	100	0.0	0.0	100	100
Middlesex	100	100	100	100	100
Nantucket	0.0	0.0	0.0	0.0	0.0
Norfolk	100	100	100	100	100
Plymouth	100	100	57.6	100	100
Suffolk	100	100	100	100	100
Worcester	100	59.2	0.0	100	100
Overall:	78.6	44.3	36.1	89.8	83.0

* No provider data were submitted by the plan

Opportunities for Improvement

- MBHP did not report CBAT service providers for three counties, and three counties did not pass any MassHealth requirements.
- Relative to substance abuse treatment, MBHP did not report Clinical Support Services for Substance Use Disorder providers for three counties, and two counties did not pass any MassHealth requirements. Monitored Inpatient Level 3.7 service providers were not reported for three counties, and six counties did not meet the time and distance standards for this service.
- MBHP did not report having any Programs of Assertive Community Treatment in Berkshire County, and three counties did not pass any MassHealth requirements.
- Five counties did not meet any MassHealth requirements for Psychiatric Day Treatment services including Worcester, Massachusetts' second-largest county.
- Network adequacy is especially weak in Nantucket County, with only Community Support Programs meeting access standards.

BEHAVIORAL HEALTH INPATIENT SERVICES

MBHP met all access requirements for Child, Adolescent, and Adult Child Psychiatric Inpatient facilities. There were, however, service gaps for Managed Inpatient Level 4 facilities.

Exhibit 5.6. Inpatient Behavioral Health Service Gaps and Corresponding Counties

County	Managed Inpatient Level 4
Barnstable	0.0
Berkshire	0.0*
Bristol	0.0
Dukes	0.0*
Essex	50.4
Franklin	0.0
Hampden	0.0
Hampshire	0.0
Middlesex	100
Nantucket	0.0*
Norfolk	100
Plymouth	44.6
Suffolk	100
Worcester	100
Overall:	35.4

* No provider data were submitted by the plan

Opportunities for Improvement

- MBHP did not report Managed Inpatient Level 4 providers for three counties.
- Barnstable and Franklin County did not meet either MassHealth requirements for Managed Inpatient Level 4 services. No providers were reported in three counties. There is no provider access west of Worcester.

BEHAVIORAL HEALTH INTENSIVE COMMUNITY TREATMENT SERVICES

MBHP met access standards for In-Home Therapy Services and Therapeutic Mentoring Services. The table that follows depicts network deficiencies for In-Home Behavioral Services.

Exhibit 5.7. In-Home Behavioral Service Gaps and Corresponding Counties

County	In-Home Behavioral Services
Barnstable	100
Berkshire	100
Bristol	100
Dukes	0.0
Essex	100
Franklin	100
Hampden	100
Hampshire	100
Middlesex	100
Nantucket	0.0
Norfolk	100
Plymouth	100
Suffolk	100
Worcester	100
Overall:	85.7

Opportunities for Improvement

- Nantucket County is not meeting any MassHealth requirements for In-Home Behavioral Services, and Dukes County is meeting only the servicing provider requirement.

OUTPATIENT BEHAVIORAL HEALTH SERVICES

MBHP met access standards for Outpatient Behavioral Health Services, Opioid Treatment Programs, and Psychology.

The table that follows depicts the network adequacy scores for those outpatient services not meeting the minimum network adequacy score.

Exhibit 5.8. Outpatient Behavioral Health Service Gaps and Corresponding Counties

County	Applied Behavioral Analysis	Psych APN	Psychiatry
Barnstable	100	100	52.8
Berkshire	57.0	100	57.5
Bristol	100	100	100
Dukes	100	100	56.6
Essex	100	100	100
Franklin	100	100	100
Hampden	100	100	100
Hampshire	100	100	100
Middlesex	100	100	100
Nantucket	0.0	0.0	0.0
Norfolk	100	100	100
Plymouth	100	100	100
Suffolk	100	100	100
Worcester	100	100	100
Overall:	89.8	92.9	83.4

Strengths & Opportunities for Improvement

- Outpatient provider access is most significantly challenged in Nantucket County.
- Only the servicing provider requirements for Applied Behavioral Analysis were met in Berkshire and Nantucket counties. All other counties are meeting all MassHealth requirements.
- All counties are meeting all MassHealth requirements for Psychiatric Advanced Practice Nurse services, except for Nantucket, which is meeting only the servicing provider requirement.
- Three counties are only meeting the Psychiatry servicing provider requirement, and Nantucket County is not meeting any MassHealth requirements.

RECOMMENDATIONS

- Kepro recommends that MBHP contract with additional providers in Nantucket County, as available, for those services not meeting requirements including, but not limited to In-Home Behavioral Services, Psychiatric Day Treatment, and both physician- and advanced practice nurse-level Psychiatry.
- Specific to substance use disorder services, Kepro recommends that MBHP expand its geographic coverage of substance use disorder (SUD) Residential Rehabilitation Services, SUD Clinical Support Services, Monitored Inpatient Level 3.7 providers, and Managed Inpatient Level 4 services.
- Kepro recommends that MBHP fill other network gaps as identified where possible.

Update to 2020 Recommendations

CMS requires that EQROs follow up on recommendations made in the previous year. MBHP's actions related to 2020 recommendations follow.

Exhibit 5.9. Update to 2020 Recommendations

2020 Recommendation	2021 Update	Degree to which MBHP Addressed Recommendations
MBHP should work to meet Psychiatric Advanced Practice Nurse access requirements in Nantucket County.	This recommendation stands. Nantucket County still does not meet MassHealth standards for Psychiatric Advanced Practice Nursing services.	Low
MBHP should work to meet Managed Inpatient Level 4 access gaps as identified.	This recommendation stands. MBHP received the same score in 2020.	Low



Contributors

CONTRIBUTORS

PERFORMANCE MEASURE VALIDATION

Katharine Iskrant, CHCA, MPH

Ms. Iskrant is the President of Healthy People, an NCQA-licensed HEDIS audit firm. She is a member of the NCQA Audit Methodology Panel and NCQA's HEDIS Data Collection Advisory Panel. She is also featured on a 2020 NCQA HEDIS Electronic Clinical Data Systems (ECDS) podcast. Ms. Iskrant has been a Certified HEDIS® Compliance Auditor since 1998 and has directed more than two thousand HEDIS audits. Previously, as CEO of the company Acumetrics, Ms. Iskrant provided consultancy services to NCQA which helped their initial development and eventual launch of the NCQA Measure Certification Program. She is a frequent speaker at HEDIS conferences, including NCQA's most recent Healthcare Quality Congress. She received her BA from Columbia University and her MPH from UC Berkeley School of Public Health. She is a member of the National Association for Healthcare Quality and is published in the fields of healthcare and public health.

PERFORMANCE IMPROVEMENT PROJECT REVIEWERS

Bonnie L. Zell, MD, MPH, FACOG, Clinical Director

Bonnie L. Zell, MD, MPH, has a diverse background in healthcare, public health, healthcare safety and quality, and has developed several new models of care delivery.

Her healthcare roles include serving as a registered nurse, practicing OB/GYN physician and chief at Northern California Kaiser Permanente, and Medical Director at the Aurora Women's Pavilion in Milwaukee, Wisconsin.

She subsequently served as Healthcare Sector Partnerships Lead at the Centers for Disease Control and Prevention. She focused on patient safety, healthcare quality, and primary prevention strategies through partnerships between key national organizations in public health and healthcare delivery with the goal of linking multi-stakeholder efforts to improve the health of regional populations.

As Senior Director, Population Health at the National Quality Forum, she provided leadership to advance population health strategies through endorsement of measures that align action and integration of public health and healthcare to improve health.

Dr. Zell developed a comprehensive model of care for a regional community health initiative that focused on achieving the Triple Aim focused on asthma prevention and management for Contra Costa County in California.

She served as Executive Director of Clinical Improvement at the statewide Hospital Quality Institute in California, building the capacity and capability of healthcare organizations to

improve quality and safety by reliably implementing evidence-based practices at all sites of care through the CMS Partnership for Patients initiative.

Previously, Dr. Zell co-founded a telehealth company, Lemonaid Health, that provided remote primary care services. She served as Chief Medical Officer and Chief Quality Officer. Subsequently she served as Chief Medical Officer of a second telehealth company, Pill Club, which provided hormonal contraception.

She is an Institute for Healthcare Improvement Fellow and continues to provide healthcare quality and safety coaching to healthcare organizations.

Dr. Zell returned to office gynecology to assess translation of national initiatives in safety and quality into front line care. In addition, she provided outpatient methadone management for patients with Opioid Use Disorder for several years.

Currently, she is faculty and coach for Management and Clinical Excellence, a leadership development program, at Sutter Health in California.

Wayne J. Stelk, Ph.D.

Wayne J. Stelk, Ph.D., is a psychologist with over forty years of experience in the design, implementation, and management of large-scale health and human service systems. His expertise includes improving health providers' service effectiveness and efficiency through data-driven performance management systems. Dr. Stelk has consulted with Kepro for five years as a senior external quality reviewer and technical advisor for healthcare performance improvement projects.

During his 10-year tenure as Vice President for Quality Management at the Massachusetts Behavioral Health Partnership (MBHP), Dr. Stelk designed and managed over 150 quality improvement projects involving primary care and behavioral health practices across the state. He is well-versed in creating strategies to improve healthcare service delivery that maximize clinical outcomes and minimize service costs. He also implemented a statewide outcomes management program for behavioral health providers in the MBHP network, the first of its kind in Massachusetts.

After leaving MBHP in 2010, he consulted on several projects involving the integration of primary care, behavioral healthcare, and long-term services and supports. Other areas of expertise include: implementing evidence-based interventions and treatment practices; designing systems for the measurement of treatment outcomes; and developing data-collection systems for quality metrics that are used to improve provider accountability. Dr. Stelk has lectured at conferences nationally and internationally on healthcare performance management.

PROJECT MANAGEMENT

Cassandra Eckhof, M.S.

Ms. Eckhof has over 25 years managed care and quality management experience and has worked in the private, non-profit, and government sectors. She has managed the MassHealth external quality review program since 2016. Ms. Eckhof has a Master of Science degree in healthcare administration and is a Certified Professional in Healthcare Quality. She is pursuing a graduate certificate in Public Health Ethics at the University of Massachusetts at Amherst.

Emily Olson B.B.A

This is Ms. Olson's first year working with the Kepro team as a Project Coordinator. Her previous work was in the banking industry. She has a bachelor's degree in business management and human resources from Western Illinois University.