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TECHNICAL REPORT

Massachusetts Behavioral Health Partnership
External Quality Review

Calendar Year 2020

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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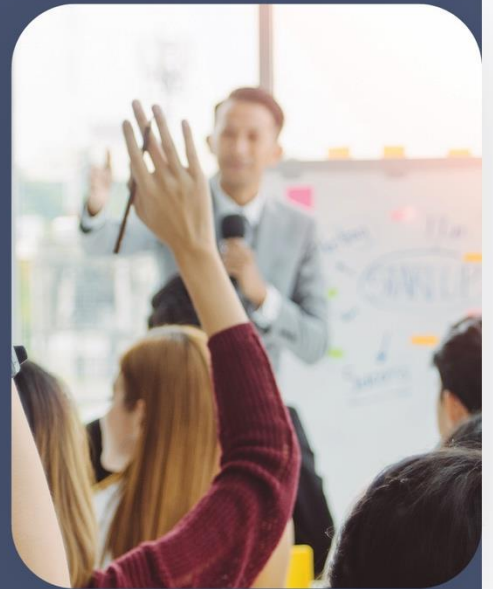
SECTION 1. INTRODUCTION

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 attributed to MassHealth Primary Care Accountable Care Organizations, i.e., Community Care Cooperative, Partners HealthCare Choice, Steward Health Choice, as well as to the managed care organization Health New England. As of December 31, 2019, 522,780 individuals statewide were under the care of the Partnership.

MBHP is a Beacon Health Options company. Headquartered in Boston with regional offices in Bridgewater, Danvers, Worcester, and Springfield, MBHP has received full NCQA Managed Behavioral Healthcare Organization (MBHO) accreditation.

Section 2:

Executive Summary

SECTION 2. EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 was an omnibus legislative package enacted by the United States 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 health care 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.

An 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). It 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 CY 2020 review cycle:

- Validation of three performance measures, including an Information Systems Capability Assessment;
- Validation of two Performance Improvement Projects (PIPs);
- Validation of compliance with Medicaid managed care regulations and related contractual requirements; and
- Validation of network adequacy.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2020 reflect 2019 quality measurement performance. References to HEDIS® 2020 performance reflect data collected in 2019. Performance Improvement Project reporting is inclusive of activities conducted in CY 2020.

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 the managed care plan and to determine the extent to which the managed care plan 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	A Data Acquisition Questionnaire, the source code used to produce the validated performance measures, a list of interventions related to those performance measures, and follow-up documentation as requested by the auditor.
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 2020, 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 as follows:

- Follow-up after Emergency Department (ED) Visit for Mental Illness (FUM): 7-Day Follow-Up;
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD – Alcohol Abuse or Dependence; and
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD - Opioid Abuse or Dependence.

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 has 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 Performance Improvement Project (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 2020, the Final Implementation Progress Report (March 2020) and the Final Implementation Annual Report (September 2020). 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

In late-2017, MBHP submitted proposed topics for two three-year projects to MassHealth for its review and approval and initiated their implementation in 2018. Its work on these projects continued through 2020, the third of the three-year quality cycle. These projects are:

- Initiation and Engagement in Alcohol and Other Drug Treatment: Using Intervention Efforts to Improve the Percentage of Members Who Initiate and Engage in Alcohol and Other Drug Dependence Treatment; and
- Improve Care Coordination and Continuity of Care by Increasing Notification to Primary Care Clinicians (PCCs) Following Inpatient Hospital Discharge.

Kepro evaluates each Performance Improvement Project (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 did not discern any issues related to its quality of care or the timeliness of or access to care. Kepro has high confidence in the validity of the projects' results.

COMPLIANCE VALIDATION

Exhibit 2.3: Compliance Validation Process Overview

Topic	Description
Objectives	The mandatory compliance validation protocol is used to determine, in a manner consistent with standard industry practices, the extent to which Medicaid managed care entities comply with quality standards mandated by the Balanced Budget Act of 1997 (BBA), 42 CFR 438. Also considered is compliance with related sections of the plans' contracts with CMS and MassHealth.
Technical methods of data collection and analysis	Kepro conducted a desk review of documentation submitted by MBHP. Clarification was obtained at a follow-up site visit. Results were compared to regulatory and contractual requirements.
Data obtained	MBHP submitted evidence of compliance 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; and credentialing files.
Conclusions	Overall, MBHP demonstrated compliance with most of the federal and State contractual standards for its delegated functions for the PCC Plan membership. MBHP performed best in areas that related to the quality of care and services. While MBHP performed provider access analysis, the review showed that its analysis did not meet MassHealth's requirement to ensure a choice of at least two behavioral health providers.

The mandatory compliance validation protocol is used to determine, in a manner consistent with standard industry practices, the extent to which Medicaid managed care entities comply with quality standards mandated by the Balanced Budget Act of 1997 (BBA). Also considered is

compliance with related sections of the plans' contracts with CMS and MassHealth. The validation process is conducted triennially.

Based on regulatory and contract requirements, compliance reviews were divided into the following 14 standards:

- Enrollee Rights and Protections
- Enrollee Information
- Availability and Accessibility of Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Practice Guidelines
- Enrollment and Disenrollment
- Grievance System
- Subcontractual Relationships and Delegation
- Quality Assessment and Performance Improvement Program
- Credentialing
- Confidentiality of Health Information
- Health Information Systems
- Program Integrity

Kepro compliance reviewers performed desk review of all documentation provided by the plans. In addition, two-day on-site visits were conducted to interview key plan personnel, review selected case files, participate in systems demonstrations, and allowed for further clarification/provision of documentation.

An overall percentage compliance score for each of the 14 standards was calculated based on the total points scored divided by total possible points. In addition, an overall percentage compliance score for all fourteen standards combined was calculated. MBHP's composite score was 98%. It scored 100% in eight standards. Its lowest score was in the Subcontractual Relationships and Delegation standard, 88.5%.

MBHP was required to submit a corrective action plan (CAP) for each area identified as Partially Met or Not Met in a format agreeable to MassHealth.

NETWORK ADEQUACY VALIDATION

Exhibit 2.4: 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	MBHP received an overall network adequacy score of 86.5. Not surprisingly, rural Dukes and Nantucket counties experienced the most gaps in provider network adequacy. The state may want to consider conducting further analysis into these regions to assess whether these counties have the ability to 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 micro counties.

QUALITY STRATEGY EVALUATION

States operating Medicaid managed care programs under any authority must have a written quality strategy for assessing and improving the quality of health care 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. An updated 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, was submitted to CMS in November 2018. As is required by CMS, the strategy will be updated in 2021 and will be made available to the public on the MassHealth website.

In 2020, MassHealth asked Kepro to evaluate the effectiveness of this strategy and this evaluation is in process. The final report will be posted to the MassHealth website as it becomes available.

HIGH-LEVEL RECOMMENDATIONS

Kepro has included in its 2020 Technical Reports several recommendations to MassHealth for how it can target the goals and objectives in the Comprehensive Managed Care Quality Strategy to better support improvement in the quality, timeliness, and access to health care services. In addition to the managed care plan-specific recommendations made throughout this Technical Report, Kepro offers the following recommendations to MassHealth.

1. **Expand the Network Adequacy Validation Scope of Work.**

The first of MassHealth's Quality Strategy Objectives is that members receive information that is "clear, engaging, timely, accessible, and culturally and linguistically appropriate to [its] members and providers." A foundational element in culturally and linguistically appropriate care is the inclusion of non-English-speaking providers in managed care plan provider networks. Kepro's network adequacy analytic tool, Quest, can report on a number of these providers. While in 2020, some managed care plans did provide this information, this was not universal. Going forward, Kepro recommends that the non-English-speaking capabilities of all managed care plans be analyzed.

Kepro found some providers with de-activated NPI numbers were in the managed care plan provider directory as evidenced by a search on the plan's website. While not of a significant number, Kepro suggests that network adequacy validation be expanded to include validation of provider directory information.

2. **Require managed care plans to conduct closer oversight of network adequacy and availability.**

Not directly related to the Quality Strategy, but fundamental to the delivery of quality, accessible, and timely care, network adequacy is a foundation of managed care. Across all managed care plans, Kepro did not find strong evidence of processes for evaluating appointment access against the MassHealth standards for services such as symptomatic and non-symptomatic office visits and urgent care. Managed care plans lacked a process to address appointment access concerns with providers. While accessibility of services is an opportunity for improvement for all managed care plans, Kepro found that plans were not completely clear on the expectations for access to services related to compliance thresholds. Kepro recommends that MassHealth more closely monitor network oversight activities.

3. **Continue to support and reinforce the importance of conducting performance improvement projects using a rigorous project methodology.**

MassHealth's Quality Strategy puts forth a focus on quality improvement activities related to chronic disease management and behavioral health.   An analysis undertaken by Kepro showed a correlation between a strong project management approach and an improvement in project performance indicators. To ensure that the investment in PIP-related resources is sound, Kepro recommends that MassHealth continue to require that managed care plans conduct well-executed projects. Kepro welcomes the opportunity to continue to provide managed care plan project-based staff with technical assistance, especially as it relates to the measurement of intervention effectiveness.

4. **Foster cross-plan learning about performance improvement project strategies.**

In the most recent Quality Improvement Cycle, ten MassHealth managed care plans conduct performance improvement projects related to depression. To decrease redundancy and maximize the potential for success, Kepro recommends that a mechanism be instituted for plans conducting similar improvement activities be provided an opportunity for a synergistic sharing of lessons learned. 2020's Racial Disparity Learning Collaborative will provide valuable lessons learned for future work in this area.

5. **Improve the quality of race, ethnicity, and language data provided to the managed care plans.**

A key MassHealth Quality Strategy goal is the identification and resolution of health disparities to provide equitable care.   From conducting population analyses to designing interventions, managed care plans feel challenged by the quality of REL data they receive from MassHealth. A shared concern is the overwriting of plan REL updates by the MassHealth enrollment files. Kepro strongly encourages MassHealth to resolve this issue as these data are required to better measure and address disparities in care and access.

Section 3:

Performance Measure Validation
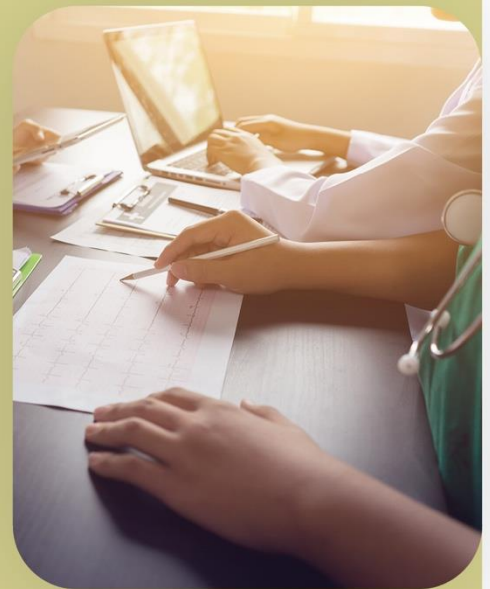
SECTION 3. PERFORMANCE MEASURE VALIDATION

PERFORMANCE MEASURE VALIDATION METHODOLOGY

The Performance Measure Validation (PMV) 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 trends 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 the PCC Plan.

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 the PCC Plan.

Conducted in accordance with 42 CFR § 438.358(b)(ii), Kepro's PMV audit methodology assesses both the quality of the source data that feed into the PMV 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 Performance Measure Validation (PMV) process consists of a desk review of documentation submitted by the managed care organization. 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.

Kepro's PMV audit methodology assesses both the quality of the source data that feed into the PMV 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.

MassHealth requires the validation of three HEDIS® performance measures for each managed care plan. 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 2020

HEDIS Measure Name and Abbreviation	Measure Description
Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up *Rationale for Selection: MBHP's performance in this measure was above the NCQA 2020 Medicaid Quality Compass 95th percentile.*	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 7 days of the ED visit (8 total days).
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of AOD - Alcohol Abuse or Dependence *Rationale for Selection: Difference in IET performance between in IET rates for Alcohol Abuse (between the NCQA 2020 Medicaid Quality Compass 33rd and 50th percentiles) and Opioid Abuse (between the 66th and 75th percentiles).*	The percentage 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, partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of AOD - Opioid Abuse or Dependence *Rationale for Selection: Difference in IET performance between in IET rates for Alcohol Abuse (between the NCQA 2020 Medicaid Quality Compass 33rd and 50th percentiles) and Opioid Abuse (between the 66th and 75th percentiles).*	The percentage of adolescent and adult members with a new episode of opioid abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, 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:

Document Reviewed	Purpose of Kepro Review
Data Acquisition Questionnaire (DAQ)	Reviewed to assess health plan systems and processes related to performance measure production.
Source code used to produce performance measures	For those measures that were not produced using NCQA-certified measure software, reviewed software program/code to determine accuracy of programming and compliance with measure specifications.
List of interventions related to performance measures	Reviewed to help explain changes in performance measure rates.
Follow-up documentation, as requested by the auditor, during the course of validation	Requested to obtain missing or incomplete information, support and validate plan processes, and verify the completeness and accuracy of information provided in the DAQ, onsite interviews, and systems demonstrations.

PERFORMANCE MEASURE VALIDATION RESULTS

Kepro has leveraged CMS Worksheet 2.14, A Framework for Summarizing Information About Performance Measures, from EQR Protocol 2, to report managed care plan-specific 2020 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.

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:
- ☐ Agency for Healthcare Research and Quality (AHRQ)
- ☐ Centers for Disease Control and Prevention (CDC)
- ☐ Centers for Medicare & Medicaid Services (CMS)
- ☒ National Committee for Quality Assurance (NCQA)
- ☐ The Joint Commission (TJC)
- ☐ No measure steward, developed by state/EQRO
- ☐ Other measure steward (specify) _____

Is the performance measure part of an existing measure set? (check all that apply)
- ☒ HEDIS®
- ☐ CMS Child or Adult Core Set
- ☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)
- ☒ Administrative data (describe) Claims and encounter data
- ☐ Medical records (describe) _____
- ☐ Other (specify) _____

If the hybrid method was used, describe the sampling approach used to select the medical records:

- ☒ Not applicable (hybrid method not used)

Definition of denominator (describe): Number of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm

Definition of numerator (describe): Number 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 7 days of the ED visit (8 total days).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP

Measurement period (start/end date) January 1, 2019 – December 31, 2019

2. Performance Measure Results (

Numerator	3262
Denominator	4242
Rate	76.9%

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).

MBHP followed HEDIS technical specifications in the production of this measure.

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 EDI claim submissions. Sufficient claims editing processes were initiated on the front-end of claims submissions and additional claims editing checks were in place within CAS. For the small volume of paper claim submissions, MBHP handled them 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.

Supplemental Data. MBHP did not use supplemental data sources in the production of the performance measure rates under review. Therefore, this section is not applicable.

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 with regard to 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: ☒ High confidence   ☐ Moderate confidence   ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of performance measure calculation: None identified.

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 - Alcohol Abuse or Dependence**	

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by state/EQRO
☐ Other measure steward (specify) _____

Is the performance measure part of an existing measure set? (check all that apply)
☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe) Claims and encounter data
☐ Medical records (describe) _____
☐ Other (specify) _____

If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ 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: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP

Measurement period (start/end date) January 1, 2019 – December 31, 2019

2. Performance Measure Results

Numerator	2635
Denominator	6347
Rate	41.52%

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). MBHP adhered to HEDIS technical specifications for the production of this measure.

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 EDI claim submissions. Sufficient claims editing processes were initiated on the front-end of claims submissions and additional claims editing checks were in place within CAS. For the small volume of paper claim submissions, MBHP handled them 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.

Supplemental Data. MBHP did not use supplemental data sources in the production of the performance measure rates under review. Therefore, this section is not applicable.

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 with regard to 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: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

EQRO recommendations for improvement of performance measure calculation:

Continue quality improvement initiatives for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of AOD - Alcohol Abuse or Dependence* measure.

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 - Opioid Abuse or Dependence**	

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by state/EQRO
☐ Other measure steward (specify) _____

Is the performance measure part of an existing measure set? (check all that apply)
☒ HEDIS®
☒ CMS Child or Adult Core Set
☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe) Claims and encounter data
☐ Medical records (describe) _____
☐ Other (specify) _____

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe): The number of adolescent and adult members with a new episode of opioid abuse or dependence.

Definition of numerator (describe):   The number of adolescent and adult members with a new episode of opioid 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: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP

Measurement period (start/end date) January 1, 2019 – December 31, 2019

2. Performance Measure Results

Numerator	2123
Denominator	3275
Rate	64.82%

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).

MBHP adhered to HEDIS technical specifications for the production of this measure.

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 EDI claim submissions. Sufficient claims editing processes were initiated on the front-end of claims submissions and additional claims editing checks were in place within CAS. For the small volume of paper claim submissions, MBHP handled them 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.

Supplemental Data. MBHP did not use supplemental data sources in the production of the performance measure rates under review. Therefore, this section is not applicable.

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 with regard to 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: ☒ High confidence   ☐ Moderate confidence   ☐ Low confidence ☐ No confidence

EQRO recommendations for improvement of performance measure calculation:

Continue quality improvement initiatives for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of AOD - Alcohol Abuse or Dependence* measure.

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.

Exhibit 3.3: FUM Technical Specification Compliance

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

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element[1]	Rating
DENOMINATOR	
Population	
Medicaid population was appropriately segregated from other product lines.	Met
Members continuously enrolled on or before the date of the emergency department (ED) visit that had a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year.	Met
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: Enrollment Calculation	
Members 6 years and older as of the date of the ED visit.	Met
Members continuously enrolled on or before the date of the qualifying ED visit that had a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year.	Met
Data Quality	
Based on the information system analysis assessment findings, the data sources for this denominator were accurate.	Met
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	
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
NUMERATOR	

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[1] Review elements contained in the tables in Exhibit 3.3 are derived from NCQA HEDIS Technical Specifications. Not all elements may apply to the MBHP member population.

Review Element[1]	Rating
Administrative Data: Counting Clinical Events	
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

Exhibit 3.4: AOD Alcohol Abuse Technical Specification Compliance

Performance Measure Validation: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD - Alcohol Abuse or Dependence Rate

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	Rating
DENOMINATOR	
Population	
Medicaid population was appropriately segregated from other product lines.	Met
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
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: Enrollment Calculation	
Members 13 years and older as of December 31 of the measurement year.	Met
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
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	
Exclude members who had a claim/encounter with a diagnosis of Alcohol or Other Drug (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
NUMERATOR	
Administrative Data: Counting Clinical Events	
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

Exhibit 3.5: AOD Opioid Abuse Technical Specification Compliance

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of AOD - Opioid Abuse or Dependence

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	Rating
DENOMINATOR *Population*	
Medicaid population was appropriately segregated from other product lines.	Met
Members with intake for a new episode of opioid abuse or dependence on or between January 1 and November 14 of the measurement year.	Met
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: Enrollment Calculation	
Members 13 years and older as of December 31st of the measurement year.	Met
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
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	
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
NUMERATOR *Administrative Data: Counting Clinical Events*	
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

FOLLOW UP TO CALENDAR YEAR 2019 RECOMMENDATIONS

CMS requires that EQROs follow up on recommendations made in the previous year. MBHP's actions related to 2019 recommendations follow.

Exhibit 3.6: Follow Up to 2019 Recommendations

Calendar Year 2019 Recommendation	2020 Update
Develop and begin quality improvement initiatives for the Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure. This measure requires coordination between MBHP and the health plans.	**Integrated Care Management Program (ICMP) Pilot Project**: MBHP partnered with two providers to tailor a project using ICMP and Community Health Worker services to provide support and technical assistance to the population of members who were at increased risk for diabetes due to their antipsychotic medication or who have been previously diagnosed with diabetes. The project was facilitated by PCC Support Managers (SMs) and MBHP's Integrated Care Managers (ICMs) who worked with provider sites to develop diabetes management and prevention plans. **One-pager:** PCC SMs shared a one-page document that explains the SPMI Diabetes Project including the rationale for focusing on this population and best practices for providers who are managing care for these members. The one-pager also stressed the importance of communication and coordination between PCCs and behavioral health providers for this population. **Two-way communication form:** MBHP encouraged behavioral health and PCC providers to use the two-way communication form to share important information on their shared members. This form was intended to strengthen integration and coordination across levels of care. **Patient consent form**: MBHP encouraged members to sign release of information in order to increase coordination of care between their different providers. MBHP provided education and advocacy on the importance of care coordination and

provider partnerships to support best care outcomes for members with SPMI. This was done through PCC SM site visits with providers.

Community Support Providers (CSP): MBHP's CSPs provided support to member's with SPMI by helping them to overcome challenges to their engagement in care such as transportation, administrative work, and appointment coordination.

Literature review and packet of resources for providers treating members at risk for developing diabetes and/or previously diagnosed: Continued to revise and update the *Welcome Packet* MBHP previously created for PCCs, which includes literature and best practice guidelines for preventing, diagnosing, and managing diabetes in an SPMI population.

Implement quality improvement initiatives for the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure. This measure requires coordination between MBHP and the health plans.	**Metabolic mailing program:** MBHP created a report to identify pediatric members under the age of eighteen that had a diagnosis of schizophrenia and/or bipolar disorder and who had been prescribed antipsychotic medication and had not had documentation of a lipid or glucose screening test completed within the last year. MBHP distributed letters to the pediatric prescribers and shared the screening program guideline recommendations to have a metabolic screening at least annually. The analysis of the project showed that – compared to the control group who did not receive letters – Members who had a letter had 29% higher rate of metabolic screening.

Annual stakeholder feedback: MBHP presented the screening program and initiatives to the Behavioral Health Clinical Advisory Council (CAC) twice during 2019. During these meetings, MBHP requested feedback and input on the design and opportunities to improve the measure. The |

	results are reviewed after each meeting and inform intervention strategies for the subsequent year.
MBHP and MassHealth should consider the possibility of transferring pharmacy data more frequently than monthly.	This recommendation stands.

CONCLUSIONS

Strengths:
- MBHP used an NCQA-certified vendor to calculate performance measures.
- MBHP demonstrated a strong, collaborative relationship with the PCCP related to data collection, reporting, and improvement efforts.
- MBHP provided monthly data loads to its software vendor to calculate a rolling 12-month rate, which MBHP used for quality improvement and benchmarking purposes.
- MBHP scored above the NCQA 2020 Medicaid Quality Compass 95th percentile for the HEDIS measure, *Follow-up after ED Visit for Mental Illness* -7-Day.

Opportunities:
- The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of AOD - Alcohol Abuse or Dependence* measure rate is under the 50th percentile compared to the NCQA 2020 Medicaid Quality Compass.
- MassHealth does not provide MBHP with Medication Assisted Treatment (MAT) prescription claims data, which could enable MBHP to calculate more accurate pharmacy-related rates.

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
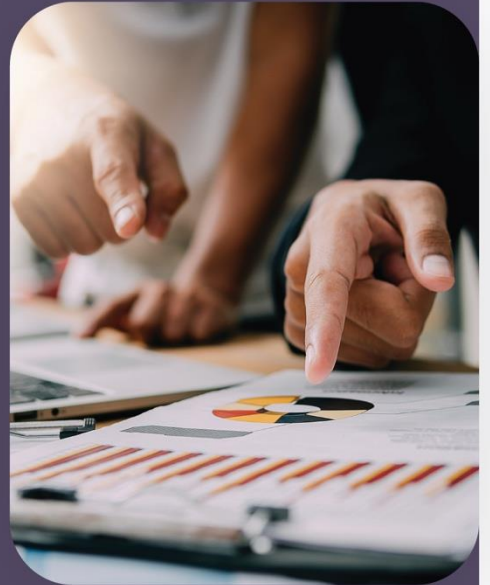
SECTION 4. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

METHODOLOGY

In 2017, MassHealth introduced a new approach to conducting Performance Improvement Projects. In the past, plans submitted their annual project report in July to permit the use the project year HEDIS® data. Kepro's evaluation of the project was not complete until October. Plans received formal project evaluations ten months or more after the end of the project year. The lack of timely feedback made it difficult for the plans to make timely changes in interventions and project design that might positively affect project outcomes.

To permit a more real-time review of Performance Improvement Projects, MassHealth adopted a three-stage approach:

Baseline/Initial Implementation Period: Calendar Year 2018

Planning Phase: *January 2018 - March 2018*
During this period, plans developed detailed plans for interventions. Plans conducted a population analysis, a literature review, and root cause and barrier analyses all of which contributed to the design of appropriate interventions. Plans reported on this activity in March 2018. These reports described planned activities, performance measures, and data collection plans for initial implementation.

Initial Implementation: March 2018 - December 2018
Incorporating feedback received from MassHealth and Kepro, the plans undertook the implementation of their proposed interventions. The plans submitted a progress report in September. In this report, the plans provided baseline data for the performance measures that had been previously approved by MassHealth and Kepro.

Mid-cycle Implementation Period: Calendar Year 2019

Mid-Cycle Progress Reports: *March 2019*
Managed care plans submitted progress reports detailing changes made because of feedback or lessons learned in the previous cycle as well as updates on the current year's interventions.

Mid-Cycle Annual Report: September 2019
Managed care plans submitted annual reports describing current interventions, short-term indicators and small tests of change, and performance data as applicable. It also assessed the results of the projects, including successes and challenges.

Final Implementation Period: Calendar Year 2020

Final Implementation Progress Reports: *March 2020*
MBHP submitted another progress report that described current interventions, short-term indicators, and small tests of change. It also assessed the results of the project to date, including successes and challenges.

Final Implementation Annual Report: September 2020
MBHP submitted a second annual report that described current interventions and performance data as applicable. It also assessed the results of the project, including successes and challenges and described plans for the final quarter of the initiative.

These reports were reviewed by Kepro. The 2020 Progress and Annual Reports are discussed herein. Each project was evaluated to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 1, *Performance Improvement Project Validation*. This evaluation also determined whether the projects have achieved or likely will achieve favorable results. Kepro distributed detailed evaluation criteria and instructions to the plans to support their efforts.

The review of each report is a four-step process:

1) *PIP Questionnaire*. Plans submit a completed reporting questionnaire for each PIP. This questionnaire is stage-specific. In 2020, plans submitted a Project Update (March) and a report on Project Results (September). The Progress Update report asked for a description of stakeholder involvement; an update to project goals, if any; the status of intervention implementation and any barriers experienced; and plans for going forward. The Project Results report included a description of the strategies used to ensure the cultural competence of interventions; an updated population analysis; an analysis of intervention outcome effectiveness; the remeasurement of identified performance indicators; status and barriers; and a description of lessons learned by the project team.

2) *Desktop Review*. Kepro staff conduct a desktop review for each PIP. The Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plans. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is on the structural quality of the project. The Medical Director's focus is on clinical integrity and interventions.

3) *Conference with the Plans*. The Technical Reviewer and Medical Director meet telephonically with representatives selected by the plans to obtain clarification on identified issues as well as to offer recommendations for improvement. The plans are offered the opportunity to resubmit the PIP questionnaire within ten calendar days, although they are not required to do so.

4) **Final Report.** A PIP Validation Rating Form 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 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.

In 2020, the third of the three-year quality cycle, MBHP continued the implementation of two improvement projects undertaken in 2018:

- Initiation and Engagement in Alcohol and Other Drug Treatment: Using intervention efforts to improve the percentage of members who initiate and engage in alcohol and other drug dependence treatment; and
- Improve care coordination and continuity of care by increasing notification to Primary Care Clinicians (PCC) following inpatient hospital discharge.

Based on its review of MBHP's Performance Improvement Projects, Kepro did not discern any issues related to any plan's quality of care or the timeliness of or access to care.

INITIATION AND ENGAGEMENT IN ALCOHOL AND OTHER DRUG TREATMENT: USING INTERVENTION EFFORTS TO IMPROVE THE PERCENTAGE OF MEMBERS WHO INITIATE AND ENGAGE IN ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

1. General PIP Information

Managed Care Plan (MCP) Name: Massachusetts Behavioral Health Partnership (MBHP)
PIP Title: Initiation and Engagement in Alcohol and Other Drug Treatment: Using intervention efforts to improve the percentage of Members who initiate and engage in alcohol and other drug dependence treatment

PIP Aim Statement:
Member-Focused
• Improve access to Substance Use Disorder (SUD) treatment and/or behavioral health services for MBHP members;
• Improve member retention in SUD treatment and/or behavioral health services for members to receive intended benefits of services, thereby improving clinical outcomes;
• Reduce waitlists for SUD treatment and/or behavioral health services so that members can access more timely services that meet their needs at a critical point in treatment/engagement;
• Increase member awareness of available SUD services and/or behavioral health services so that members can choose services that best meet their needs and are able to find other treatment options;
• Support members' engagement in treatment by addressing their unique needs;
• Reduce prevalence of SUD among members by assisting in recovery and supporting positive clinical outcomes; and
• Increase access and engagement.
Provider-Focused
• Assist in increasing care coordination and integration between providers across levels of care (both primary care and behavioral health);
• Facilitate referral pathways to SUD and/or behavioral health services within and across organizations;
• Increase primary care clinician (PCC) level of comfort treating and managing SUD and co-occurring behavioral health needs; and
• Increase PCC awareness of available services for members and how providers can access resources and information related to those services.

Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)
☐ State-mandated (state required plans to conduct a PIP on this specific topic)
☐ Collaborative (plans worked together during the planning or implementation phases)
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)
☒ Plan choice (state allowed the plan to identify the PIP topic)

Target age group (check one):
☐ Children only (ages 0–17)*   ☐ Adults only (age 18 and over)   ☒ Both adults and children
*If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify): All MBHP members
Programs: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) None identified.
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 created a workgroup of stakeholders, including behavioral health and medical providers, emergency services staff, school counselors and nurses, and representatives from the local police and correctional offices, to make system-level changes for the treatment of substance use disorders in youth. MBHP developed a partnership with a pediatric primary care practice to improve processes to increase access to care, reduce wait times, and/or improve retention in treatment. Using the NIATx model for process improvement, MBHP collaborated with providers in Northeastern Massachusetts to improve processes related to access and retention in Medication Assisted Treatment (MAT).
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) None identified.

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
IET Initiation – Alcohol Total NCQA 0004	2017	1740/ 4212 41.31%	2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	2635/6347 41.52%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
IET Engagement – Alcohol Total NCQA 0004	2017	532/ 4212 12.63%	2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	851/6347 13.41%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.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: None identified.

Exhibit 4.1. MBHP IET

MBHP IET Initiation Rate Compared to Goal

IET Initiation Rate

	2017	2018	2019
MBHP Goal	44.24%	45.34%	46.38%
MBHP Rate	41.31%	39.54%	41.41%

MBHP Rate   MBHP Goal

+
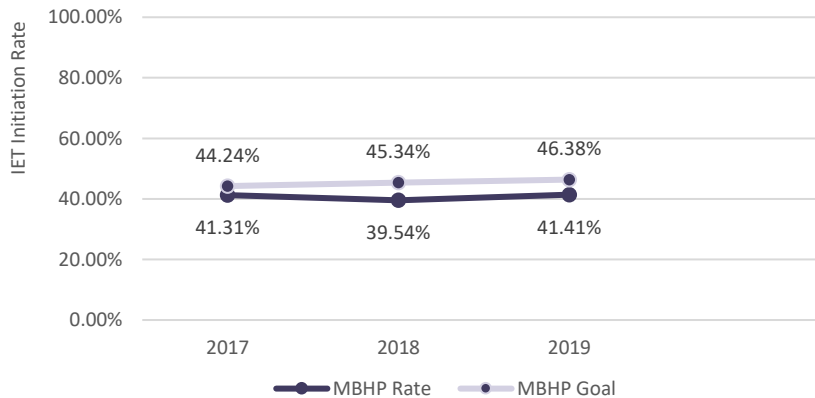
MBHP IET Engagement Rate Compared to Goal

IET Engagement Rate

	2017	2018	2019
MBHP Goal	13.52%	13.76%	14.25%
MBHP Rate	12.63%	12.43%	13.42%

MBHP Rate   MBHP Goal
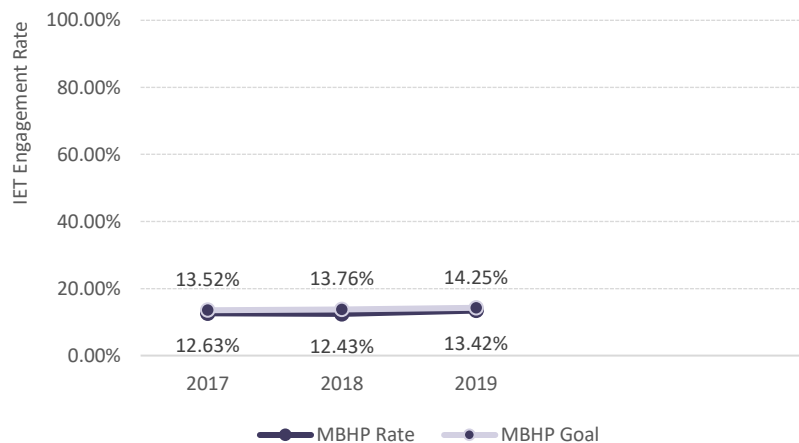
<u>Performance Improvement Project Rating</u>

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 100% 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 Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	6.0	18.0	18.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Lessons Learned	2	6	6	100%
Overall Validation Rating Score	**26.0**	**78.0**	**78.0**	**100%**

<u>Plan & Project Strengths</u>

- MBHP is commended for its population analysis that is grounded in advanced statistical analyses that identified barriers to performance indicators' success and the probable strength of the barriers.
- MBHP's results show that the NIATx site interventions led to sustained improvement in rates of initiation for members with Opioid Use Disorder, especially compared to members at these sites with other forms of Alcohol and Other Drug disorder.
- Kepro commends MBHP for considering novel ways to reach out to youth through telehealth, including text messaging to assess readiness for change, providing specific support depending on member readiness, and visits using remote platforms.
- MBHP's analysts are commended for the high quality of the quantitative analyses presented in this report.
- Kepro commends MBHP for its stratified performance indicators that identified the factors most tied to progress among its subpopulations.

<u>Update on Calendar Year 2019 Recommendations</u>

Kepro is required by CMS to determine the status of recommendations made in the previous reporting year. No recommendations, however, were identified in 2019.

IMPROVE CARE COORDINATION AND CONTINUITY OF CARE BY INCREASING NOTIFICATION TO PRIMARY CARE CLINICIANS (PCCs) FOLLOWING INPATIENT HOSPITAL DISCHARGE

1. General PIP Information

Managed Care Plan (MCP) Name: Massachusetts Behavioral Health Partnership (MBHP)
PIP Title: Improve care coordination and continuity of care by increasing notification to Primary Care Clinicians (PCCs) following inpatient hospital discharge
PIP Aim Statement *Member-Focused* • Improve timely access to primary care services following inpatient discharge; • Improve member experience and clinical outcomes by increasing coordination between primary care and mental health; • Support Members' engagement in primary care treatment in order to treat the member's whole health; and • Improve clinical outcomes for members by strengthening the role of the PCC in their treatment plan by educating the PCC to actively contribute to prevention, appropriate referral, and treatment to address co-occurring disorders. *Provider-Focused* • Increase care coordination and integration by increasing the rate of PCC notifications following member discharge from inpatient hospitalization; • Develop processes to improve MBHP's inpatient discharge reporting form in order to make it easier for inpatient providers to notify a member's PCC of their discharge; • Develop education and resources to support provider hand-offs and care plan-sharing from inpatient to PCC; and • Empower PCCs to have an active role in a member's behavioral health treatment plan through education, outreach, and other supporting resources.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☒ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify): All MBHP Members
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

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

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

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Inpatient sites are being educated about the role of PCCs in the discharge plan and the importance of notifying a Member's PCC of their inpatient discharge. Provider Quality Managers met with low-performing providers to explore providers' barriers to higher rates of performance.	
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 enhanced its existing inpatient provider reporting platform, Provider Connect, to encourage inpatient providers to input information related to PCC notification when completing the discharge form.	

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
The percentage of inpatient psychiatric episodes for which the PCC Plan or ACO-affiliated primary care provider is notified upon discharge as reported to MBHP by the discharging facilities	2017	1310/ 6260 20.94%	2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	6360/ 10,010 63.54%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): $p < 0.005$

| 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
The number of eligible Members who are readmitted to a network inpatient mental health facility within 90 days of discharge from a network inpatient facility	2017	1617/ 4987 32.42%	2019 ☐ Not applicable—PIP is in planning or implementation phase, results not available	3293/ 9164 35.93% (lower is better)	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.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

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EQRO recommendations for improvement of PIP:

MBHP's data show the rates at which inpatient providers are not able to notify the PCC of their patient's discharge for two primary reasons: they could not get a release of information (ROI) from the member (8%) or the member did not know his/her PCC (24%).

This presents an opportunity for future educational initiatives, where PQMs can work with providers to focus on opportunities to increase the number of ROIs or reduce the number of cases where the PCC remains unknown by working with members upon admission to identify their PCC.

Using its reporting data, MBHP can target providers who more frequently indicated that they did not contact a member's PCP relative to their peer providers. The PQMs can work with these providers to develop Strategic Plans that focus on implementing improvement strategies.

As part of its future deliberations about the continued deployment of this project, MBHP should be asking itself about the clinical outcomes of this project that has the goal of improving post-hospitalization care for members with psychiatric diagnoses who are served by their PCCs. It is the goal of the PCC notification protocol to reduce future psychiatric hospital admissions, or is there some other health benefits that can be documented as a result of improved links between psychiatric hospitals and PCC practices?

Exhibit 4.3: MBHP PCC Notification Rates

MBHP Percentage of Inpatient Psychiatric Episodes and the PCC Plan is Notified Upon Discharge
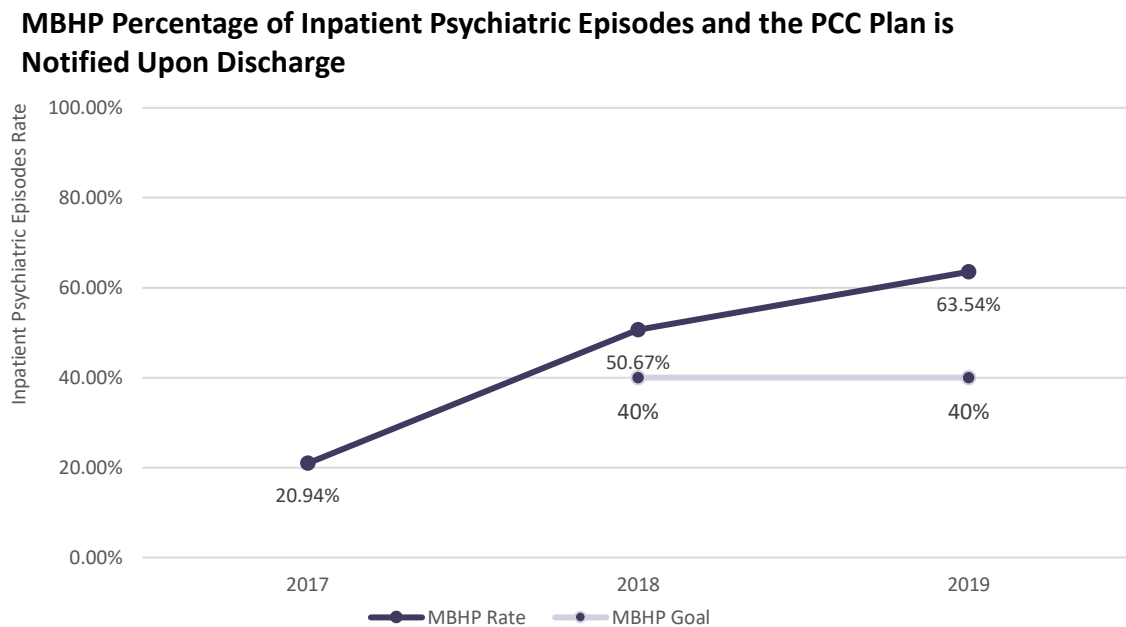
Exhibit 4.4: Member Rate of Readmission to Network Inpatient Facility

MBHP Members Readmitted to an Inpatient Network Facility within 90 Days of Discharge

Lower is Better
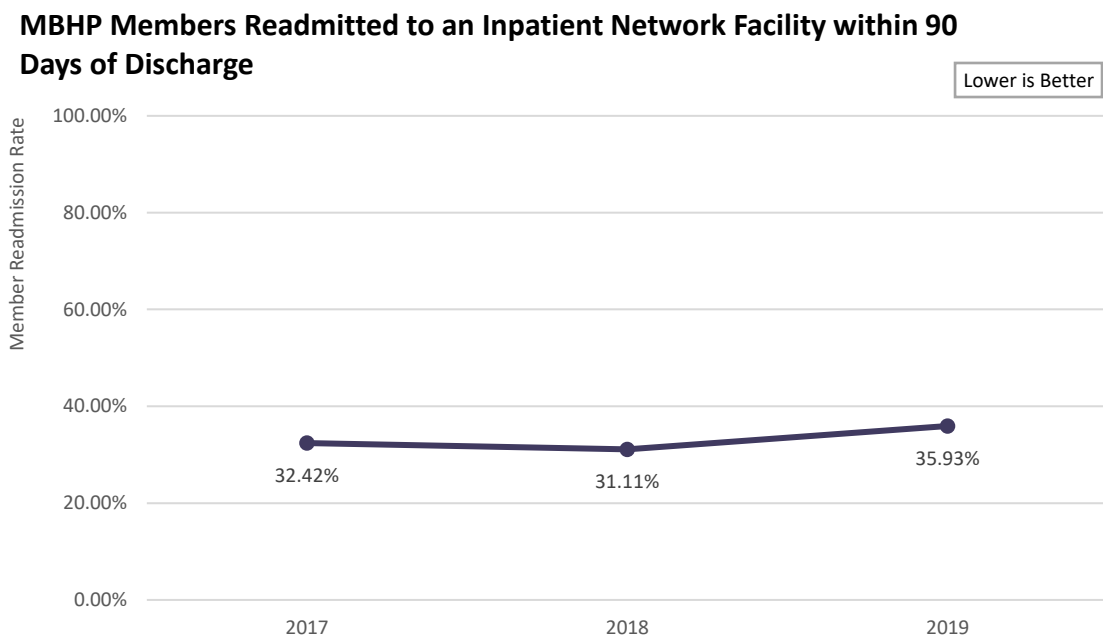
Performance Improvement Project Evaluation

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 100% on this Performance Improvement Project.

Exhibit 4.5: Performance Improvement Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	9	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	4.0	12.0	12.0	100%
Remeasurement Performance Indicator Rates	3.5	10.5	10.5	100%
Conclusions and Lessons Learned	2	6	6	100%
Overall Validation Rating Score	**23.5**	**70.5**	**70.5**	**100%**

Plan and Project Strengths

- MBHP presented a comprehensive population analysis showing the rate of PCC notifications of member inpatient discharge disaggregated by a range of factors including demographics, community support programs, co-occurring diagnoses, incidents of 90-day readmissions, and access to follow-up care.

- MBHP reports steady and significant improvement over the two years of remeasurement in its goal to notify primary care providers when patients in their panels are discharged from psychiatric inpatient facilities. From a baseline rate of 20.9% in 2017, the notification rate increased to 50.7% in 2018 and then 63.5% in 2019. The difference in the rate of notification between Baseline and Remeasurement 2 nearly tripled.

- MBHP is commended for the excellent design of this PIP methodology and for the successes demonstrated in the achievement of its performance incentive goals in this first remeasurement report.

Follow Up to 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year. No recommendations, however, were made in 2019.

Section 5:

Compliance
Validation

SECTION 5: COMPLIANCE VALIDATION

INTRODUCTION

Kepro uses the mandatory compliance validation protocol to determine, in a manner consistent with standard industry practices, the extent to which Medicaid managed care entities comply with Federal quality standards mandated by the Balanced Budget Act of 1997. This validation process is conducted triennially.

The 2020 compliance reviews were structured based on program requirements as outlined in 42 CFR 438. In addition, compliance with provisions in contracts as they relate to 42 CFR 438 between MassHealth and each Managed Care Plan (MCP), including MBHP, were assessed. The most stringent of the requirements were used to assess for compliance when State and federal requirements differed.

REVIEW (LOOK-BACK) PERIOD

MBHP activity and services occurring for calendar year 2019 (January 1 – December 31, 2019) were subject to review.

REVIEW STANDARDS

Based on regulatory and contract requirements, compliance reviews were divided into the following 11 standards, consistent with CMS October 2019 EQR protocols.

- Availability of Services
    - Enrollee Information
    - Enrollee Rights and Protections
    - Enrollment and Disenrollment
- Assurances and Adequate Capacity of Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Provider Selection
- Confidentiality
- Grievance and Appeal System
- Subcontractual Relationships and Delegation
- Practice Guidelines
- Health Information Systems
- Quality Assessment and Performance Improvement Program

COMPLIANCE REVIEW TOOLS

Compliance review tools included detailed regulatory and contractual requirements in each standard area. The review tools were customized based on the specific MBHP contract and applicable requirements.

REVIEW PROCESS

Kepro provided communication to MBHP prior to the formal review period that included an overview of the compliance review activity and timeline. MBHP was provided with a preparatory packet that included the project timeline, the draft virtual review agenda, the compliance review tools, and data submission information. Finally, Kepro scheduled a pre-review conference call with MBHP approximately two weeks prior to the virtual review to cover review logistics.

MBHP was provided with the appropriate review tools and asked to provide documentation to substantiate compliance with each requirement during the review period. Examples of documentation provided included:

- Policies and procedures;
- Standard operating procedures;
- Workflows;
- Desk tools;
- Reports;
- Member materials;
- Care management files;
- Utilization management denial files;
- Appeals files;
- Grievance files; and
- Credentialing files.

Kepro compliance reviewers performed a desk review of all documentation provided by MBHP. In addition, two-day virtual reviews were conducted to interview key MBHP personnel, review selected case files, participate in systems demonstrations, and obtain clarification and additional documentation. At the conclusion of the two-day virtual review, Kepro conducted a closing conference to provide preliminary feedback to MBHP on the review team's observations, strengths, opportunities for improvement, recommendations, and next steps.

SCORING METHODOLOGY

For each regulatory/contractual requirement for each program, a three-point scoring system was used. Scores are defined as follows:

- Met – Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and MBHP staff interviews provided information consistent with documentation provided.
- Partially Met (any one of the following may be applicable) -
  - Documentation to substantiate compliance with the entirety of the regulatory requirement or contractual provision was provided. MBHP staff interviews, however, provided information that was not consistent with the documentation provided.
  - Documentation to substantiate compliance with some but not the entirety of the regulatory requirement or contractual provision was provided although MBHP staff interviews provided information consistent with all requirements.
  - Documentation to substantiate compliance with some but not the entirety of the regulatory requirement or contractual provision was provided, and MBHP staff interviews provided information inconsistent with compliance with all requirements.
- Not Met - There was an absence of documentation to substantiate compliance with any of regulatory or contractual requirements and MBHP staff did not provide information to support compliance with those requirements.

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by the total points possible (Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points). In addition, an overall percentage compliance score for all standards was calculated to give each standard equal weight. The total percentages from each standard were divided by the total number of standards reviewed. For each area identified as Partially Met or Not Met, MBHP was required to submit a corrective action plan (CAP) in a format agreeable to MassHealth.

Per 42 CFR 438.360, Nonduplication of Mandatory Activities, Kepro accepted NCQA accreditation to avoid duplicative work. To implement the deeming option, Kepro obtained the most current NCQA accreditation standards and reviewed the accreditation standards against the CFRs. In cases in which the accreditation standard was at least as stringent as the CFR, Kepro flagged the review element as eligible for deeming. For a review standard to be deemed, Kepro evaluated MBHP's most current accreditation review and scored the review element as "Met" if MBHP scored 100 percent on the accreditation review element.

MBHP COMPLIANCE VALIDATION RESULTS

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 22 – 23, 2020. Kepro used the technical scores along with qualitative review results to outline high-level strengths, findings, and recommendations.

MassHealth required MBHP to submit CAPs for all Partially Met and Not Met elements identified from the 2020 Compliance Reviews. MassHealth will evaluate the CAPs and either approve or request additional documentation. Kepro will evaluate actions taken to address recommendations in the next EQR report and will conduct a comprehensive review again in 2023.

The table that follows depicts the 2020 compliance scores for MBHP by review area.

Exhibit 5.1: MBHP 2020 Compliance Scores

Topic	Score
Availability of Services	98.0%
Assurances and Adequate Capacity and Services	100%
Enrollee Rights and Protection	100%
Enrollment/Disenrollment	100%
Availability of Services – Enrollee Information	96.0%
Provider Selection	100%
Grievance and Appeal System	93.9%
Subcontractual Relationships and Delegation	88.5%
Quality Assessment and Performance Improvement Program	98.4%
Health Information Systems	100%
Coverage and Authorization of Services	96.8%
Practice Guidelines	100%
Confidentiality of Health Information	100%
Coordination and Continuity of Care	100%
Composite Score	98%

Strengths
- Overall, MBHP demonstrated compliance with most of the federal and State contractual standards for its delegated functions for the PCC Plan membership. MBHP performed best in areas that related to the quality of care and services.
- Kepro noted the relationship between MBHP and the PCC Plan as a strength for providing behavioral health services to some of the most vulnerable Medicaid-eligible members, such as those with Serious and Persistent Mental Illness. Kepro found this model to be a best practice for the integration of physical and behavioral health services. This was a consistent finding from the prior review period.
- The review found that MBHP's robust analytics and ongoing evaluation of its services and performance was a strength. Overall, MBHP's quality program was comprehensive and had good alignment with many of MassHealth's quality strategy aims.
- MBHP demonstrated collaboration with its providers, positive provider interactions, and involvement of providers in solutions.

- MBHP made a system enhancement in 2019 to use InterQual criteria for its coverage and authorization decisions. The transition was well-received from the provider community and supports services being provided consistent with medical necessity criteria. In addition, MBHP's use of peer-to-peer consultation and documentation was noted as a strength. This process appears to support a more collaborative decision between MBHP and treating providers related to coverage decisions and appropriate level-of-care.
- MBHP demonstrated ongoing efforts related to care coordination with emphasis on transitions of care.
- In general, Kepro found that MBHP addressed opportunities for improvement from the prior compliance review.

Substantive Findings
- Overall, MBHP had some opportunities for improvement that could affect timeliness of care and access to care.
- Many of the identified review deficiencies were related to policies and procedures that lacked the more stringent MassHealth requirements. The review noted that many of these issues were related to policies and procedures developed at the parent company level and not modified to be more responsive the MassHealth MBHP requirements.
- A review of files related to member grievances, coverage decisions, and appeals did not always clearly explain the decision, action taken by MBHP, and outcome. In addition, MBHP was challenged to meet timelines for acknowledging member grievances.
- While MBHP performed provider access analysis, the review showed that its analysis did not meet MassHealth's requirement to ensure a choice of at least two behavioral health providers. Therefore, Kepro was not able to fully access network accessibility.

Recommendations
- MBHP should review and update its policies and procedures to ensure compliance with all federal and MassHealth standards that were identified as deficient as part of the review.
- MBHP should review its member letter templates and ensure that the templates and customized language is well-written and in a manner that is easily understood.
- MBHP needs to improve its grievance process to ensure timely acknowledgement of the grievance, action, and resolution as related to non-quality of care issues.
- MBHP needs to revise its geo-access reporting to meet MassHealth standards for accessibility.

Section 6:

Network Adequacy Validation

SECTION 6: NETWORK ADEQUACY EVALUATION

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 stipulates contractually required time and distance standards as well as threshold member to provider ration to ensure access to timely care.

In 2020, MassHealth, in conjunction with its EQRO contractor, Kepro, initiated an evaluation process to identify the strengths of the health plan's provider networks, as well as to offer recommendations for bridging network gaps. This process of evaluating a plan's network is termed Network Adequacy Validation. While this type of evaluation and reporting is not required by CMS at this time, the Commonwealth of Massachusetts was strongly encouraged by CMS to incorporate this activity as an annual process evaluation, 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 specialties. The program also provides information about all 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 that Kepro obtained. These suggestions will help close gaps and provide Medicaid members with improved access to timely healthcare, the primary goal.

REQUEST OF PLAN

To build this software tool, MassHealth requested a complete data set from MBHP, which included the following data points:

- Facility or Provider Name
- Address Information
- Phone Number
- NPI Information
- Non-English Languages Spoken by the Provider

This request applied to the following areas of service:

- Behavioral Health Specialists; and
- Behavioral Health Services

It's important to note that no information regarding beneficiaries was requested from the plans. The goal of Network Adequacy is to ensure that every carrier has adequate access to care for 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, MassHealth, performed the network adequacy reviews using a representative set of population points, 3% of the population, distributed throughout the service area based on population patterns. This methodology allowed MassHealth to ensure each carrier was measured consistently against the same population distribution and that the entire service area has adequate access to care within the prescribed time and distance criteria.

TIME AND DISTANCE STANDARDS

For Medicaid members to receive appropriate access to care for medical services, MassHealth requires MBHP to adhere to certain time and distance standards. These standards create an overall provider network for members to receive care.

MBHP is required to meet both the time and the distance standard, not either or. For example, the standard for In-Home Therapy Services are within a 30-mile radius AND no more than 30 minutes away from the member.

It's important to note that for some specialties, the time and distance standards vary based on the county CMS designation, i.e., large metro, metro, or micro. MBHP services all 14 counties. Below is a map of the county designations, for reference:

Exhibit 6.1: Map of Massachusetts County Designations
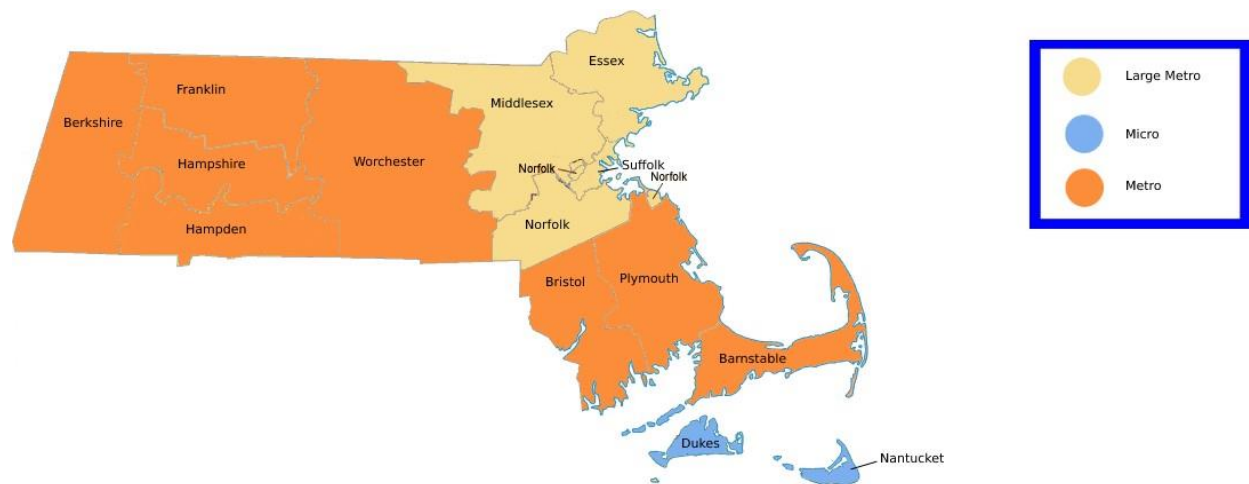
BEHAVIORAL HEALTH DIVERSIONARY SERVICES:

MassHealth requires all specialties in this category adhere to a standard of 30 miles <u>and</u> 30 minutes. The list of specific specialties included in this category are in the chart that follows.

Exhibit 6.2: 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 specialties in this provider group, i.e., Managed Inpatient Level 4, Adult Psychiatric Inpatient, Adolescent Psychiatric Inpatient, and Child Psychiatric Inpatient. MassHealth defines a 60-mile and 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 requires a time and distance standard of 30 miles and 30 minutes for these services.

BEHAVIORAL HEALTH OUTPATIENT SERVICES:

MassHealth requires all specialties in this category to follow a time and distance standard of 30 miles and 30 minutes. Four of these specialties are required to have a minimum of two providers within this standard; Applied Behavior Analysis and BH Outpatient do not have a provider number standard. The four specialties and provider requirements are outlined in the chart that follows:

Exhibit 6.3: Behavioral Health Outpatient Specialties and Required Provider

Specialty	# of Providers
Opioid Treatment Programs	2
Psychiatry	2
Psych APN (PCNS or CNP)	2
Psychology	2

RESULTS

The Quest system depicts the results of the evaluation using a color scheme to identify strong areas and gaps in service. These colors will be referenced throughout this report. The following chart describes the colors used and description, for reference.

Exhibit 6.4: Results Color Scheme

Color	Description
Green	Meets all distance (Access) and provider to member ratio (Servicing Provider) Requirements
Yellow	Meets either the requirements or the Servicing Provider requirements, but is not meeting both requirements
Red	Meets neither the Access nor Servicing Provider requirements

The highest score possible is a 100.0. MBHP received a score of **86.5**, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 6.5: MBHP Network Adequacy Score

Viewing service area results for
14 counties in 1 state
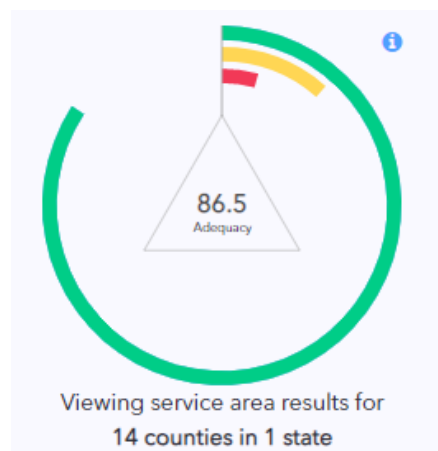
- The **green** bar indicates that 84.30% fully meet the adequacy requirements.

- The **yellow** bar indicates that 11.40% meet the servicing provider requirements, but not the travel time standard.

- The **red** bar indicates that 4.30% do not meet any adequacy requirements.

STRENGTHS

MBHP received a 100 or a **Green** score, in multiple services areas. Four services in the Behavioral Health Diversionary category, three services in the Inpatient category, three services in the Outpatient category, and two services in the Intensive Community Treatment category received a 100. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 6.6: Services receiving a score of 100

BH Diversionary	
Community Support Program	Recovery Coaching
Intensive Outpatient Program	Recovery Support Navigators
BH Inpatient	**BH Outpatient**
Psych Inpatient Adolescent	BH Outpatient
Psych Inpatient Adult	Opioid Treatment Programs
Psych Inpatient Child	Psychology
BH Intensive Community Treatment (CBHI)	
In-Home Therapy Services	Therapeutic Mentoring Services

AREAS OF IMPROVEMENT

Certain geographic areas and services are not currently meeting the time and distance standards. The chart that follows designates the health services and counties in which certain requirements have not been met.

Exhibit 6.7: Gaps in Service for Behavioral Health Diversionary Specialties

County:	CBAT	Clinical Support Services for SUD	Monitored Inpatient Level 3.7	Partial Hospitalization Program	Program of Assertive Community Treatment	Psychiatric Day Treatment	Residential Rehab Services for SUD	Structured Outpatient Addiction Program
Barnstable	Yellow	Yellow	Yellow	Green	Green	Red	Yellow	Yellow
Berkshire	Yellow	Green	Green	Green	Yellow	Yellow	Green	Yellow
Bristol	Green	Green	Green	Green	Green	Green	Green	Green
Dukes	Red	Yellow	Yellow	Yellow	Yellow	Red	Green	Green
Essex	Yellow	Green	Green	Green	Green	Green	Green	Green
Franklin	Yellow	Green	Green	Green	Yellow	Yellow	Green	Green
Hampden	Green	Green	Green	Green	Green	Green	Green	Green
Hampshire	Green	Green	Green	Green	Yellow	Yellow	Green	Green
Middlesex	Green	Green	Green	Green	Green	Green	Green	Green
Nantucket	Red	Red	Red	Yellow	Yellow	Red	Red	Yellow
Norfolk	Green	Green	Green	Green	Green	Green	Green	Green
Plymouth	Yellow	Green	Green	Green	Green	Green	Green	Green
Suffolk	Green	Green	Green	Green	Green	Green	Green	Green
Worcester	Yellow	Yellow	Yellow	Green	Yellow	Yellow	Green	Green

Exhibit 6.8: Gaps in Service for other Medical Services

| County:	BH Inpatient	CBHI	BH Outpatient		
	Managed Inpatient Level 4	In-Home Behavioral Services	Applied Behavior Analysis	Psych APN	Psychiatry
Barnstable	Red	Green	Green	Green	Yellow
Berkshire	Red	Green	Yellow	Green	Yellow
Bristol	Yellow	Green	Green	Green	Green
Dukes	Red	Yellow	Green	Green	Yellow
Essex	Yellow	Green	Green	Green	Green
Franklin	Red	Green	Green	Green	Green
Hampden	Yellow	Green	Green	Green	Green
Hampshire	Yellow	Green	Green	Green	Green
Middlesex	Green	Green	Green	Green	Green
Nantucket	Red	Red	Yellow	Yellow	Red
Norfolk	Green	Green	Green	Green	Green
Plymouth	Yellow	Green	Green	Green	Green
Suffolk	Green	Green	Green	Green	Green
Worcester	Green	Green	Green	Green	Green

- Nantucket County has the most gaps in the provider network when compared to the other 13 counties. More than half of the gaps are not meeting any requirements.
- Most counties are not meeting all Managed Inpatient Level 4 requirements. Four counties are meeting all requirements, five counties are only meeting the servicing provider requirements, and the other five counties are not meeting any requirements.
- Middlesex, Norfolk, and Suffolk counties are meeting all requirements in all services and counties.
- Bristol County is meeting all requirements in all counties and services except one, Managed Inpatient Level 4, which is only meeting the servicing provider requirements.
- Psych APN services are meeting all requirements in all counties except one, Nantucket County.

CONCLUSION

Over the course of this analysis, Kepro has identified multiple areas of strength in MBHP's provider network. Certain areas, such as Psychiatric Inpatient Services for Children, Adolescents, and Adults, excelled across all geographic areas that MBHP services. This year's network adequacy evaluation allowed MassHealth to assess baseline performance and identify several opportunities for performance. MassHealth is working with Plans to address areas of noncompliance.

While not all requirements are being met in all areas, MBHP has opportunities to improve the network for improved access to care for its members. Certain geographical areas seem to struggle more than others, particularly Dukes and Nantucket counties. With the most gaps in the provider network, MBHP could focus on improving the network across multiple health care services. Strengthening these areas could greatly improve both the network and the network adequacy evaluation that will be conducted annually.

The state may want to consider conducting further analysis into these regions to assess whether or not these counties have the ability to meet the standards in their entirety. If not, the state could approve an exception for these plans, or adjust the standards going forward, in order to accommodate the plan's ability to provide health care to its members.

Section 7
Appendices

APPENDIX: 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.

Chantal Laperle, MA, CPHQ, NCQA CCE
Chantal Laperle has over 25 years of experience in the development and implementation of quality initiatives in a wide variety of health care delivery settings. She has successfully held many positions, in both public and private sectors, utilizing her clinical background to affect change. She has contributed to the development of a multitude of quality programs from the ground up requiring her to be hands-on through implementation. She is experienced in The Joint Commission, National Committee for Quality Assurance, The Commission on Accreditation of Rehabilitation Facilities, and Accreditation Association for Ambulatory Health Care accreditation and recognition programs. She is skilled in developing workflows and using tools to build a successful process, as well as monitor accordingly. She also coaches teams through the development and implementation process of a project.

Ms. Laperle holds both a bachelor's and master's degrees in psychology. She is a Certified Professional in Health Care Quality and Certified in Health Care Risk Management through the University of South Florida. She is also certified in Advanced Facilitation and the Seven Tools of Quality Control through GOAL/QPC, an Instructor for Nonviolent Crisis Intervention, a Yellow Belt in Lean Six Sigma, a Telehealth Liaison through the National School of Applied telehealth, and a Certified Content Expert for Patient Centered Medical Home through NCQA.

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 health care, 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.

Compliance Validation Reviewers

Jennifer Lenz, MPH, CHCA

Ms. Lenz has more than 19 years' experience in the healthcare industry, with expertise in implementing and managing external quality review activities, managing teams, and driving quality improvement initiatives. Ms. Lenz has working experience in both private and public health sectors. Her experience includes managed care organization responsibility for accreditation and quality management activities; managing chronic disease programs for a state health department; and in performing external quality review organization activities. She has conducted compliance review activities across health plans in the states of California, Georgia, Massachusetts, Ohio, Utah, and Virginia. Ms. Lenz is a Certified HEDIS® Compliance Auditor through the NCQA. She holds a Master of Public Health degree from the University of Arizona.

Jane Goldsmith, RN, MBA, CSSGB, CHC

Ms. Goldsmith has more than 30 years' experience in the healthcare industry with expertise in leading teams in public health nursing activities and implementing quality assurance, regulatory compliance, and accreditation activities. Her prior experience includes senior management and executive roles in managed care organizations with responsibility for quality improvement,

regulatory compliance, accreditation, and internal audit. She has conducted external quality review activities across health plans in the states of California, Virginia, Florida, Illinois, Ohio, and Michigan. She also served five years as an adjunct faculty member for John Hopkins Bloomberg School of Public Health. Ms. Goldsmith has been Certified in Healthcare Compliance (CHC) by the Compliance Certification Board (CCB) and Certified as Six-Sigma Green Belt (CSSBG) by Villanova University. She received her Bachelor of Science in Nursing degree from Eastern Michigan University and her master's degree in business administration in integrative management from Michigan State University. She holds registered nurse licenses in Michigan, Illinois, and Florida.

Sue McConnell, RN, MSN

Ms. McConnell has more than 40 years' experience is various aspects of the health care industry. She served as the Director of Nursing for a south side Chicago medical center, ran the clinical management area for a national PPO, developed and implemented insured products for a national PPO including meeting all regulatory requirements, developed and implemented a national workers' compensation managed care program, managed a multi-site, multi-specialty provider group. Most recently Ms. McConnell was responsible for the management of a federal employee national PPO health plan with responsibilities that included regulatory compliance, HEDIS and CAHPS program management, quality improvement initiatives and outcomes, member services, product development and management, client relations, claims administration and patient centered programs for health maintenance and improvement. Her clinical background includes long term care, intensive care, emergency services, acute care clinical management, and outpatient service. Ms. McConnell received her master's in nursing service administration from University of Illinois-Medical Center.

Poornima Dabir, MPH, CHCA

Ms. Dabir has over 20 years of experience in the health care industry, with expertise in project management, compliance audits and regulatory assessments, performance measurement, and quality improvement. She has worked over 17 years as a lead HEDIS® Compliance auditor involving reviews of public and private health insurance product lines of numerous national as well as local health plans. She also works on other validation and regulatory audits, including URAC validation reviews of pharmacies, Medicare data validation audits, and numerous state compliance audits of health plans and behavioral health organizations. Her previous experiences include managing an organization's Medicare data validation audit program, leading quality improvement projects for an external review organization, and working at local managed care organizations in areas of quality improvement and Medicare compliance. Ms. Dabir is a Certified HEDIS® Compliance Auditor through the NCQA. She received her master's degree in public health from the University at Albany, School of Public Health.

Debra Homovich, BA

Ms. Homovich has 10 years of experience in the healthcare industry, with expertise in conducting quality reviews and in managing teams performing healthcare compliance validations. Her prior experience includes URAC data validation, compliance auditing, and performance of external quality review organization activities. She has conducted compliance review activities in the states of Alabama, Massachusetts, and South Dakota. Ms. Homovich is a Certified Public Accountant licensed in Pennsylvania. She received her bachelor's degree in accounting from Alvernia University.

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's of science degree in health care administration and is a Certified Professional in Healthcare Quality.   She is currently 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.