

**MassHealth
One Care
External Quality Review Technical Report
Calendar Year 2017**



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. MASSHEALTH'S ONE CARE ORGANIZATIONS

COMMONWEALTH CARE ALLIANCE HEALTH PLAN

CCA is a community-based, not-for-profit healthcare organization dedicated to improving care for individuals with complex medical, behavioral health and social needs, including those with disabilities. Among the more than 8,900 members of CCA's Senior Care Options plan (HMO-SNP) for individuals 65 and over who are eligible for MassHealth Standard, 70% are nursing-home eligible, 62% do not speak English, and approximately the same proportion of members has diabetes. CCA operates 4 disability-competent Commonwealth Community Care centers in Boston, Lawrence, MetroWest/Worcester, and Springfield. Its service area includes all cities and towns in Bristol, Essex, Hampden, Hampshire, Middlesex, Suffolk and Worcester counties as well as many cities and towns in Franklin, Norfolk, and Plymouth counties. CCA received 4 Stars out of 5 possible Stars for 2018, according to the U.S. Centers for Medicare & Medicaid Services Star Ratings. Its corporate offices are located in Boston.

TUFTS HEALTH PUBLIC PLANS

Tufts Health Plan, Inc., is a not-for-profit health maintenance organization headquartered in Watertown serving its members in Massachusetts, New Hampshire, and Rhode Island. Its private HMO/POS and Massachusetts PPO plans are rated 5 out of 5 by the National Committee for Quality Assurance (NCQA). Tufts Health Plan is the only health plan in the nation to receive the rating for both its HMO and PPO products. Tufts Health Plan's MA PPO is the only PPO plan in America to receive the 5 out of 5 rating. Its Medicaid plan is rated 4.5 out of a possible 5. Tufts Medicare Preferred HMO and Senior Care Options earned 5 stars out of a possible 5 from the Centers for Medicare and Medicaid Services for 2018, putting it in the top 4 percent of plans in the country.

Exhibit 1: One Care Membership

One Care Plan	Membership as of December 31, 2016	Percent of Total OneCare Population
Commonwealth Care Alliance	11,770	82%
Tufts Health Public Plans	2,560	18%
Total	14,330	100%

SECTION 2. CONTRIBUTORS

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. Her most recent experience was as director of Quality Management at a Chronic Condition Special Needs Plan for individuals with end-stage renal disease. Ms. Eckhof has a Master of Science degree in health care administration.

PERFORMANCE MEASURE VALIDATION REVIEWER

Katharine Iskrant, MPH, CPHQ, CHCA

Ms. Iskrant is a member of the National Committee for Quality Assurance (NCQA) Audit Methodology Panel and has been a Certified Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Auditor since 1998 directing more than 600 HEDIS® audits. She directed the consultant team that developed the original NCQA Software Certification ProgramSM on behalf of NCQA. She is a frequent speaker at HEDIS® vendor and health plan conferences, such as National Alliance of State Health CO-OPs (NASHCO) conferences. Ms. Iskrant 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.

COMPLIANCE VALIDATION REVIEWERS

Jennifer Lenz, MPH, CHCA

Ms. Lenz has more than 17 years of 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 prior 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, Ohio, Utah, and West Virginia. Ms. Lenz is a Certified Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Auditor through the National Committee for Quality Assurance (NCQA). She received her Master of Public Health in Health Administration and Policy from the University of Arizona.

Lois Heffernan, RN, BSN, MBA

Ms. Heffernan has 20 years of experience in the healthcare industry, with expertise in quality-related activities, including quality project management, development and implementation of provider and enrollee quality initiatives, and driving compliance with regulatory, contractual, and accreditation requirements. Her prior experience includes direct management of the development of quality improvement programs, accreditation activities, data analysis and initiative development and implementation, provider credentialing, and quality of care issue resolution within managed care organizations. She has conducted compliance review activities in the states of Virginia and Ohio. Ms. Heffernan received both her Bachelor of Science and her Master of Business Administration from the Ohio State University.

Teresa Huysman, RN, BSN

Ms. Huysman has more than 30 years of experience in the healthcare industry, with expertise in clinical care and healthcare compliance. Her prior experience includes Medicaid managed care responsibility for corporate compliance, ensuring compliance with regulatory and contractual requirements, including oversight and management of a Corporate Integrity Agreement (CIA) entered into with the Office of Inspector General (OIG). She additionally has expertise in managed care clinical appeals, case management, quality improvement, including HEDIS) oversight, and utilization management review. She has managed and/or conducted compliance review activities across health plans in the states of Kentucky, Georgia, Indiana, Michigan, Ohio, and Utah. Ms. Huysman has been certified in Healthcare Compliance (CHC) by the Compliance Certification Board (CCB) and received her Bachelor of Science Degree from Miami University of Ohio.

PERFORMANCE IMPROVEMENT PROJECT REVIEWERS

Marietta Scholten, MD, FAAFP

Dr. Marietta Scholten is a Board-Certified Family Medicine physician who has practiced for 27 years in Vermont, initially in private practice, then founding the Mylan Family Health Center which provides medical and occupational care for its employees and dependents. For the past seven years, she has practiced at the University of Vermont Medical Center where she is also an Assistant Clinical Professor.

Dr. Scholten was the Medical Director for the Vermont Chronic Care Initiative for seven years working with the 5% of Medicaid beneficiaries costing 40% of the Medicaid budget. She was responsible for creating targeted interventions to improve the health of beneficiaries, coordinate their care, and reduce costs. She has been the Hospice Medical Director for Franklin County Home Health and Hospice providing oversight of medical services and community education for the past 26 years.

In addition, Dr. Scholten is a Board Member of Northwestern Medical Center where she is currently Chair of the Quality and Safety Committee and is a member of the Ethics and Compliance Committees.

Wayne J. Stelk, Ph.D.

Wayne J. Stelk, Ph.D., is a psychologist with over 40 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.

During his 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 intervention and treatment practices; designing systems for the measurement of treatment outcomes; and developing data-collections systems for quality metrics that are used to improve provider accountability.

SECTION 3. EXECUTIVE SUMMARY



INTRODUCTION

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 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 entity or its contractors furnish to Medicaid recipients. In Massachusetts, KEPRO has entered into an agreement with the Commonwealth to perform EQR services to its contracted managed care entities, i.e., managed care organizations, integrated care organizations (effective September 30, 2016), prepaid inpatient health plans, primary care case management plans, and senior care organizations.

The EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services. 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 MassHealth Integrated Care Organizations in the CY 2017 review cycle:

1. Validation of one performance measure, including an information systems capabilities analysis;
2. The validation of two Performance Improvement Projects (PIPs); and
3. Validation of compliance with federal Medicaid managed care regulations and applicable elements of the three-way contract between EOHHS, CMS, and the One Care Plan.

To clarify reporting periods, EQR Technical Reports that have been produced in calendar year 2017 reflect 2016 quality performance. References to HEDIS® 2017 performance reflect data collected in 2016.

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ANALYSIS

The Performance Measure validation process assesses the accuracy of performance measures reported by the managed care entity. It determines the extent to which the managed care entity follows state specifications and reporting requirements.

In 2016, KEPRO conducted Performance Measure Validation in accordance with CMS Protocol #2 on the HEDIS measure, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). Both One Care plans followed HEDIS specifications and reporting requirements and produced valid measures.

The focus of the Information Systems Capability Analysis is on components of each plan's 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 verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate.

Both MassHealth One Care plans demonstrated compliance with these requirements.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

MassHealth One Care plans are required to conduct two Performance Improvement Projects annually. Each plan was required to conduct two Performance Improvement Projects as specified in Appendix E of the three-way contract between CMS, EOHHS, and the plan.

KEPRO evaluates each Performance Improvement Project (PIP) to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. The KEPRO technical reviewer assesses project methodology. The Medical Director evaluates the clinical soundness of the interventions. The review considers the 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 the One Care 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. Recommendations made were plan-specific.

COMPLIANCE VALIDATION

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 are in compliance 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. Commonwealth Care Alliance received an overall score of 90.39 percent. Tufts Health Public Plans' overall score was 94.46 percent. The plan 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.

SECTION 4. PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ANALYSES



INTRODUCTION

The Performance Measure Validation (PMV) process assesses the accuracy of performance measures reported by the managed care entity (MCE). It determines the extent to which the managed care entity 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. In Calendar Year 2017, KEPRO validated the HEDIS measure, Initiation and Engagement of Treatment.

The Performance Measure Validation process consists of a desk review of documentation submitted by the One Care plan. A site visit is conducted at plans that do not receive a formal HEDIS audit, but as both plans underwent a formal HEDIS audit, site visits were not required in 2017.

A list of the documentation submitted by One Care plans in support of Calendar Year 2017 Performance Measure Validation follows.

Exhibit 1: Documentation Submitted by One Care Plans

Document Reviewed	Purpose of KEPRO Review
HEDIS® 2017 Roadmap and attachments	Reviewed to assess health plan systems and processes related to performance measure production.
HEDIS 2017 Final Audit Report	Reviewed to note if there were any underlying process issues related to HEDIS® measure production that were documented in the Final Audit Report.
2017 HEDIS® Interactive Data Submission System (IDSS) and previous two years IDSS, as available	Used to compile final rates for comparison to prior years' performance and industry standard benchmarks.
Follow-up documentation as requested by the reviewer	Plan-specific documentation requested to obtain missing or incomplete information, support and validate plan processes, and verify the completeness and accuracy of information provided in the Roadmap, onsite interviews, and systems demonstrations.

COMPARATIVE ANALYSIS

In 2016, KEPRO conducted Performance Measure Validation on the HEDIS measure, Initiation and Engagement in Alcohol and Other Drug Treatment.

The tables that follow contain the criteria through which performance measures are validated as well as KEPRO's determination as to whether the One Care plan met these criteria. KEPRO uses the following ratings for performance measurement review elements:

- **Met:** The plan correctly and consistently evidenced review element;
- **Partially met:** The plan partially or inconsistently evidenced review element;
- **Not met:** The plan did not evidence review element or incorrectly evidenced review element; and
- **N/A:** Review element is not applicable

Performance Measure Validation: Initiation and Engagement of AOD Dependence Treatment (IET)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid
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Review Element	CCA	THPP
DENOMINATOR		
<u>Population</u>		
The One Care population was appropriately segregated from other product lines.	Met	Met
Members were 13 years or older as of the December 31 of the measurement year. Two age stratifications (13 through 17 years and 18 years and older) and a total rate were reported.	Met	Met
All members have medical and chemical dependency benefits.	Met	Met
Continuous enrollment was 60 days prior to the index episode start date through 44 days after the index episode start date (105 total days).	Met	Met
<u>Geographic Area</u>		
Includes only those Medicaid enrollees served in the OneCare's reporting area.	Met	Met
NUMERATORS		
<u>Administrative Data: Counting Clinical Events</u>		
For Initiation of AOD Treatment, the index episode was correctly identified.	Met	Met
Data sources used to calculate the numerators (e.g., claims files, medical records, 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	Met
For Engagement of AOD, there was identification of Initiation of AOD Treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). Multiple engagement visits may have occurred on the same day, but they must be with different providers in order to be counted.	Met	Met
<u>Data Quality</u>		
Based on the IS assessment findings, the data sources used were accurate.	Met	Met

Review Element	CCA	THPP
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
<i>Proper Exclusion Methodology in Administrative Data (if no exclusions were taken, mark as N/A)</i>		
Index episodes that include detoxification codes (including inpatient detoxification) were not counted as being initiation of treatment.	Met	Met
The denominator excluded members whose initiation encounter was an inpatient stay with a discharge date after December 1 of the measurement year.	Met	Met

Performance Measure Sampling Validation

Review Element	CCA	THPP
<i>The One Care plan followed the specified sampling method to produce an unbiased sample representative of the entire at-risk population.</i>		
Each relevant member or provider had an equal chance of being selected; there were no systematic exclusions from the sample.	NA	NA
The One Care plan followed the specifications set forth in the performance measure (PM) regarding the treatment of sample exclusions and replacements, and if any activity took place involving replacements or exclusions, the plan has adequate documentation of that activity.	NA	NA
Each provider serving a given number of enrollees had the same probability of being selected as any other provider serving the same number of enrollees.	NA	NA
The One Care plan examined its samples files for bias, and if any bias was detected, the plan has documentation describing efforts taken to correct for that bias.	NA	NA
The sampling methodology treated all measures independently, and there is no correlation between drawn samples.	NA	NA
Relevant members or providers who were not included in the sample for the baseline measurement had the same chance of being selected for the follow-up measurement as those included in the baseline.	NA	NA
<i>The One Care plan maintains its performance measurement population files / datasets in a manner allowing a sample to be re-drawn, or used as a source for replacement.</i>		
The One Care plan has policies and procedures to maintain files from which samples are drawn in order to keep the population intact in the event that a sample must be re-drawn, or replacements made, and documentation that the original population is intact.	NA	NA
<i>Sample sizes collected conform to the methodology set forth in PM specifications, and the sample is representative of the entire population.</i>		
Samples sizes met the requirements of PM specifications.	NA	NA
The One Care plan appropriately handles the documentation and reporting of the measure if the requested sample size exceeds the population size.	NA	NA
The One Care plan properly over-sampled in order to accommodate potential exclusions.	NA	NA
<i>For PMs that include medical record review, the One Care plan followed proper substitution methodology.</i>		

Review Element	CCA	THPP
Substitution applied only to those members who met the exclusion criteria specified in PM definitions or requirements.	NA	NA
The One Care plan made substitutions for properly excluded records and documented the percentage of substituted records.	NA	NA

Performance Measure Denominator Validation

Review Element	CCA	THPP
<i>The One Care plan included all members of the relevant populations identified in PM specifications in the population from which each denominator was produced.</i>		
The One Care plan included in the initial populations from which the final denominators were produced all members eligible to receive the specified services. This at-risk population included both members who received the services, as well as those who did not receive the services. The same standard applied to provider groups or other relevant populations identified in the specifications of each PM.	Met	Met
<i>Adequate programming logic or source code appropriately identified all relevant members of the specified denominator populations.</i>		
For each PM, The One Care plan appropriately applied according to specifications programming logic or source code identifying, tracking, and linking member enrollment within and across product lines, by age and sex, as well as through any periods of enrollment and disenrollment.	Met	Met
The One Care plan correctly carried out and applied to each applicable PM calculations of continuous enrollment criteria.	Met	Met
The One Care plan used proper mathematic operations to determine patient age or range.	Met	Met
The One Care plan can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate PM denominators, and the plan can explain what classification it carried out if neither of the required codes were present.	Met	Met
<i>The One Care plan correctly calculated member months and member years.</i>		
For each applicable PM, the One Care plan correctly calculated member months and member years.	Met	Met
<i>Codes used to identify medical events were complete and accurate, and the One Care plan appropriately applied those codes.</i>		
The One Care plan properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and appropriately identified and applied these codes as specified by each PM.	Met	Met
<i>The One Care plan followed specified time parameters.</i>		
The One Care plan followed any time parameters required by PM specifications; examples include cutoff dates for data collection, or counting 30 calendar days after discharge from a hospital.	Met	Met
<i>The One Care plan followed exclusion criteria in PM specifications</i>		
The One Care plan followed PM specifications or definitions that excluded members from a denominator. For example, if a PM relates to a specific service, the denominator may have required adjustment to reflect any instances in which the patient refuses the service of the service is contraindicated.	Met	Met

Performance Measure Numerator Validation

Review Element	CCA	THPP
<i>The One Care plan used all appropriate data to identify the entire at-risk population.</i>		
The One Care plan used appropriate data, including linked data from separate datasets, to identify the entire at-risk population.	Met	Met
The One Care plan utilized procedures to capture data for those performance indicators that could easily be underreported due to the availability of services outside of the plan.	Met	Met
<i>The One Care plan properly identified qualifying medical events, such as diagnoses, procedures, and prescriptions, and confirmed those events for inclusion in terms of time and services.</i>		
The One Care plan's use of codes to identify medical events was complete, accurate, and specific in correctly describing what had transpired and when.	Met	Met
The One Care plan correctly evaluated medical event codes when classifying members for inclusion in or exclusion from the numerator.	Met	Met
The One Care plan avoided or eliminated all double-counted members or numerator events.	Met	Met
The One Care plan adhered to any parameters required by PM specifications (i.e., the measure event occurred during the time period that the PM specified or defined).	Met	Met
The One Care plan made substitutions for properly excluded records and documented the percentage of substituted records.	Met	Met
<i>The One Care plan properly collected medical record data extracted for inclusion in the numerator.</i>		
The One Care plan carried out medical record reviews and abstractions in a manner that facilitated the collection of complete, accurate, and valid data.	NA	NA
Record review staff were properly trained and supervised for the task.	NA	NA
Record abstraction tools required the appropriate notation that the measure event occurred.	NA	NA
Record abstraction tools required notation of the results or findings of the measured event, as applicable.	NA	NA
Data in the record extract files were consistent with data in the medical records as evidenced by a review of a sample of medical records for applicable PMs.	NA	NA
The process of integrating administrative and medical record data for the purpose of determining the numerator was consistent and valid.	NA	NA

Data and Processes to Calculate and Report Performance Measures

Review Element	CCA	THPP
<i>The One Care plan has measurement plans and policies stipulating and enforcing documentation of data requirements, issues, validation efforts, and results.</i>		
The One Care plan documented data file and field definitions for each PM.	Met	Met

Review Element	CCA	THPP
The One Care plan documented maps to standard coding if not used in the original data collection.	Met	Met
The One Care plan conducted statistical testing of results and made any correction or adjustments after processing.	Met	Met
<i>The One Care plan has complete documentation of programming specifications (either as a schematic diagram or in narrative form) for each PM.</i>		
The One Care plan documented all data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data, if applicable.	Met	Met
The One Care plan documented detailed medical record review methods and practices, including the qualifications of record review supervisors and staff persons; training materials; tools, including completed copies of each record-level reviewer determination; all case-level critical PM data elements to determine either a positive or negative event, or exclusion; and inter-rater reliability testing procedures and results.	Met	Met
The One Care plan documented detailed computer queries, programming logic, or source code to identify the population or sample for the denominator and/or numerator.	Met	Met
If the One Care plan employed sampling, it documented sampling techniques, and documentation that assures the reviewer that it chose samples for PM baseline and repeat measurements that used the same sampling frame and methodology.	Met	Met
The One Care plan documented calculations for changes in performance from previous periods, as applicable, including tests of statistical significance.	Met	Met
Data that are related from measure to measure, such as membership counts, provider totals, or number of pregnancies and births, are consistent.	Met	Met
The One Care plan uses appropriate statistical functions to determine confidence intervals when it uses sampling.	NA	NA
When determining improvement in performance between measurement periods, the One Care plan applies appropriate statistical methodology to determine levels of significance of changes.	Met	Met

Data Integration and Control

Review Element	CCA	THPP
<i>The One Care plan has in place processes to ensure the accuracy of data transfers to assigned PM repository.</i>		
The One Care plan accurately and completely processes transfer data from transaction files, such as members, provider, and encounter/claims, into the repository used to keep the data until the calculations of the PMs have been completed and validated.	Met	Met
<i>The One Care plan has in place processes to ensure the accuracy of file consolidations, extracts, and derivations.</i>		
The One Care plan's processes to consolidate diversified files, and to extract required information from the PM repository, are appropriate.	Met	Met
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the PM database.	Met	Met
Computer program reports or documentation reflect vendor coordination activities, and no data necessary to PM reporting are lost or inappropriately modified during transfer.	Met	Met
<i>The structure and format of the One Care plan's PM data repository facilitates any required programming necessary to calculate required PMs.</i>		
The repository's design, program flow charts, and source codes enable analyses and reporting.	Met	Met
The One Care plan employs proper linkage mechanisms to join data from all necessary sources; for example, identifying a member with a given disease/condition.	Met	Met
<i>The One Care plan effectively manages report production and reporting software.</i>		
The One Care plan follows prescribed cutoff dates.	Met	Met
The One Care plan retains copies of files or databases for PM reporting in the case that it must reproduce results.	Met	Met
The One Care plan properly documented reporting software program with respect to every aspect of the PM reporting repository, including building, maintaining, managing, testing, and report production.	Met	Met
The One Care plan's processes and documentation comply with its standards associated with reporting program specifications, code review, and testing.	Met	Met
<i>The One Care plan followed specified time parameters.</i>		
The One Care plan followed any time parameters required by PM specifications, such as cutoff dates for data collection or counting 30 calendar days after discharge from a hospital.	Met	Met
<i>The One Care plan followed exclusion criteria included in PM specifications.</i>		
The One Care plan follows PM specifications of definitions that exclude eligible members from a denominator. For example, if a measure relates to a select age group, the denominator may need to be adjusted to reflect only those members within that age group.	Met	Met

RESULTS

The chart that follows depicts Initiation and Engagement for Alcohol and Other Drug Treatment rates for both of MassHealth's One Care plans. No plan's performance exceeded the NCQA National Medicaid Quality Compass 90th percentile. The weighted average Initiation rate was 43.97 percent and the weighted average Engagement rate was 13.26 percent. Tufts Health Public Plan's performance exceeded CCA's on both measures.

Tufts Health Public Plans' IET Initiation rate increased a statistically significant 7.92 percentage points between HEDIS 2016 and HEDIS 2017. The Engagement rate increased a statistically insignificant 2.47 percentage points. The performance trend line for both measures is moving up.

CCA's IET Initiation rate decreased a statistically insignificant 0.29 percentage points between HEDIS 2016 and HEDIS 2017. Its engagement rate increased 1.48 percentage points, also statistically insignificant. Performance is trending up for the Engagement rate and is level for the Initiation rate.

Exhibit 2: 2017 IET Initiation Rates for MassHealth One Care Plans

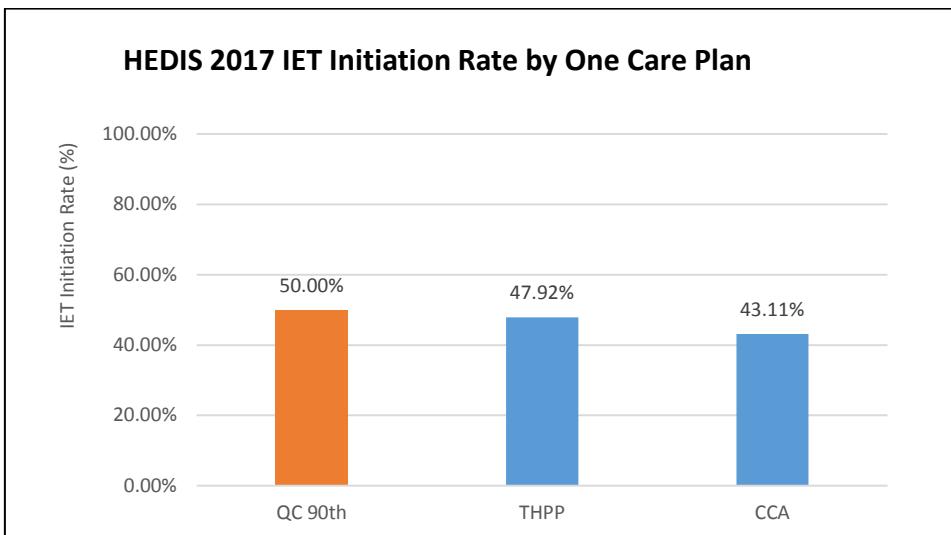
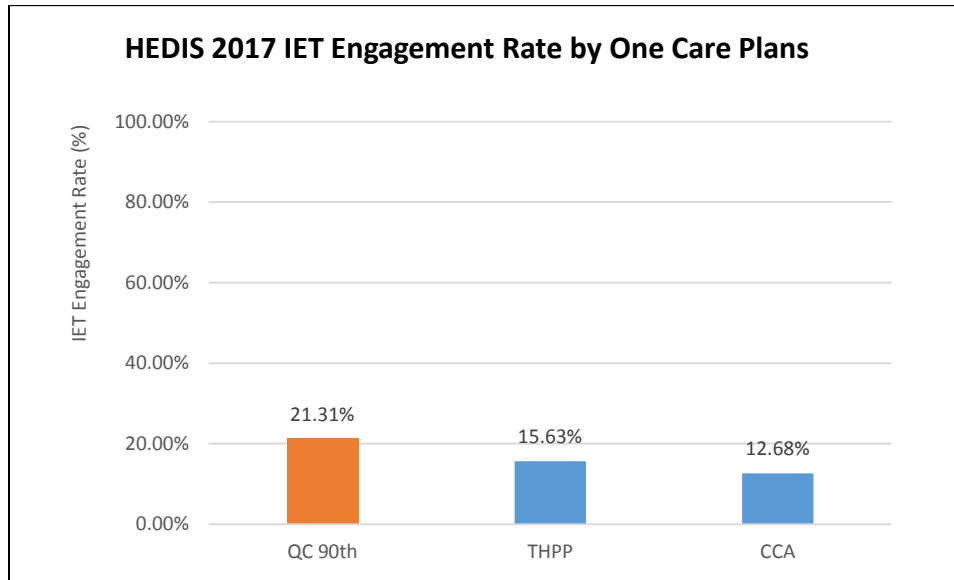


Exhibit 3: 2017 IET Engagement Rates for MassHealth One Care Plans



The tables that follow depict trended IET performance.

Exhibit 4: Trended IET Initiation Data for MassHealth One Care Plans

		HEDIS 2015	HEDIS 2016	HEDIS 2017	Trend Line	Percentile Ranking
IET Initiation	HEDIS 90 th			50.00%		
	CCA	43.80%	43.40%	43.11%	↔	50th – 66th
	THPP	32.81%	40.00%	47.92%	↑	75th – 90th

Exhibit 5: Trended IET Engagement Data for MassHealth One Care Plans

		HEDIS 2015	HEDIS 2016	HEDIS 2017	Trend Line	Percentile Ranking
IET Engagement	HEDIS 90 th			21.31%		
	CCA	7.1%	11.20%	12.68%	↑	50th - 66th
	THPP	9.38%	13.16%	15.63%	↑	66th – 75th

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

CMS regulations require that each managed care entity also undergo an annual Information Systems Capability Assessment. The focus of the review is on components of One Care 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 verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate. The findings of this assessment follow:

Exhibit 6: Information Systems Capability Assessment Findings

	CCA	THPP
Adequate documentation; data integration, data control and performance measure development	Acceptable	Acceptable
Claims systems and process adequacy; no non-standard forms used for claims	Acceptable	Acceptable
All primary and secondary coding schemes captured	Acceptable	Acceptable
Appropriate membership and enrollment file processing	Acceptable	Acceptable
Appropriate appeals data systems and accurate classification of appeal types and appeal reasons	Acceptable	Acceptable
Adequate call center systems and processes	Acceptable	Acceptable
Required measures received a "Reportable" designation	Acceptable	Acceptable

RECOMMENDATIONS

KEPRO's only recommendation is that CCA and Tufts continue efforts underway to improve rates of initiation and engagement and that Tufts continue efforts underway.

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION AND INFORMATION SYSTEM CAPABILITIES ANALYSES

COMMONWEALTH CARE ALLIANCE (CCA)

Performance Measure Results

The charts that follow depict Commonwealth Care Alliance's performance in the measure selected by MassHealth for validation, Initiation and Engagement in Alcohol and Other Drug Treatment. The NCQA Medicaid Quality Compass 90th percentile is included for comparison purposes. CCA's IET Initiation rate decreased a statistically insignificant 0.29 percentage points between HEDIS 2016 and HEDIS 2017. Its engagement rate increased 1.48 percentage points, also not statistically significant. Performance is trending up for the Engagement rate and is level for the Initiation rate.

Exhibit 7: CCA IET Initiation Performance Rate

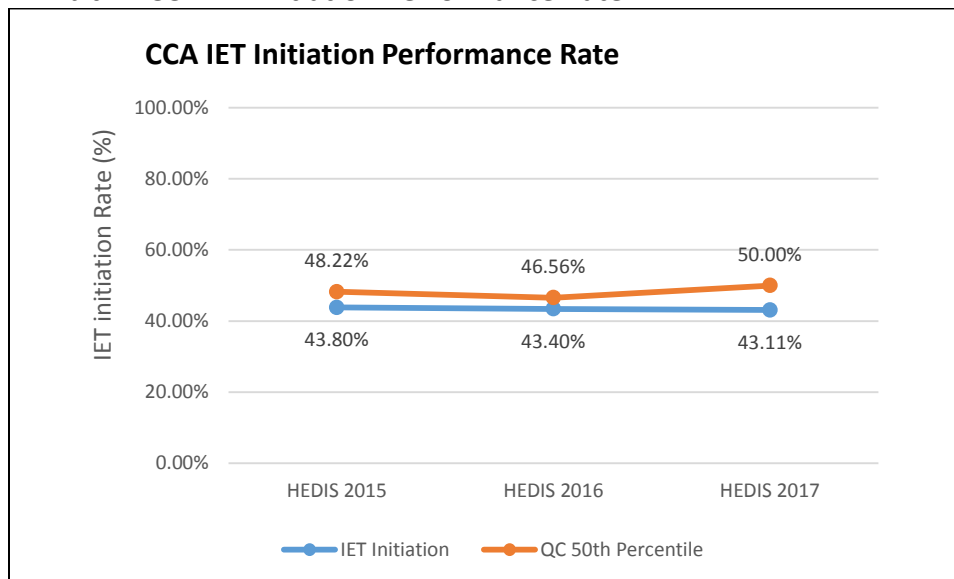
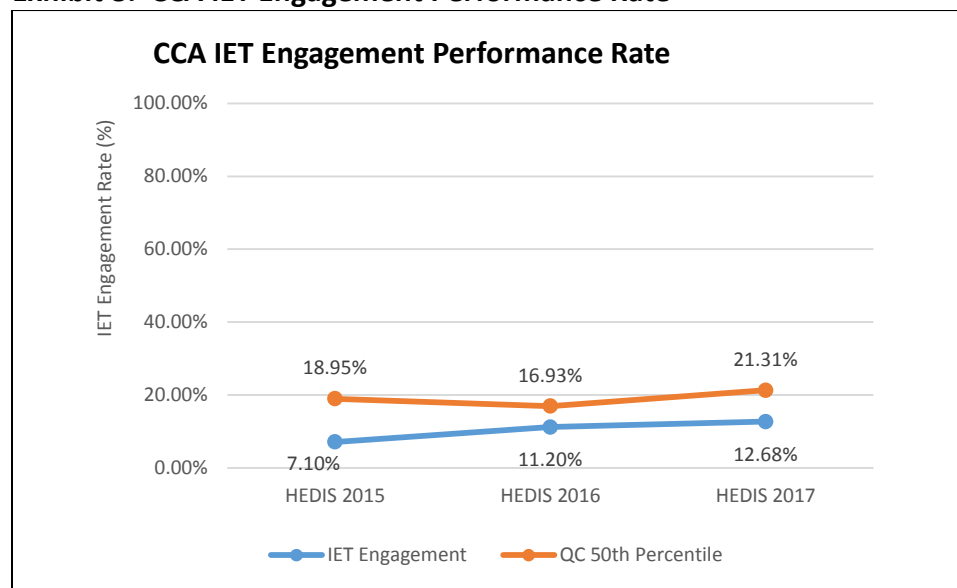


Exhibit 8: CCA IET Engagement Performance Rate



Information Systems Capability Analysis

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of CCA's information system that contribute to performance measure production.

- 1. Claims and Encounter Data.** Claims, including lab claims, were processed by a vendor, PCG, using the EZ Cap system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. PCG demonstrated adequate monitoring of data quality and CCA maintained adequate oversight of PCG. CCA had adequate processes to monitor claims data completeness, including comparing actual to expected volumes to ensure all claims and encounters were submitted. CCA's pharmacy benefits manager, Navitus Health Solutions, fully met standards in the processing of pharmacy data for the plan. There were no issues identified with claims or encounter data processing.
- 2. Enrollment Data.** CCA enrollment data is housed in the Market Prominence system. All necessary enrollment fields are captured for HEDIS reporting. Prospective members were enrolled by the MassHealth enrollment vendor. Enrollment data were transmitted to the plan daily in electronic 834 format. The 834 data was uploaded first into the Talend system for quality-checking and then into Market Prominence. Eligibility was verified with both MassHealth and CMS. CCA had adequate processes for data quality-monitoring and reconciliation. The plan had processes to combine data for members with multiple identification numbers. There were no issues identified with enrollment processes.
- 3. Medical Record Review.** The One Care performance measure, IET, was not calculated using medical record data. Therefore, this review is not applicable.

4. **Supplemental Data.** CCA's eClinicalworks electronic medical record supplemental data source did not contribute to the plan's performance measure rates for IET. Therefore, this section is not applicable.
5. **Data Integration.** CCA's IET performance measure was produced using Inovalon software. Data transfers to the Inovalon repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. CCA maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.
6. **Source Code.** CCA used NCQA-certified Inovalon HEDIS software to produce performance measures. Inovalon received NCQA measure certification to produce the performance measure under the scope of this review: IET. There were no source code issues identified.

Based on this Information Systems Capability Analysis, no issues were identified for any of these data categories for CCA.

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Advent Advisory Group, which performed a HEDIS® Compliance Audit on Commonwealth Care Alliance, the results of which were distributed on June 15, 2017.

Table 9: CCA HEDIS Audit Results

Audit Element	Findings
Medical data	CCA met requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Practitioner data	Practitioner data related to performance measure production is adequate to support reporting.
Medical record review	Not applicable to EQR performance measure reporting for the IET measure.
Supplemental Data	No supplemental data used for the EQR performance measure: IET.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Update on 2016 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2016 to CCA follows.

Calendar Year 2016 Recommendation	2017 Update
Consider developing quality improvement initiatives to improve rates of initiation and engagement.	CCA focused continued attention on deploying CCA behavioral health clinicians to provide timely visits to members with newly diagnosed of recurrent drug or alcohol dependence. CCA implemented a plan to capture qualifying treatment encounters documented in the electronic record but not picked up in claims data by creating a supplemental data set. This data set was approved by the HEDIS auditor.

Plan Strengths

- CCA used an NCQA-certified vendor, Inovalon, for the production of HEDIS measures.
- Thorough documentation was supplied for performance measure validation.
- Both IET rates rank above the 50th percentile when compared to the NCQA National Medicaid Quality Compass.

Opportunities

- KEPRO suggests that CCA monitor the IET measure rates year-round with prospective HEDIS 2018 data to maximize measure intervention opportunities.

Recommendations

- Consider developing quality improvement initiatives to improve rates of initiation and engagement.

TUFTS HEALTH PUBLIC PLANS (THPP)

Performance Measure Results

The charts below depict Tufts Health Public Plans' performance in the IET measure. The NCQA Medicaid Quality Compass 90th percentile is included for comparison purposes. Tufts Health Public Plans' IET Initiation rate increased a statistically significant 7.92 percentage points between HEDIS 2016 and HEDIS 2017. The Engagement rate increased a statistically insignificant 2.47 percentage points. The performance trend line for both measures is moving up.

Exhibit 10: THPP IET Initiation Performance Rate

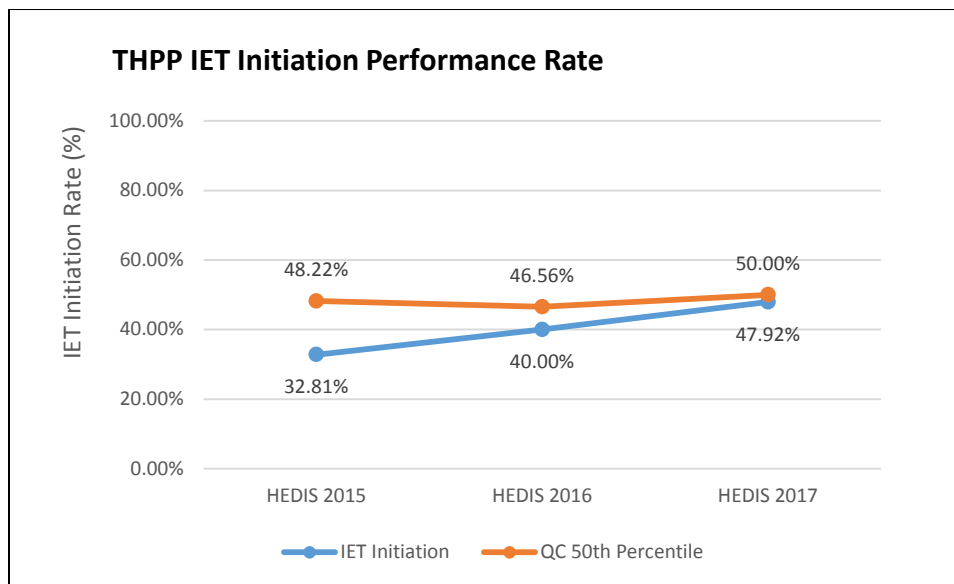
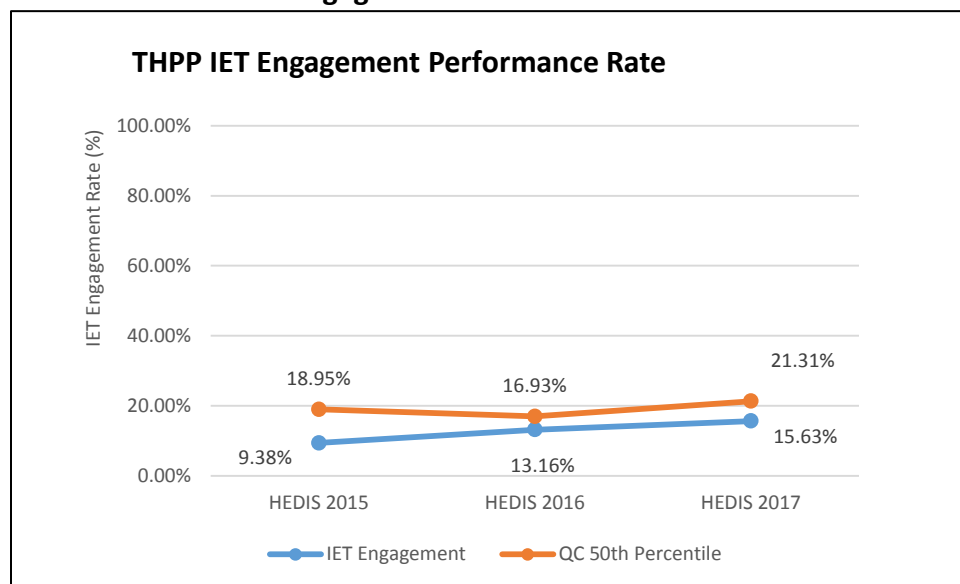


Exhibit 11: THPP IET Engagement Performance Rate



Information System Capability Analysis

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of Tufts Health Public Plans' information system that contribute to performance measure production.

- 1. Claims and Encounter Data.** THPP processed claims during 2016, including lab and behavioral health claims, using the Monument Xpress system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Most claims were submitted electronically to THPP and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. THPP had robust claims editing and coding review processes. THPP processed all claims within Monument Xpress except for pharmacy claims which were handled by THPP's pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.
- 2. Enrollment Data.** Member enrollment data in an 834 format were received daily from EOHHS and processed by THPP. The daily file included additions, changes, and terminations. Enrollment data were loaded into THPP's Monument Xpress system. The Monument Xpress system captured all necessary enrollment fields for HEDIS reporting. THPP also received a full monthly refresh file and conducted reconciliation between Monument Xpress and the file from EOHHS. Monument Xpress retained Medicaid identification (ID) numbers and THPP assigned a unique Monument Xpress system ID. THPP could appropriately distinguish One Care members from MCO members within Monument Xpress. THPP had adequate data

quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

3. **Medical Record Review.** The IET performance measure was not calculated using medical record data. Therefore, this section is not applicable.
4. **Supplemental Data.** THPP's supplemental data sources did not contribute to the IET performance measure rate. Therefore, this section is not applicable.
5. **Data Integration.** THPP's IET measure rate was produced using GDIT software. Data from the transaction system were loaded to THPP's data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into GDIT-compliant extracts and loaded into the measure production software. THPP had adequate processes to track completeness and accuracy of data at each transfer point. HEDIS measure report production was managed effectively. The GDIT software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. THPP maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.
6. **Source Code.** THPP used NCQA-certified GDIT HEDIS software to produce performance measures. GDIT received NCQA measure certification to produce the performance measure under the scope of this review. There were no source code issues identified.

Based on this Information Systems Capability Analysis, no issues were identified for any of these data categories for THPP.

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Tufts Health Public Plans, the results of which were distributed on June 15, 2017:

Audit Element	Findings
Medical data	THPP met all requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Practitioner data	Practitioner data related to performance measure production was adequate to support reporting.
Medical record review	Medical record review was not applicable to performance measure reporting.
Supplemental Data	THPP had many supplemental databases, including electronic medical record feeds.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Follow Up to Calendar Year 2016 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on 2016 PMV recommendation follows:

Calendar Year 2016 Recommendation	2017 Status
Consider developing quality improvement initiatives to improve rates of initiation and engagement.	Tufts Health Public Plans uses its Care Management Model to address the needs of members with substance use conditions. The initial psychosocial assessment is conducted by a licensed Behavioral Health Case Manager and includes questions on substance use. The care manager works with the member to evaluate at what stage the member is in his/her readiness for treatment, e.g., contemplation or action. Care managers with members on care plans that address substance abuse conditions may refer the members to substance abuse treatment. The care managers also maintain ongoing collaboration with substance abuse treatment providers as permitted by the member as part of the care plan. Tufts Health Public Plans also has a substance abuse coordinator available to speak with members, other case managers, and families about substance abuse treatment options. Additionally, the health plan has developed relationships with facilities that provide substance abuse treatment to help facilitate care.

Plan Strengths

Tufts Health Public Plans used an NCQA-certified vendor to produce its performance measures.

- THPP had an adequate number of staff members with subject matter expertise to manage and report valid performance measure rates.
- Both IET rates ranked above the 50th percentile in comparison to the NCQA National Medicaid Quality Compass.

Opportunities

- No opportunities were identified.

Recommendations:

- Continue developing quality improvement initiatives to improve rates of initiation and engagement.

SECTION 5. PERFORMANCE IMPROVEMENT PROJECT VALIDATION



INTRODUCTION

KEPRO evaluates each Performance Improvement Project (PIP) to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. It also determines whether the projects have achieved or likely will achieve favorable results.

The PIP review is a four-step process:

1. *PIP Questionnaire.* The managed care entity submits a completed questionnaire for each PIP. This questionnaire requests a project goal, a description of associated interventions; and a description of the performance measures being used to assess the effectiveness of these interventions. The plan describes the effectiveness of its interventions, its results, and next steps.
2. *Desktop Review.* A desktop review is conducted for each PIP. The Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plan. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the project. The Medical Director's focus is on proposed or implemented clinical interventions.
3. *Conference with the Plan.* The Technical Reviewer and Medical Director meet telephonically with representatives of the plan to obtain clarification on identified issues as well as to offer recommendations for improvement. The plan is offered the opportunity to resubmit the PIP questionnaire within ten calendar days, although it is not required to do so.
4. *Final Report.* A PIP Verification Worksheet based on CMS EQR Protocol Number 3 is completed by the Technical Reviewer. KEPRO evaluates a plan's performance against a set of pre-determined criteria. In addition, the Medical Director documents his or her findings. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer 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 available points by the sum of all points received. This ratio is presented as a percentage. The findings of the Technical Reviewer and Medical Director are synthesized into a final report to KEPRO.

Appendix E of the three-way contract between CMS, EOHHHS, and the One Care organization lays out quality improvement project requirements. According to this document, One Care plans are expected to conduct projects from the following categories:

- 1) Emergency Department (ED) utilization, the goal being to better understand reasons for ED utilization among One Care Enrollees, and the impact of Long-Term Services and Supports (LTSS) to such usage.
- 2) IL-LTSS Coordinator, the goal being to better understand the use of IL-LTSS Coordinators by One Care Enrollees.
- 3) Barriers to Health Access, the goal being to better understand access issues experienced by One Care Enrollees.

In Calendar Year 2016, MassHealth Integrated Care Organizations conducted the following quality improvement projects:

- | | |
|----------------------------|--|
| Commonwealth Care Alliance | <ul style="list-style-type: none">• Improve the rate of cervical cancer screening• Increase Referrals and Improve Member Experience with Long Term Services Coordinators (LTSC) |
| Tufts Health Public Plans | <ul style="list-style-type: none">• Adherence with Diabetic Screening Measures• Reducing Emergency Department (ED) Utilization |

KEPRO evaluates each Performance Improvement Project (PIP) to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. It also determines whether the projects have achieved or likely will achieve favorable results.

Based on its review of the MassHealth One Care plans 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.

COMPARATIVE ANALYSIS

Two of the four performance improvement projects conducted by One Care plans in 2016 were considered to be baseline projects. CCA's cervical cancer project was considered to be a baseline report because of a change in the scope of the PIP in 2016, along with changes to the 2017 interventions and performance indicators. THPP's emergency department utilization PIP was evaluated as a baseline project because of the redesign of interventions and the change of measures to better align with those interventions.

Both THPP and CCA serve a challenging population and both have presented good population analyses which drill down into demographics and comorbidities. The presence of a behavioral health disorder is identified throughout the PIP reports as a key barrier to improvement. The One Care plans are challenged to design interventions that speaks to that barrier.

Because the topics of the four PIPs are so distinct, it is difficult to draw additional conclusions.

PLAN-SPECIFIC PERFORMANCE IMPROVEMENT PROJECTS

COMMONWEALTH CARE ALLIANCE: IMPROVING THE RATE OF CERVICAL CANCER SCREENING

Interventions

To increase member knowledge of the importance of cervical cancer screening:

- Improve reporting processes to timely identify women due for cervical cancer screening;
- Integrate education about cervical cancer screening into comprehensive assessments;
- Mail members information about the importance of cervical cancer screening; and
- Conduct telephonic outreach to members identified as being due for a screening.

To increase provider knowledge and skills:

- Standardize cervical cancer screening practices at all Commonwealth Community Care clinics;
- Develop a Standard of Practice for distribution to CCA clinicians;
- Integrate Pap test recommendations and resources into the annual women's health education series; and
- Development and distribution of reports identifying women due for cervical cancer screening.

To improve member access to screening, CCA will establish sessions at all Commonwealth Community Care Clinics at which members will be given an opportunity to receive cervical cancer screenings in a location that accommodates individuals with mobility challenges and provides additional time for visits as needed.

Results

Calendar Year 2016 represents a baseline year for this initiative. The baseline rate is 64%. CCA's goal is to increase its cervical cancer screening rate to 70% by Calendar Year 2020.

Performance Improvement Project Score

The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer 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 available points by the sum of all points received. This ratio is presented as a percentage. CCA received a score of 100% on its Cervical Cancer PIP.

Exhibit 12: CCA Cervical Cancer Screening PIP Scores

Results of Validation Ratings (for Y/N Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Intervention Parameters	3	3	3	100%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating Score (for Y/N Values)	7	7	7	100%

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Problem Statement	4	12	12	100%
Member Population Analysis	3	9	9	100%
Barriers & Root Cause Analyses	2	6	6	100%
Intervention Parameters	5	15	15	100%
Rationale for Performance Indicators	1	3	3	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	3	9	9	100%
Baseline Performance Rates	1	3	3	100%
Validation Rating Score (for 3, 2, or 1 Values)	20	60	60	100%

Overall Validation Rating Score	27	67	67	100%
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Plan and Project Strengths

- CCA has a well-defined scope and goals for this project.
- CCA is commended for comparing the health risks of its members to national rates for cervical cancer screening.
- CCA is commended for including members and providers as participants in its process for barrier and root cause analysis.

Opportunities

No opportunities of note were identified.

Recommendations

KEPRO has no recommendations of note to offer.

COMMONWEALTH CARE ALLIANCE: INCREASING REFERRALS AND IMPROVE MEMBER EXPERIENCE WITH LONG-TERM SERVICES COORDINATORS (LTSCs)

Interventions

- To increase the number of LTSC referrals for members whose primary language is neither English nor Spanish, a new consent form was designed and translated into multiple languages.
- A new referral process was developed to simplify workflows and reduce the amount of lost referrals sent by fax.
- CCA undertook a staff education program about LTSCs using multiple forums including the newsletter, the intranet, and in-person presentations.
- In June, 2016, the CCA Program Manager for LTSS initiated site visits to LTSC partners. LTSCs were given access to and trained on CCA's electronic medical record. The Director met with LTSC agency partners to check in on progress learning eCW and to build relationships. Visits were conducted in Summer 2016.
- CCA sends post cards to members who have been offered, but have not accepted, LTSC support.

Results

Based on KEPRO's review of the 2016 baseline report, CCA made changes to the PIP indicators and interventions in the 2017 EQR cycle. While CCA is commended for making improvements to its LTSC PIP methodology, the result of the 2017 changes is that the 2016 indicator rates (baseline) cannot be compared to the 2017 indicator rates (remeasurement 1). The 2017 indicator rates are now considered to be CCA's baseline.

Table 13: CCA Baseline Performance

Indicator	2017 Performance	CCA Goal
Members accepting an LTSC referral at their initial assessment	49	50
Members who did not have an LTSC who accepted an LTSC referral in response to outreach mailing	TBD	5%
Member understanding of LTSC role	N/A	N/A
LTSC meeting member needs	67	70
Member satisfaction with LTSC	88	80

Performance Improvement Project Score

The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer 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 available points by the sum of all points received. This ratio is presented as a percentage. CCA received a rating score of 89% on its LTSC PIP.

Exhibit 14: CCA's LTSC PIP Rating Score

Results of Validation Ratings (for Y/N Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Reassessing Intervention Parameters & Strategies	3	3	3	100%
Performance Indicator Data Collection*	3	3	3	100%
Validation Rating Score (for Y/N Values)	7	7	7	100%

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	15	100%
Reassessing Intervention Parameters & Strategies	4	12	8	67%
Performance Indicator Parameters	1	3	2	87%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	2.2	73%
Member Population Analysis	2	6	4	67%
Conclusions & Future PIP Improvements	3	9	9	100%
Validation Rating Score (for 3, 2, or 1 Values)	20	60	52.8	88%

Overall Validation Rating Score	20	60	52.8	89%
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Plan and Project Strengths

- CCA's capacity for data analysis appears to be robust.
- CCA is commended for exploring future options for including non-English speaking members in their member surveys.

Opportunities

CCA states that the member survey was only administered to English-speaking members. Considering that CCA's seeks to increase LTSC referrals for members who are non-English and non-Spanish speaking, KEPRO notes that an important segment of their member population (including Spanish-speaking) was omitted from their member survey.

Recommendations

KEPRO recommends that CCA check the grade-level of the LTSC Consent Form to ensure it meets the health literacy capabilities of its members.

TUFTS HEALTH PUBLIC PLANS: REDUCING EMERGENCY DEPARTMENT (ED) UTILIZATION

Note: During last year's 2016 EQR cycle, KEPRO asked this question to clarify the goal of this project: Did THPP intend to improve access to long-term services and supports or reduce emergency department utilization? In this 2017 PIP report, THPP has clearly aligned this project with the goal of reducing the rate of emergency department utilization. KEPRO evaluated this performance improvement project baseline project.as a

Interventions

- The member assessment was modified to include emergency department (ED) utilization risk factors; the plan of care now includes ED risk reduction activities.
- All care managers were provided ED claims data on their members based on a weekly report that included ED dates of service.

Results

THPP uses a variation of the HEDIS Emergency Department Utilization – Observed Visits to measure the success of its ED utilization project. Calendar Year 2016 performance, 1509 emergency department visits per thousand members, represents THPP's baseline rate. THPP's goal for the Calendar Year 2017 is 1358 visits per thousand members.

Performance Improvement Project Score

The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer 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 available points by the sum of all points received. This ratio is presented as a percentage. THPP received a rating score of 93% on its EDU PIP.

Table 15: THPP EDU PIP Rating Score

Summary Results of Validation Ratings (for Y/N values)	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Reassessing Intervention Parameters & Strategies	3	3	3	100%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating Score (for Y/N Values)	7	7	7	100%

Results of Validation Ratings (for 3, 2, or 1 values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	15	100%
Reassessing Intervention Parameters & Strategies	4	12	10	83%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	5	83%
Conclusions & Future PIP Improvements	3	9	7	78%
Validation Rating Score (for 3, 2, or 1 values)	20	60	55	92%

Overall Validation Rating Score	27	67	62	93%
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Plan and Project Strengths

- KEPRO commends THPP for its efforts to improve the methodology in this PIP based on feedback from KEPRO in 2016.
- THPP is commended for its efforts to improve the engagement of members defined as hard to engage and for the addition of care management staff.
- THPP is commended for its use of findings from the literature regarding the risk factors for its members. THPP is also commended for its population and survey analyses.
- THPP presented an excellent analysis of its 2016 member emergency department utilization data.

Opportunities

- Although THPP has identified behavioral health conditions as a significant barrier affecting as many as 90 percent of its members, THPP has not addressed these conditions in any of its intervention activities.
- KEPRO encourages THPP to design interventions with an explicit strategy of improving member engagement in care planning. Such a member-centric strategy could include interventions to improve healthcare self-management, symptom recognition, and access to providers and their services.

Recommendations

- KEPRO recommends that education be provided to care managers about how to utilize the risk information available to them to improve care management strategies.

- KEPRO recommends that THPP create interventions that work with hospitals that have high rates of ED utilization by its members.
- KEPRO recommends that THPP focus on members presenting highest risks for ED utilization. Having identified these higher-risk member groups, THPP staff should assess the root causes to explore why these groups are at higher-risk. THPP should develop intervention strategies that are informed by the population-based root cause analysis.
- KEPRO recommends that stakeholders, such as members and providers, be included in the process of barrier identification and root cause analysis.

TUFTS HEALTH PUBLIC PLANS: COMPLIANCE WITH DIABETIC SCREENING MEASURES

Interventions

- The diabetes-related member assessment and the associated automated care plans were amended to ensure standard care management practice. The care plan documentation system was revised to include additional problems, goals and interventions related to self-care strategies, including compliance with screens, access to primary care physicians and specialists. New care planning documentation supported evidence-based practices endorsed by the ADA.
- A new work flow was implemented in which the care manager is informed of gaps in care so that the care manager can conduct appropriate member outreach. The initial focus has been on increasing the rate of diabetic eye examinations which represent the greatest opportunity for improvement.
- Members with an HbA1C level of 8 or greater will be invited to enroll in a Diabetes Disease Management Program that includes telephonic outreach and coaching based on ADA guidelines and evidence-based practice protocols.

Results

Tufts Health Public Plans uses three of the HEDIS Comprehensive Diabetes Care indicators to measure the success of its diabetes-related interventions. The Dilated Eye Exam rate, 68.61 percent, increased a statistically insignificant 8.72 percent between HEDIS 2016 and HEDIS 2017. HEDIS 2017 performance is below the HEDIS 2015 baseline. The HbA1c Screening rate increased a statistically insignificant 3.62 percent between HEDIS 2016 and HEDIS 2017 and this rate, 91.97 percent, is slightly above the 91.91 percent baseline rate. The Nephropathy Screening rate has remained almost unchanged over three years. The HEDIS 2017 rate of 93.19 percent is a 0.05 percent decrease from the 93.66 percent HEDIS 2016 rate.

Exhibit 16: THPP's Dilated Eye Exam Performance

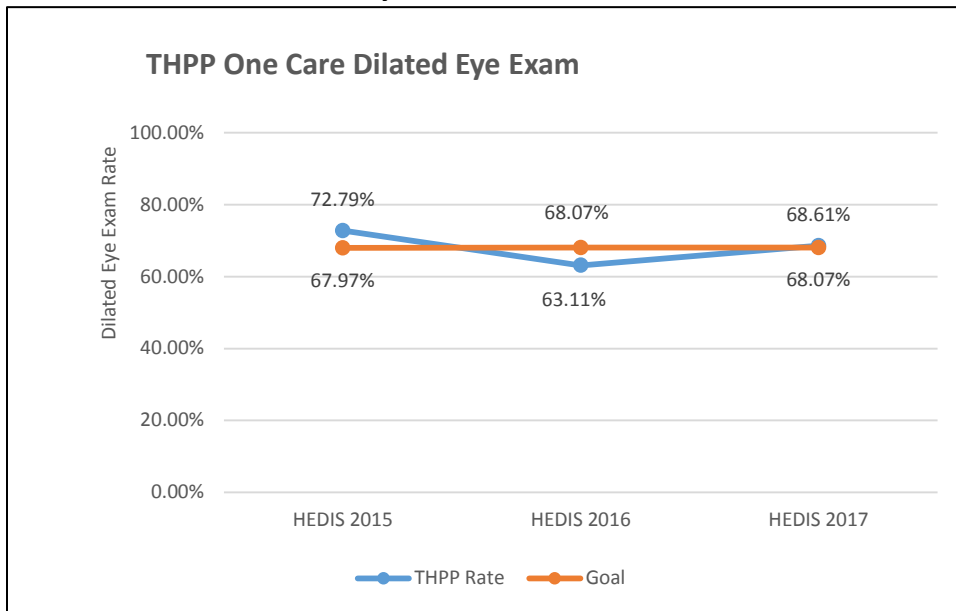


Exhibit 17: THPP's HbA1c Screening Performance

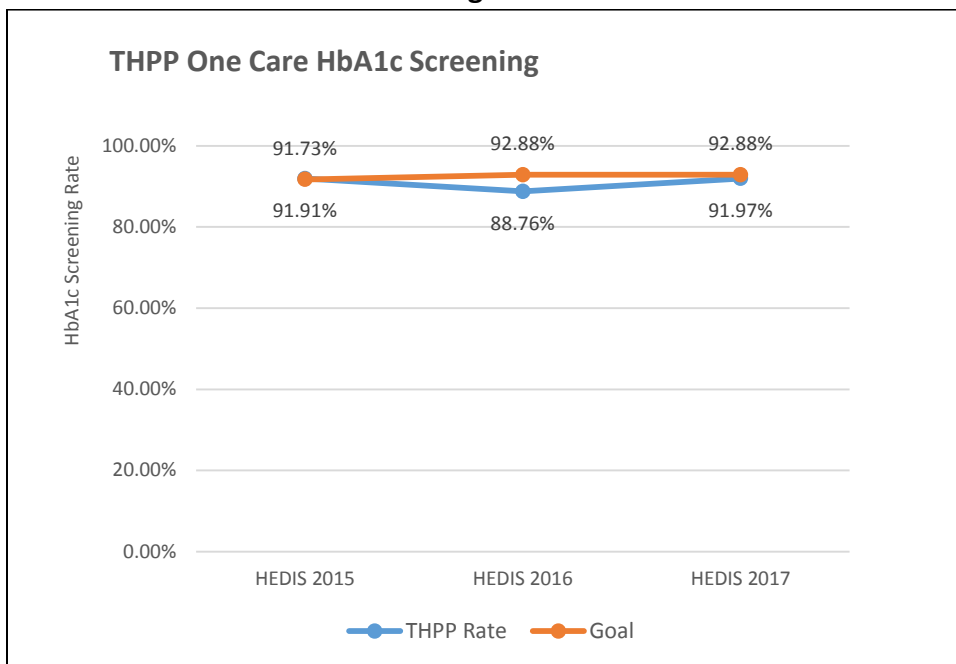
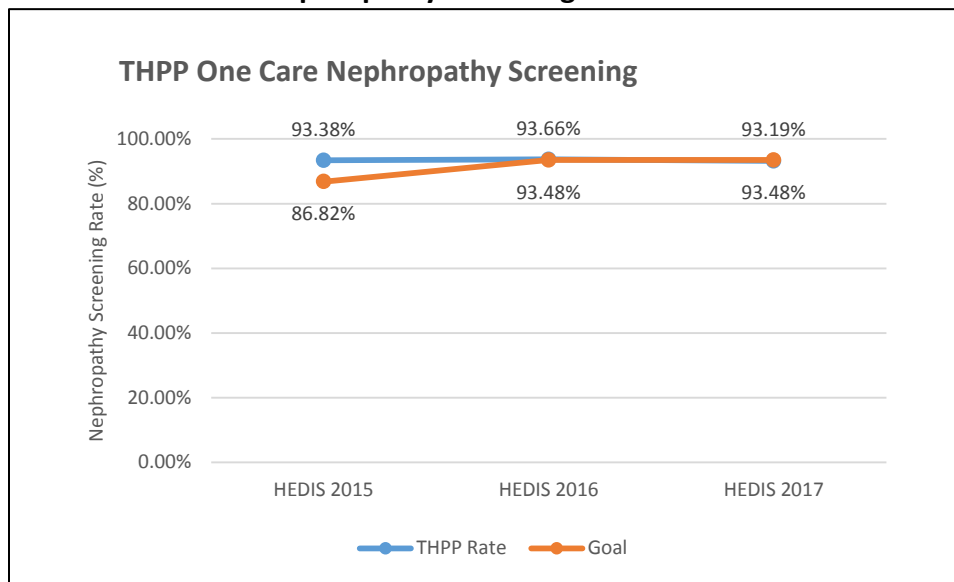


Exhibit 18: THPP's Nephropathy Screening Performance



Performance Improvement Project Rating Score

The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer 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 available points by the sum of all points received. This ratio is presented as a percentage. THPP receiving a rating score of 82% on its diabetes-related PIP.

Exhibit 19: THPP's Diabetes-Related PIP Rating Score

Results of Validation Ratings (for Y/N values)	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Reassessing Intervention Parameters & Strategies	3	3	1	33%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating Score for Y/N Values)	7	7	5	71%

Summary Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	4	12	10	83%
Reassessing Intervention Parameters & Strategies	4	12	4	33%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	6	100%
Conclusions & Future PIP Improvements	4	12	12	100%
Validation Rating Score (for 3, 2, or 1 Values)	20	60	50	83%

Overall Validation Rating Score	27	67	55	82%
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Project and Plan Strengths

- THPP is commended for the addition of care management resources in support of this PIP. THPP is further commended for its use of chart audits to identify gaps in screening services.
- KEPRO commends THPP for training the care management staff in motivational interviewing. This is a skill-set that is helpful to care management staff who are trying to engage members in services who might otherwise resist engagement.

Opportunities

- THPP alludes to the need for an intervention to address the barrier presented by the prevalence of behavioral health conditions, but none of the three interventions address these conditions.
- In addition to working toward continuous improvement in members' self-care management, THPP should also consider strategies to improve providers' support for members regarding timely diabetes screening tests. This is one of the barriers THPP identified in its barrier analysis. KEPRO endorses this as a barrier in need of THPP's attention.

Recommendations

KEPRO recommends that future brainstorming about barriers include representative members and providers, especially behavioral health providers that work closely with primary care practices.

- THPP presents an excellent population analysis that reports indicator rates that have been disaggregated by a number of categories, such as gender, age, race and clinical risk categories.
- KEPRO encourages THPP to improve its data collection related to intervention activities in order to assess the effectiveness of its interventions.

SECTION 6. 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 are in compliance with Federal quality standards mandated by the Balanced Budget Act of 1997 (BBA). This validation process is conducted triennially.

The 2017 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 One Care plan were assessed. Appropriate provisions in the Code of Massachusetts Regulations (CMR) were included in the reviews as indicated. The most stringent of the requirements were used to assess for compliance when State and Federal requirements differed.

One Care activity and services occurring for calendar year 2016 were subject to review.

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;
- Sub-contractual Relationships and Delegation;
- Quality Assessment and Performance Improvement Program;
- Credentialing;
- Confidentiality of Health Information;
- Health Information Systems; and
- Program Integrity.

Compliance review tools included detailed regulatory and contractual requirements in each standard area.

KEPRO communicated an overview of the compliance review activity and timeline to the One Care plans prior to the formal review period. Preferred dates for the onsite reviews were solicited. In addition, KEPRO hosted a webinar on April 10, 2017, to provide more detailed information and instructions for the plans to prepare for the compliance review. Plans were provided with a preparatory packet that included the project timeline, a draft onsite agenda, the compliance review tools, and data submission information. KEPRO scheduled a 30-minute call with each plan approximately two weeks prior to the onsite review that covered review logistics.

One Care plans were 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;
- Credentialing files; and
- Delegation files.

KEPRO compliance reviewers performed a desk review of all documentation provided by the One Care plans. In addition, two-day onsite visits were conducted to interview key plan personnel, review selected case files, and participate in systems demonstrations. The onsite allowed the plans to provide clarification of documentation already submitted and to submit additional documentation. At the conclusion of the onsite review, KEPRO conducted a closing conference to provide preliminary feedback to the plan on the review team's observations about the plan's strengths and opportunities for improvement as well as recommendations and next steps.

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

- **Met** – 1.0 point
Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and staff interviews provided information consistent with documentation provided.
- **Partially Met** (Any one of the following may be applicable) – 0.5 points

- Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. Staff interviews, however, provided information that was not consistent with documentation provided; or
- Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided although staff interviews provided information consistent with compliance with all requirements; or
- Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided, and staff interviews provided information inconsistent with compliance with all requirements.
- **Not Met – 0 points**
There was an absence of documentation to substantiate compliance with any of regulatory or contractual requirements and staff did not provide information to support compliance with requirements.

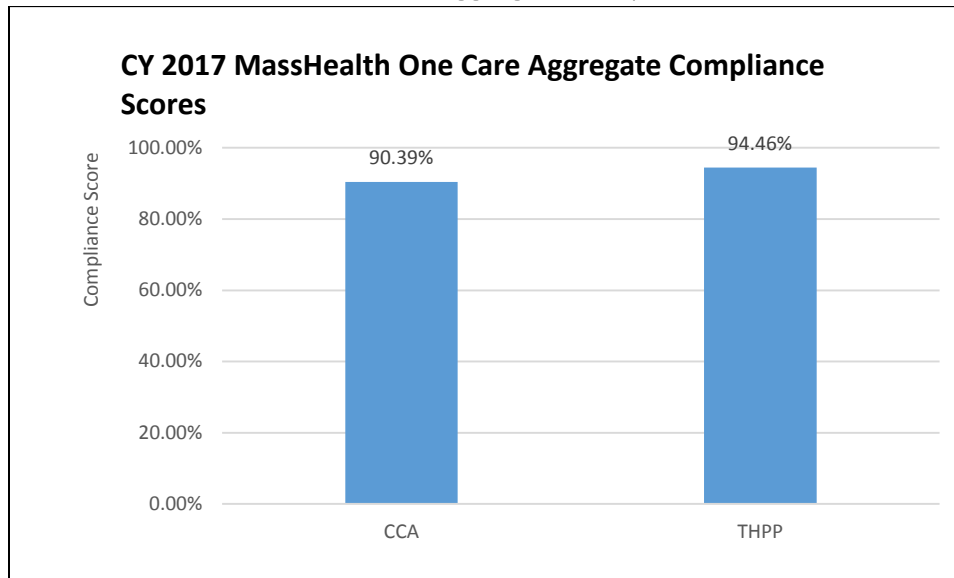
An overall percentage compliance score for each of the 14 standards was calculated based on the total points scored divided by total possible points. In addition, an overall percentage compliance score for all fourteen standards combined was calculated. For each area identified as Partially Met or Not Met, the plan 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 reviewed the NCQA 2016 managed care organization accreditation standards against the CFRs. Where 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 considered deemed, KEPRO evaluated each MCEs most current accreditation review and score the review element as “Met” if the MCE scored 100 percent on the accreditation review element.

COMPLIANCE VALIDATION COMPARATIVE ANALYSIS

The graph that follows depicts the compliance scores for the two One Care plans reviewed.

Exhibit 21: MassHealth One Care Aggregate Compliance Scores



The table that follows provides scores for each of the compliance review elements.

Exhibit 22: Compliance Scores Received by One Care Plans

Compliance Review Elements	CCA	THPP
Enrollee Rights and Protections	8/8	8/8
Enrollee Information	37/38	38/38
Availability and Accessibility of Services	34.5/42	38.5/43
Coordination and Continuity of Care	73/74	73.5/74
Coverage and Authorization of Services	42/43	42/43
Practice Guidelines	2/8	6.5/8
Enrollment and Disenrollment	8/8	8/8
Grievance System	30.5/33	32.5/33
Subcontractual Relationships and Delegation	14.5/16	16/16
Quality Assessment Performance Improvement Program	19.5/25	15/25
Credentialing	19/25	24.5/25
Confidentiality of Health Information	4/4	4/4
Health Information Systems	2/2	2/2
Program Integrity	7/7	7/7
Total Received/Possible	301/333	315.5/334
Score Calculated as Percentage	90.39%	94.46%

AGGREGATE OBSERVATIONS AND RECOMMENDATIONS

The 2017 Compliance Review was the first formal comprehensive review period since the inception of the One Care program. The plans did remarkably well demonstrating compliance with many of the program's Federal and State contractual requirements. Due to the unique needs of the One Care population, which includes individuals 21-64 years of age who are eligible for both Medicaid and Medicare and who have physical disabilities, developmental disabilities, serious mental illness, or substance abuse disorders, the Review placed a heavy emphasis was on the coordination and continuity of care standard in this review. In general, the plans demonstrated strong models of care supporting the overarching goal of coordinated care for One Care members.

Both One Care Plans were fully compliant with the Enrollment and Disenrollment, Confidentiality of Health Information, Health Information Systems, and Program Integrity standards. Both plans had aggregate compliance scores above 90 percent.

While KEPRO identified many overall strengths and successes of the One Care model, the review revealed some challenges as well. KEPRO found that the plans had challenges with their ability to maintain a centralized enrollee record (CER) since the plans were not fully integrated with provider operations. Given the existing model, the requirement to maintain a CER may be unrealistic for these plans within the current service delivery structure.

KEPRO found that utilization management denial letter language was inconsistent between One Care plans. Some letters appeared to be overly complex with up to thirteen-page letters provided to members. Furthermore, there was some inconsistency in how the plans handle appeals given the complexity of administering coordinated Medicare and Medicaid benefits and determining the appeal path available to members.

Furthermore, KEPRO identified that One Care plans varied in their understanding and use of medical necessity denials versus the use of administrative denials. Some plans reviewed everything for medical necessity regardless of benefit coverage. While medical necessity review is required for Medicaid populations under 21 for EPSDT services, KEPRO was unaware of similar requirements for adult populations. This presented some challenges within the plan utilization management process since the path of appeal options available to the member varies based on the designation of the denial as administrative or clinical.

Based on the 2017 aggregate compliance review results, KEPRO offers the following recommendations.

- MassHealth might consider a focused case management file review on a sample of One Care members. While the plans were in general compliance with the Coordination and Continuity of Care Standard, this type of review would better evaluate the effect of the overall model of care at the individual member level. A file review might provide more meaningful feedback in terms of strengths and actionable findings to further improve the delivery of care to members covered under the One Care model.
- MassHealth should review its expectations and contract requirements related to the One Care centralized enrollee records and its overall CER-related goals since One Care plans are not fully integrated with their providers.
- MassHealth should provide guidance to One Care plans on appeal procedures to increase consistency across plans. The guidance should ensure that plans administer member appeal rights based on the service being denied under what benefit. Medicare services and benefits should afford members appeal rights consistent with Medicare guidelines including an Independent Review Entity review, as appropriate, and Medicaid services and benefits should afford members appeal rights consistent with MassHealth guidelines, including the State Board of Hearings, as appropriate.
- MassHealth should provide clarity to One Care Plans on its expectations related to medical necessity and administrative denials.

NEXT STEPS

MassHealth required that One Care plans submit Corrective Action Plans (CAPs) for all Partially Met and Not Met elements identified from the 2017 Compliance Reviews. MassHealth will evaluate the CAPs and either approve them 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 2020.

PLAN-SPECIFIC COMPLIANCE VALIDATION RESULTS

In the section that follows, KEPRO provides a description of strengths, findings, and recommendations for each of the 14 standards reviewed in the following tables for both One Care Plans.

COMMONWEALTH CARE ALLIANCE

KEPRO reviewed all documents that were submitted by Commonwealth Care Alliance in support of the compliance validation process. In addition, KEPRO conducted a site visit on September 6-7, 2017.

Enrollee Rights & Protections

Strengths	<ul style="list-style-type: none">▪ CCA's documentation was sufficient to demonstrate that staff and providers take member rights and responsibilities into account when providing services to members.▪ CCA was fully compliant with this standard.
Findings	CCA was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollee Information

Strengths	<ul style="list-style-type: none">▪ CCA demonstrated a member-centric focus in the delivery of enrollee information.▪ CCA captured both oral and written language preferences of its One Care population within its health information system.
Findings	Not Met: <ul style="list-style-type: none">▪ CCA did not provide information to its enrollees on its physician incentive plans during the review period.
Recommendations	<ul style="list-style-type: none">▪ CCA should include language about physician incentive plans, upon request, within its member Evidence of Coverage document or through another mechanism.

Availability and Accessibility of Services

Strengths	<ul style="list-style-type: none">▪ CCA's EasCare paramedic program was very innovative and appeared to be successful.▪ CCA's structure included having individual nurse practitioners and behavioral health clinicians available to manage One Care members, which KEPRO found as a good strategy for addressing member barriers to accessing appropriate care.▪ CCA's primary care model included a process for addressing frequent PCP changes and offering members the opportunity to go to a Commonwealth Care Center provider.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none">▪ CCA developed a comprehensive ADA Work Plan in 2014. However, it was not updated after it was developed.▪ CCA's Member Handbook described direct access to women's health specialists. It did not, however, indicate that women's health specialists may serve as PCPs.▪ CCA's Behavioral Health Agreement Appendix included appropriate 24/7 emergency service availability, but it did not address the emergency face-to face 60-minute requirement or urgent care and other care standards.▪ While CCA's Facility Agreement included provisions of emergency treatment, it did not specifically address the Emergency Medical Treatment and Labor Act (EMTALA).▪ CCA's Provider Manual and Provider Agreements did not include a provision requiring the provider to make interpretation services available or that CCA's language line is available to the provider as needed for interpretation services.▪ No reference to requiring substance abuse providers to track referrals by referral source was included in the Behavioral Health Provider Agreement Appendix or the Provider Manual.▪ While CCA provided an Evaluation Services policy which addresses providing Personal Care Attendant evaluation services in a timely manner, no evidence of tracking evaluation timeliness was provided. <p>Not Met:</p> <ul style="list-style-type: none">▪ CCA's outpatient Behavioral Health Agreement Appendix indicated that providers must "Maintain availability to provide Covered Services to Enrollees during hours and days appropriate to the specific Covered Services provided, and to ensure convenient access for Enrollees." It did not reference, however, the specific office visit availability requirements.▪ CCA's provider agreements did not include a provision for office hour parity.

	<ul style="list-style-type: none"> ▪ CCA did not provide evidence of a mechanism to ensure appointment access compliance, ongoing monitoring of compliance, or corrective action for noncompliant providers. ▪ While CCA provided a standard operating procedure, Provider Termination, the procedure did not include a reference to CMS notification of significant provider network changes.
Recommendations	<ul style="list-style-type: none"> ▪ CCA should update its ADA Work Plan and put a process in place to update it annually thereafter. ▪ CCA should update its Member Handbook to include that the appropriate women's health specialists may serve as PCPs. ▪ CCA should update the appropriate Behavioral Health Agreement Appendices to include the specific appointment availability standards. ▪ CCA should update its Facility Agreement to include EMTALA requirements. ▪ CCA should implement and document a process for regular monitoring of provider appointment access compliance and taking corrective action for noncompliant providers. ▪ CCA should update its Provider Manual to require providers to make interpretation services available as necessary and take advantage of CCA's language line as needed. ▪ CCA should revise its policy to include a reference to CMS notification of significant network changes. ▪ CCA should update either its Behavioral Health Provider Agreement Appendix or its Provider Manual to include a provision to require substance abuse disorder treatment providers to track referrals by source, the outcome of the referral, and the reason for refusing any referral. ▪ CCA should update its policy and practice for addressing Personal Care Attendant evaluation services in a timely manner.

Coordination and Continuity of Care

Strengths	<ul style="list-style-type: none"> ▪ CCA demonstrated an individualized, high-touch model of care with evidence of medical and behavioral health integration. ▪ The use of stabilization centers was an innovative resource for members as well as CCA's care team. ▪ CCA demonstrated a process for obtaining inpatient admission and emergency room notification from larger provider groups facilitating the joint management of member needs.
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Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ The individualized care plan did not include the service plan which identifies long-term services and supports the member has in place. Additionally, the functionality of the current electronic system limits the creation of a robust care plan. ▪ CCA indicated that there are limited lab and radiology results in the Centralized Enrollee Record (CER). The customary medical record is the adjunct to the CER and is maintained with the PCP.
Recommendations	<ul style="list-style-type: none"> ▪ CCA should expand the care plan to include the service plan. As a new electronic documentation system is implemented, CCA should develop capability for the creation of individualized care plans, with measurable goals and progress in goal achievement. ▪ Full integration of medical records is an ongoing challenge for health plans. Currently, a limited number of providers use the same medical record documentation system as CCA. KEPRO recommends continued discussions with MassHealth related to expectations for full data integration.

Coverage and Authorization of Services

Strengths	<ul style="list-style-type: none"> ▪ CCA's transitions of care team and care management team collaborated on notification and review of inpatient admissions and transitions of care. ▪ CCA integrated its utilization reviews and care management activities within the same information system. ▪ CCA's respite and crisis stabilization units were noted by KEPRO to be a best practice.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ The Clinical 017 Medical Necessity Review for Select Service policy had not been reviewed or revised since 2009. The policy lists prior authorization requirements for Substance Use Disorder services. The plan did note that there are no prior authorization requirements for these services, nor were there prior authorization requirements in 2016. ▪ During the file reviews, it was found that written notification was not always provided to the member.

Recommendations	<ul style="list-style-type: none"> ▪ CCA should review and revise the Clinical 017 Medical Necessity Review for Select Service policy. Additionally, it should establish a process for the annual review of this and all policies. ▪ CCA should consistently provide written notification to members of any adverse action. During quality monitoring of the service decision process, CCA should include member notification as a review element.
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Practice Guidelines

Strengths	<ul style="list-style-type: none"> ▪ CCA used an evidence-based clinical decision support resource to guide staff member clinical decision-making.
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Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ CCA had implemented internal practice guidelines and additionally utilized the resource “UpToDate” to guide clinical decision-making and for support of the care management process. CCA had not adopted evidenced-based practice guidelines that are reviewed and approved through a committee process. ▪ CCA did evaluate the needs of its members, but indicated that the population’s needs were not best served by standardized practice guidelines. ▪ CCA had internal practice guidelines and also used the resource “UpToDate” to inform its utilization management decisions and for support of its care management program. It did not have a formalized process for the adoption of evidence-based practice guidelines. ▪ CCA did not formalize its adoption of evidenced-based practice guidelines and submit them to EOHHS. <p>Not Met:</p> <ul style="list-style-type: none"> ▪ CCA did not have a formalized process for the development and/or review of practice guidelines that included consultation with contracted health care professionals. ▪ CCA did not have a formalized process for the development and/or review of practice guidelines and therefore, did not review them against existing Massachusetts-promulgated guidelines for any contradiction. ▪ CCA did not have a formalized process for the development and review of practice guidelines and therefore, they were not updated periodically. ▪ While CCA disseminated preventive care guidelines to network providers and members in 2015. It did not have, however, a formalized process for the development or review of practice guidelines and therefore did not disseminate these to affected providers and enrollees.
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Recommendations	<ul style="list-style-type: none"> • CCA should develop, review, and formalize the adoption of practice guidelines. The guidelines should not be in conflict with Massachusetts guidelines. ▪ CCA should consider the review of multiple national and regional practice guidelines and, when not appropriate to its population, consider the development of its own guidelines. ▪ CCA should include contracted health professionals in the process for reviewing practice guidelines. ▪ CCA should update the guidelines periodically as appropriate. ▪ Upon the formal adoption of practice guidelines, CCA should disseminate them to all network providers; include them on its provider and member website; and develop a process to provide them to members upon request. ▪ Upon the formal adoption of practice guidelines, CCA should incorporate the guidelines into utilization and care management processes. ▪ Upon request, CCA should provide a listing and description of its adopted practice guidelines to EOHHS.
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Enrollment and Disenrollment

Strengths	<ul style="list-style-type: none"> ▪ CCA was fully compliant with this standard.
Findings	CCA was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Grievance System

Strengths	<ul style="list-style-type: none"> CCA demonstrated timely resolution of grievances.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> The onsite file review showed that, in some instances, CCA extended the appeal timeframe to allow the internal reviewer additional time to review documentation and render a decision. The regulatory requirement for extension must be in the member's best interest and should not be made based on staff resources. CCA's Evidence of Coverage (EOC) lacked language that the member must exhaust CCA's internal approval process before accessing the State Board of Hearings. The onsite file review for Part D appeals showed that CCA was moving some expedited requests to a standard request without justification for the reclassification and notification to the enrollee. <p>Not Met:</p> <ul style="list-style-type: none"> CCA's policies did not include the required provision that a representative of a deceased enrollee's estate is party to the State fair hearing process.
Recommendations	<ul style="list-style-type: none"> An extension should be taken by CCA when there are efforts to obtain additional documentation that may be in the member's best interest. In general, documentation received within the 14-day timeframe should enable a decision within the timeframe. CCA should update its EOC and grievance policy to indicate the requirement to exhaust the internal appeal process before accessing the State's Board of Hearings. CCA should revise its policies and procedures to include language that indicates that a representative of the enrollee's estate is party to the State fair hearing process. CCA should mirror its Part C process for handling expedited appeals, including the notification to the enrollee when an expedited case is moved to a standard request.

Subcontractual Relationships and Delegation

Strengths	<ul style="list-style-type: none">▪ CCA demonstrated allocation of resources and efforts to formalize processes related to delegation oversight.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none">▪ While CCA used its Request for Proposal process as its mechanism for evaluating prospective subcontractor's ability to perform activities to be delegated, it lacked a formal policy, procedure, and process related to delegation activities.▪ While CCA demonstrated some delegation oversight, it lacked a formal process during 2016 to address subcontractor's performance.▪ While CCA had a mechanism to monitor delegated entity performance, including corrective action plans, it did not have a formalized process that clearly delineated responsibility for delegation oversight, including the formal, ongoing monitoring of its delegated entities.
Recommendations	<ul style="list-style-type: none">▪ CCA should more formally develop its delegation process to include a policy and procedure that delineates its process to evaluate a prospective subcontractor's ability to perform delegated activities.▪ CCA should develop a policy and procedure that outlines its process for periodic, formal review of its delegated entities.▪ CCA should establish a delegation oversight committee or equivalent responsible entity that includes a charter to describe the composition, scope, and authority of the committee, and its role in the initiation and monitoring of corrective action plans.

Quality Assessment and Performance Improvement Program

Strengths	<ul style="list-style-type: none"> ▪ CCA demonstrated a focus on seeking member input and feedback on quality activities through the use of focus groups, consumer advisory councils, and member interviews. ▪ CCA had good analyses related to under- and over-utilization of services. ▪ CCA's Clinical Best Practice Conference and behavioral health seminars included relevant and valuable topics.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ CCA provided a Work Plan which included a Summary of 2015 Interventions, 2016 Improvement Plan, and Measures of Success. The Work Plan did not specifically include objectives, short- and long-term time frames, responsible individuals, identification of issues, how to resolve issues, a program review process, or a process for correcting deficiencies. ▪ While CCA's One Care QI Program Description 2016 referred to Utilization Management (UM), it did not specifically address the structure, goals, and objectives of the UM program. ▪ CCA's One Care QI Program Description 2016 indicated that the CCA Value Management Committee was responsible for monitoring over- and under-utilization. While evidence of various activities addressing aspects of over- and under-utilization was provided, CCA did not provide a description of an overall process or protocol for monitoring over- and under-utilization. ▪ While CCA indicated that a medical record review might be done at a site visit resulting from complaints about provider, it did not provide evidence of a medical record review process to monitor provider compliance with policies and procedures and appropriateness of care. In addition, no evidence was provided of a routine inter-rater reliability process for Utilization Management staff. ▪ CCA did not provide evidence that it routinely assesses the effectiveness and efficiency of the Utilization Management program. In addition, while CCA indicated that, if a member or provider requests coverage of a certain technology, a review by a Medical Director staff would occur. No evidence, however, of a formal process for technology assessment was in place. ▪ While CCA's Provider Agreement included provisions for data submission relative to claims, it did not include requirements for behavioral health providers to collect clinical outcomes data, to incorporate that data in treatment planning and

	<p>within the medical record, and to make clinical outcomes data available to CCA, upon request. It also did not require providers to make Behavioral Health Clinical Assessment and outcomes data available for Quality and Network Management purposes.</p> <ul style="list-style-type: none"> ▪ While CCA provided evidence of a number of provider profiling activities, it did not provide a written protocol for assessments of provider performance for each component of the provider network. ▪ While CCA documented provider profiling activities for some providers, it did not provide a formal methodology to identify which and how many providers to profile and to identify appropriate profiling measures. In addition, profiling activities documented did not include quality improvement plans for providers with a relatively high denial rate for authorization requests. ▪ CCA provided evidence of having conducted onsite visits to network providers for quality improvement purposes, but did not establish provider-specific quality improvement goals for underperforming providers. In addition, the use of provider incentives was limited. ▪ CCA did not provide evidence of having informed PCPs about the use of standardized behavioral health screening tools, how to evaluate results from screenings, and how and where to make referrals for behavioral health and LTSS assessments. ▪ CCA did not provide evidence of a formal strategy that includes the use of provider profiling to identify and manage outliers, a system to establish and measure progress toward meeting improvement goals, and conducting onsite visits for assessing meaningful compliance with ADA requirements.
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Recommendations	<ul style="list-style-type: none"> ▪ CCA should expand its annual QI Work Plan to be a dynamic document, updated through the year, including the requirements noted above. ▪ CCA should annually describe the structure, goals, and objectives of the UM program, either in the QI Program Description or as a separate document. The description should include how UM information is collected and used for QI activities. ▪ CCA should develop a written protocol for routine monitoring of over-and under-utilization, describing what services will be monitored and how they will be monitored. ▪ CCA should develop a routine medical record review process to monitor provider compliance with policies and procedures and appropriateness of care. In addition, it should implement a formal, routine process to assess the inter-rater reliability of its Utilization Management staff. ▪ CCA should implement a process to develop an annual Utilization Management Evaluation document that addresses both the effectiveness and efficiency of the program. In addition, CCA should develop and implement a formal process for technology review. ▪ CCA should update its Behavioral Health Provider Agreement Appendix to include the requirements related to clinical assessments and outcomes. ▪ CCA should develop a formal written protocol for provider profiling activities to include resource utilization, clinical performance measures, interdisciplinary team performance, enrollee experience, and timely access. ▪ CCA should develop a formal methodology for provider profiling addressing all requirements of this element and that, for providers with high authorization denial rates, a quality improvement plan, including provider education, be put in place. ▪ CCA should use provider profiling results to establish provider-specific goals, annually measure progress toward meeting goals, and develop appropriate incentives to improve performance. ▪ CCA should develop resource material for PCPs to assist in addressing behavioral health issues, including the use of screening tools, how to evaluate results, and how and where to make referrals for specialty care. ▪ CCA should develop a formal strategy for provider profiling that addresses these requirements and uses onsite visits for quality purposes as an opportunity to address ADA compliance.
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Credentialing

Strengths	<ul style="list-style-type: none">CCA initiated efforts in 2017 to address self-identified opportunities for improvement.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none">CCA did not provide evidence of protocols that included a review of enrollee complaints and appeals, results of quality reviews, utilization management activities, and enrollee surveys in the recredentialing process.CCA's Credentialing 001 policy indicated that the Plan "shall make every effort" to ensure that all providers were credentialed prior to becoming network providers.While CCA demonstrated through file review that recredentialing occurred every two years, no consideration of grievances, quality reviews, utilization management information, or enrollee satisfaction surveys was considered in the recredentialing process.While CCA had a nondiscrimination policy, it did not include a reference to nondiscrimination for providers based solely on license or certification.While CCA indicated that the Board of Registration in Medicine (BORIM) was checked twice per month, no documentation of this verification process was provided.While CCA indicated a process for ensuring nonpayment to excluded providers, no documented process was in place to address this requirement.While the Credentialing 001 policy and general Provider Agreement template included language related to nondiscrimination by providers, the Primary Care and Primary Care Health Home Provider Agreements did not include similar language.CCA did not provide evidence of requiring that all applicant physicians be board-certified in their practicing medical specialty or be in the process of achieving initial certification as a condition of participation.CCA did not provide documentation of a process for submitting documentation on access should EOHHS require it for the purpose of waiving board certification requirements for providers.While CCA described an informal process for the Medical Director's review of quality-of-care issues arising from complaints, there was no evidence of a formal process for addressing complaints involving medical provider errors, taking corrective action, and filing reports with CMS and MassHealth

	<p>within three business days.</p> <p>Not Met:</p> <ul style="list-style-type: none"> CCA did not provide evidence of requiring substance use disorder providers to report CEU trainings. In addition, the Behavioral Health Provider Agreement Appendix did not include requirements related to human rights.
Recommendations	<ul style="list-style-type: none"> CCA should implement and document a formal process of review of enrollee complaints and appeals, quality reviews, utilization management activities, and enrollee satisfaction surveys, as available, in the recredentialing process. CCA should update the policy and ensure that the process confirms that providers are credentialed prior to becoming network providers. CCA should implement a process for substance use disorder providers to report CEU trainings. It should also update its inpatient facility Behavioral Health Provider Agreement Appendix to include human rights requirements. CCA should update its policy and ensure that its processes do not discriminate against providers based solely on license or certification. CCA should ensure that, through its ongoing monitoring process, BORIM is checked twice monthly and that this requirement is documented in the appropriate policy. CCA should document a formal process for ensuring nonpayment to excluded providers. CCA should update the Primary Care and Primary Care Health Home Provider Agreements to include appropriate nondiscrimination provisions. CCA should implement and document a process of verifying that providers are board-certified or are in the process of achieving initial certification. CCA should implement and document a process for submitting board certification waiver requests to EOHHS for review and approval. CCA should implement a formal quality-of-care process to include the review, corrective action, and required reporting to CMS and MassHealth for complaints related to quality-of-care and medical errors.

Confidentiality of Health Information

Strengths	CCA was fully compliant with this standard.
Findings	CCA was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Health Information Systems

Strengths	<ul style="list-style-type: none">▪ CCA initiated efforts to automate some of its manual processes.▪ CCA demonstrated efforts to improve encounter data reporting.▪ CCA had a process for addressing member retention.▪ Provider data audit processes were enhanced in 2017.
Findings	CCA was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Program Integrity

Strengths	<ul style="list-style-type: none">▪ CCA demonstrated collaboration with its data and clinical teams to address outliers identified as part of data-mining.▪ CCA staff had easy access to compliance program expectations and information on its Compliance Connect landing page on the intranet.▪ CCA participated in State and health plan meetings to address fraud, waste, and abuse.
Findings	CCA was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

TUFTS HEALTH PUBLIC PLANS

KEPRO reviewed all documents that were submitted by Tufts Health Public Plans in support of the compliance validation process. In addition, KEPRO conducted a site visit on August 29 – 31, 2017.

Enrollee Rights & Protections

Strengths	Tufts was fully compliant with this standard.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollee Information

Strengths	<ul style="list-style-type: none">▪ In general, the enrollee handbook met contract requirements and was easy to read.▪ Tufts had an innovative call center tool which served as a resource for its customer service representatives when helping its One Care members.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Availability and Accessibility of Services

Strengths	<ul style="list-style-type: none">▪ Tufts had an extensive provider network to serve the One Care population.
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Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ Tufts did not provide evidence of contracting with freestanding birthing centers. ▪ Tufts Health Plan's Provider Agreement with Unify, the Provider Manual, and the Access Standards for Practitioners policy included access standards that were inconsistent with requirements. These documents indicated appointment access standards for PCPs of 45 days for non-symptomatic care, 10 days for non-urgent symptomatic care, and 48 hours for urgent care office visits. For specialists, documentation indicated a 30 day appointment access standard for non-urgent symptomatic care, 60 days for urgent symptomatic care, and 48 hours for urgent care office visits. ▪ The Access Standards for Practitioners policy included the appropriate language about appointment access standards. It did not, however, address office hours parity. ▪ Tufts Health Plan provided evidence of the results of an appointment access survey, which was described to have been done internally by phone. It indicated that providers found to be noncompliant during the phone survey would have been advised of appropriate standards at that time. No evidence was provided to demonstrate that corrective action plans for noncompliant providers were implemented. ▪ THPP reported its PCP turnover rate and explanation of the rate exceeding 7 percent to EOHHS as required. Tufts, however, did not provide evidence of monitoring individual enrollee PCP changes to identify and address opportunities for enrollee education and potential intervention with the PCP. <p>Not Met:</p> <ul style="list-style-type: none"> ▪ THPP did not provide any documentation on or description of referral processes to state-operated community mental health centers. ▪ The THPP Personal Care Attendant Amendment included reference to timelines for Personal Attendant Service evaluations identified in the contract. No contract and no additional documentation on how Tufts ensures that timely Personal Attendant Service evaluations were provided.
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Recommendations	<ul style="list-style-type: none"> ▪ THPP should ensure that freestanding birthing centers are included in its network. ▪ THPP should ensure that the Provider Agreement, Provider Manual, and the Access Standards for Practitioners policy include appointment access standards consistent with requirements. ▪ THPP should update its Provider Agreement and/or Provider Manual to include the provision requiring office hours parity with commercial and Medicaid fee-for-service enrollees. ▪ THPP should ensure that when providers are found to be noncompliant with appointment access standards during the access phone survey, a corrective action plan is put in place with follow up to ensure that deficiencies have been corrected. ▪ THPP should put a process in place to monitor individual frequent changes in PCP and provide enrollee education or intervene with the PCP as needed. ▪ THPP should ensure and document that cases referred to state-operated community mental health centers are consistent with network referrals in general. ▪ THPP should document its process for ensuring that timely Personal Attendant Service evaluations are being conducted.
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Coordination and Continuity of Care

Strengths	<ul style="list-style-type: none"> ▪ Tufts had established relationships with many providers, allowing it to gain access to electronic medical records and embed a care manager at some sites. ▪ Tufts automated several functions that improved care manager efficiency. ▪ Tufts had demonstrated engagement of its interdisciplinary care teams.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ The Centralized Enrollee Record (CER) included some laboratory and radiology reports but was not all-inclusive. The medical records maintained by the PCP were considered adjunct to the CER.
Recommendations	<ul style="list-style-type: none"> ▪ Full integration of medical records is an ongoing challenge for all plans. Currently, a limited number of providers use the same medical record documentation system as Tufts. KEPRO recommends continued discussions with MassHealth related to expectations for full data integration.

Coverage and Authorization of Services

Strengths	<ul style="list-style-type: none">▪ Tufts demonstrated coordination between the care management and utilization management teams.
Findings	<p>Not Met:</p> <ul style="list-style-type: none">▪ The pharmacy team noted buprenorphine/naloxone required prior authorization, as they adhere to the Medicare Part D requirement to ensure the drug was not being ordered for pain management.
Recommendations	<ul style="list-style-type: none">▪ To meet State contract requirements, THPP should review current prior authorization requirements associated with buprenorphine/naloxone and develop processes to remove the requirement.

Practice Guidelines

Strengths	<ul style="list-style-type: none">▪ Tufts Health Plan's process for adopting and disseminating practice guidelines was comprehensive.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none">▪ While Tufts described processes that ensure that enrollee needs are considered when adopting practice guidelines, this was not documented in the cited Model of Care.▪ While Tufts described that Medical Advisory Committees, including contracted providers, may review practice guidelines, there was no documentation of this process in the Model of Care document cited.▪ While Tufts described informal processes for the consistent application of practice guidelines across utilization management decisions and enrollee education, explicit procedures were not provided.
Recommendations	<ul style="list-style-type: none">▪ Tufts should update the Model of Care to reflect the process by which enrollee needs are considered when adopting practice guidelines.▪ Tufts should update the Model of Care to reflect how contracted providers are consulted for adoption of practice guidelines.▪ Tufts should document explicit procedures for application of guidelines across utilization management decisions and enrollee education.

Enrollment and Disenrollment

Strengths	Tufts was fully compliant with this standard.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Grievance System

Strengths	<ul style="list-style-type: none">▪ Tufts was compliant with meeting grievance resolution timeframes.▪ Tufts had a good process for the handling of quality-of-care grievances by its clinical staff and providers.▪ Tufts made several advances to reduce the manual processing of appeals.▪ Tufts had a good level of understanding of managing appeals based on the service and benefit type.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none">▪ The grievance file review showed that Tufts was inconsistent in using the appropriate grievance resolution template throughout the measurement period. In addition, the grievance file review found that the grievance resolution letter included language for requesting the letter in English when the letter was written in English.
Recommendations	<ul style="list-style-type: none">▪ Tufts should ensure that its grievance template for quality-of-care grievances includes Quality Improvement Organization language, as appropriate. In addition, Tufts should update its letter template to be more understandable by removing or revising the language regarding requesting the letter in another language.

Subcontractual Relationships and Delegation

Strengths	Tufts was fully compliant with this standard.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Quality Assessment and Performance Improvement Program

Strengths	<ul style="list-style-type: none"> ▪ Tufts had good conceptualization and well-documented mandated program initiatives (preventive immunizations, cancer screenings, and disease management programs). ▪ Tufts overall organizational structure allowed for strong quality and care management integration, which is conducive to implementing effective outreach and initiatives.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ THPP documented a Quality-of-Care Committee which includes network providers. Responsibilities of this committee include carrying out those program components which require medical peer review. There was no specific evidence, however, that feedback was provided by Network Providers in the design, planning, and implementation of continuing quality improvement activities. ▪ The Quality Improvement (QI) Work Plan provided includes limited initiatives relative to the One Care program. Also, the Work Plan did not include timeframes or issues tracking and resolution. ▪ While the 2016 Corporate Quality Improvement Program Plan indicated that over- and under-utilization are to be monitored and evaluated, no actual report of analysis of over- and under-utilization was provided. ▪ The Unify Provider Profiling Report includes a detailed description of provider profiling reports under development, but no actual report was provided. ▪ THPP's Quality Improvement Work Plan noted limited use of quality metrics in designing QI initiatives for the One Care QI program. ▪ THPP's QI Work Plan activities included limited evidence of using HEDIS, CAHPS, and Health Outcomes Survey results in the design of QI activities for the One Care program. No evidence of the required medical record review process was provided. ▪ THPP's QI Work Plan Evaluation and Corporate QI Evaluation did not include an assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, and accomplishment and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan for the On Care program. ▪ While Tufts provided a UM Evaluation document, it did not address the effectiveness and efficiency of the UM program. In addition, documentation was not provided relative to: <ul style="list-style-type: none"> ➤ Targeting areas of suspected inappropriate utilization;

	<ul style="list-style-type: none"> ➤ Detecting over- and under-utilization; ➤ Comparing utilization with norms; and ➤ Routine monitoring of utilization by service type. <ul style="list-style-type: none"> ▪ Tufts did not provide evidence of seeking input from network providers and medical professionals in the development of QI functions and activities. ▪ THPP's Unify Provider Profiling Report included a description of provider profiling report development. However, no actual profile reports were provided nor was a methodology for identifying which and how many providers to profile. ▪ Provider Profiling Committee minutes from 2016 reflected planning for some profiling measures, but actual profiling did not appear to have been completed. ▪ Tufts did not provide documentation of having informed PCPs about: <ul style="list-style-type: none"> ➤ The use of standardized behavioral health screening tools; and ➤ How to evaluate behavioral health information gathered during screenings. ▪ Tufts did not provide documentation of a network management strategy to include provider profiling and benchmarking data and identification of goals and measurement of progress toward goals. <p>Not Met:</p> <ul style="list-style-type: none"> ▪ Evidence of the assessment of the quality of appropriateness of care furnished to enrollees with special health care needs was not provided. ▪ Tufts did not provide evidence that an annual CAHPS survey was conducted for the One Care program in 2016. ▪ Tufts' Provider Agreement requires the provider to cooperate with and participate in the Plan's quality improvement program. There were no specific references, however, to require Behavioral Health providers to collect clinical outcomes data; include them in treatment planning and within the medical record; and to make assessments and outcomes available to the plan. In addition, no evidence was provided of outcome measures being used for behavioral health best practices. ▪ Because Tufts did not provide evidence of conducting provider profiling activities in 2016, results were not available to meet the requirements of this provision.
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Recommendations	<ul style="list-style-type: none"> ▪ Tufts should formalize its process for obtaining network provider feedback on the design, planning, and implementation of continuous quality improvement activities as well as QI functions and activities. ▪ Tufts should expand its QI Work Plan to include its various clinical and non-clinical QI initiatives related to the One Care Program. Timeframes, issues tracking, and resolution over time should be included. ▪ Tufts should expand its QI Work Plan to include the various metrics that drive clinical initiatives in place in the One Care program. ▪ Tufts should expand the QI Work Plan to include clinical and non-clinical initiatives based on survey results for the One Care program. Also, Tufts should implement a medical record review process to monitor provider network compliance with policies and procedures and appropriateness of care. ▪ Tufts should implement a formal process for addressing over- and under-utilization by service type. ▪ Tufts should assess the quality and appropriateness of care for enrollees with special health care needs through a formal evaluation of the care management program. ▪ Tufts should conduct an annual CAHPS survey. ▪ Tufts should develop a QI Work Plan Evaluation or a separate QI Program Evaluation to address the requirements above. ▪ Tufts should expand its UM Evaluation to include an assessment of the effectiveness and efficiency of the program. In addition, Tufts should implement a process to monitor utilization by service type and use this to target areas of inappropriate utilization, detect over- and under-utilization, and compare utilization to norms. ▪ Tufts should update either its Provider Agreement or Manual to include behavioral health data requirements and the requirement that the use of outcome measures for behavioral health best practices be documented. ▪ Tufts should develop formal provider profiles that include resource utilization, clinical performance measures, interdisciplinary team performance, enrollee experience, and timely access metrics. ▪ Tufts should implement a comprehensive provider profiling program which includes the requirements of this provision. ▪ As provider profiling results are available, Tufts should develop a program to establish provider-specific goals, develop and implement appropriate incentives, conduct onsite visits to providers, and measure progress toward goals at least annually. ▪ Tufts should develop a mechanism for informing PCPs about the use of standardized behavioral health screening tools and how to evaluate behavioral health information gathered during screenings. ▪ Tufts should develop and implement a network management
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	strategy that includes the use of provider profiling data to manage outliers and a system for identifying provider goals and tracking progress toward goal achievement.
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Credentialing

Strengths	<ul style="list-style-type: none"> Tufts had excellent documentation.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> The Behavioral Health Provider Agreement stated that providers must maintain current knowledge, ability, and expertise in the provider's area of specialty by obtaining Continuing Medical Education (CME) credits, participating in other training opportunities, if appropriate, and undertaking such other activities as are necessary or required by law. The Agreement, however, did not address submission of CEUs for training on substance abuse disorders.
Recommendations	<ul style="list-style-type: none"> Tufts should update its Provider Agreement to address the submission of CEUs for training on substance abuse disorders.

Confidentiality of Health Information

Strengths	<ul style="list-style-type: none"> Tufts had excellent documentation of its confidentiality program. Tufts was fully compliant with this standard.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Health Information Systems

Strengths	Tufts was fully compliant with this standard.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Program Integrity

Strengths	Tufts had documentation of a strong program.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.