

**MassHealth
One Care
External Quality Review Technical Report
Calendar Year 2018**



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SECTION 1. MASSHEALTH'S ONE CARE ORGANIZATIONS

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) introduced the Duals Demonstration program to address the longstanding barrier of the financial misalignment between the Medicare and Medicaid programs. CMS seeks to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain costs for individuals aged 21 – 64 who are both Medicaid and Medicare beneficiaries, referred to as “dual eligibles.” In 2012, the Massachusetts Executive Office of Health and Human Services (EOHHS) conducted a procurement of Integrated Care Organizations (ICOs) to participate in the Duals Demonstration program. Two of the ICOs originally procured, Commonwealth Care Alliance and Tufts Health Public Plans, continued to enroll dual eligibles in 2017 in which is now called the One Care Plan.

COMMONWEALTH CARE ALLIANCE HEALTH PLAN (CCA)

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 10,300 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 four 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, Barnstable, and Plymouth counties. CCA received 4 out of 5 possible stars for 2018 and 2019, according to the U.S. Centers for Medicare & Medicaid Services Star Ratings. Its corporate offices are located in Boston.

TUFTS HEALTH PUBLIC PLANS (THPP)

Tufts Health Plan, Inc., parent company of Tufts Health Public Plans, is a not-for-profit organization headquartered in Watertown and serves members in Massachusetts, New Hampshire, and Rhode Island. Its private Health Maintenance Organization/Point of Service (HMO/POS) and Massachusetts Preferred Provider Organization (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 Massachusetts 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 them in the top 4% of plans in the country.

Exhibit 1: One Care Membership

One Care Plan	Membership as of December 31, 2017	Percent of Total OneCare Population
Commonwealth Care Alliance	15,558	84%
Tufts Health Public Plans	2,991	16%
Total	18,549	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 IMPROVEMENT PROJECT REVIEWERS

Bonnie L. Zell, MD, MPH, FACOG

Dr. Zell brings to KEPRO a broad spectrum of healthcare experience as a nurse, an OB/GYN physician chief at Kaiser Permanente, and a hospital medical director. She has also had leadership roles in public health and national policy. As a nurse, she worked in community hospitals, served as head nurse of a surgical ward, and was a Methadone dispensing nurse at a medication-assisted treatment program. As OB/GYN chief, she developed new models of care based on patient's needs rather than system structure, integrating the department with psychologists, social workers, family medicine, and internal medicine.

In public health roles as Partnerships Lead at the CDC and Senior Director for Population Health at the National Quality Forum, she advanced strategies to integrate public health and healthcare, engaging healthcare and public health leaders in joint initiatives. As an Institute for Healthcare Improvement (IHI) fellow, Dr. Zell led quality improvement curriculum development, coaching, and training for multiple public health and healthcare institutions.

In February 2015, Dr. Zell co-founded a telehealth company, Icebreaker Health, which developed Lemonaid Health, a telehealth model for delivering simple uncomplicated primary care accessed through an app and website. Serving as Chief Medical Officer and Chief Quality Officer, she built the systems, protocols, quality standards and care review processes. Her role then expanded to building partnerships to integrate this telehealth model of care into multiple health systems and studying it with national academic leaders.

Dr. Zell continues to have an interest in supporting communities of greatest need. She works part-time as a physician in Medication Assisted Treatment for opiate addiction. She has published and presented extensively.

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.

MassHealth Comprehensive Quality Strategy



SECTION 3. MASSHEALTH COMPREHENSIVE QUALITY STRATEGY

Introduction

Under the Balanced Budget Act managed care rule 42 CFR 438 subpart E, Medicaid programs are required to develop a managed care quality strategy. The first MassHealth Quality Strategy was published in 2006. An updated version, the MassHealth Comprehensive Quality Strategy which focused not only to fulfill managed care quality requirements but to improve the quality of managed care services in Massachusetts, was submitted to CMS in November 2018. The updated version broadens the scope of the initial strategy, which focused on regulatory managed care requirements. The quality strategy is now more comprehensive and serves as a framework for EOHHS-wide quality activities. A living and breathing approach to quality, the strategy will evolve to reflect the balance of agency-wide and program-specific activities; increase the alignment of priorities and goals where appropriate; and facilitate strategic focus across the organization.

MassHealth Goals

The mission of MassHealth is to improve *the health outcomes of its diverse members by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life.*

MassHealth defined its goals as part of the MassHealth Comprehensive Quality Strategy development process. MassHealth goals aim to:

1. *Deliver a seamless, streamlined, and accessible patient-centered member experience, with focus on preventative, patient-centered primary care, and community-based services and supports;*
2. *Enact payment and delivery system reforms that promote member-driven, integrated, coordinated care; and hold providers accountable for the quality and total cost of care;*
3. *Improve integrated care systems among physical health, behavioral health, long-term services and supports and health-related social services;*
4. *Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals;*
5. *Maintain our commitment to careful stewardship of public resources through innovative program integrity initiatives; and*
6. *Create an internal culture and infrastructure to support our ability to meet the evolving needs of our members and partners.*

Stakeholder Involvement

MassHealth actively seeks input from a broad set of organizations and individual stakeholders. Stakeholders include, but are not limited to, members, providers, managed care entities, advocacy groups, and sister EOHHS agencies, e.g., the Departments of Children and Families and Mental Health. These groups represent an important source of guidance for quality programs as well as for broader strategic agency. To that end, KEPRO places an emphasis on the importance of the stakeholder voice.

MassHealth Delivery System Restructuring

In November 2016, MassHealth received approval from the Centers for Medicare and Medicaid Services to implement a five-year waiver authorizing a \$52.4 billion restructuring of MassHealth. The waiver included the introduction of Accountable Care Organizations (ACOs). In this model, providers have a financial interest in delivering quality, coordinated, member-centric care. Organizations applying for ACO status were required to be certified by the Massachusetts Health Policy Commissions set of standards for ACOs. Certification required that the organization met criteria in the domains of governance, member representation, performance improvement activities, experience with quality-based risk contracts, population health, and cross-continuum care. In this way, quality was a foundational component of the ACO program. Seventeen ACOs were approved to enroll members effective March 1, 2018.

Another important development during this period was the reprocurement of MassHealth managed care organizations. It was MassHealth's objective to select MCOs with a clear track record of delivering high-quality member experience and strong financial performance. The Request for Response and model contract were released in December 2016; selections were announced in October 2017. Tufts Health Public Plans and Boston Medical Center HealthNet Plan were awarded contracts to continue operating as MCOs. Contracts with the remaining MCOs (CeltiCare, Fallon Health, Health New England, and Neighborhood Health Plan) ended in February 2018.

Quality Evaluation

MassHealth evaluates the quality of its program using at least three mechanisms:

- Contract management – MassHealth contracts with plans include requirements for quality measurement, quality improvement, and reporting. MassHealth staff review submissions and evaluate contract compliance.
- Quality improvement performance programs – Each managed care entity is required to complete two Performance Improvement Projects (PIPs) annually, in accordance with 42 CFR 438.330(d).

- State-level data collection and monitoring – MassHealth routinely collects HEDIS^{1®} and other performance measure data from its managed care plans.

How KEPRO Supports the MassHealth Managed Care Quality Strategy

As MassHealth’s External Quality Review Organization, KEPRO performs the three mandatory activities required by 42 CFR 438.330:

- 1) Performance Measure Validation – MassHealth Managed Care Quality Strategy. MassHealth has traditionally asked that three measures be validated.
- 2) Performance Improvement Project Validation – KEPRO validates two projects per year.
- 3) Compliance Validation – Performed on a triennial basis, KEPRO assesses plan compliance with contractual and regulatory requirements.

The matrix below depicts ways in which KEPRO, through the External Quality Review (EQR) process, supports the MassHealth Managed Care Quality Strategy:

EQR Activity	Support to MassHealth Quality Strategy
Performance Measure Validation	<ul style="list-style-type: none"> • Assure that performance measures are calculated accurately. • Offer a comparative analysis of plan performance to identify outliers and trends. • Provide technical assistance. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.

¹ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

EQR Activity	Support to MassHealth Quality Strategy
Performance Improvement Project Validation	<ul style="list-style-type: none"> • Ensure the inclusion of an assessment of cultural competency within interventions. • Ensure the alignment of MassHealth Priority Areas and Quality Goals with MassHealth goals. • Ensure that performance improvement projects are appropriately structured and that meaningful performance measures are used to assess improvement. • Ensure that Performance Improvement Projects incorporate stakeholder feedback. • Share best practices, both clinical and operational. • Provide technical assistance. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.
Compliance Validation	<ul style="list-style-type: none"> • Assess plan compliance with contractual requirements. • Assess plan compliance with regulatory requirements. • Recommend mechanisms through which plans can achieve compliance. • Facilitate the Corrective Action Plan process. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.

Section 4. Executive Summary



SECTION 4. 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, prepaid inpatient health plans, primary care case management plans, senior care organizations, and accountable 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 validated two Performance Improvement Projects for each One Care plan during the CY 2018 review cycle. The Health Services Advisory Group, Inc., (HSAG) validated two performance measures in this same period. More information about HSAG's review is provided below.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2018 reflect 2017 quality measurement performance. References to HEDIS® 2018 performance reflect data collected in 2017. Performance Improvement Project reporting is inclusive of activities conducted in CY 2018.

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

One Care Plans are required by CMS to participate in performance measure validation (PMV) on an annual basis. Validation ensures that the plans reported the required measures annually and that they followed the specifications provided by the State to produce valid and accurate rates.

In 2018 at the direction of the Centers for Medicare & Medicaid Services (CMS), NORC at the University of Chicago with HSAG conducted performance measure validation of capitated Medicare-Medicaid Plans. HSAG validated the following measures for MassHealth:

- Core Measure 2.1 – Members with an Assessment Completed within 90 Days of Enrollment; and
- MA1.1 -- Members with Care Plans within 90 days of Enrollment.

Section 438.360 of the Medicaid External Quality Review regulations, “Nonduplication of Mandatory Activities with Medicare or Accreditation Review,” allows states to use information from a Medicare or private accreditation review to meet annual External Quality Review requirements. MassHealth chose to use information from HSAG’s review to meet its EQR requirements.

To verify that the technical methods used complied with CMS EQR Protocol #2, KEPRO reviewed the NORC reports, “Medicare-Medicaid Capitated Financial Alignment Initiative 2018 Performance Measure Validation for Commonwealth Care Alliance, Inc.,” and “Medicare-Medicaid Capitated Financial Alignment Initiative 2018 Performance Measure Validation for Tufts Health Public Plans, Inc.” KEPRO also reviewed both plan’s HEDIS^{®2} Final Audit Reports.

KEPRO determined that all One Care Plans followed specifications and reporting requirements and produced valid measures.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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 either plan’s quality of care or the timeliness of or access to care. Recommendations made were plan-specific.

² The Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of NCQA.

Section 5. Performance Measure Validation



SECTION 5. PERFORMANCE MEASURE VALIDATION

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.

Section 438.360 of the Medicaid External Quality Review regulations, “Nonduplication of Mandatory Activities with Medicare or Accreditation Review,” allows states to use information from a Medicare or private accreditation review to meet annual External Quality Review requirements. KEPRO did not independently conduct performance measure validation of MassHealth’s Medicare-Medicaid Plans, known in Massachusetts as One Care Plans. Instead, through NORC at the University of Chicago, CMS subcontracted with the Health Services Advisory Group, Inc., (HSAG) in 2018 to conduct performance measure validation of One Care Plans. HSAG validated the following measures:

- Core Measure 2.1, Core Measure 2.1 – Members with an Assessment Completed within 90 Days of Enrollment. This measure assesses the number of members who had a completed health risk assessment (HRA) within 90 days of enrollment in the One Care Plan as well as the number of members who either refused to complete the assessment or could not be reached by the OneCare Plan to complete the assessment.
- MA1.1, Members with Care Plans within 90 Days of Enrollment. This Massachusetts-specific measure assesses the number of members who were successfully contacted and for whom a care plan was completed within 90 days of enrollment as well as the number of members who refused to complete a care plan or could not be reached by the OneCare Plan.

MassHealth chose to use information from this review to meet its EQR requirements. A summary of HSAG’s validation activities follows.

For the 2018 Performance Measure Validation, One Care Plans submitted the documentation that follows.

Exhibit 2: Documentation Submitted by One Care Plans

Document Reviewed	Purpose of Review
Information Systems Capabilities Assessment Tool	Reviewed to assess health plan systems and processes related to performance measure production.
Source code and software programming or process steps used to generate the performance measure data element values	Used for a line-by-line review to assess accuracy of the rates.
Member-level files for each of the quarters being validated	Used to conduct primary source verification as well as calculate accuracy of the rates.

HSAG's review consisted of pre-validation, remote validation, and post-validation activities focusing on enrollment and eligibility data processes, assessment and care plan processes, performance measure production, and primary source verification findings.

All MassHealth One Care Plans followed specifications and reporting requirements and produced valid measures.

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

The focus of the Information Systems Capability Assessment is on components of 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.

All MassHealth One Care Plans demonstrated compliance with all requirements.

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION

COMMONWEALTH CARE ALLIANCE

KEPRO used the following sources to review 2018 Performance Measure Validation for Tufts Health Public Plans:

- “Medicare-Medicaid Capitated Financial Alignment Initiative 2018 Performance Measure Validation for Tufts Health Public Plans, Inc.,” prepared by HSAG and presented by NORC at the University of Chicago (HSAG); and
- The HEDIS Compliance Audit Report from Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Tufts Health Public Plan’s One Care Plan, the results of which were distributed on July 10, 2018 (Attest).

The source from which information below is drawn is notated in each section.

Enrollment and Eligibility Data Processes

CCA used the enrollment information from the CMS daily transaction reply report (DTRR) obtained from CMS by means of a secure electronic file transfer (EFT). In addition, CCA used the state’s daily and monthly 834 enrollment files to populate additional demographic data for members to support outreach attempts. CCA loaded enrollment into Market Prominence, its enrollment system, daily. If any discrepancies were identified, CCA forwarded the records to its point of contact at the state for resolution. CCA processed the enrollment files within three business days of receipt. CCA experienced no significant issues with the receipt or processing of these files during 2017. (HSAG)

Assessment Processes and Systems

CCA used its care management system, MDS Assist, to track outreach attempts and refusals and used eClinical Works to track comprehensive assessment completion dates. For all activities, MDS Assist and eClinical Works provided an automated date and time stamp that could not be modified. CCA and its health homes performed at least three telephonic outreach attempts within 90 days of enrollment. If telephonic outreach was unsuccessful, CCA mailed an unable-to-reach letter to the member requesting a callback. All outreach attempts were documented directly in MDS. CCA identified the assessment completion date as the date the comprehensive assessment was marked completed in MDS Assist as. (HSAG)

Care Plan Processes and Systems

CCA and its health homes used MDS Assist to track outreach attempts, refusals, and care plan completion dates. MDS and eClinical Works provided an automated date/time stamp that could not be modified. The care plan was developed using the member’s responses to the comprehensive assessment as a base and included discussion with the member to identify problems, interventions, and goals, and to create measurable objectives and time frames for

meeting those objectives. CCA considered a care plan completed if CCA’s care planning unit or the health homes’ care managers documented problems, interventions, and goals in MDS Assist or eClinical works. (HSAG)

Performance Measure Production

CCA’s Business Intelligence Team extracted data from Market Prominence and MDS Assist and generated internal reports for Core Measure 2.1. Data was extracted from Market Prominence, MDS Assist, and eClinical Works to generate MA 1.1. (HSAG)

Primary Source Verification

After resubmission of data for Core Measure 2.1 and MA 1.1, the results of CCA’s primary source validation did not reveal any concerns. (HSAG)

HEDIS® Final Audit Report & Information Systems Analysis

The review of information systems was performed to collect information that documented CCA efforts to ensure the accuracy and completeness of reported HEDIS rates. CCA demonstrated that it had the systems, processes and data control procedures needed to ensure that all data relevant to HEDIS measure calculation was stored, maintained, translated, and analyzed correctly. The audit evaluated aspects of the information system environment that specifically affect the ability to accurately report HEDIS measures. HSAG found that CCA demonstrated the accuracy and completeness of its primary databases – including claims and encounters, membership and enrollment, and provider and provider credentialing – as well as the ability to coordinate accurately and house safely the data for HEDIS reporting purposes. (Attest)

Follow Up to Calendar Year 2017 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on the 2017 PMV recommendation made by KEPRO follows.

Calendar Year 2017 Recommendations	2018 Update
Consider developing quality improvement initiatives to improve rates of initiation and engagement.	Most 2017 activity related to maximizing documentation required to optimally collect data for this measure.

TUFTS HEALTH PUBLIC PLANS

KEPRO used the following sources to review 2018 Performance Measure Validation for Tufts Health Public Plans:

- “Medicare-Medicaid Capitated Financial Alignment Initiative 2018 Performance Measure Validation for Tufts Health Public Plans, Inc.,” prepared by HSAG and presented by NORC at the University of Chicago (HSAG)
- The HEDIS Compliance Audit Report from Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Tufts Health Public Plan’s One Care Plan, the results of which were distributed on July 10, 2018 (Attest)

The source from which information below is drawn is notated in each section.

Enrollment and Eligibility Data Processes

Tufts received and used data from two data sources as part of its enrollment and eligibility processing. Tufts used the enrollment information from the CMS daily transaction reply report (DTRR) obtained from CMS by means of a secure electronic file transfer (EFT) to determine the eligibility effective date of MMP members. In addition, Tufts used the state daily and month 834 enrollment files received through the MassHealth secure file transfer protocol site to populate additional demographic data for members to support outreach efforts. Tufts loaded enrollment data into HealthTrio Xpress, its enrollment system, daily. If any discrepancies were identified, Tufts submitted a weekly file with the records to the state for reconciliation and correction. HSAG identified no issues with Tufts’ process of eligibility data. (HSAG)

Assessment Processes and Systems

Tufts used the care management system CCMS to track outreach attempts, refusals, and completed assessments. For all activities, CCMS provided an automated date/time stamp that could not be modified. (HSAG)

Care Plan Processes and Systems

Tufts used CCMS to track outreach attempts, refusals, and completed care plans. For all activities, CCMS provided an automated date and time stamp that could not be modified. Tufts considered a care plan completed if the care manager could create at least one problem, intervention, and goal in CCMS. Tufts uploaded a copy of the care plan to its member portal, HealthTrio Connect, for access by the member and the member’s Interdisciplinary Care Team. (HSAG)

Performance Measure Production

Tufts Quality Training and Analytics team extracted data from the CCMS data warehouse, which was the data repository for CCMS and generated internal reports for Core Measure 2.1 and

MA1.1. Tufts' care management team validated enrollment counts and completed assessments and care plans using roster reports after the data were extracted from CCMS. (HSAG)

Primary Source Verification

After resubmission of data for Core Measure 2.1 and MA 1.1, the results of Tufts' primary source validation did not reveal any concerns. (HSAG)

HEDIS® Final Audit Report & Information Systems Capabilities Analysis

A review of information systems was performed to collect information that documented its efforts to ensure the accuracy and completeness of reported HEDIS rates. Tufts demonstrated that it had the systems, processes, and data control procedures needed to ensure that all data relevant to HEDIS measure calculation were stored, maintained, translated, and analyzed correctly. The audit evaluated aspects of the information system environment that specifically affect the ability to accurately report HEDIS measures. Tufts demonstrated the accuracy and completeness of its primary databases – including claims and encounters, membership and enrollment, and provider and provider credentialing – as well as its ability to coordinate accurately and house safely the data for HEDIS reporting purposes. The findings from the information capabilities assessment formed the basis of a closer examination of the procedures used to develop the various HEDIS measures. (Attest)

Follow Up to Calendar Year 2017 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on the 2017 PMV recommendation made by KEPRO follows.

Calendar Year 2017 Recommendations	2018 Update
Continue developing quality improvement initiatives to improve rates of initiation and engagement (IET).	Tufts did not conduct formal quality improvement activity related to IET rates in 2018.

A collage of business-related graphics. In the foreground, a blue and silver pen lies diagonally across a document. The document features a bar chart with red, blue, and yellow bars, a pie chart with red, blue, and yellow segments, and a calendar for Q1 and Q2. A smartphone in the upper right corner displays a pie chart with six segments (red, orange, yellow, green, blue, red) and a calendar for Q1 and Q2. The background is a light blue surface with various documents and charts, including a bar chart with red, blue, and yellow bars, a pie chart with red, blue, and yellow segments, and a calendar for Q1 and Q2. The overall theme is business and data analysis.

SECTION 6. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

METHODOLOGY

In 2018, MassHealth introduced a new approach to conducting Performance Improvement Projects. In the past, plans submitted their annual project report in July to permit the use the project year HEDIS® data. KEPRO's evaluation of the project was not complete until October. Plans received formal project evaluations ten months or more after the end of the project year. The lack of timely feedback made it difficult for the plans to make changes in interventions and project design that might positively affect project outcomes.

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

Baseline/Initial Implementation Period: January 1, 2018 – December 31, 2018

Planning Phase: January - March 2018

During this period, plans developed detailed plans for interventions. Plans conducted a population analysis, a literature review, root cause, and barrier analyses all of which contributed to the design of appropriate interventions. Plans reported on this activity in March 2018. These reports described planned activities, performance measures, and data collection plans for initial implementation. Plans were subject to review and approval by MassHealth and KEPRO.

Initial Implementation: March 2018 - December 2018

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

Mid-cycle Implementation Period: January 1, 2019 – December 31, 2019

Mid-Cycle Progress Reports: March 2019

One Care plans will submit progress reports detailing changes made because of feedback or lessons learned in the previous cycle as well as updates on the current year's interventions

Mid-Cycle Annual Report: September 2019

One Care plans submit annual reports describing current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the projects, including successes and challenges.

Final Implementation Period: (January 1, 2020 – December 31, 2020)

Final Implementation Progress Reports: March 2020

One Care plans will submit another progress report that describes current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including successes and challenges.

Final Implementation Annual Report: September 2020

One Care plans will submit a second annual report that describes current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including successes and challenges and describe plans for the final quarter of the initiative.

All of these reports will be reviewed by KEPRO (the 2018 reports are discussed herein). Each project is evaluated to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. This evaluation also determines whether the projects have achieved or likely will achieve favorable results. KEPRO distributes detailed evaluation criteria and instructions to the plans to support their efforts.

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

- 1) *PIP Questionnaire.* Plans submit a completed reporting template for each PIP. This template is stage-specific. The Baseline Report 1 asks the One Care plans to provide a project rationale; member and provider goals; a barrier analysis; a description of stakeholder involvement; a description of the intervention and implementation plans; plans for small tests of change and effectiveness analysis; anticipated barriers to implementation and plans to address those barriers; and proposed performance indicators. Baseline Report 2 asks the One Care plans to provide a population analysis of the affected population; a strategy for member and/or provider engagement; updates to project goals; an update on intervention implementation progress; the use of small tests of change; plans to improve the intervention(s); plans for data analysis; a description of performance indicators; and baseline performance rates. The 2019 templates will focus on remeasurement.
- 2) *Desktop Review.* KEPRO staff conduct a desktop review for each PIP. The Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plans. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is on the structural quality of the questionnaire. The Medical Director's focus is on clinical interventions.
- 3) *Conference with the Plans.* The Technical Reviewer and Medical Director meet telephonically with representatives selected by the plans to obtain clarification on

identified issues as well as recommendations for improvement. The plans are offered the opportunity to resubmit the PIP questionnaire within ten calendar days, although they are not required to do so.

- 4) *Final Report.* A PIP Validation Worksheet based on CMS EQR Protocol Number 3 is completed by the Technical Reviewer. Individual standards are rated either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by all available points. The Medical Director documents his or her findings and, in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report.

PERFORMANCE IMPROVEMENT PROJECT TOPICS

MassHealth One Care plans conduct two contractually required PIPs annually. In accordance with Appendix E of their contract, plans must propose to MassHealth one PIP from each of two domains:

- Domain 1: Behavioral Health – Promoting well-being through prevention and treatment of mental illness, including substance use and other dependencies.
- Domain 2: Chronic Disease Management – Providing services and assistance to enrollees with or at risk for specific diseases and/or conditions.

In Calendar Year 2018, MassHealth One Care plans conducted the following Performance Improvement Projects:

- | | |
|----------------------------|--|
| Commonwealth Care Alliance | <ul style="list-style-type: none">• Improve the Rate of Cervical Cancer Screening• Cardiovascular Disease (CVD) Prevention in OneCare Members with Mental Illness and Multiple Risk Factors |
| 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 to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. KEPRO 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

Both THPP and CCA serve complex populations, 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 responsible for designing interventions that speak to that barrier.

PLAN-SPECIFIC PERFORMANCE IMPROVEMENT PROJECTS

COMMONWEALTH CARE ALLIANCE: IMPROVING THE RATE OF CERVICAL CANCER SCREENING AMONG CCA ONE CARE MEMBERS

Project Rationale

“Cervical cancer screening through Pap tests and HPV co-testing is an effective, low cost evidence-based activity for the prevention and early detection of cervical cancer ... OneCare members’ physical and/or mental health disabilities place them at greater risk for not receiving recommended cervical cancer screenings. Approximately 50% of this group has four or more chronic health conditions, 70% have a behavioral health diagnosis including major depression, bipolar disorder, schizophrenia, and substance use disorders, and 25% have a serious developmental or mental health disability. In a 2016 research brief, CDC Cancer Research Fellow, Natasha Crawford, observed, “A larger proportion of women with multiple chronic conditions reported not receiving the recommended screening for cervical cancer. ...women with arthritis, diabetes, and myocardial infarction were less likely to be screened for cervical cancer. In addition ... a larger proportion of women with COPD, depression, heart disease, or kidney disease did not adhere to cervical cancer screening recommendations compared with women without these conditions.”

Project Goals

Member-Focused

- Identify female members, age 24 to 64, who have not received cervical cancer screening within the recommended timeframe (Pap test within 3 years or Pap with HPV co-testing within 5 years).
- Educate members about the importance of cervical cancer screening and their options for receiving this test.
- Outreach to members to engage and motivate them to schedule cervical cancer screening.

Provider-Focused

- Identify members who have not received cervical cancer screening within the recommended period.
- Educate CCA clinicians and care partners to understand the cervical cancer screening recommendations and offer providers support to help members schedule screenings.
- Provide member-level gap reports to CCA-contracted providers which identify those patients with a cervical cancer screening gap and collaborate with these providers to engage these One Care members to schedule cervical cancer screenings.

Interventions

- CCA distributed an educational member newsletter (English, Spanish, and Portuguese) and a mailing (English, Spanish) to women with a gap in care. An Interactive Voice Recognition (IVR) phone call program was launched to remind women with a gap in care to schedule

cervical cancer screening services. Through these programs, the member can elect to be connected to Member Services for help scheduling an appointment.

- CCA-employed providers and care partners received education in women’s health. CCA developed a gap report for every member that notes all the screening services available, and which of these services the member is missing, including cervical, breast, and colon cancer screening; HbA1c screening; kidney care; and retinal eye exams.
- CCA collaborated with CCA-contracted providers to engage members identified through gap reporting to receive preventive care screening.
- CCA established Women’s Health clinics in Commonwealth Community Care locations.

Performance Indicators

CCA is using the HEDIS® measure: women 24-64 years of age who were screened for cervical cancer according to guidelines. CCA’s 2017 baseline performance was 65%. Its goal for the first remeasurement is 67%.

Performance Improvement Project Evaluation

KEPRO evaluates performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. CCA received a rating score of 100% on this Performance Improvement Project.

Exhibit 3: Performance Improvement Project Evaluation

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	3	9	9	100%
B11: Performance Indicator Parameters	6	18	18	100%
B12: Baseline Indicator Performance Rates	5	15	15	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	29	87	87	100%

Plan & Project Strengths

- CCA is commended for its use of its gap reports that includes cervical cancer screenings.
- CCA is commended for making its newsletter available to Portuguese- and Spanish-speaking members, as well as its IVR telephonic reminder campaign.
- CCA describes an excellent process for monitoring the effectiveness of IVR calls.

Opportunities for Improvement

- CCA presents many demographic details about its One Care population in general, but few details about the female members eligible for inclusion in this PIP.

Recommendations

- KEPRO suggests that CCA consider other ways to assess HPV status, such as through urine screening for HPV.
- KEPRO suggests that CCA make scripts available for use by a variety of practice clinicians for when they interact with women who could benefit from cervical cancer screening. If clinicians could internalize these scripts, the narrative could be more easily inserted into the routine conversations that clinicians have with women who fit the risk profile, e.g., multiple sexual partners and smoking.
- CCA is encouraging use of its Commonwealth Community Care clinics. Considering that marketing the expansion of this resource has not increased referrals, the question is whether more marketing will make a difference. KEPRO suggests that CCA conduct a focused barrier analysis on this question that includes a representative group of members and providers.

COMMONWEALTH CARE ALLIANCE: CARDIOVASCULAR DISEASE PREVENTION IN ONE CARE MEMBERS WITH MENTAL ILLNESS AND MULTIPLE RISK FACTORS

Project Rationale

“The prevalence of serious and persistent mental illness (SPMI) in the CCA One Care membership is relatively high (16%). Of those members, there is a high prevalence of diabetes (28%), hypertension (29%), or comorbid diabetes and hypertension (14%). We estimate that approximately 354 CCA One Care members have SPMI, diabetes, and hypertension, and that about 128 of them are smokers. Thus, the problem of poorly controlled modifiable cardiovascular disease (CVD) risk factors in individuals with SPMI is highly relevant to CCA’s members.”

Project Goals

Member-Focused

- Decrease the risk of CVD in members at highest risk of CVD through elimination or improvement in key modifiable risk factors through decreased smoking and improved adherence to medications for diabetes, blood pressure, and cholesterol.
- Improve member knowledge and self-efficacy in CVD risk factor self-management and encourage collaboration with their primary care providers to manage their CVD risk factors.

Provider-Focused

- Increase primary care providers’ and CCA care partners’ awareness of the relevant health delivery disparities that exist for members of this cohort so they will encourage/support their patients to engage with CCA’s CVD risk reduction coaching program.
- Increase providers’ appropriate prescribing of medication-assisted treatment (MAT) for smoking cessation for members of this cohort.

Interventions

- CCA developed a coaching guide and plan for Health Outreach Workers that guides the coach through an assessment process. These workers received training in Motivational Interviewing as well as working with individuals with serious and persistent mental illness (SPMI). A member resource library was assembled.
- CCA has identified the phase one member cohort (smokers with a diagnosis of SPMI, diabetes, and hypertension). Member care partners engage the member in a 10-week health coaching intervention consisting of counseling, resource materials, and medication-assisted treatment.
- Communicate individual member participation to the member’s primary care provider, care partner, and Department of Mental Health case managers.

Performance Indicators

CCA will measure the success of this intervention using seven rates:

1. *The Short-Term Smoking Cessation Rate*, which is defined as a ratio of the number of members who were smokers at the time they were offered the coaching program who report at the time they completed the program that they had quit smoking, to the number of members offered the coaching program who were smokers at the time they were offered the coaching program. CCA did not have baseline data at the time of reporting; its goal for remeasurement is a 5% cessation rate.
2. *The Short-Term Smoking Reduction Act*, which is defined as a ratio of the number of members who were smokers at the time they were offered the coaching program who reported at the time they completed the program that they reduced their smoking by at least 20%, to the number of members offered the coaching program who were smokers at the time they were offered the coaching program. CCA did not have baseline data at the time of reporting; its goal for remeasurement is a 20% reduction rate.
3. *The Long-Term Smoking Cessation Rate*, which is defined as the number of members who were smokers at the time they were offered the coaching program who report six months after they were offered the coaching program that they were not smoking to the number of members offered the coaching program who were smokers at the time they were offered the coaching program. CCA did not have baseline data at the time of reporting; its goal for remeasurement is a 2% increase in long-term smoking cessation six months post-intervention.
4. *The Long-Term Smoking Reduction Rate*, which is defined as the number of members who were smokers at the time they were offered the coaching program who report six months after they were offered the coaching program that they had reduced their smoking by at least 10%, to the number of members offered the coaching program who were smokers at the time they were offered the coaching program. CCA did not have baseline data at the time of reporting; its goal for remeasurement is a 10% increase in the number of members who have reduced their smoking six months post-intervention.
5. *The Oral Diabetes Medication Non-Adherence Improvement Rate*, which is defined as a ratio of the number of members offered the coaching program who were adherent to their oral diabetes medications six months following the coaching program, to the number of members offered the coaching program who had been prescribed oral diabetes medications. Baseline data are not available. CCA's goal is a 25% increase in adherence with oral diabetes medications.
6. *The RAS Antagonist Medication Non-Adherence Improvement Rate*, which is defined as a ratio of the number of members offered the coaching program who were adherent to their RAS Antagonist medications six months following the coaching program to the number of members offered the coaching program who had been prescribed RAS Antagonist medications. Baseline data are not available. CCA's goal is a 25% increase in adherence with RAS Antagonist medications.

7. *The Statin Medication Non-Adherence Improvement Rate*, which is defined as a ratio of the number of members offered the coaching program who were adherent to their statin medications six months following the coaching program to the number of members offered the coaching program who had been prescribed statin medications. Baseline data are not available. CCA's remeasurement goal is a 25% increase in adherence with statin medications.

Performance Improvement Project Evaluation

KEPRO evaluates performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of available points. This ratio is presented as a percentage. CCA received a rating score of 100% on this Performance Improvement Project. Indicator rates were not scored in Calendar Year 2018 as the PIPs reported baseline measurements.

Exhibit 4: Performance Improvement Project Evaluation

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	3	9.0	9.0	100%
B12: Baseline Indicator Performance Rates	Not rated	Not rated	Not rated	-
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	20	60	60	100%

Plan & Project Strengths

- CCA is commended for considering members' preferred languages when developing educational materials.
- CCA is commended for its support of the Health Outreach Workers (HOWs) program by developing resource materials and training staff to use member engagement protocols. CCA is further commended for training HOWs in Motivational Interviewing (MI).

Opportunities for Improvement

None noted.

Recommendations

- CCA might consider more structured means of gathering feedback, not only from staff, but also from external stakeholders (members and providers).
- In addition to the PCP-related outreach, KEPRO suggests that CCA also use for outreach medical assistants, nurses, receptionists, and others to connect with members for education and to promote smoking cessation resources during all face-to-face encounters with PIP-eligible members.

TUFTS HEALTH PUBLIC PLANS: IMPROVE THERAPY VISIT RATE FOR MEMBERS WITH DEPRESSION

Project Rationale

“Given the complexity of the One Care membership’s clinical profile and a steadily growing membership, treating and improving depression management is a top priority for THPP.”

Project Goals

Member-Focused

- Increase the rate of behavioral therapy follow-up visits for members with depression.
- Identify and intervene on psychosocial factors that are barriers to receiving behavioral therapy.
- Increase member engagement in accepting peer support and advocacy services.
- Increase the members’ adherence to behavioral health treatment.

Provider-Focused

- Increase depression screening by primary care providers.
- Increase referrals to behavioral health specialists.
- Increase provider awareness and use of evidence-based protocols related to the management of depression.

Interventions

- Tufts published an education article in its provider newsletter to raise awareness of the importance of depression screening and follow up. The article included pertinent information on depression clinical practice guidelines.
- Tufts informed targeted community health center primary care providers of members in their panels who had received a diagnosis of depression but did not receive behavioral health therapy services. Tufts staff then conducted a follow-up phone call to the primary care provider. Care managers conducted telephonic outreach to this same member cohort.

Performance Indicators

- Tufts will measure performance using the Therapy Visit Rate for Depressed Members measure seen at high-volume health centers. Tufts’ baseline performance was 34.6%. Its goal for the first remeasurement is 36.1%.

Performance Improvement Project Evaluation

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

Exhibit 5: Performance Improvement Project Evaluation

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	4	12	11	92%
B12: Baseline Indicator Performance Rates	4	12	12	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	25	75	74	99%

Strengths

- THPP is making useful provider-specific information available for member follow-up.
- KEPRO commends THPP for distributing provider-specific data through its service gap reports.
- THP is commended for adding an intervention that focuses directly on member engagement in treatment, which in turn supports their efforts in provider outreach.
- KEPRO commends THP for training its outreach staff in motivational interviewing (MI), a coaching method for helping members resolve their resistance to treatment.
- THP is commended for soliciting feedback from providers and its plan to review this PIP with its Consumer Advisory Council.

Opportunities

- KEPRO advises THPP to show evidence of a structured quality improvement process, especially small tests of change, in its next remeasurement report.

Recommendations

- KEPRO suggests that THPP consider including others who could do outreach to members such as medical assistants, nurses, and care manager to do the repeated outreach. A broader outreach team could do this through phone, email, or texting.

- KEPRO suggests that THPP track whether or not providers are reading the educational materials it distributed and evaluate whether the newsletter is changing provider behavior in any way.

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

Project Rationale

“Tufts Health Plan (THP) is committed to ensuring members receive quality care in the appropriate setting. In 2017, over 55% of the One Care members had an ED visit. THP hopes that by learning more about ED utilization, we can identify and implement targeted interventions to reduce unnecessary ED utilization. Given the complexity of the One Care membership’s clinical profile and a steadily growing membership, preventing unnecessary ED utilization is a top priority for THP.”

Project Goals

Member-Focused

- Implement a post-hospital discharge phone call using an evidence-based tool designed to assess gaps in primary care or treatment follow-up and compliance with medication regimen for all members after their discharge.
- Implement a post-ED follow-up phone call using a tool designed to assess gaps in PCP or treatment follow-up and compliance with medication regimen for all members who were treated and discharged from the ED.
- Improve the member’s understanding on how to best manage their healthcare needs and need for timely primary care follow-up.
- Improve the member’s understanding of access to Urgent Care Centers for non-urgent health needs rather than the ED when appropriate.

Provider-Focused

- Educate providers on the ED utilization reduction quality improvement initiative.
- Increase provider engagement on the Interdisciplinary Care Team (ICT) for members who are assessed to be at high risk for ED over-utilization.
- Increase provider awareness to recommend Urgent Care Centers as an alternative to the ED for members’ non-urgent needs.

Interventions

- Tufts performs two kinds of member outreach. The first is conducted within 72 hours of discharge at which time a care manager assesses the member’s transition of care status and any gaps that require intervention. The second outreach type is conducted upon receipt of an ED claim. During this telephone call, the care manager assesses the member’s risk for complications that might cause a return to the ED.
- Tufts invited all Massachusetts Urgent Care Centers to a meeting at which member benefit information was provided.

- A description of this initiative was sent to high-volume, high-impact medical groups. Health center clinical leaders were invited to discuss non-emergency ED utilization with the Tufts medical director.

Performance Indicators

Tufts will use the HEDIS® Emergency Department Utilization (EDU) measure to assess the success of this initiative. Baseline performance was 1,440 emergency department visits per 1,000 members. Tuft's goal for the first remeasurement is 1,422 emergency department visits per 1,000 members.

Performance Improvement Project Evaluation

KEPRO evaluates performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. Tufts Health Public Plans received a rating score of 100% on this Performance Improvement Project.

Exhibit 6: Performance Improvement Project Evaluation

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	4	4	100%
B11: Performance Indicator Parameters	4	12	12	100%
B12: Baseline Indicator Performance Rates	4	12	12	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	25	73	73	100%

Plan & Project Strengths

- THPP has completed a commendable population analysis, including detail about race, ethnicity, and language (REL) and other lifestyle factors that could be related to ED usage, such as living situation, homelessness, cigarette smoking, and substance use. The detailed stratification of members adds to the utility of the population analysis.
- KEPRO commends THPP for its use of community health workers who could be a source of very useful information regarding challenges that any particular member might have, such as transportation issues, support needed at home, etc.
- KEPRO suggests that a project strength is the Motivational Interviewing training that has provided to clinical and care management staff during this past year.

Opportunities for Improvement

None identified.

Recommendations

Tufts' focus on high-volume providers is commendable. KEPRO suggests that THPP survey this group of providers to find out what they are learning about the members who use their services. THPP might query whether its outreach services are helpful to these providers with respect to the prevention of non-emergency ED visits.