

TECHNICAL REPORT

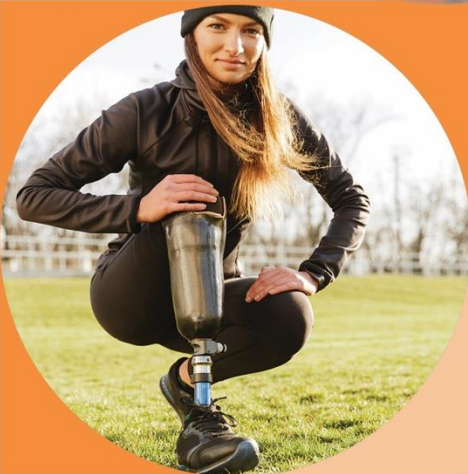
One Care Plans External Quality Review

Calendar Year 2020



MassHealth

Massachusetts Executive Office of Health &
Human Services



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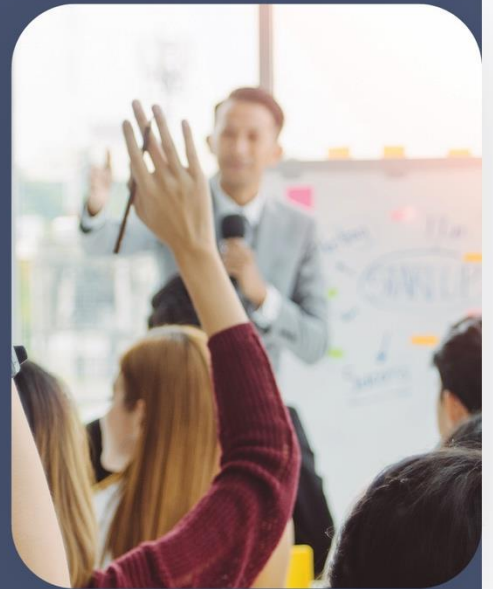
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Section 1:

Introduction



SECTION 1. 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 Medicare-Medicaid Plans (MMPs) to participate in the Duals Demonstration program. Two of the Integrated Care Organizations (ICOs) originally procured, Commonwealth Care Alliance and Tufts Health Public Plans, continued to enroll dual eligibles in 2020 in what are now called One Care Plans.

COMMONWEALTH CARE ALLIANCE (CCA)

Dual eligible Medicare and Medicaid beneficiaries from all Massachusetts counties with the exception of Dukes and Nantucket counties are eligible to enroll in CCA One Care. Its headquarters are in Boston. Additional information about CCA One Care is available at <https://www.commonwealthcarealliance.org>.

TUFTS HEALTH PUBLIC PLANS (THPP)

Tufts Health Unify is the One Care Plan operated by Tufts Health Public Plans, the corporate parent of which is Tufts Health Plan, Inc. Its headquarters are in Watertown. Unify serves beneficiaries in Middlesex, Suffolk, and Worcester counties. Additional information is available at <https://tuftshealthplan.com/provider/our-plans/tufts-health-public-plans/tufts-health-unify>.

Exhibit 1.1. One Care Membership¹

One Care Plan	Acronym Used in this Report	Membership as of December 31, 2019	Percent of Total OneCare Population
Commonwealth Care Alliance	CCA	33,903	92.44%
Tufts Health Public Plans	THPP	2,773	7.56%
Total		36,676	

¹ Plan-reported data.

Section 2:

Executive Summary



SECTION 2. 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 plan or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth has entered into an agreement with the Kepro to perform EQR services related to its contracted managed care plans.

The EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services (CMS). 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 One Care plans in the CY 2020 review cycle:

- Validation of three performance measures, including an Information Systems Capability Assessment;
- Validation of two Performance Improvement Projects (PIPs);
- Validation of compliance with regulations and contract requirements related to member access to timely, quality healthcare; and
- Validation of network adequacy.

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

The Massachusetts One Care plans include Commonwealth Care Alliance and Tufts Health Public Plans.

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

Exhibit 2.1. Performance Measure Validation Process Overview

Topic	Description
Objectives	To assess the accuracy of performance measures in accordance with 42 CFR § 438.358(b)(ii) reported by the managed care plan and to determine the extent to which the managed care plan follows state specifications and reporting requirements.
Technical methods of data collection and analysis	Kepro's Lead Performance Measure Validation Auditor conducted this activity in accordance with 42 CFR § 438.358(b)(ii).
Data obtained	Each One Care Plan submitted its HEDIS Final Audit Report, the NCQA Roadmap, the plans' NCQA IDSS worksheets, and follow-up documentation as requested by the auditor.
Conclusions	Kepro's validation review of the selected performance measures indicates that One Care Plan measurement and reporting processes were fully compliant with specifications and were methodologically sound.

The Performance Measure Validation process assesses the accuracy of performance measures reported by the managed care plan. It determines the extent to which the managed care plan follows state specifications and reporting requirements. In 2020, Kepro conducted Performance Measure Validation in accordance with CMS EQR protocols on three measures that were selected by MassHealth and Kepro. The three measures validated in 2020 were:

- Colorectal Cancer Screening
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Antidepressant Medication Management – Effective Treatment

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

In early 2020, CMS suspended Medicare Advantage HEDIS 2020 reporting, indicating that CMS was committed to allowing health plans, providers, and physician offices to focus on caring for beneficiaries during the COVID-19 pandemic. For the purposes of 2020 One Care Plans Performance Measure Validation, MassHealth directed Kepro to validate three HEDIS 2019 measures that had not been validated in the prior year.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Exhibit 2.2. Performance Improvement Project Validation Process Overview

Topic	Description
Objectives	To assess overall project methodology as well as the overall validity and reliability of the Performance Improvement Project (PIP) methods and findings to determine confidence in the results.
Technical methods of data collection and analysis	Performance Improvement Projects were validated in accordance with § 438.330(b)(i).
Data obtained	One Care Plans submitted two PIP reports in 2020, the Final Implementation Progress Report (March 2020) and the Final Implementation Annual Report (September 2020). They also submitted related supporting documentation.
Conclusions	Based on its review of One Care Plan Performance Improvement Projects, Kepro did not discern any issues related to their quality of care or the timeliness of or access to care.

MassHealth One Care Plans are required to conduct two Performance Improvement Projects annually as specified in Appendix E of their Three-way Contract between CMS and EOHHS. One project must be conducted for each of the following 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 late-2017, the plans submitted proposed topics for three-year projects to MassHealth for its review and approval and initiated their implementation in 2018. The plans' work on these projects continued through 2020, the third of the three-year quality cycle.

In Calendar Year 2020, MassHealth One Care Plans continued the implementation of the following Performance Improvement Projects begun in 2018:

Exhibit 2.3. Plan PIP Titles

Plan	PIP Topic
Commonwealth Care Alliance	<ul style="list-style-type: none">• Improve the Rate of Cervical Cancer Screening• Cardiovascular Disease (CVD) Prevention in One Care Members with Mental Illness and Multiple Risk Factors
Tufts Health Public Plans	<ul style="list-style-type: none">• Improve Therapy Visit Rates for Members with Depression• Reducing Emergency Department (ED) Utilization

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

COMPLIANCE VALIDATION

Exhibit 2.4. Topic Overview

Topic	Description
Objectives	The mandatory compliance validation protocol is used to determine, in a manner consistent with standard industry practices, the extent to which Medicaid managed care entities comply with quality standards mandated by the Balanced Budget Act of 1997 (BBA). Also considered is compliance with related sections of the plans' contracts with CMS and MassHealth.
Technical methods of data collection and analysis	Kepro conducted a desk review of documentation submitted by the One Care Plans. Clarification was obtained at a follow-up site visit. Results were compared to regulatory and contractual requirements.
Data obtained	One Care Plans submitted evidence of compliance including, but not limited to, policies and procedures; standard operating procedures; workflows; desk tools; reports; member materials; care management files; utilization management denial files; appeals files; grievance files; and credentialing files.
Conclusions	In general, the One Care plans demonstrated strong models of care supporting the overarching goals of coordinated care for One Care members. Overall, the 2020 compliance review found that One Care plans performed best in the areas of care delivery and quality of care. Plans' greatest opportunity for improvement is related to the accessibility of care standards.

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. The plans' scores were almost identical: CCA had a total score of 93.4% and Tufts' score was 93.5%. Due to the unique needs of the One Care population, a heavy emphasis was placed on the coordination and continuity of care standard during the review. In general, the One Care plans demonstrated strong models of care supporting the overarching goals of coordinated care for One Care members. Overall, the 2020 compliance review found that One Care plans performed best in the areas of care delivery and quality of care. Plans' greatest opportunity for improvement is related to the accessibility of care standards.

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

NETWORK ADEQUACY VALIDATION

Exhibit 2.5. Network Adequacy Validation Process Overview

Topic	Description
Objectives	The Network Adequacy Validation process assesses a managed care plan's compliance with the time and distance standards established by MassHealth. CMS has not published a formal protocol for this external quality review activity.
Technical methods of data collection and analysis	Quest Analytics enterprise network adequacy validation solution was used to compile and analyze network information provided by the One Care Plans.
Data obtained	One Care Plans provided Excel worksheets in December 2020 containing demographic information about their provider network.
Conclusions	In general, One Care Plans demonstrated high levels of compliance with Medicare Advantage provider to member ratio requirements and time and distance standards with few exceptions.

For the first year of network validation activities, the technical report focuses specifically on plan adequacy with regard to Medicare Advantage network standards. KEPRO is currently assessing compliance with Medicaid Network Adequacy standards and related reporting will be posted to the MassHealth website when it becomes available.

One Care plans demonstrated many network strengths. Tufts Health Public Plans met all Medicare Advantage network requirements with the exception of the member to provider ratio requirement in Middlesex County. Commonwealth Care Alliance had challenges meeting time and distance requirements for several specialties in Berkshire County.

QUALITY STRATEGY EVALUATION

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

The first MassHealth Quality Strategy was published in 2006. An updated version, the MassHealth Comprehensive Quality Strategy, focused not only on fulfilling managed care quality requirements but on improving the quality of managed care services in Massachusetts, was submitted to CMS in November 2018. As is required by CMS, the strategy will be updated in 2021 and will be made available to the public on the MassHealth website.

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

HIGH-LEVEL RECOMMENDATIONS

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

1. Expand the Network Adequacy Validation Scope of Work.

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

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

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

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

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

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

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

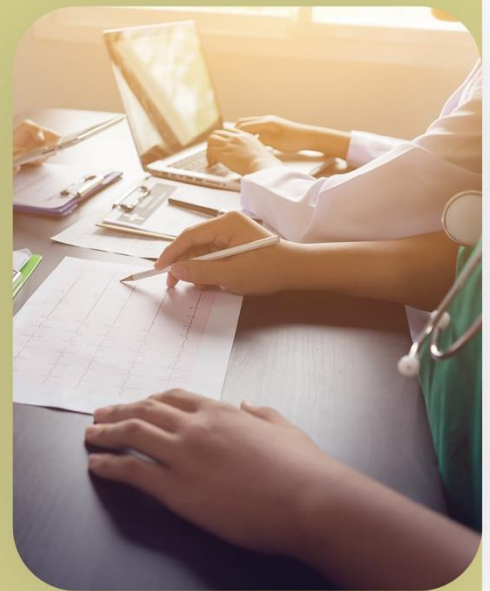
In the most recent Quality Improvement Cycle, ten MassHealth managed care plans conduct performance improvement projects related to depression. To decrease redundancy and maximize the potential for success, Kepro recommends that a mechanism be instituted for plans conducting similar improvement activities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

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

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

Section 3:

Performance Measure Validation



SECTION 3. PERFORMANCE MEASURE VALIDATION

PERFORMANCE MEASURE VALIDATION METHODOLOGY

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

Historically, the Performance Measure Validation process has consisted of a desk review of documentation submitted by the plan, notably the NCQA HEDIS Final Audit Report. The HEDIS Audit addresses an organization's:

- Information practices and control procedures;
- Sampling methods and procedures;
- Data integrity;
- Compliance with HEDIS specifications;
- Analytic file production; and
- Reporting and documentation.

The first part of the audit is a review of an organization's overall information systems capabilities for collecting, storing, analyzing, and reporting health information. The plan must demonstrate its ability to process medical, member and provider information as this is the foundation for accurate HEDIS reporting. It must also show evidence of effective systems, information practices, and control procedures for producing and using information in core business functions. Also reviewed are the plan-prepared HEDIS Roadmaps, which describe any organizational information management practices that affect HEDIS reporting. The Final Audit Report contains the plan's results for measures audited.

In early-2020, CMS determined that the COVID-19 pandemic was affecting key aspects of HEDIS hybrid data collection. The collection of medical records was compromised by the plan's inability to access charts from provider offices for abstraction due to nationwide physical-distancing requirements. NCQA therefore lifted the requirement for the submission of HEDIS data and the associated Compliance Audits by Medicare Advantage plans. For the purposes of 2020 Performance Measure Validation, MassHealth directed Kepro to validate three 2019 measures that had not been validated previously. Kepro's Lead Reviewer recommended the validation of the following measures:

Exhibit 3.1. Performance Measures Validated in 2020

HEDIS Measure Name and Abbreviation	Measure Description
Colorectal Cancer Screening (COL)	Adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years.
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	Adults 40 years of age and older who have a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD, who received spirometry testing to confirm the diagnosis.
Antidepressant Medication Management - Effective Continuation Phase Treatment (AMM)	Adults 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).

For 2020 Performance Measure Validation (PMV), One Care Plans submitted the documentation that follows.

Exhibit 3.2. Documentation Submitted by One Care Plans

Document Reviewed	Purpose of Review
HEDIS 2019 Roadmap	Reviewed to assess health plan systems and processes related to performance measure production.
2019 HEDIS Final Audit Report	Reviewed to determine if there were any underlying process issues related to HEDIS measure production.
HEDIS 2019 IDSS	Used to compile rates for comparison to prior years' performance and industry standard benchmarks.

Note: HEDIS® 2019 rates reflect the calendar year 2018 measurement period.

Kepro's One Care PMV audit methodology assesses both the quality of the source data that feed into the PMV measure under review and the accuracy of the calculation. Source data review includes evaluating the plan's data management structure, data sources, and data collection methodology. Measure calculation review includes reviewing the logic and analytic framework for determining the measure numerator, denominator, and exclusion cases, if applicable.

COMPARATIVE ANALYSIS

The tables that follow contain the elements through which performance measures are validated, as well as Kepro's determination as to whether or not the plans met these criteria. Results are presented for both plans reviewed in order to facilitate comparison across plans.

Exhibit 3.3. Performance Measure Validation Worksheets

Performance Measure Validation: Colorectal Cancer Screening (COL)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid
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Review Element ²	CCA	Tufts
DENOMINATOR		
<u>Population</u>		
One Care population was appropriately segregated from other product lines.	Met	Met
Members 51-75 years of age or older as of December 31 of the measurement year.	Met	Met
Members were continuously enrolled during the measurement year and the year prior to the measurement year, with no more than a one-month gap in either year. Members must also be enrolled on December 31 of the measurement year.	Met	Met
<u>Geographic Area</u>		
Includes only those Medicaid enrollees served in the plan's reporting area.	Met	Met
NUMERATOR		
<u>Counting Clinical Events</u>		
Data sources used to calculate the numerators (e.g., claims files, medical records, provider files, 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
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met
One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following: <ul style="list-style-type: none"> FOBT during the measurement year. Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. Colonoscopy during the measurement year or the nine years prior to the measurement year. CT colonography during the measurement year or the four years prior to the measurement year. FIT-DNA during the measurement year or the two years prior to the measurement year. 	Met	Met
<u>Data Quality</u>		

² Elements contained in the tables in Exhibit 3.3 are taken verbatim from the NCQA HEDIS Technical Specifications. Not all elements may apply to the One Care member population.

Review Element ²	CCA	Tufts
Based on the IS assessment findings, the data sources used were accurate.	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
<u>Proper Exclusion Methodology in Administrative Data</u>		
Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: <ul style="list-style-type: none"> Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. 	Met	Met
Optional Exclusion: Either of the following any time during the member's history through December 31 of the measurement year: <ul style="list-style-type: none"> Colorectal cancer Total colectomy 	Met	Met
Exclude members who meet any of the following criteria: <ul style="list-style-type: none"> Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet <i>both</i> of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> At least one claim/encounter for frailty during the measurement year. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ol style="list-style-type: none"> At least two outpatient visits, observation visits, ED visits, nonacute inpatient encounters or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: <ol style="list-style-type: none"> Identify all acute and nonacute inpatient stays. Confirm the stay was for nonacute care based on the presence of a nonacute code on the claim. Identify the discharge date for the stay. At least one acute inpatient encounter with an advanced illness diagnosis. At least one acute inpatient discharge with an advanced illness diagnosis. To identify an acute inpatient discharge: <ol style="list-style-type: none"> Identify all acute and nonacute inpatient stays. Exclude nonacute inpatient stays. Identify the discharge date for the stay. A dispensed dementia medication. Members 81 years of age and older as of December 31 of the measurement year with frailty during the measurement year.	Met	Met
<u>Hybrid Measure</u>		
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met
If the hybrid method was used, the One Care Plan passed the NCQA Final Medical Record Review Overread component of the HEDIS 2019 Compliance Audit.	Met	Met
SAMPLING		
<u>Unbiased Sample</u>		
As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met

Review Element ²	CCA	Tufts
<i><u>Sample Size</u></i>		
After exclusions, the sample size was equal to 1) 411, 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or 3) the total population.	Met	Met
<i><u>Proper Substitution Methodology in Medical Record Review</u></i>		
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors, if applicable.	Met	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met

Performance Measure Validation: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid
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Review Element	CCA	Tufts
DENOMINATOR		
<u>Population</u>		
One Care population was appropriately segregated from other product lines.	Met	Met
Identify all members who had any of the following during the Intake Period. <ul style="list-style-type: none"> An outpatient visit, an observation visit or an ED visit with any diagnosis of COPD, emphysema or chronic bronchitis. Do not include outpatient, ED or observation visits that result in an inpatient stay. Do not include telehealth. An acute inpatient encounter with any diagnosis of COPD, emphysema or chronic bronchitis. An acute inpatient discharge with any diagnosis of COPD, emphysema or chronic bronchitis on the discharge claim. To identify acute inpatient discharges: <ol style="list-style-type: none"> Identify all acute and nonacute inpatient stays. Exclude nonacute inpatient stays. Identify the discharge date for the stay. <p>If the member had more than one eligible visit, include only the first visit.</p>	Met	Met
<u>Geographic Area</u>		
Includes only those enrollees served in the One Care Plan's reporting area.	Met	Met
<u>Age & Sex:</u>		
<u>Enrollment Calculation</u>		
Members 42 years or older as of December 31 of the measurement year.	Met	Met
730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD. One month gap in enrollment is allowed in each of the 12-month periods prior to the IESD or in the 6-month period after the IESD, for a maximum of two gaps total. Enrollment on the IESD is required.	Met	Met
<u>Data Quality</u>		
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met

<u>Proper Exclusion Methodology in Administrative Data</u>		
<p>Test for Negative Diagnosis History. Exclude members who had any of the following during the 730 days prior to the IESD:</p> <ul style="list-style-type: none"> • An outpatient visit, a telephone visit, an online assessment, an observation visit or an ED visit with any diagnosis of COPD, emphysema or chronic bronchitis. • Do not include outpatient, ED or observation visits that result in an acute inpatient stay. To identify acute inpatient discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays. 2. Exclude nonacute inpatient stays. 3. Identify the admission date and the discharge date. • An acute inpatient encounter with any diagnosis of COPD, emphysema or chronic bronchitis. • An acute inpatient discharge with any diagnosis of COPD, emphysema or chronic bronchitis on the discharge claim. To identify acute inpatient discharges: <ul style="list-style-type: none"> • Identify all acute and nonacute inpatient stays. • Exclude nonacute inpatient stays. • Identify the discharge date for the stay. <p><i>For an acute inpatient discharge IESD, use the IESD date of admission to determine the 730 days prior to the IESD.</i></p> <p><i>For direct transfers, use the admission date of the original admission to determine the 730 days prior to the IESD.</i></p>	Met	Met
NUMERATOR		
<u>Administrative Data: Counting Clinical Events</u>		
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met
At least one claim/encounter for spirometry during the 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.	Met	Met

Performance Measure Validation: Antidepressant Medication Management (AMM): Effective Acute

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid
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Review Element	CCA	Tufts
DENOMINATOR		
<u>Population</u>		
One_Care population was appropriately segregated from other product lines.	Met	Met
Population was defined as being eligible and having an episode start date for depression during the intake period of 5/1/PY-4/30/MY.	Met	Met
Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication during the Intake Period.	Met	Met
<u>Geographic Area</u>		
Includes only those enrollees served in the One Care Plan's reporting area.	Met	Met
<u>Age & Sex:</u>		
<u>Enrollment Calculation</u>		
Members were 18 years of age or older as of April 30 of the measurement year.	Met	Met
Members must be continuously enrolled from 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD. Members must also be enrolled on the IPSD.	Met	Met
<u>Data Quality</u>		
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
<u>Proper Exclusion Methodology in Administrative Data</u>		
Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.	Met	Met

Review Element	CCA	Tufts
<p>Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSP, through the IPSP and the 60 days after the IPSP. Members who meet any of the following criteria remain in the eligible population:</p> <ul style="list-style-type: none"> • An acute or nonacute inpatient stay with any diagnosis of major depression on the discharge claim. To identify acute and nonacute inpatient stays: <ul style="list-style-type: none"> ○ Identify all acute and nonacute inpatient stays. ○ Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. ○ An acute inpatient encounter with any diagnosis of major depression. ○ A nonacute inpatient encounter with any diagnosis of major depression. ○ An outpatient visit with any diagnosis of major depression. ○ An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. ○ A community mental health center visit with any diagnosis of major depression. ○ Electroconvulsive therapy with any diagnosis of major depression. ○ Transcranial magnetic stimulation visit with any diagnosis of major depression. ○ A telehealth visit with any diagnosis of major depression. ○ An observation visit with any diagnosis of major depression. ○ An ED visit with any diagnosis of major depression. ○ A telephone visit with any diagnosis of major depression 	Met	Met

COMPARATIVE RESULTS

Exhibit 3.4. Colorectal Cancer Screening

Rate	HEDIS 2019	
CCA	71.26%	CCA's performance decreased 17.03 percentage points between HEDIS 2018 and HEDIS 2019. Its HEDIS 2019 performance is between the CMS SNP Public Use File (PUF) 40 and 45 percentiles.
THPP	58.72%	Tufts' performance decreased 3.25 percentage points between HEDIS 2018 and HEDIS 2019. THPP's performance is under the tenth percentile of the CMS SNP PUF.

Exhibit 3.5. Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Rate	HEDIS 2019	
CCA	30.26%	CCA's performance increased 2.28 percentage points between HEDIS 2018 and HEDIS 2019. Its performance is between the Medicaid Quality Compass 2019 33rd and 50th percentiles.
THPP	38.64%	Tufts' performance increased 5.90 percentage points between HEDIS 2018 and HEDIS 2019. Its performance is between the 75th and 90th Medicaid Quality Compass 2019 percentiles.

Exhibit 3.6. Antidepressant Medication Management – Effective Acute Treatment Phase

Rate	HEDIS 2019	
CCA	63.44%	CCA's MRP performance increased 6.33 percentage points between HEDIS 2018 and HEDIS 2019. CCA's performance is between the 75th and 90th NCQA Medicaid Quality Compass percentiles.
THPP	85.4%	Tufts MRP performance increased 4.87 percentage points between HEDIS 2018 and HEDIS 2019. This performance is above the 95th NCQA Medicaid Quality Compass percentiles.

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

CMS regulations require that each managed care plan also undergo an annual Information Systems Capability Assessment. The focus of the review is on components of health 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 for both CCA and THPP were acceptable.

Exhibit 3.7. Results of Information Systems Capability Analysis

Criterion	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

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION

Performance Measure Summaries

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

COMMONWEALTH CARE ALLIANCE

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Commonwealth Care Alliance (CCA)
Performance measure name: Colorectal Cancer Screening (COL)
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) 348 medical records selected in accordance with NCQA requirements (see below) <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed. <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): Members 50–75 years of age
Definition of numerator (describe): The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

2. Performance Measure Results

Numerator	248
Denominator	348
Rate	71.26%

3. Performance Measure Validation Status

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

In early 2020, CMS suspended HEDIS 2020 reporting for Medicare Advantage plans, indicating that CMS was committed to allowing health plans, providers, and physician offices to focus on caring for beneficiaries during the

COVID-19 pandemic. For the purposes of 2020 Performance Measure Validation, MassHealth directed Kepro to validate three HEDIS 2019 measures that had not been validated in the prior year.

There were no deviations from the 2019 HEDIS Technical Specifications.

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

Claims and Encounter Data. 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. 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 benefit 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.

Enrollment Data. CCA enrollment data is housed in the Market Prominence system. All necessary enrollment fields are captured for HEDIS reporting. CCA had adequate processes for data quality monitoring and reconciliation. The plan had processes to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

Supplemental Data. CCA's eClinicalworks EMR supplemental data source successfully contributed to the performance measure rates for COL.

Data Integration. CCA's performance measures were 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.

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

☐ Not applicable (ISCA not reviewed)

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

Medical record review data for *Colorectal Cancer Screening* was collected by CCA using in-house reviewers and Inovalon medical record abstraction tools. All tools and training materials were compliant with HEDIS technical specifications. CCA had adequate processes to ensure inter-rater reliability. The plan performed ongoing quality monitoring on both abstraction and data entry throughout the medical record review process. No issues were identified with medical record review.

☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the performance measure calculation.

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Because its performance on the Colorectal Cancer Screening was below the CMS SNP PUF 45th percentile, Kepro recommends that CCA consider developing and implementing related quality improvement initiatives.

Strengths:

CCA used an NCQA-certified vendor.

CCA used supplemental data for HEDIS reporting.

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Commonwealth Care Alliance
Performance measure name: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 40 years of age and older with a new diagnosis of COPD or newly active COPD
Definition of numerator (describe): The number of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

2. Performance Measure Results

Numerator	69
Denominator	228
Rate	30.26%

3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>In early 2020, CMS suspended HEDIS 2020 reporting for Medicare Advantage plans, indicating that CMS was committed to allowing health plans, providers, and physician offices to focus on caring for beneficiaries during the COVID-19 pandemic. For the purposes of 2020 Performance Measure Validation, MassHealth directed Kepro to validate three HEDIS 2019 measures that had not been validated in the prior year.</p> <p>There were no deviations from the 2019 HEDIS Technical Specifications.</p>

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

Claims and Encounter Data. 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. 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 benefit 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.

Enrollment Data. CCA enrollment data is housed in the Market Prominence system. All necessary enrollment fields are captured for HEDIS reporting. CCA had adequate processes for data quality monitoring and reconciliation. The plan had processes to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

Supplemental Data. CCA's eClinicalworks EMR supplemental data source successfully contributed to the performance measure rates for SPR .

Data Integration. CCA's performance measures were 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.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the performance measure calculation.

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Because its performance on the *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure was below the 2020 NCQA Medicaid Quality Compass 50th percentile, Kepro recommends that CCA consider developing and implementing related quality improvement initiatives.

Strengths

CCA used an NCQA-certified vendor.
CCA used supplemental data for HEDIS reporting.

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Commonwealth Care Alliance (CCA)
Performance measure name: Antidepressant Medication Management (AMM) Effective Acute Phase Treatment
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): Members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression.
Definition of numerator (describe): Members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication for at least 84 days (12 weeks).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2018 – December 31, 2018

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)

Numerator	557
Denominator	878
Rate	63.44%

3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). In early 2020, CMS suspended HEDIS 2020 reporting for Medicare Advantage plans, indicating that CMS was committed to allowing health plans, providers, and physician offices to focus on caring for beneficiaries during the COVID-19 pandemic. For the purposes of 2020 Performance Measure Validation, MassHealth directed Kepro to validate three HEDIS 2019 measures that had not been validated in the prior year.
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There were no deviations from the 2019 HEDIS Technical Specifications.

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

Claims and Encounter Data. 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. 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 benefit 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.

Enrollment Data. CCA enrollment data is housed in the Market Prominence system. All necessary enrollment fields are captured for HEDIS reporting. CCA had adequate processes for data quality monitoring and reconciliation. The plan had processes to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

Supplemental Data. CCA's eClinicalworks EMR supplemental data source successfully contributed to the performance measure rates for-AMM .

Data Integration. CCA's performance measures were 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.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the performance measure calculation.

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

Strengths:

CCA used an NCQA-certified vendor.
CCA used supplemental data for HEDIS reporting.

Update on 2019 Recommendations

Kepro is required by CMS to determine the status of recommendations made in the previous reporting year.

2019 Recommendation	2020 Update
Implement quality improvement initiatives to increase the Medication Reconciliation Post-Discharge rate.	<p>In 2020, CCA implemented the following initiatives to increase the Medication Reconciliation Post-Discharge rate:</p> <ul style="list-style-type: none">• Developed and disseminated training and tools for all frontline and pharmacy staff including a module on the Learning Management System on a revised policy and procedure.• Implemented more robust systems for more timely member discharge notification of staff.• Revised the procedure for Medication Reconciliation Post-Discharge to include telephonic reconciliation by nurses.• Increased member access to mid-level clinicians, nurses, and pharmacists.• Reeducated care management teams on medication reconciliation requirements and appropriate documentation including documentation workflows in the care management system.

TUFTS HEALTH PUBLIC PLANS

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Tufts Health Public Plans
Performance measure name: Colorectal Cancer Screening (COL)
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) 407 medical records selected in accordance with NCQA requirements <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed. <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): Members 50–75 years of age
Definition of numerator (describe): The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

2. Performance Measure Results (If measure contains more than one rate, add columns to the table)

Numerator	239
Denominator	407
Rate	58.72%

3. Performance Measure Validation Status

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

In early 2020, CMS suspended HEDIS 2020 reporting for Medicare Advantage plans, indicating that CMS was committed to allowing health plans, providers, and physician offices to focus on caring for beneficiaries during the

COVID-19 pandemic. For the purposes of 2020 Performance Measure Validation, MassHealth directed Kepro to validate three HEDIS 2019 measures that had not been validated in the prior year.

There were no deviations from the 2019 HEDIS Technical Specifications.

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

Claims and Encounter Data. Tufts processed 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 Tufts and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims within Monument Xpress except for pharmacy claims which were handled by Tufts' 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.

Enrollment Data. MMP enrollment data were loaded into THPP's Monument Xpress system. The Monument Xpress system captured all necessary enrollment fields for HEDIS reporting. THPP could appropriately distinguish One Care plan members from all other members within Monument Xpress. THPP had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Supplemental Data. THPP's supplemental data sources did not contribute to the three measures under review. Therefore, this section is not applicable.

Data Integration. THPP's HEDIS measure rates were produced using GDIT software. Data from the transaction system were loaded to Tufts' 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, GDIT. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

Medical record review data for the *Colorectal Cancer Screening* measure were collected by Tufts using in-house reviewers and GDIT medical record abstraction tools. All tools and training materials were compliant with HEDIS technical specifications. THPP had adequate processes for ensuring inter-rater reliability. The plan performed ongoing quality monitoring on both abstraction and data entry throughout the medical record review process. No issues were identified with medical record review.

☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the performance measure calculation.

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Because Tufts performance in the *Colorectal Cancer Screening* Measure was below the CMS SNP PUF 10th percentile, Kepro recommends that Tufts consider developing and implementing related quality improvement initiatives.

Strengths:

Tufts used an NCQA-certified vendor to produce measurements.

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Tufts Health Public Plans – Tufts Unify
Performance measure name: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) 407 medical records selected in accordance with NCQA requirements <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 40 years of age and older with a new diagnosis of COPD or newly active COPD
Definition of numerator (describe): The number of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

2. Performance Measure Results

Numerator	17
Denominator	44
Rate	38.64%

3. Performance Measure Validation Status

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

In early 2020, CMS suspended HEDIS 2020 reporting for Medicare Advantage plans, indicating that CMS was committed to allowing health plans, providers, and physician offices to focus on caring for beneficiaries during the COVID-19 pandemic. For the purposes of 2020 Performance Measure Validation, MassHealth directed Kepro to validate three HEDIS 2019 measures that had not been validated in the prior year.

There were no deviations from the 2019 HEDIS Technical Specifications.
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Claims and Encounter Data. Tufts processed 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 Tufts and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims within Monument Xpress except for pharmacy claims which were handled by Tufts' 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.</p> <p>Enrollment Data. MMP enrollment data were loaded into THPP's Monument Xpress system. The Monument Xpress system captured all necessary enrollment fields for HEDIS reporting. THPP could appropriately distinguish One Care plan members from all other members within Monument Xpress. THPP had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.</p> <p>Supplemental Data. THPP's supplemental data sources did not contribute to the three measures under review. Therefore, this section is not applicable.</p> <p>Data Integration. THPP's HEDIS measure rates were produced using GDIT software. Data from the transaction system were loaded to Tufts' 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, GDIT. There were no issues identified with data integration processes.</p> <p>Source Code. THPP used NCQA-certified GDIT HEDIS software to produce performance measures. GDIT received NCQA measure certification to produce the performance measures under the scope of this review. There were no source code issues identified.</p> <p><input type="checkbox"/> Not applicable (ISCA not reviewed)</p>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p><input checked="" type="checkbox"/> Not applicable (medical record review not conducted)</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

Strengths:

Tufts used an NCQA-certified vendor to produce measurements.

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Tufts Health Public Plans
Performance measure name: Antidepressant Medication Management (AMM) Effective Acute Phase Treatment
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) 407 medical records selected in accordance with NCQA requirements <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): Members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression
Definition of numerator (describe): Members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication for at least 84 days (12 weeks).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

2. Performance Measure Results

Numerator	105
Denominator	123
Rate	85.4%

3. Performance Measure Validation Status

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

In early 2020, CMS suspended HEDIS 2020 reporting for Medicare Advantage plans, indicating that CMS was committed to allowing health plans, providers, and physician offices to focus on caring for beneficiaries during the COVID-19 pandemic. For the purposes of 2020 Performance Measure Validation, MassHealth directed Kepro to validate three HEDIS 2019 measures that had not been validated in the prior year.

There were no deviations from the 2019 HEDIS Technical Specifications.

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

Claims and Encounter Data. Tufts processed 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 Tufts and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims within Monument Xpress except for pharmacy claims which were handled by Tufts' 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.

Enrollment Data. MMP enrollment data were loaded into THPP's Monument Xpress system. The Monument Xpress system captured all necessary enrollment fields for HEDIS reporting. THPP could appropriately distinguish One Care plan members from all other members within Monument Xpress. THPP had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Supplemental Data. THPP's supplemental data sources did not contribute to the three measures under review. Therefore, this section is not applicable.

Data Integration. THPP's HEDIS measure rates were produced using GDIT software. Data from the transaction system were loaded to Tufts' 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, GDIT. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the performance measure calculation.

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None.

Strengths

Tufts used an NCQA-certified vendor to produce measurements.

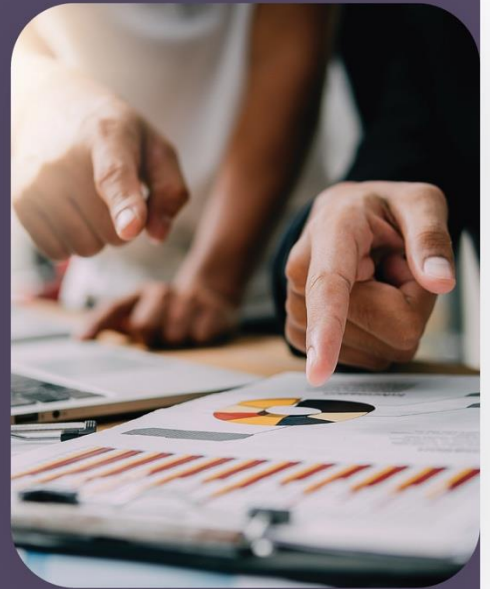
Follow Up to 2019 Recommendations

Kepro is required by CMS to determine the status of recommendations made in the previous reporting year.

2019 Recommendation	2020 Update
Implement quality improvement initiatives to increase the Medication Reconciliation Post-Discharge rate.	Tufts reported making efforts to improve data capture.

Section 4:

Performance Improvement Project Validation



SECTION 4. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

THE PERFORMANCE IMPROVEMENT PROJECT LIFE CYCLE

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

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

Baseline/Initial Implementation Period: Calendar Year 2018

Planning Phase: January 2018 - March 2018

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

Initial Implementation: March 2018 - December 2018

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

Mid-cycle Implementation Period: Calendar Year 2019

Mid-Cycle Progress Reports: March 2019

One Care Plans submitted progress reports detailing changes made because of feedback from Kepro 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 submitted annual reports describing current interventions, short-term indicators and small tests of change, and performance data as applicable. They also assessed the results of the projects, including successes and challenges.

Final Implementation Period: Calendar Year 2020

Final Implementation Progress Reports: March 2020

One Care Plans submitted a progress report that described current interventions, short-term indicators and small tests of change, and performance data, as applicable. They also assessed the results of the project, including successes and challenges.

Final Implementation Annual Report: September 2020

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

Each of these reports were reviewed by Kepro. The 2020 reports are discussed herein. Each project was evaluated to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 1, *Performance Improvement Project Validation*. This evaluation also determined whether the projects had achieved or likely would 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 questionnaire for each PIP. This questionnaire is stage-specific. In 2020, plans submitted a Project Update (March) and a report on Project Results report (September). The Progress Update report asked for a description of stakeholder involvement; an update to project goals, if any; the status of intervention implementation and any barriers experienced; and plans for going forward. The Project Results report included a description of the strategies used to ensure the cultural competence of interventions; an updated population analysis; an analysis of intervention outcome effectiveness; the remeasurement of identified performance indicators; status and barriers; and a description of lessons learned by the project team.
- 2) **Desktop Review.** Kepro staff conduct a desktop review for each PIP. The Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plans. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is on the structural quality of the project. The Medical Director's focus is on clinical integrity and interventions.
- 3) **Conference with the Plans.** The Technical Reviewer and Medical Director meet telephonically with representatives selected by the plans to obtain clarification on identified issues as well as to offer recommendations for improvement. The plans are

offered the opportunity to resubmit the PIP questionnaire within ten calendar days, although they are not required to do so.

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

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 two PIPs to MassHealth from the following categories:

- Emergency Department (ED) utilization;
- IL-LTSS Coordinator, to better understand the use of IL-LTSS Coordinators by One Care members;
- Barriers to Health Access, to better understand access issues experienced by One Care members; or
- Other topic areas to be identified through annual guidance by CMS and EOHHS.

In Calendar Year 2020, MassHealth One Care Plans continued the implementation of the following Performance Improvement Projects begun in 2018:

Exhibit 4.1 Plan PIP Titles

Plan	PIP Title
Commonwealth Care Alliance	• Cardiovascular Disease (CVD) Prevention in One Care Members with Mental Illness and Multiple Risk Factors
	• Improve the Rate of Cervical Cancer Screening
Tufts Health Public Plans	• Improve Therapy Visit Rate for Members with Depression
	• Reducing Emergency Department (ED) Utilization

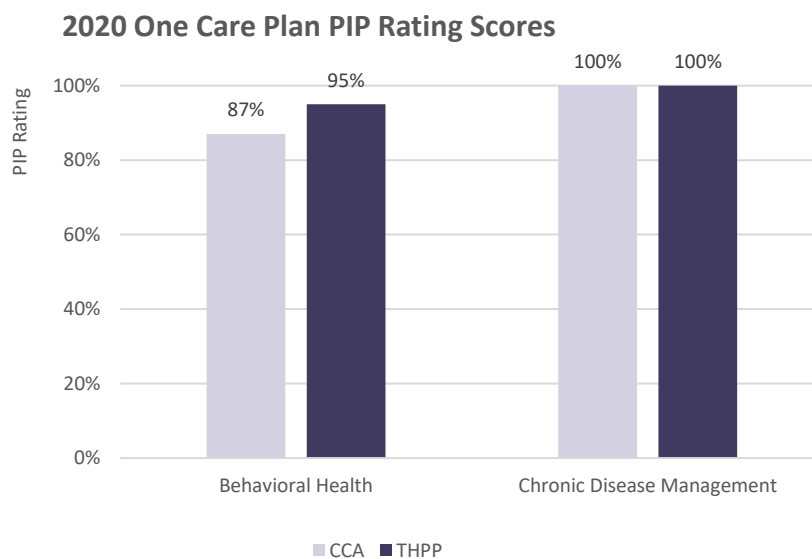
Kepro evaluates each Performance Improvement Project to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 1. Kepro also assesses whether the projects have achieved or likely will achieve favorable results.

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

The chart that follows depicts One Care Plan rating scores for Performance Improvement Projects validated in 2020.

Exhibit 4.2. One Care Plan PIP Rating Scores



PLAN-SPECIFIC PERFORMANCE IMPROVEMENT PROJECT RESULTS

As required by CMS, Kepro is providing project-specific summaries using CMS Worksheet Number 1.11 from EQR Protocol Number 1, Validating Performance Improvement Projects. The PIP Aim Statement is taken directly from the managed care plan's report to Kepro as are the Improvement Strategies or Interventions. Performance indicator data was taken from this report as well. Kepro calculated statistical significance for results using the Z test. Kepro validated each of these projects, meaning that it reviewed all relevant parts of each PIP and made a determination as to its validity. The PIP Technical Reviewer assigned a validation confidence rating, which refers to Kepro's overall confidence that the PIP adhered to

acceptable methodologies for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement or the potential for improvement. Recommendations offered were taken from the Reviewers' rating forms. As is required by CMS, Kepro has identified managed care plan and project strengths as evidenced in the PIP.

DOMAIN 1: BEHAVIORAL HEALTH

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

1. General PIP Information

Managed Care Plan (MCP) Name: Commonwealth Care Alliance (CCA) One Care Plan
PIP Title: Cardiovascular Disease Prevention in One Care Members with Mental Illness and Multiple Risk Factors
PIP Aim Statement: <i>Member-Focused</i> <ul style="list-style-type: none"> 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. <i>Provider-Focused</i> <ul style="list-style-type: none"> 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.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify): Duals
Programs: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Health Outreach Workers provide health-coaching and support for members with mental illness whose smoking puts them at high risk of developing cardiovascular disease.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Not applicable.

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

Health Outreach Workers communicate individual member smoking cessation program participation to the member's primary care provider, care partner, and Department of Mental Health case managers.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>Short-Term Smoking Cessation Rate</i> – The number of members who were smokers at the time they were offered the coaching program who report at the time of program completion that they had quit smoking at the completion of the ten-week intervention.	2017	0/70 0%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	6/67 9%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
<i>Long-Term Smoking Cessation Rate</i> – The number of members who were smokers at the time they were offered the coaching program who continued to report that they had quit smoking six months after completing the program.	2017	0/70 0%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	5/76 7%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Validation phase (check all that apply): <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input checked="" type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input checked="" type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of PIP: A stronger response would have presented a table summarizing the findings from the Smoking Cessation Questionnaire broken out by members who completed the health coaching curriculum compared to those members who did not complete it. Kepro advises that the PIP leadership team especially learn the difference between a process-descriptive summary of intervention activities versus an outcomes (effectiveness) evaluation of intervention activities.

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 85% on this Performance Improvement Project.

Exhibit 4.3. CCA CVD PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	7	78%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	9.0	75%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5.0	15.0	13.0	87%
Remeasurement Performance Indicator Rates	5.0	15.0	11.6	77%
Conclusions and Lessons Learned	2	6	5	83%
Overall Validation Rating Score	25.0	75.0	63.6	85%

Plan & Project Strengths

CCA is commended for modifying its member outreach services in order to make this a more positive experience for its PIP-eligible members. Instead of Health Outreach Workers serving as outreach staff who have no prior relationship with the member, CCA is now using Care Partners who have an established relationship with the PIP-eligible members.

CCA is commended for its use of the Smoking Assessment Questionnaire as a method to assess each member's individual characteristics relative to smoking cessation.

Follow Up to 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Follow Up
Kepto suggests that CCA continue tracking the results of coaching to determine opportunities to improve the desired outcome of smoking cessation. In addition to motivational interviewing skill improvement, CCA could consider other options for engaging with members, such as text messages to provide ongoing brief educational messages and support.	The outreach staff who completed the smoking cessation coaching program were knowledgeable and dedicated to the task.
In future reports, Kepto suggests that CCA speak in more detail to the value of MAT in improving the rate of members' smoking cessation.	CCA has presented no comparative data analysis to support its conclusion that Medication Assisted Treatment is successful when administered in combination with its behavioral coaching program.

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

1. General PIP Information

Managed Care Plan (MCP) Name: Tufts Health Public Plans (THPP) One Care Plan
PIP Title: Improve Therapy Visit Rate for Members with Depression
PIP Aim Statement: <i>Member-Focused</i> <ul style="list-style-type: none"> • 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; and • Increase the members' adherence to behavioral health treatment. <i>Provider-Focused</i> <ul style="list-style-type: none"> • Increase depression screening by primary care providers; • Increase referrals to behavioral health specialists; and • Increase provider awareness and use of evidence-based protocols related to the management of depression.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify): Duals
Programs: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Tufts Care Managers conduct outreach to members diagnosed with depression who are not receiving therapy.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Tufts published an educational 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 in writing 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.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) Not applicable.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Therapy Visit Rate for Depressed Members seen at high-volume health centers.	2017	189/546 34.6%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	195/532 36.7%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
The rate of depressed members not receiving behavioral health therapy services	2017	342/848 40.8%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	273/596 45.8%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input checked="" type="checkbox"/> <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Validation phase (check all that apply): <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input checked="" type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify): Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of PIP: In future population analyses for this project, Kepro encourages THP to include all members with a diagnosis of depression and disaggregating the data by members served in the 10 high-volume provider groups compared to members with depression who were not served by the high-volume provider groups. This expanded analysis would allow THP to determine whether members with depression served by the high-volume provider groups are comparable to members with depression not served by them.

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 100% on this Performance Improvement Project.

Exhibit 4.4. THPP PIP Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	5.0	15.0	15.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Lessons Learned	2	6	6	100%
Overall Validation Rating Score	24	72	72	100%

Plan & Project Strengths

- THPP is commended for the activities it has pursued to ensure the cultural competency of its PIP-related services.
- Kepro commends THPP for utilizing telehealth services for both outreach and behavioral health visits. Kepro commends THPP for partnering with community organizations such as City Block Health to address specific social challenges for members with high poverty rates.
- Kepro commends the PIP team for its excellent and dedicated work on this project.

Follow Up to 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Follow Up
Kepro recommends considering additional activities to engage with members for appropriate follow up after screening positive for depression such as text messages.	Kepro commends THPP for utilizing telehealth services for both outreach and behavioral health visits.
Kepro recommends that THPP develop strategies for bringing together PCP and BH providers for a discussion of the barriers related to the successful management of referrals for BH care and the integration of care. These barriers can then be clarified through a root cause analysis, which can in turn lead to provider-informed strategies for new intervention activities.	Tufts does not speak to this recommendation in its report.
Kepro recommends that providers be queried about their knowledge of, or relationship with, BH specialty providers. PCPs may be reluctant to make referrals to BH specialists if they do not know to whom they are referring their patients.	Tufts does not speak to this recommendation in its report.

DOMAIN 2: CHRONIC DISEASE MANAGEMENT

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

1. General PIP Information

Managed Care Plan (MCP) Name: Commonwealth Care Alliance (CCA) One Care Plan
PIP Title: Improving the Rate of Cervical Cancer Screening Among CCA One Care Members
PIP Aim Statement: <i>Member-Focused</i> <ul style="list-style-type: none"> 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; and Outreach to members to engage and motivate them to schedule cervical cancer screening. <i>Provider-Focused</i> <ul style="list-style-type: none"> 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; and 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.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify): Duals
Programs: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>CCA distributed an educational member newsletter in English, Spanish, and Portuguese and a mailing in English and 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.</p>
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Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

Not applicable.

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

CCA-employed providers and care partners received education in women's health.
CCA established Women's Health clinics in Commonwealth Community Care locations.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Women 24-64 years of age who were screened for cervical cancer NCQA 0032	2017	247/380 65.00%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	135/315 55.56%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☐ First remeasurement ☒ Second remeasurement ☐ Other (specify):

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

EQRO recommendations for improvement of PIP:

CCA presents no evidence of having assessed the effectiveness of its provider education program to improve the rate of cervical cancer screenings among providers who had been exposed to its educational program compared to those not exposed.

It did not conduct an appropriate evaluation of its member education program. CCA appears to have evaluated the response of its members to its IVR campaign, comparing the response rate of 2018 to 2019. The data that CCA present in this item is a process evaluation of the extent to which modifications to IVR protocol improved the rate at which members access to screening for cervical cancer. For example, CCA found that its IVR improvements led to a higher rate (nine percentage points) of members transferred to member services when 2019 was compared to

2018. This finding is positive for the project, but an increase in the rate of members transferred to member services does not necessarily demonstrate that these members improved their rate of cancer screenings.

CCA's findings are inadequately explained. It does not explain how the subset of eligible members screened by its Women's Health Clinic relates to the overall performance rate of eligible members who were not screened at its Women Health Clinic.

CCA presents a list of important lessons that it learned from the operation of this project. Kepro encourages CCA to keep these lessons in mind when formulating new PIPs in 2021.

Kepro strongly advises CCA to learn how to evaluate the effectiveness of its interventions by understanding the difference between a process description, how many activities were completed, versus an effectiveness evaluation, how those intervention activities changed member behavior or provider practice behavior.

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 95% on this Performance Improvement Project.

Exhibit 4.5. CCA Validation Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	9	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	7.7	64%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	7	21	21	100%
Remeasurement Performance Indicator Rates	5	15	15	100%
Conclusions and Lessons Learned	2	6	6	100%
Overall Validation Rating Score	28.0	84.0	79.7	95%

Plan & Project Strengths

CCA has described an appropriate methodology for medical record data abstraction and is commended for its robust inter-rater reliability evaluation.

CCA has devoted a lot of attention and resources to this project to improve cervical cancer screening rates for women 24 to 64. The PIP team is commended for the good work that was put into this project.

Follow Up to 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Follow Up
As a practice recommendation for providers, Kepro suggests integrating cervical cancer screening into its workflows proactively. CCA might consider adding an EHR flag to initiate a discussion about the benefits of screening prior to the member's visit to a PCP or OB/GYN.	CCA did not speak to this recommendation in its final report.
Kepro recommends that CCA track the response rate to its Interactive Voice Response (IVR) calls.	CCA did not speak to this recommendation in its final report.

TUFTS HEALTH PUBLIC PLANS: EMERGENCY DEPARTMENT UTILIZATION

1. General PIP Information

Managed Care Plan (MCP) Name: Tufts Health Public Plans One Care Program
PIP Title: Emergency Department Utilization
PIP Aim Statement: <i>Member-Focused</i> <ul style="list-style-type: none"> 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; and Improve the member's understanding of access to Urgent Care Centers for non-urgent health needs rather than the ED when appropriate. <i>Provider-Focused</i> <ul style="list-style-type: none"> 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; and Increase provider awareness of Urgent Care Centers as an option for members' non-urgent needs.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
Target population description, such as duals, LTSS or pregnant women (please specify): Duals
Programs: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>THPP contacts members after an emergency department visit to encourage them to be seen by their primary care provider for follow up with the goal of preventing future ED visits through better PCP care management.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>

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

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.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Emergency Department Utilization (EDU) NCQA 1768	2017	2347/ 3380 1440/K members	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	2372/3150 1328/K members	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):

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

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

EQRO recommendations for improvement of PIP:

Kepro encourages THPP to continue working with its high-volume provider groups to drill down on the trends in utilization rates for its three utilization risk-groups: members with 1-3 visits, 4-9 visits, and more than 10 visits. THPP may find that each of these risk-groups present their own unique challenges that may require modifications to interventions depending on the barriers presented by these three cohorts.

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 100% on this Performance Improvement Project.

Exhibit 4.6. THPP Emergency Department Utilization PIP Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes*	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters*	4	12	12	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Lessons Learned	2	6	6	100%
Overall Validation Rating Score	23	69	69	100%

Plan & Project Strengths

- THPP is commended for the range of factors that it included in its population analysis, which characterized the many barriers related to lowering the rate of ED utilization for high-risk members, including comorbidities, need for transportation assistance and durable medical equipment at home, substance use, and homelessness. THPP's response to this item stratifies these potential barriers into intervention activities related to both members and providers. THPP is commended for the proposed intervention activities with the objective of addressing these barriers.
- THPP has presented a viable and commendable methodology for assessing the effectiveness of its member outreach intervention.
- THPP is commended for its dedication to contact members with avoidable ED visits and its diligence in collecting post-discharge structured feedback from members contacted regarding reasons for the ED visits and members' perception of options for alternative care.

Follow Up to 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Follow Up
THPP should consider focusing on the members with high rates of ED utilization by attempting to engage them in intensive care management.	Substance use disorder and homelessness are contributing factors to high ED utilization. Tufts intends to explore collaboration between the care management and behavioral health teams to share knowledge on how to minimize these members' ED visits.

Section 5:

Compliance Validation



SECTION 5: COMPLIANCE VALIDATION

INTRODUCTION

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

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

REVIEW (LOOK-BACK) PERIOD

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

REVIEW STANDARDS

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

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

COMPLIANCE REVIEW TOOLS

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

REVIEW PROCESS

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

One Care plans were provided with the appropriate review tools and asked to provide documentation to substantiate compliance with each requirement during the review period. Examples of documentation provided included:

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

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

SCORING METHODOLOGY

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

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

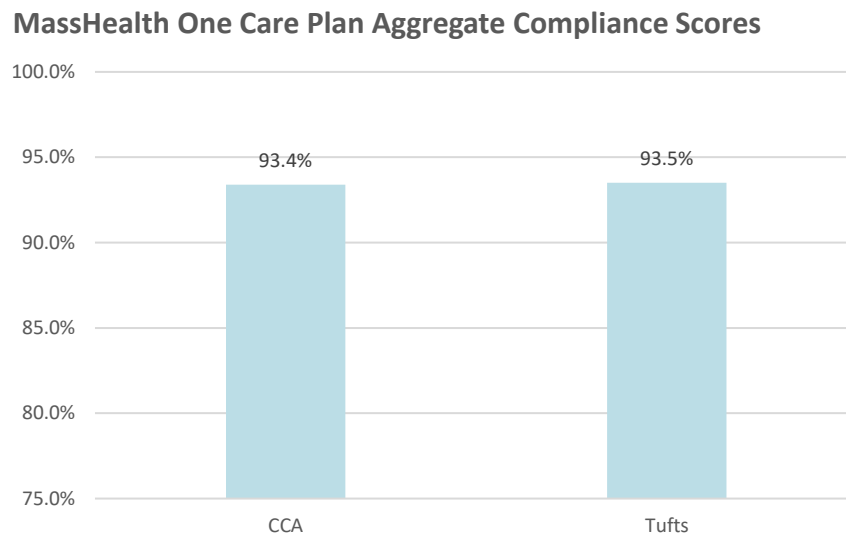
An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by the total possible points (Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points). In addition, an overall percentage compliance score for all standards was calculated to give each standard equal weighting. The total percentages from each standard were divided by the total number of standards reviewed. For each area identified as Partially Met or Not Met, 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 obtained the most current NCQA accreditation standards and reviewed the accreditation standards against the CFRs. In cases in which the accreditation standard was at least as stringent as the CFR, Kepro flagged the review element as eligible for deeming. For a review standard to be deemed, Kepro evaluated the One Care plan's most current accreditation review and scored the review element as "Met" if it scored 100 percent on the accreditation review element.

ONE CARE COMPLIANCE VALIDATION RESULTS

The graph that follows depicts the compliance scores for each One Care plan reviewed:

Exhibit 5.1: One Care Plan Aggregate Compliance Scores



The table the follows depicts One Care Plan scores on individual compliance standards.

Exhibit 5.2: One Care Plan Compliance Scores by Standard

Compliance Standard	Commonwealth Care Alliance	Tufts Health Public Plans
Availability of Services	91.1%	88.4%
Assurances and Adequate Capacity and Services	100%	100%
Enrollee Rights and Protection	100%	78.6%
Enrollment/Disenrollment	100%	90.9%
Availability of Services – Enrollee Information	95.0%	79.9%
Provider Selection	94.7%	94.7%
Grievance and Appeal System	93.1%	96.2%
Subcontractual Relationships and Delegation	92.9%	96.4%
QAPI	99.0%	98.0%
Health Information Systems	100%	100%
Coverage and Authorization of Services	93.4%	90.6%
Practice Guidelines	50.0%	100%
Confidentiality of Health Information	100%	100%
Coordination and Continuity of Care	100%	94.2%

AGGREGATE OBSERVATIONS AND RECOMMENDATIONS

The 2020 Compliance Review was the second formal comprehensive review period since the inception of the One Care program. The One Care plans performed remarkably well with demonstrating compliance with many of the federal and State contractual requirements for the

One Care program. Due to the unique needs of the One Care population, which includes non-elderly adults (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, a heavy emphasis of review was placed on the coordination and continuity of care standard. In general, the One Care plans demonstrated strong models of care supporting the overarching goals of coordinated care for One Care members.

Overall, the models of care were found to be a strength of both CCA and Tufts. The service delivery model to meet the unique needs of the One Care population was remarkable. Both plans demonstrated excellence in services provided to their One Care members. Many of these members rely on One Care services daily and, without them, would likely be institutionalized. The review found that the One Care plans were highly successful with innovative strategies to deliver high quality care and services to members.

In general, the One Care plans' greatest opportunity for improvement is related to the availability of service standards. The review found that, while One Care plans were conducting analysis to evaluate network adequacy, not all requirements were being met across all service categories, including some within Long-Term Services and Supports (LTSS). In addition, Kepro did not find strong evidence of One Care plans' process for evaluating appointment access against the MassHealth standards.

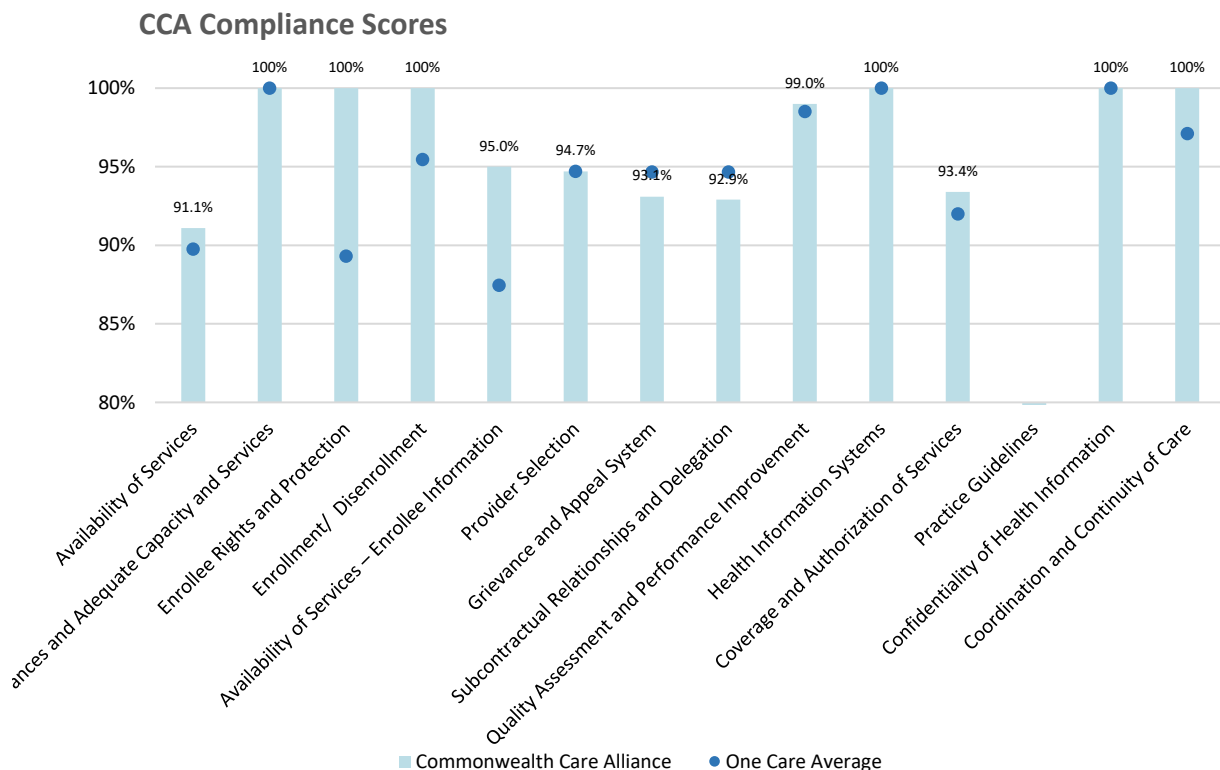
Overall, the 2020 compliance review found that One Care plans performed best in the areas of care delivery and quality of care. The review showed focused activities and resources to meet the needs of the One Care population. In addition, One Care plans did well meeting compliance standards related to timeliness of care, i.e., One Care plans did well with meeting timelines for making coverage and appeal decisions and resolving grievances, thereby reducing unnecessary delays in care and service. One Care plans have opportunities to improve mechanisms to access network adequacy across all service categories as well as appointment access to determine if there are deficiencies.

PLAN-SPECIFIC COMPLIANCE VALIDATION RESULTS

Commonwealth Care Alliance

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 24-25, 2020.

Exhibit 5.3. CCA Compliance Scores



Strengths

- CCA performed best overall and the highest in most compliance review standards when compared to its competitor One Care plan.
- CCA was found to be the highest performing One Care plan in terms of fidelity to its model of care, innovation of care, and service delivery to meet the needs of its membership.
- CCA demonstrated a highly data-driven quality program. The review found CCA to have a comprehensive understanding of its One Care members' needs, with most members have either a physical or behavioral health disability – or both -- who touch the health care system every day.
- CCA excelled in its service delivery of care, services, and overall quality program. The review noted CCA's Complex Transitional Care Program aimed at hospital care transitions for high-need members and the instead program, which provides a mobile integrated health solution for members with urgent care needs, as examples of innovation as well as success.

Substantive Findings

- The review found that, while CCA performed best in overall service delivery, CCA's administrative systems and processes need improvement. In general, CCA's policies and procedures were outdated and did not accurately reflect operational practices. There was a lack of consistency for annual policy and procedure review, edits, and approval.
- The audit found that while CCA performed geo-access analysis, the plan had some challenges meeting behavioral health and LTSS proximity access requirements. In addition, CCA did not have a process for monitoring provider availability and appointment scheduling standards. Furthermore, CCA did not have a process to demonstrate access for non-English speaking members choice of providers within each service category.
- In the areas of Grievance and Appeals, which was one of CCA's lowest scoring areas, findings were primarily related to policies and procedures being outdated as well as the absence of specific language to address federal and State contract provisions.
- CCA's lowest performance was in the area of practice guidelines. The review found that CCA lacked evidence supporting review of clinical practice guidelines in 2019. The review also found that while CCA used criteria for utilization management, these criteria were not sufficient to meet clinical guideline requirements.

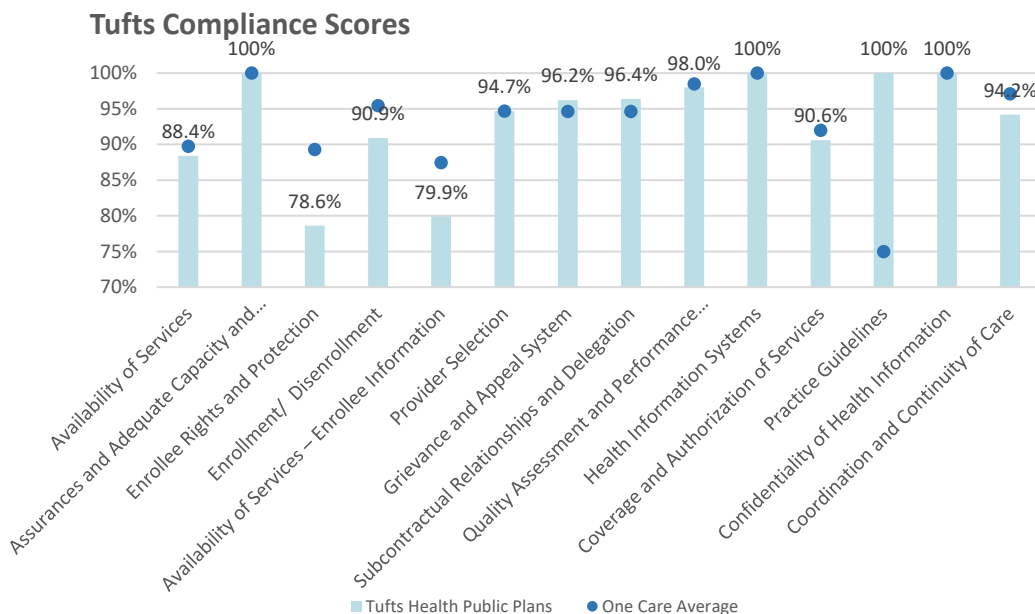
Recommendations

- CCA needs to revise many of its outdated policies and procedures to ensure compliance with all federal and MassHealth standards. In addition, the policies and procedures need to be streamlined to align with existing operational practices. CCA may benefit from technology solutions to aid in the tracking of policies and procedures across the organization.
- CCA needs to continue to work towards meeting MassHealth network adequacy and accessibility standards.
- CCA needs to adopt practice guidelines in consultation with contracting health care professionals and ensure that they are reviewed and updated periodically, as appropriate.
- CCA needs to address all Partially Met and Not Met findings identified as part of the 2020 compliance review.

Tufts Health Public Plans

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 29 – October 1, 2020.

Exhibit 5.4. Tufts Compliance Scores



Strengths

- The review found that Tufts made an effort in 2019 to consolidate some of its utilization management functions that had been previously managed by care management into its utilization management team. In addition, efforts were made to better align behavioral health activities with behavioral health clinical expertise. The consolidations may better position Tufts to manage coverage determinations more efficiently and consistently and may improve the management of One Care members with behavioral health needs.
- The review revealed that one of Tufts' greatest strengths is its focus on person-centered care. This focus spanned functional areas across the organization. Tufts demonstrated a good effort to ensure that enrollees had access to Long-Term Services and Supports. Tufts incorporated the use of a survey to better assess services provided by the Aging Services Access Points (ASAPs), identified deficiencies, and collaboratively worked with vendors to address areas of concern.
- Kepro noted that Tufts credentialing manual is a best practice which aligns with Tufts high performance in the area of Provider Selection.
- Tufts identified and incorporated the use of some creative resources to engage and outreach members. In addition, Tufts developed its own member satisfaction survey to obtain member experience information since it identified limitations with using national

CAHPS surveys. These activities demonstrate Tufts' focus on enhancing service delivery specific to the needs of the One Care population.

Substantive Findings

- Kepro noted some gaps in the routine revision and approval of policies and procedures in 2019, which were likely due in part to Tufts consolidation efforts.
- Kepro found functional areas to be somewhat siloed and, while staff were knowledgeable of their functional responsibilities, staff members were less likely to see how their role fits into the large organization.
- The review found that Tufts greatest opportunity is related to the Availability of Services standard. Tufts did not meet all time and proximity standards and did not meet all specialist-to-Enrollee ratios for all specialty provider types. In addition, Tufts lacked evidence of appointment access monitoring to ensure that State access standards were being met. Furthermore, Tufts did not have a process to demonstrate access for non-speaking members choice of providers within each service category.
- Tufts remaining deficiencies were largely due to outdated policies and procedures that need minor revisions to bring them into compliance, some revisions to enrollee communications, and submission of reporting to MassHealth. While these were found to be non-compliant and need to be addressed, they were not substantive enough in nature to raise concerns as to the delivery of care and services.

Recommendations

- Tufts needs to continue its efforts related to policy and procedure and documentation revisions to ensure compliance with all federal and MassHealth standards.
- Tufts' One Care population reflects a very small percentage of its total membership. One Care members, however, present with higher complexity and need more resources. Tufts needs to continue to ensure that staff members work on cross-team communication and collaboration to ensure One Care members' needs are met.
- Tufts needs to continue efforts to meet all State requirements for time and proximity and for availability of service standards.
- Tufts needs to implement a mechanism to assess appointment access to ensure that State access standards are met.
- Tufts needs to address all Partially Met and Not Met findings identified as part of the 2020 compliance review.

Section 6:

Network Adequacy Validation



SECTION 6: NETWORK ADEQUACY VALIDATION

INTRODUCTION

The concept of Network Adequacy revolves around a managed care plan's ability to provide its members with an adequate number of in-network providers located within a reasonable distance from the member's home. Insufficient or inconvenient access points can create gaps in healthcare. To avoid such gaps, MassHealth stipulates contractually required time and distance standards as well as threshold member to provider ratio to ensure access to timely care.

In 2020, MassHealth, in conjunction with its EQRO contractor, Kepro, initiated an evaluation process to identify the strengths of the health plan's provider networks, as well as to offer recommendations for bridging network gaps. This process of evaluating a plan's network is termed Network Adequacy Validation. While this type of evaluation and reporting is not required by CMS at this time, the Commonwealth of Massachusetts was strongly encouraged by CMS to incorporate this activity as an annual process evaluation, as it will be required in the future.

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

Using Quest, Kepro has analyzed the current performance of the plans based on the time and distance standards that the state requires, while also identifying gaps in coverage by geographic area and specialties. The program also provides information about all available providers should network expansion be required. This information is based on a list of all licensed physicians from the Massachusetts Board of Registration in Medicine that Kepro obtained. These suggestions will help close gaps and provide Medicaid members with improved access to timely healthcare, the primary goal.

REQUEST OF PLAN

To build this software tool, MassHealth requested a complete data set from each One Care plan, which included the following data points:

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

For the first year of network validation activities, the technical report focuses specifically on plan adequacy with regard to Medicare Advantage network standards. KEPRO is currently assessing compliance with Medicaid Network Adequacy standards and related reporting will be posted to the MassHealth website when it becomes available.

It's important to note that no information regarding beneficiaries was requested from the plans. The goal of Network Adequacy is to ensure that every carrier has adequate access to care for the plan's entire service area. When measuring access to care using only existing membership, that dataset may not always be representative of the entire service area. Additionally, measuring only existing membership does not account for future growth or expansion of existing service areas. Therefore, MassHealth, performed the network adequacy reviews using a representative set of population points, 3% of the population, distributed throughout the service area based on population patterns. This methodology allowed MassHealth to ensure each carrier was measured consistently against the same population distribution and that the entire service area has adequate access to care within the prescribed time and distance criteria.

The following section compiles the Time and Distance Standards to which MassHealth requires the One Care plans adhere for their provider networks.

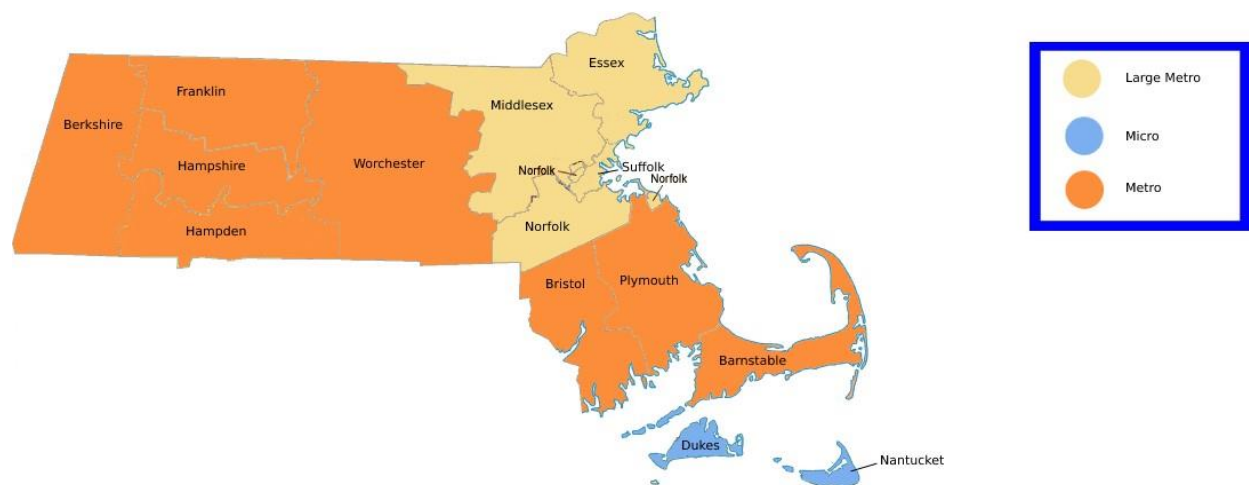
TIME AND DISTANCE STANDARDS

For Medicaid members to receive appropriate access to care for medical services, MassHealth requires the One Care plans adhere to certain time and distance standards.

As required by Medicare Advantage regulations, One Care plans must meet both the time and the distance standard for Medicare Advantage-specified providers, not either or. For example, the standard for Emergency Support Services is a minimum of two providers within a 15-mile radius of the member's home AND a distance of no more than 30 minutes.

It's important to note that for some specialties, the time and distance standards vary based on the county CMS designation, i.e., large metro, metro, or micro. The following map shows the county designations, for reference:

Exhibit 6.1. Map of Massachusetts County Designations



The standards for all Medicare Advantage specified medical services are outlined below, according to grouping and specialty.

PRIMARY CARE: ADULT PCP SERVICES:

The time and distance standard for Adult Primary Care Providers requirement is within 15 miles and 30 minutes.

MEDICAL FACILITIES:

The Acute Inpatient Hospitals, the standard changes based on the county type, outlined in the following table:

Exhibit 6.2. Acute Inpatient Hospital Standards

Specialty	County Type	# of Providers	Time (Minutes)	Distance (Miles)
Acute Inpatient Hospital	Large Metro	≥2	25	10
Acute Inpatient Hospital	Metro	≥2	45	30
Acute Inpatient Hospital	Micro	≥2	80	60

SPECIALIST SERVICES:

CMS requires a variety of different standards for specialists based on the specialty as well as the county size. Specialty services are also required to meet a certain ratio of providers to plan members. The charts below outline the specialty type and the corresponding standards, separated by the county designation. Also included is the required ratio of providers to managed care plan members. It is important to note that the One Care plans do not service the Micro counties, Dukes and Nantucket.

The chart that follows outlines the time and distance requirements for Large Metro and Metro Counties.

Exhibit 6.3. Specialist Standards for Large Metro and Metro Counties

Specialty	Large Metro Counties			Metro Counties		
	Ratio	Time (Minutes)	Distance (Miles)	Ratio	Time (Minutes)	Distance (Miles)
OB/GYN	0.04	30	15	0.04	45	30
Allergy and Immunology	0.05	30	15	0.05	53	35
Cardiology	0.27	20	10	0.27	38	25
Cardiothoracic Surgery	0.01	30	15	0.01	60	40
Chiropractor	0.1	30	15	0.1	45	30
Dermatology	0.16	20	10	0.16	45	30
Endocrinology	0.04	30	15	0.04	75	50
ENT/Otolaryngology	0.06	30	15	0.06	45	30
Gastroenterology	0.12	20	10	0.12	45	30
General Surgery	0.28	20	10	0.28	30	20
Infectious Diseases	0.03	30	15	0.03	75	50
Nephrology	0.09	30	15	0.09	53	35
Neurology	0.12	20	10	0.12	45	30
Neurosurgery	0.01	30	15	0.01	60	40
Oncology - Medical, Surgical	0.19	20	10	0.19	45	30
Oncology - Radiation	0.06	30	15	0.06	60	40

Ophthalmology	0.24	20	10	0.24	38	25
Orthopedic Surgery	0.2	20	10	0.2	38	25
Physiatry, Rehabilitative Medicine	0.04	30	15	0.04	53	35
Plastic Surgery	0.01	30	15	0.01	75	50
Podiatry	0.19	20	10	0.19	45	30
Psychiatry	0.14	20	10	0.14	45	30
Pulmonology	0.13	20	10	0.13	45	30
Rheumatology	0.07	30	15	0.07	60	40
Urology	0.12	20	10	0.12	45	30
Vascular Surgery	0.02	30	15	0.02	75	50

EVALUATION METHOD

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

Exhibit 6.4. Results Color Scheme

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

RESULTS BY PLAN

COMMONWEALTH CARE ALLIANCE

At the time that Network Adequacy Validation was completed, CCA had expanded its service areas into Berkshire County and the remainder of Plymouth County. Previous measures were evaluated based on CCA's geographic footprint in 2019. Dually eligible Medicare and Medicaid beneficiaries from Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties are eligible to enroll in CCA One Care

STRENGTHS

The majority of CCA Specialty Provider time and distance access standards received the highest score of 100 or a **Green** color. All services that received a **Green** color are outlined in the chart that follows.

Exhibit 6.5. Services with a 100score

Medical Facility		
Acute Inpatient Hospital		
Specialists		
Cardiology	Infectious Diseases	Plastic Surgery
Cardiothoracic Surgery	Nephrology	Podiatry
Chiropractor	Neurology	Psychiatry
Endocrinology	OBGYN	Pulmonology
ENT/Otolaryngology	Oncology - Medical, Surgical	Rheumatology
Gastroenterology	Ophthalmology	Urology
General Surgery	Orthopedic Surgery	Vascular Surgery

AREAS FOR IMPROVEMENT

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

Table 6.6 Specialty Care Gaps in Service

County	Adult PCP	Allergy and Immunology	Dermatology	Neurosurgery	Oncology – Radiation	Physiatry – Rehab Medicine*
Barnstable						
Berkshire						
Bristol						
Essex						
Franklin						
Hampden						
Hampshire						
Middlesex						
Norfolk						
Plymouth						
Suffolk						
Worcester						

*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

FINDINGS

- The plan submitted no data For Physiatry–Rehab Medicine. CCA received a red score for this service.
- Berkshire County currently has the most gaps in access to care when compared to the other 11 counties.

TUFTS HEALTH PLAN

This plan services Middlesex, Suffolk, and Worcester counties.

STRENGTHS

All Tufts Specialties except one, Cardiothoracic Surgery, received the highest score of 100, or a **Green** color. Similarly, the Primary Care Adult PCP and one Medical Facility service also received this score. All services that received a **Green** color are outlined in the chart that follows.

Exhibit 6.7.. Services with a 100 score

Primary Care	Medical Facility
Adult PCP	Acute Inpatient Hospital
Specialists	
Allergy and Immunology	Oncology - Medical, Surgical
Cardiology	Oncology - Radiation/Radiation Oncology
Chiropractor	Ophthalmology
Dermatology	Orthopedic Surgery
Endocrinology	Physiatry, Rehabilitative Medicine
ENT/Otolaryngology	Plastic Surgery
Gastroenterology	Podiatry
General Surgery	Psychiatry
Infectious Diseases	Pulmonology
Nephrology	Rheumatology
Neurology	Urology
Neurosurgery	Vascular Surgery
OBGYN	

AREAS FOR IMPROVEMENT

Only Cardiothoracic Surgery is not currently meeting the time and distance standards. And only in Middlesex County.

Exhibit 6.8. Specialty Gaps and Corresponding Counties

Category	Specialty	Counties		
		Middlesex	Suffolk	Worcester
Specialists	Cardiothoracic Surgery			

FINDINGS

- The only Specialty service to have a gap in the network is Cardiothoracic Surgery. In Middlesex county, this service is only meeting the provider to member ratio requirement.

CONCLUSION

Over the course of this analysis, Kepro has identified many strengths across the One Care plans. Certain areas, such as Acute Inpatient Hospitals, excelled in both One Care plan's analysis of the provider network.

This year's network adequacy evaluation allowed MassHealth to assess baseline performance and identified several opportunities for performance. MassHealth is working with Plans to address areas of noncompliance.

While not all requirements are being met in all areas, there are opportunities for the plans to strengthen the network for improved medical and behavioral health care to One Care members. Both One Care plans experienced difficulty submitting complete provider data for analysis, resulting in lower scores for various services. This could be a result of a lack of infrastructure to analyze and obtain the data necessary to evaluate a plan's overall health care network and access to that care. Although stated contractually, these plans may not be fully aware of the compliance aspect of this evaluation, or the expectations of the data request. Strengthening or creating these structural mechanisms would be key to improving the network and meeting compliance standards. As this is the first year conducting this review, One Care plans may need to build analytic processes for future reporting. Both plans need to continue working towards meeting the network adequacy and accessibility standards.

This report also shows that certain geographical areas struggle to meet the time and distance standard overall, across all health care services. The state may conduct further analysis into these regions to assess whether or not these counties have the ability to meet the standards in their entirety. If not, the state may want to consider approving an exception for these plans, or adjust the standards going forward, in order to accommodate the plan's ability to provide health care to its members.



Section 8

Appendices

APPENDIX. CONTRIBUTORS

PERFORMANCE MEASURE VALIDATION REVIEWER

Katharine Iskrant, MPH, CHCA, CPHQ

Katharine is the President of Healthy People, an NCQA-licensed HEDIS audit firm. She is a member of the NCQA Audit Methodology Panel and NCQA's HEDIS Data Collection Advisory Panel. She is also featured on a 2020 NCQA HEDIS Electronic Clinical Data Systems (ECDS) podcast. Katharine has been a Certified HEDIS® Compliance Auditor since 1998 and has directed more than two thousand HEDIS audits.

Previously, as CEO of the company Acumetrics, Katharine provided consultancy services to NCQA which helped their initial development and eventual launch of the NCQA Measure Certification Program.

Katharine is a frequent speaker at HEDIS conferences, including NCQA's most recent Healthcare Quality Congress. She received her BA from Columbia University and her MPH from UC Berkeley School of Public Health. She is a member of the National Association for Healthcare Quality and is published in the fields of healthcare and public health.

PERFORMANCE IMPROVEMENT PROJECT REVIEWERS

Bonnie L. Zell, MD, MPH, FACOG

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

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

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

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

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

She served as Executive Director of Clinical Improvement at the statewide Hospital Quality Institute in California, building the capacity and capability of healthcare organizations to improve quality and safety by reliably implementing evidence-based practices at all sites of care through the CMS Partnership for Patients initiative.

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

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

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

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

Dr. Zell is Clinical Director for Kepro, providing External Quality Review to improve Medicaid Managed Care performance improvement projects through evaluation of project design, measure validation and feedback to improve intervention impact.

Wayne J. Stelk, Ph.D.

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

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

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

COMPLIANCE VALIDATION REVIEWERS

Jennifer Lenz, MPH, CHCA

Ms. Lenz has more than 19 years' experience in the healthcare industry, with expertise in implementing and managing external quality review activities, managing teams, and driving quality improvement initiatives. Ms. Lenz has working experience in both private and public health sectors. Her 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, Massachusetts, Ohio, Utah, and Virginia. Ms. Lenz is a Certified HEDIS® Compliance Auditor through the NCQA. She holds a Master in Public Health from the University of Arizona.

Jane Goldsmith, RN, MBA, CSSGB, CHC

Ms. Goldsmith has more than 30 years' experience in the healthcare industry with expertise in leading teams in public health nursing activities and implementing quality assurance, regulatory compliance, and accreditation activities. Her prior experience includes senior management and executive roles in managed care organizations with responsibility for quality improvement, regulatory compliance, accreditation, and internal audit. She has conducted external quality review activities across health plans in the states of California, Virginia, Florida, Illinois, Ohio, and Michigan. She also served five years as an adjunct faculty member for John Hopkins Bloomberg School of Public Health. Ms. Goldsmith has been Certified in Healthcare Compliance (CHC) by the Compliance Certification Board (CCB) and Certified as Six-Sigma Green Belt (CSSBG) by Villanova University. She received her Bachelor of Science in Nursing from Eastern Michigan University and master's in business administration in Integrative Management from Michigan State University. She holds registered nurse licenses in Michigan, Illinois, and Florida.

Sue McConnell, RN, MSN

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

Poornima Dabir, MPH, CHCA

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

Debra Homovich, BA

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

PROJECT MANAGEMENT

Cassandra Eckhof, MS, CPHQ

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

Emily Olson, BBA

This is Ms. Olson's first year working with the Kepro team as a Project Coordinator. Her previous work was in the banking industry. She has a Bachelor's in Business Management and Human Resources from Western Illinois University.