



TECHNICAL REPORT

One Care Plans External Quality Review

Calendar Year 2021



MassHealth

Massachusetts Executive Office
of Health & Human Services



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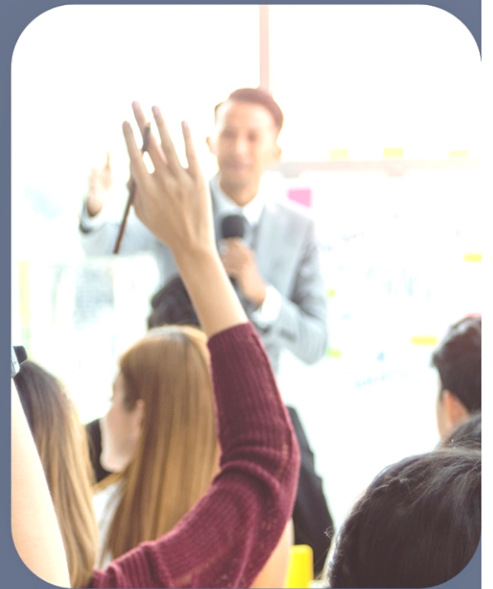
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Section 1.

The One Care Plans



SECTION 1. THE ONE CARE PLANS

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 to 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 Unify, continued to enroll dual eligibles in 2021 in what are now called One Care plans.

COMMONWEALTH CARE ALLIANCE (CCA)

CCA is a community-based, not-for-profit healthcare organization headquartered in Boston. Its service area includes Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. It is seeking NCQA accreditation for 2022. More information about CCA is available at www.commonwealthcare.org.

TUFTS HEALTH PUBLIC PLANS (TUFTS HEALTH UNIFY)

Tufts Health Unify is operated by Tufts Health Public Plans. On January 1, 2021, Tufts Health Plan merged with Harvard Pilgrim Health Care as of January 1, 2021. The newly formed corporate parent is Point32Health. Its headquarters are in Canton. Tufts Health Unify serves beneficiaries in Middlesex, Suffolk, and Worcester counties. Additional information is available at <https://tuftshealthplan.com/member/tufts-health-unify/home>.

Exhibit 1.1. One Care Membership¹

One Care Plan	Acronym Used in this Report	Membership as of December 31, 2021	Percent of Total One Care Population
Commonwealth Care Alliance	CCA	28,593	89.9%
Tufts Health Public Plans	Tufts Health Unify	3,206	10.1%
Total		31,799	100%

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 plans to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a managed care plan or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth has entered into an agreement with Kepro to perform EQR services related to its contracted managed care plans including the One Care plans that are the subject of this report. All MassHealth managed care plans participate in external quality review activities.

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

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

Kepro conducted the following external quality review activities for MassHealth One Care plans in the CY 2021 review cycle:

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

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

METHODOLOGY FOR PREPARING THE EXTERNAL QUALITY REVIEW TECHNICAL REPORT

To fulfill the requirements of 42 CFR §438.358, subsections 1-5, Kepro compiled the overall findings for each EQR activity it conducted. It assessed the One Care plans' strengths, areas requiring improvement, and opportunities to further strengthen its processes, documentation, and performance outcomes with respect to the quality and timeliness of, and access to, health care services. Kepro also assessed the extent to which the managed care organization followed up on recommendations regarding opportunities for improvement made in the previous reporting period.

Data Sources

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

Performance Measure Validation

- The One Care plan's HEDIS Final Audit Report
- The One Care plan's HEDIS IDSS worksheet
- The 2021 NCQA Medicaid Quality Compass
- 2020 CMS Special Needs Plan Public Use Files
- The Performance Measure Validation recommendations included in the 2020 EQR technical report.

Performance Improvement Project Validation

- The Baseline Project Planning and Baseline Performance Indicator Reports
- Supplemental information as identified by the managed care plan
- Recommendations offered in the previous reporting period, Spring 2021

Network Adequacy Validation

- Network provider files in an Excel format provided by the One Care plans
- MassHealth provider network adequacy standards
- CMS Medicare Advantage Plan provider network adequacy standards
- Recommendations included in the 2020 EQR technical report

Data Analysis

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

Analytic Methodologies in Conclusions

Kepro's reviewers used analytic questions such as those noted below in undertaking their review of the various components of the EQR.

- Performance Measure Validation: Did the One Care plan's methodology for measure calculation comply with HEDIS technical specifications?
- Performance Improvement Project Validation: Did the One Care plan's Performance Improvement Project Report comply with established criteria? Do the interventions show promise for effecting improvement?
- Did the One Care plan's provider network files appear to be complete? Did the analysis show a sufficient geographic locations and number of providers and facilities to serve MassHealth members?

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

Exhibit 2.1. Performance Measure Validation Process Overview

Topic	Description
Objectives	To assess the accuracy of performance measures in accordance with 42 CFR § 438.358(b)(ii) reported by 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) using the analytic approach established in CMS EQR Protocol 2.
Data obtained	Each One Care plan submitted its HEDIS Final Audit Report, the NCQA Roadmap, 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 One Care plan. It determines the extent to which the managed care plan uses accurate and complete data and follows state specifications and reporting requirements. In 2021, 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 2021 were:

- Care for Older Adults (COA): Functional Status Assessment;
- Transitions of Care (TRC): Notification of Inpatient Admission; and
- Transitions of Care (TRC): Medication Reconciliation Post-Discharge

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: data received from providers are accurate and complete; the accuracy and timeliness of reported data are verified; the data have been screened for completeness, logic, and consistency; and service information is collected in standardized formats to the extent feasible and appropriate.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Exhibit 2.2. PIP Validation Process Overview

Topic	Description
Objectives	To assess overall project methodology as well as the overall validity and reliability of the PIP methods and findings to determine confidence in the results.
Technical methods of data collection and analysis	PIP Projects were validated in accordance with § 438.330(b)(i) using the analytic approach established in CMS EQR Protocol 1.
Data obtained	One Care plans submitted two PIP reports in 2021, the Baseline Report: Project Planning Report (March 2021) and the Baseline Report: Performance Indicator Rates Report (September 2021). They also submitted related supporting documentation. Clarifying information was obtained at virtual meetings with the One Care plan project teams.
Conclusions	Based on its review of One Care plan PIPs, Kepro did not discern any significant issues related to their quality of care or the timeliness of or access to care. Issues identified were plan-specific. Kepro's reviewers had high confidence in the validity of all four PIPs submitted by the plans.

MassHealth One Care plans are required to conduct two PIPs annually as specified in Appendix E of their three-way contract with CMS and EOHHS. In 2021, MassHealth directed One Care plans to conduct projects that address the following topics:

- Vaccination
- Telehealth Access

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

NETWORK ADEQUACY VALIDATION

Exhibit 2.30. Network Adequacy Validation Process Overview

Topic	Description
Objectives	The Network Adequacy Validation process assesses a managed care plan's compliance with the provider-to-member ratios and time and distance standards established by Medicare and 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. In CY 2021, Tufts Health Unify enrolled beneficiaries in Middlesex, Suffolk, and Worcester counties. CMS approved network expansion into three additional counties as of January 1, 2022, i.e., Bristol, Norfolk, and Plymouth Counties. Kepro validated Tufts Health Unify's network based on this expansion.
Data obtained	One Care plans provided Excel worksheets containing demographic information about their provider network in February 2021.
Conclusions	In general, One Care plans demonstrated high levels of compliance with Medicare and Medicaid provider-to-member ratio requirements and time and distance standards. CCA received an overall Medicare network adequacy score of 99.1/100 and Tufts Health Unify received an overall Medicare network score of 99.4/100. CCA's Medicaid network adequacy score was 91.4. Tufts Health Unify's Medicaid network adequacy score was 91.7.

Both plans demonstrated full compliance with Medicare service network requirements. Tufts Health Unify had challenges meeting time and distance requirements for several Medicaid specialties in Bristol County. CCA had challenges meeting MassHealth requirements for Monitored Inpatient Level 3.7 providers in all counties.

MASSHEALTH QUALITY STRATEGY

States operating Medicaid managed care programs under any authority must have a written quality strategy for assessing and improving the quality of 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. The most recent version was submitted to CMS in November 2018. The 2018 version, the MassHealth Comprehensive Quality Strategy, focused not only on fulfilling managed care quality requirements, but on improving the quality of managed care services in Massachusetts. An updated strategy is currently being finalized and is anticipated to be available to the public in early 2022. It will incorporate new behavioral health, health equity, and waiver strategies and will align with the CMS toolkit and webinar guidance released in Summer 2021.

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

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

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

Provider Network

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

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

MassHealth and the plans both need to increase their oversight of network adequacy, especially as it relates to appointment access. Network adequacy validation activities demonstrated non-compliance with the contractually required time and distance standards detailed in Section 5. Kepro encourages MassHealth program staff to take a more active role in monitoring One Care plan compliance with these requirements. Kepro also recommends that MassHealth provide direction related to evaluating appointment access against MassHealth standards for services such as sick and well office visits, behavioral health, and urgent care. Finally, Kepro encourages MassHealth to consider the practical feasibility of its network adequacy standards, especially those for the less populated areas of Berkshire, Dukes, and Nantucket counties. The Quest Analytics systems permits the designation of exceptions for individual provider-county combinations. Doing so would allow the system to report a more accurate picture of network adequacy. *(Access, Timeliness of Care)*

Health Equity

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

In 2021, managed care plans were required to design vaccination-related interventions with the goal of reducing health disparities. It was Kepro's experience that managed care plans struggled

with this requirement experiencing difficulty with the definition of a focal population and culturally sensitive project plans. Kepro strongly encourages MassHealth to consider ways in which technical assistance can be provided to the plans on REL data analysis and the design of associated project interventions. *(Access)*

Performance Improvement Projects

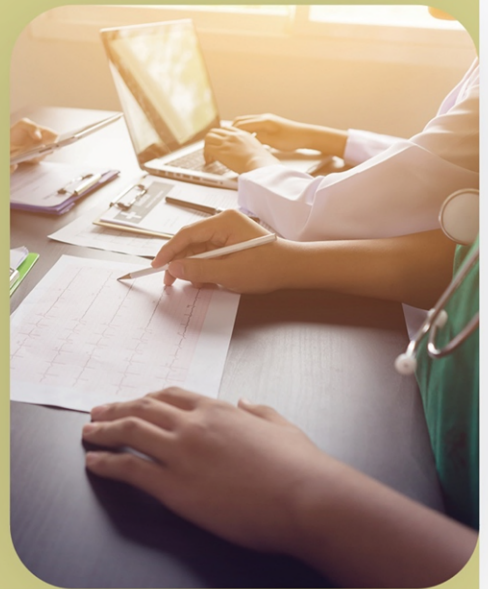
Performance Improvement Projects are resource-intensive undertakings. Kepro believes it is essential that PIP topics focus on priority topics established by MassHealth, topics addressing low-performance areas as identified by performance rates; and topics that address at least 10% or more of the One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

Communication Pathways

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

Section 3.

Performance Measure Validation



SECTION 3. PERFORMANCE MEASURE VALIDATION

PERFORMANCE MEASURE VALIDATION METHODOLOGY

The Performance Measure Validation (PMV) process assesses the accuracy of performance measures reported by the One Care plan. It determines the extent to which the managed care plan collects and uses accurate data and 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 reported rates and health outcomes. Kepro validates three performance measures annually for One Care plans.

The Performance Measure Validation process consists 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.

Kepro's Lead Reviewer recommended the validation of the following measures:

Exhibit 3.1. Performance Measures Validated in 2021

HEDIS Measure Name and Abbreviation	Measure Description
Care for Older Adults (COA): Functional Status Assessment	The percentage of adults 66 years and older who had a functional status assessment during the measurement year.
<i>Rationale for Selection: Wide variation in plan performance</i>	
Transitions of Care (TRC): Notification of Inpatient Admission	The percentage of discharges for members 18 years of age and older who had documentation in their outpatient medical record of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days).
<i>Rationale for Selection: Wide variation in plan performance.</i>	
Transitions of Care (TRC): Medication Reconciliation Post-Discharge	The percentage of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
<i>Rationale for Selection: Wide variation in plan performance.</i>	

For 2021 PMV, One Care plans submitted the documentation that follows.

Exhibit 3.2. Documentation Submitted by One Care Plans

Document Reviewed	Purpose of Review
HEDIS MY2020 Roadmap	Reviewed to assess health plan systems and processes related to performance measure production
HEDIS MY2020 Final Audit Report	Reviewed to determine if there were any underlying process issues related to HEDIS measure production
HEDIS MY2020 IDSS	Used to evaluate PMV rates for PMV measure selection, PMV measure results, and to compare PMV results to industry-standard benchmarks
List of interventions related to performance measures	Reviewed to help explain changes in performance measure rates

Kepro's One Care plan audit methodology assesses both the quality of the source data that feed into the PMV measure under review and the accuracy of 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.

TECHNICAL COMPLIANCE

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. In 2021, Kepro validated three measures that were recommended by the Lead PMV Reviewer. Kepro uses the following ratings for PMV review elements:

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

Care for Older Adults (COA): Functional Status Assessment

COA is calculated using the HEDIS hybrid methodology. The following tables outline the review elements and ratings that the One Care plans received.

Exhibit 3.3a. COA Technical Specification Compliance

Category	Denominator Element	CCA	Tufts Health Unify
Population	One Care plan population was appropriately segregated from other product lines.	Met	Met
Population	66 years and older as of December 31 of the measurement year.	Met	Met
Population	Members were continuously enrolled during the measurement year, with no more than a one-month gap.	Met	Met
Geographic Area	Includes only those Medicaid enrollees served in the One Care plan's reporting area.	Met	Met

Exhibit 3.3b. COA Technical Specification Compliance

Category	Numerator Element	CCA	Tufts Health Unify
Counting Clinical Events	At least one functional status assessment during the measurement year. Exclude services provided in an acute inpatient setting.	Met	Met
Counting Clinical Events	Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
Counting Clinical Events	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
Data Quality	Based on the IS assessment findings, the data sources used were accurate.	Met	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
Proper Exclusion Methodology in Administrative Data	Members in hospice during the measurement year.	Met	Met

Category	Numerator Element	CCA	Tufts Health Unify
Hybrid Measure	If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met
Hybrid Measure	If the hybrid method was used, the One Care plan passed the Final Medical Record Review Over-Read component of their MY 2020 HEDIS Compliance Audit.	Met	Met

Exhibit 3.3c. COA Technical Specification Compliance

Category	Sampling Element	CCA	Tufts Health Unify
Unbiased Sample	As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met
Sample Size	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
Proper Substitution Methodology in Medical Record Review	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
Proper Substitution Methodology in Medical Record Review	Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met

Transitions of Care (TRC): Notification of Inpatient Admission

The TRC measure is calculated using the HEDIS hybrid methodology. The following tables outline the review elements and ratings that the One Care plans received.

Exhibit 3.4a. TRC Technical Specification Compliance

Category	Denominator Element	CCA	Tufts Health Unify
Population	One Care plan population was appropriately segregated from other product lines.	Met	Met
Population	18 years and older as of December 31 of the measurement year.	Met	Met
Population	Members were continuously enrolled from the date of discharge (from below) through 30 days after discharge (31 total days).	Met	Met
Population	An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.	Met	Met
Geographic Area	Includes only those Medicaid enrollees served in the One Care plan's reporting area.	Met	Met

Exhibit 3.4b. TRC Technical Specification Compliance

Category	Numerator Element	CCA	Tufts Health Unify
Counting Clinical Events	Documentation in the outpatient medical record of receipt of notification of inpatient admission on the day of admission or on the day of admission through two days after the admission (three total days).	Met	Met
Counting Clinical Events	Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
Counting Clinical Events	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
Data Quality	Based on the IS assessment findings, the data sources used were accurate.	Met	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
Proper Exclusion Methodology in Administrative Data	If a member remains in an acute or nonacute facility through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained Admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.	Met	Met
Hybrid Measure	If hybrid measure was used, the integration of supplemental data and medical record data was adequate.	Met	Met
Hybrid Measure	If the hybrid method was used, the One Care plan passed the Final Medical Record Review Over-Read component of their MY 2020 HEDIS Compliance Audit.	Met	Met

Exhibit 3.4c. TRC Technical Specification Compliance

Category	Sampling Element	CCA	Tufts Health Unify
Unbiased Sample	As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met
Sample Size	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
Proper Substitution Methodology in Medical Record Review	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
Proper Substitution Methodology in Medical Record Review	Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met

Transitions of Care (TRC): Medication Reconciliation Post-Discharge

The TRC measure is calculated using HEDIS hybrid methodology. The following tables outline the review elements and ratings that the One Care plans received.

Exhibit 3.5a. TRC Technical Specification Compliance

Category	Denominator Element	CCA	Tufts Health Unify
Population	One Care plan population was appropriately segregated from other product lines.	Met	Met
Population	18 years and older as of December 31 of the measurement year.	Met	Met
Population	Members were continuously enrolled from the date of discharge (from below) through 30 days after discharge (31 total days).	Met	Met
Population	<p>An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Identify the discharge date for the stay. <p>The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p>	Met	Met
Geographic Area	Includes only those Medicaid enrollees served in the One Care plan's reporting area.	Met	Met

Exhibit 3.5b. TRC Technical Specification Compliance

Category	Numerator Element	CCA	Tufts Health Unify
Counting Clinical Events	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).	Met	Met
Counting Clinical Events	Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
Counting Clinical Events	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
Data Quality	Based on the IS assessment findings, the data sources used were accurate.	Met	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
Proper Exclusion Methodology in Administrative Data	If a member remains in an acute or nonacute facility through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.	Met	Met
Hybrid Measure	If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met

Category	Numerator Element	CCA	Tufts Health Unify
Hybrid Measure	If the hybrid method was used, the One Care plan passed the Final Medical Record Review Over-Read component of their MY 2020 HEDIS Compliance Audit.	Met	Met

Exhibit 3.5c. TRC Technical Specification Compliance

Category	Sampling Element	CCA	Tufts Health Unify
Unbiased Sample	As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met
Sample Size	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
Proper Substitution Methodology in Medical Record Review	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
Proper Substitution Methodology in Medical Record Review	Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met

COMPARATIVE RESULTS

Exhibit 3.6. Care for Older Adults (COA): Functional Status Assessment

Rate	2020	CMS MY 2020 SNP PUF Percentile Range
CCA	85.9%	Between 33 and 50
Tufts Health Unify	11.1%	Below 5

Exhibit 3.7. Transitions of Care (TRC): Notification of Inpatient Admission

Rate	2020	2020 NCQA Medicare Quality Compass Percentile Range
CCA	65.9%	Between 90 and 95
Tufts Health Unify	1.7%	Between 10 and 25

Exhibit 3.8. Transitions of Care (TRC): Medication Reconciliation Post-Discharge

Rate	2020	2020 NCQA Medicare Quality Compass Percentile Range
CCA	44.3%	Between 10 and 25
Tufts Health Unify	10.5%	Below 5

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 managed care plan information systems that contribute to performance measure production. This is to ensure that the system can collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system or other methods. The system must be able to: ensure that data received from providers are accurate and complete and verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate. The findings for both CCA and Tufts Health Unify were acceptable.

Exhibit 3.9. Results of Information Systems Capability Analysis

Criterion	CCA	Tufts Health Unify
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 AND INFORMATION SYSTEM CAPABILITY ASSESSMENT

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 PMV 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 PMV 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

CMS Worksheet 2.14.

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Commonwealth Care Alliance (CCA)
Performance measure name: Care for Older Adults (COA): Functional Status Assessment
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) 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): The number of adults 66 years and older
Definition of numerator (describe): The number of adults 66 years and older who had a functional status assessment during the measurement year
Program(s) included in the measure: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2020 – December 31, 2020

2. Performance Measure Results

Numerator	304
Denominator	354
Rate	85.88%

3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). None Identified.

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

Claims and Encounter Data. Claims, including lab claims, were processed by a vendor, PCG, using the EZ Cap system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. PCG demonstrated adequate monitoring of data quality and CCA maintained adequate oversight of PCG. CCA had adequate processes to monitor claims data completeness including comparing actual to expected volumes to ensure all claims and encounters were submitted. CCA's pharmacy 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.

Medical Record Review. CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. CCA successfully used supplemental data for HEDIS reporting. CCA provided complete supplemental data documentation and no concerns were identified.

Data Integration. CCA's performance measures were produced using Inovalon software. Data transfers to the Inovalon repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant regarding 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.

CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring 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:

Quality-Related: CCA's performance on the *Care for Older Adults (COA): Functional Status Assessment* measure was below the 50th percentile compared to the CMS SNP PUF MY 2020 data. Kepro recommends that CCA consider the development of related quality improvement initiatives.

CMS Worksheet 2.14.

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Commonwealth Care Alliance (CCA)
Performance measure name: Transitions of Care (TRC): Notification of Inpatient Admission
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) 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): The number of discharges for members 18 years and older
Definition of numerator (describe): The number of discharges for members 18 years of age and older who had documentation in their outpatient medical record of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days).
Program(s) included in the measure: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2020 – December 31, 2020

2. Performance Measure Results

Numerator	271
Denominator	411
Rate	65.94%

3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). None Identified.

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

Claims and Encounter Data. Claims, including lab claims, were processed by a vendor, PCG, using the EZ Cap system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. PCG demonstrated adequate monitoring of data quality and CCA maintained adequate oversight of PCG. CCA had adequate processes to monitor claims data completeness including comparing actual to expected volumes to ensure all claims and encounters were submitted. CCA's pharmacy 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.

Medical Record Review. CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. CCA successfully used supplemental data for HEDIS reporting. CCA provided complete supplemental data documentation and no concerns were identified.

Data Integration. CCA's performance measures were produced using Inovalon software. Data transfers to the Inovalon repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant regarding 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.

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

CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring 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:

None Identified.

CMS Worksheet 2.14.

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Commonwealth Care Alliance (CCA)
Performance measure name: Transitions of Care (TRC): Medication Reconciliation Post-Discharge
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) 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): The number of discharges for members 18 years of age and older
Definition of numerator (describe): The number of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2020 – December 31, 2020

2. Performance Measure Results

Numerator	182
Denominator	411
Rate	44.28%

3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). None Identified.

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

Claims and Encounter Data. Claims, including lab claims, were processed by a vendor, PCG, using the EZ Cap system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. PCG demonstrated adequate monitoring of data quality and CCA maintained adequate oversight of PCG. CCA had adequate processes to monitor claims data completeness including comparing actual to expected volumes to ensure all claims and encounters were submitted. CCA's pharmacy 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.

Medical Record Review. CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. CCA successfully used supplemental data for HEDIS reporting. CCA provided complete supplemental data documentation and no concerns were identified.

Data Integration. CCA's performance measures were produced using Inovalon software. Data transfers to the Inovalon repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant regarding 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.

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

CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring 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:

Quality-Related: CCA's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that CCA consider the development of related quality improvement initiatives.

Plan Strengths

- **Quality-Related:** CCA's performance on the *Transitions of Care (TRC): Notification of Inpatient Admission* measure was above the 90th percentile compared to the NCQA Medicare Quality Compass MY 2020 data.
- **Quality-Related:** CCA used supplemental data for HEDIS reporting.

Opportunities for Improvement

- **Quality-Related:** CCA's performance on the *Care for Older Adults (COA): Functional Status Assessment* measure was below the 50th percentile compared to the CMS SNP PUF MY 2020 data. Kepro recommends that CCA consider the development of related quality improvement initiatives.
- **Quality-Related:** CCA's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that CCA consider the development of related quality improvement initiatives.

Follow-up to Calendar Year 2020 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2020 PMV recommendation follows:

Exhibit 3.10a. Update to CY 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
CCA's <i>Colorectal Cancer Screening</i> was below the CMS SNP PUF 45 th percentile. Kepro recommends developing and implementing related quality improvement initiatives.	<ul style="list-style-type: none">• Increased monitoring of gap reports• Provided education to PCP offices on the value of colorectal cancer screening• Offered home-based cancer screening to members as an alternative to colonoscopy• Enhanced HEDIS vendor data and CCA systems to improve target-setting, tracking, and intervention planning	Medium

Exhibit 3.10b. Update to CY 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
CCA's <i>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i> measure was below the 2020 NCQA Medicaid Quality Compass 50th percentile. Kepro recommends developing and implementing related quality improvement initiatives.	Due to the public health emergency and, specifically, the nature of COVID as an air-borne communicable disease, CCA did not actualize SPR-specific interventions during this time period. In addition, pulmonologist access was limited because of COVID.	Low

TUFTS HEALTH PUBLIC PLANS (TUFTS HEALTH UNIFY)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Tufts Health Public Plans
Performance measure name: Care for Older Adults (COA): Functional Status Assessment
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) 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): The number of adults 66 years and older
Definition of numerator (describe): The number of adults 66 years and older who had a functional status assessment during the measurement year
Program(s) included in the measure: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2020 – December 31, 2020

2. Performance Measure Results

Numerator	9
Denominator	81
Rate	11.1%

3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). None Identified.

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

Claims and Encounter Data. Tufts Health Unify processed claims using the Monument Xpress system and the Health Edge HealthRules Payor system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Tufts Health Unify only accepted claims submitted on standard claims forms. Most claims were submitted electronically to Tufts Health Unify and there were adequate monitoring processes in place including daily electronic submission summary reports to identify issues. Tufts Health Unify had robust claims editing and coding review processes. Tufts Health Unify processed all claims except for pharmacy claims which were handled by its 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 or with claims or encounter data processing.

Enrollment Data. Tufts Health Unify processed Medicaid enrollment data using Health Edge HealthRules Payor. All necessary enrollment fields are captured for HEDIS reporting. Medicaid enrollment data were received daily from the state in an 834 format and processed by Tufts Health Unify. The daily file included additions, changes, and terminations. Enrollment data were loaded into Tufts Health Unify's Health Edge HealthRules Payor system. Tufts Health Unify also received a full monthly refresh file and conducted reconciliation between Health Edge HealthRules Payor and the state file. Health Edge HealthRules Payor retained Medicaid identification numbers and the plan assigned a unique Health Edge HealthRules Payor system ID. Tufts Health Unify had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. Tufts Health Unify passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts Health Unify conducted the medical record reviews. Tufts Health Unify had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. Tufts Health Unify used multiple supplemental data sources, including EMR data. Tufts Health Unify provided all required supplemental data source documentation. There were no concerns or issues identified with the use of these supplemental data sources.

Data Integration. All performance measure rates were produced using Cotiviti's software which received measure certification from NCQA for all measures under the scope of the review. Data from the transaction system were loaded to Tufts Health Unify's data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt, and then formatted into Cotiviti-compliant extracts and loaded into the measure production software. Tufts Health Unify had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. There were no issues identified with data integration processes for the measures under review. Data transfers from source transaction systems to the Cotiviti repository were accurate. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. Tufts Health Unify maintains adequate oversight of its vendor, Cotiviti. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

Tufts Health Unify passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts Health Unify conducted the medical record reviews. Tufts Health Unify had mature processes in place for medical record

<p>abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.</p> <p><input 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>Quality-Related: Tufts Health Unify' performance on the <i>Care for Older Adults (COA): Functional Status Assessment</i> measure was below the 5th percentile compared to the CMS SNP PUF MY 2020 data. Tufts Health Unify chose not to improve their performance by reporting this measure utilizing the hybrid reporting option; instead, Tufts Health Unify reported an administrative rate for this measure. Kepro recommends that Tufts Health Unify consider the development of related quality improvement initiatives and always report the <i>Care for Older Adults</i> measure utilizing the hybrid reporting method.</p>

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: Tufts Health Public Plans (Tufts Health Unify)
Performance measure name: Transitions of Care (TRC): Notification of Inpatient Admission
<p>Measure steward:</p> <p><input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ)</p> <p><input type="checkbox"/> Centers for Disease Control and Prevention (CDC)</p> <p><input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS)</p> <p><input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA)</p> <p><input type="checkbox"/> The Joint Commission (TJC)</p> <p><input type="checkbox"/> No measure steward, developed by state/EQRO</p> <p><input type="checkbox"/> Other measure steward (specify) _____</p>
<p>Is the performance measure part of an existing measure set? (check all that apply)</p> <p><input checked="" type="checkbox"/> HEDIS®</p> <p><input type="checkbox"/> CMS Child or Adult Core Set</p> <p><input type="checkbox"/> Other (specify) _____</p>
<p>What data source(s) was used to calculate the measure? (check all that apply)</p> <p><input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources</p> <p><input checked="" type="checkbox"/> Medical records (describe) See below</p> <p><input type="checkbox"/> Other (specify) _____</p>
<p>If the hybrid method was used, describe the sampling approach used to select the medical records:</p> <p>NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.</p> <p><input type="checkbox"/> Not applicable (hybrid method not used)</p>
Definition of denominator (describe): The number of discharges for members 18 years and older

Definition of numerator (describe): The number of discharges for members 18 years of age and older who had documentation in their outpatient medical record of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days).

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

Measurement period (start/end date) January 1, 2020 – December 31, 2020

2. Performance Measure Results

Numerator	7
Denominator	411
Rate	1.70%

3. Performance Measure Validation Status

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

None Identified.

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

Claims and Encounter Data. Tufts Health Unify processed claims using the Monument Xpress system and the Health Edge HealthRules Payor system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Tufts Health Unify only accepted claims submitted on standard claims forms. Most claims were submitted electronically to Tufts Health Unify and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. Tufts Health Unify had robust claims editing and coding review processes. Tufts Health Unify processed all claims except for pharmacy claims which were handled by its 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 or with claims or encounter data processing.

Enrollment Data. Tufts Health Unify processed Medicaid enrollment data using Health Edge HealthRules Payor. All necessary enrollment fields are captured for HEDIS reporting. Medicaid enrollment data were received daily from the state in an 834 format and processed by Tufts Health Unify. The daily file included additions, changes, and terminations. Enrollment data were loaded into Tufts Health Unify's Health Edge HealthRules Payor system. Tufts Health Unify also received a full monthly refresh file and conducted reconciliation between Health Edge HealthRules Payor and the state file. Health Edge HealthRules Payor retained Medicaid identification numbers and the plan assigned a unique Health Edge HealthRules Payor system ID. Tufts Health Unify had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. Tufts Health Unify passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts Health Unify conducted the medical record reviews. Tufts Health Unify had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. Tufts Health Unify used multiple supplemental data sources, including EMR data. Tufts Health Unify provided all required supplemental data source documentation. There were no concerns or issues identified with the use of these supplemental data sources.

Data Integration. All performance measure rates were produced using Cotiviti's software which received measure certification from NCQA for all measures under the scope of the review. Data from the transaction system were loaded to Tufts Health Unify's data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt, and then formatted into Cotiviti-compliant extracts and loaded into the measure

production software. Tufts Health Unify had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. There were no issues identified with data integration processes for the measures under review. Data transfers from source transaction systems to the Cotiviti repository were accurate. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. Tufts Health Unify maintains adequate oversight of its vendor, Cotiviti. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

Tufts Health Unify passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts Health Unify conducted the medical record reviews. Tufts Health Unify had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring 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:

Quality-Related: Tufts Health Unify' performance on the *Transitions of Care (TRC): Notification of Inpatient Admission* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts Health Unify consider the development of related quality improvement initiatives.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Tufts Health Public Plans (Tufts Health Unify)**

Performance measure name: **Transitions of Care (TRC): Medication Reconciliation Post-Discharge**

Measure steward:

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

<p>Is the performance measure part of an existing measure set? (check all that apply)</p> <p><input checked="" type="checkbox"/> HEDIS®</p> <p><input type="checkbox"/> CMS Child or Adult Core Set</p> <p><input type="checkbox"/> Other (specify) _____</p>
<p>What data source(s) was used to calculate the measure? (check all that apply)</p> <p><input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources</p> <p><input checked="" type="checkbox"/> Medical records (describe) See below</p> <p><input type="checkbox"/> Other (specify) _____</p>
<p>If the hybrid method was used, describe the sampling approach used to select the medical records:</p> <p>NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.</p> <p><input type="checkbox"/> Not applicable (hybrid method not used)</p>
<p>Definition of denominator (describe): The number of discharges for members 18 years of age and older</p>
<p>Definition of numerator (describe): The number of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).</p>
<p>Program(s) included in the measure: <input type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" type="checkbox"/> Medicaid and CHIP</p>
<p>Measurement period (start/end date) January 1, 2020 – December 31, 2020</p>

2. Performance Measure Results

Numerator	43
Denominator	411
Rate	10.46%

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>None Identified.</p>
<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 Health Unify processed claims using the Monument Xpress system and the Health Edge HealthRules Payor system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Tufts Health Unify only accepted claims submitted on standard claims forms. Most claims were submitted electronically to Tufts Health Unify and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. Tufts Health Unify had robust claims editing and coding review processes. Tufts Health Unify processed all claims except for pharmacy claims which were handled by its 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 or with claims or encounter data processing.</p> <p>Enrollment Data. Tufts Health Unify processed Medicaid enrollment data using Health Edge HealthRules Payor. All necessary enrollment fields are captured for HEDIS reporting. Medicaid enrollment data were received daily from the state in an 834 format and processed by Tufts Health Unify. The daily file included additions, changes, and terminations. Enrollment data were loaded into Tufts Health Unify's Health Edge HealthRules Payor system. Tufts Health Unify also received a full monthly refresh file and conducted reconciliation between Health Edge</p>

HealthRules Payor and the state file. Health Edge HealthRules Payor retained Medicaid identification numbers and the plan assigned a unique Health Edge HealthRules Payor system ID. Tufts Health Unify had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. Tufts Health Unify passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts Health Unify conducted the medical record reviews. Tufts Health Unify had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. Tufts Health Unify used multiple supplemental data sources, including EMR data. Tufts Health Unify provided all required supplemental data source documentation. There were no concerns or issues identified with the use of these supplemental data sources.

Data Integration. All performance measure rates were produced using Cotiviti's software which received measure certification from NCQA for all measures under the scope of the review. Data from the transaction system were loaded to Tufts Health Unify's data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt, and then formatted into Cotiviti-compliant extracts and loaded into the measure production software. Tufts Health Unify had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. There were no issues identified with data integration processes for the measures under review. Data transfers from source transaction systems to the Cotiviti repository were accurate. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. Tufts Health Unify maintains adequate oversight of its vendor, Cotiviti. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

Tufts Health Unify passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts Health Unify conducted the medical record reviews. Tufts Health Unify had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring 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:

Quality-Related: Tufts Health Unify's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 5th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts Health Unify consider the development of related quality improvement initiatives.

Plan Strengths

Quality-Related: Tufts Health Unify used supplemental data for HEDIS reporting.

Opportunities for Improvement

- **Quality-Related:** Tufts Health Unify's performance on the *Care for Older Adults (COA): Functional Status Assessment* measure was below the 5th percentile compared to the CMS SNP PUF MY 2020 data. Tufts Health Unify chose not to improve their performance by reporting this measure utilizing the hybrid reporting option; instead, Tufts Health Unify reported an administrative rate for this measure. Kepro recommends that Tufts Health Unify consider the development of related quality improvement initiatives and always report the *Care for Older Adults* measure utilizing the hybrid reporting method.
- **Quality-Related:** Tufts Health Unify's performance on the *Transitions of Care (TRC): Notification of Inpatient Admission* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts Health Unify consider the development of related quality improvement initiatives.
- **Quality-Related:** Tufts Health Unify's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 5th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts Health Unify consider the development of related quality improvement initiatives.

Follow-up to Calendar Year 2020 Recommendations

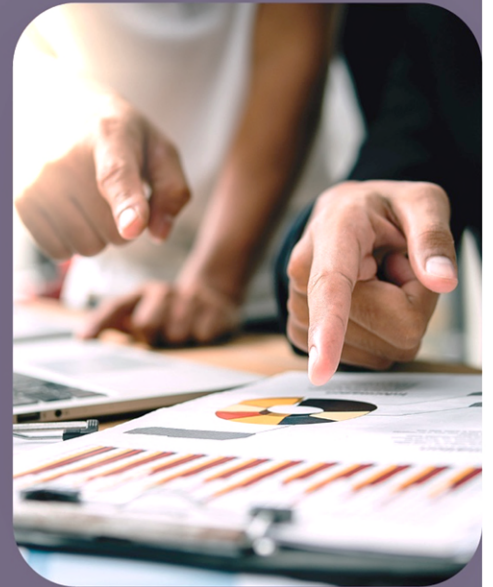
CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2020 PMV recommendation follows:

Exhibit 3.11. Update to CY 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
Tufts performance in the <i>Colorectal Cancer Screening</i> Measure was below the CMS SNP PUF 10th percentile. Kepro recommends Tufts consider developing and implementing related quality improvement initiatives	This recommendation stands. Tufts Health Unify did not conduct related quality improvement activities in 2021.	Low

Section 4.

Performance Improvement Validation



SECTION 4. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

INTRODUCTION

MassHealth One Care plans conduct two contractually required Performance Improvement Projects (PIPs) annually. In 2021, MassHealth directed One Care plans to conduct PIPs on the following topics:

- Immunization rates; and
- Telehealth access

Mid-year, MassHealth received feedback from managed care plans that work on the flu project was diverting resources from COVID-19 immunization efforts. In response, MassHealth permitted the plans to select an immunization campaign of their choice, e.g., flu and. COVID-19.

Reflecting its strategic priority of reducing health inequities, MassHealth required that each plan conduct a vaccination-related intervention with the goal of reducing health disparities. Based on an analysis of the membership, plans were required to identify a targeted member population with lower vaccination rates and develop an associated intervention.

In calendar year 2021, MassHealth One Care plans planned and implemented the following PIPs:

Exhibit 4.1. Plan PIP Titles

Plan	PIP Title
CCA	<ul style="list-style-type: none">• Flu Vaccine Improvement• Addressing Barriers to Virtual Care
Tufts Health Unify	<ul style="list-style-type: none">• Improving flu immunization in Tufts Health Public Plan's One Care population.• Decreasing barriers to Behavioral Health Telehealth Services

OBJECTIVE

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

DATA OBTAINED

One Care plans submitted two PIP reports in 2021. In April 2021, the plans submitted a Project Planning Baseline Report in which they described project goals, planned stakeholder

involvement, anticipated barriers, proposed interventions, a plan for intervention effectiveness analysis, and performance indicators. Plans also submitted a detailed population analysis. The One Care plans reported project updates and baseline data in their September 2021 Performance Indicator Rate reports.

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

MANAGED CARE PLAN SUPPORT

Kepro provided support to One Care plans in the submission of their project reports.

- Early in the project cycle, Kepro sponsored a workshop on flu immunization in Massachusetts that featured speakers from the Department of Public Health and the Massachusetts Immunization Coalition. This workshop provided all MassHealth managed care plans with a baseline understanding of flu immunization in Massachusetts.
- To support plan development of health equity-related project interventions, Kepro entered into an agreement with the MGH Center for Disparity Solutions in which its director led a four-session Health Disparity Learning Collaborative. This Learning Collaborative provided a forum for sharing best practices and exchanging ideas.
- Kepro created a library of PIP resources that included recent literature on vaccine hesitancy, telehealth, health disparities, and best practices for building strong project interventions.
- In addition to instructions embedded in report submission forms, Kepro made a Guidance Manual available to plans, which provides detailed descriptions of the information requested. In many cases, sample responses were offered.
- Kepro made one-on-one technical assistance for PIP development or report production available to plans.

TECHNICAL METHODS OF DATA COLLECTION AND ANALYSIS

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

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

- 1) **PIP Project Report.** Managed care plans submit a project report for each PIP to the EQRO Teams site. This report is specific to the stage of the project. All 2021 PIPs were baseline projects.
- 2) **Desktop Review.** A desktop review is performed for each PIP. Kepro conducts inter-rater reliability to ensure consistency among reviewers. The Technical Reviewer and Medical Director review the project report and any supporting documentation submitted by the plan. Working collaboratively, they identify project strengths, issues requiring clarification, and opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the project. The Medical Director's focus is on clinical integrity and interventions.
- 3) **Conference with the Plan.** The Technical Reviewer and Medical Director meet virtually with plan representatives to obtain clarification on identified issues as well as to offer recommendations for improvement. When it is not possible to assign a validation rating to a project due to incomplete or missing information, the plan is required to remediate the report and resubmit it within 10 calendar days. In all cases, the plan is offered the opportunity to resubmit the report to address feedback received from Kepro, although it is not required to do so.
- 4) **Final Report.** A PIP Validation Worksheet based on CMS EQR Protocol Number 1 is completed by the Technical Reviewer. Kepro rates Fall reports; reports submitted in the Spring are not rated. Kepro conducts inter-rater reliability to ensure consistency among reviewers. Individual standards are rated either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. The Medical Director documents his or her findings, and in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report. A determination is made by the Technical Reviewers as to the validity of the project.

FINDINGS

One Care plans assembled project teams that generally submitted well-developed project plans. In general, the plans continued to struggle with the design of intervention effectiveness evaluations. Often, a plan revealed real project strengths during its meeting with Kepro that it hadn't included in its report submission. Kepro encouraged those plans to resubmit their reports to improve their scores.

One Care plans struggled with the design of immunization health equity interventions. Some PIPs required resubmission because either a target population was not identified or the intervention design was not expected to lead to a decrease in the identified disparity. Kepro recommends that MassHealth consider providing managed care plans with additional coaching for health equity projects going forward.

COMPARATIVE ANALYSIS

Interventions

MassHealth One Care plans used a variety of approaches to address their project goals.

Exhibit 4.2. Intervention Approach

Intervention Approach	Number of Interventions Immunization	Number of Interventions Telehealth
Member Education & Outreach	3	2
Provider Education	1	1
Programs and Practices	1	1

PIP Ratings

Kepro evaluates each PIP 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.

Kepro rates PIPs using a predetermined set of criteria, outlined in the table below. As stated previously, individual standards are rated either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. The table that follows depicts the average rating score by rating component.

Exhibit 4.3. Average PIP Score by Rating Component

Rating Component	Immunization	Telehealth
Updates to Project Descriptions and Goals	100%	94.5%
Update to Stakeholder Involvement	100%	87.5%
Intervention Activities Updates	87%	96.5%
Performance Indicator Data Collection	100%	100%
Capacity for Indicator Data Analysis	100%	100%
Performance Indicator Parameters	100%	91.5%
Baseline Performance Indicator Rates	100%	100%
Conclusions and Planning for Next Cycle	100%	100%

The table that follows depicts One Care plan rating scores for PIPs validated in 2020.

Exhibit 4.4. One Care Plan PIP Rating Scores

Plan	Vaccination	Telehealth Access
CCA	98%	100%
Tufts Health Unify	97%	91%

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 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.

TOPIC 1: VACCINATION RATES

COMMONWEALTH CARE ALLIANCE: FLU VACCINE IMPROVEMENT

1. General PIP Information

Managed Care Plan (MCP) Name: Commonwealth Care Alliance (CCA) One Care Plan
PIP Title: Flu Vaccine Improvement
PIP Aim Statement: Member-Focused <ul style="list-style-type: none">• Increase CCA One Care member knowledge about the importance of flu vaccination.• Increase flu vaccination rates for One Care members. Provider-Focused <ul style="list-style-type: none">• Increase provider identification of members who have not received a flu vaccination.• Increase provider knowledge and skills to understand and overcome members' reasons for vaccine hesitancy.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) <input checked="" 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 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 type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" 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) Educate One Care members about the efficacy and safety of influenza vaccinations and promote receipt of the vaccine.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) CCA plans to educate providers about member reasons for vaccine hesitancy, address misinformation and mistrust, and enhance their skills through communication tools and strategies to effectively address members' concerns and encourage flu vaccinations.

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 has convened a Vaccine Task Force, the charter of which is to design and implement operational standards and practices for vaccine administration; standardize vaccine procurement statewide; standardize flu vaccine administration and documentation; and to develop standard operating procedures for vaccine administration to ensure the uniform implementation of standards and safety procedures.

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
Flu Immunization Rate	2021	476/785 61%	<input checked="" type="checkbox"/> Not applicable – PIP is in planning or implementation phase, results not available	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Validation phase (check all that apply): <input type="checkbox"/> PIP submitted for approval <input checked="" type="checkbox"/> Planning phase <input checked="" type="checkbox"/> Implementation phase <input checked="" type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of PIP: <ul style="list-style-type: none"> Quality-Related: Kepro understands that, programmatically, CCA considers its One Care and SCO members as one population of medically high-risk individuals. At the same time, the two populations present different clinical and demographic profiles that should be taken into consideration when analyzing stakeholder input. Quality-Related: Kepro strongly advises CCA to develop a standing consumer advisory committee that convenes (perhaps remotely) quarterly or semi-annually. Quality-Related: Kepro recommends pilot testing different workflow strategies to determine which processes work best in which settings and for which populations. Access-Related: Kepro advises that, in future PIP reporting on this intervention, CCA develop explicit strategies for identifying and educating members with low rates of flu vaccination that may be associated with REL factors.

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 98% on this Performance Improvement Project.

Exhibit 4.5. CCA Flu PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	13.3	87%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	4	12	12	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	25	75	73.3	98%

Plan & Project Strengths

- **Quality-Related:** CCA is commended for having convened a Vaccine Task Force that is responsible for directing policy and initiating change related to vaccine procurement, documentation, training, and workflows involving flu vaccine administration.
- **Quality-Related:** Kepro commends CCA on establishing standardized system-wide documentation, procurement, training, and administration protocols.
- **Access-Related:** Kepro commends the Care Integrity and Quality Assurance Team for its plan to identify community leaders who can serve as role models in promoting techniques for reducing influenza vaccination hesitancy.
- **Access-, and Quality-Related:** Kepro commends CCA for developing refined and standardized vaccination workflows for CCA community-focused nurses and advanced practitioners with defined member panels who develop a detailed understanding of CCA members within their geographical areas.

Opportunities for Improvement

- **Quality-Related:** Kepro understands that, programmatically, CCA considers its One Care and SCO members as one population of medically high-risk individuals. At the same time, the two populations present different clinical and demographic profiles that should be taken into consideration when analyzing stakeholder input.
- **Quality-Related:** Kepro strongly advises CCA to develop a standing consumer advisory committee that convenes (perhaps remotely) quarterly or semi-annually. The voice of the customer provides valuable information.
- **Quality-Related:** Kepro recommends pilot testing different workflow strategies to determine which processes work best in which settings and for which populations.
- **Access-Related:** Kepro advises that, in future PIP reporting on this intervention, CCA develop explicit strategies for identifying and educating members with low rates of flu vaccination that may be associated with REL factors.

TUFTS HEALTH PUBLIC PLANS: IMPROVING FLU IMMUNIZATION IN TUFTS HEALTH PUBLIC PLANS' ONE CARE POPULATION

1. General PIP Information

Managed Care Plan (MCP) Name: Tufts Health Public Plans
PIP Title: Improving flu immunization in Tufts Health Public Plans' One Care population.
PIP Aim Statement: Member-Focused <ul style="list-style-type: none"> • Provide educational information to members about the importance of getting the flu vaccine during outreach calls made by the Care Management team. • Identify educational materials related to the flu vaccine and provide them to the member in their preferred written language. • Obtain feedback from Tufts Health Unify One Care members on barriers to getting the flu vaccine. Provider-Focused <ul style="list-style-type: none"> • Conduct outreach to provider groups to discuss flu vaccination rates, barriers, and best practices. • Develop and publish provider education materials related to flu immunization.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) <input checked="" 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 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 type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" 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) <ul style="list-style-type: none"> • Member education including but not limited to flu reminder blasts focused on the southern seacoast cities of New Bedford and Fall River; an educational article posted to the Tufts Health Unify member-facing website; and a postcard mailing. • Member outreach conducted by Tufts Health Unify' care management vendor, Cityblock Health. Cityblock will also be managing a Community Response Program in which staff are sent directly to the member's home to administer the vaccine if they are unable to attend in person.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) None identified.

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

None identified.

3. Performance Measures and Results

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
Flu Immunization Rate	2021	845/ 2,858 29.57%	<input checked="" type="checkbox"/> Not applicable – PIP is in planning or implementation phase, results not available	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Validation phase (check all that apply): <input type="checkbox"/> PIP submitted for approval <input checked="" type="checkbox"/> Planning phase <input checked="" type="checkbox"/> Implementation phase <input checked="" type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of PIP: Access-Related: Tufts Health Unify states that Cityblock Health model offers services that are tailored to diverse populations in their preferred language. Tufts Health Unify describes the cultural competency training offered to Cityblock Health staff. What is lacking are details about subpopulations and how their unique needs are being addressed. Kepro recommends providing more information about how members with low vaccination rates will be identified and how care managers will assist these underserved members.

Performance Improvement Project Evaluation

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

Exhibit 4.6. Tufts Health Unify Flu PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	12.5	83%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	5	15	15	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	28	84	81.5	97%

Plan & Project Strengths

- **Quality-Related:** Tufts Health Unify's PIP to increase the rate of flu immunizations in its One Care population is well-designed and staff members are commended for the work being put into these intervention activities.
- **Access-Related:** This PIP has strength in its potential to reach a population broader than the Tufts Health Unify membership. By identifying individual members who have not been vaccinated for the flu, Tufts Health Unify can categorically focus on under-vaccinated ethnic groups or neighborhoods. By engaging associated household members in the vaccination campaign, Tufts Health Unify is serving a broad public health function of reducing the spread of flu in high-risk communities.
- **Access-Related:** Tufts Health Unify is commended for the work of its Health Equity Task Force and its partnership with the Massachusetts Department of Public Health. Tufts Health Unify notes that the activities of the task force will focus on the towns of Fall River and New Bedford, both of which are diverse communities with low flu vaccination rates.

Opportunities for Improvement

- **Access-Related:** Tufts Health Unify states that Cityblock Health model offers services that are tailored to diverse populations in their preferred language. Tufts Health Unify describes the cultural competency training offered to Cityblock Health staff. What is lacking are details about subpopulations and how their unique needs are being addressed. Kepro recommends providing more information about how members with low vaccination rates will be identified and how care managers will assist these underserved members.

TOPIC 2: TELEHEALTH ACCESS

COMMONWEALTH CARE ALLIANCE: ADDRESSING BARRIERS TO VIRTUAL CARE

1. General PIP Information

Managed Care Plan (MCP) Name: Commonwealth Care Alliance (CCA) One Care Plan
PIP Title: Addressing Barriers to Virtual Care
PIP Aim Statement: Member-Focused <ul style="list-style-type: none">• Increase the effective use of virtual care among our members by creating and implementing a robust member support strategy which includes trainings, educational resource materials, and live-agent support to troubleshoot and address virtual care issues.• Improve member access to virtual care by conducting virtual care readiness assessments to proactively identify barriers and overcome barriers.• Increase efforts to address device and connectivity barriers by referring members who are identified as not being virtual care ready to outreach workers who can support the member in obtaining a device or connectivity.• Decrease technology issues during virtual visits by referring members to live agent support to test out virtual capabilities and troubleshoot issues prior to visit. Provider-Focused <ul style="list-style-type: none">• Activate CCA schedulers and CCA care teams to more effectively identify members who are virtual care ready by conducting readiness assessments.• Refer members that have barriers to virtual care to health outreach workers to address accessibility concerns.• Increase the number of CCA virtual care providers through the integration of telehealth in workflows, resource guides, trainings, and other educational materials.• Implement a virtual care platform across the organization for providers to conduct virtual visits.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) <input checked="" 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 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 type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" 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) CCA intends to provide the support needed by members to engage in virtual care and is implementing a virtual care readiness assessment. The questions in the assessment will be related to what type of device the member has if any, what connectivity access they have, their e-mail address, and whether the member consents to engaging in virtual care. If the member is not virtual care ready, they will be referred to a CCA health outreach
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worker for support accessing telehealth resources. If the member is virtual care ready, they will be referred to live agent support for device testing and troubleshooting in advance of their first virtual care visit.

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

None identified.

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 is launching a dashboard to review the number of virtual care readiness assessments completed including responses to each question as well as data on the number of virtual care visits completed by CCA providers. The data will be broken down by member, member demographic variables such as race, ethnicity and language, provider type, specialty, visit type, communication method (audio only vs audio + video), and month.

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
MPT - Mental Health Utilization NQF #9999	2021	14,447/ 24,682 59%	<input checked="" type="checkbox"/> Not applicable – PIP is in planning or implementation phase, results not available	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): 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:

Quality-Related: Kepro is aware that CCA considers its MassHealth members, both One Care and SCO, to be one member population. In this regard, especially with respect to telehealth access readiness, Kepro recommends that CCA consider the generational difference in its younger One Care members versus its elderly SCO members.

Performance Improvement Project Evaluation

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

Exhibit 4.7. CCA Validation Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	15	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4	12	12	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	26	78	78	100%

Plan & Project Strengths

- **Access-Related:** CCA is commended for its plan to refer members who are assessed as not “virtual care ready” to outreach workers who will assist the member to access public connectivity resources.
- **Quality-Related:** CCA is commended for developing a telehealth dashboard that will be available to the PIP team and some internal CCA providers.

Opportunities for Improvement

- **Quality-Related:** Kepro is aware that CCA considers its MassHealth members, both One Care and SCO, to be one member population. In this regard, especially with respect to telehealth access readiness, Kepro recommends that CCA consider the generational difference in its younger One Care members versus its elderly SCO members.

TUFTS HEALTH PUBLIC PLANS: DECREASING BARRIERS TO BEHAVIORAL HEALTH TELEHEALTH SERVICES

1. General PIP Information

Managed Care Plan (MCP) Name: Tufts Health Public Plans
PIP Title: Decreasing Barriers to Behavioral Health Telehealth Services
PIP Aim Statement: Member-Focused <ul style="list-style-type: none"> • Increase educational resources for members related to behavioral health (BH) telehealth: provide information to members to educate members on what telehealth services are and coverage details about BH telehealth services, including how to access BH telehealth services. • Improve access for members by providing members with a cellphone when they indicate a need in order to engage in BH telehealth services. • Improve access for members by increasing the behavioral health provider network and partnering with telehealth vendors. • Collect feedback from members related to challenges to engaging in telehealth in order to inform future activities. Provider-Focused <ul style="list-style-type: none"> • Establish telehealth best practices based on provider feedback and communicate these through a newsletter article to behavioral health providers. • Publish resources for providers that educate them on how to correctly bill for telehealth services such as articles and webinars. • Create communication channels between behavioral health providers and the Tufts Health Public Plans' Medical Director to share best practices on behavioral health telehealth.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) <input checked="" 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 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 type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input checked="" 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 Health Unify seeks to improve access to behavioral health telehealth services by implementing a number of member-focused initiatives: <ul style="list-style-type: none"> • A loaner phone program • Expansion of the behavioral health telehealth provider network • Promotion of the Safelink program, a government-sponsored cellular service offered to members meeting eligibility criteria • A radio campaign highlighting BH telehealth services that are offered to members.

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

- The intent of the Provider Outreach and Education initiative is to increase access to BH telehealth services for Tufts Health Unify One Care members by understanding both best practices and barriers to telehealth delivery faced by BH providers. Understanding these challenges will allow Tufts Health Unify to determine if there are any barriers that the health plan can work to help mitigate.
- The Senior BH Medical Director conducts outreach to providers have high rates of BH telehealth services. This outreach is aimed at obtaining information from these providers about what allows them to deliver high rates of telehealth services and any barriers experienced. Information gleaned will also be used to support providers who are not accessing telehealth at a high-volume rate.

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

None identified.

3. Performance Measures and Results

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
MPT - Mental Health Utilization NQF #9999	2021	1,228 / 1,706 71.98%	<input checked="" type="checkbox"/> Not applicable – PIP is in planning or implementation phase, results not available	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):

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

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

EQRO recommendations for improvement of PIP:

Access-Related: Kepro recommends that Tufts Health Unify consider developing a provider report showing practice-specific rates of BH telehealth utilization. Stratifying the practice-specific rate by REL could bring to providers' attention the sub-populations of members who are under-utilizing BH telehealth.

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 Unify received a rating score of 91% on this PIP.

Exhibit 4.8. Tufts Health Unify Validation Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	8	89%
Update to Stakeholder Involvement	4	12	9	75%
Intervention Activities Updates	5	15	14	93%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	4	12	10	83%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	25	75	68	91%

Plan & Project Strengths

- **Quality-Related:** Kepro commends Tufts Health Unify for its strong member-focused intervention activities.
- **Quality-Related:** Medical Director outreach to high-volume providers is a very positive activity.

Opportunities for Improvement

- **Access-Related:** Kepro recommends that Tufts Health Unify consider developing a provider report showing practice-specific rates of BH telehealth utilization. Stratifying the practice-specific rate by REL could bring to providers' attention the sub-populations of members who are under-utilizing BH telehealth.

Section 5.

Network Adequacy Validation



SECTION 5. NETWORK ADEQUACY VALIDATION

INTRODUCTION

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

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

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

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

REQUEST OF PLAN

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

For One Care plans, this request applied to the following areas of service:

- PCPs and OB/Gyn
- Acute Inpatient and Rehabilitation Hospitals
- Urgent Care Services
- Specialists
- Long-Term Services and Supports
- Behavioral Health Services

TIME AND DISTANCE STANDARDS

To ensure that members have appropriate access to care for covered services, CMS and MassHealth require One Care plans to adhere to certain time and distance standards.

One Care plans are required to meet both the time *and* the distance standards for Medicare Advantage-specified services. For example, the standard for Adult PCP services requires that a minimum of two providers be within a 15-mile radius of the member's home *and* a travel time of no more than 30 minutes.

To be considered compliant, One Care plans can meet either the time *or* the distance standard for Medicaid-specified services. For example, the standard for behavioral health outpatient services requires that a minimum of two providers be located within a 15-mile radius of the member's home *or* a travel time 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 5.1. Map of Massachusetts County Designations



ACUTE TREATMENT SERVICES: EMERGENCY SUPPORT SERVICES

Two providers within 15 miles or 30 minutes.

PRIMARY CARE: ADULT PCP SERVICES

Two providers within 15 miles and 30 minutes.

BEHAVIORAL HEALTH OUTPATIENT SERVICES

Greater than or equal to two providers within 15 miles or 30 minutes.

BEHAVIORAL HEALTH DIVERSIONARY SERVICES

MassHealth requires a minimum of two providers be located within 15 miles or 30 minutes of the member. These standards apply to all services outlined in the table that follows.

Exhibit 5.2. Behavioral Health Diversionary Services

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

MEDICAL FACILITY SERVICES

MassHealth requires all Rehabilitation Hospitals to be located within a 15-mile radius or 30-minute travel time, regardless of the county type. Acute Inpatient Hospitals are required to meet a time and distance standard, but the standard changes based on the county designation. They are outlined in the table that follows and must meet both the time and distance standard:

Exhibit 5.3. Acute Inpatient Hospital Standards

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

LONG-TERM SERVICES AND SUPPORT (LTSS)

MassHealth requires a minimum of two Skilled Nursing Facilities be located within 15 miles and 30 minutes of the member. The requirement for all other LTSS services calls for a minimum of two providers within 15 miles or 30 minutes from the member's home. These standards apply to all services outlined in the table that follows.

Exhibit 5.4. Long-Term Services and Support Services

LTSS Specialties	
Adult Day Health	Occupational Therapy
Adult Foster Care	Orthotics and Prosthetics
Day Habilitation	Oxygen and Respiratory Equipment
Day Services	Personal Care Assistant
Group Adult Foster Care	Physical Therapy
Hospice	Speech Therapy

SPECIALTY SERVICES

CMS has established specialty- and county-size-specific standards. Specialty services must also meet a specified ratio of providers-to-plan members. The tables that follow outline the specialty and the corresponding standards, separated by the county designation. Also included is the required ratio of providers-to-members. All services are required to meet both the time and distance standard. It is important to note that the One Care plans do not service the Micro counties in Massachusetts – Dukes and Nantucket.

Exhibit 5.5. Specialty Standards for Large Metro and Metro Counties

Specialty	Large Metro Ratio	Large Metro Time (Minutes)	Large Metro Distance (Miles)	Metro Ratio	Metro Time (Minutes)	Metro 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	0.10	30	15	0.10	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	0.20	20	10	0.20	38	25
Physiatry, Rehab 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

For the following specialties, enrollees must have a choice of two providers within the applicable time and distance standards. However, if only one provider is located within a county, the second provider may be within a 50-mile radius of the enrollee's ZIP code.

Exhibit 5.6. Services with Special Rule

Specialty
Acute Inpatient Hospital
Adult PCP
Skilled Nursing Facility
Clinical Support Services for Substance Use Disorders (Level 3.5)
Community Crisis Stabilization
Community Support Program
Intensive Outpatient Program
Monitored Inpatient Level 3.7
Partial Hospitalization Program
Program of Assertive Community Treatment
Psychiatric Day Treatment
Recovery Coaching
Recovery Support Navigators
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)
Structured Outpatient Addiction Program

EVALUATION METHOD AND INTERPRETATION OF RESULTS

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

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

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

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

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

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

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

Exhibit 5.7. Massachusetts County Designations and 2020 Population

County	County Designations	2020 Population ²
Middlesex	Large Metro	1,632,002
Worcester	Metro	862,111
Essex	Large Metro	809,829
Suffolk	Large Metro	797,936
Norfolk	Large Metro	725,981
Bristol	Metro	579,200
Plymouth	Metro	530,819
Hampden	Metro	465,825
Barnstable	Metro	228,996
Hampshire	Metro	162,308
Berkshire	Metro	129,026
Franklin	Metro	71,029
Dukes	Micro	20,600
Nantucket	Micro	14,255

² Census.gov, accessed November 10, 2021

AGGREGATE RESULTS

As stated previously, One Care plans must meet the time and distance standards with a score of 90 or above to be considered in compliance with network adequacy requirements. This report evaluates each One Care plan's network adequacy results against this requirement.

The following tables depict the scores received by the plans:

Exhibit 5.8. Plan overall scores
Medicare Services

Plan	Score
CCA	99.1
Tufts Health Unify	99.4

Exhibit 5.9. Plan overall scores
Medicaid Services

Plan	Score
CCA	91.4
Tufts Health Unify	91.7

All plans met network adequacy requirements for all Medicare services. The table that follows provides a high-level summary of Medicaid service network adequacy deficiencies by plan and by specialty. An "X" indicates a network deficiency.

Exhibit 5.10. One Care Medicaid Service Network Deficient Networks by Specialty

Services	CCA	Tufts Health Unify
Emergency Services Program		
Clinical Support Services for SUD Level 3.5		X
Community Crisis Stabilization		
Community Support Program		
Intensive Outpatient Program		X
Monitored Inpatient Level 3.7	X	X
Partial Hospitalization Programs		
Programs of Assertive Community Treatment		
Psychiatric Day Treatment		
Recovery Coaching		
Recovery Support Navigators		
Residential Rehab Services for SUD		
Structured Outpatient Addiction Programs		
BH Outpatient		
Adult Day Health		
Adult Foster Care		
Day Habilitation		
Day Services		
Group Adult Foster Care		
Hospice		
Orthotics and Prosthetics		
Oxygen and Respiratory Equipment	X	
Personal Care Assistant	X	X
Physical Therapy		
Occupational Therapy		X
Speech Therapy		
Rehabilitation Hospital	X	

RESULTS BY PLAN

COMMONWEALTH CARE ALLIANCE

CCA enrolls beneficiaries in all counties except for Dukes and Nantucket.

Medicare Services

CCA received an overall score of 99.1 for Medicare services.

- 98.28% of CCA's health care service network fully met the adequacy requirements.
- 1.72% of CCA's health care service network met only the servicing provider requirements.

Primary Care and Medical Facilities

CCA's network of Primary Care Providers and Medical Facilities met all network adequacy requirements.

Specialty Services

CCA's network of Specialty Providers met all network adequacy requirements.

Long-Term Services and Supports

CCA met all Nursing Facility access requirements.

Findings

CCA's network of Medicare service providers is strong.

Medicaid Services

CCA received an overall score of 91.4 for Medicaid services.

- 91.36% of CCA's healthcare service network fully met the adequacy requirements.
- 6.17% of CCA's healthcare service network met only the servicing provider requirements.
- 2.47% of CCA's healthcare service network did not meet any adequacy requirements.

Emergency Services and Rehabilitation Hospitals

CCA met all network access requirements for Emergency Services. The table that follows depicts the network adequacy scores for Rehabilitation Hospitals.

Exhibit 5.11. Rehabilitation Hospital Gaps

County	Rehabilitation Hospitals
Barnstable	100
Berkshire	100
Bristol	100
Essex	100
Franklin	0.0
Hampden	100
Hampshire	100
Middlesex	100
Norfolk	100
Plymouth	100
Suffolk	100
Worcester	60.3
Overall	88.4

Findings

Rehabilitation Hospitals met only the number of servicing provider requirement in Franklin and Worcester Counties.

Behavioral Health Services

The table that follows depicts the network adequacy scores for those behavioral health services meeting the minimum network adequacy score.

Exhibit 5.12. Behavioral Health Services with a Passing Network Adequacy Score

Behavioral Health Service	Score	Behavioral Health Service	Score
Behavioral Health Outpatient	100	PACT Services	100
Clinical Support Services for SUD	91.7	Psychiatric Day Treatment	100
Community Crisis Stabilization	100	Recovery Coaching	100
Community Support Programs	100	Recovery Support Navigators	100
Intensive Outpatient Programs	91.7	Residential Rehabilitation Services for SUD	100
Partial Hospitalization Programs	91.7	Structured Outpatient Addiction Programs	100

The table that follows depicts the network gaps for Monitored Inpatient Level 3.7 services.

Exhibit 5.13. Monitored Inpatient Level 3.7 Service Gaps

County	Monitored Inpatient Level 3.7
Barnstable	0.0*
Berkshire	0.0
Bristol	0.0
Essex	0.0*
Franklin	0.0*
Hampden	0.0
Hampshire	0.0
Middlesex	0.0
Norfolk	0.0
Plymouth	0.0
Suffolk	0.0*
Worcester	0.0
Overall	0.0

* No provider data were submitted by the plan

Findings

Monitored Inpatient Level 3.7 services are meeting only the number of servicing provider requirements in Hampshire County, seven counties are not meeting any requirements, and CCA did not report having providers in four counties.

Long-Term Services and Supports

The table that follows depicts the network adequacy scores for those long-term services and supports meeting the minimum network adequacy score.

Exhibit 5.14. Long-Term Services and Supports with a Passing Network Adequacy Score

LTSS Service	Score	LTSS Service	Score
Adult Day Health	91.7	Hospice	100
Adult Foster Care	91.7	Orthotics and Prosthetics	91.7
Day Habilitation	100	Physical Therapy	100
Day Services	91.7	Occupational Therapy	100
Group Adult Foster Care	91.7	Speech Therapy	100

The table that follows depicts the network adequacy scores for Oxygen and Respiratory Equipment and Personal Care Assistants.

Exhibit 5.15. Oxygen and Respiratory Equipment and Personal Care Assistants

County	Oxygen and Respiratory Equipment	Personal Care Assistants
Barnstable	100	0.0
Berkshire	100	0.0
Bristol	100	0.0
Essex	61.0	61.1
Franklin	0.0	62.2
Hampden	100	100
Hampshire	100	100
Middlesex	100	61.8
Norfolk	100	100
Plymouth	100	55.0
Suffolk	100	100
Worcester	100	55.2
Overall	88.4	57.9

Findings

- Essex and Franklin counties met only the servicing provider requirement for Oxygen and Respiratory Equipment.
- Access standards for Personal Care Assistants were met in four counties. Seven counties only met the servicing provider requirement. Personal Care Assistant access in Barnstable County does not meet any MassHealth requirements.

Recommendations

- Kepro recommends contracting with additional Oxygen and Respiratory Equipment providers in Essex and Franklin Counties.
- Kepro recommends contracting with additional Personal Care Assistant providers in counties not meeting MassHealth requirements.
- Kepro recommends contracting with additional Rehabilitation Hospitals as available in Franklin and Worcester Counties.
- Kepro recommends contracting with additional Monitored Inpatient Level 3.7 providers as available in all counties that CCA services.

TUFTS HEALTH PUBLIC PLANS

In CY 2021, Tufts Health Unify enrolled beneficiaries in Middlesex, Suffolk, and Worcester counties. CMS approved network expansion into three additional counties as of January 1, 2022, i.e., Bristol, Norfolk, and Plymouth Counties. Kepro validated Tufts Health Unify's network based on this expansion.

Medicare Services

Tufts Health Unify received an overall score of 99.4 for Medicaid services.

- 98.85% of Tufts Health Unify's health care service network fully met the adequacy requirements.
- 1.15% of Tufts Health Unify's health care service network met only the servicing provider requirements.

Primary Care and Medical Facilities

Tufts Health Unify's network of Primary Care Providers and Medical Facilities met all network adequacy requirements.

Specialty Services

Tufts Health Unify's network of Specialty providers met all network adequacy requirements.

Long-Term Services and Supports

Tufts Health Unify met all Nursing Facility access requirements.

Findings

Tufts Health Unify's network of Medicare service providers is strong.

Medicaid Services

Tufts Health Unify received an overall score of 91.7 for Medicaid services.

- 87.04% of Tufts Health Unify's health care service network fully met the adequacy requirements.
- 12.96% of Tufts Health Unify's health care service network met only the servicing provider requirements.

Emergency Services and Rehabilitation Hospitals

Tufts Health Unify met all network access requirements for Emergency Services and Rehabilitation Hospitals.

Behavioral Health Services

The table that follows depicts the network adequacy scores for those behavioral health services meeting the minimum network adequacy score.

Exhibit 5.16. Behavioral Health Services with a Passing Network Adequacy Score

Behavioral Health Service	Score	Behavioral Health Service	Score
Behavioral Health Outpatient	100	Psychiatric Day Treatment	100
Community Crisis Stabilization	92.3	Recovery Coaching	100
Community Support Programs	100	Recovery Support Navigators	100
PACT Services	100	Residential Rehabilitation Services for SUD	100
Partial Hospitalization Programs	100	Structured Outpatient Addiction Programs	100

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

Exhibit 5.17. Behavioral Health Service Gaps and Corresponding Counties

County	Clinical Support Services for Substance Use Disorders	Intensive Outpatient Programs	Monitored Inpatient Level 3.7
Bristol	0.0	51.2	0.0
Middlesex	100	100	100
Norfolk	100	100	100
Plymouth	59.2	59.2	100
Suffolk	100	100	100
Worcester	47.0	100	50.1
Overall	67.7	85.1	75.0

Findings

- Three counties only met the servicing provider requirement for Clinical Support Services for substance use disorders. The other three counties passed all MassHealth requirements.

- Four counties do not have Intensive Outpatient Programs available for contracting. The extended 50-mile radius distance standard was applied, and SOAP services now meet access requirements in two of those four counties. Bristol and Plymouth Counties continue to not meet access requirements.

Long-Term Services and Supports

The table that follows depicts the network adequacy scores for those long-term services and supports meeting the minimum network adequacy score.

Exhibit 5.18. Long-Term Services and Supports with a Passing Network Adequacy Score

LTSS Service	Score	LTSS Service	Score
Adult Day Health	100	Hospice	100
Adult Foster Care	100	Orthotics and Prosthetics	100
Day Habilitation	100	Oxygen and Respiratory Equipment	100
Day Services	100	Physical Therapy	100
Group Adult Foster Care	92.0	Speech Therapy	93.6

The table that follows depicts the network adequacy scores for those long-term services and supports not meeting the minimum network adequacy score.

Exhibit 5.19. Long-Term Services and Support Gaps and Corresponding Counties

County	Personal Care Assistants	Occupational Therapy
Bristol	0.0	0.0
Middlesex	50.5	61.9
Norfolk	59.3	45.9
Plymouth	0.0	0.0
Suffolk	100	100
Worcester	48.4	0.0
Overall	43.0	34.6

Findings

- Suffolk County met all MassHealth requirements for both Personal Care Assistants and Occupational Therapy services. All other counties only met the servicing provider requirements.

Recommendations

- Kepro recommends contracting with additional Clinical Support Services for substance use disorders in the counties not meeting MassHealth requirements.
- Kepro recommends MassHealth determine if exceptions to access requirements need to be made for Intensive Outpatient Programs, as these services are difficult to contract.
- Kepro recommends contracting with additional Personal Care Assistants and Occupational Therapy providers in all counties that Tufts Health Unify services except for Suffolk County.



Contributors

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 podcast. Katharine has been a Certified HEDIS® Compliance Auditor since 1998 and has directed more than 2,000 HEDIS audits.

Previously, as CEO of the company Acumetrics, Katharine provided consultancy services to NCQA, which helped its 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, and 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 frontline 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 40 years of experience in the design, implementation, and management of large-scale health and human service systems. His expertise includes improving health providers' service effectiveness and efficiency through data-driven performance management systems. 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.

PROJECT MANAGEMENT

Cassandra Eckhof, MS, CPHQ

Ms. Eckhof has over 25 years of 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.