MassHealth
One Care
External Quality Review Technical Report
Calendar Year 2019

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Section 1. Executive Summary

SECTION 1. EXECUTIVE SUMMARY

INTRODUCTION

The Balanced Budget Act of 1997 was an omnibus legislative package enacted by the United States Congress with the intent of balancing the federal budget by 2002. Among its other provisions, this expansive bill authorized states to provide Medicaid benefits (except to special needs children) through managed care entities. Regulations were promulgated, including those related to the quality of care and service provided by managed care entities to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a managed care entity or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth has entered into an agreement with the KEPRO to perform EQR services related to its contracted managed care plans.

The EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services (CMS). It is also posted to the Medicaid agency website.

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

KEPRO conducted the following external quality review activities for MassHealth One Care plans in the CY 2019 review cycle:

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

Compliance validation must be conducted by the EQRO on a triennial basis. One Care compliance validation was last conducted in 2017 and will be repeated in 2020.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2019 reflect 2018 quality measurement performance. References to HEDIS® 2019 performance reflect data collected in 2018. Performance Improvement Project reporting is inclusive of activities conducted in CY 2019.

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

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

The Performance Measure Validation process assesses the accuracy of performance measures reported by the managed care entity. It determines the extent to which the managed care entity follows state specifications and reporting requirements. The three measures validated in 2018 were:

- Seven-Day Follow Up After Hospitalization for Mental Illness;
- Controlling High Blood Pressure; and
- 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 that data received from providers are accurate and complete and that the accuracy and timeliness of reported data are verified; that the data has been screened for completeness, logic, and consistency; and that service information is collected in standardized formats to the extent feasible and appropriate.

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

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

MassHealth One Care Plans are required to conduct two Performance Improvement Projects annually as specified in Appendix E of their three-way contract between CMS and EOHHS. One project must be conducted for each of the following domains:

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

 In late-2017, the plans submitted proposed topics for three-year projects to MassHealth for its review and approval and initiated their implementation in 2018. The plans' work on these projects continued through 2019, the second of the three-year quality cycle.

In Calendar Year 2019, MassHealth One Care Plans continued the implementation of the following Performance Improvement Projects begun in 2018:

Commonwealth Care Alliance
- Improve the Rate of Cervical Cancer Screening
- Cardiovascular Disease (CVD) Prevention in One Care Members with Mental Illness and Multiple Risk Factors

| Tufts Health Public Plans | • Improve Therapy Visit Rates for Members with Depression
• Reducing Emergency Department (ED) Utilization |

KEPRO evaluates each Performance Improvement Project (PIP) to determine whether the organization selected, designed, and executed the project in a manner consistent with CMS EQR Protocol 3, *Performance Improvement Project Validation*. The KEPRO Technical Reviewer assesses project methodology. The Medical Director evaluates the clinical soundness of the interventions. The review considers the plan's performance in the areas of problem definition, data analysis, measurement, improvement strategies, and outcome. Recommendations are offered to the plan.

> *Based on its review of the One Care Performance Improvement Projects, KEPRO did not discern any issues related to either plan's quality of care or the timeliness of or access to care. Recommendations made were plan-specific.*

Section 2. MassHealth Comprehensive Managed Care Quality Strategy

SECTION 3. MASSHEALTH COMPREHENSIVE QUALITY STRATEGY

Introduction

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

MassHealth Goals

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

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

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

Stakeholder Involvement

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

MassHealth Delivery System Restructuring

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

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

Quality Evaluation

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

- Contract management – MassHealth contracts with plans include requirements for quality measurement, quality improvement, and reporting. MassHealth staff review submissions and evaluate contract compliance.
- Quality improvement performance programs – Each managed care entity is required to complete two Performance Improvement Projects (PIPs) annually, in accordance with 42 CFR 438.330(d).
- State-level data collection and monitoring – MassHealth routinely collects HEDIS[1]® and other performance measure data from its managed care plans.

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

How KEPRO Supports the MassHealth Managed Care Quality Strategy

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

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

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

EQR Activity	Support to MassHealth Quality Strategy
Performance Measure Validation	• Assure that performance measures are calculated accurately. • Offer a comparative analysis of plan performance to identify outliers and trends. • Provide technical assistance. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.
Performance Improvement Project Validation	• Ensure the inclusion of an assessment of cultural competency within interventions. • Ensure the alignment of MassHealth Priority Areas and Quality Goals with MassHealth goals. • Ensure that performance improvement projects are appropriately structured and that meaningful performance measures are used to assess improvement. • Ensure that Performance Improvement Projects incorporate stakeholder feedback. • Share best practices, both clinical and operational. • Provide technical assistance. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.

Compliance Validation	- Assess plan compliance with contractual requirements. - Assess plan compliance with regulatory requirements. - Recommend mechanisms through which plans can achieve compliance. - Facilitate the Corrective Action Plan process. - Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.

Section 3. MassHealth One Care Plans

SECTION 3. MASSHEALTH'S ONE CARE PLANS

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) introduced the Duals Demonstration program to address the longstanding barrier of the financial misalignment between the Medicare and Medicaid programs. CMS seeks to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain costs for individuals aged 21 – 64 who are both Medicaid and Medicare beneficiaries, referred to as "dual eligibles." In 2012, the Massachusetts Executive Office of Health and Human Services (EOHHS) conducted a procurement of Medicare-Medicaid Plans to participate in the Duals Demonstration program. Two of the ICOs originally procured, Commonwealth Care Alliance and Tufts Health Public Plans, continued to enroll dual eligibles in 2018 in what are now called One Care Plans.

COMMONWEALTH CARE ALLIANCE (CCA)

Dually eligible Medicare and Medicaid beneficiaries from Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Suffolk, Worcester, and parts of Plymouth counties are eligible to enroll in CCA One Care. Its headquarters are in Boston. Additional information about CCA One Care is available at http://www.commonwealthcarealliance.org/about-us/cca.

TUFTS HEALTH PUBLIC PLANS (THPP)

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

Exhibit 1: One Care Membership

One Care Plan	Acronym Used in this Report	Membership as of December 31, 2018	Percent of Total OneCare Population
Commonwealth Care Alliance	CCA	19,537	87%
Tufts Health Public Plans	THPP	2,976	13%
Total		22,513	100%

Section 4. Performance Measure Validation

SECTION 5. PERFORMANCE MEASURE VALIDATION

PERFORMANCE MEASURE VALIDATION METHODOLOGY

The Performance Measure Validation (PMV) process assesses the accuracy of performance measures reported by the managed care entity. It determines the extent to which the managed care entity follows state specifications and reporting requirements. In addition to validation processes and the reported results, KEPRO evaluates performance trends in comparison to national benchmarks. 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 HEDIS® Final Audit Report and Roadmaps. The desk review affords the reviewer an opportunity to become familiar with plan systems and data flows. If indicated by the results of the Audit, the reviewer conducts an independent verification of a sample of individuals belonging to the positive numerator of a hybrid measure.

For 2019 Performance Measure Validation, One Care Plans submitted the documentation that follows.

Exhibit 2: Documentation Submitted by One Care Plans

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

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

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

In order to review the quality of the source data and the PMV measure calculation accuracy, KEPRO reviews the HEDIS® Record of Administration, Data Management and Processes (Roadmap), the HEDIS® 2019 Final Audit Report, and PMV measure data. KEPRO evaluates whether the plan passed the NCQA Final Medical Record Review Over-Read component of the

HEDIS® 2019 Compliance Audit and if there are any possible reporting risks stemming from the chart reviews conducted for the PMV hybrid measure under evaluation. Performance is compared to historical rates if the measures have been validated in the past.

Exhibit 3: Performance Measures Validated in 2019

HEDIS Measure Name and Abbreviation	Measure Description
Follow-up After Hospitalization for Mental Illness (FUH) - 7 day numerator *Rationale for Selection:* *Probability of inherent error*	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 7 days after discharge.
Controlling High Blood Pressure (CBP) *Rationale for Selection:* *Probability of inherent error*	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Medication Reconciliation Post-Discharge (MRP) *Rationale for Selection* *Probability of inherent error*	The percentage of discharges from January 1-December 1 of the measurement year for members 18 years or age and older for whom medications were reconciled the date of discharge through 30 days after discharge.

COMPARATIVE ANALYSIS

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

Exhibit 4: Performance Measure Validation Worksheets

Performance Measure Validation: Follow-Up After Hospitalization for Mental Illness (FUH) - Seven- Day Rate

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Rating Categories: Met, Needs Improvement, Not Met, Not Applicable (N/A)

Review Element	CCA	THPP
DENOMINATOR		
Population		
One Care Plan population was appropriately segregated from other product lines.	Met	Met
Members continuously enrolled on or before the date of the qualifying discharge that had a principal diagnosis of mental illness on or between January 1 and December of the measurement year, through 30 days post-discharge.	Met	Met
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
Members 6 years and older as of the date of discharge.	Met	Met
Geographic Area		
Includes only those One Care Plan enrollees served in plan's reporting area.	Met	Met
Data Quality		
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
Proper Exclusion Methodology in Administrative		
Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health.	Met	Met
NUMERATOR – 7 DAY FOLLOW-UP RATE		
Administrative Data: Counting Clinical Events		
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met
A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge.	Met	Met

Performance Measure Validation: Controlling High Blood Pressure (CBP)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Rating Categories: Met, Needs Improvement, Not Met, Not Applicable (N/A)

Review Element	CCA	THPP
DENOMINATOR		
Population		
One Care Plan population was appropriately segregated from other product lines.	Met	Met
Members were aged 18-85 as of December 31 of the measurement year.	Met	Met
Members were continuously enrolled during the measurement year, with no more than a one-month gap.	Met	Met
Members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (count services that occur over both years). Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: • Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). • An online assessment (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). Only one of the two visits may be a telephone visit, an online assessment or an outpatient telehealth visit. Identify outpatient telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit.	Met	Met
Geographic Area		
Includes only those One Care Plan enrollees served in the plan's reporting area.	Met	Met
NUMERATOR		
Counting Clinical Events		
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
Data sources and decision logic used to calculate the numerators (e.g., claims 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
The most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a member's BP to be controlled the systolic and diastolic BP must be <140/90 mm Hg (adequate control).	Met	Met
Data Quality		

Review Element	CCA	THPP
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
Proper Exclusion Methodology in Administrative Data		
• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year. • Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. • Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay.	Met	Met
Data Quality		
The eligible population was properly identified.	Met	Met
Based on the IS assessment findings, data sources used for this numerator were accurate.	Met	Met
Hybrid Measure		
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met
If the hybrid method was used, the One Care Plan passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit.	Met	Met
SAMPLING		
Unbiased Sample		
As specified in the NCQA specifications, systematic sampling method was utilized.	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.	Met	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented.	Not Applicable	Not Applicable

Performance Measure Validation: Medication Reconciliation Post-Discharge (MRP)

Methodology for Calculating Measure:	Administrative	Medical Record Review	**Hybrid**

Rating Categories: Met, Needs Improvement, Not Met, Not Applicable (N/A)
Comments apply only if review element is rated needs improvement or not met.

Review Element	CCA	THPP
DENOMINATOR		
Population		
One Care Plan population was appropriately segregated from other product lines.	Met	Met
Members were age 18+ as of December 31 of the measurement year.	Met	Met
Members had a qualifying acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year and met the continuous enrollment requirements.	Met	Met
Geographic Area		
Includes only those One Care Plan enrollees served in the plan's reporting area.	Met	Met
NUMERATOR		
Counting Clinical Events		
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
Data sources and decision logic used to calculate the numerators (e.g., claims 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
Members had a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.	Met	Met
Data Quality		
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
Proper Exclusion Methodology in Administrative Data		
If the discharge is followed by readmission or direct transfer to an acute or non-acute facility within the 30 day follow up period, only the readmission or transfer discharge is counted. Exclude if the readmission/direct transfer discharge occurs after December 1 of the measurement year or if the member remains in the facility through December 1 of the measurement year.	Met	Met
Data Quality		
The eligible population was properly identified.	Met	Met
Based on the IS assessment findings, data sources used for this numerator were accurate.	Met	Met
Hybrid Measure		
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met

Review Element	CCA	THPP
If the hybrid method was used, the One Care Plan passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit.	Met	Met
SAMPLING		
Unbiased Sample		
As specified in the NCQA specifications, systematic sampling method was utilized.	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.	Met	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented.	Not Applicable	Not Applicable

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

CMS regulations require that each managed care entity also undergo an annual Information Systems Capability Assessment. The focus of the review is on components of MCO information systems that contribute to performance measure production. This is to ensure that the system can collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system or other methods. The system must be able to ensure that data received from providers are accurate and complete and verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate. The findings for both CCA and THPP were acceptable.

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

COMPARATIVE RESULTS

2019 was the first year in which the performance measures below were validated. HEDIS 2017 and HEDIS 2018 rates, although not validated through the external quality review process, are provided for comparison purposes.

Exhibit 5: Seven-Day Follow-up After Hospitalization for Mental Illness (FUH)

Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
CCA	61.15%	58.67%	41.64%	CCA's performance decreased 17.03 percentage points between HEDIS 2018 and HEDIS 2019. Its HEDIS 2019 performance is between the Medicaid Quality Compass 2019 66th and 75th percentiles.
THPP	58.27%	54.86%	51.59%	Tufts' performance decreased 3.25 percentage points between HEDIS 2018 and HEDIS 2019. THPP's performance is between the 75th and 90th Medicaid Quality Compass 2019 percentiles.

Exhibit 6: Controlling High Blood Pressure (CBP)

Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
CCA	64.29%	69.74%	72.02%	CCA's performance increased 2.28 percentage points between HEDIS 2018 and HEDIS 2019. Its performance is between the Medicaid Quality Compass 2019 75th and 90th percentiles.
THPP	67.37%	68.31%	74.21%	Tufts' performance increased 5.90 percentage points between HEDIS 2018 and HEDIS 2019. Its performance is between the 90th and 95th Medicaid Quality Compass 2019 percentiles.

Exhibit 7: Medication Reconciliation Post-Discharge (MRP)

Medication Reconciliation Post-Discharge (MRP)				
Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change HEDIS 2018 to HEDIS 2019
CCA	61.80%	49.39%	55.72%	CCA's MRP performance increased 6.33 percentage points between HEDIS 2018 and HEDIS 2019. CCA's performance is between the 25th and 33rd CMS SNP PUF percentiles.
THPP	16.30%	33.82%	38.69%	Tufts MRP performance increased 4.87 percentage points between HEDIS 2018 and HEDIS 2019. This performance is between the 5th and 10th CMS SNP PUF percentiles.

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION

COMMMONWEALTH CARE ALLIANCE

Performance Measure Results

Commonwealth Care Alliance performance in the three measures selected for validation follows. Its performance relative to Quality Compass 2019 is provided for comparison purposes.

Exhibit 7: CCA Follow-up After Hospitalization for Mental Illness (FUH)

CCA One Care Plan Rate				
Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
7-Day Follow-up Rate	61.15%	58.67%	41.64%	CCA's performance decreased 17.03 percentage points between HEDIS 2018 and HEDIS 2019. Its HEDIS 2019 performance is between the Medicaid Quality Compass 2019 66th and 75th percentiles.

Exhibit 8: CCA Controlling High Blood Pressure (CBP)

CCA One Care Plan Rate				
Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
CBP Rate	64.29%	69.74%	72.02%	CCA's performance increased 2.28 percentage points between HEDIS 2018 and HEDIS 2019. Its performance is between the Medicaid Quality Compass 2019 75th and 90th percentiles.

Exhibit 9: CCA Medication Reconciliation Post-Discharge (MRP)

CCA One Care Plan Rate				
Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
MRP Rate	61.80%	49.39%	55.72%	CCA's MRP performance increased 6.33 percentage points between HEDIS 2018 and HEDIS 2019. CCA's performance is between the 25th and 33rd CMS SNP PUF percentiles.

Information Systems Capability Assessment

1. **Claims and Encounter Data**. Claims, including lab claims, were processed by a vendor, PCG, using the EZ Cap system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. PCG demonstrated adequate monitoring of data quality and the Commonwealth Care Alliance (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.

2. **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.

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

4. **Supplemental Data**. CCA's eClinicalworks electronic medical record supplemental data source successfully contributed to the performance measure rates for CBP and MRP.

5. **Data Integration**. CCA's performance measures were produced using Inovalon software. Data transfers to the Inovalon repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances

investigated. CCA maintains adequate oversight of Inovalon. There were no issues identified with data integration processes.

6. **Source Code**. CCA used NCQA-certified Inovalon HEDIS software to produce performance measures. There were no source code issues identified.

HEDIS® Roadmap and Final Audit Report

Name of Auditing Firm: Advent Advisory Group
Date Distributed: June 18, 2019

Audit Element	Findings
Medical Data	CCA met requirements for timely and accurate claims data capture.
Enrollment Data	Enrollment data processing met all HEDIS standards.
Practitioner Data	Practitioner data related to performance measure production are adequate to support reporting.
Medical Record Review	Medical record tools, training materials, medical record process, and quality monitoring met requirements. Plan passed Medical Record Review Validation.
Supplemental Data	Supplemental data processes and procedures were adequate and met technical specifications.
Data Integration	Data integration processes were adequate to support data completeness and performance measure production.

Medical Record Review Validation

CCA passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit. There were no measure reportability risks stemming from the chart reviews. Further medical record review accuracy determinations were deemed unnecessary. KEPRO therefore did not sample any medical records for the hybrid measures being validated.

Compliance with NCQA Specifications

Measure-Specific Validation Designation		
Performance Measure	**Validation Designation**	**Definition**
Follow-up After Hospitalization for Mental Illness (FUH) - 7 day numerator	Valid measure (no bias)	Measure data were compliant with NCQA specifications, and the data, as reported, were valid.
Controlling High Blood Pressure (CBP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications, and the data, as reported, were valid.
Medication Reconciliation Post-Discharge (MRP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications, and the data, as reported, were valid.

Update on 2018 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. No re commendations, however, were made to CCA in 2018.

Strengths

- CCA used an NCQA-certified vendor.
- CCA used supplemental data for HEDIS reporting.
- CCA supplied thorough documentation for review.
- CCA scored above the Medicaid Quality Compass 2019 66th percentile for the seven-day follow-up rate for the HEDIS measure, Follow-Up after Hospitalization for Mental Illness.
- CCA scored above the Medicaid Quality Compass 2019 75th percentile for the HEDIS measure, Controlling High Blood Pressure.

Opportunities

- CCA scored below the CMS PUF 33rd percentile for the HEDIS measure, Medication Reconciliation Post-Discharge.

Recommendations

- Implement quality improvement initiatives to increase the Medication Reconciliation Post-Discharge rate.

Performance Measure Results

Exhibit 10: THPP Follow-up After Hospitalization for Mental Illness (FUH)

Follow-up After Hospitalization for Mental Illness (FUH)				
Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
FUH Rate	58.27%	54.86%	51.59%	Tufts' performance decreased 26.08 percentage points between HEDIS 2018 and HEDIS 2019. THPP's performance is between the 75th and 90th Medicaid Quality Compass 2019 percentiles.

Exhibit 11: THPP Controlling High Blood Pressure (CBP)

Controlling High Blood Pressure (CBP)				
Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
CBP Rate	67.37%	68.31%	74.21%	Tufts' performance increased 5.90 percentage points between HEDIS 2018 and HEDIS 2019. Its performance is between the 90th and 95th Medicaid Quality Compass 2019 percentiles.

Exhibit 12: THPP Medication Reconciliation Post-Discharge (MRP)

Medication Reconciliation Post-Discharge (MRP)				
Rate	HEDIS 2017	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
MRP Rate	16.30%	33.82%	38.69%	Tufts' MRP performance increased 4.87 percentage points between HEDIS 2018 and HEDIS 2019. This performance is between the 5th and 10th CMS SNP PUF percentiles.

Information Systems Capability Assessment

1. **Claims and Encounter Data.** Tufts Health Public Plans processed claims using the Monument Xpress system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes.

Most claims were submitted electronically to THPP and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. THPP had robust claims editing and coding review processes.

THPP processed all claims within Monument Xpress except for pharmacy claims which were handled by THPP's pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness or with claims or encounter data processing.

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

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

4. **Supplemental Data.** THPP's supplemental data sources did not contribute to the three PMV measures under review. This section, therefore, is not applicable.

5. **Data Integration.** THPP's HEDIS measure rates were produced using GDIT software. Data from the transaction system was loaded to THPP's data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into GDIT-compliant extracts and loaded into the measure production software. THPP had adequate processes to track completeness and accuracy of data at each transfer point.

   HEDIS measure report production was managed effectively. The GDIT software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. THPP maintains adequate oversight of GDIT. There were no issues identified with data integration processes.

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

Review of One Care Plan's Final HEDIS 2019 Compliance Audit Report

Name of Auditing Firm: Attest Health Care Advisors
Date Distributed: July 8, 2019

Audit Element	Findings
Medical data	THPP met requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Practitioner data	Practitioner data related to performance measure production is adequate to support reporting.
Medical record review	Medical record tools, training materials, medical record process, and quality monitoring met requirements. THPP passed Medical Record Review Validation.
Supplemental data	Supplemental data processes and procedures were adequate and met technical specifications.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Medical Record Validation

THPP passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit. There were no measure reportability risks stemming from the chart reviews. Further medical record review accuracy determinations were deemed unnecessary. KEPRO therefore did not sample any medical records for the PMV hybrid measures under evaluation.

Compliance with NCQA Specifications

Measure-Specific Validation Designation		
Performance Measure	**Validation Designation**	**Definition**
Seven-Day Follow-up After Hospitalization for Mental Illness (FUH)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Controlling High Blood Pressure (CBP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Medication Reconciliation Post-Discharge (MRP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.

Follow Up to 2018 Recommendations

- No recommendations were made in 2018.

Strengths

- THPP used an NCQA-certified vendor.
- THPP had adequate staff with subject matter expertise to manage and report valid performance measure rates.
- THPP scored above the Medicaid Quality Compass 75th percentile for the seven-day follow-up rate for the HEDIS measure, Follow-Up After Hospitalization for Mental Illness.
- THPP scored above the Medicaid Quality Compass 2019 90th percentile for the HEDIS measure, Controlling High Blood Pressure.

Opportunities

- THPP scored below the CMS PUF10th percentile for the HEDIS measure, Medication Reconciliation Post-Discharge.

Recommendations

- Implement quality improvement initiatives to increase the Medication Reconciliation Post-Discharge rate.

Section 5. Performance Improvement Project Validation

SECTION 6. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

THE PERFORMANCE IMPROVEMENT PROJECT LIFE CYCLE

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

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

Baseline/Initial Implementation Period: Calendar Year 2018

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

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

Mid-cycle Implementation Period: Calendar Year 2019

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

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

Final Implementation Period: Calendar Year 2020

Final Implementation Progress Reports: *March 2020*
One Care Plans will submit another progress report that describes current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including successes and challenges.

Final Implementation Annual Report: September 2020
One Care Plans will submit a second annual report that describes current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including successes and challenges and describe plans for the final quarter of the initiative.

All of these reports are reviewed by KEPRO. The 2019 reports are discussed herein. Each project is evaluated to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3, *Performance Improvement Project Validation*. This evaluation also determines whether the projects have achieved or likely will achieve favorable results. KEPRO distributes detailed evaluation criteria and instructions to the plans to support their efforts.

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

1) *PIP Questionnaire*. Plans submit a completed reporting questionnaire for each PIP. This questionnaire is stage-specific. In 2019, plans submitted a Mid-Cycle Progress and a Mid-Cycle Annual Report. The Progress Report asks the One Care Plans to provide a barrier analysis and associated mitigation strategies; project goals; intervention status including the results of small tests of change and future direction; a description of stakeholder involvement; and proposed performance indicators. The Mid-Cycle Annual Report asks for a description and rationale for any changes made to the topic, method, goals, interventions, and cultural competence strategies; an updated population analysis; intervention updates; planned changes; and the remeasurement of selected performance indicators.

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

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

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

PERFORMANCE IMPROVEMENT PROJECT TOPICS

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

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

In Calendar Year 2019, MassHealth One Care Plans continued the implementation of the following Performance Improvement Projects begun in 2018:

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

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

> *Based on its review of the MassHealth One Care Plans' Performance Improvement Projects, KEPRO did not discern any issues related to any plan's quality of care or the timeliness of or access to care.*

COMPARATIVE ANALYSIS

Both THPP and CCA serve complex populations, and both have presented good population analyses that provide granular information about demographics and comorbidities. The presence of a behavioral health disorder is identified throughout the PIP reports as a key barrier to improvement.

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.

The chart that follows depicts One Care Plan rating scores for Performance Improvement Projects validated in 2019.

Exhibit 13: One Care Plan PIP Rating Scores

2019 One Care Plan PIP Rating Scores
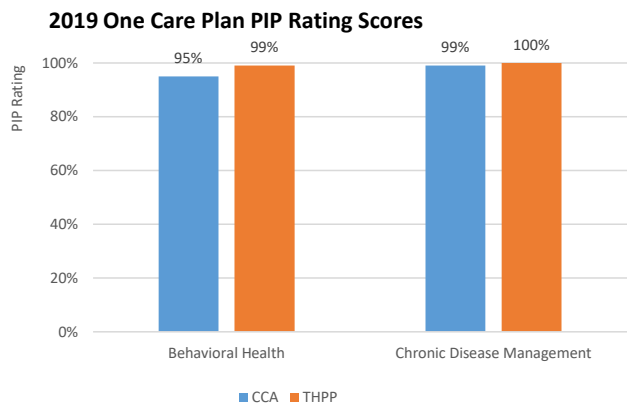
SUMMARY OF PLAN-SPECIFIC PERFORMANCE IMPROVEMENT PROJECTS

Summaries of One Care Plan performance improvement projects follow. The section below is intended to provide the reader with a reference for how the project description content was derived.

Project Title	The project title is assigned by the managed care plan.
Rationale for Project Selection	In their project proposals, managed care plans are required to provide a rationale for the project's selection. The language in this section is extracted from the project proposal submitted by the plan to MassHealth in November 2018.
Project Goals	Managed care plans articulated project goals in the Planning Report and in the Initial Implementation Report. To eliminate the possibility of misinterpretation, KEPRO has provided these goals exactly as stated by the managed care plan. One Care Plans first reported on this project in 2018. Updates from the 2018 are noted accordingly.
Performance Indicators	This section identifies the performance indicators by which the managed care plan intends to evaluate the success of the performance improvement project. Baseline (2018) performance is provided as is the plan's goal for the 2019 remeasurement period. One Care Plans first reported on this project in 2018. Updates from the 2018 are noted accordingly.
Interventions	Here, KEPRO summarizes at a high level the interventions the plan has or plans to implement to achieve its goals. One Care Plans first reported on this project in 2018. Updates from the 2018 are noted accordingly.

Plan interventions are often complex, multi-layered initiatives with many moving parts. Space limitations preclude providing detailed, comprehensive descriptions of each intervention. |
| Performance Improvement Project Evaluation | KEPRO evaluates projects against a set of pre-determined criteria that speak to the strength of the interventions as well as the overall project design. Elements of project design include, but are not limited to, the size of the affected population; analyses of the member population and barriers; barrier mitigation strategies; and intervention effectiveness. These criteria are summarized in the first |

	column of the accompanying table. The managed care plan's success at meeting the criteria are summarized in the 2019 final rating score.
Plan and Project Strengths	In this section, KEPRO recognizes the managed care plan's efforts as they relate to project design. It also recognizes organizational structures that contribute to the overall quality improvement process.
Recommendations and Opportunities for Improvement	In this section, KEPRO offers suggestions for improving the design of the quality improvement project including both intervention design and the overall construct of the project.

DOMAIN 1: BEHAVIORAL HEALTH

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

Project Rationale

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

Project Goals

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

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

Interventions

- Health Outreach Workers provide health-coaching and support for members with mental illness whose smoking puts them at high risk of developing cardiovascular disease.

  2019 Update: CCA learned that members felt uncomfortable having smoking-related conversations with Health Outreach Workers with whom they were not familiar. Going forward, the primary Care Partner will partner with the Health Outreach Worker in these communications. There will also be an increased level of outreach to the members' Primary Care Providers with updates on the members' smoking cessation efforts.

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

   2019 Update: PCPs' participation in the program was not optimal. CCA has designated the Care Partner as the member of the care team charged with engaging members in the smoking cessation program. CCA intends to clarify the role of the PCP in acquiring Medication Assisted Treatment (MAT) and an alternative means for accessing MAT will be developed in addition to through the PCP.

Performance Indicators

CCA's initially intended to measure the success of this intervention using seven rates, i.e., 1) the Short-Term Smoking Cessation Rate; 2) the Short-Term Smoking Reduction Rate; 3) the Long-Term Smoking Cessation Rate; 4) the Long-Term Smoking Reduction Rate; 5) the Oral Diabetes Medication Non-Adherence Improvement Rate; 6) the RAS Antagonist Medication Non-Adherence Improvement Rate; and 7) the Statin Medication Non-Adherence Improvement Rate. It has since simplified its performance measurement strategy to focus on fewer, more relevant measures.

Short-Term Smoking Cessation Rate – The number of members who were smokers at the time they were offered the coaching program who report at the time of program completion that they had quit smoking at the completion of the ten-week intervention.
- CCA's 2017 baseline performance rate was 0%.
- Its 2018 rate was 9% (6/67), which exceeded CCA's 5% goal.

Intermediate Smoking Cessation Rate – The number of members who were smokers at the time they were offered the coaching program who continued to report that they had quit smoking three months after program completion.
- CCA's 2017 pre-implementation baseline performance rate was 0%.
- Its 2018 rate was 9% (6/67), which exceeded CCA's 5% goal.

Long-Term Smoking Cessation Rate – The number of members who were smokers at the time they were offered the coaching program who continued to report that they had quit smoking six months after completing the program.
- CCA's 2017 baseline performance rate was 0%.
- Its 2018 rate was 9% (6/67), which exceeded CCA's 5% goal.

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 95% on this Performance Improvement Project.

Exhibit 15: CCA CVD PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	11	92%
Population Analysis Update	2	6	4	67%
Assessing Intervention Outcomes	4.0	12.0	11	92%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	3.0	9.0	9.0	100%
Remeasurement Performance Indicator Rates	5.0	15.0	15.0	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	**26**	**78**	**74**	**95%**

Plan & Project Strengths

- CCA's 9% smoking cessation rate of the intervention group exceeded the 5% reduction goal.

Opportunities for Improvement

- CCA's population analysis should consider risks that could preclude improved self-healthcare among the participating members, as well as clinical and demographic factors that could be barriers for achieving smoking cessation and improving cardiovascular health.

- KEPRO suggests that CCA continue tracking the results of coaching to determine opportunities to improve the desired outcome of smoking cessation. In addition to motivational interviewing skill improvement, CCA could consider other options for engaging with members, such as text messages to provide ongoing brief educational messages and support.

- In future reports, KEPRO suggests that CCA speak in more detail to the value of MAT in improving the rate of members' smoking cessation.

Follow Up to 2018 Recommendations

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

2018 Recommendation	2019 Follow Up
CCA might consider more structured means of gathering feedback, not only from staff, but also from external stakeholders (members and providers).	CCA surveyed members to determine if their PCP and/or Care Partner encouraged them to participate in the smoking cessation program and if they were offered medication assisted treatment (MAT).
KEPRO suggests that CCA also medical assistants, nurses, receptionists, and others to connect with members for education and to promote smoking cessation resources during all face-to-face encounters with PIP-eligible members.	The nature of the intervention and available resources necessitated prioritizing the care partners and primary care providers in their need to emphasize smoking cessation in all face-to face members of the cohort.

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

Project Rationale

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

Project Goals

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

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

Interventions

- Tufts published an educational article in its provider newsletter to raise awareness of the importance of depression screening and follow up. The article included pertinent information on depression clinical practice guidelines.

  2019 Update: The project workgroup regularly conducts internal review of the provider article to assess whether improvements can be made. The article was distributed at provider meetings.

- Tufts informed targeted community health center primary care providers in writing of members in their panels who had received a diagnosis of depression but did not receive behavioral health therapy services. Tufts staff then conducted a follow-up phone call to the primary care provider.

  2019 Update: Tufts had limited success reaching primary care providers. Alternative strategies, including face-to-face meetings between the Tufts Care Management Manager and providers, are under development.

- Tufts Care Managers conduct outreach to members diagnosed with depression who are not receiving therapy.

2019 Update: The Care Management Team intends to explore leveraging peer specialists for outreach calls. Outreach trends are discussed by Care Managers during daily huddles.

<u>Performance Indicators</u>

Tufts will measure performance using the Therapy Visit Rate for Depressed Members seen at high-volume health centers.
- Tufts' 2017 baseline performance was 34.6%. Its goal for the first remeasurement is 33.1%.
- Its 2018 40.4% rate reflects a statistically significant 16.71% increase ($p < 0.05$).

2019 Update: Tufts added the rate of depressed members not receiving behavioral health therapy services as a performance indicator.
- Its 2017 baseline performance in this measure was 40.8%, which exceeded its goal of 39.3%.
- Its performance in 2018 was 41.9%, which is a statistically insignificant negative increase of 2.79%.

<u>Performance Improvement Project Evaluation</u>

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

Exhibit 16: THPP Depression Therapy PIP Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	4	12	12	100%
Performance Indicator Parameters	4.0	12.0	12.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	**27**	**81**	**81**	**100%**

Strengths

- THPP is commended for increasing the staff resources for care management and for decreasing the caseloads for its Community Health Workers (CHW).
- KEPRO commends THPP for piloting telephonic outreach to primary care providers as an additional outreach effort after finding that a letter did not have the effect of decreasing rates of members not receiving behavioral health therapy.

Recommendations & Opportunities for Improvement

- KEPRO recommends considering additional activities to engage with members for appropriate follow up after screening positive for depression such as text messages.
- KEPRO recommends that THPP develop strategies for bringing together PCP and BH providers for a discussion of the barriers related to the successful management of referrals for BH care and the integration of care. These barriers can then be clarified through a root cause analysis, which can in turn lead to provider-informed strategies for new intervention activities.
- KEPRO recommends that providers be queried about their knowledge of, or relationship with, BH specialty providers. PCPs may be reluctant to make referrals to BH specialists if they do not know to whom they are referring their patients.

<u>Follow Up to 2018 Recommendations</u>

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

2018 Recommendation	2019 Follow Up
KEPRO suggested that THPP consider including others who could do outreach to members such as medical assistants, nurses, and care managers to do the repeated outreach. A broader outreach team could do this through phone, email, or texting.	THPP is considering the use of peer specialists to conduct outreach to members.
KEPRO suggests that THPP track whether or not providers are reading the educational materials it distributed and evaluate whether the newsletter is changing provider behavior in any way.	Tufts attempted to conduct a telephone survey of providers to assess the usefulness of the educational material in the newsletter, but experienced a very low response rate. As a proxy measure, Tufts used provider satisfaction survey questions related to the newsletter, to which 75% of providers agreed or strongly agreed that it is useful.

DOMAIN 2: CHRONIC DISEASE MANAGEMENT

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

Project Rationale

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

Project Goals

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

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

<u>Interventions</u>

- CCA distributed an educational member newsletter in English, Spanish, and Portuguese and a mailing in English and Spanish to women with a gap in care. An Interactive Voice Recognition (IVR) phone call program was launched to remind women with a gap in care to schedule cervical cancer screening services. Through these programs, the member can elect to be connected to Member Services for help scheduling an appointment.

  2019 Update: CCA is continuing the IVR calling campaign with script modifications designed to improve member engagement to remain on the call.

- CCA-employed providers and care partners received education in women's health.

  2019 Update: CCA conducted an in-house Provider Education Survey that assessed both familiarity with cervical cancer screening and participation in provider education. It also assessed the providers' preferred training method. CCA is using this information to inform the design of ongoing education.

- CCA established Women's Health clinics in Commonwealth Community Care locations.

  2019 CCA plans to continue to promote the Women's Health clinics to improve access. CCA did not provide information about additional interventions that will be developed or tested.

<u>Performance Indicators</u>

CCA is using the HEDIS® measure: women 24-64 years of age who were screened for cervical cancer according to guidelines. Its performance goal is 67%.
- CCA's 2017 baseline performance was 65%.
- CCA's 2018 rate, 62.89%, represents a statistically insignificant decrease of 3.24%.

<u>Performance Improvement Project Evaluation</u>

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

Exhibit 14: CCA Cervical Cancer PIP Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	11.3	94%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	4	12	12	100%
Performance Indicator Parameters	6	18	18	100%
Remeasurement Performance Indicator Rates	5	15	15	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	**30**	**90**	**89.3**	**99%**

Plan & Project Strengths

- KEPRO commends CCA for its educational activities with its practitioners. By evaluating the effect of this education on providers' screening practices, CCA can assure itself that its educational efforts are matched by improved rates of screening.

- The PIP team is commended for its collaboration with CCA's Consumer-Centered Quality and Marketing Departments, as well as for its engagement of members as stakeholder in support of this PIP.

Recommendations and Opportunities for Improvement

- As a practice recommendation for providers, KEPRO suggests integrating cervical cancer screening into its workflows proactively. CCA might consider adding an EHR flag to initiate a discussion about the benefits of screening prior to the member's visit to a PCP or OB/GYN. KEPRO recommends that CCA track the response rate to its Interactive Voice Response (IVR) calls.

Follow Up to 2018 Recommendations

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

2018 Recommendation	2019 Follow Up
KEPRO suggests that CCA consider other ways to assess HPV status, such as through urine screening for HPV.	In a conversation with the reviewers, CCA noted that urine or other testing for HPV is not approved in the U.S.
KEPRO suggests that CCA make scripts available for use by a variety of practice clinicians for when they interact with women who could benefit from cervical cancer screening. If clinicians could internalize these scripts, the narrative could be more easily inserted into the routine conversations that clinicians have with women who fit the risk profile, e.g., multiple sexual partners and smoking.	When this was discussed with Surveyors, CCA explained that in our capacity as a health plan, CCA does not have the ability to require network providers or their staff to have specific, directed conversations with patients about cervical cancer screening. As such, CCA educates network providers about the recommended clinical practice guidelines through a quarterly provider newsletter and encourages the discussion of appropriate screening with their patients. Specifically in 2019, CCA addressed the guideline addition of providing cervical HPV testing only every five years as well as the feedback received from a targeted Member Focus Group about barriers to cervical cancer screening and how providers can help women overcome those barriers.
CCA is encouraging use of its Commonwealth Community Care (CCC) clinics. Considering that marketing the expansion of this resource has not increased referrals, the question is whether more marketing will make a difference. KEPRO suggests that CCA conduct a focused barrier analysis on this question that includes a representative group of members and providers.	CCA is commended for identifying the barriers to timely screenings as applicable to the high clinical risk members treated by the CCC clinicians.

TUFTS HEALTH PUBLIC PLANS: EMERGENCY DEPARTMENT UTILIZATION

Project Rationale

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

Project Goals

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

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

Interventions

- THPP contacts members after an emergency department visit to encourage them to be seen by their primary care provider for follow up with the goal of preventing future ED visits through better PCP care management.

  2019 Update: THPP is redesigning the scripts and interview tools used to conduct the post-discharge outreach by the care managers to increase the effect of PCP follow-up appointments and to emphasize alternative sites for urgent care such as community-based urgent care centers. THPP engaged an external organization, PreManage, which provides real-time information on ED admissions, transfers, and discharges. Additionally, it is hoped

that the stratification of utilizers into low-, high-, and super-utilizer cohorts will yield actionable next steps.

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

  2019 Update: Eighty percent of these providers had reductions in ED visit numbers in 2018 compared to 2017. THPP is using a care management community model of treatment that addresses Social Determinants of Health at the community level.

Performance Indicators

Tufts will use the HEDIS® Emergency Department Utilization (EDU) measure to assess the success of this initiative. In this measure, a lower rate reflects better performance.
- 2017 baseline performance was 1,440 emergency department visits per thousand members. Tuft's goal for the 2018 remeasurement period was 1,422 emergency department visits per 1,000 members.
- Tufts 2018 rate was 1,447 emergency department visits per thousand 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 Public Plans received a rating score of 100% on this Performance Improvement Project.

Exhibit 17: THPP Emergency Department PIP Rating

Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5	15	15	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	**26**	**78**	**78**	**100%**

Plan & Project Strengths

- THPP is commended for case mangers' use of motivational interviewing with members.
- THPP is commended for its analysis of provider group trends in ED visits and for directing its provider outreach to those provider groups showing increases in the absolute count of ED visits.
- THPP is commended for its methodology for assessing the effectiveness of its member outreach activities using data collected based on ED utilization stratifications.
- THPP is commended for its varied strategies to improve the effectiveness of its PIP interventions over the next reporting cycle.

Recommendations and Opportunities for Improvement

- THPP should consider focusing on the members with high rates of ED utilization by attempting to engage them in intensive care management.

Follow Up to 2018 Recommendations

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

Commented [HM1]: How is the plan currently using pre-existing resources to reduce ED utilization? Do Care Coordinators and/or LTSS Coordinators get a notice from PreMange when their member was in the ED? What is the time line for follow-up, etc.

2018 Recommendation	2019 Follow Up
KEPRO suggests that THPP survey this group of providers to find out what they are learning about the members who use their services. THPP might query whether its outreach services are helpful to these providers with respect to the prevention of non-emergency ED visits.	THPP did not speak to this recommendation.

APPENDIX. CONTRIBUTORS

PERFORMANCE MEASURE VALIDATION REVIEWER

Katharine Iskrant, MPH, CHCA, CPHQ

Ms. Iskrant is a member of the National Committee for Quality Assurance (NCQA) Audit Methodology Panel and has been a Certified Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Auditor since 1998. She directed the consultant team that developed the original NCQA Software Certification Program^{SM} on behalf of NCQA. She is a frequent speaker at national HEDIS® conferences. Ms. Iskrant received her Bachelor of Arts from Columbia University and her Master of Public Health from the University of California at Berkeley School of Public Health. She is a member of the National Association for Healthcare Quality (NAHQ) and is published in the fields of healthcare and public health.

PERFORMANCE IMPROVEMENT PROJECT REVIEWERS

Bonnie L. Zell, MD, MPH, FACOG

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

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

In February 2015, Dr. Zell co-founded a telehealth company, Icebreaker Health, which developed Lemonaid Health, a telehealth model for delivering simple, uncomplicated primary care accessed through an app and website. Serving as chief medical officer and chief quality officer, she built the systems, protocols, quality standards, and care review processes. Her role then expanded to building partnerships to integrate this telehealth model of care into multiple health systems and study it with national academic leaders. Dr. Zell continues to have an interest in supporting communities of greatest need. She has published and presented extensively. Currently, Dr. Zell is serving as a healthcare quality coach for Sutter Health and is Chief Medical Officer of Pill Club providing telehealth care for women.

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 the effectiveness and efficiency of managed health services through data-driven performance management systems.

During his tenure as Vice-President for Quality Management and Analytics 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 with behavioral health care, and improving access to long-term services and supports for health plan members with complex medical needs. Other areas of expertise include implementing evidence-based intervention and treatment practices; designing systems for the measurement of treatment outcomes; and developing data-collections systems for quality metrics that are used to improve provider accountability.

PROJECT MANAGEMENT

Cassandra Eckhof, M.S., CPHQ

Ms. Eckhof has over 25 years managed care and quality management experience and has worked in the private, non-profit, and government sectors. Her most recent experience was as director of Quality Management at a Chronic Condition Special Needs Plan for individuals with end-stage renal disease. Ms. Eckhof has a Master of Science degree in health care administration and is a certified professional in healthcare quality.