



TECHNICAL REPORT

# Primary Care Accountable Care Organizations External Quality Review

Calendar Year 2021



**MassHealth**

Massachusetts Executive Office  
of Health and Human Services



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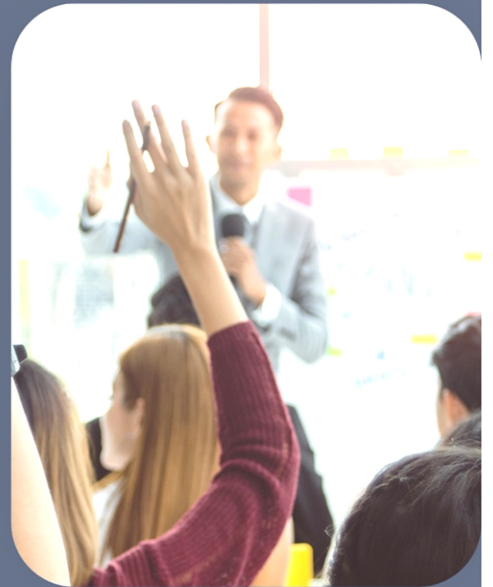
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**Section 1.**

# **The Primary Care Accountable Care Organizations**

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# SECTION 1. INTRODUCTION

## PRIMARY CARE ACCOUNTABLE CARE ORGANIZATION DESCRIPTION

In November 2016, MassHealth received approval from the Centers for Medicare and Medicaid Services to implement a five-year waiver authorizing a 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. Three ACO models were implemented in Massachusetts:

Exhibit 1.1. Massachusetts Accountable Care Organization Models

ACO Model	Description
Accountable Care Partnership Plans (ACPPs), also referred to as “Model A ACOs” (N=13)	Groups of primary care providers (PCPs) who work with just one managed care organization to create a full network that includes PCPs, specialists, behavioral health providers, and hospitals. 2021 ACPP external quality review activities are described in a separate report.
Primary Care Accountable Care Organizations (PCACOs), also referred to as “Model B ACOs” (N=3)	Groups of PCPs who form an ACO that is responsible for treating the member and coordinating their care. Primary Care ACO Plans work with the MassHealth network of specialists and hospitals and may have certain providers in their referral circle. The referral circle provides direct access to certain other providers or specialists without the need for a referral. Behavioral health services are managed by the Massachusetts Behavioral Health Partnership.
Lahey-MassHealth Primary Care Organization, also referred to as the “Model C ACO” (N=1)	The Lahey-MassHealth ACO is comprised of 16 primary care practice sites. The ACO has contracted with MassHealth managed care organizations to administer claims and manage membership. CMS has determined it does not meet the criteria to be considered a managed care organization and thus is not subject to external quality review requirements.

The MassHealth PCACOs are listed in the table that follows.

Exhibit 1.2. MassHealth Primary Care Accountable Care Organizations

PCACO	Abbreviation Used in this Report
Community Care Cooperative	CCC
Mass General Brigham	MGB
Steward Health Choice	Steward

**Section 2.**

# **Executive Summary**

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# SECTION 2. EXECUTIVE SUMMARY

## INTRODUCTION

The Balanced Budget Act of 1997 was an omnibus legislative package enacted by the U.S. 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 children with special needs) through managed care plans. Regulations were promulgated, including those related to the quality of care and service provided by managed care entities to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a managed care plan or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth has entered into an agreement with Kepro to perform External Quality Review (EQR) services for its contracted managed care plans including the Accountable Care Organizations that are the subject of this report. All MassHealth managed care plans participate in external quality review.

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

Primary Care Accountable Care Organizations (PCACOs) are considered by CMS to be primary care case management plans and are required to participate in performance measure and compliance validation. Compliance validation must be conducted by the EQRO on a triennial basis. PCACO compliance validation was conducted in this reporting period.

Kepro conducted the following external quality review activities for MassHealth PCACOs in the CY 2021 review cycle:

- Validation of three performance measures, including an Information Systems Capability Assessment; and
- Validation of compliance with regulations and contract requirements related to member access to timely, quality healthcare.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2021 reflect 2020 quality activity. Performance measure data for Measurement Year 2020 were collected, but due to barriers presented by the COVID-19 pandemic, and as allowed by CMS, were not used for 2020 quality performance measurement. MassHealth made the determination that 2019 data would be used instead. For this reason, Kepro validated 2019 data.



## 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 PCACO strengths, areas requiring improvement, and opportunities to further strengthen its processes, documentation, and/or performance outcomes with respect to the quality and timeliness of, and access to, healthcare services. It also followed up on recommendations 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

- A completed Information Systems Capability Assessment Tool (ISCAT)
- Performance measure data reports from DST for the three measures selected for validation
- An Excel spreadsheet from DST<sup>1</sup> containing numerator-compliant data for the three measures selected for validation for primary source verification purposes
- Enrollment data for 30 members selected at random for the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure
- Enrollment data for 30 members selected at random for the Follow Up After Hospitalization for Mental Illness measure
- Numerator raw data for 30 member cases for each of the three measures selected for validation to ensure that numerator events were accurately identified.

#### Compliance Validation

- Documentation to substantiate compliance with each requirement during the review period, including but not limited to:
  - Policies and procedures
  - Standard operating procedures
  - Workflows
  - Desk tools
  - Reports
  - Member materials
  - Care management files
  - Utilization management denial files
  - Appeals files
  - Grievance files
  - Credentialing files
- 42 CFR 438
- Appropriate provisions in the Code of Massachusetts Regulations (CMR)
- ACPP agreements with MassHealth

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<sup>1</sup> DST calculated final administrative rates and the administrative component of hybrid measures on behalf of MassHealth's contractor, Telligen.



## 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 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 based on the available data.

## Drawing Conclusions

Kepro's reviewers drew conclusions in response to these and similar questions as pertinent to the scope of the external quality review. The responses are considered in comparison with national benchmarks and best practices.

- Performance Measure Validation: Did the PCACO's methodology for measure calculation comply with HEDIS technical specifications?
- Compliance Validation: Did the PCACO supply documentation evidencing compliance with regulatory and contractual requirements? Did staff interviews demonstrate consistency with compliance?

## PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

Exhibit 2.1. Performance Measure Validation 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 EQR Protocol 2.
Data obtained	A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounters, and enrollment data), and data transferred to Telligen <sup>2</sup> as well as performance measure creation and measure data validation protocols; performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final measure rate calculation; an Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes; enrollment data for 30 members selected at random by the auditor; measure enrollment processing outcomes for the 30 PCACO members from DST for the measures.

<sup>2</sup> Telligen calculated PCACO performance measures on MassHealth's behalf.

Topic	Description
Conclusions	<p>Kepro’s validation review of the selected performance measures indicates that the PCACO measurement and reporting processes were fully compliant with specifications and were methodologically sound.</p> <p>The focus of the Information Systems Capability Assessment is on the components of the MassHealth, Telligen, and DST information systems that contribute to performance measure production. No issues were identified in data, source code, or processes.</p>

The Performance Measure Validation process assesses the accuracy of performance measures reported by the PCACO. It determines the extent to which the PCACO uses accurate and complete data and follows state specifications and reporting requirements in the production of performance measures.

In 2021, Kepro conducted Performance Measure Validation in accordance with CMS EQR Protocol #2 on measures selected by MassHealth, which were the following:

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD Treatment
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Engagement of AOD Treatment
- Follow Up After Hospitalization for Mental Illness (FUH): 7-Day Follow-up

Performance measure data for Measurement Year 2020 were collected, but due to barriers presented by the COVID-19 pandemic, were not used for 2020 Quality Scoring. MassHealth made the determination that 2019 data would be used instead. For this reason, Kepro validated 2019 data.

Kepro found the measure data to be compliant with NCQA specifications and the data, as reported, were valid. The PCACO measure rates are referred to as “Certified, Unaudited, HEDIS Rates” because the measure was audited through EQR PMV review, but not through an NCQA HEDIS Compliance Audit.

## COMPLIANCE VALIDATION

### Exhibit 2.2. Compliance Validation Process Overview

Topic	Description
Objective	To determine the extent to which PCACOs comply with standards set forth at 42 CFR § 438.358(b)(iii), state standards, and PCACO contract requirements.
Technical methods of data collection and analysis	The 2021 compliance reviews were structured based on program requirements as outlined in 42 CFR 438. In addition, compliance with provisions in contracts between MassHealth and each PCACO as they

Topic	Description
	<p>relate to 42 CFR 438 were assessed. Appropriate provisions in the Code of Massachusetts Regulations were also included in the reviews.</p>
Data obtained	<p>PCACOs provided documentation to substantiate compliance with each requirement during the review period. Examples of documentation provided included:</p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Standard operating procedures</li> <li>• Workflows</li> <li>• Desk tools</li> <li>• Reports</li> <li>• Member materials</li> <li>• Care management files</li> <li>• Utilization management denial files</li> <li>• Appeals files</li> <li>• Grievance files</li> <li>• Credentialing files</li> </ul> <p>Additional information was obtained from interviews with key PCACO personnel, case file reviews, and systems demonstrations.</p>
Conclusions	<p>Overall, the PCACOs demonstrated compliance with many of the federal and state contractual standards for their memberships. Due to the unique design of the PCACO program, a heavy emphasis was placed on the review of the coordination and continuity of care standards. In general, the PCACOs demonstrated strong, innovative models of care to identify and coordinate care for high-risk and high-need members willing to engage in care management support.</p> <p>The review found the greatest strength across the PCACOs related to the overall structure that allowed the PCACOs to use their providers as active and more equitable partners in the delivery of care and services. In general, the PCACOs' greatest opportunity for improvement is related to structure, operations, and attention to the more technical aspects of compliance and oversight. While the PCACOs demonstrated ongoing collaboration and communication with partnering organizations, the PCACOs could benefit from more formalized processes to evaluate their partnering organizations.</p>

## QUALITY STRATEGY EVALUATION

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

The first MassHealth Quality Strategy was published in 2006. 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 healthcare services furnished to Medicaid beneficiaries.

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

### **Provider Network**

2021 EQR activities shed 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 abuse services. For example, the Commonwealth might consider lived experience to be an alternate qualification to a professional degree akin to the Department of Mental Health Peer Support Training and Certification Program. (*Access, Timeliness of Care*)

MassHealth and the plans both need to increase their oversight of network adequacy. The compliance and network adequacy validation activities demonstrated non-compliance with contractually required time and distance standards. Kepro encourages MassHealth program staff to take a more active role in monitoring these requirements. 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 system 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*)

Given that approximately 600,000 members rely on its specialty network, Kepro strongly encourages MassHealth to voluntarily participate in network adequacy validation. (*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 REL data and fix the ever-vexing issue of enrollment updates with no REL data overwriting plan-collected data. (*Access*)

### **Communication Pathways**

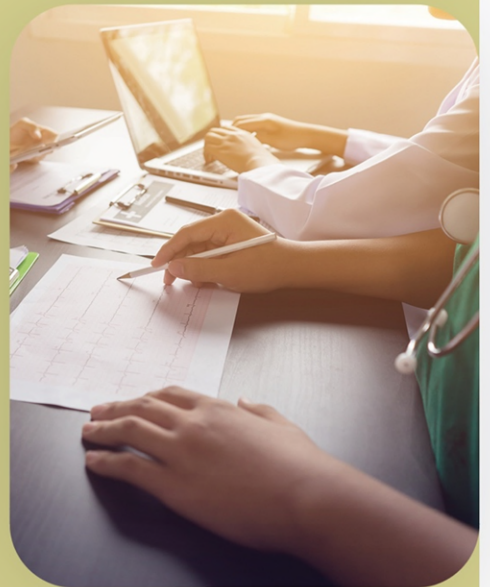
Over the years, Kepro has encouraged managed care plans to convene consumer advisory councils as a forum for gathering the members' voices in the design of performance improvement project interventions. A lack of available internal resources and COVID-associated meeting restrictions have represented barriers. Kepro encourages MassHealth to sponsor a statewide Consumer Advisory Council with the charter of advising MassHealth on its priorities for managed care plan performance management. Such a council, which could meet virtually, has the potential for being an effective vehicle for ensuring the consideration of consumer feedback on healthcare performance improvement priorities. (*Quality*)

Kepro respectfully suggests that MassHealth consider including the EQRO, 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

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# SECTION 3. PERFORMANCE MEASURE VALIDATION

## PERFORMANCE MEASURE VALIDATION METHODOLOGY

The Performance Measure Validation (PMV) process assesses the accuracy of the performance measures reported by the PCACO. It determines the extent to which the PCACO uses accurate and complete data and follows state specifications and reporting requirements.

Kepro's PMV audit methodology assesses both the quality of the source data that fed into the measure under review and the accuracy of the measure calculation. As part of source data review, a sample of numerator-compliant cases were verified. Enrollment data were also reviewed for accuracy. Measure calculation review included reviewing the logic and analytic framework for determining the measure numerator, denominator, and exclusion cases.

Telligen calculated the PCACO performance measures on MassHealth's behalf. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. MassHealth provided Telligen PCACO claims and encounter data files on a quarterly basis through a comprehensive data file referred to as the mega-data extract. Additionally, Telligen collected and transformed supplemental data received from individual PCACOs to support measurement.

Telligen worked with a subcontractor, SS&C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect PCACO-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the PCACO hybrid measures.

PMV focused on these organizations' data and processes. Individual PCACOs did not participate in or contribute to the PMV process. The following documents and files were provided by MassHealth in support of the PMV process:

- A completed Information System Capability Analysis Tool (ISCAT) for performance measure data collection information (claims, encounters, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols
- Performance measure data reports from DST for the selected validation
- An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes
- Enrollment data for 30 members selected at random by the auditor
- Measure enrollment processing outcomes for 30 numerator-positive members for the IET and FUH measures (60 members total), all selected at random by the auditor, to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure



The table that follows presents the measures selected for PMV for Measurement Year 2019 as well as the measure descriptions as provided by NCQA.

Exhibit 3.1. CY 2021 Validated Performance Measure

<b>HEDIS Measure Name and Abbreviation</b>	<b>Measure Description</b>
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD Treatment	The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) Engagement of AOD Treatment	The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.
Follow Up After Hospitalization for Mental Illness (FUH): 7-Day Follow-Up	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 provider within 7 days after discharge.

MassHealth submitted the documentation that follows in support of the PMV process.

### Exhibit 3.2. Submitted Documentation

Document Reviewed	Purpose of Kepro Review
A completed ISCAT for performance measure data collection information (claims, encounters, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols	Reviewed to assess plan systems and processes related to performance measure production
Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final measure rate calculation	Information about rates is essential to the PMV process
An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification	Used to generate a random sample of medical records for independent review to confirm the accuracy of the medical record review process
Enrollment segment data for 60 members selected at random by the auditor	Used in primary source verification
DST measure enrollment processing outcomes	Used to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment processing for the selected validation measure

## INFORMATION SYSTEMS CAPABILITY ASSESSMENT

The focus of the Information Systems Capability Assessment is on the components of the MassHealth, Telligen, and DST information systems that contribute to performance measure production. Kepro's review addresses the following:

- The accuracy and completeness of data received from providers
- The accuracy and timeliness of the data as reported
- The completeness, logic, and consistency of the data
- The collection of service information using standardized formats to the extent feasible and appropriate

**Enrollment Data.** Enrollment data for 30 members were selected at random for the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure. Enrollment data for 30 members was also selected at random for the Follow Up After Hospitalization for Mental Illness measure. Enrollment data for the same 60 members was compared to DST enrollment data processing for these same 60 members to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing. The reviewer determined that the enrollment data for the sample of 60 members successfully matched. There were no issues identified with enrollment data or processes.

**Claims and Encounter Data Review.** Numerator raw data review of 30 ACO cases for each of the three PMV numerators was conducted by the reviewer to ensure that DST processed the PMV numerators accurately for the three PMV numerators. The reviewer determined that the claims and encounter data for the sample of 90 members successfully matched the DST numerator processing of the 90 cases. There were no issues identified with claims or encounter data or processes.

**Medical Record and Supplemental Data Review.** No medical record or supplemental data were used in the calculation of the three validation measures.

**Data Integration.** PCACO performance measure rates were produced using DST software. Telligen provided PCACO data to DST in CareAnalyzer-compliant extract format. The data were then loaded into the DST measure production software. There were adequate processes to track the completeness and accuracy of data at each transfer point.

**Source Code.** NCQA-certified DST software was used to produce the three performance measures under review. There were no source code issues identified. The PCACO performance measure rates are referred to as a "Certified, Unaudited, HEDIS Rates" because the measures were audited through EQR PMV review, but not through a NCQA HEDIS Compliance Audit.

## COMPARATIVE ANALYSIS

The tables that follow contain the technical specifications for the validated performance measures as well as Kepro's determination as to whether the PCACOs complied with these specifications. Kepro uses the following ratings for Performance Measure Validation review elements:

- **Met:** The plan correctly and consistently evidenced review element
- **Partially met:** The plan partially or inconsistently evidenced review element; and
- **Not met:** The plan did not evidence review element or incorrectly evidenced review element.

## Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD

The IET measure was produced using the HEDIS Administrative methodology. The following tables outline the review elements and ratings that the PCACOs received.

Exhibit 3.3a. IET – Initiation Technical Specifications Compliance

Category	Denominator Element	CCC	MGB	Steward
Population	PCACO population was appropriately segregated from other product lines.	Met	Met	Met
Population	Members with intake for a new episode of alcohol abuse or dependence on or between January 1 and November 14 of the measurement year.	Met	Met	Met
Population	Members must have medical, pharmacy and chemical dependency (inpatient and outpatient) benefits.	Met	Met	Met
Geographic Area	Includes only those Medicaid enrollees served in PCACO's reporting area.	Met	Met	Met
Age & Sex	Members 13 years and older as of December 31 of the measurement year.	Met	Met	Met
Enrollment Calculation	Members enrolled 60 days prior to the new episode through 47 days after the new episode.	Met	Met	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	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	Met
Proper Exclusion Methodology in Administrative	Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment, or an alcohol or opioid dependency treatment medication dispensing event during the 60 days before the new episode.	Met	Met	Met

Exhibit 3.3b. IET – Initiation Technical Specifications Compliance

Administrative Data: Counting Clinical Events	CCC	MGB	Steward
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	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	Met

## Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): Engagement of AOD

The IET measure was produced using the HEDIS Administrative methodology. The following tables outline the review elements and ratings that the PCACOs received.

Exhibit 3.4a. IET – Engagement Technical Specifications Compliance

Category	Denominator Element	CCC	MGB	Steward
Population	PCACO population was appropriately segregated from other product lines.	Met	Met	Met
Population	Members with intake for a new episode of alcohol abuse or dependence on or between January 1 and November 14 of the measurement year.	Met	Met	Met
Population	Members must have medical, pharmacy, and chemical dependency (inpatient and outpatient) benefits.	Met	Met	Met
Geographic Area	Includes only those Medicaid enrollees served in PCACO's reporting area.	Met	Met	Met
Age & Sex	Members 13 years and older as of December 31 of the measurement year.	Met	Met	Met
Enrollment Calculation	Members enrolled 60 days prior to the new episode through 47 days after the new episode.	Met	Met	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	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	Met
Proper Exclusion Methodology in Administrative	Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment, or an alcohol or opioid dependency treatment medication dispensing event during the 60 days before the new episode.	Met	Met	Met

Exhibit 3.4b. IET – Engagement Technical Specifications Compliance

Administrative Data: Counting Clinical Events	CCC	MGB	Steward
Identify all members compliant for the Initiation of AOD Treatment numerator. Then determine those who met the Engagement numerator.	Met	Met	Met
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	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	Met

## Follow Up After Hospitalization for Mental Illness (FUH): 7-Day Follow up

The FUH measure was produced using the HEDIS Administrative methodology. The following tables outline the review elements and ratings that the PCACOs received.

Exhibit 3.5a. FUH Technical Specifications Compliance

Category	Denominator Element	CCC	MGB	Steward
Population	PCACO population was appropriately segregated from other product lines.	Met	Met	Met
Population	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 1 of the measurement year.	Met	Met	Met
Population	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	Met
Geographic Area	Includes only those Medicaid enrollees served in the plan's reporting area.	Met	Met	Met
Age & Sex	Members 6 years and older as of the date of the discharge.	Met	Met	Met
Enrollment Calculation	Members continuously enrolled from the date of discharge through 30 days after.	Met	Met	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	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	Met
Proper Exclusion Methodology in Administrative	<p>Identify readmissions and direct transfers to an acute inpatient care setting during the 7-day follow-up period:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays.</li> <li>2. Exclude nonacute inpatient stays.</li> <li>3. Identify the admission date for the stay.</li> </ol> <p>Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.</p> <p>If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm, count only the last discharge.</p> <p>If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim), exclude both the original and the readmission/direct transfer discharge.</p>	Met	Met	Met
Proper Exclusion Methodology in Administrative	<p>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. To identify readmissions and direct transfers to a nonacute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays.</li> <li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code on the claim.</li> <li>3. Identify the admission date for the stay.</li> </ol> <p>These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.</p>	Met	Met	Met

Exhibit 3.5b. FUH Technical Specifications Compliance

<b>Administrative Data: Counting Clinical Events</b>	<b>CCC</b>	<b>MGB</b>	<b>Steward</b>
A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.	Met	Met	Met
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	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	Met



## COMPARATIVE RESULTS

Performance measure data for Measurement Year 2020 were collected, but due to barriers presented by the COVID-19 pandemic, were not used for 2020 Quality Scoring. MassHealth made the determination that 2019 data would be used instead. For this reason, Kepro validated 2019 data.

The tables that follow depict the validation designation for the three measures validated by Kepro for Calendar Year 2021. Because NCQA has not developed benchmarks specific to accountable care organizations, no performance benchmarks are provided for comparison purposes.

### 2019 Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment (IET): Initiation of AOD Treatment

The range of performance rates was 2.6 percentage points. The lowest-performing PCACO was Steward at 42.1%. The highest-performing PCACO was CCC at 44.7%. Please note that these rates are reported as certified, unaudited, HEDIS rates.

Exhibit 3.6. 2019 IET – Initiation of AOD Treatment Rates

2019 Certified, Unaudited HEDIS Rate	CCC	MGB	Steward
IET: Initiation of AOD Treatment	44.7%	44.3%	42.1%

### 2019 Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment (IET): Engagement of AOD Treatment

The range of performance rates was 3.8 percentage points. The lowest-performing PCACO was MGB at 14.2%. The highest-performing PCACO was CCC at 18.0%. Please note that these rates are reported as certified, unaudited, HEDIS rates.

Exhibit 3.7. 2019 IET – Engagement of AOD Treatment Rates

2019 Certified, Unaudited HEDIS Rate	CCC	MGB	Steward
IET: Engagement of AOD Treatment	18.0%	14.2%	16.3%

### 2019 Follow Up after Hospitalization for Mental Illness: 7-Day Follow Up

The range of the 2019 Follow Up After Hospitalization for Mental Illness: 7-Day Follow Up performance rates was 4.4 percentage points. The lowest-performing PCACO was CCC at 48.5%. The highest-performing PCACO was MGB at 52.9%. Please note that these rates are reported as certified, unaudited, HEDIS rates.

Exhibit 3.8. 2019 FUH – 7-Day Follow up Rates

2019 Certified, Unaudited HEDIS Rate	CCC	MGB	Steward
FUH: 7-Day Follow-Up	48.5%	52.9%	52.1%

## **PROGRAM STRENGTHS**

- MassHealth used an NCQA-certified vendor, DST, to produce PCACO performance measures.
- In its third year of external quality review, the PCACO program again successfully completed PMV.

## **OPPORTUNITIES & RECOMMENDATIONS**

None identified.

## **CONCLUSION**

In summary, Kepro's validation review of the selected performance measures indicates that MassHealth's PCACOs' measurement and reporting processes were fully compliant with specifications and were methodologically sound.

Section 4.

# Compliance Validation

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# SECTION 4. COMPLIANCE VALIDATION

## INTRODUCTION

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

The 2021 compliance reviews were structured based on program requirements as outlined in 42 CFR 438. In addition, compliance with provisions in contracts as they relate to 42 CFR 438 between MassHealth and each PCACO were assessed. Appropriate provisions in the CMR were included in the reviews as indicated. The most stringent of the requirements were used to assess for compliance when state and federal requirements differed.

### REVIEW (LOOK-BACK) PERIOD

PCACO activity and services occurring for calendar year 2020 (January 1 to December 31, 2020) were subject to review.

### REVIEW STANDARDS

Based on regulatory and contract requirements, compliance reviews were divided into the following 11 standards consistent with CMS October 2021 EQR protocols. Based on the PCACO contract, several of the review area functions were retained at the state level and not covered under the PCACO contract. The areas that are noted as “NA” were not applicable to the PCACO review.

- Availability of services
  - Enrollee information
  - Enrollee rights and protections
  - Enrollment and disenrollment – NA
- Assurances and adequate capacity of services – NA
- Coordination and continuity of care
- Coverage and authorization of services – NA
- Provider selection – NA
- Confidentiality
- Grievance and appeal system
- Subcontractual relationships and delegation
- Practice guidelines – NA
- Health information systems – NA
- Quality assessment and performance improvement program

## **COMPLIANCE REVIEW TOOLS**

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

## **REVIEW PROCESS**

Kepro provided communication to the PCACOs prior to the formal review period that included an overview of the compliance review activity and timeline. The PCACOs were provided with a preparatory packet that included the project timeline, the draft virtual review agenda, the compliance review tools, and the data submission information. Kepro scheduled a pre-review conference call with each PCACO in advance of the virtual review to cover review logistics.

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

- Policies and procedures
- Standard operating procedures
- Workflows
- Desk tools
- Reports
- Member materials
- Care management files
- Grievance files

Kepro compliance reviewers performed a desk review of all documentation provided by each PCACO. In addition, virtual reviews were conducted to interview key PCACO personnel, review selected case files, participate in systems demonstrations, and allow for further clarification and provision of documentation. At the conclusion of the virtual review, Kepro conducted a closing conference to provide preliminary feedback to each PCACO on observations, strengths, opportunities for improvement, recommendations, and next steps.

## **SCORING METHODOLOGY**

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

- Met: Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and PCACO staff interviews provided information consistent with documentation provided.
- Partially Met (any one of the following may be applicable):
  - Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. PCACO staff interviews, however, provided information that was not consistent with documentation provided.

- Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided although PCACO staff interviews provided information consistent with compliance with all requirements.
- Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided and PCACO staff interviews provided information inconsistent with compliance with all requirements.
- Not Met: There was an absence of documentation to substantiate compliance with any of the regulatory or contractual requirements and PCACO staff did not provide information to support compliance with requirements.

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by total possible points (Met = 1 point, Partially Met = 0.5 points, and Not Met = 0 points). In addition, an overall percentage compliance score for all standards was calculated to give each standard equal weighting. The total percentages from each standard were divided by the total number of standards reviewed. For each standard identified as Partially Met or Not Met, the PCACO was required to submit a corrective action plan (CAP) in a format agreeable to MassHealth.

Per 42 CFR 438.360, Nonduplication of Mandatory Activities, Kepro accepted NCQA accreditation to avoid duplicative work. To implement the deeming option, Kepro obtained the most current NCQA accreditation standards and reviewed them against the CFRs. Where the accreditation standard was at least as stringent as the CFR, Kepro flagged the review element as eligible for deeming. For a review standard to be deemed, Kepro evaluated each PCACO's most current accreditation review and scored the review element as Met if the PCACO scored 100 percent on the accreditation review element.

## PCACO COMPLIANCE VALIDATION RESULTS

The table that follows depicts the aggregate compliance scores for each PCACO reviewed:

Exhibit 4.1. Compliance Validation Scores

Review Element	CCC	MGB	Steward	Average
Availability of Services	92.3%	92.6%	91.1%	92.0%
Enrollee Rights and Protection	90.0%	100%	100%	96.7%
Availability of Services – Enrollee Information	98.9%	94.6%	97.8%	97.1%
Grievance and Appeal System	96.9%	84.4%	87.5%	89.6%
Subcontractual Relationships and Delegation	86.8%	97.4%	94.7%	93.0%
Quality Assurance & Performance Improvement	100%	87.5%	100%	95.8%
Confidentiality of Health Information	50.0%	100%	100%	83.3%
Coordination and Continuity of Care	100%	99.1%	100%	99.7%
<b>Total Composite Score</b>	<b>89.4%</b>	<b>94.5%</b>	<b>96.4%</b>	<b>93.4%</b>

## AGGREGATE PCACO OBSERVATIONS AND RECOMMENDATIONS

Overall, the PCACOs demonstrated compliance with many of the federal and state contractual standards for their memberships. Due to the unique design of the PCACO program, a heavy emphasis was placed on the review of the coordination and continuity of care standard. In general, the PCACOs demonstrated strong, innovative models of care to identify and coordinate care for high-risk and high-need members willing to engage in care management support. The review found that each plan had unique structural characteristics with most leaning on its provider network to stand up the PCACO model and built governance around the partnering provider organizations. This effort contrasted with the ACPPs, which primarily used management care organization experience and structures and then developed their partner provider networks. The review found significant value in allowing flexibility among the PCACO's structure and approach.

While there were some overarching strengths identified among the plans, each one excelled in different areas. The review found the greatest strength across the PCACOs related to the overall structure that allowed the plans to use their providers as active and more equitable partners in the delivery of care and services. The model promotes greater flexibility to support primary care providers and members by bringing in services that are helping to manage medical expenditures by addressing some aspects of the social determinants of health and integrating care across the community rather than applying greater restrictions on elements of coverage such as benefits, services, and co-payments.

High performance among all PCACOs in the area of coordination and continuity of care along with quality assessment and performance improvement standards suggests that the PCACOs performed best in the area of quality care. There were many innovative practices and activities implemented across each plan in attempts to improve care outcomes.

In general, the PCACOs' greatest opportunities for improvement are related to structure, operations, and attention to the more technical aspects of compliance and oversight. While the PCACOs demonstrated ongoing collaboration and communication with partnering organizations, the plans could benefit from more formalized processes to evaluate their partnering organizations, which could include both process and outcome metrics as a mechanism to evaluate overall performance. In addition, the review found many policies and procedures that either need to be formalized or revised to meet all contractual requirements. PCACOs could benefit from standardizing a formal annual review process of policies and procedures to ensure they are consistent with contract requirements and are consistent with operational practices.

The review found that, while the PCACOs were generally in compliance with the Quality Assessment Performance Improvement standards, the MassHealth PCACO contract had very few requirements of the plans. The review found that more robust standards for quality improvement programs among the PCACO are needed. MassHealth should consider adding some requirements similar to the ACPP contracts that provide some assurances for quality



improvement structures, program descriptions, workplans, and quality evaluations. The review found that much of the strength demonstrated from the compliance review among the PCACOs may be largely underrepresented in absence of formalized quality programs.

Despite the overwhelming positive contribution of the PCACO program, there were a few identified challenges that spanned across the plans. The responsibilities and handoffs between the plans and behavioral health and LTSS community partners are ineffective. The review found the documentation cumbersome and some timing issues with the handoff and completion of assessments. MassHealth and the PCACOs should explore opportunities to improve this component of the care model. PCACO staff relayed that the Care Needs Screening activity did not provide value to any PCACO in being able to reliably obtain information or use the information obtained from the screening in a meaningful way. MassHealth and the PCACOs should explore the feasibility of accomplishing the intent of this activity in another way that could use resources more efficiently and provide greater value. Finally, sustainability was a key concern among PCACOs; therefore, MassHealth and the PCACOs should work collaboratively on strategies that provide greater stability as the program evolves into future cycles.

Overall, the 2021 compliance review found that the PCACOs performed best in the areas of care delivery and quality of care. The review showed focused activities and resources to meet the needs of the population. In addition, the PCACOs did well with meeting compliance standards related to relevant access of care standards for network adequacy. PCACOs have opportunities to improve some of their processes related to operational and structural standards such as the grievance system and subcontractual relationship oversight that may span the areas of quality of, access to, and timeliness of care. Finally, the 2021 compliance review was focused on the areas contained in the PCACO contracts; therefore, Kepro recommends that in future years, MassHealth consider undergoing an audit review that would include components of the PCACO program within its scope of responsibility as a mechanism to highlight strengths as well as identify opportunities for improvement.

## **NEXT STEPS**

MassHealth required PCACOs to submit CAPs for all Partially Met and Not Met elements identified from the 2021 Compliance Reviews. MassHealth will evaluate the CAPs and either approve them or request additional documentation. Kepro will evaluate actions taken to address recommendations in the next EQR report and will conduct a comprehensive review in 2024.

## PLAN-SPECIFIC COMPLIANCE VALIDATION RESULTS

Kepro presents PCACO 2021 Compliance Validation Results by individual plan in this section. Kepro used the technical scores along with qualitative review results to outline high-level strengths, findings, and recommendations.

### CCC

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 14-15, 2021. The table that follows compiles the scores that CCC received from the review.

Exhibit 4.2. CCC Compliance Validation Scores

Review Element	Score
Availability of Services	92.3%
Enrollee Rights and Protection	90.0%
Availability of Services – Enrollee Information	98.9%
Grievance and Appeal System	96.9%
Subcontractual Relationships and Delegation	86.8%
Quality Assurance & Performance Improvement	100%
Confidentiality of Health Information	50.0%
Coordination and Continuity of Care	100%
<b>Total Composite Score</b>	<b>89.4%</b>

#### Strengths

- Overall, CCC demonstrated compliance with most of the federal and state contractual standards for the 2021 compliance review across review areas.
- The review identified many achievements that have taken place since the CCC ACO began operations in 2017. CCC serves members statewide through its unique model of partnering Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs). Each FQHC and CHC entering the cooperative is established as a corporate member, and CCC is managed by a board of directors. CCC lends support and expertise to its corporate members related to practice transformation while all interactions take place at the health centers, which is a fundamental aspect of this model.
- The greatest strength noted from the review is CCC's model that capitalizes on existing FQHCs and CHCs that have well-established processes for service delivery, established credibility with providing services in their respective communities, and vast experience with providing care to Medicaid members and diverse populations.
- Another aspect of CCC's model strength was found in its lean structure that has allowed the PCACO to be nimble in its start-up, agile to make mid-course corrections, and implement and execute changes effectively.
- The review found that CCC brought consistency and maturity to some processes across FQHCs, including the evolution of care coordination, to bring consistency and efficiency in its

approach for implementing an integrated care model. In addition, CCC has served as a valuable vehicle for collaboration and a forum for best practice sharing among the FQHCs.

- CCC has improved aspects of continuity and coordination of care, including the centralization of transition of care programs, at each health center and moved care management from a disease-state model to a fully integrated model that takes into consideration physical and behavioral health needs along with social determinants of health.
- Nearly all the 18 FQHCs and CHCs use the same electronic medical record system, which allows for communication across the care teams and care settings. In addition, CCC has helped provide data analytics to the clinical teams, which has provided increased visibility of care outcomes and fosters a culture of improving care.

### **Opportunities for Improvement**

- The 2021 review was the first external compliance audit for CCC as a PCACO. While the PCACO was found to demonstrate strength in its ability to provide care and services to its members, it had challenges meeting some of the technical aspects of the review such as ensuring formal policies and procedures that meet all federal and state requirements. This included policies and procedures related to:
  - Formal training on member protections to referral circles and employees
  - Assistance to American Indian enrollees who elect an Indian Health Services care provider
  - Grievance policy revisions related to ensuring clinical expertise in review of grievances of a clinical nature
  - Tracking and monitoring mechanisms to ensure confidentiality trainings are completed by staff at hire and at least annually thereafter
- The audit found that CCC lacked processes to monitor performance more formally among its FQHC and CHC partners. This included activities such as monitoring health center fulfillment of provider termination notifications as well as having a formalized process for annual reviews.
- CCC's subcontracts lacked some specific provisions related to the right to audit and inspect records, making premises, facilities, equipment records, systems available for audit, and timeframes for the right to audit.

### **Recommendations**

- CCC needs to revise and/or implement policies and procedures to address the deficient areas to bring the PCACO into full compliance with federal and state contract requirements.
- CCC needs to create and implement a formal monitoring and annual performance review process, including processes for initiating corrective action, as appropriate.
- CCC needs to revise its subcontractual agreements to add provisions for the right to audit and inspect records, making premises, facilities, equipment records, systems available for audit, and timeframes for the right to audit.
- CCC needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review.

## MASS GENERAL BRIGHAM

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 21-22, 2021. The table that follows compiles the scores that MGB received from the review.

Exhibit 4.3. MGB Compliance Validation Scores

Review Element	Score
Availability of Services	92.6%
Enrollee Rights and Protection	100%
Availability of Services – Enrollee Information	94.6%
Grievance and Appeal System	84.4%
Subcontractual Relationships and Delegation	97.4%
Quality Assurance & Performance Improvement	87.5%
Confidentiality of Health Information	100%
Coordination and Continuity of Care	99.1%
<b>Total Composite Score</b>	<b>94.5%</b>

### Strengths

- Overall, MGB demonstrated compliance with most of the federal and state contractual standards for the 2021 compliance review across review areas.
- The review identified many achievements that have taken place since the MGB ACO began operations in 2017. The plan serves members statewide through its well-established network of community and specialty hospitals and physician network. MGB established a partnership with AllWays Health Plan to support some of the operational functions of the PCACO, including call center and customer service, a clinical nurse advise line, care needs screening oversight, grievances, and ad-hoc reporting needs. MGB operates the PCACO using 11 Regional Service Organizations (RSOs), which represent its integrated and affiliated providers. MGB had a well-established service delivery network. It was, therefore, already positioned well to serve as a PCACO at the inception of the program. This maturity allowed MGB to evaluate its needs and leverage expertise from its partners to be thoughtful about the implementation of the program within the first cycle.
- The review found MGB to be highly data-driven, which was supported by all the expertise available to the PCACO by virtue of its academic model. MGB demonstrated robust analytics and impressive evaluation capabilities, including analysis in terms of cost-savings and utilization management.
- Nearly all providers with the PCACO use the same electronic medical record system which allows for communication across the care teams and care settings. In addition, all care management functions are documented in the EMR. This supports all aspects of the PCACO and provides a critical advantage for care management.
- Another aspect of MGB's model strength was found in its engagement of primary care providers to help identify members who would likely benefit from care management. This

practice promoted increased buy-in from its primary care providers. This was a unique strength noted from the review across both Accountable Care Partnership Plans and PCACOs.

- The review found efforts to address social determinants of health using flexible services funds to establish food and housing partners within each RSO.

### **Opportunities for Improvement**

- The 2021 review was the first external compliance audit for MGB as a PCACO. While MGB was found to demonstrate strength in its ability to provide care and services to its members, it had challenges meeting some of the technical aspects of the review such as ensuring formal policies and procedures were in place that meet all federal and state requirements. This included policies and procedures related to:
  - Data-sharing and interoperability to describe its operational practice for real-time notification of events in care such as emergency room and inpatient events
  - Ensuring the use of the Child and Adolescent Needs and Strengths (CANS) tool by primary care providers for enrollees under 21 years of age
  - Coordinating care for criminal justice-involved enrollees to describe its process for ensuring access to medically necessary services, including behavioral health services and care management and care coordination, as appropriate
  - New enrollee information timeframes for fulfilling contractual requirements, state approval of new enrollee information, and identification card mailing and monitoring processes
  - Quality of care grievances
  - Assistance to American Indian enrollees who elect an Indian Health Services care provider
  - Grievance policy revisions related to ensuring clinical expertise in review of grievances of a clinical nature
  - Tracking and monitoring mechanisms to ensure confidentiality trainings are completed by staff at hire and at least annually thereafter
- While MGB had contractual references that outline specific access standards based on visit type and office hours, the language did not specifically ensure that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations
- The audit found that MGB lacked processes to formally monitor performance among its RSOs, including a formalized process for annual reviews
- MGB's new enrollee information lacked information regarding the ombudsman process
- While MGB indicated that all of its academic medical centers and regional service organizations offer basic accommodations for members with disabilities, the PCACO did not include this information in its provider directory or on its website

- While the PCACO had a delegate in place to identify and intake grievances from enrollees, the review found that this person did not consider expressions of dissatisfaction that were resolved during a single call as a grievance. This process is inconsistent with the definition of a grievance found in the policy as an expression of dissatisfaction by a member or their representative
- While the PCACO had a grievance response process managed by a delegate, Kepro noted that its resolution letters did not include a Babel card or other information regarding the availability of translation

### **Recommendations**

- MGB needs to revise and/or implement policies and procedures to address the deficient areas to bring the PCACO into full compliance with federal and state contract requirements.
- MGB should revise its contract language or include information in a provider manual that ensures that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.
- MGB needs to create and implement a subcontractor monitoring policy and procedure, including information on who has responsibility for oversight, the oversight functions, who has decision-making authority regarding contractual issues, and CAPs.
- MGB needs to include information about the ombudsperson in its member handbook or as part of its new enrollee information materials.
- MGB needs to revise its directory to indicate whether the provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.
- MGB needs to revise its processes to ensure that all expressions of dissatisfaction are counted and reported as grievances even if they are resolved during a single phone call or are categorized internally as a compliant.
- MGB needs to work with its delegate to create and implement a PCACO-branded Babel card to be included with grievance correspondence.
- MGB needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its CAP with MassHealth.

## STEWARD

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 28-29, 2021. The table that follows compiles the scores that Steward received from the review.

Exhibit 4.4. Steward Compliance Validation Scores

Review Element	Score
Availability of Services	91.1%
Enrollee Rights and Protection	100%
Availability of Services – Enrollee Information	97.8%
Grievance and Appeal System	87.5%
Subcontractual Relationships and Delegation	94.7%
Quality Assurance & Performance Improvement	100%
Confidentiality of Health Information	100%
Coordination and Continuity of Care	100%
<b>Total Composite Score</b>	<b>96.4%</b>

### Strengths

- Overall, Steward demonstrated compliance with most of the federal and state contractual standards for the 2021 compliance review across review areas.
- The review identified many achievements that have taken place since the Steward ACO began operations in 2017. The Steward Health Care System is the parent organization and is a large national company. Steward serves members statewide through its established provider network of community-based organizations, community-based hospitals, employed providers and affiliates, as well as small and medium practices. Steward had a mature commercial health plan model and was able to leverage existing relationships for the PCACO and build upon that network. The review found the Steward team's prior managed care experience and expertise as being a notable strength. The review also found that Steward has a highly sophisticated structure and thoughtful consideration related to its governance of the PCACO.
- Steward had robust and mature oversight and monitoring mechanisms for its material subcontractors. This area is particularly important with the high volume of collaborating organizations.
- The review found that Steward's unique attribute of allowing smaller primary care provider practices to participate in the PCACO was a strength and a contrast to other models. The review found that the PCACO helps support some of these smaller primary care practices in their care of members with social needs, which can be challenging for smaller primary care practices.
- Steward was knowledgeable about its member population and noted that roughly 50 percent of it is pediatric. Steward has a large volume of pediatricians to meet this need.

- Steward implemented innovative activities, including its Healthy Beginnings program, which uses a doula, a trained non-healthcare professional who provides support to a pregnant woman before, during, and after delivery. In addition, Steward provides on-demand non-emergency medical transportation.
- A demonstration of the Steward care management system noted strong functionality to help track and manage members in its program. In addition, Steward established relationships with organizations using flexible spending services funds to assist with providing rapid housing, home modification, moving assistance, utility assistance, and nutrition services.

### **Opportunities for Improvement**

- The 2021 review was the first external compliance audit for Steward as a PCACO. While Steward was found to demonstrate strength in its ability to provide care and services to its members, it had challenges meeting some of the technical aspects of the review such as ensuring formal policies and procedures that meet all federal and state requirements. This included policies and procedures related to:
  - Assistance to American Indian enrollees who elect an Indian Health Services care provider
  - Identification and assignment of enrollees to Behavioral Health Community Partner policies related to timeframes
  - Monitoring of its contracted providers' fulfillment of notification terminations
  - Grievance policy revisions related to ombudsman access and activities, quality of care grievances, and information included in the review process
- While Steward indicated that it has processes in place for monitoring its provider panel sizes, the PCACO did not have documentation to support its ability to offer at least two appropriate primary care providers with open panels.
- While Steward had contractual references that outline specific access standards based on visit type and office hours, the language did not specifically ensure that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.
- Steward's new enrollee information lacked information regarding how to report fraud or abuse to the PCACO.
- While Steward had a robust monitoring and annual review process of its material subcontractors performed by its compliance team for certain aspects of the contract, there was not a documented process to monitor and annually review the business-related performance of a material subcontractor.
- Steward subcontracts lacked some specific provisions related to the right to audit and inspect records, making premises, facilities, equipment records, systems available for audit, and timeframes for the right to audit.
- Although there were no significant compliance-related deficiencies, the audit review noted that, due to the broad nature of Steward's service delivery network, its efforts to effectively



communicate with and educate providers under the PCACO using a national model may present some challenges related to balancing the centralization of operational functions yet keeping the program with a local feel.

- While Steward had high technical scores for the compliance aspects, the review found some opportunities related to continuity and coordination of care. The care management structure appeared to be modeled in a traditional managed care organization approach for many of its members with care management occurring apart from the treatment team. Practices into which Steward was able to embed care management within primary care appeared to provide greater engagement among the primary care providers and members.

### **Recommendations**

- Steward needs to revise and/or implement policies and procedures to address the deficient areas to bring the PCACO into full compliance with federal and state contract requirements.
- Steward needs to develop a mechanism to demonstrate the offering of at least two appropriate primary care providers with open panels across its service areas.
- Steward should revise its contract language or include information in a manual that ensures that its providers offer hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid fee-for-service populations.
- Steward needs to modify its member handbook to include information on how to report fraud or abuse to the PCACO.
- Steward needs to implement and document an ongoing monitoring and formal annual review process of material subcontractors on business-related performance measures and requirements, including how CAPs would be initiated and overseen, internal reporting, and decision-making requirements.
- Steward should continue to develop communication and education strategies to keep its broad network informed and supported in the PCACO model.
- Steward should continue to explore strategies to integrate care management within primary care and develop relationships with community partners.
- Steward needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its CAP with MassHealth.



# **Contributors**

# CONTRIBUTORS

## PERFORMANCE MEASURE VALIDATION

### **Katharine Iskrant, CHCA, MPH**

Ms. Iskrant is the President of Healthy People, an NCQA-licensed HEDIS audit firm. She is a member of the NCQA Audit Methodology Panel and NCQA's HEDIS Data Collection Advisory Panel. She is also featured on a 2020 NCQA HEDIS Electronic Clinical Data Systems (ECDS) podcast. Ms. Iskrant has been a Certified HEDIS® Compliance Auditor since 1998 and has directed more than two thousand HEDIS audits. Previously, as CEO of the company Acumetrics, Ms. Iskrant provided consultancy services to NCQA which helped their initial development and eventual launch of the NCQA Measure Certification Program. She is a frequent speaker at HEDIS conferences, including NCQA's most recent Healthcare Quality Congress. She received her bachelor's degree from Columbia University and her master's degree in public health from the University of California at Berkeley School of Public Health. She is a member of the National Association for Healthcare Quality and is published in the fields of health care and public health.

## COMPLIANCE VALIDATION REVIEWERS

### **Jennifer Lenz, MPH, CHCA**

Ms. Lenz has more than 19 years' experience in the healthcare industry, with expertise in implementing and managing external quality review activities, managing teams, and driving quality improvement initiatives. Ms. Lenz has working experience in both private and public health sectors. Her experience includes managed care organization responsibility for accreditation and quality management activities; managing chronic disease programs for a state health department; and in performing external quality review organization activities. She has conducted compliance review activities across health plans in California, Georgia, Massachusetts, Ohio, Utah, and Virginia. Ms. Lenz is a Certified HEDIS® Compliance Auditor through the NCQA. She holds a Master of Public Health degree from the University of Arizona.

### **Jane Goldsmith, RN, MBA, CSSGB, CHC**

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

University and her master's degree in business administration in integrative management from Michigan State University. She holds registered nurse licenses in Michigan, Illinois, and Florida.

**Sue McConnell, RN, MSN**

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

**Poornima Dabir, MPH, CHCA**

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

**Debra Homovich, BA**

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

## **PROJECT MANAGEMENT**

### **Cassandra Eckhof, MS**

Ms. Eckhof has over 25 years' managed care and quality management experience and has worked in the private, non-profit, and government sectors. She has managed the MassHealth external quality review program since 2016. Ms. Eckhof has a master's of science degree in healthcare administration and is a Certified Professional in Healthcare Quality. She is currently pursuing a graduate certificate in medical ethics at the University of Massachusetts at Amherst.

### **Emily Olson B.B.A**

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 degree in business management and human resources from Western Illinois University.