

The Massachusetts Behavioral Health Partnership A Prepaid Inpatient Health Plan

External Quality Review Technical Report Calendar Year 2017



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SECTION I. CONTRIBUTORS

PROJECT MANAGEMENT

Cassandra Eckhof, M.S.

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

PERFORMANCE MEASURE VALIDATION REVIEWER

Katharine Iskrant, CHCA, MPH

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 directing more than 600 HEDIS[®] audits. She directed the consultant team that developed the original NCQA Software Certification ProgramSM on behalf of NCQA. She is a frequent speaker at HEDIS[®] vendor and health plan conferences, such as National Alliance of State Health CO-OPs (NASHCO) conferences. Ms. Iskrant received her Bachelor of Arts from Columbia University and her Master of Public Health from UC 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.

COMPLIANCE VALIDATION REVIEWERS

Jennifer Lenz, MPH, CHCA, Lead Reviewer

Ms. Lenz has more than 17 years of experience in the healthcare industry, with expertise in implementing and managing external quality review activities, managing teams, and driving quality improvement initiatives. Ms. Lenz has working experience in both private and public health sectors. Her prior experience includes managed care organization responsibility for accreditation and quality management activities; managing chronic disease programs for a

state health department; and in performing external quality review organization activities. She has conducted compliance review activities across health plans in the states of California, Georgia, Ohio, Utah, and West Virginia. Ms. Lenz is a Certified HEDIS® Compliance Auditor through the NCQA. She received her MPH in Health Administration and Policy from the University of Arizona.

Lois Heffernan, RN, BSN, MBA

Ms. Heffernan has 20 years of experience in the healthcare industry, with expertise in quality-related activities, including quality project management, development and implementation of provider and enrollee quality initiatives, and driving compliance with regulatory, contractual, and accreditation requirements. Her prior experience includes direct management of the development of quality improvement programs, accreditation activities, data analysis and initiative development and implementation, provider credentialing, and quality of care issue resolution within managed care organizations. She has conducted compliance review activities in the states of Virginia and Ohio. Ms. Heffernan received both her Bachelor of Science and her Master of Business Administration from the Ohio State University.

Teresa Huysman, RN, BSN

Ms. Huysman has more than 30 years of experience in the healthcare industry, with expertise in clinical care and healthcare compliance. Her prior experience includes Medicaid managed care responsibility for corporate compliance, ensuring compliance with regulatory and contractual requirements, including oversight and management of a Corporate Integrity Agreement (CIA) entered into with the Office of Inspector General (OIG). She additionally has expertise in managed care clinical appeals, case management, quality improvement, including HEDIS oversight, and utilization management review. She has managed and/or conducted compliance review activities across health plans in the states of Kentucky, Georgia, Indiana, Michigan, Ohio, and Utah. Ms. Huysman has been certified in Healthcare Compliance (CHC) by the Compliance Certification Board (CCB) and received her BS Degree from Miami University of Ohio.

PERFORMANCE IMPROVEMENT PROJECT REVIEWERS

Marietta Scholten, MD, FAAFP

Dr. Marietta Scholten is a Board-Certified Family Medicine physician who has practiced for 27 years in Vermont, initially in private practice, then founding the Mylan Family Health Center which provides medical and occupational care for its employees and dependents. For the past seven years, she has practiced at the University of Vermont Medical Center where she is also an Assistant Clinical Professor.

Dr. Scholten was the Medical Director for the Vermont Chronic Care Initiative for seven years working with the 5 percent of Medicaid beneficiaries costing 40 percent of the Medicaid budget. She was responsible for creating targeted interventions to improve the health of beneficiaries, coordinate their care, and reduce costs. She has been the Hospice Medical Director for Franklin County Home Health and Hospice providing oversight of medical services and community education for the past 26 years.

In addition, Dr. Scholten is a Board Member of Northwestern Medical Center where she is currently Chair of the Quality and Safety Committee and is a member of the Ethics and Compliance Committees.

Wayne J. Stelk, Ph.D.

Wayne J. Stelk, Ph.D., is a psychologist with over 40 years of experience in the design, implementation, and management of large-scale health and human service systems. His expertise includes improving health providers' service effectiveness and efficiency through data-driven performance management systems.

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

After leaving MBHP in 2010, he consulted on several projects involving the integration of primary care, behavioral health care, and long-term services and supports. Other areas of expertise include implementing evidence-based intervention and treatment practices; designing systems for the measurement of treatment outcomes; and developing data-collections systems for quality metrics that are used to improve provider accountability.

SECTION II. EXECUTIVE SUMMARY



The Balanced Budget Act of 1997 was an omnibus legislative package enacted by the United States Congress with the intent of balancing the federal budget by 2002. Among its other provisions, this expansive bill authorized states to provide Medicaid benefits (except to special needs children) through managed care entities. Regulations were promulgated including those related to the quality of care and service provided by managed care entities to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a managed care entity or its contractors furnish to Medicaid recipients. In Massachusetts, KEPRO has entered into an agreement with the Commonwealth to perform EQR services to its contracted managed care entities, i.e., managed care organizations, integrated care organizations (effective September 30, 2016), prepaid inpatient health plans, primary care case management plans, and senior care organizations.

EQR regulations require that two activities be performed on an annual basis:

- 1) Validation of three performance measures including an information systems capabilities analysis; and
- 2) The validation of two Performance Improvement Projects (PIPs).

Compliance with federal Medicaid managed care regulations and related Executive Office of Health and Human Services (EOHHS) contract requirements is validated by the EQRO on a triennial basis. Compliance was validated in Calendar Year 2017.

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. The report includes:

- A determination of the quality, timeliness, and access to the health care services furnished by a managed care entity to Medicaid recipients;
- An assessment of the organization's strengths and opportunities for improvement;
- A comparison of performance year over year with national Medicaid and [Medicare] benchmarks;
- Recommendations for improving the quality of care; and
- An assessment of the degree to which the organization addressed recommendations from the prior review cycle.

KEPRO's technical report on the Massachusetts Behavioral Health Partnership (MBHP) follows.

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

KEPRO conducted the following external quality review activities for the Massachusetts Behavioral Health Partnership (the Partnership) in the CY 2017 review cycle:

1. Validation of three performance measures, including an information systems capabilities analysis;
2. The validation of two Performance Improvement Projects (PIPs); and
3. Validation of compliance with federal Medicaid managed care regulations and applicable elements of the contract between EOHHS and MBHP.

To clarify reporting periods, EQR Technical Reports that have been produced in calendar year 2017 reflect 2016 quality performance. References to HEDIS® 2017 performance reflect data collected in 2016.

ORGANIZATION DESCRIPTION

The Massachusetts Behavioral Health Partnership (MBHP) is a managed behavioral healthcare organization (MBHO) that provides services to members of the MassHealth Primary Care Clinician Plan, children in state custody, and certain children enrolled in MassHealth who have commercial insurance as their primary insurance. As of December 31, 2016, 454,412 individuals statewide were under the care of the Partnership. MBHP signed a five-year contract with the Commonwealth effective October 1, 2012 to provide integrated physical and behavioral health programs, management support services, and behavioral health specialty services. Formerly a ValueOptions company, MBHP is now part of Beacon Health Options, the combined company resulting from the merger of Beacon Health Strategies and ValueOptions in 2015. Located in Boston, MBHP has received full NCQA MBHO accreditation.

MBHP also manages behavioral health care for Health New England (HNE) Be Healthy, a MassHealth plan serving Western Massachusetts. Their performance under this contract is described in the Health New England technical report.

PERFORMANCE MEASURE VALIDATION

The Performance Measure validation process assesses the accuracy of performance measures reported by the managed care entity. It determines the extent to which the managed care entity follows state specifications and reporting requirements.

- **Antidepressant Medication Management (AMM)** — The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:
 1. *Effective Acute Phase Treatment*: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks); and

2. *Effective Continuation Phase Treatment*: The percentage of members who remained on an antidepressant medication for at least 180 days (six months).
- **Follow-up after Hospitalization for Mental Illness (FUH)** — The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:
 1. The percentage of discharges for which the member received follow-up within 30 days of discharge.
 2. The percentage of discharges for which the member received follow-up within seven days of discharge.
 - **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)** — The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:
 - a. *Initiation of AOD Treatment*: The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
 - b. *Engagement of AOD Treatment*: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

KEPRO bases its performance measure validation on the quality of source data and the calculation of the measure, including data management structure, sources and collection, and the logic and analytic framework for determining numerators and denominators.

PERFORMANCE MEASURE RESULTS

The charts below depict MBHP's performance in the three measures by HEDIS® measurement year, selected by MassHealth for validation. The HEDIS® Medicaid National 90th percentile is included for comparison purposes.

Antidepressant Medication Management (AMM) — Calendar Year 2017 represents the first year in which MBHP’s AMM performance measures were validated. MBHP’s performance in the AMM Effective Acute Phase treatment, 54.52 percent, is 9.63 percentage points below the NCQA Medicaid Quality Compass 90th percentile of 64.15 percent. Its rate falls between the 66th and 75th Quality Compass percentiles. MBHP’s performance in the AMM Effective Continuation Phase is 40.02 percent. This rate also falls between the 66th and 75th Quality Compass percentiles and falls 10.39 percentage points short of the 90th percentile.

Table1: MBHP AMM Effective Acute Phase Treatment Rates

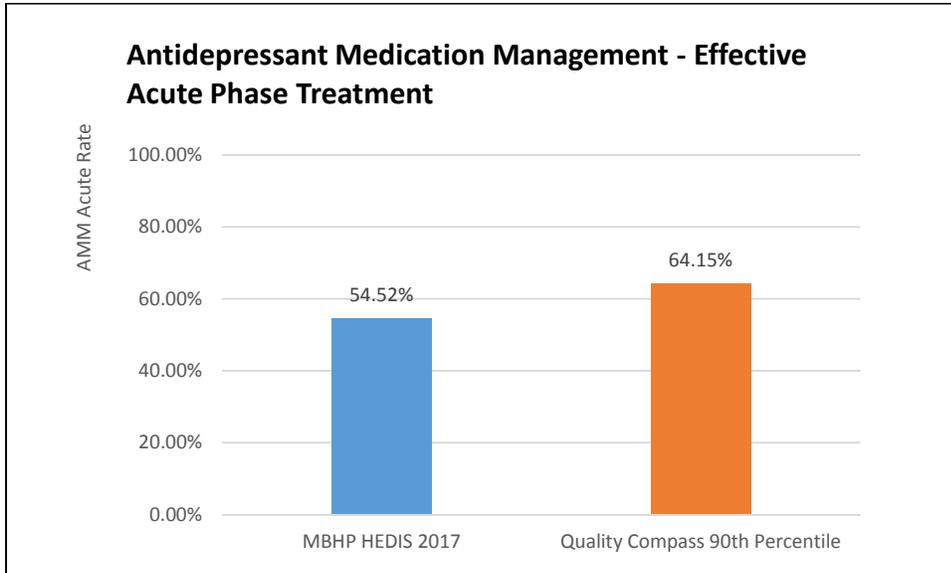
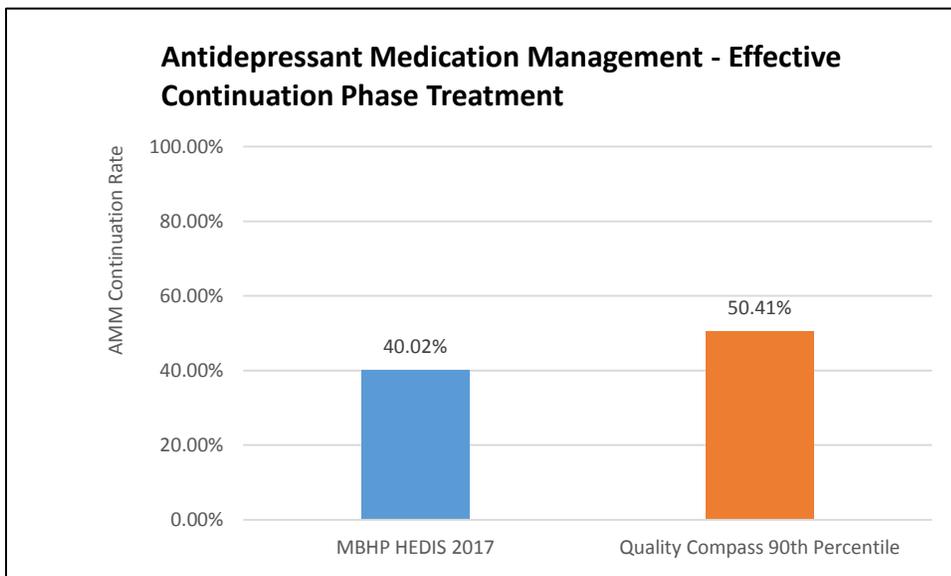
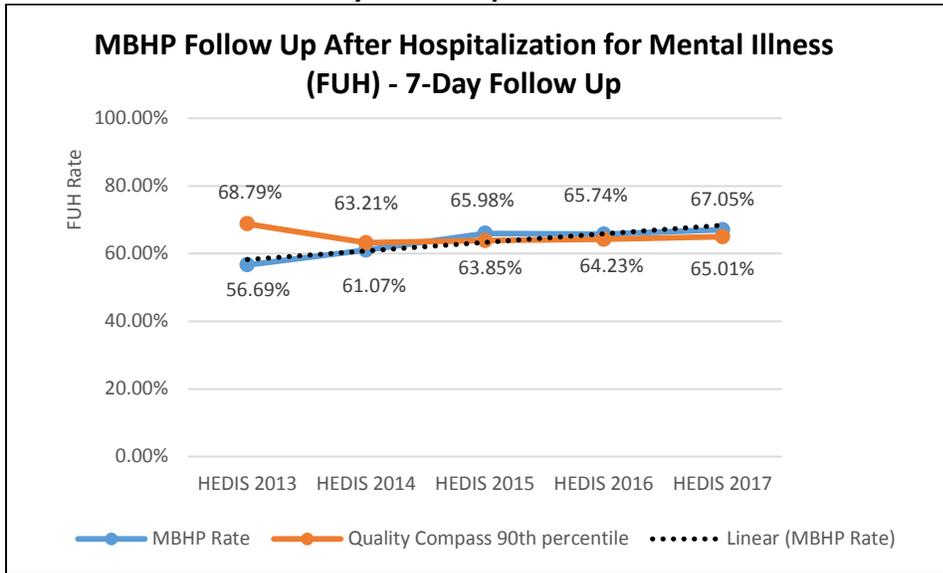


Table 2: MBHP AMM Effective Continuation Phase Treatment

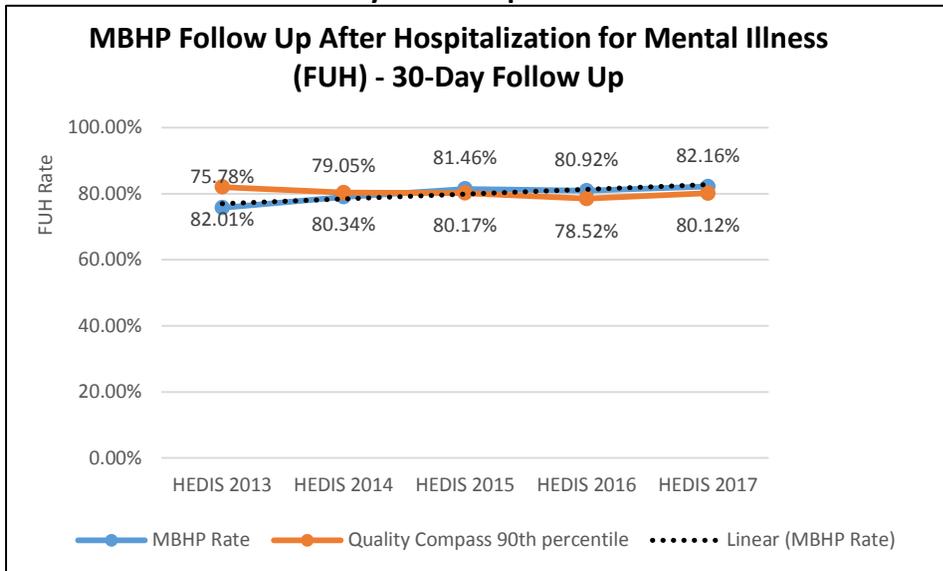


Follow-up after Hospitalization for Mental Illness (FUH) — MBHP’s performance rate for 7-Day Follow Up After Hospitalization for Mental Illness is 67.05 percent, which is between the 90th and 95th Quality Compass percentiles. Its rate increased a statistically significant 1.24 percentage points between HEDIS 2016 and HEDIS 2017. MBHP’s performance on the 30-day follow up measure, 82.16 percent, also ranks between the 90th and 95th percentiles compared to the Quality Compass. Performance increased 1.31 percentage points between HEDIS 2016 and HEDIS 2017. This rate change was not statistically significant. Performance is trending up for both measures.

Tables 3: MBHP FUH 7-Day Follow Up Rates



Tables 4: MBHP FUH 30-Day Follow Up Rates



Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) — MBHP’s performance on the IET Initiation measure decreased a statistically insignificant 0.44 percentage points between HEDIS 2016 and HEDIS 2017, from 45.31 percent to 44.87 percent. MBHP’s performance ranks between the 66th and 75th percentiles of the Quality Compass. IET Engagement performance increased from 16.17 percent to 16.38 percent. This change is not statistically significant. MBHP’s performance on the IET Engagement measure falls between the 75th and 90th percentiles compared to the Quality Compass. Performance for both the IET Initiation and IET Engagement measures is trending down.

Table 5: MBHP IET Initiation Rates

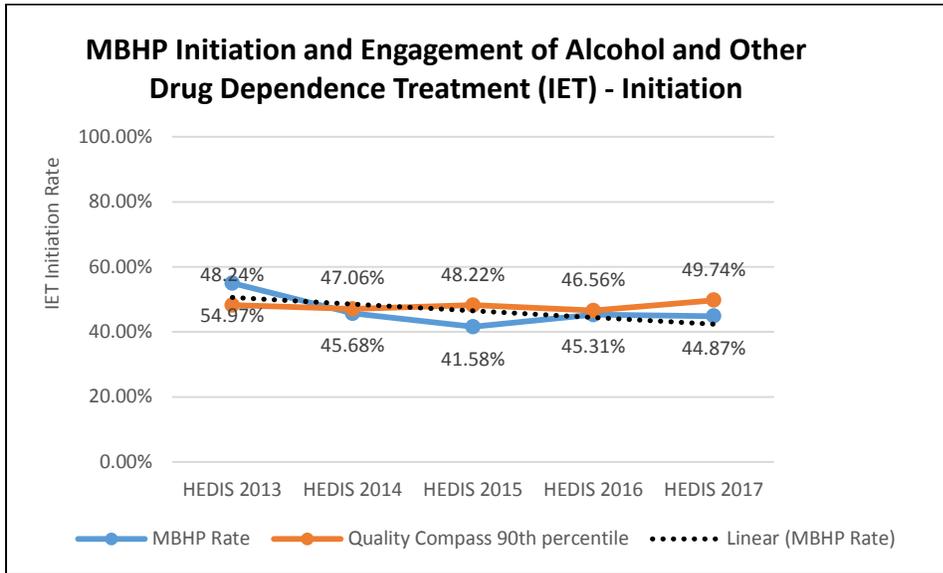
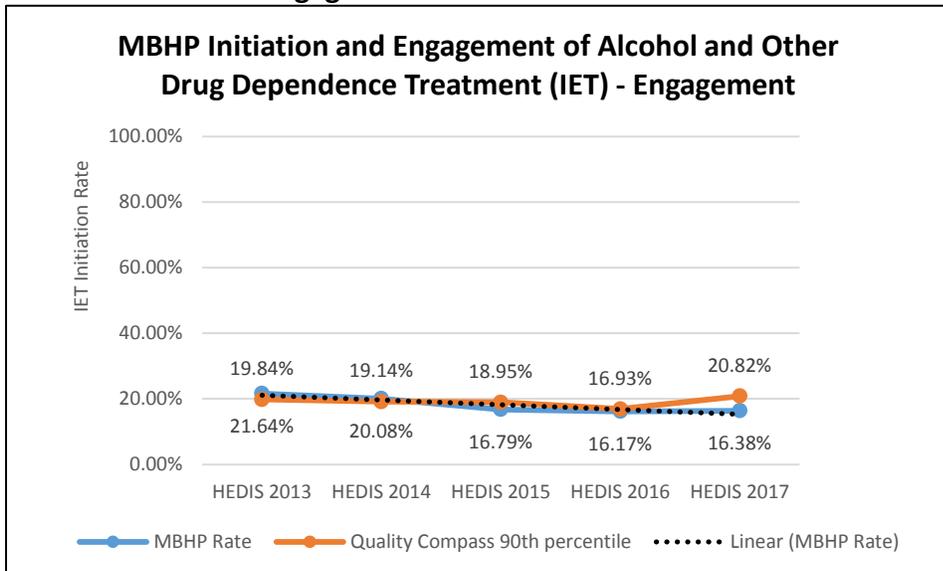


Table 6: MBHP IET Engagement Rates



INFORMATION SYSTEMS CAPABILITIES ANALYSIS

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of MBHP's information system that contribute to performance measure production. The following categories of data are reviewed for completeness, integrity of processing, the presence of quality control and oversight systems, and accuracy:

- Claims and Encounter Data;
- Enrollment Data;
- Provider Data;
- Data Collected for Hybrid Measures¹ (Medical Record Reviews);
- Supplemental Data;
- Data Integration; and
- Source Code.

Based on the Information Systems Capability Analysis, no issues were identified for any of these data categories for MBHP.

RECOMMENDATIONS

To facilitate early interventions with members who may not be adherent to their antidepressant medication regimens, pharmacy data should be provided to MBHP more frequently than monthly.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

¹ Managed care entities are permitted to calculate measures that have been designated as "hybrid" by NCQA using both claims data and data abstracted from a sample of medical records.

INITIATION AND ENGAGEMENT IN ALCOHOL AND OTHER DRUG TREATMENT

Project Goal as Stated by MBHP

Use intervention efforts to improve the percentage of members who initiate and engage in alcohol and other drug dependence treatment.

Interventions

Regional Network Managers (RNMs) have been distributing Provider Profile Reports to providers since August 2014. The Profile reports include information related to substance use treatment rates across MBHP, and among members seen at a particular provider. The report compares a provider's performance to the national Medicaid benchmarks and to similarly sized and regionally located providers, and sets a goal for the provider to meet by the end of the year, based on their individual performance. In 2016, MBHP provided extensive training to RNMs on the report contents and how to have a meaningful discussion with the provider about the results and interpretation of the reports.

In the Quality Workgroup initiative, providers at different levels of care within each region met regularly to discuss opportunities to improve substance use care pathways by improving access to care, referrals processes, and increased engagement in care. This resulted in provider-driven subcommittees within each region focused on short and long-term change projects.

Results

The graphs that follow depict MBHP’s Initiation and Engagement of Treatment rates. The Initiation rate decreased 0.97 percent between 2016 and 2017, which is a statistically insignificant change. MBHP’s rate falls between the Medicaid Quality Compass 75th and 90th percentiles. The Engagement rate increased a statistically insignificant 1.26 percent. Both rates have been trending down for four consecutive measurement periods.

Table 7: MBHP IET Initiation Rates

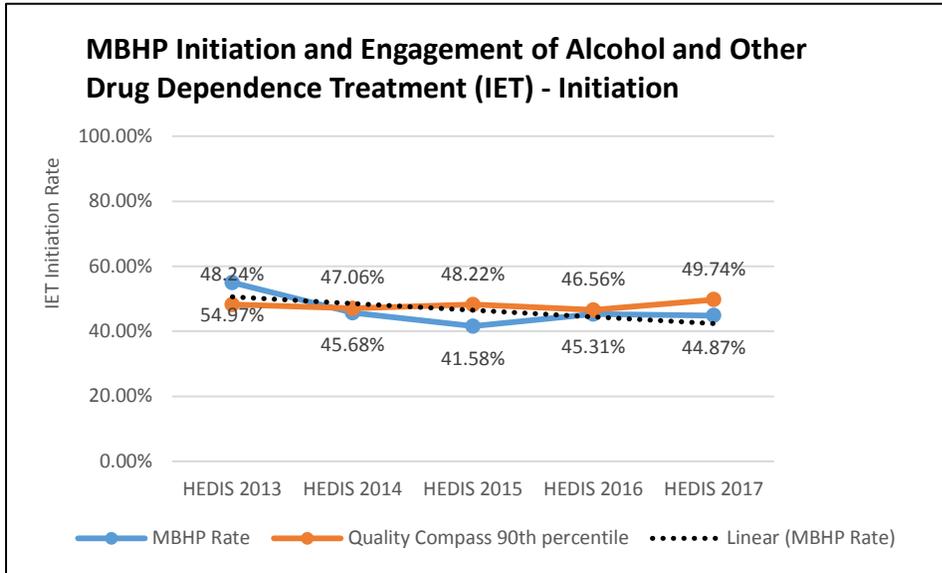
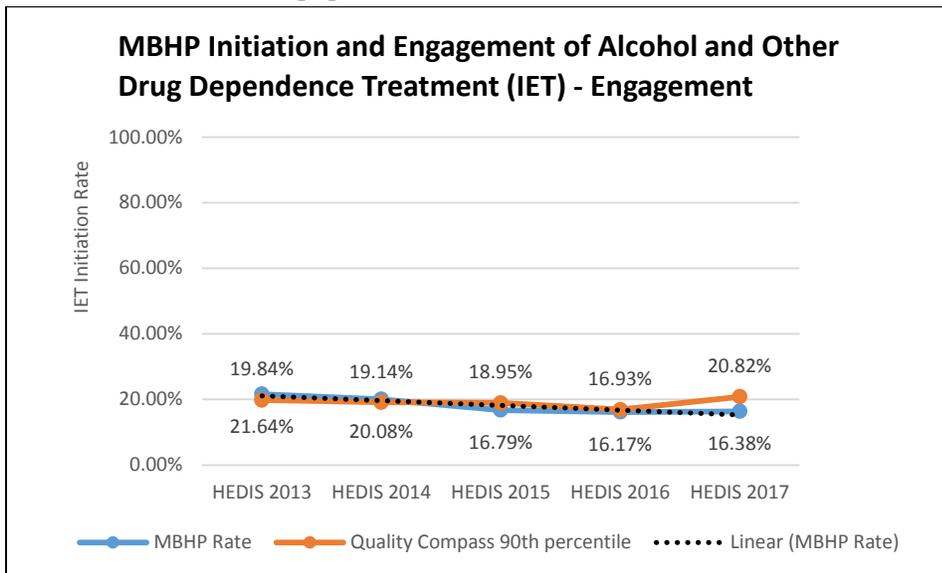


Table 8: MBHP IET Engagement Rates



Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. UnitedHealthcare received a rating score of 87% on this Performance Improvement Project. MBHP received a rating score of 100 percent on this PIP.

Recommendations

KEPRO has no recommendations for MBHP on this performance improvement project.

IMPROVING COMPREHENSIVE DIABETES CARE (CDC) FOR PCC PLAN MEMBERS WHO ARE DEPARTMENT OF MENTAL HEALTH (DMH) ENROLLEES

Project Goal As Stated by MBHP

"The primary goal of the CDC measure, as applied to PCC Plan-DMH enrollees, is to develop an integrated model of engagement that supports the member in making personal choices about health behaviors and adherence to medical recommendations for treatment, including diet and exercise, appointments, screenings, and lab tests."

Interventions

MBHP implemented a focused care management program conducted jointly by care managers at MBHP and the Department of Mental Health. Working together, these teams of care managers identified member barriers to care and put plans in place to achieve care goals. MBHP Intensive Care Management clinicians conducted outreach to their assigned members who had a diagnosis of diabetes. The clinician discussed the need to attend primary care visits for monitoring their diabetes, including referrals for eye examinations.

Results

Calendar year 2016 represented the baseline year for this PIP. The table below depicts MBHP's baseline performance and the Partnership's goals.

Table 9: MBHP CDC Baseline Performance

CDC Measure	MBHP 2016 Performance	Performance Goal (HEDIS 2017 50th percentile)
HbA1c < 8%	41.21%	48.91%
Blood Pressure < 140/90	52.31%	60.72%
Dilated Retinal Eye Exam	36.46%	53.70%
Medical Attention for Nephropathy	89.63%	90.27%

Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. UnitedHealthcare received a rating score of 87% on this Performance Improvement Project. MBHP received a rating score of 95 percent on this PIP.

Recommendations

- Because of the well-known health disparities that exist in the Hispanic and African-American populations in the treatment of diabetes, KEPRO recommends that MBHP include a REL analysis in future population descriptions.
- MBHP cites no relevant literature. If MBHP searched for literature relative to this intervention (whatever the primary focus), then MBHP should briefly describe its attempted search and lack of relevant literature.

Conclusion

In summary, KEPRO's validation review of the selected performance indicators and performance improvement projects indicates that MBHP's measurement and reporting processes were fully compliant with specifications and methodologically sound.

SECTION III. PERFORMANCE MEASURE VALIDATION



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

METHODOLOGY

The two-step Performance Measure Validation process consists of a desk review of documentation submitted by the managed care organization as well as an onsite review. The desk review affords the reviewer an opportunity to become familiar with plan systems and data flows. In addition, the reviewer conducts an independent verification of a sample of individuals belonging to the positive numerator of a hybrid measure. At the onsite review, the reviewer confirms information contained in the Data Acquisition Questionnaire, inspects information systems, and by interviewing staff, obtains clarification about performance measurement and information transfer processes.

For the Calendar Year 2017 external quality review, MBHP submitted the following documentation:

Exhibit 10: MBHP Performance Measure Validation Supporting Documentation

Document Reviewed	Purpose of KEPRO Review
Data Acquisition Questionnaire	Reviewed to assess health plan systems and processes related to performance measure production.
Measure-specific documentation from DST, the producer of MBHP's HEDIS rates	Reviewed to note if there were any underlying process issues related to HEDIS measure production
Follow-up documentation as requested by the reviewer	For those measures that were not produced using NCQA-certified measure software, reviewed software program/code to determine accuracy of programming and compliance with measure specifications.

MassHealth requires the validation of three HEDIS® performance measures for each managed care entity. The measures selected for review in Calendar Year 2017 were as follows:

- **Antidepressant Medication Management (AMM)** — The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:
 1. *Effective Acute Phase Treatment*: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
 2. *Effective Continuation Phase Treatment*: The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

- **Follow-up after Hospitalization for Mental Illness (FUH)** — The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:
 1. The percentage of discharges for which the member received follow-up within 30 days of discharge.
 2. The percentage of discharges for which the member received follow-up within 7 days of discharge.

- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)** — The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:
 - a. *Initiation of AOD Treatment*. The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
 - b. *Engagement of AOD Treatment*. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of MBHP's 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.

- **Claims and Encounter Data.** MBHP processed behavioral health claims during 2016 using its proprietary Claims Adjudication System (CAS). All necessary fields were

captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Approximately 96 percent of claims were submitted electronically, either through clearinghouses or directly to MBHP. There were adequate monitoring processes in place to monitor electronic data interface claim submissions. Sufficient claims editing processes were initiated on the front-end of claims submissions and additional. The small volume of paper claim submissions were processed in-house. Staff manually keyed the data into CAS. MBHP received medical encounter files from the Primary Care Clinician (PCC Plan) on a nightly basis. Pharmacy encounter files were received from the PCC Plan monthly. There were adequate processes for the receipt and processing of these encounter data files. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

- **Enrollment Data.** MBHP processed Medicaid enrollment data using the CAS system. All necessary enrollment fields are captured for HEDIS reporting. MBHP member enrollment data were received daily in an 834 format from the State and processed by MBHP. The daily file included additions, changes, and terminations. Enrollment data were loaded into CAS. MBHP also received a full monthly refresh file and conducted reconciliation between CAS and the State file. MBHP had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.
- **Medical Record Review.** The MBHP performance measures were not calculated using medical record data. Therefore, this section is not applicable.
- **Supplemental Data.** MBHP did not use supplemental data sources in the production of performance measure rates under review. Therefore, this section is not applicable.
- **Data Integration.** MBHP's performance measure rates were produced using DST software. Data from the transaction system were loaded to MBHP's enterprise-wide data warehouse nightly. MBHP used an automated process to populate a local data warehouse to facilitate the production of performance measures for the MBHP population. There were adequate processes and validation of data between the enterprise-wide and local data warehouses. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into DST-compliant extracts and loaded into the measure production software monthly. MBHP staff members conducted monthly primary source verification of the data within DST and traced the information to the MBHP source data systems to ensure the software logic was being applied appropriately. MBHP had adequate processes to track completeness and accuracy of data at each transfer point. Data transfers to the DST repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. DST's repository structure was compliant. HEDIS measure report production was managed effectively. The DST software was compliant with regard to development,

methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. MBHP maintains adequate oversight of its vendor, DST. There were no issues identified with data integration processes.

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

PERFORMANCE MEASURE RESULTS

The graphs below depict MBHP’s performance in measures selected by MassHealth for validation. The National Medicaid Quality Compass 90th percentile rate is included for comparison purposes.

Antidepressant Medication Management — 2017 was the first year for which MassHealth requested validation of this performance measure. MBHP’s performance for both the Acute Phase and the Continuous Phase lies between the HEDIS National Medicaid 66th and 75th percentiles.

Table 11: MBHP AMM Acute Phase Rates Compared to Quality Compass

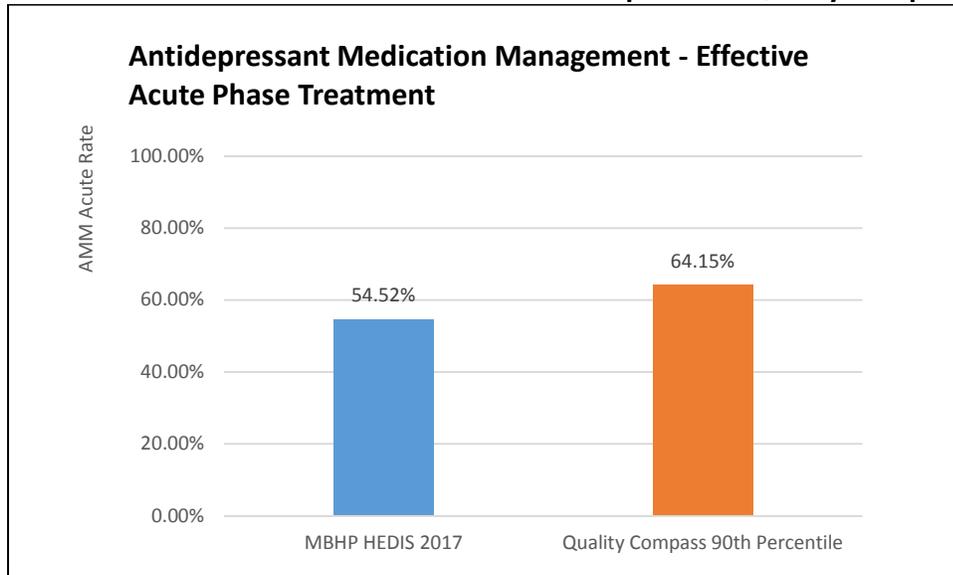
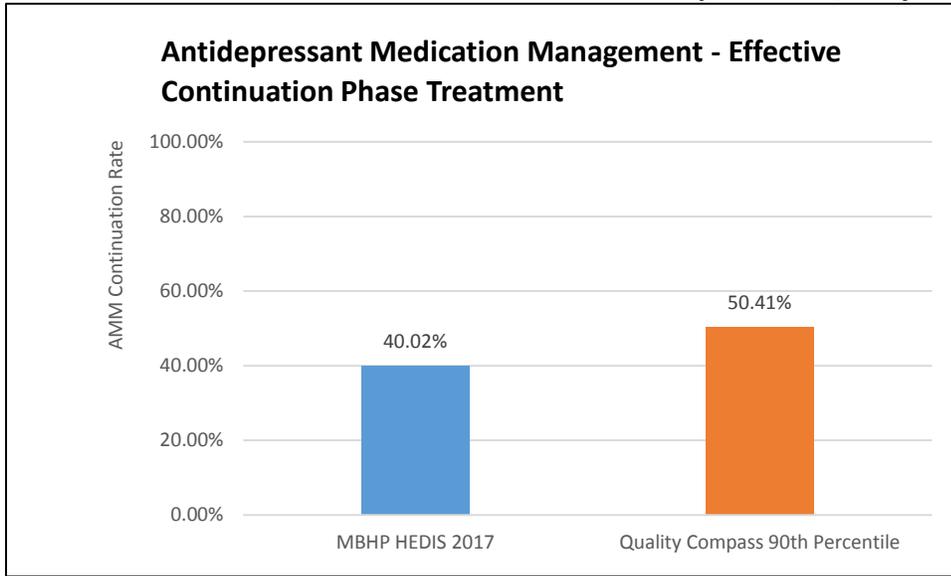


Table 12: MBHP AMM Continuous Phase Rates Compared to Quality Compass



Follow-up after Hospitalization for Mental Illness (FUH) — The 7-day follow-up post-hospitalization increased a statistically insignificant 1.31 percentage points. The 30-day follow-up rate increased 1.24 percentage points, also not statistically significant. MBHP’s performance ranks between the 90th and 95th Medicaid National Quality Compass percentiles for both measures. Performance on both measures is trending upward.

Table 13: MBHP FUH 7-Day Follow Up Rate Compared to Quality Compass

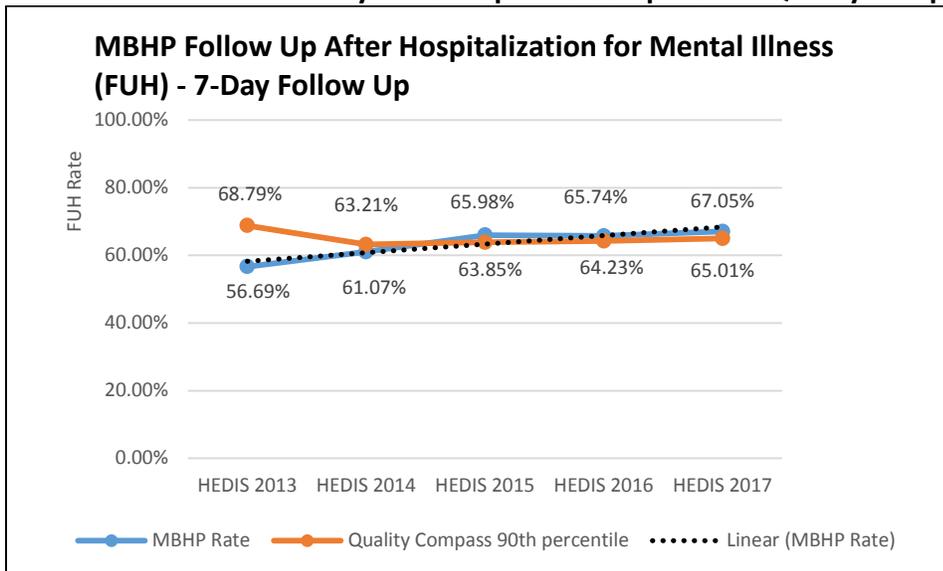
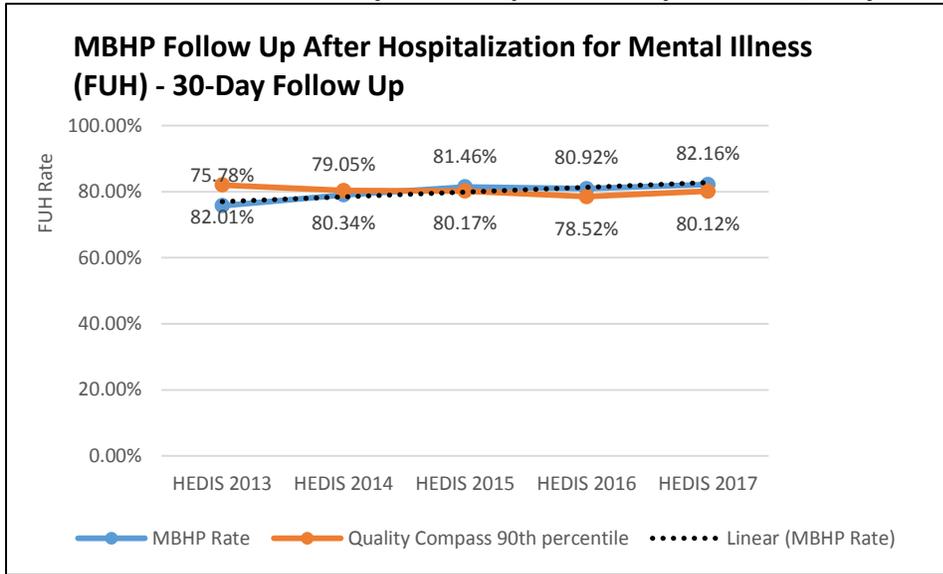


Table 14: MBHP FUH 30-Day Follow Up Rate Compared to Quality Compass



Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) — MBHP’s IET initiation rate decreased a statistically insignificant 0.44 percentage points. MBHP’s performance in this measure ranks between the 66th and 75th percentiles of the National Medicaid Quality Compass. The engagement component of the IET rate increased 0.21 percentage points, which was not a statistically significant change. MBHP’s engagement rate ranks between the 75th and 90th percentiles of the Quality Compass.

Table 15: MBHP IET Initiation Performance Compared to Quality Compass

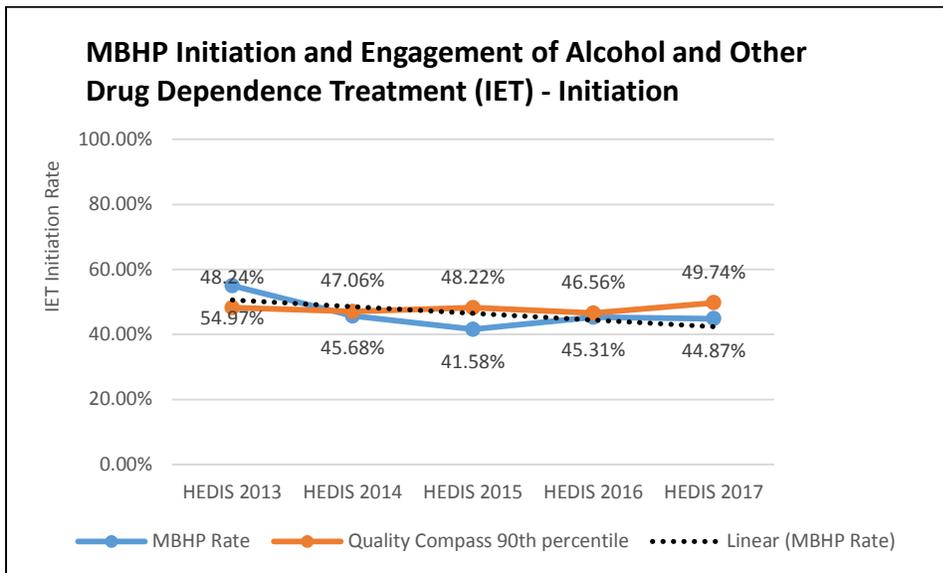
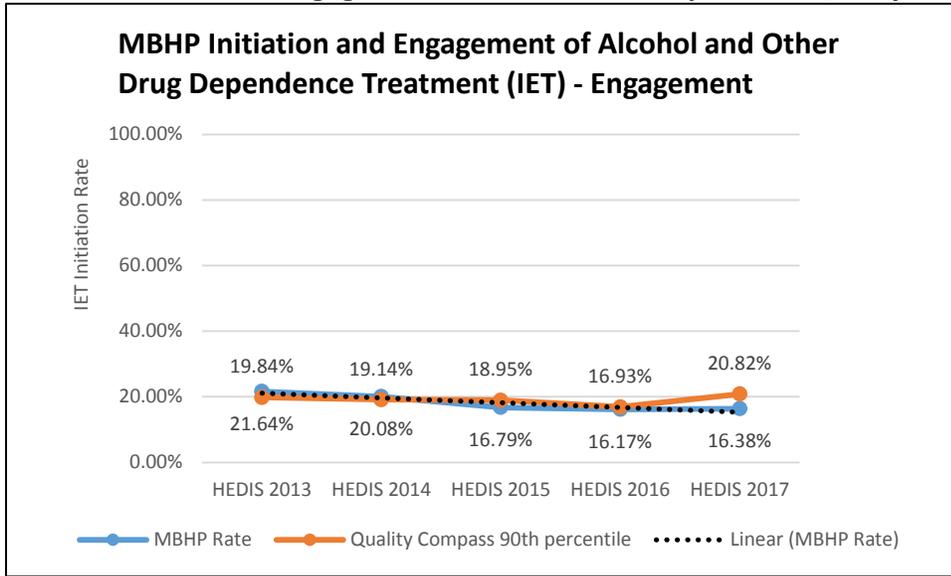


Table 16: MBHP IET Engagement Performance Compared to Quality Compass



CONCLUSIONS

Plan Strengths

- MBHP used an NCQA-certified vendor to produce its measures.
- MBHP has high performance across all performance measures.
- MBHP demonstrated a strong, collaborative relationship with the PCC Plan relative to data collection, reporting, and improvement efforts.
- MBHP provided monthly data loads to its software vendor to calculate a rolling 12-month rate, which MBHP used for quality improvement and benchmarking purposes.

Opportunities

MassHealth does not provide MBHP with the Medication Assisted Treatment (MAT) prescription claims data, which could enable MHPB to calculate more accurate pharmacy-related PMV rates.

Recommendations

To facilitate early interventions with members who may not be treatment adherent, pharmacy data should be provided to MBHP more frequently than monthly.

FOLLOW UP TO 2016 RECOMMENDATIONS

CMS requires that EQROs assess the status of recommendations made in prior years. The table below describes MBHP’s follow up to last year’s recommendations.

Exhibit 17: Follow Up to 2016 Recommendations

Calendar Year 2016 Recommendation	2017 Update
<p>MBHP should conduct root-cause analysis to determine factors contributing to members not seeking or continuing with alcohol and other drug dependence treatment and implement interventions that target performance improvement.</p>	<p>MBHP initiated several interventions focused on improving the likelihood of follow-up treatment including doctor-to-doctor forums to support substance abuse disorders in the primary care setting, profiling of low-performing providers with site visits, and development of substance abuse materials that included coding information and motivational interviewing strategies to support primary care providers.</p>
<p>MBHP may consider working with MassHealth to determine whether there are other performance measures in need of improvement that should be formally reported in the future and retire some of the performance measures that had sustained high performance from formal reporting.</p>	<p>The PMV reporting set for MBHP has been updated since last year.</p>

PERFORMANCE IMPROVEMENT PROJECT REVIEW PROCESS

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

The PIP review is a three-step process:

- 1) **Desktop Review.** A desktop review is conducted for each PIP. The Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plan. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the questionnaire. The Medical Director's focus is on proposed or implemented clinical interventions.
- 2) **Conference with the Plan.** The Technical Reviewer and Medical Director meet telephonically with representatives selected by the plan to obtain clarification on identified issues as well as to offer recommendations for improvement. The plan is offered the opportunity to resubmit the PIP questionnaire within 10 calendar days, although it is not required to do so.
- 3) **Final Report.** A PIP Verification Worksheet based on CMS EQR Protocol 3 is completed by the Technical Reviewer. KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. UnitedHealthcare received a rating score of 87% on this Performance Improvement Project.

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 to KEPRO.

KEPRO reviewed two improvement projects that MBHP conducted in 2016:

1. Initiation and Engagement in Alcohol and Other Drug Treatment; and
2. Improving Comprehensive Diabetes Care (CDC) for PCC Plan Members who are Department of Mental Health Enrollees.

INITIATION AND ENGAGEMENT IN ALCOHOL AND OTHER DRUG TREATMENT

Project Goal as Stated by the Partnership

“Use intervention efforts to improve the percentage of Members who initiate and engage in alcohol and other drug dependence treatment.”

Performance Measure Descriptions

MBHP measures its success toward this goal using its performance on the HEDIS Initiation and Engagement of Treatment (IET) measure. This measure has two components:

1. The percentage of adolescent and adult Members ages 13 years and older with a new episode of alcohol or other drug (AOD) dependence who initiated treatment within 14 days of the initiation visit.
2. The percentage of adolescent and adult Members ages 13 years and older with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

Interventions

MBHP had the following interventions in place in 2017 to improve substance use dependence treatment patterns:

- MBHP used data in the quarterly Provider Profile Reports to drive provider performance on transferring patients to substance use dependence treatment. These reports compare individual provider performance to national Medicaid benchmarks and similarly sized and located providers. MBHP sets individual provider goals. The plan also trained Regional Network Management staff to encourage meaningful conversations with providers.
- In response from the key lessons learned from previous two years of quality improvement activity, MBHP established region-specific workgroups focused on improving substance use care pathways and effective treatment for patients with substance abuse disorders. Providers at different levels of care within each region met regularly to discuss access to care, referral processes, and increased engagement in care.

Results

The graphs below depict MBHP’s Initiation and Engagement of Treatment rates. The Initiation rate decreased 0.97 percent between 2016 and 2017, which is a statistically insignificant change. The Engagement rate increased a statistically insignificant 1.26 percent. Both rates have been trending down for four consecutive measurement periods. MBHP fell 1.41 percentage points short of achieving its IET Initiation rate of 46.28% and only slightly more than half a point short of achieving its IET engagement rate.

Table 18: MBHP IET Initiation Rates Compared to Goal

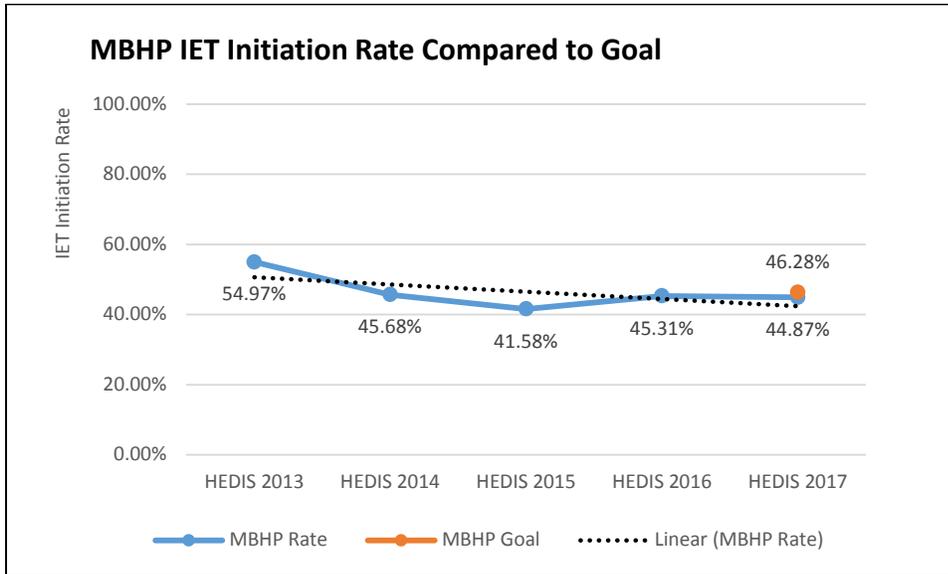
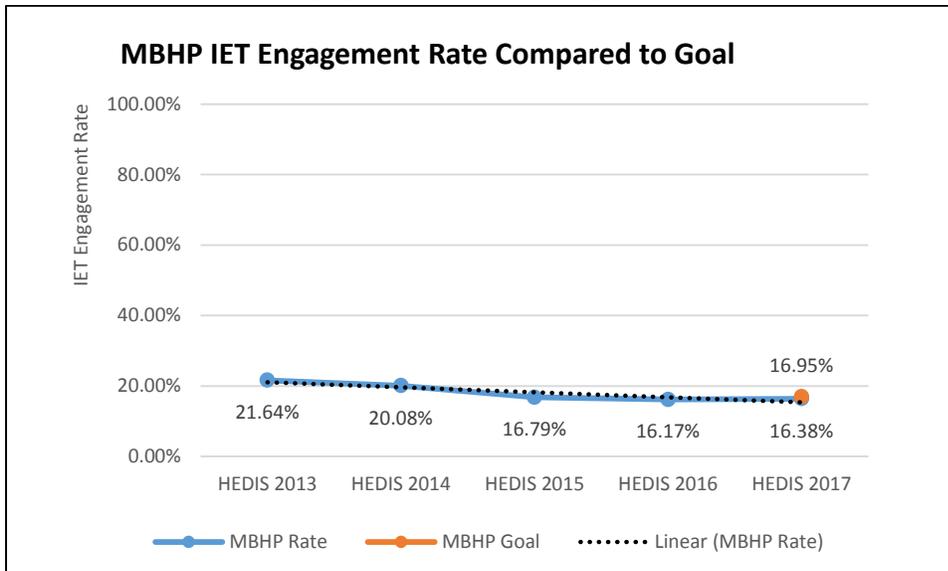


Table 19: MBHP IET Engagement Rates Compared to Goal



Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. UnitedHealthcare received a rating score of 87% on this Performance Improvement Project. MBHP received a rating score of 100 percent on this Performance Improvement Project.

Exhibit 20: PIP Rating Score

Results of Validation Ratings for Y/N Values	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Reassessing Intervention Parameters & Strategies	3	3	3	100%
Performance Indicator Data Collection	3	3	3	100%
Overall Validation Rating Score for Y/N Values	7	7	7	100%

Summary Results of Validation Ratings for 3, 2, or 1 Values	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	15	100%
Reassessing Intervention Parameters & Strategies	4	12	12	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	6	100%
Conclusions & Future PIP Improvements	3	9	9	100%
Validation Rating Score for 3, 2, or 1 Values	20	60	60	100%

Validation Rating Score	27	67	67	100%
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Plan & Project Strengths

- MBHP is commended for using its indicator data to stratify members by those who responded favorably to CSP and those who did not, and then for modifying their CSP deployment strategies accordingly.
- MBHP is commended for including ATS providers in the intervention improvement process.
- MBHP is highly commended for its data-based root cause analysis of the barriers to improved performance rates. MBHP has involved both participating providers and its Consumer Advisory Council as stakeholders in its process for improving its ATS continuing care interventions.
- MBHP is commended for expanding its Provider Profile Report initiative utilizing automated reporting mechanisms and for training Regional Network Managers in its interpretation.
- MBHP has presented excellent analytics.
- MBHP is highly commended for its quality workgroups that bring providers together locally to share best practices, common barriers, and intervention strategies.

Opportunities

MBHP's approach to using provider-driven subcommittees to conduct regional barrier analyses and identify local interventions is unique and innovative. KEPRO encourages MBHP to write a formal description of this process, along with data-driven analyses of effectiveness, and publish this intervention as a report for public dissemination through the healthcare literature.

Update on Calendar Year 2016 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2016 to MBHP follows.

Exhibit 21: Update on Calendar Year 2016 MBHP PIP Recommendations

Calendar Year 2016 Recommendation	2017 Update
It is recommended that MBHP conduct a brief comparison of the outcomes of this performance improvement project with the outcomes of MBHP's corollary project, which has the goal of reducing readmissions to Acute Treatment Services (ATS).	MBHP did not provide evidence of such a comparison.

Recommendations

KEPRO has no recommendations to offer to MBHP.

IMPROVING COMPREHENSIVE DIABETES CARE (CDC) FOR PCC PLAN MEMBERS WHO ARE DEPARTMENT OF MENTAL HEALTH ENROLLEES

Project Goal As Stated by the Partnership

“The primary goal of the CDC measure, as applied to PCC Plan-Department of Mental Health (DMH) dual enrollees, is to develop an integrated model of engagement that supports the Member in making personal choices about health behaviors and adherence to medical recommendations for treatment, including diet and exercise, appointments, screenings, and lab tests.”

Performance Measure Description

MBHP is measuring its performance using four of the measures in the HEDIS Comprehensive Diabetes Care measure set. The denominator for each of these measures is the number of eligible adult PCC Plan members who are DMH enrollees and have been diagnosed with diabetes.

1. Number of eligible Members who have HbA1c <8%;
2. Number of eligible Members who have Blood Pressure Control <140/90 mm Hg;
3. Number of eligible Members who have a dilated or retinal eye exam; and
4. Number of eligible Members who have medical attention for nephropathy.

Interventions

MBHP implemented a focused care management program conducted jointly by care managers at MBHP and the Department of Mental Health. Working together, these teams of care managers identified member barriers to care and put plans in place to achieve care goals. MBHP Intensive Care Management clinicians conducted outreach to their assigned members who had a diagnosis of diabetes. The clinician discussed the need to attend primary care visits for monitoring their diabetes, including referrals for eye examinations.

Results

Calendar year 2016 represented the baseline year for this PIP. The table below depicts MBHP’s baseline performance and the Partnership’s goals.

Table 22: MBHP CDC Baseline Performance

CDC Measure	MBHP 2016 Performance	Performance Goal (HEDIS 2017 50th percentile)
HbA1c < 8%	41.21%	48.91%
Blood Pressure < 140/90	52.31%	60.72%
Dilated Retinal Eye Exam	36.46%	53.70%
Medical Attention for Nephropathy	89.63%	90.27%

Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. UnitedHealthcare received a rating score of 87% on this Performance Improvement Project. MBHP received a rating score of 95% percent on this Performance Improvement Project.

Table 23: PIP Rating Score

Results of Validation Ratings for Y/N Values	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Intervention Parameters	3	3	3	100%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating Score for Y/N Values	7	7	7	100%

Summary Results of Validation Ratings for 3, 2, or 1 Values	Number of Items	Total Available Points	Points Scored	Rating Averages
Problem Statement	4	12	12	100%
Member Population Analysis	3	9	9	100%
Barriers & Root Cause Analyses	2	6	6	100%
Intervention Parameters	5.0	15.0	11.5	77%
Rationale for Performance Indicators	1	3	3	100%
Performance Indicator Parameters	1.0	3.0	3.0	100%
Performance Indicator Data Analysis	3	9	9	100%
Baseline Performance Rates	1.0	3.0	3.0	100%
Validation Rating Score for 3, 2, or 1 Values	20	60	56.5	94%

Validation Rating Score	27	67	67	95%
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Plan and Project Strengths

- MBHP is commended for soliciting feedback about diabetes management through a variety of processes, which included stakeholder surveys and focus groups.
- MBHP presented an excellent population analysis. Among other descriptive information, MBHP stratified the CDC performance measures by gender and indicated support services were received by the member,
- MBHP is commended for its excellent graphic showing the results of its root cause analysis. The fishbone analysis presented in Appendix 1 displays a multi-dimensional view of the topics (barriers, sub-barriers, related interventions). This fishbone diagram is a model for any MCE conducting a root cause analysis of key barriers.

Opportunities

MBHP identified the purpose of this intervention as improving the integration of behavioral and primary health care for two member cohorts: those engaged with MBHP's ICMs and those engaged in high-volume PCC practices. As noted earlier, MBHP needs to develop a metric for determining successful engagement among both cohorts. Indicator rates can then be calculated for members successfully engaged with the ICM compared to those whose engagement was not successful. Similar rates can be run for members engaged with PCC practices compared to those not engaged.

Recommendations

Because of the well-known health disparities that exist in the Hispanic and African-American populations in the treatment of diabetes, KEPRO recommends that MBHP include a REL analysis in future population descriptions.

MBHP cites no relevant literature. If MBHP searched for literature relative to this intervention (whatever the primary focus), then MBHP should briefly describe its attempted search and lack of relevant literature.

SECTION V. 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 are in compliance with Federal quality standards mandated by the Balanced Budget Act of 1997 (BBA). This validation process is conducted triennially.

The 2017 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 MBHP were assessed. Appropriate provisions in the Code of Massachusetts Regulations (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.

MBHP activity and services occurring for calendar year 2016 were subject to review.

Based on regulatory and contract requirements, compliance reviews were divided into the following 14 standards:

- Enrollee Rights and Protections;
- Enrollee Information;
- Availability and Accessibility of Services;
- Coordination and Continuity of Care;
- Coverage and Authorization of Services;
- Practice Guidelines;
- Enrollment and Disenrollment;
- Grievance System;
- Sub-contractual Relationships and Delegation;
- Quality Assessment and Performance Improvement Program;
- Credentialing;
- Confidentiality of Health Information;
- Health Information Systems; and
- Program Integrity.

Compliance review tools included detailed regulatory and contractual requirements in each standard area.

KEPRO communicated an overview of the compliance review activity and timeline to MBHP prior to the formal review period. Preferred dates for the onsite reviews were solicited. In

addition, KEPRO hosted a webinar on April 10, 2017, to provide more detailed information and instructions for MBHP to prepare for the compliance review. MBHP was provided with a preparatory packet that included the project timeline, a draft onsite agenda, the compliance review tools, and data submission information. KEPRO scheduled a 30-minute call with MBHP approximately two weeks prior to the onsite review that covered review logistics.

MBHP was asked to provide documentation to substantiate compliance with each requirement during the review period. Examples of documentation provided included:

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

KEPRO compliance reviewers performed a desk review of all documentation provided by MBHP. In addition, a two-day onsite visit was conducted to interview key MBHP personnel, review selected case files, and participate in systems demonstrations. The onsite allowed MBHP to provide clarification of documentation already submitted and to submit additional documentation. At the conclusion of the onsite review, KEPRO conducted a closing conference to provide preliminary feedback on the review team's observations about MBHP's strengths and opportunities for improvement as well as recommendations and next steps.

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

- Met – 1.0 point
Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and MBHP staff interviews provided information consistent with documentation provided.
- Partially Met (Any one of the following may be applicable) – 0.5 points
 - Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. MBHP staff interviews, however, provided information that was not consistent with documentation provided; or

- Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided although MBHP staff interviews provided information consistent with compliance with all requirements; or
- Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided, and MBHP staff interviews provided information inconsistent with compliance with all requirements.
- Not Met – 0 points
There was an absence of documentation to substantiate compliance with any of regulatory or contractual requirements and MBHP staff did not provide information to support compliance with requirements.

An overall percentage compliance score for each of the 14 standards was calculated based on the total points scored divided by total possible points. In addition, an overall percentage compliance score for all fourteen standards combined was calculated. For each area identified as Partially Met or Not Met, MBHP 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 reviewed the NCQA 2016 managed behavioral health organization accreditation standards 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 considered deemed, KEPRO evaluated MBHP's most current accreditation review and scored the review element as "Met" if MBHP scored 100 percent on the accreditation review element.

COMPLIANCE VALIDATION ANALYSIS

The graph that follows depicts the compliance scores for MBHP:

Exhibit 24: Compliance Scores Received by MBHP

Compliance Review Elements	MBHP
Enrollee Rights and Protections	6/6
Enrollee Information	22.5/23
Availability and Accessibility of Services	15.5/17
Coordination and Continuity of Care	29/29
Coverage and Authorization of Services	23.5/24
Practice Guidelines	7/7
Enrollment and Disenrollment	4/4
Grievance System	27/28
Sub-contractual Relationships and Delegation	4/4
Quality Assessment and Performance Improvement Program	22.5/23
Credentialing	10.5/11
Confidentiality of Health Information	6/7
Health Information Systems	3/3
Program Integrity	10/10
Total Received/Possible	190.5/196
Score Calculated as Percentage	97.24%

Overall, MBHP demonstrated compliance with most of the federal and State contractual standards for its delegated functions for the PCC Plan. MBHP was fully compliant with Enrollee Rights and Protections, Coordination and Continuity of Care, Practice Guidelines, Enrollment and Disenrollment, Sub-contractual Relationships and Delegations, Health Information Systems, and Program Integrity standards.

KEPRO noted the relationship between MBHP and the PCC Plan as a strength for providing behavioral health services to some of the most vulnerable of the Medicaid-eligible population, such as those with Serious and Persistent Mental Illness. KEPRO found this model to be a best practice for the integration of physical and behavioral health services.

While MBHP was compliant with most areas, KEPRO identified some areas for future consideration. The review revealed that the PCC Plan was responsible for the member handbook used for PCC members, which included behavioral health services provided by MBHP. KEPRO recommends that the PCC plan consider a process to provide MBHP an opportunity to review and provide input on the member handbook as it relates to behavioral health services. Additionally, the PPC Plan delegates the requirement for MBHP to conduct welcome calls to members. The compliance review revealed that while MBHP was compliant with performing the welcome calls, the engagement rate was extremely low with results of less than 15 percent. KEPRO recommends that the PCC Plan and MBHP consider conducting a cost-benefit analysis of this activity and determine whether an alternative strategy may be

indicated. KEPRO also recommends that the PCC Plan review the MBHP contract language related to non-network providers in Section 3.1.F.3., which includes the assurance that non-network provider agreements include provisions noted in Section 3.1.C.4. KEPRO believes the reference to 3.1.C.4 should be 3.1.5.C; however, this section refers to network providers and all requirements may not be appropriate for non-network providers.

MBHP COMPLIANCE VALIDATION RESULTS

KEPRO provides a detailed description of strengths, findings, recommendations, and score for each of the 14 standards reviewed in the following tables for MBHP. KEPRO reviewed all documents that were submitted in support of the compliance validation process. In addition, KEPRO conducted a site visit on August 23 – 24, 2017.

Enrollee Rights & Protections

Strengths	<ul style="list-style-type: none"> ▪ MBHP had a good process for ensuring contractual requirements related to restraint and seclusion including information in the provider manual; a process to review provider policies and procedures during credentialing and recredentialing review; and a process for monitoring any member or provider complaints. ▪ MBHP’s process included cross-communication between departments related to any violation of member right infringement to fully investigate and resolve issues.
Findings	MBHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollee Information

Strengths	<ul style="list-style-type: none"> ▪ MBHP had adequate processes in place to meet the cultural and linguistic needs of its membership.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ While MBHP demonstrated that it conducted welcome calls to new members during 2016 and received reports from its vendor on a regular basis, MBHP did not have a report that clearly demonstrated performance for its adherence rate for providing the orientation to enrollees within 30 calendar days of the initial date of enrollment.
Recommendations	<ul style="list-style-type: none"> ▪ MBHP needs to implement a process to formally report its adherence rate for providing enrollee orientation within 30 calendar days of the initial date of enrollment.

Availability and Accessibility of Services

Strengths	<ul style="list-style-type: none"> ▪ MBHP’s provider application material was comprehensive and its development plan process for working with providers to address deficiencies was strong. ▪ MBHP’s single case agreement process for out-of-network providers was very comprehensive. ▪ MBHP’s waitlist management processes for youth was impressive.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ While MBHP has a robust system for ensuring access to covered services, no evidence of tracking other intensive home- and community-based services was provided. ▪ MBHP’s Monthly Access Report Instructions to providers indicated that urgent care must be available within three days instead of the required 48 hours. ▪ While MBHP has a robust waiting list management system in place for youth, no evidence of waiting list monitoring and management for adults was provided.
Recommendations	<ul style="list-style-type: none"> ▪ Like the other required services, MBHP should monitor intensive home- and community-based services for children and adults to ensure access in all cities and towns in the Commonwealth. ▪ MBHP should update instructions to providers to include the required 48-hour timeframe for urgent care. ▪ MBHP should implement a system to monitor and manage waiting lists for the adult population.

Coordination and Continuity of Care

Strengths	<ul style="list-style-type: none"> ▪ MBHP had its utilization management and care management activities housed within the same system. ▪ MBHP had good processes to integrate physical and behavioral health. ▪ MBHP had documented processes to support its management of members transitioning between care settings with notice and inclusion of the member’s care manager.
Findings	MBHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Coverage and Authorization of Services

Strengths	<ul style="list-style-type: none"> ▪ MBHP demonstrated good congruence between its operational practices and its written policies and procedures. ▪ MBHP’s interactive voice response system was noted as a good tool for providers, reducing administrative burden for them as well as internal staff members. ▪ MBHP had good evidence of strong collaboration with requesting providers to ensure clarity on the services requested and in determining the appropriate level of care for members. This included front-line reviewers as well as medical directors. ▪ KEPRO noted the Emergency Services Program (ESP) is a best practice resource for members, families, and emergency personnel.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ During the onsite denial file review, it was difficult to ascertain the actual date of receipt of the authorization request. The receipt of authorization request date in the case file was manually entered and did not always reflect the date of receipt of the faxed request. Additionally, if the provider attempted to use the IVR system, it appeared that the IVR attempt date was captured as the initial start of the case.
Recommendations	<ul style="list-style-type: none"> ▪ MBHP should consider exploring systematic options for populating the receipt of request fields and the end date of the case when possible. In addition, MBHP should include verification of received date for manual entries within the scope of case audits, to support accuracy in both monitoring and reporting of turnaround times.

Practice Guidelines

Strengths	<ul style="list-style-type: none"> ▪ MBHP had member-friendly versions of the clinical practice guidelines for dissemination to providers for their use with members, which served as a way to enhance provider-member interaction and discussion. ▪ MBHP had robust provider profiling and initiatives related to payment.
Findings	MBHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollment and Disenrollment

Strengths	MBHP was fully compliant with this standard.
Findings	MBHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Grievance System

Strengths	<ul style="list-style-type: none"> ▪ MBHP grievance policies and procedures contained the required language and timeframes. ▪ MBHP demonstrated excellent documentation in its grievance system regarding the steps MBHP took to resolve member concerns. KEPRO found evidence of MBHP helping members access care if there was a concern or unacceptable wait time. ▪ MBHP met timeliness standards for appeals as noted as part of the onsite file review.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ A review of the grievance system and a review of 10 grievance files showed that MBHP lacked a process to ensure the capture and date and time of grievance receipt. During 2016, MBHP was using the date an email was received by the Quality Department as opposed to the actual grievance receipt date. Additionally, the form used by the internal team did not differentiate between oral and written grievances. ▪ MBHP's appeal policy lacked language regarding the circumstances under which a member may request the continuation of benefit if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
Recommendations	<ul style="list-style-type: none"> ▪ MBHP should develop a process to ensure that date and time of the member grievance is captured and used as the start for resolution. In addition, MBHP should update its grievance form to include a designation for oral as opposed to written grievances. ▪ While MBHP does not typically terminate, suspend, or reduce a previously authorized service, MBHP needs to update its policy to include the federal language as well as ensure staff are trained on the revision.

Subcontractual Relationships and Delegation

Strengths	MBHP was fully compliant with this standard.
Findings	MBHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Quality Assessment and Performance Improvement Program

Strengths	<ul style="list-style-type: none"> ▪ MBHP had an interdepartmental Quality Operations Committee that met weekly, which allowed for ongoing, consistent focus on quality and quality initiatives throughout the organization. ▪ MBHP had interdepartmental teams for each of its quality improvement projects that met weekly. KEPRO identified this is a best practice for facilitating effective implementation of initiatives. ▪ MBHP held quarterly trainings for Network Management staff on quality initiatives and HEDIS measures to promote better and more effective provider engagement in initiatives. ▪ MBHP’s Substance Abuse Care Coordination Project allowed for the facilitation of goal development and initiative implementation with providers. ▪ MBHP’s annual integration meeting included the sharing of best practices for improving coordination between behavioral health and primary care.
Findings	<p>Partially Met:</p> <ul style="list-style-type: none"> ▪ While MBHP’s care management enrollee survey provided some feedback on the effectiveness of treatment services, no evidence of employing standard measures of symptom reduction and management and measures of functional status and recovery were included in the Quality Management Plan.
Recommendations	<ul style="list-style-type: none"> ▪ MBHP should update the Quality Management Plan to include the use of standard measures of symptom reduction and management as well as measures of functional status and recovery.

Credentialing

Strengths	<ul style="list-style-type: none">▪ MBHP had strong quality assurance processes.▪ MBHP's process to ensure non-payment for excluded and suspended providers was comprehensive.
Findings	Partially Met: <ul style="list-style-type: none">▪ MBHP's Emergency Termination policy did not include the requirement to notify a network provider of termination from the network within three business days if the provider is terminated or suspended from MassHealth, Medicare, or another state's Medicaid program.
Recommendations	<ul style="list-style-type: none">▪ MBHP should update the Emergency Termination policy to include the three- business day notice to provider requirement.

Confidentiality of Health Information

Strengths	<ul style="list-style-type: none">▪ MBHP's policies and procedures were comprehensive.
Findings	Not Met: <ul style="list-style-type: none">▪ MBHP did not provide documentation that outlined compliance with EOHHS requests to make amendments to Personal Information or required notification to EOHHS relative to an individual's request to amend Personal Information.
Recommendations	<ul style="list-style-type: none">▪ MBHP should update the appropriate policy to include the MBHP's responsibilities relative to an individual's request to amend Personal Information.

Health Information Systems

Strengths	<ul style="list-style-type: none">▪ MBHP demonstrated comprehensive utilization reporting, which attests to the strength of MBHP's claims production system and the analytics and reporting teams.▪ MBHP collected a significant amount of relevant provider data that was important for ensuring member access to appropriate services.
Findings	MBHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Program Integrity

Strengths	<ul style="list-style-type: none">▪ MBHP had good processes to detect fraud, waste, and abuse (FWA), which included having a Special Investigations Unit and FWA analyst co-located with claims process to address questions and identify possible referrals for investigation.
Findings	MBHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

NEXT STEPS

MassHealth required MBHP to submit Corrective Action Plans (CAPs) for all Partially Met and Not Met elements identified in the course of the 2017 Compliance Review. MassHealth will evaluate the CAPs and either approve or request additional documentation. KEPRO will evaluate actions taken to address recommendations in the next EQR report and will conduct a comprehensive review again in 2020.