MassHealth Managed Care Quality Strategy

2005-2006

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Appendices

Section I. PURPOSE OF STRATEGY

MassHealth, the Medicaid Program of the Commonwealth of Massachusetts, provides managed care services to eligible enrollees through its Managed Care Organization (MCO) Program, Primary Care Clinician (PCC) Plan, and the PCC Plan's associated contracted behavioral health plan, and Senior Care Options (SCO). All MassHealth enrollees, except those over age 65, those who are dually eligible for Medicare, those with comprehensive third party insurance, and those who are institutionalized are required to choose one of the State's managed care options. Persons over age 65, who may or may not be dually eligible for Medicare, may voluntarily choose to enroll in SCO. MassHealth, through its BH Program (BH Program), currently contracts with the Massachusetts Behavioral Health Partnership (MBHP) for behavioral health care for PCC Plan enrollees. MBHP is considered a Prepaid Inpatient Health Plan (PIHP) under Balanced Budget Amendment (BBA) regulations.

The MassHealth Managed Care Quality Strategy (Strategy) was developed at the direction of the Executive Office of Health and Human Services (EOHHS). The Strategy incorporates the efforts and activities of several entities that serve enrollees in the Massachusetts Medicaid Program.[1]

A. *Strategy Vision and Values*

The vision and values are intended to guide present and future priority setting as well as further Strategy development. The vision represents a view of the outcomes to be achieved through implementation of the Strategy. The values express fundamental principles embodied by the Strategy. The vision and values are intended to endure through several years of Strategy implementation.

Strategy Vision:

> To ensure that the health services provided to MassHealth enrollees are accessible, coordinated, of high clinical quality, and lead to desired enrollee outcomes, in terms of health, functional status and enrollee satisfaction.

Strategy Values:

- Promote a positive impact on enrollee health to the greatest extent possible

[1] At present, the following units within the Massachusetts EOHHS coordinate and/or provide services to Medicaid enrollees:

- Office of Acute and Ambulatory Care, under which the MCO Program and PCC Plan are administered
- Office of Elder Affairs, under which the SCO Program is administered
- Department of Mental Health, under which the MassHealth BH Program is administered
- Department of Public Health
- Department of Youth Services
- Department of Social Services
- Department of Mental Retardation

- Enhance enrollee experiences with health care services
- Improve service delivery, especially with respect to inclusiveness, equity and fairness
- Increase enrollee access to care
- Support inter-program collaboration at the State level

The Strategy values embody key elements from definitions of quality developed by leading national organizations:

- Doing the right thing at the right time in the right way for the right person, and having the best possible results. (AHRQ)[2]
- The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. (Institute of Medicine)[3]

The Strategy links the values with domains of quality, including clinical quality (effectiveness, timeliness, and safety), member experience, coordination of care, and access, to guide the processes of measurement and improvement as described below.

B. *Objectives of the FY 2006 Quality Strategy*

Specific goals of the Strategy will be revisited periodically and updated as needed. Objectives for the FY2006 Strategy include:

- Set forth BBA and EOHHS standards for ensuring quality, as well as State activities related to these standards
- Present reporting requirements for assessing compliance with BBA and EOHHS standards
- Embody in all aspects of the Strategy, the values articulated above

Section II. SCOPE OF STRATEGY

This Strategy covers the time period beginning July 1, 2005, and focuses on compliance with the Balanced Budget Amendment (BBA) requirements of 42 CFR 438. July 1, 2005 marks the date by which the State must come into compliance with the BBA for its managed care programs serving persons under 65 years of age. Prior to July 1, 2005, the Massachusetts Medicaid Program operated under an 1115 waiver and its quality activities were grandfathered under the waiver. Because the SCO is a new program, and will not complete its first full 12-month contract year until December 31, 2005, CMS has agreed that the SCO Program does not need to become fully compliant with the BBA until July 1, 2006.

The managed care entities subject to the provisions of this Strategy include:

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[2] http://www.ahrq.gov/consumer/qntascii/qntqlook.htm. Accessed February 26, 2005

[3] Institute of Medicine (IOM) (1990). Medicare: A Strategy for Quality Assurance. K. N. Lohr. Washington, D.C., National Academy Press. Volume 1, p.21.

- Contracted managed care organizations (MCOs): Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Network Health, and Neighborhood Health Plan
- Contracted BH provider: Massachusetts Behavioral Health Partnership (MBHP) for PCC Plan enrollees
- Contracted Senior Care Organizations (SCO): Commonwealth Care Alliance, Evercare Massachusetts, Senior Whole Health

The term managed care entity, used throughout this document, refers to the above entities.

While the PCC Plan, as a primary care case management (PCCM) program, is not subject to the BBA provisions, it is supporting and participating in many of the activities presented in this Strategy to promote a coordinated approach to quality for MassHealth enrollees. Specific PCC Plan activities that relate to the BBA requirements are described throughout this document.

Section III. QUALITY STRATEGY DEVELOPMENT

This Strategy was developed with input from multiple stakeholders, subject to a public comment period, and will be updated routinely (see section IV.C: Monitoring and Oversight).

The initial Strategy was drafted by a workgroup comprised of State staff familiar with managed care contractual and programmatic activities and facilitated by an outside consultant. The staff represented the Office of Acute and Ambulatory Care, the Office of Medicaid, the Office of Elder Affairs, and the Department of Mental Health. After internal review by the executive staff of the offices and departments listed above, the Strategy was made available to external stakeholders including the managed care community, providers, consumer advocates and MassHealth enrollees through a posting of a draft of the document on the MassHealth web site and published notice in the Massachusetts Register.

Section IV. QUALITY STRATEGY ELEMENTS

A. *Overview*

The Strategy is based on fundamental principles of quality management: planning, monitoring, improvement and evaluation. The standards presented address structures and procedures necessary to ensure that quality care is delivered to MassHealth enrollees. The standards form the foundation for current and future delivery of services.

This Strategy has been divided into sections that address contractual standards and quality elements, as specified by the BBA.

Section IV.B addresses contractual standards pertaining to access, structure and operations, and quality measurement and improvement.

Section IV.C describes monitoring and oversight activities related to quality, including the BBA mandated EQRO activities.

Section IV.D describes provisions for intermediate sanctions for non-performance

Each section presents a specific standard, outlines responsibilities of each managed care entity and the State in relation to the standard, and details the reporting requirements associated with the standard. In addition, Appendix 1 presents, in tabular format, the standards and their associated reporting requirements.

B. *Standards for Access, Structure, Operations, and Quality Monitoring and Improvement*

Section 42 CFR 438.200 - 438.242, Subpart D reinforces the importance of planning for quality care, taking into account access, structure and operations, and measurement and improvement. Subpart D sets forth minimum standards for managed care entities and the State, addressing each of the above areas in three sections: Access (438.206-438.210), Structure and Operations (438.214-438.230), and Measurement and Improvement (438.236-438.242). Each of these sections consists of multiple components as delineated in the following table.

Table 1: BBA Quality Standards

B1. Access Standards

42 CFR 438.206 Availability of services
42 CFR 438.207 Assurances of adequate capacity and services
42 CFR 438.208 Coordination and continuity of care
42 CFR 438.210 Coverage and authorization of services

B2. Structure and Operational Standards

42 CFR 438.214 Provider selection
42 CFR 438.218 Enrollee information
42 CFR 438.224 Confidentiality
42 CFR 438.226 Enrollment and disenrollment
42 CFR 438.228 Grievance systems
42 CFR 438.230 Subcontractual relationships and delegation

B3. Measurement and Improvement Standards

42 CFR 438.236 Practice guidelines
42 CFR 438.240 Quality assessment and performance improvement program
42 CFR 438.242 Health information systems

B1. Access Standards

Access to care is defined as the ease with which needed health care services can be obtained.[4] Without access, an individual lacks the opportunity to receive clinically appropriate or effective care. Domains of access include:

- Geographic access

[4] Agency for Health Care Policy and Research (1995). Using Clinical Practice Guidelines to Evaluate Quality of Care. Rockville, MD, Agency for Health Care Policy and Research.

- Organizational access – including timeliness
- Equitable access – including culturally and linguistically appropriate access
- Financial access

The MassHealth Managed Care Quality Strategy explicitly addresses the first three domains; the fourth domain is addressed by the MassHealth eligibility requirements.

B1.a 42 CFR 438.206 - Availability of services

These standards ensure that services covered under contracts are available and accessible to enrollees, and address geographic, organizational and equitable access.

Managed Care Entity Responsibilities

Delivery networks

Each managed care entity must maintain and monitor a network of providers that is supported by written agreements and sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each entity must take into account the following:

- Anticipated MassHealth enrollment
- Expected use of services by enrollees, considering the characteristics and health care needs of specific MassHealth enrollee populations
- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish contracted services
- Numbers of network providers who are not accepting new MassHealth patients
- Geographic location of providers and MassHealth managed care enrollees, considering distance, travel time and modes of transportation typically used by MassHealth managed care enrollees, and whether the location provides physical access for MassHealth enrollees with disabilities

Each managed care entity must provide female enrollees with direct access to a women's health specialist within the network to provide covered women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

Each managed care entity also must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.

Each managed care entity must adequately cover, in a timely manner, necessary services, covered under the contract, if its network is unable to provide these services.

The PCC Plan monitors delivery networks through its semiannual Provider Capacity Report. This Report gives a snapshot of MassHealth enrollment and includes information on the PCC Plan and unenrolled populations by service area.

Timely access

In addition to delivery system structure and organization, timeliness of services is central to provision of accessible care. Each managed care entity must:

- Ensure that providers give timely access to care and services, taking into account the urgency of the need for services
- Ensure that network providers offer hours of operation that are no less than those offered to commercial enrollees (or comparable to MassHealth fee-for-service if a provider serves only MassHealth enrollees)
- Make services included in the contract available 24 hours a day, 7 days a week when medically necessary
- Monitor providers for compliance with the above standards regularly and take corrective action if there is failure to comply

The PCC Plan and MCOs have collaborated to create and implement a survey to monitor waiting time and availability of specific services at Primary Care Sites on a regular basis.

Cultural considerations

This standard seeks to promote the delivery of services in a culturally competent manner, and thus address any barriers to access that arise from an individual's cultural circumstances. Each managed care entity must:

- Ensure availability of multi-lingual providers and skilled medical interpreters for the commonly used languages in each region
- Make written information available in prevalent languages, as determined by the State, to enrollees and potential enrollees
  - EOHHS defines prevalent languages as those spoken by 5% or more of MassHealth enrollees. Through analyses of MassHealth data, State-wide and by EOHHS region (Boston, Metro West, Central MA, Western MA, Northeastern MA and Southeastern MA), EOHHS identified Spanish and English as the prevalent languages in which written information must be made available
- Make available, free of charge, oral interpretation services in all non-English languages to assist enrollees with interpretation of all written materials provided to potential enrollees and enrollees
- Participate in any State efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural backgrounds

State Activities

EOHHS, including the MCO Program, SCO, BH Program, and the PCC Plan, makes all written materials that it distributes available in prevalent languages, per the above definition applicable to managed care entities.

The Massachusetts legislature established a special Commission on Health Disparities in 2004. The Commission includes the Secretary of EOHHS, the Medicaid Director, and the Commissioner of the Department of Public Health (DPH). The State legislation identified several areas on which the Commission will focus, including breast, cervical, prostate, and colorectal cancers, stroke and heart attack, diabetes, infant mortality, HIV/AIDS, and asthma and other respiratory illnesses. To date, the Commission has been meeting and has created four subgroups focusing on: Social Context (Inequities and Environment), Access to Care, Health Care Service Delivery, and Workforce Development/Diversity. The activities of the Commission may provide future direction to the MassHealth program regarding ways to improve equitable access.

B1.b 42 CFR 438.207 – Assurances of adequate capacity and services

This standard specifies how compliance with 438.206 should be monitored. Managed care entities must assure the State (and codify through their contracts with the State) that they have the capacity to serve the expected enrollment in their service areas, in accordance with the State's standards for access to care, and must provide supporting documentation that demonstrates that they have such capacity.

Reporting requirements for this standard

Appendix 1 details the reports required by each managed care program to address this standard.

B1.c 42 CFR 438.208 - Coordination and continuity of care

Modern health care delivery systems are multi-faceted and involve complex interactions between many providers. Such delivery systems require coordination across the continuum of care. This standard requires managed care entities to implement procedures to deliver primary care to and coordinate health care services for all enrollees.

Managed Care Entity Responsibilities

Primary care coordination

Each managed care entity must ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care delivered to the enrollee.

Members with special health care needs

Each managed care entity must have mechanisms in place to assess enrollees identified as having special health care needs. For each enrollee that the managed care entity confirms as having special health care needs, the individual's need for ongoing treatment and monitoring must be determined. In addition, for those determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each managed care entity must have a mechanism in place to allow such enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

In identifying enrollees with special health care needs, managed care entities may rely on information shared by the State. This includes Categories of Assistance, such as SSI

disabled only, to which enrollees are assigned by MassHealth, as well as information provided by other State agencies.[5]

MCO Program Activities. MCO contracts define individuals with special health care needs so that MCOs may identify such enrollees through information contained in Health Risk Assessments[6], claims data review, or any other available data source. Individuals with special health care needs are defined, at a minimum, as those:

a) Who have, or are at increased risk to have chronic physical, developmental, or behavioral health condition(s)
b) Who require an amount or type of services beyond that typically required for individuals of similar age; and/or
c) Who may receive these services from an array of public and/or private providers across health, education and social systems of care

MCOs are required to provide care management services to enrollees identified in accordance with the above and who are determined to be able to benefit from components of Care Management, as specified in contracts, except to the extent that enrollees are unwilling or unable to receive such services.

With respect to direct access to specialists, MCO contracts require that this benefit extend beyond those identified with special health care needs to all enrollees determined through an assessment by appropriate health care professionals to need a course of treatment requiring access to a specialist or regular care monitoring by a specialist.

SCO Program Activities. Upon enrollment in the SCO Program, individuals are assessed for Complex Care Needs. The SCO program defines complex care needs as any condition or situation that demonstrates the need for expert coordination of multiple services including, but not limited to:

a) Clinical eligibility for institutional long term care; and

b) Medical illness, psychiatric illness, or cognitive impairment that requires skilled nursing to manage essential unskilled services and care.

Individuals who are determined to have Complex Care Needs in the SCO program are reassessed at least quarterly for continuing care needs.

BH Program Activities. The BH Program identifies individuals who may benefit from care management through clinical review, review of utilization of BH

[5] Identification of enrollees receiving services from DMH, DYS, and DSS

[6] The Health Risk Assessment is a form developed and administered by MCOs upon member enrollment as one means of identifying members with special health care needs or social circumstances who may benefit from particular courses of treatment or care management

services, and review of utilization of selected medical services (such as the Emergency Department). In addition, members may be self-referred or referred by a provider, family member, or member of the community. Referrals are reviewed by a clinician to determine whether care management would be beneficial, and if so, the level of care management that would be appropriate.

Activities specific to the PCC Plan. Two PCC Plan programs address the special needs of members with complex conditions. The Essential Care program focuses on a subset of members with Essential Coverage and provides them with field-based care management. The PCC Plan Site-Based Care Management Pilot program offers care coordination and management to PCC Plan members that meet certain clinical criteria. In addition, all members receiving care coordination through the care management programs offered by the BH Program are PCC Plan-enrolled members.

Reporting requirements for this standard

Appendix 1 details the reports required by each managed care program to address this standard.

B1.d 42 CFR 438.210 - Coverage and authorization of services

This standard lays out the minimum benefit package to be provided to all MassHealth enrollees.

Managed Care Entity Responsibilities

Coverage

Each managed care entity must specify the amount, duration, and scope of each covered service. Services may be no less than the amount, duration, and scope for the same services furnished to beneficiaries under MassHealth fee-for-service, may not be compromised solely because of diagnosis, type of illness, or condition of an enrollee, and must be rendered in accordance with the medical necessity standard. All MassHealth managed care programs operate under the same definition of medical necessity as MassHealth fee-for-service.

Authorization of services

Each managed care entity must have in place and implement written policies and procedures for processing requests for authorizations of services. Authorization decisions must be based on consistently applied review criteria and consultation with requesting providers, when appropriate, and must be conducted in a timely fashion as required by regulation and contract.

The PCC Plan follows MassHealth processes for accepting and responding in a timely manner to requests for Prior Authorization of services that require such authorization.

Notice of adverse decisions and timing of such decisions

Denials, reductions, terminations and modifications of services must be made by a health professional who has appropriate clinical expertise in treating the enrollee's condition or disease, and must notify the requesting provider and enrollee in a timely manner, as codified in entity contracts, suitable to the urgency of the enrollee's condition.

Reporting requirements for this standard

Appendix 1 details the reports required by each managed care program to address this standard.

B2. Structure and Operational Standards

The standards in this section address essential MassHealth structural and operational activities to support high quality clinical and administrative service delivery, access, and appropriate handling of information.

B2.a 42 CFR 438.214 - Provider selection

Service delivery by appropriately qualified individuals promotes patient safety and thus represents one essential structural component of a high quality delivery system. This standard ensures that managed care entities implement written policies and procedures for the selection and retention of providers.

Managed Care Entity Responsibilities

Credentialing

Each managed care entity must establish documented processes to credential and recredential providers with whom it has signed contracts or participation agreements.

The State requires all managed care entities to adhere to a uniform credentialing and recredentialing policy, attached as Appendix 3. The State's policy requires that the scope and structure of the processes for credentialing, at a minimum, be consistent with recognized industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant State regulations, including regulations issued by the Board of Registration of Medicine at 243 CMR 3.13.

In addition, the MCO Program requires that a site visit be conducted of PCPs before they provide services to members, and the BH Program requires that such a site visit be conducted of network providers before they provide services.

The PCC Plan performs credentialing through a credentialing review process, for which specific criteria are applied.

Nondiscrimination

Managed care entities, in establishing contractual relationships with providers, may not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Excluded providers

Managed care entities may not contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act (42 U.S.C. 1320a-7). In addition, managed care entities may not authorize any providers terminated or suspended from MassHealth to treat enrollees and must deny payment to such providers. This does not preclude managed care entities from terminating or suspending providers for cause prior to action by MassHealth. Each

managed care entity is responsible for providing timely notification to enrollees when a provider has been terminated or suspended.

State Activities

With respect to excluded providers, the State conducts regular MassHealth Provider Review Committee meetings. Representatives of the MCO Program, BH Program, and PCC Plan attend these meetings and notify affected entities when MassHealth suspends or terminates a provider.

Reporting requirements for this standard

The MCO Program requires MCOs to provide their credentialing policies and procedures annually and certify that providers are credentialed in accordance with the uniform credentialing policy. All three Programs require notification from managed care entities of changes to the provider network (see Appendix 1).

B2.b 42 CFR 438.218 - Enrollee information

Good communication enhances access to care, appropriate use of services, and satisfaction. This standard delineates requirements for communicating with enrollees and potential enrollees.

Managed Care Entity Responsibilities

Each managed care entity must provide all enrollee notices, information materials and instructional material in a manner and format that may be easily understood, in accordance with 42 CFR 438.10. This includes ensuring capacity to meet the needs of non-English linguistic groups in their service areas (see Section B1.a: Availability of Services; *Cultural Considerations*) and making available materials in alternative formats upon request.

On an annual basis, managed care entities must provide enrollees with notice of their right to request and obtain information on the various items required in 42 CFR 438.10(f).

In addition, managed care entities must provide enrollees with 30-day prior written notification of any significant changes, including changes to enrollee cost sharing and benefits. Managed care entities must make a good faith effort to provide written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by the terminated provider. The PCC Plan also requires the notice provisions specified in this paragraph.

State Activities

The State or its enrollment broker provides all enrollment notices, information materials and instructional material to enrollees and potential enrollees in a manner and format that may be easily understood, in accordance with 42 CFR 438.10. In doing so, EOHHS, including the MCO Program, SCO, BH Program, and the PCC Plan, makes all written materials available in prevalent languages (see Section B1.a: Availability of Services; *Cultural Considerations*). Materials are designed to assist enrollees and potential enrollees in understanding MassHealth managed care programs, addressing program features including benefits, cost sharing, service areas, provider network characteristics, and policies and procedures concerning enrollee rights and protections.

On an annual basis, and upon enrollee request, EOHHS provides enrollees with the following information in a comparative, chart-like format: service areas of the managed care entities, benefits covered, any cost sharing imposed, and to the extent available, quality and performance indicators, including enrollee satisfaction. In addition, on an annual basis, EOHHS provides enrollees with information on their right to transfer at any time between plans for which they are eligible.

B2.c 42 CFR 438.224 - Confidentiality

This standard requires that managed care entities and the State take appropriate steps to safeguard personal health information.

Managed Care Entity Responsibilities

Managed care entities may use and disclose individually identifiable health information only if done in a manner that is in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. Privacy requirements apply to the PCC Plan as well.

State Activities

In accordance with the confidentiality requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), MassHealth operates a Privacy and Security Office to ensure compliance with the HIPAA Privacy and Security requirements.

B2.d 42 CFR 438.226 - Enrollment and disenrollment

This standard outlines requirements for the enrollment and disenrollment procedures of managed care entities.

Managed Care Entity Responsibilities

In accordance with 42 CFR 438.56, each managed care entity must follow certain specified procedures for enrollment and disenrollment of members (voluntary as well as involuntary). Managed care entities may not disenroll an individual because of any of the following: an adverse change in the enrollee's health status, utilization patterns, or behavior related to special needs. In addition, managed care entities must accept all persons who voluntarily enroll or are assigned to their plan. Members may switch health plans at any time without cause.

The PCC Plan manages PCC requests for member disenrollment, and applies criteria to such requests, to ensure that members are not disenrolled for prohibited reasons.

Reporting requirements for this standard

Appendix 1 details the reports required by each managed care program to address this standard.[7]

[7] BH Program members are enrolled through the PCC Plan and thus enrollment data are maintained by the PCC Plan.

B2.e 42 CFR 438.228 - Grievance systems

This standard seeks to ensure that enrollees are granted and understand mechanisms that allow them to file a grievance concerning managed care programs or processes.

Managed Care Entity Responsibilities

Each managed care entity must establish internal processes that allow enrollees the right to file a grievance about medical services and to appeal and request a fair hearing as the result of any adverse action or inaction taken by the entity. Each managed care entity also must notify enrollees of grievance and appeals processes and decisions in a timely manner.

State Activities

Once the first level of the managed care entity internal appeals process has been exhausted (when required), the State permits enrollees to request and obtain a State fair hearing, as detailed in MassHealth regulations.

The PCC Plan follows the MassHealth regulations for fair hearings. The information on fair hearings includes a general description, statement of processes, and method for the hearing. MassHealth Member Services provides a system of tracking and maintaining member grievances for the PCC Plan.

Reporting requirements for this standard

Appendix 1 details the reports required by each managed care program to address this standard.

B2.f 42 CFR 438.230 - Subcontractual relationships and delegation

Managed care entities typically contract with many different providers and vendors of services to deliver the full package of services to enrollees. These standards ensure that managed care entities are accountable for the actions and performance of any subcontractor.

Managed Care Entity Responsibilities

Each managed care entity must oversee and remain accountable for any functions and responsibilities that are delegated to subcontractors. This entails ongoing monitoring and formal review of subcontractor performance, and corrective action, given identification of deficiencies or areas for improvement.

Reporting requirements for this standard

Appendix 1 details the reports required by each managed care program to address this standard.

B3. Measurement and Improvement Standards

Continuous monitoring and improvement activities are central to any quality strategy, and must include:

- Identifying current levels of quality
- Identifying areas for improvement
- Designing interventions to achieve improvement

- Charting progress towards quality goals

The standards in this section address MassHealth managed care quality measurement and improvement activities.

B3.a 42 CFR 438.236 - Practice guidelines

This standard promotes the implementation of evidence-informed practice through the dissemination and use of practice guidelines.

Managed Care Entity Responsibilities

Managed care entities are responsible for adopting, disseminating and using clinical practice guidelines. The guidelines must be based on reliable and valid clinical evidence or consensus of health care professionals in the relevant field, appropriate to the needs of managed care enrollees, and adopted in consultation with health care professionals. In addition, managed care entities must develop explicit processes for monitoring adherence to guidelines, including ensuring that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. Managed care entities also must establish processes for reviewing and updating guidelines.

Guidelines that MassHealth endorses include, but are not limited to, the following:

- Massachusetts Department of Public Health Guidelines for Adult Diabetes Care
- Massachusetts Health Quality Partners Guidelines for Adult and Child Preventive Care
- National Heart, Lung and Blood Institute (NHLBI) Asthma Guidelines
- Massachusetts Health Quality Partners Guidelines for Perinatal Preventive Care

Managed care entities are expected to use these guidelines, as appropriate, for their members. The PCC Plan has adopted these guidelines, and uses them in creating PCC performance measures.

State Activities

During 2005, the Massachusetts Department of Public Health will be revising the Adult Diabetes Guidelines. Massachusetts Health Quality Partners is updating the Adult and Child Preventive Care Guidelines in 2005 as well.

Reporting requirements for this standard

MCOs are not required to report on which guidelines are adopted or the extent of adherence to guidelines. For the MCO Program, however, 2005-2006 Asthma and Diabetes QI goals specify that improvement interventions be consistent with the NHLBI Asthma Guidelines and Massachusetts Adult Diabetes Guidelines, respectively.

B3.b 42 CFR 438.240 -- Quality assessment and performance improvement program

These standards address measurement and improvement requirements for managed care entities.

Managed Care Entity Responsibilities

Utilization of services.

Each managed care entity must have mechanisms to detect underutilization and overutilization of services, and must ensure that such mechanisms do not provide incentives for those responsible for conducting utilization management activities to deny, limit, or discontinue medically necessary services.

The PCC Plan has a process in place to monitor possible over- and under-utilization of services delivered by PCC providers.

Performance measurement.

Measurement identifies current quality levels, opportunities for improvement and progress towards better quality. Managed care entities must measure and report data to the State, or submit data to the State, in accordance with State specifications.

State Activities

The State coordinates MCO, PCC Plan, and BH Program performance measurement activities that focus on access to care, clinical quality, coordination of care, and enrollee experience. These include the annual HEDIS measurement, the biennial member survey and the annual Clinical Topic Review, all described further below.

The annual HEDIS measurement initiative addresses both access and clinical quality. HEDIS measures are selected on a rotating basis with consideration of measure relevance to MassHealth and its stakeholders, as well as actionability. Data are collected by the plans, submitted to an external vendor, and summarized in an annual report.[8]

The biennial member survey assesses member experience, using an external vendor for data collection and production of a report. For the last three survey cycles, the Consumer Assessment of Health Plans (CAHPS) survey has been used to collect information about member experience.

The annual Clinical Topic Review (CTR) focuses on clinical quality and provides an opportunity to target specific areas through medical record reviews. Through collaboration with plans and the State, an external vendor designs the CTR, collects and analyzes the data, and produces a final report. For FY06, the CTR is focusing on health care provided to children aged 0-4.

In addition to the three measurement initiatives described above, the PCC Plan administers the Performance Improvement Management Series (PIMS) programs for PCCs. The principal activity of PIMS is the production of the semiannual PCC Profile Report to assist PCCs in identifying opportunities for quality improvement.

The SCO Program requires senior care organizations to conduct an annual survey of all enrollees to assess access, coordination of care and enrollee experience. In addition,

[8] See Appendix 2 for a list of HEDIS measures to be collected in calendar year 2005 (FY 05 and FY06).

the SCO Program requires the senior care organizations to report annually on the following clinical indicators:

- Preventable hospital admission
- Discharge planning
- Preventive immunization
- Cancer screening
- Disease management
- Management of dementia
- Appropriate use of nursing facilities
- Alcohol abuse prevention and treatment
- Abuse and neglect identification
- Health promotion and wellness

Performance improvement.

Improvement entails design of interventions that focus on identified areas so as to bring about progress. Managed care entities must establish ongoing performance improvement projects that focus on clinical and nonclinical areas and involve the following: measurement of performance using objective quality indicators, implementation of interventions to achieve improvements, evaluation of the effectiveness of interventions, and planning and initiation of activities for sustaining improvement.

The MCO Program requires MCOs to conduct annual performance improvement projects, per State specifications of QI goals and measures. For the FY 2006 QI cycle, QI goals relate to asthma, diabetes, maternal and child health, behavioral health, and care management. MCOs are required to submit mid-cycle and final written reports, addressing progress, barriers, and new knowledge gained for each objective of each goal. In addition, MCOs host presentations on these areas for EOHHS staff at the end of each cycle.

The BH Program requires MBHP to participate in annual Performance Incentive (PI) projects. Recent PI projects have focused on programmatic issues or specific vulnerable populations, and provide a vehicle for interagency and external stakeholder collaborations. Each project has a specified set of deliverables.

Both MBHP and the PCC Plan participate in Profile Improvement Cycles (PICs) for quality improvement. These cycles record and track improvement activities at practice sites as they relate to the Plan-Do-Check-Act Model for improvement. At the PCC level, a Regional Network Manager visits each practice receiving a PCC Profile Report to review findings and develop action plans that support quality improvement activities.

The PCC Plan also conducts special quality improvement projects relating to several of the areas targeted by the MCO Program QI Goals, including asthma, diabetes, and maternal and child health.

In addition, during FY06, MCOs and the PCC Plan, in collaboration with DPH, UMass Medical School, and Argus Communications, are relaunching the Massachusetts Adolescent Anticipatory Guidance Public Awareness Campaign (MAAGPAC), initially

launched in June 2003 to promote preventive healthcare among adolescents through a multi-faceted approach, utilizing the insights of 14-16 year olds.

Reporting requirements

Appendix 1 details the reports required by each managed care program to address this standard.

B3.c 42 CFR 438.242 - Health information systems

These standards address the health information systems required to support quality service delivery.

Managed Care Entity Responsibilities

Each managed care entity must maintain a health information system (or systems) that collects, analyzes, integrates and reports data. The system must collect data on enrollee and provider characteristics and on services furnished to enrollees.

MCOs and MBHP are required to ensure that data received from providers is accurate and complete by:

- Verifying the accuracy and timeliness of reported data
- Screening the data for completeness, logic, and consistency; and
- Collecting service information in standardized formats to the extent feasible and appropriate

State Activities

EOHHS validates encounter data submitted by MCOs and MBHP.

Reporting requirements for this standard

Appendix 1 details the reports required by each managed care program to address this standard.

C. *Monitoring and Oversight*

The standards described above as part of this Strategy represent efforts to set in place efficient plans for quality service delivery. The success of the Strategy requires effective implementation. The next two sections describe how implementation of the Strategy will be measured, monitored and evaluated. Monitoring activities described below will:

(a) Detect potential areas for improvement

(b) Issue early warning of problems

(c) Confirm that the standards are being appropriately implemented

C1. Internal monitoring

EOHHS monitors compliance with this Strategy through routine reporting requirements (see Appendix 1), regular meetings with entities, and ongoing communications as appropriate and necessary.

To ensure that the Strategy continues to embody the vision and values described in Section I, above, the Strategy will undergo review during FY07, following the first year of implementation, by an internal workgroup. At that time, revisions will be made accordingly, and the workgroup will determine frequency of subsequent reviews.

C2. External oversight – 42 CFR 438.310 – 438.370

EOHHS will contract with an External Quality Review Organization (EQRO) to conduct activities mandated by BBA Subpart E of 42 CFR 438, including validation of performance measures and validation of performance improvement projects. Beginning in FY06, the EQRO will validate performance measures reported by managed care entities (including MCOs, MBHP, the PCC Plan, and, as of FY07, SCOs) during the previous year on an annual basis. Beginning in FY07, the EQRO will validate performance improvement projects implemented by managed care entities (including MCOs, MBHP, SCOs) during the previous year on an annual basis (new managed care entities will be subject to validation during year 2 of the new contract). The PCC Plan will participate voluntarily in the performance measurement validation.

Relying on the internal monitoring processes described in Section C1, EOHHS will review compliance of managed care entities with access, structural, and operational standards, as set forth in this Strategy. Beginning in FY08, and at least every three years thereafter, EOHHS will provide information as necessary and appropriate to the EQRO, which will be responsible for compiling and incorporating such information in its technical report, along with results of the above validation activities, in accordance with the third activity mandated by BBA Subpart E of 42 CFR 438.

The above activities will be conducted using protocols that are consistent with the CMS protocols, available at http://www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp[9] [10] The protocols were developed by The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), working with a number of contractors and in consultation with an expert panel comprised of representatives of private accrediting organizations, quality measurement experts, state Medicaid agencies, and advocates for Medicaid beneficiaries.

D. *Use of Intermediate Sanctions-42 CFR 438.700*

EOHHS may apply intermediate sanctions should managed care entities act or fail to act as follows:

- Fail to provide medically necessary services

[9] Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Validating Performance Measures. A protocol for use in Conducting Medicaid External Quality Review Activities," May 1, 2002.

[10] Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Validating Performance Improvement Projects. A protocol for use in Conducting Medicaid External Quality Review Activities," May 1, 2002.

- Impose excess premiums or charges on enrollees
- Discriminate among enrollees on the basis of health status or need for services
- Misrepresent or falsify information submitted to EOHHS or CMS
- Misrepresent or falsify information to enrollees or providers
- Fail to comply with the requirements for physician incentive plans

MCO Program contracts, the MBHP contract, and SCO contracts identify additional circumstances under which sanctions may be imposed:

- Fails to comply with federal or state statutory or regulatory requirements
- Violates restrictions or other requirements regarding marketing materials
- Fails to comply with any corrective action plan required by MassHealth
- Fails to comply with financial solvency requirements
- Fails to comply with the contract

Both the MCO Program and the SCO Program also may impose sanctions if the managed care entity:

- Fails to comply with quality improvement plan requirements

The BH Program may impose sanctions if the managed care entity:

- Fails to comply, as determined from audit findings, with any provision of the contract related to Direct Service Reserve Accounts (DSRAs).

These sanctions may include (per 438.702):

- Civil monetary penalties
- Appointment of a temporary manager
- Suspension of new enrollment
- Suspension of payment

Both MCO and the SCO contracts include the following additional sanctions:

- Disenrollment of enrollees
- Service area limitations

The MBHP contract specifies additional sanctions:

- Withholding of administrative payments
- Withholding of Performance Incentive bonuses
- Adjusting or withholding of Service Compensation Payments
- Adjusting or withholding ECPs or other Capitation Rate payments
- Adjusting or withholding the DMH Administrative Compensation Rate or DMA Administrative Compensation Rate payments and Withholding gain from any risk-sharing arrangement.

Appendix 1: Quality Strategy Reporting Requirements

Strategy Section	Program	Report Title	Description
Availability of Services: Delivery networks BBA Sections: 42 CFR 438.206 - Availability of services 42 CFR 438.207 – Assurances of adequate capacity and services	MCO Program	PCP Proximity Table (this report will terminated in FY07 and replaced by the PCP-Geographic-Access Report)	• Quarterly report of geographic location of PCPs by service area, and open vs. closed PCPs
	MCO Program	PCP Geographic-Access Report	• Semi-annual report of geographic location of adult and pediatric PCPs by service area
	MCO Program	Enrollee-to-PCP Ratio Report	• Semi-annual report of open and closed adult and pediatric PCPs per number of enrollees by Service Area
	MCO Program	Top 5 High Volume Specialist, BH Provider and OB/GYN Geographic-Access Report	• Annual report of geographic access to top 5 high volume specialty types, as defined by EOHHS, BH Providers and OB/GYNs based on utilization
	MCO Program	Enrollee-to-Specialist Ratio Report	• Annual report of number of specialists by specialty type per number of enrollees by Service Area
	MCO Program	Pharmacy Network Geographic-Access Report	• Annual report of pharmacy network by service area
	MCO Program	Significant Changes in Provider Network Report	• Quarterly report of significant changes in provider network
	SCO Program	Report of members of Provider Network by Zip Code and capacity for accepting new enrollees	• Annual report of the number of PCPs and those with closed practices • Upon event: Provider network changes must be reported to State and CMS within 5 business days
	BH Program	Provider Network Semiannual Report	• Semiannual report of provider sites, credentials and covered services
	BH Program	Provider Changes Report	• Quarterly report of network changes
	BH Program	Provider Expertise/Specialty Report	• Annual report listing providers and their areas of expertise
	BH Program	Emergency Services Program Activity	• Monthly report of utilization and follow-up of ESP encounters

Appendix 1: Quality Strategy Reporting Requirements

Strategy Section	Program	Report Title	Description
	BH Program	Inpatient Cases Awaiting Resolution and Discharge (CARD) Census Report	• Biweekly report of members who do not meet the Inpatient Services Level of Care but remain in an inpatient setting awaiting discharge.
Availability of Services: Timely access BBA Sections: 42 CFR 438.206 - Availability of services 42 CFR 438.207 – Assurances of adequate capacity and services	MCO Program	Telephone Statistics Report	• Quarterly telephone answer statistics
	MCO Program	Waiting Time Access Report for PCPs and Specialists	• Annual report of compliance with contract standards for waiting times re: emergency services, urgent care, non-urgent symptomatic primary care, non-symptomatic primary care
	BH Program	Clinical Access Line Report	• Monthly report of telephone answering statistics
	BH Program	Community Relations Call Volume Report	• Monthly report of community relations telephone answering statistics
Coordination and continuity of care BBA Section: 42 CFR 438.208 - Coordination and continuity of care	MCO Program	Care/Disease/Behavioral Health Care Management Report	• Semiannual report of enrollees with completed Health Risk Assessment, sources of referral to and enrollment in CM/DM/BH, and reasons for case openings and closings
	BH Program	Service Access and Continuity of Care Measures Report	• Quarterly report, stratified by level of care and age with data on readmissions, inpatients diversions, follow-up after hospitalization and medication monitoring following discharge
	BH Program	Care Management Referrals Report Care Management Utilization and Cost Report	• Semiannual reports of referrals to and utilization of care management
	SCO Program	Health Outcome Survey	• Annual Health Outcomes Survey (HOS) per CMS requirements

Appendix 1: Quality Strategy Reporting Requirements

Strategy Section	Program	Report Title	Description
Coverage and authorization of services BBA Section: 42 CFR 438.210 - Coverage and authorization of services	BH Program	Service Authorization and Utilization Review Report	• Monthly report regarding services authorized and denied
Enrollment and disenrollment[11] BBA Section: 42 CFR 438.226 - Enrollment and disenrollment	MCO Program	Membership Discrepancy Report Unreachable Enrollees Notification of Birth Form PCP Assignment Report	• Monthly report of enrollment statistics • Upon event: notification of birth form • Ad hoc report: For the PCP Assignment report, the number and % of members not assigned to a PCP within 15 days of enrollment
	SCO Program	Enrollees medically eligible for nursing facility services	• Quarterly report on enrollees who are medically eligible for nursing facility service
	SCO Program	Monthly reports of disenrollments by reason	• Annual report of mortality data
Grievance systems BBA Section: 42 CFR 438.228 - Grievance systems	MCO Program	Enrollee Inquiries Enrollee Grievances Enrollee Appeals Board of Hearings Appeals	• Semiannual report of inquiries, grievances and appeals
	SCO Program	Report of number and types of complaints and appeals filed by enrollees	• Monthly report of complaints, and appeals, including reporting on how and in what time frame the complaints were resolved
	BH Program BH Program	Appeals report Covered individual complaints and grievances report	• Quarterly report of clinical and administrative appeals • Monthly report of complaints and grievances made by covered individuals
Subcontractual relationships and delegation BBA Section:	MCO Program	Notification of Termination	• Upon event: Notice of termination of subcontractors

[11] Please note: There are no MBH reports for this standard as members are enrolled under the PCC Plan.

Appendix 1: Quality Strategy Reporting Requirements

Strategy Section	Program	Report Title	Description
42 CFR 438.230 - Subcontractual relationships and delegation			
	MCO Program	Notification of Intent to Re-procure Services of a Material Subcontractor	• At least 60 days prior to reprocurement of services of a Material Subcontractor, notify EOHHS
Quality assessment BBA Section: 42 CFR 438.240 -- Quality assessment and performance improvement program	MCO Program	HEDIS Clinical Topic Review (CTR)	• Annual report, prepared by an external contractor of performance measurement
	SCO Program	HEDIS and other geriatric clinical indicators	• Annual report of performance measurement
	BH Program	HEDIS Clinical Topic Review (CTR) Satisfaction survey	• Annual reports, prepared by external contractors of performance measurement
Performance improvement BBA Section: 42 CFR 438.240 -- Quality assessment and performance improvement program	MCO Program	Quality improvement goal reports	• Semiannual reports of progress toward QI goals.
	SCO Program	Quality management goal reports	• Annual reports of progress towards QM goals
	BH Program	QM Activities Report	• Annual summary of contractor's quality management activities for the year
Information systems BBA Section: 42 CFR 438.242 - Health information systems	MCO Program	Encounter data	• Quarterly submission of encounter data
	SCO Program	Utilization reports	• Annual reports in key areas of hospital, nursing facility, and community service
	BH Program	Encounter data	• Monthly submission of encounter data
EQRO activities BBA Section: External oversight – 42 CFR 438.310 – 438.370	MCO, BH, and SCO Programs	Technical Report of mandatory EQR activities	• Validation of performance improvement projects • Validation of performance measures • Compliance with strategy standards

Appendix 2: HEDIS Measures for 2005 (FY 05 and FY 06)

HEDIS Domain	Measure	Most Recently Collected	Collection Methodology
Effectiveness	Breast Cancer Screening	2003	Hybrid or Administrative
	Cervical Cancer Screening	2003	Hybrid or Administrative
	Antidepressant Medication Management	2003	Administrative
	Follow-up After Hospitalization for Mental Illness	2003	Administrative
	Controlling High Blood Pressure	NA	Hybrid
	Appropriate Treatment for Children with Upper Respiratory Infections	NA	Administrative
Access	Prenatal and Postpartum Care	2003	Hybrid or Administrative
	Adult Access to Preventive/Ambulatory Health Services	1997	Administrative
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NA	Administrative
Use of Services	Frequency of Ongoing Prenatal Care	2003	Hybrid or Administrative
	Outpatient Drug Utilization	NA	Administrative

Appendix 3

Uniform Credentialing Policy per 42 CFR 438.214 for MCOs, PIHPs, and PAHPs.

This policy is applicable to all MassHealth-contracted Managed Care Organizations (MCOs) and Senior Care Organizations (SCOs) and MassHealth's behavioral health contractor (the Massachusetts Behavioral Health Partnership) (collectively, Contractor(s)).

I. Definitions

BOH Appeal - a written request to the BOH, made by an Enrollee or authorized representative seeking reconsideration of an action that is appealable pursuant to 130 CMR 610.032(E).

Enrollee - a Member enrolled in the Contractor's managed care program administered by contract with EOHHS, either by choice or assignment by the EOHHS.

Executive Office of Health and Human Services (EOHHS) – the single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L. c. 118E and Title XIX of the Social Security Act and other applicable laws and waivers.

Grievance - any expression of dissatisfaction by an Enrollee or an authorized representative, about any action or inaction by the Contractor other than an action that is appealable pursuant to 130 CMR 610.032(E).

Internal Appeals – a request by an Enrollee or authorized representative made to the Contractor for reconsideration of an action that is appealable pursuant to 130 CMR 610.032(E).

MassHealth - the Medical Assistance or benefit programs administered by EOHHS pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), M.G.L. c. 118E, and other applicable laws and waivers to furnish and to pay for medical services to eligible Members.

Member – a person determined by EOHHS to be eligible for MassHealth.

Network Provider or Provider – an individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any subcontractor, for the delivery of services covered under the Contractor's contract with EOHHS and that is credentialed according to this policy.

Provider Network - the collective group of Network Providers who have entered into provider agreements with the Contractor for the delivery of services covered under the Contractor's contract with EOHHS.

II. Contractor Responsibilities

Each Contractor shall:

1. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Providers and all other licensed and certified Providers who participate in the Contractor's Provider Network. At a minimum, the scope

and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations, including regulations issued by the Board of Registration of Medicine at 243 CMR 3.13.

2. Ensure that all Providers are credentialed prior to becoming Network Providers.
3. Maintain a documented re-credentialing process which shall occur at least every two years and shall take into consideration various forms of data such as Enrollee Grievances, results of quality reviews, Enrollee satisfaction surveys, and utilization management information.
4. Require physician Providers and other licensed or certified professional Providers to maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to obtain Continuing Medical Education (CME) credits and participate in other training opportunities, as appropriate.
5. Ensure that its Provider selection policies and procedures do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
6. Not employ or contract with, or otherwise pay for any items or services furnished, directed or prescribed by, Providers excluded from participation in federal health care programs by the Office of Inspector General of the U.S. Department of Health and Human Services under either section 1128 or section 1128A of the Social Security Act, except as permitted under 42 CFR 1001.1801 and 1001.1901.
7. Upon notice from EOHHS, not authorize any Providers terminated or suspended from MassHealth participation to treat Enrollees and deny payment to such Providers. This section does not preclude the Contractor from suspending or terminating Providers for cause prior to the ultimate suspension or termination from participation in MassHealth by EOHHS.
8. Ensure that no credentialed Provider engages in any practice with respect to any Member that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90.
9. Implement stringent waiver policies and procedures to be rigorously applied to all Providers to address situations in which a Provider is unable to meet one or more of the criteria set forth in the previous paragraphs.