

TECHNICAL REPORT

# Accountable Care Partnership Plans External Quality Review

Calendar Year 2020



**MassHealth**

Massachusetts Department  
of Health & Human Services



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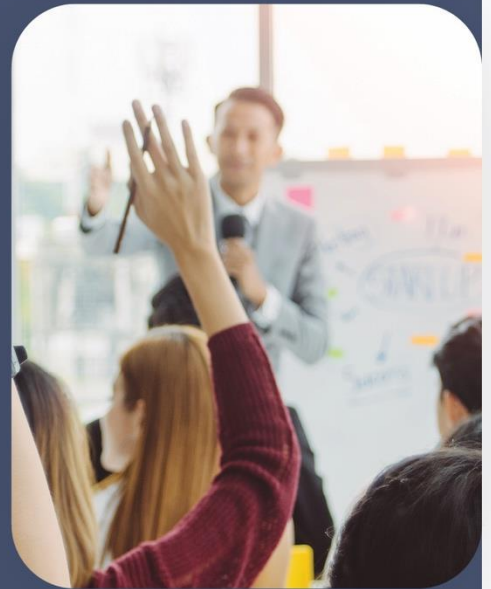
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Section 1:

# Introduction

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## SECTION 1. INTRODUCTION

In November 2016, MassHealth received approval from the Centers for Medicare and Medicaid Services to implement a five-year waiver authorizing a restructuring of MassHealth. The waiver included the introduction of Accountable Care Organizations (ACOs). In this model, providers have a financial interest in delivering quality, coordinated, member-centric care. Three ACO models were implemented in Massachusetts:

**Exhibit 1.1: Massachusetts Accountable Care Organization Models**

<b>ACO Model</b>	<b>Description</b>
Accountable Care Partnership Plans (ACPPs), also referred to as “Model A ACOs” (N=13)	Groups of primary care providers (PCPs) who work with just one managed care organization to create a full network that includes PCPs, specialists, behavioral health providers, and hospitals.
Primary Care Accountable Care Organizations (PCACOs), also referred to as “Model B ACOs” (N=3)	Groups of primary PCPs who form an ACO that is responsible for treating the member and coordinating their care. Primary Care ACO Plans work with the MassHealth network of specialists and hospitals and may have certain providers in their “referral circle.” The “referral circle” provides direct access to certain other providers or specialists without the need for a referral.
Lahey-MassHealth Primary Care Organization, also referred to as the “Model C ACO” (N=1)	The Lahey MassHealth ACO is comprised of 16 primary care practice sites. The ACO has contracted with MassHealth managed care organizations to administer claims and manage membership.

CMS has determined that ACPPs are considered managed care organizations and, as such, are required to participate in all mandatory External Quality Review activities (see below). Primary Care Accountable Care Organizations are considered primary care case management plans and are required to participate in performance measure and compliance validation. 2019 PCACO external quality review activities are described in a separate technical report.

The Massachusetts Accountable Care Partnership Plans are listed in the table that follows.

## Exhibit 1.2: MassHealth Accountable Care Partnership Plans

Accountable Care Partnership Plans	Abbreviation Used in this Report	Membership as of December 31, 2019	Percent of Total ACP Population
Be Healthy Partnership	HNE-Be Healthy	38,593	7.1%
Berkshire Fallon Health Collaborative	Fallon-BFHC	15,860	2.9%
BMC HealthNet Plan Community Alliance	BMCHP-BACO	115,864	21.2%
BMC HealthNet Plan Mercy Alliance	BMCHP Mercy	28,254	5.2%
BMC HealthNet Plan Signature Alliance	BMCHP-Signature	18,080	3.3%
BMC HealthNet Plan Southcoast Alliance	BMCHP-Southcoast	16,731	3.1%
Fallon 365 Care	Fallon 365	32,969	6%
My Care Family	AllWays-My Care Family	33,026	6%
Tufts Health Together with Atrius Health	Tufts-Atrius	32,992	6%
Tufts Health Together with BIDCO	Tufts-BIDCO	37,400	6.8%
Tufts Health Together with Boston Children's ACO	Tufts-BCH	97,823	17.9%
Tufts Health Together with Cambridge Health Alliance	Tufts-CHA	28,420	5.2%
Wellforce Care Plan	Fallon-Wellforce	50,789	9.3%
<b>Total</b>		<b>546,801</b>	<b>100%</b>

Section 2:

# Executive Summary

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## SECTION 2. 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 children with special needs) 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 plan or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth has entered into an agreement with Kepro to perform EQR services for its contracted managed care entities.

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. It is also posted to the Medicaid agency website.

### SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

Kepro conducted the following external quality review activities for MassHealth Accountable Care Partnership Plans in the CY 2019 review cycle:

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

Compliance validation must be conducted by the EQRO on a triennial basis. ACP compliance validation will be conducted in 2021.

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

## PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

Exhibit 2.1: Performance Measure Validation Overview

Topic	Description
Objectives	To assess the accuracy of performance measures in accordance with 42 CFR § 438.358(b)(ii) reported by the managed care plan and to determine the extent to which the managed care plan follows state specifications and reporting requirements.
Technical methods of data collection and analysis	Kepro's Lead Performance Measure Validation Auditor conducted this activity in accordance with 42 CFR § 438.358(b)(ii).
Data obtained	A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols; performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final measure rate calculation; an Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes; enrollment data for 30 ACPP members selected at random by the auditor; measure enrollment processing outcomes for the same 30 ACPP members from DST for the HEDIS <i>Comprehensive Diabetes Care</i> measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure; and chart review numerator-compliant data and/or supplemental database numerator-compliant data from the ACPPs for the selected measure.
Conclusions	Kepro's validation review of the selected performance measures indicates that the Accountable Care Partnership Plans measurement and reporting processes were fully compliant with specifications and were methodologically sound.

The Performance Measure Validation process assesses the accuracy of performance measures reported by the managed care plan. It determines the extent to which the managed care plan follows state specifications and reporting requirements. In 2020, Kepro conducted Performance Measure Validation in accordance with CMS EQR Protocol #2 on the measure selected by MassHealth, Comprehensive Diabetes Care (CDC): HbA1c < 8.

The focus of the Information Systems Capability Assessment is on components of information systems that contribute to performance measure production. This is to ensure that the system can collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system or other methods. The system must be able to ensure that data received from providers are accurate and complete and verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate.

*Kepro determined that all MassHealth ACPs followed specifications and reporting requirements and produced valid measures.*

## PERFORMANCE IMPROVEMENT PROJECT VALIDATION

### Exhibit 2.2. Performance Improvement Project Validation Process Overview

Topic	Description
Objectives	To assess overall project methodology as well as the overall validity and reliability of the Performance Improvement Project (PIP) methods and findings to determine confidence in the results.
Technical methods of data collection and analysis	Performance Improvement Projects were validated in accordance with § 438.330(b)(i).
Data obtained	ACPPs submitted two PIP reports in 2020, the Final Implementation Progress Report (March 2020) and the Final Implementation Annual Report (September 2020). They also submitted related supporting documentation.
Conclusions	Based on its review of Accountable Care Partnership Plans Performance Improvement Projects, Kepro did not discern any issues related to their quality of care or the timeliness of or access to care.

MassHealth ACPPs conduct two contractually required Performance Improvement Projects (PIPs) annually. In accordance with Appendix E of their contract with EOHHS, must conduct one PIP from each of the two domains:

- Domain 1: Behavioral Health – Promoting well-being through prevention, assessment, and treatment of mental illness including substance use and other dependencies.
- Domain 2: Population and Community Needs Assessment and Risk Stratification – Identifying and assessing priority populations for health conditions and social determinant factors with the most significant size and impact and developing interventions to address the appropriate and timely care of these priority populations.

In Calendar Year 2020, Accountable Care Partnership Plans continued the implementation of the following Performance Improvement Projects begun in 2019:

### **Domain 1: Behavioral Health**

Five ACPPs focused on increasing the rate of follow up visits within seven days of discharge for members hospitalized for a mental illness (BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, and Be Healthy Partnership).

Seven ACPPs focused on improving the rate of depression screenings and follow-up plans (Berkshire Fallon Health Collaborative, Fallon 365 Care, Wellforce Care Plan, Tufts Health Together with Atrius Health, Tufts Health Together with BIDCO, Tufts Health Together with Boston Children's ACO, and Tufts Health Together with Cambridge Health Alliance).

One ACPP focused on Initiation and Engagement in Treatment (Always-My Care Family).

### **Domain 2: Population and Community Needs Assessment**

Five ACPPs focused on improving Asthma Control and Medication Adherence (BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, and Always-My Care Family).

Four ACPPs focused on utilizing Health-Related Social Needs Screening to identify both pediatric and adult members in need of additional services to improve health outcomes (Tufts Health Together with Atrius Health, Tufts Health Together with Boston Children's ACO, Tufts Health Together with BIDCO, and Tufts Health Together with Cambridge Health Alliance).

One ACPP each focused on the following areas:

- Improving Rates of Controlling High Blood Pressure (Berkshire Fallon Health Collaborative).
- Improving Rates of Immunizations for Adolescents - Combo 2 (Fallon 365 Care).
- Improving Rates of CDC - HbA1c testing for the diabetic population (Wellforce Care Plan).

- Improving outcomes in diabetic patients through integrated care management (Be Healthy Partnership).

Kepro evaluates each PIP to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 1.. The Kepro technical reviewer assesses project methodology. The Medical Director evaluates the clinical soundness of the interventions. The review considers the ACPP's performance in the areas of problem definition, data analysis, measurement, improvement strategies, and outcome. Recommendations are offered to the ACPP.

Based on its review of the MassHealth ACPP PIPs, Kepro did not discern any issues related to any plan's quality of care or the timeliness of or access to care. Recommendations made were ACPP-specific, the only theme emerging being the importance of evaluating the effectiveness of quality improvement interventions to determine their value in the improvement process.

## HIGH-LEVEL RECOMMENDATIONS

Kepro has included in its 2020 Technical Reports several recommendations to MassHealth for how it can target the goals and objectives in the comprehensive quality strategy to better support improvement in the quality, timeliness, and access to health care services. In addition to the managed care plan-specific recommendations made throughout this Technical Report, Kepro offers the following recommendations to MassHealth.

### 1. Expand the Network Adequacy Validation Scope of Work.

The first of MassHealth's Quality Objectives is that members receive information that is "clear, engaging, timely, accessible, and culturally and linguistically appropriate to [its] members and providers." A foundational element in culturally and linguistically appropriate care is the inclusion of non-English-speaking providers in managed care plan provider networks. Kepro's network adequacy analytic tool, Quest, can report on number of these providers. While in 2020, some managed care plans did provide this information, this was not universal. Going forward, Kepro recommends that the non-English-speaking capabilities of all managed care plans be analyzed.

Kepro found some providers with de-activated NPI numbers were in managed care plan provider directories as evidenced by a search on the plan's website. While not of a significant

number, Kepro suggests that network adequacy validation be expanded to include validation of provider directory information.

**2. Continue to support and reinforce the importance of conducting performance improvement projects using a rigorous project methodology.**

An analysis undertaken by Kepro showed a correlation between a strong project management approach and an improvement in project performance indicators. Kepro appreciates the support it receives from MassHealth in requiring well-executed projects. Kepro welcomes the opportunity to provide managed care plan project-based staff with technical assistance, especially as it relates to the measurement of intervention effectiveness.

**3. Foster cross-plan learning about performance improvement project strategies.**

In the most recent Quality Improvement Cycle, ten MassHealth managed care plans conduct performance improvement projects related to depression. To decrease redundancy and maximize the potential for success, Kepro recommends that a mechanism be instituted for plans conducting similar improvement activities be provided an opportunity for a synergistic sharing of lessons learned. 2020's Racial Disparity Learning Collaborative will provide valuable lessons learned for future work in this area.

**4. Improve the quality of race, ethnicity, and language data provided to the managed care plans.**

From conducting population analyses to designing interventions, managed care plans feel challenged by the quality of REL data they receive from MassHealth. A shared concern is the overwriting of plan REL updates by the MassHealth enrollment files. Kepro strongly encourages MassHealth to resolve this issue as these data are required to better measure and address disparities in care and access.

## **MASSHEALTH QUALITY STRATEGY EVALUATION**

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

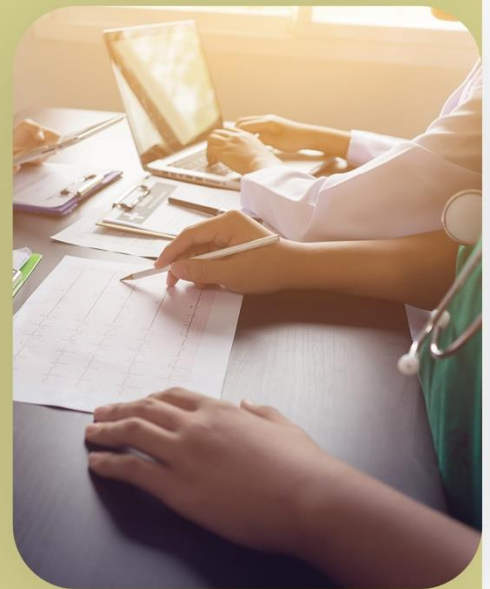
The first MassHealth Quality Strategy was published in 2006. An updated version, the MassHealth Comprehensive Quality Strategy, focused not only on fulfilling managed care quality requirements but on improving the quality of managed care services in Massachusetts, was submitted to CMS in November 2018. As is required by CMS, the strategy will be updated in 2021 and will be made available to the public on the MassHealth website.

In 2020, MassHealth asked Kepro to evaluate the effectiveness of this strategy and this evaluation is in process. The final report will be posted to the MassHealth website as it becomes available.

**Section 3:**

# **Performance Measure Validation**

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## SECTION 3. PERFORMANCE MEASURE VALIDATION

### PERFORMANCE MEASURE VALIDATION METHODOLOGY

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

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

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

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

Performance measure validation focused on these organizations' data and processes. Individual ACPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:

- A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;
- Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final measure rate calculation;



- An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;
- Enrollment data for 30 ACPP members selected at random by the auditor;
- Measure enrollment processing outcomes for the same 30 ACPP members from DST for the HEDIS *Comprehensive Diabetes Care* measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure; and
- Chart review numerator-compliant data and/or supplemental database numerator-compliant data from the ACPPs for the selected measure.

## COMPARATIVE ANALYSIS

The table that follows contains the criteria against which the performance measure was validated as well as Kepro's determination as to whether the ACPPs met these criteria.

### Performance Measure Validation: Comprehensive Diabetes Care (CDC): Comprehensive Diabetes Care (CDC): HbA1c < 8

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid
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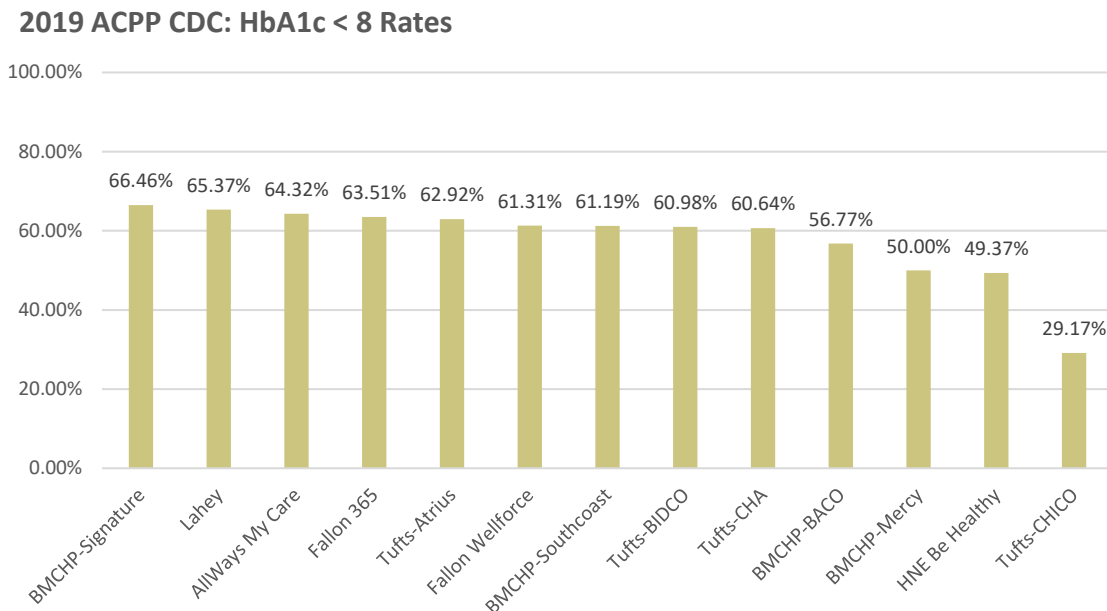
Review Element	ACPPs' Rating
<b>DENOMINATOR</b>	
<u>Population</u>	
ACPP population was appropriately segregated from other product lines.	Met
Members aged 18–75 years as of Dec. 31 of the measurement year.	Met
Members enrolled all of the measurement year allowing for a one-month break, but not in December.	Met
Diabetics were appropriately identified using both specified methods. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. ACPP must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.	Met
<u>Geographic Area</u>	
Includes only Medicaid enrollees served in ACPP's reporting area.	Met
<b>NUMERATOR – HBA1C LESS THAN 8.0</b>	
<u>Counting Clinical Events</u>	
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met
Data sources and decision logic used to calculate the numerators (e.g., claims files, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met
Members whose most recent HbA1c level (performed during the measurement year) is less than 8, as documented through claims, supplemental data, or medical record review.	Met
<u>Data Quality</u>	
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met

Review Element	ACPPs' Rating
<u>Proper Exclusion Methodology in Administrative Data</u>	
Members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year. (Optional Exclusion).	Met
<u>Medical Record Review Documentation Standards</u>	
Record abstraction tool required notation of all key numerator fields.	Met
<u>Data Quality</u>	
The eligible population was properly identified.	Met
Based on the IS assessment findings, data sources used for this numerator were accurate.	Met
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met
If the hybrid method was used, the ACP- passed auditor review for the accuracy of all 15 randomly selected abstracted charts for HbA1c<8. If all 15 randomly selected charts did not pass, then 58 randomly selected charts were reviewed and the 58 randomly selected charts had an error rate of less than 5% for the abstraction of the HbA1c<8 numerator.	Met
<b>SAMPLING</b>	
<u>Unbiased Sample</u>	
As specified in the NCQA specifications, systematic sampling method was utilized.	Met
<u>Sample Size</u>	
After exclusions, the sample size was equal to 1) 411, 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or 3) the total population, after measure exclusions.	Met
<u>Proper Substitution Methodology in Medical Record Review</u>	
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors.	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented.	Met

## COMPARATIVE PERFORMANCE MEASURE RESULTS

The table and graph that follow depict ACP performance on the HbA1c<8 rate. NCQA has not developed benchmarks specific to accountable care organizations, therefore no performance benchmark is provided for comparison purposes. The range of the performance rates was 37.29 percentage points. The lowest performing ACP was Tufts-BCH at 29.17%. The highest performing plan was BMCHP-Signature at 66.46%. Please note that these rates are reported as certified, unaudited, HEDIS rates.

### Exhibit 3.1: 2019 ACPP CDC HbA1c < 8 Rates



## MEASURE-SPECIFIC VALIDATION DESIGNATION

### Exhibit 3.2. Measure-Specification Validation Designation

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
Comprehensive Diabetes Care (CDC): HbA1c < 8	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid. The ACPP measure rates are referred to as “Certified, Unaudited, HEDIS Rates” because the measure was audited using EQR PMV methodology, but not through a NCQA HEDIS Compliance Audit.

## ACO-SPECIFIC PERFORMANCE MEASURE VALIDATION RESULTS

### Performance Measure Summaries

Kepro has leveraged CMS Worksheet 2.14, A Framework for Summarizing Information About Performance Measures, to report managed care plan-specific 2020 performance measure validation activities. As is required by CMS, Kepro has identified managed care plan and project strengths as evidenced through the validation process as well as follow up to 2020 recommendations. Kepro's Lead Performance Measure Validation Auditor assigned a validation confidence rating that refers to Kepro's overall confidence that the calculation of the performance measure adhered to acceptable methodology.

### AllWays - My Care Family

#### 1. Overview of Performance Measure

ACCP Name: <b>AllWays-My Care Family</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and AllWays-My Care Family. MassHealth provided Telligen the claims and encounter data files for AllWays-My Care Family on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from AllWays-My Care Family to support measurement. <input checked="" type="checkbox"/> Medical records (describe): AllWays-My Care Family medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by AllWays-My Care Family containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

Measurement period (start/end date): January 1, 2019 to December 31, 2019.

## 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	247
<b>Denominator</b>	384
<b>Rate</b>	64.32%

## 3. Performance Measure Validation Status

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

None identified. MassHealth was compliant with the HEDIS® Information System Standards and HEDIS® Determination Standards and used an NCQA-certified software vendor for HEDIS® measure production.

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

Telligen worked with a subcontractor, SS&C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:

- A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;
- Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;
- An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;
- Enrollment data for 30 members selected at random by the auditor;
- Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.
- Chart review numerator-compliant data and/or supplemental database numerator-compliant data from AllWays-My Care Family for the selected measure.

No issues were found that affected the reliability or validity of the performance measure results.

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

The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c<8 numerator to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for all ACCPs. There were no issues identified.

Describe any other validation findings that affected the accuracy of the performance measure calculation.

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## Boston Medical Center HealthNet Plan Community Alliance

### 1. Overview of Performance Measure

ACCP name: <b>Boston Medical Center HealthNet Plan Community Alliance (BMCHP-BACO)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and BMCHP-BACO. MassHealth provided Telligen the claims and encounter data files for BMCHP-BACO on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from BMCHP-BACO to support measurement. <input checked="" type="checkbox"/> Medical records (describe): ACCP medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by BMCHP-BACO containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	218
<b>Denominator</b>	384
<b>Rate</b>	56.77%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"> <li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li> <li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li> <li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li> <li>• Enrollment data for 30 members selected at random by the auditor;</li> <li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li> <li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from BMCHP-BACO for the selected measure.</li> </ul> <p>No issues were found that affected the reliability or validity of the performance measure results.</p>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for BMCHP-BACO. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>



## Boston Medical Center HealthNet Plan Mercy Alliance

### 1. Overview of Performance Measure

ACCP name: <b>Boston Medical Center HealthNet Plan Mercy Alliance (BMCHP-Mercy)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and BMCHP-Mercy. Telligen the claims and encounter data files for BMCHP-Mercy on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from BMCHP-Mercy to support measurement. <input checked="" type="checkbox"/> Medical records (describe): ACCP medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by BMCHP-Mercy containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	180
<b>Denominator</b>	360
<b>Rate</b>	50.00%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"> <li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li> <li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li> <li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li> <li>• Enrollment data for 30 members selected at random by the auditor;</li> <li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li> <li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from BMCHP-Mercy for the selected measure.</li> </ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for BMCHP-Mercy to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for BMCHP-Mercy. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

## Boston Medical Center HealthNet Plan Signature Alliance

### 1. Overview of Performance Measure

ACCP name: <b>Boston Medical Center HealthNet Plan Signature Alliance (BMCHP-Signature)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and BMCHP-Signature. MassHealth provided Telligen the claims and encounter data files for BMCHP-Signature on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from BMCHP-Signature to support measurement. <input checked="" type="checkbox"/> Medical records (describe): BMCHP-Signature medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by BMCHP-Signature containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	218
<b>Denominator</b>	328
<b>Rate</b>	66.46%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"><li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li><li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li><li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li><li>• Enrollment data for 30 members selected at random by the auditor;</li><li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li><li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from BMCHP-Signature for the selected measure.</li></ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for BMCHP-Signature. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

## Boston Medical Center HealthNet Plan Southcoast Alliance

### 1. Overview of Performance Measure

ACCP name: <b>Boston Medical Center HealthNet Plan Southcoast Alliance (BMCHP-Southcoast)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and BMCHP-Southcoast. MassHealth provided Telligen the claims and encounter data files for BMCHP-Southcoast on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from BMCHP-Southcoast to support measurement. <input checked="" type="checkbox"/> Medical records (describe): BMCHP-Southcoast medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by BMCHP-Southcoast containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	205
<b>Denominator</b>	335
<b>Rate</b>	61.19%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"> <li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li> <li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li> <li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li> <li>• Enrollment data for 30 members selected at random by the auditor;</li> <li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li> <li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from BMCHP-Southcoast for the selected measure.</li> </ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for BMCHP-Southcoast. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

## Berkshire Fallon Health Cooperative

### 1. Overview of Performance Measure

ACCP Name: <b>Berkshire Fallon Health Cooperative (Fallon-Berkshire)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and Fallon-Berkshire. MassHealth provided Telligen the claims and encounter data files for Fallon-Berkshire on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from Fallon-Berkshire to support measurement. <input checked="" type="checkbox"/> Medical records (describe): Fallon-Berkshire medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by Fallon-Berkshire containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	179
<b>Denominator</b>	328
<b>Rate</b>	54.57%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"> <li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li> <li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li> <li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li> <li>• Enrollment data for 30 members selected at random by the auditor;</li> <li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li> <li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from Fallon-Berkshire for the selected measure.</li> </ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for all ACCPs. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>



## Fallon 365 Care

### 1. Overview of Performance Measure

ACCP name: <b>Fallon 365 Care (Fallon 365)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and Fallon 365. MassHealth provided Telligen the claims and encounter data files for Fallon 365 on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from Fallon 365 to support measurement. <input checked="" type="checkbox"/> Medical records (describe): Fallon 365 medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by Fallon 365 containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic was followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	188
<b>Denominator</b>	296
<b>Rate</b>	63.51%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"><li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li><li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li><li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li><li>• Enrollment data for 30 Fallon-365 members selected at random by the auditor;</li><li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li><li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from Fallon 365 for the selected measure.</li></ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for Fallon 365. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

## Fallon Wellforce Care Plan

### 1. Overview of Performance Measure

ACCP name: <b>Fallon Wellforce Care Plan (Fallon Wellforce)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and Fallon Wellforce. MassHealth provided Telligen the claims and encounter data files for Fallon Wellforce on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from Fallon Wellforce to support measurement. <input checked="" type="checkbox"/> Medical records (describe): Fallon Wellforce medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by Fallon Wellforce containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	252
<b>Denominator</b>	411
<b>Rate</b>	61.31%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"><li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li><li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li><li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li><li>• Enrollment data for 30 members selected at random by the auditor;</li><li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li><li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from Fallon-Wellforce for the selected measure.</li></ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for Fallon-Wellforce. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

## Be Healthy Partnership

### 1. Overview of Performance Measure

ACCP Name: <b>Be Healthy Partnership (Be Healthy)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and Be Healthy. MassHealth provided Telligen the claims and encounter data files for Be Healthy on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from Be Healthy to support measurement. <input checked="" type="checkbox"/> Medical records (describe): Be Healthy medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by Be Healthy containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	195
<b>Denominator</b>	395
<b>Rate</b>	49.37%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"> <li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li> <li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li> <li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li> <li>• Enrollment data for 30 members selected at random by the auditor;</li> <li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li> <li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from Be Healthy for the selected measure.</li> </ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for Be Healthy. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

EQRO recommendations for improvement of performance measure calculation:

None identified.

## Tufts Health Together with Atrius

### 1. Overview of Performance Measure

ACCP name: <b>Tufts Health Together with Atrius (Tufts-Atrius)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and Tufts-Atrius. MassHealth provided Telligen the claims and encounter data files for Tufts-Atrius on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from Tufts-Atrius to support measurement. <input checked="" type="checkbox"/> Medical records (describe): Tufts-Atrius medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by Tufts-Atrius containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic was followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	565
<b>Denominator</b>	898
<b>Rate</b>	62.92%



### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"> <li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li> <li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li> <li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li> <li>• Enrollment data for 30 Tufts-Atrius members selected at random by the auditor;</li> <li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li> <li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from Tufts-Atrius for the selected measure.</li> </ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for Tufts-Atrius. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

## Tufts Health Together with BIDCO

### 1. Overview of Performance Measure

ACCP names: <b>Tufts Health Together with BIDCO (Tufts-BIDCO)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and Tufts-BIDCO. MassHealth provided Telligen the claims and encounter data files for Tufts-BIDCO on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from Tufts-BIDCO to support measurement. <input checked="" type="checkbox"/> Medical records (describe): Tufts-BIDCO medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by Tufts-BIDCO containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	186
<b>Denominator</b>	305
<b>Rate</b>	60.98%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"> <li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li> <li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li> <li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li> <li>• Enrollment data for 30 Tufts-BIDCO members selected at random by the auditor;</li> <li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li> <li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from Tufts-BIDCO for the selected measure.</li> </ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for all ACCPs. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

## Tufts Health Together with Cambridge Health Alliance

### 1. Overview of Performance Measure

ACCP names: <b>Tufts Health Together with Cambridge Health Alliance (Tufts-CHA)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and Tufts-CHA. MassHealth provided Telligen the claims and encounter data files for Tufts-CHA on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from Tufts-CHA to support measurement. <input checked="" type="checkbox"/> Medical records (describe): Tufts-CHA medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by Tufts-CHA containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	228
<b>Denominator</b>	376
<b>Rate</b>	60.64%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"><li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li><li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li><li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li><li>• Enrollment data for 30 members selected at random by the auditor;</li><li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li><li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from Tufts-CHA for the selected measure.</li></ul>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for all ACCPs. There were no issues identified.</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>None identified.</p>

## Tufts Health Together with Boston Children's Hospital

### 1. Overview of Performance Measure

ACCP names: <b>Tufts Health Together with Boston Children's Hospital (Tufts-BCH)</b>
Performance measure name: <b>Comprehensive Diabetes Care HbA1c&lt;8</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe): Telligen, Inc., calculated the performance measure on behalf of MassHealth and Tufts-BCH. MassHealth provided Telligen the claims and encounter data files for Tufts-BCH on a quarterly basis through a comprehensive data file referred to as the mega data extract. With direction from MassHealth, Telligen extracted and transformed the data elements necessary for measure calculation. Additionally, Telligen collected and transformed supplemental data from Tufts-BCH to support measurement. <input checked="" type="checkbox"/> Medical records (describe): Tufts-BCH medical records containing HbA1c values. <input checked="" type="checkbox"/> Other (specify): Non-standard and standard supplemental databases provided by Tufts-BCH containing HbA1c values.
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology, with NCQA hybrid sample size reduction logic was followed.
Definition of denominator (describe): Members 18–75 years of age with diabetes (type 1 and type 2)
Definition of numerator (describe): Diabetic members whose HbA1c was under control (<8.0%).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date): January 1, 2019 to December 31, 2019.

### 2. Performance Measure Results: 2019 Certified, Unaudited HEDIS Rate: Comprehensive Diabetes Care HbA1c<8

<b>Numerator</b>	21
<b>Denominator</b>	72
<b>Rate</b>	29.17%

### 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
None identified.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.
<p>Telligen worked with a subcontractor, SS&amp;C (DST), using its HEDIS-certified software (Care Analyzer) to calculate final administrative rates and the administrative component of the hybrid rate for the performance measures. Additionally, Telligen used DST's clinical data collection tool, Clinical Repository, to collect ACCP-specific clinical data. At project completion, DST integrated the administrative data with the hybrid results to generate the final rates for the ACCP hybrid measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACCPs did not participate in or contribute to the PMV process, with the exception of providing supplemental data files and hybrid medical record review data for performance measure calculation. The following documents and files were provided in support of the performance measure validation process:</p> <ul style="list-style-type: none"> <li>• A completed Information Systems Capability Assessment Tool (ISCAT) for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to Telligen, as well as performance measure creation and measure data validation protocols;</li> <li>• Performance measure data reports from DST for the selected validation measure that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;</li> <li>• An Excel spreadsheet from DST containing numerator-compliant data for the selected measure for primary source verification purposes;</li> <li>• Enrollment data for 30 Tufts-BCH members selected at random by the auditor;</li> <li>• Measure enrollment processing outcome for the same 30 members from DST for the HEDIS 'Comprehensive Diabetes Care' measure to ensure that the enrollment data matched the MassHealth primary source enrollment data after DST enrollment data processing for the selected validation measure.</li> <li>• Chart review numerator-compliant data and/or supplemental database numerator-compliant data from Tufts-BCH for the selected measure.</li> </ul>
Describe any findings from medical record review that affected the reliability or validity of the performance measure results.
<p>The reviewer audited 15 numerator-compliant cases for the hybrid Comprehensive Diabetes Care HbA1c&lt;8 numerator for each ACCP to ensure that numerator positive status was accurate for the hybrid cases that were designated as numerator positive based on either chart review or supplemental data use. If all 15 cases did not pass audit for a given ACCP, then the reviewer expanded the review to 58 cases selected at random for the ACCP. If the error rate was less than 5%, the ACCP passed medical record and supplemental data review. The primary source documentation submitted established that the numerator data met the numerator requirements for all ACCPs. There were no issues identified.</p>
Describe any other validation findings that affected the accuracy of the performance measure calculation.
None identified.
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
EQRO recommendations for improvement of performance measure calculation:
None identified.

## STRENGTHS

- MassHealth used an NCQA-certified vendor, DST, to produce ACP performance measures.
- In its second year of external quality review, the ACP program successfully completed performance measure validation.

## OPPORTUNITIES & RECOMMENDATIONS

None identified.

## CONCLUSION

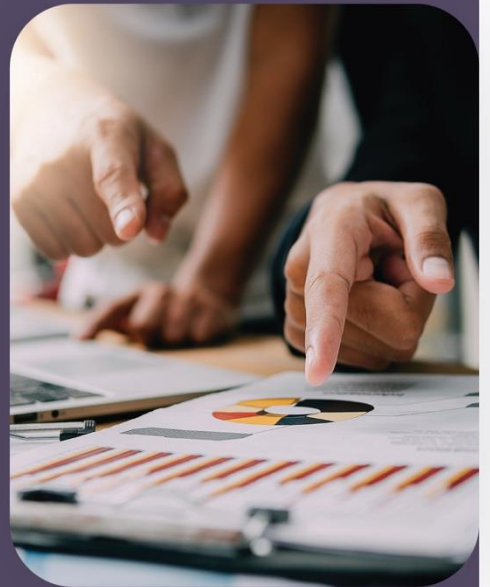
*In summary, Kepro's validation review of the selected performance measures indicates that the MassHealth Accountable Care Partnership Plans' measurement and reporting processes were fully compliant with specifications and were methodologically sound. The validation process did not reveal any deficiencies related to member access to timely quality care.*



Section 4:

# Performance Improvement Project Validation

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## SECTION 4: PERFORMANCE IMPROVEMENT PROJECT VALIDATION

### PERFORMANCE IMPROVEMENT PROJECT LIFE CYCLE

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

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

**Baseline/Initial Implementation Period:** Calendar Year 2019

*Planning Phase: January - March 2019*

During this period, the ACPs developed detailed plans for interventions. ACPs conducted a population analysis, a literature review, and root cause and barrier analyses, all of which contributed to the design of appropriate interventions. ACPs reported on this activity in March 2019. These reports described planned activities, performance measures, and data collection plans for initial implementation.

*Initial Implementation: March 2018 - December 2019*

Incorporating feedback received from MassHealth and Kepro, the ACPs undertook the implementation of their proposed interventions. The ACPs submitted a progress report in September. In this report, the ACPs provided baseline data for the performance measures that had been previously approved by MassHealth and Kepro.

**Final Implementation Period:** Calendar Year 2020

*Final Implementation Progress Reports: March 2020*

ACPs submitted another progress report that described current interventions, short-term indicators and small tests of change, and performance data as applicable. They also assessed the results of the project, including success and challenges.

*Final Implementation Annual Report: September 2020*

ACPs submitted a second annual report that described current interventions, intervention effectiveness, and performance data as applicable. They assessed the results of the project, including success and challenges, and described plans for the final quarter of the initiative.

Each of these reports was reviewed by Kepro. The 2020 Progress and Annual Reports are discussed herein. Each project was evaluated to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 1. Kepro also determined whether the projects achieved or are likely to achieve favorable results. Kepro distributed detailed evaluation criteria and instructions to the ACPs to support their efforts.

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

- 1) **PIP Questionnaire.** Plans submit a completed reporting questionnaire for each PIP. This questionnaire is stage-specific. In 2020, plans submitted a Project Update (March) and a report on Project Results report (September). The Progress Update report asked for a description of stakeholder involvement; an update to project goals, if any; the status of intervention implementation and any barriers experienced; and plans for going forward. The Project Results report included a description of the strategies used to ensure the cultural competence of interventions; an updated population analysis; an analysis of intervention outcome effectiveness; the remeasurement of identified performance indicators; status and barriers; and a description of lessons learned by the project team.
- 2) **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 project. The Medical Director's focus is on clinical integrity and interventions.
- 3) **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 ten calendar days, although it is not required to do so.
- 4) **Final Report.** A PIP Validation Worksheet based on CMS EQR Protocol Number 1 is completed by the Technical Reviewer. Individual standards are rated either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. The Medical Director documents his or her findings, and in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report.

## PERFORMANCE IMPROVEMENT PROJECT TOPICS

MassHealth ACPPs conduct two contractually required PIPs annually. In accordance with Appendix B of the Model A ACPP's contract, ACPPs proposed to MassHealth one PIP from each of the two domains:

Domain 1: Behavioral Health – Promoting well-being through prevention, assessment, and treatment of mental illness including substance use and other dependencies.

Domain 2: Population and Community Needs Assessment and Risk Stratification – Identifying and assessing priority populations for health conditions and social determinant factors with the most significant size and impact and developing interventions to address the appropriate and timely care of these priority populations.

In Calendar Year 2020, Accountable Care Partnership Plans continued work on the following Performance Improvement Projects (PIPs):

### **Domain 1: Behavioral Health**

Five ACPPs focused on increasing the rate of follow up visits within seven days of discharge for members hospitalized for a mental illness (BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, and Be Healthy Partnership).

Seven ACPPs focused on improving the rate of depression screenings and follow-up plans (Berkshire Fallon Health Collaborative, Fallon 365 Care, Wellforce Care Plan, Tufts Health Together with Atrius Health, Tufts Health Together with BIDCO, Tufts Health Together with Boston Children's ACO, and Tufts Health Together with Cambridge Health Alliance).

One ACPP focused on Initiation and Engagement in Treatment (My Care Family).

### **Domain 2: Population and Community Needs Assessment**

Five ACPPs focused on improving Asthma Control and Medication Adherence (BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, and My Care Family).

Four ACPPs focused on utilizing Health-Related Social Needs Screening to identify both pediatric and adult members in need of additional services to improve health outcomes (Tufts Health Together with Atrius Health, Tufts Health Together with Boston Children's ACO, Tufts Health Together with BIDCO, and Tufts Health Together with Cambridge Health Alliance).

One ACPP each focused on the following areas:

- Improving Rates of Controlling High Blood Pressure (Berkshire Fallon Health Collaborative).

- Improving Rates of Immunizations for Adolescents - Combo 2 (Fallon 365 Care).
- Improving Rates of CDC - HbA1c testing for the diabetic population (Wellforce Care Plan).
- Improving outcomes in diabetic patients through integrated care management (Be Healthy Partnership).

*Based on its review of the MassHealth Accountable Care Organizations' performance improvement projects, including an analysis of project methodology, performance indicators, and the likelihood of sustained improvement, Kepro did not discern any issues related to any plan's quality of care or the timeliness of or access to care.*

## COMPARATIVE ANALYSIS

In 2020, ACPPs reported statistically significant improvement for 13 of 26 (50%) performance improvement projects. Kepro considers this accomplishment to be remarkable as these projects were of only a two-year duration.

With respect to the ACPPs meeting the challenges of designing and implementing a PIP, the ACPPs assembled project teams that generally submitted well-developed project plans. In general, ACPPs continued to struggle with the required evaluation of intervention effectiveness.

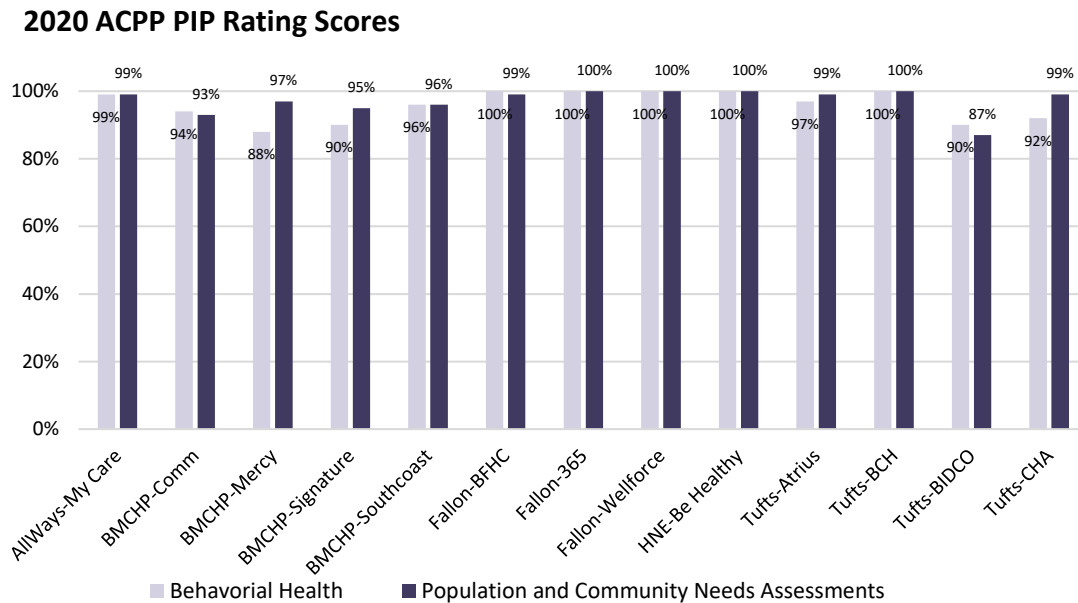
The chart that follows shows the average ratings scores by PIP section stratified by PIP domain, i.e., behavioral health or population and community needs assessment.

**Exhibit 4.1: Average Results of Validation Ratings**

Results of Validation Ratings	Behavioral Health		Population and Community Needs Assessment	
	Average Score (%)	Range (%)	Average Score (%)	Range (%)
Updates to Project Topic and Scope	97.08	89-100	96.46	89-100
Population Analysis Update	97.38	83-100	100.00	100
Assessing Intervention Outcomes	77.33	57-100	90.15	56-100
Performance Indicator Data Collection	100	100	100	100
Capacity for Indicator Data Analysis	96.08	83-100	96.08	83-100
Performance Indicator Parameters	100	100	100	100
Remeasurement Performance Indicator Rates	100	100	97.38	66-100
Conclusions and Lessons Learned	93.15	67-100	100.00	100

The chart that follows depicts the Performance Improvement Project Total Rating Score received by each Accountable Care Partnership Plan.

Exhibit 4.2: PIP Ratings by ACPP and Domain



MassHealth Accountable Care Partnership Plans used a wide variety of approaches to address their project goals.

Exhibit 4.3: Interventions by Domain

Intervention	Behavioral Health	Population and Community Needs Assessment and Risk Stratification
Care Management	3	5
Member Education	3	3
Provider Education	5	4
Technology-Based Solutions	6	3
Staffing	3	0
Workflow Modifications	7	5

Going forward into 2021, Kepro is looking forward to supporting ACPP work related to flu immunization rates and telehealth utilization.

### **Performance Improvement Project Summaries**

As required by CMS, Kepro is providing project-specific summaries using CMS Worksheet Number 1.11 from EQR Protocol Number 1, Validating Performance Improvement Projects. The PIP Aim Statement is taken directly from the managed care plan's report to Kepro as are the Improvement Strategies or Interventions. Performance indicator data was taken from this report as well. Kepro calculated statistical significance for results using the Z test. Kepro validated each of these projects, meaning that it reviewed all relevant parts of each PIP and made a determination as to its validity. The PIP Technical Reviewer assigned a validation confidence rating, which refers to Kepro's overall confidence that the PIP adhered to acceptable methodologies for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement or the potential for improvement. Recommendations offered were taken from the Reviewers' rating forms. As is required by CMS, Kepro has identified managed care plan and project strengths as evidenced in the PIP.



# DOMAIN 1: BEHAVIORAL HEALTH

## DEPRESSION

### Berkshire Fallon Health Collaborative (Fallon-BFHC) - Improving the Rate of Depression Screenings and Follow-Up Plans for the Berkshire Fallon Health Collaborative Population

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name: Berkshire Fallon Health Collaborative (BFHC)</b>
<b>PIP Title:</b> Improving the rate of depression screenings and follow-up plans for the Berkshire Fallon Health Collaborative population
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"><li>• Increase the number of members who are screened for depression using a paper-based PHQ-9 or other approved screening tool, as evidenced by a 2019 calendar year baseline of 6.12%, a 10% improvement above the 2018 baseline rate of 5.56%.</li></ul> <i>Provider-Focused</i> <ul style="list-style-type: none"><li>• At least 80% of providers will receive education to improve understanding of the resources available for members with an elevated PHQ-9.</li><li>• At least 80% of providers will receive education to improve documentation of follow-up interventions provided or offered to members with an elevated PHQ-9 screening or other approved screening tool.</li><li>• Increase the number of encounters during the measurement year for which providers who administer a PHQ-9, and have a positive finding, document the appropriate follow up as evidenced by a 10% improvement above the 2018 baseline rate of 75%, leading to an overall rate of 82.5%.</li></ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Members 12-64 years of age
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

#### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Not applicable.

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

Not applicable.

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

Fallon-BFHC piloted a paper-based PHQ-9 screening at two practices, one large and one small, to enable the analysis of workflow challenges in differently sized practices. The document was then scanned into the patient's record and made available to the provider in advance of the encounter. Initially, the screen was given to patients attending their first visit at the practice. The ACPP plans to expand the process to apply to screening patients at all visits.

Positive screens were flagged by medical assistants and nurses in preparation for the patient encounter. Guidelines for determining appropriate follow-up protocols were posted on the organization's SharePoint site.

A database was created of members who have not completed a PHQ-9 within the year. This intervention has been rolled out to all practices. Focus groups with practice administrators are being held to see how this intervention may be improved.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<p>The rate of Fallon-BFHC members 12 to 64 years of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool and, if screened positive, a follow-up plan is documented on the date of the positive screen.</p> <p>NCQA 0418</p>	2018	19/408 4.7%	<p>2019</p> <p><input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available</p>	97/339 28.61%	<p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Specify P-value:</p> <p><input type="checkbox"/> &lt;.01 <input type="checkbox"/> &lt;.05</p> <p>Other (specify): p &lt; 0.005</p>

### 4. PIP Validation Information

<p><b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Validation phase (check all that apply):</b></p> <p><input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year</p> <p><input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):</p> <p>Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p><b>EQRO recommendations for improvement of PIP:</b></p> <p>Kepro suggests a methodology that allows determination of whether the intervention utilizing the PHQ-9 questionnaire is increasing rates of screening.</p>

## Performance Improvement Project Evaluation

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

### Exhibit 4.4: Fallon-BFHC PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	6	18	18	100%
Remeasurement Performance Indicator Rates	3.0	9.0	9	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>26</b>	<b>78</b>	<b>78</b>	<b>100%</b>

### Plan & Project Strengths

- Kepro commends Fallon-BFHC for the Social Determinant of Health initiative started in 2019, as a partnership between New England Quality Care Alliance and Health Management Associates. The initiative aimed at heightening awareness with members who struggle with an SDOH and understanding the disparities relevant to race, ethnicity, and language.
- Fallon-BFHC reported that although it could not report the same indicator parameters as Baseline Report 2, the project team is satisfied with the increase in the CDF rate from 2018 to 2019, as there was an increase of 23.91 percentage points. This increase shows that the plan is not only screening members at higher rates, but also documenting follow-ups after a positive screen correctly and following the guidelines issued by MassHealth in 2019.

## Fallon 365 Care

### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Fallon 365 Care
<b>PIP Title:</b> Improving the Rate of Depression Screenings and Follow-Up Plans for the Fallon 365 Care Population
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Increase member completion of depression screening by 10% above the 2018 baseline rate of 20.53% through the use of tablet computer screening technology.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Increase the rate of provider offices administering the PRIME MD – PHQ-2, PHQ-9, PSC-17, or other approved screening tools by 10% above the 2018 baseline of 20.53%.</li> <li>Increase the rate of provider follow-up for members identified as having a positive screening by 10% above the baseline rate of 69.23%.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here: 12-18
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Members 12-64 years of age
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)  Fallon 365 implemented tablet computer-based depression screening. Fallon 365 is training staff appropriately to utilize tablet computers to complete screenings for clinical depression with the goal of improving the organizations overall screening rates, as well as follow-up for positive screens. The screening administration protocol is that members/parents self-administer the questionnaire.

As data from the tablet screening are entered into the electronic medical record, there is a pop-up provider notification in the medical record to alert providers to a positive screening. Quarterly data are collected and monitored to compare screening rates before implementation of this intervention to the rates obtained using tablets.

During the course of implementing the tablet-based screening protocol, Fallon 365 learned that members were not completing the screening process. Staff were deployed to the waiting room to observe patients complete the screen. They learned that members had insufficient time in the waiting room to finish answering the questions on the screen. Fallon 365 modified its practices to allow sufficient time for patients to complete the screen.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of ACP members aged 12 – 64 on the date of the encounter, with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year and, if screened positive, a follow-up plan is documented on the date of the positive screen.  NCQA 0418	2018	72/395 18.2%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	137/364 37.64%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):  p < 0.005

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

**Validation phase (check all that apply):**

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

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

**EQRO recommendations for improvement of PIP:**

None identified.

**Performance Improvement Project Evaluation**

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Fallon 365 received a rating score of 100% on this Performance Improvement Project.

**Exhibit 4.5: Fallon 365 PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points)	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	6	18.0	18.0	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>29</b>	<b>81</b>	<b>81</b>	<b>100%</b>

**Plan & Project Strengths**

Fallon 365 well-described how it is meeting the linguistic needs of the population. Kepro commends Fallon 365 for ensuring the cultural competency of this project by implementing hiring practices that reflect the population's different cultural backgrounds. In addition, the use of tablet technology for screening adds another level of understanding for the population's need for privacy.

Overall, Fallon 365, as well as the project leaders and participants, believe this intervention was a success. Many of the project goals were met. A goal of this project was to increase instances of follow up after a positive screen. The data collected as part of this project demonstrate that follow-up events did indeed increase.

# Tufts Health Together with Atrius – Improving Depression Screening and Treatment in Adolescents and Adults

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Together with Atrius Health
<b>PIP Title:</b> Improving the Rate of Depression Screening and Follow Up for Adolescents and Adults
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase the rate of initial depression screening among adolescent and adult members.</li> <li>• Improve the rate of treatment for patients screening positive for depression.</li> <li>• Improve the rate of follow-up screening after a positive screen.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Improve pre- and at-visit workflows to enable depression screening.</li> <li>• Improve alerts and reminders for initial and follow-up screening.</li> <li>• Improve education and training of treatment options.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here: 12 to 17 years of age</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Members aged 12 to 64
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Tufts-Atrius adopted clinical guidelines for depression screening and treatment and conducted extensive provider training. A webinar offering Continuing Medical Education (CME) units, the Management of Depression in Primary Care, was presented to providers and later made available to providers on demand. Psychopharmacology-focused training was offered in Atrius Internal Medicine departments. Behavioral Health also hosted a session on psychopharmacological issues and offered CMEs as well. Other department-based trainings were offered in Ob/Gyn and Pediatrics.



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

Atrius Health modified its electronic medical record system to accommodate and facilitate depression screening and treatment.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of ACP- attributed members 12 to 64 years of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year. NCQA 0418	2018	74/342 21.6%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	74/289 25.6%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
The rate of patients with a positive depression score who have a treatment plan. NCQA 0418	2018	12/74 16.2%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	14/74 18.9%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

**Validation phase (check all that apply):**

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

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

**EQRO recommendations for improvement of PIP:**

Tufts-Atrius outlined the activities implemented to engage providers in adopting the guidelines. Tufts-Atrius states that screening rates for providers that adopted the guidelines and adapted workflows provided evidence of success in changing providers' behaviors. Tufts-Atrius's response would have been stronger had "pre-post" data been provided. Tufts-Atrius is commended for soliciting providers' feedback about its depression screening protocol. However, to assess whether these forums were successful in providers adopting the screening protocols, pre-post comparative data would have helped Tufts-Atrius verify its claim that these interventions were effective in changing provider practices.

**Performance Improvement Project Evaluation**

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

**Exhibit 4.6: Tufts-Atrius PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	11.0	92%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	3.0	9.0	9.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Lessons Learned	2	6	5	83%
<b>Overall Validation Rating Score</b>	<b>23</b>	<b>69</b>	<b>67</b>	<b>97%</b>

**Plan and Project Strengths**

Tufts-Atrius is commended for its efforts to ensure the cultural competence of its services especially with respect to its diversity and cultural competency training manual that is presented monthly during new hire orientation sessions for nurses.

Kepro commends Tufts-Atrius for continuously soliciting feedback from frontline providers, for enlisting engagement in multiple members of the healthcare team such as medical assistants, and working to continuously test changes to workflow integration.

Tufts-Atrius has presented well-articulated lists of "lessons learned" that document the challenges of improving depression screening and follow-up, the options for improving these performance rates, and strategies needed to pursue its project goals in the future.

# Tufts Health Together with BIDCO – Improving Depression Screening and Treatment in Adolescents and Adults

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Together with BIDCO
<b>PIP Title:</b> Improving Depression Screening and Treatment in Adolescents and Adults
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Improve patient knowledge about depression.</li> <li>• Improve patient screening for depression.</li> <li>• Improve patient access to resources to treat depression.</li> <li>• Improve patient outcomes for patients treated for depression.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Improve provider knowledge about depression.</li> <li>• Improve provider screening for depression.</li> <li>• Improve provider knowledge of access to resources to treat depression.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Members 12 to 64 years of age
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Provide Member education on depression screening and treatment.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) Develop and implement provider and staff education and training to implement improved workflows for depression screening and treatment.  Develop and improve standardized workflows for depression screening and treatment.  Build technology and data analytics capabilities within the EMR to assist providers in identifying patients, screening and treatment for depression.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Tufts-BIDCO-attributed members 12 to 64 years of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year. NCQA 0418	2018	160/423 37.8%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	198/389 50.9%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Tufts-BIDCO-attributed members 12 to 64 years of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year and, if screened positive, a follow-up plan is documented on the date of the positive screen. NCQA 0418	2018	157/423 37.1%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	193/389 49.6%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
ACO-attributed members 12 to 64 years of age with a diagnosis of depression and an elevated PHQ-9 score, who received follow-up PHQ-9 and showed evidence of remission or response between four and eight months of the elevated score.  NCQA 1884	2018	2/451 0.4%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	10/79 12.7%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Depression Remission.</i> Members who achieve remission of depression symptoms as demonstrated by a PHQ-9 depression response score of <5 recorded in the medical record (or ECDS) during the depression follow-up period.	2018	1/451 0.2%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	0/79 0.0%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members who indicate a response to treatment for depression as demonstrated by a PHQ-9 depression response score at least 50 percent lower than the PHQ-9 score associated with the index episode start date recorded in the medical record during the depression follow-up period.	2018	1/451 0.2%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	2/79 0.03%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

#### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input checked="" type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b> <ul style="list-style-type: none"> <li>• Kepro advises Tufts-BIDCO to consider other means of ensuring culturally competent services for itself, as a health plan, and for its provider practices by promoting racial and linguistic diversity among its staff and adapting methods of member outreach to the cultural and linguistic characteristics of the members that Tufts-BIDCO is trying to engage.</li> <li>• Kepro recommends that salient aspects of Tufts-BIDCO's population analysis be put into a presentation format and made available to practitioners through its multimodal training platforms.</li> <li>• Kepro recommends an evaluation methodology that includes following-up with a sample of members who received the materials to determine if the member read the materials, did surveys to determine what the members learned so the plan can modify accordingly.</li> </ul>

## Performance Improvement Project Evaluation

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts-BIDCO received a rating score of 90% on this Performance Improvement Project.

### Exhibit 4.7: Tufts-BIDCO PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	6.8	57%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	3.0	9.0	9.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Lessons Learned	2	6	4	67%
<b>Overall Validation Rating Score</b>	<b>24</b>	<b>72</b>	<b>64.8</b>	<b>90%</b>

### Plan & Project Strengths

- Tufts-BIDCO is commended for its use of Performance Improvement Facilitators (PIFs), who offer site-specific technical assistance to its practices.
- Tufts-BIDCO is commended for the central distribution of monthly care reports containing member-specific depression protocol details.



# Tufts Health Together with Boston Children's ACO – Increasing Screening for Clinical Depression with Documentation of Follow-Up Plans after a Positive Screen

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Together with Boston Children's ACO
<b>PIP Title:</b> Increasing Screening for Clinical Depression with Documentation of Follow-Up Plans after a Positive Screen
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase rates of screening for depression using one of the following age-appropriate screens during well child exams approved by MassHealth, i.e., PSC17, MFQ, PHQ9, and PHQ2.</li> <li>• Improve documentation of appropriate follow-up plans after a positive screen for depression.</li> <li>• Reduce duration and severity of depressive episodes in affected teens by facilitating identification of patients in need of a referral to a behavioral health specialist.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Improve rates of depression screening at Tufts-BCH community-based practices (Pediatric Physicians' Organization at Boston Children's Hospital (PPOC) practices).</li> <li>• Improve rates of documenting plans for follow up after a positive screen at PPOC practices.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here: Ages 12 to 17 years of age</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b>
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  In 2018, Tufts-BCH embarked on the streamlining of workflows for depression screening and documentation of a follow-up plan. The network determined that documentation of follow-up plans would become mandatory in the event of a positive depression screen. The electronic medical record (EMR) was modified to accommodate this change in practice. A dashboard was added on which providers could review their rate of behavioral screening and identify patients requiring screening.  Tufts-BCH's quality improvement initiatives involve data-driven assessment of barriers to change. This project is a component of the PPOC's Behavioral Health Integration Program (BHIP). BHIP meets regularly with PPOC practices offers learning communities for interested clinicians. The BHIP team supports offices as they work to integrate behavioral health services within primary care offices and is acutely aware of the difficulties pediatric primary care practices and mental health clinicians have in detecting and treating adolescents with depression,

given current societal stigma, medical-legal regulations, and other developmental difficulties working with this population.

These learning communities are opportunities for the BHIP team to engage with practices, share best practices, and hear concerns or suggestions from actual providers. Tufts-BCH reports that its educational opportunities are well attended by the PPOC practices not only because they offer valuable teaching, but because they give practices the opportunity to share with each other their barriers and successes when confronting teens and young adults with mental health concerns. The constant contact of the BHIP team with PPOC practices has generated a deep understanding of the barriers to screening for depression that are ongoing across the PPOC practice network, and their input has informed the barrier analysis presented here.

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Tufts-BCH-attributed members 12-64 years of age on the date of the encounter with a well visit during the measurement year and no prior diagnosis of depression who are screened for clinical depression using a standardized tool during the measurement year.  NCQA 0418	2018	11,703/ 14,521 80.6%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	17,317/ 19,174 90.3%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<p>The rate of Tufts-BCH-attributed members 12-64 years of age on the date of the encounter with a well visit during the measurement year and no prior diagnosis of depression who screened positive at least once for clinical depression using a standardized tool during the measurement year and have a follow-up plan documented on the date of the positive screen.</p> <p>NCQA 0418</p>	2018	697/1904 36.6%	<p>2019</p> <p><input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available</p>	1530/2925 52.3%	<p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Specify P-value: <input type="checkbox"/> &lt;.01 <input type="checkbox"/> &lt;.05</p> <p>Other (specify): p &lt; 0.005</p>

#### 4. PIP Validation Information

<p><b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Validation phase (check all that apply):</b></p> <p><input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year</p> <p><input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):</p> <p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>

#### EQRO recommendations for improvement of PIP:

In future population analyses, Kepro suggests that Tufts-BCH include clinical factors, such as comorbidities with a positive screen for depression. As data are available, positive depression screens could be stratified by health-related social needs.

#### Performance Improvement Project Evaluation

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

#### Exhibit 4.8: Tufts-BCH PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	3.0	9.0	9.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>23</b>	<b>69</b>	<b>69</b>	<b>100%</b>

#### Plan & Project Strengths

- Tufts-BCH is commended for the data and charts presented that support Tufts-BCH's documentation of the roll-out for this screening protocol and its uptake within the practice workflows.
- Kepro commends Tufts-BCH for its ongoing monthly tracking and suggests continuing monitoring to ensure improvement is sustained.
- Tufts-BCH improved its rate of depression screening from a 2018 baseline rate of 80.6% to a 2019 remeasurement rate of 90.3%, a gain of 9.7 percentage points which achieved and exceeded its performance goal of 85%.
- Tufts-BCH is commended for its excellence shown in both the management of this performance improvement project and for the production of this External Quality Review (EQR) report.

# Tufts Health Together with Cambridge Health Alliance – Improving the Rate of Depression Screening and Follow Up for Adolescents in Primary Care

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Together with Cambridge Health Alliance
<b>PIP Title:</b> Improving the Rate of Depression Screening and Follow Up for Adolescents in Primary Care
<p><b>PIP Aim Statement:</b></p> <p><i>Member-Focused</i></p> <ul style="list-style-type: none"> <li>• Increase the rate of depression screening among adolescent members between the ages 12 years old up to 17 years and 364 days of age.</li> <li>• Improve follow up and utilization of behavioral health services for adolescent members who yield a positive depression screening result.</li> </ul> <p><i>Provider-Focused</i></p> <ul style="list-style-type: none"> <li>• Increase provider knowledge of the importance of depression screening and follow-up services.</li> <li>• Increase the number of referrals to behavioral health services when appropriate.</li> <li>• Increase the rate of collaborative care interventions including integrated behavioral health services and support for adolescent patients with depression.</li> </ul>
<p><b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b></p> <p><input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic)</p> <p><input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases)</p> <p><input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)</p> <p><input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)</p>
<p><b>Target age group (check one):</b></p> <p><input checked="" type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children</p> <p>*If PIP uses different age threshold for children, specify age range here: 12-17</p>
<p><b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Children 12-17 years of age</p>
<p><b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP</p>

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Tufts-CHA is training and integrating mental health staff into its clinics that includes Family Care Partners, Integrated Child Therapists (PhD or LICSW), and Psychiatrists. Their availability at each clinic will vary and so the handoff and follow-up process will vary depending on which team member is available. Furthermore, they will play a role in educating PC Staff regarding mental health care such that PC staff will also provide parental education and the process will not be dependent on presence of mental health staff. Together PC staff and mental health staff will work as a team to implement this workflow.</p>

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

Tufts-CHA is moving forward with the integration of PHQ-2 and PHQ-9 screening into primary care workflows for adolescents. Implementation will include:

- Focus groups to identify barriers to adoption of the depression screening protocols, and
- Trainings with medical assistants and primary care providers regarding the screening protocol. Medical assistants complete the screening and advise the PCC.

A registry of patients with depression has been developed for Tufts-CHA to use proactively for depression management. This registry allows Tufts-CHA integrated behavioral staff to proactively identify members who screen positive and follow up with these members during a depressive episode, as well as to keep track of these members' progress over time.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Rate of Tufts-CHA-attributed members 12 – 17 years 364 days of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using the PHQ-2 and PHQ-9 during the measurement year.	2018	36/3170 1.14%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	37/3465 1.07%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Tufts-CHA-attributed members 12-17 years 364 days of age = on the date of the encounter who screened positive for clinical depression with a treatment plan.  NCQA 0418	10/11	90.0%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	30/30 100%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input checked="" type="checkbox"/> <.05 Other (specify):

#### 4. PIP Validation Information

<p><b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.</p>
<p><b>Validation phase (check all that apply):</b></p> <p><input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year</p> <p><input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):</p> <p>Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>
<p><b>EQRO recommendations for improvement of PIP:</b></p> <p>Kepro suggests soliciting feedback from providers about how to best provide information about depression rates and steps needed to follow up on positive screens and stay connected with members.</p> <p>For future performance improvement projects, Kepro advises Tufts-CHA to learn the methodology for determining that its intervention activities can be evaluated for their effectiveness in changing provider practices and members' behavior relative to the objectives of the project goals.</p>

#### Performance Improvement Project Evaluation

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts Health Together with Cambridge Health Alliance received a rating score of 92% on this Performance Improvement Project.

#### Exhibit 4.9: Tufts-CHA PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	5	100%
Assessing Intervention Outcomes	4.0	12.0	8.3	69%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4.0	12.0	12.0	100%
Remeasurement Performance Indicator Rates	3.0	9.0	8.0	100%
Conclusions and Lessons Learned	2	6	6	94%
<b>Overall Validation Rating Score</b>	<b>23</b>	<b>69</b>	<b>63.3</b>	<b>92%</b>

#### Plan & Project Strengths

Tufts-CHA is commended for its efforts to ensure culturally and linguistically competent scripting regarding behavioral health, as well as continuing the integration of culturally and linguistically competent Family Care Partners as resources to its adolescent members and their families.

Tufts-CHA has presented a reasonable description of the strengths and challenges of implementing this project that should improve the continued deployment of this depression screening protocol for adolescents in other practice groups.



## Wellforce Care Plan – Improving the Rate of Depression Screenings and Follow-Up Plans for the Wellforce Care Plan Population

### 1. General PIP Information

<b>Managed Care Plan (MCP) Name: Wellforce Care Plan</b>
<b>PIP Title:</b> Improving the Rate of Depression Screenings and Follow-Up Plans for the Wellforce Care Plan Population
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase the number of members screened for depression during the PCP annual [examination] and/or pertinent office visits 5% over the 2018 calendar year baseline of 9%.</li> <li>• Increase the number of members receiving a follow-up plan after a positive depression screening by 5% over the 2018 calendar year baseline of 37.5%.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Offer education to providers and clinical office staff, with at least 80% participation, to increase depression screening assessment.</li> <li>• Improve clinical staff and provider workflows to adhere to depression evidence-based guidelines (EBGs). For each practice/department, a minimum of 15 records will be audited and demonstrate 70% level of compliance with EBGs.</li> <li>• Providers will increase depression screenings conducted during encounters with MassHealth ACPP members as evidenced by an increase of 5% over the 2018 calendar year baseline that will be calculated following the first year of data collection.</li> <li>• Providers will increase rates of follow up for Fallon-Wellforce members who screen positive on the PHQ-9 by an increase of 5% over the 2018 calendar year baseline that will be calculated following the first year of data collection.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here: Ages 12 to 17 years of age
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Members 12 – 64 years of age
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
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Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

Fallon-Wellforce implemented the Patient-Centered Medical Home depression workflow at those practices that use the eClinicalWorks electronic medical record. The system triggers a task that tracks patients needing follow up. It also requires providers to document a follow-up plan for all patients with a positive depression screen.

Using a train-the-trainer approach, the Quality Improvement Specialist trained charge nurses from each primary care department at Lowell Community Health Center on the depression screening and follow-up measure requirements. Based on staff feedback about the need to identify patients who require screening, a modification was made in the electronic medical record to alert staff that a depression screening is due.

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Fallon-Wellforce members aged 12-64 on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year and, if screened positive, a follow-up plan is documented on the date of the positive screen.  NCQA 0418	2018	26/411 6.3%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	173/367 47.14%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  None identified.

## Performance Improvement Project Evaluation

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

### Exhibit 4.10: Fallon-Wellforce PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	6	18	18	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>27</b>	<b>81</b>	<b>81</b>	<b>100%</b>

### Plan & Project Strengths

- Kepro commends the plan for the Social Determinant of Health initiative started in 2019, as a partnership between New England Quality Care Alliance and Health Management Associates. The initiative is aimed at heightening awareness with members who struggle with an SDOH and understanding the disparities relevant to race, ethnicity and language.

## SUBSTANCE USE DISORDERS

### Always-My Care Family - Increase the Initiation and Engagement in Treatment (IET) Rates for Always-My Care Family with a New Episode of Alcohol or Other Drug (AOD) Abuse or Dependence

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Always-My Care Family
<b>PIP Title:</b> Increase the Initiation and Engagement in Treatment (IET) Rates for My Care Family with a New Episode of Alcohol or Other Drug (AOD) Abuse or Dependence
<p><b>PIP Aim Statement:</b></p> <p><i>Member-Focused</i></p> <ul style="list-style-type: none"> <li>To increase by 5% over baseline (CY18) the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of diagnosis.</li> <li>To increase by 5% over baseline (CY18) the percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.</li> </ul> <p><i>Provider-Focused</i></p> <ul style="list-style-type: none"> <li>Improve medical and BH providers' knowledge of IET measure requirements and referral resources for the ACP population, as evidenced by provider responses to Always-My Care Family's post-training provider survey.</li> <li>Increase primary care providers' use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues, as evidenced by the percent of PCPs using SBIRT during the measurement period.</li> </ul>
<p><b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b></p> <p><input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic)</p> <p><input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases)</p> <p><input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)</p> <p><input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)</p>
<p><b>Target age group (check one):</b></p> <p><input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children</p> <p>*If PIP uses different age threshold for children, specify age range here:</p>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

#### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

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

Not applicable.

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

In partnership with its behavioral health vendor, Optum, Allways-My Care Family is offering education to medical and behavioral health providers on the IET measure and referral options for members with substance use disorders. This training uses multiple approaches to reach providers including in-person training, email, and video.

Allways-My Care Family developed a process workflow for use by PCP providers for the evaluation of patient needs in order to direct them to the most appropriate care management or substance use support program.

This intervention is being piloted at the Greater Lawrence Family Health Center and will include training PCP providers on the SBIRT protocol.

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

Using a predictive modeling algorithm, Allways-My Care Family generates a monthly list of high-risk members with a new episode of substance abuse and attempts with the goal of engaging them in care management and treatment.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization or medication treatment within 14 days of diagnosis.  NCQA 0004	2018	270/782 34.53%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	235/641 36.66%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The number of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.  NCQA 0004	2018	93/782 11.89%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	87/641 13.57%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

#### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  Kepro suggests considering additional platforms for outreach to engage members, via text messaging and telephonic connections.

#### Performance Improvement Project Evaluation

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

#### Exhibit 4.11: AllWays-My Care Family PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	9	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	11.33	94%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4	12	12	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>23</b>	<b>69</b>	<b>68.33</b>	<b>99%</b>

#### Plan & Project Strengths

- AllWays-My Care Family concluded that the interventions are having a positive effect on the AOD population relative to initiation and engagement in treatment.



## BEHAVIORAL HEALTH FOLLOW UP POST-DISCHARGE

### Be Healthy Partnership – Use of a Hospital-Based Transition of Care Team (TOC) to Ensure Follow Up Within Seven Days After Hospitalization for Mental Illness

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Be Healthy Partnership
<b>PIP Title:</b> Use of a Hospital-Based Transition of Care team (TOC) to Ensure Follow Up Within Seven Days After Hospitalization for Mental Illness
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Decrease hospital readmissions for mental health within seven or thirty days.</li> <li>Increase the number of completed follow-up visits within seven days following discharge.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Increase the number of contacts made to identified patients for the TOC program.</li> <li>Increase the number of appointments made for members post-discharge within seven days of discharge.</li> <li>Improve information provided to behavioral health and primary care providers by means of the patient discharge summary.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here: Ages 6 to 17
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Members 6 to 64 years of age
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

#### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  The Be Healthy Partnership implemented a Transition of Care Program in which a social worker meets high-risk and high-utilizing patients in the inpatient unit. They follow up with the patient within 48 hours of discharge, preferably at the patient's home, to ensure the coordination of care. If the social worker is unable to reach the patient by phone, they attempt a home visit. Ultimately, a warm hand-off is made to the patient's primary care team.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of patients 6 to 64 years of age as of the date of discharge who had a follow-up visit with a mental health practitioner within 7 days after discharge. NCQA 0576	2018	90/167 53.9%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	145/413 35.1%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005
The rate of patients 18 to 64 years of age with an acute inpatient stay during the measurement year that were followed by an acute unplanned readmission for any diagnosis within 30 days. NCQA 1768	2018	4/167 2.4%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	18/413 4.4%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members 18 to 64 years of age who were hospitalized for the treatment of selected mental illness diagnoses contacted by a member of the TOC team within 48 hours of discharge.	2018	10/97 10.3%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	142/413 34.3%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

#### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):  Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  None identified.

#### Performance Improvement Project Evaluation

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

#### Exhibit 4.12: HNE-BeHealthy PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	2	6	6	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
Overall Validation Rating Score	<b>23</b>	<b>69</b>	<b>69</b>	<b>100%</b>

#### Plan & Project Strengths

- Kepro commends HNE-Be Healthy for conducting a risk analysis on this population which identifies this group at greater risk compared to the average population.
- HNE-Be Healthy reported that the remeasurement of this PIP demonstrated that when members are admitted to the hospital for mental health conditions and engaged with the Transition of Care team prior to discharge, it can lead to higher rates of follow-up with a practitioner within 7 days of discharge.

# BMC Healthnet Plan Community Alliance – Increase the Rate of Follow-Up Visits Within Seven Days of Discharge for Members Hospitalized for a Mental Illness

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan Community Alliance
<b>PIP Title:</b> Increase the Rate of Follow-Up Visits Within Seven Days of Discharge for Members Hospitalized for a Mental Illness
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Educate members to help communicate to them the importance of engaging in ongoing outpatient services, to provide information to them regarding mental health services available, and to support follow-up compliance.</li> <li>Ensure members get timely outpatient follow up after inpatient hospitalization discharge and engage in ongoing outpatient services to meet members' needs.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Bridge the gap between inpatient and outpatient facilities.</li> <li>Enable proactive outreach to patients to help navigation and encourage engagement.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here: Ages 6 through 17
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b>
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  BMCHP-BACO collected four weeks of data and identified 96 patients on Beacon's reports for outreach by clinical staff to support scheduling follow-up appointments. Out of these 96 patients, outreach workers were able to connect with 19 patients at participating inpatient psych facilities, and then helped schedule 3 appointments. Other ACPP sites reported similarly low outreach rates for outreach and referral. In an effort to improve these rates of outreach and referral, outreach is now being conducted at patient-attributed BMCHP-BACO sites.

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

A part-time Beacon Health Options care manager has been embedded at high-volume facilities to improve patient engagement.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who have a follow-up visit with a mental health practitioner within 7 days of discharge, not including visits that occur on the date of discharge.  NCQA 0576	2018	530/ 1227 43.19%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	944/2067 45.67%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):

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

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

**EQRO recommendations for improvement of PIP:**

- Kepro recommends further describing how the intervention resulted in the performance rate, since other factors could have adjusted the outcome.

**Performance Improvement Project Evaluation**

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMC HealthNet Plan Community Alliance received a rating score of 94% on this Performance Improvement Project.

**Exhibit 4.13: BMCHP-BACO PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	8	89%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	9	75%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>24</b>	<b>72</b>	<b>68</b>	<b>94%</b>

**Plan & Project Strengths**

- The plan encouraged behavioral health hospitals to integrate an admit/discharge/transfer feed that provides real-time notifications of admissions or discharges to PCPs and behavioral health providers, in order to follow up with its members efficiently.

## BMC Healthnet Plan Mercy Alliance – Increase the Rate of Follow-Up Visits Within Seven Days of Discharge for Members Hospitalized for a Mental Illness

### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan Mercy Alliance
<b>PIP Title:</b> Increase the Rate of Follow-Up Visits within Seven Days of Discharge for Members Hospitalized for a mental illness
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>To decrease or eliminate the stigma of mental illness and support follow-up compliance, educate members about available behavioral health services available.</li> <li>Facilitate a connection to mental health peer supports.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Educate providers about practices for follow-up care with high-volume inpatient facilities.</li> <li>Create and transmit a daily report of psychiatric admissions of BMCHP-Mercy patients to the BMCHP-Mercy team and high-volume inpatient providers, allowing proactive facilitation of care management and follow up with seven days of discharge.</li> <li>Establish improved access to outpatient behavioral health care through collaboration with community partner site(s) or build an open access-focused capacity in an outpatient clinic.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>CSP workers meet with patients in advance of discharge. BMCHP-Mercy is exploring other ways to begin outreach to the patient's community-based therapist shortly after admission, rather than waiting until discharge.</p> <p>BMCHP-Mercy plans to develop a process for educating patients about aftercare resources and how their assigned CSP worker is available to support their access to post-discharge services.</p>
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Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

To forge a stronger working relationship and encourage ongoing communication, BMCHP-Mercy facilitated a meeting between the facility, a high-volume outpatient provider, and Community Support Program (CSP) workers.

The inpatient facility developed operational workflows to identify patients at admission and begin the process of aftercare planning on the first day of treatment. Each morning, projected discharge dates are reviewed for after care planning and scheduling purposes.

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The number of discharges identified in the denominator with a follow-up visit with a mental health practitioner within 7 days after discharge, not including visits that occur on the date of discharge.  NCQA 0576	2018	108/199 54.27%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	105/204 51.47%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

**Was the PIP validated?** ☒ Yes ☐ No

**Validation phase (check all that apply):**  
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year  
☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):

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

**EQRO recommendations for improvement of PIP:**

- Kepro recommends further describing how intervention activities are culturally meaningful.
- BMCHP-Mercy reported intervention results, but it did not assess the intervention's effectiveness. Effectiveness is measured by determining the extent to which the intervention was successful in generating the desired outcomes for the population of focus.
- Kepro recommends further describing how the intervention resulted in the performance rate.
- Kepro recommends describing the conclusions drawn from the remeasurement year of this report (2019) in order to apply lessons learned going forward.

**Performance Improvement Project Evaluation**

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMC HealthNet Plan Mercy Alliance received a rating score of 88% on this Performance Improvement Project.

**Exhibit 4.14: BMCHP-Mercy PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	11	92%
Population Analysis Update	2	6	5	83%
Assessing Intervention Outcomes	4.0	12.0	8	67%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	5	83%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	4	67%
<b>Overall Validation Rating Score</b>	<b>25</b>	<b>75</b>	<b>66</b>	<b>88%</b>

**Plan & Project Strengths**

- BMCHP-Mercy reported the PIP topic has changed due to the closure of The Mercy, Inc. d/b/a Providence Behavioral Health Hospital Inpatient Psychiatric Unit. The approach is now to identify psychiatric hospitals that provide services for members, help support healthy after-care planning, and patient compliance after discharge.
- BMCHP-Mercy started analyzing where other hospitals' members are going for services and pulling compliance data for post-discharge follow-up within 7 days in order to collaborate with those hospitals to engage and improve rates.

# BMC Healthnet Plan Signature Alliance – Increase the Rate of Follow-Up Visits Within Seven Days of Discharge for Members Hospitalized for a Mental Illness

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan Signature Alliance
<b>PIP Title:</b> Increase the Rate of Follow-Up Visits Within Seven Days of Discharge for Members Hospitalized for a Mental Illness
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Ensure members get timely outpatient follow up after inpatient hospitalization discharge and engage in ongoing outpatient services to meet members' needs.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Bridge gap in communication between inpatient facilities and outpatient clinics on shared patients to enable scheduling of post-discharge appointments within 7 days for shared members.</li> <li>Enable proactive outreach to patients to help navigation and encourage engagement.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here: Ages 6 through 17</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Member 6 to 64 years of age
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>On a daily basis, each care team receives a list of members who have been discharged from mental illness-related inpatient hospitalization. Social workers conduct outreach to each patient on the day of discharge. If the patient does not have a follow-up appointment, the social worker assists with scheduling. A note is placed in the electronic record indicating the need for a follow-up appointment. This note is routed to the patient's primary care provider's office.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>
<p>MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)</p>

Because BMC HealthNet Plan Signature Alliance has no outpatient behavioral health providers in its system, it is exploring developing relationships with other local systems and accountable care organizations.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who have a follow-up visit with a mental health practitioner within 7 days of discharge, not including visits that occur on the date of discharge.  NCQA 0576	2018	103/198 52.02%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	117/259 45.17%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence

**EQRO recommendations for improvement of PIP:**

- BMCHP-Signature concluded that given the low contact rate and number of members with appointments at discharge or after follow-up outreach, this intervention was not effective. Kepro recommends this be explored further, as it is difficult to surmise the effect of the intervention with such small numbers.
- Kepro recommends exploring novel approaches for outreach such as telephonic, video and text messaging to connect with members.

**Performance Improvement Project Evaluation**

Kepro evaluates an ACPPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMC HealthNet Plan Signature Alliance received a rating score of 90% on this Performance Improvement Project.

**Exhibit 4.15: BMCHP-Signature PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	11	92%
Population Analysis Update	2	6	5	83%
Assessing Intervention Outcomes	4.0	12.0	8	67%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	5	83%
Performance Indicator Parameters	3.0	12.0	12	100%
Remeasurement Performance Indicator Rates	2.0	9.0	9	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>21</b>	<b>69</b>	<b>62</b>	<b>90%</b>

**Plan & Project Strengths**

- BMCHP-Signature reported the data showed that the intervention of this project seemed ineffective at meeting the goal. Therefore, the plan has shifted to better understand the behavioral health needs of its members and assist when applicable.

# BMC Healthnet Plan Southcoast Alliance – Increase the Rate of Follow-Up Visits Within Seven Days of Discharge for Members Hospitalized for a Mental Illness

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan Southcoast Alliance
<b>PIP Title:</b> Increase the Rate of Follow-up Visits Within Seven Days of Discharge for Members Hospitalized for a Mental Illness
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Communicate importance of engaging in ongoing outpatient services, provide information regarding mental health services available, and support follow up compliance.</li> <li>Ensure members get timely outpatient follow up after inpatient hospitalization discharge and engage in outpatient services to meet members' needs.</li> <li>Support patients in navigating an often confusing landscape of appointments post-hospital discharge.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Bridge the gap in patient care between the behavioral health facility and outpatient providers.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Members 6 – 64 years of age
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  None identified.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Behavioral health (BH) providers have been embedded in five BMCHP-Southcoast practice sites. By embedding BH providers into its primary care sites, BMCHP-Southcoast plans to bridge visits to its Medicaid ACP patients if the inpatient BH facility is not able to secure an outpatient provider appointment with their current BH provider within seven days of their discharge from the facility. These BH embedded providers will then do a warm handoff either to the patient's new or current provider. BMCHP-Southcoast believes that this protocol will ensure continuous, high touch patient care for its highly vulnerable patient population.

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

BMCHP-Southcoast is pursuing a clinical affiliation with a large outpatient behavioral health provider to improve member access to behavioral health providers.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who have a follow-up visit with a mental health practitioner within 7 days of discharge, not including visits that occur on the date of discharge.  NCQA 0576	2018	96/174 55.17%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	120/228 52.63%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):

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

**EQRO recommendations for improvement of PIP:**

- The plan reported that the results indicate this intervention (single-point-of-contact) did not appear to improve outcomes. Kepro recommends exploring this intervention further and determining if in fact it was contact to inpatient that affected data or possibly patient amenability for further treatment.

**Performance Improvement Project Evaluation**

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMCHP-Southcoast received a rating score of 96% on this Performance Improvement Project.

**Exhibit 4.16: BMCHP-Southcoast PIP Rating**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	8	89%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	1.5	4.5	4	89%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	5	83%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>21.5</b>	<b>64.5</b>	<b>62</b>	<b>96%</b>

**Project & Plan Strengths**

- BMCHP-Southcoast showed the updated population analysis verified that many patients have co-existing medical conditions as well as a behavioral diagnosis. The Care Navigation Team is an integrated team of both medical & behavioral health staff which allows for the social workers to partner with their medical colleagues to better engage patients and address the member's complex needs



## DOMAIN 2: POPULATION & COMMUNITY NEEDS ASSESSMENT AND RISK STRATIFICATION

### ASTHMA

#### BMC Healthnet Plan Community Alliance – Improving Asthma Control and Medication Adherence

##### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan Community Alliance
<b>PIP Title:</b> Improving Asthma Control and Medication Adherence
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Member awareness of asthma-related triggers, awareness of the differences between asthma controller and rescue medications, as well as appropriate use of the medications.</li> <li>Medication adherence support.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Asthma-focused care coordination and ambulatory engagement.</li> <li>Provider education (escalation, appropriate prescribing patterns, asthma assessment, BMCHP formulary guide).</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

##### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>A pharmacy-led asthma adherence program that has the goal of improving asthma control by ensuring that patients with persistent asthma have access to controller inhalers, and are appropriately using them.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members with asthma that have a medication ratio of 0.50 or greater.  NCQA 1800	2018	273/485 56.29%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	298/570 52.28%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
The rate of members with asthma that have achieved a Proportion of Days Covered of at least 75% for the asthma controller medications.  NCQA 1799	2018	125/369 33.88%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	174/430 40.47%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input checked="" type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):

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

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

**EQRO recommendations for improvement of PIP:**

- The plan did not describe how it assessed the effectiveness of the pharmacy-led asthma program in the results. Kepro recommends exploring this further.

**Performance Improvement Project Evaluation**

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMCHP- BACO received a rating score of 93% on this Performance Improvement Project.

**Exhibit 4.17: BMCHP-BACO's PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	8	89%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	9	75%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	5	83%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>24</b>	<b>72</b>	<b>67</b>	<b>93%</b>

**Project & Plan Strengths**

- BMCHP-BACO described implementing an escalation pathway to member's primary care site for those who are difficult to engage or do not respond effectively to the intervention. Additionally, periodic "rounds" will begin with PCPs and pharmacy staff outreaching members to determine the best approach to engage them.

# BMC HEALTHNET PLAN MERCY ALLIANCE – IMPROVING ASTHMA CONTROL AND MEDICATION ADHERENCE

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan Mercy Alliance
<b>PIP Title:</b> Improving Asthma Control and Medication Adherence
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Provide member education to increase awareness of asthma-related triggers and the difference between asthma controller and rescue medications as well as the appropriate use of the medications.</li> <li>• Ensure that patients receive appropriate medication to minimize the effect of asthma on patient life.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Implement asthma-focused care coordination and treatment protocols.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  A pulmonologist addressed a meeting of Adult Medicine providers about asthma management from the perspective of the primary care provider.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)  BMCHP-Mercy implemented a rescue inhaler zero-refill policy for pure asthmatics, i.e., individuals with COPD-asthma and chronic bronchitis-asthma comorbidities are excluded from the policy.  A provider-facing alert was implemented in the electronic medical record that reminds providers, in the event of a second patient refill request within four months, of the importance of office follow up.

BMCHP-Mercy tracks patients' asthma medication ratios monthly and provide reports to practices on successes and gaps.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members with persistent asthma who have a medication ratio of 0.50 or greater during the measurement year.  NCQA 1800	2018	108/199 54.27	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	130/217 59.91	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
The rate of members with persistent asthma who achieved a Proportion of Days Covered (PDC) of at least 75% for asthma controller medications.  NCQA 1799	2018	69/190 36.30%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	63/183 34.43%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

**Validation phase (check all that apply):**

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

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

**EQRO recommendations for improvement of PIP:**

- BMCHP-Mercy stated it is using the criteria for Asthma Medication Ratio (AMR) to measure effectiveness of this intervention. While the results can inform intervention effectiveness, it did not determine if the intervention had been successful in generating the desired outcomes for the population of focus.
- In early 2020, the predominant NDC codes used for albuterol sulfate switched – and that the new code was not captured in HEDIS specs until November 2019 when NCQA released its annual drug list update. Throughout 2019, the plan's performance appeared to be very high, however, when it re-ran the data through their HEDIS software in spring 2020, performance dropped significantly, due to the update.

**Performance Improvement Project Evaluation**

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

**Exhibit 4.17: BMCHP PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	10	83%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>25</b>	<b>75</b>	<b>73</b>	<b>97%</b>

**Plan & Projects Strengths**

- BMCHP-Mercy described how it plans to find better ways to engage and support patients who are not engaged on case management, as they are less likely to meet the AMR metric. Additionally, the plan seeks to understand how patient race and obesity contributes to non-compliance so they can offer additional support.
- BMCHP-Mercy reported that the PIP intervention appeared to be successful, improving performance from baseline and remeasurement year for the AMR measure. There was a decrease in the MMA measure, but the plan will research the reason.

# BMC Healthnet Plan Signature Alliance – Improving Asthma Control and Medication Adherence

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan Signature Alliance
<b>PIP Title:</b> Improving Asthma Control and Medication Adherence
<b>PIP Aim Statement:</b>  <u>Project Goals</u>  BMC HealthNet Plan Signature Alliance did not write their goals as goal statements, but rather intervention summaries, e.g., “Pharmacy-led outreach to members to help members navigate prescription fills, refills, and medication-related questions.”
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  BMC HealthNet Plan Signature Alliance implemented an asthma medication protocol. After identifying a patient who have an asthma controller medication ratio of less than 0.50 during the measurement year. The BMCHP-Signature pharmacy team entered a task for the primary care department alerting them to an upcoming opportunity for patient with asthma. The pharmacy team conducted outreach to the member, provided counseling, and removed any existing barriers to care such as transportation to the pharmacy. The team confirmed that the member kept their appointment and followed up as necessary. The patient was contacted two weeks before the expiration of a prescription. A key challenge in implementing this intervention has been provider engagement, but BMCHP-Signature reports having made strides in this area over time.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)  Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members with asthma that have a medication ratio of 0.50 or greater.  NCQA 1800	2018	43/82 52.44%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	61/111 54.95%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
The rate of members with asthma that have achieved a Proportion of Days Covered (PDC) of at least 75% for the asthma controller medications.  NCQA 1799	2018	19/61 31.10%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	35/82 42.68%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  <ul style="list-style-type: none"> <li>• Kepro recommends further exploring intervention effectiveness beyond just analysis of results. One possible area to explore would be to survey patients that were outreached or educated to see if it affected their behavior.</li> <li>• Kepro suggests considering additional methods of outreach to members such as text messaging to connect with members, provide education, and solicit information about rescue inhaler use.</li> </ul>



## Performance Improvement Project Evaluation

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMC HealthNet Plan Signature Alliance received a rating score of 95% on this Performance Improvement Project.

### Exhibit 4.18: BMCHP-Signature PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	11	92%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	10	83%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	5	83%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>25</b>	<b>75</b>	<b>71</b>	<b>95%</b>

### Plan & Project Strengths

- BMCHP-Signature reported plans to spend more time in person with both providers and patients to develop relationships for more effective education.
- BMCHP-Signature has made progress toward meeting the goals as a result of increased outreach frequency and engagement of providers, which has had a positive effect on the outcomes.

# BMC Healthnet Plan Southcoast Alliance – Improving Asthma Control and Medication Adherence

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan Southcoast Alliance
<b>PIP Title:</b> Improving Asthma Control and Medication Adherence
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Awareness of asthma-related triggers, awareness of the difference between asthma controller and rescue medications, as well as the appropriate use of the medications.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Proper diagnosis and treatment path.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  BMCHP-Southcoast undertook a provider education campaign and also completed a pilot test of the asthma control test (ACT) screening tool and electronic medical record alerts with two providers. Based on the success of the pilot, the ACT will be implemented in all primary care practices. Providers were presented with anecdotal stories about inhaler stockpiling, which was sufficient to convince them to set a no-refill policy. The results of this change will be shared at committee meetings, in newsletters, and in provider education materials.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)  The default number of refills for relief medications was changed from eleven to zero.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members with asthma that have a medication ratio of 0.50 or greater.  NCQA 1800	2018	80/148 54.05%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	90/169 53.25%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
The rate of members with asthma that have achieved a Proportion of Days Covered (PDC) of at least 75% for the asthma controller medications.  NCQA 1799	2018	49/120 40.83%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	50/132 37.88%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence

**EQRO recommendations for improvement of PIP:**

- Kepro recommends exploring other factors that could have affected patient follow-up appointments, e.g., no shows.
- BMCHP-Southcoast reported no conclusions as a result of variability, and data evaluation issues due to an update discovered in early 2020 that the predominant NDC codes used for albuterol sulfate had been switched and the new code was not captured in HEDIS specs until November 2019 when NCQA released its annual drug list update. This resulted in outreach that was not sufficient to close the gaps and achieve the goals.

**Performance Improvement Project Evaluation**

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMCHP-Southcoast received a rating score of 96% on this Performance Improvement Project.

**Exhibit 4.19: BMCHP-Southcoast PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	11	92%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	3.0	9.0	8	89%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	5	83%
Performance Indicator Parameters	4.7	14.0	14	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>23.7</b>	<b>71</b>	<b>68</b>	<b>96%</b>

**Plan & Project Strengths**

- BMCHP-Southcoast reported that as a result of the conclusions, the plan is considering requesting a modification to the existing report or request a new custom report to determine if there is a way to electronically verify that the ACT is administered whenever a patient with asthma meets the threshold for screening as defined in the protocol.

## Allways-My Care Family - Increase the Asthma Medication Ratio (AMR) Rate for My Care Family Members with Persistent Asthma 5-64 Years of Age

### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Allways-My Care Family
<b>PIP Title:</b> Increase the Asthma Medication Ratio (AMR) Rate for Allways-My Care Family Members with Persistent Asthma 5-64 Years of Age
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>To increase by 5% over baseline [2018] the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Increase Primary Care Physicians' knowledge of referral resources for their Allways-My Care Family panel of members with persistent asthma, as evidenced by an increase in PCP referrals to care and disease management programs.</li> <li>Increase Primary Care Physicians' knowledge about the AMR measure requirements and how to use actionable AMR gaps in care reports as evidenced by an increase in their AMR rates.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here: Five years of age and older</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members.
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Allways-My Care Family implemented a broad-scale member education program that uses a combination of telephonic and in-person counseling and text messaging to teach members with persistent asthma about the proper use of asthma medication and how to self-manage their condition. These activities include, but are not limited to, weekly asthma member-education sessions conducted by Care/Disease Managers at high-volume primary care locations and monthly text messaging to medication non-adherent members. Incentives (allergy-free bedding) are offered to members attending education sessions. Pharmacy staff conduct outreach to members, administer the Asthma Control Test, assess social determinants of health, and complete an environmental screening. Asthma education visits at school-based health centers is planned.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members with asthma that have a medication ratio of 0.50 or greater.  NCQA 1800	2018	93/151 61.59%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	61/111 54.95	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):  Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  None identified.

### Performance Improvement Project Evaluation

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

#### Exhibit 4.20: AllWays-My Care Family PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	8	89%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4	12	12	100%
Remeasurement Performance Indicator Rates	5.0	15.0	15	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>24</b>	<b>72</b>	<b>71</b>	<b>99%</b>

#### Plan & Project Strengths

- Along with addressing the linguistic needs of this population, AllWays-My Care Family described how Care Managers/Disease Managers/Population Health Managers at Greater Lawrence Family Center/AllWays-My Care Family are using a holistic approach when outreaching members with persistent asthma. In addition to providing education regarding proper use of asthma medication, they also address other medical and behavioral health conditions and comorbidities.
- AllWays-My Care Family concludes that educating providers had a positive impact with the recognition that repetition will be needed.
- In addition to supporting providers utilizing the new guidelines, AllWays-My Care Family plans to implement provider-specific asthma quality reports for the patient panel, supporting a multidisciplinary approach to streamline asthma care, asthma-focused peer review, and a focus on asthma in ACO newsletter updates.
- In adapting to patient care with regards to minimizing the risk of COVID-19 for patients and healthcare providers, AllWays-My Care Family is engaging more patients through telehealth asthma visits and a pharmacist assisting with outreach calls.

## DIABETES

### Wellforce Care Plan – Improving the Rate of Hba1c Testing in the Wellforce Care Plan Diabetic Population

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Wellforce Care Plan
<b>PIP Title:</b> Improving the Rate of HbA1c Testing in the Wellforce Care Plan Diabetic Population
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Achieve a member HbA1c testing rate of 92.7%.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Improve tracking and monitoring of gaps in care for members with diabetes with the involvement of quality personnel.</li> <li>Improve communication between specialist and PCP offices with quality team personnel to discuss gaps in care for non-adherent members through in-person meetings or other correspondence.</li> <li>Develop reference materials and disseminate them to provider offices related to evidence-based guidelines for diabetic members.</li> <li>Identify members with HbA1c values that are <math>\geq 9\%</math> for focused provider outreach and educate providers regarding referrals to disease management and case management programs that are available to assist with disease management strategies.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Adult members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

#### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Gaps in care registries were generated for members attributed to the Lowell General Physician Hospital Organization and the Lowell Community Health centers. Providers were encouraged to telephone non-adherent patients. Physician administrators and the Practice Performance Team are developing a remediation intervention plan to address low-performing providers.



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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The percentage of Fallon-Wellforce members 18-64 years of age with diabetes (type 1 and type 2) who had Hba1c testing.  NCQA 0057	2018	25/30 83.33%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	1676/1865 89.87%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  None identified.

### Performance Improvement Project Evaluation

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

#### Exhibit 4.21: Fallon-Wellforce PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>26</b>	<b>78</b>	<b>78</b>	<b>100%</b>

#### Plan & Project Strengths

- Kepro commends the plan for the Social Determinant of Health (SDOH) initiative started in 2019, as a partnership between New England Quality Care Alliance and Health Management Associates, aimed at heightening awareness with members who struggle with an SDOH and understanding the disparities relevant to race, ethnicity and language.
- The plan stated it cannot make definitive conclusions regarding the effectiveness of these interventions. However, HbA1C testing rates have increased from 2018 to 2019, observed in HEDIS data, which may be indicative that outreach efforts are having a positive effect.
- Fallon-Wellforce described multiple strategies for improving outcomes that were implemented (or will be) in 2020, including revised outreach, telephone or virtual "home visits," multiple resources for members, new outreach strategies.

# BeHealthy Partnership – Improving Outcomes in Diabetic Patients Through Integrated Care Management

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BeHealthy Partnership
<b>PIP Title:</b> Improving Outcomes in Diabetic Patients Through Integrated Care Management
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Decrease member HbA1c results.</li> <li>Increase the volume of members connected with housing, food, and transportation supports.</li> <li>Decrease hospitalizations and emergency department visits due to diabetic complications.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Increase the number of contacts made to identified patients for the Diabetic/SDoH program.</li> <li>Increase the number of referrals made for members with identified SDoH issues.</li> <li>Increase the number of patients using in-center diabetic services, e.g., group visits and primary care visits.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Adult members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Registries of members with diabetes and housing, food, and transportation issues are shared with Community Health Workers (CHWs) at each of four health centers. The CHW collaborates with the member's primary care team to identify the appropriate treatment pathway. The CHW then refers the member to the needed community resources and follows up to ensure adherence with the treatment and social plan.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)  Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Members referred to a diabetes management program who are 18 to 64 years of age with type 1 or type 2 diabetes who had HbA1c poor control, i.e., greater than 9.0%.  NCQA 0059	2018	32/91 35.2%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	31/69 44.9%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Inpatient Admission rate for diabetics with SDOH. The rate is limited to the identified members for this project.  EOHHS	2018	200/200 100%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	98/98 100%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Members referred to a diabetes management program identified with SDOH referred to a Social Service Agency.	2018	14/27 51.9%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	69/98 70.4%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input checked="" type="checkbox"/> <.05 Other (specify):

#### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):  Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  HNE-Be Healthy well described lessons learned from this project. Kepro recommends these lessons be applied when considering expansion of this project in the future.

#### Performance Improvement Project Evaluation

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

#### Exhibit 4.22: HNE-BeHealthy PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	2	6	6	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	5.0	15	15	100%
Remeasurement Performance Indicator Rates	3.6	10.8	10.8	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>23.6</b>	<b>70.8</b>	<b>70.8</b>	<b>100%</b>

#### Plan & Project Strengths

- HNE-Be Healthy stated that the SDOH interventions on the overall rate of the 66 Diabetic members with poor HbA1C control appears to have a significant impact on the HbA1C levels of these patients as well as the ability to control their diabetes.
- The average HbA1C level significantly decreased from baseline in members who were engaged by a CHW and referred to social service agencies that address their identified SDOH, dropping the percentage of those with poor HbA1C control (>9.0) from 62% to 47%.
- HNE-Be Healthy stated the outcomes of this project supported that addressing SDOH factors as well as clinical factors had a positive impact on the effectiveness of diabetes control.

## HEART DISEASE

### Berkshire Fallon Health Collaborative (Fallon-BFHC) – Improve Blood Pressure Control in the Berkshire Fallon Health Collaborative Population

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Berkshire Fallon Health Collaborative (BFHC)
<b>PIP Title:</b> Improve Blood Pressure Control in the Berkshire Fallon Health Collaborative Population
<b>PIP Aim Statement:</b>  <u>Member-Focused</u> <ul style="list-style-type: none"><li>• Increase the percentage of members diagnosed with hypertension who have adequately controlled blood pressure to a baseline rate of 67.2%, which is an increase of 10% from the 2018 baseline rate.</li><li>• Increase members' participation in a self-measured blood pressure monitoring program (Get Cuffed Program) by 50% from a baseline of 6% of eligible members.</li></ul> <u>Provider-Focused</u> <ul style="list-style-type: none"><li>• Increase provider referrals to the Get Cuffed Program (self-measured blood pressure) for members with elevated blood pressures by 40% from a baseline rate of 10% of provider referrals.</li><li>• Improve accuracy of blood pressure measurement technique by providing provider education and performing post-education assessments, ensuring 100% staff participation in this education.</li></ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Adult members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

#### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  BFHC implemented the Get Cuffed program. Referred patients attend a class in which they learn how to self-monitor blood pressure. They are then sent home with a fitted automatic blood pressure cuff to self-monitor. They are instructed to conduct two readings per day, one in the morning and one in the evening. Seven days later, a program nurse reaches out to the patient to discuss the readings and develop next steps as indicated.

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

To ensure accuracy in blood pressure measurement, staff were asked to complete the interactive blood pressure education tool available on the American Heart Association's Target Blood Pressure website. Practice managers tracked training completion. Is)

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members 18-64 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.  NCQA 0018	2018	251/411 61.07%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	292/392 74.49%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  None identified.

## Performance Improvement Project Evaluation

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

### Exhibit 4.23: Fallon-BFHC PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	11	92%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	6	18	18	100%
Remeasurement Performance Indicator Rates	5.0	15.0	15	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>29</b>	<b>84</b>	<b>83</b>	<b>99%</b>

### Plan & Project Strengths

- The ACO consistently strives to mitigate issues such as transportation and other Social Determinants of Health that pose barriers for members.
- Fallon-BFHC were pleased that it surpassed the goal of 67.2%. For Remeasurement Year 1, the preliminary CBP rate was 74.49%, which is an increase of 13.49 percentage points. This increase shows that more hypertensive patients' blood pressures are being addressed, and adequately controlled, which may increase their overall health
- Fallon-BFHC will continue to collect referral, participation, and completion rates for all participating members and provider offices. For the offices that have low rates, reminders will be sent out that outline the program and referral process.



## PREVENTION

### FALLON 365 CARE – INCREASING THE HPV IMMUNIZATION RATE FOR ADOLESCENTS AMONG FALLON 365 CARE MEMBERS

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Fallon 365
<b>PIP Title:</b> Increasing the HPV Immunization Rate for Adolescents among ACO Members
<b>PIP Aim Statement:</b>  <u>Member-Focused</u> 80% of members/parent(s) will be able to identify the chief reason for vaccinating themselves/their child for HPV following provision of the Massachusetts Department of Public Health (MDPH) HPV Infographic and related clinical discussion. This will be measured by documenting, in the affirmative that any successful recall of information occurred. Due to the fact that, the MDPH HPV Infographic is not available in Spanish, Reliant will utilize the HPV Infographic authored by the Immunization Action Coalition (IAC) for Spanish-speaking members.  Improve acceptance of HPV vaccination amongst members/parent(s) as evidenced by a 5% increase from the 2018 baseline rate of (18.81%) for the number of 9 -12 year olds where the HPV vaccination series has been initiated.  <u>Provider-Focused</u> Offer education to 100% of providers and clinical office staff, with at least 80% participation, by September 20, 2019 to improve understanding of current CDC guidelines, American Cancer Society HPV Guidelines, and associated indications for vaccinating members on or between their 9th and 13th birthdays.  Improve HPV vaccination series completion rate in adolescents by age 13 as evidenced by a 10% increase above Reliant's 2018 calendar year baseline of 32.5%.
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input checked="" type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here: Ages 9 - 13
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Adolescents
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

#### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Patients or parents are given an HPV-related infographic. A version is available in Spanish as well. A brief survey is administered to the patients or parents to gather information about the rationale behind their vaccination decisions.
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Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

Fallon 365 is sponsoring provider training on motivational interviewing and persuasion techniques that offers Continuing Medical Education units. Providers who fail to increase their vaccination rates by at least 5% will be offered additional education related to motivational interviewing techniques.

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

None identified.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of members who have completed the HPV series on or between the members' 9th and 13th birthdays.  NCQA 1407	2018	102/313 32.5%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	16/156 39.1%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
The initiation rate of HPV vaccination for members between the ages of 9 and 12.	2018	712/3896 18.81%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	688/2974 23.13%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

**Validation phase (check all that apply):**

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

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

**EQRO recommendations for improvement of PIP:**

None identified.

**Performance Improvement Project Evaluation**

Kepro evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Fallon 365 received a rating score of 100% on this Performance Improvement Project.

**Exhibit 4.24: Fallon 365 PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	5.5	16.5	16.5	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>26.5</b>	<b>79.5</b>	<b>79.5</b>	<b>100%</b>

**Plan & Project Strengths**

- Fallon 365 is commended for not only ensuring it is meeting the linguistic needs of the population in the interventions but also acknowledging the influence of member's cultural and religious beliefs on outcomes.
- Fallon 365 focused the findings to address language barriers, transportation issues, moderate to severe mental and/or physical ailments, housing and/or food insecurity and many other challenges that affect members on a daily basis.

## SOCIAL DETERMINANTS OF HEALTH

### Tufts Health Together with Cambridge Health Alliance – Utilize Health-Related Social Needs Screening to Improve Member Health Outcomes

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Together with Cambridge Health Alliance
<b>PIP Title:</b> Utilize Health-Related Social Needs Screening to Improve Member Health Outcomes
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase member response rate to Social Determinants of Health (SDoH) screening.</li> <li>• Identify and refer members with SDoH needs to appropriate community resources.</li> <li>• Leverage SDoH screening results to help stratify members for care management services and support to maximize members' health care status and independence.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Increase provider knowledge about SDoH screening.</li> <li>• Make SDoH screening results available electronically to primary care providers (PCPs) at the point of care.</li> <li>• Improve provider knowledge about available community resources to members.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

#### 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.

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

Tufts Health Together with Cambridge Health Alliance incorporated the Connect S SDoH screening tool into its electronic medical record. It is piloting the use of tablet technology to increase the rate of screening. Having been implemented in primary care, Tufts-CHA plans to spread tablets to inpatient and specialty settings. SDoH results are integrated in all complex care management assessments. Workflows for positive screens have been developed and the After-Visit Summary was enhanced to include a standard list of community services.

Tufts-CHA has established working relationships with community service agencies. It is adopting the Aunt Bertha platform, a web-based social service resource directory, to connect patients with social services.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Tufts-CHA-attributed members aged 0 to 64 years of age who were screened for health-related social determinants of health during the measurement year.  EOHHS	2018	5534/ 28,204 19.6%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	7514/ 28,420 26.44%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):

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

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

**EQRO recommendations for improvement of PIP:**

- Given the small increase in screening, Kepro recommends continued close monitoring since the change might be due to normal variation rather than actual improvement.
- Kepro recommends that Tufts-CHA continue to solicit feedback from providers and ancillary staff about additional avenues for screening, given the rates are extremely low.
- Kepro recommends soliciting feedback from members regarding their experience of completing the screening forms, their satisfaction with the resource guide and referral process, as well as the responsiveness of the community resource agencies in meeting the identified needs of members who screening positive.
- Kepro recommends that Tufts-CHA structure its interventions in such a way that the intervention activities can be evaluated for effectiveness in either changing provider practices or in motivating members to access services.
- Tufts-CHA is encouraged to learn the difference between a quality process evaluation compared to an intervention effectiveness evaluation.

**Performance Improvement Project Evaluation**

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

**Exhibit 4.25: Tufts-CHA PIP Rating Score**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	11.3	94%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	3	9	9	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>23</b>	<b>69</b>	<b>68.3</b>	<b>99%</b>

**Project & Plan Strengths**

- Tufts-CHA is commended for expanding the use of the EHR platform with electronic tablets.
- Tufts-CHA is commended for this comparative assessment of the effectiveness of its screening tool as an intervention.
- Tufts-CHA is commended for the positive outcomes from the use of its SDOH screening tool.
- Tufts-CHA is commended for using and increasing its modalities for direct member outreach and expanding these modalities through pilot installations and by learning the benefits and challenges of these pilots.

# Tufts Health Together with Atrius Health – Improving Health-Related Social Needs Screening and Follow Up

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Together with Atrius Health
<b>PIP Title:</b> Improving Health-Related Social Needs Screening and Follow Up
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase the rate of SDoH screenings completed by members.</li> <li>• Refer members with positive SDoH screens to community resources.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Increase provider knowledge and awareness of the importance of SDoH and the value of SDoH screening.</li> <li>• Improve pre- and at-visit workflows to enable health-related social needs screening.</li> <li>• Improve clinician acceptance of and confidence in activating the workflow to connect patients with needed community resources.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)  Tufts Health Together with Atrius Health selected a modified version of the PRAPARE health-related social needs screening tool and implemented it in paper form in July 2018. Its use was piloted by one primary care provider and then expanded to all department clinicians. The project team later determined that computer-based screening was more effective than the paper screening form. Tufts-Atrius developed and refined workflows to link patients and families with services that meet their needs. Resources were identified and made available to staff on the Atrius Health intranet.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Tufts-Atrius-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.  EOHHS	2018	4/411 1%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	85/432 19.68%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  While this overall screen rate is a positive outcome, Tufts-Atrius's evaluation of the effectiveness of this intervention could have been strengthened by a comparative analysis of the differential screen rates for the medical practices presented. This type of differential analysis (both qualitative and quantitative, if possible) could have identified success factors for the highest performing practices as well as barrier factors for the lowest performing practices.

### Performance Improvement Project Evaluation

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



#### Exhibit 4.26: Tufts-Atrius PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	11.0	92%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	3	9	9	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>23</b>	<b>69</b>	<b>68</b>	<b>99%</b>

#### Project & Plan Strengths

- The data produced by Tufts-Atrius is commendable and should be useful for identifying practices that are successful in engaging members or challenged by having its members screened. This practice analysis will allow Tufts-Atrius to focus on practice sites that are challenged by the screening protocol.
- Tufts-Atrius states that based on the data, there is good evidence that the intervention activities were effective in increasing the rate of HRSN screening. The goal was 12% and the actual rate was 20%.

# Tufts Health Together with Boston Children’s ACO – Increasing Screening for Health-Related Social Needs (HRSN) Using an Electronic Data Capture System

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Together with Boston Children’s ACO
<b>PIP Title:</b> Increasing Screening for Health-Related Social Needs (HRSN) Using an Electronic Data Capture System
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase the rate of screening for social determinants of health using a MassHealth-approved screening tool.</li> <li>• Use health-related social needs screening to improve access to resources for patients and families with health-related social needs.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Implement comprehensive electronic documentation of health-related social needs screening.</li> <li>• Conduct analyses of health-related social needs screening results at regular intervals to better understand the health-related social needs of the Tufts-BCH population and support data-informed decision-making.</li> <li>• Establish clinic systems and workflows to connect patients and families to resources by using results of analyses to educate providers and build partnerships with resource organizations.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input checked="" type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Children
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Tufts-BCH conducted focus groups and interviewed key stakeholders to inform creation of a new social risk screener which was subsequently approved by MassHealth. A paper version of the screen was implemented and response algorithms were developed that, for positive screens, guide providers to the appropriate staff member.

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

- Tufts-BCH had planned to migrate to electronic-based medical record screening, but issues related to system compatibility surfaced.
- Efforts are underway to forge community partnerships with resources relevant to the patient population's needs.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Tufts-BCH-attributed members 0 to 64 years of age at the Children's Hospital Primary Care Center with a well visit who were screened for health-related social needs and had screening results documented electronically during the measurement period.	2018	0/7374 0%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	0/7776 0%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
The rate of Tufts-BCH-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.  EOHHS	2018	0/53 0%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	9/41 22.0%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

#### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):  Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  None identified.

#### Performance Improvement Project Evaluation

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

#### Exhibit 4.27: Tufts-BCH PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	3.0	9.0	9.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>24</b>	<b>72</b>	<b>72</b>	<b>100%</b>

#### Plan & Project Strengths

- Tufts-BCH is commended for gathering provider feedback regarding how certain questions are framed and making quality improvement changes accordingly.
- Tufts-BCH is committed to continuing to inform the partnerships with HRSN reports for the purpose of connecting patient families to the appropriate resources.

# Tufts Health Together with Beth Israel Deaconess Care Organization (BIDCO) – Improving Social Determinants of Health Screening and Referral in Pediatrics and Adults

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name: Tufts Health Together with Beth Israel Deaconess Care Organization (BIDCO)</b>
<b>PIP Title:</b> Improving Social Determinants of Health Screening and Referral in Pediatrics and Adults
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase member screening for social determinants of health.</li> <li>• Improve member access to resources to address social determinants of health.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Increase provider knowledge about social determinants of health.</li> <li>• Increase provider screening for social determinants of health.</li> <li>• Increase provider knowledge of community resources for members with deficits in social and nutritional determinants of health.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> All members
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

## 2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Tufts Health Together with BIDCO implemented a pilot at an eight-physician practice in which providers and staff received multi-modal training and education on Social Determinants of Health screening and community resources. This training was modified to become more ongoing and individualized. As of the report date, 16 of 34 independent physician practices have begun training. In addition, Tufts-BIDCO developed workflows for rooming, screening, and referral processes.

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The rate of Tufts-BIDCO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.	2018	57/453 12.6%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	149/411 36.3%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): <i>p &lt; 0.005</i>
The rate of Tufts-BIDCO-attributed members 0 to 64 years of age who were screened positive for health-related social needs and were referred to community resources in the measurement year.  EOHHS	2018	57/453 12.6%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	149/411 36.3%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): <i>p &lt; 0.005</i>

#### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input checked="" type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input checked="" type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b> <ul style="list-style-type: none"> <li>• Tufts-BIDCO has not presented a viable evaluation methodology. In this regard, Tufts-BIDCO did not incorporate the recommendations made by Kepro in 2019 into this report.</li> <li>• As a project report that meets EQR rating criteria, Tufts-BIDCO needs to improve its methodology for evaluating the effectiveness of its intervention activities.</li> <li>• Tufts-BIDCO's presentation of the indicator rates have no relationship to the evaluation methodology proposed in its 2019 baseline project proposal. Had Tufts-BIDCO conducted a survey of its members regarding their response to its educational materials, Tufts-BIDCO would have had data for this evaluation.</li> <li>• As Tufts-BIDCO develops its project goals and intervention activities for its 2021 PIPs, Kepro advises Tufts-BIDCO to avail itself of the guidance documents associated with these project forms.</li> </ul>

#### Performance Improvement Project Evaluation

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

#### Exhibit 4.28: Tufts-BIDCO PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	6.8	56%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	3.0	9.0	9.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	8.0	66%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>24</b>	<b>72</b>	<b>62.8</b>	<b>87%</b>

#### Plan & Project Strengths

- As a project benefiting its members healthcare status, Tufts-BIDCO has done an excellent job of improving the rate at which members are screened for health-related social needs.
- Through its population analysis, Tufts-BIDCO has identified several areas that represent barriers to this PIP meeting its performance goals. In response to this analysis, Tufts-BIDCO has proposed interventions to mitigate these population-based barriers.

Section 5:

# Network Adequacy Validation

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## SECTION 5: NETWORK ADEQUACY VALIDATION

### INTRODUCTION

The concept of Network Adequacy revolves around a managed care plan's ability to provide its members with an adequate number of in-network providers located within a reasonable distance from the member's home. Insufficient or inconvenient access points can create gaps in healthcare. To avoid such gaps, MassHealth stipulates contractually required time and distance standards as well as threshold member to provider ratios to ensure access to timely care.

In 2020, MassHealth, in conjunction with its EQRO contractor, Kepro, initiated an evaluation process to identify the strengths of the health plan's provider networks, as well as to offer recommendations for bridging network gaps. This process of evaluating a plan's network is termed Network Adequacy Validation. While this type of evaluation and reporting is not required by CMS at this time, the Commonwealth of Massachusetts was strongly encouraged by CMS to incorporate this activity as an annual process evaluation, as it will be required in the future.

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

Using Quest, Kepro has analyzed the current performance of the plans based on the time and distance standards that the state requires, while also identifying gaps in coverage by geographic area and specialties. The program also provides information about all available providers should network expansion be required. This information is based on a list of all licensed physicians from the Massachusetts Board of Registration in Medicine that Kepro obtained. These suggestions will help close gaps and provide Medicaid members with improved access to timely healthcare, the primary goal.

## PLAN DATA REQUEST

To build this software tool, MassHealth requested a complete data set from each ACCP plan, which included the following data points:

- Facility or Provider Name
- Address Information
- Phone Number
- NPI Information
- Any Non-English Language Options

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

- PCPs and OBGYNs
- Hospital Rehabilitation Urgent
- Specialists
- Behavioral Health Services; and
- Pharmacies

It's important to note that no information regarding beneficiaries was requested from the plans. The goal of Network Adequacy is to ensure that every carrier has adequate access to care for the plan's entire service area. When measuring access to care using only existing membership, that dataset may not always be representative of the entire service area. Additionally, measuring only existing membership does not account for future growth or expansion of existing service areas. Therefore, MassHealth, performed the network adequacy reviews using a representative set of population points, 3% of the population, distributed throughout the service area based on population patterns. This methodology allowed MassHealth to ensure each carrier was measured consistently against the same population distribution and that the entire service area has adequate access to care within the prescribed time and distance criteria.

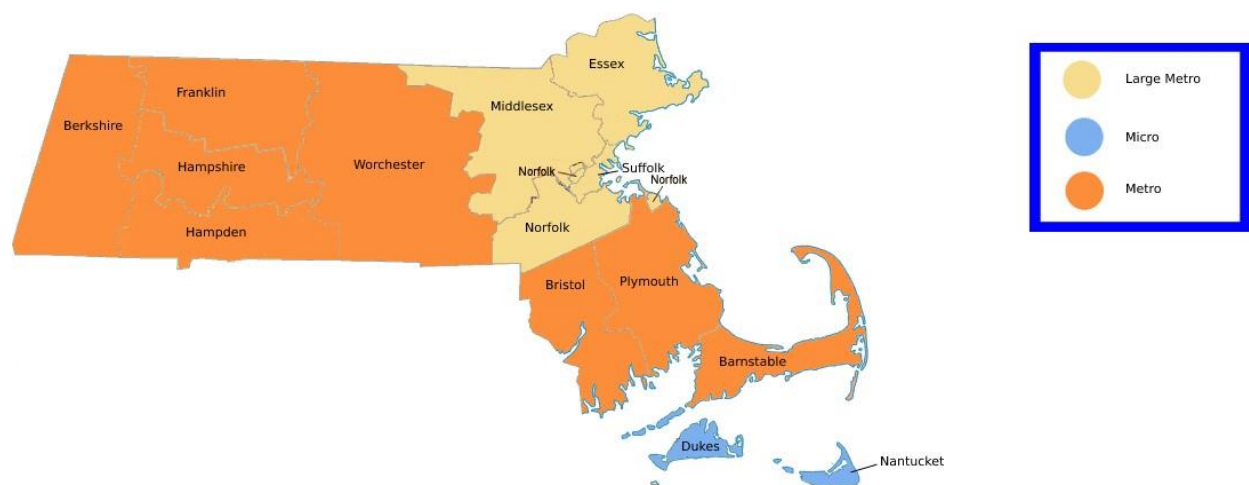
## TIME AND DISTANCE STANDARDS

For Medicaid members to receive appropriate access to care for medical services, MassHealth requires the ACCP plans to adhere to certain time and distance standards.

The ACCP plans are required to meet a time and the distance standard but are not required to meet both. For example, the standard for Urgent Care Medical Facilities are located within a 15 miles radius OR no more than 30 minutes travel time from the member.

It's important to note that for some specialties, the time and distance standards vary based on the size of the county, or county designation. Below is a map of the county designations, for reference:

**Exhibit 5.1: Map of Massachusetts County Designations**



The standards for all medical services are outlined below, according to grouping and specialty.

### BEHAVIORAL HEALTH DIVERSIONARY SERVICES:

MassHealth requires a time and distance standard of 30 miles or 30 minutes. These standards apply to all specialties outlined in the chart below:

**Exhibit 5.2: Behavioral Health Diversionary Specialties**

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

### BEHAVIORAL HEALTH INPATIENT SERVICES:

There are four specialties in this provider group, i.e., Managed Inpatient Level 4, Adult Psychiatric Inpatient, Adolescent Psychiatric Inpatient, and Child Psychiatric Inpatient. MassHealth outlines a 60-mile or 60-minute standard for these services.

### BEHAVIORAL HEALTH INTENSIVE COMMUNITY TREATMENT SERVICES:

There are three specialties in this provider group, i.e., In-Home Behavioral Services, In-Home Therapy Services, and Therapeutic Monitoring Services. MassHealth stipulates a time and distance standard of 30 miles or 30 minutes for these services.

### BEHAVIORAL HEALTH OUTPATIENT SERVICES:

MassHealth requires all three specialties in this category to comply with a time and distance standard of 30 miles or 30 minutes. One of these specialties is required to have a minimum of two providers within this standard. The three specialties and provider requirement are outlined in the chart below:

Exhibit 5.3: Behavioral Health Outpatient Specialties and Required Providers

Specialty	# of Providers
Applied Behavior Analysis	NA
BH Outpatient	NA
Opioid Treatment Programs	2

### MEDICAL FACILITY SERVICES:

There are three specialties in this category, all of which have a different time and distance standard that MassHealth Requires. The three specialties are outlined in the chart below. It is important to note that providers are required to meet the time standard or the distance, not both.

Exhibit 5.4: Medical Facility Specialties and Required Standards

Specialty	Time (Minutes)	Distance (Miles)
Acute Inpatient Hospital	40	20
Rehabilitation hospital	60	30
Urgent care services	30	15

### PHARMACY SERVICES:

All pharmacy providers must adhere to a 15 mile or 30 minute standard.

### PRIMARY CARE SERVICES:

With only two specialties in this category, MassHealth requires both to follow a standard of 15 miles or 30 minutes. The state also requires a specific provider to member ratio for these specialties, which are outlined in the chart below:

#### Exhibit 5.5: Primary Care Specialties and Required Ratios

Specialty	Ratio
Adult PCP	1:200 adult
Pediatric PCP	1:200 pedi

#### SPECIALTY SERVICES:

MassHealth requires all specialties in the chart that follows to comply with a time and distance standard of 20 miles or 40 minutes:

#### Exhibit 5.6: Specialty Services

Specialty	
Allergy and Immunology	Oncology - Medical, Surgical
Anesthesiology	Oncology - Radiation/Radiation Oncology
Audiology	Ophthalmology
Cardiology	Oral Surgery
Cardiothoracic Surgery	Orthopedic Surgery
Chiropractor	Pathology
Dermatology	Physiatry, Rehabilitative Medicine
Emergency Medicine	Plastic Surgery
Endocrinology	Podiatry
ENT/Otolaryngology	Pulmonology
Gastroenterology	Radiology
General Surgery	Rheumatology
Hematology	Urology
Infectious Diseases	Vascular Surgery
Nephrology	Psych APN (PCNS or CNP)
Neurology	Psychiatry
Neurosurgery	Psychology
Nuclear Medicine	

One specialty, Ob/Gyn, has separate requirements, as well as a provider to member ratio set by the state.

#### Exhibit 5.7: OB/GYN Specialty Standard Requirements

Specialty	Ratio	Time (Minutes)	Distance (Miles)
Ob/Gyn	1:500 female >= 10 yo	30	15

## EVALUATION METHOD

The Quest system depicts the results of the evaluation using a color scheme to identify strong areas and gaps in service, as well as to facilitate plan comparison. These colors will be referenced throughout this report. The following chart describes the colors used and description.

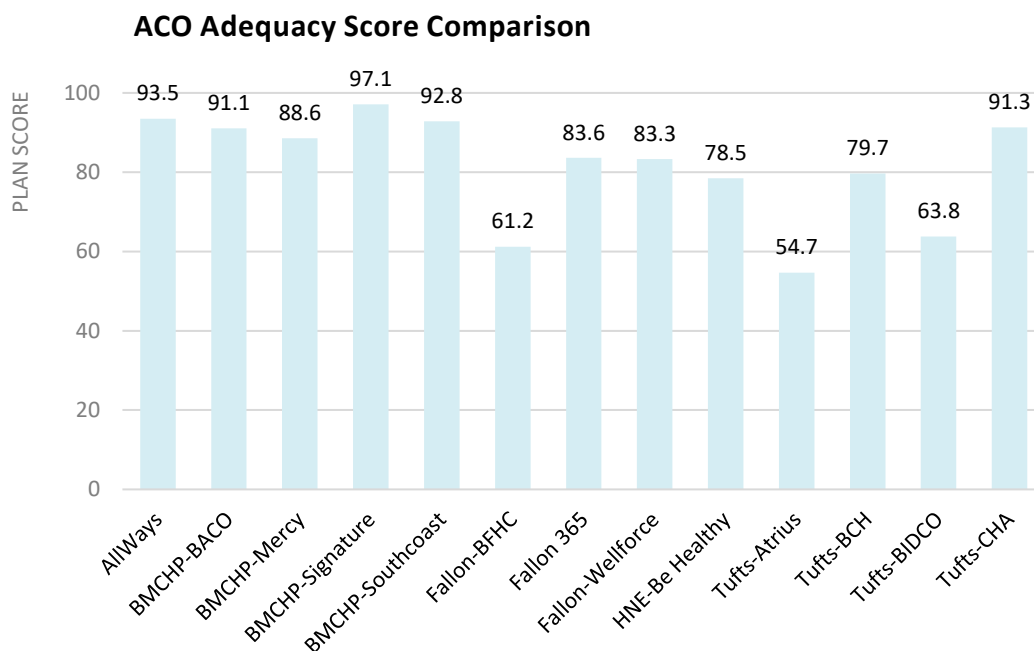
Exhibit 5.8: Results Color Scheme

Color	Description
Green	Meets all time and distance (Access) and provider to member ratio (Servicing Provider) Requirements
Yellow	Meets either the Access requirements or the Servicing Provider requirements, but is not meeting both requirements
Red	Meets neither the Access nor Servicing Provider requirements

The following chart depicts the overall scores that each plan received, which is the aggregate score of the plan's networks adequacy results based on the average across all specialties.

The highest score possible is a 100. The lowest scoring plan is Tufts-Atrius, with a 54.7. The highest scoring plan is BMCHP-Signature with a score of 97.1.

Exhibit 5.9: Adequacy Score Chart

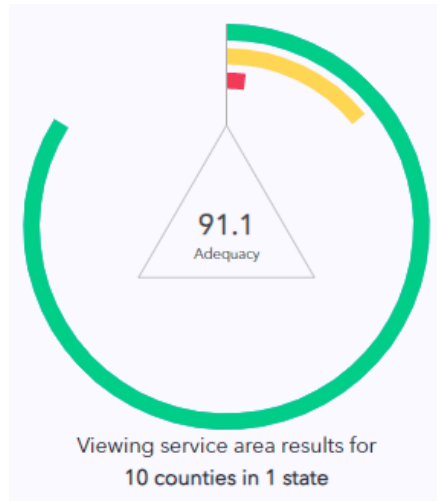


## RESULTS BY PLAN

### BMC HEALTHNET PLAN COMMUNITY ALLIANCE

This plan services Barnstable, Bristol, Dukes, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, and Suffolk counties, partially. The BMCHP-BACO plan received an overall score of 91.1, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.10: BMCHP-BACO Adequacy Score



- The **green** bar indicates that 83.90% fully meet the adequacy requirements.
- The **yellow** bar indicates that 14.10% meet only the servicing provider requirements.
- The **red** bar indicates that 2.00% do not meet any adequacy requirements.

### STRENGTHS

BMCHP-BACO received a 100, or a **Green** score, in multiple service areas. Two services in the Behavioral Health Outpatient category, one Medical Facility service, nine services in the Behavioral Health Diversionary category, three services in the Intensive Community Treatment category, four services in the Behavioral Health Inpatient category and fifteen Specialty services received a 100 score. The chart that follows depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.11: Services with a 100 score.

BH Outpatient		Medical Facility
Applied Behavior Analysis	BH Outpatient	Acute Inpatient Hospital
BH Diversionary		
CBAT	Monitored Inpatient Level 3.7	Recovery Support Navigators
Clinical Support Services for SUD	Partial Hospitalization Program	Residential Rehab Services for SUD
Community Support Program	Recovery Coaching	Structured Outpatient Addiction Program
BH Intensive Community Treatment		
In-Home Behavioral Services	In-Home Therapy Services	Therapeutic Mentoring Services
BH Inpatient		
Managed Inpatient Level 4		Psych Inpatient Adult
Psych Inpatient Adolescent		Psych Inpatient Child
Specialists		
Anesthesiology		Orthopedic Surgery
Cardiology		Physiatry, Rehabilitative Medicine
Chiropractor		Podiatry
Emergency Medicine		Psych APN
Endocrinology		Psychiatry
Gastroenterology		Psychology
General Surgery		Urology
Ophthalmology		

The following section outlines the gaps in access to health care services for BMCHP-BACO members.

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The charts that follow designate the health services and counties where certain requirements have not been met.

Table 5.12: Specialty Service Gaps

County	Allergy and Immunology	Audiology	Cardiothoracic Surgery	Dermatology	ENT / Otolaryngology	Hematology	Infectious Diseases
Barnstable							
Bristol							
Dukes							
Franklin							
Hampden							
Hampshire							
Middlesex							
Norfolk							
Plymouth							
Suffolk							



County	Nephrology	Neurology	Neurosurgery	Nuclear Medicine	OBGYN	Oncology - Medical	Oncology - Radiation
Barnstable							
Bristol							
Dukes							
Franklin							
Hampden							
Hampshire							
Middlesex							
Norfolk							
Plymouth							
Suffolk							

County	Oral Surgery	Pathology	Plastic Surgery	Pulmonology	Radiology	Rheumatology	Vascular Surgery
Barnstable							
Bristol							
Dukes							
Franklin							
Hampden							
Hampshire							
Middlesex							
Norfolk							
Plymouth							
Suffolk							

Table 5.13: Various Gaps in Service

County	Primary Care		BH Diversionary			BH Outpatient	Medical Facility		Pharmacies
	Adult PCP	Pediatric PCP	Intensive Outpatient Program	Program of Assertive Community Treatment	Psychiatric Day Treatment	Opioid Treatment Programs*	Rehab Hospital	Urgent Care Services	Retail Pharmacies
Barnstable									
Bristol									
Dukes									
Franklin									
Hampden									
Hampshire									
Middlesex									
Norfolk									
Plymouth									
Suffolk									

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

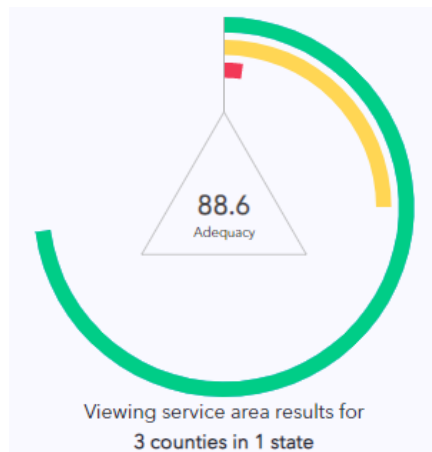
## FINDINGS

- For Opioid Treatment Programs, the plan submitted no data for review. BMCHP-BACO received a red score for this service.
- For all Specialty services, Middlesex and Suffolk counties meet all requirements.
- For Oral Surgery services, only 3 counties meet all requirements, while the other seven are only meeting the servicing provider requirements.
- For both Primary Care services, Adult PCP and Pediatric PCP, three counties are meeting all requirements, Bristol, Norfolk, and Suffolk. All other counties are only meeting the servicing requirements. Hampden county is not meeting any requirements for Pediatric PCP.
- For the Programs of Assertive Community Treatment, three counties are meeting all requirements, five counties are only meeting the servicing provider requirements, and two counties are not meeting any requirements.
- Franklin County has the most gaps in the network, in comparison to the other 9 counties.

## BMC HEALTHNET PLAN MERCY ALLIANCE

This plan services Franklin, Hampden, and Hampshire counties, partially. The BMCHP-Mercy plan received an overall score of 88.6, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.14: BMCHP-Mercy Adequacy Score



- The **green** bar indicates that 72.90% fully meet the adequacy requirements.
- The **yellow** bar indicates that 25.00% meet only the servicing provider requirements.
- The **red** bar indicates that 2.10% do not meet any adequacy requirements.

## STRENGTHS

BMCHP-Mercy received a 100, or a **Green** score, in multiple service areas. Two services in the Behavioral Health Outpatient category, one Medical Facility service, three services in the Intensive Community Treatment category, four services in the Behavioral Health Inpatient category, ten services in the Behavioral Health Diversionary category, and sixteen Specialty services received a 100 score. The chart that follows depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.14: Services with a 100 score.

BH Outpatient		Medical Facility
Applied Behavior Analysis	BH Outpatient	Acute Inpatient Hospital
BH Intensive Community Treatment		
In-Home Behavioral Services	In-Home Therapy Services	Therapeutic Mentoring Services
BH Inpatient		
Managed Inpatient Level 4		Psych Inpatient Adult
Psych Inpatient Adolescent		Psych Inpatient Child
BH Diversionary		
CBAT		Psychiatric Day Treatment
Clinical Support Services for SUD		Recovery Coaching
Community Support Program		Recovery Support Navigators
Monitored Inpatient Level 3.7		Residential Rehab Services for SUD
Partial Hospitalization Program		Structured Outpatient Addiction Program
Specialists		
Anesthesiology		Orthopedic Surgery
Cardiology		Physiatry, Rehabilitative Medicine
Chiropractor		Podiatry
Emergency Medicine		Psych APN
Endocrinology		Psychiatry
Gastroenterology		Psychology
General Surgery		Radiology
Ophthalmology		Urology

The following section outlines the gaps in access to health care services for BMCHP-Mercy members.

### AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The chart that follows designates the health services and counties where certain requirements have not been met.

Exhibit 5.15: Gaps in Services and Counties

Category	Specialty	County Score		
		Franklin	Hampden	Hampshire
Primary Care	Adult PCP			
	Pediatric PCP			
Specialties	Allergy and Immunology			
	Audiology			
	Cardiothoracic Surgery			
	Dermatology			
	ENT/Otolaryngology			
	Hematology			
	Infectious Diseases			
	Nephrology			
	Neurology			
	Neurosurgery			
	Nuclear Medicine			
	OBGYN			
	Oncology - Medical			
	Oncology – Radiation			
	Oral Surgery			
	Pathology			
	Plastic Surgery			
	Pulmonology			
	Rheumatology			
	Vascular Surgery			
BH Diversionary	Intensive Outpatient Program			
	Program of Assertive Community Treatment			
BH Outpatient	Opioid Treatment Programs*			
Medical Facility	Rehab Hospital			
	Urgent Care Services			
Pharmacy	Retail Pharmacies			

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

## FINDINGS

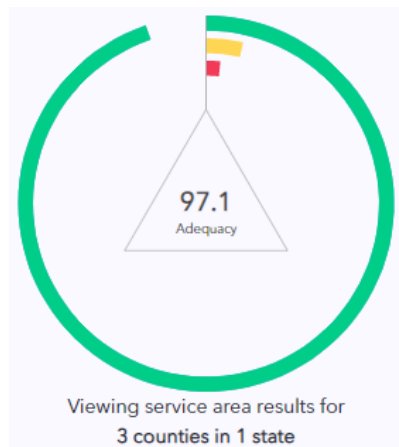
- The plan submitted no Opioid Treatment Program data for review. BMCHP-Mercy received a red score for this service.
- Hampshire county has the most gaps in the network, in comparison to the other two counties. Franklin county has the least gaps.

- No county is meeting all requirements Adult PCP and Pediatric PCP. All counties are only meeting the servicing provider requirements except for Hampden County for Pediatric PCP, which is not meeting any requirements.
- For Cardiothoracic Surgery and Programs of Assertive Community Treatment, no counties are meeting all requirements. All of them are only meeting the servicing provider requirements.

## BMC HEALTHNET PLAN SIGNATURE ALLIANCE

This plan services Bristol, Norfolk, and Plymouth counties, partially. The BMCHP-Signature plan received an overall score of 97.1, the aggregate score of the plan's network adequacy results based on the average across all specialties. This plan scored the highest amongst all the ACO plans. The score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.16: BMCHP-Signature Adequacy Score



- The **green** bar indicates that 94.80% fully meet the adequacy requirements.
- The **yellow** bar indicates that 3.60% meet only the servicing provider requirements.
- The **red** bar indicates that 1.60% do not meet any adequacy requirements.

## STRENGTHS

BMCHP-Signature received a 100, or a **Green** score, in multiple service areas. All Specialties except one received a **Green** score. Additionally, three services in the Intensive Community Treatment category, three Medical Facility services, four services in the Behavioral Health Inpatient category, Pharmacy Services, two services in the Behavioral Health Outpatient category, and eleven services in the Behavioral Health Diversionary category, also received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.17: Services with a 100 score.

<b>BH Intensive Community Treatment</b>	<b>Medical Facility</b>
In-Home Behavioral Services	Acute Inpatient Hospital
In-Home Therapy Services	Rehab Hospital
Therapeutic Mentoring Services	Urgent Care Services
<b>BH Inpatient</b>	<b>Pharmacy</b>
Managed Inpatient Level 4	Retail Pharmacies
Psych Inpatient Adolescent	<b>BH Outpatient</b>
Psych Inpatient Adult	Applied Behavior Analysis
Psych Inpatient Child	BH Outpatient
<b>BH Diversionary</b>	
CBAT	Psychiatric Day Treatment
Clinical Support Services for SUD	Recovery Coaching
Community Support Program	Recovery Support Navigators
Intensive Outpatient Program	Residential Rehab Services for SUD
Monitored Inpatient Level 3.7	Structured Outpatient Addiction Program
Partial Hospitalization Program	
<b>Specialists</b>	
Allergy and Immunology	OBGYN
Anesthesiology	Oncology – Medical
Audiology	Oncology – Radiation
Cardiology	Ophthalmology
Cardiothoracic Surgery	Orthopedic Surgery
Chiropractor	Pathology
Dermatology	Physiatry, Rehabilitative Medicine
Emergency Medicine	Plastic Surgery
Endocrinology	Podiatry
ENT/Otolaryngology	Psych APN
Gastroenterology	Psychiatry
General Surgery	Psychology
Hematology	Pulmonology
Infectious Diseases	Radiology
Nephrology	Rheumatology
Neurology	Urology
Neurosurgery	Vascular Surgery
Nuclear Medicine	

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The chart that follows designates the health services and counties where certain requirements have not been met.



### Exhibit 5.18: Gaps in Services and Counties

Category	Specialty	County Score		
		Bristol	Norfolk	Plymouth
Primary Care	Adult PCP			
Primary Care	Pediatric PCP			
Specialists	Oral Surgery			
BH Diversionary	Program of Assertive Community Treatment			
BH Outpatient	Opioid Treatment Programs*			

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

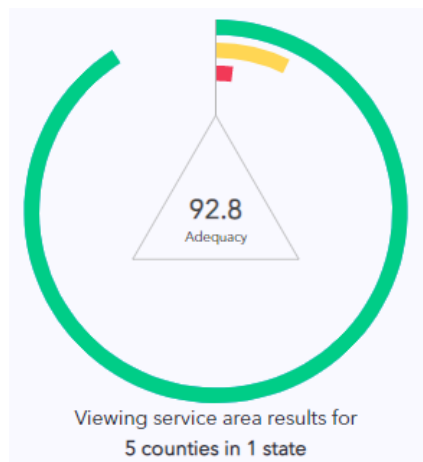
### FINDINGS

- The plan submitted no Opioid Treatment Program data for review. BMCHP-Signature received a red score for this service.
- Norfolk county is meeting all requirements in all health care services and counties except one, for Opioid Treatment Programs, an area where the plan submitted no data.
- Bristol County has the most gaps in the network, in comparison to the other two counties.
- All Specialty services are meeting all requirements except one, Oral Surgery.

## BMC HEALTHNET PLAN SOUTHCOAST ALLIANCE

This plan services Barnstable, Bristol, Dukes, Norfolk, and Plymouth counties, partially. The BMCHP-Southcoast plan received an overall score of 92.8, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.19: BMCHP-Southcoast Adequacy Score



- The **green** bar indicates that 90.90% fully meet the adequacy requirements.
- The **yellow** bar indicates that 7.20% meet only the servicing provider requirements.
- The **red** bar indicates that 1.90% do not meet any adequacy requirements.

### STRENGTHS

BMCHP-Southcoast received a 100, or a **Green** score, in multiple service areas. All Specialties except four received a **Green** score. Additionally, three services in the Intensive Community Treatment category, two Medical Facility services, four services in the Behavioral Health Inpatient category, Pharmacy Services, two services in the Behavioral Health Outpatient category, and eleven services in the Behavioral Health Diversionary category, also received a 100 score. The chart that follows depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.20: Services with a 100 score.

<b>BH Intensive Community Treatment</b>	<b>Medical Facility</b>
In-Home Behavioral Services	Acute Inpatient Hospital
In-Home Therapy Services	Rehab Hospital
Therapeutic Mentoring Services	
<b>BH Inpatient</b>	<b>Pharmacy</b>
Managed Inpatient Level 4	Retail Pharmacies
Psych Inpatient Adolescent	<b>BH Outpatient</b>
Psych Inpatient Adult	Applied Behavior Analysis
Psych Inpatient Child	BH Outpatient
<b>BH Diversionary</b>	
CBAT	Psychiatric Day Treatment
Clinical Support Services for SUD	Recovery Coaching
Community Support Program	Recovery Support Navigators
Intensive Outpatient Program	Residential Rehab Services for SUD
Monitored Inpatient Level 3.7	Structured Outpatient Addiction Program
Partial Hospitalization Program	
<b>Specialists</b>	
Allergy and Immunology	OBGYN
Anesthesiology	Oncology – Medical
Audiology	Oncology – Radiation
Cardiology	Ophthalmology
Chiropractor	Orthopedic Surgery
Dermatology	Physiatry, Rehabilitative Medicine
Emergency Medicine	Plastic Surgery
Endocrinology	Podiatry
ENT/Otolaryngology	Psych APN
Gastroenterology	Psychiatry
General Surgery	Psychology
Hematology	Pulmonology
Infectious Diseases	Radiology
Nephrology	Rheumatology
Neurology	Urology
Neurosurgery	Vascular Surgery

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The chart that follows designates the health services and counties where certain requirements have not been met.

### Exhibit 5.21: Gaps in Services and Counties

Category	Specialty	County Score				
		Barnstable	Bristol	Dukes	Norfolk	Plymouth
Primary Care	Adult PCP					
Primary Care	Pediatric PCP					
Specialists	Cardiothoracic Surgery					
	Nuclear Medicine					
	Oral Surgery					
	Pathology					
BH Diversionary	Program of Assertive Community Treatment					
BH Outpatient	Opioid Treatment Programs*					
Medical Facility	Urgent Care Services					

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

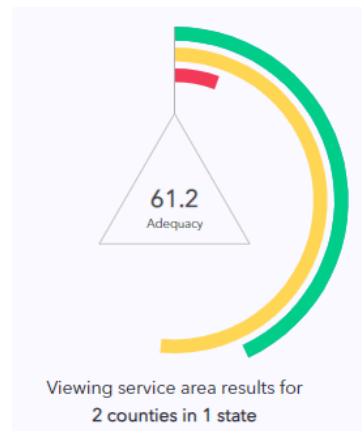
### FINDINGS

- The plan submitted no Opioid Treatment Program data for review. BMCHP-Southcoast received a red score for this service.
- Barnstable County has the most gaps in the network, in comparison to the other 4 counties.
- Cardiothoracic Surgery, Pathology, and Urgent Care Services are meeting all requirements in all counties except one, which varies.
- Only Norfolk County is meeting all Program of Assertive Community Treatment requirements. Dukes County is not meeting any PACT requirements.
- All counties are only meeting the servicing provider requirements. For Pediatric primary care.
- Only Dukes County is meeting all Adult primary care requirements. All other counties are only meeting the servicing provider requirements.

## BERKSHIRE FALLON HEALTH COLLABORATIVE (FALLON-BFHC)

This plan services Berkshire and Franklin counties, partially. The Fallon-BFHC plan received an overall score of 61.2, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.22: Fallon-BFHC Adequacy Score



- The **green** bar indicates that 43.00% fully meet the adequacy requirements.
- The **yellow** bar indicates that 51.50% meet only the servicing provider requirements.
- The **red** bar indicates that 5.50% do not meet any adequacy requirements.

## STRENGTHS

Fallon-BFHC received a 100 or a **Green** score, in multiple service areas. Three services in the Intensive Community Treatment category, four services in the Behavioral Health Inpatient category, three services in the Behavioral Health Diversionary category, two services in the Behavioral Health Outpatient category, and five Specialist services received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.23: Services with a 100 score.

BH Intensive Community Treatment	BH Inpatient
In-Home Behavioral Services	Managed Inpatient Level 4
In-Home Therapy Services	Psych Inpatient Adolescent
Therapeutic Mentoring Services	Psych Inpatient Adult
<b>BH Diversionary</b>	Psych Inpatient Child
Community Support Program	<b>Specialists</b>
Recovery Coaching	Chiropractor
Recovery Support Navigators	Emergency Medicine
<b>BH Outpatient</b>	Orthopedic Surgery
Applied Behavior Analysis	Psychiatry
BH Outpatient	Psychology

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The chart that follows designates the health services and counties where certain requirements have not been met.

Exhibit 5.24: Gaps in Services and Counties

Category	Specialty	County Score	
		Berkshire	Franklin
Primary Care	Adult PCP		
Primary Care	Pediatric PCP		
Specialties	Allergy and Immunology		
	Anesthesiology		
	Audiology		
	Cardiology		
	Cardiothoracic Surgery		
	Dermatology		
	Endocrinology		
	ENT/Otolaryngology		
	Gastroenterology		
	General Surgery		
	Hematology		
	Infectious Diseases		
	Nephrology		
	Neurology		
	Neurosurgery		
	Nuclear Medicine		
	OBGYN		
	Oncology - Medical		
	Oncology – Radiation		
	Ophthalmology		
	Oral Surgery		
	Pathology		
	Physiatry		
	Plastic Surgery		
	Podiatry		
	Psych APN		
	Pulmonology		
	Radiology		
	Rheumatology		
	Urology		
	Vascular Surgery		
BH Diversionary	CBAT		
	Clinical Support Services for SUD		

	Intensive Outpatient Program		
	Monitored Inpatient Level 3.7		
	Partial Hospitalization Program		
	Program of Assertive Community Treatment		
	Psych Day Treatment		
	Residential Rehab Services for Substance Use Disorders		
	Structured Outpatient Addiction Program		
BH Outpatient	Opioid Treatment Programs*		
Medical Facility	Acute Inpatient Hospital		
	Rehab Hospital		
	Urgent Care Services		
Pharmacy	Retail Pharmacies		

\*No plan data were submitted for these specialties. Kepro is unable to discern whether there are no network providers or this is a data omission.

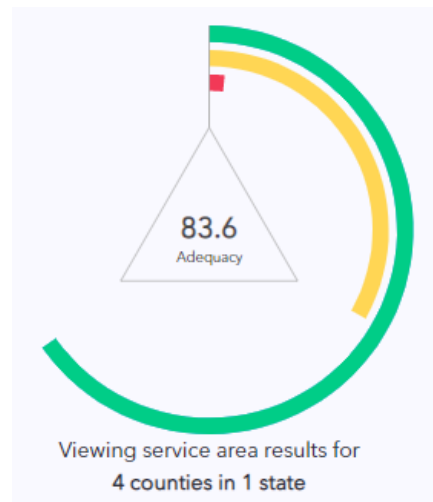
## FINDINGS

- The plan submitted no Opioid Treatment Program data. Fallon-BFHC received a red score for this service.
- Only one Program of Assertive Community Treatment provider was submitted for the entire network. This service is currently not meeting any requirements.
- The plan submitted Retail Pharmacy providers that are outside the service area network. No providers submitted pharmacies in Berkshire or Franklin County. Since no providers are within the time and distance standard of the service area, the plan received a red score for not meeting the requirements.
- Of the two counties in this network, Berkshire County has more gaps in the network compared to Franklin County.
- Franklin County is not meeting any Oncology – Medical services requirements.
- Both counties are only meeting the servicing provider requirements for all three services in the Medical Facility category.

## FALLON 365 CARE

This plan services Hampden, Middlesex, Norfolk, and Worcester counties, partially. The Fallon 365 plan received an overall score of **83.6**, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.25: Fallon 365 Adequacy Score



- The **green** bar indicates that 65.20% fully meet the adequacy requirements.
- The **yellow** bar indicates that 33.20% meet only the servicing provider requirements.
- The **red** bar indicates that 1.60% do not meet any adequacy requirements.

The following section includes breakdowns of the network adequacy evaluation by specialty.

## STRENGTHS

Fallon 365 received a 100, or a **Green** score, in multiple service areas. Four services in the Behavioral Health Inpatient category, Pharmacy Services, two services in the Behavioral Health Outpatient category, eight services in the Behavioral Health Diversionary category, three services in the Intensive Community Treatment category, and nine Specialist services received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.



Exhibit 5.26: Services with a 100 score

BH Inpatient		Pharmacy	
Managed Inpatient Level 4		Retail Pharmacies	
Psych Inpatient Adolescent		BH Outpatient	
Psych Inpatient Adult		Applied Behavior Analysis	
Psych Inpatient Child		BH Outpatient	
BH Diversionary			
CBAT		Psychiatric Day Treatment	
Community Support Program		Recovery Coaching	
Intensive Outpatient Program		Recovery Support Navigators	
Partial Hospitalization Program		Structured Outpatient Addiction Program	
BH Intensive Community Treatment			
In-Home Behavioral Services	In-Home Therapy Services	Therapeutic Mentoring Services	
Specialists			
Cardiology	Endocrinology	Psych APN	
Chiropractor	Ophthalmology	Psychiatry	
Emergency Medicine	Podiatry	Psychology	

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The chart that follows details the health services and counties where certain requirements have not been met.

Exhibit 5.27: Gaps in Services and Counties

Category	Specialty	County Score			
		Hampden	Middlesex	Norfolk	Worcester
Primary Care	Adult PCP				
Primary Care	Pediatric PCP				
Specialty	Allergy and Immunology				
	Anesthesiology				
	Audiology				
	Cardiothoracic Surgery				
	Dermatology				
	ENT/Otolaryngology				
	Gastroenterology				
	General Surgery				
	Hematology				
	Infectious Diseases				
	Nephrology				
	Neurology				
	Neurosurgery				
	Nuclear Medicine				
	OBGYN				
	Oncology - Medical				
	Oncology – Radiation				
	Oral Surgery				
	Orthopedic Surgery				
	Pathology				
	Physiatry				
	Plastic Surgery				
	Pulmonology				
	Radiology				
	Rheumatology				
	Urology				
	Vascular Surgery				
BH Diversionary	Clinical Support Services for SUD				
	Monitored Inpatient Level 3.7				
	Program of Assertive Community Treatment				
	Residential Rehab Services for Substance Use Disorders				
BH Outpatient	Opioid Treatment Programs*				
Medical Facility	Acute Inpatient Hospital				
	Rehab Hospital				
	Urgent Care Services				

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

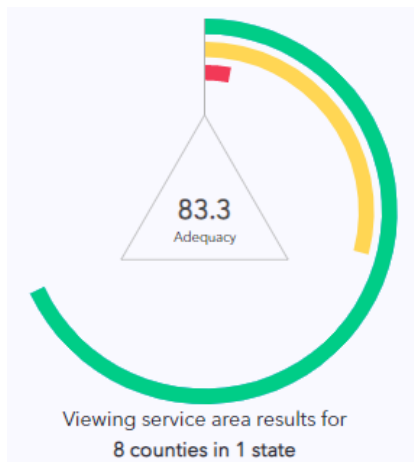
## FINDINGS

- The plan submitted no Opioid Treatment Program data for review. Fallon 365 received a red score for this service.
- Worcester County has the most gaps in the network, in comparison to the other three counties.
- Both Primary Care services, Adult PCP and Pediatric PCP, are only meeting the servicing provider requirements in all four counties.
- Allergy and Immunology, Nuclear Medicine, and Pathology are only meeting the servicing provider requirements in all four counties.

## WELLFORCE CARE PLAN

This plan services Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties, partially. The Fallon-Wellforce plan received an overall score of 83.3, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.28: Fallon-Wellforce Adequacy Score



- The **green** bar indicates that 68.00% fully meet the adequacy requirements.
- The **yellow** bar indicates that 29.10% meet only the servicing provider requirements.
- The **red** bar indicates that 2.90% do not meet any adequacy requirements.

## STRENGTHS

Fallon-Wellforce received a 100, or a **Green** score, in multiple service areas. Three services in the Behavioral Health Inpatient category, six Specialty services, two services in the Behavioral Health Outpatient category, one service in the Intensive Community Treatment category, and eight services in the Behavioral Health Diversionary category received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.29: Services with a 100 score

BH Inpatient		
Psych Inpatient Adolescent	Psych Inpatient Adult	Psych Inpatient Child
Specialists		
Chiropractor	Psych APN	Psychology
Emergency Medicine	Psychiatry	Psychiatry
BH Outpatient		BH Intensive Community Treatment
Applied Behavior Analysis	BH Outpatient	In-Home Therapy Services
BH Diversionary		
Clinical Support Services for SUD		Partial Hospitalization Program
Community Support Program		Recovery Coaching
Intensive Outpatient Program		Recovery Support Navigators
Monitored Inpatient Level 3.7		Structured Outpatient Addiction Program

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The charts that follow designate the health services and counties where certain requirements have not been met.

**Table 5.30: Various Gaps in Service**

County	Primary Care		BH Diversionary				BH Inpatient
	Adult PCP	Pediatric PCP	CBAT	Program of Assertive Community Treatment	Psychiatric Day Treatment	Residential Rehab Services for SUD	Managed Inpatient Level 4
Barnstable							
Bristol							
Essex							
Middlesex							
Norfolk							
Plymouth							
Suffolk							
Worcester							

County	BH Intensive Community Treatment		BH Outpatient	Medical Facility			Pharmacies
	In-Home Behavioral Services	Therapeutic Mentoring Services	Opioid Treatment Program*	Acute Inpatient Hospital	Rehab Hospital	Urgent Care Services	Retail Pharmacies
Barnstable							
Bristol							
Essex							
Middlesex							
Norfolk							
Plymouth							
Suffolk							
Worcester							

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

The following tables depict the gaps in Specialty provider networks.

Table 5.31: Specialty Service Gaps

County	Allergy and Immunology	Anesthesiology	Audiology	Cardiology	Cardiothoracic Surgery	Dermatology	Endocrinology	ENT / Otolaryngology
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

County	Gastroenterology	General Surgery	Hematology	Infectious Diseases	Nephrology	Neurology	Neurosurgery	Nuclear Medicine
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

County	OBGYN	Oncology - Medical	Oncology - Radiation	Ophthalmology	Oral Surgery	Orthopedic Surgery	Pathology	Physiatry
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

County	Plastic Surgery	Podiatry	Pulmonology	Radiology	Rheumatology	Urology	Vascular Surgery
Barnstable							
Bristol							
Essex							
Middlesex							
Norfolk							
Plymouth							
Suffolk							
Worcester							

## FINDINGS

- The plan submitted no Opioid Treatment Program data for review. Fallon-Wellforce received a red score for this service.
- Barnstable County has the most gaps in the network when compared to the other seven counties.
- Adult PCP, Pediatric PCP, Programs of Assertive Community Treatment, Oral Surgery, and Pathology, Barnstable County are not meeting any requirements. Fallon-Wellforce received a red score for these services.
- Only Worcester County is meeting all Pharmacy Provider requirements. All other counties are only meeting the servicing provider requirements except for Barnstable County, which is not meeting any requirements.

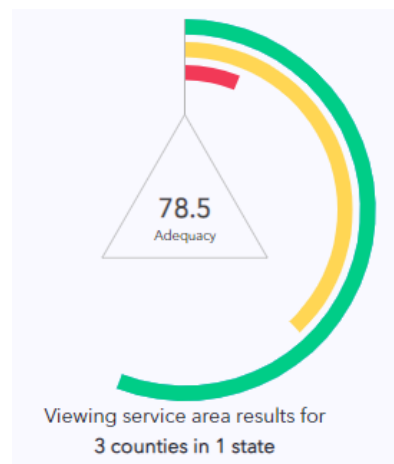
- Only Suffolk County is meeting all Nuclear Medicine requirements. All other counties are only meeting the servicing provider requirement except one, Barnstable County, which is not meeting any requirements.
- Only Suffolk County is meeting all Cardiothoracic Surgery requirements. All other counties are only meeting the servicing provider requirements.
- Suffolk County is meeting all requirements in all counties for all Specialty services.



## HNE-BE HEALTHY PARTNERSHIP

This plan services Franklin, Hampden, and Hampshire counties, partially. The HNE-Be Healthy plan received an overall score of 78.5, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.32: HNE-BeHealthy Adequacy Score



- The **green** bar indicates that 55.80% fully meet the adequacy requirements.
- The **yellow** bar indicates that 38.00% meet only the servicing provider requirements.
- The **red** bar indicates that 6.20% do not meet any adequacy requirements.

The following section includes breakdowns of the network adequacy evaluation by specialty.

### STRENGTHS

HNE-Be Healthy received a 100, or a **Green** score, in multiple service areas. Three services in the Intensive Community Treatment category, three services in the Behavioral Health Inpatient category, five Specialist services, one Medical Facility service, three services in the Behavioral Health Outpatient category, and six services in the Behavioral Health Diversionary category received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.34: Services with a 100 score

<b>BH Intensive Community Treatment</b>	<b>BH Inpatient</b>
In-Home Behavioral Services	Psych Inpatient Adolescent
In-Home Therapy Services	Psych Inpatient Adult
Therapeutic Mentoring Services	Psych Inpatient Child
<b>Specialists</b>	<b>Medical Facility</b>
Cardiology	Acute Inpatient Hospital
Emergency Medicine	<b>BH Outpatient</b>
General Surgery	Applied Behavior Analysis
Ophthalmology	BH Outpatient
Psychology	Opioid Treatment Programs
<b>BH Diversionary</b>	
Community Support Program	Recovery Coaching
Intensive Outpatient Program	Recovery Support Navigators
Partial Hospitalization Program	Structured Outpatient Addiction Program

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The chart that follows designates the health services and counties where certain requirements have not been met.

### Exhibit 5.35: Gaps in Services and Counties

Category	Specialty	County Score		
		Franklin	Hampden	Hampshire
Primary Care	Adult PCP			
Primary Care	Pediatric PCP			
Specialty	Allergy and Immunology			
	Anesthesiology			
	Audiology			
	Cardiothoracic Surgery			
	Chiropractor*			
	Dermatology			
	Endocrinology			
	ENT/Otolaryngology			
	Gastroenterology			
	Hematology			
	Infectious Diseases			
	Nephrology			
	Neurology			
	Neurosurgery			
	Nuclear Medicine*			
	OBGYN			
	Oncology - Medical			
	Oncology – Radiation			
	Oral Surgery			
	Orthopedic Surgery			
	Pathology			
	Physiatry*			
	Plastic Surgery			
	Podiatry			
	Psych APN			
	Psychiatry			
	Pulmonology			
	Radiology			
	Rheumatology			
	Urology			
	Vascular Surgery			
BH Diversionary	CBAT			
	Clinical Support Services for SUD			
	Monitored Inpatient Level 3.7			
	Program of Assertive Community Treatment			
	Psych Day Treatment			
	Residential Rehab Services for Substance Use Disorders			
BH Inpatient	Managed Inpatient Level 4*			
Medical Facility	Rehab Hospital			
	Urgent Care Services			
Pharmacy	Retail Pharmacies			

\*No plan data were submitted for these specialties. Kepro is unable to discern whether there are no network providers or this is a data omission.

### FINDINGS

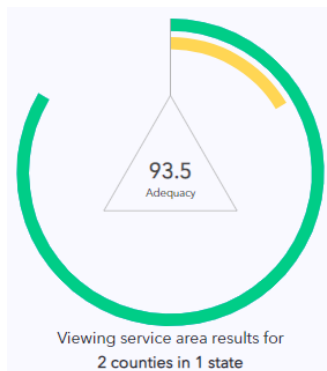
- The plan submitted no Managed Inpatient Level 4, Chiropractic Services, Nuclear Medicine, and Physiatry Services data for review. HNE-Be Healthy received a red score for these services.
- All three counties are only meeting the servicing provider requirements for Adult PCP and Pediatric PCP.

- All three counties are only meeting the servicing provider requirement for Cardiothoracic Surgery, Programs of Assertive Community Treatment, Psychiatric Day Treatment, and Urgent Care Services.
- Hampshire County has the most gaps in the network when compared to the other two counties. Franklin County has the least gaps.

## ALLWAYS-MY CARE FAMILY

This plan services Essex and Middlesex counties, partially. AllWays My Care Family received an overall score of 93.5, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.36: AllWays-My Care Family Adequacy Score



- The **green** bar indicates that 83.60% fully meet the adequacy requirements.
- The **yellow** bar indicates that 16.40% meet only the servicing provider requirements.

## STRENGTHS

AllWays-My Care Family received a 100, or a **Green** score, in multiple service areas. Primary Care services, two services in the Intensive Community Treatment category, Pharmacy services, three services in the Behavioral Health Inpatient category, three services in the Behavioral Health Outpatient category, three Medical Facility services, eight services in the Behavioral Health Diversionary category, and 24 Specialist services received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.37: Services with a 100 score

Primary Care	BH Intensive Community Treatment	Pharmacy
Adult PCP	In-Home Therapy Services	Retail Pharmacies
Pediatric PCP	Therapeutic Mentoring Services	
BH Inpatient	BH Outpatient	Medical Facility
Psych Inpatient Adolescent	Applied Behavior Analysis	Acute Inpatient Hospital
Psych Inpatient Adult	BH Outpatient	Rehab Hospital
Psych Inpatient Child	Opioid Treatment Programs	Urgent Care Services
BH Diversionary		
Clinical Support Services for SUD	Psychiatric Day Treatment	
Intensive Outpatient Program	Recovery Coaching	
Monitored Inpatient Level 3.7	Residential Rehab Services for SUD	
Partial Hospitalization Program	Structured Outpatient Addiction Program	
Specialists		
Anesthesiology	Ophthalmology	
Cardiology	Oral Surgery	
Chiropractor	Orthopedic Surgery	
Endocrinology	Physiatry, Rehabilitative Medicine	
ENT/Otolaryngology	Plastic Surgery	
Gastroenterology	Podiatry	
General Surgery	Psych APN	
Hematology	Psychiatry	
Infectious Diseases	Psychology	
Nephrology	Pulmonology	
OBGYN	Radiology	
Oncology – Medical	Rheumatology	

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The chart that follows designates the health services and counties where certain requirements have not been met.

### Exhibit 5.37: Gaps in Services and Counties

Category	Specialty	County Score	
		Essex	Middlesex
Specialists	Allergy and Immunology		
	Audiology		
	Cardiothoracic Surgery		
	Dermatology		
	Emergency Medicine		
	Neurology		
	Neurosurgery		
	Nuclear Medicine		
	Oncology – Radiation		
	Urology		
	Vascular Surgery		
BH Diversionary	CBAT		
	Community Support Program		
	Program of Assertive Community Treatment		
	Recovery Support Navigators		
BH Inpatient	Managed Inpatient Level 4		
BH Intensive Community Treatment	In-Home Behavioral Services		

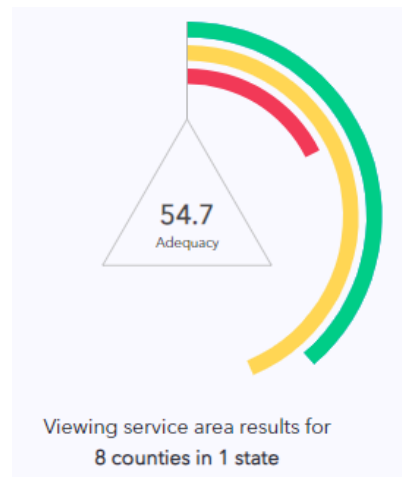
### FINDINGS

- No single service in any county received a red score. All services are meeting access requirements.
- Essex County has more gaps in the network than Middlesex County.
- Both counties are only meeting the provider to member ratio requirements for Neurology, Neurosurgery, Nuclear Medicine, and Recovery Support Navigators. All other services are meeting time and distance and provider to member ratio requirements in at least one county.

## TUFTS HEALTH TOGETHER WITH ATRIUS HEALTH

This plan services Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties, partially. The Tufts-Atrius plan received an overall score of 54.7, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.38: Tufts-Atrius Adequacy Score



- The **green** bar indicates that 38.70% fully meet the adequacy requirements.
- The **yellow** bar indicates that 0.60% meet only the access requirements.
- The **yellow** bar also indicates that 43.10% meet only the servicing provider requirements.
- The **red** bar indicates that 17.60% do not meet any adequacy requirements.

## STRENGTHS

Tufts-Atrius received a 100, or a **Green** score, in multiple service areas. Pharmacy services, one Behavioral Health Diversionary service, one Medical Facility service, three services in the Behavioral Health Inpatient category, four Specialist services, two services in the Intensive Community Treatment category, and two services in the Behavioral Health Outpatient category received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.39: Services with a 100 score

Pharmacy	BH Diversionary	Medical Facility
Retail Pharmacies	Structured Outpatient Addiction Program	Acute Inpatient Hospital
BH Inpatient		
Psych Inpatient Adolescent	Psych Inpatient Adult	Psych Inpatient Child
Specialists		
Chiropractor	Psychiatry	
Psych APN	Psychology	
BH Intensive Community Treatment		
In-Home Therapy Services	Therapeutic Mentoring Services	
BH Outpatient		
Applied Behavior Analysis	BH Outpatient	



## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The charts that follow designate the health services and counties where certain requirements have not been met.

**Table 5.40: Various Gaps in Service**

County	Primary Care		BH Inpatient	BH Intensive Community Treatment	BH Outpatient	Medical Facility	
	Adult PCP	Pediatric PCP	Managed Inpatient Level 4	In-Home Behavioral Services	Opioid Treatment Programs*	Rehab Hospital	Urgent Care Services
Barnstable							
Bristol							
Essex							
Middlesex							
Norfolk							
Plymouth							
Suffolk							
Worcester							

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

The following table display the gaps in provider networks for the Behavioral Health Diversionary category.

**Table 5.41: BH Diversionary Service Gaps**

County	CBAT	Clinical Support Services for SUD	Community Support Program	Intensive Outpatient Program	Monitored Inpatient Level 3.7	Partial Hospitalization Program	Program of Assertive Community Treatment	Psychiatric Day Treatment*	Recovery Coaching	Recovery Support Navigators*	Residential Rehab Services for SUD
Barnstable											
Bristol											
Essex											
Middlesex											
Norfolk											
Plymouth											
Suffolk											
Worcester											

\*No plan data were submitted for these specialties. Kepro is unable to discern whether there are no network providers or this is a data omission.

The following tables detail the gaps in provider networks for the Specialty category.

**Table 5.42: Specialty Service Gaps**

County	Allergy and Immunology	Anesthesiology	Audiology	Cardiology	Cardiothoracic Surgery*	Dermatology	Emergency Medicine	Endocrinology
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

County	ENT / Otolaryngology	Gastroenterology	General Surgery	Hematology	Infectious Diseases	Nephrology	Neurology	Neurosurgery*
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

County	Nuclear Medicine	OBGYN	Oncology - Medical	Oncology - Radiation*	Ophthalmology	Oral Surgery*	Orthopedic Surgery	Pathology
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

\*No plan data were submitted for these specialties. Kepro is unable to discern whether there are no network providers or this is a data omission.

County	Physiatry	Plastic Surgery	Podiatry	Pulmonology	Radiology	Rheumatology	Urology	Vascular Surgery
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								

Suffolk								
Worcester								

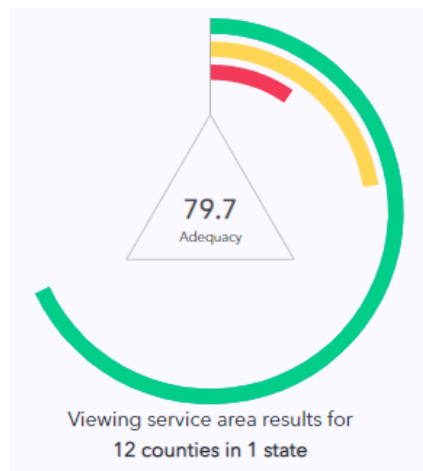
## FINDINGS

- The plan submitted no data for Opioid Treatment Programs, Recovery Support Navigators, and Psychiatric Day Treatment services. Tufts-Atrius received a red score for these services.
  - Only Adult PCP and Pediatric PCP in Suffolk County met all requirements. All other counties are only meeting the servicing provider requirements.
  - Only one Clinical Support Services for SUD provider was submitted for the review. Worcester County met the servicing provider requirements, but all other counties did not meet any requirements.
  - Only Bristol County met all Recovery Coaching requirements. Five counties met only the servicing provider requirements and two counties did not meet any requirements.
  - In the Specialist category, no plan data were submitted for Cardiothoracic Surgery, Neurosurgery, Radiation Oncology, and Oral Surgery services. Tufts-Atrius received a red score for these services.
  - Eighteen specialist services received the same scoring in the same counties. Suffolk County met all requirements, Barnstable County did not meet any requirements, and the remaining counties only met the servicing provider requirements. The specialty services that received this score are listed below.
    - Allergy and Immunology
    - Emergency Medicine
    - Endocrinology
    - ENT
    - Gastroenterology
    - General Surgery
    - Hematology
    - Infectious Diseases
    - Nephrology
    - Neurology
    - OBGYN
    - Oncology – Medical
    - Physiatry
    - Podiatry
    - Pulmonology
    - Radiology
    - Urology
    - Vascular Surgery
- Pathology and Plastic Surgery services received a similar score, except Suffolk County also met only the servicing provider requirement.

## TUFTS HEALTH TOGETHER WITH BOSTON CHILDREN'S ACO

This plan services all counties except for Berkshire and Nantucket, partially. The Tufts-BCH plan received an overall score of 79.7, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.43: Tufts-BCH Adequacy Score



- The **green** bar indicates that 68.00% fully meet the adequacy requirements.
- The **yellow** bar indicates that 0.50% meet only the access requirements.
- The **yellow** bar also indicates that 22.00% meet only the servicing provider requirements.
- The **red** bar indicates that 9.50% do not meet any adequacy requirements.

## STRENGTHS

Tufts-BCH received a 100, or a **Green** score, in multiple service areas. One service in the Behavioral Health Diversionary category, one Medical Facility service, one service in the Behavioral Health Inpatient category, one service in the Behavioral Health Outpatient category, and six Specialist services received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.43: Services with a 100 score

BH Diversionary		Medical Facility	
Structured Outpatient Addiction Program		Rehab Hospital	
BH Inpatient		BH Outpatient	
Psych Inpatient Adolescent		BH Outpatient	
Specialists			
Chiropractor		Psychiatry	
Emergency Medicine		Psychology	
Psych APN		Pulmonology	

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The charts that follow designate the health services and counties where certain requirements have not been met.

Table 5.44: Various Gaps in Service

County	Primary Care		BH Outpatient		BH Inpatient		
	Adult PCP*	Pediatric PCP	Applied Behavior Analysis	Opioid Treatment Program**	Managed Inpatient Level 4	Psych Inpatient Adult	Psych Inpatient Child
Barnstable							
Bristol							
Dukes							
Essex							
Franklin							
Hampden							
Hampshire							
Middlesex							
Norfolk							
Plymouth							
Suffolk							
Worcester							

\*Tufts-BCH serves a predominantly pediatric population.

\*\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

County	BH Intensive Community Treatment			Medical Facility		Pharmacies
	In-Home Behavioral Services	In-Home Therapy Services	Therapeutic Mentoring Services	Acute Inpatient Hospital	Urgent Care Services	Retail Pharmacies
Barnstable						
Bristol						
Dukes						
Essex						
Franklin						
Hampden						
Hampshire						
Middlesex						
Norfolk						
Plymouth						
Suffolk						
Worcester						

The following table presents the gaps in provider networks for the Behavioral Health Diversionary category.

Table 5.45: BH Diversionary Service Gaps

County	CBAT	Clinical Support Services for SUD	Community Support Program	Intensive Outpatient Program	Monitored Inpatient Level 3.7	Partial Hospitalization Program	Program of Assertive Community Treatment	Psychiatric Day Treatment*	Recovery Coaching	Recovery Support Navigators*	Residential Rehab Services for SUD
Barnstable											
Bristol											
Dukes											
Essex											
Franklin											
Hampden											
Hampshire											
Middlesex											
Norfolk											
Plymouth											
Suffolk											
Worcester											

\*No plan data were submitted for these specialties. Kepro is unable to discern whether there are no network providers or this is a data omission.

The following tables depict the gaps in provider networks for the Specialty category.

Table 5.46: Specialty Service Gaps

County	Allergy and Immunology	Anesthesiology	Audiology	Cardiology	Cardiothoracic Surgery	Dermatology	Endocrinology
Barnstable							
Bristol							
Dukes							
Essex							
Franklin							
Hampden							
Hampshire							
Middlesex							
Norfolk							
Plymouth							
Suffolk							
Worcester							

County	ENT / Otolaryngology	Gastroenterology	General Surgery	Hematology	Infectious Diseases	Nephrology	Neurology
Barnstable							
Bristol							
Dukes							
Essex							
Franklin							
Hampden							
Hampshire							
Middlesex							
Norfolk							
Plymouth							
Suffolk							
Worcester							



County	Neurosurgery	Nuclear Medicine	OBGYN	Oncology - Medical	Oncology - Radiation	Ophthalmology	Oral Surgery	Orthopedic Surgery
Barnstable								
Bristol								
Dukes								
Essex								
Franklin								
Hampden								
Hampshire								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

County	Pathology	Physiatry	Plastic Surgery	Podiatry	Radiology	Rheumatology	Urology	Vascular Surgery
Barnstable								
Bristol								
Dukes								
Essex								
Franklin								
Hampden								
Hampshire								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

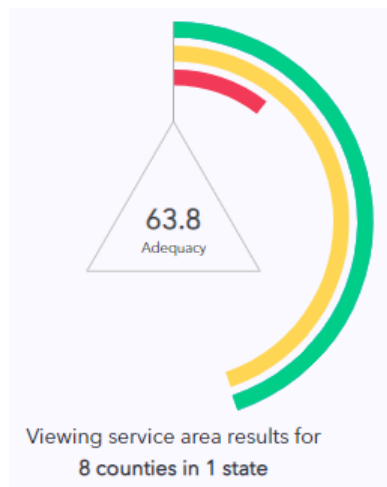
## FINDINGS

- The plan submitted no data for Opioid Treatment Programs, Recovery Support Navigators, and Psychiatric Day Treatment services. Tufts-BCH received a red score.
- Barnstable County has the most gaps in the network when compared to the other eleven counties.
- Only one county for one specialty did not meet any requirements, i.e., Oral Surgery in Dukes County, which only met all requirements in two other counties.
- Behavioral Health Diversionary services had the most gaps in the provider network.
  - Recovery Coaching only met all requirements in one county, Dukes. Four counties met the servicing provider requirements, and the remaining seven counties did not meet any requirements.
  - Clinical Support Services for SUD did not meet all requirements in any county in the service area. Four counties only met the servicing provider requirements, and eight counties did not meet any requirements.
  - Community Support Programs only met all requirements in Suffolk county. Six counties only met the servicing provider requirements, and five counties did not meet any requirements.
  - Partial Hospitalization Programs met all requirements in only Suffolk county. Nine counties only met the servicing provider requirements, and two counties did not meet any requirements.

## TUFTS HEALTH TOGETHER WITH BIDCO

This plan services Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties, partially. The Tufts-BIDCO plan received an overall score of 63.8, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.47: Tufts-BIDCO Adequacy Score



- The **green** bar indicates that 44.80% fully meet the adequacy requirements.
- The **yellow** bar indicates that 0.40% meet only the access requirements.
- The **yellow** bar also indicates that 44.30% meet only the servicing provider requirements.
- The **red** bar indicates that 10.50% do not meet any adequacy requirements.

## STRENGTHS

Tufts-BIDCO received a 100, or a **Green** score, in multiple service areas. One service in the Behavioral Health Outpatient category, one Medical Facility service, Pharmacy services, one service in the Behavioral Health Inpatient category, one service in the Behavioral Health Diversionary category, and four Specialty services received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 5.48: Services with a 100 score

BH Outpatient	Medical Facility	Pharmacy
BH Outpatient	Rehab Hospital	Retail Pharmacies
BH Inpatient	BH Diversionary	
Psych Inpatient Adolescent	Structured Outpatient Addiction Program	
Specialists		
Chiropractor	Psychiatry	
Psych APN	Psychology	

## AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The charts that follow designate the health services and counties where certain requirements have not been met. Directly following are findings from the data.

Table 5.49: Various Gaps in Service

County	Primary Care		BH Outpatient		Medical Facility	
	Adult PCP	Pediatric PCP	Applied Behavior Analysis	Opioid Treatment Program*	Acute Inpatient Hospital	Urgent Care Services
Barnstable						
Bristol						
Essex						
Middlesex						
Norfolk						
Plymouth						
Suffolk						
Worcester						

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

County	BH Intensive Community Treatment			BH Inpatient		
	In-Home Behavioral Services	In-Home Therapy Services	Therapeutic Mentoring Services	Managed Inpatient Level 4	Psych Inpatient Adult	Psych Inpatient Child
Barnstable						
Bristol						
Essex						
Middlesex						
Norfolk						
Plymouth						
Suffolk						
Worcester						

The following table depicts the gaps in provider networks for the Behavioral Health Diversionary category.

**Table 5.50: BH Diversionary Service Gaps**

County	CBAT	Clinical Support Services for SUD	Community Support Program	Intensive Outpatient Program	Monitored Inpatient Level 3.7	Partial Hospitalization Program	Program of Assertive Community Treatment	Psychiatric Day Treatment*	Recovery Coaching	Recovery Support Navigators*	Residential Rehab Services for SUD
Barnstable											
Bristol											
Essex											
Middlesex											
Norfolk											
Plymouth											
Suffolk											
Worcester											

\*No plan data were submitted for these specialties. Kepro is unable to discern whether there are no network providers or this is a data omission.

The following tables depict the gaps in provider networks for the Specialty category.

**Table 5.51: Specialty Service Gaps**

County	Allergy and Immunology	Anesthesiology	Audiology	Cardiology	Cardiothoracic Surgery	Dermatology	Emergency Medicine	Endocrinology
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

County	ENT / Otolaryngology	Gastroenterology	General Surgery	Hematology	Infectious Diseases	Nephrology	Neurology	Neurosurgery
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

County	Nuclear Medicine	OBGYN	Oncology - Medical	Oncology - Radiation	Ophthalmology	Oral Surgery*	Orthopedic Surgery	Pathology
Barnstable								
Bristol								
Essex								
Middlesex								
Norfolk								
Plymouth								
Suffolk								
Worcester								

\*No plan data were submitted for this specialty. Kepro is unable to discern whether there are no network providers or this is a data omission.

County	Physiatry	Plastic Surgery	Podiatry	Pulmonology	Radiology	Rheumatology	Urology	Vascular Surgery
Barnstable								
Bristol								
Essex								
Middlesex								

Norfolk								
Plymouth								
Suffolk								
Worcester								

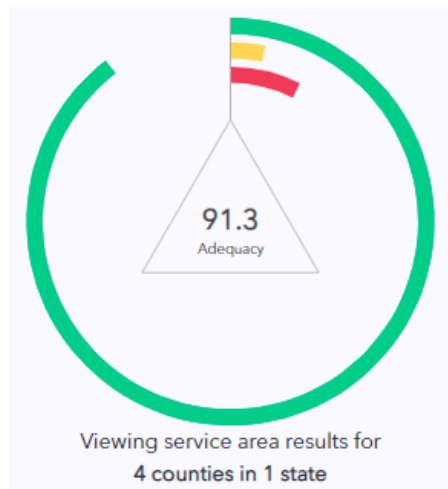
## FINDINGS

- The plan submitted no data For Opioid Treatment Programs, Recovery Support Navigators, Psychiatric Day Treatment, and Oral Surgery services. Tufts-BIDCO received a red score for these services.
- Only Suffolk County met all Adult PCP and Pediatric PCP requirements. All other counties only met the servicing provider requirements except Barnstable County, which did not meet any requirements.
- Only one Clinical Support Services for SUD provider was submitted for the review. Worcester County met the servicing provider requirements, but all other counties did not meet any requirements.
- Only one county met all Recovery Coaching requirements, i.e., Bristol County. Three counties met the servicing provider requirements only, and four counties did not meet any requirements.
- Ten Specialty Services received the same scoring in the same counties. Suffolk County met all requirements and the remaining counties only met the servicing provider requirements. The specialty services that received this score are:
  - Cardiothoracic Surgery
  - General Surgery
  - Hematology
  - Neurosurgery
  - Oncology – Medical
  - Oncology - Radiation
  - Pathology
  - Plastic Surgery
  - Pulmonology
  - Vascular Surgery
- Infectious Diseases, Nuclear Medicine, and Rheumatology services received a similar score, except Barnstable County did not meet any requirements.

## TUFTS HEALTH TOGETHER WITH CAMBRIDGE HEALTH ALLIANCE

This plan services Essex, Middlesex, Norfolk, and Suffolk counties, partially. The Tufts-CHA plan received an overall score of 91.3, the aggregate score of the plan's network adequacy results based on the average across all specialties. This score wheel indicates multiple percentages, outlined in the bullets:

Exhibit 5.52: Tufts-CHA Adequacy Score



- The **green** bar indicates that 89.50% fully meet the adequacy requirements.
- The **yellow** bar indicates that 0.80% meet only the access requirements.
- The **yellow** bar also indicates that 2.30% meet only the servicing provider requirements.
- The **red** bar indicates that 7.40% do not meet any adequacy requirements.

## STRENGTHS

Tufts-CHA received a 100, or a **Green** score, in multiple service areas. All Specialties except one received a **Green** score. Additionally, three services in the Intensive Community Treatment category, three Medical Facility services, four services in the Behavioral Health Inpatient category, Pharmacy Services, two services in the Behavioral Health Outpatient category, and seven services in the Behavioral Health Diversionary category, also received a 100 score. The following chart depicts the specific areas in which the plan received **Green** scores.



### Exhibit 5.53: Services with a 100 score

<b>BH Intensive Community Treatment</b>	<b>Medical Facility</b>
In-Home Behavioral Services	Acute Inpatient Hospital
In-Home Therapy Services	Rehab Hospital
Therapeutic Mentoring Services	Urgent Care Services
<b>BH Inpatient</b>	<b>Pharmacy</b>
Managed Inpatient Level 4	Retail Pharmacies
Psych Inpatient Adolescent	<b>BH Outpatient</b>
Psych Inpatient Adult	Applied Behavior Analysis
Psych Inpatient Child	BH Outpatient
<b>BH Diversionary</b>	
Community Support Program	Program of Assertive Community Treatment
Intensive Outpatient Program	Residential Rehab Services for SUD
Monitored Inpatient Level 3.7	Structured Outpatient Addiction Program
Partial Hospitalization Program	
<b>Specialists</b>	
Allergy and Immunology	OBGYN
Anesthesiology	Oncology – Medical
Audiology	Oncology – Radiation
Cardiology	Ophthalmology
Cardiothoracic Surgery	Orthopedic Surgery
Chiropractor	Pathology
Dermatology	Physiatry, Rehabilitative Medicine
Emergency Medicine	Plastic Surgery
Endocrinology	Podiatry
ENT/Otolaryngology	Psych APN
Gastroenterology	Psychiatry
General Surgery	Psychology
Hematology	Pulmonology
Infectious Diseases	Radiology
Nephrology	Rheumatology
Neurology	Urology
Neurosurgery	Vascular Surgery
Nuclear Medicine	

### AREAS FOR IMPROVEMENT

Certain areas and services are not currently meeting the time and distance standards. The chart that follows designates the health services and counties where certain requirements have not been met.

### Exhibit 5.54: Gaps in Services and Counties

Category	Specialty	County Score			
		Essex	Middlesex	Norfolk	Suffolk
Primary Care	Adult PCP				
Primary Care	Pediatric PCP				
Specialists	Oral Surgery*				
BH Diversionary	CBAT				
	Clinical Support Services for SUD				
	Psychiatric Day Treatment*				
	Recovery Coaching				
	Recovery Support Navigators*				
BH Outpatient	Opioid Treatment Programs*				

\*No plan data were submitted for these specialties. Kepro is unable to discern whether there are no network providers or this is a data omission.

### FINDINGS

- The plan submitted no data for Opioid Treatment Programs, Recovery Support Navigators, Psychiatric Day Treatment, and Oral Surgery Services. Tufts-CHA received a red score for these services.
- Only one Clinical Support Services for SUD provider was submitted, which was located in Norfolk County. This county meets some requirements, while the other three counties are not meeting any requirements.
- Middlesex County has the most gaps in the network, in comparison to the other three counties.
- Only Essex County is only meeting the CBAT servicing provider requirement. All other counties are meeting all requirements.
- For both Primary Care services, Adult PCP and Pediatric PCP, both Middlesex and Norfolk counties met only the servicing provider requirement.

## CONCLUSION

Over the course of this analysis, Kepro has identified many strengths across all the ACO plans. Certain areas, such as Behavioral Health Outpatient, Psychology, and Psychiatric Inpatient services for adolescents, excelled in all the ACO plans analysis of the provider network.

This year's network adequacy evaluation allowed MassHealth to assess baseline performance and identified several opportunities for performance. MassHealth is working with Plans to address areas of noncompliance.

While not all requirements are being met in all areas, there are many opportunities the plans could implement in order to strengthen the provider network to improve medical care to Medicaid members. A majority of the ACO plans did not submit complete provider data for this analysis, resulting in lower scores for various services. All ACO plans except for AllWays-My Care Family and HNE-Be Healthy submitted no data for Opioid Treatment Programs, which calls to question either the network for these services or the definition itself. MassHealth may need to analyze this service category to determine what providers fall into this topic, or further describe to the plans what data should be submitted for these services. This issue of incomplete data could also be a result of a lack of ability for plans to collect this data, the plans lack of understanding to the expectations of this analysis, or of the compliance aspect to this evaluation. Strengthening or creating these structural mechanisms would be key to improving the network and meeting compliance standards. As this is the first year conducting this report, a majority of the ACO plans may need to build analysis processes for future reporting to improve the provider network and the network adequacy evaluation.

This report also shows that certain geographical areas struggle to meet the time and distance standard overall. Certain counties, such as Barnstable County for some ACO plans, had the most gaps in the provider network than all other counties. The state may conduct further analysis into these regions to assess whether these counties have the ability to meet the standards in their entirety. If not, the state may want to consider approving an exception for these plans, or adjust the standards going forward, to accommodate the plan's ability to provide health care to its members.



Section 7

# Appendices

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# CONTRIBUTORS

## Performance Measure Validation

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

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

## Performance Improvement Project Reviewers

### **Bonnie L. Zell, MD, MPH, FACOG, Clinical Director**

Bonnie L. Zell, MD, MPH, has a diverse background in healthcare, public health, healthcare safety and quality, and has developed several new models of care delivery.

Her healthcare roles include serving as a registered nurse, practicing OB/GYN physician and chief at Northern California Kaiser Permanente, and Medical Director at the Aurora Women's Pavilion in Milwaukee, Wisconsin.

She subsequently served as Healthcare Sector Partnerships Lead at the Centers for Disease Control and Prevention. She focused on patient safety, healthcare quality, and primary prevention strategies through partnerships between key national organizations in public health and healthcare delivery with the goal of linking multi-stakeholder efforts to improve the health of regional populations.

As Senior Director, Population Health at the National Quality Forum she provided leadership to advance population health strategies through endorsement of measures that align action and integration of public health and healthcare to improve health.

Dr. Zell developed a comprehensive model of care for a regional community health initiative that focused on achieving the Triple Aim focused on asthma prevention and management for Contra Costa County in California.

She served as Executive Director of Clinical Improvement at the statewide Hospital Quality Institute in California, building the capacity and capability of healthcare organizations to improve quality and safety by reliably implementing evidence-based practices at all sites of care through the CMS Partnership for Patients initiative.

Previously, Dr. Zell Co-Founded a telehealth company, Lemonaid Health that provided remote primary care services. She served as Chief Medical Officer and Chief Quality Officer. Subsequently she served as Chief Medical Officer of a second telehealth company, Pill Club, which provided hormonal contraception.

She is an Institute for Healthcare Improvement Fellow and continues to provide healthcare quality and safety coaching to healthcare organizations.

Dr. Zell returned to office gynecology to assess translation of national initiatives in safety and quality into front line care. In addition, she provided outpatient methadone management for patients with Opioid Use Disorder for several years.

Currently, she is faculty and coach for Management and Clinical Excellence, a leadership development program, at Sutter Health in California.

#### **Chantal Laperle, MA, CPHQ, NCQA CCE**

Chantal Laperle has over 25 years of experience in the development and implementation of quality initiatives in a wide variety of health care delivery settings. She has successfully held many positions, in both public and private sectors, utilizing her clinical background to affect change. She has contributed to the development of a multitude of quality programs from the ground up requiring her to be hands-on through implementation. She is experienced in The Joint Commission, National Committee for Quality Assurance, The Commission on Accreditation of Rehabilitation Facilities, and Accreditation Association for Ambulatory Health Care accreditation and recognition programs. She is skilled in developing workflows and using tools to build a successful process, as well as monitor accordingly. She also coaches teams through the development and implementation process of a project.

Ms. Laperle holds both a bachelor's and master's degrees in psychology. She is a Certified Professional in Health Care Quality and Certified in Health Care Risk Management through the University of South Florida. She is also certified in Advanced Facilitation and the Seven Tools of Quality Control through GOAL/QPC, an Instructor for Nonviolent Crisis Intervention, a Yellow Belt in Lean Six Sigma, a Telehealth Liaison through the National School of Applied telehealth, and a Certified Content Expert for Patient Centered Medical Home through NCQA.

#### **Wayne J. Stelk, Ph.D.**

Wayne J. Stelk, Ph.D., is a psychologist with over forty years of experience in the design, implementation, and management of large-scale health and human service systems. His

expertise includes improving health providers' service effectiveness and efficiency through data-driven performance management systems. Dr. Stelk has consulted with Kepro for five years as a senior external quality reviewer and technical advisor for healthcare performance improvement projects.

During his 10-year tenure as Vice-President for Quality Management at the Massachusetts Behavioral Health Partnership (MBHP), Dr. Stelk designed and managed over 150 quality improvement projects involving primary care and behavioral health practices across the state. He is well-versed in creating strategies to improve healthcare service delivery that maximize clinical outcomes and minimize service costs. He also implemented a statewide outcomes management program for behavioral health providers in the MBHP network, the first of its kind in Massachusetts.

After leaving MBHP in 2010, he consulted on several projects involving the integration of primary care, behavioral health care, and long-term services and supports. Other areas of expertise include implementing evidence-based interventions and treatment practices; designing systems for the measurement of treatment outcomes; and developing data-collection systems for quality metrics that are used to improve provider accountability. Dr. Stelk has lectured at conferences nationally and internationally on healthcare performance management.

## **Project Management**

### **Cassandra Eckhof, 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. She has managed the MassHealth external quality review program since 2016. Ms. Eckhof has a master's of science degree in health care administration and is a Certified Professional in Healthcare Quality. She is currently pursuing a graduate certificate in Public Health Ethics at the University of Massachusetts at Amherst.

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

This is Ms. Olson's first year working with the Kepro team as a Project Coordinator. Her previous work was in the banking industry. She has a bachelor's degree in business management and human resources from Western Illinois University.