TECHNICAL REPORT

Managed Care Organizations External Quality Review

Calendar Year 2021

MassHealth
Massachusetts Executive Office
of Health & Human Services

This program is supported in full by the
Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid.

Table of Contents

Section 1.

The Managed Care Organizations

SECTION 1. THE MANAGED CARE ORGANIZATIONS

BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

Boston Medical Center HealthNet Plan is headquartered in Charlestown. It received a 4-star rating from the National Committee on Quality Assurance (NCQA). Its corporate parent is Boston Medical Center Health System, Inc. Beneficiaries in all counties of Massachusetts are eligible to enroll. More information is available at www.bmchp.org/.

TUFTS HEALTH PUBLIC PLANS (TUFTS)

Tufts Health Public Plans' managed care organization, Tufts Health Together, is headquartered in Canton. On January 1, 2021, Tufts Health Plan merged with Harvard Pilgrim Health Care. The newly formed corporate parent is Point32Health, Inc. Tufts received a 4.5-star rating from NCQA. More information is available at www.tuftshealthplan.com/provider/our-plans/tufts-health-public-plans/overview.

Exhibit 1.1. MassHealth Managed Care Organization Membership

Managed Care Organization	Abbreviation Used in this Report	Membership as of December 31, 2021	Percent of Total MCO Population
Boston Medical Center HealthNet Plan	BMCHP	44,798	39.38%
Tufts Health Public Plans, Inc.	Tufts	68,962	60.62%
Total		**113,760**	

Membership provided by the MCO.

Section 2.

Executive Summary

SECTION 2. EXECUTIVE SUMMARY

INTRODUCTION

The Balanced Budget Act of 1997 was an omnibus legislative package enacted by the United States Congress with the intent of balancing the federal budget by 2002. Among its other provisions, this expansive bill authorized states to provide Medicaid benefits (except to special needs children) through managed care plans. Regulations were promulgated, including those related to the quality of care and service provided by managed care plans 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 healthcare services that a managed care plan or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth entered into an agreement with Kepro to perform EQR services related to its contracted managed care plans, including the Managed Care Organizations which are the subject of this report. All MassHealth managed care plans participate in external quality review.

As part of its analysis and evaluation activities, the EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services (CMS). The report is also posted to the Medicaid agency website.

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

Kepro conducted the following external quality review activities for MassHealth Managed Care Organizations (MCOs) in the calendar year (CY) 2021 review cycle:

- Validation of three performance measures, including an Information Systems Capability Assessment;
- Validation of two Performance Improvement Projects (PIPs);
- Validation of compliance with regulations and contract requirements related to member access to timely, quality healthcare; and
- Validation of network adequacy.

To clarify reporting periods, EQR Technical Reports that have been produced in calendar year 2021 reflect 2020 quality performance. References to HEDIS® MY2020 performance reflect data collected in 2020. Performance Improvement Project reporting is inclusive of activities conducted in CY 2021.

METHODOLOGY FOR PREPARING THE EXTERNAL QUALITY REVIEW TECHNICAL REPORT

To fulfill the requirements of 42 CFR §438.358 subsections 1-5, Kepro compiled the overall findings for each EQR activity it conducted. It assessed the MCOs' strengths, areas requiring improvement, and opportunities to further strengthen their processes, documentation, and/or performance outcomes with respect to the quality and timeliness of, and access to, healthcare services. Kepro also assessed the extent to which the MCO followed up on recommendations regarding opportunities for improvement made in the previous reporting period.

Data Sources
Kepro used the following data sources to complete its assessment and to prepare this annual EQR technical report:

Performance Measure Validation
- The MCO HEDIS Final Audit Report
- The HEDIS IDSS worksheet
- The 2021 NCQA Medicaid Quality Compass
- 2020 Performance Measure Validation recommendations

Performance Improvement Project Validation
- The Baseline Project Planning and Baseline Performance Indicator Reports
- Supplemental information as identified by the MCO
- Recommendations offered in the 2020 EQR technical reports

Compliance Validation
- Documentation to substantiate MCO compliance with each requirement during the review period including, but not limited to:
  - Policies and Procedures
  - Standard Operating Procedures
  - Workflows
  - Desk Tools
  - Reports
  - Member Materials
  - Care Management Files
  - Utilization Management Denial Files
  - Appeals Files
  - Grievance Files
  - Credentialing Files
- 42 CFR 438
- Appropriate provisions in the Code of Massachusetts Regulations (CMR)
- MCO agreements with MassHealth
- Recommendations made as part of 2017 Compliance Validation

<u>Network Adequacy Validation</u>
- Network provider files in an Excel format provided by the MCO
- MassHealth provider network adequacy standards
- Related recommendations made in the 2021 EQR technical report

Data Analysis

For each of the EQR activities, Kepro conducted a thorough review and analysis of the data within the parameters set forth in CMS' EQR Protocols. Reviewers were assigned to EQR activities based on professional experience and credentials. Because the activities varied in terms of types of data collected and used, Kepro designed data analysis methodologies specific to each activity in order to allow reviewers to identify strengths and weaknesses.

Drawing Conclusions

Kepro's reviewers used analytic questions such as those noted below in undertaking their review of the various EQR activities:

- Performance Measure Validation: Did the MCO's methodology for measure calculation comply with HEDIS technical specifications?
- Performance Improvement Validation: Did the MCO's Performance Improvement Project Report comply with established criteria as set forth in EQR Protocol 1? Do the interventions show promise for effecting improvement?
- Compliance Validation: Did the MCO supply documentation evidencing compliance with regulatory and contractual requirements? Did staff interviews demonstrate consistency with compliance?
- Network Adequacy Validation: Did the MCO's provider network files appear to be complete? Did the analysis show compliance with MassHealth time and distance standards and provider to member ratios?

PERFORMANCE MEASURE VALIDATION (PMV) & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

Exhibit 2.1. Performance Measure Validation Process Overview

Topic	Description
Objectives	To assess the accuracy of performance measures reported by the MCO in accordance with 42 CFR § 438.358(b)(ii) and to determine the extent to which the MCO follows state specifications and reporting requirements.
Technical methods of data collection and analysis	Kepro's Lead PMV Auditor conducted this activity in accordance with 42 CFR § 438.358(b)(ii) using the analytic approach established in CMS EQR Protocol 2.
Data obtained	Each Managed Care Organization submitted its HEDIS Final Audit Report, the NCQA Roadmap, the plans' NCQA IDSS worksheets, and follow-up documentation as requested by the auditor.
Conclusions	Kepro's validation review of the selected performance measures indicates that MCO measurement and reporting processes were fully compliant with specifications and were methodologically sound. Quality-Related: The performance of both managed care organizations on the Asthma Medication Ratio was below the 33rd 2020 NCQA Medicaid Quality Compass. Kepro encourages the plans to undertake related quality improvement initiatives.

The Performance Measure Validation process assesses the accuracy of performance measures reported by the MCO. It determines the extent to which the MCO uses accurate and complete data and follows state specifications and reporting requirements to produce performance measures. In 2021, Kepro conducted PMV in accordance with CMS EQR Protocol 2 on three measures that were selected by MassHealth and Kepro. The measures validated were as follows:

- Asthma Medication Ratio (AMR);
- Follow-Up After an Emergency Department (ED) Visit for Mental Illness (FUM): 7-Day Follow-Up; and
- Pharmacotherapy for Opioid Use Disorder (POD).

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

Kepro determined that both managed care organizations 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 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) using the analytic approach established in CMS EQR Protocol 3.
Data obtained	Managed Care Organizations submitted two PIP reports in 2021, Baseline Report: Project Planning (April 2021) and Baseline Report: Performance Indicator Rates (September 2021). They also submitted related supporting documentation.
Conclusions	Access and Timeliness Related: In its Telehealth PIP, Tufts describes a statewide situation in which access to behavioral health services is limited.

In 2021, MassHealth directed Managed Care Organizations to conduct two Performance Improvement Projects, one related to increasing vaccination rates and one related to decreasing barriers to telehealth services.

Kepro evaluated each PIP to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3, "Performance Improvement Project Validation." The Kepro technical reviewer assesses project methodology. The medical director evaluates the clinical soundness of the interventions. The review considers the plan's performance in the areas of problem definition, data analysis, measurement, improvement strategies, and outcomes. Recommendations are offered to the plan. Of the four Performance Improvement Projects validated by Kepro, the reviewers had high confidence in the validity of three reports and moderate confidence in one.

COMPLIANCE VALIDATION

Exhibit 2.3. Compliance Validation Process Overview

Topic	Description
Objectives	To determine the extent to which MCOs comply with standards set forth at 42 C.F.R. § 438.358(b)(iii), state standards, and MCO contract requirements.
Technical methods of data collection and analysis	The 2021 compliance reviews were structured based on program requirements as outlined in 42 CFR 438. In addition, compliance with provisions in contracts between MassHealth and the MCO as they relate to 42 CFR 438 were assessed. Appropriate provisions in the Code of Massachusetts Regulations (CMR) were included in the reviews as indicated.
Data obtained	MCOs provided documentation to substantiate compliance with each requirement during the review period. Examples of documentation provided included: • Policies and Procedures • Standard Operating Procedures • Workflows • Desk Tools • Reports • Member Materials • Care Management Files • Utilization Management Denial Files • Appeals Files • Grievance Files • Credentialing Files Additional information was obtained from interviews with key MCO personnel, case file reviews, and systems demonstrations.
Conclusions	Overall, the MCOs demonstrated compliance with the vast majority of the federal and state contractual standards for their memberships. The review found that when compared with the prior review findings from the most recent Compliance Validation in 2017, MCOs had addressed the previous review findings to full compliance or made progress in areas that were not fully met. The review found that MCOs performed best in the areas of care delivery and quality of care. The review showed innovative approaches to address challenges presented by COVID-19 within their care management programs. MCOs have opportunities to improve mechanisms to assess network adequacy across all service categories as well as appointment access to determine if there are deficiencies.

NETWORK ADEQUACY VALIDATION

Exhibit 2.4. Network Adequacy Validation Process Overview

Topic	Description
Objectives	The Network Adequacy Validation process assesses a MCO's compliance with the time and distance standards established by MassHealth. CMS has not published a formal protocol for this external quality review activity.
Technical methods of data collection and analysis	Quest Analytics' enterprise network adequacy validation solution was used to compile and analyze network information provided by the Managed Care Organizations.
Data obtained	MCOs provided Excel worksheets containing demographic information about their provider network.
Conclusions	On a scale of 1 to 100, BMCHP received an overall network adequacy score of 84.1 and Tufts received an overall network adequacy score of 86.4. Both plans showed improvement from the previous analysis. Network deficiencies represent a combination of actual network gaps and health plan omission of required data.

Network Adequacy Validation assesses a MCO's ability to provide its members with an adequate number of in-network providers at a reasonable distance from their homes. MassHealth sets forth time and distance standards as well as threshold provider to member ratios to ensure access to timely care. Both MCOs demonstrated network strengths. Certain areas, such as Behavioral Health Outpatient and Psychiatry services, were strong for both MCO plans. There are, however, many opportunities for the plans to strengthen the provider network to improve access to medical care for Medicaid members. Neither MCO plan submitted complete provider data for this analysis, resulting in lower scores for certain services. Incomplete data could reflect plan inability to collect these data or the plan's inability to contract with providers within certain counties.

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 organizations. States must also conduct an evaluation of the effectiveness of the quality strategy and update the strategy as needed, but no less than once every three years.

The first MassHealth Quality Strategy was published in 2006. The most recent updated version was submitted to CMS in November 2018. The 2018 version, the MassHealth Comprehensive Quality Strategy, focused not only on fulfilling managed care quality requirements but on improving the quality of managed care services in Massachusetts. An updated strategy is currently being finalized and is anticipated to be available to the public in early 2022. It will incorporate new behavioral health, health equity, and waiver strategies and will align with the recent CMS toolkit and webinar guidance released in Summer 2021.

SUPPORTING IMPROVEMENT IN THE QUALITY, TIMELINESS, AND ACCESS TO HEALTH CARE SERVICES: RECOMMENDATIONS TO MASSHEALTH

CMS requires that the EQRO offer recommendations for how the State can target goals and objectives in the quality strategy, under § 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

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

Provider Network

2021 EQR activities shed light on the need for both inpatient and outpatient behavioral health services statewide. Kepro strongly recommends that MassHealth work with partners statewide to address workforce and infrastructure solutions to increase the availability of behavioral health and substance abuse services. For example, the Commonwealth might consider lived experience to be an alternate qualification to a professional degree akin to the Department of Mental Health Peer Support Training and Certification Program. *(Access, Timeliness of Care)*

A consistent finding in this year's Compliance Validation was MassHealth MCO non-compliance with the requirement to implement a process and methodology to evaluate non-English speaking enrollees' choice of primary care and behavioral health providers in prevalent languages. Kepro recommends that MassHealth leverage Quest Analytics' ability to report on provider non-English language capacity. Additionally, Kepro recommends that MassHealth conduct provider directory verification as the provider directory is a foundational piece of member information. *(Access, Timeliness of Care)*

MassHealth and the plans both need to increase their oversight of network adequacy, especially as it relates to appointment access. The compliance and network adequacy validation activities demonstrated non-compliance with some contractually required time and distance standards. Kepro encourages MassHealth program staff to take a more active role in monitoring MCO compliance with these requirements. In addition, Kepro did not find strong evidence of a process for evaluating appointment access against the MassHealth standards for services such as sick and well office visits, behavioral health, and urgent care. Kepro recommends that MassHealth provide related direction to these plans. Finally, Kepro encourages MassHealth to consider the practical feasibility of its network adequacy standards, especially those for the less populated areas of Berkshire, Dukes, and Nantucket counties. The Quest Analytics systems permits the designation of exceptions for individual provider-county combinations. Doing so would allow the system to report a more accurate picture of network adequacy. *(Access, Timeliness of Care)*

Health Equity
To support MassHealth's priority of achieving health equity, it is essential that it improve the quality of its REL data and fix the ever-vexing issue of enrollment updates with no REL data overwriting plan-collected data. *(Access)*

In 2021, MCOs were required to design vaccination-related interventions with the goal of reducing health disparities. It was Kepro's experience that MCOs struggled with this requirement experiencing difficulty with the definition of a focal population and culturally sensitive project plans. Kepro strongly encourages MassHealth to consider ways in which technical assistance can be provided to the plans on REL data analysis and the design of associated project interventions. *(Access and Timeliness)*

Performance Improvement Projects
Performance Improvement Projects are resource-intensive undertakings. Kepro believes it is essential that PIP topics focus on priority topics established by MassHealth; topics addressing low-performance areas as identified by performance rates; and topics that address at least 10% or more of the MCO's MassHealth population. Kepro recommends that these criteria be applied as part of the Baseline Project Planning reporting process. *(Quality)*

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

Kepro respectfully suggests that MassHealth consider including the External Quality Review Organization, as appropriate, as a contributor to internal agency deliberations regarding MCO quality improvement initiatives. With its strong links to plan staff and knowledge of plan quality-related activities, Kepro can offer MassHealth a nuanced understanding of the environment. *(Quality)*

Section 3.

Performance Measure Validation
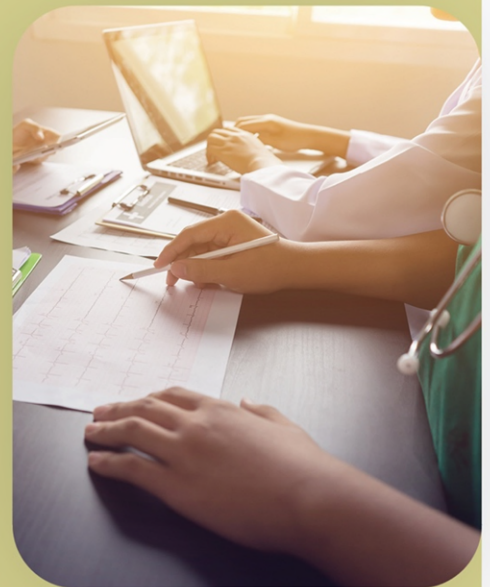
SECTION 3. PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ANALYSIS

PERFORMANCE MEASURE VALIDATION METHODOLOGY

The Performance Measure Validation process assesses the accuracy of performance measures reported by the MCO. It determines the extent to which the MCO collects and uses accurate data, and follows state specifications and reporting requirements. In addition to validation processes and the reported results, Kepro evaluates performance trends in comparison to national benchmarks. Kepro validates three performance measures annually for MCOs.

The Performance Measure Validation process consists of a desk review of documentation submitted by the plan, notably the NCQA HEDIS Final Audit Report. The HEDIS Audit addresses an organization's:

- Information practices and control procedures;
- Sampling methods and procedures;
- Data integrity;
- Compliance with HEDIS specifications;
- Analytic file production; and
- Reporting and documentation.

The first part of the audit is a review of an organization's overall information systems capabilities for collecting, storing, analyzing, and reporting health information. The plan must demonstrate its ability to process medical, member, and provider information as this is the foundation for accurate HEDIS reporting. It must also show evidence of effective systems, information practices, and control procedures for producing and using information in core business functions. Also reviewed are the plan-prepared HEDIS Roadmaps, which describe any organizational information management practices that affect HEDIS reporting. The Final Audit Report contains the plan's results for measures audited.

Kepro's Lead Reviewer recommended the validation of the following measures:

Exhibit 3.1. Performance Measures Validated in 2021

HEDIS Measure Name and Abbreviation	Measure Description
Asthma Medication Ratio (AMR) *Rationale for Selection: Variation in plan performance*	The percentage of members 5 to 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.
Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up *Rationale for Selection: High plan performance*	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit (8 total days).
Pharmacotherapy for Opioid Use Disorder (POD) *Rationale for Selection: New accreditation measure effective 2021*	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members aged 16 and older with a diagnosis of OUD.

Kepro's PMV audit methodology assesses both the quality of the source data that feed into the measures under review and the accuracy of its calculation. Source data review includes evaluating the plan's data management structure, data sources, and data collection methodology. Measure calculation review includes reviewing the logic and analytic framework for determining the measure numerator, denominator, and exclusion cases, if applicable. For 2021 Performance Measure Validation, MCOs submitted the documentation that follows.

Exhibit 3.2. Documentation Submitted by MCOs

Document Reviewed	Purpose of Review
HEDIS MY 2020 Roadmap	Reviewed to assess health plan systems and processes related to performance measure production.
HEDIS MY 2020 Final Audit Report	Reviewed to determine if there were any underlying process issues related to HEDIS measure production.
HEDIS MY 2020 IDSS	Used to evaluate PMV rates for PMV measure selection, PMV measure results, and to compare PMV results to industry standard benchmarks.
List of interventions related to performance measures	Reviewed to help explain changes in performance measure rates.

COMPARATIVE ANALYSIS

The tables that follow contain the criteria against which performance measures are validated as well as Kepro's determination as to whether the plans met these criteria. Results are presented for both plans reviewed to facilitate comparison across plans. Kepro uses the following ratings for Performance Measure Validation review elements:

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

Asthma Medication Ratio (AMR)

Managed Care Organizations produced AMR measures using the HEDIS Administrative methodology. The following charts outline the review elements and ratings that the MCO plans received.

Exhibit 3.3a. AMR Technical Specification Compliance

Category	Element	BMCHP	Tufts
Population	Medicaid population was appropriately segregated from other product lines.	Met	Met

Population	Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
	
	• At least one ED visit with a principal diagnosis of asthma.
	
	• At least one acute inpatient encounter with a principal diagnosis of asthma without telehealth.
	
	• At least one acute inpatient discharge with a principal diagnosis of asthma on the discharge claim. To identify an acute inpatient discharge:
	  1. Identify all acute and nonacute inpatient stays.
	  2. Exclude nonacute inpatient stays.
	  3. Identify the discharge date for the stay.
	
	• At least four outpatient visits, observation visits, telephone visits or e-visits or virtual check-ins, on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
	
	• At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
		Met	Met

Population	A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma in any setting, in the same year as the leukotriene modifier or antibody inhibitor.	Met	Met
Geographic Area	Includes only those Medicaid enrollees served in the MCO's reporting area.	Met	Met
Age & Sex	Ages 5 to 64 as of December 31 of the measurement year.	Met	Met
Enrollment Calculation	A pharmacy benefit is required during the measurement year.	Met	Met
Enrollment Calculation	Continuous enrollment during the measurement year and the year prior to the measurement year, with no more than a one-month gap in coverage during each year. Enrollment is required on December 31 of the measurement year.	Met	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met

| Proper Exclusion Methodology in Administrative Data | Exclude members who met any of the following criteria:

• Members who had no asthma controller or reliever medications dispensed during the measurement year.

• Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
    ○ Emphysema Value Set
    ○ Other Emphysema Value Set
    ○ COPD Value Set
    ○ Obstructive Chronic Bronchitis Value Set
    ○ Chronic Respiratory Conditions Due to Fumes or Vapors Value Set
    ○ Cystic Fibrosis Value Set
    ○ Acute Respiratory Failure Value Set | **Met** | **Met** |

Exhibit 3.3b. AMR Technical Specification Compliance

Administrative Data: Counting Clinical Events	BMCHP	Tufts
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met
The number of members who have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Met	Met

Follow-up After ED Visit for Mental Illness (FUM) – Seven-Day Rate

Managed Care Organizations produced FUM measures using the HEDIS Administrative methodology. The following tables outline the review elements and ratings that the MCO plans received.

Exhibit 3.4a. FUM Technical Specification Compliance

Category	Element	BMCHP	Tufts
Population	MCO population was appropriately segregated from other product lines.	Met	Met
Population	Members continuously enrolled on or before the date of the ED visit that had a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.	Met	Met
Population	The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period.	Met	Met
Geographic Area	Includes only those Medicaid enrollees served in MCO's reporting area.	Met	Met
Age & Sex	Members 6 years and older as of the date of the ED visit.	Met	Met
Enrollment Calculation	Members continuously enrolled from the date of the ED visit through 30 days after.	Met	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
Proper Exclusion Methodology in Administrative Data	Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission.	Met	Met

Exhibit 3.4b. FUM Technical Specification Compliance

Administrative Data: Counting Clinical Events	BMCHP	Tufts
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met

Pharmacotherapy for Opioid Use Disorder (POD)

Managed Care Organizations produced POD measures using the HEDIS Administrative methodology. The following tables outline the review elements and ratings that the MCO plans received.

Exhibit 3.5a. POD Technical Specification Compliance

Category	Element	BMCHP	Tufts
Population	MCO population was appropriately segregated from other product lines.	Met	Met
Population	Follow the steps below to identify eligible events.	Met	Met
	1. Identify members with any diagnosis of opioid use disorder (OUD) (Opioid Abuse and Dependence Value Set) during the Intake Period.		
	2. For each member identified in step 1, identify all OUD dispensing events or OUD medication administration events during the Intake Period. Use all medication lists and value sets in the Opioid Use Disorder Treatment Medications table below to identify OUD dispensing events and OUD administration events.		
	3. Test for Negative Medication History. For each OUD dispensing event or OUD medication administration event in step 2, test for a Negative Medication History. Exclude events that do not have a negative medication history. All remaining events with a negative medication history are considered Treatment Period Start Dates.		
	4. Exclude any Treatment Period Start Dates where the member had an acute or nonacute inpatient stay of eight or more days during the Treatment Period:		
	a) Identify all acute and nonacute inpatient stays.		
	b) Identify the admission and discharge dates for the stay.		
	c) Calculate length of stay (LOS) as the admission date through and including the discharge date. If there are direct transfers between stays, add the LOS from any subsequent direct transfers to the initial LOS to calculate a total LOS.		
	5. Calculate continuous enrollment. Members must be continuously enrolled from 31 days prior to the Treatment Period Start Date through 179 days after the Treatment Period Start Date (211 total days).		
Geographic Area	Includes only those Medicaid enrollees served in MCO's reporting area.	Met	Met
Age & Sex	16 years and older as of December 31 of the measurement year.	Met	Met
Enrollment Calculation	Members continuously enrolled 31 days prior to the Treatment Period Start Date through 179 days after the Treatment Period Start Date (211 total days).	Met	Met
Enrollment Calculation	Members with pharmacy benefits.	Met	Met
Data Quality	Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met
Proper Exclusion Methodology in Administrative Data	See relevant denominator criteria, above.	Met	Met

Exhibit 3.5b. POD Technical Specification Compliance

Administrative Data: Counting Clinical Events	BMCHP	Tufts
New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in treatment of 8 or more consecutive days.	Met	Met
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met

COMPARATIVE RESULTS

Exhibit 3.6. Asthma Medication Ratio (AMR)

MCO	2020	2021 NCQA Medicaid Quality Compass Percentile Comparison
BMCHP	56.9%	Between 10 and 25
Tufts	61.5%	Between 25 and 33

Exhibit 3.7. Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up

MCO	2020	2021 NCQA Medicaid Quality Compass Percentile Comparison
BMCHP	72.5%	Greater than 95
Tufts	78.1%	Greater than 95

Exhibit 3.8. Pharmacotherapy for Opioid Use Disorder (POD)

MCO	2020	2021 NCQA Medicaid Quality Compass Percentile Comparison
BMCHP	31.5%	Between 50 and 66
Tufts	46.1%	Between 90 and 95

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

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

Exhibit 3.9. Results of Information Systems Capability Analysis

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

CONCLUSION

Performance measure results were determined to be valid and information systems supported the calculation of accurate measures.

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION AND INFORMATION SYSTEM CAPABILITY ASSESSMENT

Kepro has leveraged CMS Worksheet 2.14, *A Framework for Summarizing Information About Performance Measures,* to report MCO-specific 2021 performance measure validation activities. As is required by CMS, Kepro has identified MCO strengths as evidenced through the validation process as well as follow up to 2020 recommendations. Kepro's Lead PMV Auditor assigned a validation confidence rating that refers to Kepro's overall confidence that the calculation of the performance measure adhered to acceptable methodology.

BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Boston Medical Center HealthNet Plan (BMCHP)**
Performance measure name**: Asthma Medication Ratio (AMR)**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☐ Medical records (describe) _____ ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): Members 5 to 64 years of age
Definition of numerator (describe): Members 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.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	2,196
Denominator	3,860
Rate	56.89%

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). There were no deviations from 2020 HEDIS Technical Specifications.

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

Claims and Encounter Data. BMCHP processed claims using the Facets system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Lab claims were processed internally using standard codes. The plan had a high rate of both electronic claims submission and auto-adjudication. BMCHP had adequate quality control and monitoring of claims processing. BMCHP received encounters on a weekly basis from both its pharmacy benefit manager, Envision Rx, and its behavioral health vendor, Beacon Health Options. BMCHP received encounters on a bi-weekly basis from its vision vendor, Vision Services Plan. The plan maintained adequate oversight of its vendors. There were no issues identified with claims or encounter data processing.

Enrollment Data. BMCHP processed Medicaid enrollment data using the Facets system. All necessary enrollment fields were captured for HEDIS reporting. BMCHP received a daily 834 file from MassHealth. The plan had adequate data quality monitoring and reconciliation processes including the ability to combine data for members with more than one member ID using a master member ID. There were no issues identified with the plan's enrollment processes.

Medical Record Review. Medical record review compliance was evaluated as a part of PMV measure selection. BMCHP passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. BMCHP conducted the medical record reviews. BMCHP had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. BMCHP used a lab results supplemental data source. BMCHP provided all required supplemental data source documentation. There were no concerns or issues identified with the use of the lab results supplemental data source.

Data Integration. BMCHP's performance measure rates were produced using Inovalon software. Data from the transaction system were loaded to the plan's data warehouse on a daily basis. Vendor data feeds were loaded into the warehouse weekly. BMCHP had adequate processes to track completeness and accuracy of data transfer into the warehouse. Data were then formatted into Inovalon-compliant extracts and loaded into the measure production software. Data load and reject reports were thoroughly reviewed. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were compared to prior years and monthly rates produced throughout the measurement year. Any discrepancies were thoroughly analyzed to ensure rate accuracy. BMCHP maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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:

Quality-Related: Continue quality improvement initiatives for the *Asthma Medication Ratio* measure, which ranks below the 25th percentile compared to the NCQA Medicaid Quality Compass MY 2020 data.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Boston Medical Center HealthNet Plan (BMCHP)**
Performance measure name: **Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) NCQA-approved data sources ☐ Medical records (describe) ☐ Other (specify)
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm.
Definition of numerator (describe): The number of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 7 days of the ED visit (8 total days).
Program(s) included in the measure: ☐ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	1,444
Denominator	1,992
Rate	72.49%

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). There were no deviations from NCQA HEDIS technical specifications.

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

Claims and Encounter Data. BMCHP processed claims using the Facets system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Lab claims were processed internally using standard codes. The plan had a high rate of both electronic claims submission and auto-adjudication. BMCHP had adequate quality control and monitoring of claims processing. BMCHP received encounters on a weekly basis from both its pharmacy benefit manager, Envision Rx, and its behavioral health vendor, Beacon Health Options. BMCHP received encounters on a bi-weekly basis from its vision vendor, Vision Services Plan. The plan maintained adequate oversight of its vendors. There were no issues identified with claims or encounter data processing.

Enrollment Data. BMCHP processed Medicaid enrollment data using the Facets system. All necessary enrollment fields were captured for HEDIS reporting. BMCHP received a daily 834 file from MassHealth. The plan had adequate data quality monitoring and reconciliation processes, including the ability to combine data for members with more than one member ID using a master member ID. There were no issues identified with the plan's enrollment processes.

Medical Record Review. Medical record review compliance was evaluated as a part of PMV measure selection. BMCHP passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. BMCHP conducted the medical record reviews. BMCHP had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. BMCHP used a lab results supplemental data source. BMCHP provided all required supplemental data source documentation. There were no concerns or issues identified with the use of the lab results supplemental data source.

Data Integration. BMCHP's performance measure rates were produced using Inovalon software. Data from the transaction system were loaded to the plan's data warehouse on a daily basis. Vendor data feeds were loaded into the warehouse weekly. BMCHP had adequate processes to track completeness and accuracy of data transfer into the warehouse. Data were then formatted into Inovalon-compliant extracts and loaded into the measure production software. Data load and reject reports were thoroughly reviewed. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were compared to prior years and monthly rates produced throughout the measurement year. Any discrepancies were thoroughly analyzed to ensure rate accuracy. BMCHP maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Boston Medical Center HealthNet Plan (BMCHP)**
Performance measure name: **Pharmacotherapy for Opioid Use Disorder (POD)**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ)   ☐ Centers for Disease Control and Prevention (CDC)   ☐ Centers for Medicare & Medicaid Services (CMS)   ☒ National Committee for Quality Assurance (NCQA)   ☐ The Joint Commission (TJC)   ☐ No measure steward, developed by state/EQRO   ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply)   ☒ HEDIS®   ☒ CMS Child or Adult Core Set   ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply)   ☒ Administrative data (describe) NCQA-approved data sources   ☐ Medical records (describe)   ☐ Other (specify)
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members aged 16 and older with a diagnosis of OUD.
Definition of numerator (describe): The number of members aged 16 and older with a diagnosis of OUD with pharmacotherapy events for 180 or more days.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	1,337
Denominator	4,249
Rate	31.47%

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).   There were no deviations from NCQA HEDIS technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.   **Claims and Encounter Data.** BMCHP processed claims using the Facets system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Lab claims

were processed internally using standard codes. The plan had a high rate of both electronic claims submission and auto-adjudication. BMCHP had adequate quality control and monitoring of claims processing. BMCHP received encounters on a weekly basis from both its pharmacy benefit manager, Envision Rx, and its behavioral health vendor, Beacon Health Options. BMCHP received encounters on a bi-weekly basis from its vision vendor, Vision Services Plan. The plan maintained adequate oversight of its vendors. There were no issues identified with claims or encounter data processing.

Enrollment Data. BMCHP processed Medicaid enrollment data using the Facets system. All necessary enrollment fields were captured for HEDIS reporting. BMCHP received a daily 834 file from MassHealth. The plan had adequate data quality monitoring and reconciliation processes, including the ability to combine data for members with more than one member ID using a master member ID. There were no issues identified with the plan's enrollment processes.

Medical Record Review. Medical record review compliance was evaluated as a part of PMV measure selection. BMCHP passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. BMCHP conducted the medical record reviews. BMCHP had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. BMCHP used a lab results supplemental data source. BMCHP provided all required supplemental data source documentation. There were no concerns or issues identified with the use of the lab results supplemental data source.

Data Integration. BMCHP's performance measure rates were produced using Inovalon software. Data from the transaction system were loaded to the plan's data warehouse on a daily basis. Vendor data feeds were loaded into the warehouse weekly. BMCHP had adequate processes to track completeness and accuracy of data transfer into the warehouse. Data were then formatted into Inovalon-compliant extracts and loaded into the measure production software. Data load and reject reports were thoroughly reviewed. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were compared to prior years and monthly rates produced throughout the measurement year. Any discrepancies were thoroughly analyzed to ensure rate accuracy. BMCHP maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the performance measure results. ☒ Not applicable (medical record review not conducted)
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.

Plan Strengths

Access-, Timeliness-, and Quality-Related: BMCHP scored higher than the 95th percentile on the *Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up* measure compared to the NCQA Medicaid Quality Compass MY 2020 data.

Opportunities for Improvement

Quality-Related: Continue quality improvement initiatives for the Asthma Medication Ratio measure, which ranks below the 25th percentile compared to the NCQA Medicaid Quality Compass MY 2020 data.

Follow-Up to Calendar Year 2020 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2020 PMV recommendation follows:

2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
Continue quality improvement initiatives for the *Asthma Medication Ratio* measure, which ranks below the 25th percentile compared to the NCQA Medicaid Quality Compass MY 2020 data	Update not provided by BMCHP.	Unknown

TUFTS HEALTH PUBLIC PLANS (TUFTS)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Tufts Health Public Plans (Tufts)**
Performance measure name**: Asthma Medication Ratio (AMR)**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☐ Medical records (describe) _____ ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): Members 5 to 64 years of age
Definition of numerator (describe): Members 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.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	3,160
Denominator	5,135
Rate	61.54%

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). Tufts did not deviate from 2020 HEDIS Technical Specifications.

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

Claims and Encounter Data. Tufts processed claims using the Monument Xpress system and the Health Edge HealthRules Payor system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Tufts only accepted claims submitted on standard claims forms. Most claims were submitted electronically to Tufts and there were adequate monitoring processes in place, including daily electronic submission summary reports, to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims except for pharmacy claims which were handled by its pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness or with claims or encounter data processing.

Enrollment Data. Tufts processed Medicaid enrollment data using Health Edge HealthRules Payor. All necessary enrollment fields were captured for HEDIS reporting. Medicaid enrollment data in an 834 format were received daily from the state and processed by Tufts. The daily file included additions, changes, and terminations. Enrollment data were loaded into Tufts' Health Edge HealthRules Payor system. Tufts also received a full monthly refresh file and conducted reconciliation between Health Edge HealthRules Payor and the state file. Health Edge HealthRules Payor retained Medicaid Identification (ID) numbers and the plan assigned a unique Health Edge HealthRules Payor system ID. Tufts had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. Medical record review compliance was evaluated as a part of PMV measure selection. Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts conducted the medical record reviews. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. Tufts used multiple supplemental data sources, including electronic medical record data. Tufts provided all required supplemental data source documentation. There were no concerns or issues identified with the use of these supplemental data sources.

Data Integration. All performance measure rates were produced using Cotiviti's software which received measure certification from NCQA for all measures under the scope of the review. Data from the transaction system were loaded to Tufts' data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into Cotiviti-compliant extracts and loaded into the measure production software. Tufts had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. There were no issues identified with data integration processes for the measures under review. Data transfers to the Cotiviti repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. Tufts maintained adequate oversight of its vendor, Cotiviti. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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: **Quality-Related:** Continue to develop and initiate quality improvement initiatives for the *Asthma Medication Ratio* measure. This measure ranks between the 25th and 33rd percentiles compared to the NCQA Medicaid Quality Compass MY 2020 data.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Tufts Health Public Plans (Tufts)**
Performance measure name: **Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) NCQA-approved data sources ☐ Medical records (describe) ☐ Other (specify)
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm
Definition of numerator (describe): The number of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 7 days of the ED visit (8 total days).
Program(s) included in the measure: ☐ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	1,189
Denominator	1,522
Rate	78.12%

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). There were no deviations from NCQA HEDIS technical specifications.

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

Claims and Encounter Data. Tufts processed claims using the Monument Xpress system and the Health Edge HealthRules Payor system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Tufts only accepted claims submitted on standard claims forms. Most claims were submitted electronically to Tufts and there were adequate monitoring processes in place, including daily electronic submission summary reports, to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims except for pharmacy claims which were handled by its pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness or with claims or encounter data processing.

Enrollment Data. Tufts processed Medicaid enrollment data using Health Edge HealthRules Payor. All necessary enrollment fields were captured for HEDIS reporting. Medicaid enrollment data in an 834 format were received daily from the state and processed by Tufts. The daily file included additions, changes, and terminations. Enrollment data were loaded into Tufts' Health Edge HealthRules Payor system. Tufts also received a full monthly refresh file and conducted reconciliation between Health Edge HealthRules Payor and the state file. Health Edge HealthRules Payor retained Medicaid Identification (ID) numbers and the plan assigned a unique Health Edge HealthRules Payor system ID. Tufts had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. Medical record review compliance was evaluated as a part of PMV measure selection. Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts conducted the medical record reviews. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. Tufts used multiple supplemental data sources, including electronic medical record data. Tufts provided all required supplemental data source documentation. There were no concerns or issues identified with the use of these supplemental data sources.

Data Integration. All performance measure rates were produced using Cotiviti's software which received measure certification from NCQA for all measures under the scope of the review. Data from the transaction system were loaded to Tufts' data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into Cotiviti-compliant extracts and loaded into the measure production software. Tufts had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. There were no issues identified with data integration processes for the measures under review. Data transfers to the Cotiviti repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. Tufts maintains adequate oversight of its vendor, Cotiviti. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Tufts Health Public Plans (Tufts)**
Performance measure name: **Pharmacotherapy for Opioid Use Disorder (POD)**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) NCQA-approved data sources ☐ Medical records (describe) ☐ Other (specify)
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members aged 16 and older with a diagnosis of OUD.
Definition of numerator (describe): The number of members aged 16 and older with a diagnosis of OUD with pharmacotherapy events for 180 or more days.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	667
Denominator	1,446
Rate	46.13%

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). There were no deviations from NCQA HEDIS technical specifications.

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

Claims and Encounter Data. Tufts processed claims using the Monument Xpress system and the Health Edge HealthRules Payor system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Tufts only accepted claims submitted on standard claims forms. Most claims were submitted electronically to Tufts and there were adequate monitoring processes in place, including daily electronic submission summary reports, to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims except for pharmacy claims which were handled by its pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness or with claims or encounter data processing.

Enrollment Data. Tufts processed Medicaid enrollment data using Health Edge HealthRules Payor. All necessary enrollment fields are captured for HEDIS reporting. Medicaid enrollment data in an 834 format were received daily from the state and processed by Tufts. The daily file included additions, changes, and terminations. Enrollment data were loaded into Tufts' Health Edge HealthRules Payor system. Tufts also received a full monthly refresh file and conducted reconciliation between Health Edge HealthRules Payor and the state file. Health Edge HealthRules Payor retained Medicaid Identification (ID) numbers and the plan assigned a unique Health Edge HealthRules Payor system ID. Tufts had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

Medical Record Review. Medical record review compliance was evaluated as a part of PMV measure selection. Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Tufts conducted the medical record reviews. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. Tufts used multiple supplemental data sources, including electronic medical record data. Tufts provided all required supplemental data source documentation. There were no concerns or issues identified with the use of these supplemental data sources.

Data Integration. All performance measure rates were produced using Cotiviti's software which received measure certification from NCQA for all measures under the scope of the review. Data from the transaction system were loaded to Tufts' data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into Cotiviti-compliant extracts and loaded into the measure production software. Tufts had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. There were no issues identified with data integration processes for the measures under review. Data transfers to the Cotiviti repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. Tufts maintains adequate oversight of its vendor, Cotiviti. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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.

Plan Strengths

- **Access-, Timeliness-, and Quality-Related:** Tufts ranks above the 95th percentile compared to the NCQA Medicaid Quality Compass MY 2020 data for the *Follow-up after ED Visit for Mental Illness (FUM): 7-Day Follow-Up* measure.
- **Access- and Quality-Related:** Tufts ranks between the 90th and 95th percentiles compared to the NCQA Medicaid Quality Compass MY 2020 data for the Pharmacotherapy for Opioid Use Disorder (POD) measure.
- **Quality-Related:** Tufts used many supplemental data sources for HEDIS reporting. This helps provide a complete picture of Tufts' performance.

Opportunities for Improvement

Quality-Related: Continue to develop and initiate quality improvement initiatives for the Asthma Medication Ratio measure. This measure ranks between the 25th and 33rd percentiles compared to the NCQA 2021 Medicaid Quality Compass.

Follow Up to Calendar Year 2020 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2020 PMV recommendation follows:

Exhibit 3.10. Update to 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
Continue to develop and initiate quality improvement initiatives for the *Asthma Medication Ratio* measure.	• The Case Management (CM) team received reports containing targeted asthma cases to be outreached and followed-up on based on their assessed needs. • Auto-referrals implemented for members needing additional support. • Asthma screening results provided to CM to help stratify the population based on clinical risk for CM services and to maximize member's independence in managing their asthma condition in all environments (home, work, school, etc.). • CM assisted population in facilitating discussions and appointments with providers to ensure wrap around and community resource (care coordination) were offered to the member. • Educational materials developed.	High

Section 4.

Performance Improvement Project Validation

SECTION 4. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

INTRODUCTION

MassHealth Managed Care Organizations conduct two contractually required Performance Improvement Projects (PIPs) annually. In 2021, MassHealth directed the MCOs to conduct PIPs on the following topics:

- Flu Immunization; and
- Telehealth access.

Mid-year, MassHealth received feedback from the managed care plans that work on the flu project was diverting resources from COVID-19 immunization efforts. In response, MassHealth permitted the plans to select an immunization campaign of their choice, e.g., flu, COVID-19, and routine pediatric vaccines.

Reflecting its strategic priority of reducing health inequities, MassHealth required that each plan conduct a vaccination-related intervention with the goal of reducing health disparities. Based on an analysis of the membership, plans were required to identify a targeted member population with lower vaccination rates and develop an associated intervention.

OBJECTIVE

The purpose of Performance Improvement Project Validation is to assess overall project methodology as well as the overall validity and reliability of the methods and findings to determine confidence in the results.

DATA OBTAINED

MCOs submitted two PIP reports in 2021. In April 2021, the MCOs submitted a Baseline: Project Planning Report in which they described project goals, planned stakeholder involvement, anticipated barriers, proposed interventions, a plan for intervention effectiveness analysis, and performance indicators. Plans also submitted a detailed population analysis. The MCOs reported project updates and baseline data in their September 2021 Baseline: Performance Indicator Rate reports.

Kepro PIP reviewers, the Kepro Medical Director, and the MCO project staff met virtually after the submission of each report. This afforded an opportunity for Kepro and the MCO project team to engage in a collegial discussion about the project as well as for the team to provide recent project updates. Kepro was able to ask clarifying questions about the project and offer suggestions.

MANAGED CARE PLAN SUPPORT

Kepro provided support to MCOs in the submission of their project reports.

- Early in the project cycle, Kepro sponsored a workshop on flu immunization in Massachusetts that featured speakers from the Department of Public Health and the Massachusetts Immunization Coalition. This workshop provided all MassHealth managed care plans with a baseline understanding of flu immunization in Massachusetts.
- To support plan development of health equity-related project interventions, Kepro entered into an agreement with the MGH Center for Disparity Solutions in which its director led a four-session Health Disparity Learning Collaborative. This Learning Collaborative provided a forum for sharing best practices and exchanging ideas.
- Kepro created a library of PIP resources that included recent literature on vaccine hesitancy, health disparities, and best practices for building strong project interventions.
- In addition to instructions embedded in report submission forms, Kepro made a Guidance Manual available to plans, which provide detailed descriptions of the information requested. In many cases, sample responses are offered.
- Kepro made one-on-one technical assistance for PIP development and report preparation available to plans.

TECHNICAL METHODS OF DATA COLLECTION AND ANALYSIS

Performance Improvement Projects were validated in accordance with §438.330(b)(i). Validation was performed by Kepro's Technical Reviewers with support from the Clinical Director. Kepro's lead reviewer, Wayne Stelk, Ph.D., has extensive experience in the implementation of statewide quality improvement projects. Chantal Laperle, MS CPHQ, brings quality management experience from her years at Federally Qualified Health Centers and managed care plans. Bonnie Zell, MD, Medical Director, is a practicing obstetrician and former Institute for Health Improvement fellow.

To permit more real-time review of Performance Improvement Projects, MassHealth has required biannual PIP validation since 2017. Each review is a four-step process:

1) *PIP Project Report.* Managed care plans submit a project report for each PIP to the EQRO Teams site. This report is specific to the stage of the project. All 2021 performance improvement projects were baseline projects.

2) *Desktop Review.* A desktop review is performed for each PIP. The Technical Reviewer and Medical Director review the project report and any supporting documentation submitted by the plan. Working collaboratively, they identify project strengths, issues requiring clarification, and 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 virtually with plan representatives to obtain clarification on identified issues as well as to offer recommendations for improvement. When it is not possible to assign a validation rating to a project due to incomplete or missing information, the plan is required to remediate the report and resubmit it within 10 calendar days. In all cases, the plan is offered the opportunity to resubmit the report to address feedback received from Kepro 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. Kepro conducts inter-rater reliability to ensure consistency between reviewers. Reports submitted in Fall 2021 were scored by the reviewers. Individual standards are scored 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. A determination is made by the Technical Reviewers as to the validity of the project.

FINDINGS

The MCOs assembled project teams that generally submitted well-developed project plans. In general, MCOs continued to struggle with the design of intervention effectiveness evaluations. Often, a plan revealed real project strengths during its meeting with Kepro that it hadn't included in its report submission. Kepro encouraged those plans to resubmit their reports to improve their scores.

MCOs struggled with the design of immunization health equity interventions. Some performance improvement projects required resubmission because either a target population was not identified, or the intervention design was not expected to lead to a decrease in the identified disparity. Kepro recommends that MassHealth consider providing managed care plans with additional coaching for health equity projects going forward.

COMPARATIVE ANALYSIS

Interventions

MassHealth Managed Care Organizations used a variety of approaches to address their project goals.

Exhibit 4.1. Intervention Approach

Intervention Approach	Number of Interventions Immunization	Number of Interventions Telehealth Access
Member Education & Outreach	3	1
Provider Education	2	1
Partnerships	1	1
Programs and Practices	-	1

Performance Improvement Project Ratings

Kepro rated Performance Improvement Projects submitted in Fall 2021 using a predetermined set of criteria, outlined in the table below with the average percentage of the two MCO plans. Reports submitted in the spring are not rated.

Exhibit 4.2. Average PIP Score by Rating Component

Rating Component	Immunization	Telehealth Access
Updates to Project Descriptions and Goals	94.5%	94.5%
Update to Stakeholder Involvement	100%	91.5%
Intervention Activities Updates	86%	92%
Performance Indicator Data Collection	100%	100%
Capacity for Indicator Data Analysis	100%	100%
Performance Indicator Parameters	93.5%	100%
Baseline Performance Indicator Rates	100%	100%
Conclusions and Planning for Next Cycle	91.5%	91.5%

As stated previously, 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 table that follows depicts the final rating score of each project MCO and domain.

Exhibit 4.3. MCO PIP Ratings by Project Topic

Plan	Immunization	Telehealth Access
BMCHP	91%	97%
Tufts	96%	95%

PLAN-SPECIFIC PERFORMANCE IMPROVEMENT PROJECTS

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 MCO's report to Kepro as are the Improvement Strategies or Interventions. Performance indicator data were taken from this report as well. 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 MCO and project strengths as evidenced in the PIP. Because each of these projects is in its first year, there is no follow-up to prior year recommendations.

TOPIC 1: VACCINATION

BOSTON MEDICAL CENTER HEALTHNET PLAN: INCREASING THE RATE OF COVID-19 VACCINATION FOR ALL BMCHP MASSHEALTH MCO MEMBERS, WITH A SPECIAL FOCUS ON REDUCING RACIAL DISPARITIES IN COVID-19 VACCINATION ACCESS

1. General PIP Information

Managed Care Plan (MCP) Name: Boston Medical Center HealthNet Plan (BMCHP)
PIP Title: Increasing the rate of COVID-19 vaccination for all BMCHP MassHealth MCO members, with a special focus on reducing racial disparities in COVID-19 vaccination access
PIP Aim Statement: *Member-Focused* • Conduct a member survey with at least 20% of the Black and Hispanic populations that has not had a COVID vaccine to identify barriers. • Implement culturally appropriate interventions based on the findings from the survey to increase COVID vaccinations to 75%. *Provider-Focused* • Collaborate with provider practices to increase/improve COVID-19 vaccination rates to 75% in areas with higher percentages of Black and Hispanic populations.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☒ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0 to 17)*   ☐ Adults only (age 18 and over)   ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify): All Members
Programs: ☐ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☒ 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) BMCHP is implementing a texting pilot program with a focus on Black and Hispanic members enrolled since August 2021. This population was selected as its vaccination rates fall below the MassHealth vaccination average. The draft texting script provides links to member education about the vaccine and informs members that BMCHP will provide transportation to vaccination appointments.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) None identified.

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
COVID-19 Vaccination Rate	2021	15,237 / 38,060 40%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.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: • **Access-Related:** Kepro recommends tailoring text messages for specific populations. • **Quality-Related:** Kepro recommends the development of additional interventions.

Performance Improvement Project Rating Score

Kepro evaluates an MCO'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. BMCHP received a rating score of 91% on this PIP.

Exhibit 4.4. BMCHP PIP Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	8	89%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	12	80%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	1	100%
Performance Indicator Parameters	5	15	15	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	5	83%
Overall Validation Rating Score	**26**	**78**	**71**	**91%**

Plan and Project Strengths

Access-Related: BMCHP conducted both member and provider surveys to develop an intervention based on identified barriers to vaccination in the Black and Hispanic member populations to increase COVID-19 vaccination rates.

Opportunities for Improvement

- **Access-Related:** Kepro recommends tailoring text messages for specific populations.
- **Quality-Related:** Kepro recommends the development of additional interventions.

TUFTS HEALTH PUBLIC PLANS: INCREASE FLU IMMUNIZATION RATE AMONG TUFTS HEALTH PUBLIC PLAN MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Tufts Health Public Plans (Tufts)
PIP Title: Increase Flu Immunization Rate Among Tufts Health Public Plan Members

PIP Aim Statement:

Member-Focused
- Provide information to members about flu vaccine safety and efficacy and promote information via various member communication channels.
- Provide information to members about flu vaccine availability by promoting information via multiple member communication channels.
- Broaden member access to the flu vaccine by promoting availability of the vaccine through member specific outreach done by the care management team and communications, such as web articles, informing members of various locations they can receive the vaccine (pharmacies, provider offices, public health centers, etc.).

Provider-Focused
- Educate providers about where members can receive the Flu vaccine.
- Communicate member barriers, in biweekly webinars with providers and office managers and Medical Director outreach, so that providers can better understand the specific challenges MCO members face and can work to help dispel misinformation and encourage members to get vaccinated.

Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)

☒ State-mandated (state required plans to conduct a PIP on this specific topic)
☐ Collaborative (plans worked together during the planning or implementation phases)
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)
☐ Plan choice (state allowed the plan to identify the PIP topic)

Target age group (check one):

☐ Children only (ages 0 to 17)*   ☐ Adults only (age 18 and over)   ☒ Both adults and children

*If PIP uses different age threshold for children, specify age range here:

Target population description, such as duals, LTSS or pregnant women (please specify): All members

Programs: ☐ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☒ 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)

- Care Managers help members create individual care plans and educate on the importance of the flu vaccine. Care Managers refer members to Community Health Workers to assist with a MassHealth Provider Transportation application and partners with the member's assigned Visiting Nurse Association (VNA) to provide access to the vaccine.
- An educational article was placed on the member website.

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 is conducting a provider educational campaign aimed at informing providers of locations of flu vaccinations.
- Tufts is offering providers with billing support and training related to claims processing to ensure accurate flu vaccination claims are captured.

- Multiple webinars/office manager meetings have been held throughout the fall highlighting the importance of reminding members to get their flu vaccine and verifying that members can receive their flu vaccine and COVID vaccine/booster at the same time.
- An article outlining the importance of encouraging members to receive the flu vaccine was placed in the provider newsletter.

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 has partnered with Commonwealth Medicine to allow the more than 160 public health clinics in Massachusetts that offer flu vaccination to bill Tufts for the vaccine and receive payment without being contracted.

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
Flu Immunization Rate	2020	16,548 / 51,901 31.88%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.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: **Quality-Related:** Kepro recommends that, for its own project management purposes, Tufts construct a more detailed workplan with a greater breakdown of sub-activities and timelines.

Performance Improvement Project Rating Score

Kepro evaluates an MCO'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 received a rating score of 96% on this PIP.

Exhibit 4.5. Tufts PIP Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	13.8	92%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	5	15	13	87%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**26**	**78**	**74.8**	**96%**

Plan and Project Strengths

- **Quality-Related:** Tufts is commended for training care managers in Motivational Interviewing methods.
- **Access-Related:** Tufts is commended for offering transportation to members who cannot access a flu vaccination site.
- **Access-Related:** Tufts is commended for partnering with Commonwealth Medicine to allow the more than 160 public health clinics in Massachusetts that offer flu vaccination to bill Tufts for the vaccine and receive payment without being contracted.
- **Quality- and Access-Related:** Tufts is commended for planning a flu vaccination gap report that will focus on member populations with low vaccination rates, i.e., Black/African American, Caribbean Islander, and Native American subpopulations.

Opportunities for Improvement

Quality-Related: Kepro recommends that, for its own project management purposes, Tufts construct a more detailed workplan with a greater breakdown of sub-activities and timelines.

TOPIC 2: TELEHEALTH ACCESS

BOSTON MEDICAL CENTER HEALTHNET PLAN: IMPROVING ACCESS TO TELEHEALTH AMBULATORY CARE AMONG BMCHP MASSHEALTH MCO MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Boston Medical Center HealthNet Plan (BMCHP)
PIP Title: Improving Access to Telehealth Ambulatory Care among BMCHP MassHealth MCO members
PIP Aim Statement: ***Member-Focused*** • Increase telehealth ambulatory care access among all BMCHP MassHealth MCO members to 4% based on outreach and education. ***Provider-Focused*** • Increase telehealth ambulatory care rates among providers for BMCHP MassHealth MCO members to 4%.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☒ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0 to 17)*   ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify): All BMCHP Members
Programs: ☐ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☒ 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) BMCHP intends to work with the highest-volume provider groups within the Asian and Hispanic communities and collaborate on ways to promote telehealth services.
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
Rate of telehealth ambulatory care utilization (AMB) NQF #9999	2020	3,269 / 102,024 3.20%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.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: **Access-Related:** BMCHP reported that targeting the high-volume provider groups within the Asian and Hispanic communities will ensure the approach will be culturally and linguistically appropriate. Kepro recommends that BMCHP gather additional information from other sources to ensure cultural barriers are addressed.

Performance Improvement Project Rating Score

Kepro evaluates an MCO'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. BMCHP received a rating score of 97% on this PIP.

Exhibit 4.6. BMCHP PIP Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	8	89%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	14.6	97%
Performance Indicator Data Collection	1	3	3	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	4	12	12	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	5	83%
Overall Validation Rating Score	**24**	**72**	**69.6**	**97%**

Plan and Project Strengths

Access-Related: BMCHP reported it plans to monitor the piloted two high-volume provider groups' Asian and Hispanic member use of telehealth visits. Kepro commends BMCHP for targeting these populations who have, as of the report date, had no telehealth utilization.

Opportunities for Improvement

Access-Related: BMCHP reported that targeting the high-volume provider groups within the Asian and Hispanic communities will ensure the approach will be culturally and linguistically appropriate. Kepro recommends that BMCHP gather additional information from other sources to ensure cultural barriers are addressed.

TUFTS HEALTH PUBLIC PLANS: INCREASING ACCESS TO BEHAVIORAL HEALTH TELEHEALTH SERVICES TO TUFTS HEALTH PUBLIC PLAN MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Tufts Health Public Plans (Tufts)
PIP Title: Increasing Access to Behavioral Health (BH) Telehealth Services to Tufts Health Public Plan Members

PIP Aim Statement:

Member-Focused
- Educate members through web articles on what telehealth services are, benefits of telehealth, and coverage of BH telehealth services, as well as how to access these services.
- Broaden member's access to BH telehealth services through activities such as technological assistance.
- Collect feedback from members to understand what barriers they experience with telehealth.
- Collaborate with community-based organizations and schools to help foster awareness of the availability of BH telehealth services offered through FasPsych, a THP-approved telepsychiatry and tele-mental service vendor.

Provider-Focused
- Connect with BH providers to capture their most up-to-date availability, contact information, and whether they offer telehealth services.
- Educate BH providers on how to correctly bill for telehealth services to ensure accuracy of telehealth reporting for claims.
- Communicate member barriers to providers so that providers can continuously work to improve their services and reduce barriers for members seeking BH telehealth services.

Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)

☒ State-mandated (state required plans to conduct a PIP on this specific topic)

☐ Collaborative (plans worked together during the planning or implementation phases)

☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)

☐ Plan choice (state allowed the plan to identify the PIP topic)

Target age group (check one):

☐ Children only (ages 0 to 17)*   ☐ Adults only (age 18 and over)   ☒ Both adults and children

*If PIP uses different age threshold for children, specify age range here: Aged 3 to 17 years

---

Target population description, such as duals, LTSS or pregnant women (please specify): All members

---

Programs: ☐ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☒ 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)

- Tufts has identified interventions based on its population analysis indicating that members 0 to 17 years of age are less likely to receive behavioral health telehealth services. Tufts will conduct a radio marketing campaign focused on reducing stigma related to utilization of behavioral health services and will highlight the private and secure use of telehealth services.

- Tufts will encourage members receiving care management to apply for the government-funded service, Safelink, as appropriate.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
None identified.

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 aims to increase member access to behavioral health telehealth services through increasing the number of available providers by contracting with vendors offering telehealth services, e.g., iHope (contract expired), FasPsych, and PsychConnect.   • In partnership with Boys and Girls Clubs, faith-based organizations, and schools, Tufts will encourage and foster utilization of these BH telehealth service providers.   • Tufts seeks to leverage the behavioral health provider network of its new parent company, Point32.

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
Mental Health Utilization (MPT) NQF #9999	2020	7,299 / 11,117 65.66%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.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: **Quality-Related:** Tufts' workplans are marginally acceptable but could be strengthened by listing additional detail on sub-activities.

Performance Improvement Project Score

Kepro evaluates an MCO'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 received a rating score of 95% on this PIP.

Exhibit 4.7. Tufts PIP Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	10	83%
Intervention Activities Updates*	5	15	13.3	87%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	4	12	12	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**25**	**75**	**71.3**	**95%**

Plan and Project Strengths

- **Quality-Related:** Kepro commends Tufts on its multiple member outreach strategies to understand member needs and barriers to promote BH telehealth services.
- **Quality-Related:** Tufts is commended for, in consideration of the next phase of this project, planning to create a training position focused on enhancing the skills and competencies of integrated care management teams related to BH conditions, engagement strategies, and interventions.

Opportunities for Improvement

Quality-Related: Tufts' workplans are marginally acceptable but could be strengthened by listing additional detail on sub-activities.

Section 5.

Compliance Validation

SECTION 5. COMPLIANCE VALIDATION

INTRODUCTION

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

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

REVIEW (LOOK-BACK) PERIOD
MCO activity and services occurring in CY 2020 (January 1, 2020, through December 31, 2020) were subject to review.

REVIEW STANDARDS
Based on regulatory and contract requirements, compliance reviews were be divided into the following 11 standards, consistent with CMS October 2021 EQR protocols.
- Availability of Services
  - Availability of Services – Enrollee Information
  - Availability of Services – Enrollee Rights and Protections
  - Availability of Services – Enrollment and Disenrollment
- Assurances and Adequate Capacity of Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Provider Selection
- Confidentiality
- Grievance and Appeal System
- Subcontractual Relationships and Delegation
- Practice Guidelines
- Health Information Systems
- Quality Assessment and Performance Improvement Program

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

REVIEW PROCESS
Kepro provided communication to the MCOs prior to the formal review period that included an overview of the compliance review activity and timeline. The MCOs were provided with a preparatory packet that included the project timeline, the draft virtual review agenda, the compliance review tools, and data submission information. Finally, Kepro scheduled a prereview conference call with each MCO approximately two weeks prior to the virtual review to cover review logistics.

The MCOs were provided with the appropriate review tools and asked to provide documentation to substantiate compliance with each requirement during the review period. Examples of documentation provided included:
- Policies and Procedures
- Standard Operating Procedures
- Workflows
- Desk Tools
- Reports
- Member Materials
- Care Management Files
- Utilization Management Denial Files
- Appeals Files
- Grievance Files
- Credentialing Files

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

SCORING METHODOLOGY
For each regulatory/contractual requirement for each program, a three-point scoring system was used. Scores are defined as follows:
- Met: Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and MCO staff interviews provided information consistent with documentation provided.
- Partially Met (Any one of the following may be applicable):

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

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

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

MCO COMPLIANCE VALIDATION RESULTS

The table below depicts the aggregate compliance scores for MassHealth's MCO plans.

Exhibit 5.1. MCO Plan Compliance Validation Scores

Review Element	BMCHP	Tufts	MCO Average
Availability of Services	94.7%	84.0%	89.4%
Assurances and Adequate Capacity and Services	100%	100%	100.0%
Enrollee Rights and Protection	100%	92.9%	96.5%
Enrollment/ Disenrollment	61.1%	100%	80.6%
Availability of Services – Enrollee Information	100%	96.2%	98.1%
Provider Selection	94.4%	97.2%	95.8%
Grievance and Appeal System	97.5%	98.3%	97.9%
Subcontractual Relationships and Delegation	98.8%	97.6%	98.2%
QAPI	98.4%	98.4%	98.4%
Health Information Systems	100%	100%	100.0%
Coverage and Authorization of Services	98.4%	97.5%	98.0%
Practice Guidelines	100%	100%	100.0%
Confidentiality of Health Information	100%	100%	100.0%
Coordination and Continuity of Care	100%	98.4%	99.2%
Total Composite Score	**96.0%**	**97.2%**	**96.6%**

AGGREGATE MCO OBSERVATIONS AND RECOMMENDATIONS

Overall, the MCOs demonstrated compliance with the vast majority of the federal and State contractual standards for their membership. After the last compliance review conducted in 2017, MassHealth conducted a reprocurement of managed care organizations. Of the six MCOs reviewed in 2017, BMC HealthNet Plan and Tufts Health Public Plans were reprocured. The MCOs reviewed in 2021 had mature systems and processes in place and had undergone prior compliance reviews. They demonstrated high scores for compliance and had an overall MCO composite score of 96.6 percent which showed subtle improvement when compared with the 2017 compliance review results of 94.8 percent. Both MCOs had 100 percent performance in the areas of Assurance and Adequate Capacity of Services, Health Information Systems, Practice Guidelines, and Confidentiality of Health Information. The MCOs demonstrated strength in the Continuity and Coordination of Care review standard.

In general, the MCOs' greatest opportunity for improvement is related to the accessibility of care standards. The review found that, while MCOs were conducting geo-access analysis to evaluate network adequacy, not all requirements were being met. In addition, timeliness of appointment access standards was not met for the MassHealth rigorous requirement of 100 percent. Furthermore, MCOs had difficulty demonstrating a choice of at least two primary care providers (PCPs) and behavioral health providers for non-English speaking enrollees to access for prevalent languages. However, this finding is likely attributed to the lack of a specific

methodology for demonstrating choice of providers in the required categories. The audit found that while MassHealth implemented the use of Accountable Care Organizations (ACOs) throughout the state, which largely replaced the MCO model type, the MCO model type provided a viable option for Medicaid members who were not attributed to an ACO or did not have access to an ACO model type in their area. Some of the geo-access challenges for MCOs may also reflect some of the difficulty in providing access to members across a broader geography.

The review found that when compared with the prior review findings from 2017, MCOs addressed the previous review findings to full compliance or made progress in areas that were not fully met. Many findings for the 2021 review were related to changes in the federal requirements or MCO state contract requirements. These findings were of a technical nature, requiring policy and procedure revisions rather than substantive concerns with the delivery of care.

Overall, the 2021 compliance review found that MCOs performed best in the areas of care delivery and quality of care. The review showed innovative approaches to address challenges presented by COVID-19 within its care management programs. In addition, MCOs did well meeting compliance standards related to timeliness of care, that is, MCOs did well with meeting timelines for making coverage and appeal decisions and resolving grievances, thereby reducing unnecessary delays in care and service. MCOs have opportunities to improve mechanisms to assess network adequacy across all service categories as well as appointment access to determine if there are deficiencies.

NEXT STEPS

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

MCO-SPECIFIC COMPLIANCE VALIDATION RESULTS

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

BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on August 16, 2021, through August 18, 2021.

Exhibit 5.2. BMCHP Compliance Validation Scores

Review Element	Score
Availability of Services	94.7%
Assurances and Adequate Capacity and Services	100%
Enrollee Rights and Protection	100%
Enrollment/ Disenrollment	61.1%
Availability of Services – Enrollee Information	100%
Provider Selection	94.4%
Grievance and Appeal System	97.5%
Subcontractual Relationships and Delegation	98.8%
QAPI	98.4%
Health Information Systems	100%
Coverage and Authorization of Services	98.4%
Practice Guidelines	100%
Confidentiality of Health Information	100%
Coordination and Continuity of Care	100%
Total Composite Score	**96%**

Strengths

- Overall, BMCHP demonstrated compliance with most of the federal and state contractual standards for the 2021 compliance review across review areas.
- The review noted BMCHP's data-driven approach as being a strength of the MCO. BMCHP had robust analytics and demonstrated use of these at all levels of the organization. In addition, BMCHP demonstrated a strong investment in system solutions and technology. This was demonstrated with the implementation of a new care management system to help meet the needs of this ever-evolving program. In addition, BMCHP noted opportunities to enhance its appeals and grievance systems in the future.
- In general, Kepro found that BMCHP addressed opportunities for improvement from the prior compliance review.
- BMCHP demonstrated strength in coordination and continuity of care relative to its response to COVID-19. BMCHP implemented some innovative approaches to keep in contact with members using its "TLC" program. BMCHP used its enhanced registry that uses

Race/Ethnicity to identify potential at-risk members. There was collaboration noted between the MCO, MassHealth, and BMCHP's partners to determine resources for long-term services and support (LTSS) members and implemented the use of telehealth services more broadly. In addition, the care management process had efficient systems for the documentation and tracking of health risk assessments, care treatment plans, medication reconciliation, and transitions of care.

Opportunities for Improvement
- Although there were no concerns with BMCHP's handling of MCO member enrollment as directed by MassHealth, the audit found that prior to May 2020, BMCHP's policy and procedure was not fully compliant with all aspects of enrollment and disenrollment.
- Some policies and procedures were found to be outdated or having missed a formal review. Several of the Grievance and Appeal Systems' review elements that were Partially Met were related to minor revisions and changes that needed to be made to better reflect contractual and operational practices.
- While the MCO had many programs and policies in place to address the various quality assessment and performance improvement components, including a Standards for Medical Record Documentation Policy, the MCO's policy did not specifically outline a process or mechanism to monitor network provider compliance with the standards and requirements.
- While BMCHP, in general, demonstrated timely coverage determination and appeal decisions including timely notification to members, the review found that the denial and appeal letters contained language that was difficult to understand. The language in the letters was clinical in nature and not always easily understood.
- The audit found that, while BMCHP performed geo-access analysis, it did not meet all MassHealth-required time and distance standards. The analysis did not include a process and methodology to evaluate non-English speaking enrollees' choice of primary care and behavioral health providers in prevalent languages.

Recommendations
- BMCHP needs to ensure annual review and approval of its policies and procedures against the most recent federal and state contract requirements to ensure continued compliance with all federal and MassHealth standards.
- BMCHP needs to create and implement a medical record review process to monitor network provider compliance with policies and procedures and specifications and appropriateness of care.
- BMCHP should revise the language used in denial and appeals letters to convey decision rationale in a manner that is easily understood.
- BMCHP needs to work towards compliance with accessibility standards to meet MassHealth requirements. In addition, BMCHP needs to develop a mechanism to evaluate non-English speaking enrollees' choice of primary and behavioral health providers in prevalent languages.
- BMCHP needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its Corrective Action Plan to MassHealth.

TUFTS HEALTH PUBLIC PLANS

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on August 30, 2021, through August 31, 2021.

Exhibit 5.3. Tufts Compliance Validation Scores

Review Element	Score
Availability of Services	84.0%
Assurances and Adequate Capacity and Services	100%
Enrollee Rights and Protection	92.9%
Enrollment/ Disenrollment	100%
Availability of Services – Enrollee Information	96.2%
Provider Selection	97.2%
Grievance and Appeal System	98.3%
Subcontractual Relationships and Delegation	97.6%
QAPI	98.4%
Health Information Systems	100%
Coverage and Authorization of Services	97.5%
Practice Guidelines	100%
Confidentiality of Health Information	100%
Coordination and Continuity of Care	98.4%
Total Composite Score	**97.2%**

Strengths
- Overall, Tufts demonstrated compliance with most of the federal and state contractual standards for the 2021 compliance review across review areas.
- In general, Kepro found that Tufts addressed opportunities for improvement from the prior compliance review.
- The review found that Tufts made enhancements to its care management approach with a large focus to better integrate behavioral health into its integrated team. Tufts reorganized its care management team to better integrate care which included making internal and external connections to help meet the needs of its members. Much of the success noted from Tufts care management of its high needs Senior Care Options and One Care populations has been replicated for the MCO population, as appropriate.
- Tufts grievance resolution letters were found to be very thorough and detailed. The letters conveyed that each member's concern was being taking seriously and that the concern had been addressed.
- Tufts credentialing manual was identified as a best practice by Kepro.

Opportunities for Improvement
- Based on Tufts organizational size, Kepro found that, for some review elements overlapping different functional areas had information that was submitted from a narrowed vantage point and not necessarily reviewed at a higher level to determine if the documentation submitted was appropriate and/or complete to address the review standard.
- The audit found that, while Tufts performed geo-access analysis, it did not meet all MassHealth-required time and distance standards. The analysis did not include a process and methodology to evaluate non-English speaking enrollees' choice of primary care and behavioral health providers in prevalent languages. In addition, Tufts lacked formal policies to address some aspects of behavioral healthcare including continuity of care for behavioral health inpatient and 24-hour diversionary services, processes to link enrollees to Family Support and Training Services and In-Home Therapy Services, and processes to address enrollee access to Behavioral Health Emergency Services Programs (ESPs), when appropriate.
- The review found that Tufts' member handbook lacked some specific contractual provisions related to copayments and costs of services related to adverse appeal determinations.
- Tufts grievance and appeals policy lacked some specific contractual provisions related to timelines, parties to an internal appeal, and Board of Hearing liaison training attendance.
- While Tufts had a comprehensive Quality Improvement (QI) Program Description that included many required components, it did not demonstrate the actual completion of all the requirements including medical record review, medical interrater reliability review (IRR), fidelity report, and the ICC and IHT medical record review. In addition, it was noted that the Family and Enrollee Advisory Council was not yet functional in 2020.
- While Tufts, in general, demonstrated timely coverage determination and appeal decisions including timely notification to members, the review found that the denial and appeal letters had language that was difficult to understand. The language in the letters was clinical in nature and not always easily understood.

Recommendations
- Tufts should implement an internal quality review process for compliance review preparation to ensure representation of all necessary functional areas and to ensure review elements were documented to demonstrate full compliance.
- Tufts needs to continue to work towards compliance with accessibility standards to meet MassHealth requirements. In addition, Tufts needs to develop a mechanism to evaluate non-English speaking enrollees' choice of primary and behavioral health providers in prevalent languages. Furthermore, Tufts needs to develop more formal policies and procedures to address behavioral health requirements.
- Tufts should revise its member handbook to address the specific contractual provisions related to timelines, parties to an internal appeal, and Board of Hearing liaison training attendance.
- Tufts needs to revise its grievance and appeals policy related to timelines, parties to an internal appeal, and Board of Hearing liaison training attendance.

- Tufts needs to integrate all required components into its QI Program Description including medical record review, medical interrater reliability review (IRR), fidelity report, and the ICC and IHT medical record review. In addition, Tufts needs to activate its Family and Enrollee Advisory Council.
- Tufts should revise the language used in denial and appeals letters to covey decision rationale in a manner that is easily understood.
- Tufts needs to address all Partially Met and Not Met findings identified as part of the 2021 compliance review included as part of its Corrective Action Plan to MassHealth.

Section 6.
Network Adequacy Validation

SECTION 6. 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 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 sets forth contractually required time and distance standards as well as threshold member to provider ratios to ensure access to timely care.
In 2021, MassHealth, in conjunction with its External Quality Review Organization, Kepro, evaluated and identified the strengths of the health plan's provider networks, as well as offered recommendations for bridging network gaps. This process of evaluating a plan's network is termed Network Adequacy Validation. While not required by CMS at this time, MassHealth was strongly encouraged by CMS to incorporate this activity as an annual validation activity 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 specialty. The program also provides information about 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.

As stated above, the goal of network adequacy analysis is to ensure that every managed care plan offers adequate access to care across 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, the network adequacy review was performed using a representative set of population points, 3% of the population, distributed throughout the service area based on population patterns. The member file was provided by MassHealth. This methodology allowed MassHealth to ensure each plan was measured consistently against the same population distribution and that the entire service area had adequate access to care within the prescribed time and distance criteria

REQUEST OF PLAN

MassHealth requested a complete provider data set from each managed care plan, which included the following data points:

- Facility or Provider Name;
- Address Information;
- Phone Number; and
- NPI Information.

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

- PCPs and Obstetricians- Gynecologists (Ob/Gyns);
- Rehabilitation Hospitals;
- Urgent Care Services;
- Specialists;
- Behavioral Health Services; and
- Pharmacies.

TIME AND DISTANCE STANDARDS

MassHealth requires MCOs to adhere to certain time and distance standards. MCOs are required to meet the time and the distance standard but are not required to meet both. For example, Urgent Care Medical Facilities are required to be located within a 15-mile radius from the member's home or no more than 30 minutes travel time from the member, but not both.

BEHAVIORAL HEALTH DIVERSIONARY SERVICES

MassHealth requires a time and distance standard of 30 miles or 30 minutes. These standards apply to the services outlined in the table that follows:

Exhibit 6.1. Behavioral Health Diversionary Specialties

BH Diversionary Specialties	
CBAT-ICBAT-TCU	Program of Assertive Community Treatment
Monitored Inpatient Level 3.7	Psychiatric Day Treatment
Community Support Program	Recovery Coaching
Intensive Outpatient Program	Recovery Support Navigators
Clinical Support Services for Substance Use Disorders (Level 3.5)	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 has established 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 has established a 30-mile or 30-minute standard for these services.

BEHAVIORAL HEALTH OUTPATIENT SERVICES

There are three specialties in this provider group, i.e., Applied Behavior Analysis, Behavioral Health Outpatient services, and Opioid Treatment Programs. MassHealth has established a 30-mile or 30-minute standard for these services. Plans are required to have two Opioid Treatment Specialty providers within this time and distance standard.

MEDICAL FACILITY SERVICES

There are three specialties in this category, each of which has a different time and distance standard. Providers are required to meet the time or distance standard.

Exhibit 6.2. Medical Facility Services 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 meet a 15-mile or 30-minute standard.

PRIMARY CARE SERVICES

MassHealth has established a 15-mile or 30-minute standard for primary care. The state has also established a specific provider to member ratio.

Exhibit 6.3. Primary Care Services and Required Provider to Member Ratios

Specialty	Ratio
Adult PCP	1:200 adult PCPs
Pediatric PCP	1:200 pediatricians

SPECIALTY SERVICES

MassHealth requires that all specialties in the following table adhere to a time and distance standard of 20 miles or 40 minutes:

Exhibit 6.4. Specialty Services

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

The provider to member ratio and the time and distance standards for ObGyn services follow.

Exhibit 6.5. Ob/Gyn Service Standard Requirements

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

EVALUATION METHOD AND INTERPRETATION OF RESULTS

The Quest system generates a network adequacy score by combining the following files together:

- Service area zip codes
- Managed care plan provider files
- The time, distance, and minimum provider-to-member ratios established by MassHealth; and
- A representative membership file

The system assigns a score on a scale of 1 to 100. Scores are assigned at both the specialty and county level. The overall score is derived from the average of all county scores. This report depicts each plan's scores at the county level.

The following text uses an example to describe how to interpret the results.

Exhibit 6.6. Evaluation Method Example Table

County	Service
Barnstable	100
Berkshire	70
Bristol	56
Hampden	0
Hampshire	0
Worcester	0*
Overall:	37.6

- Both the access requirement and the servicing provider requirements are met in Barnstable County. Thus, an Adequacy Index Score of 100 is assigned.
- A score of 70 has been assigned to Berkshire County as the requirement for the number of servicing providers has not been met.
- In Bristol County, the servicing provider requirement is met, but the access requirement is less than what is required (80%), so the Adequacy Index Score is 56, as 70% of 80 = 56.
- The 0 assigned to Hampden County means that neither the time and distance nor number of servicing provider requirements are met.
- The 0 assigned to Hampshire County means that less than 70% of the membership is within the time and distance standards but the number of servicing provider requirements are met.
- Worcester County shows an asterisk with the zero score, indicating that no provider data were submitted for review by the plan.
- The overall score is an average of the county scores: (70 + 56 + 100 + 0 + 0 + 0) / 6 = 37.6

Managed Care Organization Service Areas

Quest Analytics' geo-mapping process is county-based. Managed Care Organization service areas are tied to MassHealth-defined geographical areas that are zip code-based. To accommodate this distinction, Quest assigned counties on a zip code basis. For example, Easthampton is part of the MassHealth Northampton service area. Quest assigned both Easthampton and Northampton to Hampshire County and the results for these two cities are included in the results for that county. There may be very few situations in which a county may appear to have network deficiencies but, in fact, may be meeting network requirements. Kepro has identified these situations as it is possible to do so with the information at hand.

To assist in the interpretation of results, a county map of Massachusetts follows as well as a ranked list of county populations.

Exhibit 6.7. Map of Massachusetts County Designations
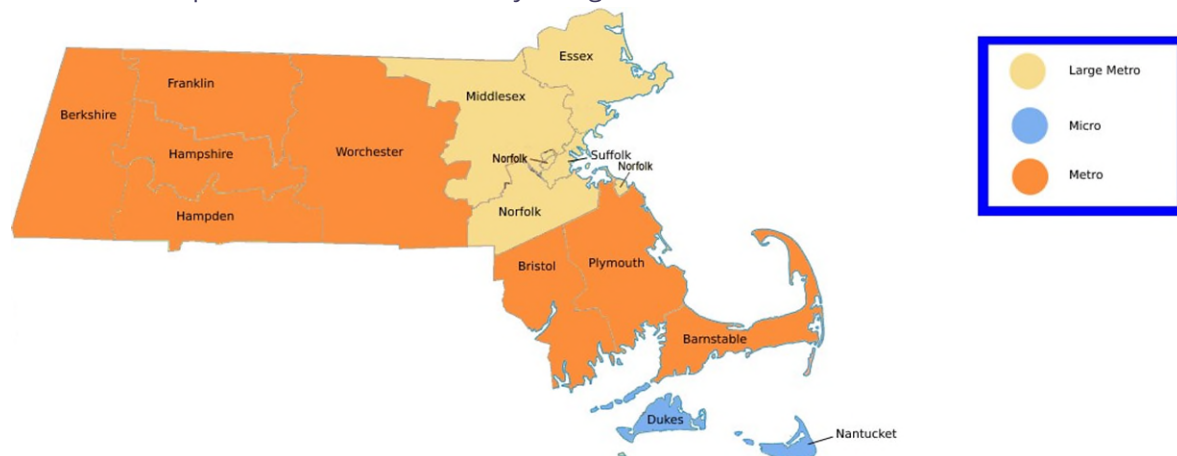
Exhibit 6.8. Massachusetts County Designations and 2020 Population

County	County Designations	2020 Population[1]
Middlesex	Large Metro	1,632,002
Worcester	Metro	862,111
Essex	Large Metro	809,829
Suffolk	Large Metro	797,936
Norfolk	Large Metro	725,981
Bristol	Metro	579,200
Plymouth	Metro	530,819
Hampden	Metro	465,825
Barnstable	Metro	228,996
Hampshire	Metro	162,308
Berkshire	Metro	129,026

[1] Census.gov, accessed November 10, 2021

County	County Designations	2020 Population[1]
Franklin	Metro	71,029
Dukes	Micro	20,600
Nantucket	Micro	14,255

AGGREGATE RESULTS

The graphic below provides a comparison of the managed care organization network adequacy scores. These scores are explored in more detail in the pages that follow.

Exhibit 6.9. Comparison of MCO Network Adequacy Scores

Boston Medical Center HealthNet Plan	Tufts Health Public Plans
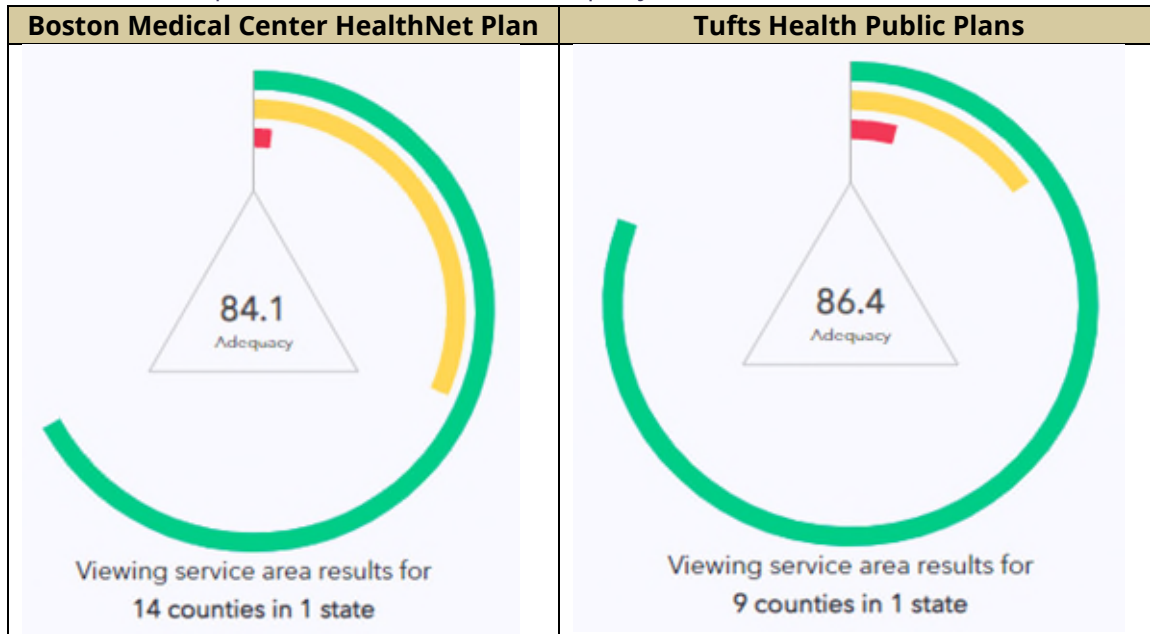
To permit a cross-plan comparison and facilitate statewide provider recruitment, the table that follows lists specialty networks with identified deficiencies. An "X" indicates a network adequacy deficiency.

Exhibit 6.10. MCO Network Adequacy – Deficient Networks by Specialty

Services	BMCHP	Tufts
Adult PCP	X	
Pediatric PCP	X	
Allergy and Immunology	X	
Anesthesiology		
Audiology	X	
Cardiology		
Cardiothoracic Surgery	X	
Chiropractor		
Dermatology		
Emergency Medicine		
Endocrinology		
ENT/Otolaryngology		
Gastroenterology		
General Surgery		
Hematology		
Infectious Diseases		
Nephrology		
Neurology		
Neurosurgery	X	
Nuclear Medicine	X	X
OBGYN		
Oncology – Medical		
Oncology – Radiation	X	X
Ophthalmology		
Oral Surgery	X	X
Orthopedic Surgery		
Pathology		
Physiatry, Rehabilitative Medicine		
Plastic Surgery	X	X
Podiatry		
Psych APN		
Psychiatry		
Psychology		
Pulmonology		
Radiology		
Rheumatology		
Urology		
Vascular Surgery	X	
CBAT		X

Services	BMCHP	Tufts
Clinical Support Services for SUD	X	X
Community Support Program		
Intensive Outpatient Programs	X	X
Monitored Inpatient Level 3.7	X	X
Partial Hospitalization Program		X
PACT	X	X
Psychiatric Day Treatment	X	X
Recovery Coaching		X
Recovery Support Navigators		X
Residential Rehab Services for SUD (Level 3.1)	X	X
Structured Outpatient Addiction Programs		
Managed Inpatient Level 4	X	X
Psychiatric Inpatient Adolescent		X
Psychiatric Inpatient Adult		
Psychiatric Inpatient Child		X
In-Home Behavioral Services		X
In-Home Therapy Services		
Therapeutic Monitoring Services		
Applied Behavioral Analysis		X
Behavioral Health Outpatient		
Opioid Treatment Programs	X	X
Acute Inpatient Hospitals		
Rehabilitation Hospitals		
Urgent Care Services	X	X
Retail Pharmacies		

RESULTS BY PLAN

BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

BMCHP received an overall adequacy index score of 84.1. Last year, BMCHP MCO received an overall adequacy score of 83.1. The plan has increased its overall adequacy index score by 1 point in this year's analysis.

The score wheel below provides multiple scores which are outlined in the bulleted items. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 6.11. BMCHP Adequacy Score

Viewing service area results for 14 counties in 1 state
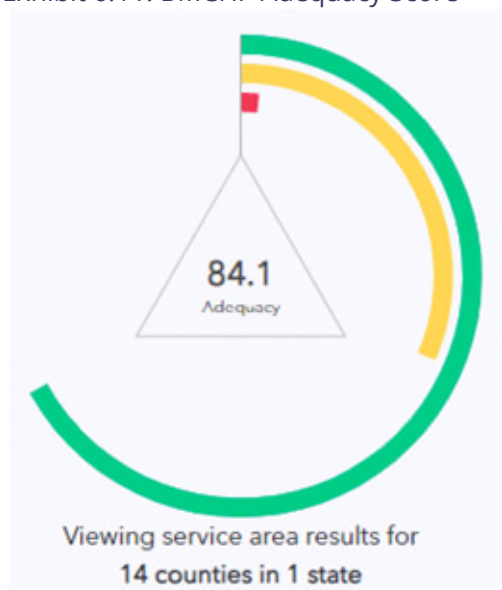
- The green bar indicates that 66.9% of BMCHP's healthcare service network fully meets the adequacy requirements.

- The yellow bar indicates that 31.5% of BMCHP's healthcare service network meets only the number of servicing provider requirements.

- The red bar indicates that 1.6% of BMCHP's healthcare service network does not meet any adequacy requirements. For services for which the plan did not submit data, the percentage is included in this category.

Primary Care, Medical Facilities, and Pharmacies

The table that follows depicts the network adequacy scores for Primary Care, Medical Facility, and Pharmacy services.

Exhibit 6.12. Primary Care, Medical Facility, and Pharmacy Services

County	Adult PCP	Pediatric PCP	Acute Inpatient Hospital	Rehab Hospital	Urgent Care Services	Retail Pharmacies
Barnstable	65.1	65.7	63.4	100	67.8	100
Berkshire	0.0	0.0	69.9	0.0	0.0	69.4
Bristol	69.8	100	100	100	100	100
Dukes	100	69.1	69.6	100	53.4	100
Essex	100	100	100	100	69.4	100
Franklin	69.6	69.6	100	58.9	0.0	100
Hampden	69.8	69.7	100	100	69.3	69.9
Hampshire	68.6	68.2	100	69.2	62.7	69.5
Middlesex	69.9	100	100	100	69.9	100
Nantucket	0.0	100	100	0.0	0.0*	100
Norfolk	100	69.8	100	100	100	100
Plymouth	68.1	69.5	100	100	100	100
Suffolk	100	100	100	100	100	100
Worcester	100	68.5	100	68.5	67.6	100
Overall:	**70.1**	**75.0**	**93.1**	**78.3**	**61.4**	**93.5**

* No provider data were submitted by the plan

Behavioral Health Services

BMCHP's behavioral health network of Outpatient Behavioral Health providers, Adult Psychiatric Inpatient facilities, Recovery Coaches, and Recovery Support Navigators met network adequacy standards.

The tables that follow depict the network adequacy scores for those behavioral health services not meeting the minimum network adequacy score.

Exhibit 6.13a. Behavioral Health Service Gaps and Corresponding Counties

County	Applied Behavioral Analysis	CBAT	Clinical Support Services for SUD	Community Support Program	In-Home Behavioral Services	In-Home Therapy Services
Barnstable	100	69.9	100	100	69.2	100
Berkshire	100	0.0	69.1	100	100	100
Bristol	100	100	100	100	100	100
Dukes	100	0.0	100	100	100	100
Essex	100	100	100	69.9	67.8	69.9
Franklin	100	100	100	100	100	100
Hampden	100	100	100	100	100	100
Hampshire	100	100	100	100	100	100
Middlesex	100	100	100	100	100	100
Nantucket	0.0	0.0	0.0	68.7	0.0	0.0
Norfolk	100	100	100	100	100	100
Plymouth	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100
Worcester	100	100	100	100	100	100
Overall:	92.9	76.4	90.6	95.6	88.4	90.7

Exhibit 6.13b. Behavioral Health Service Gaps and Corresponding Counties

County	Intensive Outpatient Program	Managed Inpatient Level 4	Monitored Inpatient Level 3.7	Opioid Treatment Programs	Partial Hospitalization Program	Program of Assertive Community Treatment
Barnstable	100	100	100	54.1	100	0.0
Berkshire	0.0	100	69.0	56.6	69.1	0.0
Bristol	100	100	100	67.2	100	69.4
Dukes	100	100	100	0.0	100	0.0
Essex	100	100	100	65.7	100	69.9
Franklin	67.6	100	100	0.0	100	100
Hampden	69.9	100	100	0.0	100	68.9
Hampshire	100	100	100	0.0	100	62.5
Middlesex	100	100	100	100	100	100
Nantucket	0.0	0.0*	0.0	0.0	0.0	0.0
Norfolk	100	100	100	100	100	67.4
Plymouth	100	100	100	100	100	64.7
Suffolk	100	100	100	100	100	100
Worcester	100	100	100	69.8	100	61.7
Overall:	81.2	92.9	90.6	51.0	90.6	54.6

* No provider data were submitted by the plan

Exhibit 6.13c. Behavioral Health Service Gaps and Corresponding Counties

County	Psychiatric Day Treatment	Psychiatric Inpatient Adolescent	Psychiatric Inpatient Child	Residential Rehab Services for SUD	Structured Outpatient Addiction Program	Therapeutic Mentoring Services
Barnstable	64.5	100	100	52.5	100	69.2
Berkshire	69.1	100	100	0.0	69.1	100
Bristol	100	100	100	100	100	100
Dukes	64.2	100	100	100	100	100
Essex	69.9	100	100	60.8	100	69.9
Franklin	100	100	100	100	100	100
Hampden	100	100	100	100	100	100
Hampshire	100	100	100	100	100	100
Middlesex	100	100	100	100	100	100
Nantucket	0.0	68.7	68.7	0.0	0.0	0.0
Norfolk	100	100	100	100	100	100
Plymouth	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100
Worcester	100	100	100	69.2	100	100
Overall:	**83.4**	**97.8**	**97.8**	**77.3**	**90.6**	**88.5**

Specialty Services

BMCHP's specialty network of Psychiatrists and Psychologists met network adequacy standards.

The tables that follow depict the network adequacy scores for those specialty services not meeting the minimum network adequacy score.

Exhibit 6.14a. Specialty Service Gaps and Corresponding Counties

County	Allergy and Immunology	Anesthes	Audiology	Cardiology	Cardiothor Surgery	Chiropractor
Barnstable	64.8	63.4	68.4	100	62.1	100
Berkshire	52.4	69.9	61.7	69.9	0.0	100
Bristol	100	100	100	100	100	100
Dukes	0.0	69.6	100	69.6	0.0	100
Essex	68.9	100	100	100	68.5	100
Franklin	69.2	100	0.0	100	0.0	100
Hampden	69.9	100	69.8	100	69.6	100
Hampshire	69.9	100	65.4	100	49.2	100
Middlesex	100	100	67.5	100	69.7	100
Nantucket	0.0	100	0.0	100	0.0	0.0
Norfolk	100	100	100	100	100	100
Plymouth	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100
Worcester	67.3	100	63.9	100	57.8	100
Overall:	**68.7**	**93.1**	**71.2**	**95.7**	**55.5**	**92.9**

Exhibit 6.14b. Specialty Service Gaps and Corresponding Counties

County	Dermatology	Emergency Medicine	Endocrin	ENT / Otolar	Gastro	General Surgery
Barnstable	100	100	63.6	100	68.4	68.7
Berkshire	62.1	69.9	69.9	69.9	63.0	100
Bristol	100	100	100	100	100	100
Dukes	69.6	100	0.0	69.6	100	69.6
Essex	100	100	100	69.3	100	100
Franklin	44.2	100	100	46.6	100	100
Hampden	69.7	100	100	69.7	100	100
Hampshire	66.6	100	100	69.7	100	100
Middlesex	100	100	100	100	100	100
Nantucket	100	100	100	100	100	100
Norfolk	100	100	100	100	100	100
Plymouth	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100
Worcester	67.1	100	100	69.6	100	100
Overall:	**84.2**	**97.9**	**88.1**	**83.2**	**95.1**	**95.6**

Exhibit 6.14c. Specialty Service Gaps and Corresponding Counties

County	Hematology	Infectious Diseases	Nephrology	Neurology	Nuclear Medicine	OBGYN	Oncology - Medical
Barnstable	63.4	63.4	64.8	68.0	0.0	57.9	63.4
Berkshire	69.9	56.6	69.9	69.9	0.0	61.3	69.9
Bristol	100	100	100	100	69.6	100	100
Dukes	69.6	67.3	69.6	96.2	0.0	100	69.6
Essex	100	100	69.5	69.9	68.4	100	100
Franklin	59.2	44.4	100	100	0.0	67.4	59.2
Hampden	68.8	100	69.9	100	68.8	69.7	100
Hampshire	66.1	69.4	100	69.9	62.2	68.1	66.0
Middlesex	100	100	100	100	100	100	100
Nantucket	100	0.0	100	100	0.0*	100	100
Norfolk	100	100	100	100	69.9	100	100
Plymouth	100	100	100	100	59.3	100	100
Suffolk	100	100	100	100	100	100	100
Worcester	66.0	69.9	67.9	69.9	56.8	69.9	69.9
Overall:	**83.1**	**76.5**	**86.5**	**86.8**	**46.8**	**85.3**	**85.6**

* No provider data were submitted by the plan

Exhibit 6.14d. Specialty Service Gaps and Corresponding Counties

County	Oncology - Radiation	Ophthalmology	Oral Surgery	Orthopedic Surgery	Pathology	Physiatry	Plastic Surgery
Barnstable	63.4	67.5	63.6	63.6	63.3	63.6	64.5
Berkshire	54.3	69.9	0.0	69.9	68.5	69.9	56.5
Bristol	100	100	0.0	100	100	100	100
Dukes	67.3	69.6	67.8	69.6	0.0	51.6	69.6
Essex	69.9	100	100	100	100	66.6	69.9
Franklin	0.0	100	69.2	100	65.1	69.9	0.0
Hampden	69.8	100	69.2	100	69.9	100	100
Hampshire	64.8	100	49.1	100	69.9	100	69.7
Middlesex	100	100	69.2	100	100	100	69.6
Nantucket	0.0	100	0.0	100	100	0.0	0.0
Norfolk	100	100	64.3	100	100	100	100
Plymouth	69.2	100	67.9	100	100	100	100
Suffolk	100	100	100	100	100	100	100
Worcester	67.8	100	62.0	100	69.9	69.9	58.9
Overall:	**66.2**	**93.4**	**55.9**	**93.1**	**79.0**	**78.0**	**68.5**

Exhibit 6.14e. Specialty Service Gaps and Corresponding Counties

County	Podiatry	Psych APN	Pulmonology	Radiology	Rheumatology	Urology	Vascular Surgery
Barnstable	100	100	100	67.0	63.6	63.6	63.6
Berkshire	60.9	65.5	53.0	62.9	53.9	69.9	62.9
Bristol	100	100	100	100	100	100	100
Dukes	69.6	100	69.6	68.2	67.3	68.2	67.3
Essex	100	100	100	100	68.4	69.9	69.5
Franklin	100	100	69.2	69.2	69.6	100	0.0
Hampden	100	100	69.8	100	100	100	68.9
Hampshire	100	100	66.5	100	69.9	100	68.0
Middlesex	100	100	100	100	100	100	100
Nantucket	100	100	100	0.0	100	100	0.0
Norfolk	100	100	100	100	100	100	100
Plymouth	100	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100	100
Worcester	100	100	100	100	100	100	63.5
Overall:	**95.0**	**97.5**	**87.7**	**83.4**	**85.2**	**90.8**	**68.8**

Findings

- Adult and pediatric primary care services do not meet either the time and distance or the servicing provider requirement in Barnstable County.
- Suffolk County is the only county meeting all network adequacy standards.
- Conversely, the network of services in Berkshire County does not meet MassHealth requirements.
- BMCHP did not report having Urgent Care service providers in Nantucket County and nine other counties met only the servicing provider requirement. Only four counties are meeting all Urgent Care service requirements.
- BMCHP's behavioral health network is relatively strong with only PACT and Opioid Treatment Programs demonstrating deficiencies consistently.
- Network development in Barnstable, Berkshire, Dukes, and Nantucket Counties represents an opportunity for improvement for BMCHP.
- Nuclear Medicine network adequacy requirements are met in Middlesex and Suffolk Counties only.
- Oral Surgery network adequacy requirements are met in Essex and Suffolk Counties only.
- Other specialties representing an opportunity for network development more broadly include Allergy and Immunology, ENT, Oncology – Radiation, Plastic Surgery, and Vascular Surgery.

Recommendations

- Kepro recommends that BMCHP expand its network of Primary Care Providers (Adult and Pediatric) in Barnstable County.
- Network development in Barnstable, Berkshire, Dukes, and Nantucket Counties represents an opportunity for improvement for BMCHP.
- Kepro recommends contracting with additional providers as available to close other network gaps.
- Kepro recommends that MassHealth review Nantucket County's capacity for meeting requirements.

Update to 2020 Recommendations

Kepro offered no recommendations in 2020.

TUFTS HEALTH PUBLIC PLANS (TUFTS)

Tufts received an overall adequacy index score of 86.4. Last year, Tufts received an overall adequacy score of 75.5. The plan has increased its overall adequacy index score by 10.9 points in this year's analysis.

The score wheel reflects multiple scores which are outlined in the bulleted items. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 6.15. Tufts' Network Adequacy Score

86.4
Adequacy

Viewing service area results for
9 counties in 1 state
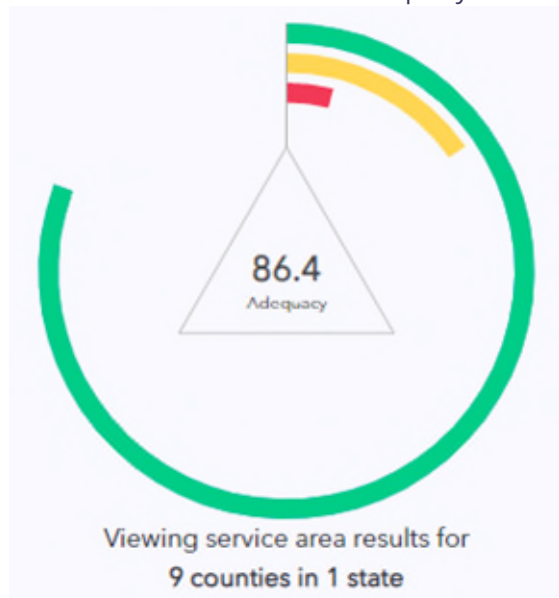
- The green bar indicates that 80.7% of Tufts' healthcare service network fully meets the adequacy requirements.

- The yellow bar indicates that 15.3% of Tufts' healthcare service network meets only the number of servicing provider requirements.

- The red bar indicates that 4% of Tufts' health care service network does not meet either adequacy requirement. Services for which the plan did not submit data are included in this category.

Primary Care, Medical Facilities, and Pharmacies

The table that follows depicts the network adequacy scores for those Primary Care and Pharmacy services meeting the minimum network adequacy score.

Exhibit 6.16. Primary Care and Pharmacies with a Passing Network Adequacy Score

Service
Adult PCP
Pediatric PCP
Retail Pharmacies

The table that follows depicts the network adequacy scores for Medical Facility services not meeting the minimum network adequacy score.

Exhibit 6.17. Medical Facility Gaps and Corresponding Counties

County	Acute Inpatient Hospital	Rehab Hospital	Urgent Care Services
Berkshire	100	100	58.3
Essex	100	100	60.9
Franklin	57.2	67.1	0.0
Hampden	100	100	100
Hampshire	100	100	100
Middlesex	100	100	100
Norfolk	100	100	100
Suffolk	100	100	100
Worcester	100	100	64.9
Overall:	**95.2**	**96.3**	**76.0**

Behavioral Health Services

The table that follows depicts the network adequacy scores for those behavioral health services meeting the minimum network adequacy score.

Exhibit 6.18. Behavioral Health Services with a Passing Network Adequacy Score

Behavioral Health Service	
BH Outpatient	Structured Outpatient Addiction Programs
In-Home Therapy Services	Therapeutic Mentoring Services
Psych Inpatient Adult	

The tables that follow depict the network adequacy scores for those behavioral health services not meeting the minimum network adequacy score.

Exhibit 6.19a. Behavioral Health Service Gaps and Corresponding Counties

County	Applied Behavioral Analysis	CBAT	Clinical Support Services for SUD	Community Support Program	In-Home Behavioral Services	Intensive Outpatient Program
Berkshire	0.0*	0.0	0.0*	100	0.0*	0.0
Essex	0.0	0.0	100	69.2	100	69.9
Franklin	0.0*	69.0	0.0*	100	0.0	0.0*
Hampden	0.0*	100	100	100	100	0.0*
Hampshire	0.0*	100	100	100	100	0.0*
Middlesex	64.0	55.0	100	100	100	100
Norfolk	100	100	100	100	100	100
Suffolk	62.6	100	100	100	100	100
Worcester	0.0	69.0	60.6	100	65.3	60.6
Overall:	**25.2**	**65.9**	**73.4**	**96.6**	**73.9**	**47.8**

* No provider data were submitted by the plan

Exhibit 6.19b. Behavioral Health Service Gaps and Corresponding Counties

County	Managed Inpatient Level 4	Monitored Inpatient Level 3.7	Opioid Treatment Programs	Partial Hosp Program	Program of Assertive Community Treatment
Berkshire	0.0*	0.0*	0.0	0.0*	0.0*
Essex	100	100	69.8	100	100
Franklin	100	100	100	100	0.0*
Hampden	0.0	0.0*	100	0.0	0.0*
Hampshire	100	100	100	100	0.0*
Middlesex	100	100	100	100	100
Norfolk	100	100	100	100	100
Suffolk	100	100	100	100	100
Worcester	100	60.3	0.0	100	60.6
Overall:	77.8	73.4	74.4	77.8	51.2

* No provider data were submitted by the plan

Exhibit 6.19c. Behavioral Health Service Gaps and Corresponding Counties

County	Psychiatric Day Treatment	Psych Inpatient Adolescent	Psych Inpatient Child	Recovery Coaching	Recovery Support Navigators	Residential Rehab Services for SUD
Berkshire	0.0*	0.0*	0.0*	0.0	0.0	0.0
Essex	61.5	100	100	68.6	68.6	60.8
Franklin	0.0	100	0.0	0.0*	0.0*	100
Hampden	0.0	0.0	0.0	0.0	0.0	0.0
Hampshire	0.0	0.0	0.0	0.0	0.0	0.0
Middlesex	100	100	100	100	100	100
Norfolk	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100
Worcester	65.4	100	66.1	100	100	58.0
Overall:	47.4	66.7	51.8	52.1	52.1	57.6

* No provider data were submitted by the plan

Specialty Services

The table that follows depicts the network adequacy scores for those behavioral health services meeting the minimum network adequacy score.

Exhibit 6.20. Specialty Services with a Passing Network Adequacy Score

Specialists		
Anesthesiology	General Surgery	Physiatry, Rehabilitative Medicine
Cardiology	Neurology	Psychiatry
Chiropractor	OBGYN	Pulmonology
Emergency Medicine	Ophthalmology	Radiology
Endocrinology	Orthopedic Surgery	Urology
Gastroenterology		

The tables that follow depict the network adequacy scores for those specialties not meeting the minimum network adequacy score.

Exhibit 6.21a. Specialty Service Gaps and Corresponding Counties

County	Allergy and Immunology	Audiology	Cardiothor Surgery	Dermatology	ENT / Otolar	Hematology
Berkshire	69.3	100	100	100	100	100
Essex	100	100	100	100	100	100
Franklin	100	63.6	57.2	0.0	66.1	64.6
Hampden	100	100	100	100	100	100
Hampshire	100	100	100	100	100	100
Middlesex	100	100	100	100	100	100
Norfolk	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100
Worcester	65.0	48.0	100	100	100	100
Overall:	92.7	90.2	95.2	88.9	96.2	96.1

Exhibit 6.21b. Specialty Service Gaps and Corresponding Counties

County	Infectious Diseases	Nephrology	Neurosurgery	Nuclear Medicine	Oncology - Medical	Oncology - Radiation
Berkshire	100	100	100	0.0	100	69.3
Essex	100	100	100	68.6	100	100
Franklin	100	100	0.0	100	57.2	47.8
Hampden	100	100	100	100	100	100
Hampshire	100	100	100	100	100	100
Middlesex	100	100	100	100	100	100
Norfolk	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100
Worcester	66.4	69.9	49.4	58.0	100	65.9
Overall:	96.3	96.7	83.3	80.7	95.2	87.0

Exhibit 6.21c. Specialty Service Gaps and Corresponding Counties

County	Oral Surgery	Path	Plastic Surgery	Podiatry	Psych APN	Psychology	Rheum	Vascular Surgery
Berkshire	100	100	69.3	64.8	0.0	0.0	100	100
Essex	68.6	100	100	100	100	100	68.9	100
Franklin	0.0	47.8	57.2	100	100	100	100	57.2
Hampden	0.0	100	100	100	100	100	100	100
Hampshire	0.0	100	100	100	100	100	100	100
Middlesex	100	100	100	100	100	100	100	100
Norfolk	100	100	100	100	100	100	100	100
Suffolk	100	100	100	100	100	100	100	100
Worcester	65.0	100	63.4	100	60.9	100	100	65.7
Overall:	59.3	94.2	87.8	96.1	84.5	88.9	96.6	91.4

Findings
- Franklin County's medical facility network meets the number of servicing provider requirement only.
- Tufts did not report having Behavioral Health Services in 23 service-county combinations.
- Tufts has a well-developed network of specialists.
- Opportunities for improvement exist in Berkshire, Franklin, and Worcester Counties.

Recommendations
- Kepro recommends that Tufts fill network gaps as identified.
- Kepro suggests that Tufts focus network development efforts on Berkshire, Franklin, and Worcester Counties.
- Tufts' behavioral health service network presents multiple opportunities for improvement.
- Kepro suggests that Tufts prioritize behavioral health network development in Berkshire and Hampden Counties.
- Kepro recommends that Tufts contract with additional Child and Adolescent Inpatient Psychiatric Facilities, as available, in Western Massachusetts.

Update to 2020 Recommendations
Kepro offered no recommendations to Tufts in 2020.

Contributors

CONTRIBUTORS

PERFORMANCE MEASURE VALIDATION

Katharine Iskrant, CHCA, MPH
Ms. Iskrant is the President of Healthy People, an NCQA-licensed HEDIS audit firm. She is a member of the NCQA Audit Methodology Panel and NCQA's HEDIS Data Collection Advisory Panel. She is also featured on a 2020 NCQA HEDIS Electronic Clinical Data Systems (ECDS) podcast. Katharine has been a Certified HEDIS® Compliance Auditor since 1998 and has directed more than 2,000 HEDIS audits.

Previously, as CEO of the company Acumetrics, Katharine provided consultancy services to NCQA which helped their initial development and eventual launch of the NCQA Measure Certification Program.

Katharine 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
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 of Population Health at the National Quality Forum, she provided leadership to advance population health strategies through the 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, which 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.

Dr. Zell is Clinical Director for Kepro, providing External Quality Review to improve Medicaid Managed Care performance improvement projects through evaluation of project design, measure validation and feedback to improve intervention impact.

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 healthcare 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 Healthcare Quality and Certified in Healthcare 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 40 years of experience in the design, implementation, and management of large-scale health and human service systems. His expertise includes improving health providers' service effectiveness and efficiency through data-driven performance management systems. 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 healthcare, 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.

COMPLIANCE VALIDATION REVIEWERS

Jennifer Lenz, MPH, CHCA

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

Jane Goldsmith, RN, MBA, CSSGB, CHC

Ms. Goldsmith has more than 30 years' experience in the healthcare industry with expertise in leading teams in public health nursing activities and implementing quality assurance, regulatory compliance, and accreditation activities. Her prior experience includes senior management and executive roles in managed care organizations with responsibility for quality improvement, regulatory compliance, accreditation, and internal audit. She has conducted external quality review activities across health plans in the states of California, Virginia, Florida, Illinois, Ohio,

and Michigan. She also served five years as an adjunct faculty member for Johns Hopkins Bloomberg School of Public Health. Ms. Goldsmith has been Certified in Healthcare Compliance (CHC) by the Compliance Certification Board (CCB) and Certified as Six-Sigma Green Belt (CSSBG) by Villanova University. She received her Bachelor of Science in Nursing degree from Eastern Michigan University and her master's degree in business administration in integrative management from Michigan State University. She holds registered nurse licenses in Michigan, Illinois, and Florida.

Sue McConnell, RN, MSN

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

Poornima Dabir, MPH, CHCA

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

Debra Homovich, BA

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

PROJECT MANAGEMENT

Cassandra Eckhof, M.S., CPHQ

Ms. Eckhof has over 25 years' managed care and quality management experience and has worked in the private, non-profit, and government sectors. She has managed the MassHealth external quality review program since 2016. Ms. Eckhof has a Master of Science degree in healthcare 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.