MassHealth

Managed Care Organizations
External Quality Review Technical Report
Calendar Year 2017

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CONTENTS

SECTION 1. MASSHEALTH MANAGED CARE ORGANIZATIONS

BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

Boston Medical Center Healthnet Plan is a Medicaid managed care organization (MCO) located in Charlestown. Accredited by the National Committee on Quality Assurance (NCQA), its Medicaid line of business received a rating of 4.0 out of a possible 5.0 for 2017-2018. BMCHP's behavioral health partner is Beacon Health Options.

CELTICARE (CEL)

CeltiCare was founded in 2009. Its 38,849[1] members are covered by MassHealth's CarePlus program, coverage that offers a broad range of health care benefits to certain adults who are not eligible for MassHealth Standard. This statewide MCO enrolls individuals who are between the ages of 21 and 64 whose income is between 100 and 133 percent of the Federal Poverty Level. The membership is primarily male (60%) and between the ages of 22 and 45. Women who are pregnant are not eligible to be covered by CarePlus[2] and are not enrolled in this plan. CeltiCare is owned by Centene, a national insurer that also owns CeltiCare's pharmacy benefits manager, US Scripts, as well as its behavioral health partner, Cenpatico. Centene provides health plans through Medicaid, Medicare, and the Health Insurance Marketplace. CeltiCare is accredited by NCQA and received a 2017-2018 quality score of 3.5 from this organization. Its offices are located in Waltham. CeltiCare draws upon Centene's corporate functions for some activities.

FALLON HEALTH (FH)

Fallon Health Plan, located in Worcester, was founded in 1977. Its broad product portfolio includes a variety of group and non-group health plan options (managed care, point-of-service, and a preferred provider organization), as well as Medicaid and Medicare Advantage plans. Fallon Health also offers a Program of All-inclusive Care and a plan for dually insured individuals over the age of 65. Its Medicaid plan is rated 4.0 out of 5.0 by NCQA in 2017-2018, from whom this plan has received accreditation. Enrolling members in Executive Office of Health and Human Services' (EOHHS) northeastern and central regions, Fallon Health's Medicaid membership was 42,997 at the end of 2016. Fallon experienced organizational changes in 2015-

[1] As of December 31, 2016

[2] Women who become pregnant while enrolled in CarePlus can continue to be covered until MassHealth is contacted and informed of the pregnancy to upgrade their MassHealth eligibility.

2016 including the addition of a new chief medical officer as well as a new chief executive officer. Fallon Health's behavioral health partner is Beacon Health Options.

HEALTH NEW ENGLAND (HNE)

Health New England serves 65,664[3] MassHealth members in four counties of Massachusetts. It also enrolls individuals in its commercial and Medicare lines of business. Health New England's Medicaid product is accredited by NCQA and received a quality score of 4.0 out of 5.0 for 2017-2018. Health New England's behavioral health partner is the Massachusetts Behavioral Health Partnership and its pharmacy benefit manager is Caremark.

NEIGHBORHOOD HEALTH PLAN (NHP)

Neighborhood Health Plan is a member of Partners HealthCare, Inc., effective October 1, 2012. It moved from Boston to new offices in Somerville in 2017. It had 283,794 MassHealth members as of December 31, 2016. NHP's Medicaid product is accredited by NCQA and received a quality score of 4.0 out of 5.0 in 2017-2018. In 2016, NHP undertook a major effort to evaluate its clinical and quality services. Among other interventions, it developed and implemented Neighborhood Care Circle, a field-based community health worker program serving the 0.5 percent of NHP's most high-risk members. NHP uses surveys posted to Neighborhood Green, an online community where NHP members can share their thoughts and ideas to inform improvement initiative design. Its behavioral health partner is Beacon Health Options.

TUFTS HEALTH PUBLIC PLANS (THPP)

Tufts Health Public Plans MCO located in Watertown, was formerly known as Network Health. Network Health was acquired by Tufts Associated Health Plan in 2011. It serves 209,812[4] Medicaid beneficiaries in all regions of the Commonwealth. Accredited by NCQA, Tufts Health Public Plans MCO received a quality rating of 4.5 out of 5.0 for the 2017-2018 period.

Exhibit 1: MassHealth Managed Care Organization Membership

Managed Care Organization	Membership as of December 31, 2016	Percent of Total MCO Population
Neighborhood Health Plan	283,791	34.6%
Tufts Health Public Plans	209,812	25.6%
Boston Medical Center HealthNet	179,816	21.9%
Health New England	65,664	8.0%
Fallon Health	42,997	5.2%

[3] As of December 31, 2016.
[4] As of December 31, 2016.

CeltiCare	38,849	4.7%
Total	**820,932**	

SECTION 2. CONTRIBUTORS

PROJECT MANAGEMENT

Cassandra Eckhof, M.S.

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

PERFORMANCE MEASURE VALIDATION REVIEWER

Katharine Iskrant, CHCA, MPH

Ms. Iskrant is a member of the National Committee for Quality Assurance (NCQA) Audit Methodology Panel and has been a Certified Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Auditor since 1998 directing more than 600 HEDIS® audits. She directed the consultant team that developed the original NCQA Software Certification Program℠ on behalf of NCQA. She is a frequent speaker at HEDIS® vendor and health plan conferences, such as National Alliance of State Health CO-OPs (NASHCO) conferences. Ms. Iskrant received her 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.

COMPLIANCE VALIDATION REVIEWERS

Jennifer Lenz, MPH, CHCA

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

state health department; and in performing external quality review organization activities. She has conducted compliance review activities across health plans in the states of California, Georgia, Ohio, Utah, and West Virginia. Ms. Lenz is a Certified Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Auditor through the National Committee for Quality Assurance (NCQA). She received her Master of Public Health in Health Administration and Policy from the University of Arizona.

Lois Heffernan, RN, BSN, MBA

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

Teresa Huysman, RN, BSN

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

PERFORMANCE IMPROVEMENT PROJECT REVIEWERS

Marietta Scholten, MD, FAAFP

Dr. Marietta Scholten is a Board-Certified Family Medicine physician who has practiced for 27 years in Vermont, initially in private practice, then founding the Mylan Family Health Center which provides medical and occupational care for its employees and dependents. For the past

seven years, she has practiced at the University of Vermont Medical Center where she is also an Assistant Clinical Professor.

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

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

Wayne J. Stelk, Ph.D.

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

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

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

SECTION 3. EXECUTIVE SUMMARY

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

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

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

Compliance with federal Medicaid managed care regulations is validated by the EQRO on a triennial basis. MassHealth managed care organization compliance was reviewed in 2017. Plans provide evidence of compliance with regulations as well as the related sections of their contract with EOHHS.

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). It is also posted to the Medicaid agency website.

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ANALYSIS

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

In 2017, KEPRO conducted Performance Measure Validation in accordance with CMS EQR Protocol 2 on three measures that were selected by MassHealth. The measures validated were as follows:

- Antidepressant Medication Management (AMM);

- Postpartum Care (PPV); and
- Annual Monitoring for Patients on Persistent Medications (MPM).

All MCOs followed specifications and reporting requirements and produced valid measures. The focus of the Information Systems Capability Analysis 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.

All MassHealth MCOs demonstrated compliance with these requirements.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

MassHealth MCOs are required to conduct two Performance Improvement Projects (PIP) annually and the agency selects the topics. Each MCO was required to conduct a project related to antidepressant medication management and a second project related to postpartum visits.[5]

KEPRO evaluates each PIP to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. 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.

Based on its review of the MassHealth MCO PIP, KEPRO did not discern any issues related to any plan's quality of care or the timeliness of or access to care. Recommendations made were plan-specific, the only theme emerging being the importance of gathering stakeholder input in project design. In addition, some MCOs demonstrated a knowledge gap in intervention design and evaluation.

[5] Because pregnant women are not eligible to enroll in CeltiCare, this plan undertook a project related to the reduction of emergency department utilization.

COMPLIANCE VALIDATION

The mandatory compliance validation protocol is used to determine, in a manner consistent with standard industry practices, the extent to which Medicaid managed care entities are in compliance with quality standards mandated by the Balanced Budget Act of 1997 (BBA). Also considered is compliance with related sections of the plans' contract with MassHealth as well as compliance with appropriate provisions in the Code of Massachusetts Regulations (CMR). This validation process is conducted triennially.

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

1. Enrollee Rights and Protections
2. Enrollee Information
3. Availability and Accessibility of Services
4. Coordination and Continuity of Care
5. Coverage and Authorization of Services
6. Practice Guidelines
7. Enrollment and Disenrollment
8. Grievance System
9. Sub-contractual Relationships and Delegation
10. Quality Assessment and Performance Improvement Program
11. Credentialing
12. Confidentiality of Health Information
13. Health Information Systems
14. Program Integrity

KEPRO compliance reviewers performed desk reviews of all documentation provided by the MCOs. In addition, two-day onsite visits were conducted to interview key MCO personnel, review selected case files, participate in systems demonstrations, and receive further clarification and documentation.

All MCOs received a compliance score higher than 90%. The weighted average compliance score was 95.16%. MCOs performed best in the areas of Enrollee Rights and Protections, Practice Guidelines, Enrollment and Disenrollment, Subcontractual Relationships and Delegation, Credentialing, Confidentiality of Health Information, Health Information Systems, and Program Integrity. An opportunity for improvement was demonstrated in the areas of Enrollee Information, Availability and Accessibility of Services, and Quality Assessment and Performance Improvement Program standards. Plans were required to submit a corrective action plan for each standard identified as Partially Met or Not Met.

SECTION 4. PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ANALYSES

The Performance Measure Validation (PMV) process assesses the accuracy of performance measures reported by the managed care entity. It determines the extent to which the managed care entity follows state specifications and reporting requirements. In addition to validation processes and the reported results, KEPRO evaluates performance trends in comparison to national benchmarks. KEPRO validates three performance measures annually for Managed Care Organizations.

The Performance Measure Validation process consists of a desk review of documentation submitted by the MCO, notably the HEDIS® Final Audit Report and Roadmaps. The desk review affords the reviewer an opportunity to become familiar with plan systems and data flows. In addition, the reviewer conducts an independent verification of a sample of individuals belonging to the positive numerator of a hybrid measure.

MCOs submitted the documentation that follows in support of the Calendar Year 2017 PMV process.

Note: HEDIS 2017 rates reflect the calendar year 2016 measurement period.

Exhibit 2: Documentation Submitted by MCOs

Document Reviewed	Purpose of KEPRO Review
HEDIS 2017 Roadmap and attachments	Reviewed to assess health plan systems and processes related to performance measure production.
2017 Final Audit Report	Reviewed to note if there were any underlying process issues related to HEDIS® measure production that were documented in the Final Audit Report.
2017 HEDIS Interactive Data Submission System (IDSS) worksheets in both Excel and csv format.	Used to compile final rates for comparison to prior years' performance and industry standard benchmarks.
Follow-up documentation as requested by the reviewer	Plan-specific documentation requested to obtain missing or incomplete information, support and validate plan processes, and verify the completeness and accuracy of information provided in the Roadmap, and systems demonstrations.

COMPARATIVE ANALYSIS

KEPRO conducted PMV on three measures that were selected by MassHealth. The measures validated were as follows:

- Antidepressant Medication Management (AMM);
- Annual Monitoring for Patients on Persistent Medications (MPM); and
- Postpartum Care (PPC-Postpartum).

The tables that follow contain the criteria through which performance measures are validated as well as KEPRO's determination as to whether the MCO met these criteria. Results are presented for all six MCOs in order to facilitate comparison across plans.

Exhibit 3: Performance Measure Validation Worksheets

Performance Measure Validation: Antidepressant Medication Management (AMM)

Methodology for Calculating Measure:	**Administrative**	**Medical Record Review**		**Hybrid**		
Review Element	**BMCHP**	**CEL**	**FAL**	**HNE**	**NHP**	**THPP**
DENOMINATOR *Population*						
Medicaid population was appropriately segregated from commercial and Medicare mixture.	Met	Met	Met	Met	Met	Met
Population was defined as being eligible and having an episode start date for depression during the intake period of 5/1/PY-4/30/MY.	Met	Met	Met	Met	Met	Met
Members had diagnosis of depression from 60 days prior to the index prescription start date (IPSD), through the IPSD and the 60 days after the IPSD.	Met	Met	Met	Met	Met	Met
Geographic Area						
Includes only those Medicaid enrollees served in the MCO's reporting area.	Met	Met	Met	Met	Met	Met
Age & Sex: *Enrollment Calculation*						
Members were 18 years of age or older.	Met	Met	Met	Met	Met	Met
Population was defined as being continuously enrolled from 105 days prior to the IPSD through 231 days after the IPSD.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CEL	FAL	HNE	NHP	THPP
Data Quality						
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data (if no exclusions were taken, mark as N/A)						
Only members with contraindications or data errors were excluded.	Met	Met	Met	Met	Met	Met
Contraindication and exclusions were performed according to current NCQA specifications.	Met	Met	Met	Met	Met	Met
Only the codes listed in specifications as defined by NCQA were counted as contraindications.	Met	Met	Met	Met	Met	Met

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

Performance Measure Validation: Annual Monitoring for Patients on Persistent Medications (MPM)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	BCMHP	CEL	FH	HNE	NHP	THPP
DENOMINATOR *Population*						
Medicaid population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members received at least 180 treatment days of ACE/ARB, digoxin, or diuretic medications.	Met	Met	Met	Met	Met	Met
Geographic Area						
Includes only those Medicaid enrollees served in the MCO's reporting area.	Met	Met	Met	Met	Met	Met
Age & Sex: *Enrollment Calculation*						
Members are aged 18+ as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Population was defined as being continuously enrolled during the measurement year, with no more than a one-month gap.	Met	Met	Met	Met	Met	Met
Data Quality						
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data (if no exclusions were taken, mark as N/A)						
Members who had an inpatient (acute or non-acute) claim during the measurement year were excluded (optional exclusion).	Met	Met	Met	Met	Met	Met

Review Element	BCMHP	CEL	FH	HNE	NHP	THPP
NUMERATOR *Administrative Data: Counting Clinical Events*						
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
All code types were included in analysis, including CPT, ICD9, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met	Met	Met	Met	Met
Members were counted only once.	Met	Met	Met	Met	Met	Met
Members taking ACE/ARB or diuretics had at least one serum potassium test and at least one serum creatinine in the measurement year. Members taking digoxin had at least one serum potassium test, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test in the measurement year.	Met	Met	Met	Met	Met	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met	Met	Met	Met	Met

Performance Measure Validation: Postpartum Care (PPC-Postpartum)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	BMCHP	CEL	FH	HNE	NHP	THPP
DENOMINATOR *Population*						
Medicaid population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members were continuously enrolled 43 days prior to delivery through 56 days after delivery.	Met	Met	Met	Met	Met	Met
Women with live births were appropriately identified using both specified methods.	Met	Met	Met	Met	Met	Met
Geographic Area						
Includes only those Medicaid enrollees served in the MCO's reporting area.	Met	Met	Met	Met	Met	Met
NUMERATOR – POSTPARTUM CARE *Counting Clinical Events*						
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
Data sources and decision logic used to calculate the numerators (e.g., claims files, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met	Met	Met	Met	Met
Members with postpartum visits within the postpartum timeframe were counted.	Met	Met	Met	Met	Met	Met

Review Element	BCMHP	CEL	FH	HNE	NHP	THPP
Data Quality						
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data (if no exclusions were taken, mark as N/A)						
There were no exclusions for this measure.	N/A	N/A	N/A	N/A	N/A	N/A
Medical Record Review Documentation Standards						
Record abstraction tool required notation of the date of enrollment, date of delivery, and the date/number of prenatal visits and date/content of postpartum visits.	Met	Met	Met	Met	Met	Met
Data Quality						
The eligible population was properly identified.	Met	Met	Met	Met	Met	Met
Based on the IS assessment findings, data sources used for this numerator were accurate.	Met	Met	Met	Met	Met	Met
Hybrid Measure						
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
If hybrid method or solely MRR was used, the results of the MRR validation substantiated the reported numerator.	N/A	N/A	N/A	N/A	N/A	N/A
SAMPLING						
Unbiased Sample						
As specified in the NCQA specifications, systematic sampling method was utilized.	Met	Met	Met	Met	Met	Met
Sample Size						
After exclusions, the sample size was equal to 1) 411, 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or 3) the total population.	Met	Met	Met	Met	Met	Met
Proper Substitution Methodology in Medical Record Review (if no exclusions were taken, mark as N/A)						
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors.	Met	Met	Met	Met	Met	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented.	Met	Met	Met	Met	Met	Met

Performance Measure Sampling Validation

Review Element	BMCHP	CEL	FH	HNE	NHP	THPP
MCO followed the specified sampling method to produce an unbiased sample representative of the entire at-risk population.						
Each relevant member or provider had an equal chance of being selected; there were no systematic exclusions from the sample.	Met	Met	Met	Met	Met	Met
MCO followed the specifications set forth in the PM regarding the treatment of sample exclusions and replacements, and if any activity took place involving replacements or exclusions, MCO has adequate documentation of that activity.	Met	Met	Met	Met	Met	Met
Each provider serving a given number of enrollees had the same probability of being selected as any other provider serving the same number of enrollees.	Met	Met	Met	Met	Met	Met
MCO examined its samples files for bias, and if any bias was detected, MCO has documentation describing efforts taken to correct for that bias.	Met	Met	Met	Met	Met	Met
The sampling methodology treated all measures independently, and there is no correlation between drawn samples.	Met	Met	Met	Met	Met	Met
Relevant members or providers who were not included in the sample for the baseline measurement had the same chance of being selected for the follow-up measurement as those included in the baseline.	Met	Met	Met	Met	Met	Met
MCO maintains its performance measurement population files/datasets in a manner allowing a sample to be re-drawn, or used as a source for replacement.						
MCO has policies and procedures to maintain files from which samples are drawn in order to keep the population intact in the event that a sample must be re-drawn, or replacements made, and documentation that the original population is intact.	Met	Met	Met	Met	Met	Met
Sample sizes collected conform to the methodology set forth in PM specifications, and the sample is representative of the entire population.						
Samples sizes met the requirements of PM specifications.	Met	Met	Met	Met	Met	Met
MCO appropriately handles the documentation and reporting of the measure if the requested sample size exceeds the population size.	Met	Met	Met	Met	Met	Met
MCO properly over-sampled in order to accommodate potential exclusions.	Met	Met	Met	Met	Met	Met
For PMs that include medical record review, MCO followed proper substitution methodology.						
Substitution applied only to those members who met the exclusion criteria specified in PM definitions or requirements.	Met	Met	Met	Met	Met	Met
MCO made substitutions for properly excluded records and documented the percentage of substituted records.	Met	Met	Met	Met	Met	Met

Performance Measure Denominator Validation

Review Element	Rating					
MCO included all members of the relevant populations identified in PM specifications in the population from which each denominator was produced.						
	BMCHP	**CEL**	**FAL**	**HNE**	**NHP**	**THPP**
MCO included in the initial populations from which the final denominators were produced all members eligible to receive the specified services. This at-risk population included both members who received the services, as well as those who did not receive the services. The same standard applied to provider groups or other relevant populations identified in the specifications of each PM.	Met	Met	Met	Met	Met	Met
Adequate programming logic or source code appropriately identified all relevant members of the specified denominator populations.						
For each PM, MCO appropriately applied according to specifications programming logic or source code identifying, tracking, and linking member enrollment within and across product lines, by age and sex, as well as through any periods of enrollment and disenrollment.	Met	Met	Met	Met	Met	Met
MCO correctly carried out and applied to each applicable PM calculations of continuous enrollment criteria.	Met	Met	Met	Met	Met	Met
MCO used proper mathematic operations to determine patient age or range.	Met	Met	Met	Met	Met	Met
MCO can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate PM denominators, and MCO can explain what classification it carried out if neither of the required codes were present.	Met	Met	Met	Met	Met	Met
MCO correctly calculated member months and member years.						
For each applicable PM, MCO correctly calculated member months and member years.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CEL	FAL	HNE	NHP	THPP
Codes used to identify medical events were complete and accurate, and MCO appropriately applied those codes.						
MCO properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and appropriately identified and applied these codes as specified by each PM.	Met	Met	Met	Met	Met	Met
MCO followed specified time parameters.						
MCO followed any time parameters required by PM specifications; examples include cutoff dates for data collection, or counting 30 calendar days after discharge from a hospital.	Met	Met	Met	Met	Met	Met
MCO followed exclusion criteria in PM specifications.						
MCO followed PM specifications or definitions that excluded members from a denominator. For example, if a PM relates to a specific service, the denominator may have required adjustment to reflect any instances in which the patient refuses the service of the service is contraindicated.	Met	Met	Met	Met	Met	Met

Performance Measure Numerator Validation

Review Element	BMCHP	CEL	FH	HNE	NHP	THPP
MCO used all appropriate data to identify the entire at-risk population.						
MCO used appropriate data, including linked data from separate datasets, to identify the entire at-risk population.	Met	Met	Met	Met	Met	Met
MCO utilized procedures to capture data for those performance indicators that could easily be underreported due to the availability of services outside of the MCO.	Met	Met	Met	Met	Met	Met
MCO properly identified qualifying medical events, such as diagnoses, procedures, and prescriptions, and confirmed those events for inclusion in terms of time and services.						
MCO's use of codes to identify medical events was complete, accurate, and specific in correctly describing what had transpired and when.	Met	Met	Met	Met	Met	Met
MCO correctly evaluated medical event codes when classifying members for inclusion in or exclusion from the numerator.	Met	Met	Met	Met	Met	Met
MCO avoided or eliminated all double-counted members or numerator events.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CEL	FH	HNE	NHP	THPP
MCO adhered to any parameters required by PM specifications (e.g., the measure event occurred during the time period that the PM specified or defined).	Met	Met	Met	Met	Met	Met
MCO made substitutions for properly excluded records and documented the percentage of substituted records.	Met	Met	Met	Met	Met	Met
MCO properly collected medical record data extracted for inclusion in the numerator.						
MCO carried out medical record reviews and abstractions in a manner that facilitated the collection of complete, accurate, and valid data.	Met	Met	Met	Met	Met	Met
Record review staff were properly trained and supervised for the task.	Met	Met	Met	Met	Met	Met
Record abstraction tools required the appropriate notation that the measure event occurred.	Met	Met	Met	Met	Met	Met
Record abstraction tools required notation of the results or findings of the measured event, as applicable.	Met	Met	Met	Met	Met	Met
Data in the record extract files were consistent with data in the medical records as evidenced by a review of a sample of medical records for applicable PMs.	Met	Met	Met	Met	Met	Met
The process of integrating administrative and medical record data for the purpose of determining the numerator was consistent and valid.	Met	Met	Met	Met	Met	Met

Data and Processes to Calculate and Report Performance Measures

Review Element	BMCHP	CEL	FH	HNE	NHP	THPP
MCO has measurement plans and policies stipulating and enforcing documentation of data requirements, issues, validation efforts, and results.						
MCO documented data file and field definitions for each PM.	Met	Met	Met	Met	Met	Met
MCO documented maps to standard coding if not used in the original data collection.	Met	Met	Met	Met	Met	Met
MCO conducted statistical testing of results and made any correction or adjustments after processing.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CEL	FH	HNE	NHP	THPP
MCO has complete documentation of programming specifications (either as a schematic diagram or in narrative form) for each PM.						
MCO documented all data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data, if applicable.	Met	Met	Met	Met	Met	Met
MCO documented detailed medical record review methods and practices, including the qualifications of record review supervisors and staff persons; training materials; tools, including completed copies of each record-level reviewer determination; all case-level critical PM data elements to determine either a positive or negative event, or exclusion; and inter-rater reliability testing procedures and results.	Met	Met	Met	Met	Met	Met
MCO documented detailed computer queries, programming logic, or source code to identify the population or sample for the denominator and/or numerator.	Met	Met	Met	Met	Met	Met
If MCO employed sampling, MCO documented sampling techniques, and documentation that assures the reviewer that MCO chose samples for PM baseline and repeat measurements that used the same sampling frame and methodology.	Met	Met	Met	Met	Met	Met
MCO documented calculations for changes in performance from previous periods, as applicable, including tests of statistical significance.	Met	Met	Met	Met	Met	Met
Data that are related from measure to measure, such as membership counts, provider totals, or number of pregnancies and births, are consistent.	Met	Met	Met	Met	Met	Met
MCO uses appropriate statistical functions to determine confidence intervals when it uses sampling.	Met	Met	Met	Met	Met	Met
When determining improvement in performance between measurement periods, MCO applies appropriate statistical methodology to determine levels of significance of changes.	Met	Met	Met	Met	Met	Met

Data Integration and Control

Review Element	BMCHP	CEL	FH	HNE	NHP	THPP
MCO has in place processes to ensure the accuracy of data transfers to assigned PM repository.						
MCO accurately and completely processes transfer data from transaction files, such as members, provider, and encounter/claims, into the repository used to keep the data until the calculations of the PMs have been completed and validated.	Met	Met	Met	Met	Met	Met
MCO has in place processes to ensure the accuracy of file consolidations, extracts, and derivations.						
MCO's processes to consolidate diversified files, and to extract required information from the PM repository, are appropriate.	Met	Met	Met	Met	Met	Met
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the PM database.	Met	Met	Met	Met	Met	Met
Computer program reports or documentation reflect vendor coordination activities, and no data necessary to PM reporting are lost or inappropriately modified during transfer.	Met	Met	Met	Met	Met	Met
The structure and format of the MCO's PM data repository facilitates any required programming necessary to calculate required PMs.						
The repository's design, program flow charts, and source codes enable analyses and reporting.	Met	Met	Met	Met	Met	Met
MCO employs proper linkage mechanisms to join data from all necessary sources; for example, identifying a member with a given disease/condition.	Met	Met	Met	Met	Met	Met
MCO effectively manages report production and reporting software.						
MCO follows prescribed cutoff dates.	Met	Met	Met	Met	Met	Met
MCO retains copies of files or databases for PM reporting in the case that it must reproduce results.	Met	Met	Met	Met	Met	Met
MCO properly documented reporting software program with respect to every aspect of the PM reporting repository, including building, maintaining, managing, testing, and report production.	Met	Met	Met	Met	Met	Met
MCO's processes and documentation comply with its standards associated with reporting program specifications, code review, and testing.	Met	Met	Met	Met	Met	Met
MCO followed specified time parameters.						
MCO followed any time parameters required by PM specifications, such as cutoff dates for data collection or counting 30 calendar days after discharge from a hospital.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CEL	FH	HNE	NHP	THPP
MCO followed exclusion criteria included in PM specifications.						
MCO follows PM specifications of definitions that exclude eligible members from a denominator. For example, if a measure relates to a select age group, the denominator may need to be adjusted to reflect only those members within that age group.	Met	Met	Met	Met	Met	Met

RESULTS

Antidepressant Medication Monitoring

The charts below depict MCO performance on the Antidepressant Medication Monitoring performance measure. The NCQA National Medicaid Quality Compass 90th percentile rate is included for comparison purposes. THPP's rates were the highest for both measures (58.09 percent for AMM Acute Treatment and 45.15 percent for the Continuous Treatment rate). HNE's performance was the lowest for both measures (42.55 percent for Acute and 28.05 percent for Continuous Treatment). No plan's performance equaled or surpassed the HEDIS 90th percentile. The weighted average AMM Acute rate was 50.62 percent; the weighted average AMM Continuous rate was 35.64 percent. Of concern, HNE's performance in both rates is between the 5th – 10th percentile and is trending down. Fallon's AMM Continuous Treatment rate is also between the 5th – 10th percentile and trending down.

Exhibit 4: HEDIS 2017 AMM Acute Rate by MCO

Exhibit 5: HEDIS 2017 AMM Continuous Treatment Rates by MCO

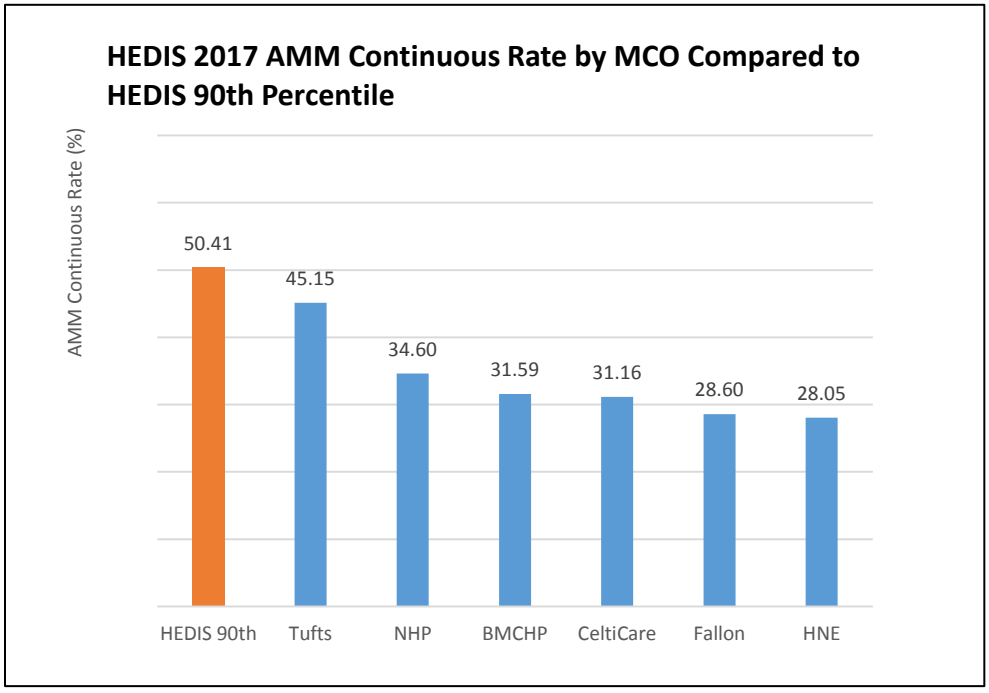


Exhibit 6: Trended AMM Acute Treatment Rates

		HEDIS 2013	HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017	Linear Performance Trend Line	2017 QC Percentile Ranking
AMM Acute (%)	**HEDIS 90th**	**61.03**	**59.92**	**62.56**	**67.57**	**64.15**		
	BMCHP	44.94	42.35	44.25	44.85	44.74	↔	10th – 25th
	CeltiCare	-	-	44.21	43.88	47.56	↑	10th – 25th
	Fallon	52.14	38.80	51.23	49.73	51.74	↑	33rd – 50th
	HNE	51.19	39.81	47.11	46.12	42.55	↓	5th – 10th
	NHP	46.51	45.71	48.47	48.96	50.93	↑	33rd – 50th
	Tufts	56.62	56.30	58.01	55.37	58.09	↔	75th – 90th

Exhibit 7: Trended AMM Continuous Treatment Rates

		HEDIS 2013	HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017	Linear Performance Trend Line	2017 QC Percentile Ranking
AMM Continuous (%)	**HEDIS 90th**	**45.86**	**44.08**	**48.39**	**54.30**	**50.41**		
	BMCHP	32.41	28.92	30.02	30.97	31.59	↔	10th – 25th
	CeltiCare	-	-	30.99	29.69	31.16	↔	10th – 25th
	Fallon	37.86	22.00	32.43	26.67	28.60	↓	5th – 10th
	HNE	35.71	28.64	32.63	29.93	28.05	↓	5th – 10th
	NHP	31.91	31.24	33.61	33.77	34.60	↑	33rd – 50th
	Tufts	44.94	43.17	44.17	41.42	45.15	↔	75th – 90th

Exhibit 8: 2017 NCQA Quality Compass AMM Percentiles

Acute Treatment Rate

5th	10th	25th	33rd	50th	66th	75th	90th	95th
42.17	44.5	48.22	49.41	51.9	54.5	57.14	64.15	66.67

Continuous Treatment Rate

5th	10th	25th	33rd	50th	66th	75th	90th	95th
25.78	29.07	32.58	33.91	36.21	39.34	41.29	50.41	55.22

Annual Monitoring for Patients on Persistent Medications

The chart that follows depicts 2017 MCO performance on the measure, "Annual Monitoring for Patients on Persistent Medications (MPM)." 2017 is the first year in which this measure was validated. None of the MCOs achieved the NCQA Quality Compass 90th percentile. The weighted average performance rate was 86.32 percent, the high being 88.47 percent (Fallon) and the low being 81.00 percent (CeltiCare).

Exhibit 9: HEDIS 2017 MPM Rate by MCO

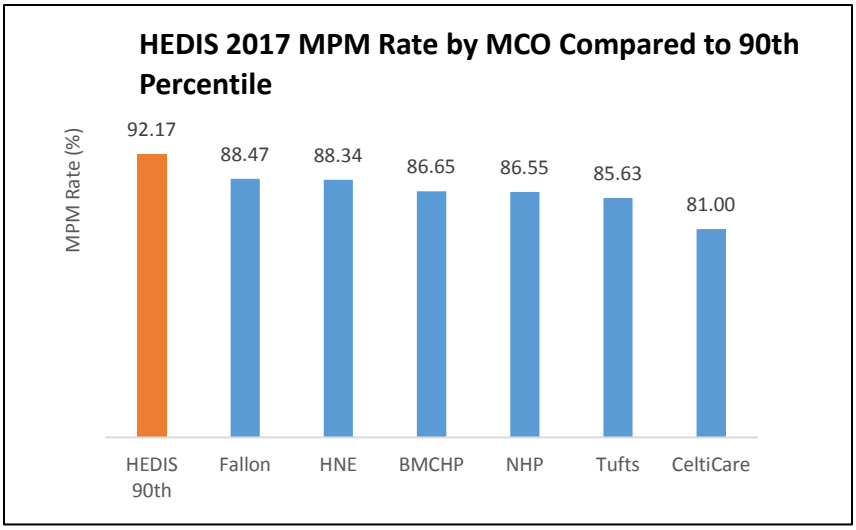


Exhibit 10: 2017 NCQA Quality Compass MPM Percentiles

5th	10th	25th	33rd	50th	66th	75th	90th	95th
82.22	83.67	85.58	86.32	87.38	88.99	89.98	92.17	93.38

Postpartum Visit Rates

The chart that follows depicts 2017 MCO performance on the Postpartum Visit component of the HEDIS measure "Prenatal Care." BMCHP's performance was approximately one percentage point below the NCQA Quality Compass 90th percentile. The weighted average rate was 69.42 percent, the high being 72.59 percent (BMCHP) and the low being 65.79 percent (Neighborhood Health Plan).

Exhibit 11: HEDIS 2017 Postpartum Visit Rates by MCO

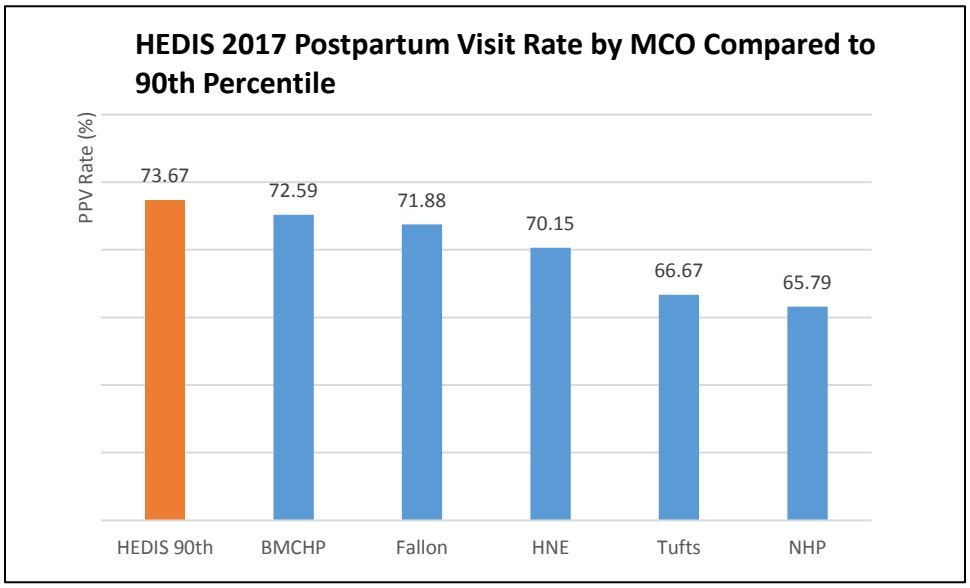


Exhibit 12: Trended PPV Rate by MCO

		HEDIS 2013	HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017	Linear Performance Trend Line	2017 QC Percentile Ranking
PPV Rate (%)	**HEDIS 90th**	**73.83**	**74.03**	**72.43**	**73.61**	**73.67**		
	BMCHP	67.71	69.58	71.55	66.94	72.59	↑	75th – 90th
	Fallon	73.83	76.63	64.92	73.39	71.88	↓	75th – 90th
	HNE	-	76.03	79.92	72.27	70.15	↓	75th – 90th
	NHP	67.65	65.85	67.29	68.19	65.79	↔	50th – 66th
	Tufts	76.64	75.61	70.31	73.85	66.67	↓	50th – 66th

Exhibit 13: 2017 NCQA Quality Compass PPV Percentiles

5th	10th	25th	33rd	50th	66th	75th	90th	95th
45.76	51.74	59.59	61.07	64.38	67.75	69.44	73.67	75.74

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

CMS regulations require that each managed care entity also undergo an annual 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 of this assessment follow.

Exhibit 14: Information Systems Capability Assessment Findings

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

RECOMMENDATIONS

KEPRO did not identify any significant issues related to the results of the Performance Measure Validation process. Five of six plans received a recommendation to focus on quality improvement initiatives for measures for which their rates were either less than 50 percent or were below the 25th percentile. Other recommendations were very specific to individual plan circumstances. For example, it was recommended to CeltiCare that it implement a process to ensure that enrollment spans for members covered under the same organization ID number through NCQA are considered when determining continuous enrollment calculations. Another

example was the recommendation made to Health New England to develop a new process to retrieve medical records due to the plan's low retrieval rate from provider offices.

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION AND INFORMATION SYSTEM CAPABILITIES ANALYSES

BOSTON MEDICAL CENTER HEALTHNET (BMCHP)

Performance Measure Results

The charts below depict Boston Medical Center HealthNet's performance in the three measures selected by MassHealth for validation. The NCQA Medicaid Quality Compass 90th percentile is included for comparison purposes.

Antidepressant Medication Management (AMM) - The charts below depict BMCHP's performance for the Acute and Continuous AMM measure. BMCHP's 44.74 percent HEDIS 2017 rate represents a statistically insignificant 0.25 percent decrease from its 2016 44.85 percent rate. There is an almost 20-point difference between the NCQA Medicaid Quality Compass 90th percentile and BMCHP's 2017 rate. The AMM Continuous rate, 31.59 percent, is a statistically insignificant decrease of 2.01 percent from the 30.97 percent 2016 rate. Again, this is an almost 20-point difference from the Quality Compass 90th percentile. Both AMM rates rank between the 10th and 25th percentiles compared to the Quality Compass.

Exhibit 15: BMCHP AMM Acute Treatment Rates

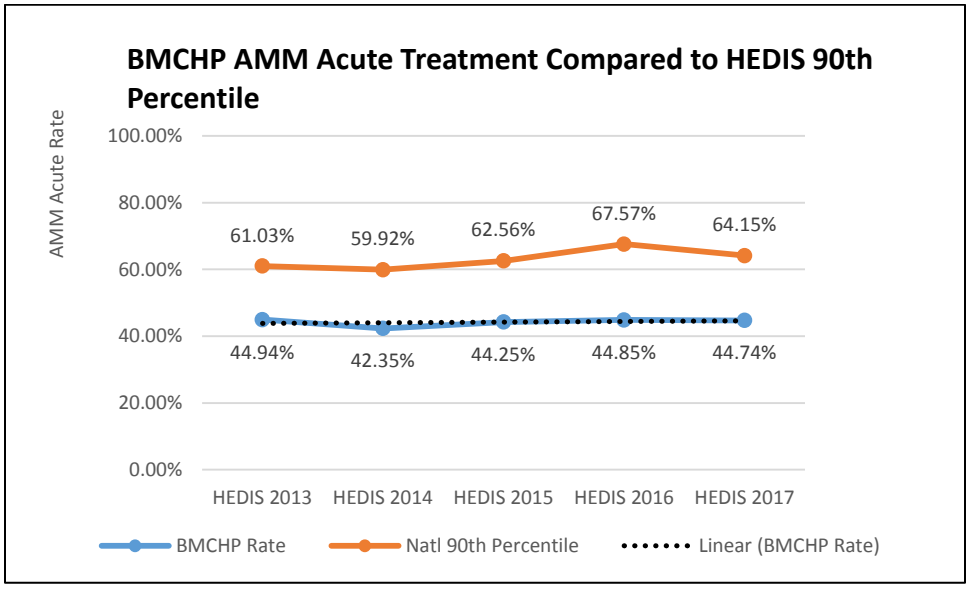
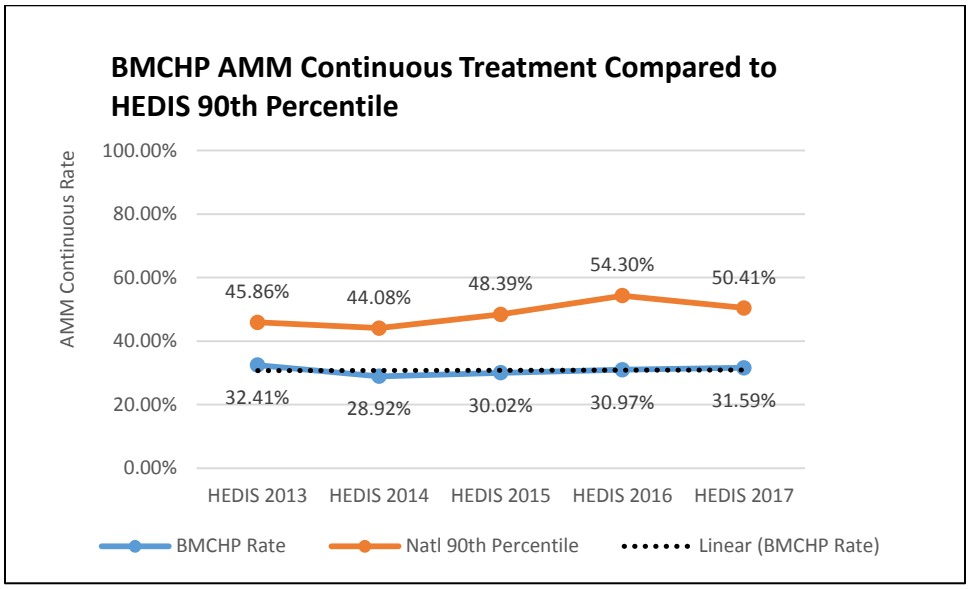
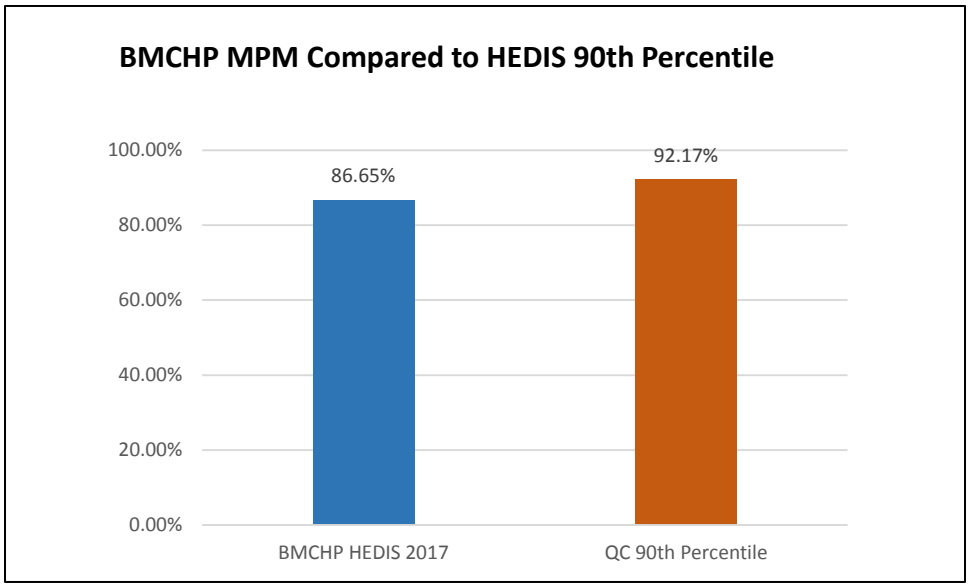


Exhibit 16: BMCHP AMM Continuous Treatment Rates



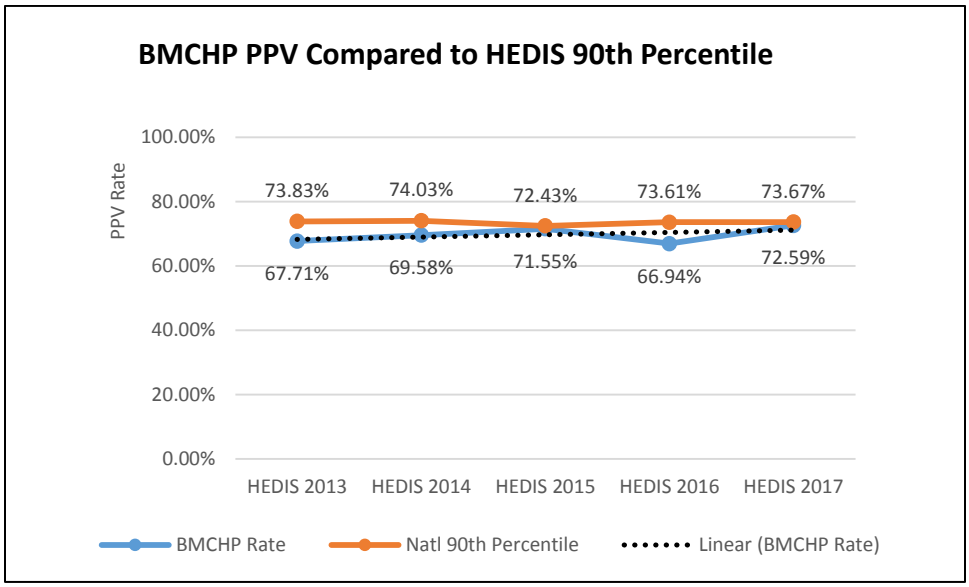
Annual Monitoring for Patients on Persistent Medications (MPM) – 2017 was the first year in which the MPM measure was selected by MassHealth for performance measure validation. In HEDIS 2017, BMCHP's 86.65 percent rate ranks between the 33rd and 50th NCQA Medicaid Quality Compass percentiles.

Exhibit 17: BMCHP MPM Rate



The Postpartum Visit Component of Prenatal Care (PPC) – BMCHP's performance in the postpartum care measure increased a statistically significant 8.53 percent ($p < 0.05$) between HEDIS 2016 and HEDIS 2017 from 66.94 percent to 72.59 percent. BMCHP's performance ranks between the 75th and 90th percentiles of the NCQA Medicaid Quality Compass.

Exhibit 18: BMCHP PPV Rate



Information Systems Capabilities Analysis

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of BMCHP's information system that contribute to performance measure production.

- 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. Since maternity services were often billed globally, the plan relied on medical record review to accurately report the Postpartum Care performance measure. BMCHP had adequate quality control and monitoring of claims processing. BMCHP received encounters on a weekly basis from both its pharmacy benefits manager, Envision Rx, and its behavioral health vendor, Beacon Health Options. The plan maintained adequate oversight of both Beacon and Envision Rx. 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

enrollment 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 through the use of a master member ID. There were no issues identified with the plan's enrollment processes.

- Medical Record Review
  Inovalon's software (QSI and QSHR) was used to produce the postpartum component of the Prenatal and Postpartum Care measure. No issues were identified with medical record review for the postpartum measure.

- Supplemental Data
  None of the plan's supplemental data sources contributed to the performance measure rates. Therefore, this section is not applicable.

- Data Integration
  BMCHP's performance measure rates were produced in-house 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 QSI-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' rates and to 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.

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

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Boston Medical Center HealthNet, the results of which were distributed on July 10, 2017:

Exhibit 19: BMCHP Final Audit Results

Audit Element	Findings
Medical data	BMCHP met requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Practitioner data	Practitioner data related to performance measure production were adequate to support reporting.
Medical record review	Inovalon's software (QSI and QSHR) was used to produce the postpartum component of the Prenatal and Postpartum Care measure. No issues were identified with medical record review for the postpartum measure.
Supplemental Data	Supplemental data processes and procedures were adequate and met technical specifications.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
Consider improving data streams to include more frequent receipt of data from large provider groups. Develop standard format to be used for EMR data from multiple provider groups.	EMR data was not used for HEDIS reporting.
Improve medical record data retrieval processes.	Medical record data retrieval was compliant for HEDIS 2017.
Continue to collaborate with Beacon Health Options.	Plan continued to collaborate with Beacon Health Options.
Determine if recent interventions contribute to positive rate trends for performance measures.	Interventions should be enhanced, as two of the three PMV measures had rates below the 50th percentile compared to the Quality Compass Medicaid data.

Plan Strengths

- BMCHP used an NCQA-certified vendor.
- BMCHP staff continued to demonstrate a thorough understanding of the HEDIS process.
- All documents required for this review were submitted in a timely manner.

Opportunities

- Rates for both the acute and continuation components of the Antidepressant Medication Management measure were below the NCQA Medicaid Quality Compass 50th percentile.
- Annual Monitoring for Patients on Persistent Medications performance was also under the NCQA Medicaid Quality Compass 50th percentile.

Recommendations

- Focus on quality improvement initiatives for the Antidepressant Medication Management measure.
- Focus on quality improvement initiatives for the Annual Monitoring for Patients on Persistent Medications measure.
- Medical record review accuracy rates should be improved for HEDIS 2018 reporting.

CELTICARE

Performance Measure Results

The charts below depict CeltiCare's performance in the three measures selected by MassHealth for validation. The NCQA National Medicaid Quality Compass 90th percentile is included for comparison purposes.

Antidepressant Medication Monitoring (AMM) – CeltiCare's AMM Acute Treatment rate of 47.56 percent in HEDIS 2017 reflects a statistically insignificant increase of 8.38 percent from its 2016 43.88 percent rate. The HEDIS 2017 31.16 percent Continuous Treatment rate represents a statistically insignificant 4.96 percent increase from the 29.69 percent 2016 rate. Both rates fall between the 10th and 25th Quality Compass percentiles and have experienced a relatively flat trend line.

Exhibit 20: CeltiCare AMM Acute Treatment Rates

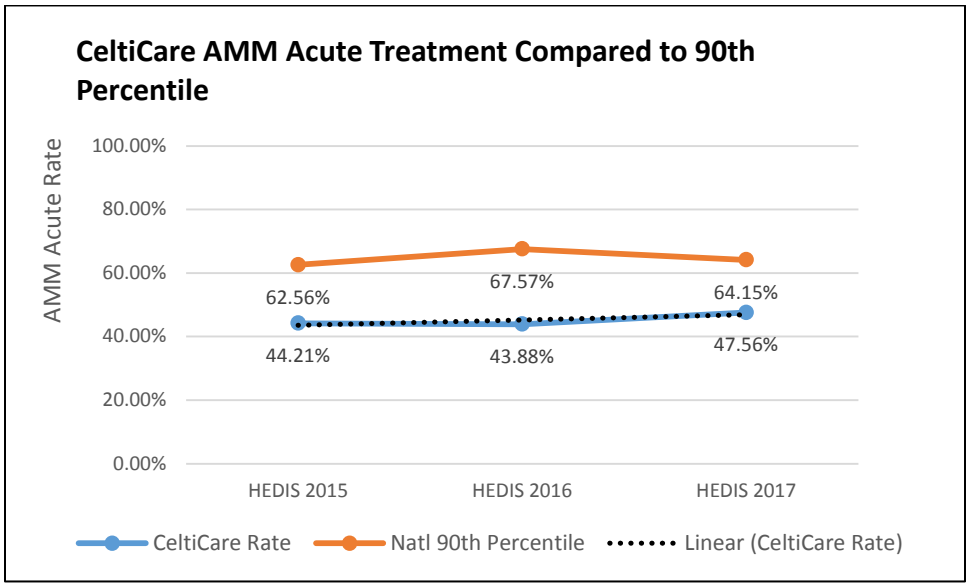
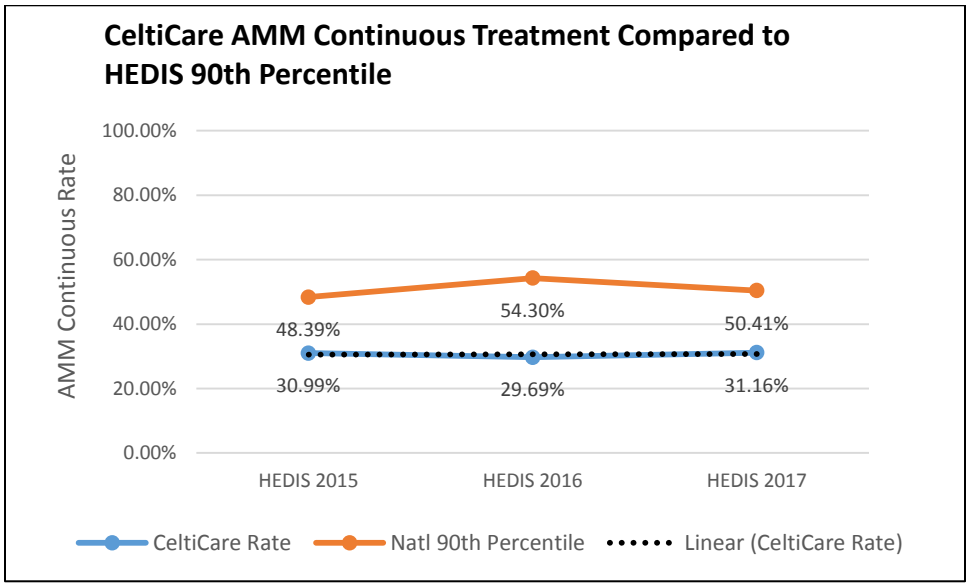


Exhibit 21: CeltiCare AMM Continuous Treatment Rates



Controlled Blood Pressure (CBP) – CeltiCare's CBP rate increased a statistically significant ($p < 0.01$) 14.37 percent from the HEDIS 2016 59.07 percent rate to the 2017 67.56 percent. CeltiCare's performance ranks between the 75th and 90th percentiles of the NCQA Quality Compass.

Exhibit 22: CeltiCare CBP Rates

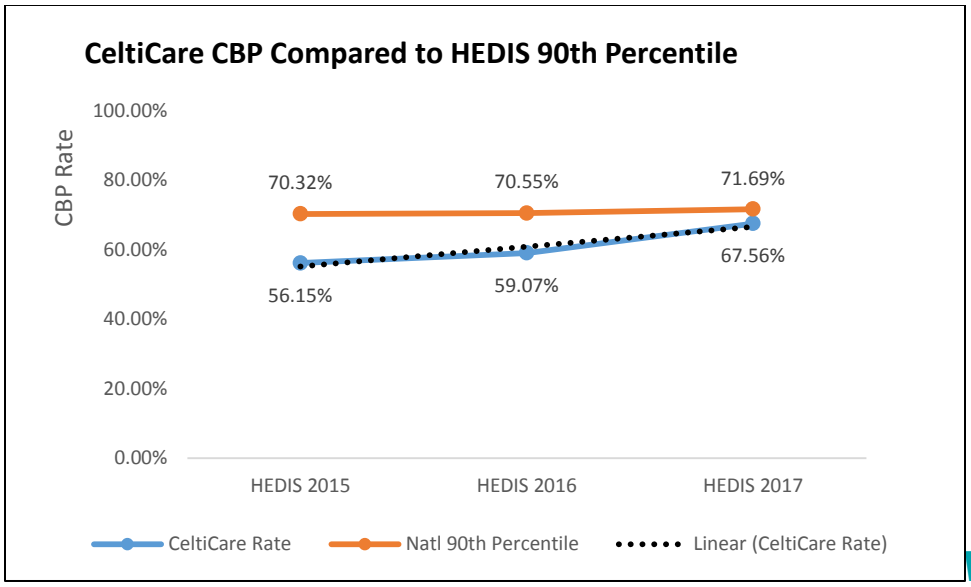
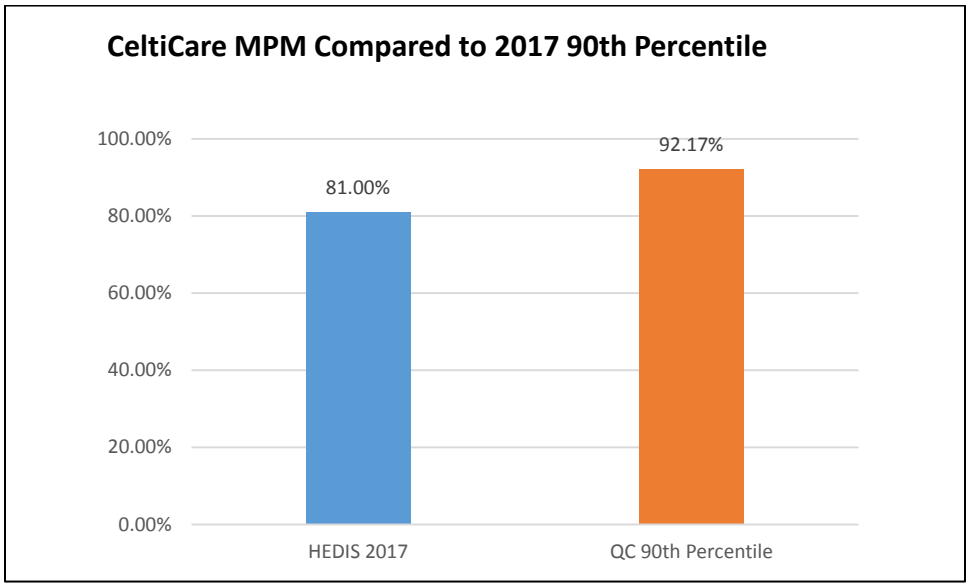


Exhibit 23: 2017 NCQA Quality Compass CBP Percentiles

5th	10th	25th	33rd	50th	66th	75th	90th	95th
35.88	39.9	47.69	51.33	56.93	63.11	64.79	71.69	74.21

Annual Monitoring for Patients on Persistent Medications (MPM) – 2016 was the first year in which the MPM measure was selected by MassHealth for performance measure validation. In HEDIS 2017, CeltiCare's 81.00 percent rate is below the 5th NCQA Medicaid Quality Compass percentile.

Exhibit 24: CeltiCare MPM Rates



Information Systems Capabilities Analysis

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of CeltiCare information system that contribute to performance measure production.

- Claims and Encounter Data
  CeltiCare processed claims using AMISYS Advance (AMISYS). All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. CeltiCare only accepted claims submitted on standard claims forms. Claims processing timeframes met timeliness thresholds. CeltiCare had a high rate of electronic claims submissions through a clearinghouse which had appropriate claims edits before being loaded into AMISYS. CeltiCare had reconciliation processes for electronic claim submissions using claims counts. CeltiCare auto-adjudicated approximately 90 percent of claims for its MCO population. CeltiCare had sufficient claims edits in AMISYS as well as through Emdeon. For the small volume of paper claim submissions, CeltiCare handled the processing in-house by its centralized paper claims processing center in Farmington,

Missouri. All paper claims were turned into electronic data interchange (EDI) claims using optical character recognition (OCR) software and there was adequate accuracy reports and oversight of the scanning process.

CeltiCare used Cenpatico Behavioral Health (Cenpatico), under the Centene corporation umbrella, to process behavioral health claims. Cenpatico used AMISYS to process behavioral health claims using all standard codes, standard claims forms, and capture of all required fields. Cenpatico did not have any capitated behavioral health arrangements in place; therefore, there were no concerns with data completeness from Cenpatico. CeltiCare used US Scripts, also under the Centene corporation umbrella, to process pharmacy claims. Pharmacy claims data were received daily from US Scripts and loaded to Centene's data warehouse, EDW. While both Cenpatico and US Scripts were considered sister organizations to CeltiCare under the Centene umbrella, CeltiCare managed both entities as vendors with sufficient oversight including the use of joint operating committees.

There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

- Enrollment Data
  CeltiCare processed Medicaid enrollment data using AMISYS. 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 CeltiCare. The daily file included additions, changes, and terminations were loaded into UnifyMemberView and then through an automated feed into CeltiCare's enrollment system, AMISYS. CeltiCare also received a full monthly refresh file and conducted reconciliation between AMISYS and the State file. AMISYS retained the Medicaid identification (ID) number as well as a unique plan ID. CeltiCare had adequate data quality-monitoring and reconciliation processes.

  KEPRO identified that CeltiCare maintained its Marketplace population separately from its Medicaid population; therefore, member enrollment spans for members who switched product lines from Marketplace to Medicaid were not used to calculate continuous enrollment, which violated NCQA's continuous enrollment HEDIS General Guideline 23. The guideline indicates that members who enrolled in different products or product lines in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the product and product-line specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period. KEPRO confirmed with NCQA that this guideline included the Marketplace product line. KEPRO determined that the number of members moving between product lines would not bias performance measure rates for CY 2016. CeltiCare; however, needs to implement a process to ensure that enrollment spans for members covered under the same organization ID number through NCQA are considered when determining continuous enrollment calculations.

- Provider Data
  CeltiCare had processes in place to capture provider specialty within its provider credentialing system, Portico, which fed the AMISYS system. There were no concerns with the capture of provider data information.

- Medical Record Review
  CeltiCare used Inovalon software to produce the Controlling High Blood Pressure measure. The CBP data abstraction tool and training materials were found to be compliant with the HEDIS technical specifications. No issues were identified with the medical record review process.

- Supplemental Data
  CeltiCare used LabCorp data as a standard supplemental data source to capture lab test and results. The plan's Roadmap submission to KEPRO and the HEDIS 2017 Final Audit Report indicated that supplemental data did not impact the MPM measure. LabCorp data; however, resulted in one numerator-positive case for the MPM measure. CeltiCare needs to ensure that future Roadmap submissions and the final audit report correctly indicate which HEDIS measures were affected by the use of supplemental data.

- Data Integration
  CeltiCare's performance measure rates were produced using Inovalon's software. Data from the transaction system were loaded to CeltiCare's data warehouse nightly. US Script data feeds were loaded into the warehouse upon receipt. Data were then formatted into Inovalon-compliant extracts and loaded into the measure production software. CeltiCare had adequate processes to track completeness and accuracy of data at each transfer point. Data transfers to the Inovalon repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. 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 reviewed and any variances investigated. CeltiCare maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes apart from the enrollment issue noted above.

- Source Code
  CeltiCare 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.

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on CeltiCare, the results of which were distributed on July 10, 2017:

Table 25: CeltiCare Final Audit Results

Audit Element	Findings
Medical data	CeltiCare met all requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met HEDIS standards.
Practitioner data	Practitioner data related to performance measure production was adequate to support reporting.
Medical record review	Medical record tools, training materials, medical record process, and quality-monitoring met requirements.
Supplemental Data	Supplemental data processes and procedures were adequate and met technical specifications.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Follow Up to Calendar Year 2016 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on 2016 PMV recommendation follows:

Calendar Year 2016 Recommendation	2017 Status
Implement a process for Roadmap review to ensure information is representative of the MassHealth MCO population.	The same issue is still present in the HEDIS 2017 Roadmap. This recommendation stands.
Conduct root-cause analysis to determine factors that contributed to the sub-optimal performance for both AMM measure indicators and implement specific interventions to increase performance.	This recommendation stands. The plan ranks between the 10th and 25th percentiles compared to the Quality Compass on the AMM measure for both indicators.
CeltiCare staff should familiarize themselves with relevant corporate processes.	This recommendation stands.
CeltiCare must implement a process to adhere to NCQA cross-product continuous enrollment requirements.	This recommendation stands.

Plan Strengths

- CeltiCare used an NCQA-certified vendor.

- CeltiCare had local staff members knowledgeable about its MCO population and historical changes.

Opportunities

- The HEDIS Roadmap and Final Audit Report do not accurately indicate which HEDIS measures were affected by the use of supplemental data.
- Both numerators of the Antidepressant Medication Management measure ('Effective Acute Phase Treatment' and 'Effective Continuation Phase Treatment') were under the 50th percentile compared to Quality Compass Medicaid data.
- The Annual Monitoring for Patients on Persistent Medications measure was under the 50th percentile compared to the Quality Compass Medicaid data.

Recommendations

- Become compliant with HEDIS General Guideline 23 related to continuous enrollment calculation.
- Focus on quality improvement initiatives for the Antidepressant Medication Management measure.
- Focus on quality improvement initiatives for the Annual Monitoring for Patients on Persistent Medications measure.

FALLON HEALTH

Performance Measure Results

The charts below depict Fallon Health MCO performance in the three measures selected by MassHealth for validation. The NCQA Medicaid Quality Compass 90th percentile is included for comparison purposes.

Antidepressant Medication Monitoring (AMM) - Fallon Health's MCO's AMM Acute Treatment rate increasesd a statistically insignificant 4.03 percent between HEDIS 2016 and 2017, from 49.73 percent to 51.74 percent. The Continuous rate increased 7.23 percent from 26.67 percent in HEDIS 2016 to 28.60 percent in HEDIS 2017. This change was also statistically insignificant. The Acute rate ranks between the 33rd and 50th percentiles NCQA National Medicaid Quality Compass. The Continuous rate is between the 5th and 10th percentiles.

Exhibit 26: Fallon AMM Acute Treatment Rates

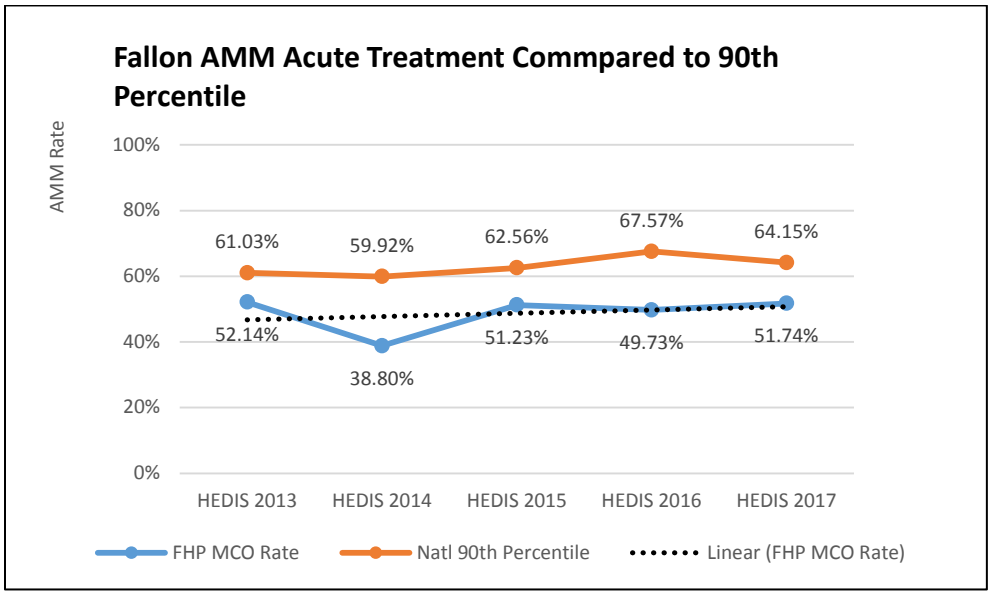
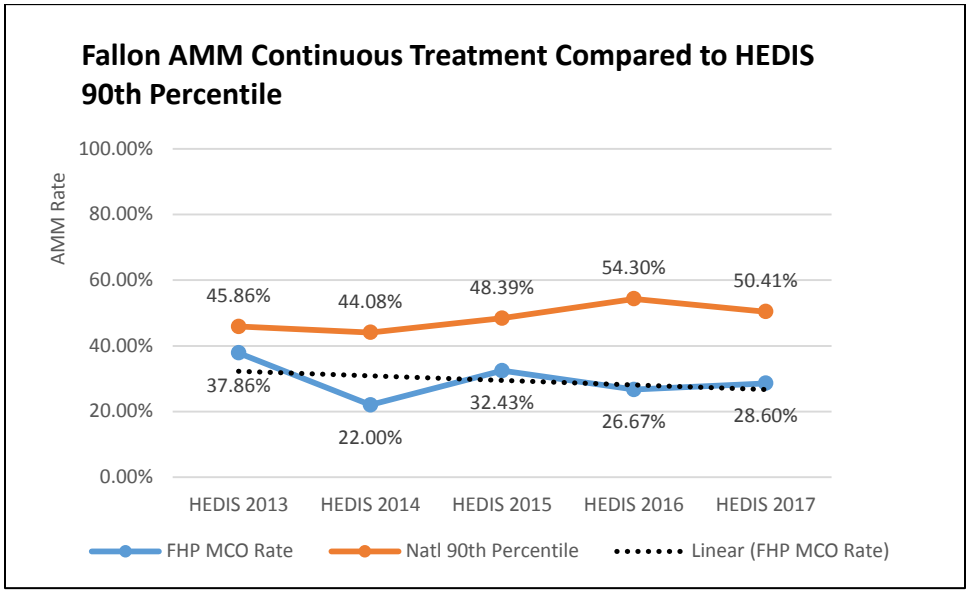
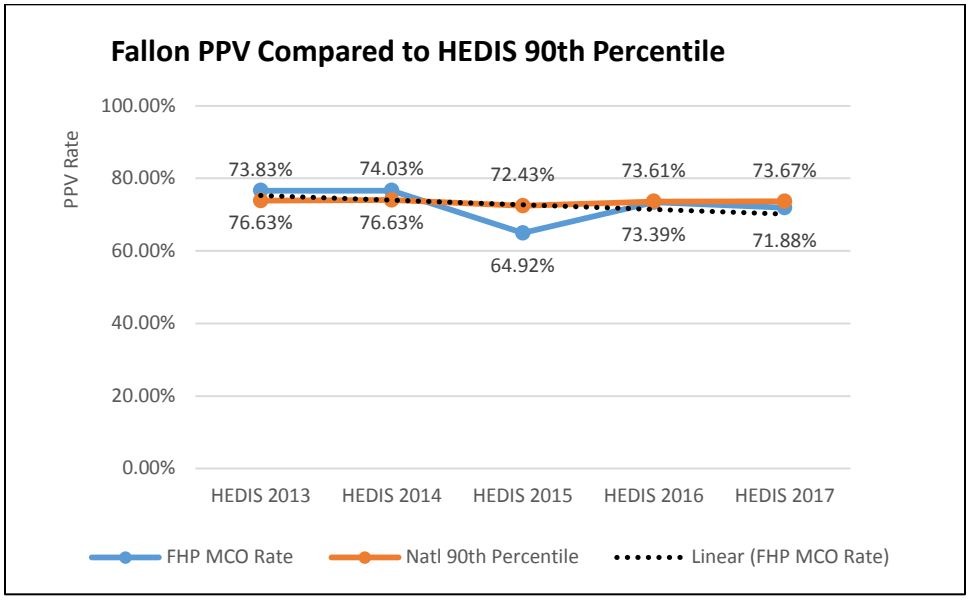


Exhibit 27: Fallon AMM Continuous Treatment Rates



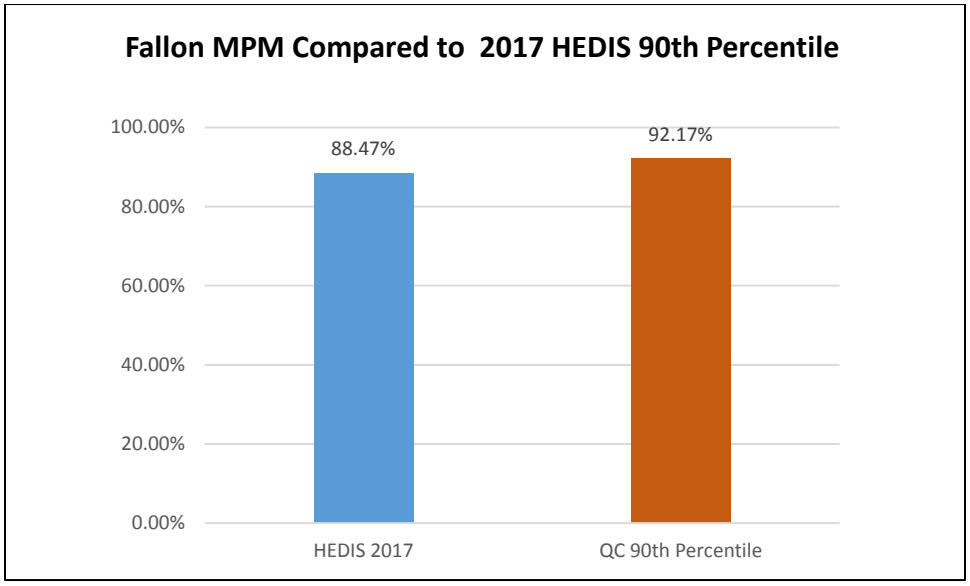
Postpartum Visit Rate (PPV) - Fallon Health MCO's Postpartum Visit rate decreased a statistically insignificant 2.06 percent between HEDIS 2016 and 2017 from 73.99 percent to 71.88 percent. The five-year performance trend line is downward. Fallon Health's performance lies between the 75th and 90th percentiles of the NCQA National Medicaid Quality Compass.

Exhibit 28: Fallon PPV Rates



Annual Monitoring for Patients on Persistent Medications (MPM) – 2017 was the first year in which the MPM measure was selected by MassHealth for performance measure validation. In HEDIS 2017, Fallon Health's 88.47 percent is between the 50th and 66th NCQA Medicaid Quality Compass percentiles.

Exhibit 29: Fallon MPM Rates



Information Systems Capabilities Analysis

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

- Claims and Encounter Data
  Claims were processed using the QNXT system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Fallon Health had processes in place to closely monitor encounter submission to ensure complete data receipt. Claims lag reports also demonstrated that claims were submitted in a timely manner. Internal claims quality-monitoring processes were adequate. Fallon received encounters on a weekly basis from its behavioral health vendor, Beacon Health Options, and on a daily basis from its pharmacy benefits manager, CVS Caremark. The plan maintained adequate oversight of both Beacon and Caremark. There were no issues identified with claims or encounter data processing.

- Enrollment Data
  Fallon Health processed Medicaid enrollment data using the QNXT system. All necessary enrollment fields are captured for HEDIS reporting. The plan received a daily 834 file from MassHealth. There were adequate data quality-monitoring and reconciliation processes, including the ability to combine data for members with more than one member identification number. Both vendors, Beacon Health Options and Caremark, received daily files with changes in enrollment, with monthly full data files transmitted for reconciliation. There were no issues identified with enrollment processes.

- Medical Record Review
  Fallon Health used internally developed source code to produce performance measures. Data abstraction tools and training materials developed by the plan were compliant with HEDIS technical specifications. Fallon Health had 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
  A standard supplemental data source, lab results, were demonstrated to have had an effect on the MCO performance measure rate for the AMM measure. The supplemental data source met the HEDIS technical specifications. There were no issues with supplemental data.

- Data Integration
  All data from the transaction system and the vendors were stored in the plan's data warehouse. The warehouse is refreshed nightly. Fallon had adequate processes for ensuring data completeness and referential integrity within the data warehouse. Internally developed source code was used to produce the performance measures. Findings specific to source code are discussed below. There was a peer review process to check the accuracy of the source code and to ensure that all technical updates were included. Fallon reviewed preliminary rates thoroughly at multiple levels within the organization. There were no issues identified with data integration processes.

- Source Code
  Fallon produced performance measures using internally developed source code. Source code was reviewed for consistency with the HEDIS technical specifications. The source code for each PMV measure was found to be compliant.

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Fallon Health, the results of which were distributed on July 10, 2017:

Exhibit 30: Fallon Health Final Audit Results

Audit Element	Findings
Medical data	Fallon met requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Practitioner data	Practitioner data related to performance measure production is adequate to support reporting.
Medical record review	Medical record tools, training materials, medical record process, and quality monitoring met requirements. Fallon Health passed Medical Record Review Validation.
Supplemental Data	Supplemental data processes and procedures were adequate and met technical specifications.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Follow Up to Calendar Year 2016 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2016 PMV recommendation follows:

Calendar Year 2016 Recommendation	Update
Continue to work with provider groups to receive and incorporate electronic medical record (EMR) data.	Fallon has continued to work with provider groups to receive and incorporate EMR data.
Work with hospital clinics to ensure that attending provider information is populated on UB claims submission forms.	Fallon's claims processing fully met HEDIS 2017 standards.
Consider increasing IRR and IQC activities to mitigate risk of MRRV process.	MRRV processes were not altered, however no issues were noted with HEDIS 2017 MRR activities.
Continue to collaborate with Beacon Health Options.	Fallon collaborated with Beacon Health Options related to plan HEDIS measures.

Plan Strengths

- Fallon Health staff have excellent understanding of HEDIS processes.
- Thorough documentation supplied for review.
- Daily refresh of data warehouse, including pharmacy data, allow near real-time access to data for analysis and improvement.

Opportunities

- Both the Acute and Continuous Treatment components of the Antidepressant Medication Management rate were below the 2017 Quality Compass 50th percentile.

Recommendations

- KEPRO has no recommendations.

HEALTH NEW ENGLAND (HNE)

Performance Measure Results

The charts that follow below depict Health New England's performance in the three measures selected by MassHealth for validation. The NCQA Medicaid Quality Compass 90th percentile is included for comparison purposes.

Antidepressant Medication Management (AMM) – Health New England's AMM Acute Treatment rate decreased a statistically significant 7.75 percent from 46.12 percent in HEDIS 2016 to 42.55 percent in HEDIS 2017 ($p < 0.05$). The Continuous Treatment rate also decreased, but the 6.30 percent decrease from 29.93 percent to 28.05 percent was not statistically significant. Both AMM rates fall between the 5th and 10th percentiles of the NCQA National Medicaid Quality Compass and both are trending downward.

Exhibit 31: HNE AMM Acute Treatment Rates

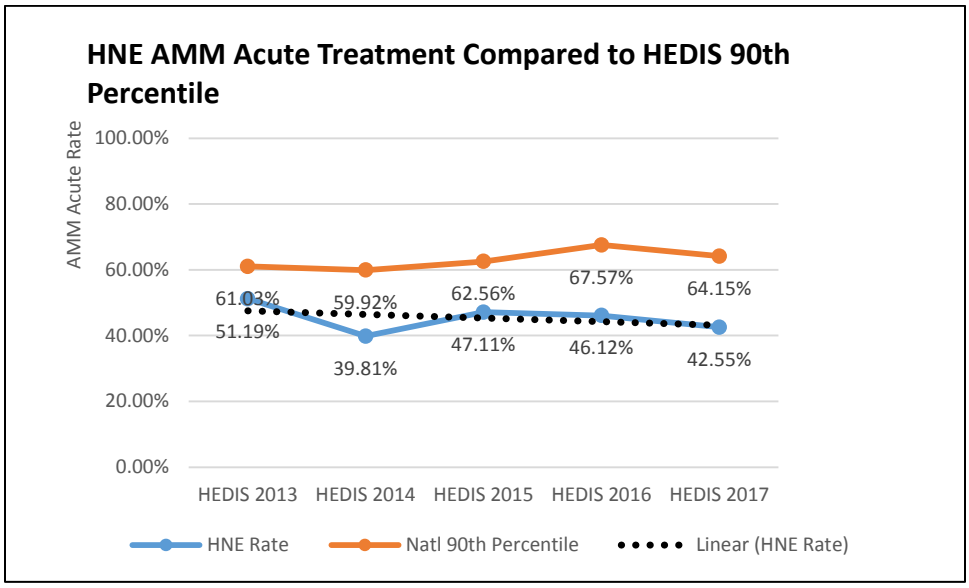
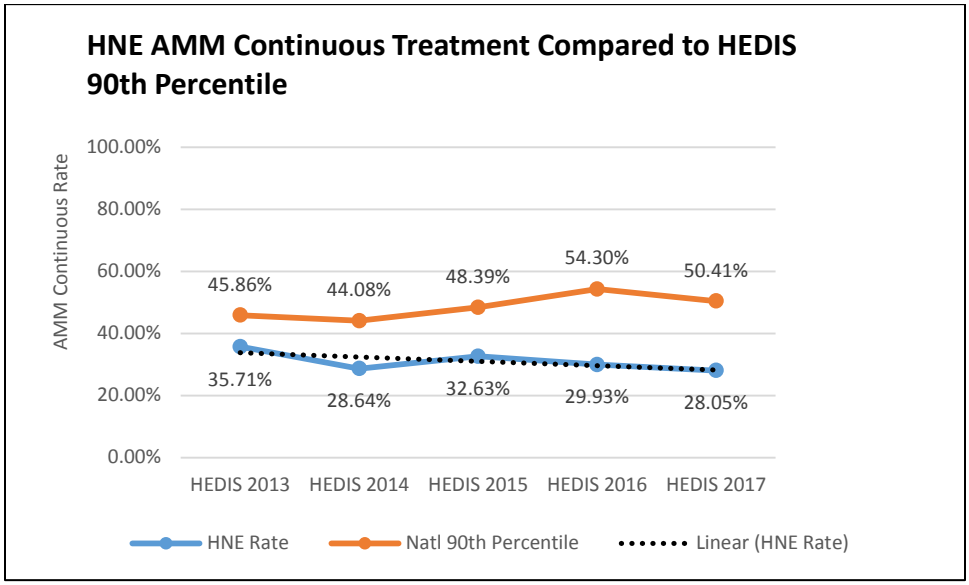
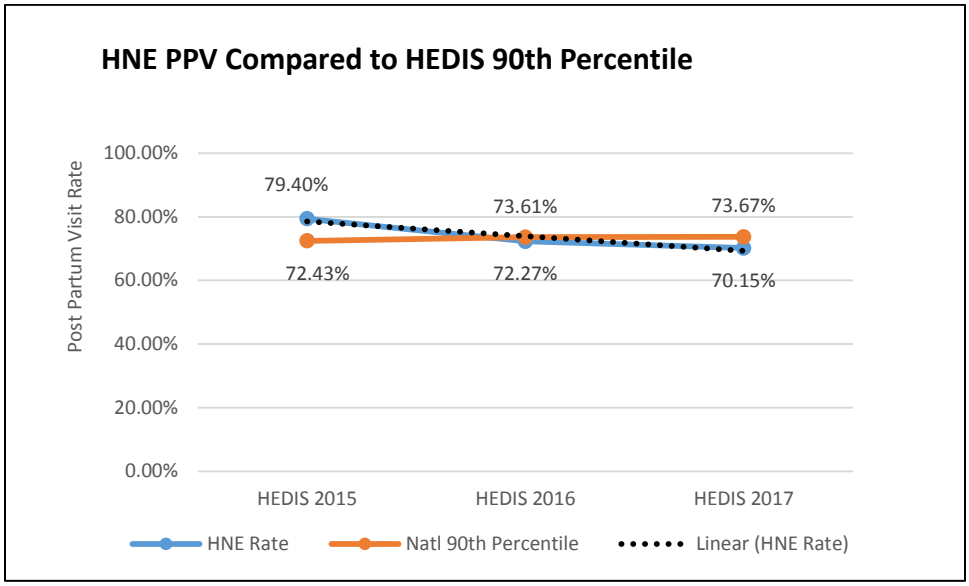


Exhibit 32: HNE AMM Continuous Treatment Rates



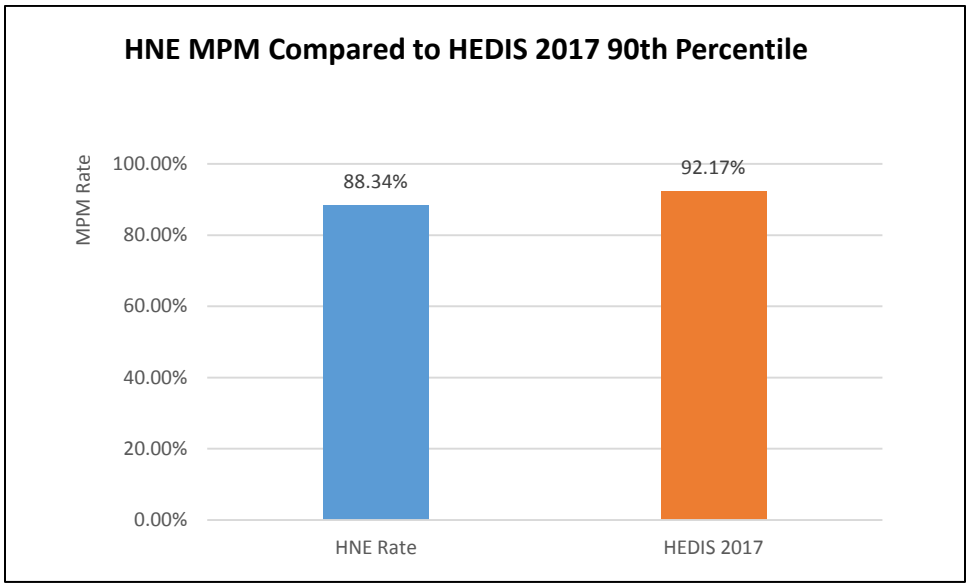
Postpartum Visit Rate (PPV) – Health New England's Postpartum Visit decreased a statistically insignificant 2.94 percent between HEDIS 2016 (72.27%) and HEDIS 2017 (70.15%). Health New England's performance ranks between the 75th and 90th percentiles of the NCQA National Medicaid Quality Compass.

Exhibit 33: HNE PPV Rates



Annual Monitoring for Patients on Persistent Medications (MPM) - 2017 was the first year in which the MPM measure was selected by MassHealth for performance measure validation. In HEDIS 2017, Health New England's MPM rate of 88.34 percent is between the 50th and 66th NCQA Medicaid Quality Compass percentiles.

Exhibit 34: HNE MPM Rates



Information Systems Capabilities Analysis

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of Health New England's information system that contribute to performance measure production.

- Claims and Encounter Data
  Claims were processed using the AMISYS system. All necessary fields were captured for HEDIS reporting. It was confirmed during the audit process that although a small percentage of services were billed using non-standard codes, these services were not pertinent to the performance measures. Since maternity services were primarily billed globally, the plan continued to rely on medical record review to accurately report the Postpartum Care performance measure. HNE had adequate quality control and monitoring of internal claims processing. HNE received encounters from its behavioral health delegate, MBHP, monthly, and from its pharmacy benefits manager, Optum Rx, twice a month. The plan maintained adequate oversight of both vendors. There were no issues identified with claims or encounter data processing.

- Enrollment Data
  HNE processed Medicaid enrollment data, using the AMISYS system. All necessary enrollment fields are captured for HEDIS reporting. Medicaid enrollment data in 834 format

were received from the state on a daily basis. Data were first loaded to an internal application, HNE Direct for review and confirmation of eligibility. Data was then uploaded to AMISYS. The plan had adequate data quality-monitoring and reconciliation processes, including the ability to combine data for members with more than one member identification number. Both MBHP and Optum Rx received a daily enrollment file from HNE. There were no issues identified with enrollment processes.

- Medical Record Review
  HNE used GDIT's MedCapture software to produce the postpartum component of the Prenatal and Postpartum Care measure. GDIT's data abstraction tools and training materials were reviewed and found to be compliant with HEDIS technical specifications. The plan demonstrated adequate processes for inter-rater reliability throughout the medical record review process. KEPRO found the final GDIT medical record review hybrid exclusion case listing to be in error. HNE had higher final exclusion numbers from chart review for one or more HEDIS measures, so KEPRO reviewed all PPC-Postpartum exclusion cases from a chart review. KEPRO determined that the PPC-Postpartum exclusion cases were handled correctly.

- Supplemental Data
  None of the plan's supplemental data sources contributed to the performance measure rates under review. Therefore, this section is not applicable.

- Data Integration
  HNE's performance measure rates were produced using GDIT 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 upon receipt. Data were then formatted into GDIT-compliant extracts and loaded into the measure production software. HNE had adequate processes to track completeness and accuracy of data at each transfer point. Data transfers to GDIT repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. GDIT's repository structure was compliant. HEDIS measure report production was managed effectively. The GDIT software was compliant with regard to development, methodology, documentation, revision control, and testing for the PMV measures under audit. Preliminary rates were reviewed and any variances investigated. HNE maintains adequate oversight of its vendor, GDIT. There were no issues identified with data integration processes.

- Source Code
  HNE used NCQA-certified GDIT HEDIS software to produce performance measures. GDIT received NCQA measure certification to produce the performance measures under the

scope of this review. There were no source code issues identified for the PMV measures under review.

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of the DTS Group, which performed a HEDIS® Compliance Audit on Health New England, the results of which were distributed on July 15, 2017:

Exhibit 35: Health New England Final Audit Results

Audit Element	Findings
Medical data	HNE met requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Practitioner data	Practitioner data related to performance measure production is adequate to support reporting.
Medical record review	Medical record tools, training materials, medical record process, and quality monitoring met requirements. Plan passed Medical Record Review Validation. HNE used GDIT's MedCapture software to produce the postpartum component of the Prenatal and Postpartum Care measure. GDIT's data abstraction tools and training materials were reviewed and found to be compliant with HEDIS technical specifications. The plan demonstrated adequate processes for inter-rater reliability throughout the medical record review process. The auditor found the final GDIT medical record review hybrid exclusion case listing to be in error. HNE had higher final exclusion numbers from chart review for one or more HEDIS measures, so KEPRO reviewed all PPC-Postpartum exclusion cases from chart review. KEPRO determined that the PPC-Postpartum exclusion cases were handled correctly.
Supplemental Data	Supplemental data processes and procedures were adequate and met technical specifications.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Follow Up to Calendar Year 2016 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on calendar year 2016 PMV recommendation follows:

Calendar Year 2016 Recommendation	Update
Continue to assess whether receiving more frequent pharmacy encounters would assist in improving performance measure rate.	HNE's frequency of receiving pharmacy encounters increased from monthly to twice a month.
Continue efforts to incorporate more electronic medical record (EMR) data sources as supplemental data to reduce medical record review burden. Expand the elements received on the current EMR feed.	HNE anticipates that two additional provider groups will begin submitting EMR data before the close of 2017. HNE revised their 2017 Physician Pay-for-Performance program to eliminate medical record review and to require providers to submit standard supplemental data or use CPT Category II codes for identified outcome measures.
Assess current improvement initiatives. Consider development of additional interventions, for example, increased member outreach or use of incentives.	HNE piloted the use of incentives in 2016 in an attempt to increase the Medicaid Adolescent Well-Care Visit Rate.
Continue to collaborate with MBHP. Determine if there is a possibility to work with psychiatrists to try to improve rates of diabetes testing for members taking antipsychotic medications. Also consider exploring options to exchange pharmacy data with the BH vendor.	HNE is currently working with MBHP to expand MBHP responsibilities for quality-related activities as well as performance guarantees. The exchange of pharmacy data with MBHP is also in active discussion.

Plan Strengths

- HNE used an NCQA-certified vendor.
- HNE staff provided thoroughly completed documentation in a timely manner.
- HNE has a good process for loading enrollment first to an internal application to resolve issues prior to loading into AMISYS.

Opportunities

- The HEDIS vendor's medical record review exclusion listing report was incorrect for HEDIS 2017. HNE needs to work with its HEDIS vendor to ensure that this report is accurate for future HEDIS reporting years.
- Both components of the Antidepressant Medication Management measure ('Effective Acute Phase Treatment' and 'Effective Continuation Phase Treatment') were both under the 50th percentile compared to the Quality Compass Medicaid data.

Recommendations

- Focus on quality improvement initiatives for the Antidepressant Medication Management measure.
- Identify a more robust approach to medical record retrieval for hybrid measures. HNE relies on provider offices to submit requested medical records. For HEDIS 2017, providers did not submit 17 percent of the requested charts.

NEIGHBORHOOD HEALTH PLAN (NHP)

Performance Measure Results

The charts below depict Neighborhood Health Plan's performance in the three measures selected by MassHealth for validation. The NCQA National Quality Compass 90th percentile is included for comparison purposes.

Antidepressant Medication Management (AMM) – NHP's AMM Acute performance increased a statistically significant 19.08 percent between HEDIS 2016 and HEDIS 2017 ($p < 0.005$). The Continuous Treatment rate increased a statistically insignificant 2.47 percent. Both the Acute and Continuous Treatment rates are trending upward and rank between the 33rd and 50th percentiles of the Quality Compass.

Exhibit 36: NHP AMM Acute Treatment Rate

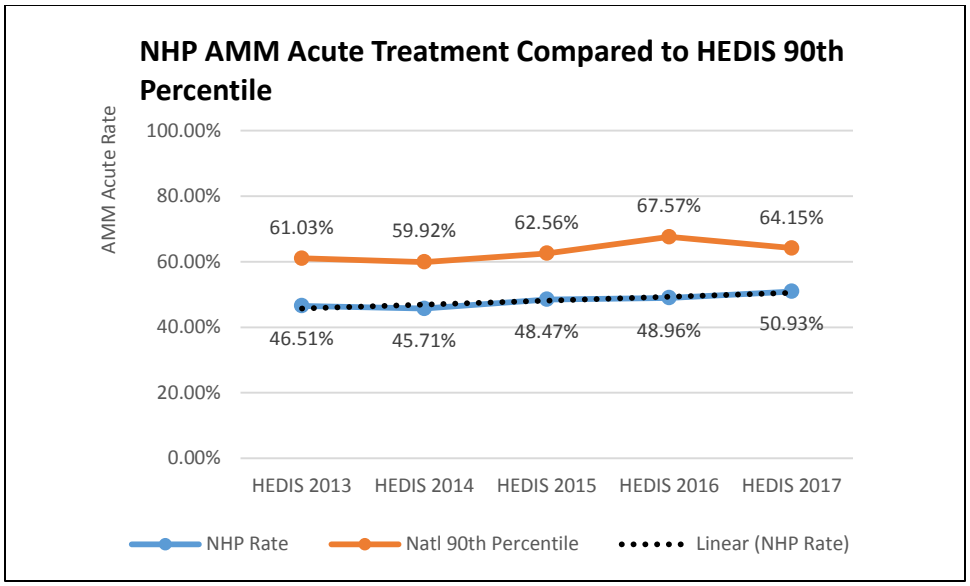
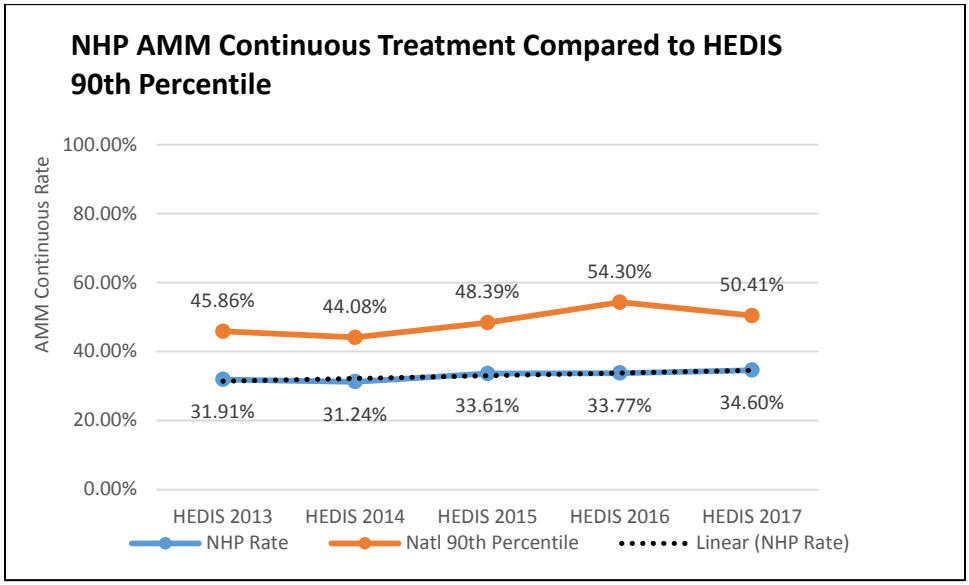
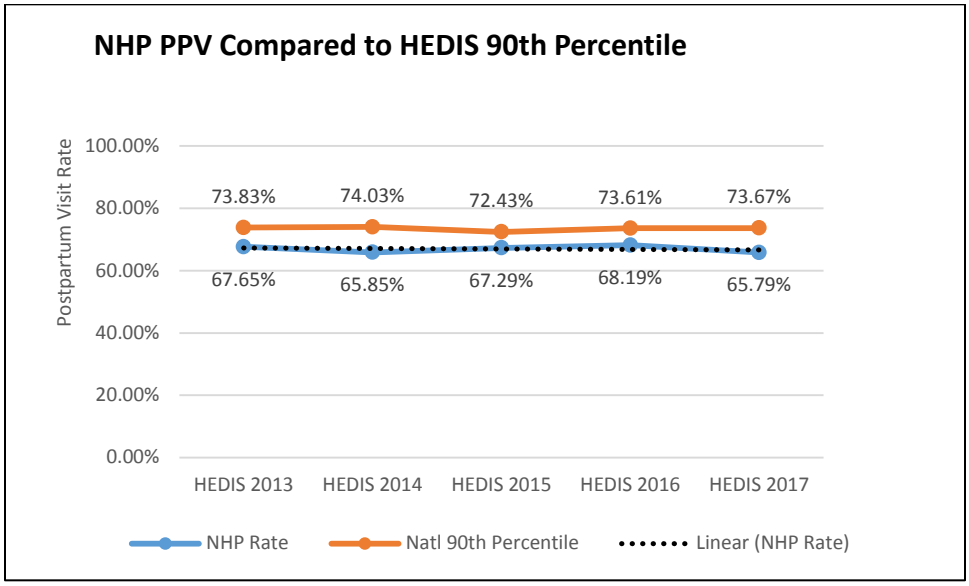


Exhibit 37: NHP AMM Continuous Treatment Rate



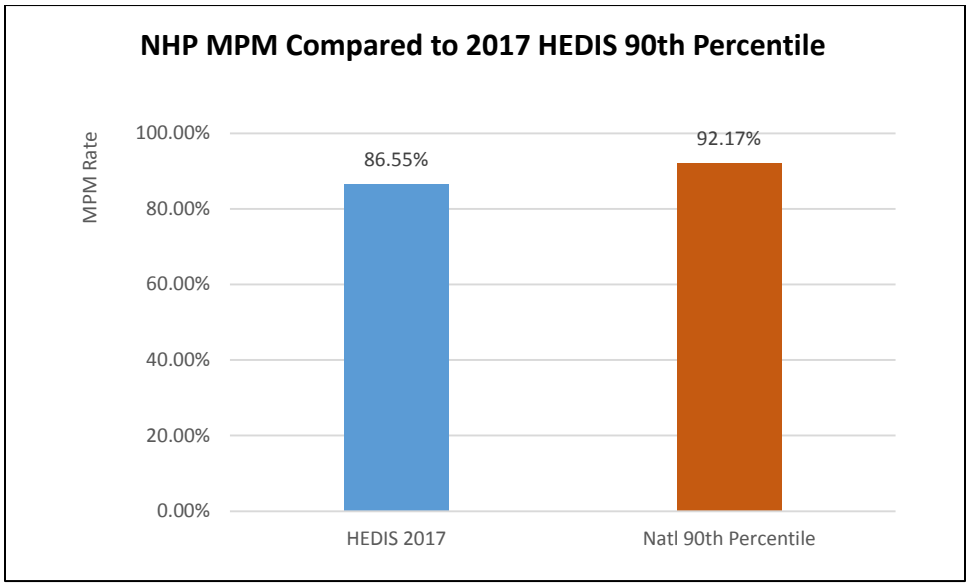
Postpartum Visit Rates (PPV) – Although NHP has been reporting its postpartum visit rate for a number of years, 2016 represents a baseline performance year. Its historical performance has experienced level rates. The baseline rate of 65.79 percent falls between the NCQA Medicaid Quality Compass 50th and 66th percentiles.

Exhibit 38: NHP PPV Rates



Annual Monitoring for Patients on Persistent Medications (MPM) - 2017 was the first year in which the MPM measure was selected by MassHealth for performance measure validation. In HEDIS 2017, Neighborhood Health Plan's rate of 86.55 percent is between the 33rd and 50th NCQA Medicaid Quality Compass percentiles.

Exhibit 39: NHP MPM Rates



Information Systems Capabilities Analysis

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of Neighborhood Health Plan's information system that contribute to performance measure production.

- Claims and Encounter Data

  NHP processed claims, including lab claims, using QNXT. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Since maternity services were primarily billed globally, NHP continued to rely on medical record review to accurately report the Postpartum Care performance measure. Most claims were submitted electronically to NHP through clearinghouses that had adequate edits checks for code set validation and data formatting. In addition, QNXT had sufficient logical edit checks. For the small volume of paper claim submissions, NHP contracted with its vendor, Trizetto, to manually key paper claims and scan the paper claim image. Paper claims were turned into EDI claims and followed the same process as electronic claims. NHP used its vendor, Beacon Health Options (Beacon), to handle behavioral health claims. Beacon had adequate processes in place to handle EDI and paper claims. Beacon used acknowledgement and response files for notifying providers of receipt of EDI submissions.

Beacon processed claims within FlexCare 360. CVS Caremark was contracted by NHP to process pharmacy claims. Pharmacy claims data were received daily from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no issues identified with claims or encounter data processing or data completeness.

- Enrollment Data
  NHP processed Medicaid enrollment data using the QNXT system. 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 NHP. The daily file included additions, changes, and terminations. Enrollment data were loaded into NHP's enrollment system, QNXT, and the system captured current and historical enrollment spans. NHP also received a full monthly refresh file and conducted reconciliation between QNXT and the State file. QNXT retained Medicaid identification (ID) numbers and the plan assigned a unique QNXT system ID. NHP had adequate data quality monitoring and reconciliation processes. There were no issues identified with enrollment processes.

- Medical Record Review
  NHP used Verscend software to produce the postpartum component of the Prenatal and Postpartum Care measure. Verscend's data abstraction tool materials were reviewed and found to be compliant with HEDIS technical specifications. NHP used its own internal abstraction training and the training manual was reviewed and found to be compliant with HEDIS technical specifications. NHP had sufficient oversight 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 the medical record review process.

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

- Data Integration
  NHP's performance measure rates were produced using Verscend software. Data from the transaction system were loaded to NHP's data warehouse for a monthly build. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into Verscend-compliant extracts and loaded into the measure production software. Data transfers to the Verscend repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. Verscend's repository structure was

compliant. HEDIS measure report production was managed effectively. The Verscend software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. NHP maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

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

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Neighborhood Health Plan, the results of which were distributed on July 10, 2017.

Exhibit 40: NHP's Final Audit Results

Audit Element	Findings
Medical data	NHP met all requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Practitioner data	Practitioner data related to performance measure production was adequate to support reporting.
Medical record review	Medical record tools, training materials, medical record process, and quality monitoring met requirements. NHP passed Medical Record Review Validation.
Supplemental Data	Supplemental data processes and procedures were adequate and met technical specifications.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Follow Up to Calendar Year 2016 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on calendar year 2016 PMV recommendation follows:

Calendar Year 2016 Recommendation	Update
NHP should conduct root-cause analysis to explore opportunities to improve performance measure rates, particularly AMM and SSD measure rates since they fall below the 25th and 33rd national Medicaid percentiles, respectively.	SSD is no longer a PMV measure. NHP performance on the AMM measure still warrants improvement efforts.
NHP needs to implement a mechanism to provider greater oversight of the abstraction of medical record exclusions to ensure that the abstraction is consistent with HEDIS technical specifications.	NHP was in full compliance for medical record review for HEDIS 2017.

Plan Strengths

- NHP used an NCQA-certified vendor.
- The audit process revealed a culture of improvement as it relates to HEDIS measure production processes with staff members consistently articulating changes made to improve efficiency or planned changes to help drive improvement.
- NHP had robust processes in place to obtain electronic medical record data from many of its larger health system providers.

Opportunities

- Both components of the Antidepressant Medication Management measure ('Effective Acute Phase Treatment' and 'Effective Continuation Phase Treatment') were both under the 50th percentile compared to the Quality Compass National Medicaid data.
- NHP's performance on the Annual Monitoring for Patients on Persistent Medications measure was under the 50th percentile compared to Quality Compass National Medicaid data.

Recommendations

- Focus on quality improvement initiatives for the Antidepressant Medication Management measure.
- Focus on quality improvement initiatives for the Annual Monitoring for Patients on Persistent Medications measure.

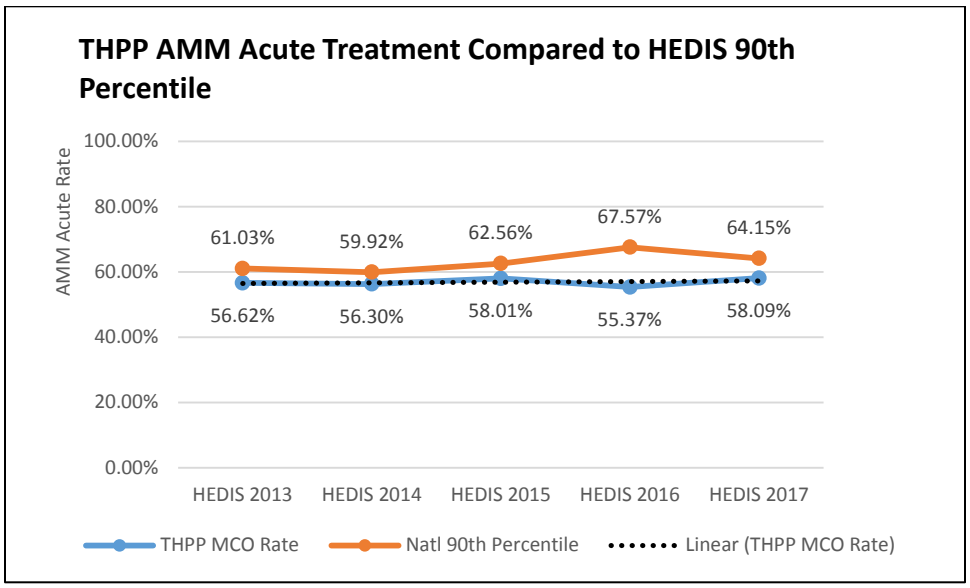
TUFTS HEALTH PUBLIC PLANS (THPP)

Performance Measure Results

The charts that follow below depict Tufts Health Public Plans' MCO's performance in the three measures selected by MassHealth for validation. The NCQA National Medicaid 90th percentile is included for comparison purposes.

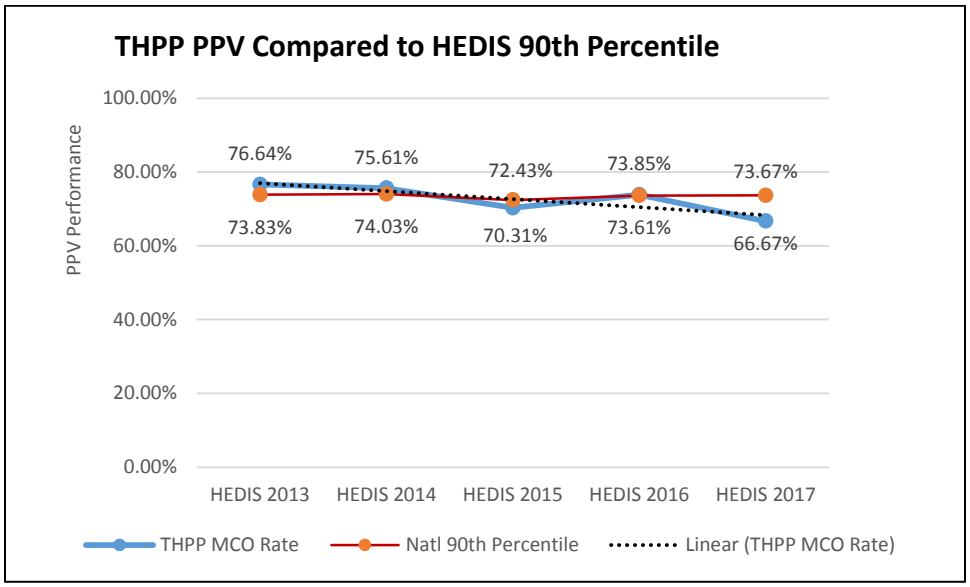
Antidepressant Medication Management (AMM) - Both the THPP Acute and Continuous AMM rates increased statistically significantly between HEDIS 2016 and HEDIS 2017. The Acute rate, 58.09 percent, increased 4.92 percent ($p < 0.005$). The Continuous rate, 45.15 percent, represents a 9 percent ($p < 0.005$) increase. Both rates lie between the 75th and 90th NCQA Medicaid Quality Compass percentiles.

Exhibit 41: THPP AMM Acute Treatment Rates



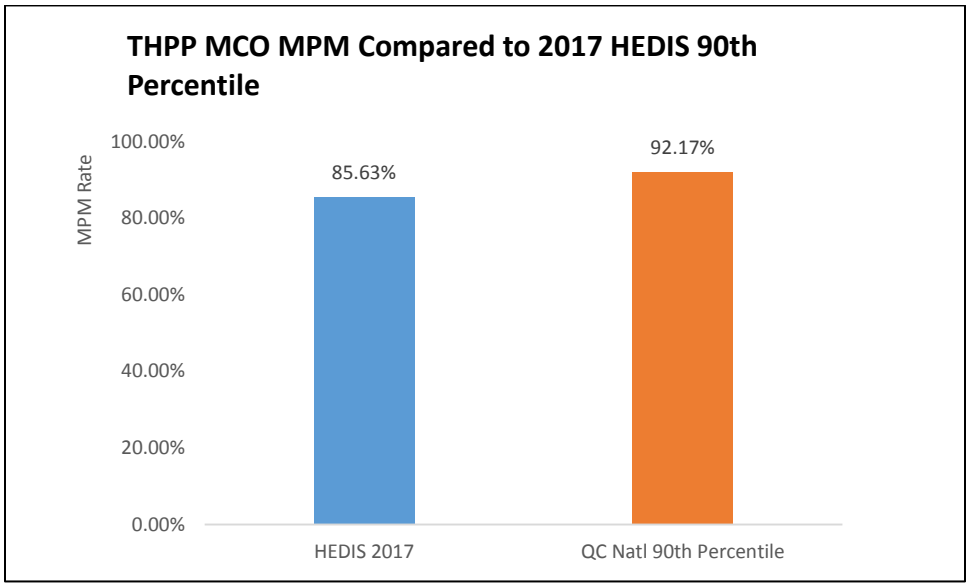
Postpartum Visit Rate (PPV) - In HEDIS 2017, the rate of 66.67 percent represents a statistically significant decrease of 9.73 percent ($p < 0.05$) from HEDIS 2016 (73.85%). Tufts Health Public Plans' rate lies between the NCQA Medicaid Quality Compass 50th and 67th percentiles.

Exhibit 42: THPP PPV Rates



Annual Monitoring for Patients on Persistent Medications (MPM) - 2017 was the first year in which the MPM measure was selected by MassHealth for performance measure validation. In HEDIS 2017, THPP's rate of 85.63 percent is between the 25th and 33rd NCQA Medicaid Quality Compass percentiles.

Exhibit 43: THPP MPM Rates



Information Systems Capabilities Analysis

CMS regulations require that each managed care entity undergo an annual Information Systems Capability Assessment. The focus of the review is on components of Tufts Health Public Plan's information system that contribute to performance measure production.

- Claims and Encounter Data

  THPP processed claims using the Monument Xpress system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. THPP only accepted claims submitted on standard claims forms. Since maternity services were primarily billed globally, THPP continued to rely on medical record review to accurately report the Postpartum Care performance measure. Most claims were submitted electronically to THPP and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. THPP had robust claims editing and coding review processes. THPP processed all claims within Monument Xpress except for pharmacy claims which were handled by THPP's 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. There were no issues identified with claims or encounter data processing.

- Enrollment Data

  THPP processed Medicaid enrollment data using Monument Xpress. 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 THPP. The daily file included additions, changes, and terminations. Enrollment data were loaded into THPP's Monument Xpress system. THPP also received a full monthly refresh file and conducted reconciliation between Monument Xpress and the State file. Monument Xpress retained Medicaid identification (ID) numbers and the plan assigned a unique Monument Xpress system ID. THPP had adequate data quality-monitoring and reconciliation processes. THPP provided daily enrollment files to CVS Caremark. There were no issues identified with enrollment processes.

- Medical Record Review

  THPP used GDIT's MedCapture software to produce the postpartum component of the Prenatal and Postpartum Care measure. GDIT's data abstraction tools and training materials were reviewed prior to the onsite visit and found to be compliant with HEDIS technical specifications. THPP 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 the medical record review process.

- Supplemental Data
  THPP used multiple standard supplemental data sources, including electronic medical record data from many entities. THPP 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 GDIT's software which received measure certification from NCQA for all measures under the scope of the review. Data from the transaction system was loaded to THPP's data warehouse and refreshed monthly. Vendor data feeds were loaded into the warehouse upon receipt. Data were then formatted into GDIT-compliant extracts and loaded into the measure production software. THPP 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 GDIT repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. GDIT's repository structure was compliant. HEDIS measure report production was managed effectively. The GDIT software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. THPP maintains adequate oversight of its vendor, GDIT. There were no issues identified with data integration processes.

- Source Code
  THPP used NCQA-certified GDIT HEDIS software to produce performance measures. GDIT 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.

Based on the Information Systems Capability Analysis, no issues were identified for any of these data categories for Tufts Health Public Plan's MCO.

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Tufts Health Public Plan MCO, the results of which were distributed on June 29, 2017.

Audit Element	Findings
Medical data	THPP met all requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Practitioner data	Practitioner data related to performance measure production was adequate to support reporting.
Medical record review	Medical record tools, training materials, medical record process, and quality monitoring met requirements. The plan passed Medical Record Review Validation.
Supplemental Data	Supplemental data processes and procedures were adequate and met technical specifications.
Data integration	Data integration processes were adequate to support data completeness and performance measure production.

Follow Up to Calendar Year 2016 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on calendar year 2016 PMV recommendation follows:

Calendar Year 2016 Recommendation	Update
Conduct root-cause analysis to determine factors that contributed to the decline in performance for the AMM measures and develop strategies to improve performance.	AMM measure performance increased statistically significantly.
Develop a mechanism to evaluate the effectiveness of measure-specific interventions to determine whether to expand, continue, revise, or abandon the intervention.	Because of the decrease in the postpartum care measure, this recommendation stands.

Plan Strengths

- THPP used an NCQA-certified vendor.
- THPP had adequate staff members with subject matter expertise to manage and report valid performance measure rates.
- THPP is in full Information Systems compliance for PMV reporting.

Plan Opportunities

- The Annual Monitoring for Patients on Persistent Medications measure was under the 50th percentile compared to the Quality Compass Medicaid data.

Recommendations

- Focus on quality improvement initiatives for the Annual Monitoring for Patients on Persistent Medications measure.
- Determine and intervene on root cause(s) for the postpartum care rate decrease.

SECTION 5. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Introduction

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

The PIP review is a four-step process:

1) **PIP Questionnaire.** The MCO submits a completed questionnaire for each PIP. This questionnaire requests a project goal, a description of associated interventions; and a description of the performance measures being used to assess the effectiveness of these interventions. The plan describes its data analysis plan, results, and next steps.

2) **Desktop Review.** A desktop review is conducted for each PIP. The Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plan. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the questionnaire. The Medical Director's focus is on proposed or implemented clinical interventions.

3) **Conference with the Plan.** The Technical Reviewer and Medical Director meet telephonically with representatives selected by the plan to obtain clarification on identified issues as well as to offer recommendations for improvement. The plan is offered the opportunity to resubmit the PIP questionnaire within 10 calendar days, although it is not required to do so.

Final Report. The reviewer assesses the plan's performance in the areas of problem definition, analysis, measurement, improvement strategies, and outcome effectiveness analysis. The Medical Director documents his or her findings and, in collaboration with the Technical Reviewer, develops recommendations. KEPRO evaluates an MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. The findings of the Technical Reviewer and Medical Director are synthesized into a final report to KEPRO.

MassHealth selects the topics of the Performance Improvement Projects; plans are given the discretion to design interventions appropriate to their population. Each MCO was required to conduct a project to increase the number of members receiving treatment within the specifications of the antidepressant medication management (AMM) HEDIS measure and increase the number of childbearing women who attend a postpartum visit. Because CeltiCare

does not enroll pregnant women, a project to decrease the emergency department utilization rate was conducted.

Based on its review of the MassHealth MCO performance improvement projects, KEPRO did not discern any issues related to any plan's quality of care or the timeliness of or access to care.

IMPROVING THE ANTIDEPRESSANT MEDICATION MANAGEMENT RATE: A COMPARATIVE ANALYSIS

2016 INTERVENTIONS

Member Education

- BMCHP issues a monthly educational mailing to adult members diagnosed with major depression who initiated treatment with antidepressant medication. A pill box is included with the mailing. A second mailing, generated on a twice-weekly basis, is sent to adult members who were newly prescribed an SSRI medication. Written in both English and Spanish, the mailing encourages adherence. (BMCHP)

- CeltiCare distributes brochures and letters to members with a new antidepressant medication prescription and a diagnosis of depression. These materials are printed in both English and Spanish. (CeltiCare)

Provider-Focused

- Fallon and Beacon developed an informational flyer to introduce Fallon's primary care providers to the content of the Primary Care Physician (PCP) Toolkit. This toolkit contains member resources, prescribing references, and information about the PCP Consult Line. (Fallon)

- PCPs received information about the antidepressant medication adherence rate of members. (CeltiCare)

- The Plan conducted individualized, face-to-face trainings with providers at Codman Square Health Center, a community health center with low AMM performance rates. (Neighborhood Health Plan)

Care Management

- Care management staff received training in Motivational Interviewing. (CeltiCare, Fallon)

- An AMM Member Outreach program was implemented. Case Management Navigators, which increased in number from one to seven in August 2016, conducted telephonic outreach to members newly diagnosed with major depressive disorder and who were prescribed an antidepressant medication. (Fallon)

- The Case Management outreach call script was enhanced with antidepressant prescription-related education. (Fallon)

- An assessment was developed and embedded in the centralized enrollee record that provided information regarding medication compliance, directed the staff with educating the member about the importance of medication adherence and ultimately will capture information that will allow for greater barrier analysis in the future. (Fallon)

- The AMM Outreach Program was designed to improve medication adherence among adult members prescribed antidepressant medication, including members diagnosed with major depression who are prescribed an antidepressant medication. Care Management staff conducted telephonic outreach to members identified as having recently been prescribed an antidepressant medication, by querying current pharmacy claims data to identify members who have been newly prescribed an antidepressant. (Tufts Health Public Plans)

- Resources for telephonic outreach were increased by adding pharmacy and behavioral health staff. These staff were trained on barriers to adherence including untoward side effects. (CeltiCare)

Data-Mining

- Beacon's Psychotropic Medication Intervention Program identifies medication-related problems through claims review, analytics, clinical review, and health informatics. (Neighborhood Health Plan)

The table below depicts the type of intervention undertaken by the plan.

Exhibit 44: 2016 Intervention Type by Managed Care Organization

	BMCHP	CEL	FAL	HNE	NHP	THPP
Member Education	X	X				
Provider Education		X	X		X	
Care Management		X	X			X
Data Mining					X	

RESULTS

The AMM measure assesses adults 18 years of age and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on their antidepressant medications. Two rates are reported:

1. **Effective Acute Phase Treatment:** Adults who remained on an antidepressant medication for at least 84 days (12 weeks).

2. **Effective Continuation Phase Treatment:** Adults who remained on an antidepressant medication for at least 180 days (6 months).

The tables that follow depict MCO performance on the AMM measures in HEDIS 2017. As previously mentioned, these data reflect 2016 performance.

Exhibit 45: HEDIS 2017 AMM Acute Treatment Rates by MCO

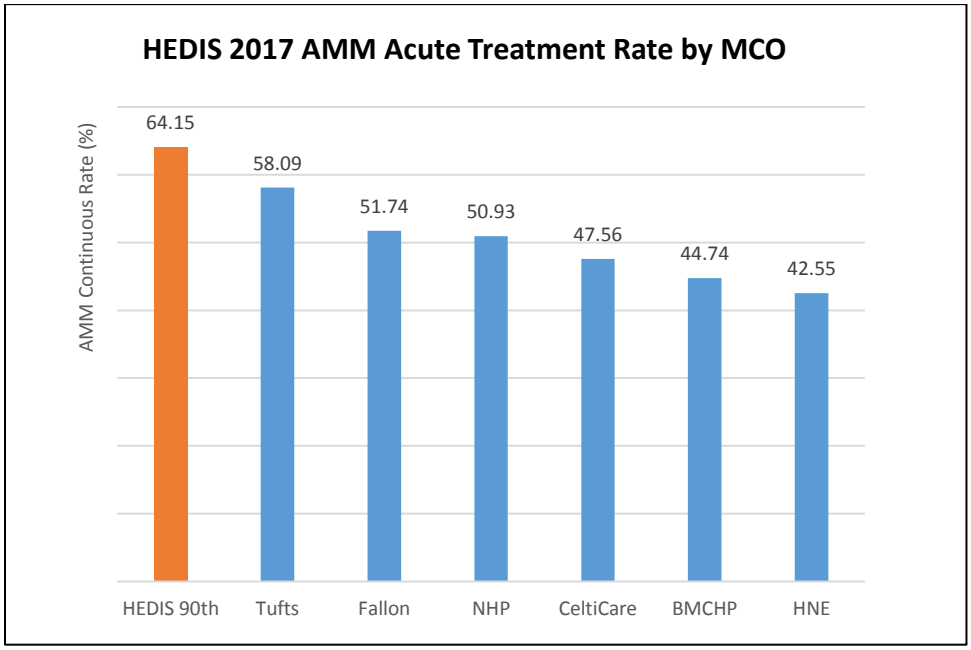
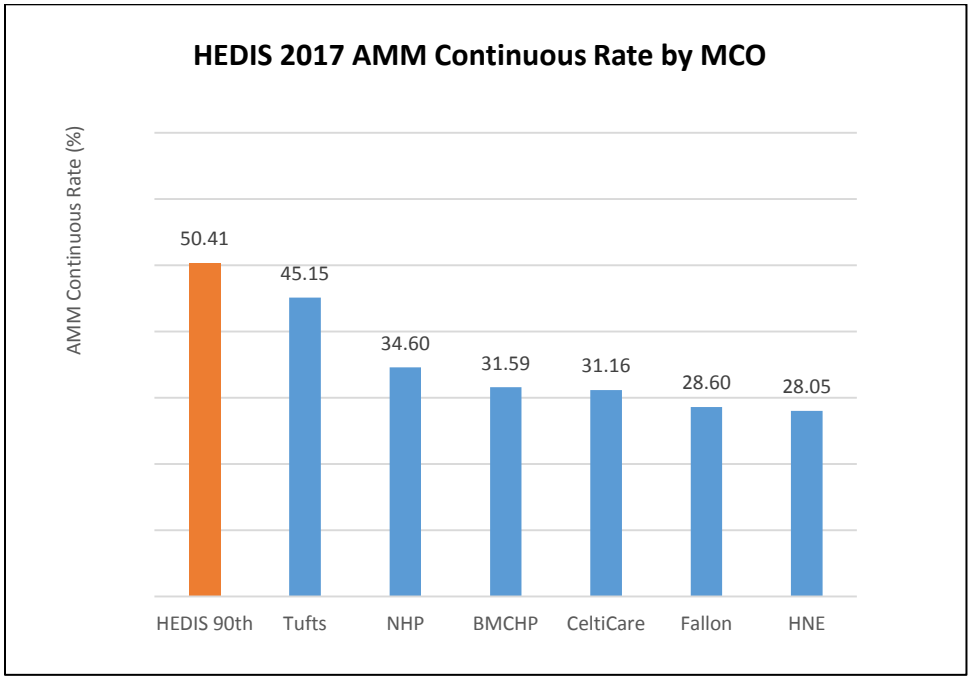


Exhibit 46: HEDIS 2017 AMM Continuous Treatment Rates by MCO



The tables below depict trended AMM performance by MCO. The performance trend line and the plan's 2017 Quality Compass percentile ranking are included for comparison purposes.

Exhibit 47: Trended AMM Acute Treatment Performance by MCO

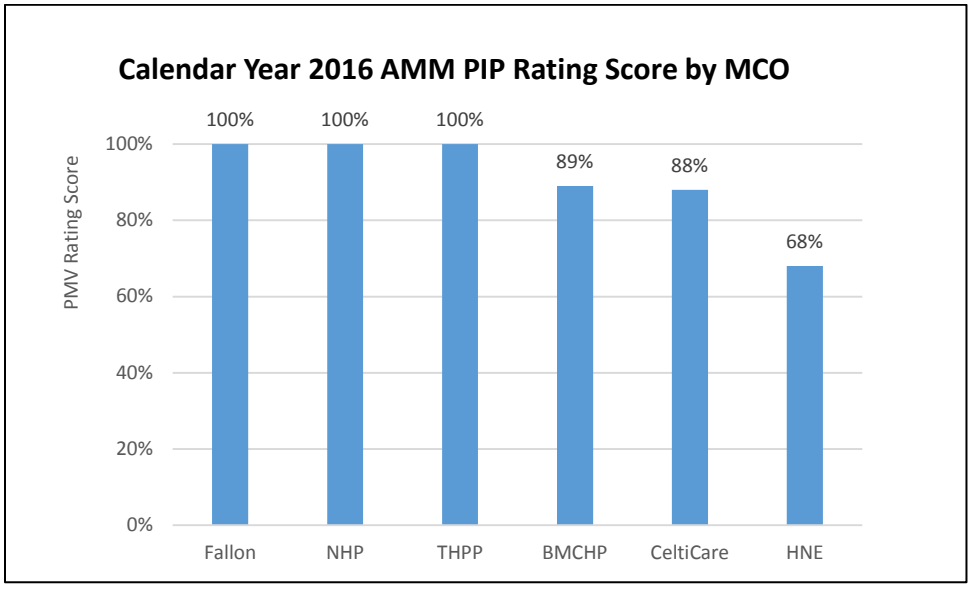
		HEDIS 2013	HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017	Linear Performance Trend Line	2017 QC Percentile Ranking
AMM Acute (%)	**HEDIS 90th**	61.03%	59.92%	62.56%	67.57%	64.15%		
	BMCHP	44.94%	42.35%	44.25%	44.85%	44.74%	↔	10th – 25th
	CeltiCare	-	-	44.21%	43.88%	47.56%	↑	10th – 25th
	Fallon	52.14%	38.80%	51.23%	49.73%	51.74%	↑	33rd – 50th
	HNE	51.19%	39.31%	47.11%	46.12%	42.55%	↓	5th – 10th
	NHP	46.51%	45.71%	48.47%	48.96%	50.93%	↑	33rd – 50th
	Tufts	56.62%	56.30%	58.01%	55.37%	58.09%	↔	75th – 90th

Exhibit 48: Trended AMM Continuous Treatment Performance by MCO

		HEDIS 2013	HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017	Linear Performance Trend Line	2017 QC Percentile Ranking
AMM Continuous (%)	**HEDIS 90th**	45.86%	44.08%	48.39%	54.30%	50.41%		
	BMCHP	32.41%	28.92%	30.02%	30.97%	31.59%	↔	10th – 25th
	CeltiCare	-	-	30.99%	29.69%	31.16%	↔	10th – 25th
	Fallon	37.86%	22.00%	32.43%	26.67%	28.60%	↓	5th – 10th
	HNE	35.71%	28.64%	32.63%	29.93%	28.05%	↓	5th – 10th
	NHP	31.91%	31.24%	33.61%	33.77%	34.60%	↑	33rd – 50th
	Tufts	44.94%	43.17%	44.17%	41.42%	45.15%	↔	75th – 90th

The chart that follows depicts the performance improvement project rating score received by each MCO. KEPRO evaluates an MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage.

Exhibit 49: MCO AMM PIP Rating Scores by MCO



Discussion

Generally speaking, all plans conducted comprehensive barrier and population analyses. One challenge, however, was that a number of plans did not take the next step and designed interventions that spoke to these analyses. For example, if I finding was that members ages 21-

30 have lower rates of adherence compared to other age groups, the plan should design an intervention targeted at that age group.

Because plans often post educational material to the member and provider pages of their websites, KEPRO was very pleased to see some plans start to analyze site usage. Using Google analytics, one plan was able to identify a remarkable 226% increase in page-views during 2016.

Also of interest, KEPRO observed that strong performance in the Acute Phase measure does not guarantee strong performance in the Continuing Phase. This suggests that different approaches are required for the two AMM rates.

Some plans using case management-based interventions experienced difficulty with member engagement. The content of the programs themselves was strong, but despite multiple outreaches, it was often not possible to engage the member. A recommendation was made to focus plans' limited resources on the highest-risk members.

Finally, the publication of member educational materials in prevalent languages is a positive development.

INCREASING THE RATE OF POSTPARTUM VISITS: COMPARATIVE ANALYSIS

2016 INTERVENTIONS

Exhibit 50: 2016 PPV Intervention Type by MCO

	BMCHP	Fallon	HNE	NHP	THPP
Care Management		X		X	X
Incentive Programs	X	X			
Member Education				X	
Provider Education				X	
Internal Systems		X			

Care Management

- THPP conducts outreach and education by mail (a welcome baby card) and phone (a telephonic postpartum follow-up assessment). (Tufts Health Public Plans)

- The Doula[6] by My Side program operates in Worcester and Suffolk Counties. In this program, a doula provides expectant mothers with education, assistance, guidance, and support as needed. (Tufts Health Public Plans)

- The care management program focuses on highest-risk expectant mothers and mothers of preterm newborns. (Neighborhood Health Plan)

- Telephonic outreach is made to its pregnant members and encourages their participation in a postpartum visit. If a member does not have transportation, Case Management Navigators educate members on PT-1 services, and apply for this benefit on the member's behalf. They follow up with the member to verify that these benefits were received and to coordinate future ride services. Case management continues to train staff in motivational interviewing techniques. (Fallon)

Incentive Programs

- A vendor was contracted to implement and administer a pilot a rewards program for women who attended postpartum visits between 21 and 56 days after delivery. In this pilot, the vendor called members after delivery to inform them of the rewards program and encouraged the member to attend the postpartum visit. Members attending the postpartum visit were eligible to select items from a rewards catalog. (BMCHP)

[6] A doula is a trained professional who provides nonmedical care including education, household organization, and general support before and after the birth of a child.

- A $20 gift card is offered to members who attend a postpartum visit and who provide the plan with a letter signed by the provider. (Fallon Health)

Member Education

- A text-messaging outreach campaign was implemented. (Neighborhood Health Plan)

Provider Education

- Providers are educated about HEDIS postpartum care rates using web-based tools. (Neighborhood Health Plan)

Internal System Changes

- Two care management Navigators are dedicated to updating pertinent data for this intervention. When a Navigator cannot reach a member due to a wrong phone number, the Navigator reaches out to the PCP or OB/GYN to obtain an alternate number. (Fallon Health)

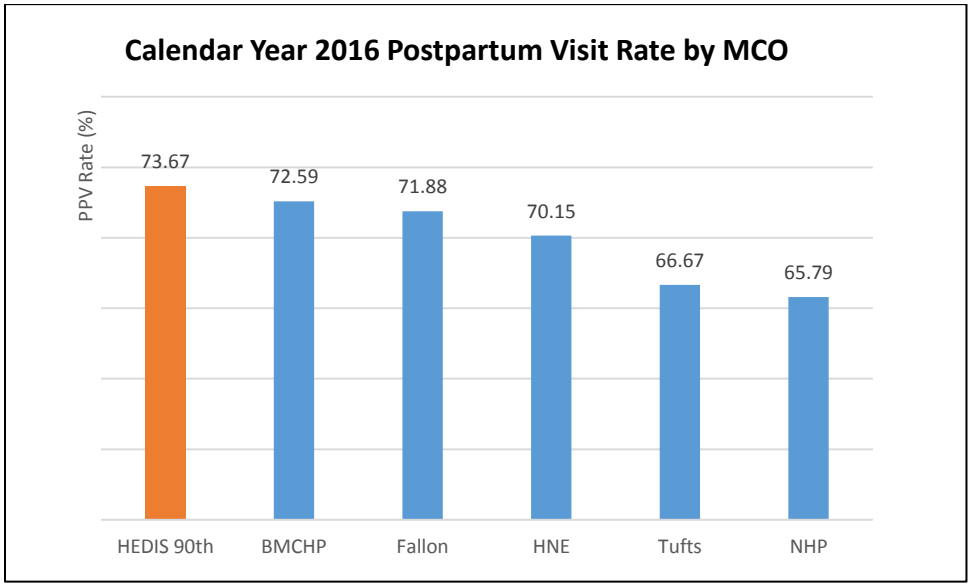
The table that follows depicts 2016 PPV interventions by type for MassHealth MCOs.

RESULTS

The HEDIS postpartum visit rate can be described as a ratio of postpartum visits for a pelvic exam or postpartum care on or between 21 and 56 days after delivery to a sample of live births, as documented through either administrative data or medical record review. The exhibits that follow depict MCO performance on the HEDIS postpartum visit rate.

A chart that describes the postpartum visit rate by MCO follows. The NCQA 2017 Medicaid Quality Compass 90th percentile is included for comparison purposes.

Exhibit 51: 2017 MCO Postpartum Visit Rates



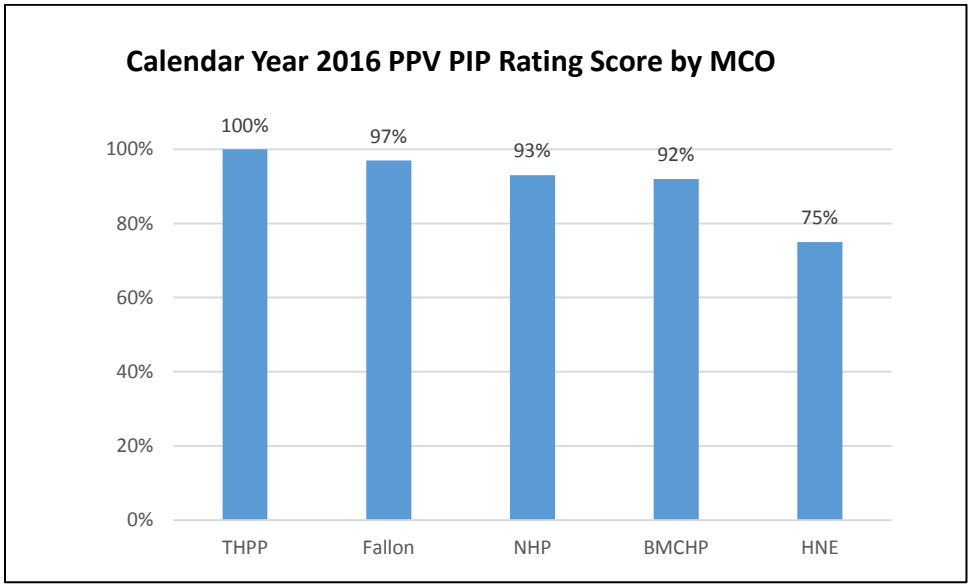
The table below depicts trended PPV performance by MCO. The performance trend line and the 2017 NCQA Medicaid Quality Compass percentile ranking are included for comparison purposes.

Exhibit 52: Trended MCO PPV Rates

		HEDIS 2013	HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017	Trend Line	2017 QC Percentile Ranking
PPV Acute (%)	**HEDIS 90th**	73.83%	74.03%	72.43%	73.61%	73.67%		
	BMCHP	67.71%	69.58%	71.55%	66.94%	72.59%	↑	75th – 90th
	Fallon	76.63%	76.63%	64.92%	73.39%	71.88%	↓	75th – 90th
	HNE	-	76.03%	79.92%	72.27%	70.15%	↓	75th – 90th
	NHP	67.65%	65.85%	67.29%	68.19%	65.79%	↔	50th – 66th
	Tufts	76.64%	75.61%	70.31%	73.85%	66.67%	↓	50th – 66th

KEPRO evaluates a MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. MCO rating scores follow.

Exhibit 53: PPV PIP Rating Scores by MCO



Discussion

We can observe when comparing Exhibit 51 (2017 MCO Postpartum Visit Rates) to Exhibit 50 (2016 PPV Intervention Type by MCO), that the breadth of interventions do not necessarily correlate to improved performance. For example, BMCHP reports one intervention, yet is the highest performing plan and it is the only plan whose performance is trending up.

The Performance Improvement Project Reporting Template asks plans for an assessment of intervention effectiveness. Few plans, however, completed such an analysis. This makes it difficult to identify best practices and while some interventions are intriguing, e.g., THPP's Doula by My Side" program, without a formal analysis, KEPRO is not able to endorse this or any other intervention. This represents an opportunity for KEPRO to provide technical training.

PLAN-SPECIFIC ANTIDEPRESSANT MEDICATION MANAGEMENT PIPS

All MassHealth MCOs conducted PIPs targeted at improving AMM performance.

BOSTON MEDICAL CENTER HEALTHNET

2016 Interventions

- BMCHP issues a monthly educational mailing to adult members diagnosed with major depression who initiated treatment with antidepressant medication.

- A pill box is included with the mailing. A second mailing is sent on a twice-weekly basis to adult members who were newly prescribed an SSRI medication. Written in both English and Spanish, the mailing encourages adherence.

Results

The tables that follow depict BMCHP's performance on the two HEDIS Antidepressant Medication Management rates. BMCHP's HEDIS 2017 AMM Acute rate was 44.74 percent, which reflects a statistically significant decrease of 0.25 percent from HEDIS 2016. Performance over the past five years has remained level. The AMM Continuous rate increased 2.01 percent, which is also statistically significant. As is the case with the Acute rate, performance has been level over the past five years. BMCHP did not achieve its stated goal for either measure. Both rates fall between the 10th and 25th HEDIS Medicaid Quality Compass percentiles.

Exhibit 54: BMCHP AMM Acute Treatment Rates Compared to Goal

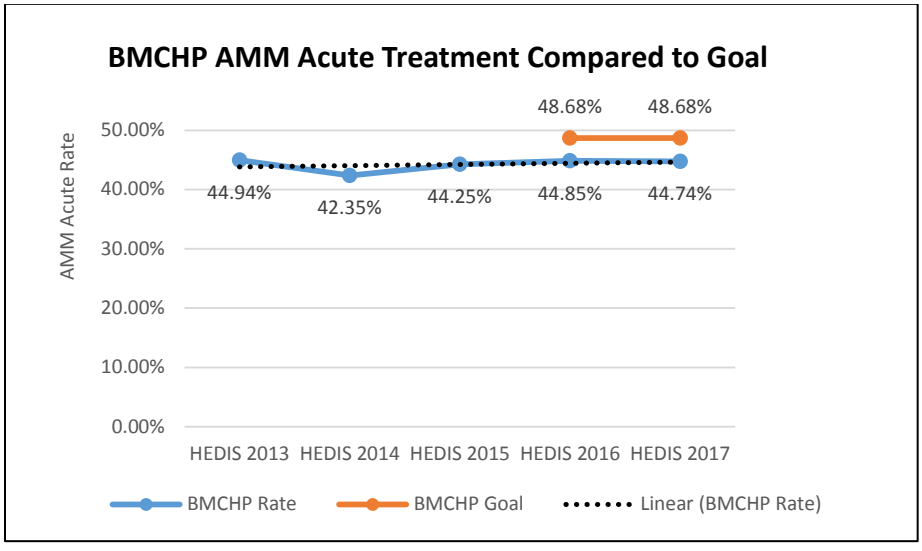
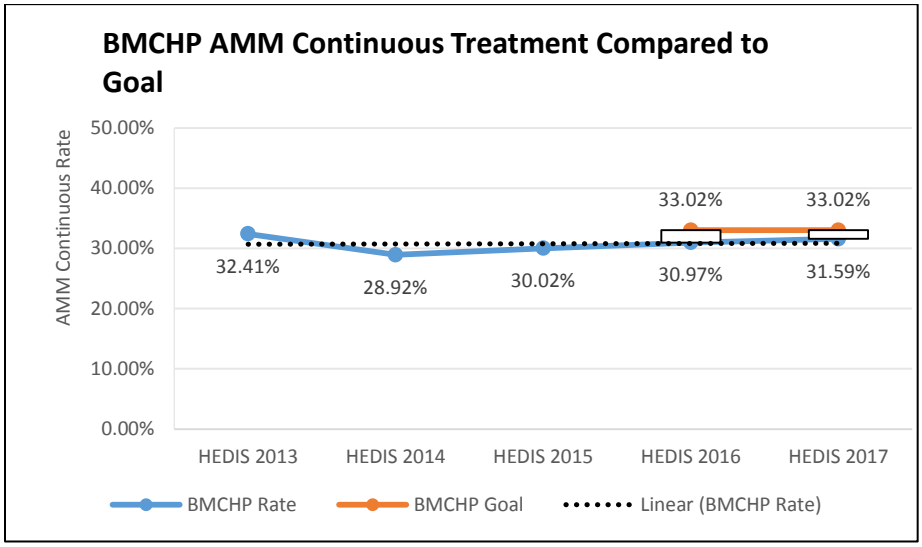


Exhibit 55: BMCHP AMM Continuous Treatment Rates Compared to Goal



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. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. BMCHP received a rating score of 98% on its AMM PIP.

Exhibit 56: BMCHP AMM PIP Scores

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

Results of Validation Ratings for 3, 2, or 1 Values	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	4	12	12	100%
Reassessing Intervention Parameters & Strategies	4	12	11	92%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	6	100%
Conclusions & Future PIP Improvements	3	9	9	100%
Validation Rating Score for 3, 2, or 1 Values	**19**	**57**	**56**	**98%**

Overall Validation Rating Score	26	64	63	98%

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
An ethnic disparity was found with Hispanics being the least adherent of racial and ethnic groups. PCP groups in the Western and Southern regions were low-performers. A focus group of BMCHP members who are Hispanic and located in the Southern and Western regions could bring better understanding of the reasons for non-adherence.	No evidence of related activity was provided.
An analysis of why members are non-adherent would allow for further refinement of interventions. For example, if members are forgetting to take their medication, then looking into a medication reminder phone application would be useful.	No evidence of related activity was provided.

Plan and Project Strengths

- BMCHP is commended for publishing the newsletters in Spanish and making it available in other languages.
- BMCHP is also commended for its commitment to a cross-functional interdepartmental team approach.
- BMCHP appears to have a great capacity for data analysis.

Opportunities

- BMCHP should consider methods to assess how members respond to its newsletter. Understanding whether members read it or find the information helpful may help refine the content.

Recommendations

- KEPRO strongly recommends that BMCHP solicit structured and regular feedback from members and providers in the design and refinement of its interventions.

CELTICARE

2016 Interventions

- CeltiCare distributes brochures and letters to members with a new antidepressant medication prescription and a diagnosis of depression. These materials are printed in both English and Spanish.

- The evidence-based intervention, Motivational Interviewing, was implemented in the telephonic care management training.

- Resources for telephonic outreach was increased by adding pharmacy and behavioral health staff. These staff were trained on barriers to adherence including untoward side effects.

- PCPs received information about the antidepressant medication adherence rate of members.

Results

The charts that follow depict CeltiCare's AMM Acute and Continuous performance over time. The AMM Acute rate increased a statistically insignificant 8.38 percent between 2015 and 2016. The AMM Continuous rate increased 4.96 percent, also statistically insignificant. CeltiCare decreased its performance goals in 2016. Nonetheless, the plan did not meet its targets. Both rates fall between the 10th and 25th Medicaid Quality Compass percentiles.

Exhibit 57: CeltiCare AMM Acute Treatment Rates Compared to Goal

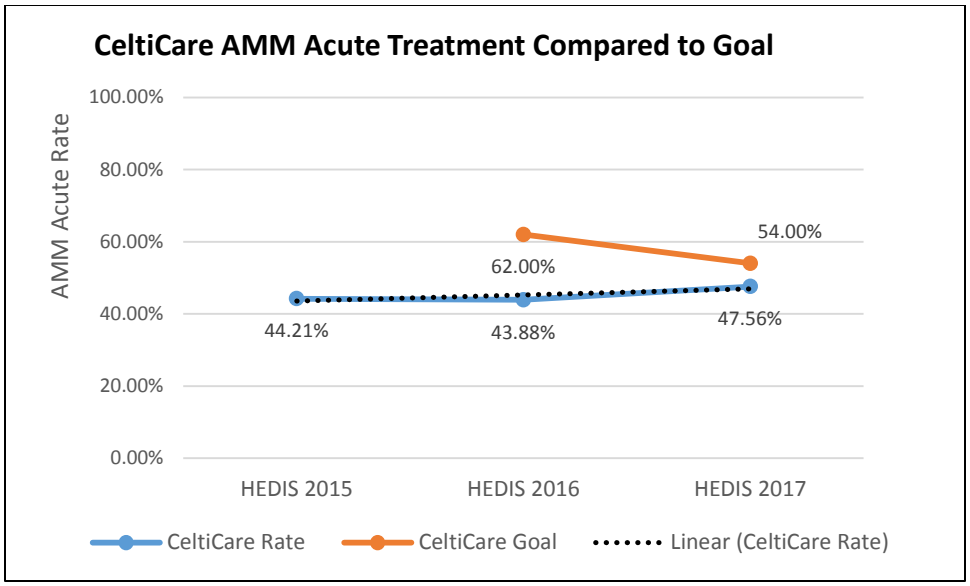
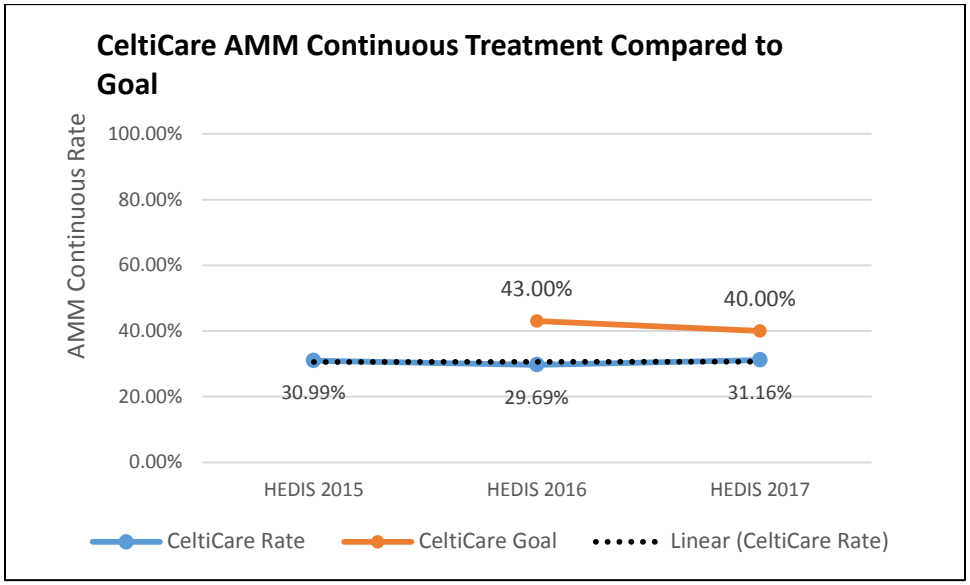


Exhibit 58: CeltiCare AMM Continuous Treatment Rates Compared to Goal



Performance Improvement Project Score

KEPRO evaluates a MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. CeltiCare received a rating score of 88% on its AMM PIP.

Exhibit 59: CeltiCare AMM PIP Scores

Summary Results of Validation Ratings for Y/N Values	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Reassessing Intervention Parameters & Strategies	3	3	1.3	44%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating Score (for Y/N Items)	**7**	**7**	**5.3**	**76%**

Summary Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	15	100%
Reassessing Intervention Parameters & Strategies	4	12	8	66%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1.0	3.0	2.5	83%
Member Population Analysis	2	6	5	83%
Conclusions & Future PIP Improvements	3	9	8	83%
Validation Rating Score (for 3, 2, or 1 Values)	**20**	**60**	**53.5**	**89%**

Overall Validation Rating Score	27	67	58.8	88%

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
CeltiCare is encouraged to identify case managers with the strongest track record in supporting members to make follow-up appointments or work through members' resistance to medication adherence. These "best practice" case managers should share their methods in team meetings. Also, as resources allow, case managers could benefit from even an abbreviated training in Motivational Interviewing. This evidence-based patient coaching method would work well to assist members attain medication compliance.	CeltiCare reported having trained telephone case managers in Motivational Interviewing.

Calendar Year 2016 Recommendation	2017 Update
It is recommended that CeltiCare continue to find strategies for improved documentation of member contact information through software solutions, such that updated contact information is not lost when the updated eligibility data from MassHealth are loaded.	Updated demographic information is stored in the CeltiCare Operations Department.
This project could benefit from a comparative analysis of adherent and non-adherent members regarding their demographics and racial, ethnicity, and language factors, depending on data availability. The goal of the analysis would be to identify differentiating characteristics for the purpose of better selecting interventions that target the barriers that are unique to members who are non-adherent.	CeltiCare conducted an analysis of adherent members based on spoken language, gender, and race. No interventions were implemented that targeted specific non-adherent populations.

Plan and Project Strengths

- CeltiCare completed a strong population analysis that identified categories of members at high risk of non-adherence.
- CeltiCare is commended for completing its 2015 randomized control study of the effectiveness of its Member Antidepressant Brochure. Based on the finding that receiving the brochure did not result in improved rates of medication adherence, the intervention was expanded to include care managers trained in motivational interviewing.
- Training outreach staff in Motivational Interviewing is commended.
- CeltiCare is commended for its monthly data collection and the plan appears well-resourced for data collection and analysis.

Opportunities

- Data is collected monthly but is analyzed semi-annually.
- The plan presents some conclusions about the effectiveness of its interventions but does not make clear how it arrived at these conclusions. For example, the plan determined that the material distributed to members was not effective but did not provide the methodology used to reach this determination.

Recommendations

KEPRO offers the following recommendations to CeltiCare:

- Provide tips for adherence to medication for members.

- Provide information about how long it will take before the member feels better, and about the need for dosage adjustment.
- Consider contacting a provider when a medication refill gap is noted, or sending a notice to providers when gaps are noted.

FALLON HEALTH'S MCO

2016 Interventions

- An AMM Member Outreach program was implemented.
- The Case Management Navigator staff, which increased from one to seven during 2016, was trained in Motivational Interviewing and conducted telephonic outreach to members newly diagnosed with major depressive disorder who were prescribed an antidepressant medication.
- The Case Management outreach call script was enhanced with prescription-related education.
- An assessment was developed and embedded in the centralized enrollee record.
- Fallon and Beacon developed an informational flyer to introduce Fallon's primary care providers to the content of the PCP Toolkit. This toolkit contains member resources, prescribing references, and information about the PCP Consult Line.

Results

The charts that follow depict Fallon Health's AMM Acute and Continuous performance over time. The AMM Acute rate increased a statistically insignificant 4.03 percent between 2015 and 2016. Fallon's Acute rate is between the Medicaid Quality Compass 33rd and 50th percentiles. The AMM Continuous rate, which falls between the 5th and 10th percentiles, increased 7.23 percent, also statistically insignificant. The plan did not meet its performance goal for either measure. The Acute rate is trending up slightly and the Continuous rate is trending down.

Exhibit 60: Fallon AMM Acute Treatment Rates Compared to Goal

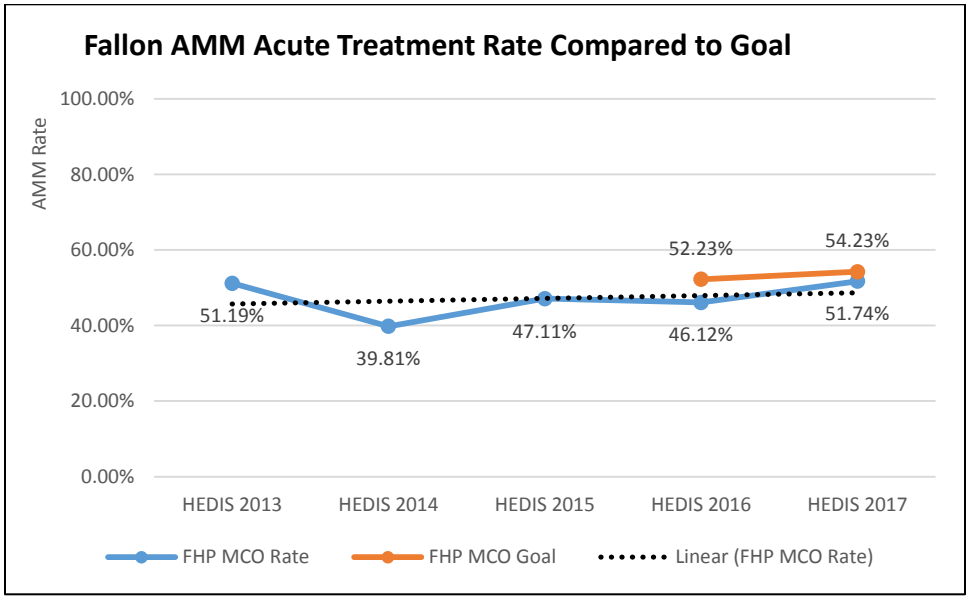
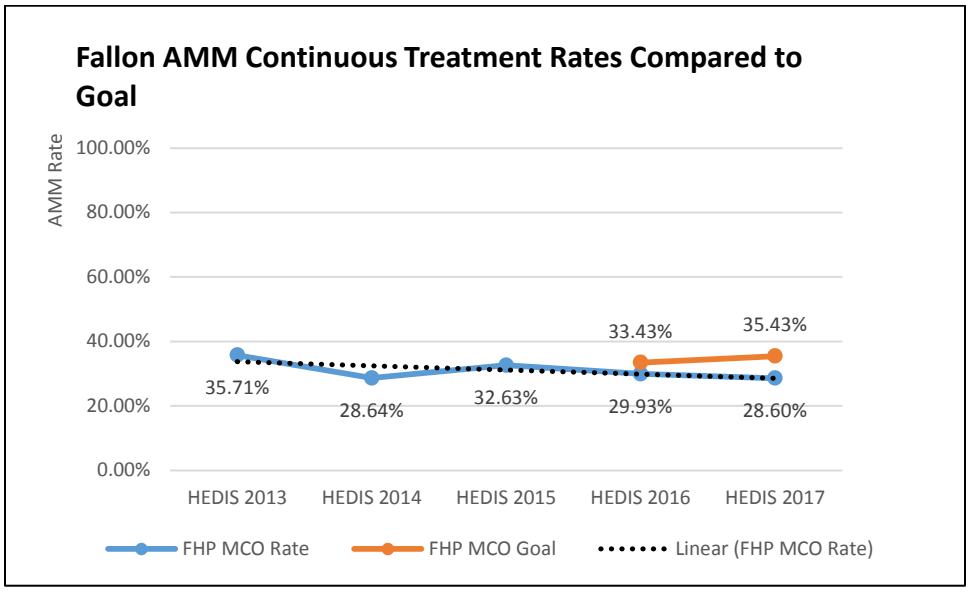


Exhibit 61: Fallon AMM Continuous Treatment Rates Compared to Goal



Performance Improvement Project Score

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

Exhibit 62: Fallon Health MCO's AMM PIP Scores

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

Summary Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	15	100%
Reassessing Intervention Parameters & Strategies	4	12	12	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	6	100%
Conclusions & Future PIP Improvements	4	12	12	100%
Rating Score for (3, 2, or 1 Values)	**21**	**63**	**63**	**100%**

Overall Validation Rating Score	34	74	74	100%

Updates on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
Given the diversity of Fallon Health's member population, it could promote training in cultural competence among providers.	KEPRO recommends that Fallon Health consider sharing the results of its excellent population analysis with a broad representation of staff.
Moderately depressed members may have cognitive challenges that present a barrier to calling for their own follow-up appointments. Fallon Health may wish to consider evaluating whether three-way calls for certain members may be beneficial.	Fallon Health AMM care managers work to minimize barriers to care including facilitating transportation to provider appointments.

Plan & Project Strengths

Fallon is commended for:

- Improvements to its interventions during the measurement year, notably its efforts to create an outreach call script for care managers, trying to identify difficult to reach members, participation with warm transfers, Motivational Interviewing training for staff, and the dedication of increased staff resources for outreach.
- Educating members about public transportation systems to address identified barriers associated with transportation.
- The ongoing training of staff and motivational interviewing.
- Increasing the number of care management navigator positions.
- The use of Google Analytics to measure the volume of page views by providers.
- Its excellent population analyses, especially for its comparative analysis of several key demographics comparing HEDIS 2016 data to HEDIS 2017 data.

Opportunities

None identified.

Recommendations

KEPRO offers the following recommendations to Fallon Health:

- Soliciting member feedback could lead to further improvements.
- KEPRO recommends that Fallon consider adding other media for outreach, such as phone apps and text messages.

HEALTH NEW ENGLAND

2016 Interventions

- Health New England did not implement new interventions in 2016. It did not report making any insignificant modifications to existing interventions which include member and provider educational materials as well as a Depression Disease Management Program.

Results

Health New England's AMM Acute performance rate in HEDIS 2017 was 42.55 percent. It did not meet its goal of 73.40 percent. This rate represents a statistically significant decrease of 7.75 percent from HEDIS 2016 ($p < 0.05$). The HEDIS 2017 AMM Continuous rate was 28.05 percent, a statistically insignificant increase from HEDIS 2016 of 6.30 percent. Performance is trending down for both measures. Both measures fall between the 5th and 10th percentiles of the Medicaid Quality Compass.

Exhibit 63: Health New England's AMM Acute Treatment Rates Compared to Goal

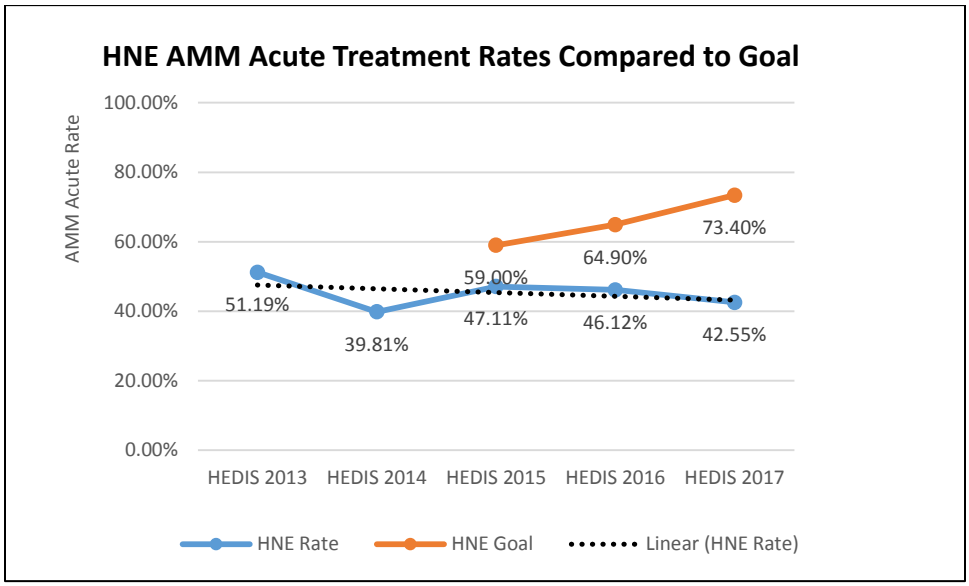
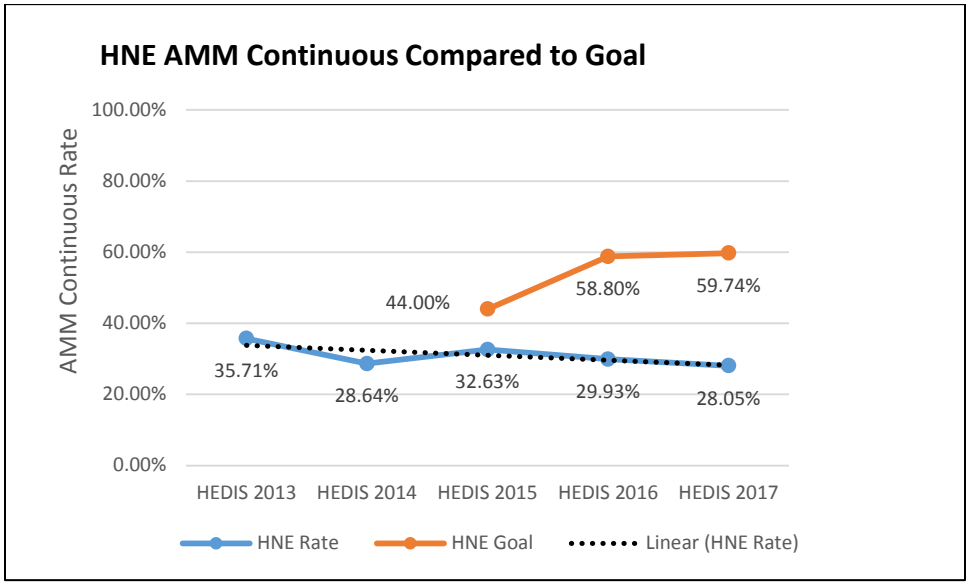


Exhibit 64: Health New England's AMM Continuous Treatment Rates Compared to Goal



Performance Improvement Project Score

KEPRO evaluates a MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. HNE received a score of 68% on its AMM PIP.

Exhibit 65: Health New England's AMM PIP Scores

Results of Validation Ratings (for Y/N Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Reassessing Intervention Parameters & Strategies	3	3	2.3	77%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating Score for Y/N Items	**7**	**7**	**6.3**	**90%**

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	10	67%
Reassessing Intervention Parameters & Strategies	4	12	6.7	56%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	2	33%
Conclusions & Future PIP Improvements	4	12	5	42%
Validation Rating Score for 3, 2, or 1 Values	**28**	**63**	**41.7**	**66%**

Overall Validation Rating Score	34	70	48	68%

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
HNE's quality improvement process could be strengthened by collecting structured feedback from members regarding their response to interventions. Such feedback could be gathered by creating a short survey that the case manager could complete while talking with the member. Stakeholder advisory councils are recommended as vehicles through which members and providers can conduct a dialogue with HNE staff about barriers to care and interventions.	No related activity was reported.
As resources allow, HNE is encouraged to expand interventions that are now reaching only a small number of members.	HNE's interventions continue to reach only a small number of members. This recommendation stands.
Because so many of HNE's interventions involve posting information to its website, it is recommended that HNE monitor hits to its web page and that of MBHP in order to better assess how many members and providers access educational materials. Providers can also be asked to rate HNE's webinars and the resources presented on its website.	This recommendation stands.
In addition to interventions such as church-based education and its *Tip Sheet for the Culturally Sensitive Practitioner,* HNE could promote training in cultural competence among providers.	No related activity was reported.

Plan and Project Strengths

- HNE is commended for reporting its statistical tests of difference between rates for current and prior measurement years.

Opportunities

- There is no reference to making educational materials available to members in languages other than English.
- Given that its performance rates are declining and the care management intervention is engaging so few members, HNE's description of the status of its intervention implementation as "ongoing" is inadequate.
- HNE did not provide a population analysis due to "conflicting priorities."

Recommendations

KEPRO offers the following recommendations to Health New England:

- HNE needs to review and consider how it designs its PIPs, including how it designs and implements interventions, and how it allocates staff resources and management expertise to the oversight and guidance of these projects.
- KEPRO recommends that HNE partner with an NCQA medical home and large pharmacy once the reasons for medication non-adherence have been determined to improve medication adherence for antidepressant medication.
- Because face-to-face education is generally more effective than brochures and newsletters, it is recommended that HNE report on its in-office provider interface.
- KEPRO recommends monitoring member and provider access to the HNE and Beacon websites.
- KEPRO recommends that HNE use the REL data available in its MassHealth eligibility data files, and continuously work to improve its collection of REL data.

NEIGHBORHOOD HEALTH PLAN

2016 Interventions

- NHP uses Beacon's Psychotropic Medication Intervention Program that identifies medication-related problems through claims review, analytics, clinical review, and health informatics.

- NHP conducted individualized, face-to-face trainings with providers at Codman Square Health Center, a community health center with low AMM performance rates. This CHC showed a statistically significant improvement in performance.

Results

Neighborhood Health Plan's AMM Acute rate increased a statistically significant 19.08 percent ($p < 0.0005$) from 48.96 percent in HEDIS 2016 to 50.93 percent in HEDIS 2017. The AMM Continuous rate increased a statistically insignificant 2.47 percent between these two measurement periods. Although NHP did not meet its goal of the NCQA Quality Compass HEDIS Medicaid 50th percentile, performance for both measures continues to trend up. NHP's performance for both rates falls between the 33rd and 50th percentile.

Exhibit 66: NHP AMM Acute Treatment Rates Compared to Goal

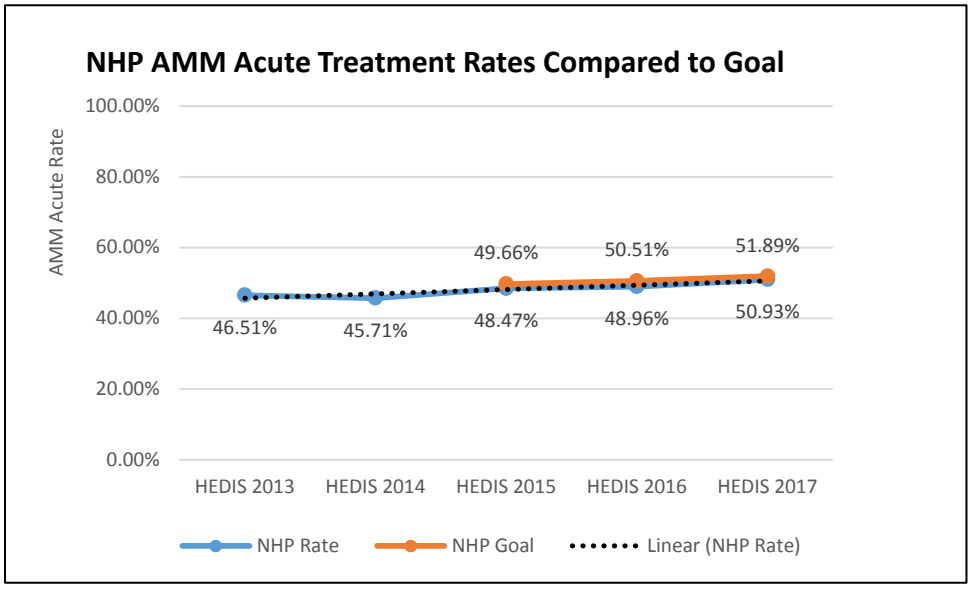
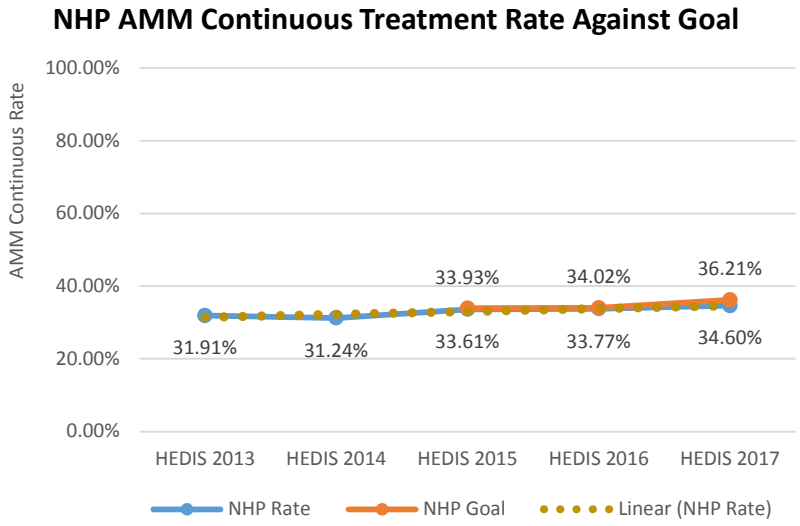


Exhibit 67: NHP AMM Continuous Treatment Rates Compared to Goal



Performance Improvement Project Score

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

Exhibit 68: Neighborhood Health Plan's AMM PIP Scores

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

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	15	100%
Reassessing Intervention Parameters & Strategies	4	12	12	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	6	100%
Conclusions & Future PIP Improvements	4	12	12	100%
Validation Rating Score (for 3, 2, or 1 Values)	**21**	**63**	**63**	100%

Overall Validation Rating Score	28	70	70	100%

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
For the next measurement cycle (CY2017), KEPRO strongly recommends that NHP use its two years of data to understand the demographic and clinical characteristics of members who are adherent compared to those who are non-adherent. Using data-based analysis, NHP should examine which interventions are appropriate to the identified needs of members who are non-adherent to their antidepressant medications.	NHP conducted a robust analysis of the qualities of members who are adherent and non-adherent.
NHP is urged to engage members and providers to get feedback regarding the relevance and significance of the barriers listed. Stakeholder feedback will also inform choice of interventions. Based upon this feedback, NHP should prioritize the interventions, such that those with positive feedback are strengthened, and the less effective interventions should be modified or dropped. This exercise will allow NHP to focus its limited resources to those interventions that are viewed by stakeholders as having the greatest relevance for performance improvement. NHP should assess and prioritize which of its 37 interventions in use over the past two years are the most relevant and effective.	NHP's progression from 37 broad-scale interventions to ones that are more targeted to members at risk for non-adherence is commendable. NHP is commended for soliciting feedback from providers about improving AMM adherence during its May 2016 conference presentation.
NHP should profile and stratify provider data managed by the PDIP program with respect to their members' adherence rates, members' history of polypharmacy, and prescribers' patterns of sub-therapeutic dosing.	NHP's provider data analysis included AMM performance stratified by community health center.
NHP is encouraged to research evidence-based interventions and adapt these interventions for use with members and providers, where feasible.	This recommendation is offered again in 2017.

Plan and Project Strengths

- NHP's progression from broad-scale interventions to ones that are more targeted to members at risk for non-adherence is commendable.
- NHP is highly commended for its excellent assessments of intervention effectiveness.
- NHP's efforts at provider education are commendable and the provider training program is excellent.
- NHP is commended for soliciting feedback from providers about improving AMM adherence during its May 2016 conference presentation.
- NHP is commended for its frequent data collection and analysis.
- NHP presented a detailed and excellent population analysis of members included in this AMM project. This analysis stands out as a model population analysis.

Opportunities

- No opportunities of note were identified.

Recommendations

KEPRO offers the following recommendations to Neighborhood Health Plan:

- KEPRO suggests that NHP consider a text messaging campaign with tips for medication adherence and making those text messages available in languages other than English.
- NHP may not have sufficient resources for their targeted interventions. KEPRO recommends that NHP management review its resource commitment for this project.
- KEPRO encourages NHP to formalize feedback from members and providers through surveys and advisory meeting minutes.
- KEPRO encourages NHP to continue to look for any evidence-based interventions that are applicable to medication adherence, as well as continue to solicit feedback from providers about how NHP can engage and support them in this effort to improve medication adherence rates.
- Any materials sent directly to members should have the benefit of pre-review by a panel of members who can give ideas about the usefulness and readability of the materials.

2016 Interventions

The AMM Outreach Program is designed to improve medication adherence among adult members prescribed antidepressant medication, including members diagnosed with major depression who are prescribed an antidepressant medication. Care Management staff conduct telephonic outreach to members identified as having recently been prescribed an antidepressant medication by querying current pharmacy claims data.

Results

Both the THPP Acute and Continuous Treatment AMM rates increased significantly between HEDIS 2016 and HEDIS 2017. The Acute rate, 58.09 percent, increased 4.92 percent ($p < 0.005$) bringing THPP closer to its goal of 59.17 percent. The Continuous rate, 45.15 percent, represents a 9.00 percent ($p < 0.005$) increase. THPP surpassed its goal of 45.05 percent by 0.10 percentage points. Both rates lie between the 75th and 90th NCQA Medicaid Quality Compass percentiles.

Exhibit 69: THPP AMM Acute Treatment Rates Compared to Goal

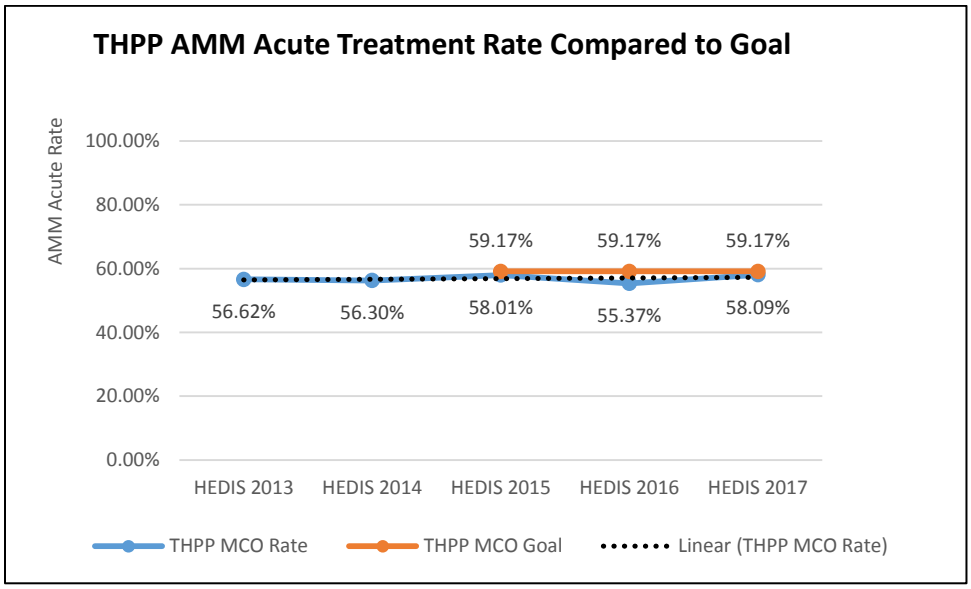
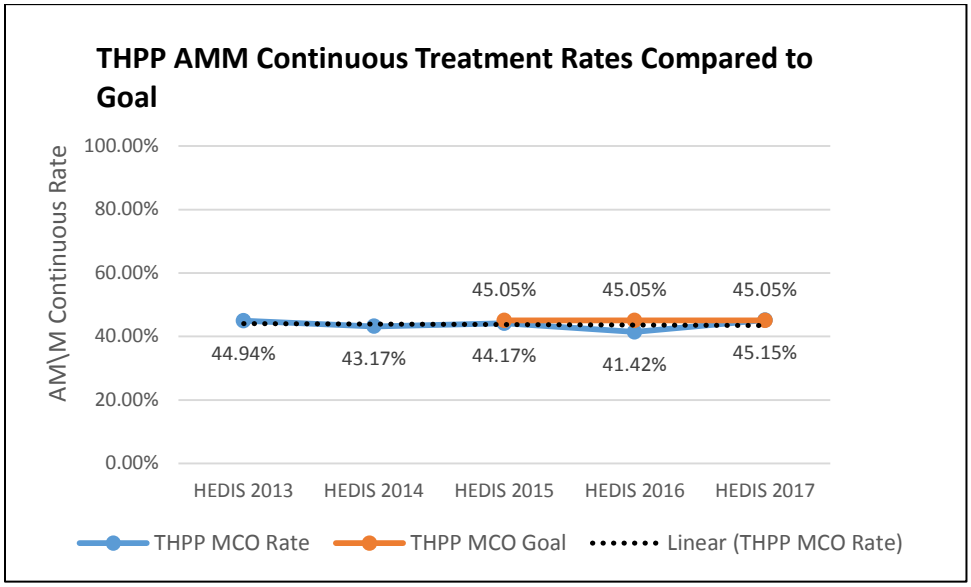


Exhibit 70: THPP AMM Continuous Treatment Rates Compared to Goal



Performance Improvement Project Score

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

Exhibit 71: Tufts Health Public Plan's AMM PIP Scores

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

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	4	12	12	100%
Reassessing Intervention Parameters & Strategies	4	12	12	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	6	100%
Conclusions & Future PIP Improvements	3	9	9	100%
Validation Rating Score (for 3, 2, or 1 Values)	**19**	**57**	**57**	**100%**

Overall Validation Rating Score	**26**	**69**	**69**	**100%**

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
THPP should consider drawing subsets of data at least quarterly to better identify trends in quality indicators that are related to the primary indicator. A less formal data set could be assessed for trends and be reviewed through THPP's quality management committees.	Tufts continues to draw and analyze its data on an annual basis.
THPP should consider improving its stakeholder engagement by convening recurring activities, such as advisory councils, or through ad hoc events, such as focus groups.	THPP did not provide evidence of this activity.
THPP should continue to explore a more frequent exchange of data with the pharmacy benefits manager to facilitate more immediate member interventions.	THPP did not indicate that the exchange of data is more frequent.

Plan and Project Strengths

- THPP is highly commended for the compilation of the population analysis. Having identified members with a diagnosis of depression, the analysis stratifies 195,445 members by a variety of demographic, REL (race, ethnicity, and language), MassHealth region, and MassHealth rating category. As such, this is a good analysis of the prevalence of depression in its entire member population.
- It is especially commended for its staff trainings, which included motivational interviewing and cultural competency.

Opportunities

No opportunities of note were identified.

Recommendations

KEPRO offers the following recommendations to Tufts Health Public Plan:

- While THPP has presented a highly commendable stratification of all members with depression and its qualified PIP members relative to adherence and non-adherence, KEPRO recommends that THPP present a more detailed list of conclusions and take-aways as these conclusions relate to and inform its intervention strategies.
- KEPRO recommends that THPP consider strategies to increase the number of members engaged by this intervention and to assess the effectiveness of this engagement.

PLAN-SPECIFIC POSTPARTUM CARE PIPS

Boston Medical Center HealthNet, Fallon Health's MCO, Health New England, and Tufts Health Public Plans participated in PIPs targeted at improving the rate at which women attend postpartum visits.

BOSTON MEDICAL CENTER HEALTHNET

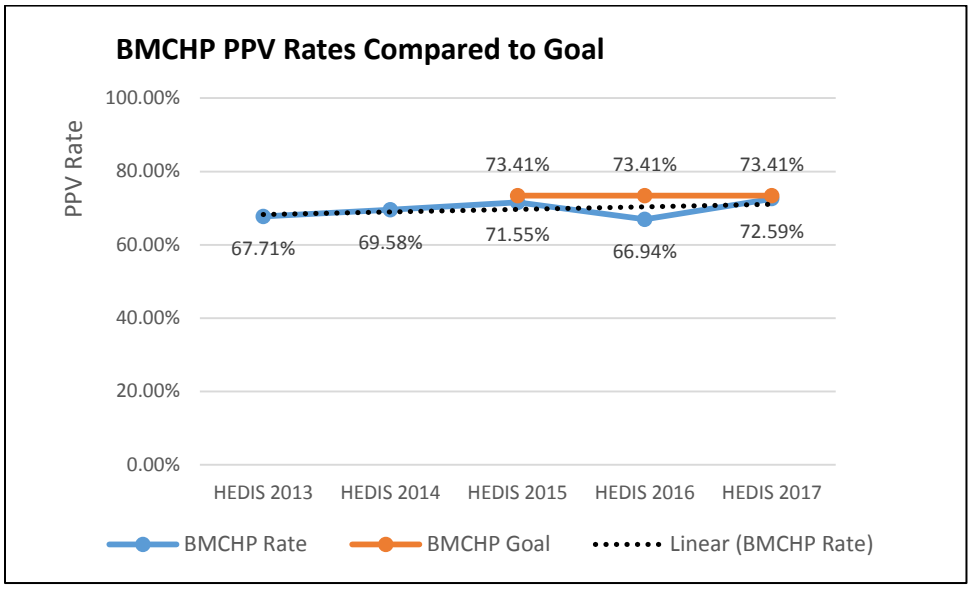
2016 Interventions

- In 2016, BMCHP partnered with a rewards vendor to pilot a rewards program for women who attended postpartum visits 21 to 56 days after delivery. In this pilot, the vendor called members after delivery to inform them of the rewards program and encouraged them to attend the postpartum visit. Members attending the postpartum visit were eligible to select items from a rewards catalog.

Results

The chart below depicts BMCHP's postpartum visit rate performance against goal, the trend for which has been up for five years. The rate increased a statistically significant 8.43 percent ($p < 0.05$) between HEDIS 2016 (66.94%) and HEDIS 2017 (72.59%). BMCHP did not achieve its performance goal of 73.41 percent by approximately 0.05 percentage points. BMCHP's HEDIS 2017 rate is between the 75th and 90th NCQA Medicaid Quality Compass percentiles.

Exhibit 72: BMCHP PPV Rates Compared to Goal



Performance Improvement Project Score

KEPRO evaluates a MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. BMCHP received a rating score of 92% on its PPV PIP.

Exhibit 73: Boston Medical Center HealthNet PPV PIP Scores

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

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	4	12	12	100%
Reassessing Intervention Parameters & Strategies	4	12	10	83%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	5	83%
Conclusions & Future PIP Improvements	3	9	7	78%
Validation Rating Score (for 3, 2, or 1 Values)	**19**	**57**	**52**	**93%**

Overall Validation Rating Score	26	64	59	92%

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
KEPRO continues to recommend that BMCHP develop interventions to determine the effectiveness of outreach and education efforts including emails, mailings, and all other outreach used in changing member behavior.	BMCHP conducted a robust analysis of the effectiveness of its member rewards program.
Survey providers to determine if a postpartum visit calendar would be a useful tool. Providing a laminated calendar to front office staff may help schedule appointments within the required timeframe.	No evidence of this activity was provided.
Consider targeted interventions in the southeastern and western regions, especially for low-performing providers.	BMCHP identified potential interventions for low-performing providers.

Plan and Project Strengths

- BMCHP is commended for using care management resources to confirm postpartum appointments with doctors.
- BMCHP is commended for assessment of the member incentive intervention and for its assessment of member satisfaction.
- BMCHP presented an excellent population analysis.

Opportunities

- BMCHP could strengthen its already strong quality management review process by facilitating periodic discussions with separate panels of members and participating providers.

Recommendations

- KEPRO recommends that BMCHP drill down on high-risk subgroups identified in the population analysis to determine the reasons for their low performance rates. The findings from this analysis could then be used to inform and strengthen intervention strategies.

FALLON HEALTH'S MCO

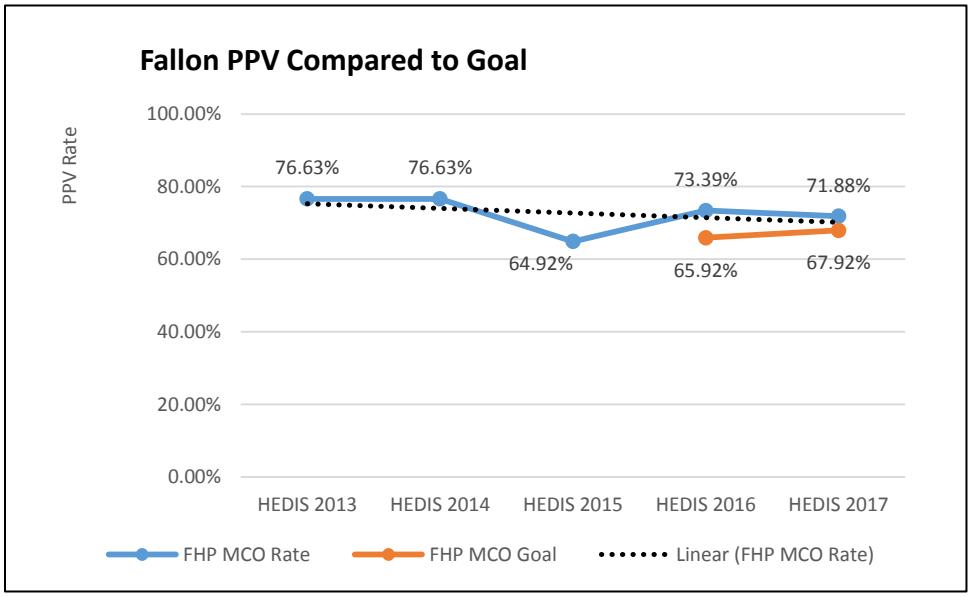
2016 Interventions

- Fallon Health conducted telephonic outreach to its pregnant members and encouraged their participation in a postpartum visit.
- Fallon Health Case Management continued to train staff in motivational interviewing techniques.
- Fallon Health Case Management dedicated two Navigators to update pertinent data for this intervention.
- Fallon Health offered a $20 gift card to members who attended a postpartum visit and who provided the plan with a letter signed by the provider.
- When Case Management Navigators could not reach a member due to a wrong phone number, the Navigator reached out to the PCP or OB/GYN to obtain an alternate number.
- If a member did not have transportation, Case Management Navigators educated members on PT-1 services, and applied for this benefit on the member's behalf. They followed up with the member to verify that these benefits were received and to coordinate future ride services.

Results

Fallon's Postpartum Visit rate decreased a statistically insignificant 2.06 percent between HEDIS 2016 and 2017 from 73.99 percent to 71.88 percent. For the second consecutive year, Fallon's performance exceeded its goal. The five-year performance trends down.

Exhibit 74: Fallon PPV Rates Compared to Goal



Performance Improvement Project Score

KEPRO evaluates a MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. Fallon received a rating score of 97% on its PPV PIP.

Exhibit 75: Fallon Health's PPV PIP Scores

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

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	15	100%
Reassessing Intervention Parameters & Strategies	4	12	10	83%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	6	100%
Conclusions & Future PIP Improvements	4	12	12	100%
Validation Rating Score (for 3, 2, or 1 Values)	**21**	**63**	**61**	**97%**

Overall Validation Rating Score	28	70	68	97%

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
KEPRO again recommends stratifying rates by the statuses of multiparous and nulliparous. A frequently suggested hypothesis is that multiparous women are less likely to attend a postpartum visit. The results of the analysis could provide important information and allow for targeted intervention.	Fallon Health provided no evidence of such a data stratification.
Fallon Health's analysis showed Spanish-speaking members to be prevalent and at higher risk for not have a timely postpartum visit. It is recommended that all informational materials regarding follow-up visits and appointment incentives that are distributed to members should be printed in English on one side and Spanish on the reverse side.	While a Babel sheet is included in the postpartum visit mailing, Spanish language versions are not included in member mailings. This recommendation stands.
The effectiveness of the postpartum reminder packet might be increased by giving the reminder packet to the provider who then gives it to the member and explains its contents.	The reminder packet continues to be mailed to the member.
Fallon Health can improve the workings of its Provider Community Council by having workgroups that focus on some particular Fallon Health initiative. Similar to the Provider Council, Fallon Health is encouraged to create a forum through which members can review and provide feedback on Fallon Health quality initiatives.	This recommendation stands.

Plan and Project Strengths

- Fallon is commended for providing information to members about public transportation services and benefits.
- Fallon is commended for making real-time (daily) information available to its Navigators regarding its postpartum members.
- Because of the prevalence of postpartum depression, Fallon is commended for administering the PHQ-2 depression screening tool during outreach calls.
- Fallon is commended for its excellent population analyses present in several attachments. Fallon is especially commended for its comparative analysis of several key demographics using HEDIS 2016 data in contrast to HEDIS 2017 data.

Opportunities

- If the PHQ-2 continues to be used, Fallon should use the assessment data to assess the effect of depression on mothers' postpartum visit rates.
- To identify potential correlations between postpartum visit attendance, KEPRO encourages the analyses of pregnancy outcomes, e.g., cesarean, preterm, neonatal intensive care unit, and/or preterm infants, as well multiple vs nulliparous status. KEPRO would also like to see an analysis of the reasons members do not to attend a postpartum visit, e.g., no shows, outside timeframe for HEDIS, incision-only visit, no medical record, or access to appointment times that are convenient.

Recommendations

- KEPRO notes that the "unable to reach" letter makes no reference to the need for a postpartum visit and the associated timelines. KEPRO recommends that these references be added to its letter.

HEALTH NEW ENGLAND

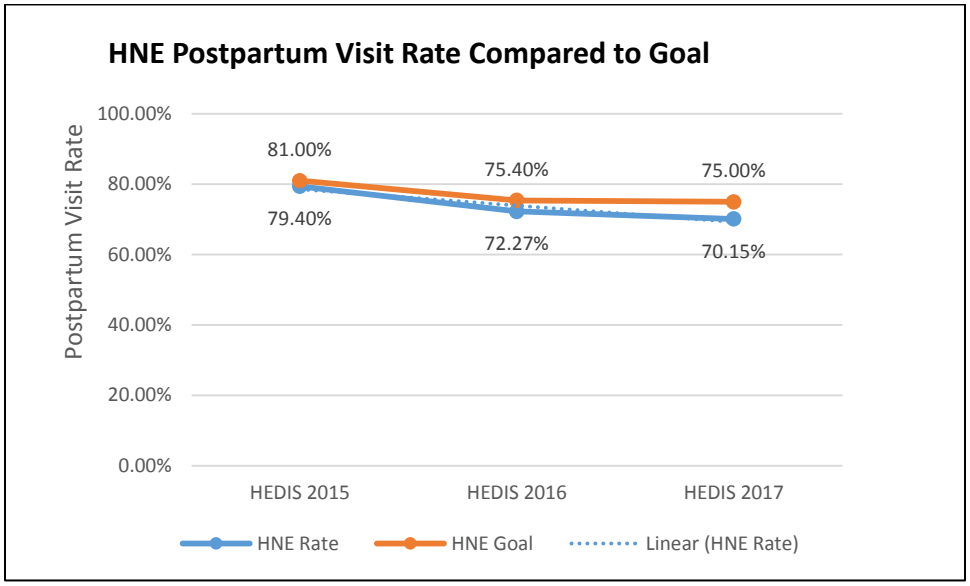
2016 Interventions

Health New England did not implement new interventions in 2016. It did not report making any significant modifications to the existing intervention, the Maternity Management Program, which was implemented in 2003 and extended to the Medicaid population in 2010. HNE combined live-calls, TEXT4BABY, e-mail, and mailed education materials to give the expectant member a solid foundation of knowledge that extends through the postpartum period.

Results

The table that follows depicts HNE's Postpartum Visit Rate over a period of three years, during which time performance has been trending down. Health New England's postpartum visit decreased a statistically insignificant 2.94 percent between HEDIS 2016 (72.27%) and HEDIS 2017 (70.15%). It did not achieve its Calendar Year 2016 goal of 75 percent.

Exhibit 76: HNE PPV Rates Compared to Goal



Performance Improvement Project Score

KEPRO evaluates a MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. HNE received a rating score of 75% on its PMV PIP.

Exhibit 77: Health New England's PMV PIP Scores

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

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	5	15	12	80%
Reassessing Intervention Parameters & Strategies	4	12	6.3	53%
Performance Indicator Parameters	1	3	2	67%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	2	33%
Conclusions & Future PIP Improvements	4	12	8	67%
Validation Rating Score (for 3, 2, or 1 Values)	**21**	**63**	**45.3**	**72%**

Overall Validation Rating Score	28	70	52.3	75%

Follow Up to 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
When a member needs to schedule a postpartum visit, the care coordinator could offer to stay on the line on a three-way call with the member and postpartum care provider.	HNE did not present related analysis in 2017.
During an outreach call, the care coordinator could inquire about the member's use of Text4Bbaby and record use for later tabulation. This would help HNE both better understand use of this messaging system and promote the program.	HNE did not present related analysis in 2017.

Plan and Project Strengths

- HNE is commended for PIP improvements including adapting its educational materials to the MassHealth population, the addition of a bilingual care coordinator, and improvements to real-time notifications of live births.
- HNE is commended for its analysis, for three successive years, of the reasons why members do not attend timely PPVs. This is an excellent example of a drill-down barrier analysis, which could lead to improvements in its intervention strategies. It is important that the findings from this analysis are directed toward improved intervention strategies.

Opportunities

- HNE notes that it has the capacity to produce a population analysis, but that its resources were not available due to "conflicting priorities and other reporting demands." KEPRO has serious concerns about the lack of analytic and reporting resources provided by HNE management to this PIP.
- HNE is encouraged to pull and analyze data related to this PIP more frequently than annually.
- HNE is encouraged to also solicit information (ideally structured, or at least anecdotal) about barriers from providers and members. Structured feedback can be collected during face-to-face outreach to members and provider practices.

Recommendations

- Considering the declining trend of the PPV rate over the past two measurement cycles, KEPRO strongly recommends that HNE conduct a thorough review of its intervention strategies to identify opportunities for improvement.
- Training in Motivational Interviewing is highly recommended for care management staff as a strategy for increasing staff skills in improving member engagement.
- HNE should consider sending an email or web-link that provides information about the *Perinatal Clinical Guidelines 2017* to targeted practices that are struggling with the PPV measure.

NEIGHBORHOOD HEALTH PLAN

Calendar Year 2016 represents a baseline performance year for Neighborhood Health Plan.

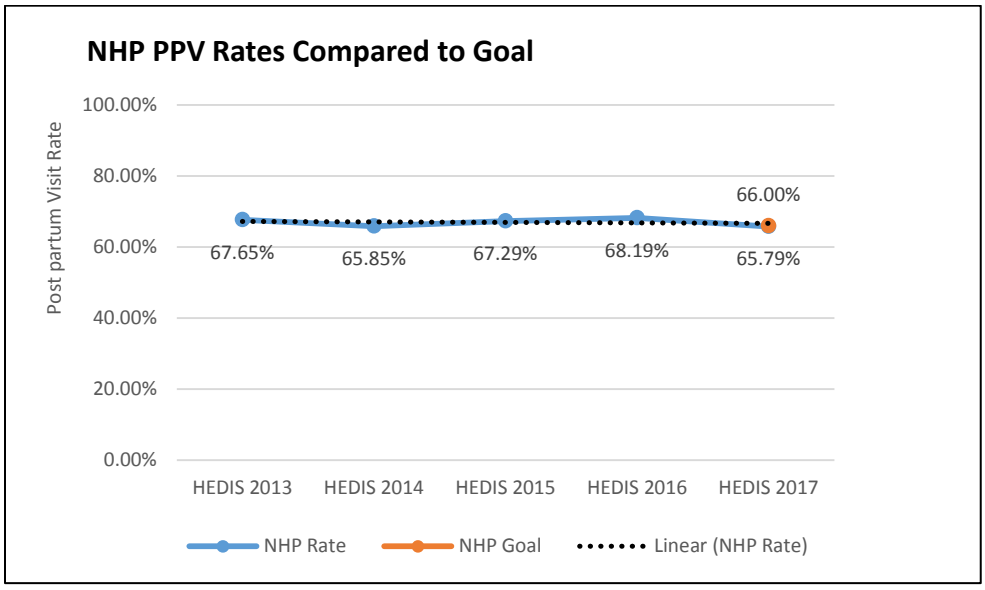
2016 Interventions

- A care management program focused on its highest-risk expectant mothers and mothers of preterm newborns (implemented April 2017).
- A text-messaging outreach campaign (implemented April 2017).
- Provider education about HEDIS postpartum care rates using web-based tools (implemented January 2017).

Results

Again, 2016 represents a baseline performance year for Neighborhood Health Plan's postpartum visit rate PIP. Its historical performance has experienced level rates. The baseline rate of 65.79 percent falls between the NCQA Medicaid Quality Compass 50th and 67th percentiles. A goal of 66 percent has been established as the goal for the first remeasurement in 2018.

Exhibit 78: NHP PPV Rates



Performance Improvement Project Score

KEPRO evaluates a MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. NHP receiving a rating score of 93% on its PPV PIP.

Exhibit 79: Neighborhood Health Plan's Postpartum Visit PIP Scores

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

Summary Results of Validation Ratings for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Problem Statement	4	12	12	100%
Member Population Analysis	3	9	9	100%
Barriers & Root Cause Analyses	2	6	5	83%
Intervention Parameters	5	15	13	87%
Rationale for Performance Indicators	1	3	3	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	3	9	7	78%
Baseline Performance Rates	1	3	3	100%
Validation Rating Score (for 3, 2, 1 Values)	**20**	**60**	**55.3**	**92%**

Overall Validation Rating Score	27	67	62.3	93%

Follow Up to 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
It is hypothesized that, due to child care concerns and a perceived lack of need, multiparous women attend postpartum visits at a lower rate than first-time mothers. KEPRO suggests that NHP assess the differences between the multiparous versus the first-time mother in accessing postpartum care. This information could inform targeted interventions.	Such an analysis was not included in this year's report.
Increase educational efforts about the importance of post-partum visits to low-performing providers.	Targeted provider education is not part of NHP's current improvement strategy.

Plan and Project Strengths

- NHP is commended for soliciting member and provider feedback through a variety of venues, formal and informal. NHP's plan to solicit members' feedback through its website, Neighborhood Green[7], is an interesting option that is worth pursuing.
- NHP is commended for its design to focus its care management interventions on high-risk mothers and babies. NHP has presented an informative table that links several barriers to indicator performance to their respective interventions.

Opportunities

- NHP's description of its provider education intervention is minimal. NHP describes making educational information available to providers though web-based tools, but these tools are not described. NHP presents no description of how the educational materials are developed.

Recommendations

- KEPRO recommends that feedback from external stakeholders be captured in a report that summarizes input regarding barriers from members compared to providers.
- The care management intervention is projected to engage 35 members. Considering that the sampling denominator is 380 members, this intervention is projected to engage about 9 percent of the eligible members (or fewer when considering the total number of women

[7] Neighborhood Green is an online community in which NHP members can share their comments about NHP's products and services using surveys, discussion boards, and other forums.

who have live births). KEPRO recommends that consider strategies for increasing the number of members to be engaged through care management.

TUFTS HEALTH PUBLIC PLANS MCO

2016 Interventions

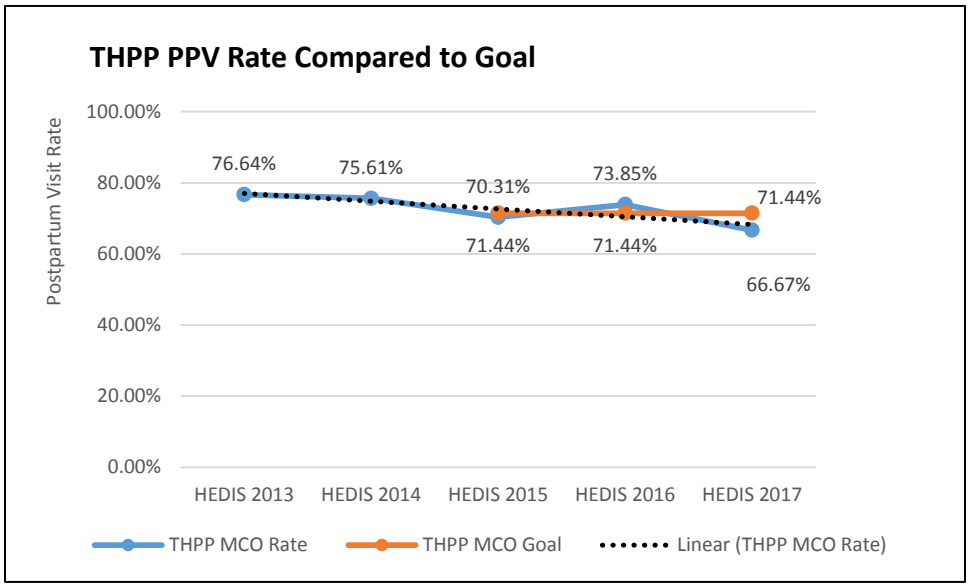
THPP conducts outreach and education by mail (a welcome baby card) and phone (a telephonic postpartum follow-up assessment).

THPP operates the Doula[8] by My Side program in Worcester and Suffolk Counties. In this program, a doula provides expectant mothers with education, assistance, guidance, and support as needed.

Results

The table that follows depicts THPP's Postpartum Visit rate against its goal over a period of five years, during which time performance has been trending down. In HEDIS 2017, the rate of 66.67 percent represents a statistically significant decrease of 9.73 percent ($p < 0.05$) from HEDIS 2016 (73.85%). Tufts Health Public Plans' rate lies between the NCQA Medicaid Quality Compass 50th and 67th percentiles.

Exhibit 80: THPP PPV Rates Compared to Goal



[8] A doula is a trained professional who provides nonmedical care including education, household organization, and general support before and after the birth of a child.

Performance Improvement Project Score

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

Exhibit 81: THPP's PPV PIP Scores

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

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
Reassessing PIP Goals & Barriers	4	12	12	100%
Reassessing Intervention Parameters & Strategies	4	12	12	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	4	12	12	100%
Performance Indicator Results	1	3	3	100%
Member Population Analysis	2	6	6	100%
Conclusions & Future PIP Improvements	3	9	9	100%
Validation Rating Score (for 3, 2, or 1 Values)	**19**	**57**	**57**	**100%**

Overall Validation Rating Score	26	64	64	100%

Update on Calendar Year 2016 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2016 to Tufts Health Public Plans follows:

Calendar Year 2016 Recommendation	2017 Update
In order to promote the continuous improvement in this evidence-based practice, THPP MCO should consider offering periodic Motivational Interviewing (MI) refresher courses. KEPRO also recommends that Care Management supervisors receive advanced training, which they can then use to support their staff. KEPRO also recommends that doulas receive MI training. The use of these skills will help women adopt healthy behaviors and achieve health goals such as attendance at the postpartum visit.	All department staff began attending a series of internal Motivational Interviewing (MI) training sessions in 2017, and thereafter will receive periodic refresher trainings. Additionally, staff conducting postpartum outreach calls will be encouraged to utilize MI techniques during calls with members. This will be reinforced by the refresher trainings as well as periodic workgroup and subgroup meetings and ongoing coaching by care management leaders and trainers.
Where feasible, THPP MCO should evaluate individual member and provider interventions for effectiveness and relevance.	THPP did not provide evidence of this activity.
It is recommended that THPP MCO convene member and provider advisory councils as a structured vehicle for receiving stakeholder feedback on its performance improvement projects.	THPP did not provide evidence of convening advisory councils.

Plan & Project Strengths

- THPP is commended for its addition of a clinical outreach coordinator and its postpartum follow-up assessment.
- THPP is commended for adding the depression screening protocol for mothers with high-risk pregnancies.
- The Doula by My Side appears to be an excellent intervention and THPP is commended for expanding it beyond Worcester County in 2017.
- THPP completed an excellent population analysis.

Opportunities

No opportunities of note were identified.

EMERGENCY DEPARTMENT UTILIZATION

Because pregnant women are not eligible to enroll in CeltiCare, this health plan undertook a PIP targeted at decreasing emergency department utilization.

CELTICARE

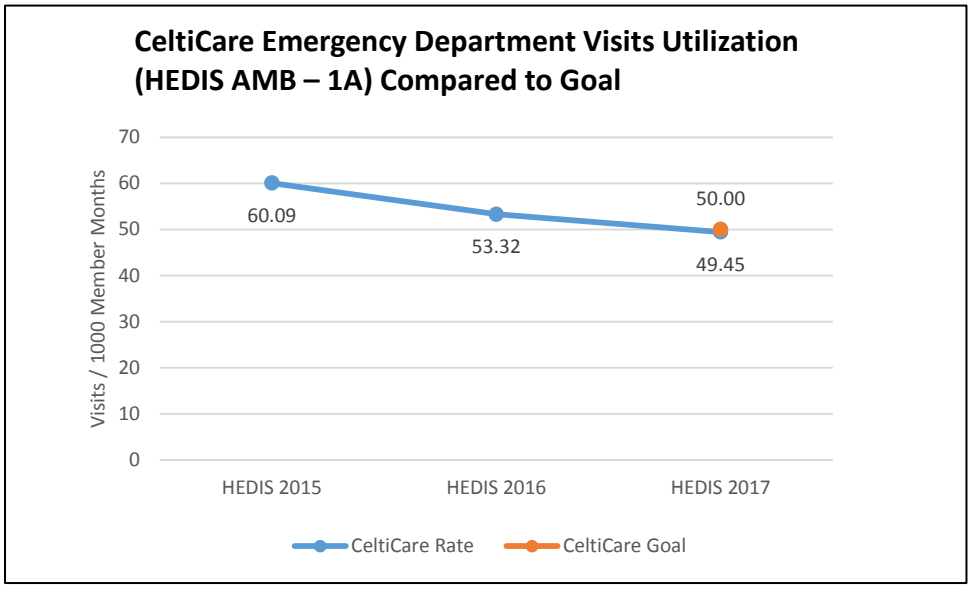
2016 Interventions

- CeltiCare Health Integrated Care Managers educated members on appropriate emergency department (ED) usage during care manager contacts. In 2016, behavioral health case managers were added to the care management team. Care Managers conduct telephonic outreach to members who were treated for ambulatory sensitive conditions or behavioral health conditions and provide education on appropriate ED utilization.

Results

CeltiCare evaluated Emergency Department Utilization performance using two measures. The first of these, a ratio of the total number of emergency department claims annualized to the total number of CeltiCare enrolled members, could not be validated by KEPRO because the calculation methodology was not provided. The second measure by which performance is measured is HEDIS Amb-1A, Emergency Department Visit Utilization. The chart below depicts CeltiCare's performance for a three-year period. In HEDIS 2017, CeltiCare met its goal of 50 visits per thousand members. This goal is a benchmark set by Centene, CeltiCare's corporate parent.

Exhibit 82: CEL ED Utilization Rates



Performance Improvement Project Score

KEPRO evaluates a MCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. CeltiCare received a rating score of 82% on its ED Utilization PIP.

Exhibit 83: CeltiCare ED Utilization PIP Scores

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

Results of Validation Ratings (for 3, 2, or 1 Values)	Number of Items	Total Available Points	Points Scored	Rating Averages
R2. Reassessing PIP Goals & Barriers	5	15	11	73%
R3. Reassessing Intervention Parameters & Strategies	4	12	11	92%
R4. Performance Indicator Parameters	1	3	2	66%
R6. Performance Indicator Data Analysis	4	12	12	100%
R7. Performance Indicator Results	1	3	1.5	50%
R8. Member Population Analysis	2	6	4	67%
R9. Conclusions & Future PIP Improvements	3	9	7	78%
Validation Rating Score (for 3, 2, or 1 Values)	**20**	**60**	**48.5**	**81%**

Overall Validation Rating Score	27	67	55.5	82%

Update on 2016 Recommendations

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

Calendar Year 2016 Recommendation	2017 Update
Consider using the provider portal to push an electronic notification of a member's admission to the ED to the provider. The provider could be informed that the member is eligible for case management services and be given directions how to connect the member with case management.	No evidence of related activity is reported.
Continue to build relationships with high-volume hospitals and obtain census-level data that allows timely interventions.	No evidence of related activity is reported.
Because CeltiCare identified that a lack of member knowledge regarding who their PCPs are is a barrier, explore expanding the scope of the nurse call line to include assistance with member connection to his or her PCP.	No evidence of related activity is reported.
Consider adding the nurse call line telephone number to the member ED brochure. Adding this number could promote calls to the nurse call line and divert ED visits.	The NurseWise telephone number appears in the ED brochure.
Consider training in basic research methodology for the staff members who design and execute the performance indicator calculations.	No evidence of related activity is reported.
Collaborate with colleagues or consultants who are skilled at developing valid performance measures so that changes in performance can be accurately calculated.	No evidence of related activity is reported.

Plan & Project Strengths

- CeltiCare is commended for improving its integrated case management program by adding behavioral health nurse care mangers to its staffing complement.
- CeltiCare is commended for its commitment to expanding urgent care and walk-in centers within the provider network.

Opportunities

- A metric used to measure performance, a ratio of the total number of emergency department claims annualized to the total number of CeltiCare enrolled members, could not be validated by KEPRO because the calculation methodology was not provided.
- This population analysis presents very little detail about the characteristics of members accessing emergency departments. There is no analysis of frequent utilizers, who could then be targeted for intensive care management. Frequent ED utilizers' symptoms are presented, but no strategy for provider education about risk conditions is offered.

Recommendations

- KEPRO suggests that CeltiCare conduct an analysis of members who engage and who don't engage in care management to understand their characteristics and tailor interventions.
- KEPRO recommends that CeltiCare further assess the clinical risks of its frequent ED utilizers and train both care managers and providers to anticipate members who are at risk for ED utilization.
- To ensure that members are not receiving follow up for chronic health conditions at urgent care centers, survey members to determine whether there are access issues with the current provider network.
- KEPRO recommends that CeltiCare gather its own demographics in order to improve its outreach success. This information can be received from the hospital, nurse line, primary care provider, or urgent care center.

SECTION 6. COMPLIANCE VALIDATION

INTRODUCTION

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

The 2017 compliance reviews were structured based on program requirements as outlined in 42 CFR 438. In addition, compliance with provisions in contracts as they relate to 42 CFR 438 between MassHealth and the Managed Care Organizations (MCOs) were assessed. Appropriate provisions in the Code of Massachusetts Regulations (CMR) were included in the reviews as indicated. The most stringent of the requirements were used to assess for compliance when State and Federal requirements differed.

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

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

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

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

KEPRO communicated an overview of the compliance review activity and timeline to the MCOs prior to the formal review period. Preferred dates for the onsite reviews were solicited. In addition, KEPRO hosted a webinar on April 10, 2017, to provide more detailed information and instructions for the MCOs to prepare for the compliance review. MCOs were provided with a

preparatory packet that included the project timeline, a draft onsite agenda, the compliance review tools, and data submission information. KEPRO scheduled a 30-minute call with each MCO approximately two weeks prior to the onsite review that covered review logistics.

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

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

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

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

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

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

An overall percentage compliance score for each of the 14 standards was calculated based on the total points scored divided by total possible points. In addition, an overall percentage compliance score for all fourteen standards combined was calculated. For each area identified as Partially Met or Not Met, the MCOs were required to submit a corrective action plan (CAP) in a format agreeable to MassHealth.

Per 42 CFR 438.360, Nonduplication of Mandatory Activities, KEPRO accepted NCQA accreditation to avoid duplicative work. To implement the deeming option, KEPRO reviewed the NCQA 2016 managed care organization accreditation standards against the CFRs. Where the accreditation standard was at least as stringent as the CFR, KEPRO flagged the review element as eligible for deeming. For a review standard to be considered deemed, KEPRO evaluated the MCOs' most current accreditation review and scored the review element as "Met" if the MCO scored 100 percent on the accreditation review element.

COMPLIANCE VALIDATION COMPARATIVE ANALYSIS

The graph that follows depicts the compliance scores for each of the MCOs reviewed:

Exhibit 84: CY 2016 MassHealth MCO Aggregate Compliance Scores

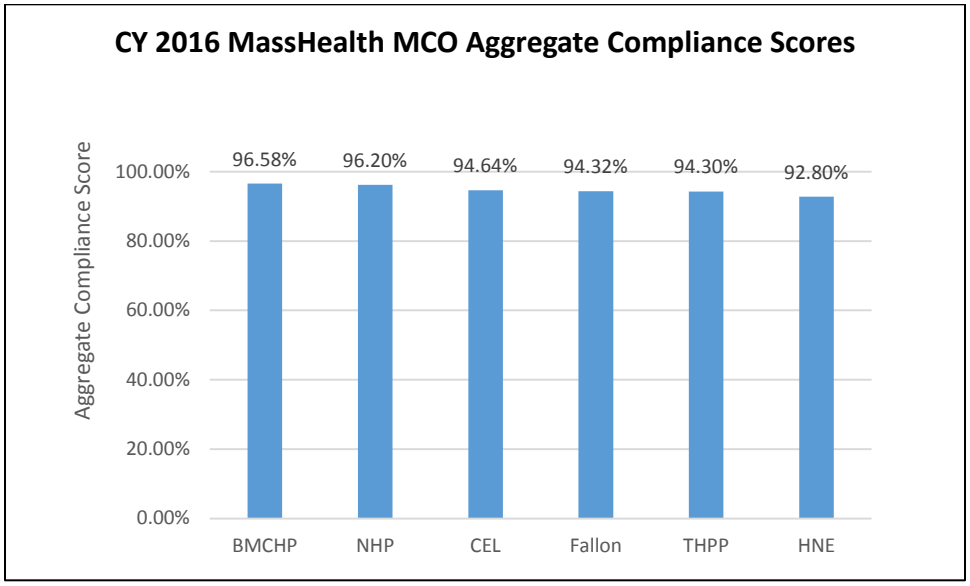


Exhibit 85: Compliance Scores Received by MCOs

Compliance Review Elements	BMCHP	CeltiCare	Fallon	HNE	NHP	Tufts
Enrollee Rights and Protections	5/5	5/5	5/5	5/5	5/5	5/5
Enrollee Information	28.5/31	29/31	28.5/31	27/31	28.5/31	30.5/31
Availability and Accessibility of Services	26.5/29	25.5/29	26/29	25/29	26.5/29	24.5/29
Coordination and Continuity of Care	30/30	28.5/30	29/30	28/30	30/30	29.5/30
Coverage and Authorization of Services	40.5/42	41/42	40.5/42	39/42	41/42	40.5/42
Practice Guidelines	8/8	8/8	8/8	8/8	8/8	6/7
Enrollment and Disenrollment	4/4	5/5	4.5/5	4.5/5	4.5/5	5/5
Grievance System	37.5/39	37/39	38/39	37.5/39	37/39	38/39
Sub-contractual Relationships and Delegation	17/17	14/14	16/17	17/17	17/17	17/17
Quality Assessment and Performance Improvement Program	23/24	21.5/24	21/24	21.5/24	22.5/23	18.5/24
Credentialing	12/12	10.5/12	11/12	11.5/12	12/12	12/12
Confidentiality of Health Information	3/3	3/3	2.5/3	2.5/3	3/3	3/3
Health Information Systems	2/2	2/2	2/2	1.5/2	2/2	2/2
Program Integrity	17/17	17/17	17/17	17/17	16/17	16.5/17
Total Received/Possible*	**254/263**	**247/261**	**249/264**	**245/264**	**253/263**	**248/263**
Score Calculated as Percentage[1]	**96.58%**	**94.64%**	**94.32%**	**92.80%**	**96.20%**	**94.30%**

Note: The total possible number of elements may vary slightly due to the number of not applicable elements.
[1] The score calculated as percentage is equal to the total score received divided by the total number of elements possible.

AGGREGATE OBSERVATIONS AND RECOMMENDATIONS

Overall, the MCO's demonstrated compliance with many of the Federal and State contractual requirements for its MassHealth Medicaid membership. In general, the MCOs performed best in the areas of Enrollee Rights and Protections, Practice Guidelines, Enrollment and Disenrollment, Subcontractual Relationships and Delegation, Credentialing, Confidentiality of Health Information, Health Information Systems, and Program Integrity. All MCOs had aggregate scores above 92 percent. In general, the MCOs demonstrated an opportunity for improvement in the areas of Enrollee Information, Availability and Accessibility of Services, and Quality Assessment and Performance Improvement Program standards.

While KEPRO identified many overall strengths and successes of the MCO model, the review revealed some challenges as well. KEPRO identified that MCOs varied in their understanding and use of medical necessity denials versus the use of administrative denials. While medical necessity review is required for Medicaid populations under 21 for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, some MCOs reviewed everything for medical necessity regardless of age. Other MCOs did not apply EPSDT requirements in the medical necessity review of their under-21 populations. For those MCOs that applied clinical necessity to all services, this presented some challenges within the MCOs' utilization management processes since appeal path options available to the member varies based on the classification of the denial. MCOs that did not apply or understand EPSDT requirements may be putting their organizations and the MassHealth program at risk.

MassHealth made changes in the level of appeals afforded to members at the health plan level. MassHealth moved the requirement from two levels of health plan appeal to one level of appeal. With the change, MassHealth also required that members exhaust the health plan appeal level before accessing the State Board of Hearings process. KEPRO found that MCOs were inconsistent with their knowledge, timing, and implementation of these changes.

While MCOs received MassHealth approval for the member handbooks, KEPRO identified that many of the MCOs did not include all required federal language and that some MassHealth template language related to the behavioral health diversion program did not read at required literacy levels.

MCOs had very robust processes and quality improvement initiatives underway. The documentation, however, of these activities and their results within the Quality Improvement Evaluation was lacking for many MCOs. The Evaluation was not reflective of many of the innovative and impressive activities that were articulated during the onsite reviews.

Based on the 2017 aggregate compliance review results, KEPRO recommends:

- MassHealth needs to provide clarity to MCOs on its expectations related to medical necessity and administrative denials. MassHealth should consider conducting an EPSDT training to ensure that all MCOs are complying with these utilization management review requirements.
- For changes made by MassHealth by means of a contract amendment, MassHealth may consider requiring a policy review of MCOs to ensure that there is consistency between MCO operational practices and that the changes are implemented at the same time. MassHealth should ensure that MCOs are consistent in their knowledge and practice of appeal levels of review.
- MassHealth may consider including Federally required CFR member language as part of its member handbook review criteria to ensure that MCOs are complying with both Federally and State-required language requirements. In addition, MassHealth should review its member handbook template language to ensure it meets language literacy levels for the MCO population.
- MCOs should re-evaluate their processes for documenting their Quality Improvement Programs, Quality Improvement Work Plans, and Quality Improvement Evaluations to better reflect the activities and initiatives planned for the upcoming year; include these activities in the work plan for ongoing monitoring; and have a mechanism to evaluate and report results as part of the annual Quality Improvement Evaluation.

NEXT STEPS

MassHealth required MCOs to submit CAPs for all Partially Met and Not Met elements identified from the 2017 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 EQR report and will conduct a comprehensive review again in 2020.

PLAN-SPECIFIC COMPLIANCE VALIDATION RESULTS

KEPRO provides a detailed description of strengths, findings, recommendations, and score for each of the 14 standards reviewed in the following tables for each MCO.

BOSTON MEDICAL CENTER HEALTH PLAN

KEPRO reviewed all documents that were submitted by Boston Medical Center Health Plan support of the compliance validation process. In addition, KEPRO conducted a site visit on August 7 – 8, 2017.

Enrollee Rights & Protections

Strengths	▪ BMCHP had well-documented policies and procedures including a revision history of dates and changes. ▪ BMCHP was fully compliant with this standard.
Findings	BMCHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollee Information

Strengths	▪ BMCHP's member handbook was produced in an easy-to-read format. ▪ BMCHP demonstrated its ability to take members' languages, cultural preferences, and special format needs into consideration when providing oral information and written materials.
Findings	Partially Met: ▪ BMCHP demonstrated that it conducted new enrollee orientation during 2016 and had a process to monitor timeliness using a dynamic daily report. BMCHP, however, did not have a formal mechanism for reporting its adherence rate of the Enrollee Outreach, Orientation, and Education being completed within 30 days of the Enrollee's Effective Date of Enrollment for a specified timeframe, such as monthly or annually. Not Met: ▪ BMCHP did not provide information on how enrollees could request information on its structure and operations. Additionally, BMCHP did not provide information to its enrollees on its physician incentive plans during the review period. ▪ BMCHP did not meet the contract requirement for having 90 percent of telephone calls answered by a trained customer service department representative within 30 seconds or less.

Recommendations	▪ BMCHP should implement a process to formally report its adherence rate for providing Enrollee Outreach, Orientation, and Education within 30 days of the Enrollee's Effective Date of Enrollment. In addition, BMCHP should consider formally reporting its results through its committee structure for tracking and trending of its performance. ▪ BMCHP should include language about physician incentive plans and how enrollees can obtain information on the structure and operations of the plan upon request within its member Evidence of Coverage document or another mechanism. ▪ BMCHP should explore strategies for meeting call answer timeliness standards during peak periods to ensure compliance with the contract requirement that 90 percent of all calls are answered by a trained customer department representative within 30 seconds or less.

Availability and Accessibility of Services

Strengths	▪ BMCHP's cultural competency documentation and online provider training was comprehensive. ▪ BMCHP's Member Service Workflow for malpractice history inquiries was well-documented. ▪ BMCHP had a good process for monitoring frequent primary care provider (PCP) changes along with talking points for its member services representatives. ▪ BMCHP demonstrated a good process for calculating the PCP turnover rate and development of an action plan to refine termination codes to better identify actionable areas.

Findings	Partially Met: ▪ BMCHP's Analysis of After Hours Access did not include corrective action to be taken for unreachable or noncompliant practices. ▪ BMCHP's welcome call script for enrollee orientation did not include information on the provider directory. ▪ BMCHP's Provider Data Form includes all areas of expertise, skills, and training with the exception of children in the care or custody of the Department of Children and Families (DCF) or detained or committed youth affiliated with the Department of Youth Services (DYS). ▪ BMCHP's Clinical Information Form included all specialty populations and conditions with the exception of child welfare and juvenile justice. ▪ BMCHP lacked evidence of policies and procedures to ensure that contracted ESPs utilize, as necessary, the statewide Bed Finder technology.
Recommendations	▪ BMCHP should ensure that corrective action is taken and recorded for noncompliant practices after future surveys. ▪ Because the welcome call is the enrollee's orientation to the plan, BMCHP should update the script to include an introduction to the provider directory. ▪ BMCHP should update the Provider Data Form to include a selection for children in the care or custody of DCF or youth affiliated with DYS. ▪ BMCHP should update its Clinical Information Form to include a selection for expertise in child welfare and juvenile justice. ▪ BMCHP should ensure that Emergency Service Provider (ESP) policies and procedures address the use of the statewide bed finder technology.

<u>Coordination and Continuity of Care</u>

Strengths	▪ BMCHP had good policies and procedures in place related to outreach and member support services. ▪ KEPRO identified BMCHP's initiatives on community partnerships and its depression medication management program as a best practice.
Findings	BMCHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Coverage and Authorization of Services

Strengths	▪ Overall, BMCHP's policy and procedures were compliant with contractual requirements. ▪ BMCHP demonstrated timely utilization management decisions based on file review results and aging reports.
Findings	Partially Met: ▪ During the onsite review, there were differing responses about the process for managing prior authorization service requests that exceed the specified timeframes for making an authorization decision. Not Met: ▪ BMCHP's policy did not address termination, suspension, or reduction of previously authorized services and therefore the policy did not address the 10-day notification process. BMCHP staff noted that it has not been its operational practice to terminate, suspend, or reduce previously authorized services.
Recommendations	▪ BMCHP should add clarity to its policy to address the requirement that an untimely decision is considered an adverse determination. In addition, BMCHP should provide training for its staff members to ensure a consistent understanding of the process. When it is in the best interest of the member to allow additional time to obtain the necessary information, BMCHP should consider the use of an extension to ensure adherence to the Federal requirements. ▪ While MBHP has not encountered a need to terminate, suspend, or reduce previously authorized services, it should incorporate language into its current policy to address this requirement and staff should be educated on the revision should a future service decision require such notification.

Practice Guidelines

Strengths	▪ The quarterly informatics analysis related to BMCHP's population demographics and most common diagnoses supported the adoption of appropriate clinical practice guidelines. ▪ BMCHP demonstrated evidence that community providers participate in committees related to clinical practice recommendations. ▪ BMCHP had an effective process in place to ensure that the adoption of clinical practice guidelines was used to inform medical policy and utilization management decision making.
Findings	BMCHP was fully compliant with this standard.

Recommendations	There were no recommendations identified for this standard.

Enrollment and Disenrollment

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

Grievance System

Strengths	▪ BMCHP's grievance process included a mechanism to obtain feedback from providers regarding member complaints. ▪ BMCHP demonstrated timely resolution of both grievances and appeals as evidenced by the file review.
Findings	Partially Met: ▪ A review of ten grievance files revealed that while BMCHP provided grievance notification resolution, the resolution content did not always contain language that was appropriate for the member. Some cases that were reviewed showed that it used language from the provider in response to the plan's request for comment on the grievance. The provider's comments related to the grievance were not necessarily written with acknowledgement that the provider's response would be inserted into the resolution letter verbatim. ▪ A review of ten grievance files showed that BMCHP was inconsistent in using the appropriate state-specific grievance resolution letter. ▪ A review of ten appeals files found that for one expedited appeal, BMCHP did not have evidence of making reasonable efforts to provide oral notification of its decision. Not Met: ▪ BMCHP's policies did not include the required provision that a representative of a deceased enrollee's estate is party to the State Fair Hearing process.

Recommendations	▪ BMCHP should evaluate its grievance resolution letter process to ensure that concise, member-friendly language is used. Information obtained by providers should be reworded appropriately before being included in member communications. For cases in which BMCHP determined that the grievance was unsubstantiated, it should consider the development of some language to notify the member of its process. ▪ BMCHP should consider implementing a quality review process of all grievance letters before they are sent to members. ▪ BMCHP should ensure that, for all expedited appeals, reasonable effort is made to provide oral notification of its decision and that those efforts are documented. ▪ BMCHP should revise its policies and procedures to include language that indicates that a representative of the enrollee's estate is party to the State Fair Hearing process.

Subcontractual Relationships and Delegation

Strengths	▪ BMCHP demonstrated strong monitoring, reporting, and review of delegated entities.
Findings	BMCHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Quality Assessment and Performance Improvement Program

Strengths	▪ BMCHP achieved NCQA's Excellent Accreditation rating for its MCO product line. ▪ BMCHP demonstrated a comprehensive program for improving CAHPS scores that included extensive analysis and relevant interventions. ▪ BMCHP began development of a provider concierge program.
Findings	Partially Met: ▪ BMCHP's Monitoring Appropriate Utilization Policy referred to analysis of emergency department, inpatient, readmissions, specialized outpatient, out-of-area, out-of-network, and ancillary services. The Over/Underutilization Grid dated 2017 includes a comprehensive list of different reports (description only) to address over- and under-utilization. This included service by type as well as HEDIS and prescription measures. While both the policy and grid included reports relevant to under- and over-utilization, they were not consistent. The Medical Expense Report provided was focused on expenses as opposed to under- and over-utilization. Actual reports were not provided as evidence. ▪ The Enrollee Advisory Council did not convene in 2016.
Recommendations	▪ BMCHP should make its Monitoring Appropriate Utilization Policy and the over- and under-utilization reporting grid consistent. Reports should be produced on a regular basis and presented at the Utilization Management Committee (UMC) for discussion and action as necessary. ▪ BMCHP should convene its Enrollee Advisory Council in 2017.

Credentialing

Strengths	▪ BMCHP had a good process for ensuring that non-participating providers were not excluded prior to payment.
Findings	BMCHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Confidentiality of Health Information

Strengths	▪ BMCHP had comprehensive policies. ▪ BMCHP was fully compliant with this standard.
Findings	BMCHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Health Information Systems

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

Program Integrity

Strengths	▪ BMCHP demonstrated comprehensive documentation for compliance, fraud, waste and abuse, and audit oversight. ▪ BMCHP engaged with external agencies, including other health plans, related to fraud, waste, and abuse trends. ▪ BMCHP had documented evidence of monitoring for debarred individuals monthly.
Findings	BMCHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

CELTICARE

KEPRO reviewed all documents that were submitted by CeltiCare in support of the compliance validation process. In addition, KEPRO conducted a site visit on September 11-12, 2017.

Enrollee Rights & Protections

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

Enrollee Information

Strengths	▪ CeltiCare had sufficient evidence of oral, written, and alternative format procedures to address member preferences for oral and written translation as well as alternative formats for members with special needs. ▪ CeltiCare's member materials were of high quality and written in an understandable and easy-to-read format.
Findings	Partially Met: ▪ CeltiCare demonstrated that it conducted new enrollee orientation calls during 2016 and had a process to monitor and report call outcomes using its dashboard report. It did not, however, have a reportable metric for its adherence rate of enrollee outreach, orientation, and education being completed within 30 days of the enrollee's effective date of enrollment for a specified timeframe, such as monthly or annually. ▪ CeltiCare did not provide information to its enrollees on its physician incentive plans during the review period. Not Met: • CeltiCare had a provider termination policy that referenced significant network changes and notification to the enrollee. CeltiCare's policy should delineate its process for a provider *termination*, which has different timeframes and procedures than for significant *changes* to the provider network.

Recommendations	▪ CeltiCare should implement a metric to monitor its adherence rate for providing enrollee outreach, orientation, and education within 30 days of the enrollee's effective date of enrollment. ▪ CeltiCare should revise its provider termination policy to more clearly delineate its handling of a provider termination as opposed to a significant network change. ▪ CeltiCare should include language about physician incentive plans upon member request, within its member Evidence of Coverage document, or through another mechanism.

Availability and Accessibility of Services

Strengths	▪ CeltiCare's policies and procedures were well-documented.
Findings	Partially Met: ▪ Acute inpatient and rehabilitation hospital services were not included in CeltiCare's Geoaccess analyses. ▪ CeltiCare's Single Case Agreement template does not include provisions that describe the provider's obligation to have the ability to communicate with the member in his or her primary language. ▪ CeltiCare's Health Care Administrative Solutions (HCAS) Provider Enrollment Form does not include information regarding experience treating people with HIV, homeless persons, people with disabilities, and people who are visually or hearing-impaired. ▪ CeltiCare did not provide evidence of a workflow to provide information to members upon request from the Board of Registration in Medicine (BORIM) or the National Practitioners Database (NPDB) on provider malpractice history. ▪ CeltiCare's Behavioral Health Provider Profile Form includes a list of special populations and conditions. It does not include, however, fire-setting behavior as one of these conditions. ▪ CeltiCare did not provide evidence of requiring that Emergency Service Provider (ESP) response time for face-to-face evaluations does not exceed one hour from either notification by telephone from the referring party or from the time of presentation of the Enrollee. ▪ While CeltiCare tracks member PCP changes, no evidence of education or outreach to members with frequent PCP changes was made available. ▪ While CeltiCare Indicated that it did not experience any significant network changes during 2016, no evidence was provided of a policy regarding significant network changes and providing the required notice and information to EOHHS.

Recommendations	CeltiCare should expand its Geoaccess analyes to include availability of acute inpatient and rehabilitation hospitals. CeltiCare should update its single case agreement template to describe the provider's obligation to be able to communicate with the member in his or her primary language. CeltiCare should develop and implement a workflow for providing information about a provider's malpractice history from BORIM or NPDB to members upon request. CeltiCare should update its Behavioral Health Provider Profile Form to include fire-setting behavior as one of the conditions in which the provider may have expertise. CeltiCare should update its provider agreement or Provider Manual to include a provision requiring a face-to-face ESP response within one hour. CeltiCare should implement a process of outreach and education to members with frequent PCP changes. CeltiCare should develop a policy that describes steps to be taken in the event of significant network changes, including the 1) appropriate notification to EOHSS; for behavioral health network changes, the number of affected enrollees; and the specific steps the plan is taking to ensure that affected members continue to have access to medically necessary services.

Coordination and Continuity of Care

Strengths	▪ CeltiCare used a multi-disciplinary team with co-located staff members which allowed for a good flow of communication and sharing of information and resources to support and address member needs. ▪ CeltiCare held weekly rounds as an additional venue to address challenging members. ▪ CeltiCare had multiple resources and programs available to those members that engaged in the care management program.

Findings	Partially Met: ▪ The Health Needs Assessment (HNA) addresses privacy protections but did not include a disclosure indicating how the information obtained may be used. Specifically, there was no indication of with whom the information may be shared. Not Met: ▪ The Provider Manual indicated CeltiCare Health and Cenpatico (CeltiCare's behavioral health partner) will offer trainings to PCP and mental health or substance use treatment practitioners. While there was evidence of some training completed with behavior health providers and agencies there was no specific training for PCPs. Neither the CeltiCare nor Cenpatico provider websites included screening tools or other resources.
Recommendations	• CeltiCare should include a disclosure statement on the HNA addressing with whom the information may be shared. • CeltiCare should create appropriate tools for PCPs to use to proactively identify behavior health needs and refer appropriately. The tools should be disseminated to PCPs with training as indicated and posted on the respective websites with an annual review and updates as needed.

Coverage and Authorization of Services

Strengths	▪ CeltiCare demonstrated timely utilization management decisions and had good processes in place to obtain necessary clinical information. ▪ CeltiCare had good documentation of the medical directors' decision-making processes. ▪ CelitiCare's denial letters included rationale that was well-written and understandable to the member.

Findings	Partially Met: ▪ The plan must conduct monthly reviews of a random sample of no fewer than 500 members to ensure they received the services for which providers billed. Within the last year, it was internally identified that this process was not in place. The finding was self-reported to EOHHS by the plan and has since been implemented at the Corporate level. ▪ The adverse action policy appropriately addressed the requirement for failure to act within the timeframes for making authorization decisions. During the onsite interviews, however, the staff indicated untimely decisions would be automatically approved.
Recommendations	▪ CeltiCare should continue internal monitoring with the Corporate office to ensure the mailing process continues on a monthly basis. ▪ CeltiCare should review the Adverse Action Notification policy and initiate training for utilization management staff.

Practice Guidelines

Strengths	▪ CeltiCare demonstrated good oversight of the full adoption of clinical practice guidelines throughout the organization. ▪ CeltiCare had member appropriate brochures for distribution upon member request or through case management.
Findings	CeltiCare was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollment and Disenrollment

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

Grievance System

Strengths	▪ CeltiCare's internal grievance and appeals processes were noted as strengths. ▪ CeltiCare's internal grievance team had a good process and documentation to resolve quality-of-care grievances.

Findings	Partially Met: ▪ A file review of 10 grievance cases and 10 appeals cases showed that, while fully compliant with all grievances and appeals received internally, one grievance case received from Cenpatico did not have the required written acknowledgement within one business day. In one case, Cenpatico did not provide written acknowledgement of an appeal. ▪ A review of 10 appeals files revealed that Cenpatico was inconsistent in documenting efforts to make reasonable efforts to provide oral notification of the expedited appeal disposition ▪ The file review showed that, internally handled appeals were resolved and included the appropriate content for the initial denial, first level, second level, and Board of Hearing rights. CeltiCare's internal vendor, US Scripts, included the incorrect timeframe for handling the appeal. Cenpatico also included inconsistent and incorrect timeframes in the initial denial letter and appeal processes. In some behavioral health cases, the files referenced a state law requiring CeltiCare to cover inpatient days for services initially denied during the review period. The specific references to this State requirement, however, were not provided to substantiate this practice. ▪ CeltiCare had a comprehensive grievance process that addressed the process for handling and cooperating with Board of Hearing appeals. CeltiCare's policy, however, lacked the specific provision for instructing enrollees for whom an Adjustment has been made about the process of informing the Board of Hearing in writing of all Adjustments. It also lacked the requirement to assist the enrollee, upon request, with this provision.

Recommendations	▪ CeltiCare should develop a process to ensure immediate transfer of behavioral health grievances received by Cenpatico to ensure timely acknowledgement. In addition, CeltiCare should consider increasing its oversight of Cenpatico to ensure that written appeal acknowledgements are in compliance with contractual requirements. ▪ CeltiCare should ensure that, for all expedited appeals, Cenpatico makes reasonable effort to provide oral notification of its decision and that those efforts are documented. ▪ CeltiCare should increase its oversight of delegated appeals to ensure that the content of appeal disposition letters is consistent with specific state requirements. In addition, CeltiCare should review its process related to behavioral health denials and determine whether its interpretation of the State law is consistent with its operational practice. Either the policy and procedure should be updated to adjust for state-specific requirement or CeltiCare should revise its operational practice. ▪ CeltiCare should modify existing MA QI.11 Grievance Systems policy to include the required process as it relates to Adjustments.

Subcontractual Relationships and Delegation

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

Quality Assessment and Performance Improvement Program

Strengths	▪ CeltiCare achieved NCQA's commendable accreditation status. ▪ CeltiCare's Quality Improvement Program and policies and procedures were well-documented. ▪ CeltiCare demonstrated a good review of the effectiveness of utilization management and care management programs that included presentation to its internal Utilization Management Committee and Quality Improvement Committee.

Findings	Partially Met: ▪ CeltiCare provided a comprehensive policy for monitoring utilization that included a significant number of metrics to be reviewed. In actual practice, only a small number of these metrics were actually formally reviewed. ▪ CeltiCare did not provide evidence of a medical review process for monitoring network provider compliance with policies and procedures, specifications, and appropriateness of care. ▪ While CeltiCare provided evidence of tracking and reporting medical and behavioral health inpatient hospital, emergency department, and behavioral health diversionary services, no evidence of tracking out-of-network, behavioral health outpatient, or ESP utilization was provided. Not Met: ▪ While CeltiCare provided a variety of educational resources for behavioral health providers, no evidence was provided of informing PCPs of the use of standardized behavioral health screening tools, how to evaluate the results, and how and where to make referrals for follow-up behavioral health services.
Recommendations	▪ The Monitoring Utilization policy should be updated to include the key utilization metrics to be reviewed, including HEDIS measures, to identify underutilization. CeltiCare should ensure that the measures reviewed in actual practice are consistent with the policy. ▪ CeltiCare should implement a medical record review process to assess network provider compliance with policies and procedures, specifications, and appropriateness of care. ▪ CeltiCare should expand its tracking reporting of utilization data to include out-of-network, behavioral health outpatient, and ESP service utilization. ▪ CeltiCare should expand its provider resources to include education for PCPs on the appropriate use of behavioral health screening tools, how to use the information gathered, and how and where to make referrals to behavioral health services as needed.

Credentialing

Strengths	▪ In general, CeltiCare had a comprehensive credentialing and recredentialing process.
Findings	Partially Met: ▪ CeltiCare did not provide evidence of a policy that included the requirement to notify EOHHS when a provider is terminated from the network or denied network inclusion due to federal exclusion. ▪ CeltiCare did not provide evidence of notifying EOHHS when a provider failed credentialing or recredentialing for a program integrity reason. ▪ While CeltiCare has a comprehensive Board Certification policy, it did not include the requirement to submit requests to waive board certification requirements to EOHHS for review and approval.
Recommendations	▪ CeltiCare should either add the requirement to notify EOHHS of excluded providers to the Ongoing Monitoring of Sanctions policy or develop a new policy that includes all notifications required for provider terminations or denials. ▪ CeltiCare should either add the requirement to notify EOHHS of providers that fail credentialing or recredentialing due to program integrity reasons to the appropriate credentialing policy or develop a new policy that includes all notifications required for provider terminations or denials. ▪ CeltiCare should update its Board Certification policy to include the required submission of requests to waive board certification requirements to EOHHS for review and approval.

Confidentiality of Health Information

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

Health Information Systems

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

Program Integrity

Strengths	▪ CeltiCare had a strong Special Investigations Unit at the corporate level to support the MassHealth MCO. ▪ CeltiCare had new compliance staff members working locally to increase compliance awareness, create accountability, and memorialize policy and process. ▪ CeltiCare had evidence of several activities and communication with staff members, including communications by means of a Compliance Corner, compliance staff attendance at departmental meetings, and rounding to identify possible HIPAA challenges.
Findings	CeltiCare was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

FALLON HEALTH

KEPRO reviewed all documents that were submitted by Fallon Health in support of the compliance validation process. In addition, KEPRO conducted a site visit on September 13 – 14, 2017.

Enrollee Rights & Protections

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

Enrollee Information

Strengths	▪ Fallon demonstrated compliance with providing services to members in a culturally and linguistically appropriate manner.
Findings	Partially Met: ▪ While Fallon demonstrated that it conducted new enrollee orientation during 2016 and had a process to monitor performance, it did not have a formal mechanism for monitoring its adherence rate for providing the orientation to new enrollees within 30 calendar days of the initial date of enrollment. ▪ Fallon did not provide information to its enrollees on its physician incentive plans during the review period. ▪ While Fallon's handbook described its behavioral health program, the handbook did not specially provide a description of the CANS tool and its use in Behavioral Health Clinical Assessment and in the Discharge Planning process by providers for members under the age of 21. Not Met: ▪ While Fallon had a provider termination policy and pharmacy network access policy to address changes in network providers and pharmacies, it did not have a policy that specifically addressed its process for handling significant changes and its process for notifying members.

Recommendations	▪ Fallon should implement a process to formally report its adherence rate for providing Enrollee Orientation within 30 calendar days of the initial date of enrollment. ▪ Fallon should develop a significant change policy to address Federal and State requirements. ▪ Fallon should include language about physician incentive plans upon member request, within its member Evidence of Coverage document, or through another mechanism. ▪ Fallon should revise its member handbook language to specifically reference the use of the CANS Tool.

Availability and Accessibility of Services

Strengths	▪ Fallon had a robust provider network with services that supported its membership.
Findings	Partially Met: ▪ The Beacon Provider Manual included the appropriate access standards. The Fallon Provider Manual standards, however, were inconsistent. In addition, the behavioral health access standards in the member handbook were also inconsistent with requirements. ▪ Fallon did not provide evidence of a workflow or process to provide members upon request with publicly available information maintained by the Massachusetts Board of Registration in Medicine (BORIM) and the National Practitioner Databank on the malpractice history of any provider. ▪ Fallon showed evidence of collecting all required information from behavioral health providers, except for expertise in the visually impaired, child welfare and juvenile justice, and fire-setting behaviors. ▪ Fallon did not provide evidence of policies and procedures to ensure that contracted ESPs use the statewide Bed Finder technology as necessary. ▪ Fallon monitored frequent PCP changes as required, but did not have a formal process for educating members with frequent PCP changes on the benefits of developing a long-term relationship with a PCP. ▪ Fallon did not provide evidence of a policy and procedure for providing required notice to EOHHS about significant provider network changes.

Recommendations	▪ Fallon should update its Provider Manual and member handbook to ensure the appropriate behavioral health access standards are included. ▪ Fallon should develop a workflow and train customer service staff on providing information from BORIM or NPDB on the malpractice history of providers to members upon request. ▪ Fallon should update its behavioral health provider application to include areas of expertise to include visually impairment, child welfare and juvenile justice, and fire-setting behaviors. ▪ Fallon should implement policies and procedure to ensure ESPs use the statewide Bed Finder technology as needed. ▪ Fallon should implement a process to reach out to members with frequent PCP changes to address issues that prevent them from maintaining a long-term relationship with a PCP. ▪ Fallon should implement a formal policy and procedure to provide the required notice to both EOHHS and members of significant provider network changes.

Coordination and Continuity of Care

Strengths	▪ Fallon demonstrated good processes for linking members to community resources as well as internal wellness and disease management programs. ▪ Fallon used an integrated care management model with both behavioral health and physical health care managers.
Findings	Not Met: ▪ Fallon did not differentiate members with more intensive needs as a result of medical illness or injury. Members are managed by nurse care managers in the complex care management program. The plan does not employee Nurse Practitioners or other advanced level clinicians for the care management program.
Recommendations	▪ Fallon should evaluate how to best engage the services of an advanced level clinician to either serve as the care management coordinator for those members identified with intensive needs or provide appropriate supervision for RN care managers.

Coverage and Authorization of Services

Strengths	▪ Fallon transitioned to information systems that allowed for better documentation of utilization management and care management functions. ▪ Fallon demonstrated that its utilization nurse reviewers used information provided by the case managers to address discharge and transition needs.
Findings	Partially Met: ▪ During the onsite interviews, the plan indicated there was no difference in the review of service requests for persons under the age of 21. Not Met: ▪ The UM Utilization Management Turnaround Times and Notification of Review Decisions Policy and Procedure did not specify that an untimely decision for its Medicaid line of business is an adverse determination. During onsite interviews, the plan indicated it would not issue a denial for decisions not rendered in the required timeframes.
Recommendations	▪ Fallon should review the requirements associated with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Authorization requests for persons under age 21 should always be reviewed for medical necessity regardless of benefit limitations. ▪ Fallon should review and revise, as appropriate, policies and procedures to accurately reflect the requirements related to untimely authorization decisions. An untimely decision is an adverse decision, a denial, and members should be afforded appeal rights.

Practice Guidelines

Strengths	▪ Practice guidelines were disseminated using several means. ▪ Fallon was fully compliant with this standard.
Findings	Fallon was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollment and Disenrollment

Strengths	▪ Fallon tracked its disenrollment rates, set internal thresholds, and implemented several types of member retention activities.
Findings	Partially Met: ▪ While Fallon described its processing of the State's enrollment and disenrollment file, it did not have a formal policy or process for handling plan-initiated disenrollments.
Recommendations	▪ Fallon should develop a formal policy to address circumstances that would allow for a plan-initiated disenrollment and its process for handling the disenrollment.

Grievance System

Strengths	▪ Fallon demonstrated timely resolution for grievance files. ▪ Fallon had good internal team knowledge and comprehensive policies and procedures to support the grievance system standard.
Findings	Partially Met: ▪ The grievance file review and appeals file review showed that Fallon was inconsistent with providing both grievance and appeal written acknowledgement within one business day. During the review period, it was not Fallon's policy to initiate a written appeal acknowledgement letter for expedited appeals. ▪ While Fallon had appropriate policies and procedures in place for incorporating a review by a clinical professional for both grievances and appeals, the grievance file review showed that there were cases that could have benefitted from clinical review.
Recommendations	▪ Fallon should monitor the timeliness of appeal and grievance acknowledgements to ensure it is compliant with contractual requirements. In addition, to meet State contract requirements, Fallon should change its operational practice to ensure that a written acknowledgment is issued for expedited appeals. ▪ Fallon should retrain grievance coordinators about the clinical review of grievances.

Subcontractual Relationships and Delegation

Strengths	▪ Fallon's documentation of delegation oversight committee meetings was comprehensive.
Findings	Not Met: ▪ Fallon's material subcontracts did not stipulate that Massachusetts general law or Massachusetts regulations will prevail if there is a conflict between the state law or state regulations where the Material Subcontractor is based.
Recommendations	▪ Fallon should revise its material subcontracts to include the provision that Massachusetts state regulation will prevail if there is a conflict between state law or state regulation where the Material Subcontractor is based.

Quality Assessment and Performance Improvement Program

Strengths	▪ Fallon had a well-documented Quality Improvement Program description.
Findings	Partially Met: ▪ Fallon did not provide evidence of any formal mechanism to obtain member feedback on its quality improvement program. ▪ Fallon's MassHealth Provider Utilization and Activity Analysis Policy included a general description of provider profiling. However, Fallon did not provide evidence that over- and under-utilization were monitored on a regular basis in the aggregate or at the provider level. ▪ Fallon's 2016 Assessments of Care was an appropriate population assessment. The NCQA-related evaluation of complex care management provided was limited to an assessment of satisfaction measures and inpatient admissions per thousand, which did not fully address the quality and appropriateness of care furnished to members with special health care needs. ▪ Fallon's Medical Record Review Policy included requirements for accurate abstraction of records for quality programs. It did not specifically address adequacy of documentation of records and appropriateness of care. In addition, Fallon did not convene a member and family advisory council in 2016. ▪ While the Beacon Provider Manual stated that the use of outcome measurement tools is strongly encouraged, no evidence of requiring behavioral health providers to measure and collect outcome data, to incorporate that data in treatment planning, and make outcome data available to the plan was provided. ▪ Fallon did not provide evidence of the implementation of any provider incentive programs in 2016.

Recommendations	▪ Fallon should convene a member advisory council and use this as an avenue to seek member feedback on its quality improvement program. ▪ Fallon should expand its Provider Utilization and Activity Analysis Policy to address specific measures of over- and under-utilization that will be monitored on a regular basis. The results should be presented to the appropriate committee on a regular basis. ▪ Fallon should expand its assessment of the complex care management program to include more comprehensive measures of quality and appropriateness of care. ▪ Fallon should implement a medical record review policy to monitor network provider compliance with documentation standards and appropriateness of care. ▪ Fallon should convene a member and family advisory council to include members and their families in the planning and implementation of quality and improvement activities. ▪ Fallon should ensure that behavioral health provider contracts are updated to include the required clinical outcome measure data provisions. ▪ Fallon should implement appropriate provider performance incentives.

Credentialing

Strengths	▪ Overall, Fallon had a good process for credentialing and recredentialing of providers.
Findings	Partially Met: ▪ Fallon's Credentialing Department Policies and Procedures did not include a specific reference to nondiscrimination solely on the basis of a provider's license or certification. ▪ While Fallon had a comprehensive board certification policy, it did not include the required submission to EOHHS for board certification waiver review and approval.
Recommendations	▪ Fallon should update its Credentialing Department Policies and Procedures to include that it does not discriminate against providers solely on the basis of licensure or certification. ▪ Fallon should add the required submission to EOHHS for board certification waiver and approval to the Board Certification Policy.

Confidentiality of Health Information

Strengths	▪ Overall, Fallon had adequate safeguards in place to comply with confidentiality requirements.
Findings	Partially Met: ▪ Fallon's Release of Protected Health Information (PHI) Procedure refers to securing individual authorization for the use of PHI for research purposes, but it did not address the requirement to obtain prior written authorization from EOHHS.
Recommendations	▪ Fallon should update its Release of Protected Health Information (PHI) Procedure to include the requirement to obtain EOHHS prior written authorization for the use of PHI for research purposes.

Health Information Systems

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

Program Integrity

Strengths	▪ Fallon implemented edit enhancements to guard against fraud, waste, and abuse. ▪ Fallon participated with external agencies and state partners to address fraud, waste, and abuse.
Findings	Fallon was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

HEALTH NEW ENGLAND

KEPRO reviewed all documents that were submitted by Health New England in support of the compliance validation process. In addition, KEPRO conducted a site visit on September 25 –267, 2017.

Enrollee Rights & Protections

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

Enrollee Information

Strengths	▪ HNE had sufficient processes to address members' oral and written language, cultural, and special format needs related to enrollee information. ▪ HNE's member handbook was in an understandable format.

Findings	Partially Met: ▪ While HNE demonstrated that it had a process for conducting new enrollee orientation calls during 2016, it did not meet contract requirements for conducting enrollee outreach, orientation, and education within 30 days of the enrollee's effective date of enrollment. ▪ While HNE demonstrated notification to members regarding significant changes to its provider network during 2016; it did not have a formal process for defining a significant change and for notification of members. ▪ While HNE included information on the Children's Behavioral Health Initiative in the HNE Be Healthy Member Handbook, the handbook did not include a description of the CANS tool and its use in behavioral health clinical assessment and in the discharge planning process from inpatient mental health services and community-based acute treatment services for members under the age of 21. ▪ While HNE had a process to monitor call answer timeliness, it did not meet the contract requirement to answer at least 90 percent of calls within thirty seconds. Not Met: ▪ While HNE had a process in place to address provider claim reconsideration requests, HNE did not include information in the member Evidence of Coverage or other member notification regarding the appeal rights available to the providers outside of the member's formal appeal process. ▪ HNE did not provide information on its structure and operations and its physician incentive plans to members upon request.

Recommendations	▪ HNE should address barriers and challenges that prevented it from meeting contract performance standards and take appropriate action until its performance is consistently meeting the 30-day requirement. ▪ HNE should develop a written policy and procedure for handling significant network changes. ▪ HNE should add language in its EOC or another member communication that includes a description of the process that providers have available to them to challenge a plan decision to deny a service or payment. ▪ HNE should include language about information on its structure and operations and its physician incentive plans within its member Evidence of Coverage document or through another mechanism upon member request. ▪ HNE should revise its member handbook to include a description of the CANS Tool and its use for members under the age of 21. ▪ HNE should address barriers and challenges related to call answer timeliness until its performance is consistently meeting contract requirements.

Availability and Accessibility of Services

Strengths	▪ HNE had a provider network sufficient to meet the needs of its MCO population.
Findings	Partially Met: ▪ HNE indicated that members in the care or custody of DCF are automatically assigned to the PCC Plan. The member handbook, however, includes appropriate appointment access standards for these members. If these members do indeed enroll in HNE, these standards should be made available in the Provider Manual as well. ▪ The Member Handbook includes all the appropriate appointment access standards for behavioral health services, but they are inconsistent with those in the Provider Manual. ▪ While HNE indicates that it provides access to its language line for providers needing interpreter services, this is not indicated in the Provider Manual. ▪ While HNE indicates that it does not have any PCP panels that approach the 1500-member limit, this restriction is not included in its provider agreement. ▪ HNE did not have a process or workflow in place to address member requests for publicly available information on provider malpractice history. ▪ While the MBHP behavioral health provider application allows the provider to report a large number of areas of expertise, it does not include fire-setting behaviors as one of these. ▪ HNE described an appropriate process for analyzing and addressing members' frequent PCP changes. However, the process was not formally documented in a workflow or policy and procedure. ▪ While HNE indicated appropriate handling of significant network provider changes, there was no formal policy and procedure for ensuring that the requirements, including notification to EOHHS, are met.

Recommendations	▪ HNE should update its Provider Manual to include appointment access standards for members in the care or custody of DCF. ▪ HNE should update its Provider Manual to include the availability of its language line to assist providers with interpretation service needs. ▪ HNE should update its Provider Manual to ensure that behavioral health appointment access standards are consistent with requirements and with the standards that appear in the Member Handbook. ▪ HNE should update its provider agreement to include that PCP panels may not exceed 1500 members. ▪ HNE should develop and implement a workflow that speaks to responding to a member request for information on a provider's malpractice history. ▪ HNE should work with MBHP to update the behavioral health application form to include fire-setting behaviors as an area of expertise. ▪ HNE should commit their processes for addressing frequent PCP changes to a formal workflow or policy and procedure. ▪ HNE should develop a formal policy and procedure to address actions triggered by significant provider network changes, including required notification to EOHHS.

Coordination and Continuity of Care

Strengths	▪ HNE demonstrated good evidence of engagement and collaboration with HNE's behavioral health partner along with strong oversight. ▪ HNE had a model that included embedded care managers who served as a valuable resource to both remote care managers and utilization management staff members. ▪ HNE had disease management and wellness programs that included several innovative community-based initiatives.

Findings	Partially Met: ▪ HNE's Health Needs Assessment (HNA) does not include contractually required language about how the information obtained will be disclosed. ▪ HNE does not perform home visits for face-to-face contacts with Enrollees. Additionally, the plan does not use nurse practitioners or other similarly credentialed persons within the care management program. There are no additional services afforded to members with more intensive needs. ▪ The Plan has many wellness initiatives and activities through both the care management and quality departments. However, there was no evidence of a formalized tobacco cessation program. ▪ The measurement of program effectiveness was limited, e.g., HEDIS rates, and not necessarily reflective of only those members served in care management programs.
Recommendations	▪ HNE should include contractually required language, as the HNA currently states, "We will keep the information you provide private." ▪ HNE should consider options for contracting with a nurse practitioner or other similarly credentialed clinician to function as the care management coordinator and to provide face-to-face visits. ▪ HNE should review options for a formalized tobacco cessation program. It may want to initially incorporate a formalized program into the maternal health program. ▪ HNE should enhance the care management program by assessing program effectiveness, such as utilization rates reflective of only those served by care management programs, e.g. emergency department utilization.

Coverage and Authorization of Services

Strengths	▪ HNE's policies and procedures were well-documented. ▪ HNE's denial letters were understandable.
Findings	Partially Met: ▪ There is not a plan physician available 24-hours a day to authorize medically necessary services. ▪ The pharmacy team is not included in inter-rater reliability (IRR) testing completed in the utilization management process. ▪ In the review of denial files, two of ten decisions were noted as untimely, with notice of action letters issued past the 14-day requirement. ▪ HNE noted in its policy, UM038POL, "The failure to act within the established timeframes for making authorization decisions;" "If HNE fails to meet this timeframe, the "Failure to make a decision within the standard timeframe" letter will be sent which outlines the appeals process." HNE, however, continued to review service requests that were no longer timely and did not issue a notice of action affording the member appeal rights. Not Met: ▪ Policy HS200POL indicates the following: "Claims for emergency room services are configured to match against the Automatic Pend ER Diagnosis List (see Attachment 1)." HNE provided a list of diagnosis codes that cause a claim to pend for review. In HNE's process, it then requests medical records from the facility. HNE asks the member to submit a statement indicating why the emergency visit was considered an emergency by a prudent layperson. During denial files review, an emergency department visit was denied by a medical director. The denial rationale was that the service could have been provided in a primary care office. Additionally, the Plan indicated they were responsible for emergent dental services, yet the list of diagnoses that pend ED claims included a large number of dental service codes.

Recommendations	▪ HNE should identify avenues for 24-hour access to a plan physician. The plan may consider utilizing similar methods as its behavioral health delegate. ▪ HNE should either define an IRR process for the pharmacy team to ensure consistency of application of review criteria or include the pharmacy team in the current inter-rater reliability process conducted by the Quality team. ▪ HNE should continue to monitor the aging of service requests to ensure timely review, decision, and notice of action. Additionally, if service requests are received by mail, HNE should implement a process for date-stamping within the mail room rather than date-stamping at the time of delivery to the utilization management department. ▪ HNE should review and train all utilization management staff on policy UM038POL as noted above. ▪ HNE should review and revise current policy and process, eliminating the pend process associated with a listing of diagnosis codes.

Practice Guidelines

Strengths	▪ HNE demonstrated good dissemination of its clinical practice guidelines to provider and members using newsletters, website, and birthday card reminders to members. ▪ HNE used a provider relations representative checklist that included a discussion point for clinical practice guidelines with providers during the onsite visit.
Findings	HNE was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollment and Disenrollment

Strengths	▪ HNE developed a monthly report that contained disenrollment rates with meaningful indicators and flagged unusual patterns of disenrollment with analysis.
Findings	Partially Met: ▪ While HNE did not initiate disenrollment of any MassHealth members during 2016, it did not have a formal policy and procedure or process that described the circumstances under which it would initiate a disenrollment request to MassHealth and how it would handle the disenrollment process.
Recommendations	▪ HNE should develop a disenrollment process for handling disenrollments.

Grievance System

Strengths	▪ HNE's grievance and appeal file review showed 100 percent compliance with timeliness requirements.
Findings	Partially Met: ▪ The appeal file review showed that HNE was inconsistent in providing or documenting reasonable efforts to provide oral notice to the enrollee for an expedited appeal. ▪ While HNE had a grievance policy that addressed an enrollee's representative as party to the appeal, the policy did not include that a legal representative of a deceased enrollee's estate as party to the State Fair Hearing. ▪ While HNE had a system to maintain records of grievances and appeals, the appeals file review showed inconsistency in the documented clinical rationale to support the decision.
Recommendations	▪ HNE should implement a mechanism to ensure reasonable oral notification to the enrollee for an expedited appeal. ▪ HNE should update its policy and procedures to include language that recognizes a legal representative of a deceased enrollee's estate as party to the State Fair Hearing. ▪ HNE should ensure that each appeal includes documentation within the system that included the clinical rationale for each appeal.

Subcontractual Relationships and Delegation

Strengths	▪ HNE developed a quarterly process that was initiated by the Compliance Department to trigger the relationship managers to complete their quarterly contract performance reviews on delegated entities. ▪ HNE was fully compliant with this standard.
Findings	HNE was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Quality Assessment and Performance Improvement Program

Strengths	▪ HNE had impressive analytics and monitoring, particularly on HEDIS reporting and overall utilization.
Findings	Partially Met: ▪ HNE's Integrated Care Management Program Description includes a description of satisfaction with program processes, ensuring appropriate utilization, continuity and coordination of care, and an annual evaluation. However, no formal evaluation of the quality and appropriateness of care provided to members in care management (members with special health care needs) was provided. Results of a member satisfaction survey were provided, but they were for all product lines combined and involved a very small sample size. ▪ While HNE had member and family advisory councils in place in the past, they were disbanded and did not meet in 2016. ▪ While the MBHP website does include some behavioral health resources directed toward PCPs, it does not appear to include information on appropriate behavioral health adult and EPSDT screening tools. Not Met: ▪ HNE did not implement any provider incentives in 2016.
Recommendations	▪ HNE should develop a formal process for assessing the quality and appropriateness of care furnished to members with special health care needs that includes utilization or quality metrics. ▪ HNE should plan for and convene an appropriate member and family advisory council to provide an avenue for input on quality improvement activities. ▪ HNE should develop and implement appropriate provider incentive programs to promote compliance with practice guidelines and other quality improvement initiatives. ▪ HNE should work with MBHP to ensure that access to information on behavioral health screenings is available to PCPs on their website.

Credentialing

Strengths	▪ In general, HNE's policies and procedures were comprehensive.
Findings	Partially Met: ▪ While HNE's Initial Credentialing of Practitioners and Recredentialing of Practitioners policies include that it will communicate a denial or termination decision to the provider, it does not specifically address that providers are given notice of the reasons for the denial or termination.

Recommendations	▪ HNE should update its credentialing and recredentialing policies to specifically state that they will provide written notice of the reason(s) for denial or termination to the provider.

Confidentiality of Health Information

Strengths	▪ In general, HNE had appropriate safeguards in place to meet confidentiality requirements.
Findings	Partially Met: ▪ HNE's Privacy and Security Policy addresses the use and disclosure of PHI. The policy, however, does not address securing EOHHS written prior authorization for the use of data for research or other purposes.
Recommendations	▪ HNE should update its Privacy and Security Policy to address securing EOHHS written prior authorization for the use of data for research or other purposes not directly related to performance under the contract.

Health Information Systems

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Strengths	▪ HNE had robust health information systems reporting capabilities. ▪ HNE's Information Technology team demonstrated strong support across all health information systems reporting requirements.
Findings	Partially Met: ▪ HNE captures appropriate enrollee characteristics on its Health Needs Assessment, with the exception of whether the member is visually impaired.
Recommendations	▪ HNE should update its Health Needs Assessment to include information on whether the member is visually impaired.

Program Integrity

Strengths	▪ HNE developed a dashboard for internal operational monitoring. ▪ HNE's Compliance Committee meeting minutes were well-documented and demonstrated many compliance activities including department auditing, external compliance review, and security review.
Findings	HNE was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

NEIGHBORHOOD HEALTH PLAN

KEPRO reviewed all documents that were submitted by Neighborhood Health Plan in support of the compliance validation process. In addition, KEPRO conducted a site visit on September 27 – 28, 2017.

Enrollee Rights & Protections

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

Enrollee Information

Strengths	▪ NHP met contractual obligations for providing oral and written translation of materials and providing materials in requested alternative formats. ▪ To ensure that all contractual requirements were met, NHP's Marketing and Communications team developed a grid that included its distribution of required materials and detailed all requirements and notifications by product line. ▪ NHP had significant improvement in call center timeliness between 2015 and 2016, which was attributed to NHP introducing performance goals, feedback, and enhanced management of call center staff members.
Findings	Partially Met: ▪ While NHP had a provider termination policy, it did not include a definition of a significant change. Not Met: ▪ NHP did not provide information to members on its structure, operations, physician incentive plans upon request. ▪ NHP did not have a process in place to notify EOHHS of enrollees whom, because of incorrect phone numbers or addresses, it was unable to contact.
Recommendations	▪ NHP should revise its existing policy to include a definition of significant change. ▪ NHP should provide information on its structure and operations and physician incentive plans upon member request, within its member Evidence of Coverage document, or through another mechanism. ▪ NHP should implement a process to comply with contract requirements to notify EOHHS of enrollees whom, because of incorrect phone numbers or addresses, it was unable to contact.

Availability and Accessibility of Services

Strengths	▪ NHP had an attractive and member-friendly online provider directory which included a provider rating feature. ▪ NHP's collaboration with Beacon related to access and availability was noted as a best practice.
Findings	Partially Met: ▪ NHP's Member Handbook included appropriate language relative to the second opinion benefit. However, the Member Rights and Responsibilities Policy stated that the member has the right to receive a second opinion on a medical procedure at no cost. ▪ NHP's Letter of Authorization template did not inform the medical provider of the obligation to communicate with the member in his or her primary language. ▪ NHP did not have a process or workflow in place to address member requests for publicly available information on provider malpractice history. ▪ NHP's ESP Performance Specifications met standards except for the requirement for ESPs to use the statewide Bed Finder technology, as necessary. ▪ While NHP indicated appropriate handling of significant network provider changes, there was no formal policy and procedure for ensuring that the requirements, including notification to EOHHS, were met.
Recommendations	▪ NHP should update its Member Rights and Responsibilities Policy to remove the restriction to medical procedures for the second opinion benefit. ▪ NHP should update its Letter of Authorization template to inform the provider of obligations under State and Federal law to have the ability, either directly or through a skilled medical interpreter, to communicate with the Enrollee in his or her primary language. ▪ NHP should develop and implement a workflow to address how to respond to a member's request for information on a provider's malpractice history. ▪ NHP should work with Beacon to update its ESP Performance Specifications to include the requirement to use the statewide Bed Finder Technology, as necessary. ▪ NHP should develop a formal policy and procedure to address actions needed with significant provider network changes, including required notification to EOHHS.

Coordination and Continuity of Care

Strengths	▪ NHP had strong care management and wellness programs. NHP offered a Health Coach Program which was noted as an innovative benefit for members. ▪ NHP's integration with behavioral health was well-orchestrated. ▪ NHP's Neighborhood Care Circle program was identified as a best practice. This program was geared to meeting members with high needs and was supported by a multidisciplinary team.
Findings	NHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Coverage and Authorization of Services

Strengths	▪ NHP displayed strong evidence of consultation with local specialty providers and external review entities to ensure appropriate standards of care were applied to utilization management decisions. ▪ NHP implemented the use of a dashboard to monitor aging of prior authorization requests to bring utilization management decisions in line with requirements.
Findings	Partially Met: ▪ In review of denial files, several authorization requests were not reviewed within the required timeframes. ▪ The Timeliness of Decision-Making Policy indicated the member will receive "the Failure to Meet Authorization Time Frame letter and appraised of their appeal rights" should NHP not meet the required timeframes for a service request. During the onsite review, NHP noted that, if a required timeframe is not met, the request would be expedited for review. The plan would not consider the untimely decision an adverse decision.
Recommendations	▪ NHP should continue to monitor the newly developed dashboards to ensure timely processing of service requests and member notice of action. ▪ NHP should review and train all Utilization Management staff on the Timeliness of Decision-Making Policy section related to untimely service authorization decisions. An untimely decision is an adverse action.

Practice Guidelines

Strengths	▪ The dissemination of guidelines was evidenced in multiple mediums including provider and member websites and newsletters, hard copy distribution via disease management targeted mailings, and distribution to provider offices related to identified gaps in care based on clinical practice guidelines. ▪ NHP had a clear process for the adoption of clinical practice guidelines, their impact on benefit determinations, and the associated coding and configuration of payment systems.
Findings	NHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollment and Disenrollment

Strengths	▪ NHP had a good process for handling and processing the MassHealth enrollment files for its MCO membership.
Findings	Partially Met: ▪ Although NHP's enrollment team used the daily files to understand enrollment additions, changes, and terminations, it lacked a formal process to review disenrollment data at a higher or aggregate level to determine disenrollment rates. ▪ While NHP did not initiate disenrollment for any MassHealth members during 2016, it did not have a formal policy and procedure that described under what circumstances NHP would be allowed to initiate a disenrollment request to MassHealth and how it would handle the disenrollment process.
Recommendations	▪ NHP should develop a process to formally report and review disenrollment rate data. ▪ NHP should develop a disenrollment process for submitting plan-initiated disenrollment requests to MassHealth.

Grievance System

Strengths	▪ NHP's grievance and appeal files demonstrated compliance with resolution timeliness. ▪ In general, NHP's appeal policies and procedures were sufficient to meet contract requirements.
Findings	Partially Met: ▪ While NHP had a process for handling grievances, it only captured formal grievances as opposed to capturing and treating any expression of dissatisfaction as a grievance. ▪ Based on NHP's definition of a grievance, not all grievances were captured and acknowledged in writing. ▪ While the file review showed written acknowledgement of all behavioral health-related grievances, the acknowledgement letter did not provide the member with information that the vendor would resolve and provide notification of the resolution within a specified timeframe. ▪ The grievance file review showed that not all behavioral health and medical quality-of- care grievances were reviewed by an appropriate clinician. ▪ The appeals file review showed that not all expedited appeals had documentation of reasonable efforts to notify the enrollee of expedited decisions. ▪ The appeals file review showed that NHP's written notification of the appeal disposition was not written in an easily understood manner.

Recommendations	▪ NHP should revise its definition of a grievance and revise its process to include the handling of all grievances, including those grievances that were resolved within a single contact. ▪ NHP should revise its grievance process to include a process to provide written acknowledgment. ▪ Beacon Health Options should revise its grievance acknowledgment letter to add a statement about its next step and the timeframe for handling the grievance. ▪ NHP should revise its process to ensure that all quality-of-care grievances are reviewed by a clinician, that the review is formally documented, and that there is a process to rate the severity of quality-of-care grievances that determines when the grievance requires a medical director or peer review process. In addition, NHP should ensure that its behavioral health vendor revise its process to ensure that quality-of-care grievances are reviewed by an appropriate clinician. ▪ NHP should ensure that its process includes notification to enrollees for expedited appeals and ensures appropriate documentation of the reasonable attempt. ▪ NHP should revise its written appeal notification to be written to the member rather than about the member and that the language is written in an easily understood format.

Sucontractual Relationships and Delegation

Strengths	▪ NHP's delegation agreement clearly defined the delegated function and responsibility between NHP and the delegate. ▪ NHP was fully compliant with this standard.
Findings	NHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Quality Assessment and Performance Improvement Program

Strengths	▪ NHP demonstrated updates to its committee and quality improvement support structure that may positively impact the overall quality program. ▪ NHP's Neighborhood Green chat space was innovative and results showed it to be an effective means of getting member feedback on quality and clinical initiatives. KEPRO was encouraged with the level of participation that NHP generated. ▪ NHP demonstrated good collaboration with Beacon on its quality improvement program. ▪ NHP's utilization management evaluation provided a comprehensive level of detail on utilization by service type as well as behavioral health and pharmacy utilization.
Findings	Partially Met: ▪ While NHP provided a Utilization Management Program Evaluation that addressed the effectiveness of the program, it did not include measures of efficiency of the program.
Recommendations	▪ NHP should add measures of efficiency (e.g. turnaround times) to its Utilization Management Evaluation.

Credentialing

Strengths	▪ NHP had comprehensive policies and procedures. ▪ NHP was fully compliant with this standard.
Findings	NHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Confidentiality of Health Information

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

Health Information Systems

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

Program Integrity

Strengths	▪ NHP's compliance plan and code of conduct were comprehensive. ▪ NHP demonstrated open lines of communication to the Compliance Officer to address staff concerns.
Findings	Partially Met: ▪ In review of the Fraud Reporting and Whistleblower Protections Policy and during the onsite discussions, there was limited support of a comprehensive internal Fraud and Abuse program in year 2016. ▪ NHP requires its subcontractors to annually attest to compliance with monthly sanction screening. The Sanction Screening Policy notes that the Human Resources department reviews the sanctions screening requirements for all employees monthly but does not note screening of the Board of Directors. During onsite interviews, the plan did not indicate that the Board of Directors were part of a monthly screening review.
Recommendations	▪ NHP noted engagement of new staff, updated processes, improved program design, and system upgrades to address identified deficiencies. NHP should continue focus on and commit to improving the plan's Fraud, Abuse, and Prevention program. ▪ NHP should develop a process to screen its Board of Directors to ensure no individual is excluded from participating in Federal programs.

TUFTS HEALTH PLAN

KEPRO reviewed all documents that were submitted by Tufts Health Public Plans (THPP) in support of the compliance validation process. In addition, KEPRO conducted a three-day site visit on August 29 – 31, 2017.

Enrollee Rights & Protections

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

Enrollee Information

Strengths	▪ In general, the enrollee handbook met contract requirements and was easy-to-read. ▪ Tufts had an innovative call center tool which served as a resource for its customer service representatives when helping MCO members.
Findings	Partially Met: ▪ Tufts did not meet the timeliness requirements for answering at least 90 percent of calls within 30 seconds and having an abandoned call rate of less than five percent.
Recommendations	▪ Tufts should take steps to improve call answer timeliness to meet contractual requirements.

Availability and Accessibility of Services

Strengths	▪ Tufts had a comprehensive policy on cultural and linguistic competency monitoring. ▪ Tufts had a robust provider network for its MCO population.
Findings	Partially Met: ▪ Tufts provided evidence of the results of an appointment access survey, which was described to be done internally via phone. It indicated that providers found to be noncompliant during the phone survey would have been advised of appropriate standards at that time. No evidence was provided, however, to demonstrate that corrective action plans for noncompliant providers were implemented. ▪ Tufts did not provide evidence of a process to provide publicly available information from the BORIM or NPDB on malpractice history of any provider to a member upon request. ▪ Tufts collected all required provider information on its Behavioral Health Provider Information Form, except for post-adoption issues. ▪ While Tufts executed and maintained contracts with appropriate ESPs, evidence was not provided on the following: ➢ The development of ESP Performance Specifications; ➢ Policies and procedures to ensure that contracted ESPs use the statewide Bed Finder technology as necessary; ➢ The requirement that the response time for face-to-face evaluations by ESPs does not exceed one hour from notification by telephone from the referring party or from the time of presentation by the Enrollee. ▪ Tufts provided evidence of monitoring aggregate PCP changes. It did not provide evidence of monitoring individual enrollee PCP changes to identify and address opportunities for enrollee education and potential intervention with the PCP. Not Met: ▪ Tufts did not provide a policy or report to evidence that facility availability standards were met. ▪ Tufts' Provider Agreement required provider hours of operation, but parity with commercial and Medicaid fee-for-service was not included.

Recommendations	▪ Tufts should ensure that when providers are found to be noncompliant with appointment access standards during the access phone survey, a corrective action plan is put in place with follow up to ensure that deficiencies have been corrected. ▪ Tufts should develop and communicate a process to Customer Relations staff that provides an enrollee access to publicly available BORIM and NPDB information on provider malpractice history. ▪ Tufts should update its Provider Information Form to make possible the identification of providers with expertise in post-adoption issues. ▪ Tufts should document 1) ESP Performance Specifications; 2) policies and procedures to ensure that ESPs use the statewide Bed Finder technology; and 3) the required one-hour ESP face-to-face response time. ▪ Tufts should put a process in place to monitor individual frequent changes in PCP and provide enrollee education or provider intervention as needed. ▪ Tufts should include acute inpatient services, rehabilitation hospital services, and urgent care services availability standards in a policy and produce geo-access reports to evidence the degree to which standards are met. ▪ Tufts should update its Provider Agreement or Provider Manual to include the provision requiring office hours parity with commercial and Medicaid fee-for-service enrollees.

Coordination and Continuity of Care

Strengths	▪ Tufts demonstrated an active and engaged care management team with noted efforts to outreach and engage the at-risk population. ▪ Tufts' texting program for disease management was an innovative medium to engage members.
Findings	Partially Met: ▪ The Health Needs Assessment addressed privacy protections but did not include a disclosure indicating how the information obtained may be used. Specifically, there was no indication of with whom the information may be shared.
Recommendations	▪ Tufts should include a disclosure statement on the HNA with whom the information may be shared.

Coverage and Authorization of Services

Strengths	▪ Tufts' "Think Tank," a high-visibility weekly meeting to discuss vulnerable and challenging members was identified as a best practice. ▪ Tufts used a multidisciplinary team to provide input on challenging members. ▪ Tufts offered extra value-added benefits to its MCO population.
Findings	Partially Met: ▪ During the onsite interviews, staff indicated they have a quick turnaround time for authorization requests and reach decisions timely. If an authorization was found to have not met the timeframe, Tufts would review the service request that day or as quickly as possible. The requirement is that an untimely decision is considered an adverse action, a denial, and the member must be afforded appeal rights. Not Met: ▪ The Coverage Determination and Exceptions Policy did not correctly reflect the timeliness requirements for prior authorization of prescription drugs. During the onsite interview, the pharmacy team noted that the one-day turnaround time was not yet in effect.
Recommendations	▪ Tufts should review procedures related to pre-service coverage determinations and revise, as appropriate, to indicate an untimely decision is considered a denial and the member must be afforded appeal rights. The updated procedure should be reviewed with staff. ▪ The Tufts pharmacy team should review the current Federal and State contractual requirements related to prior authorization timelines for prescription drugs and immediately implement processes to meet requirements.

Practice Guidelines

Strengths	▪ Tufts' process for disseminating practice guidelines was comprehensive.
Findings	Partially Met: ▪ While Tufts explained that enrollee needs were considered when adopting practice guidelines, the process by which those needs were identified was not documented. ▪ The UM Policy Manual stated that consistent application of guidelines was monitored related to utilization management decisions and enrollee education. There was no explicit process, however, documented to ensure this was achieved.
Recommendations	▪ Tufts should update its UM Policy Manual to document the processes used to consider enrollee needs in developing practice guidelines. ▪ Tufts should develop a policy and procedure that includes how the consistent application of clinical guidelines is achieved across utilization management decisions and enrollee education.

Enrollment and Disenrollment

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

Grievance System

Strengths	▪ Tufts had a good process for handling quality-of-care grievances by its clinical staff and demonstrated thorough research and resolution. ▪ Tufts made several advances in reducing the manual processing of appeals.
Findings	Partially Met: ▪ The grievance file review showed that Tufts was inconsistent with providing written acknowledgement of grievances within one business day. ▪ The grievance file review showed that Tufts was inconsistent with providing written resolution of grievances within 30 calendar days.

Recommendations	▪ Tufts should implement a process to monitor its compliance with meeting the written acknowledgment for grievances. ▪ Until these contractual requirements are met, Tufts should implement a process to monitor its compliance with grievance resolution within 30 calendar days.

Subcontractual Relationships and Delegation

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

Quality Assessment and Performance Improvement Program

Strengths	▪ Tufts achieved 2016 NCQA accreditation. ▪ Tufts had good conceptualization and well-documented mandated program initiatives (preventive immunizations, cancer screenings, and disease management programs). ▪ Tufts overall organizational structure allowed for strong quality and care management integration, which is conducive to implementing effective outreach and initiatives.

Findings	Partially Met: ▪ The Tufts Health Public Plans UM Policy Manual included a general reference to the review of over- and under-utilization indicators, including HEDIS, CAHPS, and other utilization metrics. No process to detect over- and under-utilization or actual report of relevant metrics was provided. ▪ The Care Management Evaluation focused on emergency department visits, readmissions, and enrollee satisfaction with the complex case management program. While this evaluation addressed aspects of appropriateness of care for enrollees with special health care needs, no quality-of-care metrics were assessed. ▪ The Quality Improvement Program Plan indicates that an objective of program was to ensure that Quality Improvement activities and decision-making were supported by data including HEDIS. However, the QI Work Plan Evaluation included a very limited number of MCO initiatives based on HEDIS (cancer screenings). ▪ Tufts did not provide evidence of a medical record review process to monitor provider compliance with policies and procedures and appropriateness of care. ▪ While evidence was presented that the CAHPS survey was conducted for enrollees, no evidence of a provider satisfaction survey was provided. ▪ The QI Program Plan included a reference to involving enrollees in Quality Management member advisory councils or boards, but minutes of these meetings were not provided. ▪ The Tufts QI Work Plan Evaluation applied to all lines of business. A limited number of items appeared to be related to the MCO product. In addition, the scope of the Evaluation was narrow, e.g. it did not include member or provider satisfaction, appeals, grievances, quality-of-care, and credentialing. ▪ The Tufts UM Evaluation did not expressly assess the effectiveness and efficiency of the program and lacked any process or outcome measures relevant to the program. ▪ Tufts did not provide evidence that inappropriate utilization or either over- or under-utilization were addressed within the UM program. ▪ Tufts did not provide evidence of provider-level utilization profiles with comparison to norms was provided, though committee minutes demonstrated that provider profiling was under development, including a review of denial rates. ▪ Routine monitoring of utilization by service type was not

	evidenced. ▪ The Member Handbook described a substantial member rewards program. However, while reward program activity was provided, no evidence of monitoring the effectiveness of the program was provided. ▪ While Tufts described provider incentives for completing suboxone training and providing notification of prenatal services, no evidence was provided on collaborating with providers on incentives. In addition, no evidence was provided on measures to assess the effectiveness of incentives. Not Met: ▪ The Behavioral Health Provider Agreement provided included a provision that the provider agrees to cooperate with and to participate in the Plan's quality improvement, quality assurance, utilization management programs and performance assessment system and other policies and procedures. It did not specifically require the collection of clinical outcomes data, incorporation of the data in the medical record, and making the data available upon request. ▪ Tufts did not provide evidence of informing PCPs of the effective use of standardized behavioral health screening tools or how to evaluate the information gathered. In addition, no evidence of educating providers on providing EPSDT behavioral health screenings was provided.

Recommendations	▪ Tufts should develop appropriate metrics to detect over- and under-utilization and produce a report and analysis of these metrics on a regular basis. ▪ Tufts should expand its Care Management Evaluation to include measures to assess the quality-of-care provided to enrollees with special health care needs. ▪ Tufts should expand the QI Work Plan to document all MCO-related initiatives based on HEDIS results. ▪ Tufts should implement a medical record review process, including sampling proportionate to service type, to monitor provider compliance with policies and procedures and appropriateness of care. ▪ Tufts should conduct and document an annual survey to assess network provider satisfaction. ▪ Tufts should ensure that member advisory council meetings are convened regularly and that enrollee input on QI activities is gathered. ▪ Tufts should expand its QI Work Plan Evaluation to include the effect and effectiveness of the wider scope of QI activities. ▪ Tufts should expand its UM Evaluation to include an assessment of the effectiveness and efficiency of the process, e.g. include turnaround times, denial rates, authorization volumes. ▪ Tufts should include a review of inappropriate and over- and under-utilization in its UM Evaluation. ▪ Tufts should implement provider-level utilization profiling; ▪ Tufts should implement routine monitoring of utilization by service type to identify trends in its UM Evaluations. ▪ Tufts should update its Behavioral Health Provider Agreement or Provider Manual to include the requirements relative to clinical outcomes data. ▪ Tufts should implement a process to assess the effectiveness of its member rewards program, including member feedback, and revise incentives, as appropriate. ▪ Tufts should consider collaborating with providers to expand incentive programs and implement a process to monitor the effectiveness of incentives, revising them as appropriate. ▪ Tufts should develop PCP education on standardized behavioral health screening tools, how to use the information gathered, and the importance of providing EPSDT behavioral health screenings.

Credentialing

Strengths	▪ Tufts documentation was comprehensive and well-presented. ▪ Tufts was fully compliant with this standard.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Confidentiality of Health Information

Strengths	▪ Tufts had excellent documentation related to confidentiality of health information and an excellent confidentiality program. ▪ Tufts was fully compliant with this standard.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Health Information Systems

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

Program Integrity

Strengths	▪ Tufts had excellent documentation of a very strong program.
Findings	Partially Met: ▪ While Tufts had a comprehensive policy and process in place for screening employees and contractors, it did not provide evidence of notifying EOHHS of any discovered exclusion of an employee or contractor.
Recommendations	▪ Tufts should update its policy and process to notify EOHHS of any discovered exclusion of an employee or contractor.