MassHealth

Senior Care Organizations
External Quality Review Technical Report
Calendar Year 2017

KEPRO
INTELLIGENT VALUE

Contents

SECTION 1. MASSHEALTH'S SENIOR CARE ORGANIZATIONS

BOSTON MEDICAL CENTER HEALTHNET (BMCHP)

BMCHP HealthNet's Senior Care Organization is a local coordinated care program (CCP) located in Charlestown, Massachusetts. In 2016 and 2017, it operated solely in Suffolk County.

COMMONWEALTH CARE ALLIANCE (CCA)

Commonwealth Care Alliance is a community-based, not-for-profit healthcare organization dedicated to improving care for people with complex chronic conditions, including multiple disabilities. Of its members, 70 percent are nursing-home eligible, 62 percent do not speak English, and approximately the same proportion of members has diabetes. It operates four disability-competent Commonwealth Community Care centers in Boston, Lawrence, MetroWest, Worcester, and Springfield. Its service area includes all cities and towns in Bristol, Essex, Hampden, Hampshire, Middlesex, Suffolk and Worcester counties as well as many cities and towns in Franklin, Norfolk, and Plymouth counties. It received 4 out of 5 possible Stars for 2018, according to the U.S. Centers for Medicare & Medicaid Services Star Ratings. Its corporate offices are located in Boston.

FALLON HEALTH (FH)

Fallon Health's Senior Care Organization (SCO), NaviCare, has a service area that includes Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties, and portions of Franklin County. It received an overall quality score of 4.5 from NCQA. Fallon Health's behavioral health partner is Beacon Health Options. Its corporate offices are located in Worcester.

SENIOR WHOLE HEALTH (SWH)

Senior Whole Health is a SCO with corporate offices located in Cambridge. It operates in all regions of the Commonwealth with the exception of Western Massachusetts. It is not yet accredited by NCQA, but a site visit is scheduled. It received a quality score of 3.0 for 2016 – 2017 from NCQA.

TUFTS HEALTH PLAN (THP)

Tufts Health Plan, Inc., is a not-for-profit health maintenance organization headquartered in Watertown, MA, serving its members in Massachusetts, New Hampshire and Rhode Island. Its private HMO/POS and Massachusetts PPO plans are rated 5 out of 5 by the National Committee for Quality Assurance (NCQA). Tufts Health Plan is the only health plan in the nation to receive the rating for both its HMO and PPO products. Tufts Medicare Preferred HMO and Senior Care Options earned 5 stars out of a possible 5 from the Centers for Medicare and Medicaid Services

for 2018, putting it in the top 4% of plans in the country. It had 3,002 SCO members as of December 31, 2016.

UNITEDHEALTHCARE (UHC)

The Senior Care Option plan is part of UHC's Community Plan line of business. UHC started operating in the Boston region but has since expanded its service area to include Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. As of December 31, 2016, 17,666 individuals belonged to the plan and lived either at home or in a nursing facility. The Centers for Medicare and Medicaid Services (CMS) has assigned a 4.5 Star Rating to UHC's SCO. Its corporate offices are located in Waltham.

MASSHEALTH SENIOR CARE ORGANIZATION MEMBERSHIP

Senior Care Organization	Membership as of December 31, 2016	Percent of Total SCO Population
UnitedHealthcare	17,666	38.4%
Senior Whole Health	12,308	26.8%
Commonwealth Care Alliance	7,968	17.3%
Fallon Health Navicare	4,893	10.6%
Tufts Health Plan	3,002	6.5%
BMCHP HealthNet	141	0.3%
Total	**45,978**	**100%**

SECTION 2. CONTRIBUTORS

PROJECT MANAGEMENT

Cassandra Eckhof, M.S.

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

PERFORMANCE MEASURE VALIDATION

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^{SM} on behalf of NCQA. She is a frequent speaker at HEDIS® vendor and health plan conferences, such as National Alliance of State Health CO-OPs (NASHCO) conferences. Ms. Iskrant received her Bachelor of Arts from Columbia University and her Master of Public Health from UC Berkeley School of Public Health. She is a member of the National Association for Healthcare Quality (NAHQ) and is published in the fields of healthcare and public health.

COMPLIANCE VALIDATION REVIEWERS

Jennifer Lenz, MPH, CHCA

Ms. Lenz has more than 17 years of experience in the healthcare industry, with expertise in implementing and managing external quality review activities, managing teams, and driving quality improvement initiatives. Ms. Lenz has working experience in both private and public health sectors. Her prior experience includes managed care organization responsibility for accreditation and quality management activities; managing chronic disease programs for a state health department; and in performing external quality review organization activities. She has conducted compliance review activities across health plans in the states of California, Georgia, Ohio, Utah, and West Virginia. Ms. Lenz is a Certified HEDIS® Compliance Auditor

through the NCQA. She received her MPH in Health Administration and Policy from the University of Arizona.

Lois Heffernan, RN, BSN, MBA

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

Teresa Huysman, RN, BSN

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

PERFORMANCE IMPROVEMENT PROJECT REVIEWERS

Marietta Scholten, MD, FAAFP

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

Dr. Scholten was the Medical Director for the Vermont Chronic Care Initiative for seven years working with the 5 percent of Medicaid beneficiaries costing 40 percent of the Medicaid budget. She was responsible for creating targeted interventions to improve the health of beneficiaries, coordinate their care, and reduce costs. She has been the Hospice Medical

Director for Franklin County Home Health and Hospice providing oversight of medical services and community education for the past 26 years.

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

Wayne J. Stelk, Ph.D.

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

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

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

SECTION 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.

The EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services. It is also posted to the Medicaid agency website.

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

KEPRO conducted the following external quality review activities for MassHealth Senior Care Organizations in the CY 2017 review cycle:

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

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

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 and the Office of Elder Affairs. The measures validated were as follows:

- Care for Older Adults (COA), Advance Care Planning (ACP);
- Annual Monitoring for Patients on Persistent Medications (MPM); and
- Medication Reconciliation Post-Discharge (MRP).

All SCOs followed specifications and reporting requirements and produced valid measures.

The focus of the Information Systems Capability Analysis is on components of SCO 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 SCOs demonstrated compliance with these requirements.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

MassHealth SCOs are required to conduct two PIPs annually. The identification of PIP topics is a collaborative process between MassHealth, the Office of Elder Affairs, and the managed care entities. Each SCO was required to conduct a project on reducing all-cause 30-day readmission rates. SCOs select a second project, subject to MassHealth approval, specific to the needs of their organizations and populations. In 2017, the projects were:

- **BMCHP** – Improving health outcomes for members with diabetes
- **Commonwealth Care Alliance** – Increasing the rate of annual preventive dental care visits
- **Fallon Health** – Reducing the use of high-risk medications in the elderly
- **Senior Whole Health** – Diabetes health management program
- **Tufts Health Plan** – Reducing risks for people with cardiovascular disease in the SCO population 65 and over with congestive heart failure (CHF) by reducing CHF admission rates
- **UnitedHealthcare** - Improving SCO member adherence to medication regimens for managing their diabetes

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 outcome. Recommendations are offered to the plan.

> *Based on its review of the MassHealth SCO PIPs, KEPRO did not discern any issues related to any plan's quality of care or the timeliness of or access to care. Recommendations made were plan-specific, the only theme emerging being the importance of gathering stakeholder input in project design.*

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 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 review of all documentation provided by the SCOs. In addition, two-day on-site visits were conducted to interview key SCO personnel, review selected case files, participate in systems demonstrations, and allowed for further clarification/provision of documentation. Plans were required to submit a corrective action plan for each standard identified as Partially Met or Not Met.

> *Overall, the SCOs demonstrated compliance with the Federal and State contractual standards for its SCO membership. Due to the unique needs of the SCO population, a heavy emphasis of the review was placed on the coordination and continuity of care standard. No issues related to quality, access to care, or timeliness of care were identified.*

SECTION 4. PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ANALYSIS

Introduction

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

In Calendar Year 2017, KEPRO modified the Performance Measure Validation process. SCOs that had undergone a formal HEDIS audit uploaded documentation to the KEPRO secure File Transfer Protocol (FTP) site. KEPRO validated the performance measures based on a desk review of these documents. If a plan did not undergo a formal HEDIS audit, the Performance Measure Validation (PMV) process was a two-step process consisting of a desk review of documentation submitted by the managed care organization (MCO) as well as an onsite review. The desk review afforded the reviewer an opportunity to become familiar with plan systems and data flows. In addition, the reviewer conducted an independent verification of a sample of individuals belonging to the positive numerator of a hybrid measure. At the onsite review, the reviewer confirms information contained in the documentation, inspected information systems, and by interviewing staff, obtained clarification about performance measurement and information transfer processes. Because all SCOs had undergone a formal HEDIS audit, none were subject to site visits.

For the 2017 Performance Measure Validation, SCOs submitted the following documentation:

Exhibit 1: Documentation Submitted by SCOs

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) and previous two years IDSS, as available	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, onsite interviews, and systems demonstrations.

COMPARATIVE ANALYSIS

In 2017, KEPRO validated three measures that were selected by MassHealth and the Office of Elder Affairs. The measures validated were as follows:

- Care for Older Adults (COA), Advance Care Planning (ACP);
- Annual Monitoring for Patients on Persistent Medications (MPM); and
- Medication Reconciliation Post-Discharge (MRP).

The results of the validation follow.

Exhibit 2: Performance Measure Validation Results

Performance Measure Validation: Annual Monitoring for Patients on Persistent Medications

Methodology for Calculating Measure:	Administrative		Medical Record Review		Hybrid	
Review Element	**BMCHP**	**CCA**	**FH**	**SWH**	**THP**	**UHC**
DENOMINATOR *Population*	[Met / Needs improvement / Not met]					
Medicaid population was appropriately segregated from commercial and Medicare mixture.	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 SCO'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

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
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
NUMERATOR *Administrative Data: Counting Clinical Events*						
Standard codes listed in state 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: Care for Older Adults – Advance Care Planning

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
DENOMINATOR *Population*	[Met / Needs improvement / Not met]					
Medicaid population was appropriately segregated from other product lines	Reporting not required - small denominator	Met	Met	Met	Met	Met
Members were 66 years of age or older as of December 31 of the measurement year.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Geographic Area						
Includes only those Medicaid enrollees served in the SCO's reporting area.	Reporting not required - small denominator	Met	Met	Met	Met	Met
NUMERATORS *Administrative Data: Counting Clinical Events*						
Standard codes listed in state specifications or properly mapped internally developed codes were used.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Data sources used to calculate the numerators (e.g., claims files, medical records, 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.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Members had evidence of advanced care planning as documented through either administrative data or medical record review.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Data Quality						
Based on the IS assessment findings, the data sources used were accurate.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Reporting not required - small denominator	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
Proper Exclusion Methodology in Administrative Data (if no exclusions were taken, mark as N/A)						
There are no exclusions for this measure.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Medical Record Review Documentation Standards						
Record abstraction tool required notation of the date of an advance care planning discussion or the presence of an advance care plan in the medical record.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Hybrid Measure						
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Reporting not required - small denominator	Met	Met	Met	Met	Met
If hybrid method or solely MRR was used, the results of the MRR validation substantiated the reported numerator.	Reporting not required - small denominator	Met	Met	Met	Met	Met
SAMPLING						
Unbiased Sample						
As specified in the state specifications, systematic sampling method was utilized.	Reporting not required - small denominator	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.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Sample treated all measures independently.	Reporting not required - small denominator	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 state, or 2) data errors.	Reporting not required - small denominator	Met	Met	Met	Met	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented.	Reporting not required - small denominator	Met	Met	Met	Met	Met

Performance Measure Validation: Medication Reconciliation Post-Discharge

Methodology for Calculating Measure:	Administrative		Medical Record Review		Hybrid	
Review Element	**BMCHP**	**CCA**	**FH**	**SWH**	**THP**	**UHC**
DENOMINATOR *Population*	[Met / Needs improvement / Not met]					
Medicaid population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members were age 66+ as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Members had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year.	Met	Met	Met	Met	Met	Met
Geographic Area						
Includes only those Medicaid enrollees served in the SCO's reporting area.	Met	Met	Met	Met	Met	Met
NUMERATORS *Administrative Data: Counting Clinical Events*						
Standard codes listed in state specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
Enrollment status, continuous enrollment, and enrollment gaps were correctly verified.	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 had a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.	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

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
Proper Exclusion Methodology in Administrative Data (if no exclusions were taken, mark as N/A)						
If the discharge is followed by readmission or direct transfer to an acute or non-acute facility within the 30 day follow up period, only the readmission or transfer discharge is counted. Exclude if the readmission/direct transfer discharge occurs after December 1 of the measurement year or if the member remains in the facility through December 1 of the measurement year.	Met	Met	Met	Met	Met	Met
Medical Record Review Documentation Standards						
Record abstraction tool requires notation of the date of medication reconciliation.	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.	Met	Met	Met	Met	Met	Met
SAMPLING						
Unbiased Sample						
As specified in the state 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
Sample treated all measures independently.	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 state, 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	CCA	FH	SWH	THP	UHC
SCO followed the specified sampling method to produce an unbiased sample representative of the entire at-risk population.						
	[Met / Needs improvement / Not met]					
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
SCO 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, SCO/PIHP 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
SCO examined its samples files for bias, and if any bias was detected, SCO 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
SCO maintains its performance measurement population files / datasets in a manner allowing a sample to be re-drawn, or used as a source for replacement.						
SCO 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
SCO appropriately handles the documentation and reporting of the measure if the requested sample size exceeds the population size.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
SCO properly over-sampled in order to accommodate potential exclusions.	Met	Met	Met	Met	Met	Met
For PMs that include medical record review, SCO 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
SCO 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	BMCHP	CCA	FH	SWH	THP	UHC
SCO included all members of the relevant populations identified in PM specifications in the population from which each denominator was produced.						
	[Met / Needs improvement / Not met]					
SCO 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, SCO 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
SCO correctly carried out and applied to each applicable PM calculations of continuous enrollment criteria.	Met	Met	Met	Met	Met	Met
SCO used proper mathematic operations to determine patient age or range.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
SCO can identify the variable(s) that define the member's gender in every file or algorithm needed to calculate PM denominators, and SCO can explain what classification it carried out if neither of the required codes were present.	Met	Met	Met	Met	Met	Met
SCO correctly calculated member months and member years.						
For each applicable PM, SCO correctly calculated member months and member years.	Met	Met	Met	Met	Met	Met
Codes used to identify medical events were complete and accurate, and SCO appropriately applied those codes.						
SCO 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
SCO followed specified time parameters.						
SCO 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
SCO followed exclusion criteria in PM specifications.						
SCO 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	CCA	FH	SWH	THP	UHC
SCO used all appropriate data to identify the entire at-risk population.						
	[Met / Needs improvement / Not met]					
SCO used appropriate data, including linked data from separate datasets, to identify the entire at-risk population.	Met	Met	Met	Met	Met	Met
SCO utilized procedures to capture data for those performance indicators that could easily be underreported due to the availability of services outside of the SCO.	Met	Met	Met	Met	Met	Met
SCO properly identified qualifying medical events, such as diagnoses, procedures, and prescriptions, and confirmed those events for inclusion in terms of time and services.						

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
SCO'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
SCO correctly evaluated medical event codes when classifying members for inclusion in or exclusion from the numerator.	Met	Met	Met	Met	Met	Met
SCO avoided or eliminated all double-counted members or numerator events.	Met	Met	Met	Met	Met	Met
SCO adhered to any parameters required by PM specifications (i.e., the measure event occurred during the time period that the PM specified or defined).	Met	Met	Met	Met	Met	Met
SCO made substitutions for properly excluded records and documented the percentage of substituted records.	Met	Met	Met	Met	Met	Met
SCO properly collected medical record data extracted for inclusion in the numerator.						
SCO 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	CCA	FH	SWH	THP	UHC
SCO has measurement plans and policies stipulating and enforcing documentation of data requirements, issues, validation efforts, and results.						
[Met / Needs improvement / Not met]						
SCO documented data file and field definitions for each PM.	Met	Met	Met	Met	Met	Met

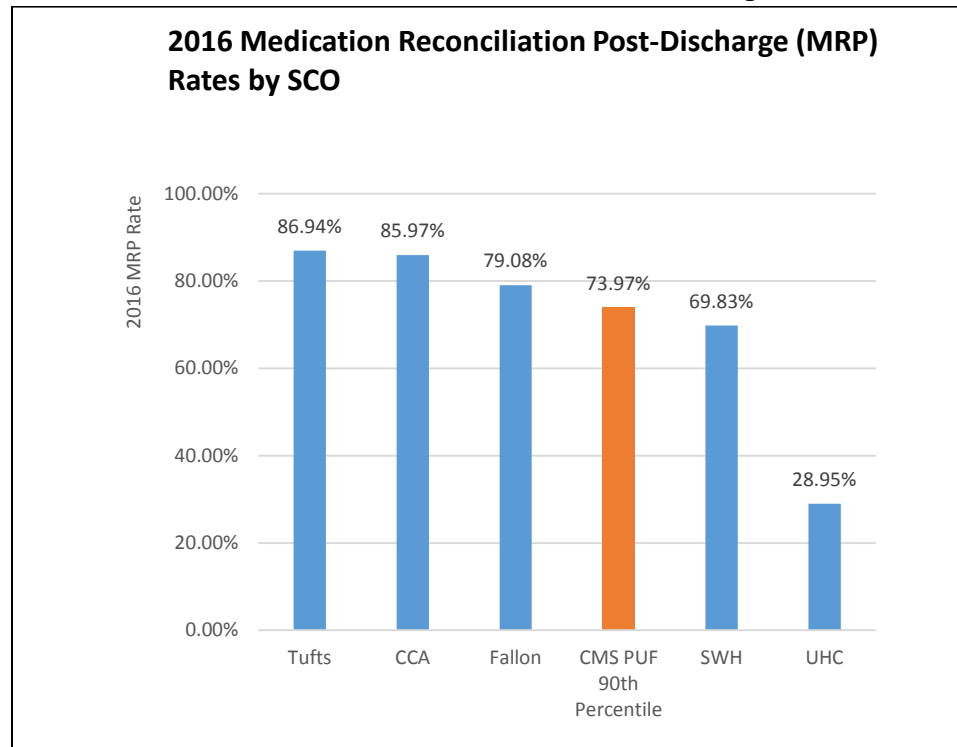| Review Element	BMCHP	CCA	FH	SWH	THP	UHC
SCO documented maps to standard coding if not used in the original data collection.	Met	Met	Met	Met	Met	Met
SCO conducted statistical testing of results and made any correction or adjustments after processing.	Met	Met	Met	Met	Met	Met
SCO has complete documentation of programming specifications (either as a schematic diagram or in narrative form) for each PM.						
SCO 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
SCO 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
SCO 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 SCO employed sampling, SCO documented sampling techniques, and documentation that assures the reviewer that SCO/PIHP chose samples for PM baseline and repeat measurements that used the same sampling frame and methodology.	Met	Met	Met	Met	Met	Met
SCO 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
SCO 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, SCO applies appropriate statistical methodology to determine levels of significance of changes.	Met	Met	Met	Met	Met	Met

Data Integration and Control

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
SCO has in place processes to ensure the accuracy of data transfers to assigned PM repository.						
	[Met / Needs improvement / Not met]					
SCO/PIHP 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
SCO has in place processes to ensure the accuracy of file consolidations, extracts, and derivations.						
SCO'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 SCO'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
SCO 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
SCO effectively manages report production and reporting software.						
SCO follows prescribed cutoff dates.	Met	Met	Met	Met	Met	Met
SCO retains copies of files or databases for PM reporting in the case that it must reproduce results.	Met	Met	Met	Met	Met	Met
SCO 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
SCO's processes and documentation comply with its standards associated with reporting program specifications, code review, and testing.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	FH	SWH	THP	UHC
SCO followed specified time parameters.						
SCO 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
SCO followed exclusion criteria included in PM specifications.						
SCO 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[1]

The chart that follows depicts Medication Reconciliation Post-Discharge (MRP). The CMS Medicare Public Use File (PUF) 90th percentile rate is included for comparison purposes. Three plans (Tufts, CCA, and Fallon Health) perform above the CMS PUF 90th percentile and CCA and Tufts perform above the 95th percentile. The performance for all plans is trending up.

**Exhibit 3: 2016 Medication Reconciliation Post-Discharge Rates for All SCOs**

2016 Medication Reconciliation Post-Discharge (MRP) Rates by SCO

	2016 MRP Rate
Tufts	86.94%
CCA	85.97%
Fallon	79.08%
CMS PUF 90th Percentile	73.97%
SWH	69.83%
UHC	28.95%

Exhibit 4:   Trended MRP Data for MassHealth SCOs

		2013	2014	2015	2016	Linear Performance Trend Line	PUF Percentile Ranking
MRP	**CMS PUF 90th**				73.97%		
	CCA	70.83%	82.47%	70.80%	85.97%	↑	> 95th
	Fallon	45.00%	52.80%	88.54%	79.08%	↑	90th – 95th
	SWH	62.04%	35.52%	43.07%	69.83%	↑	75th – 90th
	Tufts	NR	56.88%	70.14%	86.94%	↑	>95th
	UHC	32.64%	53.24%	38.84%	28.95%	↑	10th – 25th

---

[1] BMCHP did not provide reporting for the reasons listed on page 31.

The chart and table that follows depicts COA Advanced Care Planning (ACP) for each of MassHealth's SCO. The CMS PUF 90th percentile rate is included for comparison purposes. Both Senior Whole Health and Tufts perform above the CMS PUF 90th percentile. Notably, Senior Whole Health is only 0.5 points short of achieving a 100 percent rate. Performance for all plans is trending up with the exception of Fallon Health.

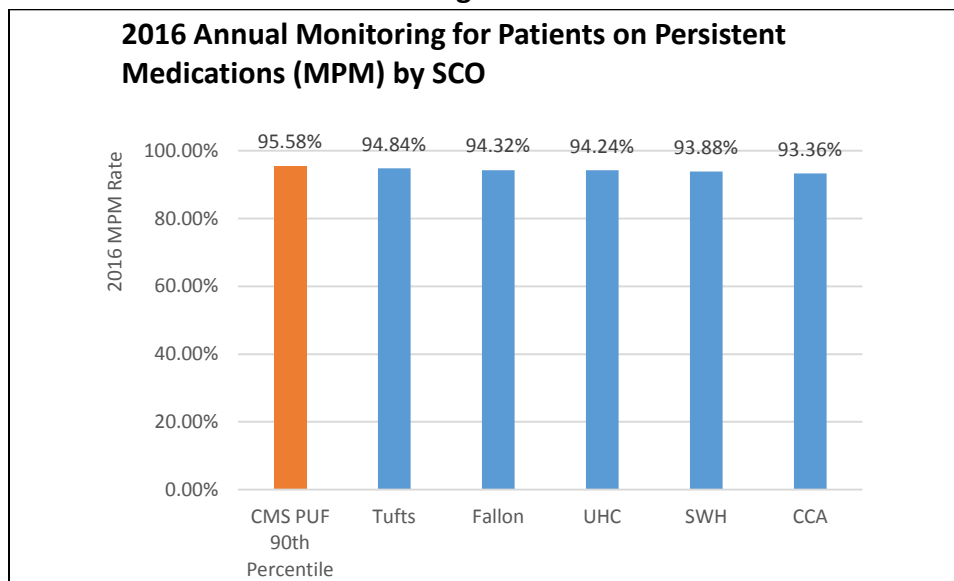**Exhibit 5: 2016 COA Advanced Care Planning Rates for all SCOs**
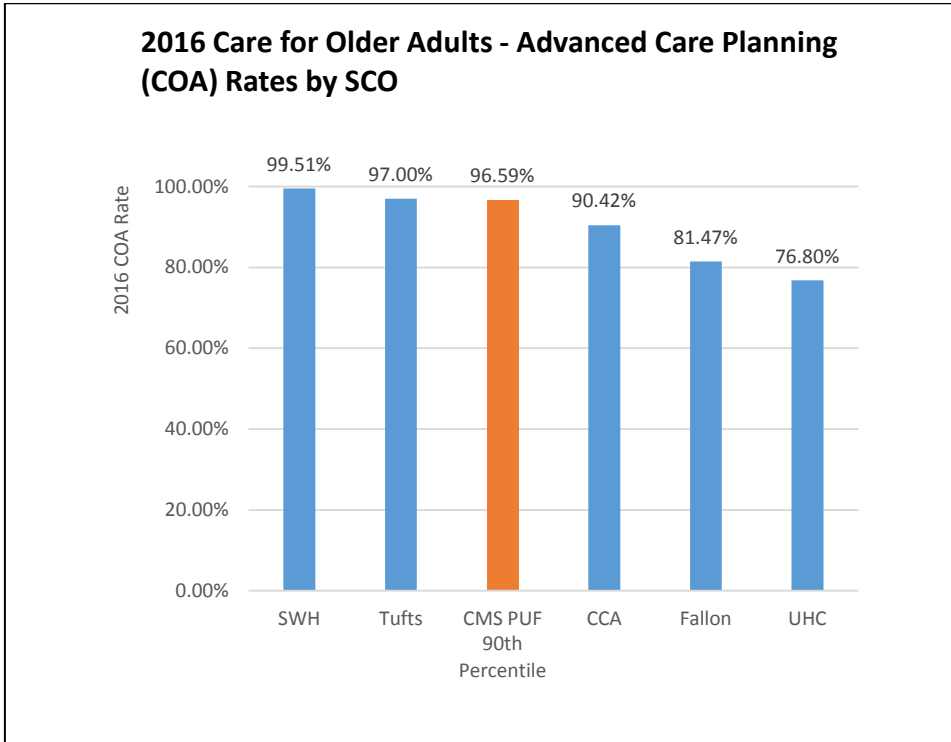
Exhibit 6: Trended COA ACP Data for MassHealth SCOs

		2013	2014	2015	2016	Linear Performance Trend Line	PUF Percentile Ranking
COA ACP	**CMS PUF 90th**				96.59%		
	CCA	84.72%%	90.20%	83.65%	90.42%	↑	75th – 90th
	Fallon	76.74%	79.67%	75.27%	81.47%	↓	66th – 75th
	SWH	47.93%	89.29%	84.88%	99.51%	↑	90th – 95th
	Tufts	NR	44.48%	100%	97.00%	↑	90th – 95th
	UHC	55.32%	67.99%	62.27%	76.80%	↑	50th – 66th

The chart that follows depicts Annual Monitoring for Patients on Persistent Medications (MPM). The CMS Medicare Public Use File (PUF) percentile rate is included for comparison purposes. Performance is relatively even across all plans with a difference of only half a percentage point between the highest- and lowest-performing SCO. The table, "Trended MPM Data for MassHealth SCOs," shows that the trend line for almost all plans is flat.

Exhibit 7: 2016 Annual Monitoring for Patients on Persistent Medications Rates for all SCOs

2016 Annual Monitoring for Patients on Persistent Medications (MPM) by SCO

	CMS PUF 90th Percentile	Tufts	Fallon	UHC	SWH	CCA
2016 MPM Rate	95.58%	94.84%	94.32%	94.24%	93.88%	93.36%

Exhibit 8: Trended MPM Data for MassHealth SCOs

		2013	2014	2015	2016	Linear Performance Trend Line	PUF Percentile Ranking
MPM	**HEDIS 95th**				95.58%		
	CCA	93.21%	94.31%	93.62%	93.36%	↔	50th – 66th
	Fallon	97.38%	97.45%	96.78%	94.32%	↔	75th – 90th
	SWH	95.74%	92.70%	92.95%	93.88%	↔	66th – 75th
	Tufts	NR	97.47%	95.42%	94.84%	↓	75th – 90th
	UHC	94.38%	94.14%	94.13%	94.24%	↔	75th – 90th

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 SCO 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 9: Information Systems Capability Assessment Findings

	BMCHP	CCA	Fallon	SWH	Tufts	UHC
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 & ANALYSIS

KEPRO did not identify any significant issues resulting from PMV. In fact, no issues at all were identified for two of the six plans. The few recommendations made related to source code, medical record review, and supplemental data.

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION AND INFORMATION SYSTEM CAPABILITIES ANALYSES

BOSTON MEDICAL CENTER HEALTHNET (BMCHP)

Performance Measure Results

Calendar year 2016 was this organization's first year of operations. Performance Measure Validation was not performed on BMCHP SCO for the following reasons:

- Annual Monitoring for Patients on Persistent Medications (MPM) — Because the denominator for this measure was less than 30, this rate is not to be publicly reported in accordance with NCQA HEDIS reporting rules.
- Care for Older Adults (COA), Advance Care Planning — CMS sets a membership threshold under which reporting of performance measures is not required. This was the case with BMCHP SCO.
- Medication Reconciliation Post-Discharge (MRP) — The denominator for this measure was less than 30, this rate is not to be publicly reported in accordance with NCQA HEDIS reporting rules.

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. 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 used Facets to process the enrollment data. Facets captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.

- Medical Record Review
  BMCHP used Inovalon's data abstraction tools for hybrid measure abstraction. BMCHP monitored the accuracy of their chart abstraction work during the abstraction time period. No issues were identified with the medical record review process for final measure reporting.

- Supplemental Data
  BMCHP used two supplemental data sources. BMCHP provided complete supplemental data documentation for each supplemental data source and no concerns were identified. The supplemental data sources were approved for HEDIS reporting.

- Data Integration
  BMCHP's performance measures were produced using Inovalon software. Data transfers to the Inovalon repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. 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. 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 the 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's SCO, the results of which were distributed on July 10, 2017.

Exhibit 10: BMCHP Final Audit Results

Audit Element	Findings
Medical data	BMCHP 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 were 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.

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

Opportunities
- None identified.

Recommendations
- The Final HEDIS Audit Report indicated that there were some issues with chart abstraction accuracy for exclusion cases. KEPRO recommends, as did Attest, that 100 percent of exclusions be reviewed prior to the closure of Medical Record Review.

COMMONWEALTH CARE ALLIANCE (CCA)

Performance Measure Results

The charts that follow depict CCA Senior Care Options' performance in the three measures selected by MassHealth for validation.
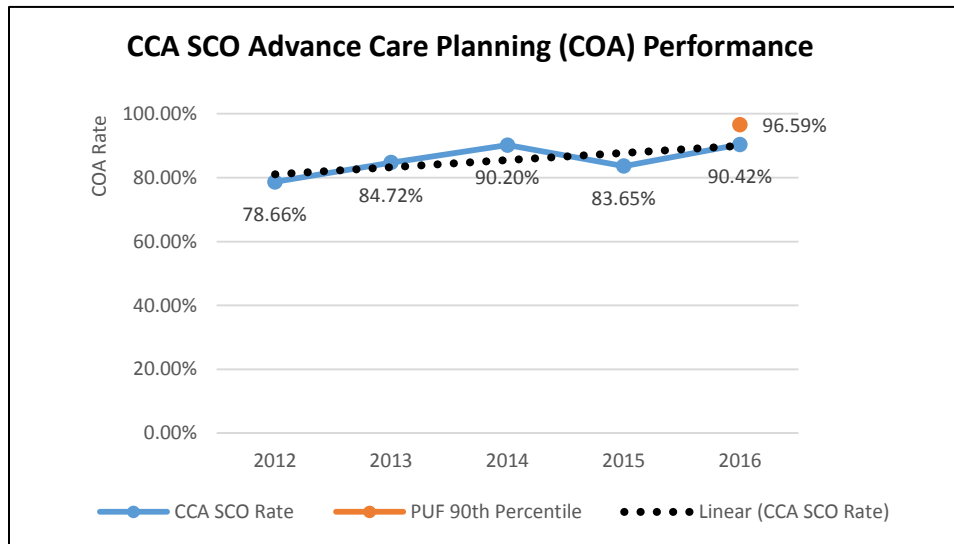
Annual Monitoring for Patients on Persistent Medications (MPM) — CCA Senior Care Options' performance rate on this measure decreased a statistically insignificant 0.26 percentage points between 2015 and 2016. Performance lies between the 50th and 66th Medicare Claims Public Use Files percentiles. This reflects an improvement from 2016 in which performance lay between the 33rd and 50th percentiles.
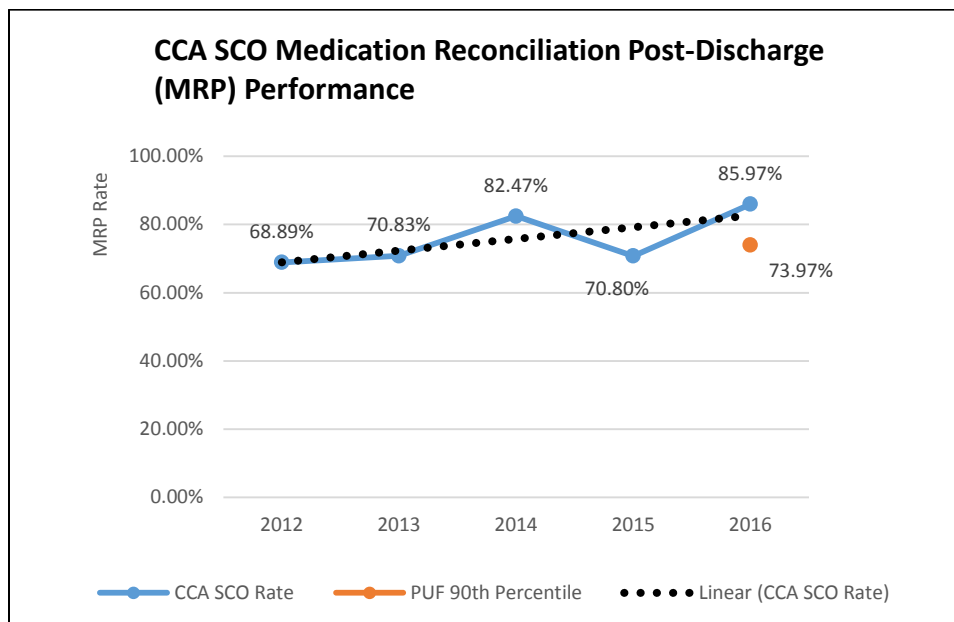
Exhibit 11: CCA MPM Performance Rates
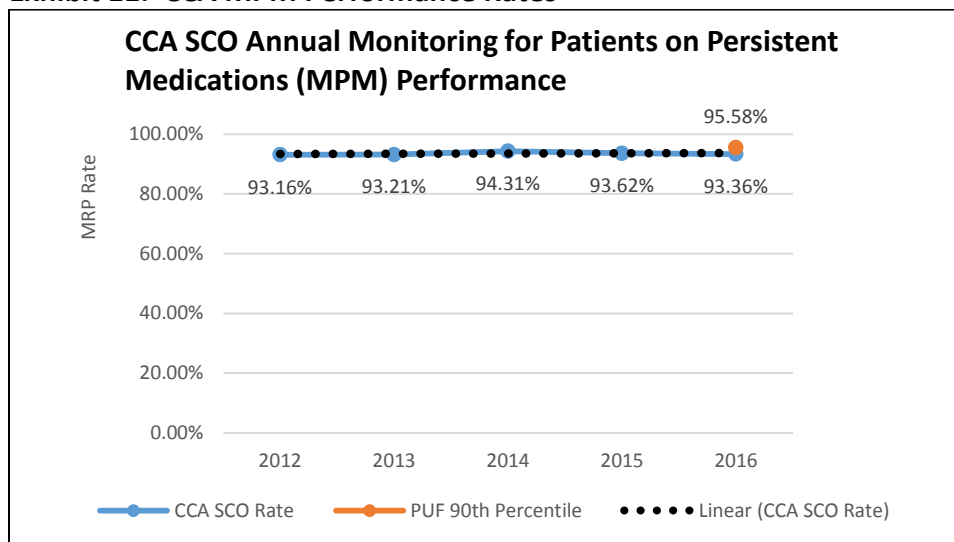
Care for Older Adults (COA), Advance Care Planning — The Advance Care Planning rate increased a statistically significant 6.77 percentage points between 2015 and 2016. CCA SCOs' performance lies between the 75th and 90th percentiles of the Medicare Claims Public Use Files.

Exhibit 12: CCA COA Performance Rates

Chart title: CCA SCO Advance Care Planning (COA) Performance
Y-axis: COA Rate
Data labels: 78.66%, 84.72%, 90.20%, 83.65%, 90.42%, 96.59%
Legend: CCA SCO Rate, PUF 90th Percentile, Linear (CCA SCO Rate)

Medication Reconciliation Post-Discharge (MRP) — Between 2015 and 2016, CCA Senior Care Options' MRP performance increased a statistically significant 15.17 percentage points. CCA Senior Care Options' performance is above the Medicare Claims Public Use Files 95th percentile.

Exhibit 13: CCA MRP Performance Rates

Chart title: CCA SCO Medication Reconciliation Post-Discharge (MRP) Performance
Y-axis: MRP Rate
Data labels: 68.89%, 70.83%, 82.47%, 70.80%, 85.97%, 73.97%
Legend: CCA SCO Rate, PUF 90th Percentile, Linear (CCA SCO 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 CCA SCOs' information system that contribute to performance measure production.

- Claims and Encounter Data
  Claims, including lab claims, were processed by a vendor, PCG, using the EZ Cap system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. PCG demonstrated adequate monitoring of data quality, and CCA maintained adequate oversight of PCG. CCA had adequate processes to monitor claims data completeness, including comparing actual to expected volumes to ensure all claims and encounters are submitted. CCA received encounters on a daily basis from its pharmacy benefits manager (PBM), Navitus Health Solutions. The plan maintained adequate oversight of the PBM. There were no issues identified with claims or encounter data processing.

- Enrollment Data
  CCA processed Medicaid enrollment data using the Market Prominence system. All necessary enrollment fields were captured for HEDIS reporting. Enrollment forms were entered manually and eligibility was verified with both CMS and MassHealth. CCA had adequate processes for data quality monitoring and reconciliation. The plan had processes to combine data for members with duplicate identification numbers. There were no issues identified with enrollment processes.

- Medical Record Review
  Medical record review data for COA and MRP were collected using Inovalon medical record abstraction tools. Training materials were prepared by the plan. All tools and training materials were compliant with the HEDIS technical specifications. CCA had adequate processes for ensuring inter-rater reliability. The plan performed ongoing quality monitoring on both abstraction and data entry throughout the medical record review process. No issues were identified with medical record review.

- Supplemental Data
  CCA's eClinical Works electronic medical record supplemental data source was not mapped for use for any of the three performance measure rates under review. Therefore, this section is not applicable.

- Data Integration
  CCA's performance measures were produced using Inovalon software. Inovalon hosts and runs the software for CCA. Inovalon-compliant extracts were produced from the plan's data warehouse. Inovalon then loaded the data and produced rates for the plan's review and approval. 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. CCA maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

- Source Code
CCA 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 the Advent Advisory Group, which performed a HEDIS® Compliance Audit on Commonwealth Care Alliance Senior Care Options, the results of which were distributed on July 15, 2017:

Exhibit 14: CCA Final Audit Results

Audit Element	Findings
Medical data	CCA 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 are adequate to support reporting.
Medical record review	Medical record tools, training materials, medical record process, and quality monitoring met requirements. CCA passed Medical Record Review Validation.
Supplemental data	No supplemental data were used for the validated measures.
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 Recommendations	2017 Update
Leverage and augment documentation in eClinical Works to improve assessment of advance care planning.	The eClinical Works data relevant to COA-ACP were not used for HEDIS 2018 reporting; the recommendation still stands.
Continue to develop new initiatives targeting MRP.	The plan continued to develop new initiatives to improve its medication reconciliation rate.

Plan Strengths

- CCA used an NCQA-certified vendor.
- CCA submitted thorough documentation for the review.
- The plan has a strong process for reviewing and verifying preliminary and final rates.
- CCA's performance on the three validated measures were above the national average.

Opportunities

- No opportunities were identified.

Recommendations

- Continue to map eClinical Works supplemental data to the Inovalon certified software format to better leverage supplemental data use for HEDIS reporting.

FALLON HEALTH

Performance Measure Results

The charts that follow depict Fallon Health Navicare's performance in the three measures selected by MassHealth for validation. The Medicare Claims Public Use File 90th[2] percentile is included for comparison purposes.

Annual Monitoring for Patients on Persistent Medications (MPM) — Fallon Health's Navicare performance rate on the MPM measure decreased a statistically significant 2.46 percentage points between 2015 and 2016. Performance lies between the 75th and 90th Medicare Claims Public Use Files percentiles.

Exhibit 15: Fallon Health's MPM Performance Rates
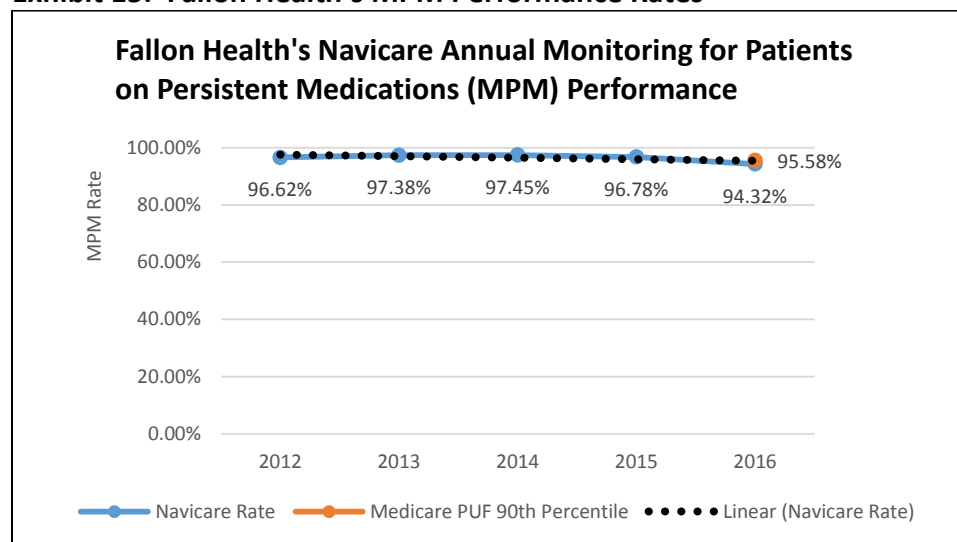
Fallon Health's Navicare Annual Monitoring for Patients on Persistent Medications (MPM) Performance
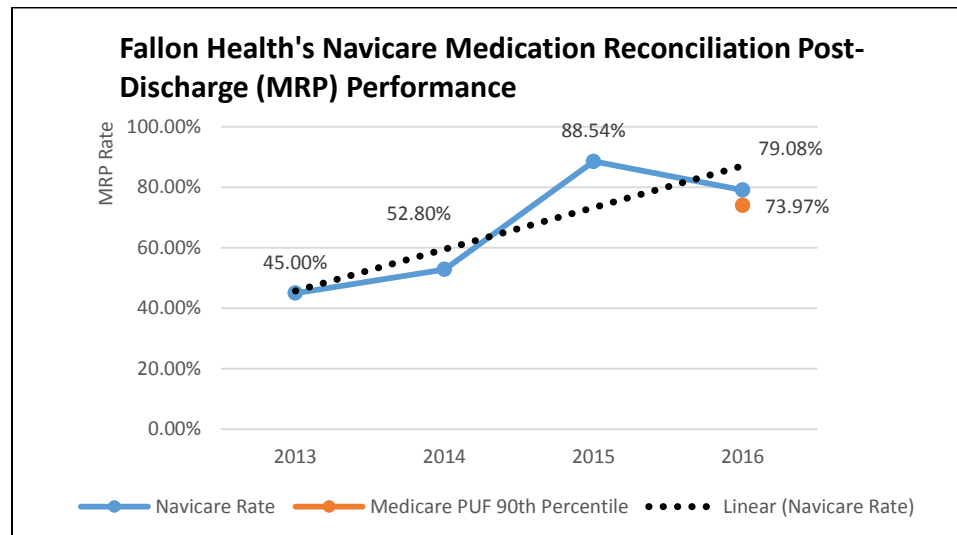

Care for Older Adults (COA), Advance Care Planning — The Advance Care Planning rate increased a statistically significant 6.20 percentage points between HEDIS® 2015 and 2016. Fallon Health's performance lies between the 66thth and 75th percentiles of the Medicare Claims Public Use Files.

Exhibit 16: Fallon Health's COA Performance Rates

Chart: Fallon Health's Navicare Care for Older Adults (COA) – Advance Care Planning Performance. COA Rate values: 89.25% (2012), 76.74% (2013), 79.67% (2014), 75.27% (2015), 81.47% (2016). Medicare PUF 90th Percentile: 96.59% (2016). Legend: Navicare Rate, Medicare PUF 90th Percentile, Linear (Navicare Rate).
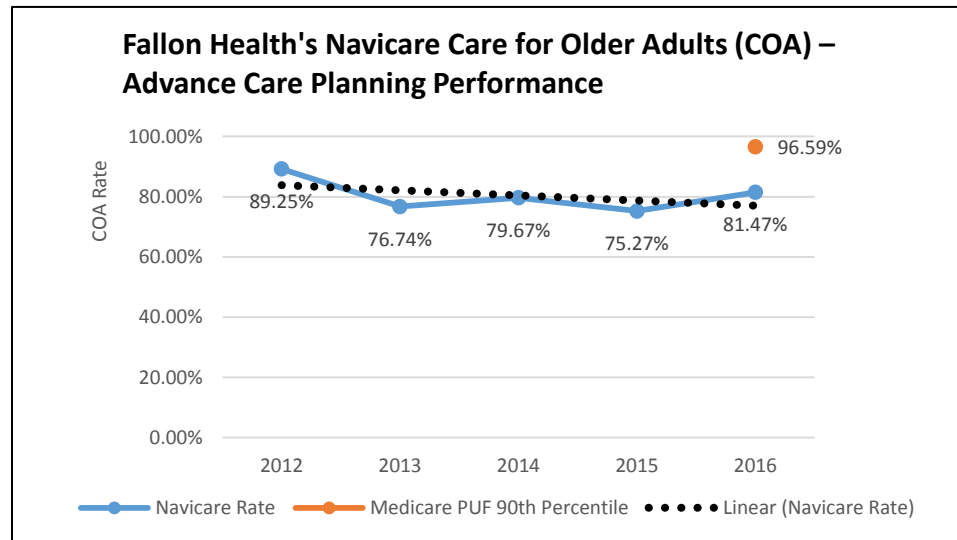
Medication Reconciliation Post-Discharge (MRP) — Between HEDIS® 2016 and 2017, Fallon Health Navicare's MRP performance decreased a statistically significant 9.46 percentage points. The plan's performance ranks between the 90th and 95th percentiles of the CMS Medicare Public Use Files.

Exhibit 17: Fallon Health's MRP Performance Rates

Chart: Fallon Health's Navicare Medication Reconciliation Post-Discharge (MRP) Performance. MRP Rate values: 45.00% (2013), 52.80% (2014), 88.54% (2015), 79.08% (2016). Medicare PUF 90th Percentile: 73.97% (2016). Legend: Navicare Rate, Medicare PUF 90th Percentile, Linear (Navicare 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 Fallon Health Navicare's information system that contribute to performance measure production.

- 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. Lab claims were processed internally, using standard codes. NaviCare had processes in place to closely monitor encounter submission to ensure complete data receipt. Lag reports also demonstrated that claims were submitted in a timely manner. NaviCare used a vendor, Smart Data Solutions, to both scan and data enter claims. The plan maintained adequate oversight of the vendor. Internal claims quality monitoring processes were also adequate. NaviCare received encounters on a daily basis from its pharmacy benefits manager, CVS Health. The plan maintained adequate oversight of CVS Health. There were no issues identified with claims or encounter data processing.

- Enrollment Data
  NaviCare processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. Enrollment forms were entered manually, and eligibility was verified with both CMS and MassHealth. There were adequate data quality monitoring and reconciliation processes, including the ability to combine data for members with duplicate identification numbers. There were no issues identified with enrollment processes.

- Medical Record Review
  NaviCare used internally developed source code to produce the performance measures. Data abstraction tools and training materials developed by the plan were compliant with HEDIS technical specifications. NaviCare 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
  NaviCare successfully used both standard and nonstandard supplemental data sources for HEDIS 2017 reporting. Supplemental data contributed to two of the PMV performance rates under review, i.e., MPM and MRP. There were no issues with the supplemental data used to produce performance measures.

- Data Integration
  All data from the transaction system and the vendors was stored in the plan's data warehouse. The warehouse is refreshed nightly. NaviCare 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. NaviCare reviewed preliminary rates thoroughly at multiple levels within the organization. There were no issues identified with data integration processes.

- Source Code
  NaviCare produced the performance measures using internally developed source code. The source code was compliant with the HEDIS technical specifications.

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

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 Navicare, the results of which were distributed on July 10, 2017.

Exhibit 18: Fallon Health's Final Audit Results

Audit Element	Findings
Medical data	NaviCare 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 processes, 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	2017 Update
Continue to work with provider groups to receive and incorporate electronic medical record data.	The plan continued to work with provider groups to receive and incorporate electronic medical record data.
Work with hospital clinics to ensure that attending provider information is populated on UB claims submission forms.	Plan claims processing was in compliance.
Consider increasing inter-rater reliability and internal quality control activities to mitigate risk of the medical record review process.	The Medical Record Review Validation process was successfully passed for HEDIS 2017.
Continue to work to improve consistency of documentation on TrueCare system, and to develop strategies to leverage these data to use as a supplemental data source.	TrueCare data was successfully used as a supplemental data source for HEDIS 2017.

Plan Strengths

- NaviCare staff have excellent understanding of HEDIS processes.
- Thorough documentation was supplied to the reviewer.
- The daily refresh of data warehouse is a best practice.
- NaviCare's performance on the measures validated were all above the national average.

Opportunities

- None identified.

Recommendations

- KEPRO endorses the recommendation made in the HEDIS Final Audit report about the development of the source code used for reporting. Due to high volume, not all the measures were coded until relatively late in the reporting process. If Fallon continues to use internal coding next year, it is recommended that it starts early using common code when possible. If Fallon transitions to a software vendor, KEPRO recommends starting this process early and running a parallel test on 2017 results.

SENIOR WHOLE HEALTH (SWH)

Performance Measure Results

The chart below depicts SWH's performance in the three measures selected by MassHealth for validation. The Medicare Claims Public Use File 90th[3] percentile is included for comparison purposes.

Annual Monitoring for Patients on Persistent Medications (MPM) — Senior Whole Health's performance rate on this measure increased a statistically insignificant 0.93 percentage points between 2015 andn2016. Performance lies between the 66th and 75th Medicare Claims Public Use Files percentiles.

Exhibit 19: SWH MPM Performance Rates

_____
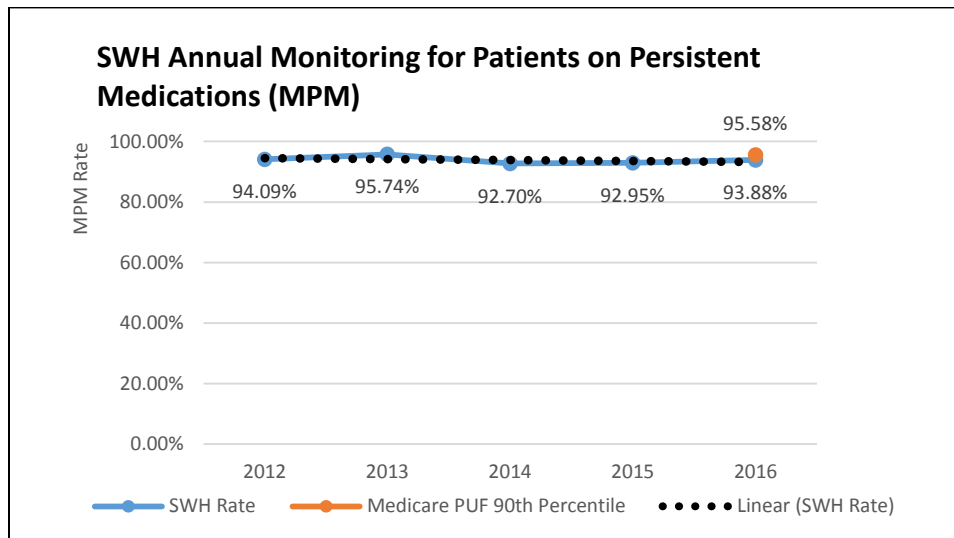
[3] The HEDIS® 2017 Medicare percentiles benchmarks for all reported measures were calculated using data from the Medicare Special Needs Plan Claims Public Use Files (PUF).

Care for Older Adults (COA), Advance Care Planning — The Advance Care Planning rate increased 14.63 percentage points between 2015 and 2016. This change is statistically significant. SWH's performance lies between the 90th and 95th percentiles of the Medicare Claims Public Use Files.

Exhibit 20: SWH COA Performance Rates

SWH Care for Older Adults (COA) – Advance Care Planning
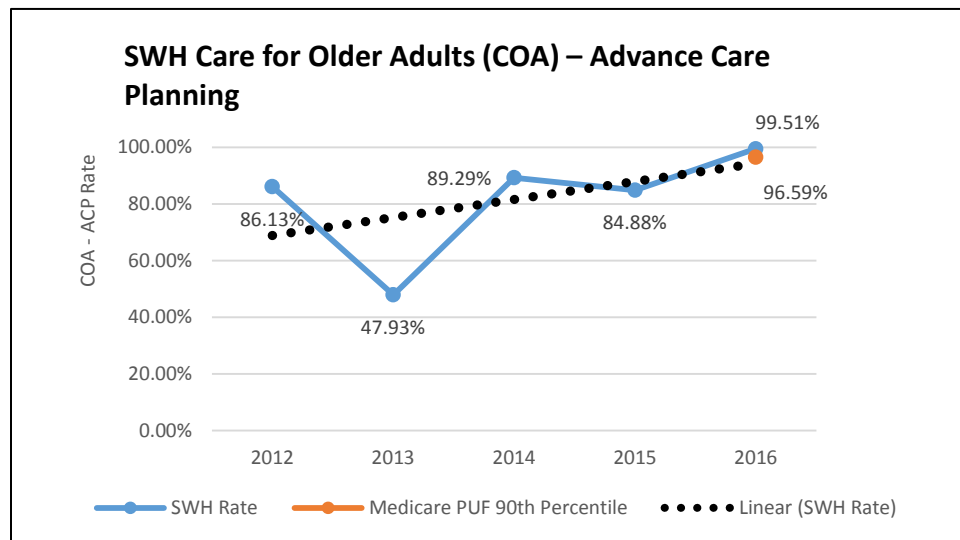
Medication Reconciliation Post-Discharge (MRP) — Between 2015 and 2016, SWH's increased a statistically significant 26.76 percentage points. The plan ranks between the 75th and 90th percentiles compared to the CMS Public Use Files.

Exhibit 21: SWH MRP Performance Rates
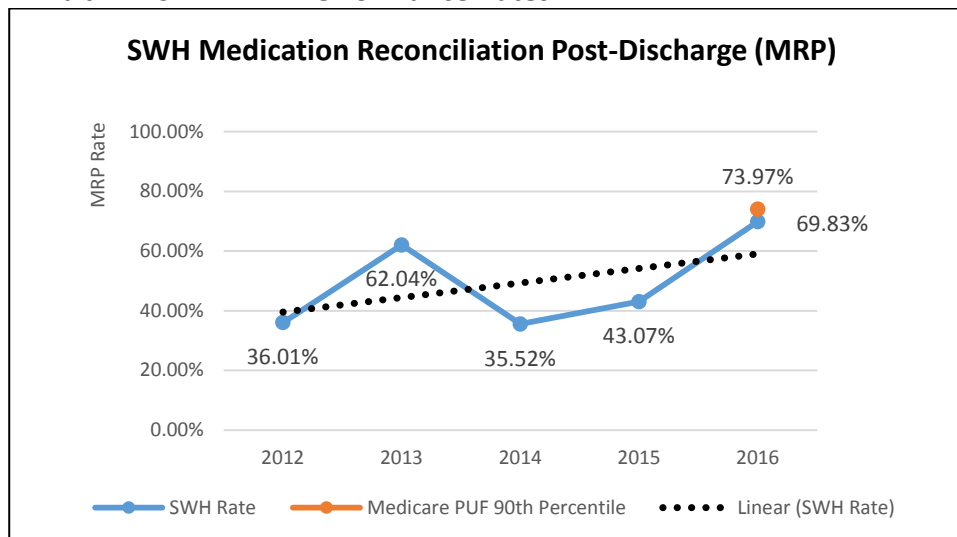
SWH Medication Reconciliation Post-Discharge (MRP)

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 SWH's information system that contribute to performance measure production.

- Claims and Encounter Data
  SWH used the QNXT system to process claims, including lab claims. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. SWH used two scanning/optical character recognition (OCR) vendors, Emdeon and WCEDI. SWH had adequate processes to monitor claims data quality and maintained strong oversight of both vendors. The plan had adequate processes to monitor claims data completeness. Pharmacy encounters containing standard codes were received on a weekly basis from the plan's pharmacy benefits manager (PBM), Express Scripts. The plan maintained adequate oversight of the PBM. There were no issues identified with claims or encounter data processing.

- Enrollment Data
  SWH processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. Enrollment forms were entered manually and eligibility was verified with MassHealth. SWH had adequate processes to ensure enrollment data quality, including regular reconciliations with both MassHealth and CMS. SWH had procedures to prevent members from being entered under more than one identification number. The plan sent daily enrollment files to Express Scripts and maintained adequate oversight. There were no issues identified with enrollment processes.

- Medical Record Review
  SWH used DST's NCQA-certified software to produce the medical record project. The Medical Review Group (MRG) served as the plan's vendor for both medical record retrieval and data abstraction. MRG's training materials and data abstraction tools were compliant with HEDIS technical specifications. No issues were identified with medical record review.

- Supplemental Data
  SWH successfully used both standard and nonstandard supplemental data sources for HEDIS 2017 reporting. The supplemental data assisted the PMV performance rates under review. There were no issues with supplemental data used to produce performance measures.

- Data Integration
  SWH's performance measures were produced using DST software. The plan's ODS data warehouse is updated nightly with data from the transactions system. Data were extracted from the ODS data warehouse and loaded into DST's CareAnalyzer. SWH had adequate processes for ensuring data completeness and referential integrity at each transfer point. Preliminary rates were reviewed and any variances investigated. There were no issues identified with data integration processes. Data transfers to the DST repository from source

transaction systems were accurate. File consolidations, derivations, and extracts were accurate. DST's repository structure was compliant. HEDIS measure report production was managed effectively. The DST software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. SWH maintains adequate oversight of its vendor, DST. There were no issues identified with data integration processes.

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

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

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of the HealthcareData Company, which performed a HEDIS® Compliance Audit on SWH, the results of which were distributed on July 15, 2017:

Exhibit 22: Senior Whole Health Final Audit Results

Audit Element	Findings
Medical data	SWH 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. Senior Whole 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	2017 Update
Streamline supplemental data documentation by producing a	The plan implemented this recommendation.

policy/procedure document for each supplemental data source.	
Consider performing over reads on numerator non-compliant charts to ensure that hybrid performance measures are not missing any potential hits.	The plan implemented this recommendation.
Continue to leverage home assessments to provide supplemental data for the COA measure.	The plan implemented this recommendation.
Consider expanding current readmission avoidance program to include medication reconciliation.	The plan implemented this recommendation.

Plan Strengths
- SWH used an NCQA-certified vendor.
- SWH supplied thorough documentation.
- SWH maintained excellent oversight of its medical record vendor.
- The plan has a strong process for reviewing and verifying preliminary and final rates.
- Performance for the three measures validated were above the national average.

Opportunities
- None identified.

Recommendations
- Continue to improve MRP performance, especially as CMS now requires reporting of the MRP numerator for the new Transitions of Care HEDIS measure.
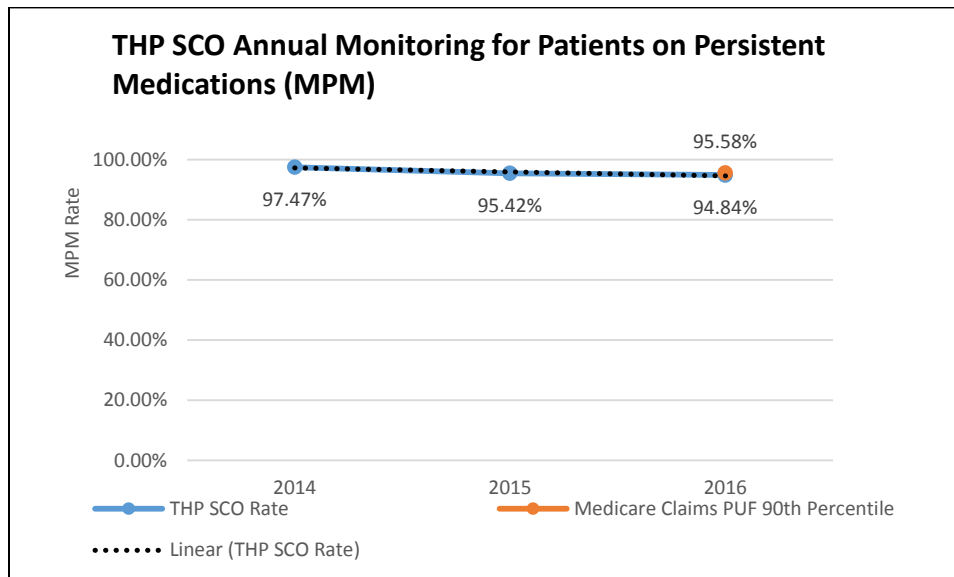
TUFTS HEALTH PLAN (THP)

Performance Measure Results

The charts below depict THP's SCO's performance in the three measures selected by MassHealth for validation. The Medicare Claims Public Use File 90th[4] percentile is included for comparison purposes.

Annual Monitoring for Patients on Persistent Medications (MPM) — THP's SCO performance rate on the MPM measure decreased a statistically significant 0.58 percentage points between 2015 and 2016. Performance lies between the 75th and 90th Medicare Claims Public Use Files percentiles.

Exhibit 23: THP MPM Performance Rates

THP SCO Annual Monitoring for Patients on Persistent Medications (MPM)

- 95.58%
- 97.47%
- 95.42%
- 94.84%

Legend: THP SCO Rate — Medicare Claims PUF 90th Percentile — Linear (THP SCO Rate)

---

[4] The percentiles for all reported measures were calculated using data from the Medicare Special Needs Plan Claims Public Use Files (PUF).

Care for Older Adults (COA), Advance Care Planning — The Advance Care Planning rate decreased 3.00 percentage points between 2015 and 2016. This change is not statistically significant. THP's performance lies between the 90th and 95th percentiles of the CMS Medicare Claims Public Use Files.

Exhibit 24: THP COA Performance Rates
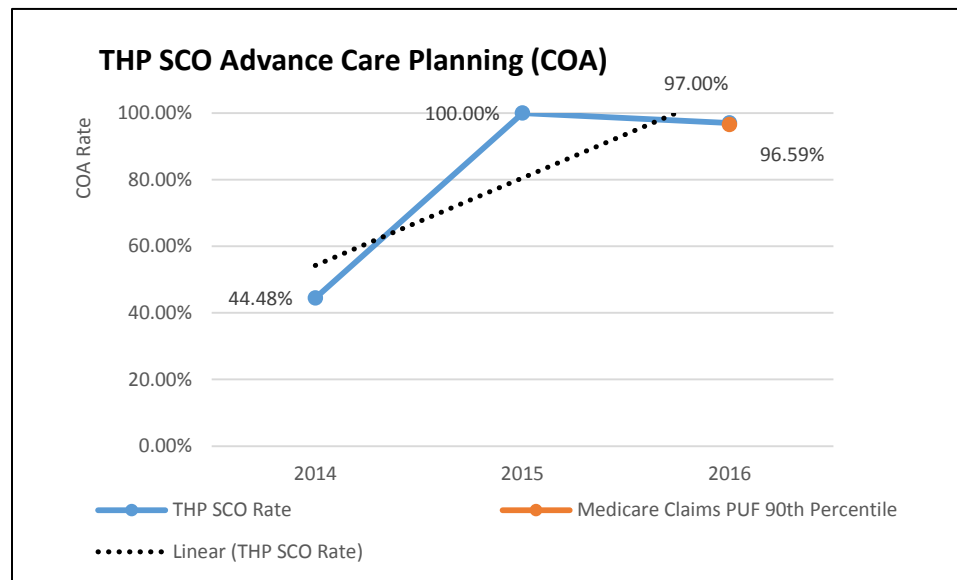
Medication Reconciliation Post-Discharge (MRP) — Between 2015 and 2016, THP's SCO MRP performance increased a statistically significant 16.80 percentage points. Performance has increased over 30 points in two years.   THP's performance is above the Medicare Claims Public Use Files 95th percentile.

Exhibit 25: THP's MRP Performance Rates
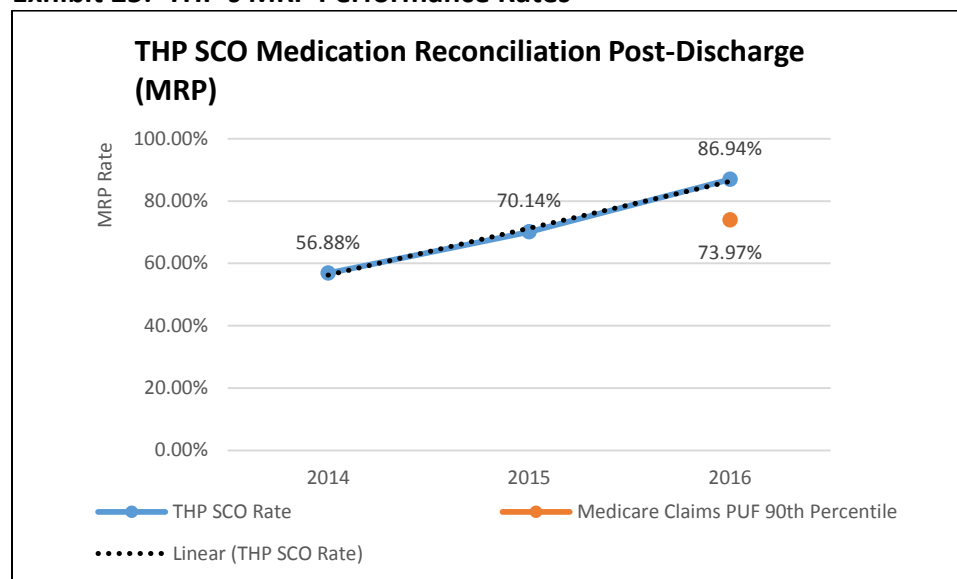
Information Systems Capabilities Analysis

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

- Claims and Encounter Data
  THP processed claims using the Diamond system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. THP only accepted claims submitted on standard claims forms, except for a small volume of member reimbursement forms which were used for services such as transportation and had no impact on the performance measures under review. Most claims were submitted electronically to THP and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. THP had robust claims editing and coding review processes. THP managed scanning of the small volume of paper claims submitted in-house using optical character recognition (OCR) software, Sun Guard. There was adequate monitoring of the OCR scanning software. THP processed all claims within Diamond except for pharmacy claims which were handled by THP'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
  THP used Market Prominence and Diamond to process enrollment data. Both systems captured all necessary enrollment fields for HEDIS reporting. THP provided daily enrollment files to CVS Caremark. There were no issues identified with enrollment processes.

- Provider Data
  THP had processes in place to capture provider data within its credentialing system, CACTUS, which had an automated feed into Diamond. THP conducted reconciliation between the two systems and no concerns were identified with the capture of provider data.

- Medical Record Review
  THP used internally developed abstraction tools and training manual for the hybrid measures. THP's abstraction tools and training manual were compliant with HEDIS technical specifications. THP had 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

THP used multiple standard and non-standard supplemental databases for HEDIS reporting. No concerns were identified with any of the supplemental data sources. The supplemental data sources were approved for HEDIS reporting.

- Data Integration
  All performance measure rates were produced internally by THP using internally-developed source code. Data from the transaction system were loaded into THP's data warehouse, Red Brick, which were overwritten with new data and refreshed. Pharmacy data were loaded into the warehouse monthly. THP had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan, including a comparison to prior year populations and rates for reasonability. There were no issues identified with data integration processes.

- Source Code
  THP source code for the three performance measures covered under the scope of the review were compliant with the HEDIS specifications.

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

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 THP's SCO, the results of which were distributed on July 10, 2017:

Exhibit 26: Tufts SCO Final Audit Results

Audit Element	Findings
Medical data	THP 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 processes, 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 recommendations follows:

Calendar Year 2016 Recommendation	2017 Update
Explore factors contributing to the suboptimal performance for the Annual Monitoring for Patients on Persistent Medications (MPM) measure rate and develop interventions to improve performance.	THP's MPM rate is above the national 75th percentile.

Plan Strengths

- Tufts Health Plan's performance on two of the validated measures (MRP and COA) exceed the Medicare Claims Public Use Files 90th percentile.

Opportunities

- None identified.

Recommendations

- None identified.

UNITEDHEALTHCARE (UHC)

Performance Measure Results

The charts below depict UHC's performance in the three measures selected by MassHealth for validation. The Medicare Claims Public Use File 90th[5] percentile is included for comparison purposes.

Annual Monitoring for Patients on Persistent Medications (MPM) — UHC's performance in the MPM measure has been flat over a period of five years. The performance rate on this measure increased a statistically insignificant 0.11 percentage points between 2015 and 2016. Performance lies between the 75th and 90th Medicare Claims Public Use Files percentiles.

Exhibit 27: UHC MPM Performance Rates
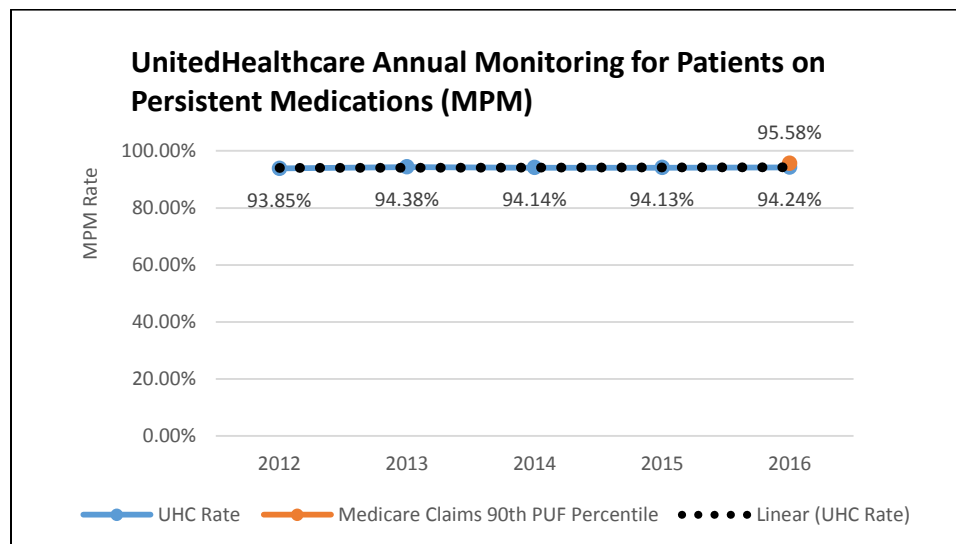
UnitedHealthcare Annual Monitoring for Patients on Persistent Medications (MPM)


Care for Older Adults (COA), Advance Care Planning — The Advance Care Planning rate increased 14.53 percentage points between 2015 and 2016. This change is statistically significant. UHC's Senior Care Options' performance lies between the 50th and 66th percentiles of the Medicare Claims Public Use Files.

Exhibit 28: UHC's COA Performance Rates
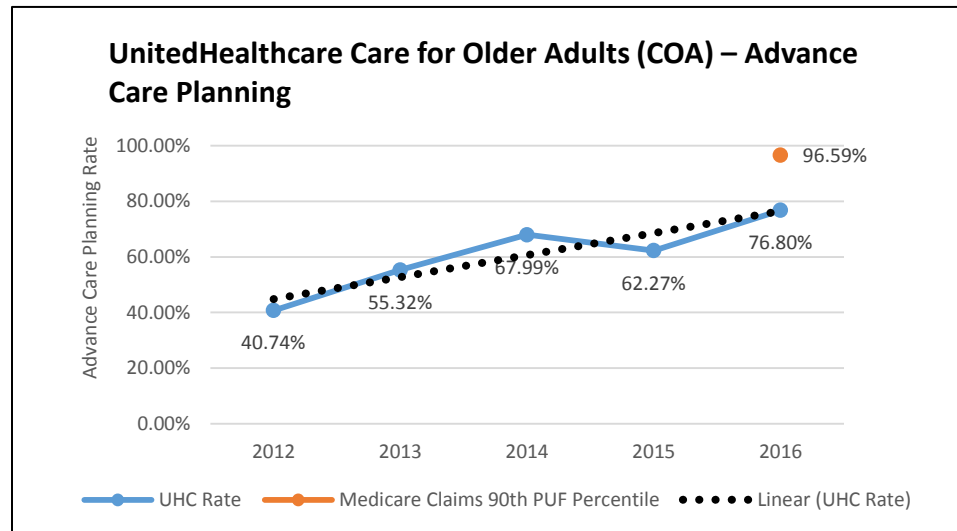
Medication Reconciliation Post-Discharge (MRP) — Between HEDIS® 2016 and 2017, UHC Senior Care Options' MRP performance decreased a statistically significant 9.89 percentage points. UHC's performance ranks between the 10th and 25th percentiles of the Medicare Claims Public Use Files 95th percentile.

Exhibit 29: UHC's MRP Performance Rates
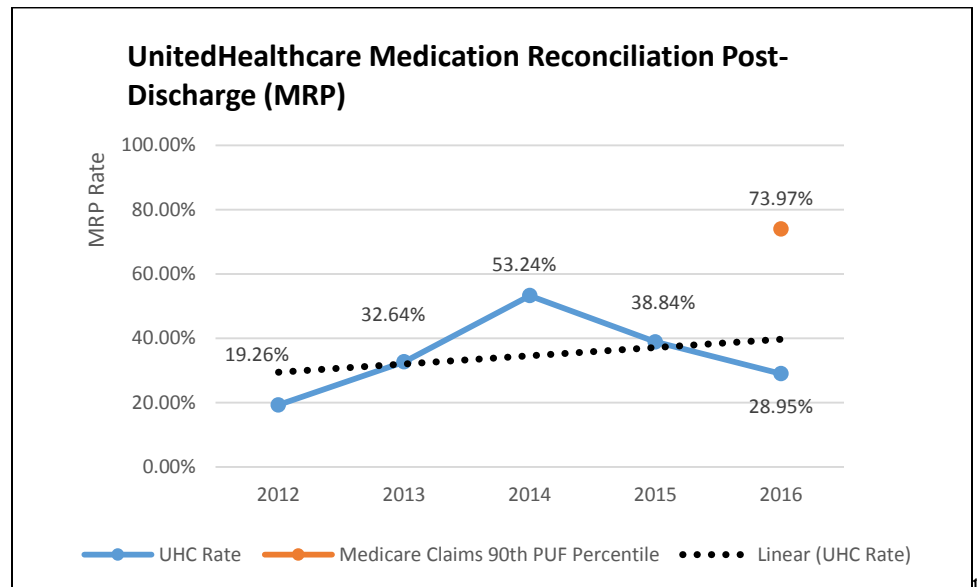
Information Systems Capabilities Analysis

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

- Claims and Encounter Data
  UHC processed claims, including lab claims, using the CSP Facets system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. CSP Facets only accepted the use of standard codes; therefore, there was no need for mapping or review of non-standard or internally developed codes. UHC had timely processing of claims and there was no backlog of claims processing. Most claims were submitted electronically through a clearinghouse to UHC and there were adequate monitoring processes in place, including batch counts and receipts. UHC had adequate claims editing and coding review processes. UHC used Optum Behavioral Health as its vendor to process behavioral health claims. Optum Behavioral Health captured all required fields for claims processing and only accepted standard codes on standard claim forms. UHC had adequate oversight of Optum Behavioral Health including the use of joint operating committees. UHC used its vendor, OptumRx, as its pharmacy benefit manager to process pharmacy claims. Pharmacy claims data were received daily from OptumRx 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
  UHC used CSP Facets to process enrollment data. CSP Facets captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.

- Medical Record Review
  UHC used Altegra's data abstraction tools and training materials for hybrid measure abstraction. Altegra's tools and training manual were compliant with HEDIS technical specifications. UHC monitored results from Altegra related to inter-rater reliability testing and conducted its own inter-rater reliability testing of the vendor. These processes demonstrated adequate vendor oversight and ongoing quality monitoring throughout the medical record review process. No issues were identified with the medical record review process.

- Supplemental Data
  UHC used several supplemental data sources. UHC provided complete supplemental data documentation for each supplemental data source and no concerns were identified. The supplemental data sources were approved for HEDIS reporting and benefitted the performance rate of each PMV measure under review.

- Data Integration
  UHC's performance measures were produced using GDIT software. UHC formatted medical record data received by Altegra into the GDIT format and had adequate processes to review the mapping. UHC 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. 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. UHC maintains adequate oversight of its vendor, GDIT. There were no issues identified with data integration processes.

- Source Code
  UHC 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.

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

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 UnitedHealthcare, the results of which were distributed on July 10, 2017:

Exhibit 30: UHC Final Audit Results

Audit Element	Findings
Medical data	UHC 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. UHC 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	2017 Update
UHC should conduct root-cause analysis to determine factors that may have contributed to the performance decline of its MRP measure rate and develop interventions aimed at improving performance.	The recommendation stands as the MRP performance rate was lower for the reporting year.
UHC should conduct root-cause analyses for the MPM and COA measures and explore development of interventions that can increase performance.	UHC implemented this recommendation.
UHC may consider the re-evaluation of the systems that currently house care management data to determine if there are opportunities to consolidate the capture of data to more efficiently report and target members for intervention.	UHC is in full compliance with HEDIS audit supplemental data standards.

Plan Strengths
- UHC used an NCQA-certified vendor.
- UHC demonstrated strong coordination among staff to support the SCO population. There was very strong local organizational accountability for SCO population performance.

Plan Opportunities
- None identified.

Recommendations
- UHC should conduct root-cause analysis to determine factors that may have contributed to the performance decline of its MRP measure rate and develop interventions aimed at improving performance.

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 SCO 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 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 ten calendar days, although it is not required to do so.

4) *Final Report*. A PIP Verification Worksheet based on CMS EQR Protocol Number 3 is completed by the Technical Reviewer. The reviewer assesses the plan's performance in the areas of problem definition, data analysis, measurement, improvement strategies, and outcome[6]. Individual standards are rated either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. The Medical Director documents his or her findings and, in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report.

The identification of PIP topics is a collaborative process between MassHealth, the Office of Elder Affairs, and the Senior Care Organizations. Each SCO was required to conduct a project on reducing all-cause 30-day readmission rates. Plans were free to select a second project of

---

[6] In this section, the t-test is used to measure statistical significance.

their choice, which was subject to approval by MassHealth and the Office of Elder Affairs. In 2016, the plan-selected projects were:

- **Boston Medical Center HealthNet** – Improving health outcomes for members with diabetes;
- **Commonwealth Care Alliance** – Increasing the rate of annual preventive dental care visits;
- **Fallon Health** – Reducing the use of high-risk medications in the elderly;
- **Senior Whole Health** – Diabetes health management program;
- **Tufts Health Plan** – Reducing risks for people with cardiovascular disease in the SCO population 65 and over with congestive heart failure (CHF) by reducing CHF admission rates; and
- **UnitedHealthcare** - Improving SCO member adherence to medication regimens for managing their diabetes.

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.

> *Based on its review of the MassHealth Senior Care Organization 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.*

REDUCING THIRTY-DAY ALL-CAUSE READMISSION RATE COMPARATIVE ANALYSIS

INTERVENTIONS

MassHealth Senior Care Organizations used a wide variety of approaches to reduce the 30-day all-cause readmission rate. These interventions are described in more detail in this report's section on Performance Improvement Project Validation, as are plan strengths and opportunities to improve quality, timeliness, and access to health care. A summary of 2016 plan interventions follows.

Care Management

- BMCHP established a Transition of Care Program in which a Care Manager was focused specifically on ensuring that members experience a seamless transition through the continuum of care including the emergency department, acute inpatient, post-acute rehabilitation hospitals, skilled nursing facilities, nursing homes, and home. The Care Manager for Transitions of Care conducted admission assessments; collaborated with Geriatric Support Services Coordinators; conducted pre-discharge and inpatient risk assessments; collaborated with the member's primary care provider, inpatient utilization management staff, and the discharge case manager; and conducted face-to-face visits at the member's home or facility to complete the post-discharge assessment. The Care Manager for Transitions of Care was a member of the Primary Care Team. *(Boston Medical Center HealthNet)*

- To proactively prevent ED admissions, care managers huddled on a weekly basis to review patients transitioning from one level of care to another. Clinical Managers also performed weekly audits to ensure that Transition of Care Assessments and Care Plans were completed within two days of plan notification of discharge. *(Fallon Health)*

- Members identified as high-utilizers were contacted by a nurse care manager for follow-up and education. A monthly report contained detailed information about the reason for the member's ER visit. The Nurse Case Manager (NCM) was responsible for contacting the member within two weeks of receiving the report to discuss the ER visit and completed the appropriate documentation. The NCM also involved other members of the member's Primary Care Team as needed. *(Fallon Health)*

Facility-Based Interventions

- Clinicians were deployed to fifteen high-volume inpatient facilities to provide enhanced care coordination and discharge planning in collaboration with the member's care manager. *(Commonwealth Care Alliance)*

- In the Skilled Nursing Facility (SNF)/Long Term Care (LTC) Liaison Program, Care Managers facilitated transitions to and from post-acute care settings. Tufts assigned Care Managers, Nurse Practitioners, and physician rounders to Tufts-identified skilled nursing and long-term facilities. The nurse practitioners collaborated with other clinicians to support the member's discharge to the community. They also oversaw plans of care for members residing in long-term care facilities. *(Tufts Health Plan)*

Inbound Call Center

- CCA implemented a 24/7 inbound call center staffed by registered nurses and behavioral health clinicians who were available to help members manage their symptoms and identify appropriate interventions and dispositions. *(Commonwealth Care Alliance)*

In-Home Assessments and Follow Up

- The Transitions of Care team worked to ensure an in-person home visit within 48 hours of discharge. The focus of this intervention in 2016 was improved communication between CCA care managers and facilities; the increased accountability of clinical directors; and increased standardization of care manager tools. *(Commonwealth Care Alliance)*

- A Coleman-trained Care Transitions Coach with immediate access to a Nurse Manager conducted an in-home assessment within three business days of discharge. The Coach ensured that the member has a follow-up PCP visit within seven days of discharge as well as any specialist follow-up appointments. A registered nurse completed medication reconciliation. The member was followed telephonically for thirty days. Weekly, Elder Services staff and SWH nurse care managers reviewed members' cases and discussed opportunities to prevent readmission. *(Senior Whole Health)*

- Senior Whole Health nurse practitioners conducted comprehensive in-home assessments of members discharged from Brockton Hospital within seven days of discharge and followed the member for another thirty days. The nurse practitioner also provided symptom recognition and caregiver support and education.   S/he conducted a home safety evaluation. The nurse practitioner ensured follow up appointments in primary care and specialty care as needed.   Weekly, these nurse practitioners and SWH nurse care managers reviewed members' cases and discussed opportunities to prevent readmission. *(Senior Whole Health)*

Telephonic or In-Home Assessments as Determined by Patient Level of Risk

- Care Managers or Complex Care Clinicians performed Post-Hospital Assessments two- and seven-days post-discharge. The goals of this assessment were to 1) assess medical complexity and the member's risk for re-hospitalization; 2) evaluate the member's level of

comfort with his or her discharge plan; and 3) remind and assist members with scheduling follow-up appointments. The care managers ensured appropriate clinical, home, and community-based services were in place. The assessment was conducted either face-to-face or telephonically. *Tufts Health Plan*

- All members were contacted by clinical staff within seven days of discharge from an acute care facility for an assessment and medication reconciliation. The type of interaction was based on the member's level of risk. Highest-risk members received a home visit from a Registered Nurse Care Manager. A Geriatric Support Services Coordinator conducted a home visit to members at medium risk. Telephonic Care Manager Associates made telephonic outreach to members at low risk. *(UnitedHealthcare)*

Medication Reviews

- Clinical Pharmacists and Nurse Practitioners completed medication reviews by reviewing medication information in the care management documentation system, the Pharmacy Benefit Management (PBM) system, and other clinical data systems. *(Tufts Health Plan)*

- A registered nurse completed medication reconciliation. *(Senior Whole Health)*
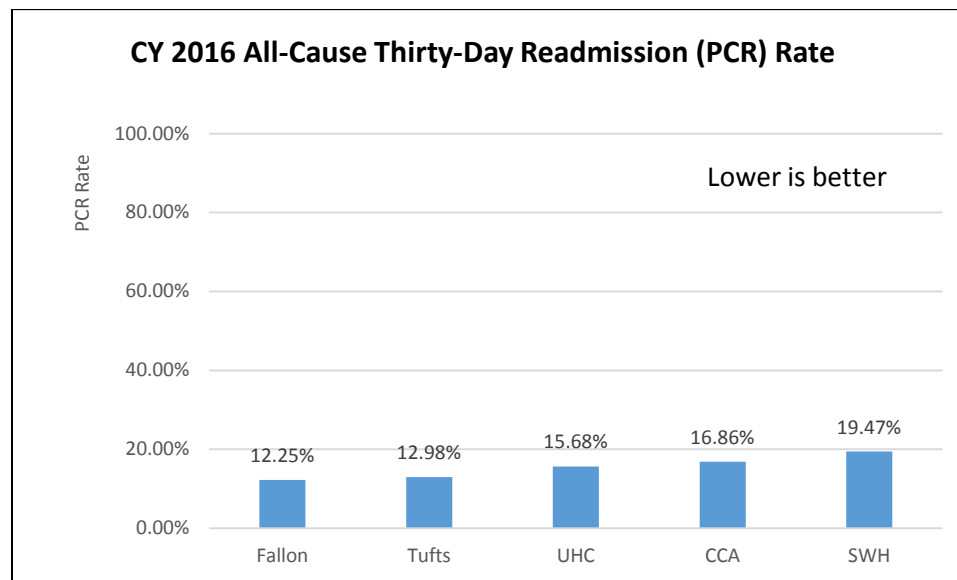
Provider Education

- UnitedHealthcare leveraged its Clinical Practice Consultant Program to educate providers about readmission and provide tools to reduce rates. In addition, provider education was included in the plan newsletter. *(UnitedHealthcare)*

RESULTS

The 30-day all-cause readmission rate can be described as the ratio of unplanned acute readmissions for any diagnosis within 30 days to all acute inpatient discharges on or between January 1 and December 1 of the measurement year in accordance with HEDIS® technical specifications. It is one of the few HEDIS measures for which a lower rate reflects better performance. The exhibits that follow depict SCO performance on the 30-Day All-Cause Readmission Rate.

Exhibit 31: 2017 SCO All-Cause Readmission Rates

CY 2016 All-Cause Thirty-Day Readmission (PCR) Rate

Lower is better

	Fallon	Tufts	UHC	CCA	SWH
PCR Rate	12.25%	12.98%	15.68%	16.86%	19.47%

Exhibit 32: Trended PCR Data for MassHealth Senior Care Organizations

		HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017	Linear Performance Trend Line
PCR	**PUF 90th**					
	CCA	-	-	13.71%	16.86%	↔
	Fallon	15.70%	16.16%	14.52%	12.25%	↔
	SWH	17.49%	19.56%	20.05%	19.47%	↔
	Tufts	-	8.69%	17.19%	12.98%	↑
	UHC	13.32%	14.84%	15.20%	15.68%	↔

CCA's 30-day all-cause readmission rate increased unfavorably from 13.71% (HEDIS 2016) to 16.86% (HEDIS 2017). This 22.94% increase is statistically significant (t-test, $p < 0.005$). CCA did not achieve its goal of a 10% readmission rate.

Fallon Health's PCR rate favorably decreased a statistically insignificant 15.65% between HEDIS 2016 and HEDIS 2017. The HEDIS 2017 rate of 12.25% fell just 0.05 percentage points short of its 12.20% goal.

Between HEDIS 2016 and HEDIS 2017, Senor Whole Health's thirty-day all-cause readmission rate favorably decreased a statistically insignificant 2.87% from its HEDIS 2016 rate of 20.05%. It did not achieve its goal of 16.00%.

Tufts Health Plan's 30-day all-cause readmission rate favorably decreased 24.49% from 17.19% to 12.98%, which is not statistically significant. Performance is trending unfavorably

upward. Tufts did not achieve its goal of 8.3%.

UnitedHealthcare's thirty-day all-cause readmission rate unfavorably increased a statistically insignificant 3.16% from 15.20% in HEDIS 2016 to 15.68% in HEDIS 2017. It did not meet its goal of 13%.

PERFORMANCE IMPROVEMENT PROJECT RATING SCORES

KEPRO assigns a score to each individual rating criteria. The Technical 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.

SCO rating scores for the thirty-day all cause readmission rate performance improvement projects follow.

Exhibit 33: SCO 2016 PIP Rating Scores
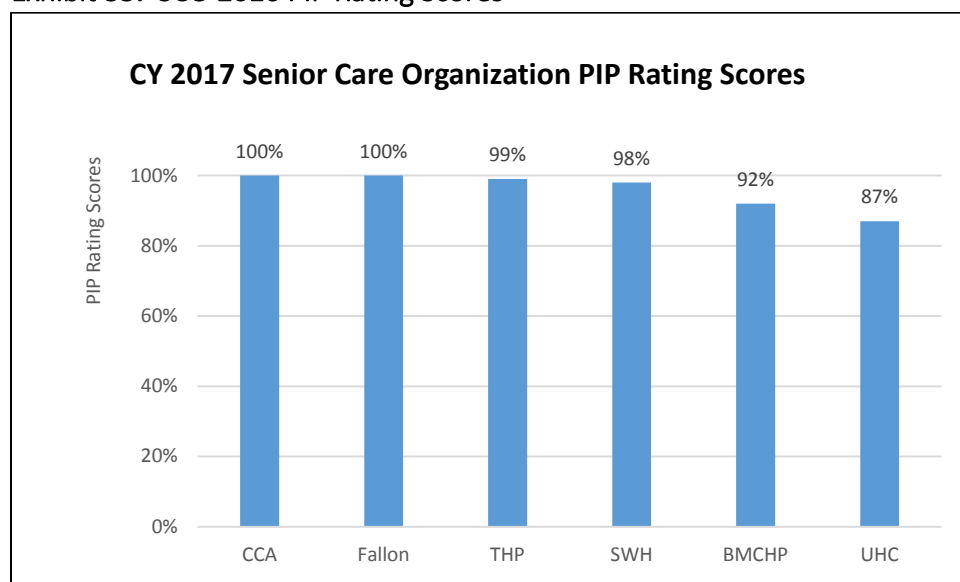
COMPARATIVE ANALYSIS

The recommendations made to the Senior Care Organizations were, in most cases, very specific to that SCO.   If any theme emerged, it was the recommendation that the plan conduct an analysis of patient risk factors and to use that analysis to inform intervention strategies. This issue will be addressed in training to be conducted by KEPRO in early-2018.   While some SCOs did a commendable job of engaging stakeholders in the barrier analysis and intervention design, others would benefit from establishing a structured process for stakeholder

involvement. KEPRO was pleased to see the number of provider-oriented interventions underway and notes that these are achieving positive results.

PLAN-SPECIFIC THIRTY-DAY ALL-CAUSE READMISSION RATE PIPS

In Calendar Year 2016, all MassHealth Senior Care Organizations conducted performance improvement projects having the goal of reducing the all-cause readmission rate.

BOSTON MEDICAL CENTER HEALTHNET

Interventions

BMCHP established a Transition of Care Program in which a Care Manager is focused specifically on ensuring that members experience a seamless transition through the continuum of care including the emergency department, acute inpatient, post-acute rehabilitation hospitals, skilled nursing facilities, nursing homes, and home. The Transition of Care Care Manager conducted admission assessments; collaborated with Geriatric Supports Services Coordinators; conducted pre-discharge and inpatient risk assessments; collaborated with the member's primary care provider, inpatient utilization management staff, and the discharge case manager; and conducted face-to-face visits at the member's home or facility to complete the post-discharge assessment. The Care Manager for Transitions of Care was a member of the Primary Care Team.

Results

Calendar Year 2016 represents BMCHP's baseline for the thirty-day all-cause readmission rate. The plan is measuring the success of its intervention using two measures, i.e., the thirty-day all-cause readmission rate and medication reconciliation post-discharge. A small denominator did not permit the calculation of the readmission rate. The reconciliation rate in 2016 was 16.67%. The plan did not specify performance goals for either measure.

Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. BMCHP received a rating score of 91% on this Performance Improvement Project.

Results of Validation Ratings for Y/N Values	Number of Items	Total Available Points	Points Scored	Rating Averages

General Information	1	1	1	100%
Intervention Parameters	3	3	3	100%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating 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
Problem Statement	4	12	11	92%
Member Population Analysis	3	9	8	89%
Barriers & Root Cause Analyses	2	6	5	83%
Intervention Parameters	5	15	12	80%
Rationale for Performance Indicators	1	3	3	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	3	9	9	100%
Baseline Performance Rates	1	3	3	100%
Validation Rating for 3, 2, or 1 Values	**20**	**60**	**54**	**90%**

Overall Validation Rating Score	**27**	**67**	**61**	**91%**

Plan & Project Strengths
- The Transition of Care program appears to be a robust intervention and the care manager job description is comprehensive.
- BMCHP is commended for including medication reconciliation (MRP) as an additional performance indicator, which supplements the plan all-cause readmission indicator (PCR).

Opportunities
Because health literacy can be a challenge for members for whom English is not their primary language, BMCHP should be offering an intervention with strategies for supporting non-English speaking members, who represent approximately 46% of its membership.

Recommendations

- KEPRO strongly recommends a more structured process for stakeholder involvement, such as a consumer advisory committee and provider forums (ad hoc or a standing clinical advisory committee).
- KEPRO strongly recommends that BMCHP address the issue of cultural-relevance in its intervention designs.
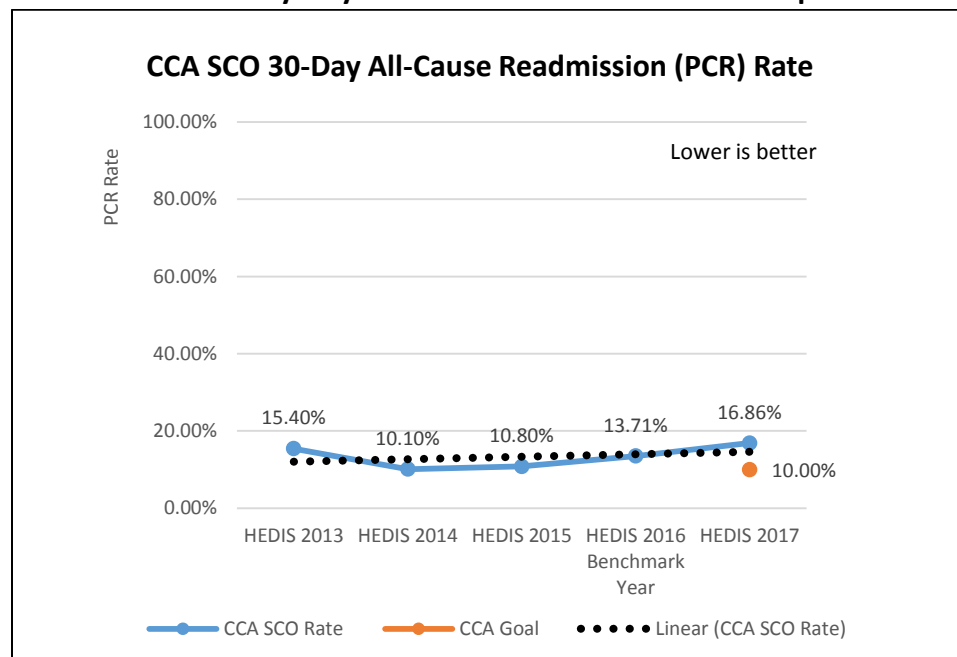- BMCHP should specify numeric goal, not a goal-range (for example, 62%; not 55-68%).

Interventions

- CCA's Transitions of Care team worked to ensure an in-person home visit within 48 hours of discharge. The focus of this intervention in 2016 was improved communication between CCA care managers and facilities; the increased accountability of clinical directors; and increased standardization of care manager tools.

- CCA clinicians were deployed to fifteen high-volume inpatient facilities to provide enhanced care coordination and discharge planning in collaboration with the member's care manager.

- In mid-December, CCA implemented a 24/7 inbound call center staffed by registered nurses and behavioral health clinicians who were available to help members manage their symptoms and identify appropriate interventions and dispositions.

Results

CCA's 30-day all-cause readmission rate increased unfavorably from 13.71% (HEDIS 2016) to 16.86% (HEDIS 2017). This 22.94% increase is statistically significant (t test, $p < 0.005$). CCA did not achieve its goal of a 10% readmission rate.

Table 34:   CCA Thirty-Day All-Cause Readmission Rate Compared to Goal

Rating Score

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

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 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	3	9	9	100%
Validation Rating for 3, 2, or 1 Values	**20**	**60**	**60**	**100%**

Overall Validation Rating Score	**27**	**67**	**67**	**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 CCA follows.

Calendar Year 2016 Recommendation	2017 Update
CCA should consider adding two questions to the home visit protocol. At the conclusion of the visit, the member could be asked, "On a scale of 0-10, what is the importance (value) of each Action Plan goal to you?" Secondly, the member could be asked about his or her level of confidence about the ability to achieve each goal. Based on the member's response to these questions, the clinician can adjust the member's goals, as needed, to have more value or to be more achievable.	CCA did not report adding these questions to the home visit protocol.
CCA should consider intervention strategies for the subset of high-risk members who have recurring admissions, multiple medications, or comorbidities. Members with known high risk profiles might be prioritized by the members' Integrated Clinical Teams for earlier post-discharge home visits or telephone calls.	CCA completed a comprehensive analysis of the characteristics of members who had been readmitted as well as those who had not. Says CCA, "CCA will utilize these insights to more specifically target subgroups of membership who are more likely to readmit."
CCA might consider more formal training of care managers in the principles of Motivational Interviewing. Through such training, care managers will be aware of the importance of "change talk," i.e., a member's awareness of the need for change in self-management activities and the member's own barriers to change. The CM and the member should be in agreement about the importance and relevance of the member's priorities for self-management, as well as strategies for moving toward healthier lifestyles.	CCA did not provide evidence of care manager training in Motivational Interviewing. This recommendation stands.

Plan & Project Strengths

CCA describes several robust interventions that evidence a significant commitment of resources by CCA to managing the goals of this PIP. The Transition of Care (TOC) teams are implementing well-designed interventions. CCA is commended for its deployment of staff resources to 15 of its highest volume facilities. CCA is also commended for promoting timely communication between the TOC team and the care managers.

Opportunities

The assessment of intervention effectiveness could be strengthened by soliciting structured feedback from providers regarding utility of these interventions with respect to their practices. Such feedback could be gathered through a provider satisfaction survey or through a provider advisory panel.

Recommendations

- For the next remeasurement cycle, KEPRO recommends that CCA clearly define the expected outcomes (that is, measurable results) of its interventions.
- KEPRO recommends that CCA use the analysis of risk factors for readmission to inform its intervention strategies, which could seek to identify members with a high risk for early admission through predictive modeling.
- KEPRO further recommends that CCA's stratification of readmission risk factors be used as material for staff training and provider education.
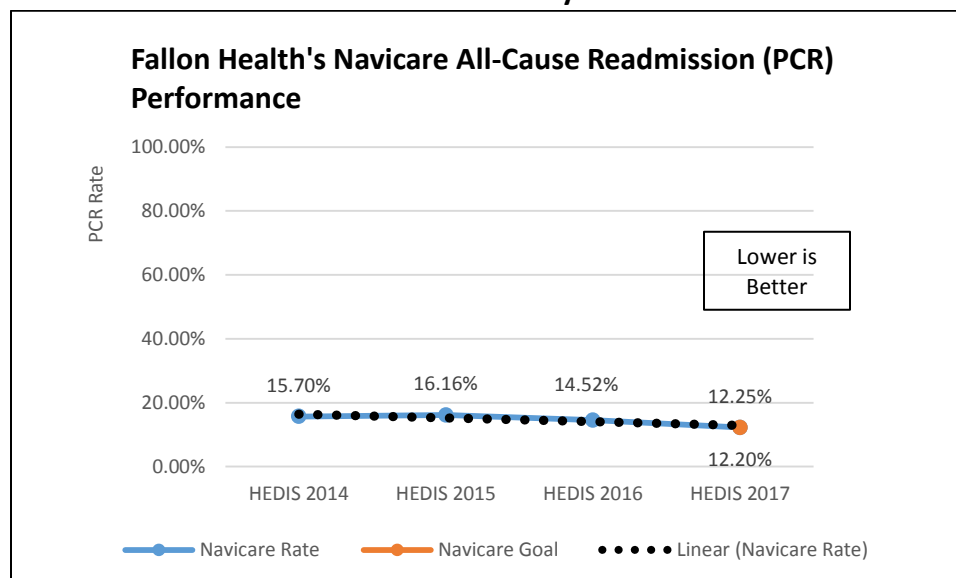
FALLON HEALTH

Interventions

- Fallon Health developed a process in which members identified as high-utilizers were contacted by a nurse care manager for follow up and education. A monthly report contained detailed information about the reason for the member's ER visit. The Nurse Case Manager (NCM) was responsible for contacting the member within two weeks of receiving the report to discuss the ER visit and complete the appropriate documentation. The NCM also involved other members of the member's Primary Care Team as needed.

- The "Unable to Reach" letter was translated into additional languages.

- To proactively prevent ED admissions, care managers huddled on a weekly basis to review patients transitioning from one level of care to another. Clinical Managers also performed weekly audits to ensure that Transition of Care Assessments and Care Plans were completed within two days of plan notification of discharge.

Results

Fallon Health's PCR rate favorably decreased a statistically insignificant 15.65% between HEDIS 2015 and 2016 (t test). The HEDIS 2016 rate of 12.25% fell just 0.05% short of its 12.20% goal.

Table 35: Fallon Health's Navicare 30-Day All-Cause Readmission Rate Compared to Goal

Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual

standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. Fallon Health Navicare received a rating score of 100% on this Performance Improvement Project.

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	3	100%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating for Y/N Values	**7**	**7**	**7**	**100%**

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

Overall Validation Rating Score	**27**	**67**	**67**	**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 Fallon Health follows.

Calendar Year 2016 Recommendation	2017 Update
Fallon Health is to be commended for its use of a provider council for input. KEPRO recommends that Fallon Health consider structured forums for member input, e.g., an advisory council or member focus groups.	Fallon Health did not report the convening of a member council or focus groups. This recommendation stands.
Considering the long list of interventions, Fallon Health should ensure that it has sufficient resources to implement these many strategies. Doing fewer interventions well is preferred to doing more less well. The many interventions are commendable, but the Fallon Health Quality Committee should assess its resource capacity and prioritize, as applicable.	Fallon Health's interventions were more focused in 2016.
In its efforts to improve its "Unable to Reach" process, Fallon Health should consider obtaining contact information for the members from the discharge hospitals.	Fallon Health's UTR process was enhanced by translation of the UTR letter into additional languages, but not by outreach to discharge hospitals.
Members with a history of multiple readmissions and complex medical and behavioral health histories are at high risk for readmission. KEPRO recommends that Fallon Health identify and prioritize these members for post-discharge home visits.	Home visits were not included in the process flows provided by Fallon Health.

Plan & Project Strengths

- Fallon is commended for the strength of its interventions.
- Fallon is commended for translating its UTR member letter into multiple languages and for its commitment to culturally competent outreach.
- Fallon is commended for reviewing data monthly.
- Fallon is commended for its excellent population analyses and is especially commended for its between-years and within-year comparative analyses of several key member demographics.

Opportunities
- KEPRO suggests that, when a member is given a prescription by an ER physician, Fallon's nurse care manager (NCM) should send a letter to the PCP regarding the ER prescription. The NCM should then contact the member to facilitate an appointment with the PCP, if necessary.
- Fallon notes that its frequent ER utilizers are characterized by high levels of behavioral health needs and yet Fallon completed no distinct analysis of this high-utilizer population in its population analysis. Such an analysis could be useful in a barrier analysis related to members with co-occurring disorders.

Recommendations
- For the next measurement cycle, KEPRO strongly recommends that Fallon convene panels of members and providers to solicit their input regarding barriers and effective interventions.
- KEPRO recommends that the excellent population analysis be shared with a wider audience, such as staff not familiar with the project and other stakeholders, e.g., advisory panels of members and providers.

SENIOR WHOLE HEALTH

Interventions

- Senior Whole Health implemented a care transition pilot involving the Elder Services of Merrimac Valley (ESMV) and the six hospitals in its catchment area (Anna Jacques Hospital, Holy Family Hospital, Lawrence General Hospital, Lowell General Hospital, Lowell General Hospital-Saints Campus, and Merrimack Valley Hospital). A Coleman-trained Care Transitions Coach with immediate access to the Nurse Manager conducted an in-home assessment within three business days of discharge. The Coach ensured that the member had a follow-up PCP visit within seven days of discharge as well as any specialist follow up appointments. A registered nurse completed medication reconciliation. The member was followed telephonically for thirty days. Weekly, ESMV staff and SWH nurse care managers reviewed members' cases and discussed opportunities to prevent readmission.

- Senior Whole Health nurse practitioners conducted comprehensive in-home assessments of members discharged from Brockton Hospital Emergency Department within seven days of discharge and followed the member for another thirty days. The nurse practitioner also provided symptom recognition and caregiver support and education. S/he conducted a home safety evaluation. The nurse practitioner ensured follow up appointments in primary care and specialty care as needed. Weekly, these nurse practitioners and SWH nurse care managers reviewed members' cases and discussed opportunities to prevent readmission.

Results

Between HEDIS 2016 and HEDIS 2017, Senior Whole Health's all-case readmission rate favorably decreased a statistically insignificant 2.87% (t test). It did not achieve its internal goal of 16%. Performance is trending unfavorably very slightly up.

Table 36:   Senior Whole Health 30-Day All-Cause Readmission Rate Compared to Goal
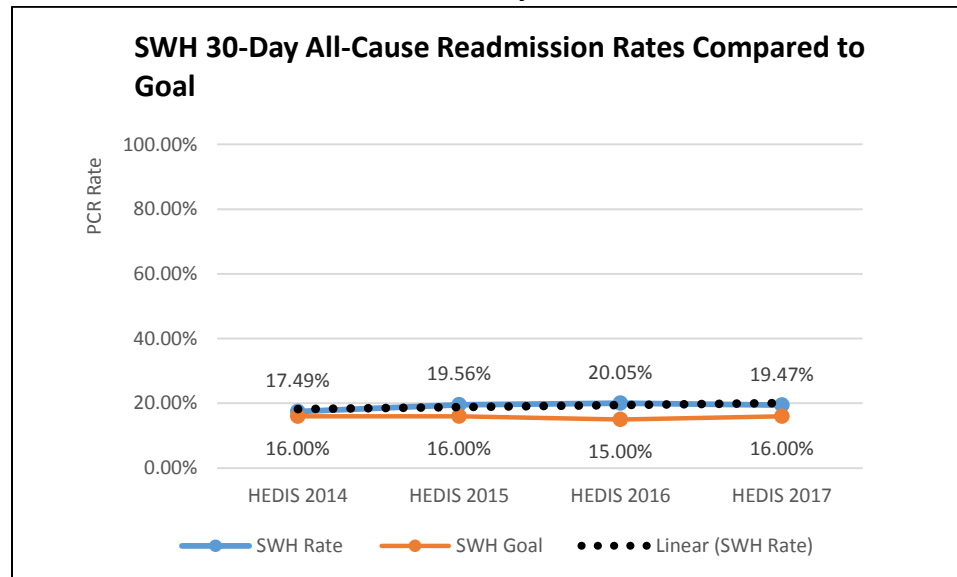
Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. Senior Whole Health received a rating score of 98% on this Performance Improvement Project.

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
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	4	12	11	92%
Validation Rating Score for 3, 2, or 1 Values	**20**	**60**	**59**	**98%**

Overall Validation Rating Score	**27**	**67**	**66**	**98%**

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 Senior Whole Health follows.

Calendar Year 2016 Recommendation	2017 Update
SWH should conduct a root cause analysis of the barriers to a decrease in the readmission rate. These barriers should be prioritized regarding impact on the rate, and the associated interventions should be evaluated relative to resources. It may be better for SWH to select a smaller list of more effective interventions and then increase the resources for these few and more effective activities.	SWH indicates that it completed a root cause analysis of barriers, but no detail of this analysis is provided in its response to this item. SWH describes internal systemic barriers related to obtaining timely discharge notification by providers. Proposed solutions to these barriers are briefly referenced and appear to be ongoing.
SWH is encouraged to research the literature for evidence-based interventions that have demonstrated positive outcomes with respect to reducing rates of readmission.	Senior Whole Health did not provide evidence of having conducted a literature review.
SWH should assess the extent to which language barriers are encountered by nurse care managers and how language barriers can be addressed, e.g., whether the NCM staff is sufficiently diverse to allow for culturally appropriate matching; and steps being taken to address RCM diversity, as applicable.	Senior Whole Health discussed the higher readmission rate of individuals who do not speak English, but did not speak to staff diversity.
Motivational Interviewing is an important evidence-based skill that nurse care managers can draw upon to assist members in adopting improved self-health management. As resources allow, SWH is encouraged to provide training in Motivational Interviewing to its nurse care managers and other care management staff.	Senior Whole Health did not provide evidence of training staff in Motivational Interviewing.

Plan & Project Strengths

- Both the Brockton Hospital and the Elder Services of Merrimack Valley Care Transitions Pilots are strong interventions and SWH is commended for organizing these coalitions of participating providers.   These are robust and intensive interventions that appear to have had a positive effect by lowering the readmission rates of those members who were engaged in the care management outreach activities.
- SWH is also commended for instituting the role of the Care Transition Coaches who ensure that members have a seven-day post-discharge follow-up visit with their PCP.
- SWH is commended for the frequency of its data collection and analysis.

Opportunities

- SWH should consider how to expand these two strong interventions to reach more members, which have a combined intervention-penetration rate of about 9% of its members in the denominator.
- KEPRO notes that hospitals are motivated to reduce readmission rates at their facilities. To the extent possible, SWH should leverage this motivation to work toward network-wide solutions.
- KEPRO suggests SWH convene a provider forum on this topic of improving the timely transmission of admission-discharge information from facilities to SWH.

Recommendations

- SWH notes that it has collected data on readmission rates for its hospitals. KEPRO encourages SWH to use this data set to run comparative analyses on its hospital so that high- and low-performing hospitals can be stratified and identified.
- KEPRO encourages SWH to conduct a rigorous barrier analysis that involves facility managers and other stakeholders, such as the care managers and its consumer advisory council. Through this process, SWH will need to identify intervention strategies to address the key barriers that account for the greatest obstacles to reducing the 30-day readmission rate.
- KEPRO recommends that feedback from all high-risk member groups be collected through a formal data gathering process, such a brief but structured member survey.
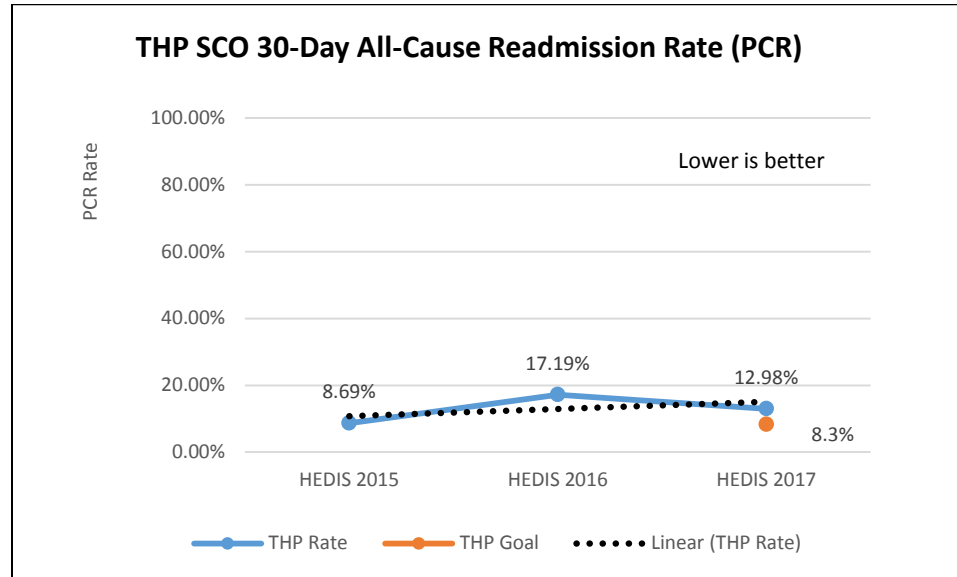
Interventions

- Tufts Care Managers or Complex Care Clinicians performed Post-Hospital Assessments two- and seven-days post-discharge. The goals of this assessment were to 1) assess medical complexity and the member's risk for re-hospitalization; 2) evaluate the member's level of comfort with his or her discharge plan; and 3) remind and assist members with scheduling of follow-up appointments. The care managers ensured appropriate clinical, home, and community-based services were in place. The assessment was conducted either face-to-face or telephonically.

- In the Skilled Nursing Facility (SNF)/Long Term Care (LTC) Liaison Program, Care Managers facilitated transitions to and from post-acute care settings. Tufts assigned Care Managers, Nurse Practitioners, and physician rounders to Tufts-identified skilled nursing and long-term facilities. The nurse practitioners collaborated with other clinicians to support the member's discharge to the community. They also oversaw plans of care for members residing in long-term care facilities.

- Clinical Pharmacists and Nurse Practitioners completed medication reviews by reviewing medication information in the care management documentation system, the Pharmacy Benefit Management (PBM) system, and other clinical data systems.

Results

Tufts Health Plan's 30-day all-cause readmission rate favorably decreased 24.49% from 17.19% to 12.98%, which is not statistically significant (t test). Tufts did not achieve its goal of 8.3%.

Table 37:   Tufts Health Plan 30-Day All-Cause Readmission Rate Compared to Goal

THP SCO 30-Day All-Cause Readmission Rate (PCR)

Lower is better

PCR Rate: 8.69% (HEDIS 2015), 17.19% (HEDIS 2016), 12.98% (HEDIS 2017), Goal 8.3%

Legend: THP Rate — THP Goal — Linear (THP Rate)

Rating Score

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

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	11.3	94%
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%
Overall Validation Rating Score	**19**	**57**	**56.3**	**99%**

Overall Validation Rating Score	**27**	**64**	**63.3**	**99%**

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 Plan follows:

Calendar Year 2016 Recommendation	2017 Update
KEPRO recommends that THP SCO create structured opportunities for representative groups of members and providers to actively participate in its identification of barriers and its review and evaluation of interventions. Standing committees, *ad hoc* workgroups, and quality forums are good vehicles for stakeholder participation.	Although Tufts conducted a survey of member satisfaction with care management, no formal structured opportunities for stakeholder feedback were established. This recommendation stands.
THP SCO assessed the characteristics of members who were admitted (denominator), but there is no assessment of members who were readmitted (numerator). Since the primary indicator for the PIP is reducing readmissions, it is recommended that THP SCO includes these members in its socio-demographic analysis of risk factors related to readmission.	Tufts analyzed the socio-demographics of the population experiencing readmissions.

Plan & Project Strengths

- THP is commended for its training "Transforming Care for High-Risk Older Adults," which was offered by THP to its SCO providers.
- THP is commended for presenting an effectiveness assessment of the post-hospital assessment administration. For both the 2-day and 7-day timeliness measures, THP reports lower readmission rates for members who were assessed on-time compared to members who were not assessed on-time.
- The medication review protocol is comprehensive and well-designed. THP is commended for providing this service to its members.
- THP presents a comprehensive population analysis. THP is commended for disaggregating members by clinically important risk categories, e.g., hearing-impaired, low education, and nursing home certifiable.

Opportunities

- KEPRO strongly encourages THP to maximize the use of its excellent population analysis. THP identified several demographic and clinical categories upon which staff can drill-down for root causes for the purpose of barrier analyses. By identifying the root causes of barriers, interventions can be modified or replaced by ones that target those barriers that can be leveraged for greatest impact on members' risks for readmission.

Recommendations

- KEPRO strongly recommends that THP include representative members and providers to identify barriers and design corrective intervention strategies.
- KEPRO recommends that in future PIP reporting, THP should ensure that, for PIPs with overlapping objectives (such as the objectives of CHF and PCR to reduce rates of hospitalization), the data for the PIP-eligible members be kept separate and be reported as PIP-specific findings, especially as this overlap relates to interventions that are shared by one or more performance improvement projects.
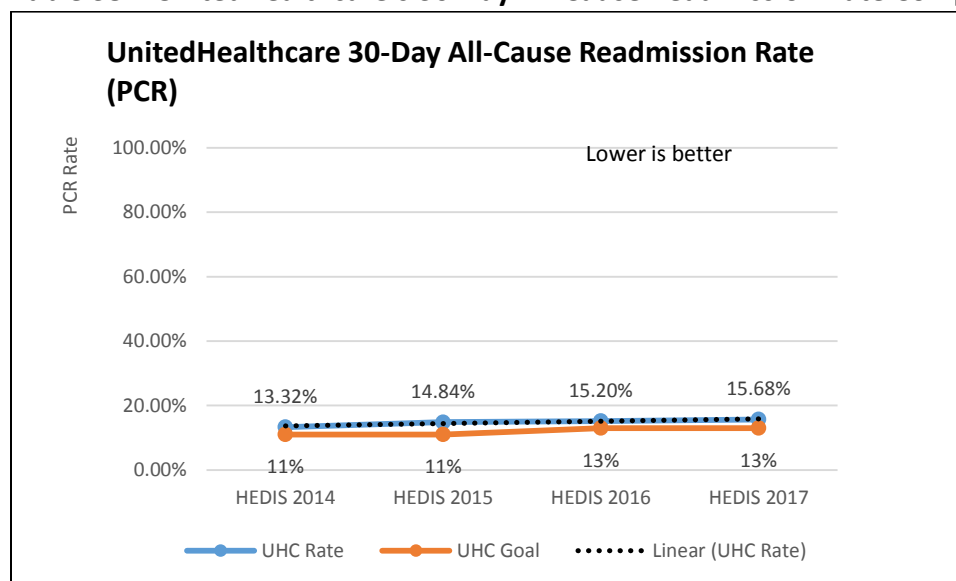
UNITEDHEALTHCARE

Interventions

- All members were contacted by clinical staff within seven days of discharge from an acute care facility for an assessment and medication reconciliation. The type of interaction was based on the member's level of risk. Highest-risk members received a home visit from a Registered Nurse Care Manager. A Geriatric Support Services Coordinator conducted a home visit to members at medium risk. Telephonic Care Manager Associates made telephonic outreach to members at low risk.
- UnitedHealthcare leveraged its Clinical Practice Consultant Program to educate providers about readmission and provide tools to reduce rates. In addition, provider education was included in the plan newsletter.

Results

UnitedHealthcare's thirty-day all-cause readmission rate unfavorably increased a statistically insignificant 3.16% from 15.20% in HEDIS 2016 to 15.68% in HEDIS 2017. It did not meet its goal of 13%.

Table 38:   UnitedHealthcare's 30-Day All-Cause Readmission Rate Compared to Goal

UnitedHealthcare 30-Day All-Cause Readmission Rate (PCR)

Lower is better

	HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017
UHC Rate	13.32%	14.84%	15.20%	15.68%
UHC Goal	11%	11%	13%	13%

UHC Rate — UHC Goal — Linear (UHC Rate)

Rating Score

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

of all points received. This ratio is presented as a percentage. UnitedHealthcare received a rating score of 87% on this Performance Improvement Project.

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	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
Reassessing PIP Goals & Barriers	4	12	11	92%
Reassessing Intervention Parameters & Strategies	4	12	9.7	81%
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	3	50%
Conclusions & Future PIP Improvements	3	9	7	78%
Validation Rating Score for 3, 2, or 1 Values	**19**	**57**	**48.7**	**85%**

Overall Validation Rating Score	**26**	**64**	**55.7**	**87%**

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 UnitedHealthcare follows.

Calendar Year 2016 Recommendation	2017 Update
Care managers telephone members at the first and second levels of risk within seven days of discharge. There may be a subpopulation that needs more intensive outreach because of literacy needs or language barriers. KEPRO recommends a review of data to determine any possible opportunities that might exist.	UHC reports, "Due to the nature of SCO members having a number of health, literacy, language, co-morbidity, frailty or socioeconomic factors, it is difficult to assess which interventions yielded the highest effectiveness." UHC did not provide related data.
UHC is urged to use its data to drill-down on the population factors (demographic, clinical, REL, hospital utilization) to identify key barriers and their component parts. With these assessments, UHC quality committees will have better information about how to prioritize interventions that will have maximum impact on the key barriers driving readmission rates.	UHC reports, "A Plan Performance Improvement Project on Health Disparities showed no difference in readmission rates by language or geographic location across a Massachusetts county adjacent to Boston."

Plan & Project Strengths
- UHC is commended for including members and pharmacists in the review of its barriers.
- UHC is commended for identifying language gaps among its care management staff and attempting to hire additional staff to fill these gaps.
- UHC is commended for its efforts to improve the cultural competency of its outreach staff.

Opportunities
- Over three remeasurement cycles, UnitedHealthcare's the membership base has increased steadily. UHC should assess the changes in the demographic and clinical risk factors that could affect its indicator rate performance.
- More detailed descriptions of the assessment and medication reconciliation processes would be helpful for KEPRO to understand this performance improvement project.

Recommendations
- As part of its PCP visit protocol, KEPRO recommends that Clinical Practice Consultants (CPCs) survey providers about their use of the provider newsletter and how it could be made more effective.
- Staff should consider options for more frequent data collection to better evaluate the indicator performance on a more real-time basis.

- KEPRO strongly recommends that UHC conduct more detailed population analyses using stratified demographic and clinical member data in order to identify the sub-groups of members that are at risk for higher readmission rates.
- KEPRO recommends that UHC assess the PCR intervention redesign beginning with a robust barrier analysis that includes the participation of a variety of stakeholders. The barriers should further be assessed for sub-barriers. Interventions need to be crafted that address the mission-critical sub-barriers. The design of its interventions should include strategies for collecting data that will allow for an outcomes assessment of their effectiveness.

COMPREHENSIVE DIABETES CARE

In Calendar Year 2016, three plans conducted projects with the goal of improving adherence to clinical guidelines for members with diabetes, i.e., Boston Medical Center HealthNet; Senior Whole Health; and UnitedHealthcare. The project goals and indicators used to measure performance varied by health plan. Performance measure results are included in the SCO-specific project descriptions that follow.

The table below depicts the categories in which the Senior Care Organization has implemented a diabetes management-related intervention and the number of those interventions.

Exhibit 39: Number and Category of Diabetes-Related Interventions

Intervention Category	BMCHP	SWH	UHC
Pharmacy-Based Interventions	1		2
Member Education	1	3	2
Provider Collaboration	1		1

A list of plan interventions follows.

Pharmacy-Based Interventions

- Network pharmacists conducted outreach to members with reminders of the need to adhere to medication instructions. The pharmacists also promoted 90-day refill cycles to members. *(UnitedHealthcare)*

- Plan-dedicated pharmacists engaged with local pharmacies to ensure that Hispanic and Latino members received medication with instruction labels in Spanish. *(UnitedHealthcare)*

- The BMCHP Pharmacy Department collaborated with the care manager on a routine basis to ensure medication adherence.   If medication adherence emerged as an issue for the member, the Clinical Pharmacist made a notation in the member's individualized care plan. Adherence issues were discussed during weekly multi-disciplinary rounds and with the Primary Care Team. *(Boston Medical Center HealthNet)*

Member Education

- Nurse care managers distributed educational material in Spanish at home visits to Spanish-speaking members discharged from Lawrence General Hospital. *(UnitedHealthcare)*

- Educational material was mailed to members with both diabetes and hypertension, but without a pharmacy claim for an antihypertensive. *(UnitedHealthcare)*

- Upon identification for inclusion in the Diabetes Population Health program through either claims or an assessment, the care manager provided education to the member (and his or her caregiver, as appropriate). Education was provided both in writing, e.g., the Self-Management Tip Sheet, and as part of a conversation. Topics covered symptom control; self-monitoring; diet modifications; appropriate medication use; exercise; managing sleep and fatigue; and improved communication with their providers. *(Boston Medical Center HealthNet)*

- Client Service Representatives provided telephonic education to well members in the community with diabetes. At six-month intervals, the Representative worked with the member to close diabetes care gaps. The Representative offered education and supporting materials. These materials were available in multiple languages. *(Senior Whole Health)*

- Nurse Care Mangers educated Nursing Home-Certifiable, higher-risk members about self-management of diabetes during home visits. Nurses were matched to members based on language and cultural background. The nurse reviewed targeted topics including, but not limited to, the importance of medication compliance and proper nutrition. Appointment facilitation and transportation was also addressed by the nurse during the encounter. *(Senior Whole Health)*

- *Healthwise* and non-written educational materials were mailed quarterly to members with diabetes about the importance of healthy eating, nutrition, depression, and basic diabetic care tip sheets. *(Senior Whole Health)*

<u>Provider Collaboration</u>

- Providers received a Diabetes Treatment Alert Report (DTAR), a member-specific report that contained the member's medication list, date and results of lab testing, and dates of diabetes-related hospital visits. Providers were asked to review the member's medication list, assess compliance with treatment goals, review lab values (if available), adjust medication and discuss insulin therapy if clinically appropriate, and coordinate care with providers and Plan staff as appropriate. Providers also received a Diabetes Trigger Report that included a list of all of their members with a diagnosis of diabetes and any required screenings. The American Diabetes Association Standards of Medical Care in Diabetes was made available to provider on the BMCHP website, in newsletters, and in other mailings. *(Boston Medical Center HealthNet)*

- The member's provider was informed of any patients diagnosed with diabetes and hypertension without a pharmacy claim for an antihypertensive. The provider was encouraged to prescribe the appropriate medications. *(UnitedHealthcare)*

IMPROVE HEALTH OUTCOMES FOR MEMBERS WITH DIABETES - BMCHP

Interventions

- Upon identification for inclusion in the Diabetes Population Health program through either claims or an assessment, the care manager provided education to the member (and his or her caregiver, as appropriate). Education was provided both in writing, e.g., the Self-Management Tip Sheet, and as part of a conversation. Topics covered symptom control; self-monitoring; diet modifications; appropriate medication use; exercise; managing sleep and fatigue; and improved communication with their providers.

- Providers received a Diabetes Treatment Alert Report (DTAR), a member-specific report that contained the member's medication list, date and results of lab testing, and dates of diabetes-related hospital visits. Providers were asked to review the member's medication list, assess compliance with treatment goals, review lab values (if available), adjust medication and discuss insulin therapy if clinically appropriate, and coordinate care with providers and Plan staff as appropriate. Providers also received a Diabetes Trigger Report that included a list of all of their members with a diagnosis of diabetes and any required screenings.   The American Diabetes Association Standards of Medical Care in Diabetes was made available to provider on the BMCHP website, in newsletters, and in other mailings.

- The BMCHP Pharmacy Department collaborated with the care manager on a routine basis to ensure medication adherence.   If medication adherence emerged as an issue for the member, the Clinical Pharmacist made a notation in the member's individualized care plan. Adherence issues were discussed during weekly multi-disciplinary rounds and with the Primary Care Team.

Results

BMCHP is using three measures to assess the success of this performance improvement project:

1. *Members ages 18-75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) test performed during the measurement year.* BMCHP was not able to calculate its 2016 performance because of a small denominator. Its performance goal is the NCQA Medicaid Quality Compass 75th percentile, 89.42%.

2. *Members ages 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c during the measurement year was >9% or is missing or not done.* BMCHP was not able to calculate its 2016 performance because of a small denominator. Its performance goal is the NCQA Medicaid Quality Compass 75th percentile, 36.87%.

3. *The percent of members 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications*. BMCHP achieved a rate of 54% in 2016. Its goal is to reach the CMS 4-Star cut point, 79%.

Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion. The Reviewer rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all available points by the sum of all points received. This ratio is presented as a percentage. BMC HealthNet Senior Care Organization received a rating score of 91% on this Performance Improvement Project.

Results of Validation Ratings for Y/N Values	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Intervention Parameters	3	3	3	100%
Performance Indicator Data Collection	3	3	3	100%
Overall 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
Problem Statement	4	12	12	100%
Member Population Analysis	3	9	8	100%
Barriers & Root Cause Analyses	2	6	3	50%
Intervention Parameters	5	15	13.3	87%
Rationale for Performance Indicators	1	3	3	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	3	9	9	100%
Baseline Performance Rates	1	3	3	100%
Validation Rating Score for 3, 2, or 1 Values	**20**	**60**	**54.3**	**91%**

Overall Validation Rating Score	**20**	**67**	**61.3**	**91%**

Plan & Project Strengths

- BMCHP's education program for members with diabetes is a robust intervention.
- BMCHP's Diabetes Treatment Alert Report is a commendable intervention for informing providers about the healthcare needs of their members as related to diabetes management.
- BMCHP is commended for its plan to have care managers collaborate with the pharmacy manager for members who are non-adherent.

Opportunities

- Given the many priorities that compete for the time of the primary care provider, BMCHP will need a strategy for bringing the ADA clinical guidelines to their attention. KEPRO recommends this strategy include sending hyperlinks to the guidelines to clinical leads and office managers.

Recommendations

- KEPRO strongly recommends a more structured process for stakeholder involvement, such as a consumer advisory committee and provider forums, either *ad hoc* or a standing committees.
- KEPRO recommends that, in its next measurement cycle, cultural competency be specifically addressed in the applicable member and provider interventions.

DIABETES HEALTH MANAGEMENT PROGRAM – SENIOR WHOLE HEALTH

Interventions

- Client Service Representatives provided telephonic education to well members in the community with diabetes. At six-month intervals, the Representative worked with the member to close diabetes care gaps. The Representative offered education and supporting materials. These materials were available in multiple languages.

- Nurse Care Mangers educated Nursing Home-Certifiable, higher-risk members about self-management of diabetes during home visits. Nurses were matched to members based on language and cultural background. The nurse reviewed targeted topics including, but not limited to, the importance of medication compliance and proper nutrition. Appointment facilitation and transportation was also addressed by the nurse during the encounter.

- *Healthwise* and non-written educational materials were mailed quarterly to members with diabetes about the importance of healthy eating, nutrition, depression, and basic diabetic care tip sheets.

Results

Senior Whole Health uses three of the NCQA Comprehensive Disease Care performance measures to assess improvement. The HbA1c Testing rate increased a statistically insignificant (t-test) 1.27% between HEDIS 2016 (95.86%) and HEDIS 2017 (97.08%). SWH's performance exceeded its goal of 96%.

The rate of individuals with an HbA1c over 9, considered poor control, unfavorably increased a statistically insignificant 26.09% (t-test) between HEDIS 2016 and HEDIS 2017, from 11.19% to 14.11%.

The percent of individuals with diabetes who had a retinal eye exam increased a statistically insignificant 3.07% between HEDIS 2016 and HEDIS 2017 (t-test). SWH's HEDIS 2017 performance of 81.75% fell just 0.25 percentage points short of its 82.00% goal.

Exhibit 40: Senior Whole Health HbA1c Testing Compared to Goal

SWH HbA1c Testing for Diabetics Performance Rate

Legend: SWH Rate, SWH Goal, Linear (SWH Rate)

Data labels: 96.35%, 97.08%, 95.86%, 97.08%, 96.00%

Y-axis: HbA1c Testing Rate — 0.00%, 20.00%, 40.00%, 60.00%, 80.00%, 100.00%

X-axis: HEDIS 2014, HEDIS 2015, HEDIS 2016, HEDIS 2017
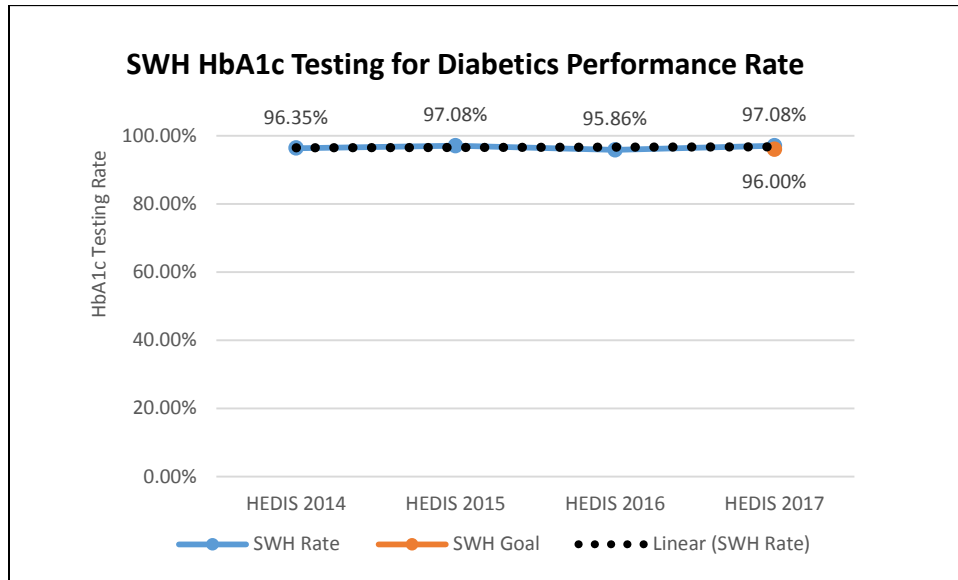
Exhibit 41: Senior Whole Health HbA1c Poor Control Compared to Goal

SWH HbA1c >9 (Poor Control) Performance Rate

Lower is better

Data labels: 23.60%, 25.50%, 11.19%, 14.11%, 10.00%

Y-axis: Poor Control Rate — 0.00%, 20.00%, 40.00%, 60.00%, 80.00%, 100.00%

X-axis: HEDIS 2014, HEDIS 2015, HEDIS 2016, HEDIS 2017

Legend: SWH Rate, SWH Goal, Linear (SWH Rate)
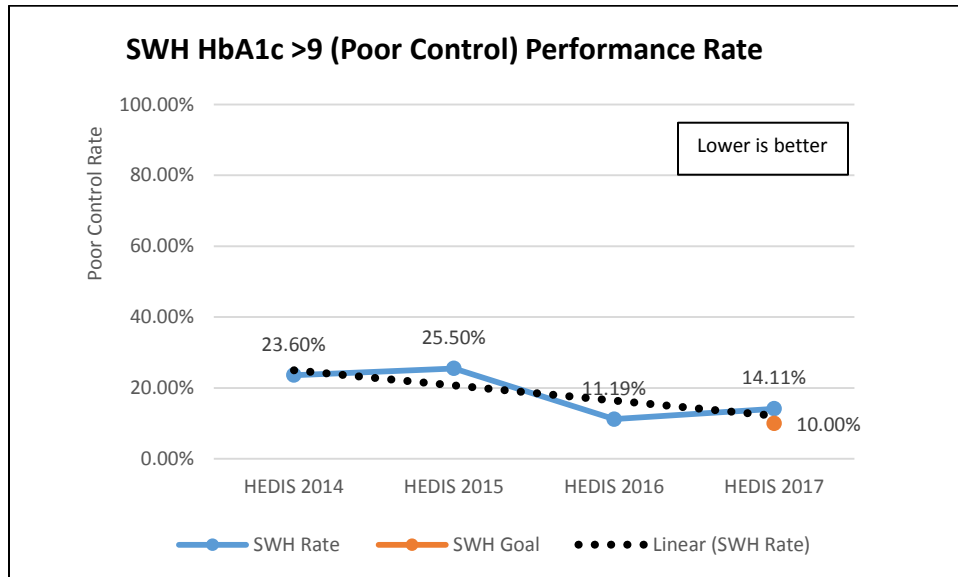
Exhibit 42: Senior Whole Health Retinal Eye Exam Compared to Goal

Rating Score

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

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	11.3	94%
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**	**56.3**	**99%**

Overall Validation Rating Score	**26**	**64**	**63.3**	**99%**

Plan & Project Strengths
- SWH is commended for addressing members' low health literacy and offering culturally competent services.
- SWH is commended for the appealing, picture-based design of the diabetes diet flyer and for making it available in several languages. KEPRO commends SWH for soliciting feedback from its Consumer Advisory Committee on its informational flyer on diet, as well as for the cultural competency of its NCMs.

Opportunities
- KEPRO suggests that a less-technical, user-friendly version of the population analysis be made available by SWH for stakeholders, such as clinical staff, providers, and the Consumer Advisory Council. The findings from this analysis could be used to educate stakeholders about the subpopulations that have higher risks for poor indicator performance.
- SWH should research evidence-based interventions for effective member engagement. Typically, member newsletters are least effective. More effective interventions involve personalized messages/reminders delivered multiple times. To achieve greater personalization, SWH should research methods to automate these reminders through blast emails and/or text messages, where feasible.

Recommendations

Looking toward the fourth remeasurement cycle, SWH has identified three higher-risk populations on which it wants to focus for improved interventions. This is a commendable strategy. KEPRO strongly recommends that these new or modified interventions be designed in such a way that they can be evaluated for effectiveness in achieving their objectives.

IMPROVING SCO MEMBER ADHERENCE TO MEDICATION REGIMENS FOR MANAGING THEIR DIABETES - UHC

Interventions

- Network pharmacists conducted outreach to members with reminders of the need to adhere to medication instructions. The pharmacists also promoted 90-day refill cycles to members.

- Educational material was mailed to members with both diabetes and hypertension, but without a pharmacy claim for an antihypertensive. The member's provider was informed that his or her patient meet these criteria. The provider is encouraged to prescribe the appropriate medications.

- Plan-dedicated pharmacists engaged with local pharmacies to ensure that Hispanic and Latino members receive medication with instruction labels in Spanish. In addition, nurse care managers distributed educational material in Spanish at home visits to this population. This focused initiative targets members discharged from Lawrence General Hospital.

Results

Calendar Year 2016 represented a baseline year for UnitedHealthcare. The Star rating measure, "Rate of member refill of non-insulin diabetes medications to ensure medication availability," is being used to measure the success of this performance improvement project. UnitedHealthcare's 2016 rate was 79%. Its goal is the CMS 4-Star cutoff point of 82%.

Rating Score

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

Results of Validation Ratings for Y/N Values	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Intervention Parameters	3	3	2.3	77%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating Score for Y/N Values	**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
Problem Statement	4	12	12	100%
Member Population Analysis	3	9	9	100%
Barriers & Root Cause Analyses	2	6	6	100%
Intervention Parameters	5	15	12.7	85%
Rationale for Performance Indicators	1	3	1	33%
Performance Indicator Parameters	1	3	1	33%
Performance Indicator Data Analysis	3	9	9	100%
Baseline Performance Rates	1	3	1	33%
Validation Rating Score for 3, 2, or 1 Values	**20**	**60**	**51.7**	**86%**

Overall Validation Rating Score	27	67	58	87%

Plan & Project Strengths
- UHC is highly commended for soliciting input from member and provider advisory groups in the design of this PIP. The plan describes robust avenues for soliciting internal and external stakeholder feedback on the PIP methodology.
- UHC's focus on non-English speaking members is commendable.
- UHC is commended for its incorporation of evidenced-based interventions, noted in the bibliography, into its intervention methodology.
- UHC is commended for creating an intervention that targets Hispanic/Latino members who cannot read medication instructional labels. KEPRO regards this as a clinically important intervention.

Opportunities
- While UHC is commended for identifying a gender gap in diabetes medication adherence, KEPRO notes that its three interventions do not specify any intervention activities that address female members as having greater risk for medication non-adherence. The challenge of female non-adherence is also not addressed in its barrier analysis.
- While the title of this intervention can be paraphrased as member engagement in a diabetes medication adherence program, it appears that the members will be engaged through their local pharmacies. KEPRO assumes that UHC staff will then educate local pharmacists on the 90-day fill-program, but this protocol has not been clearly described.

- This intervention description could be strengthened by the addition of more operational details that answer these questions: How are members identified for outreach and who makes the contact? How are members who need improved adherence linked to the local pharmacies and what role does UHC play in establishing that link? What are the timelines for the outreach? Is this member or local pharmacy outreach done by telephone? How are members with no contact information located? Is the outreach call/visit made by UHC staff scripted? How are staff trained to educate local pharmacies and what educational materials will be presented?

Recommendations
- KEPRO recommends that UHC identify its members' most frequent co-morbidities. A co-morbidity analysis could be helpful to UHC in the focusing its interventions on members with the highest clinical risks.
- KEPRO recommends that UHC conduct a root cause analysis of the barriers to determine which are the most substantive.

IMPROVING THE RATE OF MEMBERS RECEIVING ANNUAL PREVENTIVE DENTAL CARE - CCA

Commonwealth Care Alliance, based on a literature review, utilization data, expert input, and discussion with the SCO member advisory groups, initiated a project with the goal of improving the rate of members receiving annual preventive dental care.

Interventions

- CCA integrated dental health into routine care management including the incorporation of dental health in health assessments and increased staff awareness of the importance of dental health. (2017)

- CCA actively encouraged SCO members to schedule preventive dental visits and provided them with education about proper oral hygiene practices. (2017)

Results

A 2016 28.81% rate represented CCA's baseline performance for the percent of members receiving preventive dental care. CCA's goal for the first remeasurement is 33.81%.

Rating Score

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

Results of Validation Ratings for Y/N Values	Number of Items	Total Available Points	Points Scored	Rating Averages
General Information	1	1	1	100%
Intervention Parameters	3	3	3	100%
Performance Indicator Data Collection	3	3	3	100%
Validation Rating 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
Problem Statement	4	12	12	100%
Member Population Analysis	3	9	9	100%
Barriers & Root Cause Analyses	2	6	6	100%
Intervention Parameters	5	15	15	100%
Rationale for Performance Indicators	1	3	3	100%
Performance Indicator Parameters	1	3	3	100%
Performance Indicator Data Analysis	3	9	9	100%
Baseline Performance Rates	1	3	3	100%
Validation Rating for 3, 2, or 1 Values	**20**	**60**	**60**	**100%**

Overall Validation Rating Score	**27**	**67**	**67**	**100%**

Plan & Project Strengths
- CCA is commended for its rigorous vetting process in the selection of the topic for this performance improvement project.
- The population analysis is well-detailed and the examination of the preventive dental care visit rate is commendable.
- This intervention appears to be a robust educational effort directed primarily at CCA staff who provide direct member services and care management.

Opportunities
- KEPRO suggests that CCA measure the volume of member access to its educational web pages through such resources as Google Analytics.

Recommendations
- KEPRO recommends that CCA consider stratifying its members by risk level, such as those members whose physical or emotional health declined compared to the previous year; who have mobility disabilities; or who have three or more ADL impairments. Members at higher risk levels may need more personalized interventions to improve their service access rates.
- The lack of literature on best practices to increase the rates of routine dental care visits underscores the importance of CCA soliciting structured feedback from both members and providers about these interventions.

- KEPRO recommends that, to reinforce the content of the material, CCA find ways to personalize the member mailings or ensure that care mangers review the materials with the member.

REDUCING THE USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY – FALLON HEALTH

Interventions

- The NaviCare Clinical Pharmacist conducted written outreach to the prescribing provider to notify the provider that s/he has prescribed a high-risk medication, to provide suggestions for safer alternative medications, and to encourage the provider to discontinue prescribing the high-risk medications.

- The member's primary care provider was notified that the member was prescribed a high-risk medication by another provider.

- An article about high-risk medications was placed in the plan's member newsletter.

Results

The chart below depicts Fallon Health's rate of the use of high-risk medications in the elderly compared to its goal. Please note that, for this measure, a lower rate reflects higher performance. Fallon's performance increased unfavorably 27.7% between HEDIS 2016 (24.05%) and HEDIS 2017 (27.70%). It did not achieve its 22.40% goal.

Exhibit 43: Fallon Health's Use of High-Risk Medications in the Elderly Compared to Plan Goal

Rating Score

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

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	3	100%
Performance Indicator Data Collection	3	3	3	100%
Overall Validation Rating for Y/N Values	**7**	**7**	**7**	**100%**

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

Validation Rating Score	27	67	67	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 Fallon Health follows.

Calendar Year 2016 Recommendation	2017 Update
NaviCare appears to communicate with consumers through one-way information-sharing. The plan is encouraged to create a council for members that can be used to review and solicit feedback about the identification of barriers and interventions.	KEPRO recommends that Fallon convene a member advisory group to review the high-risk medication letter and to consider other media options for alerting members to their medication risks, such as personalized emails or text messages. This recommendation stands.

Plan & Project Strengths

- Fallon is commended for having its clinical pharmacist outreach to prescribers through letters that inform providers of high-risk medications in current use by members. These letters also recommend alternatives to the high-risk medications. Fallon is commended for its use of these member-specific letters. Fallon is commended for assessing the effect of these letters.
- Fallon is commended for its excellent population analyses. Fallon is especially commended for its comparative analysis of several key demographics using HEDIS 2016 data in contrast to HEDIS 2017 data.
- Fallon presents an excellent analysis that compares members who are compliant (use of lower-risk meds) vs. noncompliant (continued use of higher-risk meds) within several demographic categories. KEPRO suggests that the findings of these year-to-year and within-year analyses be written in a presentation format that can be used for educating care managers and providers. A consumer advisory group would also be interested in these findings.
- Fallon is commended for taking a critical look at its intervention strategies and how these interventions might be improved in the next remeasurement cycle.

Opportunities

From KEPRO's perspective, the format of the provider high-risk medication letters is not engaging and the most important member-specific information is found on the second page, which providers may not read.

Recommendations

KEPRO strongly recommends that Fallon solicit structured feedback from a panel of providers regarding its redesign of the provider high-risk medication letter format.

.

REDUCING RISKS FOR PEOPLE WITH CARDIOVASCULAR DISEASE IN THE SCO POPULATION 65 AND OVER WITH CONGESTIVE HEART FAILURE (CHF) BY REDUCING CONGESTIVE HEART FAILURE ADMISSION RATES - TUFTS HEALTH PLAN

Interventions

- Members with Congestive Heart Failure (CHF) were identified through self-report as well as through claims data. These members were flagged for care management follow up and assessment. Care managers sent disease-specific materials and information to promote self-management.

- Care managers conducted an assessment to evaluate all hospitalized members' statuses two- and seven-days post-hospital discharge.   The goals of this assessment were to assess medical complexity and the member's risk for re-hospitalization; to evaluate members' level of comfort with their discharge plans; and to remind members to schedule follow-up appointments. The care managers ensured that appropriate clinical, home, and community-based services are in place. Members were educated about the signs and symptoms of the potential deterioration of their condition.

- Clinical Pharmacists and Nurse Practitioners conducted medication reviews.

Results

THP had a baseline CHF acute admission rate of 31.8/1000 members. This admission rate increased (a negative trend) during Remeasurement 1 to 40.3/1000, and decreased (positively) during Remeasurement 2 to 32.0 admissions/1000 members. In this second measurement cycle, THP's acute CHF admission rate has returned to baseline.

Exhibit 44: Tufts Health Plan SCO Congestive Heart Failure Admissions per Thousand Members Compared to Goal
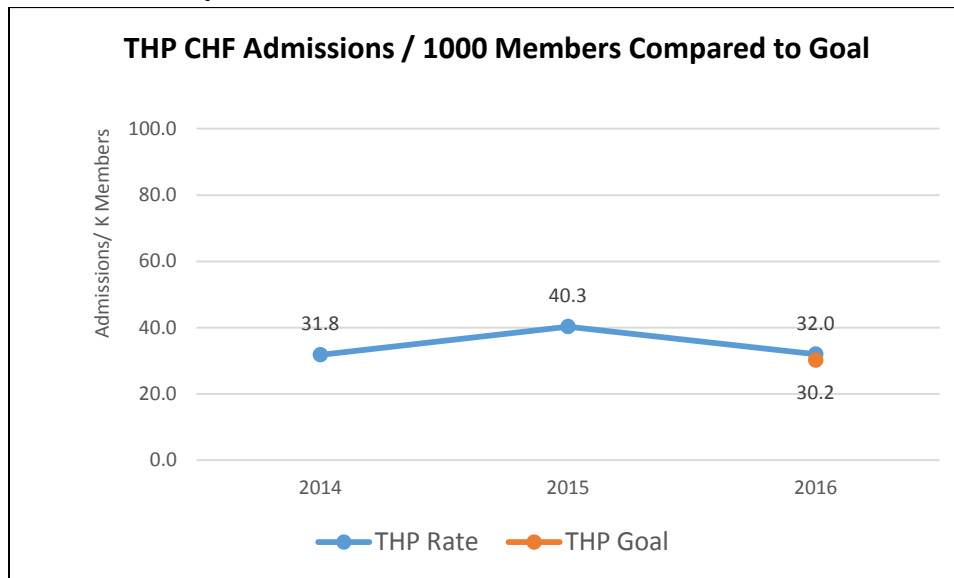
THP CHF Admissions / 1000 Members Compared to Goal

Rating Score

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

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	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
Reassessing PIP Goals & Barriers	4	12	12	100%
Reassessing Intervention Parameters & Strategies	4	12	11.7	98%
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**	**56.7**	**99%**

Validation Rating Score	**26**	**64**	**63.7**	**99%**

Update to 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 Plan follows.

Calendar Year 2016 Recommendation	2017 Update
THP SCO is encouraged to formalize its stakeholder review process by actively seeking feedback from members and providers in structured formats in addition to information gathered through anecdotal comments.	Although Tufts surveys its membership about satisfaction with the care management process, no ongoing forum for receiving structured feedback has been established. This recommendation stands.
THP SCO should continue to educate providers about the differences between systolic and diastolic heart failure, as well as the appropriate use of the three specific beta blockers for the management of systolic heart failure. THP SCO should also ensure that providers receive (and understand) the ACC Guidelines for the Management of Heart Failure.	Tufts reported, "THP also held a Symposium on Transforming Care for High-Risk Older Adults in November of 2016. Part of the training included discussions on the importance of medication review and managing comorbidities to reduce the likelihood of unnecessary admissions for chronic illnesses like CHF. THP recorded the presentation and a webcast recording is available to all SCO providers and clinical staff."

Plan & Project Strengths

- KEPRO recommends that THP include representative members and providers in the process of identifying barriers and designing corrective intervention strategies.
- THP is commended for its training "Transforming Care for High-Risk Older Adults," which was offered to THP's SCO providers.
- THP is commended for reducing the rate of CHF-related acute admissions in 2016.
- The medication review protocol is comprehensive and well-designed. THP is commended for providing this service to its members.
- THP presents a comprehensive population analysis. THP is especially commended for identifying risk categories, e.g., hearing-impaired, low-education, and NHC-eligible. The data tables presented in the population analysis are a rich source of information for identifying members with CHF who are at risk of hospitalization and readmission.

Opportunities
- THP is encouraged to research the literature on the effectiveness of sending members disease-specific educational materials in reducing the rate of CHF acute hospitalizations.
- THP is strongly encouraged to improve its assessment of intervention effectiveness for the next remeasurement cycle.
- THP should also consider public presentations of its SCO population analysis to stakeholders, such as member and provider advisory councils. Providers especially could benefit from learning about the clinical risks of their SCO patients.

Recommendations
- KEPRO recommends that THP identify the prevalence of CHF among its SCO members in order to assess the extent to which this intervention is reaching a clinically meaningful portion of its PIP-eligible members.
- THP's response meets the rating criteria for this item. KEPRO recommends that, in future PIP reporting, THP should ensure that, for PIPs with overlapping objectives (such as the objectives of CHF and PCR to reduce rates of hospitalization), the data for the PIP-eligible members be kept separate and be reported as PIP-specific findings, especially as this overlap relates to interventions that are shared by one or more performance improvement projects.

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 each Senior Care Organization 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.

SCO 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 fourteen 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;
- Subcontractual 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 provided communication to the SCOs prior to the formal review period that included an overview of the compliance review activity and timeline, and solicited preferences for the

onsite reviews. In addition, KEPRO hosted a webinar on April 10, 2017, to provide more detailed information and instructions for the SCOs to prepare for the compliance review. SCOs were provided with a preparatory packet that included the project timeline, the draft onsite agenda, the compliance review tools, and data submission information. KEPRO also conducted a thirty-minute call with each SCO approximately two weeks prior to the onsite review to cover logistics.

The SCOs were asked to provide documentation to substantiate compliance during the review period with each requirement. 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 SCOs. In addition, two-day onsite visits were conducted to interview key SCO personnel, review selected case files, and participate in systems demonstrations. It also provided the SCO with the opportunity to clarify submissions and to provide additional documentation. At the conclusion of the two-day onsite review, KEPRO conducted a closing conference to provide preliminary feedback to the SCO on the review team's observations of its strengths, opportunities for improvement, recommendations, and next steps.

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

- **Met** – 1 point
    - Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and SCO 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. SCO 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 SCO 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 SCO 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 SCO staff did not provide information to support compliance with requirements.

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

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

COMPLIANCE VALIDATION COMPARATIVE ANALYSIS

The graph that follows depicts the aggregate compliance scores for each SCO reviewed.

Exhibit 45: MassHealth SCO Aggregate Compliance Scores
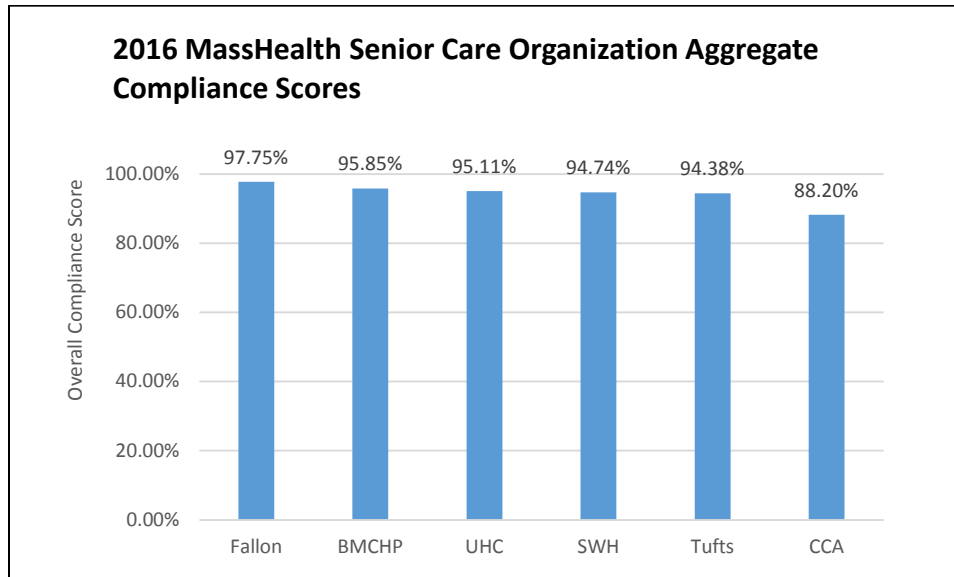
Exhibit 46: Compliance Scores Received by SCOs

Compliance Review Elements	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Enrollee Rights and Protections	5/5	5/5	5/5	5/5	5/5	5/5
Enrollee Information	29.5/31	30.5/31	29/31	30/31	31/31	31/31
Availability and Accessibility of Services	25/27	20.5/27	26.5/27	24.5/27	24/27	24.5/27
Coordination and Continuity of Care	53/53	52/53	52.5/53	52.5/53	52.5/53	50.5/53
Coverage and Authorization of Services	28.5/30	28.5/30	29/30	29.5/30	28.5/30	28.5/30
Practice Guidelines	6/6	1.5/6	6/6	6/6	4/6	6/6
Enrollment and Disenrollment	4/4	4/4	4/4	4/4	4/4	4/4
Grievance System	34.5/36	33/36	36/36	33.5/36	35.5/36	36/36
Sub-contractual Relationships and Delegation	8/8	6.5/8	8/8	7.5/8	8/8	7.5/8
Quality Assessment and Performance Improvement Program	23.5/26	20/28	26/28	24/28	21/28	23.5/28
Credentialing	13/15	10/15	15/15	12/14	15/15	12.5/14
Confidentiality of Health Information	5/5	5/5	5/5	4.5/5	5/5	5/5
Health Information Systems	2/2	2/2	2/2	2/2	2/2	2/2
Program Integrity	17/17	17/17	17/17	17/17	16.5/17	17/17
Total Received/Possible*	**254/265**	**235.5/267**	**261/267**	**252/266**	**252/267**	**253/266**
Score Calculated as Percentage[1]	**95.85%**	**88.20%**	**97.75%**	**94.74%**	**94.38%**	**95.11%**

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 SCOs demonstrated compliance with the Federal and State contractual standards for its SCO membership. Due to the unique needs of the SCO population, a heavy emphasis of the review was placed on the coordination and continuity of care standard. In general, the SCOs demonstrated strong models of care supporting the overarching goals of coordinated care for SCO members.

All SCOs were fully compliant with Member Rights and Responsibilities, Enrollment and Disenrollment, and Health Information Systems standards. Five of the six SCOs had aggregate compliance scores above 90 percent.

While KEPRO identified many overall strengths and successes of the SCO model, the review revealed some challenges as well. KEPRO found that the SCOs had challenges with their ability to have a centralized enrollee record (CER) since the SCOs were not fully integrated with providers to have all medical record data in one system, such as physician orders. Given the existing model, while this is a noble goal to work towards, the feasibility may be unrealistic for SCOs within the current service delivery structure.

In addition, KEPRO found that utilization management denial letter language was inconsistent among the SCOs. Some letters appeared to be overly complex with up to 13 pages provided to members. Furthermore, there was some inconsistency with how SCOs should handle appeals given the complexity of administering coordinated Medicare and Medicaid benefits, the management of Medicaid-only SCO members, and determining the appeal path available to members.

Furthermore, KEPRO identified that SCOs varied in their understanding and use of medical necessity denials versus the use of administrative denials. Some SCOs reviewed all requests for medical necessity regardless of benefit coverage. While medical necessity review is required for Medicaid populations under 21 for EPSDT services, KEPRO was unaware of similar requirements for adult populations. This presented some challenges within the SCOs' utilization management process since the path of appeal options available to the member varies based on the designation of a denial as administrative versus clinical.

Finally, the review revealed some challenges with information exchange between the SCOs, such as assessments, for SCO members that transfer membership from one SCO to another. Without a viable option to share information, the SCOs may be allocating unnecessary resources to re-assess members, which can be overly burdensome to both SCOs and members and may result in a delay in linkage of services.

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

- MassHealth may consider having a focused care management file review on a sample of SCO members. This would provide a better evaluation of the impact of the model of care at the member level. SCOs were in general compliance with the 2017 Coordination and Continuity of Care standard, which focused on a review of each SCO's policies, procedures, and models of care against requirements.
- MassHealth should review its expectations and contract requirements related to the CER for the SCO and its overall goals/intent for the CER since SCOs are not fully integrated with their network providers.
- MassHealth should provide guidance to the SCOs on appeal procedures to increase consistency across SCOs. The guidance should ensure that SCOs administer member appeal rights based on the service being denied and the benefit package. Medicare services and benefits should afford members appeal rights consistent with Medicare guidelines including an Independent Review Entity (IRE) review, as appropriate. Medicaid services and benefits should afford members appeal rights consistent with MassHealth guidelines, including an appeal to the State Board of Hearings, as appropriate. In addition, MassHealth should provide guidance specific to the Medicaid-only SCO population to ensure that member rights follow the MassHealth process, since these members have no Medicare eligibility and an IRE referral is not applicable.
- It is recommended that MassHealth provide clarity to SCOs on its expectations related to medical necessity and administrative denials.
- MassHealth should explore options to help facilitate the sharing of information between SCOs, such as assessments, when members transfer between SCOs to improve efficiency and reduce duplication.

NEXT STEPS

MassHealth required Senior Care Organizations to submit Corrective Action Plans (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

A detailed description of strengths, findings, recommendations, and score for each of the 14 standards reviewed is provided in the following tables for each of the six Senior Care Organizations.

BOSTON MEDICAL CENTER HEALTHNET

KEPRO reviewed all documents that were submitted in support of the Compliance Validation process. In addition, KEPRO conducted a site visit on August 7 – 8, 2017.

Enrollee Rights & Protections

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.

Enrollee Information

Strengths	▪ BMCHP's member handbook was in an easy-to-read format. ▪ BMCHP's 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: ▪ While BMCHP demonstrated that it conducted new enrollee orientation during 2016 and had a process to monitor timeliness using a dynamic daily report, BMCHP did not have a formal mechanism for monitoring its adherence rate for providing the orientation to enrollees within 30 calendar days of the initial date of enrollment. Not Met: ▪ BMCHP did not provide information on how enrollees could request information on the structure and operations of BMCHP upon request. Additionally, BMCHP did not provide information to its enrollees on its physician incentive plans during the review period.

Recommendations	- 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 service department representative within 30 seconds or less. - 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 through another mechanism.

Availability and Accessibility of Services

Strengths	BMCHP's Concierge Care Management Program provided a single number for all members to call, which made it simple and consistent for members to contact the plan.
Findings	Partially Met: - BMCHP's duals and Medicaid-only EOCs (Evidence of Coverage) indicated that a second opinion is covered only before surgery. The Provider Manual indicated that a second opinion is covered for surgery, diagnosis, and treatment for other health conditions. While, the surgery-only provision is CMS model language for dually-eligible members, the Medicaid-only EOC should not reflect "before surgery only." - The Accessibility of Practitioners policy complied with standards. However, the Provider Manual language was inconsistent with requirements. For PCPs, the Provider Manual indicated a 45-day access standard for routine non-symptomatic appointments, 10 days for non-urgent symptomatic, and 48 hours for urgent. For specialty, the Provider Manual indicated a 60-day standard for non-symptomatic appointments and 30 days for non-urgent symptomatic. - BMCHP's clinicians managed the triage system using their professional clinical judgment, care plans, and other internal resources as necessary. There were, however, no formal clinical criteria for triage and no policy was provided on the process. - BMCHP's documentation demonstrated the existence of 24-hour coverage. No policy, however, was provided that described the specific requirements for the 24-hour coverage line.

Recommendations	▪ BMCHP needs to update its Medicaid-only EOC to describe the broader second opinion benefit.
	▪ BMCHP needs to update its Provider Manual to include the appropriate appointment access requirements.
	▪ BMCHP needs to develop a policy to describe its triage system, with specific reference to the use of appropriately qualified professional clinicians.
	▪ BMCHP needs to develop a policy that describes the 24-hour coverage line to ensure the requirements indicated are all addressed.

Coordination and Continuity of Care

Strengths	▪ Despite being a new SCO program 2016, BMCHP demonstrated good progress with implementation of its care management and coordination of care activities.
	▪ BMCHP's membership had access to BMCHP's mature network of providers.
	▪ BMCHP's model of care supported strong capability for care coordination.
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 for the process for managing Part C pre-service authorization requests that exceed the specified timeframes for making an organizational determination.
	Not Met:
	▪ BMCHP's policy did not address termination, suspension, or reduction of previously authorized services and therefore the policy did not address the ten-day notification process. SCO staff noted that it has not been its operational practice to terminate, suspend, or reduce previously authorized services.

Recommendations	- BMCHP needs to add clarity to its policy for addressing service authorization requests that exceed the specified timeframe, i.e. untimely decision equals an adverse determination. In addition, KEPRO recommends that BMCHP provide training for its staff 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 BMCHP has not encountered a need to terminate, suspend, or reduce previously authorized services, BMCHP needs to incorporate language into its current policy to address the requirement and ensure staff are 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 of community/plan providers participating 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.
Findings	Partially Met: ▪ A review of three 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 BMCHP used language from the provider in response to BMCHP's request for comment on the grievance; however, the provider's comments related to the grievance were not necessarily written with acknowledgement that the provider's response would be put into the grievance resolution verbatim. Not Met: ▪ BMCHP's policies did not include the required provision that a representative of a decease enrollee's estate is party to the State fair hearing process.
Recommendations	▪ BMCHP needs to evaluate its grievance resolution letter process to ensure that grievance issues are summarized with a concise, member-friendly resolution. Information obtained by providers should be reworded appropriately before being included in member communications. In cases where BMCHP determined that the grievance was unsubstantiated, BMCHP should consider the development of some language to notify the member of its process to track and trend provider grievances. ▪ BMCHP needs to 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.

Sub-contractual Relationships and Delegation

Strengths	▪ BMCHP had good evidence of monitoring, reporting, and review of delegated entities. ▪ BMCHP was fully compliant with this standard.
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's 2017 Member Advisory Board included SCO member input on quality improvement activities. ▪ BMCHP used a modified CAHPS survey that was conducted and stratified by population.
Findings	Partially Met: ▪ BMCHP's Enrollee Advisory Council was not convened in 2016. BMCHP's Provider Advisory Council was available in 2016 in New Hampshire only. ▪ BMCHP's Monitoring Appropriate Utilization Policy refers to analysis of emergency department, inpatient, readmissions, specialized outpatient, out-of-area, out-of-network, and ancillary services. BMCHP's Over/Underutilization Grid included a comprehensive list of different reports (description only) to address over- and underutilization dated in 2017. This included service by type as well as HEDIS and prescription measures. While both the policy and grid included reports relevant to under- and overutilization, they were not consistent. BMCHP's Medical Expense Report provided was focused on expenses as opposed to under- and overutilization. Actual reports were not provided as evidence. ▪ BMCHP's Provider Profiling Policy did not include provisions for measuring and management of interdisciplinary team performance, enrollee experience, and perceptions of service delivery and timely access. ▪ BMCHP's Provider Profiling Policy did not include provisions for a corrective action process for providers whose performance was unacceptable in one or more of the areas noted above. ▪ While BMCHP's contract with major providers of services includes requirements to comply with BMCHP's quality improvement program, it does not specifically require that the provider proactively conduct activities to monitor the quality, access, and cost-effectiveness of their services and identify and address opportunities for improvement on an ongoing basis.

| Recommendations | BMCHP needs to convene the Enrollee Advisory Council in 2017. BMCHP needs to expand its Provider Advisory Council to include Massachusetts providers. BMCHP needs to make its Monitoring Appropriate Utilization Policy and the over and under-utilization reporting grid consistent, and that reporting is produced on a regular basis and is presented at UMC for discussion and action as necessary. BMCHP needs to update its Provider Profiling Policy to include measuring and management of interdisciplinary team performance, enrollee experience and perceptions of service delivery and timely access as practicable. BMCHP needs to update its Provider Profiling Policy to include appropriate corrective action processes. BMCHP needs to update its major provider contracts to include provisions requiring them to conduct monitoring activities for quality, access, cost-effectiveness and identify and address opportunities for improvement. |

Credentialing

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.

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 initiated a disenrollment workgroup. - 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 was fully compliant with this standard.
Findings	BMCHP was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

COMMONWEALTH CARE ALLIANCE

KEPRO reviewed all documents that were submitted in support of the Compliance Validation process. In addition, KEPRO conducted a site visit on September 6 – 7, 2017.

Enrollee Rights & Protections

Strengths	- CCA's documentation was sufficient for demonstrating that staff members and providers consider member rights and responsibilities when providing services to members. - CCA was fully compliant with this standard.
Findings	CCA was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollee Information

Strengths	- CCA demonstrated a member-centric focus in the delivery of enrollee information. - CCA made a business decision to translate additional written materials for languages that did not meet requirements for translation as high-prevalence but that CCA identified as a need for its SCO population. - CCA captured both oral and written language preferences of its SCO population.
Findings	Partially Met: While CCA provided member appeal rights as part of the Evidence of Coverage (EOC), there was no language that was specific to the process used by providers to challenge the failure of the organization to cover a service.
Recommendations	CCA needs to revise its EOC to include language that specifies the provider reconsideration process that the SCO makes available to providers, outside of the member appeal process.

Availability and Accessibility of Services

Strengths	- CCA's EasCare paramedic program was very innovative and appeared to be successful. - CCA's structure included having individual nurse practitioners and behavioral health clinicians available to manage SCO members, which KEPRO found as a good strategy for addressing member barriers to accessing appropriate care. - CCA's primary care model included a process for addressing frequent

	PCP changes and offering members the opportunity to go to a CCC provider.
Findings	Partially Met: ■ CCA's Clinical Ops 043 ICT and ICP policy included arranging for and coordinating services, but indicated it is applicable to the ICO program only. ■ CCA's Operations 026 ADA Compliance policy described collecting data on provider disability accessibility, requirements for provider training, and a compliance checklist. However, the policy indicated it is applicable to the ICO program only. ■ CCA's Clinical Ops 043 ICT and ICP policy includes arranging for and coordinating services, but indicates for ICO only, but indicates it is applicable to the ICO program only. ■ While CCA's Provider 007 24 Hour Coverage Policy and Procedure included appropriate information, it did not reference the clinically based triage criteria that were available to clinicians taking member calls. ■ CCA's Provider Manual and Provider Agreements did not include a provision requiring the provider to provide interpretation services or that CCA's language line was available to the provider as needed for interpretation services. ■ CCA's Standard Operating Procedure SCO 14 Provider Termination was not dated and did not include notification of termination to EOHHS within five days. ■ While CCA provided documentation on a variety of provider training resources, it did not offer training for depression or Alzheimer's disease. Not Met: ■ CCA did not provide a policy related to office visit access. In addition, the office visit access standards were not included in the Provider Manual or Provider Agreements. ■ CCA's provider agreements did not include a provision for office hour parity. ■ CCA did not provide evidence of a mechanism to ensure appointment access compliance, ongoing monitoring of compliance, or corrective action for noncompliant providers.
Recommendations	■ CCA should update the ICT and ICP policy to include that it applies to both the ICO and SCO programs. ■ CCA should update the ADA Compliance policy to include that it applies to both the ICO and SCO programs. ■ CCA should update the ICT and ICP policy to include that it applies to both the ICO and SCO programs. ■ CCA should develop a policy related to office visit access standards and include this information in either the Provider Manual or

	Provider Agreement.
	▪ CCA should update the 24 Hour Coverage Policy and Procedure to include the clinically based triage criteria that are available to clinicians taking member calls. ▪ CCA should update its provider agreements to include this provision. ▪ CCA should implement and document a process for regular monitoring of provider appointment access compliance and taking corrective action for noncompliant providers. ▪ CCA should update the Provider Manual to require providers to provide interpretation services as necessary and the availability of CCA's language line as needed. ▪ CCA should update its procedure to include a date and include notification of termination to EOHHS within five days. ▪ CCA should expand its provider training resources to include materials relevant to depression and Alzheimer's disease.

Coordination and Continuity of Care

Strengths	▪ CCA demonstrated an individualized, high-touch model of care with evidence of medical and behavioral health integration. ▪ The use of stabilization centers was an innovative resource for members as well as CCA's care team. ▪ CCA demonstrated a process for obtaining inpatient admission and emergency room visit notification from larger provider groups to jointly manage these member needs.
Findings	Partially Met: ▪ The individualized Care Plan did not include the service plan which identifies the long-term services and supports the member has in place. Additionally, the functionality of the current electronic system limits the creation of a robust care plan. ▪ CCA indicated that there were limited lab and radiology results in the Centralized Enrollee Record (CER). The customary medical record was the adjunct to the CER and is maintained by the PCP or long-term care facility.
Recommendations	▪ CCA should expand the care plan to include the service plan. As a new electronic documentation system is implemented, CCA needs to develop capability for the creation of individualized care plans, with measurable goals and progress in goal achievement. ▪ Full integration of medical records is an ongoing challenge for SCOs. CCA should continue discussions with MassHealth related to expectations for full data integration.

Coverage and Authorization of Services

Strengths	▪ CCA's transitions of care team and care management team collaborated on notification and review of inpatient admissions and transitions of care. ▪ CCA integrated its utilization reviews and care management activities within the same information system. ▪ CCA's respite and crisis stabilization units were noted by KEPRO as a best practice.
Findings	Partially Met: ▪ The Clinical 017 Medical Necessity Review for Select Service policy had not been reviewed or revised since 2009. The policy lists prior authorization requirements for Substance Use Disorder services. The plan did note, there are currently no prior authorization requirements for these services, nor were there prior authorization requirements in 2016. ▪ The Clinical Ops 002 Service Decision policy did not clearly define the professional that rendered the service denials. Additionally, during file reviews, it was noted that the nurse care manager had issued service denials. ▪ During the file reviews, it was found that written notification was not always provided to the member.
Recommendations	▪ CCA should review and revise the Clinical 017 Medical Necessity Review for Select Service policy. Additionally, CCA should establish process for the annual review of this and all policies. ▪ CCA should have the utilization or care nurse manager review and, if appropriate, approve service requests. If the request cannot be approved, the authorization request should be forwarded to the appropriate medical director for determination of medical necessity. Additionally, CCA should review the Clinical Ops 002 Service Decision policy and provide clarity as to the appropriate professional for rendering medical necessity determinations. ▪ CCA should consistently provide written notification to members of any adverse action. During quality monitoring of the service decision process, CCA should include member notification as a review element.

Practice Guidelines

Strengths	▪ CCA used an evidence-based clinical decision support resource to assist staff members with guiding clinical decisions.

Findings	Partially Met:
	▪ CCA has implemented internal practice guidelines and additionally utilizes the resource "UpToDate" to guide clinical decision-making and for support of the care management process. CCA has not adopted evidenced-based practice guidelines that are reviewed and approved through a committee process.
	▪ CCA does evaluate the needs of its members, but indicates that the population's needs are not best served by standardized practice guidelines.
	▪ CCA did not have practice guidelines in place to apply to its utilization management decisions.
	Not Met:
	▪ CCA does not have a formalized process for the development or review of practice guidelines.
	▪ The plan disseminated preventive care guidelines to network providers and to its members in 2015.
Recommendations	▪ CCA should develop, review, and formalize the adoption of practice guidelines.
	▪ CCA should consider the review of multiple national and regional practice guidelines and, when not appropriate to its population, consider the development of its own guideline.
	▪ CCA should formalize the review process of adopted practice guidelines and include contracting health professionals in the process.
	▪ CCA should formalize the process for review of adopted practice guidelines and update the guidelines periodically as appropriate.
	▪ Upon the formal adoption of practice guidelines, CCA should disseminate to all network providers, include on its provider and member website, and develop process to provide to members if requested.
	▪ Upon the adoption of practice guidelines, CCA should incorporate the guidelines into utilization and care management processes.

Enrollment and Disenrollment

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

Grievance System

Strengths	▪ CCA demonstrated timely resolution of grievances.
Findings	Partially Met: ▪ The file review showed that Part D appeal decisions were typically made by a pharmacist. In a few cases, the appeal was not reviewed for medical necessity. In addition, Personal Care Attendant service decisions were typically made by a social worker. ▪ The onsite file review showed that, in some instances, CCA extended the appeal timeframe to allow the internal reviewer additional time to review documentation and render a decision. The regulatory requirement for extension must be in the member's best interest and should not be made based on staff resources. ▪ CCA's Evidence of Coverage (EOC) lacked language that the member must exhaust CCA's internal approval process before accessing the State Board of Hearings. ▪ The onsite file review for Part D appeals showed that CCA was moving some expedited requests to a standard request without justification for the reclassification and notification to the enrollee. Not Met: ▪ CCA's policies did not include the required provision that a representative of a decease enrollee's estate is party to the State fair hearing process.
Recommendations	▪ CCA should update its workflows to ensure review by a physician for appeals or work with MassHealth to clarify expectations and contract language regarding the acceptability of other qualified staff to render a denial decision. In addition, when applicable, cases that are appropriate for medical necessity review must be reviewed for medical necessity. ▪ CCA should consider taking an extension when there are efforts to obtain additional documentation that may be in the member's best interest. In general, documentation received within the 14-day timeframe needs to have a SCO decision within that timeframe. ▪ CCA should update its EOC and grievance policies to indicate the requirement for exhaustion of CCA's internal appeal process before accessing the State's Board of Hearings. ▪ CCA should mirror its Part C process for handing expedited appeals, including the notification to the enrollee when an expedited case is moved to a standard request. ▪ CCA 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	▪ CCA demonstrated allocation of resources and efforts to formalize processes related to delegation oversight.
Findings	Partially Met: ▪ While CCA used its Request for Proposal process as its mechanism for evaluating prospective subcontractors' ability to perform activities to be delegated, CCA lacked a formal policy, procedure, and process related to the delegation activities. ▪ While CCA demonstrated some delegation oversight, CCA lacked a formal process during 2016 to address subcontractor's performance. ▪ While CCA had a mechanism to monitor delegated entity performance, including corrective action plans, CCA did not have a formalized process that clearly delineated responsibility for delegation oversight, including the formal, ongoing monitoring of its delegated entities.
Recommendations	▪ CCA should more formally develop its delegation process to include a policy and procedure that delineates its process to evaluate prospective subcontractor's ability to perform delegated activities. ▪ CCA should develop a policy and procedure that outlines its process for periodic, formal review of its delegated entities. ▪ CCA should establish a delegation oversight committee or equivalent responsible entity that includes a charter to describe the composition, scope, and authority of the committee, and its role in the initiation and/or monitoring of corrective action plans.

Quality Assessment and Performance Improvement Program

Strengths	▪ CCA demonstrated a focus on seeking member input and feedback on quality activities through the use of focus groups, consumer advisory councils, and member interviews. ▪ CCA had good analyses related to under- and overutilization of services. ▪ CCA's Clinical Best Practice Conference and behavioral health seminars included relevant and valuable topics.

Findings	Partially Met:
	▪ While CCA provided evidence of various activities addressing aspects of over- and underutilization, CCA did not provide a description of an overall process or protocol for monitoring over- and underutilization.

	▪ While CCA provided a comprehensive readmission prevention program charter, it did not include specific references to how the following requirements were addressed as part of the Model of Care:
	
	   o Monitoring and risk assessment for conditions listed;
	   o Linkage of initial and ongoing assessments; and
	   o Linkages with PCPs, Patient Care Technicians (PCTs), and other appropriate providers.

	▪ While CCA provided a comprehensive readmission prevention program which focused on post-discharge visits, it did not specifically address ICT planning on admission, involvement of the Geriatric Support Services Coordinator (GSSC), Home- and Community-Based Service (HCBS) providers, the enrollee, and care planning for needs upon discharge.
	▪ While CCA described that disease management for the listed conditions was provided on an enrollee-specific basis through its model of care approach, no evidence of providing written practice guidelines to providers or educational processes for providers in best practices was provided.
	▪ CCA did not provide evidence of practice guidelines for dementia or educational programming for caregivers with community-based care and support systems.
	▪ While CCA described how it addressed nursing facility institutionalization requirements through its model of care, no specific documentation was provided to address written protocols for nursing facility admissions, at-risk enrollee identification, ongoing assessments, linkages between PCPs, PCTs, long-term care providers, and HCBS providers.
	▪ CCA's SBIRT Screening in SNF document only addressed screening during short term nursing facility stays. No evidence of the adoption dissemination of practice guidelines, monitoring compliance with guidelines, or coordination the between PCP/PCT and behavioral health provider was provided.
	▪ CCA did not provide evidence of a formal program to assess new technology.
	▪ While family members were included in consumer advisory committees, CCA did not provide documentation of a survey or focus group to specifically address family member and caregiver assessment of CCA's ability to support family members and

	significant others.
	- While CCA's Work Plan Evaluation addressed effectiveness of some health promotion and wellness activities, no formal report of the effectiveness of these activities which included costs, benefits and lessons learned was provided. - While CCA described that payment was not made for serious reportable event services, no evidence of a documented process for ensuring non-payment was provided. - While CCA provided evidence of a number of provider profiling activities, it did not provide a written protocol for assessments of provider performance for each component of the provider network. - While CCA described an informal process for Medical Director review of quality of care issues arising from complaints, there was no evidence of a formal process for addressing complaints involving medical provider errors, taking corrective action, and filing reports with CMS and MassHealtlh within three business days. - CCA lacked evidence of proactively requiring major providers to conduct monitoring activities for quality, access, and cost-effectiveness and to identify and address opportunities for improvement.

Recommendations	- CCA should develop a written protocol for routine monitoring of over- and underutilization, describing what services will be monitored and how they will be monitored. - CCA should update its program charter to include all required Model of Care references for: - Monitoring and risk assessment for conditions listed; - Linkage of initial and ongoing assessments; and - Linkages with PCPs, PCTs, and other appropriate providers. - CCA's readmission prevention program charter should be updated to address ICT planning; involvement of relevant providers and the enrollee; and care planning for needs upon discharge as provided through the Model of Care. - CCA should document how it addresses disease management for the listed conditions through its model of care. CCA should also adopt and disseminate practice guidelines for these conditions and provide formal educational processes for providers on best practices for managing these diseases. - CCA should adopt and disseminate written practice guidelines to providers and develop educational programming for caregivers. - CCA should develop a document that addresses how these specific requirements are met through the implementation of its model of care. - CCA should adopt and disseminate appropriate practice guidelines, develop a process to monitor compliance with guidelines, document how routine assessments identify at-risk enrollees, and document how coordination between the PCP, PCT, and behavioral health provider is facilitated. - CCA should develop, implement, and document a formal program for assessing new technology based on scientific evidence. - CCA should conduct a survey focus group to assess family member and caregiver satisfaction with CCA's program. - CCA should annually evaluate the effectiveness of all health promotion and wellness activities, including their costs, benefits, and lessons learned. - CCA should document a formal process for how non-payment of services related to serious reportable events is ensured. - CCA should develop a formal written protocol for provider profiling activities to include resource utilization, clinical performance measures, interdisciplinary team performance, enrollee experience, and timely access. - Providers should be required to conduct activities to monitor the quality, access, and cost-effectiveness of their services and to identify and address opportunities for improvement on an ongoing basis.

Credentialing

Strengths	▪ CCA initiated efforts in 2017 to address self-identified opportunities for improvement.
Findings	Partially Met: ▪ CCA did not provide evidence of protocols that included a review of enrollee complaints and appeals, results of quality reviews, utilization management activities, and enrollee surveys in the recredentialing process. ▪ While CCA had a nondiscrimination policy, it did not include a reference to nondiscrimination for providers based solely on license or certification. ▪ While CCA indicated that the Board of Registration in Medicine (BORIM) was checked twice per month, no documentation of this verification process was provided. ▪ While CCA indicated a process for ensuring nonpayment to excluded providers, no documented process was in place to address this requirement. Not Met: ▪ CCA did not provide evidence of a process to ensure that nurse practitioner PCPs meet requirements to obtain annual continuing education units in geriatric practice and are certified as geriatric nurse practitioners or have at least two years' experience in the care of persons over age 65. ▪ CCA did not provide evidence of a process to ensure that physician PCPs meet requirements to obtain annual continuing medical units in geriatric practice and have at least two years' experience in the care of persons over age 65. ▪ CCA did not provide evidence of a process to ensure that physician assistants serving as PCPs meet requirements to obtain annual continuing education units in geriatric practice and have at least two years' experience in the care of persons over age 65.

Recommendations	▪ CCA should develop a protocol that includes a review of enrollee complaints and appeals, results of quality reviews, utilization management activities, and enrollee surveys in the recredentialing process. ▪ CCA should update its policy and ensure that its processes do not discriminate against providers based solely on license or certification. ▪ CCA should ensure that, through its ongoing monitoring process, BORIM is checked twice per month and that it documents this in the appropriate policy. ▪ CCA should document a formal process for ensuring nonpayment to excluded providers. ▪ CCA should implement and document a process to ensure that physicians credentialed as PCPs meet requirements to obtain annual continuing education units in geriatric practice and have at least two years' experience in the care of persons over age 65. ▪ CCA should implement and document a process to ensure that nurse practitioners credentialed as PCPs meet requirements to obtain annual continuing education units in geriatric practice and have at least two years' experience in the care of persons over age 65. ▪ CCA should implement and document a process to ensure that physician assistants credentialed as PCPs meet requirements to obtain annual continuing education units in geriatric practice and have at least two years' experience in the care of persons over age 65.

Confidentiality of Health Information

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

Health Information Systems

Strengths	▪ CCA initiated efforts to automate some of its manual processes. ▪ CCA demonstrated efforts to improve encounter data reporting. ▪ CCA had a process for addressing member retention. ▪ Provider data audit processes were enhanced in 2017.
Findings	CCA was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Program Integrity

Strengths	- CCA demonstrated collaboration with its data and clinical teams to address outliers identified as part of data-mining. - CCA staff had easy access to compliance program expectations and information by means of its Compliance Connect landing page on the intranet. - CCA participated in State and health plan meetings to address fraud, waste, and abuse.
Findings	CCA was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

FALLON HEALTH

KEPRO reviewed all documents that were submitted in support of the Compliance Validation process. In addition, KEPRO conducted a site visit on September 13 – 14, 2017.

Enrollee Rights & Protections

Strengths	Fallon Health was fully compliant with this standard.
Findings	Fallon Health 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: ▪ Fallon Health did not provide information to its enrollees on its physician incentive plans during the review period. ▪ Fallon Health did not include language about physician incentive plans upon member request within its member Evidence of Coverage document or through another mechanism. ▪ While Fallon Health demonstrated that it conducted new enrollee orientation during 2016 and had a process to monitor performance, Fallon Health 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. Not Met: ▪ Fallon Health did not have a policy that specifically addressed its process for handling significant changes and its process for notifying members.
Recommendations	▪ Fallon Health needs to develop a significant change policy to address the Federal and State requirements. ▪ Fallon Health needs to include language about physician incentive plans upon member request within its member Evidence of Coverage document or through another mechanism. ▪ Fallon Health needs to implement a process to formally report its adherence rate for providing enrollee orientation within 30 calendar days of the initial date of enrollment.

Availability and Accessibility of Services

Strengths	▪ Fallon Health had a robust provider network with services that supported its SCO membership.
Findings	Partially Met: ▪ Fallon Health did not provide evidence of a policy addressing the requirement to notify EOHHS of provider network changes that impact members' access to services within five business days.
Recommendations	▪ Fallon Health should update the appropriate provider termination policy to include the requirement to notify EOHHS of provider network changes impacting access within five business days.

Coordination and Continuity of Care

Strengths	▪ Fallon demonstrated great efforts to outreach and engage members. ▪ Fallon was timely with completion of member assessment and related reporting. ▪ Fallon initiated an innovative fall prevention pilot program.
Findings	Partially Met: ▪ The Centralized Enrollee Record (CER) included some laboratory and radiology reports but was not all-inclusive. The medical records maintained by the PCP and long-term care facility are considered adjunct to the CER.
Recommendations	▪ Full integration of medical records is an ongoing challenge for SCOs. Fallon Health should continue discussions with MassHealth related to expectations for full data integration.

Coverage and Authorization of Services

Strengths	▪ Fallon Health transitioned information systems that allowed for better documentation of utilization management and care management functions. ▪ Fallon Health demonstrated that its utilization nurse reviewers used information provided by the case managers to address discharge and transition needs.

Findings	Partially Met:
	▪ The denial file letters were reviewed. The denial rationale in the member letters was not easy to understand and included acronyms and medical terminology, such as non-hemorrhagic infarct.
	▪ The Utilization Management Decision Turnaround Time and Notification of Review Decisions policy and procedure includes the requirement to issue a denial for untimely service decisions, affording member appeal rights. During onsite interviews, the plan indicated that untimely service requests are processed as soon as they are identified and that these requests were not denied.
Recommendations	▪ Fallon Health should spell out all acronyms and simplify medical terminology in all member letters. The plan has made changes to implement these strategies in 2017.
	▪ Fallon Health should review and provide training to staff on the Utilization Management Decision Turnaround Time and Notification of Review Decisions policy and procedure.

Practice Guidelines

Strengths	▪ Practice guidelines were disseminated using several mechanisms.
	▪ 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. The Member Journey Mapping was an innovative quality improvement activity to support these efforts.
	▪ Fallon was fully compliant with this standard.
Findings	Fallon was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

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.
	▪ Fallon was fully compliant with this standard.
Findings	Fallon was fully compliant with this standard.

Recommendations	There were no recommendations identified for this standard.

Sub-contractual Relationships and Delegation

Strengths	▪ Fallon's documentation of delegation oversight committee meetings was comprehensive.
Findings	Fallon was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Quality Assessment and Performance Improvement Program

Strengths	▪ Fallon conducted internal surveys of members and caregivers. The survey questions were clear and relevant. ▪ Fallon had good documentation on the State-required quality program initiatives. ▪ Fallon had an innovative program for managing dementia with collaboration with the Alzheimer's Association.
Findings	Partially Met: ▪ In addition to CAHPS, Fallon Health administered member and caregiver surveys with specific questions related to disability and minority status. The results of the surveys, however, were not specifically stratified by non-English speaking, disability, or minority status. ▪ While Fallon Health provided detailed provider profiling reports, no written protocol or policy was in place to comply with the requirements of this element. ▪ Fallon Health did not provide evidence of a written protocol for a corrective action process for providers whose performance was found to be unacceptable in its required provider profiling activities. ▪ While Fallon Health's contract with major providers of services includes requirements to comply with Fallon Health's quality improvement program, it does not specifically require that the provider proactively conduct activities to monitor the quality, access, and cost-effectiveness of their services and to identify and address opportunities for improvement on an ongoing basis.

Recommendations	- Fallon Health should stratify its internal member survey to analyze results specifically for non-English speaking members, those with disabilities, and minorities. - Fallon Health should develop a written protocol for provider profiling activities to include all requirements of this element. - Fallon Health should develop a formal policy with its provider profiling protocol and include corrective actions for providers whose performance is found to be unacceptable. - Providers should be required to conduct activities to monitor the quality, access, and cost-effectiveness of their services and to identify and address opportunities for improvement on an ongoing basis.

Credentialing

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.

Confidentiality of Health Information

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.

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.

SENIOR WHOLE HEALTH

KEPRO reviewed all documents that were submitted by Senior Whole Health (SWH) in support of the Compliance Validation process. In addition, KEPRO conducted a site visit on August 21 – 22, 2017.

Enrollee Rights & Protections

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

Enrollee Information

Strengths	- SWH obtained oral and written language preferences of members during the application process and used these preferences when communicating with members. - SWH had good oversight of its identification card and welcome packet fulfillment vendors. - SWH met call answer timeliness standards during 2016.
Findings	Partially Met: - While SWH demonstrated that it conducted new enrollee orientation during 2016 and had a process to monitor performance, SWH did not have a formal mechanism for monitoring its adherence rate for providing the orientation to enrollees within 30 calendar days of the initial date of enrollment. - SWH had an appropriate policy and practice for handling primary care provider terminations consistent with Federal and State requirements. SWH, however, did not have the same processes in place for the termination of a specialist provider.
Recommendations	- SWH should implement a process to formally report its adherence rate for providing enrollee orientation within 30 calendar days of the initial date of enrollment. In addition, SWH needs to consider formally reporting its results through its committee structure for tracking and trending of its performance. - SWH should expand its existing practice of handling PCP terminations to include a similar process for the termination of specialist providers to meet the more stringent Federal requirement that extends to all providers.

Availability and Accessibility of Services

Strengths	- SWH's 2016 Availability of Network Practitioners Report was comprehensive in evaluating availability and was presented to the Quality Management Committee. - SWH's Network Access Adequacy Report was well-documented to include PCP and high-impact, high-volume, specialty access survey results. - SWH had a comprehensive model of care training document that was used to improve adherence.
Findings	Partially Met: - SWH's Accessibility of Primary Care Services policy complied with requirements for PCPs. However, specialist access standards were not addressed. - While SWH provided evidence that a triage system was in place, there was no policy or document that outlined the availability of a triage system consistent with requirements. - SWH's Access to Clinical Services policy addressed 24/7 availability of utilization management and care management staff. However, there was no documentation that requirements for the on-call skilled health care professional were met. Not Met: - SWH did not provide evidence of notification to EOHHS of significant provider network changes within five business days.
Recommendations	- SWH should update its Accessibility of Primary Care Services policy to include required appointment access standards for specialists. - SWH should update its Clinical Services policy to include a description of the triage system, which reflects the requirements of this element. - SWH should update its Clinical Service policy described above to include the requirements of this element. - SWH should update its appropriate policy to include the requirement to notify EOHHS of significant provider network changes within five business days.

Coordination and Continuity of Care

Strengths	- There was evidence of strong integration and coordination of the medical and behavioral health models, with the co-location of behavioral health and medical nurse care managers. - SWH's documentation within its information system included care management and utilization management services. - SWH had a "low-touch" program focused on outreach to members who had little interaction with the SWH team as a mechanism to offer services and supports to these members.
Findings	Partially Met: SWH did not obtain laboratory or radiology reports to include in the Centralized Enrollee Record (CER).
Recommendations	Full integration of medical records is an ongoing challenge for SCOs. SWH should continue discussions with MassHealth related to expectations for full data integration.

Coverage and Authorization of Services

Strengths	- SWH was NCQA-accredited for both Medicare and Medicaid service lines. - SWH demonstrated congruence between policy and actual operational practice. - SWH's process included a mechanism for its Medical Director to outreach providers for clarity on information, as appropriate, prior to the issuance of a denial, to ensure all information was considered. - SWH demonstrated a comprehensive oversight of its vendors related to utilization management.
Findings	Partially Met: During the onsite review, SWH indicated that buprenorphine/naloxone required prior authorization in 2016.
Recommendations	SWH needs to remove the prior authorization restriction for buprenorphine/naloxone.

Practice Guidelines

Strengths	- SWH used national standards and practice guidelines appropriate to its population. - Community physicians participated in SWH's Medical Advisory Committee. - SWH had member materials that included those developed for low-literacy and had materials translated into its top five prevalent languages.
Findings	SWH was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollment and Disenrollment

Strengths	- SWH's policies and procedures were comprehensive. - SWH was fully compliant with this standard.
Findings	SWH was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Grievance System

Strengths	- SWH had robust reporting of grievance data including year-to-year comparisons and grievance rates per thousand members. - SWH demonstrated compliance with grievance timeliness standards. - SWH implemented a process to conduct internal audits on appeals.

Findings	Partially Met: • While SWH accepted both oral and written grievances during 2016, it did not have a mechanism in place to differentiate the method for type of grievance. • SWH's operational practice was not to require that the member submit an appeal in writing; rather, SWH takes the request for appeal orally and puts the request for appeal into writing on the member's behalf to reduce barriers for members wanting to access the appeals process. SWH's policy, however, did not reflect this process. • A file review of ten cases found that, in general, SWH was compliant with providing grievance resolution to the member within 30 days after receipt of the grievance. There were two cases, however, identified where SWH did not reach a resolution within the required timeframe. • A file review of ten cases revealed that while SWH provided written notification of the appeal disposition to the member, the letters were written about the member versus to the member. • SWH did not require that a member exhaust its internal appeals process before accessing the Board of Hearing review, which was a MassHealth requirement for 2016. In addition, SWH's dental vendor indicated that a written appeal was required as part of its acknowledgement letter, which was inconsistent with SWH's operational practice.
Recommendations	• SWH should implement a process to capture the type of grievance received. • SWH should update its policy and procedure to explicitly state its practice so that it complies with the written requirement. • SWH should continue to monitor its grievance process to ensure that grievances are resolved within 30 days. SWH should consider implementing a quality process for internal review to increase consistency. • SWH needs to reevaluate its appeal disposition letter to ensure that the notice is easily understood and written to the member. • SWH needs to update its policies and procedures to ensure that member appeals follow MassHealth requirements for exhausting SWH's level of appeals. Additionally, SWH needs to work with its dental vendor to remove the language for requiring a written appeal in the acknowledgment letter.

Subcontractual Relationships and Delegation

Strengths	▪ KEPRO noted delegation oversight as a strength of the organization. SWH used Joint Operating Committee meetings with key vendors as a mechanism to ensure oversight. ▪ SWH demonstrated evidence of corrective action plan follow-up and appropriate action being taken by SWH. ▪ SWH's documentation of delegation activities was comprehensive.
Findings	Partially Met: ▪ While SWH described its practice to notify EOHHS on provider agreement and subcontract requirements relating to procurement and reprocurement, readiness transition documentation, terminations, and information related to Minority Business Enterprises, SWH did not have a documented process to supports its operational practice.
Recommendations	▪ SWH needs to develop a policy and procedure that mirrors its operational practice for notifying EOHHS as it relates to provider agreements and subcontracts.

Quality Assessment and Performance Improvement Program

Strengths	▪ SWH had a comprehensive program description and provider evaluation. These documents were well-organized and provided sufficient detail. ▪ SWH conducted a member survey process with large provider groups that provided feedback from members to use to improve quality.

Findings	Partially Met: ▪ SWH's Care Management Evaluation included an assessment of the transitions of care program and member satisfaction with Care Management results. However, no specific results on process or outcomes measures for quality and appropriateness of care for members in Care Management were included in the Care Management Evaluation. ▪ SWH noted that most inpatient hospital admissions were authorized on a retrospective basis. As a result, there was no opportunity to begin or participate in discharge planning at the point of admission. This also prevented the Geriatric Social Support Coordinator, appropriate providers, and the member from being involved in the determination of the appropriate discharge setting. Care planning for services that will be needed upon discharge was not routinely addressed. ▪ SWH has a robust disease management program for congestive heart failure and diabetes in place and documented. Though there were initiatives in place for chronic obstructive pulmonary disease and depression, no formal documentation of these programs were provided. ▪ SWH did not conduct enrollee surveys or focus groups specific to persons with physical disabilities or family members and significant caregivers. ▪ While SWH provided some documentation of its evaluation of individual health promotion and wellness activities, no formal evaluation of the costs, benefits, and lessons learned from these activities as a whole was provided. ▪ SWH did not provide documentation of processes in place to ensure non-payment of serious reportable events. ▪ SWH provided a comprehensive over- and underutilization policy (which actually describes physician profiling activity). Sample provider reports were not completely consistent with policy. Evaluation of interdisciplinary team performance was not accounted for. While enrollee experience with large provider groups was assessed, enrollee experience and perceptions of service delivery were not accounted for in the profiling documentation. ▪ While SWH's contract with major providers of services includes requirements to comply with its quality improvement program, it does not specifically require that the provider proactively conduct activities to monitor the quality, access, and cost-effectiveness of its services and to identify and address opportunities for improvement on an ongoing basis.
Recommendations	▪ SWH should expand its Care Management Evaluation to include

	additional process and outcome measures that reflect the quality and appropriateness of care furnished to these members.
	▪ SWH should make efforts to encourage network hospitals to submit needed authorization information at the point of admission to allow for the plan's involvement in the required discharge planning activities.
	▪ SWH should develop formal disease management documentation and initiatives for chronic obstructive pulmonary disease and depression.
	▪ SWH should conduct separate enrollee surveys or focus groups for the required groups.
	▪ SWH should conduct a formal evaluation of health promotion and wellness activities that includes the costs, benefits, and lessons learned.
	▪ SWH should document a formal process to ensure non-payment of serious reportable events.
	▪ SWH should review and update the profiling policy and procedure for consistency. In addition, evaluation of interdisciplinary team performance should be incorporated in the profiling process.
	▪ Providers should be required to conduct activities to monitor the quality, access, and cost-effectiveness of their services and to identify and address opportunities for improvement on an ongoing basis.

Credentialing

Strengths	■ SWH had comprehensive policies and procedures.
Findings	Partially Met: ■ SWH's Licensed Independent Practitioner Credentialing and Recredentialing policy included nondiscrimination requirements with the exception of nondiscrimination with respect to a medical practitioner who is acting within the scope of his or her license or certification. ■ SWH's Ongoing Monitoring policy specifically stated that excluded providers will be terminated from the provider network. However, the policy did not indicate that the credentialing and recredentialing process is terminated for providers found to be excluded from participation in Federal health care programs. ■ The policies provided by SWH did not include the requirement to notify EOHHS when a provider is terminated, suspended, or declined for termination or suspension from participation in MassHealth, Medicare, or any other state's Medicaid program. ■ SWH Licensed Independent Practitioner Credentialing and Recredentialing policy documents PCP requirements, but there was no process in place to verify experience in the care of persons over age 65 and annual continuing medical units in geriatric practice for physicians acting as PCPs.
Recommendations	■ SWH should update its QM0146 Licensed Independent Practitioner Credentialing and Recredentialing policies to include that practitioners will not be discriminated against with respect to their license or certification. ■ SWH should update its Licensed Independent Practitioner Credentialing and Recredentialing policies to indicate that the credentialing and recredentialing ends and providers are denied or terminated if found to be excluded from Federal health care programs. ■ SWH should develop a policy to include all required provider termination notices to EOHHS. This would include notices for initial credentialing denials as well as ongoing monitoring terminations. ■ SWH should implement a formal process to ensure that physicians serving as PCPs have at least two years' experience in the care of persons over the age of 65 and that these physicians obtain annual continuing medical units in geriatric practice. The attestation process used with nurse practitioners for this purpose could be expanded to the physician population.

Confidentiality of Health Information

Strengths	▪ SWH's Notice of Privacy Practices was easy to understand.
Findings	Partially Met: ▪ SWH's Password Management Policy was documented as last reviewed on 10/08/14. Policy approval was not documented for the Password Management policy and the User Access Control policy.
Recommendations	▪ SWH should ensure that password management policies are reviewed, approved, and documented as such, with continuing annual review, update as needed, and approval documented.

Health Information Systems

Strengths	▪ SWH had a process for contacting members who voluntarily disenrolled to obtain feedback on the reason for disenrollment and to improve member retention. ▪ SHW had efforts underway to improve encounter data submission quality.
Findings	SWH was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Program Integrity

Strengths	▪ SWH's operational dashboard was a good tool for monitoring compliance. ▪ SWH was fully compliant with this standard.
Findings	SWH was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

TUFTS HEALTH PLAN

KEPRO reviewed all documents that were submitted by Tufts Health Plan in support of the Compliance Validation process. In addition, KEPRO conducted a 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 SCO members.
Findings	Tufts was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Availability and Accessibility of Services

Strengths	▪ Tufts had an extensive provider network to serve its population.
Findings	Partially Met: ▪ Tufts' Independent Physician Agreement indicated "If Physician is a PCP who refers a Member to or provides coverage through a physician who has not entered into an agreement with Tufts Health Plan, use best efforts to obtain such physician's agreement to provide Health Services in accordance with Tufts Health Plan's procedures and fee schedule and in accordance with Manuals related to Tufts/SNP Product." Tufts also indicated that it does not use single case agreements as providers are required to accept Medicaid fee-for-service rates. While this may be true for Medicaid covered services, the question of how the enrollee is held harmless for Medicare covered services was not fully addressed. ▪ While Tufts Health Plan's Emergency Conditions and Urgent Care policy noted the required access standards (48 hours and 30 days), the Independent Physician agreement included access standards inconsistent with requirements, stating that preventive visits must be available within 45 days. ▪ Tufts Health Plan's Independent physician agreement indicated that access goals are evaluated annually by plan management and that member concern feedback is provided to physicians. However, no policy on evaluating access compliance and taking corrective action was provided. In addition, no report on provider compliance with access standards was provided. ▪ While the Significant Network Change policy applied to all lines of business, the effective date indicates "TBD." Also, the policy did not include the five-business day notification requirement. Not Met: ▪ Tufts Health Plan's Independent Physician Agreement did not address office hours parity.

Recommendations	▪ Tufts Health Plan should revise its process to address member liability. ▪ Tufts Health Plan should update its Independent Physician Agreement to require preventive visits be available within 30 days. ▪ Tufts Health Plan should update its Provider Agreement and/or Provider Manual to include the provision requiring office hours parity with commercial and Medicaid fee-for-service enrollees. ▪ Tufts Health Plan should develop a policy and implement a process for regularly monitoring provider compliance with access standards and ensure that corrective actions are taken for noncompliant provider. ▪ Tufts Health Plan should update the Significant Network Change policy to include the required notification timeframe and that the policy be approved and assigned an effective date.

Coordination and Continuity of Care

Strengths	▪ Tufts had established relationships with many providers, allowing Tufts to gain access to electronic medical records and embed a care manager at some sites. ▪ Tufts automated several functions that improved efficiency for care managers. ▪ Tufts had demonstrated engagement of its interdisciplinary care teams.
Findings	Partially Met: ▪ The Centralized Enrollee Record (CER) included some laboratory and radiology reports but was not all-inclusive. The medical records maintained by the PCP and long-term care facility were considered adjunct to the CER.
Recommendations	▪ Full integration of medical records is an ongoing challenge for SCOs. Tufts Health Plan should continue discussions with MassHealth related to expectations for full data integration.

Coverage and Authorization of Services

Strengths	▪ Tufts demonstrated coordination between the care management and utilization management teams.
Findings	Partially Met: ▪ The pharmacy team noted buprenorphine/naloxone required prior authorization, as they adhere to the Medicare Part D requirement, to ensure the drug was not being ordered for pain management. Not 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. However, an untimely decision is an adverse action, a denial, and the member must be afforded appeal rights.
Recommendations	▪ Tufts Health Plan should review current prior authorization requirements associated with buprenorphine/naloxone and develop process to remove the requirement to meet State contract requirements. ▪ Tufts Health Plan should review policies related to pre-service organization determinations and revise, as appropriate, to indicate an untimely decision is a denial and the member must be afforded appeal rights. The updated policy should be reviewed with staff.

Practice Guidelines

Strengths	▪ Tufts process for adopting and disseminating practice guidelines was comprehensive.
Findings	Partially Met: ▪ While Tufts Health Plan described processes that ensure that enrollee needs are considered when adopting practice guidelines, this was not documented in the QI Program Plan document cited. ▪ While Tufts Health Plan described that Medical Advisory Committees, including contracting providers, may review practice guidelines, there was no documentation of this process in the QI Program Plan document cited. ▪ While Tufts Health Plan described the process by which providers and enrollees receive guidelines, the QI Program Plan did not specifically address dissemination of guidelines to all affected providers and upon request to enrollees. ▪ While Tufts described informal processes for the consistent application of practice guidelines across Utilization Management decisions and enrollee education, explicit procedures were not provided.
Recommendations	▪ Tufts should update the QI Program Plan to reflect the process by which enrollee needs are considered when adopting practice guidelines. ▪ Tufts should update the QI Program Plan to reflect how contracting providers are consulted for adoption of practice guidelines. ▪ Tufts should document the dissemination of guidelines in the QI Program Plan. ▪ Tufts should document explicit procedures for application of guidelines 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 was compliant with meeting grievance resolution timeframes. - Tufts had a good process for handling quality-of-care grievances by its clinical staff and provided demonstrated thorough research and resolution. - Tufts made several advances to reduce the manual processing of appeals. - Tufts had a good level of understanding of managing appeals based on the service and benefit type.
Findings	Partially Met: The appeals file review showed that when moving an expedited appeal request to a standard review that Tufts did not provide the member with written notification, including the right of the member to file a grievance.
Recommendations	Tufts should implement a process to monitor compliance to ensure that the appropriate notification and grievances rights are provided to the member when an expedited appeal request is moved to the standard timeframe.

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 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:
	- While the QI Program indicated that Tufts incorporates experience from members through member advisory councils or boards, Tufts did not provide minutes from the council meetings to evidence that this input was received. - While the 2016 Corporate QI Program Plan indicated that over- and underutilization are to be monitored and evaluated, no actual report of analysis of over- and underutilization was provided. Med Group Services Funds Reports were provided which include breakdown for provider group by service type, but the title indicates the report relates to the Medicare Preferred product, not the SCO. - Tufts Health Plan's QI Work Plan Evaluation applied to all lines of business. A limited number of items appeared to be related to the SCO product. In addition, the scope of the Evaluation was narrow, e.g. it did not include not include member or provider satisfaction, appeals and grievances, quality of care, credentialing, and UM results. - Tufts Health Plan's Preventive Immunization Policy and Procedure indicated that compliance is monitored in aggregate, by member, and by PCP. However, no evidence of PCP compliance was provided. - Tufts Health Plan's Screening for Early Identification of Cancer Policy and Procedure indicated that compliance is monitored in aggregate, by member, and by PCP. However, no evidence of PCP compliance was provided. - While Tufts Health Plan's Disease Management Policy indicated that compliance with guidelines is measured through monitoring utilization metrics no actual report/analysis of compliance was provided. In addition, outcomes measurement was addressed in the Disease Management Policy, but no actual report was provided. - Tufts Health Plan's Alcohol Abuse and Treatment Policy stated that reports will identify PCPs not in compliance and the Medical Director will outreach to these PCPs. However, no reports or evidence of outreach was provided. In addition, no documentation of coordination between the PCP or PCT and behavioral health providers was provided. - Tufts Health Plan conducted a comprehensive enrollee survey administered, with results stratified by non-English speaking, disabled, and minorities. However, results specific to caregiver were not provided. - Tufts Health Plan's Health Promotion and Wellness Planning and Evaluation Outline did not include costs, benefits, and

	lessons learned for its Health Promotion and Wellness activities.
	▪ Tufts did not provide evidence of provider profiling activities.
	▪ As Tufts did not provide evidence of formal provider profiling activities, no evidence was provided for corrective action.
	▪ Tufts Health Plan lacked evidence of proactively requiring major providers to conduct monitoring activities for quality, access, and cost-effectiveness and to identify and address opportunities for improvement.
Recommendations	▪ Tufts should ensure that member advisory councils are convened regularly and that member input is sought on the quality management program.
	▪ Tufts should implement a formal process for addressing over- and underutilization by service type.
	▪ Tufts should expand its QI Work Plan Evaluation to include the impact and effectiveness of the wider scope of QI activities.
	▪ Tufts should put processes in place to monitor compliance by PCP to be consistent with policy.
	▪ Tufts should put processes to monitor compliance by PCP to be consistent with policy.
	▪ Tufts should measure compliance with guidelines and distributed to PCPs/PCTs and that outcome measures be developed to evaluate the effectiveness of the program.
	▪ Tufts should develop reports of compliance and corrective action taken to be consistent with policy. Tufts should document the process by which coordination between the PCP or PCT and the behavioral health provider is facilitated.
	▪ Tufts should ensure that the family member/ caregiver survey results are reported.
	▪ Tufts should evaluate its Health Promotion and Wellness Activities annually, including the costs, benefits, and lessons learned from its various activities.
	▪ Tufts should develop a formal provider profiling program to address the requirements of this element.
	▪ Tufts should include a corrective action process in its formal provider profiling program.
	▪ Providers should be required to conduct activities to monitor the quality, access, and cost-effectiveness of their services and to identify and address opportunities for improvement on an ongoing basis.

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 of its 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 documentation of a 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.

UNITEDHEALTHCARE

KEPRO reviewed all documents that were submitted by UnitedHealthcare (UHC) in support of the Compliance Validation process. In addition, KEPRO conducted a site visit on August 9 – 10, 2017.

Enrollee Rights & Protections

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

Enrollee Information

Strengths	- UHC demonstrated good processes to meet cultural and linguistic needs of its members. - UHC demonstrated a culture of diversity. - UHC's member materials were easy to understand.
Findings	UHC was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Availability and Accessibility of Services

Strengths	▪ UHC had good policies and procedures related to availability and accessibility of services. ▪ UHC had good analysis of its model of care training completion and interventions to improve annual provider compliance.
Findings	Partially Met: ▪ UnitedHealthcare's Access and Availability of Participating Providers Policy was most recently reviewed on 02/13/2014. ▪ UnitedHealthcare's Cultural Competence Policy, which included the language in this element, was most recently reviewed on 02/14/2014. ▪ UnitedHealthcare's provided documentation did not include time access reports. ▪ UnitedHealthcare's provided documentation did not include evidence of actual reporting on monitoring provider compliance with appointment access and after hours standards and taking corrective action if deficiencies were discovered. ▪ UnitedHealthcare's documentation narrative indicated that the Senior Director of Network Programs notifies EOHHS of terminations as needed. However, no policy regarding significant network terminations with five-day EOHHS notification requirement was provided.
Recommendations	▪ UnitedHealthcare should ensure that the Access and Availability of Participating Providers Policy is reviewed on an annual basis and includes the most current review and approval date. ▪ UnitedHealthcare should ensure that the Cultural Competence Policy is reviewed on an annual basis and includes the most current review. ▪ UnitedHealthcare should produce geo-access time access reports to meet this requirement. ▪ UnitedHealthcare should develop a formal report of the annual results of the appointment access and afterhours analysis and include corrective actions taken for deficiencies discovered. ▪ UnitedHealthcare should develop a policy that includes notification to EOHHS within five business days of any significant provider network changes, e.g. changes that affect enrollee access to covered services.

Coordination and Continuity of Care

Strengths	- UHC's care management model supported meeting its members' needs. - UHC demonstrated good engagement of field staff to make linkage of services seamless to members.
Findings	Partially Met: - UnitedHealthcare did not have a policy that includes notification to EOHHS within five business days for any significant provider network changes, e.g. changes that affect enrollee access to covered services. - A review of UnitedHealthcare's process showed that when the care manager was notified of emergency service utilization, appropriate provider notification was completed. However, the care manager was usually not notified of emergency service utilization timely. Reports of emergency utilization represent claims data. - During onsite interviews, staff indicated that there were limited lab and radiology results in the CER. The customary medical record is the adjunct to the CER and is maintained with the PCP or long-term care facility. The care manager's records are inclusive to the long-term care facility files.
Recommendations	- At minimum, the care management system should include an indicator verifying the member's (or member's representative) agreement with the plan of care and the option to receive a written copy upon request. - UnitedHealthcare should develop a policy that includes notification to EOHHS within five business days for any significant provider network changes, e.g. changes that affect enrollee access to covered services. - UnitedHealthcare should identify opportunities to partner with participating providers for notification of member emergency visits, such as a daily log. - While full integration of medical records is an ongoing challenge for SCOs, the current CER portal access afforded to providers allows all data accessible to the care managers. UnitedHealthcare should continue discussions with MassHealth related to expectations for full data integration.

Coverage and Authorization of Services

Strengths	- The file reviews demonstrated timeliness of utilization management decisions and appropriate decision-making by appropriate professionals. - UHC had a process for nurse reviewers to outreach a provider to provide advance notice of a potential adverse decision.
Findings	Partially Met: - UnitedHealthcare's policy included the required language documented in the State-specific contract requirements: "An untimely service decision constitutes a denial and is thus an adverse action." During the onsite discussions, the utilization management staff indicated they would work as expeditiously as possible on any service authorization requests that were not timely; however, they would not issue an adverse determination. Not Met: - During the onsite visit, the formulary was reviewed with the Lead Pharmacist and, during the review period, there was evidence of prior authorization requirements for buprenorphine/naloxone.
Recommendations	- UnitedHealthcare needs to ensure that the current policy reflects the Federal requirement that considered a non-timely organization determination to result in an adverse determination that affords a member his/her appeal rights. In addition, UnitedHealthcare needs to provide training to all utilization management staff about decisions not reached within the specified timeframes. - UnitedHealthcare needs to ensure that a prior authorization requirement for buprenorphine/naloxone is removed.

Practice Guidelines

Strengths	- UHC's practice to provide its local medical director an opportunity to identify the need of population-specific clinical practice guidelines in addition to national accepted guidelines was identified as a best practice. - UHC's adopted clinical practice guidelines correlated with the prevalent conditions noted in UHC's Model of Care.
Findings	UHC was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Enrollment and Disenrollment

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

Grievance System

Strengths	- UHC's processes for handling grievance and appeals was mature and robust. - UHC's written communication to members related to grievance and appeals were member-focused and easy-to-read and understand.
Findings	UHC was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Subcontractual Relationships and Delegation

Strengths	UHC had limited delegation due to its use of its sister-organization for behavioral health, dental, pharmacy, and vision services.
Findings	Partially Met: While UnitedHealthcare used monthly operations meetings as a mechanism for monitoring ongoing delegate performance, UnitedHealthcare did not have a formal delegation committee in place during 2016. UnitedHealthcare lacked clear responsibility within its committee structure for delegation oversight.
Recommendations	UnitedHealthcare needs to either implement a delegation oversight committee or revise its process to delineate responsibility for delegated entity oversight.

Quality Assessment and Performance Improvement Program

Strengths	- UHC had involvement from its Clinical Practice Consultants and Chief Medical Officer with provider groups. - UHC had a HEDIS Toolkit for provider education on recommended screenings and treatment. - UHC's model of care evaluation included several key metrics analyzed with barriers and interventions. The evaluation also described its Care Transitions Workgroup to align processes and documentation across UnitedHealthcare and delegated entities responsible for managing members. - UHC had a program description documented for its Initiative to Reduce Preventable Hospital Admissions. In addition, UHC's Transfer Alternative Program of retrospective review of hospital admissions was used to gain information on barriers and inform future interventions. - Provider profiling was comprehensive and involved review by the Chief Medical Officer for physicians above 95th or below 5th percentile.

Findings	Partially Met:
	■ UHC's evidence of enrollee input into the quality management program was limited. While UHC's Consumer Advisory Council met throughout the 2016 year, input on quality program could have been expanded.
	■ While utilization by service type was reported to the Utilization Management Committee (UMC), no evidence of presenting potential underutilization using quality measures (e.g. HEDIS rates) was presented.
	■ UHC lacked evidence demonstrating the measurement and distribution of reports relating to compliance with practice guidelines.
	■ UHC's policy did not include either evidence of processes to ensure timely nursing facility services or state specifically that discharge planning begins upon admission.
	■ UHC's link for practice guideline to treat abuse and neglect of enrollees and evaluate effectiveness of interventions on the provider website was not operational.
	■ While UHC reported comprehensive CAHPS survey results, there was evidence of specific results for the four groups listed.
	■ While UHC's QI Work Plan does include individual health promotion and wellness activities, no formal evaluation of the activities specifying costs, benefits, and lessons learned was provided.
	■ UHC's Provider Profiling Policy and Provider Profile Sample Report were comprehensive, with the exception of including the following provider–level components: interdisciplinary team performance, enrollee experience, perceptions of service delivery, and timely access.

Recommendations	- UHC should ensure that enrollee input on quality programs is addressed in its Consumer Advisory Council agenda. - In addition to utilization by service type, UHC should consider reporting aggregate HEDIS rates to the UMC to identify and develop corrective action for potential underutilization. - UHC should measure and distribute compliance with dementia practice guidelines to appropriate providers on an annual basis. - UHC should update its policy to include processes to ensure timely nursing facility services when necessary and that discharge planning begins upon admission to the institution. - UHC should update its link to treat abuse and neglect guidelines on its provider website. - UHC should either conduct separate surveys or conduct focus groups for the required groups or stratify the CAHPS results for these groups. - UHC should develop an evaluation of all health promotion and wellness activities that includes costs, benefits, and lessons learned. - UHC should add interdisciplinary team performance, enrollee experience, perceptions of service delivery, and timely access to the provider profile.

Credentialing

Strengths	- UHC had a comprehensive credentialing plan. - UHC was fully compliant with the file review.
Findings	Partially Met: - UHC's documentation did not provide evidence of including review of enrollee complaints and appeals, utilization management information or enrollee survey information on recredentialing. - UHC lacked evidence of notification to EOHHS when providers are terminated, suspended, or declined because of the reasons described or for any other independent action. - UHC's documentation complied with all requirements with the exception that two of ten recredentialing files reviewed were not completed within the 36-month timeframe requirement.

Recommendations	- UHC needs to revise its Credentialing Policy to include a review of enrollee complaints and appeals, utilization management, and enrollee survey information on recredentialing. - UHC needs to revise its Provider Sanctions Monitoring Procedure to include the requirement to notify EOHHS of terminations, suspensions, or denials for the indicated reasons. - UHC needs to ensure its recredentialing process adheres to the 36-month timeframe requirement.

Confidentiality of Health Information

Strengths	- UHC's documentation was comprehensive. - UHC was fully compliant with this standard.
Findings	UHC was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Health Information Systems

Strengths	- UHC's documentation was comprehensive. - UHC was fully compliant with this standard.
Findings	UHC was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.

Program Integrity

Strengths	- UHC had a robust fraud, waste, and abuse, and prevention program. - UHC demonstrated both a broad corporate/national and State focus. - UHC had good presence of compliance at the State level, with a local compliance officer and open lines of communication, including UHC's Compliance Corner communications.
Findings	UHC was fully compliant with this standard.
Recommendations	There were no recommendations identified for this standard.