

---

TECHNICAL REPORT

# Senior Care Organizations External Quality Review

Calendar Year 2020



**MassHealth**

Massachusetts Executive Office  
of Health & Human Services



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

# Table of Contents

<b>1</b>	<b>Section 1. MassHealth's Senior Care Organizations .....6</b>
	Plan Descriptions..... 6
	MassHealth Senior Care Organization Membership ..... 8
<b>2</b>	<b>Section 2. Executive Summary.....10</b>
	Scope of the External Quality Review Process ..... 10
	Performance Measure Validation & Information Systems Capability Assessment ..... 11
	Performance Improvement Project Validation ..... 12
	Compliance Validation ..... 14
	Network Adequacy Validation ..... 16
	Quality Strategy Evaluation - Forthcoming..... 16
	High-Level Recommendations..... 17
<b>3</b>	<b>Section 3: Performance Measure Validation .....20</b>
	Methodology ..... 20
	Comparative Analysis..... 21
	Results ..... 31
	Information Systems Capability Assessment..... 32
	Plan-Specific Performance Measure Validation ..... 34
<b>4</b>	<b>Section 4: Performance Improvement Project Validation .....81</b>
	The Performance Improvement Project Life Cycle ..... 81
	Performance Improvement Project Topics..... 83
	Comparative Analysis..... 84
	Plan-Specific Performance Improvement Project Results ..... 86
	Domain 1: Behavioral Health..... 87
	Domain 2: Chronic Disease Management Performance Improvement Projects ..... 107
<b>5</b>	<b>Section 5: Compliance Validation.....126</b>
	Introduction..... 126
	SCO Compliance Validation Results ..... 129

Aggregate SCO Observations and Recommendations .....	130
SCO-Specific Compliance Validation Results .....	132

## **6 Section 6: Network Adequacy Validation ..... 146**

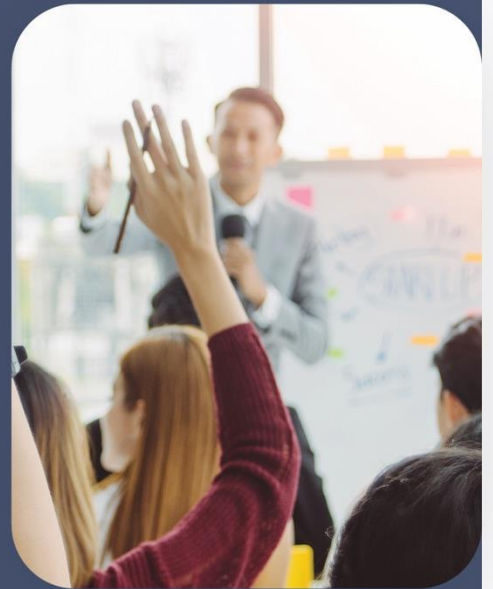
Introduction .....	146
Request of Plan.....	146
Time and Distance Standards.....	148
Evaluation Method .....	150
Results by Plan.....	151
Conclusion.....	156

## **A Appendix. Contributors ..... 159**

## Section 1:

# Introduction

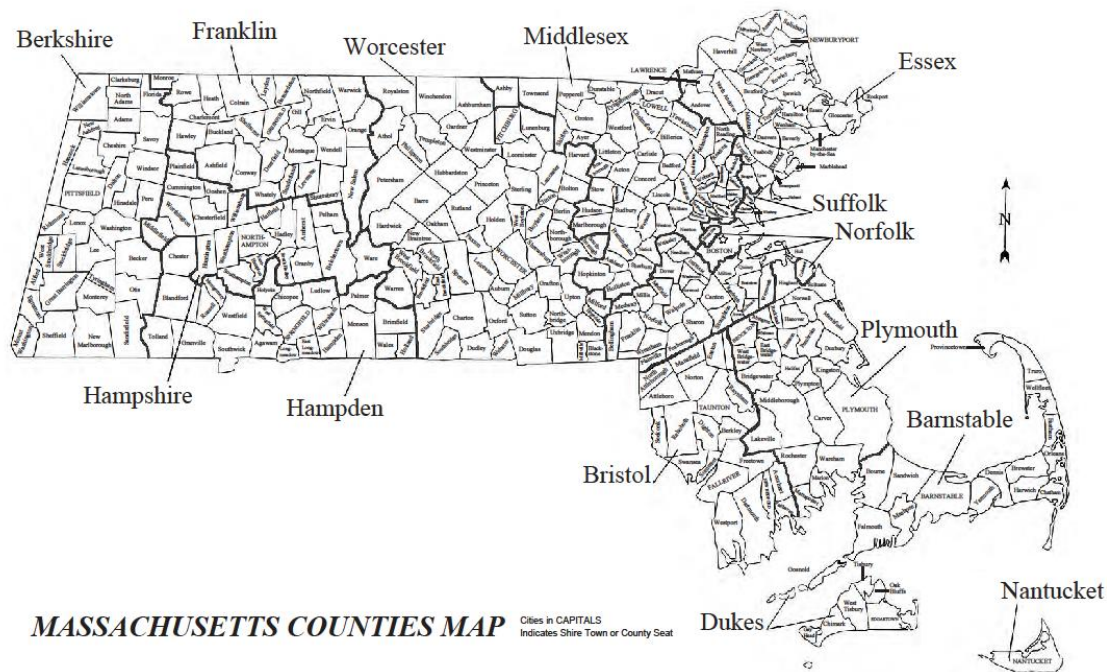
---



# SECTION 1. MASSHEALTH'S SENIOR CARE ORGANIZATIONS

Descriptions of MassHealth's Senior Care Organizations follow. A Massachusetts Counties Map is provided for your reference.<sup>1</sup>

Exhibit 1.1. County Map



## PLAN DESCRIPTIONS

### Boston Medical Center HealthNet Plan (BMCHP)

BMCHP HealthNet's Senior Care Organization is a local coordinated care program (CCP) located in Charlestown, Massachusetts. Its corporate parent is Boston Medical Center Health System, Inc. Its enrollment area includes Barnstable, Bristol, Hampden, Plymouth, and Suffolk counties. As a relatively new SCO, it has not been assigned a Star rating by CMS due to lack of adequate information. Beacon Health Options is BMCHP's behavioral health partner. Additional information is available at [www.seniorsgetmore.org](http://www.seniorsgetmore.org).

### Commonwealth Care Alliance (CCA)

Commonwealth Care Alliance is a community-based, not-for-profit healthcare organization headquartered in Boston. Its service area includes all cities and towns in Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. It

<sup>1</sup> Source: <https://www.doe.mass.edu/resources/countymap.pdf>

received 4.5 out of 5 possible stars for 2021, according to the U.S. Centers for Medicare & Medicaid Services Star Ratings. More information about CCA is available at [www.commonwealthcare.org](http://www.commonwealthcare.org).

### **Fallon Health (FH)**

Navicare, Fallon Health's Senior Care Organization, has a service area that includes the entire state of Massachusetts, with the exception of Berkshire, Dukes, and Nantucket Counties. It received a 4.5 star rating by CMS. Fallon's behavioral health partner is Beacon Health Options. Its corporate offices are located in Worcester. Additional information is available at [www.fchp.org/find-insurance/navicare](http://www.fchp.org/find-insurance/navicare).

### **Senior Whole Health (SWH)**

Senior Whole Health's corporate offices are located in Cambridge. It was acquired by its corporate parent, Magellan Complete Care, in 2017. It operates in Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. Its health plan is accredited by the National Committee on Quality Assurance for both Medicaid and Medicare and received a 4.0 Star Rating from CMS. Additional information is available at [www.seniorwholehealth.com](http://www.seniorwholehealth.com).

### **Tufts Health Plan (THP)**

Tufts Health Plan Senior Care Plan is operated by Tufts Health Plan, Inc., a not-for-profit organization headquartered in Watertown. Beneficiaries in all Massachusetts counties are eligible to enroll with the exception of residents of Berkshire, Dukes, Franklin, and Nantucket counties. CMS has assigned a 5-star rating to this plan. More information is available at [tuftshealthplan.com/provider/our-plans/tufts-health-plan-senior-care-options](http://tuftshealthplan.com/provider/our-plans/tufts-health-plan-senior-care-options).

### **UnitedHealthcare (UHC)**

Headquartered in Waltham, the Senior Care Option plan is part of UHC's Community Plan line of business. Beneficiaries in Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties are eligible to enroll. It has received a 5-star rating from CMS. Its behavioral health partner is OPTUM Health. Additional information is available at [www.uhccommunityplan.com](http://www.uhccommunityplan.com).

## MASSHEALTH SENIOR CARE ORGANIZATION MEMBERSHIP

Exhibit 1.2. 2019 MassHealth SCO Membership

Senior Care Organization	Abbreviation Used in this Report	Membership as of December 31, 2019 <sup>[1]</sup>	Percent of Total SCO Population
UnitedHealthcare	UHC	21,094	32.98%
Senior Whole Health	SWH	15,299	23.92%
Commonwealth Care Alliance	CCA	11,397	17.82%
Tufts Health Plan	THP	7,564	11.83%
Fallon Health	Fallon	7,100	11.10%
BMCHP HealthNet	BMCHP	1,503	2.35%
<b>Total</b>		<b>63,957</b>	<b>100.00%</b>

<sup>[1]</sup> SCO-reported membership figures



Section 2:

# Executive Summary

---



## SECTION 2. EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 was an omnibus legislative package enacted by the United States Congress with the intent of balancing the federal budget by 2002. Among its other provisions, this expansive bill authorized states to provide Medicaid benefits (except to 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 plans to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a managed care plan or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth has entered into an agreement with Kepro to perform EQR services for its contracted managed care entities.

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

### SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

Kepro conducted the following external quality review activities for MassHealth Senior Care Organizations (SCOs) in the CY 2020 review cycle:

- Validation of three performance measures, including an Information Systems Capability Assessment;
- Validation of two Performance Improvement Projects (PIPs);
- Validation of compliance with Medicaid managed care regulations and related contractual requirements; and
- Validation of network adequacy.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2020 reflect 2019 quality measurement performance. Performance Improvement Project reporting is inclusive of activities conducted in CY 2020.

The Massachusetts Senior Care Organization plans include Boston Medical Center HealthNet Plan, the Commonwealth Care Alliance, Fallon Health, Senior Whole Health, Tufts Health Plan, and UnitedHealthcare.

## PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

### Exhibit 2.1: Performance Measure Validation Process Overview

Topic	Description
Objectives	To assess the accuracy of performance measures in accordance with 42 CFR § 438.358(b)(ii) reported by the managed care plan and to determine the extent to which the managed care plan follows state specifications and reporting requirements.
Technical methods of data collection and analysis	Kepro's Lead Performance Measure Validation Auditor conducted this activity in accordance with 42 CFR § 438.358(b)(ii).
Data obtained	Each Senior Care Organization submitted its HEDIS Final Audit Report, the NCQA Roadmap, the plans' NCQA IDSS worksheets, and follow-up documentation as requested by the auditor.
Conclusions	Kepro's validation review of the selected performance measures indicates that SCO measurement and reporting processes were fully compliant with specifications and were methodologically sound.

The Performance Measure Validation process assesses the accuracy of performance measures reported by the managed care plan. It determines the extent to which the managed care plan follows state specifications and reporting requirements. In 2020, Kepro conducted Performance Measure Validation in accordance with CMS EQR Protocol 2 on three measures that were selected by MassHealth and Kepro. The measures validated were as follows:

- Medication Reconciliation Post-Discharge (MRP);
- Colorectal Cancer Screening (COL); and
- Antidepressant Medication Management – Effective Acute Phase Treatment (AMM)

The focus of the Information Systems Capability Assessment 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.

In early 2020, CMS suspended SCO HEDIS 2020 reporting, indicating that CMS was committed to allowing health plans, providers, and physician offices to focus on caring for beneficiaries during the COVID-19 pandemic. For the purposes of 2020 SCO Performance Measure Validation, MassHealth directed Kepro to validate three HEDIS 2019 measures that had not been validated in the prior year.

## PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Topic	Description
Objectives	To assess overall project methodology as well as the overall validity and reliability of the Performance Improvement Project (PIP) methods and findings to determine confidence in the results.
Technical methods of data collection and analysis	Performance Improvement Projects were validated in accordance with § 438.330(b)(i).
Data obtained	Senior Care Organizations submitted two PIP reports in 2020, the Final Implementation Progress Report (March 2020) and the Final Implementation Annual Report (September 2020). They also submitted related supporting documentation.
Conclusions	Based on its review of 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 the evaluation of intervention effectiveness.

MassHealth SCOs conduct two contractually required Performance Improvement Projects (PIPs) annually. In accordance with Appendix L of the contract EOHHS holds with the SCO plans, SCOs must propose to MassHealth one PIP from each of the two domains:

- Domain 1: Behavioral Health – Promoting well-being through prevention and treatment of mental illness, including substance use and other dependencies.
- Domain 2: Chronic Disease Management -- Providing services and assistance to Enrollees with or at risk for specific diseases and/or conditions.

In late-2017, the plans submitted proposed topics for three-year projects to MassHealth for its review and approval and initiated their implementation in 2018. The plans' work on these projects continued through 2020, the third of the three-year quality cycle.

In Calendar Year 2020, Senior Care Organizations continued the implementation of the following Performance Improvement Projects begun in 2018:

**Domain 1: Behavioral Health**

- Improving SCO Member Access to Behavioral Health Depression Services (BMCHP);
- Cognitive Impairment and Dementia: Detection and Care Improvement (CCA);
- Increasing Rates of Follow-Up After Hospitalization for Mental Illness Among Fallon Enrollees (Fallon);
- Improving Treatment for Depression (Senior Whole Health);
- Decrease Readmissions to Inpatient Behavioral Health Facilities by Better Managing Transitions of Care (Tufts Health Plan); and
- Improving Antidepressant Medication Management (AMM) for Members Diagnosed with Depression (UnitedHealthcare).

**Domain 2: Chronic Disease Management**

- Improving Health Outcomes for SCO Members with Diabetes (BMCHP);
- Increasing the Rate of Annual Preventive Dental Care Visits among CCA Senior Care Options Members (CCA);
- Increasing the Rate of Retinal Eye Exams among Diabetic Fallon Enrollees (Fallon);
- Cardiac Disease Management (Senior Whole Health);
- Reducing the Chronic Obstructive Pulmonary Disease (COPD) Admission Rate through Identification and Management of COPD And Co-Morbid Depression (Tufts Health Plan); and
- Improving SCO Member Adherence to Medication Regimens for Managing Their Diabetes (UnitedHealthcare).

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

## COMPLIANCE VALIDATION

### Exhibit 2.3. Compliance Validation Process Overview

Topic	Description
Objectives	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 comply with quality standards mandated by the Balanced Budget Act of 1997 (BBA). Also considered is compliance with related sections of the plans' contracts with CMS and MassHealth.
Technical methods of data collection and analysis	Kepro conducted a desk review of documentation submitted by the SCOs. Clarification was obtained at a follow-up site visit. Results were compared to regulatory and contractual requirements.
Data obtained	The SCOs submitted evidence of compliance including, but not limited to, policies and procedures; standard operating procedures; workflows; desk tools; reports; member materials; care management files; utilization management denial files; appeals files; grievance files; and credentialing files.
Conclusions	<p>In general, the SCOs demonstrated strong models of care supporting the overarching goals of coordinated care for SCO members. High performance among all SCOs in coordination and continuity of care along with practice guidelines, quality assessment, and performance improvement standards suggests that the SCOs performed best in the area of quality care.</p> <p>In general, the SCOs' greatest opportunity for improvement is related to the accessibility of care standards. SCOs have opportunities to improve mechanisms to access network adequacy across all service categories as well as appointment access to determine if there are deficiencies.</p>

The mandatory compliance validation protocol is used to determine, in a manner consistent with standard industry practices, the extent to which Medicaid managed care entities are in compliance with quality standards mandated by the Balanced Budget Act of 1997 (BBA). Also considered is compliance with related sections of the plans' contracts with CMS and MassHealth. The validation process is conducted triennially.

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

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

Kepro compliance reviewers performed desk review of all documentation provided by the plans. In addition, two-day on-site visits were conducted to interview key plan personnel, review selected case files, participate in systems demonstrations, and allowed for further clarification/provision of documentation.

An overall percentage compliance score for each of the 14 standards was calculated based on the total points scored divided by total possible points. In addition, an overall percentage compliance score for all fourteen standards combined was calculated. All plans' scores were above 95%, BMCHP having the highest score (98.9%) and CCA the lowest (96.1%). Due to the unique needs of the SCO population, a heavy emphasis was placed on the coordination and continuity of care standard during the review. In general, the SCOs demonstrated strong models of care supporting the overarching goals of coordinated care for SCO members. SCOs performed best in the area of quality of care. SCOs' greatest opportunity for improvement is related to the accessibility of care standards.

The plans were required to submit a corrective action plan (CAP) for each area identified as Partially Met or Not Met in a format agreeable to MassHealth.

## NETWORK ADEQUACY VALIDATION

### Exhibit 2.4. Network Adequacy Validation Process Overview

Topic	Description
Objectives	The Network Adequacy Validation process assesses a managed care plan's compliance with the time and distance standards established by MassHealth. CMS has not published a formal protocol for this external quality review activity.
Technical methods of data collection and analysis	Quest Analytics enterprise network adequacy validation solution was used to compile and analyze network information provided by the Senior Care Organizations.
Data obtained	SCOs provided Excel worksheets containing demographic information about their provider network.
Conclusions	Senior Care Organizations demonstrated fairly high compliance with Medicare Advantage time and distance and provider to member ratio requirements. UnitedHealthcare was in full compliance. The other plans have opportunities for improvement, the most significant of which is non-compliance by BMCHP with acute inpatient hospital requirements in Hampden County.

For the first year of network validation activities, the technical report focuses specifically on plan adequacy with regard to Medicare Advantage network standards. KEPRO is currently assessing compliance with Medicaid Network Adequacy standards and related reporting will be posted to the MassHealth website when it becomes available.

Senior Care Organizations demonstrated many network strengths. Certain specialties, such as Chiropractic Care and Psychiatry, excelled in all SCO plan analysis. Primary Care for adults excelled in all plans and areas except one county.

## QUALITY STRATEGY EVALUATION

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

The first MassHealth Quality Strategy was published in 2006. An updated version, the MassHealth Comprehensive Quality Strategy, focused not only on fulfilling managed care quality requirements but on improving the quality of managed care services in Massachusetts,



was submitted to CMS in November 2018. As is required by CMS, the strategy will be updated in 2021 and will be made available to the public on the MassHealth website.

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

## **HIGH-LEVEL RECOMMENDATIONS**

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

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

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

Kepro found some providers with de-activated NPI numbers were in the managed care plan provider directory as evidenced by a search on the plan's website. While not of a significant number, Kepro suggests that network adequacy validation be expanded to include validation of provider directory information.

### **2. Require managed care plans to conduct closer oversight of network adequacy and availability.**

Not directly related to the Quality Strategy, but fundamental to the delivery of quality, accessible, and timely care, network adequacy is a foundation of managed care. Across all managed care plans, Kepro did not find strong evidence of processes for evaluating appointment access against the MassHealth standards for services such as symptomatic and non-symptomatic office visits and urgent care. Managed care plans lacked a process to address appointment access concerns with providers. While accessibility of services is an opportunity for improvement for all managed care plans, Kepro found that plans were not completely clear on the expectations for access to services related to compliance thresholds. Kepro recommends that MassHealth more closely monitor network oversight activities.

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

MassHealth's Quality Strategy puts forth a focus on quality improvement activities related to chronic disease management and behavioral health. An analysis undertaken by Kepro showed a correlation between a strong project management approach and an improvement in project performance indicators. To ensure that the investment in PIP-related resources is sound, Kepro recommends that MassHealth continue to require that managed care plans conduct well-executed projects. Kepro welcomes the opportunity to continue to provide managed care plan project-based staff with technical assistance, especially as it relates to the measurement of intervention effectiveness.

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

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

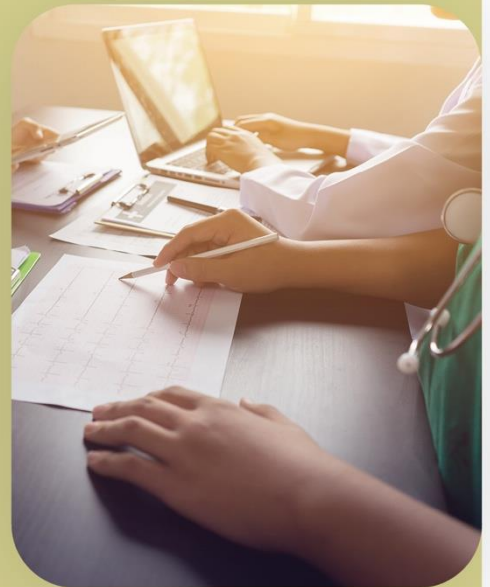
**5. Improve the quality of race, ethnicity, and language data provided to the managed care plans.**

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

**Section 3:**

# **Performance Measure Validation**

---



## SECTION 3: PERFORMANCE MEASURE VALIDATION

### METHODOLOGY

The Performance Measure Validation process assesses the accuracy of performance measures reported by the managed care plan. It determines the extent to which the managed care plan follows state specifications and reporting requirements. In addition to validation processes and the reported results, Kepro evaluates performance 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.

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

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

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

In early-2020, CMS determined that the COVID-19 pandemic was affecting key aspects of HEDIS hybrid data collection. The collection of medical records was compromised by the plan's inability to access charts from provider offices for abstraction due to nationwide social-distancing requirements. CMS therefore lifted the requirement for the submission of HEDIS data and the associated Compliance Audits by Medicare Advantage plans. For the purposes of 2020 Performance Measure Validation, MassHealth directed Kepro to validate three 2019 measures that had not been validated previously. Kepro's Lead Reviewer recommended the validation of the following measures:

### Exhibit 3.1. 2020 SCO Validated Performance Measures

Measure	Measure Description	Rationale for Selection
Medication Reconciliation Post-Discharge (MRP);	The percentage of discharges from January 1-December 1 for members 18 years of age or older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).	There was more variation in plan performance for this pharmacy-related measure than <i>Pharmacotherapy Management of COPD</i> .
Colorectal Cancer Screening (COL);	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	COL is the only cancer screening measure reported by Senior Care Organizations.
Antidepressant Medication Management – Effective Acute Treatment (AMM)	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported, i.e., Effective Acute Treatment and Effective Continuous Treatment.	The numerator for <i>Effective Acute Treatment</i> is a more difficult metric to meet than that for <i>Continuous Treatment</i> .

Kepro's Senior Care Organization PMV audit methodology assesses both the quality of the source data that feed into the PMV measure under review and the accuracy of the calculation. Source data review includes evaluating the plan's data management structure, data sources, and data collection methodology. Measure calculation review includes reviewing the logic and analytic framework for determining the measure numerator, denominator, and exclusion cases, if applicable.

## COMPARATIVE ANALYSIS

The tables that follow contain the criteria by which performance measures are validated as well as Kepro's determination as to whether the plans met these criteria. Results are presented for both plans reviewed to facilitate comparison across plans. In 2020, Kepro validated three measures that were recommended by the Lead Performance Measurement Validation Reviewer. The results of the validation follow.

## Exhibit 3.2. Performance Measure Validation Results

### Medication Reconciliation Post-Discharge (MRP)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid			
Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
DENOMINATOR						
Population						
SCO population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members 18 years and older as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Enrollment from the date of discharge through 30 days after discharge (31 total days).	Met	Met	Met	Met	Met	Met
An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays. 2. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.	Met	Met	Met	Met	Met	Met
Geographic Area						
Includes only those enrollees served in SCO’s reporting area.	Met	Met	Met	Met	Met	Met
NUMERATOR						
Counting Clinical Events						
Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).	Met	Met	Met	Met	Met	Met
Data sources used to calculate the numerators (e.g., claims files, medical records, provider 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
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
<u>Data Quality</u>						
Based on the IS assessment findings, the data sources used 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
<u>Proper Exclusion Methodology in Administrative Data</u>						
<p>If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), count only the last discharge. To identify readmissions and direct transfers during the 31-day period:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).</li> <li>2. Identify the admission date for the stay (the admission date must occur during the 31-day period).</li> <li>3. Identify the discharge date for the stay (the discharge date is the event date).</li> </ol> <p>Exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after December 1 of the measurement year.</p> <p>If the admission date and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge.</p> <p>To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).</li> <li>2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).</li> <li>3. Identify the admission date for the stay.</li> <li>4. Identify the discharge date for the stay.</li> </ol> <p>To identify nonacute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).</li> <li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set).</li> <li>3. Identify the admission date for the stay.</li> <li>4. Identify the discharge date for the stay.</li> </ol>	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
<u>Hybrid Measure</u>						
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
If the hybrid method was used, the SCO passed the NCQA Final Medical Record Review Overread component of the HEDIS 2019 Compliance Audit.	Met	Met	Met	Met	Met	Met
<b>SAMPLING</b>						
<u>Unbiased Sample</u>						
As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met	Met	Met	Met	Met
<u>Sample Size</u>						
After exclusions, the sample size was equal to 1) 411, 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or 3) the total population.	Met	Met	Met	Met	Met	Met
<u>Proper Substitution Methodology in Medical Record Review</u>						
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors, if applicable.	Met	Met	Met	Met	Met	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met	Met	Met	Met	Met



## Colorectal Cancer Screening (COL)

Methodology for Calculating Measure	Administrative	Medical Record Review	Hybrid
-------------------------------------	----------------	-----------------------	--------

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
<b>DENOMINATOR</b>						
<u>Population</u>						
SCO/OneCare population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members 51-75 years of age or older as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Members were continuously enrolled during the measurement year and the year prior to the measurement year, with no more than a one-month gap in either year. Members must also be enrolled on December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
<u>Geographic Area</u>						
Includes only those Medicaid enrollees served in SCO/OneCare's reporting area.	Met	Met	Met	Met	Met	Met
<b>NUMERATOR</b>						
<u>Counting Clinical Events</u>						
Data sources used to calculate the numerators (e.g., claims files, medical records, provider 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
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met	Met	Met	Met	Met
One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following: <ul style="list-style-type: none"> <li>• FOBT during the measurement year.</li> <li>• Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.</li> <li>• Colonoscopy during the measurement year or the nine years prior to the measurement year.</li> <li>• CT colonography during the measurement year or the four years prior to the measurement year.</li> <li>• FIT-DNA during the measurement year or the two years prior to the measurement year.</li> </ul>	Met	Met	Met	Met	Met	Met
<u>Data Quality</u>						
Based on the IS assessment findings, the data sources used were accurate.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
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
<i>Proper Exclusion Methodology in Administrative Data</i>						
Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: <ul style="list-style-type: none"> <li>Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.</li> <li>Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.</li> </ul>	Met	Met	Met	Met	Met	Met
Optional Exclusion: Either of the following any time during the member's history through December 31 of the measurement year: <ul style="list-style-type: none"> <li>Colorectal cancer</li> <li>Total colectomy</li> </ul>	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
<p>Exclude members who meet any of the following criteria:</p> <ul style="list-style-type: none"> <li>Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet <i>both</i> of the following frailty and advanced illness criteria to be excluded: <ul style="list-style-type: none"> <li>At least one claim/encounter for frailty during the measurement year.</li> <li>Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> <li>At least two outpatient visits, observation visits, ED visits, nonacute inpatient encounters or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: <ol style="list-style-type: none"> <li>Identify all acute and nonacute inpatient stays.</li> <li>Confirm the stay was for nonacute care based on the presence of a nonacute code on the claim.</li> <li>Identify the discharge date for the stay.</li> </ol> </li> <li>At least one acute inpatient encounter with an advanced illness diagnosis.</li> <li>At least one acute inpatient discharge with an advanced illness diagnosis. To identify an acute inpatient discharge: <ol style="list-style-type: none"> <li>Identify all acute and nonacute inpatient stays.</li> <li>Exclude nonacute inpatient stays.</li> <li>Identify the discharge date for the stay.</li> </ol> </li> <li>A dispensed dementia medication.</li> </ul> </li> </ul> <p>Members 81 years of age and older as of December 31 of the measurement year with frailty during the measurement year.</p> </li></ul>	Met	Met	Met	Met	Met	Met

<u>Hybrid Measure</u>						
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
If the hybrid method was used, the SCO passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit.	Met	Met	Met	Met	Met	Met
<b>SAMPLING</b>						
<u>Unbiased Sample</u>						
As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met	Met	Met	Met	Met
<u>Sample Size</u>						
After exclusions, the sample size was equal to 1) 411, 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or 3) the total population.	Met	Met	Met	Met	Met	Met
<u>Proper Substitution Methodology in Medical Record Review</u>						
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors, if applicable.	Met	Met	Met	Met	Met	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met	Met	Met	Met	Met

## Antidepressant Medication Management (AMM): Effective Acute

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid
--------------------------------------	----------------	-----------------------	--------

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
<b>DENOMINATOR</b>						
<u>Population</u>						
SCO/OneCare population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Population was defined as being eligible and having an episode start date for depression during the intake period of 5/1/PY-4/30/MY.	Met	Met	Met	Met	Met	Met
Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication during the Intake Period.	Met	Met	Met	Met	Met	Met
<u>Geographic Area</u>						
Includes only those enrollees served in the SCO's reporting area.	Met	Met	Met	Met	Met	Met
<u>Age &amp; Sex:</u>						
<u>Enrollment Calculation</u>						
Members were 18 years of age or older as of April 30 of the measurement year.	Met	Met	Met	Met	Met	Met
Members must be continuously enrolled from 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD. Members must also be enrolled on the IPSD.	Met	Met	Met	Met	Met	Met
<u>Data Quality</u>						
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
<u>Proper Exclusion Methodology in Administrative</u>						
Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
<p>Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:</p> <ul style="list-style-type: none"> <li>• An acute or nonacute inpatient stay with any diagnosis of major depression on the discharge claim. To identify acute and nonacute inpatient stays:</li> <li>• Identify all acute and nonacute inpatient stays.</li> <li>• Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.</li> <li>• An acute inpatient encounter with any diagnosis of major depression.</li> <li>• A nonacute inpatient encounter with any diagnosis of major depression.</li> <li>• An outpatient visit with any diagnosis of major depression.</li> <li>• An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression.</li> <li>• A community mental health center visit with any diagnosis of major depression.</li> <li>• Electroconvulsive therapy with any diagnosis of major depression.</li> <li>• Transcranial magnetic stimulation visit with any diagnosis of major depression.</li> <li>• A telehealth visit with any diagnosis of major depression.</li> <li>• An observation visit <i>with</i> any diagnosis of major depression.</li> <li>• An ED visit <i>with</i> any diagnosis of major depression.</li> <li>• A telephone visit <i>with</i> any diagnosis of major depression.</li> </ul>	Met	Met	Met	Met	Met	Met
<b>NUMERATOR</b>						
<u>Administrative Data: Counting Clinical Events</u>						
At least 84 days of treatment with antidepressant medication, beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met	Met	Met	Met	Met
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

## RESULTS

Medication Reconciliation Post-Discharge (MRP). The chart that follows depict MassHealth SCO performance on the Medication Reconciliation Post-Discharge rate.

Exhibit 3.3. 2018 MRP Rates of MassHealth SCOs

SCO	HEDIS 2019	CMS SNP Public Use File Percentile Comparison
BMCHP	73.7%	Between 70 and 75
CCA	70.8%	Between 65 and 70
Fallon	87.0%	Between 90 and 95
SWH	67.7%	Between 60 and 65
THP	59.4%	Between 45 and 50
UHC	53.5%	Between 30 and 35

Colorectal Cancer Screening (COL). The chart that follows depict MassHealth SCO performance on the Colorectal Cancer Screening rate.

Exhibit 3.4. 2018 Colorectal Cancer Screening Rates of MassHealth SCOs

SCO	HEDIS 2019	CMS SNP Public Use File Percentile Comparison
BMCHP	68.5%	Between 25 and 30
CCA	80.4%	Between 75 and 80
Fallon	66.1%	Between 20 and 25
SWH	84.0%	Between 85 and 90
THPP	75.8%	Between 55 and 60
UHC	82.5%	Between 80 and 85

Antidepressant Medication Management – Acute Treatment Phase (AMM). The chart that follows depict MassHealth SCO performance on the Antidepressant Medication Management – Acute Treatment Phase rate.

**Exhibit 3.5. 2018 Antidepressant Medication Management – Acute Treatment Phase (AMM) of MassHealth SCOs**

<b>SCO</b>	<b>HEDIS 2019</b>	<b>CMS SNP Public Use File Percentile Comparison</b>
BMCHP	62.5%	Between 10 and 15
CCA	72.7%	Between 60 and 65
Fallon	71.7%	Between 50 and 55
SWH	80.7%	Between 85 and 90
THPP	63.8%	Between 15 and 20
UHC	68.6%	Between 35 and 40

**INFORMATION SYSTEMS CAPABILITY ASSESSMENT**

CMS regulations require that each managed care plan 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. All SCOs' information systems were found to be compliant with the criteria as described in the table that follows.



### Exhibit 3.6. Information Systems Capability Assessment Findings

Criterion	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 from the HEDIS auditor	Acceptable	Acceptable	Acceptable	Acceptable	Acceptable	Acceptable

## PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION

### Performance Measure Summaries

Kepro has leveraged CMS Worksheet 2.14, A Framework for Summarizing Information About Performance Measures, from EQR Protocol 2, to report managed care plan-specific 2020 performance measure validation activities. As is required by CMS, Kepro has identified managed care plan and project strengths as evidenced through the validation process as well as follow up to 2020 recommendations. Kepro's Lead Performance Measure Validation Auditor assigned a validation confidence rating that refers to Kepro's overall confidence that the calculation of the performance measure adhered to acceptable methodology.

### BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

#### 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Boston Medical Center HealthNet Plan</b>
Performance measure name: <b>Medication Reconciliation Post-Discharge (MRP)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) Denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges between January 1 – December 1 of the measurement year for members 18 years of age and older
Definition of numerator (describe): The number of discharges between January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results (If measure contains more than one rate, add columns to the table)

Numerator	115
Denominator	156
Rate	73.72%

## 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p><b>Claims and Encounter Data.</b> 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. 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.</p> <p><b>Enrollment Data.</b> 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.</p> <p><b>Supplemental Data.</b> BMCHP used a lab results supplemental data source for HEDIS reporting.</p> <p><b>Data Integration.</b> 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 Inovalon. There were no issues identified with data integration processes.</p> <p><b>Source Code.</b> BMCHP used NCQA-certified Inovalon HEDIS software to produce performance measures. Inovalon received NCQA measure certification to produce the MRP performance measure. There were no source code issues identified.</p> <p><input type="checkbox"/> Not applicable (ISCA not reviewed)</p>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>Medical record review data were collected using Inovalon's data abstraction tools for hybrid measure abstraction. BMCHP monitored the accuracy of its internal chart abstraction work during the abstraction time period. No issues were identified with medical record review.</p>

<input type="checkbox"/> Not applicable (medical record review not conducted)
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence   <input type="checkbox"/> Moderate confidence   <input type="checkbox"/> Low confidence   <input type="checkbox"/> No confidence</p>
<p>EQRO recommendations for improvement of performance measure calculation:</p> <p>BMCHP used supplemental data for lab results only. BMCHP should use additional supplemental data sources in future reporting years to potentially improve HEDIS reporting rates.</p>

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Boston Medical Center HealthNet Plan</b>
Performance measure name: <b>Colorectal Cancer Screening (COL)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) Denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  BMCHP adhered to NCQA sampling specifications. Due to the small number of numerator-positive events, each of the 55 medical records was reviewed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50–75 years of age
Definition of numerator (describe): The number of members 50–75 years of age who received appropriate screening for colorectal cancer.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	37
<b>Denominator</b>	54
<b>Rate</b>	68.52%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**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. 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.

**Supplemental Data.** BMCHP used a lab results supplemental data source 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 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 COL performance measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

Medical record review data were collected using Inovalon's data abstraction tools for hybrid measure abstraction. BMCHP monitored the accuracy of its internal chart abstraction work during the abstraction time period. No issues were identified with medical record review.

☐ Not applicable (medical record review not conducted)

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

None identified.

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence  
"Validation rating" refers to the EQRO's overall confidence that the calculation of the performance measure adhered to acceptable methodology.

EQRO recommendations for improvement of performance measure calculation:

Develop and begin quality improvement initiatives for the *Colorectal Cancer Screening* measure on which BMCHP scored below the CMS SNP Public Use File benchmark data 30th percentile.

BMCHP used supplemental data for lab results only. BMCHP should use additional supplemental data sources in future reporting years to potentially improve HEDIS reporting rates.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Boston Medical Center HealthNet Plan</b>
Performance measure name: <b>Antidepressant Medication Management (AMM) Effective Acute Treatment</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression
Definition of numerator (describe): The number of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results (If measure contains more than one rate, add columns to the table)

<b>Numerator</b>	5
<b>Denominator</b>	8
<b>Rate</b>	62.50%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**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. 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.

**Supplemental Data.** BMCHP used a lab results supplemental data source 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 the AMM performance measure. Inovalon received NCQA measure certification to produce the performance measures under the scope of this review. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Develop and begin quality improvement initiatives for the *Antidepressant Medication Management (AMM): Effective Acute Phase Treatment* measure on which BMCHP scored below the CMS SNP Public Use File benchmark data 15th percentile.

BMCHP used supplemental data for lab results only. BMCHP should use additional supplemental data sources in future reporting years to potentially improve HEDIS reporting rates.

## Plan Strengths

BMCHP's *Medication Reconciliation Post-Discharge* measure scored above the CMS SNP HEDIS Public Use File benchmark data 70th percentile.



### Follow Up to Calendar Year 2019 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2019 PMV recommendation follows:

Calendar Year 2019 Recommendation	2020 Update
Implement quality improvement initiatives for the Controlling High Blood Pressure and Use of High-Risk Medications in the Elderly measures.	BMCHP was unable to implement initiatives to improve CBP and DDA/DDE rates in 2020 due to demands related to member and provider COVID-19-needs.
To improve reporting rates, Kepro recommends the use of supplemental data sources in addition to laboratory data.	This recommendation stands.

## COMMONWEALTH CARE ALLIANCE (CCA)

Managed Care Plan (MCP) name: <b>Commonwealth Care Alliance (CCA)</b>
Performance measure name: <b>Medication Reconciliation Post-Discharge (MRP)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older.
Definition of numerator (describe): The number of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

### 2. Performance Measure Results

<b>Numerator</b>	291
<b>Denominator</b>	411
<b>Rate</b>	70.80%

### 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**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 were submitted. CCA's Pharmacy Benefit Manager, Navitus Health Solutions, fully met standards in the processing of pharmacy data for the plan. There were no issues identified with claims or encounter data processing.

**Enrollment Data.** CCA enrollment data is housed in the Market Prominence system. All necessary enrollment fields are captured for HEDIS reporting. CCA had adequate processes for data quality monitoring and reconciliation. The plan had processes to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

**Supplemental Data.** CCA successfully used supplemental data for HEDIS reporting. CCA provided complete supplemental data documentation and no concerns were identified.

**Data Integration.** CCA'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. CCA maintains adequate oversight of 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 COL performance measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

Medical record review data for the *Medication Reconciliation Post-Discharge* measure were collected by CCA using Inovalon medical record abstraction tools. All tools and training materials were compliant with 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.

☐ Not applicable (medical record review not conducted)

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

None.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Commonwealth Care Alliance (CCA)</b>
Performance measure name: <b>Colorectal Cancer Screening (COL)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50–75 years of age
Definition of numerator (describe): The number of members 50–75 years of age who received appropriate screening for colorectal cancer
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	217
<b>Denominator</b>	270
<b>Rate</b>	80.37%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**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 were submitted. CCA's Pharmacy Benefit Manager, Navitus Health Solutions, fully met standards in the processing of pharmacy data for the plan. There were no issues identified with claims or encounter data processing.

**Enrollment Data.** CCA enrollment data is housed in the Market Prominence system. All necessary enrollment fields are captured for HEDIS reporting. CCA had adequate processes for data quality monitoring and reconciliation. The plan had processes to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

**Supplemental Data.** CCA successfully used supplemental data for HEDIS reporting. CCA provided complete supplemental data documentation and no concerns were identified.

**Data Integration.** CCA'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. CCA maintains adequate oversight of 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 COL performance measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

Medical record review data for the *Colorectal Cancer Screening* measure were collected by CCA using Inovalon medical record abstraction tools. All tools and training materials were compliant with 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.

☐ Not applicable (medical record review not conducted)

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

None.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Commonwealth Care Alliance (CCA)</b>
Performance measure name: <b>Antidepressant Medication Management (AMM) Effective Acute Treatment</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression
Definition of numerator (describe): The number of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	208
<b>Denominator</b>	286
<b>Rate</b>	72.73%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**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 were submitted. CCA's Pharmacy Benefit Manager, Navitus Health Solutions, fully met standards in the processing of pharmacy data for the plan. There were no issues identified with claims or encounter data processing.

**Enrollment Data.** CCA enrollment data is housed in the Market Prominence system. All necessary enrollment fields are captured for HEDIS reporting. CCA had adequate processes for data quality monitoring and reconciliation. The plan had processes to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

**Supplemental Data.** CCA successfully used supplemental data for HEDIS reporting. CCA provided complete supplemental data documentation and no concerns were identified.

**Data Integration.** CCA'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. CCA maintains adequate oversight of 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 AMM performance measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

None identified.

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence  
"Validation rating" refers to the EQRO's overall confidence that the calculation of the performance measure adhered to acceptable methodology.

EQRO recommendations for improvement of performance measure calculation:

None identified.

### Plan Strengths

- CCA's Colorectal Cancer Screening rate is above the CMS SNP Public Use File benchmark data 75th percentile.
- CCA used supplemental data for HEDIS reporting.

### Follow Up to Calendar Year 2019 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2019 PMV recommendation follows:

Calendar Year 2019 Recommendation	2020 Update
Implement quality improvement initiatives to increase the Use of High-Risk Medications in the Elderly rate.	<ul style="list-style-type: none"><li>• CCA instituted a Drug Utilization Review (DUR) process at the point of sale which flags high-risk medication use for appropriateness review by the community pharmacist.</li><li>• In 2020, CCA developed a population health program for polypharmacy-high risk medications focusing on multiple anticholinergic and neuroleptic medications. CCA provides data to network providers to support their own internal processes for decreasing the use of high-risk medications.</li><li>• CCA's Medication Therapy Management vendor assesses high risk medications at each comprehensive medication review (CMR).</li></ul>

---



## FALLON HEALTH

### 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Fallon Health (Navicare)</b>
Performance measure name: <b>Medication Reconciliation Post-Discharge (MRP)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older
Definition of numerator (describe): The number of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

### 2. Performance Measure Results

<b>Numerator</b>	87
<b>Denominator</b>	100
<b>Rate</b>	87.00%

### 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**Claims and Encounter Data.** Fallon's claims were processed using the QNXT system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Fallon 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. Fallon received encounters on a daily basis from its Pharmacy Benefit Manager (PBM), CVS. The plan maintained adequate oversight of CVS. There were no issues identified with claims or encounter data processing. Fallon used Beacon as its vendor to handle the processing of behavioral health claims. Beacon captured all required fields for claims processing and only accepted standard codes on standard claims forms. Fallon had adequate oversight of Beacon.

**Enrollment Data.** Fallon processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. There were adequate data quality monitoring and reconciliation processes, including the ability to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

**Supplemental Data.** Fallon successfully used supplemental data sources for HEDIS 2019 reporting. Fallon provided complete supplemental data documentation. There were no issues with the supplemental data used to produce HEDIS performance measures.

**Data Integration.** Fallon's performance measures were produced using Cotiviti software. Cotiviti-compliant extracts were produced from the plan's data warehouse. Cotiviti then loaded the data and produced rates for the plan's review and approval. Data transfers to the Cotiviti repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. Fallon maintained adequate oversight of its vendor, Cotiviti. There were no issues identified with data integration processes.

**Source Code.** Fallon used NCQA-certified Cotiviti HEDIS software to produce performance measures. Fallon received NCQA measure certification to produce the MRP performance measure.

☐ Not applicable (ISCA not reviewed)

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

Fallon used Cotiviti medical record abstraction tools to conduct medical record review. All tools and training materials were compliant with HEDIS technical specifications. Fallon 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 for the two hybrid PMV measures under review.

☐ Not applicable (medical record review not conducted)

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

None identified

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Fallon Health</b>
Performance measure name: <b>Colorectal Cancer Screening (COL)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50–75 years of age
Definition of numerator (describe): The number of members 50–75 years of age who received appropriate screening for colorectal cancer.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	234
<b>Denominator</b>	354
<b>Rate</b>	66.10%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**Claims and Encounter Data.** Fallon's claims were processed using the QNXT system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Fallon 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. Fallon received encounters on a daily basis from its Pharmacy Benefit Manager (PBM), CVS. The plan maintained adequate oversight of CVS. There were no issues identified with claims or encounter data processing. Fallon used Beacon Health Options as its vendor to handle the processing of behavioral health claims. Beacon captured all required fields for claims processing and only accepted standard codes on standard claims forms. Fallon had adequate oversight of Beacon.

**Enrollment Data.** Fallon processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. There were adequate data quality monitoring and reconciliation processes, including the ability to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

**Supplemental Data.** Fallon successfully used supplemental data sources for HEDIS 2019 reporting. Fallon provided complete supplemental data documentation. There were no issues with the supplemental data used to produce the HEDIS performance measures.

**Data Integration.** Fallon's performance measures were produced using Cotiviti software. Cotiviti-compliant extracts were produced from the plan's data warehouse. Cotiviti then loaded the data and produced rates for the plan's review and approval. Data transfers to the Cotiviti repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. Fallon maintained adequate oversight of Cotiviti. There were no issues identified with data integration processes.

**Source Code.** Fallon used NCQA-certified Cotiviti HEDIS software to produce performance measures. Fallon received NCQA measure certification to produce the COL performance measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

Fallon used Cotiviti medical record abstraction tools to conduct medical record review. All tools and training materials were compliant with HEDIS technical specifications. Fallon 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.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Fallon's performance on the Colorectal Cancer Screening measure was below the 25th percentile compared to the CMS SNP HEDIS Public Use File benchmark data. Kepro recommends that Fallon consider implementing quality improvement initiatives to improve this rate.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Fallon Health</b>
Performance measure name: <b>Antidepressant Medication Management (AMM) Effective Acute Treatment</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression.
Definition of numerator (describe): The number of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	124
<b>Denominator</b>	173
<b>Rate</b>	71.68%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**Claims and Encounter Data.** Fallon's claims were processed using the QNXT system. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Fallon 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. Fallon received encounters on a daily basis from its Pharmacy Benefit Manager (PBM), CVS. The plan maintained adequate oversight of CVS. There were no issues identified with claims or encounter data processing. Fallon used Beacon Health Options as its vendor to handle the processing of behavioral health claims. Beacon captured all required fields for claims processing and only accepted standard codes on standard claims forms. Fallon had adequate oversight of Beacon.

**Enrollment Data.** Fallon processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. There were adequate data quality monitoring and reconciliation processes, including the ability to combine data for members with more than one member ID. There were no issues identified with enrollment processes.

**Supplemental Data.** Fallon successfully used supplemental data sources for HEDIS 2019 reporting. Fallon provided complete supplemental data documentation. There were no issues with the supplemental data used to produce the AMM HEDIS performance measure.

**Data Integration.** Fallon's performance measures were produced using Cotiviti software. Cotiviti-compliant extracts were produced from the plan's data warehouse. Cotiviti then loaded the data and produced rates for the plan's review and approval. Data transfers to the Cotiviti repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. Fallon maintained adequate oversight of Cotiviti. There were no issues identified with data integration processes.

**Source Code.** Fallon used NCQA-certified Cotiviti HEDIS software to produce performance measures. Fallon received NCQA measure certification to produce the AMM performance measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## Plan Strengths

- Fallon's performance on the *Medication Reconciliation Post-Discharge* measure was above the CMS SNP HEDIS Public Use File benchmark data 90th percentile.
- Fallon used supplemental data for HEDIS reporting.

### **Follow Up to Calendar Year 2019 Recommendations**

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2019 PMV recommendation follows:

<b>Calendar Year 2019 Recommendation</b>	<b>2020 Update</b>
Implement quality improvement initiatives to increase the Use of High-Risk Medications in the Elderly rate.	Fallon’s Quality Management and Clinical teams identified the ten most frequently prescribed high-risk medications. The Quality team conducted prescriber outreach asking them to consider either discontinuing the medication or prescribing an alternative, safer drug. The Pharmacy program also instituted prior authorization requirements on the identified medication.

## SENIOR WHOLE HEALTH (SWH)

### 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Senior Whole Health</b>
Performance measure name: <b>Medication Reconciliation Post-Discharge (MRP)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older
Definition of numerator (describe): The number of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

### 2. Performance Measure Results

<b>Numerator</b>	285
<b>Denominator</b>	411
<b>Rate</b>	69.34%

### 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---



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

**Claims and Encounter Data.** SWH used the QNXT system to process claims. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. SWH had adequate processes to monitor claims data quality and claims data completeness. Pharmacy encounters containing standard codes were received on a weekly basis from the plan's Pharmacy Benefit Manager (PBM), Express Scripts. The plan maintained adequate oversight of the PBM. There were no issues identified with claims or encounter data processing. SWH used Beacon Health Options as its vendor to handle the processing of behavioral health claims. Beacon Health Options captured all required fields for claims processing and only accepted standard codes on standard claims forms. SWH had adequate oversight of Beacon Health Options.

**Enrollment Data.** SWH processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. 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. There were no issues identified with enrollment processes.

**Supplemental Data.** SWH successfully used both standard and nonstandard supplemental data sources for HEDIS 2019 reporting. There were no issues with the 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.

**Source Code.** SWH used NCQA-certified DST HEDIS software to produce performance measures. DST received NCQA measure certification to produce the COL performance measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

Medical record review data were collected by Health Data Vision (HDVI). HDVI's training materials and processes were compliant with the HEDIS technical specifications. No issues were identified with medical record review.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Senior Whole Health</b>
Performance measure name: <b>Colorectal Cancer Screening (COL)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50–75 years of age
Definition of numerator (describe): The number of members 50–75 years of age who received appropriate screening for colorectal cancer.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	346
<b>Denominator</b>	411
<b>Rate</b>	84.18%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**Claims and Encounter Data.** SWH used the QNXT system to process claims. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. SWH had adequate processes to monitor claims data quality and claims data completeness. Pharmacy encounters containing standard codes were received on a weekly basis from the plan's Pharmacy Benefit Manager (PBM), Express Scripts. The plan maintained adequate oversight of the PBM. There were no issues identified with claims or encounter data processing. SWH used Beacon Health Options as its vendor to handle the processing of behavioral health claims. Beacon Health Options captured all required fields for claims processing and only accepted standard codes on standard claims forms. SWH had adequate oversight of Beacon Health Options.

**Enrollment Data.** SWH processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. 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. There were no issues identified with enrollment processes.

**Supplemental Data.** SWH successfully used both standard and nonstandard supplemental data sources for HEDIS 2019 reporting. There were no issues with the 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.

**Source Code.** SWH used NCQA-certified DST HEDIS software to produce performance measures. DST received NCQA measure certification to produce the COL measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Senior Whole Health</b>
Performance measure name: <b>Antidepressant Medication Management (AMM) Effective Acute Treatment</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression
Definition of numerator (describe): The number of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	243
<b>Denominator</b>	335
<b>Rate</b>	72.54%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**Claims and Encounter Data.** SWH used the QNXT system to process claims. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. SWH had adequate processes to monitor claims data quality and claims data completeness. Pharmacy encounters containing standard codes were received on a weekly basis from the plan's Pharmacy Benefit Manager (PBM), Express Scripts. The plan maintained adequate oversight of the PBM. There were no issues identified with claims or encounter data processing. SWH used Beacon Health Options as its vendor to handle the processing of behavioral health claims. Beacon Health Options captured all required fields for claims processing and only accepted standard codes on standard claims forms. SWH had adequate oversight of Beacon Health Options.

**Enrollment Data.** SWH processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. 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. There were no issues identified with enrollment processes.

**Supplemental Data.** SWH successfully used both standard and nonstandard supplemental data sources for HEDIS 2019 reporting. There were no issues with the 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.

**Source Code.** SWH used NCQA-certified DST HEDIS software to produce performance measures. DST received NCQA measure certification to produce the AMM performance measure. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

### Plan Strengths:

- SWH's Colorectal Cancer Screening measure scored above the 85th percentile compared to the CMS SNP HEDIS Public Use File benchmark data.
- SWH's Antidepressant Medication Management (AMM): Effective Acute Phase Treatment measure scored above the 85th percentile compared to the CMS SNP HEDIS Public Use File benchmark data.
- SWH used an NCQA-certified vendor.

### **Follow Up to Calendar Year 2019 Recommendations**

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2019 PMV recommendation follows:

<b>Calendar Year 2019 Recommendation</b>	<b>2020 Update</b>
Implement quality improvement initiatives to increase the Use of High-Risk Medications in the Elderly rate.	Tufts implemented steps to capture more related data.

---

## TUFTS HEALTH PLAN (THP)

### 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Tufts Health Plan</b>
Performance measure name: <b>Medication Reconciliation Post-Discharge</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges between January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Definition of numerator (describe): The number of discharges between January 1–December 1 of the measurement year for members 18 years of age and older.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

### 2. Performance Measure Results

Numerator	244
Denominator	411
Rate	59.37%

### 3. Performance Measure Validation Status

<p>Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).</p> <p>None identified.</p>
<p>Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.</p> <p><b>Claims and Encounter Data.</b> THP processed claims using the Diamond system. 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 processed all claims within Diamond except for pharmacy claims which were handled by THP's pharmacy benefit manager, CVS Health. 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.</p> <p><b>Enrollment Data.</b> THP used Market Prominence and Diamond to process the enrollment data. Both systems captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.</p> <p><b>Supplemental Data.</b> 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.</p> <p><b>Data Integration.</b> All performance measure rates were produced internally by THP using internally developed source code. Data from the transaction system was loaded into THP's data warehouse, Red Brick, which was 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 the comparison to prior year populations and rates for reasonability. There were no issues identified with data integration processes.</p> <p><b>Source Code.</b> THP produced performance measures using internally developed source code. The source code was compliant with the HEDIS technical specifications.</p> <p><input type="checkbox"/> Not applicable (ISCA not reviewed)</p>
<p>Describe any findings from medical record review that affected the reliability or validity of the performance measure results.</p> <p>THP used internally developed abstraction tools and training manuals for the hybrid measures. THP's abstraction tools and training manual were compliant with the 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 medical record review.</p> <p><input type="checkbox"/> Not applicable (medical record review not conducted)</p>
<p>Describe any other validation findings that affected the accuracy of the performance measure calculation.</p> <p>None identified.</p>
<p>Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence</p>



EQRO recommendations for improvement of performance measure calculation:

Tufts' performance on the *Medication Reconciliation Post-Discharge* measure scored below the 50th percentile compared to the CMS SNP HEDIS Public Use File benchmark data. Kepro recommends that Tufts initiate related quality improvement initiatives.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Tufts Health Plan</b>
Performance measure name: <b>Colorectal Cancer Screening (COL)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50–75 years of age
Definition of numerator (describe): The number of members 50–75 years of age who had appropriate screening for colorectal cancer
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	254
<b>Denominator</b>	335
<b>Rate</b>	75.82%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**Claims and Encounter Data.** THP processed claims using the Diamond system. 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 processed all claims within Diamond except for pharmacy claims which were handled by THP's pharmacy benefit manager, CVS Health. 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 the enrollment data. Both systems captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.

**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 was loaded into THP's data warehouse, Red Brick, which was 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 the comparison to prior year populations and rates for reasonability. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

THP used internally developed abstraction tools and training manuals for the hybrid measures. THP's abstraction tools and training manual were compliant with the 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 medical record review.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>Tufts Health Plan</b>
Performance measure name: <b>Antidepressant Medication Management (AMM) Effective Acute Treatment</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression
Definition of numerator (describe): The number of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	67
<b>Denominator</b>	105
<b>Rate</b>	63.81%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**Claims and Encounter Data.** THP processed claims using the Diamond system. 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 processed all claims within Diamond except for pharmacy claims which were handled by THP's pharmacy benefit manager, CVS Health. 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 the enrollment data. Both systems captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.

**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 was loaded into THP's data warehouse, Red Brick, which was 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 the comparison to prior year populations and rates for reasonability. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Tufts scored below the 20th percentile compared to the CMS SNP HEDIS Public Use File benchmark data on the *Antidepressant Medication Management (AMM): Effective Acute Phase Treatment* measure. Kepro recommends that Tufts initiate related quality improvement initiatives.

## Plan Strengths

- THP used supplemental data for HEDIS reporting.

### Follow Up to Calendar Year 2019 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2019 PMV recommendation follows:

Calendar Year 2019 Recommendation	2020 Update
Implement quality improvement initiatives to increase the Use of High-Risk Medications in the Elderly rate.	THP focused its efforts on improving data capture.

---

## UNITEDHEALTHCARE (UHC)

### 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>UnitedHealthcare</b>
Performance measure name: <b>Medication Reconciliation Post-Discharge (MRP)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older
Definition of numerator (describe): The number of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

### 2. Performance Measure Results

<b>Numerator</b>	220
<b>Denominator</b>	411
<b>Rate</b>	53.53%

### 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**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 OptumBehavioralHealth as its vendor to handle the processing of behavioral health claims. OptumBehavioralHealth captured all required fields for claims processing and only accepted standard codes on standard claims forms. UHC had adequate oversight of OptumBehavioralHealth 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 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.

**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.

**Data Integration.** UHC's performance measures were produced using Inovalon software. 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 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. UHC maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

**Source Code.** UHC used NCQA-certified Inovalon HEDIS software to produce performance measures. Inovalon received NCQA measure certification to produce the MRP rate. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

Medical record review data were collected using Change HealthCare's data abstraction tools and training materials for hybrid measure abstraction. Change HealthCare's tools and training manual were compliant with the HEDIS technical specifications. UHC monitored results from Change HealthCare 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 medical record review.

☐ Not applicable (medical record review not conducted)

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

None identified.

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



EQRO recommendations for improvement of performance measure calculation:

UHC's performance on the *Medication Reconciliation Post-Discharge* measure was below the 35th percentile compared to CMS SNP HEDIS Public Use File benchmark data. Kepro recommends that UHC consider the development of related quality improvement initiatives.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>UnitedHealthcare</b>
Performance measure name: <b>Colorectal Cancer Screening (COL)</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) A random sample of denominator-positive medical records <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  NCQA hybrid systematic sampling methodology with NCQA hybrid sample size reduction logic was followed.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50–75 years of age
Definition of numerator (describe): The number of members 50–75 years of age who had appropriate screening for colorectal cancer.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results (If measure contains more than one rate, add columns to the table)

<b>Numerator</b>	339
<b>Denominator</b>	411
<b>Rate</b>	82.48%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**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 OptumBehavioralHealth as its vendor to handle the processing of behavioral health claims. OptumBehavioralHealth captured all required fields for claims processing and only accepted standard codes on standard claims forms. UHC had adequate oversight of OptumBehavioralHealth 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 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.

**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.

**Data Integration.** UHC's performance measures were produced using Inovalon software. 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 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. UHC maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

**Source Code.** UHC used NCQA-certified Inovalon HEDIS software to produce performance measures. Inovalon received NCQA measure certification to produce the COL rate. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

Medical record review data were collected using Change HealthCare's data abstraction tools and training materials for hybrid measure abstraction. Change HealthCare's tools and training manual were compliant with the HEDIS technical specifications. UHC monitored results from Change HealthCare 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 medical record review for the COL measure.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>UnitedHealthcare</b>
Performance measure name: <b>Antidepressant Medication Management (AMM) – Effective Acute Treatment</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression
Definition of numerator (describe): The number of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication for at least 84 days (12 weeks).
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2018 – December 31, 2018

## 2. Performance Measure Results

<b>Numerator</b>	326
<b>Denominator</b>	475
<b>Rate</b>	68.63%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
---

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

**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 OptumBehavioralHealth as its vendor to handle the processing of behavioral health claims. OptumBehavioralHealth captured all required fields for claims processing and only accepted standard codes on standard claims forms. UHC had adequate oversight of OptumBehavioralHealth 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 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.

**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.

**Data Integration.** UHC's performance measures were produced using Inovalon software. 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 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. UHC maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

**Source Code.** UHC used NCQA-certified Inovalon HEDIS software to produce performance measures. Inovalon received NCQA measure certification to produce the AMM rate. There were no source code issues identified.

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

UHC's performance on the *Antidepressant Medication Management (AMM): Effective Acute Phase Treatment* measure was below the 40th percentile compared to CMS SNP HEDIS Public Use File benchmark data. Kepro recommends that UHC consider the development of related quality improvement initiatives.

### Plan Strengths

- UHC's *Colorectal Cancer Screening* measure scored above the 80th percentile compared to CMS SNP HEDIS Public Use File benchmark data.
- UHC used supplemental data for HEDIS reporting.

### Follow Up to Calendar Year 2019 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2019 PMV recommendation follows:

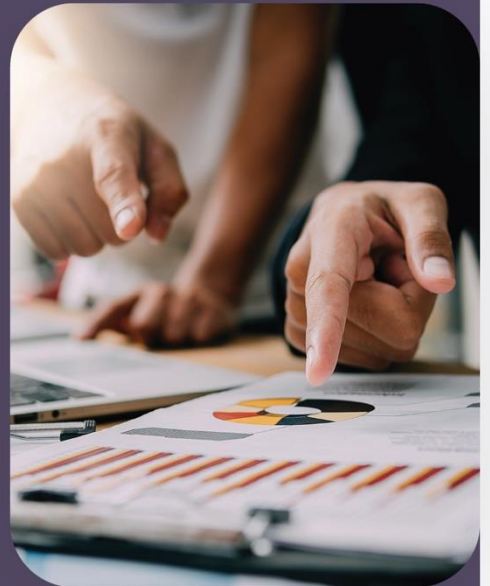
Calendar Year 2019 Recommendation	2020 Update
Implement quality improvement initiatives to increase the Use of High-Risk Medications in the Elderly rate.	In 2020, 3,604 interventions (letters sent to providers from UHC pharmacists informing them of their patient being on a high-risk medication and alternatives that could be prescribed) were issued to providers.

---

Section 4:

# Performance Improvement Project Validation

---





## SECTION 4: PERFORMANCE IMPROVEMENT PROJECT VALIDATION

### THE PERFORMANCE IMPROVEMENT PROJECT LIFE CYCLE

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

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

**Baseline/Initial Implementation Period:** Calendar Year 2018

#### Planning Phase: January - March 2018

During this period, the SCOs developed detailed plans for interventions. SCOs conducted a population analysis, a literature review, and root cause and barrier analyses, all of which contributed to the design of appropriate interventions. SCOs reported on this activity in March 2018. These reports described planned activities, performance measures, and data collection plans for initial implementation.

#### Initial Implementation: March 2018 - December 2018

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

**Mid-cycle Implementation Period:** Calendar Year 2019

#### Mid-Cycle Progress Reports: March 2019

SCOs submitted progress reports detailing changes made as a result of feedback or lessons learned in the previous cycle as well as updates on the current year's interventions.

#### Mid-Cycle Annual Report: September 2019

SCOs submitted annual reports describing current interventions, short-term indicators and small tests of change, and performance data as applicable. They also assessed the results of the project, including success and challenges.

## **Final Implementation Period: Calendar Year 2020**

### **Final Implementation Progress Reports: March 2020**

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

### **Final Implementation Annual Report: September 2020**

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

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

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

- 1) **PIP Questionnaire.** Plans submit a completed reporting questionnaire for each PIP. This questionnaire is stage-specific. In 2020, plans submitted a Project Update (March) and a report on Project Results report (September). The Progress Update report asked for a description of stakeholder involvement; an update to project goals, if any; the status of intervention implementation and any barriers experienced; and plans for going forward. The Project Results report included a description of the strategies used to ensure the cultural competence of interventions; an updated population analysis; an analysis of intervention outcome effectiveness; the remeasurement of identified performance indicators; status and barriers; and a description of lessons learned by the project team.
- 2) **Desktop Review.** A desktop review is conducted for each PIP. The Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plan. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the project. The Medical Director's focus is on clinical integrity and interventions.
- 3) **Conference with the Plan.** The Technical Reviewer and Medical Director meet telephonically with representatives selected by the plan to obtain clarification on identified issues as well as to offer recommendations for improvement. The plan is offered the opportunity to resubmit the PIP questionnaire within ten calendar days, although it is not required to do so.

- 4) **Final Report.** A PIP Validation Worksheet based on CMS EQR Protocol Number 1 is completed by the Technical Reviewer. Individual standards are rated either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. The Medical Director documents his or her findings, and in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report.

## PERFORMANCE IMPROVEMENT PROJECT TOPICS

MassHealth SCOs conduct two contractually required PIPs annually. SCOs must propose to MassHealth one PIP from each of two domains:

- Domain 1: Behavioral Health – Promoting well-being through prevention and treatment of mental illness including substance use and other dependencies.
- Domain 2: Chronic Disease Management – Providing services and assistance to enrollees with or at risk for specific diseases and/or conditions.

In Calendar Year 2020, Senior Care Organizations continued work on the following Performance Improvement Projects (PIPs):

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

- Improving SCO Member Access to Behavioral Health Depression Services (BMCHP)
- Cognitive Impairment and Dementia: Detection and Care Improvement (CCA)
- Increasing Rates of Follow-Up After Hospitalization for Mental Illness Among Fallon Enrollees (Fallon)
- Improving Treatment for Depression (Senior Whole Health)
- Decrease Readmissions to Inpatient Behavioral Health Facilities by Better Managing Transitions of Care (Tufts Health Plan)
- Improving Antidepressant Medication Management (AMM) for Members Diagnosed with Depression (UnitedHealthcare)

### **Domain 2: Chronic Disease Management**

- Improving Health Outcomes for SCO Members with Diabetes (BMCHP)
- Increasing the Rate of Annual Preventive Dental Care Visits among CCA Senior Care Options Members (CCA)
- Increasing the Rate of Retinal Eye Exams among Diabetic Fallon Enrollees (Fallon Health)
- Cardiac Disease Management (Senior Whole Health)
- Reducing the COPD Admission Rate through Identification and Management of COPD and Co-Morbid Depression (Tufts Health Plan)
- Improving SCO Member Adherence to Medication Regimens for Managing Their Diabetes (UnitedHealthcare)

*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.*

## COMPARATIVE ANALYSIS

Speaking generally, the technical quality of the Performance Improvement Projects submitted by MassHealth Senior Care Organizations exceeded that of previous years. Almost all plans had carefully thought out small tests of change built into their interventions and had considered the measurement of intervention effectiveness prior to implementation. Some SCOs were somewhat challenged by the requirement to assess intervention effectiveness. Kepro provided education to this end at its meeting with the plans, in the Guidance provided to the plans, and in individual sessions in which technical assistance was offered.

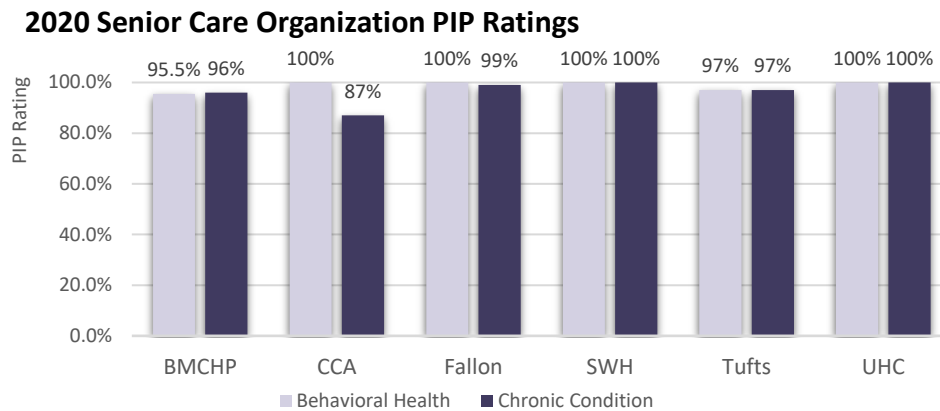
The chart that follows depicts SCO average performance on the components of the PIP Final Results report:

**Exhibit 4.1. Average PIP Score by Rating Component**

Rating Component	Behavioral Health PIPs	Chronic Disease Management PIPs
Updates to Project Topic and Scope	98%	98%
Population Analysis Update	100%	100%
Assessing Intervention Outcomes	94%	85%
Performance Indicator Data Collection	100%	100%
Capacity for Indicator Data Analysis	100%	100%
Performance Indicator Parameters	99%	100%
Remeasurement Performance Indicator Rates	100%	100%
Conclusions and Planning for Next Measurement Cycle	100%	89%

As stated previously, individual standards are rated either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. The chart that follows depicts the final rating score of each project by SCO and domain.

## Exhibit 4.2. PIP Ratings by SCO and Domain



MassHealth Senior Care Organizations used a wide variety of interventions to address their project goals, often employing multiple interventions in a single project.

## Exhibit 4.3. Interventions by Domain

Domain	Behavioral Health	Chronic Disease
Care Management	4	4
Member Education	1	4
Provider Education	2	3
Screening	2	2
Staff Education	1	3
Provider Reports	2	4
Technology	1	1
Provider Incentive	0	1
Pharmacy	2	4

## PLAN-SPECIFIC PERFORMANCE IMPROVEMENT PROJECT RESULTS

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

## DOMAIN 1: BEHAVIORAL HEALTH

### BMC HEALTHNET PLAN: IMPROVING SCO MEMBER ACCESS TO BEHAVIORAL HEALTH DEPRESSION SERVICES

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name: BMC HealthNet Plan (BMCHP) Senior Care Organization (SCO)</b>
<b>PIP Title:</b> Improving SCO Member Access to Behavioral Health Depression Services
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"><li>• Improve the number of completed PHQ-2 questionnaires;</li><li>• Increase the number of referrals to Beacon Health Options care management;</li><li>• Increase the total number of members engaged in and accepting behavioral health care management programs;</li><li>• Improve access to behavioral health services such as outpatient therapy; psychopharmacology consultations, and inpatient treatment;</li><li>• Increase SCO member use of behavioral health self-management tools;</li><li>• Increase BMCHP SCO care manager confidence in administering the PHQ-2; and</li><li>• Increase BMCHP SCO member referrals to Beacon Health Options for PHQ-2 scores <math>\geq 3</math>.</li></ul> <i>Provider-Focused</i> <ul style="list-style-type: none"><li>• Improve primary care and behavioral health provider knowledge and awareness of depression and issues related to depression in the elderly population such as identification, contributing factors, precipitant events, and members' resistance to treatment; and</li><li>• Improve primary care behavioral health provider knowledge and awareness of issues related to treating elderly members for depression such as stigma, mobility, cognition barriers, and member financial concerns.</li></ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
BMCHP care management administers the PHQ-2 questionnaire to each SCO member. If the member's score is $\geq 3$ , the member is referred to Beacon, who administers the PHQ-9. If the member's score is $\geq 10$ , the member will be referred to the indicated level of care.

<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Beacon provided provider education by means of an email blast and a webinar.</p>
<p>MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)</p> <p>Not applicable.</p>

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<p><i>Depression Diagnosis Penetration Rate</i> - Number of unique SCO members with a depression diagnosis (with a negative history of 60 days prior as defined by the AMM HEDIS specification) on an approved claim in the identified measurement year</p> <p>NCQA 0418</p>	2017	27/529 5.1%	<p>2019</p> <p><input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available</p>	105/1502 7.0%	<p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Specify P-value: <input type="checkbox"/> &lt;.01 <input type="checkbox"/> &lt;.05</p> <p>Other (specify):</p>



Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>Depression Treatment Rate -</i> Number of unique SCO members receiving depression treatment as defined by at least one out patient BH claim with a depression diagnosis within 30 days following the initial diagnosis  NQF#0418	2017	11/86 12.8%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	39/132 29.5%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

#### 4. PIP Validation Information

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

#### Performance Improvement Project Evaluation

Kepro evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMCHP received a rating score of 95.5% on this Performance Improvement Project.

#### Exhibit 4.4. PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	8	89%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	10.5	86%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	4.33	13	12.5	96%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>22.33</b>	<b>67</b>	<b>64</b>	<b>95.5%</b>

#### Plan & Project Strengths

BMCHP described lessons learned from this project including the value of identifying performance indicators that do not rely on the establishment of a process in order to obtain baseline and remeasurement data; the importance of obtaining feedback from stakeholders to provide insights into proposed activities and interventions to ensure a successful implementation; and the benefit of identifying potential outcome measures during the development of the activities.

#### Update on 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Update
Kepro recommends further detailing the clinical characteristics of this population to better inform the activities associated with this project.	BMCHP's comprehensive updated population analysis included population demographic and clinical data.
BMCHP's case management system does not capture reportable PHQ-2 results. The ensuing manual process requires a much-needed resource. Kepro recommends that resolution of this issue be prioritized in order to adequately understand baseline results for this intervention.	BMCHP did not speak to this recommendation in its September 2020 report.
Kepro recommends that BMCHP find ways to amend workflows for providers to increase PHQ-2 testing and appropriate follow up for positive screens occurs.	BMCHP did not speak to this recommendation in its September 2020 report.

# COMMONWEALTH CARE ALLIANCE: PROJECT REMIND: RECOGNIZING EARLY MEMORY IMPAIRMENT AND NEEDS ASSESSMENT FOR DEMENTIA

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Commonwealth Care Alliance (CCA) Senior Care Organization
<b>PIP Title: Project Remind:</b> Recognizing Early Memory Impairment and Needs Assessment for Dementia
<p><b>PIP Aim Statement:</b></p> <p><i>Member-Focused</i></p> <ul style="list-style-type: none"> <li>• Improve the rate of early detection of dementia or of less severe but impactful cognitive impairments;</li> <li>• Improve care for members with recently diagnosed dementia or less severe but impactful cognitive impairment; and</li> <li>• Enhance knowledge of local resources to assist caregivers for those with recently diagnosed dementia or less severe but impactful cognitive impairment.</li> </ul> <p><i>Provider-Focused</i></p> <ul style="list-style-type: none"> <li>• Activate CCA clinical staff to more reliably and effectively complete periodic formal screenings of SCO members for dementia using the Mini-Cog®;</li> <li>• Refer members that screen positive on the Mini-Cog® for a more comprehensive cognitive assessment by a CCA behavioral health provider or advanced practice clinician;</li> <li>• Increase CCA behavioral health specialist or advanced practice clinician timely completion of the cognitive assessment of all members referred after positive screening using the MoCA, MoCA-Basic, MoCA-Blind, and MMSE; and</li> <li>• Improve/increase the development and implementation of a robust care plan for those members identified with dementia or less severe but impactful cognitive impairment.</li> </ul>
<p><b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b></p> <p><input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic)</p> <p><input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases)</p> <p><input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)</p> <p><input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)</p>
<p><b>Target age group (check one):</b></p> <p><input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children</p> <p>*If PIP uses different age threshold for children, specify age range here:</p>
<p><b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior Duals</p>
<p><b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP</p>

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>CCA has implemented periodic, routine, formal screening for cognitive impairment by CCA clinical staff. This intervention involves the development and implementation of templates and documentation tools in the care management system; the development of training materials and protocols; the training of clinical staff; the implementation of a process for referrals to the behavioral health provider; and the development of an outreach script in both English and Spanish.</p> <p>A related intervention is the cognitive assessment of members screening positive for cognitive impairment by CCA behavioral health clinicians or advanced practice clinicians.</p> <p>CCA reviews the cases of members who have recently had a positive Mini-Cog® screening or who screened positive on a cognitive assessment at its inter-professional team meetings. The team reviews the member's care plan and makes changes as necessary to address evaluation, treatments, services, and support for dementia-related needs. A referral to a dementia specialist is considered.</p>
--

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

Not applicable.

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>The Mini-Cog® Screening Rate</i> , which is defined as a ratio of the number of members without a diagnosis of dementia in CY2017 that received a Mini-Cog® screening at least once during the measurement period to the number of members without a diagnosis of dementia in the measurement period.	2017	18/1060 1.70%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	125/1217 10.27%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input checked="" type="checkbox"/> <.05 Other (specify): p < 0.005

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>The Timely Cognitive Assessment Rate</i> , which is defined as a ratio of the number of members with a positive Mini-Cog® screening during the measurement year who had a cognitive assessment by a CCA behavioral health provider or advanced practice clinician within 90 days of the date of the positive Mini-Cog® screening but did not have a diagnosis of dementia in the measurement year to the number of members that had a positive Mini-Cog® screening during the measurement year without a diagnosis of dementia but did not have a cognitive assessment.	2017	0/0 0%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	31/41 76%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input checked="" type="checkbox"/> <.05 Other (specify):

#### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input checked="" type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):  Validation rating: <input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  Given the high rate of positive Mini-Cog screenings among the SCO population, finding ways to incorporate this screening into routine annual assessments will be important.  In future reporting, CCA is advised to address the successes and challenges of all performance indicators, regardless of whether the trend in the indicator rate is positive or negative.

#### Performance Improvement Project Evaluation

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

#### Exhibit 4.5. PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5.0	15.0	15.0	100%
Remeasurement Performance Indicator Rates	5.0	15.0	15.0	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>26</b>	<b>78.0</b>	<b>78.0</b>	<b>100%</b>

#### Project & Plan Strengths

- CCA is commended for the many modifications it is making to its PIP operations to maintain the forward momentum of this project, in light of the physical distancing requirements affecting member outreach and screening administration.
- CCA attributes the progress that has been made through this PIP as being due to its dedicated, multidisciplinary care team and the training that the team has been able to deal with the health outreach workers. CCA is commended for all these efforts and for its appreciation of the importance of receiving feedback and engaging in continuous quality improvement as this project continues forward.

#### Follow Up to 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Update
Kepro recommends that CCA's PIP leadership team use the early findings from this project to create a high-level presentation of its positive project outcomes and distribute this presentation to CCA's senior management team.	CCA does not speak to this recommendation in its September 2020 report.

# FALLON HEALTH: INCREASING RATES OF FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS AMONG FALLON ENROLLEES

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Fallon Health Senior Care Organization
<b>PIP Title:</b> Increasing Rates of Follow-Up after Hospitalization for Mental Illness among Fallon Enrollees
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Create a personalized aftercare assistance program in order to increase members' likelihood of engaging in post-hospitalization (outpatient) behavioral health care.</li> <li>Increase the engagement of Fallon members in follow-up care with outpatient behavioral health providers following hospitalization for mental illness.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Design and implement an aftercare and provider quality program to encourage coordination of care and discharge planning with inpatient providers.</li> <li>Design and implement an aftercare and provider quality program that promotes and encourages best practices regarding the provision of follow-up care post-hospitalization through outpatient providers.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <small>*If PIP uses different age threshold for children, specify age range here:</small>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior Duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Aftercare Coordinators generate a no-show letter to members who miss their 7-day follow-up appointment. Aftercare Coordinators continue follow-up care coordination activities within the 30-day post-discharge window. They also collaborate with the inpatient facility to obtain accurate member contact information.</p> <p>Fallon Health reported its response to COVID-19 pandemic by implementing the Free Cell Phone Initiative for members without a phone so they can engage in telehealth after discharge. Additionally, Provider Quality Managers are implementing an "Aftercare Telehealth Initiative," in order to identify several outpatient providers statewide who pledge to intake via Telehealth within 24-48 hours of a discharge, then alerting selected high-volume inpatient providers who will monitor discharge referrals and intakes.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Beacon plans to encourage outpatient providers to engage in best practices. A number of reports are planned, including Hospitalization Follow-Up, member attendance, and member engagement reports. These reports will be shared in a pilot with providers to help the provider develop strategies. Also planned is the creation of educational materials about aftercare best practices and expectations.</p>

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

To minimize the disruption of inpatient facility internal operations, Beacon obtains discharge information using its eServices portal. Discharge appointments are confirmed with the outpatient provider. Aftercare Coordinators secure appointments as needed. They also contact the member to confirm appointment information and ensure that the member understands medications and other discharge information.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>Follow-Up After Hospitalization for Mental Illness – 7-day Follow-up Rate.</i>  NCQA 0576	2017	11/24 45.8%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	12/32 37.5%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
<i>Follow-Up After Hospitalization for Mental Illness – 30-day Follow-up Rate.</i>  NCQA 0576	2017	19/24 79.2%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	24/32 75.0%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

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

### Performance Improvement Project Evaluation

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



available points. This ratio is presented as a percentage. Fallon Health received a rating score of 100% on this Performance Improvement Project.

#### Exhibit 4.6. PIP Project Rating

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

#### Plan & Project Strengths

- Fallon Health presents an excellent population analysis and is commended for applying the findings from its population analysis to outreach strategies toward members with the greatest risks.
- Kepro commends Fallon Health for determining that automating the provider performance reporting process would result in more valid, reliable, and actionable data in a timely manner.
- Fallon Health described the lessons learned from this project, highlighting the importance of stakeholder feedback in the development of activities, importance of reliable and measurements data, communication among departments and external entities.

#### Follow Up to 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year. No recommendations were offered in 2019.

# SENIOR WHOLE HEALTH: IMPROVING TREATMENT FOR DEPRESSION

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Senior Whole Health
<b>PIP Title:</b> Improving Treatment for Depression
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Improve identification of members with depression.</li> <li>• Improve member understanding of depression.</li> <li>• Improve member compliance with depression treatment.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Improve treatment of depression in the primary care and behavioral health settings.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Senior Whole Health distributes educational material by mail to members who have been diagnosed with depression and are enrolled in the Depression Health Management program.</p> <p>Members with depression are referred to Beacon case management as indicated. These case managers provide education and make provider referrals as appropriate.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>SWH will ask primary care providers to screen members determined to be at risk for depression. Using gap lists generated by Senior Whole Health, Beacon will ask some of its network providers to counsel members identified as being non-adherent with medication. SWH will also provide general provider education.</p> <p>SWH is providing education to its providers about depression management. SWH has provided a gap list to highlight members at risk of low medication adherence and those at risk for depression to ensure they are screened, as well as providing PCP guidelines to providers.</p> <p>SWH also reached out to high-volume providers in a survey to obtain feedback on its educational flyer and guidance on outreach in the future. SWH is providing trainings to promote outreach among the PIP-eligible geriatric population. It is testing specific interventions, such as pill organizing products, to determine if this has an effect on adherence.</p>

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

The Senior Whole Health nurse care manager will educate the Geriatric Services Support Coordinators about depression.

Senior Whole Health nurse care managers will receive lists of member gap rosters. Gap lists will also be provided to Beacon Health Options so that its care managers can conduct outreach to non-adherent members engaged in its care management program.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>Antidepressant Medication Management (AMM) Acute Treatment Rate.</i>  NCQA 0105	2017	190/279 68.1%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	259/321 80.69%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005
<i>Antidepressant Medication Management (AMM) Continuous Treatment Rate.</i>  NCQA 0105	2017	165/279 59.1%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	198/321 61.68%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

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

### Performance Improvement Project Evaluation

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

Exhibit 4.7. PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	7.0	21.0	21.0	100%
Remeasurement Performance Indicator Rates	5.0	15.0	15.0	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>29</b>	<b>87</b>	<b>87</b>	<b>100%</b>

### Project & Plan Strengths

- Kepro acknowledges the extensive changes to the PIP methodology that SWH put in place in response to recommendations made in the Kepro Validation Report of October 2019. The modifications made to its project strategy are very positive.
- SWH describes several excellent interventions that it has implemented to ensure the cultural competency of services related to this PIP. This includes educational material printed in several languages, Cultural Humility trainings conducted for its care management staff, and its culturally appropriate Facebook postings.
- SWH and Beacon Health Strategies, are commended for its rigorous methodology used in evaluating the effectiveness of the AMM member educational flyer.
- SWH is commended for its commitment to drawing upon the insights and resources of external stakeholders, members and providers, as it moves forward with this project.

### Follow Up to 2019 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Update
Kepro advises SWH to develop a methodology for evaluating whether intervention activities result in improved rates of medication adherence for members who engage in care management support compared to members who do not engage in care management.	SWH acknowledged the challenges of drawing conclusions about the effectiveness of care management from its studies with few members making up the comparative cohorts. As noted, Kepro commends SWH on its efforts and encourages SWH to pursue these evaluations at the appropriate time with larger member sample sizes.

# TUFTS HEALTH PLAN: DECREASE READMISSIONS TO INPATIENT BEHAVIORAL HEALTH FACILITIES BY BETTER MANAGING TRANSITIONS OF CARE

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Plan Senior Care Organization (SCO)
<b>PIP Title:</b> Decrease Readmissions to Inpatient Behavioral Health Facilities by Better Managing Transitions of Care
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase the rate of members who receive transition of care services.</li> <li>• Reduce readmission to behavioral health inpatient facilities.</li> <li>• Reduce psychosocial barriers to receiving psychotherapy through the identification and resolution of barriers to timely aftercare attendance.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Identify and begin to address provider variables related to behavioral health readmissions.</li> <li>• Reinforce the importance of the seven-day follow-up after discharge from a mental health admissions appointment as an important component of transitions management in helping to prevent readmissions.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <small>*If PIP uses different age threshold for children, specify age range here:</small>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior Duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Tufts Health Plan has implemented a four-pronged approach to transition of care services. While the member is still hospitalized, the Tufts behavioral health care manager collaborates with the facility to initiate the discharge planning process. Within two business days of discharge, the care manager contacts the member and performs a standardized transitions assessment and intervenes where needed. Weekly contact is made for thirty days post-discharge. Within seven days of discharge, a Tufts nurse care manager performs a medication reconciliation. If additional support is required, a consultation is requested with a Tufts Geriatric Psychiatry Advanced Practice Nurse.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>
<p>MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)</p> <p>A behavioral health care manager conducts a root cause analysis of instances of readmissions for presentation and problem-solving at the Interdisciplinary Care Team meeting.</p>

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Tufts is using a modified version of the HEDIS® Plan All-Cause Readmission (PCR) rate.  NCQA 1768	2017	0/15 0%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	1/32 3.1%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Follow-Up after Hospitalization for Mental Illness (FUH) – 7 Days  NCQA 0576	2017	7/15 47%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	7/32 20%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.05 (statistically significant decrease)
Follow-Up after Hospitalization for Mental Illness (FUH) – 30 Days  NCQA 0576	2017	11/15 73%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	16/32 50%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

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

**EQRO recommendations for improvement of PIP:**

As it pursues future performance improvement projects, Kepro urges THP to learn how to evaluate the outcomes of its intervention activities so that its limited resources and staff-time are determined by data-based effectiveness evaluations to produce beneficial health outcomes for its PIP-eligible members.

Throughout this 2020 Project Results report, Kepro notes that a numerator account of N=1 makes any analysis of intervention effectiveness and performance rates difficult to evaluate and draw conclusions. THP has had a secondary focus of promoting follow-up behavioral health treatment post-discharge from a psychiatric hospital, but the focus of the analyses in this project report center on its low rate of psychiatric readmissions.

In future PIP project proposals, THP should consider healthcare priorities that affect a larger percentage of its SCO members.

**Performance Improvement Project Evaluation**

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

**Exhibit 4.8. PIP Project Rating**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	3.0	9.0	7.0	78%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	4.0	12.0	12.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>22</b>	<b>66</b>	<b>64</b>	<b>97%</b>

**Project & Plan Strengths**

THP is commended for the lessons learned through this project that it intends to apply to future projects related to behavioral health. THP envisions future projects to focus on more generalized behavioral health issues related to its geriatric members, including depression, anxiety, and loneliness.

**Update to 2019 Recommendations**

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Update
Kepro advises THP to meet with a sample of providers to conduct a barrier analysis regarding the reasons for the delay in discharge notifications.	THP does not speak to this recommendation in its September 2020 report.

# UNITEDHEALTHCARE: IMPROVING ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM) FOR MEMBERS DIAGNOSED WITH DEPRESSION

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> UnitedHealthcare
<b>PIP Title:</b> Improving Antidepressant Medication Management (AMM) for Members Diagnosed with Depression
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase the HEDIS® Antidepressant Medication Management Acute Treatment rate to the Quality Compass 2017 95th percentile.</li> <li>• Increase the HEDIS® Antidepressant Medication Management Continuous Treatment rate to the Quality Compass 2017 95th percentile.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Increase the HEDIS® Antidepressant Medication Management Acute Treatment rate of members in their panel to the Quality Compass 2017 95th percentile.</li> <li>• Increase the HEDIS® Antidepressant Medication Management Continuous Treatment rate of members on their panel to the Quality Compass 2017 95th percentile.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior Duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>The UnitedHealthcare clinical pharmacist is provided with a gap report of members who have been diagnosed with major depression and prescribed antidepressant medication who are non-adherent, whose prescriptions are due to be refilled within three days, or who have not yet refilled a prescription. The pharmacist contacts the member with a reminder call. If the member cannot be reached, the pharmacist contacts the prescribing provider to notify him or her of the member's non-adherence.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>UnitedHealthcare clinical practice consultants distribute educational materials to providers during face-to-face meetings. Providers are reminded of their ability to bill for screening. In turn, the providers educate members about the \$0.00 medication copayment, the importance of filling the prescription and taking it as prescribed, and anticipated side-effects.</p>



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

None.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>Antidepressant Medication Management (AMM) Acute Treatment Rate</i>  NCQA 0105	2017	310/475 65.26%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	435/587 74.11%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005
<i>HEDIS® Antidepressant Medication Management (AMM) Continuous Treatment Rate.</i>  NCQA 0105	2017	240/475 50.53%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	366/587 62.35%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005
Claims Data for Brief, Behavioral Health Screening Administrations. This measure is a count of the total number of claims billed for CPT 96127 for unique SCO members in the calendar year.	2017	85/ 18,640 0.4%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	538/ 21,094 2.6%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

#### 4. PIP Validation Information

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

#### Performance Improvement Project Evaluation Results

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

Exhibit 4.9. PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5.0	17.0	17.0	100%
Remeasurement Performance Indicator Rates	4.3	13.0	13.0	100%
Conclusions and Planning for Next Measurement Cycle	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>25.3</b>	<b>78</b>	<b>78</b>	<b>100%</b>

#### Project & Plan Strengths

- Kepro commends UHC for its decision to add a third performance indicator to measure the rate at which members receive behavioral health screenings and for adding an intervention activity that involves the clinical pharmacist contacting members who are newly prescribed antidepressant medications.
- UHC is commended for its commitment to improving the cultural competence of its provider network, as well as making educational materials available to members in their preferred languages. Of the many strategies that UHC offers, its Physician Cultural Education Library is a notable accomplishment, as is UHC's offer continuing education units to providers practice improvement courses.
- UHC is highly commended for the depth and breadth of its population analysis.
- UHC has presented an excellent outcomes methodology which is a model for evaluating the clinical effects of provider education.
- UHC is commended for its continued progress on this project despite leadership changes.

#### Update to 2018 Recommendations

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Update
Kepro suggests that the use of other practice staff, e.g., receptionists or medical assistants, be considered for initiating screening.	Kepro again suggests that the use of other practice staff, e.g., receptionists or medical assistants, be considered for initiating screening.

## DOMAIN 2: CHRONIC DISEASE MANAGEMENT PERFORMANCE IMPROVEMENT PROJECTS

### BMC HEALTHNET PLAN: IMPROVING HEALTH OUTCOMES FOR SCO MEMBERS WITH DIABETES

#### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> BMC HealthNet Plan (BMCHP) Senior Care Organization
<b>PIP Title:</b> Improving Health Outcomes for SCO Members with Diabetes
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase SCO member engagement in the care management program.</li> <li>• Include a diabetes assessment in the member's individual care plan and link it to care management problems, interventions, and goals.</li> <li>• Increase the distribution of culturally and linguistically appropriate education materials to SCO members. Assess SCO members' values and preferences regarding diabetes self-management.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Increase awareness of care gaps and the use of care gap reports.</li> <li>• Increase awareness of medication adherence issues.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior Duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>BMCHP actively sought input from stakeholders. Members gave input on BMCHP's diabetes educational materials at a focus group and at a Member Advisory Council meeting. Useful feedback was received. BMCHP also sought provider input on care gap reports.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>

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

BMCHP conducted care manager trainings on Motivational Interviewing and the use of glucometers. Staff were also trained on the glucometer benefit and procurement process.

A new diabetes assessment tool was to be added to the Centralized Enrollee Record.

BMCHP identified subpopulations of members with diabetes and comorbid serious mental illness (SMI) and then conducted a comparative analysis of eye exam screening and HbA1c testing rates.

BMCHP is expanding and enhancing its Medication Therapy Management program.

2019 Update: The plan issues letters to the providers of medication non-adherent members. If the member is a Boston Medical Center (BMC) patient, they are referred to the BMC My Medicine Health program.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>HbA1c Testing</i>  NCQA 0057	2017	36/37 97.30%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	189/196 96.43%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
<i>Retinal Eye Exam</i>  NCQA 0055	2017	32/37 86.49%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	142/196 72.45%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.05 (negative)
<i>Diabetes Medication Adherence (CMS measure)</i>  CMS 2468	2017	31.1/37.8 82.28%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	179.08/235.58 76.02%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

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

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

**EQRO recommendations for improvement of PIP:**

BMCHP stated an inability to determine effectiveness of the intervention due to inaccurate tracking of outreach. Kepro recommends reviewing the effectiveness of this intervention based on CY 2019 data, which is the measurement period for this report. This will inform initiative going forward.

Activities related to this intervention are expected to resume in late September 2020. Kepro recommends considering novel approaches to outreach the subpopulation of members with diabetes and SMI via telehealth, either video or telephonic.

**Performance Improvement Project Evaluation**

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

**Exhibit 4.10. PIP Project Rating**

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	9	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	8.6	72%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	5.3	16.0	16	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>25.3</b>	<b>76</b>	<b>72.6</b>	<b>96%</b>

**Update to 2019 Recommendations**

CMS requires that the Performance Improvement Project validation process assesses the extent to which the plan followed up on recommendations made in the previous year.

2019 Recommendation	2020 Update
Kepro recommends that, in the future, intervention activities be more frequently tracked to be able to intervene timelier and to better understand barriers in utilization prior to ending an intervention.	BMCHP's attempts to track interventions more frequently were compromised by inaccurate data and competing staffing demands originating from the COVID-19 pandemic.

# COMMONWEALTH CARE ALLIANCE (CCA): INCREASING THE RATE OF ANNUAL PREVENTIVE DENTAL CARE VISITS AMONG CCA SCO MEMBERS

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Commonwealth Care Alliance (CCA) Senior Care Organization
<b>PIP Title:</b> Increasing the rate of annual preventive dental care visits among CCA SCO members
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Increase utilization of preventive dental visits by SCO members.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Increase the number of preventive care oral exams performed on SCO members.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>CCA is using multiple modalities to encourage members to schedule dental appointments. Members are contacted by text message and mail with reminders to schedule a preventive dental visit and maintain oral health. Articles are also placed in the member newsletter.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>
<p>MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)</p> <p>CCA is using a three-pronged approach to prompt CCA clinicians to have conversations with members to increase member engagement and facilitate access to a dentist. A dental awareness document was developed and posted periodically to the CCA intranet. This document is intended to raise awareness among staff about the importance of preventive dental care. A webinar was developed and also posted to the CCA intranet. The webinar's training goal is to increase provider knowledge of the health implications of poor oral health, the barriers members face receiving this care, oral health benefits, and the importance of integrating oral health into care management. The project team also presented oral health information at clinical staff meetings.</p>

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Members that had one or more dental care visits in which preventive dental care services were provided during the measurement year. This rate is defined as the ratio of dental claims containing a preventive dental care service code to the total number of SCO members.	2017	2369/8170 29%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	2803/9624 29%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input checked="" type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):  Validation rating: <input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input checked="" type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b>  CCA has not assessed the prevention access rate for members who were successfully “activated” through outreach compared to members who were not successfully “activated” through outreach.  CCA concludes that its provider-education initiative has been effective in increasing member access to preventative dental services, but it presents no methodology or data to support this conclusion.  Kepro notes that a PIP, as a project, and a PIP EQR report are two different entities. As a project, the CCA SCO PIP team clearly put good work into this project, both with the engaged members and the participating providers. In this regard, Kepro commends the PIP team for its excellent work.

With regard to a PIP that is evaluated relative to external quality review (EQR) criteria, the documentation of this project was found wanting in the lack of operational and statistical detail that met EQR rating criteria, especially with respect to evaluating the effectiveness of its intervention activities.

### 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 and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. CCA received a rating score of 87% on this Performance Improvement Project.

#### Exhibit 4.11. PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	5.5	46%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5	15	15	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Lessons Learned	2	6	3	50%
<b>Overall Validation Rating Score</b>	<b>25</b>	<b>75</b>	<b>65.5</b>	<b>87%</b>

### Plan and Project Strengths

CCA is commended for the use of dental scorecards, which began in late 2019. The effectiveness of these scorecards in promoting preventative dental services within practices during 2020 speaks well for this project,

### Update on Calendar Year 2019 Recommendations

Kepro is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2019 to CCA follows.

Calendar Year 2019 Recommendation	2020 Update
The population analysis contains analytic and descriptive insufficiencies that should be corrected in CCA's next submission.	<p>CCA's population analysis is represented in five charts in an appended file included in this report. The charts include members utilizing dental services, specifically preventative services. Dental services are stratified by type of service.</p> <p>In response to feedback from Kepro, CCA improved the table that shows the growth of edentulous members over the timespan of this project. Kepro appreciates the improved graphic representation of the data.</p> <p>In its first submission of this report, CCA presented its five charts as its population analysis with no descriptive summary of its findings. As advised by Kepro, CCA resubmitted its 2020 Project Results report with an improved narrative.</p>
Kepro requests source information about how CCA calculated its 47% edentulism (toothlessness) prevalence rate.	It can be inferred from CCA's report that the edentulousness rate was calculated through analyses of paid claims for dentures.



# FALLON HEALTH: INCREASING THE RATE OF RETINAL EYE EXAMS AMONG DIABETIC FALLON ENROLLEES

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Fallon Health Senior Care Organization
<b>PIP Title:</b> Increasing the Rate of Retinal Eye Exams among Diabetic Fallon Enrollees
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase the rate of retinal eye exams among SCO enrollees with diabetes.</li> <li>• Increase engagement of diabetic Fallon enrollees who are identified as being unable to be contacted (UTC) and/or are non-adherent to diabetes care management plans, i.e., receipt of a retinal eye exam.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Increase primary care provider engagement in the management of the care of enrollees with diabetes.</li> <li>• Increase primary care provider education related to the use of telemedicine and point-of-care testing for diabetic retinopathy screening.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)  Fallon has engaged primary care providers in eliminating care gaps for members with diabetes.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)  Fallon has been working to implement provider in-home retinal screenings ( <i>discontinued in 2019</i> ).  The Centralized Enrollee Record was updated to include a Health Risk Assessment (HRA) containing the HEDIS® Comprehensive Diabetes Care measures. Because an analysis revealed that Fallon had not identified all members with diabetes, Fallon Clinical Management provided reeducation and training on the HRA process.  Fallon Health reported that in late 2019, diabetes gaps-in-care letters were sent to 250 unique PCPs with a combined panel of 343 unique NaviCare members identified as needing a diabetic retinal eye exam as of 6/1/2019. Fallon Health was able to obtain a response to close gaps in care for 31 unique members for the eye exam, representing a response rate of 9.0%.

## Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The HEDIS® Comprehensive Diabetes Care (CDC) Retinal Eye Exam Rate.  NCQA 0055	2017	844/986 85.6%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	751/872 86.1%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

## 4. PIP Validation Information

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

## Performance Improvement Project Evaluation

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

### Exhibit 4.12. PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	3	9	8	89%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	5.0	15.0	15	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>25</b>	<b>75</b>	<b>74</b>	<b>99%</b>

**Plan & Project Strengths**

Fallon Health described modifications it has made based on the results of the effectiveness analysis, starting with restructuring the gaps-in-care outreach letters to include all gaps in care on one letter (rather than one indicator per letter). This presentation of consolidated information will hopefully result in improved provider acceptance and utilization to close gaps in diabetes-related care for their patient panels.

Fallon Health described lessons learned from this project, highlighting the importance of stakeholder feedback and the importance of having reliable data.

**Update on Calendar Year 2019 Recommendations**

Kepro is required by CMS to determine the status of recommendations made in the previous reporting year; no recommendations were offered to Fallon in 2019.

## SENIOR WHOLE HEALTH: CARDIAC DISEASE MANAGEMENT

### 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Senior Whole Health
<b>PIP Title:</b> Cardiac Disease Management
<b>PIP Aim Statement:</b>  <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Improve member understanding of the importance of good blood pressure control.</li> <li>• Improve member adherence with hypertension treatment.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Improve hypertension treatment in the primary care setting.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Senior Whole Health has implemented four activities under the umbrella of improving member education for hypertension and coronary artery disease. New Coronary Artery Disease (CAD) Management Program members receive a welcome letter and educational materials that speak to smoking cessation, nutrition, and weight management, flu vaccines, physical activity, and medication compliance. Outbound educational calls are made by the Community Service Coordinators. CSC nurse care managers provide coaching during scheduled home visits. Healthy Living Chronic Disease self-management classes are offered to members.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Not applicable.</p>
<p>MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)</p> <p>SWH engaged a pharmacy vendor for coaching and tracking medication refill compliance.</p>

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The HEDIS® measure, Controlling Blood Pressure (CBP).  NCQA 0018	2017	298/411 72.51%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	228/411 55.47%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005 (negative)
The CMS Stars measure, ACE/ARB Medication Compliance.  CMS 0066	2017	4950.6/ 5889.3 84%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	5006/ 5734 87.3%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005
The CMS Stars measure, Medication Adherence for Statin.  CMS 0543	2017	6038/ 7272.8 83%	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	6346/ 7323 86.66%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input checked="" type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input checked="" type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b> Kepro recommends considering additional interventions to engage providers, such as promoting them to share best practices with each other, testing novel outreach strategies to encourage positive lifestyle choices and advantages of medication adherence, such as through frequent text messaging and brief surveys to track member response that ancillary staff could manage in the practice.

### Performance Improvement Project Evaluation

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

Exhibit 4.13. PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	7.0	21.0	21.0	100%
Remeasurement Performance Indicator Rates	5.0	15.0	15.0	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>29</b>	<b>87</b>	<b>87</b>	<b>100%</b>

### Project and Plan Strengths

SWH presents several excellent and commendable interventions that it has implemented to ensure the cultural competency of services related to this PIP. This includes educational material printed in several languages, Cultural Humility trainings conducted for its care management staff, and its culturally appropriate Facebook postings.

SWH is commended for outreaching to its Consumer Advisory Committee to engage culturally diverse members for feedback about its educational materials.

### Update on Calendar Year 2019 Recommendations

Kepro is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2019 to Fallon Health follows.

Calendar Year 2019 Recommendation	2020 Update
Kepro recommends considering other forms of both educating and connecting with members to share what works for them at influencing their cardiovascular disease and hypertension management outcomes, such as text messaging, member forums, and dietary classes at which meals are cooked together at the community level.	Kepro acknowledges the challenges posed by the pandemic in connecting with members.
Kepro recommends that SWH inform providers about proven strategies to adopt, such as repetitive text messaging to patients with small bits of information about the importance of adhering to prescriptions or brief remote check-ins with patients via teleconference visits.	SWH outlines several interventions to support providers through education and with member outreach tools. These tools are for supporting medication adherence and promoting positive lifestyle enhancements for members.

# TUFTS HEALTH PLAN: REDUCING THE COPD ADMISSION RATE THROUGH IDENTIFICATION AND MANAGEMENT OF COPD AND CO-MORBID DEPRESSION

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> Tufts Health Plan
<b>PIP Title:</b> Reducing the COPD Admission Rate through Identification and Management of COPD and Comorbid Depression
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>• Increase the percentage of SCO members with COPD being managed in the SCO disease management program.</li> <li>• Identify members with COPD that may have undiagnosed depression.</li> <li>• Facilitate depression diagnoses and treatment.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>• Encourage providers to document diagnosis of depression for members who screen positive using a PHQ-9.</li> <li>• Support primary care referral to outpatient depression treatment.</li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Members who have screened positive on a PHQ-2 receive behavioral health clinician support. If the member screens positive on the PHQ-9, the member will be referred to the primary care provider. Member educational materials are shared with members.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Tufts will conduct outreach to primary care providers with members with co-occurring depression and COPD to ensure appropriate referrals are made and antidepressants prescribed.</p>
<p>MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)</p> <p>Not applicable.</p>

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<i>COPD Admission Rate</i> , a modified version of the AHRQ PQI-5.  CMS 0275	2017	79/41594 22.8 /Kmpy	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	96/72058 16.8/Kmpy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005
<i>COPD or Asthma Potentially Avoidable Admission Rate.</i>	2017	84 discharges / 41,594 mm 24.2 admits/ Kmpy	2019  <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	116 discharges / 72,058 mm  19.3 admits / K mpy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### 4. PIP Validation Information

<b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Validation phase (check all that apply):</b> <input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input checked="" type="checkbox"/> Second remeasurement <input type="checkbox"/> Other (specify):
Validation rating: <input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input checked="" type="checkbox"/> Low confidence <input type="checkbox"/> No confidence
<b>EQRO recommendations for improvement of PIP:</b> THP did not link its performance indicators to its project's goals, which is to reduce "the COPD admission rate through identification and management of COPD and Co-Morbid Depression."



### Performance Improvement Project Evaluation

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

Exhibit 4.14. PIP Project Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	11.0	92%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	6.0	18.0	18.0	100%
Remeasurement Performance Indicator Rates	5.0	15.0	15.0	100%
Conclusions and Lessons Learned	2	6	5	83%
<b>Overall Validation Rating Score</b>	<b>26</b>	<b>78</b>	<b>76</b>	<b>97%</b>

### Project & Plan Strengths

- THP has presented a robust and data-driven analysis of its efforts to refer members with positive screens for depression to behavioral health services. THP has reported improvements in behavioral health supports for members who screen positive for depression
- THP is commended for the distribution of its COPD "rescue pack" to providers, as well as its educational efforts with providers to use this resource.
- THP has listed several proposed actions for improving the effectiveness of this PIP that were apparently generated by its Quality Improvement Workgroup. The list of recommended interventions is impressive, and these interventions to address the goals of this project that are directed towards improving behavioral health treatment for members with COPD and depression.

### Update on Calendar Year 2019 Recommendations

Kepro is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2019 to Tufts Health Plan follows.

2019 Recommendation	2020 Update
Kepro recommends that THP develop protocols and workflows for each of the project management plan challenges noted. One strategy for developing these challenge-mitigating protocols is to meet with stakeholders (providers and members) to conduct a barrier analysis related to each challenging factor. The barrier analysis can become the foundation for improved intervention strategies.	THP is commended for its plans to convene a member advisory council.

# UNITEDHEALTHCARE: IMPROVING SCO MEMBER ADHERENCE TO MEDICATION REGIMENS FOR MANAGING THEIR DIABETES

## 1. General PIP Information

<b>Managed Care Plan (MCP) Name:</b> UnitedHealthcare
<b>PIP Title:</b> Improving SCO Member Adherence to Medication Regimens for Managing Their Diabetes
<b>PIP Aim Statement:</b> <i>Member-Focused</i> <ul style="list-style-type: none"> <li>Increase the rate of medication adherence for non-insulin diabetes medications for SCO members diagnosed with diabetes through encouraging member engagement in one or more clinical or pharmaceutical initiatives.</li> </ul> <i>Provider-Focused</i> <ul style="list-style-type: none"> <li>Increase the rate of medication adherence for non-insulin diabetes medications for SCO members diagnosed with diabetes through provider participation in one or more clinical or pharmaceutical initiatives. <i>(Added in September 2018)</i></li> </ul>
<b>Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required plans to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (plans worked together during the planning or implementation phases) <input type="checkbox"/> Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) <input checked="" type="checkbox"/> Plan choice (state allowed the plan to identify the PIP topic)
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children <i>*If PIP uses different age threshold for children, specify age range here:</i>
<b>Target population description, such as duals, LTSS or pregnant women (please specify):</b> Senior Duals
<b>Programs:</b> <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP

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

<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>Targeted to high-risk, Spanish-speaking members with diabetes discharged from Lawrence General Hospital, UnitedHealthcare implemented an intervention in which these members who have been prescribed oral diabetes medications receive medication instructions and labels in Spanish.</p> <p>The 90-Day Conversion Program focuses on providing members with a 90-day supply of oral diabetic medications. UnitedHealthcare identifies members with diabetes who are either non-adherent or at risk of becoming non-adherent. The hypothesis is that the reduced number of trips to the pharmacy and three-month medication supply will contribute to increased adherence. Retail pharmacists have face-to-face or telephonic interactions with targeted members are either non-adherent or at risk of becoming non-adherent and may benefit from a 90-day fill. Many language barriers can be addressed at the pharmacy level as many of the pharmacies are locally owned and embedded in the community.</p>
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)</p> <p>UnitedHealthcare has implemented the Diabetes RxMonitor program/Gaps in Care - Diabetes Program. The objective of this program is to promote the use of statin medications, a class of cholesterol-lowering drugs, in members with diabetes by promoting provider engagement with members and the completion of a thorough medication review. UnitedHealthcare conducts a retrospective review of pharmacy and claims data to identify members diagnosed with diabetes with no pharmacy claims for statin therapy. Once members have been identified as having a diagnosis of diabetes that could benefit from statin therapy, the plan faxes the member's provider a letter describing the opportunity to evaluate the</p>

member for appropriate treatment. Providers are encouraged to discuss the importance of medication adherence with members. In addition, providers receive a practice-specific report of members who could benefit from a statin regimen.

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

Not applicable.

### 3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Medication Adherence for Oral Diabetes CMS 2468	2017	2955/ 3387 84.3%	2019 <input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	3620/4080 88.73%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): p < 0.005

### 4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

Validation phase (check all that apply):

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

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

**EQRO recommendations for improvement of PIP:**

Kepro recommends that UHC consider prioritizing the integration of the Gaps-in-Care information into the electronic health record system and the incorporation of medication adherence issues into routine appointments.

### Performance Improvement Project Evaluation

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

Exhibit 4.15. PIP Project Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5	15	15	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Lessons Learned	2	6	6	100%
<b>Overall Validation Rating Score</b>	<b>25</b>	<b>78</b>	<b>78</b>	<b>100%</b>

#### Plan and Project Strengths

UHC is commended for its plans to use its population analysis to improve its member outreach. Based on the findings of its analysis, UHC will give greater focus to members identified as having low levels of diabetes medication compliance, such as members associated with specified service providers and specified cities. UHC is also commended for its plan to share the results of its population analysis with both internal and external stakeholders.

UHC is commended for conducting telehealth nutrition consultations in the member's preferred language. The dietitians from the health center speak fluent Spanish and are familiar with the local community and the cultural aspects important to improving health and wellness for its members. The members will be provided with educational materials that are written in Spanish. Kepro commends UHC for its efforts to outreach to its Spanish-speaking members using culturally and linguistically appropriate activities.

UHC is commended for its success over the two-year span of this project. Its clinical pharmacy outreach is a strong and valuable intervention.

UHC is commended for continuing this type of initiative using remote methods of outreach that are necessary during this COVID-19 pandemic.

#### Update on Calendar Year 2019 Recommendations

Kepro is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2019 to Tufts Health Plan follows.

2019 Recommendation	2020 Update
In future PIP reporting, Kepro advises UHC to provide greater detail about its method for evaluating members' response to the Gaps in Care outreach.	UHC has presented a useful analysis of its Gaps-in-Care initiative, but in future reporting, UHC should take care to present all aspects of its effectiveness calculations in order to fully explain how it arrived at its findings and conclusions.

**Section 5:**

# **Compliance Validation**

---



## SECTION 5: COMPLIANCE VALIDATION

### INTRODUCTION

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

The 2020 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 Managed Care Plan (MCP), including Senior Care Organizations, were assessed. The most stringent of the requirements were used to assess for compliance when State and Federal requirements differed.

### REVIEW PERIOD

SCO activity and services occurring for calendar year 2019 (January 1 – December 31, 2019) were subject to review.

### REVIEW STANDARDS

Based on regulatory and contractual requirements, compliance reviews were divided into the following 11 standards, consistent with CMS October 2019 EQR protocols.

- Availability of Services
  - Enrollee Information
  - Enrollee Rights and Protections
  - Enrollment and Disenrollment
- Assurances and Adequate Capacity of Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Provider Selection
- Confidentiality
- Grievance and Appeal System
- Subcontractual Relationships and Delegation
- Practice Guidelines
- Health Information Systems
- Quality Assessment and Performance Improvement Program

## COMPLIANCE REVIEW TOOLS

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

## REVIEW PROCESS

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

SCOs were provided with the appropriate tools and asked to submit documentation to substantiate compliance with each requirement during the review period. Examples of the documentation included:

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

Kepro compliance reviewers performed a desk review of all documentation provided by the SCOs. In addition, two-day virtual reviews were conducted to interview key SCO personnel, review selected case files, participate in systems demonstrations, and obtain clarification and additional documentation. At the conclusion of the two-day virtual review, Kepro conducted a closing conference to provide preliminary feedback to the SCOs on the review team's observations, as well as the SCO plan's strengths, opportunities for improvement, recommendations, and next steps.

## SCORING METHODOLOGY

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

- Met – Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided and SCO staff interviews provided information consistent with documentation provided.
- Partially Met (any one of the following may be applicable) -
  - Documentation to substantiate compliance with the entirety of the regulatory requirement or contractual provision was provided. SCO staff interviews, however, provided information that was not consistent with the documentation provided.
  - Documentation to substantiate compliance with some but not the entirety of the regulatory requirement or contractual provision was provided although SCO staff interviews provided information consistent with all requirements.
  - Documentation to substantiate compliance with some but not the entirety of the regulatory requirement or contractual provision was provided, and SCO staff interviews provided information inconsistent with compliance with all requirements.
- Not Met - There was an absence of documentation to substantiate compliance with any of the regulatory or contractual requirements and SCO staff did not provide information to support compliance with those requirements.

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

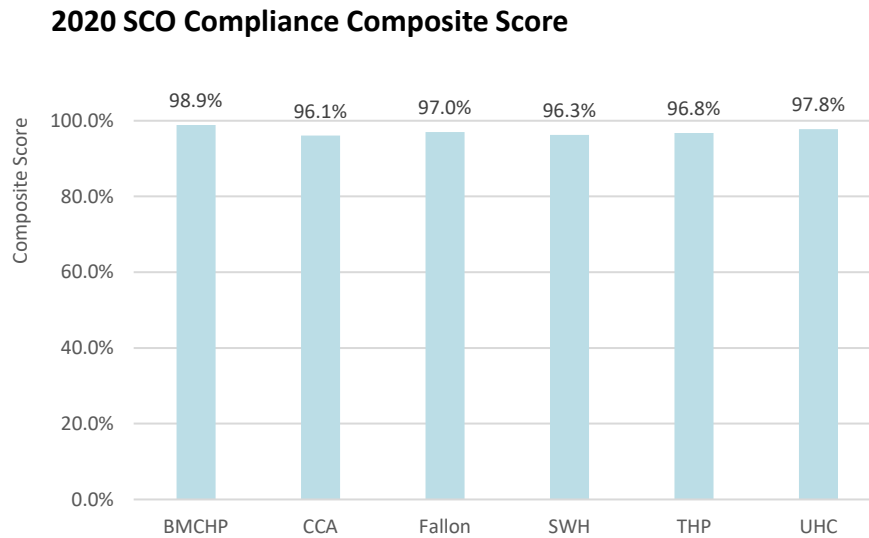
Per 42 CFR 438.360, Nonduplication of Mandatory Activities, Kepro accepted NCQA accreditation to avoid duplicative work. For implementation, Kepro obtained the most current NCQA accreditation standards and reviewed them against the CFRs. In cases where the accreditation standard was at least as stringent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



## SCO COMPLIANCE VALIDATION RESULTS

The table that follows depicts the aggregate compliance scores for each SCO reviewed:

**Exhibit 5.1. 2020 SCO Compliance Composite Score**



The table that follows presents 2020 scores by standards for each of MassHealth’s Senior Care Organizations.

**Exhibit 5.2. 2020 Standard Scores by SCO Plan**

Standard	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Availability of Services	92.9%	92.9%	87.5%	87.5%	87.5%	87.5%
Assurances and Adequate Capacity and Services	100%	100%	100%	100%	100%	100%
Enrollee Rights and Protection	100%	100%	100%	92.9%	100%	100%
Enrollment/ Disenrollment	100%	100%	100%	100%	100%	100%
Availability of Services – Enrollee Information	100%	96.4%	94.8%	98.2%	90.7%	97.7%
Provider Selection	97.9%	100%	87.5%	91.7%	97.8%	95.8%
Grievance and Appeal System	98.4%	87.1%	97.6%	94.4%	94.4%	96.8%
Subcontractual Relationships and Delegation	100%	100%	97.4%	89.5%	89.5%	94.7%
Quality Assessment and Performance Improvement	99.0%	100%	99.0%	98.0%	95.9%	100%
Health Information Systems	100%	100%	100%	100%	100%	100%
Coverage and Authorization of Services	96.5%	94.2%	94.2%	95.3%	100%	96.5%
Practice Guidelines	100%	75.0%	100%	100%	100%	100%
Confidentiality of Health Information	100%	100%	100%	100%	100%	100%
Coordination and Continuity of Care	100%	100%	100%	100%	98.8%	100%

## AGGREGATE SCO OBSERVATIONS AND RECOMMENDATIONS

Overall, the SCOs demonstrated compliance with many of the federal and State contractual standards for the plan's membership. Due to the unique needs of the SCO population, a heavy emphasis was placed on the coordination and continuity of care standard during the review. In general, the SCOs demonstrated strong models of care supporting the overarching goals of coordinated care for SCO members. High performance among all SCOs in coordination and continuity of care along with practice guidelines, quality assessment, and performance improvement standards suggests that the SCOs performed best in the area of quality care.

In general, the SCOs' greatest opportunity for improvement is related to the accessibility of care standards. The review found that, while SCOs were conducting geo-access analysis to evaluate network adequacy, not all requirements were being met. In many cases, the SCOs had conducted analysis using CMS standards, but did not include measurement of the more stringent MassHealth requirements. In addition, MassHealth required analysis of specific service categories such as Adult Day Health, Day Habilitation, and Hospice along with many home- and community-based services for which SCOs had not fully established mechanisms to analyze these service categories. Furthermore, Kepro did not find strong evidence of processes for evaluating appointment access against the MassHealth standards for services such as symptomatic and non-symptomatic office visits and urgent care. SCOs lacked a process to address appointment access concerns with providers. While accessibility of services is an opportunity for improvement for all SCOs, Kepro found that SCOs were not completely clear on the expectations for access to services related to compliance thresholds. As part of the review, MassHealth clarified that the CMS 90 percent threshold was appropriate for primary care, specialist providers, hospitals, and pharmacies. However, it required 100 percent for behavioral health services, adult day health, day habilitation, and hospice. Kepro recommends that MassHealth may need to reconsider the feasibility of 100 percent achievement for all service categories. The state may need to explore greater collaboration with SCOs related to potential exceptions for specific geographic areas that lack these services despite SCO best efforts to identify and contract for services.

The review revealed that many SCOs were focused on meeting Medicare requirements. Most of the deficiencies noted in the compliance review, however, related to MassHealth-specific Medicaid requirements that are more stringent or overlooked. While most of these deficiencies were found to be of a technical nature, requiring policy and procedure revisions rather than substantive concerns with the delivery of care, Kepro found that SCOs have an opportunity to ensure that Medicaid requirements are integrated with the same level of compliance scrutiny.

In 2019, MassHealth added some additional contractual requirements related to Frail Elder Waiver services, including evidence-based education programs, respite, and supportive day

programs. In addition, some additional credentialing requirements were added for these services. Based on the timing of these new contract requirements, MassHealth did not have Kepro formally score these requirements. SCOs, however, will need to work to meet these requirements.

In general, Kepro found that SCOs had an opportunity to improve their quality evaluations. While most were meeting the contractual requirements and compliance standards, Kepro found that the quality evaluations lacked robust analysis and evaluation specific to the delivery of care and services to SCO members. The evaluations lacked insight on how the plan was performing relative to model of care objectives. In addition, there was little evidence of evaluation specific to long-term services and supports. Kepro recommends that SCOs consider revising the format and content of their quality workplans and quality evaluations to better align with measuring performance against the objectives, while aiming within the models of care, including incorporating a LTSS-specific measurement.

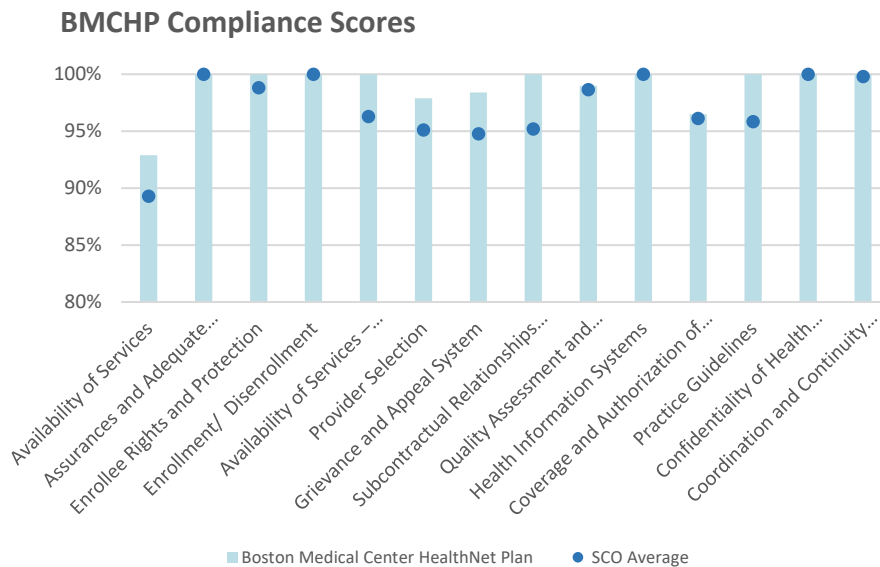
Overall, the 2020 compliance review found that SCOs performed best in the areas of care delivery and quality of care. The review showed activities and resources that focused on meeting the needs of the SCO population. In addition, SCOs did well with meeting compliance standards related to timeliness of care, e.g., SCOs excelled in meeting timelines for making coverage and appeal decisions and resolving grievances, thereby reducing unnecessary delays in care and service. SCOs have opportunities to improve mechanisms to assess network adequacy across all service categories as well as appointment access to determine if there are deficiencies.

## SCO-SPECIFIC COMPLIANCE VALIDATION RESULTS

### Boston Medical Center HealthNet Plan

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review September 16 – 17, 2020.

#### Exhibit 5.3. BMCHP Compliance Scores



#### Strengths

- Overall, BMCHP demonstrated compliance with most of the federal and State contractual standards and was the highest scoring SCO on the technical aspects of compliance.
- The review found that BMCHP had many newly-filled and dedicated positions to its SCO line of business. These dedicated resources position BMCHP to better meet the needs of its SCO membership.
- In general, Kepro found that BMCHP addressed opportunities for improvement from the prior compliance review.
- BMCHP demonstrated strength in coordination and continuity of care. The review found good collaboration with the Aging Service Access Points (ASAPs) and other community-based providers and vendors. In addition, the care management process had efficient systems for the documentation and tracking of health risk assessments, care treatment plans, medication reconciliation, and transitions of care.
- Kepro found BMCHP's handling of grievance and appeals significantly improved over the prior review. BMCHP provided outreach to enrollees with an adverse decision to ensure enrollee understanding of the process and to assist as needed. BMCHP's grievance resolution letters provided appropriate content and met federal and State requirements.

### Substantive Findings

- BMCHP experienced significant change in terms of service area expansion in 2018, including significant membership growth of the SCO population, and introduction of an accountable care organization line of business. The review found that these changes may have resulted in some processes and practices not being fully streamlined. Changes in operational leadership in functional areas and staffing turnover may have led to review findings showing that many policies and procedures were older and lacked more recent review and approval.
- While BMCHP had many activities focused on the SCO population, the review found that BMCHP has opportunities to have more robust analysis and evaluation of the SCO product line. The review found that BMCHP's workplan and quality evaluation lacked insight as to how the plan was performing relative to its model-of-care objectives. In addition, there was little evidence of evaluation specific to LTSS.
- While BMCHP, in general, demonstrated timely coverage determination and appeal decisions including timely notification to members, the review found that the denial and appeal letters contained language that was difficult to understand. The language in the letters was clinical in nature and not always easily understood.
- The audit found that while BMCHP performed geo-access analysis, it did not meet all time and distance standards to meet MassHealth requirements. The analysis did not include all required provider categories such as pharmacies and nursing facilities. In addition, BMCHP lacked a formal process to assess access to many home- and community-based services.

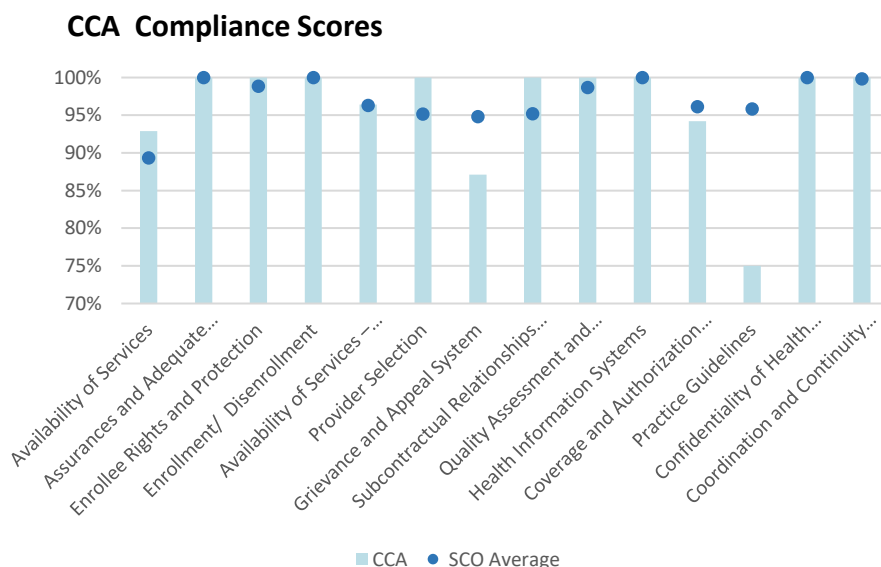
### Recommendations

- BMCHP needs to ensure annual review and approval of its policies and procedures to ensure continued compliance with all federal and MassHealth standards. BMCHP may benefit from technology solutions to aid in the tracking of policies and procedures across the organization.
- BMCHP should consider revising the format and content of its quality workplan and evaluation to better align with measuring performance against its objectives and aims within its model of care. BMCHP should explore ways to incorporate specific evaluation of its LTSS.
- BMCHP should revise the language used in denial and appeals letters to convey decision rationale in a manner that is easily understood.
- BMCHP needs to evaluate network adequacy more comprehensively in order to include MassHealth requirements and incorporate the evaluation of home- and community-based services.
- BMCHP needs to address all Partially Met and Not Met findings identified as part of the 2020 compliance review.

## Commonwealth Care Alliance

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 24 – 25, 2020.

### Exhibit 5.4. CCA Compliance Scores



#### Strengths

- While CCA had challenges with some of the technical aspects of the compliance audit, as evidenced by scoring the lowest when compared with other SCOs, from a qualitative perspective CCA was the highest-performing SCO in terms of fidelity to its model of care, innovation of care, and service delivery to meet the needs of its SCO membership.
- CCA demonstrated a highly data-driven quality program. The review found CCA to have a comprehensive understanding of its SCO members' needs, with approximately 72 percent of its SCO population nursing home-certifiable but living safely at home with many CCA services supporting the SCO population.
- CCA excelled in its service delivery of care and overall quality program.

#### Substantive Findings

- CCA had mixed performance with federal and State contractual standards and was the lowest-scoring SCO when compared to all SCOs on the technical aspects of compliance. The compliance review presents a risk for CCA as the technical scores suggest suboptimal performance and are inconsistent with performance related to measurable member outcomes of care and service.
- The review found that, while CCA out-performed other SCOs in the areas of overall service delivery, CCA's administrative systems and processes need improvement. In general, CCA's

policies and procedures were outdated and did not accurately reflect operational practices. There was a lack of consistency for annual policy and procedure review, edits, and approval.

- The audit found that, while CCA performed geo-access analysis, it did not meet all MassHealth time and distance standards for all specialists and hospitals. In addition, CCA was one of the few SCOs evaluating geo-access time and distance standards for Adult Day Health, Day Habilitation, and Hospice. CCA did not, however, meet MassHealth requirements for a choice of two providers within the required distance standards.
- In the areas of Grievance and Appeals, one of CCA's lowest scoring areas, findings were primarily related to policies and procedures being outdated and lack of specific language to address federal and State contract provisions.
- CCA's lowest area of performance was within the practice guidelines standard. The plan lacked evidence supporting review of clinical practice guidelines in 2019. The review found that, while CCA used criteria for utilization management, these were not sufficient to meet requirements for the establishment of clinical practice guidelines.

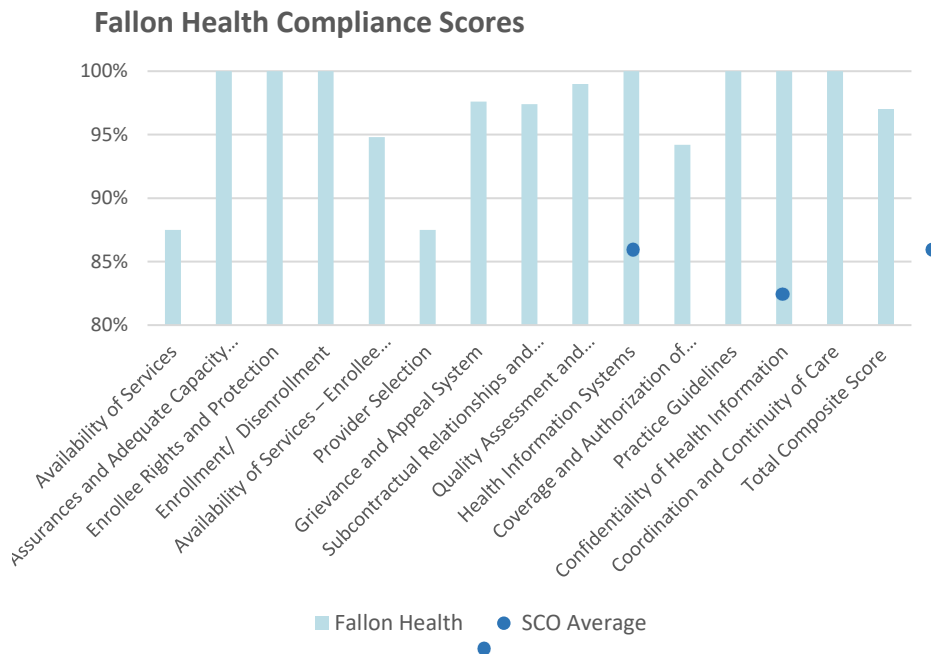
#### Recommendations

- CCA needs to revise many of its outdated policies and procedures to ensure compliance with all federal and MassHealth standards. In addition, the policies and procedures need to be streamlined to align with existing operational practices. CCA may benefit from technology solutions to aid in the tracking of policies and procedures across the organization.
- CCA needs to continue to work towards meeting MassHealth network adequacy standards for adult day habilitation and hospice providers.
- CCA needs to adopt practice guidelines in consultation with contracting health care professionals and ensure that they are reviewed and updated periodically as appropriate.
- CCA needs to address all Partially Met and Not Met findings identified as part of the 2020 compliance review.

## Fallon Health

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 1 – 2, 2020.

### Exhibit 5.5. Fallon Health Compliance Scores



### Strengths

- Overall, Fallon demonstrated compliance with most federal and State contractual standards and was among the top three scoring SCOs on the technical aspects of compliance.
- In general, Kepro found that Fallon addressed opportunities for improvement from the prior compliance review.
- The review found Fallon’s service delivery to be “high-touch,” consistent with the high needs of this population.
- One of Fallon’s strengths is the use of its navigator role as it relates to continuity of care and care coordination. Kepro identified the navigator role as used by Fallon to be a best practice. The navigator was used heavily in integrating care and interfacing with utilization management and providers across medical, behavioral health, and pharmacy, as well as ASAP GSSCs for LTSS-provided services. In addition, there was collaboration related to transitions of care across all settings as well as coordination of care for members newly enrolled with the health plan. Fallon’s structure allowed for real-time consultation with the navigator to determine how a specific request might align with the person-centered care plan. This process was supported using a centralized enrollee record which allowed for optimal use of the navigator.
- The review found more robust, mature, and enhanced services among its ASAPs.



- Fallon had an innovative strategy to use a memory specialist at the Alzheimer’s Association who participates in individual care treatment plans and serves as a resource to members and their families.
- Fallon produces a Cultural Needs and Preferences Report annually which includes a comprehensive analysis related to provider access, limited-English proficiency, and other cultural preferences. In addition, Fallon has good processes to capture information on member REL data without relying on the State’s data.

### Substantive Findings

- While Fallon met Medicare time and distance requirements for access, Fallon’s behavioral health vendor did not analyze time and distance standards for behavioral health using the more stringent MassHealth standards.
- Although Fallon was one of few SCOs that measured network appointment access, the review found that Fallon did not meet all MassHealth appointment access standards. In addition, there was no process to address accessibility concerns with its providers.
- Fallon lacked strong evidence to demonstrate measurement of the effectiveness of LTSS in delivering person-centered services designed to maintain and restore function and avoid clinical and functional decline.
- A review of Fallon’s provider directory showed that it lacked information on special experience, skills, training, and expertise in treating for some MassHealth required areas including but not limited to persons with physical disabilities, chronic illness, HIV/AIDS, and persons with serious mental illness.
- Fallon’s notice of adverse coverage determinations had acronyms that were not always easily understood.
- Fallon’s lowest-performing area was in the provider selection standard. The findings, however, were technical deficiencies related to information submission requirements to MassHealth and minor policy and procedures updates. These findings were not substantive for concerns with its network providers’ credentials, experience, training, or capabilities in treating SCO enrollees.

### Recommendations

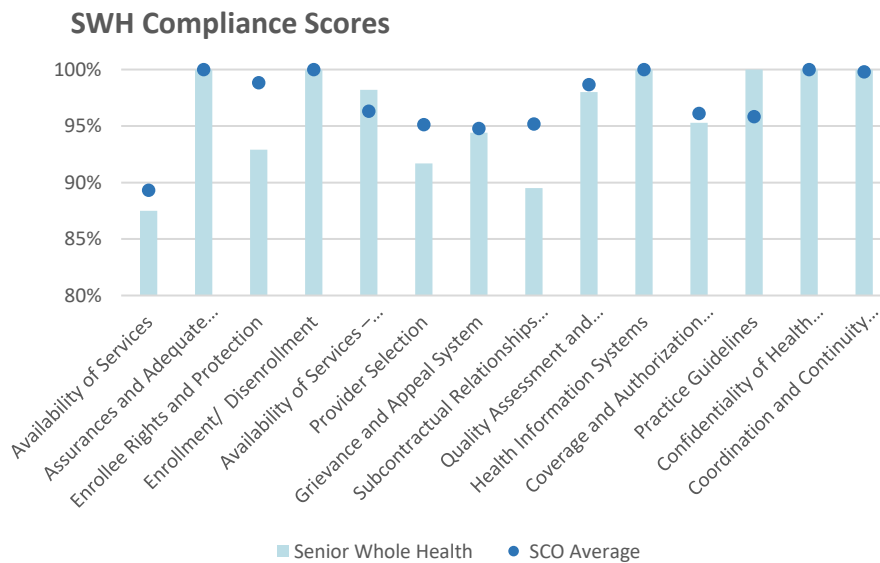
- Fallon should revise its policies and procedures and have its vendor incorporate additional analysis to measure behavioral health time and distance standards consistent with the MassHealth contract requirements.
- Fallon should improve appointment access availability and develop a process to address concerns with its providers.
- Fallon should explore ways to incorporate specific evaluation and measurement of its LTSS effectiveness on its SCO members.
- Fallon should develop a process to capture special experience, skills, training, and expertise of providers in its provider directory.

- Fallon needs to ensure that its notice of action letters are written in easily understood language.
- Fallon needs to address all Partially Met and Not Met findings identified as part of the 2020 compliance review.

## Senior Whole Health

Kepro reviewed all documents submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on October 7 – 8, 2020.

### Exhibit 5.6. SWH Compliance Scores



### Strengths

- SWH was the only SCO that was NCQA-accredited for both its Medicare and Medicaid lines of business. Kepro noted that SWH's committee structure supporting the SCO product line had well-defined descriptions of their purpose, scope, and authority. The structure allowed for streamlined reporting of all SWH functional areas.
- In general, Kepro found that SWH addressed opportunities for improvement from the prior compliance review.
- Kepro noted that SWH's relationship with Beacon Health Options was a strength in addressing some of the complex needs of the SCO population. SWH incorporated social determinants of health and the quadruple aim within its framework for service delivery.
- SWH demonstrated some good uses, integration, and adaptation of technology to improve efficiency and processes. SWH's care management system provided good functionality to staff and may translate to better care coordination for members.
- The review found SWH, a Magellan company, maintained a good balance with centralized processes for efficiencies while still leveraging local management for many aspects of care delivery.

### Substantive Findings

- SWH met most federal and state compliance requirements.

- The review found that SWH focused on meeting Medicare requirements for the SCO population, but there was less focus on ensuring compliance with the more stringent and unique State requirements for SCO. Many of the policy and procedural deficiencies for the Provider Selection and Subcontractual Relationships and Delegation standards were because State requirements that differed from Medicare processes were not always included.
- SWH lacked a robust program evaluation that described individual activities, results, and analyses. Activities that may demonstrate success in a specific area did not translate to the overall program evaluation. In addition, the overall program evaluation lacked assessment of the delivery of LTSS to SCO members.
- SWH had some challenges with its grievance and appeal process during 2019 which resulted in grievance acknowledgment letters not being sent until later in the year and no process to send out written grievance resolution letters. In addition, the file review found some instances in which a grievance should have followed the process for quality-of-care complaints.
- The audit found that, while Fallon performed geo-access analysis, it did not meet all MassHealth time and distance standards. In addition, SWH did not include all service categories, such as those provided by the ASAPs, as part of its analysis.
- While SWH met requirements for the content of its provider directory, Kepro found that searching its website for specific services was somewhat difficult.

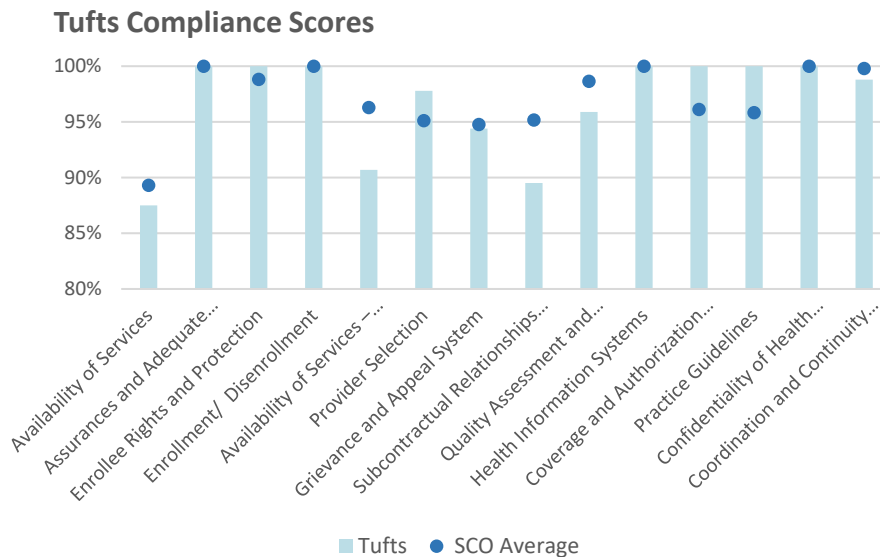
### Recommendations

- SWH needs to update its policies and procedures to be responsive to MassHealth-specific requirements that extend beyond Medicare requirements.
- SWH should revise the format and content of its quality evaluation to incorporate SCO-related activities and results and make an overall assessment of the effectiveness of its quality program for SCO members.
- SWH needs to continue its efforts to revise grievance and appeals operational functions to be fully compliant with federal and State requirements.
- SWH needs to continue to work towards meeting MassHealth network adequacy standards and establish mechanisms to incorporate LTSS and other services provided by the ASAP.
- SWH may consider the feasibility of streamlining some of the content on its website related to the provider directory that may allow SCO members to navigate the information with ease.
- SWH needs to address all Partially Met and Not Met findings identified as part of the 2020 compliance review.

## Tufts Health Plan

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 29 – October 1, 2020.

### Exhibit 5.7. Tufts Compliance Scores



### Strengths

- The review found that Tufts made efforts in 2019 to consolidate some of the utilization management functions previously performed in care management into its utilization management team. In addition, efforts were made to better align behavioral health activities with staff with behavioral health clinical expertise. The consolidations may better position Tufts to manage coverage determinations more efficiently and consistently and may improve the management of SCO members with behavioral health needs.
- In general, Kepro found that Tufts addressed opportunities for improvement from the prior compliance review.
- The review revealed that one of Tuft's greatest strengths is its focus on person-centered care. This focus spanned functional areas across the organization. Tufts demonstrated good effort to ensure that enrollees had access to long-term services and supports. Tufts incorporated the use of a survey to better assess services provided by the ASAPs, identified deficiencies, and collaboratively worked with vendors to address areas of concern.
- Kepro noted that Tufts' credentialing manual is a best practice which aligns with Tufts' high performance in the area of Provider Selection.
- Tufts identified and incorporated the use of some creative resources to engage and outreach members. In addition, Tufts developed its own member satisfaction survey to obtain member experience information since it identified limitations with using national CAHPS

surveys. These activities demonstrate Tufts' focus on enhancing service delivery specific to the needs of the SCO population.

### Substantive Findings

- Kepro noted some gaps in routine revision and approval of policies and procedures in 2019, which were likely due in part to Tufts' consolidation efforts.
- Based on Tufts' organizational size, Kepro found functional areas were somewhat siloed, and while staff were knowledgeable of their functional responsibilities, Kepro noted that staff members were less likely to see how their role fits into the large organization.
- The review found that Tufts' greatest opportunity is related to the Availability of Services standard. While Tufts conducted geo-access analysis, it did not meet all CMS and State thresholds for time and distance standards. In addition, Tufts lacked evidence of appointment access monitoring to ensure that State access standards were being met. During 2019, Tufts' primary care provider turnover rate slightly exceeded the state standard. Tufts provider directory was found to lack several required elements. Furthermore, Tufts had some challenges meeting call center timeliness in the last quarter of the year.
- While Tufts led many activities focused on the SCO population, the review found that Tufts has opportunities to conduct a more robust analysis and evaluation of the SCO product line. The review found that Tufts' quality evaluation did not provide an overall assessment of its performance of delivering care to SCO members. In addition, there was little evidence of evaluation specific to LTSS.

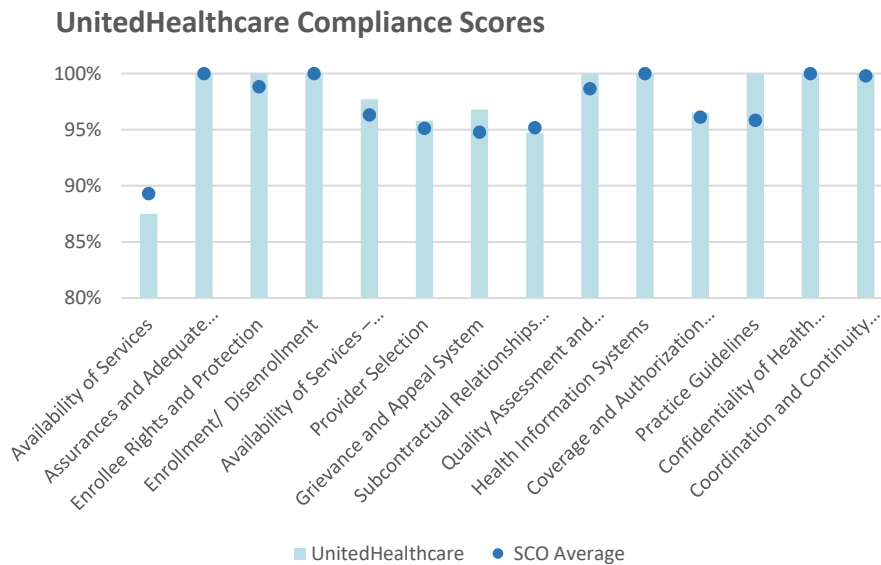
### Recommendations

- Tufts should continue its efforts related to making policy, procedure, and documentation revisions to ensure compliance with all federal and MassHealth standards.
- The SCO population reflects is a very small percentage of overall covered lines in Tufts business. SCO members, however, present a higher complexity and a need for more resources. Tufts should continue to ensure that staff members work on cross-team communication and collaboration to ensure SCO members' needs are met.
- Tufts should continue its efforts to meet all CMS and State requirements for time and distance availability.
- Tufts should implement a mechanism to assess appointment access to ensure that State access standards are met.
- Tufts should revise its provider directory to ensure all required elements are included in its contents.
- Tufts should explore strategies to ensure call center timeliness during peak times throughout the year.
- Tufts should consider revising its quality evaluation to specifically address its performance in the delivery of care and services to its SCO population. In addition, Tufts should explore ways to incorporate a specific evaluation of its LTSS.
- Tufts needs to address all Partially Met and Not Met findings identified as part of the 2020 compliance.

## UnitedHealthcare

Kepro reviewed all documents that were submitted in support of the compliance validation process. In addition, Kepro conducted a virtual review on September 3 – 4, 2020.

### Exhibit 5.8. UnitedHealthcare Compliance Scores



### Strengths

- Overall, UHC demonstrated compliance with most federal and State contractual standards and was the second highest scoring SCO when compared with all SCOs on the technical aspects of compliance.
- In general, Kepro found that UHC addressed opportunities for improvement from the prior compliance review.
- Kepro noted that UHC had a robust, real-time process to evaluate its network adequacy. UHC had very focused efforts when a specific time or distance standard was not met. UHC met all medical time and distance standards in 2019.
- UHC's member materials, including grievance resolution and notice of action letters met standards for being easily understood. In addition, UHC's provider directory was identified as a strength. The directory was easy to navigate and met all requirements.
- Kepro found some aspects of UHC's coverage and authorization process to be seamless to the member, including pharmacy needs. In addition, Kepro noted extensive use of peer-to-peer discussions in coverage determination decisions.
- The review found good collaboration between UHC, the ASAPs, and other community-based providers and vendors.

### Substantive Findings

- The audit found that while UHC met Medicare time and distance requirements for medical services, UHC's vendor did not analyze time and distance standards for behavioral health using the more stringent MassHealth standards. In addition, UHC did not assess all MassHealth provider categories such as adult day health, day habilitation, and hospice services and did not assess network adequacy related to home- and community-based services.
- UHC lacked formalized results to demonstrate provider appointment access. In addition, UHC lacked a process to address provider performance related to accessibility concerns.
- UHC's formal written grievance policy was not in place during the review period.
- While UHC had policies and procedures in place to address continuity of care, the process did not include the provision for passively enrolled individuals to appeal proposed modifications to previously authorized medical and behavioral health services.

### Recommendations

- UHC should revise its network adequacy process to incorporate additional analysis for MassHealth requirements for behavioral health time and distance standards and should include all required provider categories including adult day health, day habilitation, hospice services, and home- and community-based services.
- UHC needs to implement a mechanism to assess appointment access to ensure that State access standards are met.
- UHC needs to ensure annual review and approval of its policies and procedures to ensure continued compliance with all federal and MassHealth standards.
- UHC needs to revise its policies and procedures to include the continuity of care period for passively enrolled individuals, describing notification to the enrollee of modifications to previously authorized medical and behavioral health services, and the enrollee's opportunity to appeal the proposed modifications.
- UHC needs to address all Partially Met and Not Met findings identified as part of the 2020 compliance review.



Section 6:

# Network Adequacy Validation

---



## SECTION 6: NETWORK ADEQUACY VALIDATION

### INTRODUCTION

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

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

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

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

### REQUEST OF PLAN

To populate this software tool, Kepro obtained a complete data set from each SCO plan, which included the following data points:

- Facility or Provider Name
- Address Information
- Phone Number
- NPI Information

For the first year of network validation activities, the technical report focuses specifically on plan adequacy with regard to Medicare Advantage network standards. KEPRO is currently assessing compliance with Medicaid Network Adequacy standards and related reporting will be posted to the MassHealth website when it becomes available.

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

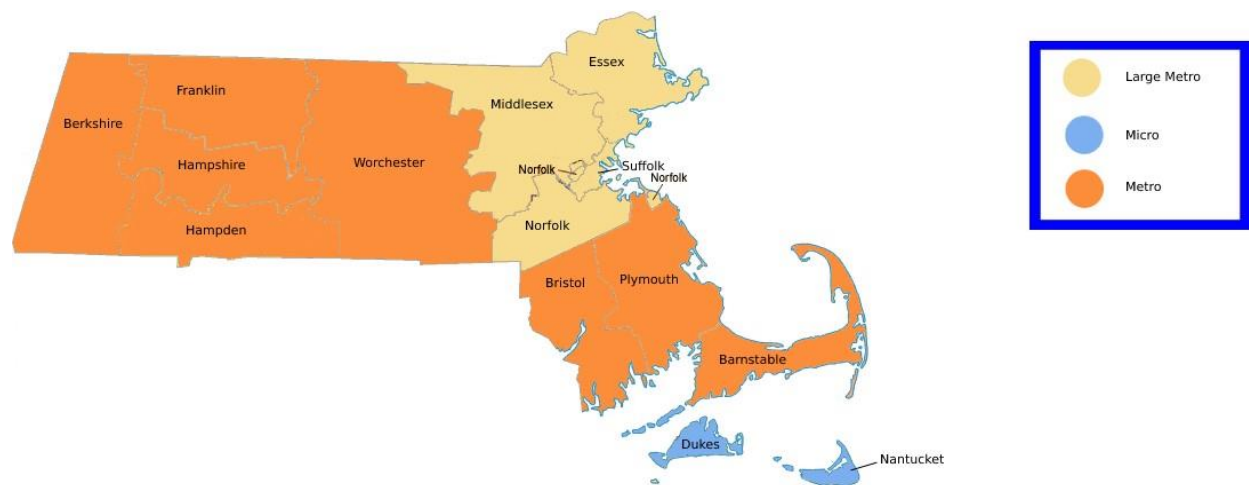
The following section compiles the Time and Distance Standards that MassHealth contractually requires the SCO plans adhere to for its provider network.

## TIME AND DISTANCE STANDARDS

For Medicaid members to receive appropriate access to care for medical services, MassHealth requires the SCO plans adhere to certain time and distance standards. These standards create an overall provider network for members to receive care.

As required by Medicare Advantage regulations, SCO plans are required to meet both the time and the distance standard, not either or. It's important to note that for some specialties, the time and distance standards vary based on the county CMS designation, i.e., large metro, metro, or micro. The following map shows the county designations, for reference:

Exhibit 6.1. Map of Massachusetts County Designations



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

### PRIMARY CARE: ADULT PCP SERVICES:

2 providers within 15 miles and 30 minutes.

### BEHAVIORAL HEALTH INPATIENT: ADULT PSYCHIATRIC INPATIENT SERVICES:

Greater than or equal to 2 providers within 20 miles and 40 minutes.

### MEDICAL FACILITY SERVICES:

The Acute Inpatient Hospital standard changes based on the county type, outlined in the table that follows.

Exhibit 6.2. Acute Inpatient Hospital Standards

Specialty	County Type	# of Providers	Time (Minutes)	Distance (Miles)
Acute Inpatient Hospital	Large Metro	≥2	25	10
Acute Inpatient Hospital	Metro	≥2	45	30
Acute Inpatient Hospital	Micro	≥2	80	60

## SPECIALTY SERVICES:

CMS requires different standards for specialists based on the specialty as well as the county size. Specialty services are also required to meet a certain ratio of providers to plan members. The charts below outline the specialty type and the corresponding standards categorized by the county designation. Also included is the required ratio of providers to managed care plan members. It is important to note that the SCOs' enrollment area does not include the Micro counties, Dukes and Nantucket.

For specialties group, the chart that follows outlines the time and distance requirements for Large Metro and Metro Counties.

**Exhibit 6.3: Specialist Standards for Large Metro and Metro Counties**

Specialty	Large Metro Counties			Metro Counties		
	Ratio	Time (Minutes)	Distance (Miles)	Ratio	Time (Minutes)	Distance (Miles)
OB/GYN	0.04	30	15	0.04	45	30
Allergy and Immunology	0.05	30	15	0.05	53	35
Cardiology	0.27	20	10	0.27	38	25
Cardiothoracic Surgery	0.01	30	15	0.01	60	40
Chiropractor	0.1	30	15	0.1	45	30
Dermatology	0.16	20	10	0.16	45	30
Endocrinology	0.04	30	15	0.04	75	50
ENT/Otolaryngology	0.06	30	15	0.06	45	30
Gastroenterology	0.12	20	10	0.12	45	30
General Surgery	0.28	20	10	0.28	30	20
Infectious Diseases	0.03	30	15	0.03	75	50
Nephrology	0.09	30	15	0.09	53	35
Neurology	0.12	20	10	0.12	45	30
Neurosurgery	0.01	30	15	0.01	60	40
Oncology - Medical, Surgical	0.19	20	10	0.19	45	30
Oncology - Radiation	0.06	30	15	0.06	60	40
Ophthalmology	0.24	20	10	0.24	38	25
Orthopedic Surgery	0.2	20	10	0.2	38	25
Physiatry, Rehabilitative Medicine	0.04	30	15	0.04	53	35
Plastic Surgery	0.01	30	15	0.01	75	50
Podiatry	0.19	20	10	0.19	45	30
Psychiatry	0.14	20	10	0.14	45	30
Pulmonology	0.13	20	10	0.13	45	30
Rheumatology	0.07	30	15	0.07	60	40
Urology	0.12	20	10	0.12	45	30
Vascular Surgery	0.02	30	15	0.02	75	50

## EVALUATION METHOD

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

Exhibit 6.4. Results Color Scheme

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

# RESULTS BY PLAN

## BOSTON MEDICAL CENTER HEALTHNET PLAN

This plan services Barnstable, Bristol, Hampden, Plymouth, and Suffolk counties.

### Strengths

All BMCHP Specialties received scores of **100**, or a **Green** Color. Similarly, Adult PCP and Behavioral Health Inpatient also received this score. All services that received a **Green** color are outlined in the chart that follows.

Exhibit 6.5. Services with a 100 score.

Primary Care	BH Inpatient
Adult PCP	Psych Inpatient Adult
Specialists	
Allergy and Immunology	OBGYN
Cardiology	Oncology - Medical, Surgical
Cardiothoracic Surgery	Oncology - Radiation/Radiation Oncology
Chiropractor	Ophthalmology
Dermatology	Orthopedic Surgery
Endocrinology	Physiatry, Rehabilitative Medicine
ENT/Otolaryngology	Plastic Surgery
Gastroenterology	Podiatry
General Surgery	Psychiatry
Infectious Diseases	Pulmonology
Nephrology	Rheumatology
Neurology	Urology
Neurosurgery	Vascular Surgery

### Areas for Improvement

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

Exhibit 6.6 Service Gaps and Corresponding Counties

Category	Specialty	County				
		Barnstable	Bristol	Hampden	Plymouth	Suffolk
Medical Facility	Acute Inpatient Hospital					

### Findings

- In Hampden County, there is one servicing Acute Inpatient Hospital, but the standard requires two hospitals. Therefore, this county and category are not meeting the requirement.
- Barnstable County has the most gaps in the network when compared to the other four counties.

## COMMONWEALTH CARE ALLIANCE

This plan services Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, and Plymouth, Suffolk, and Worcester counties.

### Strengths

CCA received a 100.0, or a **Green** score, in multiple service areas. All but two specialties, received a 100.0. The following chart depicts the specific areas in which the plan received **Green** scores.

Exhibit 6.7.. Services with a 100 score

Primary Care	BH Inpatient	Medical Facility
Adult PCP	Psych Inpatient Adult	Acute Inpatient Hospital
Specialists		
Allergy and Immunology	General Surgery	Orthopedic Surgery
Cardiology	Infectious Diseases	Plastic Surgery
Cardiothoracic Surgery	Nephrology	Podiatry
Chiropractor	Neurology	Psychiatry
Dermatology	OBGYN	Pulmonology
Endocrinology	Oncology - Medical, Surgical	Rheumatology
ENT/Otolaryngology	Oncology - Radiation/Radiation Oncology	Urology
Gastroenterology	Ophthalmology	Vascular Surgery

### Areas for Improvement

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

Exhibit 6.8.. Service Gaps and Corresponding Counties

	Neurosurgery	Physiatry Rehab Medicine*
Bristol		
Essex		
Franklin		
Hampden		
Hampshire		
Middlesex		
Norfolk		
Plymouth		
Suffolk		
Worcester		

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

### Findings

- The plan submitted no data for Physiatry. This specialty is shaded red.
- In the specialist category, all services meet all requirements in all counties except for Neurosurgery in Essex County.



## FALLON HEALTH

This plan services Barnstable, Bristol, Essex, Franklin, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties.

### Strengths

All Fallon Specialties except three received scores of **100**, or a **Green** Color. Similarly, The Primary Care Adult PCP and Behavioral Health Inpatient also received this score. All services that received a **Green** color are outlined in the chart that follows.

Exhibit 6.9. Services with a 100 score

Primary Care		BH Inpatient		Emergency Services	
Adult PCP		Psych Inpatient Adult		Emergency Services	
Specialists					
Allergy and Immunology			OBGYN		
Cardiology			Oncology - Radiation/Radiation Oncology		
Cardiothoracic Surgery			Ophthalmology		
Chiropractor			Orthopedic Surgery		
Dermatology			Plastic Surgery		
Endocrinology			Podiatry		
ENT/Otolaryngology			Psychiatry		
Gastroenterology			Pulmonology		
General Surgery			Rheumatology		
Infectious Diseases			Urology		
Nephrology			Vascular Surgery		
Neurology					

### Areas for Improvement

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

Table 6.10. Gaps in Service

County	Neurosurgery	Oncology Medical Surgical	Physiatry	Acute Inpatient Hospital
Barnstable				
Bristol				
Essex				
Franklin				
Hampden				
Middlesex				
Norfolk				
Plymouth				
Suffolk				
Worcester				

### Findings

- Hampden and Suffolk counties have met all requirements in every category.

## SENIOR WHOLE HEALTH

This plan services Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties.

### Strengths

All SWH Specialties except two received scores of **100**, or a **Green** Color. Primary Care Adult PCPs also received this score. All services that received a **Green** color are outlined in the chart that follows.

Exhibit 6.11. Services with a 100 Score

Primary Care	
Adult PCP	
Specialists	
Allergy and Immunology	OBGYN
Cardiology	Oncology - Medical, Surgical
Cardiothoracic Surgery	Oncology - Radiation/Radiation Oncology
Chiropractor	Ophthalmology
Dermatology	Orthopedic Surgery
Endocrinology	Physiatry, Rehabilitative Medicine
ENT/Otolaryngology	Plastic Surgery
Gastroenterology	Podiatry
General Surgery	Psychiatry
Infectious Diseases	Rheumatology
Nephrology	Urology
Neurosurgery	Vascular Surgery

### Areas for Improvement

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

Table 6.12. Various Service Gaps

County	Neurology	Pulmonology	Psych Inpatient Adult	Acute Inpatient Rehab
Bristol				
Essex				
Hampden				
Middlesex				
Norfolk				
Plymouth				
Suffolk				
Worcester				

### Findings

- Essex County has the most network gaps when compared to the other 7 counties.

## TUFTS HEALTH PLAN

This plan services Barnstable, Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties.

### Strengths

All Tufts Specialties except for Neurosurgery received scores of **100**, or a **Green** Color. Similarly, the Primary Care Adult PCP received this score.

Exhibit 6.13. Services with a 100 score

Primary Care	Medical Facility
Adult PCP	Acute Inpatient Hospital
Specialists	
Allergy and Immunology	Oncology - Medical, Surgical
Cardiology	Oncology - Radiation/Radiation Oncology
Cardiothoracic Surgery	Ophthalmology
Chiropractor	Orthopedic Surgery
Dermatology	Physiatry, Rehabilitative Medicine
Endocrinology	Plastic Surgery
ENT/Otolaryngology	Podiatry
Gastroenterology	Psychiatry
General Surgery	Pulmonology
Infectious Diseases	Rheumatology
Nephrology	Urology
Neurology	Vascular Surgery
OBGYN	

### Areas for Improvement

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

Table 6.14. Various Service Gaps

County	Specialists	BH Inpatient
	Neurosurgery	Psych Inpatient Adult
Barnstable		
Bristol		
Essex		
Hampden		
Middlesex		
Norfolk		
Plymouth		
Suffolk		
Worcester		

### Findings

Tufts Health Plans behavioral health inpatient network was deficient in three counties, i.e., Barnstable, Hampden, and Plymouth Counties.

## UNITEDHEALTHCARE

This plan services Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties.

### Strengths

All UHC Specialties received scores of **100**, or a **Green** Color. Similarly, Primary Care Adult PCPs and Behavioral Health Inpatient services also received this score. All services that received a score of 100 are outlined in the chart that follows.

Exhibit 6.15. Services with a 100.0 score

Primary Care	BH Inpatient	Medical Facility
Adult PCP	Psych Inpatient Adult	Acute Inpatient Hospital
Specialists		
Allergy and Immunology	OBGYN	
Cardiology	Oncology - Medical, Surgical	
Cardiothoracic Surgery	Oncology - Radiation/Radiation Oncology	
Chiropractor	Ophthalmology	
Dermatology	Orthopedic Surgery	
Endocrinology	Physiatry, Rehabilitative Medicine	
ENT/Otolaryngology	Plastic Surgery	
Gastroenterology	Podiatry	
General Surgery	Psychiatry	
Infectious Diseases	Pulmonology	
Nephrology	Rheumatology	
Neurology	Urology	
Neurosurgery	Vascular Surgery	

### Findings

UnitedHealthcare met all Medicare Advantage network requirements.

## CONCLUSION

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

Over the course of this analysis, Kepro has identified many strengths across the SCO plans. Certain areas, such as the Chiropractic Services and Psychiatry, excelled in all SCO plans' analysis. Primary Care for adults excelled in all plans and areas except one county.



Section 7

# Appendices

---

# APPENDIX. CONTRIBUTORS

## Performance Measure Validation

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

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

## Performance Improvement Project Reviewers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



data-driven performance management systems. Dr. Stelk has consulted with Kepro for five years as a senior external quality reviewer and technical advisor for healthcare performance improvement projects.

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

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

## **Compliance Validation Reviewers**

### **Jennifer Lenz, MPH, CHCA**

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

### **Jane Goldsmith, RN, MBA, CSSGB, CHC**

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

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

**Sue McConnell, RN, MSN**

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

**Poornima Dabir, MPH, CHCA**

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

**Debra Homovich, BA** Ms. Homovich has 10 years of experience in the healthcare industry, with expertise in conducting quality reviews and in managing teams performing healthcare compliance validations. Her prior experience includes URAC data validation, compliance auditing, and performance of external quality review organization activities. She has conducted

compliance review activities in the states of Alabama, Massachusetts, and South Dakota. Ms. Homovich is a Certified Public Accountant licensed in Pennsylvania. She received her bachelor's degree in accounting from Alvernia University.

## **Project Management**

### **Cassandra Eckhof, M.S.**

Ms. Eckhof has over 25 years managed care and quality management experience and has worked in the private, non-profit, and government sectors. She has managed the MassHealth external quality review program since 2016. Ms. Eckhof has a master's of science degree in health care administration and is a Certified Professional in Healthcare Quality. She is currently pursuing a graduate certificate in Public Health Ethics at the University of Massachusetts at Amherst.

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

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