Senior Care Organizations External Quality Review

Calendar Year 2021

MassHealth
Massachusetts Executive Office
of Health & Human Services

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

Table of Contents

5 | Section 5. Network Adequacy Validation 126

Contributors 167

Section 1.

The Senior Care Organizations

SECTION 1. THE SENIOR CARE ORGANIZATIONS

Descriptions of MassHealth's six Senior Care Organizations are described below. See the map of Massachusetts' counties in Exhibit 1.1 for reference in reviewing each plan's service area.[1]

Exhibit 1.1. County Map

PLAN DESCRIPTIONS

Boston Medical Center HealthNet Plan

Boston Medical Center HealthNet Plan's Senior Care Organization is headquartered in Charlestown, Massachusetts. Its corporate parent is Boston Medical Center Health System, Inc. The enrollment area includes Barnstable, Bristol, Hampden, Plymouth, and Suffolk counties. It received a 3.5-star rating overall from CMS. Additional information is available at www.seniorsgetmore.org.

Commonwealth Care Alliance

Commonwealth Care Alliance is headquartered in Boston. Beneficiaries in Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties are eligible to enroll. It was awarded 5 Stars by CMS and is seeking NCQA accreditation. More information about CCA is available at www.commonwealthcare.org.

Fallon Health

Fallon Health's Senior Care Organization has a service area that includes the entire state of Massachusetts, except for Dukes and Nantucket counties. It received a 4.5-star rating from CMS. The corporate offices are in Worcester. Additional information is available at fchp.org/find-insurance/navicare/About-NaviCare.aspx.

Senior Whole Health by Molina Healthcare

Senior Whole Health was acquired by its corporate parent, Molina Healthcare, in 2021. It operates in Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. Its health plan is accredited by NCQA for both Medicaid and Medicare and received a 4.5-star rating from CMS. Additional information is available at www.SWHMA.com.

Tufts Associated Health Maintenance Organization

Tufts' SCO plan is operated by Tufts Associated Health Maintenance Organization. On January 1, 2021, Tufts Health Plan merged with Harvard Pilgrim Health Care. Its newly formed corporate parent in Point32Health. Beneficiaries in Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties are eligible to enroll. Due to the merger, it has not yet been assigned a star rating by CMS. More information is available at www.tuftshealthplan.com/visitor/about-us/about-us.

UnitedHealthcare Community Plan

Headquartered in Waltham, the Senior Care Option plan is wholly owned by UHIC Holdings. Beneficiaries in Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties are eligible to enroll. It was awarded a 5-Star rating by CMS. Additional information is available at www.uhcprovider.com/content/provider/en/health-plans-by-state/massachusetts-health-plans/ma-medicare-plans/ma-dual-complete-snp-plans.html.

MASSHEALTH SENIOR CARE ORGANIZATION PLAN MEMBERSHIP

Exhibit 1.2. 2021 MassHealth SCO Membership

Senior Care Organization	Abbreviation Used in this Report	Membership as of December 31, 2021[1]	Percent of Total SCO Population
Boston Medical Center HealthNet Plan	BMCHP	1,781	2.56%
Commonwealth Care Alliance	CCA	12,776	18.37%
Fallon Health	Fallon	8,093	11.64%
Senior Whole Health by Molina Health Care	SWH	14,897	21.42%
Tufts Associated Health Maintenance Organization	Tufts	9,263	13.32%
UnitedHealthcare Community Plan	UHC	22,738	32.69%
Total		**69,548**	

[1] 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 U.S. 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 healthcare 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 plans, including the Senior Care Organizations which are the subject of this report. All MassHealth managed care plans participate in EQR.

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

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

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

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

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2021 reflect 2020 quality measurement performance. Performance Improvement Project reporting is inclusive of activities conducted in CY 2021.

METHODOLOGY FOR PREPARING THE EXTERNAL QUALITY REVIEW TECHNICAL REPORT

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

Data Sources

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

Performance Measure Validation
- The SCO HEDIS Final Audit Report
- The HEDIS IDSS worksheet
- The 2021 NCQA Medicare Quality Compass
- The Performance Measure Validation recommendations included in the 2020 EQR technical report

Performance Improvement Project Validation
- The Baseline Project Planning and Baseline Performance Indicator Reports
- Supplemental information as identified by the SCO
- Recommendations offered in the previous reporting period (Spring 2021)

Network Adequacy Validation
- Network provider files in an Excel format provided by the SCO
- MassHealth provider network adequacy standards
- The Network Adequacy 2021 recommendations contained in the 2021 EQR technical report

Data Analysis

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

Drawing Conclusions

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

Performance Measure Validation: Did the SCO's methodology for measure calculation comply with HEDIS technical specifications?
- Performance Improvement Plan Validation: Did the SCO's Performance Improvement Project Report comply with established criteria? Do the interventions show promise for effecting improvement?
- Network Adequacy Validation: Did the SCO's provider network files appear to be complete? Did the analysis show the required number and geographic distribution of providers and facilities to serve MassHealth members?

PERFORMANCE MEASURE VALIDATION (PMV) & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

Exhibit 2.1. Performance Measure Validation Process Overview

Topic	Description
Objectives	To assess the accuracy of performance measures in accordance with 42 CFR § 438.358(b)(ii) reported by the SCO and to determine the extent to which the SCO 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) using the analytic approach established in CMS EQR Protocol 2.
Data obtained	Each SCO submitted its HEDIS Final Audit Report, the National Committee for Quality Assurance (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 SCO. It determines the extent to which the SCO follows state specifications and reporting requirements. In 2021, 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:

- Colorectal Cancer Screening (COL);
- Controlling High Blood Pressure (CBP); and
- Transitions of Care (TRC): Medication Reconciliation Post-Discharge.

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.

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) and using the analytic approach established in CMS EQR Protocol 1.
Data obtained	SCOs submitted two PIP reports in 2021, the Baseline Project Planning Report (March 2021) and the Baseline Performance Indicator Report (September 2021). 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. Of the twelve performance improvement projects validated, Kepro's reviewers had high confidence in ten projects and moderate confidence in two.

MassHealth SCOs conduct two contractually required Performance Improvement Projects annually. In 2021, MassHealth directed the SCOs to conduct performance improvement on the following topics:

- Vaccination; and
- Telehealth Access.

In addition, MassHealth directed SCOs to conduct one vaccination-related intervention that aimed to address racial disparities within their populations.

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.

NETWORK ADEQUACY VALIDATION

Exhibit 2.3. 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 and provider to member ratio 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 software was used to compile and analyze network information provided by the SCOs.
Data obtained	SCOs provided Excel worksheets containing demographic information about their provider networks.
Conclusions	Senior Care Organizations demonstrated high compliance with Medicare Advantage time and distance and provider to member ratio requirements. All SCO plans have opportunities for improvement with Medicaid standards, the most significant of which is non-compliance with Residential Rehabilitation Services for Substance Use Disorders.

The network adequacy validation process assesses SCO compliance with Medicare Advantage and Medicaid network standards. On a scale of 1 to 100, MassHealth requires SCOs to score 90 or above to be considered in compliance. All SCO plans scored above 90 for Medicare Advantage network standards, placing them in compliance for these services. The average adequacy score was 97.18 with a range of 91.4 to 100.

SCOs demonstrated many network strengths for Medicaid services. Certain specialties, such as Outpatient Behavioral Health services, excelled in all SCO plan analysis. Recovery Coaching and Recovery Support Navigator services excelled in all plans except UnitedHealthcare. The average adequacy score for Medicaid services was 78.73, with a range of 60.3 to 91.1.

THE MASSHEALTH QUALITY STRATEGY

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

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

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

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

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

Provider Network

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

Kepro recommends that MassHealth leverage Quest Analytics' ability to report on provider non-English language capacity. Additionally, MassHealth should consider an assessment of provider directory information accuracy as the provider directory is foundational piece of member information. *(Access, Timeliness of Care)*

MassHealth and the plans both need to increase their oversight of network adequacy, especially as it relates to appointment access. The network adequacy validation activities demonstrated non-compliance with contractually required time and distance standards. Kepro encourages MassHealth program staff to take a more active role in monitoring SCO compliance with these requirements. Kepro recommends that MassHealth provide related direction on the evaluation of appointment access against standards for services such as symptomatic and non-symptomatic office visits, behavioral health, and urgent care. Finally, Kepro encourages MassHealth to consider the practical feasibility of its network adequacy standards, especially those for the less populated areas of Berkshire, Dukes, and Nantucket counties. The Quest Analytics systems permits the designation of exceptions for individual provider-county combinations. Doing so would allow the system to report a more accurate picture of network adequacy. *(Access, Timeliness of Care)*

Health Equity

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

In 2021, SCOs were required to design vaccination-related interventions with the goal of reducing health disparities. It was Kepro's experience that SCOs struggled with this

requirement experiencing difficulty with the definition of a focal population and culturally sensitive project plans. Kepro strongly encourages MassHealth to consider ways in which technical assistance can be provided to the plans on REL data analysis and the design of associated project interventions. *(Access and Quality)*

Performance Improvement Projects

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

Communication Pathways

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

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

Section 3.

Performance Measure Validation
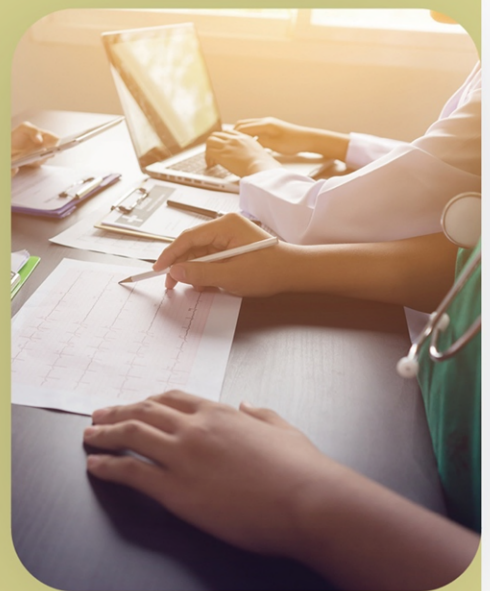
SECTION 3. PERFORMANCE MEASURE VALIDATION

The Performance Measure Validation process assesses the accuracy of performance measures reported by the SCO. It determines the extent to which the SCO collects and uses accurate data and 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.

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

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

The first part of the audit is a review of the 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 organizational information management practices that affect HEDIS reporting. The Final Audit Report contains the plan's results for measures audited.

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

Exhibit 3.1. 2021 SCO Validated Performance Measures

Measure	Measure Description
Colorectal Cancer Screening (COL) *Rationale for Selection: The Plan average is under the 50th NCQA Medicare Quality Compass percentile. There is great variability in plan performance.*	The percentage of members 50 to 75 years of age who had appropriate screening for colorectal cancer.
Controlling High Blood Pressure (CBP) *Rationale for Selection: The Plan average is under the 50th NCQA Medicare Quality Compass percentile. There is great variability in plan performance.*	The percentage of members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (less than 140/90 millimeters of mercury [mmHg]) during the measurement year.
Transitions of Care (TRC) Medication Reconciliation Post-Discharge *Rationale for Selection: There is great variability in plan performance.*	The percentage of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Kepro's SCO PMV audit methodology assesses both the quality of the source data that feed into the PMV measure under review and the accuracy of 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. Kepro uses the following ratings for Performance Measure Validation review elements:

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

Colorectal Cancer Screening (COL)

The hybrid methodology is used to calculate COL measure. The following tables outline the review elements and ratings that the SCO plans received.

Exhibit 3.2a. COL Technical Specification Compliance

Category	Denominator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Population	SCO population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Population	Members 51 to 75 years of age or older as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Population	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
Geographic Area	Includes only those Medicaid enrollees served in SCO's reporting area.	Met	Met	Met	Met	Met	Met

Exhibit 3.2b. COL Technical Specification Compliance

Category	Numerator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Counting Clinical Events	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
Counting Clinical Events	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
Counting Clinical Events	One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following: • FOBT during the measurement year. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. • Colonoscopy during the measurement year or the nine years prior to the measurement year. • Computed tomography (CT) colonography during the measurement year or the four years prior to the measurement year. • Fecal immunochemical test (FIT)-DNA during the measurement year or the two years prior to the measurement year.	Met	Met	Met	Met	Met	Met

Category	Numerator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Data Quality	Based on the IS assessment findings, the data sources used were accurate.	Met	Met	Met	Met	Met	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data	Members receiving palliative care during the measurement year.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data	Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • 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.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data	Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded: • At least one claim/encounter for frailty during the measurement year. • Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): — At least two outpatient visits, observation visits, emergency department (ED) visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters, nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. — At least one acute inpatient encounter with an advanced illness diagnosis.	Met	Met	Met	Met	Met	Met

Category	Numerator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
	— At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. — A dispensed dementia medication.						
Proper Exclusion Methodology in Administrative Data	Optional Exclusion: Either of the following any time during the member's history through December 31 of the measurement year: • Colorectal cancer • Total colectomy	Met	Met	Met	Met	Met	Met
Hybrid Measure	If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
Hybrid Measure	If the hybrid method was used, the SCO passed the NCQA Final Medical Record Review Overread component of the HEDIS MY 2020 HEDIS Compliance Audit.	Met	Met	Met	Met	Met	Met

Exhibit 3.2c. COL Technical Specification Compliance

Category	Sampling Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Unbiased Sample	As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met	Met	Met	Met	Met
Sample Size	After exclusions, the sample size was equal to 1) 411; 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate; or 3) the total population.	Met	Met	Met	Met	Met	Met
Proper Substitution Methodology in Medical Record Review	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
Proper Substitution Methodology in Medical Record Review	Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met	Met	Met	Met	Met

Controlling High Blood Pressure (CBP)

The hybrid methodology is used to calculate the CBP measure. The following tables outline the review elements and ratings that the SCO plans received.

Exhibit 3.3a. CBP Technical Specification Compliance

Category	Denominator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Population	Medicaid population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Population	Members 18 to 85 years of age or older as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Population	Members were continuously enrolled during the measurement year, with no more than a one-month gap.	Met	Met	Met	Met	Met	Met
Population	Members who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: • Outpatient visit with any diagnosis of hypertension. • A telephone visit with any diagnosis of hypertension. • An e-visit or virtual check-in with any diagnosis of hypertension.	Met	Met	Met	Met	Met	Met
Geographic Area	Includes only those Medicaid enrollees served in SCO's reporting area.	Met	Met	Met	Met	Met	Met

Exhibit 3.3b. CBP Technical Specification Compliance

Category	Numerator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Counting Clinical Events	Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
Counting Clinical Events	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
Counting Clinical Events	Members had evidence of adequately controlled blood pressure as documented through either administrative data or medical record review.	Met	Met	Met	Met	Met	Met
Data Quality	Based on the IS assessment findings, the data sources used were accurate.	Met	Met	Met	Met	Met	Met

Category	Numerator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data	Members receiving palliative care during the measurement year.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data	Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: ● Enrolled in an I-SNP any time during the measurement year. ● 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.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data	Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded: ● At least one claim/encounter for frailty during the measurement year. ● Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): — At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters, nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. — At least one acute inpatient encounter with an advanced illness diagnosis.	Met	Met	Met	Met	Met	Met

Category	Numerator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
	— At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. — A dispensed dementia medication.						
Proper Exclusion Methodology in Administrative Data	Members 81 years of age and older as of December 31 of the measurement year with frailty during the measurement year.	Met	Met	Met	Met	Met	Met
Hybrid Measure	If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
Hybrid Measure	If the hybrid method was used, the SCO passed the Final Medical Record Review Over-Read component of its MY 2020 HEDIS Compliance Audit.	Met	Met	Met	Met	Met	Met

Exhibit 3.3c. CBP Technical Specification Compliance

Category	Sampling Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Unbiased Sample	As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met	Met	Met	Met	Met
Sample Size	After exclusions, the sample size was equal to 1) 411; 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate; or 3) the total population.	Met	Met	Met	Met	Met	Met
Proper Substitution Methodology in Medical Record Review	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
Proper Substitution Methodology in Medical Record Review	Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met	Met	Met	Met	Met

Transitions of Care (TRC): Medication Reconciliation Post-Discharge

The hybrid methodology is used to calculate the TRC measure. The following tables outline the review elements and ratings that the SCO plans received.

Exhibit 3.4a. TRC Technical Specification Compliance

Category	Denominator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Population	Medicaid population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Population	18 years and older as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Population	Members were continuously enrolled from the date of discharge (from below) through 30 days after discharge (31 total days).	Met	Met	Met	Met	Met	Met
Population	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 (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on 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 Medicaid enrollees served in SCO's reporting area.	Met	Met	Met	Met	Met	Met

Exhibit 3.4b. TRC Technical Specification Compliance

Category	Numerator Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
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
Counting Clinical Events	Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
Counting Clinical Events	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
Data Quality	Based on the IS assessment findings, the data sources used were accurate.	Met	Met	Met	Met	Met	Met
Data Quality	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data	If a member remains in an acute or nonacute facility through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year and may not assume the member remained admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.	Met	Met	Met	Met	Met	Met
Hybrid Measure	If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
Hybrid Measure	If the hybrid method was used, the SCO passed the Final Medical Record Review Over-Read component of its MY 2020 HEDIS Compliance Audit.	Met	Met	Met	Met	Met	Met

Exhibit 3.4c. TRC Technical Specification Compliance

Category	Sampling Element	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Unbiased Sample	As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met	Met	Met	Met	Met
Sample Size	After exclusions, the sample size was equal to 1) 411; 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate; or 3) the total population.	Met	Met	Met	Met	Met	Met
Proper Substitution Methodology in Medical Record Review	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
Proper Substitution Methodology in Medical Record Review	Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met	Met	Met	Met	Met

COMPARATIVE RESULTS

Colorectal Cancer Screening (COL): The table that follows depicts MassHealth SCO performance on the Colorectal Cancer Screening rate.

Exhibit 3.5. 2020 COL Rates of MassHealth SCOs

SCO	HEDIS 2020	NCQA Medicare Quality Compass Percentile Range
BMCHP	69.4%	Between 33 and 50
CCA	75.7%	Between 50 and 66
Fallon	61.7%	Between 10 and 25
SWH	74.0%	Between 50 and 66
Tufts	63.9%	Between 10 and 25
UHC	77.0%	Between 66 and 75

Controlling High Blood Pressure (CBP):   The table that follows depicts MassHealth SCO performance on the Controlling High Blood Pressure rate.

Exhibit 3.6. 2020 CBP Rates of MassHealth SCOs

SCO	HEDIS 2020	NCQA Medicare Quality Compass Percentile Range
BMCHP	57.9%	Between 25 and 33
CCA	59.4%	Between 33 and 50
Fallon	57.7%	Between 25 and 33
SWH	54.9%	Between 10 and 25
Tufts	54.0%	Between 10 and 25
UHC	50.7%	Between 10 and 25

Transitions of Care (TRC): Medication Reconciliation Post-Discharge: The table that follows depicts MassHealth SCO performance on the Transitions of Care: Medication Reconciliation Post-Discharge rate.

Exhibit 3.7. 2020 TRC Rates of MassHealth SCOs

SCO	HEDIS 2020	NCQA Medicare Quality Compass Percentile Range
BMCHP	72.9%	Between 50 and 66
CCA	49.6%	Between 10 and 25
Fallon	85.4%	Between 75 and 90
SWH	43.1%	Between 10 and 25
Tufts	43.1%	Between 10 and 25
UHC	51.9%	Between 10 and 25

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

CMS regulations require that each SCO 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 3.8. 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

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

BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Boston Medical Center HealthNet Plan (BMCHP)**
Performance measure name**: Colorectal Cancer Screening (COL)**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50 to 75 years of age
Definition of numerator (describe): The number of members 50 to 75 years of age who received appropriate screening for colorectal cancer.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Measure Results

Numerator	261
Denominator	376
Rate	69.41%

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 Information Systems Capability Assessment (ISCA) or other information systems audit that affected the reliability or validity of the performance measure results.

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

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

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

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

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

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

☐ Not applicable (ISCA not reviewed)

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

BMCHP passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. BMCHP conducted the medical record reviews. BMCHP had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: BMCHP's performance on the *Colorectal Cancer Screening (COL)* measure was below the 50th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that BMCHP consider the development of related quality improvement initiatives.

Quality-Related: 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.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Boston Medical Center HealthNet Plan (BMCHP)**
Performance measure name**: Controlling High Blood Pressure (CBP)**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension
Definition of numerator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement year.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	238
Denominator	411
Rate	57.91%

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

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

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

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

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

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

☐ Not applicable (ISCA not reviewed)

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

BMCHP passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. BMCHP conducted the medical record reviews. BMCHP had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: BMCHP's performance on the *Controlling High Blood Pressure (CBP)* measure was below the 33rd percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that BMCHP consider the development of related quality improvement initiatives.

Quality-Related: 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.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Boston Medical Center HealthNet Plan (BMCHP)**
Performance measure name**: Transitions of Care (TRC): Medication Reconciliation Post-Discharge**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges for members 18 years of age and older.
Definition of numerator (describe): The number of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	231
Denominator	317
Rate	72.87%

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

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

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

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

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

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

☐ Not applicable (ISCA not reviewed)

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

BMCHP passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. BMCHP conducted the medical record reviews. BMCHP had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the performance measure calculation.
None identified.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of performance measure calculation: **Quality-Related:** 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

Quality-Related: BMCHP used a lab supplemental data source for HEDIS reporting.

Opportunities for Improvement

- **Quality-Related:** BMCHP's performance on the *Colorectal Cancer Screening (COL)* measure was below the 50th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that BMCHP consider the development of related quality improvement initiatives.
- **Quality-Related:** BMCHP's performance on the *Controlling High Blood Pressure (CBP)* measure was below the 33rd percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that BMCHP consider the development of related quality improvement initiatives.
- **Quality-Related:** 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.

Follow Up to Calendar Year 2020 Recommendations

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

Exhibit 3.9. Update to CY 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
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	Plan did not provide update	Unknown

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
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	Plan did not provide update	Unknown
To improve reporting rates, Kepro recommends the use of supplemental data sources in addition to laboratory data.	Plan did not provide update	Unknown

COMMONWEALTH CARE ALLIANCE (CCA)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Commonwealth Care Alliance (CCA)**
Performance measure name: **Colorectal Cancer Screening (COL)**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ)   ☐ Centers for Disease Control and Prevention (CDC)   ☐ Centers for Medicare & Medicaid Services (CMS)   ☒ National Committee for Quality Assurance (NCQA)   ☐ The Joint Commission (TJC)   ☐ No measure steward, developed by state/EQRO   ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply)   ☒ HEDIS®   ☐ CMS Child or Adult Core Set   ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply)   ☒ Administrative data (describe) HEDIS auditor-approved data sources   ☒ Medical records (describe) See below   ☐ 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.   ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50 to 75 years of age
Definition of numerator (describe): The number of members 50 to 75 years of age who received appropriate screening for colorectal cancer
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	193
Denominator	255
Rate	75.69%

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, Public Consulting Group (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.

Medical Record Review. CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. 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 regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. CCA maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None Identified.

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

---

EQRO recommendations for improvement of performance measure calculation:

None identified.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Commonwealth Care Alliance (CCA)**
Performance measure name**: Controlling High Blood Pressure (CBP)**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension
Definition of numerator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement year.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	244
Denominator	411
Rate	59.37%

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.

Medical Record Review. CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. 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 regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. CCA maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

None Identified. CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None Identified.

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

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: CCA's performance on the *Controlling High Blood Pressure* measure was below the 50th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that CCA consider the development of related quality improvement initiatives.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Commonwealth Care Alliance (CCA)**
Performance measure name: **Transitions of Care (TRC): Medication Reconciliation Post-Discharge**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges for members 18 years of age and older.
Definition of numerator (describe): The number of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	204
Denominator	411
Rate	49.64%

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.

Medical Record Review. CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. 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 regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. CCA maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

CCA passed Medical Record Review Validation with its licensed HEDIS audit firm, Advent Advisory Group, for HEDIS MY 2020. Inovalon's software was used to produce the HEDIS hybrid measures. CCA conducted the medical record reviews. CCA had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None Identified.

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

---

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: CCA's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that CCA consider the development of related quality improvement initiatives.

Plan Strengths
Quality-Related - CCA used supplemental data for HEDIS reporting.

Opportunities for Improvement
- **Quality-Related:** CCA's performance on the *Controlling High Blood Pressure* measure was below the 50th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that CCA consider the development of related quality improvement initiatives.
- **Quality-Related:** CCA's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that CCA consider the development of related quality improvement initiatives.

Follow Up to Calendar Year 2020 Recommendations
CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. Kepro offered no recommendations to CCA in 2020.

FALLON HEALTH (FALLON)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Fallon Health (Fallon)**
Performance measure name**: Colorectal Cancer Screening (COL)**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50 to 75 years of age
Definition of numerator (describe):   The number of members 50 to 75 years of age who received appropriate screening for colorectal cancer.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	229
Denominator	371
Rate	61.73%

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 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 daily from its Pharmacy Benefit Manager, 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 its vendors.

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.

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

Supplemental Data. Fallon successfully used supplemental data sources for HEDIS 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 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. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. 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 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.

Fallon passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Fallon conducted the medical record reviews. Fallon had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: Fallon's performance on the *Colorectal Cancer Screening (COL)* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Fallon consider the development of related quality improvement initiatives.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Fallon Health (Fallon)**
Performance measure name**: Controlling High Blood Pressure (CBP)**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension
Definition of numerator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement year.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	237
Denominator	411
Rate	57.66%

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 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 daily from its Pharmacy Benefit Manager, 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 its vendors.

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.

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

Supplemental Data. Fallon successfully used supplemental data sources for HEDIS 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 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. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. 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 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.

Fallon passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Fallon conducted the medical record reviews. Fallon had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: Fallon's performance on the *Controlling High Blood Pressure (CBP)* measure was below the 33rd percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Fallon consider the development of related quality improvement initiatives.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Fallon Health (Fallon)**
Performance measure name: **Transitions of Care (TRC): Medication Reconciliation Post-Discharge**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges for members 18 years of age and older.
Definition of numerator (describe): The number of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	351
Denominator	411
Rate	85.40%

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 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 daily from its pharmacy benefit manager, 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 its vendors.

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.

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

Supplemental Data. Fallon successfully used supplemental data sources for HEDIS 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 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. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. 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 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.

Fallon passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Cotiviti's software was used to produce the HEDIS hybrid measures. Fallon conducted the medical record reviews. Fallon had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ 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

- **Quality-Related:** Fallon's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was above the 75th percentile compared to the NCQA Medicare Quality Compass MY 2020 data.
- **Quality-Related:** Fallon used supplemental data for HEDIS reporting.

Opportunities for Improvement

- **Quality-Related:** Fallon's performance on the *Colorectal Cancer Screening (COL)* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Fallon consider the development of related quality improvement initiatives.
- **Quality-Related:** Fallon's performance on the *Controlling High Blood Pressure (CBP)* measure was below the 33rd percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Fallon consider the development of related quality improvement initiatives.

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 2020 PMV recommendation follows:

Exhibit 3.10. Update to CY 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
Implement quality improvement initiatives to increase the Colorectal Cancer Screening rate.	• Care Navigators call members to determine if they have received a colorectal cancer screening or plan on getting one and facilitate appointments as needed. • Fallon generates project in which members due for a colorectal cancer screening are identified. With provider input, members due for screenings are sent a home testing kit.	High

SENIOR WHOLE HEALTH BY MOLINA HEALTH CARE (SWH)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Senior Whole Health by Molina Health Care (SWH)**
Performance measure name: **Colorectal Cancer Screening (COL)**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50 to 75 years of age
Definition of numerator (describe): The number of members 50 to 75 years of age who received appropriate screening for colorectal cancer.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Kepro calculated SWH's COL rate as a weighted average of its two HEDIS-reported rates for Org ID: 6670, Sub IDs: 8438 and 11970.

Data Element	Sub ID 8438	Sub ID 11970	Weighted Average
Numerator	308	293	
Denominator	411	411	
Rate	74.94%	71.29%	74.01%

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 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 its vendors.

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.

Medical Record Review. SWH passed Medical Record Review Validation with its licensed HEDIS audit firm, HealthcareData Company, for HEDIS MY 2020. REVELEER medical record abstraction tools were used for HEDIS hybrid abstraction. REVELEER conducted the medical record reviews. SWH had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. SWH successfully used both standard and nonstandard supplemental data sources for HEDIS reporting. There were no issues with the supplemental data used to produce performance measures.

Data Integration. SWH's performance measures were produced using Inovalon software. SWH had adequate processes for ensuring data completeness and referential integrity at each transfer point to the Inovalon HEDIS warehouse. Preliminary rates were reviewed, and any variances investigated. There were no issues identified with data integration processes. 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 regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. SWH maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

SWH passed Medical Record Review Validation with its licensed HEDIS audit firm, HealthcareData Company, for HEDIS MY 2020. REVELEER medical record abstraction tools were used for HEDIS hybrid abstraction. REVELEER conducted the medical record reviews. SWH had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation.
None identified.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of performance measure calculation:
None identified.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Senior Whole Health by Molina Health Care (SWH)**
Performance measure name: **Controlling High Blood Pressure (CBP)**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension
Definition of numerator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement year.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Kepro calculated SWH's CBP rate as a weighted average of its two HEDIS-reported rates for Org ID: 6670, Sub IDs: 8438 and 11970.

Data Element	Sub ID 8438	Sub ID 11970	Weighted Average
Numerator	212	256	
Denominator	411	411	
Rate	51.58%	62.29%	54.91%

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 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 its vendors.

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.

Medical Record Review. SWH passed Medical Record Review Validation with its licensed HEDIS audit firm, HealthcareData Company, for HEDIS MY 2020. REVELEER medical record abstraction tools were used for HEDIS hybrid abstraction. REVELEER conducted the medical record reviews. SWH had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. SWH successfully used both standard and nonstandard supplemental data sources for HEDIS reporting. There were no issues with the supplemental data used to produce performance measures.

Data Integration. SWH's performance measures were produced using Inovalon software. SWH had adequate processes for ensuring data completeness and referential integrity at each transfer point to the Inovalon HEDIS warehouse. Preliminary rates were reviewed, and any variances investigated. There were no issues identified with data integration processes. 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 regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. SWH maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

SWH passed Medical Record Review Validation with its licensed HEDIS audit firm, HealthcareData Company, for HEDIS MY 2020. REVELEER medical record abstraction tools were used to for HEDIS hybrid abstraction. REVELEER conducted the medical record reviews. SWH had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. None identified.
Validation rating: ☒ High confidence   ☐ Moderate confidence   ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of performance measure calculation: **Quality-Related:** SWH's performance on the *Controlling High Blood Pressure* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that SWH consider the development of related quality improvement initiatives.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Senior Whole Health by Molina Health Care (SWH)**
Performance measure name: **Transitions of Care (TRC): Medication Reconciliation Post-Discharge**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges for members 18 years of age and older.
Definition of numerator (describe): The number of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Kepro calculated SWH's TRC rate as a weighted average of its two HEDIS-reported rates for Org ID: 6670, Sub IDs: 8438 and 11970.

Data Element	Sub ID 8438	Sub ID 11970	Weighted Average
Numerator	189	166	
Denominator	411	411	
Rate	45.99%	40.39%	43.10%

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. 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 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 its vendors.

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.

Medical Record Review. SWH passed Medical Record Review Validation with its licensed HEDIS audit firm, HealthcareData Company, for HEDIS MY 2020. REVELEER medical record abstraction tools were used for HEDIS hybrid abstraction. REVELEER conducted the medical record reviews. SWH had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

Supplemental Data. SWH successfully used both standard and nonstandard supplemental data sources for HEDIS reporting. There were no issues with the supplemental data used to produce performance measures.

Data Integration. SWH's performance measures were produced using Inovalon software. SWH had adequate processes for ensuring data completeness and referential integrity at each transfer point to the Inovalon HEDIS warehouse. Preliminary rates were reviewed, and any variances investigated. There were no issues identified with data integration processes. 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 regarding development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. SWH maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

SWH passed Medical Record Review Validation with its licensed HEDIS audit firm, HealthcareData Company, for HEDIS MY 2020. REVELEER medical record abstraction tools were used for HEDIS hybrid abstraction. REVELEER conducted the medical record reviews. SWH had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. None identified.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of performance measure calculation: **Quality-Related:** SWH's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that SWH consider the development of related quality improvement initiatives.

Plan Strengths
SWH used supplemental data for HEDIS reporting.

Opportunities for Improvement
- **Quality-Related:** SWH's performance on the *Controlling High Blood Pressure* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that SWH consider the development of related quality improvement initiatives.
- **Quality-Related:** SWH's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that SWH consider the development of related quality improvement initiatives.

Follow Up to Calendar Year 2020 Recommendations
CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. Kepro offered no recommendations to SWH in 2020.

TUFTS ASSOCIATED HEALTH MAINTENANCE ORGANIZATION (TUFTS)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Tufts Associated Health Maintenance Organization (Tufts)**
Performance measure name**: Colorectal Cancer Screening (COL)**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50 to 75 years of age
Definition of numerator (describe): The number of members 50 to 75 years of age who had appropriate screening for colorectal cancer
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	200
Denominator	313
Rate	63.90%

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. Tufts processed claims using the Diamond system. Most claims were submitted electronically to the plan and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims within Diamond except for pharmacy claims which were handled by its pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

Enrollment Data. Tufts used Market Prominence and Diamond to process enrollment data. Both systems captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.

Medical Record Review. Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Tufts conducted the medical record reviews on internally developed forms. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

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

Data Integration. All performance measure rates were produced internally by Tufts using internally developed source code. Tufts had adequate processes to track completeness and accuracy of data at each transfer point to its HEDIS warehouse. 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. Tufts produced the performance measures using internally developed source code. The source code was reviewed and found compliant with the HEDIS technical specifications by its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020 for two of the PMV measures: *Controlling High Blood Pressure (CBP)* and *Transitions of Care (TRC): Medication Reconciliation Post-Discharge*. Kepro reviewed and approved the source code for the *Colorectal Cancer Screening (COL)* measure.

☐ Not applicable (ISCA not reviewed)

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

Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Tufts conducted the medical record reviews on internally developed forms. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

---

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: Tufts' performance on the *Colorectal Cancer Screening (COL)* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts consider the development of related quality improvement initiatives.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Tufts Associated Health Maintenance Organization (Tufts)**
Performance measure name: **Controlling High Blood Pressure (CBP)**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension
Definition of numerator (describe): The number of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement year.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	222
Denominator	411
Rate	54.01%

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. Tufts processed claims using the Diamond system. Most claims were submitted electronically to the plan and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims within Diamond except for pharmacy claims which were handled by its pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

Enrollment Data. Tufts used Market Prominence and Diamond to process enrollment data. Both systems captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.

Medical Record Review. Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Tufts conducted the medical record reviews on internally developed forms. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

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

Data Integration. All performance measure rates were produced internally by Tufts using internally developed source code. Tufts had adequate processes to track completeness and accuracy of data at each transfer point to its HEDIS warehouse. 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. Tufts produced the performance measures using internally developed source code. The source code was reviewed and found compliant with the HEDIS technical specifications by its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020 for two of the PMV measures: *Controlling High Blood Pressure (CBP)* and *Transitions of Care (TRC): Medication Reconciliation Post-Discharge.* Kepro reviewed and approved the source code for the *Colorectal Cancer Screening (COL)* measure.

☐ Not applicable (ISCA not reviewed)

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

Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Tufts conducted the medical record reviews on internally developed forms. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

---

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: Tufts' performance on the *Controlling High Blood Pressure* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts consider the development of related quality improvement initiatives.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **Tufts Associated Health Maintenance Organization (Tufts)**
Performance measure name**: Transitions of Care (TRC): Medication Reconciliation Post-Discharge**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☒ Medical records (describe) See below ☐ 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. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of discharges for members 18 years of age and older.
Definition of numerator (describe): The number of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Numerator	177
Denominator	411
Rate	43.07%

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. Tufts processed claims using the Diamond system. Most claims were submitted electronically to the plan and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. Tufts had robust claims editing and coding review processes. Tufts processed all claims within Diamond except for pharmacy claims which were handled by its pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

Enrollment Data. Tufts used Market Prominence and Diamond to process enrollment data. Both systems captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.

Medical Record Review. Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Tufts conducted the medical record reviews on internally developed forms. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with medical record review.

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

Data Integration. All performance measure rates were produced internally by Tufts using internally developed source code. Tufts had adequate processes to track completeness and accuracy of data at each transfer point to its HEDIS warehouse. 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. Tufts produced the performance measures using internally developed source code. The source code was reviewed and found compliant with the HEDIS technical specifications by its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020 for two of the PMV measures: *Controlling High Blood Pressure (CBP)* and *Transitions of Care (TRC): Medication Reconciliation Post-Discharge.* Kepro reviewed and approved the source code for the *Colorectal Cancer Screening (COL)* measure.

☐ Not applicable (ISCA not reviewed)

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

Tufts passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Tufts conducted the medical record reviews on internally developed forms. Tufts had mature processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

---

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: Tufts' performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts consider the development of related quality improvement initiatives.

Plan Strengths

Quality-Related: Tufts used supplemental data for HEDIS reporting.

Opportunities for Improvement

- **Quality-Related:** Tufts' performance on the *Colorectal Cancer Screening (COL)* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts consider the development of related quality improvement initiatives.
- **Quality-Related:** Tufts' performance on the *Controlling High Blood Pressure* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts consider the development of related quality improvement initiatives.
- **Quality-Related:** Tufts' performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that Tufts consider the development of related quality improvement initiatives.

Follow Up to Calendar Year 2020 Recommendations

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

Exhibit 3.11a. Update to CY 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which SCO Addressed Recommendations
The *Antidepressant Medication Management: Effective Acute Phase Treatment* measure scored below the 20th percentile compared to CMS SNP Public Use File benchmark data. Kepro recommended that Tufts initiate related quality improvement initiatives	No action taken. This recommendation stands.	Low

Exhibit 3.11b. Update to CY 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which SCO Addressed Recommendations
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 recommended that Tufts initiate related quality improvement initiatives.	A new Transitions of Care (TOC) Management Program was introduced which focused on reducing readmissions, and helping members manage in the community post-inpatient discharge, facilitated by TOC nurses, Coordinators, and Paraprofessionals. TOC nurses ensure that members with an unplanned admission have a two-day Post-Hospital Intervention Assessment and a medication reconciliation and review by Day 7. The TOC Nurse also ensured that a plan is put in place to reduce or eliminate the risk of a readmission.	High

UNITEDHEALTHCARE COMMUNITY PLAN (UHC)

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **UnitedHealthcare Community Plan (UHC)**
Performance measure name: **Colorectal Cancer Screening (COL)**
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☐ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☐ Medical records (describe) See below ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 50 to 75 years of age
Definition of numerator (describe): The number of members 50 to 75 years of age who had appropriate screening for colorectal cancer.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Kepro calculated UHC's COL rate as a weighted average of its two HEDIS-reported rates for Org ID: 8744, Sub IDs 8241 and 15102.

Data Element	Sub ID 8241	Sub ID 15102	Weighted Average
Numerator	3,229	1,142	
Denominator	4,239	1,437	
Rate	76.17%	79.47%	77.01%

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 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 regarding 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 performance measures under the scope of this review. There were no source code issues identified. ☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. None identified.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of performance measure calculation: None identified.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **UnitedHealthcare Community Plan (UHC)**
Performance measure name: **Controlling High Blood Pressure (CBP)**

Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe) HEDIS auditor-approved data sources ☐ Medical records (describe) See below ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension
Definition of numerator (describe): The number of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement year.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Kepro calculated UHC's CBP rate as a weighted average of its two HEDIS-reported rates for Org ID: 8744, Sub IDs 8241 and 15102.

Data Element	Sub ID 8241	Sub ID 15102	Weighted Average
Numerator	2,438	1,076	
Denominator	4,851	2,079	
Rate	50.26%	51.76%	50.71%

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 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 regarding 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 performance measures under the scope of this review. There were no source code issues identified. ☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. None identified.
Validation rating: ☒ High confidence   ☐ Moderate confidence   ☐ Low confidence ☐ No confidence

EQRO recommendations for improvement of performance measure calculation:

Quality-Related: UHC's performance on the *Controlling High Blood Pressure* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that UHC consider the development of related quality improvement initiatives.

CMS Worksheet 2.14

1. Overview of Performance Measure

Managed Care Plan (MCP) name: **UnitedHealthcare Community Plan (UHC)**	
Performance measure name: **Transitions of Care (TRC): Medication Reconciliation Post-Discharge**	

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by state/EQRO
☐ Other measure steward (specify) _____

Is the performance measure part of an existing measure set? (check all that apply)
☒ HEDIS®
☐ CMS Child or Adult Core Set
☐ Other (specify) _____

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe) HEDIS auditor-approved data sources
☒ Medical records (describe) See below
☐ 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.

☐ Not applicable (hybrid method not used)

Definition of denominator (describe): The number of discharges for members 18 years of age and older.

Definition of numerator (describe): The number of discharges for members 18 years of age and older who had a medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP

Measurement period (start/end date) January 1, 2020, to December 31, 2020

2. Performance Measure Results

Kepro calculated UHC's TRC rate as a weighted average of its two HEDIS-reported rates for Org ID: 8744, Sub IDs 8241 and 15102.

Data Element	Sub ID 8241	Sub ID 15102	Weighted Average
Numerator	251	196	
Denominator	411	411	
Rate	61.07%	47.69%	51.90%

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 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.

Medical Record Review. UHC passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Medical record review data were collected using Ciox Quality data abstraction tools for hybrid measure abstraction. The Ciox Quality tools were compliant with the HEDIS technical specifications. No issues were identified with medical record review.

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 regarding 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 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.

UHC passed Medical Record Review Validation with its licensed HEDIS audit firm, Attest Health Care Advisors, for HEDIS MY 2020. Medical record review data were collected using Ciox Quality data abstraction tools for hybrid measure abstraction. The Ciox Quality tools were compliant with the HEDIS technical specifications.

☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the performance measure calculation. None identified.
Validation rating: ☒ High confidence   ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of performance measure calculation: **Quality-Related:** UHC's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that UHC consider the development of related quality improvement initiatives.

Plan Strengths
Quality-Related: UHC used supplemental data for HEDIS reporting.

Opportunities for Improvement
- **Quality-Related:** UHC's performance on the *Controlling High Blood Pressure* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that UHC consider the development of related quality improvement initiatives.
- **Quality-Related:** UHC's performance on the *Transitions of Care (TRC): Medication Reconciliation Post-Discharge* measure was below the 25th percentile compared to the NCQA Medicare Quality Compass MY 2020 data. Kepro recommends that UHC consider the development of related quality improvement initiatives.

Follow Up to Calendar Year 2020 Recommendations
CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2020 PMV recommendation follows:
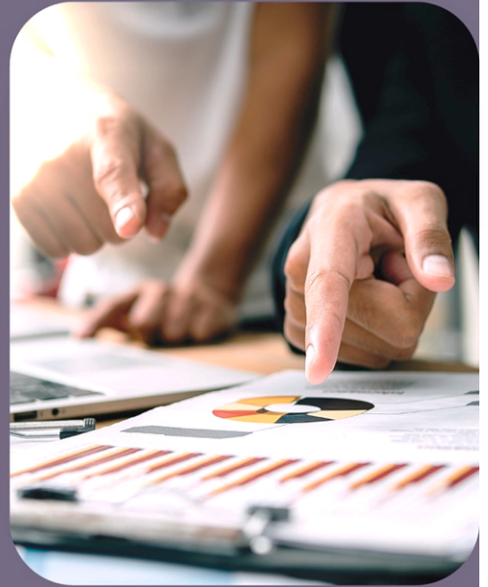
Exhibit 3.12. Update to CY 2020 Recommendations

Calendar Year 2020 Recommendation	2021 Update	Degree to Which Plan Addressed Recommendations
UHC's performance on the *Antidepressant Medication Management (AMM): Effective Acute Phase Treatment* measure was below the 40th percentile compared to CMS SNP Public Use File benchmark data. Kepro recommends that UHC consider the development of related quality improvement initiatives.	• Conducted an annual evaluation of provider performance with the AMM measure • Conducted medical record review of 63 primary care practice medical records to determine compliance with depression screening recommendations. UHC found high (95%) levels of compliance. • Created and distributed member handout on Antidepression Medication Management. The document includes a link to the Clinical Practice Guidelines for the Management of Major Depressive Disorder and well as the PHQ-9 screening tool in multiple languages.	High
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.	• Identified and corrected data-mapping issues triggering open MRP gaps in care. • Increased operational utility of the MRP Needed report. • Conduct care manager training on appropriate MRP clinical documentation and updated the associated procedure. • Refined procedures for members in long-term care.	High

Performance Improvement Project Validation

SECTION 4. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

INTRODUCTION

MassHealth SCOs conduct two contractually required PIPs annually. In 2021, MassHealth directed SCOs to conduct these PIPs on the following topics:

- Increase flu immunization rates; and
- Decrease barriers to telehealth.

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

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

OBJECTIVE

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

DATA OBTAINED

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

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

MANAGED CARE PLAN SUPPORT

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

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

TECHNICAL METHODS OF DATA COLLECTION AND ANALYSIS

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

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

1) *PIP Project Report:* SCOs submit a project report for each PIP to the EQRO Teams site. This report is specific to the stage of the project. All 2021 performance improvement projects were baseline (first-year) projects.

2) *Desktop Review:* A desktop review is performed for each PIP. The Technical Reviewer and Medical Director review the project report and any supporting documentation submitted by the plan. Working collaboratively, they identify project strengths, issues requiring clarification, and opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the project. The Medical Director's focus is on clinical integrity and interventions.

3) ***Conference with the Plan:*** The Technical Reviewer and Medical Director meet virtually with plan representatives to obtain clarification on identified issues as well as to offer recommendations for improvement. When it is not possible to assign a validation rating to a project due to incomplete or missing information, the plan is required to remediate the report and resubmit it within ten calendar days. In all cases, the plan is offered the opportunity to resubmit the report to address feedback received from Kepro, although it is not required to do so.

4) ***Final Report:*** A PIP Validation Worksheet based on CMS EQR Protocol Number 1 is completed by the Technical Reviewer. Kepro conducts inter-rater reliability to ensure consistency between reviewers. The Medical Director documents his or her findings, and in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report. A determination is made by the Technical Reviewers as to the validity of the project. PIP reports submitted in the fall are rated. 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. PIP reports submitted in the spring are not rated.

FINDINGS

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

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

COMPARATIVE ANALYSIS

Interventions

MassHealth SCOs used a variety of approaches to address their project goals.

Exhibit 4.2. Intervention Approach

Intervention Approach	Number of Interventions Immunization	Number of Interventions Telehealth Access
Member Education & Outreach	5	5
Provider Education & Outreach	5	4
Programs and Practices	2	2
Community Partnerships	5	1
Technology	0	3
Member Incentives	1	0

PERFORMANCE IMPROVEMENT PROJECT RATINGS

Kepro evaluates each Performance Improvement Project to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 1. Kepro also assesses whether the projects have achieved or likely will achieve favorable results.

Kepro rates Performance Improvement Projects using a predetermined set of criteria, outlined in the table below. 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.

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 table that follows depicts the average rating score by rating component of each project by SCO and topic.

Exhibit 4.3. Average PIP Score by Rating Component

Rating Component	Flu Vaccine PIPs	Telehealth Access PIPs
Updates to Project Descriptions and Goals	98%	100%
Update to Stakeholder Involvement	93%	100%
Intervention Activities Updates	93%	96%
Performance Indicator Data Collection	100%	97%
Capacity for Indicator Data Analysis	100%	100%
Performance Indicator Parameters	100%	100%
Baseline Performance Indicator Rates	100%	100%
Conclusions and Planning for Next Cycle	92%	92%

The table that follows depicts the final rating score of each project by SCO and topic.

Exhibit 4.4. PIP Ratings by SCO and Topic

Plan	Flu Vaccination	Telehealth Access
BMCHP	97%	96%
CCA	98%	100%
Fallon	91%	97%
SWH	100%	100%
Tufts	96%	96%
UHC	100%	100%

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 SCO's report to Kepro as are the Improvement Strategies or Interventions. Performance indicator data was taken from this report as well. Kepro validated each of these projects, meaning that it reviewed all relevant parts of each PIP and made a determination as to its validity. The PIP Technical Reviewer assigned a validation confidence rating, which refers to Kepro's overall confidence that the PIP adhered to acceptable methodologies for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement or the potential for improvement. Recommendations offered were taken from the Reviewers' rating forms. As is required by CMS, Kepro has identified SCO and project strengths as evidenced in the PIP. Because each of these projects are considered to be baselines, follow up to 2020 recommendations is not provided.

TOPIC 1: VACCINATION

BOSTON MEDICAL CENTER HEALTHNET PLAN: INCREASING THE RATE OF FLU VACCINATION FOR ALL BMCHP SCO MEMBERS, WITH A SPECIAL FOCUS ON REDUCING RACIAL DISPARITIES IN FLU VACCINATION ACCESS

1. General PIP Information

Managed Care Plan (MCP) Name: Boston Medical Center HealthNet Plan (BMCHP)
PIP Title: Increasing the Rate of Flu Vaccination for All BMCHP SCO Members, with a Special Focus on Reducing Racial Disparities in Flu Vaccination Access

PIP Aim Statement:

Member-Focused
- Increase flu vaccination access among all SCO members by educating 100% of members identified as not receiving flu vaccination, with an expected engagement rate of 20%.
- Decrease any identified disparities in flu vaccination access rates in 100% of disparate categories by educating members in those categories around flu vaccination benefits, availability, and access methods, i.e., free transportation availability.

Provider-Focused
- Increase fu vaccination rates by 10% among providers for all SCO members.
- Decrease disparities in flu vaccination access rates within provider groups with identified lower rates by 5% via provider awareness of disparities, barriers, and available services to improve member access to vaccinations.

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

Target age group (check one):
☐ Children only (ages 0 to 17)*   ☒ Adults only (age 18 and over)   ☐ Both adults and children
*If PIP uses different age threshold for children, specify age range here:

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

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

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
• BMCHP has solicited member feedback related to flu vaccinations among Hispanic and White male and Spanish-speaking populations.   • BMCHP plans to conduct tailored, targeted outreach to the population above.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
BMCHP has solicited feedback from provider practices to increase flu vaccination among Hispanic and White male and Spanish-speaking populations.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
None identified.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Flu vaccination rate	2020	704 / 1,256 56.05%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):   Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: • **Access- and Quality-Related:** Kepro suggests employing additional strategies for obtaining information from members about barriers and opportunities such as focus groups, committees that include members, or community groups.   • **Quality-Related:** Kepro recommends that BMCHP reconsider its member survey target return rate of 25 surveys. Additionally, Kepro suggests BMCHP consider conducting several focus groups of each identified population to determine if the survey is the best format for obtaining this information.   • **Quality-Related:** Kepro recommends the development of a more detailed implementation plan that extends into 2022.

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 97% on this Performance Improvement Project.

Exhibit 4.5. BMCHP PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	11	92%
Intervention Activities Updates	5	15	13.6	91%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	5	15	15	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**28**	**84**	**81.6**	**97%**

Plan & Project Strengths
Quality-Related: BMCHP described a solid plan for continuous quality improvement monitoring of the performance of this project.

Opportunities for Improvement
- **Access- and Quality Related:** Kepro suggests employing additional strategies for obtaining information from members about barriers and opportunities such as focus groups, committees that include members, or community groups.
- **Quality-Related:** Kepro recommends that BMCHP reconsider its member survey target return rate of 25 surveys. Additionally, Kepro suggests BMCHP consider conducting several focus groups of each identified population to determine if the survey is the best format for obtaining this information.
- **Quality-Related:** Kepro recommends the development of a more detailed implementation plan that extends into 2022.

COMMONWEALTH CARE ALLIANCE: FLU VACCINE IMPROVEMENT

1. General PIP Information

Managed Care Plan (MCP) Name: Commonwealth Care Alliance (CCA)
PIP Title: Project Remind: Flu Vaccine Improvement

PIP Aim Statement:

Member-Focused
- Increase CCA members' aged 65+ years knowledge about the importance of flu vaccination.
- Increase member willingness to receive vaccinations by understanding and overcoming reasons for vaccination hesitancy.
- Increase flu vaccination rates for CCA members aged 65+ years including, but not limited to, those members with dementia.

Provider-Focused
- Increase provider identification of CCA members aged 65+ who have not received a flu vaccination.
- Increase provider knowledge and skills to understand and overcome CCA members' aged 65+ years reasons for vaccine hesitancy.

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

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

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

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

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

Target age group (check one):

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

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

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

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

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

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

- Based on stakeholder feedback, CCA will design member communications in several languages as well as improve access to vaccines through CCA's primary care flu clinics and through outreach to those who are homebound.
- CCA will continue to collaborate with the Alzheimer's Association to facilitate communications with members, caregivers, and families about the challenges which may limit flu vaccinations for people with a dementia diagnosis.

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

CCA will educate provider about member reasons for vaccine hesitancy and enhance provider communication tools and strategies to help members overcome these barriers.

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)
CCA's Vaccine Task Force will continue to redefine, standardize, and organize and systemwide vaccine strategy to address vaccine procurement, documentation of vaccine administration, training, and administration of the fu vaccine.

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
CCA Primary Care SCO member flu vaccination rate	2020	242/375 64.3%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): p < 0.005

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: • **Quality-Related:** In future reporting, Kepro advises CCA to enhance its provider goals with greater operational detail that describes the criteria for determining goal achievement. • **Timeliness-Related:** Kepro strongly advises CCA to consider developing a standing consumer advisory committee that convenes (perhaps remotely) quarterly or semi-annually.

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 98% on this Performance Improvement Project.

Exhibit 4.6. CCA PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	13.3	87%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	4	12	12	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**25**	**75**	**73.3**	**98%**

Project & Plan Strengths
- **Quality-Related:** CCA is commended for its detailed listing of policy recommendations and action strategies among which include clinic interventions, emergency room visits, and homebound care.
- **Quality-Related:** Kepro commends CCA for establishing standardized system-wide documentation, procurement, training, and administration protocols. In addition, the focus on providing the vaccine at clinic encounters by developing vaccine clinics within clinic sites, utilizing community administration in homes, and utilizing the Massachusetts Immunization Information System to track vaccine administration are, as a unit, assumed to be significantly impactful interventions.
- **Access-Related:** Kepro also commends CCA for reframing the messaging from a directive for flu vaccination to enhancing member relationships and care to a more supportive role.

Opportunities for Improvement
- **Quality-Related:** In future reporting, Kepro advises CCA to enhance its provider goals with greater operational detail that describes the criteria for determining goal achievement.
- **Timeliness-Related:** Kepro strongly advises CCA to consider development a standing consumer advisory committee that convenes (perhaps remotely) quarterly or semi-annually.

FALLON HEALTH: INCREASING FLU VACCINATION RATES FOR SCO MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Fallon Health (Fallon)
PIP Title: Increasing Flu Vaccination Rates for SCO Members
PIP Aim Statement: *Member-Focused*   • Increase the rate of flu shots for members in the SCO population to 78.0% by the end of the project cycle.   • Decrease vaccine hesitancy among members who have a history of refusing flu shots.   • Mitigate racial, ethnic, and language barriers to obtaining flu shots where there are identified disparities in care.   *Provider-Focused*   • Increase the annual flu shot rate of all SCO members to 78.0% across all provider panels.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)   ☒ State-mandated (state required plans to conduct a PIP on this specific topic)   ☐ Collaborative (plans worked together during the planning or implementation phases)   ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)   ☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one):   ☐ Children only (ages 0 to 17)*   ☒ Adults only (age 18 and over)   ☐ Both adults and children   *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS, or pregnant women (please specify): Senior Duals
Programs: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)   • Educate and engage members at an individual level to facilitate and encourage flu vaccination on an annual basis via a comprehensive flu outreach program. The comprehensive flu outreach program is a large-scale initiative with outreach efforts conducted by all SCO Navigators for all current and newly enrolled SCO members.   • Encourage vaccinations by incentivizing the annual flu shot for members who participate in the incentive benefit program through which members can receive $50 toward the healthy food card if they receive a flu shot.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)   Through improved reporting, support providers in closing gaps in care for flu shots for their patient panels.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)   None identified.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Flu Vaccination Rate	2020	4,308 / 6,350 67.8%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):   Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: • **Quality-Related:** Kepro recommends the development of a provider-focused goal.   • **Quality-Related:** Fallon should prioritize obtaining stakeholder feedback and incorporating it into intervention design.   • **Quality-Related:** Fallon did not describe its plan for the continuous improvement of its interventions. Kepro recommends that a detailed plan be developed to ensure a process is in place for the continuous quality improvement of the project's interventions.

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 received a rating score of 91% on this Performance Improvement Project.

Exhibit 4.7. Fallon PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	8	89%
Update to Stakeholder Involvement	4	12	9	75%
Intervention Activities Updates	5	15	14.6	97%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	5	15	15	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	3	50%
Overall Validation Rating Score	**27**	**81**	**73.6**	**91%**

Plan & Project Strengths
- **Access-Related:** Fallon is commended for developing a comprehensive approach for engaging SCO members by utilizing Navigators who perform outreach to all current and newly enrolled SCO members.
- **Quality-Related:** Kepro commends Fallon for its innovative monetary incentive program to encourage key behavior changes with its members.

Opportunities for Improvement
- **Quality-Related:** Kepro recommends the development of a provider-focused goal.
- **Quality-Related:** Fallon should prioritize obtaining stakeholder feedback and incorporating it into intervention design.
- **Quality-Related:** Fallon did not describe its plan for the continuous improvement of its interventions. Kepro recommends that a detailed plan be developed to ensure a process is in place for the continuous quality improvement of the project's interventions.

SENIOR WHOLE HEALTH BY MOLINA HEALTH CARE: INCREASE THE RATE OF FLU VACCINATION AMONG SWH MEMBERS WITH A SPECIAL FOCUS ON REDUCING RACIAL DISPARITIES IN FLU VACCINATION ACCESS

1. General PIP Information

Managed Care Plan (MCP) Name: Senior Whole Health by Molina Health Care (SWH)
PIP Title: Increase the Rate of Flu Vaccination Among SWH Members with a Special Focus on Reducing Racial Disparities in Flu Vaccination Access.

PIP Aim Statement:

Member-Focused
- Improve flu vaccination rates among members by reducing barriers to access by conducting fu clinics in collaboration with community partners with a special focus on areas with low vaccination rates and racial disparities.
- Improve flu vaccination awareness among members through education and outreach by sending flu posts cards to members, creating social media posts, providing information through its member newsletters, and making flu resources and tools available in multiple languages.

Provider-Focused
- Promote the provider behavior of educating patients on the importance of flu vaccination during regular office visits, through outreach using our website, health plan newsletters, and social media posts, and by sending gap lists and flu educational materials to providers on an annual basis.
- Increase general awareness among providers on flu vaccination and the importance of addressing racial disparities among members through provider trainings, presentations, and sharing culturally appropriate education resources.

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

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

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

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

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

Target age group (check one):

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

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

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

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

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Improve flu vaccination rates by reducing barriers to access. By conducting flu clinics in collaboration with the community partners, especially in areas with low vaccination rates and racial disparities, SWH plans to reach a higher number of those members with low vaccination rates. SWH expects to motivate members with access issues such as lack of transportation to get a flu shot from local clinics to avoid travel.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Clinical trainings are offered to the internal clinical team as well as to external providers.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
None identified.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Flu Vaccination Rate	2020	9160 / 14,087 65%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): p < 0.005

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):   Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: 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. SWH received a rating score of 100% on this Performance Improvement Project.

Exhibit 4.8. SWH PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	15	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%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**27**	**81**	**81**	**100%**

Project & Plan Strengths
- Quality-Related: SWH is commended for its plan to identify provider groups with the lowest flu vaccination rates as well as those with highest numbers of SWH members for the first phase of a planned gap list intervention activity.
- Quality-Related: SWH is commended for its clinical training on flu vaccination for its clinical team and providers, which was conducted in March 2021.
- Access-Related: Kepro commends SWH for moving flu clinics to multiple locations where members are living to mitigate transportation issues.
- Quality-Related: SWH is commended for its range of intervention activities.

Opportunities for Improvement
None Identified.

TUFTS ASSOCIATED HEALTH MAINTENANCE ORGANIZATION: INCREASE FLU VACCINATION RATE AMONG SCO MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Tufts Associated Health Maintenance Organization (Tufts)
PIP Title: Increase Flu Vaccination rate among SCO members

PIP Aim Statement:

Member-Focused
- Provide information to members that promotes various member communications about flu vaccine safety and efficacy.
- Provide information to members about flu vaccine availability by promoting information via multiple member communication channels.
- Broaden member access to the flu vaccine.

Provider-Focused
- Promote an increase in the total number of member vaccinations by educating 90% of providers about where their members can receive the flu vaccine, discussing member barriers related to specific populations, and distributing data on who is least likely to receive a flu vaccine.
- Communicate member barriers related to Social Determinants of Health and Health equity and request that providers address these barriers that are specific to SCO members in the identified subpopulations.

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

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

Target age group (check one):
☐ Children only (ages 0 to 17)*   ☒ Adults only (age 18 and over)   ☐ Both adults and children
*If PIP uses different age threshold for children, specify age range here:

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

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

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

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

- Tufts will focus care manager support and outreach activities in the Brockton area where a concentration of Haitian-Creole and Cape Verdean members live.
- Tufts will develop resource materials to provide SCO members with robust materials that outline the importance of the flu vaccine and provides a list of locations where members can access and receive the vaccine.

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

- Tufts' Medical Director makes direct-contact calls to provider groups with low vaccination rates.
- Provider education materials will be developed to inform providers about where their members can go to receive the flu vaccine, which can vary year to year. It will also serve to remind providers to encourage their members to receive the vaccine and provide their members the support they need. Tufts is providing support

for billing training and processing for some of our community providers to ensure flu vaccines yield a claim which can better enhance reporting accuracies for this PIP.

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)

- In partnership with the Massachusetts Department of Public Health, Tufts is identifying geographical locations that have lower rates of vaccines and building interventions to meet the needs of members who live in those diverse communities. Two cities that have been identified include Fall River and New Bedford Massachusetts. The Health Equity task force will also focus on members who speak Mandarin and Spanish in those areas. The Health Equity task force is creating interventions to bring flu vaccines to these areas and make members aware of resources available to them.
- Tufts has partnered with Commonwealth Medicine to allow over 160 Massachusetts Public Health clinics that offer flu vaccination to submit a claim to Tufts for the vaccine and receive payment without being contracted.
- The Tufts Care Management team is working with the Training, Quality and Compliance team to design a mandatory training for all SCO Care Managers. The goal of this training is to help the care manager build critical Motivational Interviewing skills that can be used to address member hesitancy towards receiving vaccines.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Flu Immunization Rate	2020	2,857/ 4,604 62.05%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: **Quality-Related:** Tufts' listing of project activities is very high-level and does not include details on sub-activities.

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 received a rating score of 96% on this Performance Improvement Project.

Exhibit 4.9. Tufts PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	11	92%
Intervention Activities Updates	5	15	12.5	83%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	5	15	15	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**26**	**78**	**74.5**	**96%**

Project & Plan Strengths

- **Quality-Related:** Tufts is commended for its production of provider webinars.
- **Access-Related:** Tufts is commended for its plan to develop and distribute a flu vaccination gap report to providers.

Opportunities for Improvement

Quality-Related: Tufts' listing of project activities is very high-level and does not include details on sub-activities.

UNITEDHEALTHCARE COMMUNITY PLAN: IMPROVING FLU VACCINATION RATES FOR UNITEDHEALTHCARE SENIOR CARE OPTIONS COMMUNITY PLAN MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: UnitedHealthcare Community Plan (UHC)
PIP Title: Improving Flu Vaccination Rates for UnitedHealthcare Senior Care Options Community Plan Members

PIP Aim Statement:

Member-Focused
- Increase the flu vaccination rate for members living in the community to 78.0% by the end of this PIP.
- Increase the flu vaccination rate for Spanish-speaking members living in the community to 78.0% by the end of this PIP.
- Increase the flu vaccination rate for Russian-speaking members living in the community to 58.0% by the end of this PIP.

Provider-Focused
- Increase the provider's flu vaccination rates for members living in the community to 78.0% by the end of this PIP.
- Increase the provider's flu vaccination rate for Spanish-speaking members living in the community to 78.0% by the end of this PIP.
- Increase the provider's flu vaccination rate for Russian-speaking members living in the community to 58.0% by the end of this PIP.

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

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

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

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

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

Target age group (check one):

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

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

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

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

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

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

- Members will be provided with accurate information regarding flu vaccination by their care managers so that they can make an informed choice and/or have trust-building conversations about flu vaccination with members who are vaccine-hesitant.
- UHC is sponsoring a dedicated flu vaccination clinic for Spanish-speaking members in collaboration with Greater Lawrence Family Health Center (GLFHC) which serves a large number of its Spanish-speaking members who were not vaccinated during the 2019 to 2020 flu season.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) None identified.	
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) None identified.	

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Flu Vaccination Rate for Members Living in the Community	2020	13,512 / 17,904 75.5%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): p < 0.005
Flu Vaccination Rate for Spanish-speaking Members Living in the Community	2020	4,415 / 5,907 74.7%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): p < 0.005
Flu Vaccination Rate for Russian-speaking Members Living in the Community	2020	655 / 1,203 54.4%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): p < 0.005

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

> **EQRO recommendations for improvement of PIP:**
>
> **Access-Related:** Kepro recommends that in its next PIP report, UHC consider how it will expand its care manager outreach intervention to include a greater portion of its members with relatively low vaccination rates and their providers.

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. UHC received a rating score of 100% on this Performance Improvement Project.

Exhibit 4.10. UHC PIP Project Rating

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

Project & Plan Strengths

- **Access-Related:** UHC is commended for engaging members as stakeholders at a Member Appreciation event held during Summer 2021. A survey was verbally administered to 22 Spanish-speaking and 12 Russian-speaking members.
- **Access-Related:** UHC's care manager outreach initiative is an excellent intervention for its high-touch methodology with members for which UHC commended. UHC is highly commended for having completed a document to guide care managers' trust-building conservations about flu vaccination hesitancy and the experience of racism in healthcare.
- **Quality-Related:** UHC is commended for the overall quality and completeness of this PIP report. UHC is further commended for adding two new performance indicators for Spanish-speaking and Russian-speaking members.

Opportunities for Improvement

Access-Related: Kepro recommends that in its next PIP report, UHC consider how it will expand its care manager outreach intervention to include a greater portion of its members with relatively low vaccination rates and their providers.

TOPIC 2: TELEHEALTH ACCESS

BOSTON MEDICAL CENTER HEALTHNET PLAN: IMPROVING ACCESS TO TELEHEALTH AMBULATORY CARE AMONG SCO MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Boston Medical Center HealthNet Plan (BMCHP)
PIP Title: Improving Access to Telehealth Ambulatory Care Among SCO Members
PIP Aim Statement: ***Member-Focused***   • Increase telehealth ambulatory care access among all SCO members by educating 100% of members identified as not receiving telehealth services with an expected engagement rate of 20%.   • Decrease any identified disparities in telehealth ambulatory care rates in 100% of disparate categories by educating members in those categories around telehealth services and availability of culturally competent services, e.g., translation services.   ***Provider-Focused***   • Increase telehealth ambulatory care rates by 10% among providers for all SCO members when telehealth is identified as an appropriate clinical response for follow up.   • Decrease disparities in telehealth ambulatory care rates within provider groups with identified lower rates by 5% via provider awareness of telehealth visit protocols, available services, and technology enhancements.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)   ☒ State-mandated (state required plans to conduct a PIP on this specific topic)   ☐ Collaborative (plans worked together during the planning or implementation phases)   ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)   ☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one):   ☐ Children only (ages 0 to 17)*   ☒ Adults only (age 18 and over)   ☐ Both adults and children   *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS, or pregnant women (please specify): Senior Duals
Programs: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)   • This intervention will assess members' opinions of telehealth use for ambulatory care and gather information on existing or potential barriers to telehealth visits from the member's perspective. Responses to the survey will provide a member-driven basis for development of interventions necessary to address any disparities found. (Complete)   • Black and Hispanic members will receive targeted educational outreach designed to overcome identified barriers.

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

- BMCHP will assess providers' views on telehealth use for ambulatory care and gather information on existing or potential barriers to telehealth visits from the provider's perspective. Responses to the survey will serve as a basis for the development of provider interventions. (Complete)

- BMCHP will engage champions at its largest provider group to educate providers on the benefits of telehealth for follow-up visits with an emphasis on the need for greater access to telehealth for Black and Hispanic members; encourage providers to proactively offer education and training in use of telehealth hardware and software, particularly among the Black and Hispanic populations who have demonstrated less access to telehealth visits; encourage providers in the group to offer telehealth visits instead of in-person visits whenever appropriate; and involve schedulers in offering telehealth visits as the default option whenever appropriate.

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

None identified.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Telehealth ambulatory care utilization (AMB) NQF# 9999	2020	135 / 7,579 1.78%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply):   ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year   ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):   Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: • **Access-Related:** Kepro recommends tailoring member educational materials to target cultural factors for these focal populations.   • **Quality-Related:** Kepro recommends that BMCHP further detail project strengths and challenges.

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 4.11. BMCHP PIP Project Rating

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	14.75	98%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4	12	12	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	3	50%
Overall Validation Rating Score	**26**	**78**	**74.75**	**96%**

Plan and Project Strengths

Quality-Related: Kepro commends the use of project champions.

Opportunities for Improvement

- **Access-Related:** Kepro recommends tailoring member educational materials to target cultural factors for these focal populations.
- **Quality-Related:** Kepro recommends that BMCHP further detail project strengths and challenges.

COMMONWEALTH CARE ALLIANCE: ADDRESSING BARRIERS TO VIRTUAL CARE

1. General PIP Information

Managed Care Plan (MCP) Name: Commonwealth Care Alliance (CCA)
PIP Title: Addressing Barriers to Virtual Care

PIP Aim Statement:

Member-Focused
- Increase the effective use of virtual care among our members by creating and implementing a robust member support strategy which includes trainings, educational resource materials, and live-agent support to troubleshoot and address virtual care issues.
- Improve member access to virtual care by conducting virtual care readiness assessments to proactively identify barriers and overcome barriers.
- Increase efforts to address device and connectivity barriers by referring members who are identified as not virtual care ready to health outreach workers who can support the member in obtaining a device or connectivity.
- Decrease technology issues associated with virtual visits by referring members to live agent support to test out virtual capabilities and troubleshoot issues prior to visit.

Provider-Focused
- Activate CCA schedulers and CCA care teams to more effectively identify members who are virtual care ready by conducting readiness assessments.
- Refer members that have barriers to virtual care to health outreach workers to address accessibility concerns.
- Increase the number of CCA virtual care providers through the integration of telehealth in workflows, resource guides, trainings, and other educational materials.
- Implement a virtual care platform across the organization for providers to conduct virtual visits.

Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)
☒ State-mandated (state required plans to conduct a PIP on this specific topic)
☐ Collaborative (plans worked together during the planning or implementation phases)
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)
☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one):
☐ Children only (ages 0 to 17)*   ☒ Adults only (age 18 and over)   ☐ Both adults and children
*If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS, or pregnant women (please specify): Senior duals
Programs: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
 • CCA is rolling out a virtual care readiness assessment across its entire membership. This assessment is proactively conducted when a member joins CCA, annually at the time of their health assessment, and periodically when updates to a member's status are required. Virtual care assessments are conducted by scheduling teams, care teams, and virtual care technical support resources. • The PIP team is creating educational resources to provide member support on virtual care. These resources include a website page, articles in the quarterly member newsletter, a virtual care resource guide and training video, and other materials.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
CCA has implemented a new virtual care platform and developed associated training materials.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
None identified.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
MPT - Mental Health Utilization NQF# 9999	2020	2,987 / 11,510 26%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: **Quality-Related**: Kepro strongly advises CCA to consider developing a standing consumer advisory committee that convenes (perhaps remotely) quarterly or semi-annually.

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 4.12. CCA PIP Project Rating

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

Plan and Project Strengths
- **Quality-Related:** CCA is commended for its Virtual Care team that engaged with its Member Voices team to conduct a qualitative research study to explore members' attitudes and experiences with virtual care.
- **Quality-Related:** CCA's provider survey is highly commendable.

Opportunities for Improvement
Quality-Related: Kepro strongly advises CCA to consider developing a standing consumer advisory committee that convenes (perhaps remotely) quarterly or semi-annually.

FALLON HEALTH (FALLON): IMPROVING TELEHEALTH UTILIZATION FOR BEHAVIORAL HEALTH SERVICES FOR SCO MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Fallon Health (Fallon)
PIP Title: Improving Telehealth Utilization for Behavioral Health Services for SCO Members
PIP Aim Statement: *Member-Focused* • By project end, increase the rate of telehealth utilization for SCO members seeking outpatient behavioral health (BH) services by 5%. • By project end, increase engagement of SCO members in follow-up care with outpatient behavioral health providers within 30 days of hospitalization for mental illness by 5%. • By project end, identify disparities in care for members who are seeking telehealth BH services and increase telehealth utilization by 5% for identified subpopulations. • By project end, identify disparities in care for members discharged from an inpatient hospitalization for mental illness and increase telehealth follow-up within 30 days by 5% for identified subpopulations. *Provider-Focused* • By project end, increase the rate of telehealth utilization provided to SCO members by outpatient BH providers by 5%. • By project end, increase the rate of telehealth follow-up appointments conducted within 30 days of discharge by outpatient providers by 5%.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☒ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0 to 17)*   ☒ Adults only (age 18 and over)   ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS, or pregnant women (please specify): Senior duals
Programs: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only   ☐ Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Offer members the opportunity to access prompt follow-up outpatient services from behavioral health providers who can engage virtually upon request.
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 will focus on MPT data to monitor telehealth utilization at the outpatient provider level to better understand where to direct efforts to increase access and utilization. Specifically, low-utilizing providers will be identified and provided targeted education including information such as telehealth best practices and coding reminders.

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)						
None identified.						

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Mental Health Utilization (MPT) NQF #9999	2020	809 / 1,232 65.7%	☐ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Follow Up After Inpatient Mental Health – 30 days (FUH) NQF# 9999	2020	39 / 49 79.6%	☐ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes   ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval   ☒ Planning phase ☒ Implementation phase   ☒ Baseline year ☐ First remeasurement   ☐ Second remeasurement   ☐ Other (specify): Validation rating: ☒ High confidence   ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: **Timeliness-Related:** Kepro suggests frequent monitoring of telehealth utilization to be able to intervene timely and make an impact on the rate.

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 received a rating score of 97% on this Performance Improvement Project.

Exhibit 4.13. Fallon PIP Rating Score

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates	5	15	13.5	90%
Performance Indicator Data Collection	2	6	5	83%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	9	27	27	100%
Baseline Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**31**	**93**	**90.5**	**97%**

Plan & Project Strengths

Quality-Related: Kepro commends Fallon for the comprehensive approach being used to engage members in virtual aftercare.

Opportunities for Improvement

Timeliness-Related: Kepro suggests frequent monitoring of telehealth utilization to be able to intervene timely and make an impact on the rate.

SENIOR WHOLE HEALTH BY MOLINA HEALTH CARE: IMPROVING TELEHEALTH UTILIZATION FOR OUTPATIENT PRIMARY CARE SERVICES AMONG MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Senior Whole Health by Molina Health Care (SWH)
PIP Title: Improving Telehealth Utilization for Outpatient Primary Care Services Among Members

PIP Aim Statement:

Member-Focused
- Identify and reduce barriers to telehealth among SWH members with special focus on reducing barriers to access to telehealth educational resources by creating a SWH Telehealth Flyer, making telehealth resources available through SWH website and targeted social media posts.
- Improve member understanding on the purpose and benefits of telehealth platforms, through a targeted telehealth educational activity collaborating with ASAP partners (Aging Services Access Points) thereby promoting telehealth utilization for outpatient primary care services.

Provider-Focused
- Identify the number of in-network SWH providers currently using telehealth platforms for ambulatory care visits and bridge the gaps through a collaborative outreach intervention which includes sending telehealth resources to the providers on an ongoing basis.
- Increase provider awareness on the benefits and need for telehealth services for SWH members through outreach and training, thereby motivating more providers to offer telehealth services.

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

Target age group (check one):
☐ Children only (ages 0 to 17)*   ☒ Adults only (age 18 and over)   ☐ Both adults and children
*If PIP uses different age threshold for children, specify age range here:

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

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

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

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

Aging Service Access Point staff will work directly with SWH members to achieve the overarching goals of increasing the awareness about telehealth services and the use of telehealth services for outpatient services.

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

SWH Provider Relations outreached to key provider groups to ensure that they were offering telehealth services to SWH members. After this initial outreach, educational materials and flyers were sent to the provider groups by fax blast and email. A second outreach effort will occur in Fall 2021 to ensure providers continue to offer telehealth services to SWH members and to identify any increase in telehealth providers.

> **MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)**
>
> SWH plans to offer Motivational Interviewing training as well as Telehealth training as part of the Annual Clinical Training for its nurse care managers, with an invitation extended to network providers. This clinical training will include information on the benefits of telehealth, SWH-specific population analysis data, concepts of cultural competency and cultural humility, telehealth utilization rates, and strategies to improve telehealth rates.

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
Ambulatory Care Utilization (AMB) NQF #9999	2020	29,266 / 111,366 26%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): p < 0.005 (negative)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: None identified.

Performance Improvement Project Evaluation
Kepro evaluates 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. SWH received a rating score of 100% on this Performance Improvement Project.

Exhibit 4.14. SWH PIP Rating Score

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

Project and Plan Strengths
- **Quality-Related:** SWH is commended for its efforts to engage its providers to learn about and expand their telehealth services.
- **Access- and Quality-Related:** Kepro commends SWH for conducting an Annual Telehealth Clinical training to its nurse care managers and network providers, which included instruction on cultural competency and cultural humility.

Opportunities for Improvement
None Identified.

TUFTS ASSOCIATED HEALTH MAINTENANCE ORGANIZATION: DECREASING BARRIERS TO BEHAVIORAL HEALTH TELEHEALTH SERVICES TO SCO MEMBERS

1. General PIP Information

Managed Care Plan (MCP) Name: Tufts Associated Health Maintenance Organization (Tufts)
PIP Title: Decreasing Barriers to Behavioral Health Telehealth Services to SCO Members

PIP Aim Statement:

Member-Focused
- Educate members through web and other articles on what telehealth services are, the benefits of telehealth, and what BH telehealth services that can be covered under their medical benefit.
- Broaden member's access to BH telehealth services by means of activities such as technological assistance or provider network expansion.
- Collect feedback from members to understand what barriers they experience with BH telehealth.

Provider-Focused
- Connect with BH providers to capture their most up-to-date availability and contact information and to document if they offer telehealth services.
- Educate BH providers on how to correctly bill for telehealth services to ensure accuracy of telehealth reporting from claims.
- Communicate with providers, through web articles and MD outreach, about specific health equity needs for member subpopulations so that providers are encouraged to implement activities that improve their services resulting in improved health equity for members.

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

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

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

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

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

Target age group (check one):

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

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

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

---

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

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

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

- Tufts is educating members about their telehealth benefits such as how to use them and how to access BH providers using telehealth that will meet their needs.

- Tufts' Geriatric Support Service Coordinators assist members obtain phones or other technology needed to access BH telehealth services.

- Tufts partners with Aging Service Access Points that offer assistive technology such as iPhones or iPads for members who are a part of the Elder Services of Worcester.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Deliver provider training and resources regarding telehealth billing practices.

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)
Increase member access to BH telehealth services through the contracting of behavioral health telehealth services, expansion of its provider network, and the update of the member-facing provider search tool.

3. Performance Measures and Results

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Mental Health Utilization (MPT) NQF #9999	2020	404 / 771 52.53%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): p < 0.005

4. PIP Validation Information

Was the PIP validated? ☒ Yes   ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval   ☒ Planning phase ☒ Implementation phase   ☒ Baseline year ☐ First remeasurement   ☐ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: • **Access-Related:** Kepro advises Tufts to identify the cultural subpopulations with low telehealth rates of utilization that require specific intervention strategies for their unique barriers. Kepro suggests that SCO care mangers assist in supportive outreach to high-risk members with few resources for, or knowledge about, telehealth.   • **Quality-Related:** While it is positive that Tufts has convened a consumer advisory council (CAC), Kepro recommends that this group meet more often than annually – quarterly or semi-annually, at the least. These member-stakeholders should be encouraged to contribute strategies for performance improvement and not just satisfaction with services. The CAC should be used strategically to improve service delivery where such improvements are indicated. Kepro also recommends that Tufts develop an external provider advisory council complements its internal clinical workgroup.

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 received a rating score of 96% 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 Descriptions and Goals	3	9	9	100%
Update to Stakeholder Involvement	4	12	12	100%
Intervention Activities Updates*	5	15	12.7	85%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	1	3	3	100%
Performance Indicator Parameters	5	15	15	100%
Baseline Performance Indicator Rates	5	15	15	100%
Conclusions and Planning for Next Cycle	2	6	5	100%
Overall Validation Rating Score	**27**	**81**	**77.7**	**96%**

Project & Plan Strengths

Access-, Timeliness-, and Quality-Related: Tufts is commended for increasing the number of contracted BH providers and improving its online provider search tool for members to expedite the scheduling of BH telehealth visits.

Opportunities for Improvement

- **Access-Related:** Kepro advises Tufts to identify the cultural subpopulations with low telehealth rates of utilization that require specific intervention strategies for their unique barriers. Kepro suggests that SCO care mangers assist in supportive outreach to high-risk members with few resources for, or knowledge about, telehealth.
- **Quality-Related:** While it is positive that Tufts has convened a consumer advisory council (CAC), Kepro recommends that this group meet more often than annually – quarterly or semi-annually, at the least. These member-stakeholders should be encouraged to contribute strategies for performance improvement and not just satisfaction with services. The CAC should be used strategically to improve service delivery where such improvements are indicated. Kepro also recommends that Tufts develop an external provider advisory council that complements its internal clinical workgroup.

UNITEDHEALTHCARE COMMUNITY PLAN: INCREASING MEMBER UTILIZATION OF TELEHEALTH TO ACCESS OUTPATIENT CARE

1. General PIP Information

Managed Care Plan (MCP) Name: UnitedHealthcare Community Plan (UHC)
PIP Title: Increasing Member Utilization of Telehealth to Access Outpatient Care
PIP Aim Statement: *Member-Focused* • Increase the percentage of members utilizing the telehealth (audio-visual) modality (one or more times) as measured by increased rates of telehealth utilization compared to baseline. • Increase member telehealth (audio-visual) utilization (one or more times) for those members who did not utilize the telehealth modality in the baseline year. *Provider-Focused* • Increase the providers' telehealth (audio-visual) utilization rate as measured by increased rates of telehealth utilization for their members compared to baseline. • Increase the providers' telehealth utilization rate as measured by increased rates of telehealth utilization for their members who did not utilize the telehealth modality in the baseline year.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☒ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0 to 17)*   ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS, or pregnant women (please specify): Senior Duals
Programs: ☒ Medicaid (Title XIX) only   ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
None identified.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
None identified.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
Identify and pilot a vendor that the UHC SCO will collaborate with to provide Wi-Fi-enabled devices that reduce the most formidable barriers that our members have in using technology for telehealth visits. The device will be tailored to the needs of members, i.e., older adults with low tech literacy, low health literacy, who may not be primary English speakers, and who may have an ongoing need for technical support to be able to use the device over time. A target group of members will be chosen to pilot the device. The pilot will include initial member training and set-up and ongoing technical support that is user-friendly.

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
Ambulatory Care-Outpatient (AMB) NQF #9999	2020	15,511 / 24,096 64.37%	☒ Not applicable – PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): p < 0.005

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
EQRO recommendations for improvement of PIP: **Quality-Related**: In addition to stratifying the data by age and coverage (Medicaid only and dually eligible), Kepro advises UHC to present a telehealth performance indicator rate for its entire SCO population.

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. UHC received a rating score of 100% on this Performance Improvement Project.

Exhibit 4.16. UHC PIP Project Score

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

Plan and Project Strengths

Access-Related: UHC is commended for its efforts to conduct face-to-face or telephone interviews with members whose preferred language is Spanish, Mandarin, or Cantonese. It is also commended for translating member and provider feedback into intervention strategies.

Opportunities for Improvement

Quality-Related: In addition to stratifying the data by age and coverage (Medicaid only and dually eligible), Kepro advises UHC to present a telehealth performance indicator rate for its entire SCO population.

Network Adequacy Validation

SECTION 5. NETWORK ADEQUACY VALIDATION

INTRODUCTION

The concept of Network Adequacy revolves around a SCO'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 sets forth contractually required time and distance standards as well as threshold member to provider ratios to ensure access to timely care.

In 2021, MassHealth, in conjunction with its External Quality Review Organization, Kepro, evaluated and identified the strengths of the health plan's provider networks, as well as offered recommendations for bridging network gaps. This process of evaluating a plan's network is termed Network Adequacy Validation. While not required by CMS at this time, MassHealth was strongly encouraged by CMS to incorporate this activity as an annual validation activity as it will be required in the future.

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

Using Quest, Kepro has analyzed the current performance of the plans based on the time and distance standards that the state requires, while also identifying gaps in coverage by geographic area and specialty. The program also provides information about available providers should network expansion be required. This information is based on a list of all licensed physicians from the Massachusetts Board of Registration in Medicine.

As stated above, the goal of network adequacy analysis is to ensure that every managed care plan offers adequate access to care across the plan's entire service area. When measuring access to care using only existing membership, that dataset may not always be representative of the entire service area. Additionally, measuring only existing membership does not account for future growth or expansion of existing service areas. Therefore, the network adequacy review was performed using a representative set of population points, 3 percent of the population, distributed throughout the service area based on population patterns. The member file was provided by MassHealth. This methodology allows MassHealth to ensure each plan was measured consistently against the same population distribution and that the entire service area had adequate access to care within the prescribed time and distance criteria.

REQUEST OF PLAN

Kepro obtained a complete provider data set from each SCO, which included the following data points:
- Facility or Provider Name
- Address Information
- Phone Number; and
- NPI Information

This request applied to the following areas of service:
- Primary Care Providers and OB/GYNs;
- Rehabilitation Hospitals;
- Urgent Care Services;
- Specialists; and
- Behavioral Health Services.

TIME AND DISTANCE STANDARDS

To ensure that members have appropriate access to care for covered services, CMS and MassHealth require Senior Care Organizations to adhere to certain time and distance standards.

SCO plans are required to meet both the time *and* distance standard for Medicare Advantage-specified services. For example, the standard for Adult PCP services requires that a minimum of two providers be located within both a 15-mile radius of the member's home *and* a travel time of no more than 30 minutes.

To be considered compliant, SCO plans can meet either the time *or* the distance standard for Medicaid-specified services. For example, the standard for behavioral health outpatient services requires that a minimum of two providers be located within both a 15-mile radius of the member's home *or* a travel time of no more than 30 minutes.

It's important to note that, for some specialties, the time and distance standards vary based on the CMS county designation, i.e., large metro, metro, or micro. The map that follows shows the county designations.

Exhibit 5.1. Map of Massachusetts County Designations

ACUTE TREATMENT SERVICES: EMERGENCY SUPPORT SERVICES:

2 providers within 15 miles or 30 minutes.

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.

BEHAVIORAL HEALTH OUTPATIENT SERVICES

Greater than or equal to 2 providers within 15 miles or 30 minutes.

BEHAVIORAL HEALTH DIVERSIONARY SERVICES

MassHealth requires a minimum of 2 providers within 15 miles or 30 minutes. These standards apply to all services specified in the table that follows:

Exhibit 5.2. Behavioral Health Diversionary Services

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

MEDICAL FACILITY SERVICES

MassHealth requires all Rehabilitation Hospitals to be located within a 15-mile radius or 30-minute travel time standard, regardless of the county type. The Acute Inpatient Hospitals are required to meet the same time and distance standard, but the standard changes based on the county type. They are outlined in the table that follows and must meet both the time and distance standard:

Exhibit 5.3. Acute Inpatient Hospital Standards

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

LONG-TERM SERVICES AND SUPPORTS

MassHealth requires that a minimum of two Occupational, Physical, and Speech Therapists be located within 15 miles and 30 minutes of the member. The requirement for all other LTSS services, with the exception of Skilled Nursing Facilities, is 15 miles or 30 minutes from the member. This standard applies to all services outlined in the table that follows:

Exhibit 5.4. Long-Term Services and Supports

LTSS Specialties	
Adult Day Health	Orthotics and Prosthetics
Adult Foster Care	Oxygen and Respiratory Equipment
Day Habilitation	Personal Care Assistant
Group Adult Foster Care	

Skilled Nursing Facilities must meet the number of servicing provider requirement as well as the time and the distance standards outlined in the table that follows:

Exhibit 5.5 Skilled Nursing Facility Standards

County Type	# Of Providers	Time (Minutes)	Distance (Miles)
Large Metro	2	20	10
Metro	2	35	20
Micro	2	75	55

SPECIALTY SERVICES

CMS has established specialty- and county-size-specific standards. Specialty services must also meet a specified ratio of providers to plan members. The tables that follow detail the specialty and corresponding standards stratified by county designation. Also included is the required ratio of providers to members. All services are required to meet both the time and distance standard. SCO plans do not service the Micro counties in Massachusetts, Dukes and Nantucket.

Exhibit 5.6. Specialty Standards for Large Metro and Metro Counties

Specialty	Large Metro Ratio	Large Metro Time (Mins)	Large Metro Distance (Miles)	Metro Ratio	Metro Time (Mins)	Metro 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, Rehab 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 AND INTERPRETING RESULTS

The Quest system generates a network adequacy score by bumping the following files against each other:

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

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

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

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

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

SCO plans must meet the time and distance standards with a score of 90 or above to be considered in compliance with network adequacy requirements. This report evaluates each SCO plan's network adequacy results against this requirement.

To further assist in the interpretation of results, a ranked list of county populations follows.

Exhibit 5.7. Massachusetts County Designations and 2020 Population

County	County Designations	2020 Population[2]
Middlesex	Large Metro	1,632,002
Worcester	Metro	862,111
Essex	Large Metro	809,829
Suffolk	Large Metro	797,936
Norfolk	Large Metro	725,981
Bristol	Metro	579,200
Plymouth	Metro	530,819
Hampden	Metro	465,825
Barnstable	Metro	228,996
Hampshire	Metro	162,308
Berkshire	Metro	129,026
Franklin	Metro	71,029
Dukes	Micro	20,600
Nantucket	Micro	14,255

AGGREGATE RESULTS

As stated previously, SCO plans must meet the time and distance standards with a score of 90 or above to be considered in compliance with network adequacy requirements. The following tables depict the scores received by the plans:

Exhibit 5.8. SCO Overall Scores Medicare Services

Plan	Score
BMCHP	97.9
CCA	97.8
Fallon	96.1
SWH	91.4
Tufts	99.9
UHC	100

Exhibit 5.9. SCO Overall Scores Medicaid Services

Plan	Score
BMCHP	84.4
CCA	91.1
Fallon	82.4
SWH	60.3
Tufts	74.0
UHC	80.2

The tables that follow provide a high-level summary of network adequacy deficiencies by plan and by specialty. An "X" represents a network deficiency.

Exhibit 5.10. SCO Medicare Network Adequacy – Deficient Networks by Specialty

Services	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Adult PCP						
Allergy and Immunology						
Cardiology						
Cardiothoracic Surgery						
Chiropractor						
Dermatology						
Endocrinology						
ENT/Otolaryngology						
Gastroenterology						
General Surgery						
Infectious Diseases						
Nephrology						
Neurology						
Neurosurgery						
OBGYN						
Oncology – Medical						
Oncology – Radiation						
Ophthalmology						
Orthopedic Surgery						
Physiatry – Rehab Medicine						
Plastic Surgery						
Podiatry						
Psychiatry				X		
Pulmonology		X				
Rheumatology						
Urology						
Vascular Surgery						
Psychiatric Inpatient Adult				X		
Nursing Facility						
Physical Therapy						
Occupational Therapy	X		X	X		
Speech Therapy	X		X	X		
Acute Inpatient Hospitals	X					

Exhibit 5.11. SCO Medicaid Network Adequacy – Deficient Networks by Specialty

Services	BMCHP	CCA	Fallon	SWH	Tufts	UHC
Emergency Services Program				X	X	X
Clinical Support Services for SUD Level 3.5				X	X	X
Community Crisis Stabilization				X	X	X
Community Support Program					X	X
Intensive Outpatient Program					X	
Monitored Inpatient Level 3.7		X		X	X	
Partial Hospitalization Programs				X	X	
Psychiatric Day Treatment				X	X	X
Recovery Coaching						X
Recovery Support Navigators						X
Residential Rehab Services for SUD	X		X	X	X	X
Structured Outpatient Addiction Programs					X	
BH Outpatient						
Adult Day Health	X		X			
Adult Foster Care	X		X	X		X
Day Habilitation	X		X	X	X	X
Group Adult Foster Care	X		X	X	X	X
Orthotics and Prosthetics	X		X	X		
Oxygen and Respiratory Equipment		X	X	X	X	
Personal Care Assistant	X	X	X	X	X	
Rehabilitation Hospital	X	X	X			

RESULTS BY PLAN

BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

BMCHP enrolls beneficiaries in Barnstable, Bristol, Hampden, Plymouth, and Suffolk Counties.

Medicare Services

BMCHP received an overall score of 97.9 for Medicare services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.12. BMCHP Adequacy Score
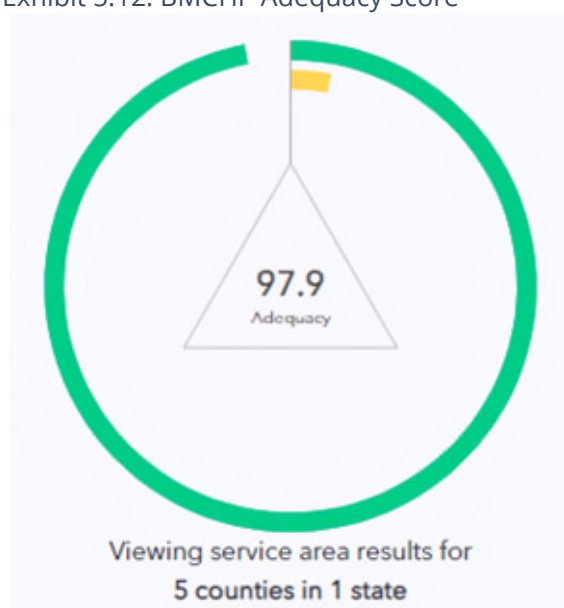
Score Wheel Percentages:
- The green bar indicates that 97% of BMCHP's healthcare service network fully meets the adequacy requirements.
- The yellow bar indicates that 3% of BMCHP's healthcare service network meets the number of servicing provider requirements only.

Primary Care and Medical Facilities

BMCHP met all network access requirements for Primary Care. The table that follows depicts the network adequacy scores for Acute Inpatient Hospitals.

Exhibit 5.13. Acute Inpatient Hospital Access Gaps and Corresponding Counties

County	Acute Inpatient Hospitals
Barnstable	100
Bristol	100
Hampden	47.9
Plymouth	100
Suffolk	100
Overall	**89.6**

Behavioral Health Inpatient Services

BMCHP met all network adequacy requirements for Behavioral Health Inpatient Services.

Specialty Services

BMCHP met all network adequacy requirements for Specialty Services.

Long-Term Services and Supports

BMCHP's Nursing Facility and Physical Therapy networks meet the minimum network adequacy requirements. The table that follows depicts the network adequacy scores for those LTSS services not meeting the minimum network adequacy score.

Exhibit 5.14. Long-Term Services and Support Gaps and Corresponding Counties

County	Occupational Therapy	Speech Therapy
Barnstable	50.8	0.0
Bristol	100	100
Hampden	100	100
Plymouth	59.5	0.0
Suffolk	100	100
Overall:	**82.1**	**60.0**

Medicaid Services

BMCHP received an overall network adequacy score of 84.4 for Medicaid services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.15. BMCHP Adequacy Score

84.4
Adequacy

Viewing service area results for
5 counties in 1 state
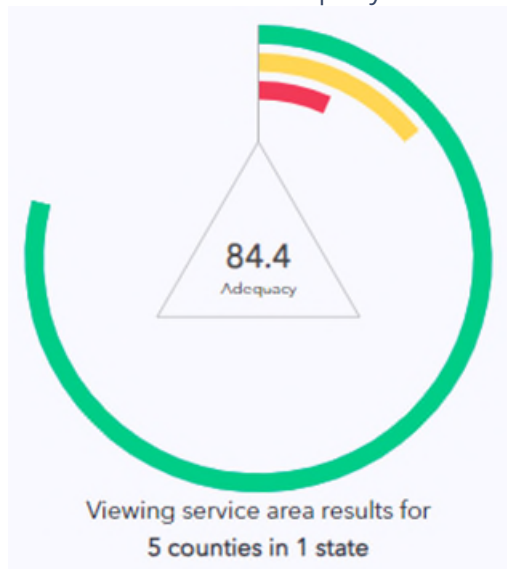
Score Wheel Percentages:
- The green bar indicates that 79% of BMCHP's healthcare service network fully meets adequacy requirements.
- The yellow bar indicates that 1% of BMCHP's healthcare service network meets time and distance requirements only and that 13.3% of BMCHP's healthcare service network meets the number of servicing provider requirements only.
- The red bar indicates that 6.7% of BMCHP's healthcare service network do not meet any adequacy requirements.

Emergency Services and Rehabilitation Hospitals

BMCHP meets all network access requirements for Emergency Service Providers. The table that follows depicts the network adequacy scores for rehabilitation hospital services.

Exhibit 5.16. Rehabilitation Hospital Gaps and Corresponding Counties

County	Rehabilitation Hospitals
Barnstable	0.0
Bristol	100
Hampden	0.0*
Plymouth	100
Suffolk	50.7
Overall:	50.1

* No provider data were submitted by the plan

Behavioral Health Services

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

Exhibit 5.17. Behavioral Health Services with a Passing Network Adequacy Score

Behavioral Health Service	Score	Behavioral Health Service	Score
Behavioral Health Outpatient	100	Partial Hospitalization Programs	100
Clinical Support Services for SUD	100	Psychiatric Day Treatment	92.4
Community Crisis Stabilization	100	Recovery Coaching	100
Community Support Programs	100	Recovery Support Navigators	100
Intensive Outpatient Programs	100	Structured Outpatient Addiction Program	100
Monitored Inpatient Level 3.7	100		

The table that follows depicts the network adequacy scores by county for Substance Use Disorder Residential Rehabilitation Services.

Exhibit 5.18. SUD Residential Rehabilitation Services and Corresponding Counties

County	Residential Rehabilitation Services for SUD
Barnstable	0.0
Bristol	100
Hampden	100
Plymouth	58.5
Suffolk	100
Overall:	71.7

Long-Term Services and Supports

Only Oxygen and Respiratory Equipment Service met MassHealth's network adequacy requirements. The table that follows depicts the network adequacy scores for those long-term services and supports not meeting the minimum network adequacy score.

Exhibit 5.19. Long-Term Services and Support Gaps and Corresponding Counties

County	Adult Day Health	Adult Foster Care	Day Habilitation	Group Adult Foster Care	Orthotics and Prosthetics	Personal Care Assistant
Barnstable	0.0*	0.0	0.0	0.0*	0.0	0.0*
Bristol	51.0	100	62.0	0.0	100	0.0
Hampden	0.0	100	70.0	100	100	100
Plymouth	47.5	100	100	53.6	61.3	47.5
Suffolk	100	100	100	100	100	100
Overall:	39.7	80.0	66.4	50.7	72.3	49.5

* No provider data were submitted by the plan

Findings
- BMCHP has a strong Medicare service network.
- Acute Inpatient Hospitals are meeting the servicing provider requirement only in Hampden County. All other counties are passing all MassHealth requirements for Acute Inpatient Hospitals.
- BMCHP does not meet the Occupational Therapy provider requirement in Barnstable and Plymouth Counties. All other counties are passing all requirements for these services.
- Only the number of servicing provider requirement is met for Speech Therapy in Barnstable and Plymouth Counties. All other counties are passing all requirements for these services.
- Residential Rehabilitation Services for Substance Use Disorders meet the number of servicing provider requirement only in Barnstable and Plymouth Counties. All other counties are passing all MassHealth requirements for these services.
- BMCHP did not report having Adult Day Health, Group Adult Foster Care, and Personal Care Assistants in Barnstable County. In addition, Adult Foster Care and Day Habilitation services are not passing any MassHealth requirements in that county.
- Rehabilitation Hospitals are only meeting the servicing provider requirement in two counties, and BMCHP did not report providers for Hampden County. All other counties are passing all MassHealth requirements for Rehabilitation Hospitals.

Recommendations
- Kepro recommends that BMCHP prioritize Barnstable County for network expansion.
- Kepro recommends contracting with additional Acute Inpatient and Rehabilitation Hospitals, as available, in Hampden County.
- Kepro recommends contracting with additional Occupational and Speech Therapists in Barnstable and Plymouth Counties.
- Kepro recommends that that BMCHP fill other network gaps as identified where possible.

Update to 2020 Recommendations

2020 Recommendation	2021 Update
Kepro recommended expansion of the BMCHP Acute Inpatient Hospital network in Hampden County.	BMCHP's inpatient hospital network in Hampden County has expanded but continues to meet only the number of servicing provider requirements.

COMMONWEALTH CARE ALLIANCE (CCA)

CCA enrolls beneficiaries from Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties.

Medicare Services

CCA received an overall score of 97.8 for Medicare services. The score wheel below indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.20. CCA Adequacy Score

97.8
Adequacy

Viewing service area results for
10 counties in 1 state
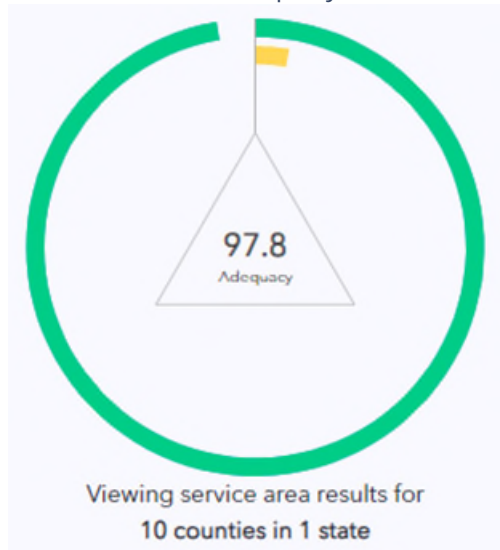
Score Wheel Percentages:
- The green bar indicates that 97.3% of CCA's healthcare service network fully meets the adequacy requirements.
- The yellow bar indicates that 2.7% of CCA's healthcare service network meets the number of servicing provider requirement only.

Primary Care and Medical Facilities

CCA's network of Primary Care and Inpatient Medical Facilities meet network adequacy requirements.

Behavioral Health Services

CCA's network of Adult Psychiatric Inpatient Facilities meet network adequacy requirements.

Specialty Services

Only Pulmonology does not meet network adequacy requirements.

Exhibit 5.21. Pulmonology Service Gaps and Corresponding Counties

County	Pulmonology
Bristol	0.0
Essex	0.0
Franklin	0.0
Hampden	100
Hampshire	100
Middlesex	0.0
Norfolk	0.0
Plymouth	0.0
Suffolk	100
Worcester	100
Overall:	40.0

Long-Term Services and Supports

CCA's network of Nursing Facilities and Physical, Occupational, and Speech Therapists met network adequacy requirements.

Medicaid Services

CCA received an overall score of 91.1 for Medicaid services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.22. CCA Adequacy Score
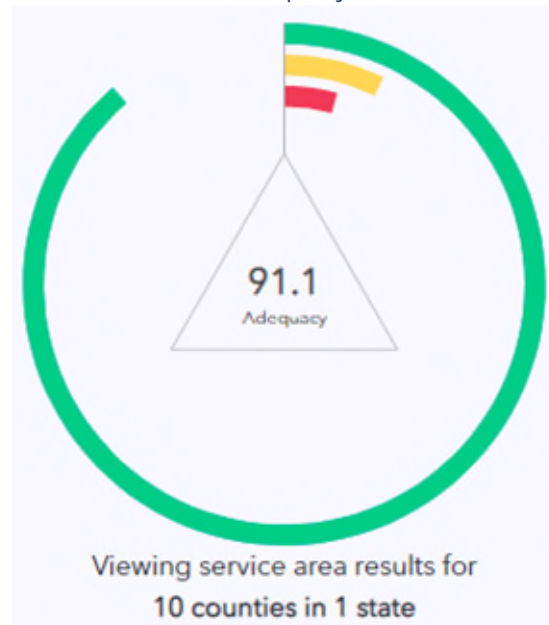
Score Wheel Percentages:
- The green bar indicates that 88.6% of CCA's healthcare service network fully meets adequacy requirements.
- The yellow bar indicates that 7.1% of CCA's healthcare service network meets the number of servicing provider requirement only.
- The red bar indicates that 4.3% of CCA's healthcare service network does not meet any adequacy requirements.

Emergency Services and Rehabilitation Hospitals

CCA's network of Emergency Service providers meets MassHealth requirements. The table that follows depicts the network adequacy scores for and counties of Rehabilitation Hospital services not meeting the minimum network adequacy score.

Exhibit 5.23. Rehabilitation Hospital Gaps and Corresponding Counties

County	Rehabilitation Hospitals
Bristol	56.4
Essex	100
Franklin	0.0
Hampden	100
Hampshire	100
Middlesex	100
Norfolk	100
Plymouth	100
Suffolk	100
Worcester	60.6
Overall:	**81.7**

Behavioral Health Services

CCA's network of Behavioral Health Services meets all requirements except for Monitored Inpatient Level 3.7 Detox Services.

Long-Term Services and Supports

CCA's network of Long-Term Services and Supports meets all requirements except for Oxygen and Respiratory Equipment and Personal Care Assistants.

The table that follows depicts the network adequacy scores for and counties of Long-Term Services and supports not meeting the minimum network adequacy score.

Exhibit 5.24. Long-Term Services and Support Gaps and Corresponding Counties

County	Oxygen and Respiratory Equipment	Personal Care Assistant
Bristol	100	0.0
Essex	61.0	61.1
Franklin	0.0	61.9
Hampden	100	100
Hampshire	100	100
Middlesex	100	59.8
Norfolk	100	100
Plymouth	100	55.0
Suffolk	100	100
Worcester	100	0.0
Overall:	**86.1**	**63.8**

Findings

- Although only four counties are meeting requirements for Pulmonology services, these counties represent Massachusetts population hubs.
- CCA's network of Rehabilitation Hospitals is deficient in Bristol, Franklin, and Worcester Counties.
- CCA's network of Monitored Inpatient Level 3.7 Detox Service providers is deficient in all 10 counties in its service area.
- Only the number of servicing provider requirement for Oxygen and Respiratory Equipment services is met in Essex and Franklin Counties.
- CCA's network of Personal Care Assistants is deficient in six counties.

Recommendations

- Kepro recommends that CCA contract with additional Oxygen and Respiratory Equipment service providers as available in Essex and Franklin Counties.
- Kepro recommends that CCA expand its network of Personal Care Assistant providers as available in those counties that are not meeting MassHealth requirements.
- Kepro recommends that CCA contract with additional Rehabilitation Hospitals as available in Bristol, Franklin, and Worcester Counties.
- Kepro recommends that CCA contract with additional Monitored Inpatient Level 3.7 providers as available in those counties that are not meeting MassHealth requirements.

Updates to 2020 Recommendations

Kepro offered no recommendations to CCA in 2020.

FALLON HEALTH (FALLON)

Fallon enrolls beneficiaries from Barnstable, Bristol, Essex, Franklin, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties.

Medicare Services

Fallon received an overall network adequacy score of 96.1 for Medicare services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.25. Fallon Network Adequacy Score
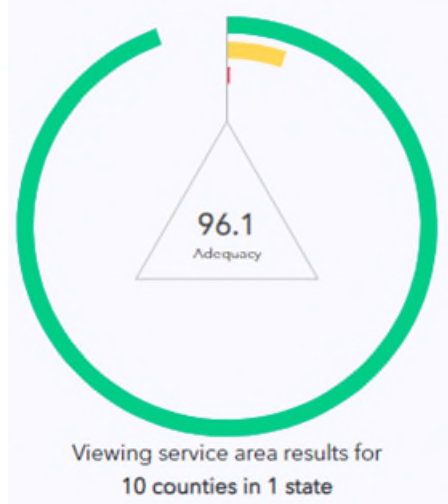
Score Wheel Percentages:
- The green bar indicates that 94.5% of Fallon's healthcare service network fully meets the adequacy requirements.
- The yellow bar indicates that 5.2% of Fallon's healthcare service network meets only the servicing provider requirements.
- The red bar indicates that 0.3% of Fallon's healthcare service network does not meet any adequacy requirements.

Primary Care and Medical Facilities

Fallon meets all network adequacy requirements for Primary Care and Acute Inpatient Hospital services.

Behavioral Health Services

Fallon meets all network adequacy requirements for Psychiatric Inpatient services.

Specialty Services

Fallon meets all specialty service network adequacy requirements.

Long-Term Services and Supports

Fallon meets network adequacy requirements for Nursing Facilities and for Physical Therapy.

The table that follows depicts the network adequacy scores for those long-term services and supports not meeting the minimum network adequacy score.

Exhibit 5.26. Long-Term Services and Support Gaps and Corresponding Counties

County	Occupational Therapy	Speech Therapy
Barnstable	0.0	0.0
Bristol	100	0.0
Essex	0.0	0.0
Franklin	0.0	0.0
Hampden	100	100
Middlesex	59.0	49.7
Norfolk	100	51.4
Plymouth	100	0.0
Suffolk	100	100
Worcester	58.6	59.6
Overall:	**61.8**	**36.1**

Medicaid Services

Fallon received an overall network adequacy score of 82.4 for Medicaid services. This score wheel indicates multiple scores, outlined in the bullets.

These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.27. Fallon Adequacy Score

82.4
Adequacy

Viewing service area results for
10 counties in 1 state
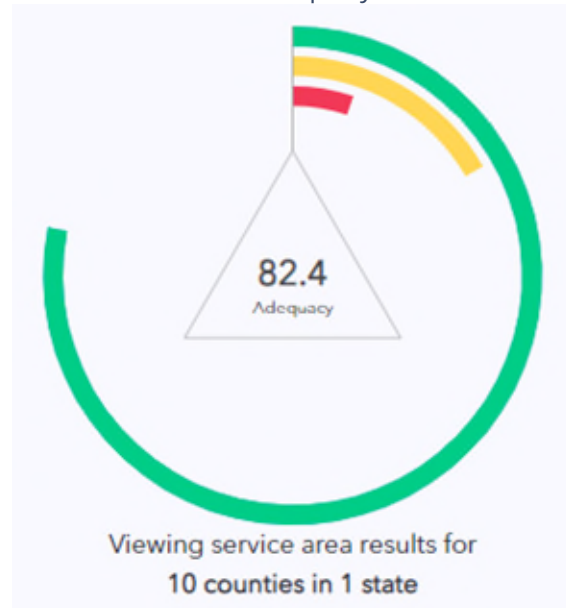
Score Wheel Percentages:
- The green bar indicates that 78.1% of Fallon's Medicaid service network fully meets the adequacy requirements.
- The yellow bar indicates that 16.7% of Fallon's Medicaid service network meets only the servicing provider requirements.
- The red bar indicates that 5.2% of Fallon's Medicaid service network does not meet any adequacy requirements.

Emergency Services and Rehabilitation Hospitals

Fallon fully meets Emergency Service Program time and distance and number of servicing provider requirements. The table that follows depicts the network adequacy scores for services not meeting the minimum network adequacy score.

Exhibit 5.28. Rehabilitation Hospital Gaps and Corresponding Counties

County	Rehabilitation Hospitals
Barnstable	0.0*
Bristol	0.0
Essex	100
Franklin	0.0
Hampden	100
Middlesex	100
Norfolk	100
Plymouth	50.9
Suffolk	100
Worcester	59.5
Overall:	61.0

* No provider data were submitted by the plan

Behavioral Health Services

Fallon met all Behavioral Health Service adequacy requirements except for Residential Rehabilitation Services for Substance Abuse Disorders.

Exhibit 29. Behavioral Health Service Gaps and Corresponding Counties

County	Residential Rehabilitation Services for SUD
Barnstable	0.0
Bristol	100
Essex	60.6
Franklin	100
Hampden	100
Middlesex	100
Norfolk	100
Plymouth	58.5
Suffolk	100
Worcester	61.9
Overall:	78.1

Long-Term Services and Supports

The table that follows depicts the network adequacy scores for those long-term services and supports not meeting the minimum network adequacy score.

Exhibit 5.30. Long-Term Service and Support Gaps and Corresponding Counties

County	Adult Day Health	Adult Foster Care	Day Habilitation	Group Adult Foster Care	Orthotics and Prosthetics	Oxygen and Respiratory Equipment	Personal Care Assistant
Barnstable	0.0	52.9	100	0.0	0.0	0.0	0.0
Bristol	100	100	62.1	100	52.1	0.0	0.0
Essex	61	100	0.0	54.6	100	0.0	0.0
Franklin	100	45	0.0	100	100	0.0*	0.0
Hampden	100	100	0.0	100	100	0.0	0.0
Middlesex	100	100	0.0	100	100	0.0	0.0
Norfolk	100	100	0.0	100	100	0.0	100
Plymouth	100	100	100	62.2	61.7	0.0	48.7
Suffolk	100	100	0.0	100	100	0.0	100
Worcester	100	100	0.0	100	100	48.7	0.0
Overall:	**86.1**	**89.8**	**26.2**	**81.7**	**81.4**	**4.9**	**24.9**

* No provider data were submitted by the plan

Findings

- Occupational Therapy services are meeting the number of servicing provider requirement only.
- Only two counties are passing all requirements for Speech Therapy services. Barnstable County is not meeting either requirement.
- Fallon did not report having Rehabilitation Hospital providers in Barnstable County. The number of servicing provider requirement only is met in Bristol, Franklin, Plymouth, and Worcester Counties.
- Residential Rehabilitation Services for Substance Use Disorders services meet only the number of servicing provider requirement in Barnstable, Essex, Plymouth, and Worcester Counties.
- Barnstable County only meets all network adequacy requirements for Day Habilitation services.
- Oxygen and Respiratory Equipment requirements are not met in any county.
- Standards for Personal Care Assistants are met only in Eastern counties of Norfolk, Suffolk, and Plymouth.

Recommendations

- Kepro recommends that Fallon contract with Occupational and Speech Therapy providers in those counties are not meeting requirements.
- Kepro recommends Fallon contract with additional Rehabilitation Hospitals as available in Barnstable County, as well as in those counties not passing MassHealth requirements.
- Kepro recommends contracting with additional Residential Rehabilitation Services for SUD as available in those counties not meeting all MassHealth requirements.
- Kepro recommends that Fallon close network adequacy gaps in its LTSS provider network notably in Oxygen and Personal Care Assistant services.

SENIOR WHOLE HEALTH BY MOLINA HEALTH CARE (SWH)

SWH enrolls beneficiaries from Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties.

Medicare Services

SWH received an overall score of 91.4 for Medicare services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.31. SWH Adequacy Score
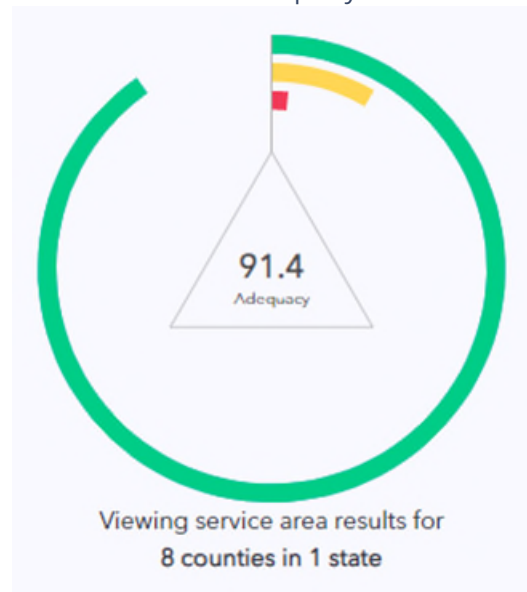
Score Wheel Percentages:
- The green bar indicates that 90.2% of SWH's healthcare service network fully meet the adequacy requirements.
- The yellow bar indicates that 8.3% of SWH's healthcare service network meet only the servicing provider requirements.
- The red bar indicates that 1.5% of SWH's healthcare service network do not meet any adequacy requirements.

Primary Care and Medical Facilities

SWH's Primary Care and Medical Facility networks meet all network adequacy requirements.

Behavioral Health Services

The table that follows depicts the network adequacy scores for Psychiatric Inpatient services.

Exhibit 5.32. Adult Psychiatric Inpatient Service Gaps and Corresponding Counties

County	Adult Psychiatric Inpatient
Bristol	0.0
Essex	100
Hampden	0.0
Middlesex	100
Norfolk	100
Plymouth	0.0
Suffolk	100
Worcester	0.0
Overall:	50.0

Specialty Services

SWH's network of Medicare specialty services met network adequacy requirements except for Psychiatry. The table that follows depicts the network adequacy scores for this specialty.

Exhibit 5.33. Psychiatry Service Gaps and Corresponding Counties

County	Psychiatry
Bristol	0.0
Essex	0.0
Hampden	0.0*
Middlesex	0.0
Norfolk	0.0
Plymouth	0.0
Suffolk	100
Worcester	0.0
Overall:	12.5

* No provider data were submitted by the plan

Long-Term Services and Supports

Nursing Facility and Physical Therapy service requirements were met in all counties served by SWH. The table that follows depicts the network adequacy scores for those long-term services and supports not meeting the minimum network adequacy score.

Exhibit 5.34. Long-Term Services and Support Gaps and Corresponding Counties

County	Occupational Therapy	Speech Therapy
Bristol	100	45.9
Essex	0.0	0.0
Hampden	0.0*	0.0*
Middlesex	0.0	0.0
Norfolk	100	45.6
Plymouth	51.0	0.0
Suffolk	100	100
Worcester	0.0	0.0
Overall:	**43.9**	**23.9**

* No provider data were submitted by the plan

Medicaid Services

SWH received an overall score of 60.3 for Medicaid services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.35. SWH Adequacy Score

60.3
Adequacy

Viewing service area results for
8 counties in 1 state
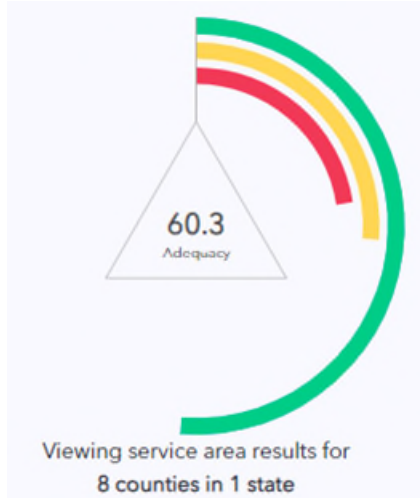
Score Wheel Percentages:
- The green bar indicates that 51.2% of SWH's network fully meets Medicaid service adequacy requirements.
- The yellow bar indicates that 26.2% of SWH's network meets only Medicaid service number of servicing provider requirements.
- The red bar indicates that 22.6% of SWH's healthcare service network does not meet any Medicaid service adequacy requirements.

Emergency Services and Rehabilitation Hospitals

SWH's network of Rehabilitation Hospitals fully meets network adequacy requirements. The table that follows depicts Emergency Provider network adequacy scores.

Exhibit 5.36. Emergency Services Gaps and Corresponding Counties

County	Emergency Service Programs
Bristol	0.0
Essex	0.0
Hampden	0.0*
Middlesex	0.0
Norfolk	48
Plymouth	46
Suffolk	0.0
Worcester	0.0
Overall:	11.8

* No provider data were submitted by the plan

Behavioral Health Services

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

Exhibit 5.37. Behavioral Health Services with a Passing Network Adequacy Score

Behavioral Health Service	Score	Behavioral Health Service	Score
Behavioral Health Outpatient	100	Recovery Coaching	100
Community Support Programs	100	Recovery Support Navigators	100
Intensive Outpatient Programs	100	Structured Outpatient Addiction Programs	100

The table that follows depicts the network adequacy scores for those behavioral health services not meeting the minimum network adequacy score.

Exhibit 5.38. Behavioral Health Service Gaps and Corresponding Counties

County	Clinical Support Services for SUD	Community Crisis Stabilization	Monitored Inpatient Level 3.7	Partial Hospitalization Program	Psychiatric Day Treatment	Residential Rehabilitation Services for SUD
Bristol	0.0*	62.3	0.0	0.0	100	0.0*
Essex	0.0*	0.0	47.1	47.1	47.1	0.0*
Hampden	0.0*	0.0	100	0.0	100	0.0*
Middlesex	0.0*	0.0	53.3	53.3	56.2	0.0*
Norfolk	0.0*	62.9	58.0	58.0	100	0.0*
Plymouth	0.0*	62.2	0.0	0.0	62.2	0.0*
Suffolk	0.0*	100	100	100	100	0.0*
Worcester	0.0*	47.9	0.0	0.0	50.5	0.0*
Overall:	**0.0**	**41.9**	**44.8**	**32.3**	**77.0**	**0.0**

* No provider data were submitted by the plan

Long-Term Services and Supports

SWH's network of Adult Day Health providers meets all network adequacy requirements. The table that follows depicts the network adequacy scores for those long-term services and supports not meeting the minimum network adequacy score.

Exhibit 5.39. Long-Term Services and Support Gaps and Corresponding Counties

County	Adult Foster Care	Day Habilitation	Group Adult Foster Care	Orthotics and Prosthetics	Oxygen and Respiratory Equipment	Personal Care Assistant
Bristol	57.9	0.0*	100	49.6	0.0	100
Essex	0.0	0.0*	53.1	59.6	0.0*	100
Hampden	0.0	0.0*	0.0	0.0	0.0	0.0
Middlesex	55.6	0.0*	100	100	0.0	100
Norfolk	100	0.0*	100	100	0.0	100
Plymouth	50.8	0.0*	60.7	0.0	0.0	58.0
Suffolk	100	0.0*	100	100	0.0*	100
Worcester	48.3	0.0*	51.8	56.1	0.0	100
Overall:	**51.6**	**0.0**	**70.7**	**58.2**	**0.0**	**82.3**

* No provider data were submitted by the plan

Findings
- Psychiatric Inpatient services meet only the servicing provider requirement in three counties and Hampden County meets neither requirement. Suffolk County is the only county passing all MassHealth requirements for Psychiatry services.
- SWH did not report having Occupational Therapy or Speech Therapy providers in Hampden County.
- Three counties are passing all requirements for Occupational Therapy services and four counties are only meeting the servicing provider requirement.
- Suffolk County is passing all requirements for Speech Therapy services. All other counties are only meeting the servicing provider requirement.
- SWH did not report having providers for Clinical Support and Residential Rehabilitation Services for Substance Use Disorders.
- While SWH's network of behavioral health services is strong in Suffolk County (except for the above-noted deficiency), its coverage is uneven in all other counties.
- SWH did not report having Emergency Service providers in Hampden County.
- SWH did not report having providers for Day Habilitation services nor did it report having Oxygen and Respiratory Equipment providers in Essex and Suffolk Counties.
- SWH did not meet network adequacy requirements for Oxygen and Respiratory Equipment Providers statewide.
- No LTSS services meet requirements in Hampden County and there are numerous gaps in Plymouth County.

Recommendations
- Kepro recommends that SWH prioritize closing network gaps for Medicaid LTSS services.
- Kepro recommends contracting with additional Psychiatric Inpatient Adult and Psychiatry service providers in identified counties.
- Similarly, Kepro recommends that SWH expand its network of Clinical Support Services for SUD, Community Crisis Stabilization, Psychiatric Day Treatment, Monitored Level 3.7, Partial Hospitalization, and Residential Support Services for SUD in those counties not meeting MassHealth network adequacy requirements.
- Kepro recommends that SWH expand its network of Occupational and Speech Therapy providers, especially in Hampden County.

Update to 2020 Recommendations
Kepro offered no recommendations in 2020.

TUFTS ASSOCIATED HEALTH MAINTENANCE ORGANIZATION (TUFTS)

Tufts enrolls beneficiaries in Barnstable, Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties.

Medicare Services

Tufts received an overall network adequacy score of 99.9 for Medicare services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.40. Tufts Adequacy Score
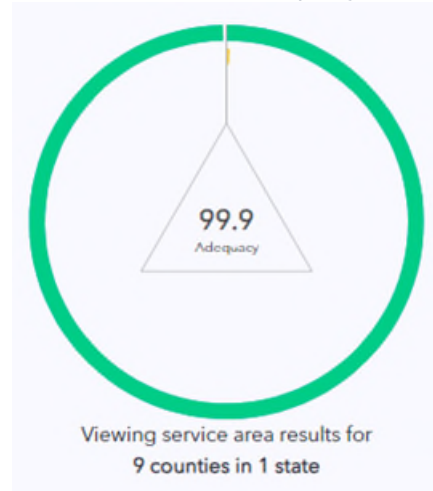
Score Wheel Percentages:
- The green bar indicates that 99.7% of Tufts' healthcare service network fully meet the adequacy requirements.
- The yellow bar indicates that 0.3% of Tufts' healthcare service network meet only the servicing provider requirements.

Primary Care and Medical Facilities

Tufts' network of Primary Care Providers and Acute Inpatient Hospitals meets all Medicare network adequacy requirements.

Behavioral Health Services

Tufts' network of Psychiatric Inpatient Hospitals meets all Medicare network adequacy requirements.

Specialty Services

Tufts' Specialty Service network meets all Medicare network adequacy requirements.

Long-Term Services and Supports

Tufts' LTSS network meets all Medicare network adequacy requirements.

Medicaid Services

Tufts received an overall network adequacy score of 74.0 for Medicaid services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.41. Tufts Adequacy Score
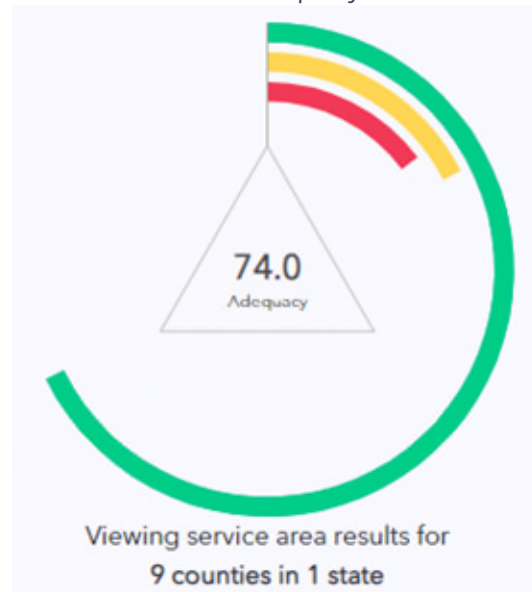
Score Wheel Percentages:
- The green bar indicates that 67.7% of Tufts' healthcare service network fully meet the adequacy requirements.
- The yellow bar indicates that 17.5% of Tufts' healthcare service network meet only the servicing provider requirements.
- The red bar indicates that 14.8% of Tufts' healthcare service network do not meet any adequacy requirements.

Emergency Services and Rehabilitation Hospitals

Tufts' Rehabilitation Hospital network meets all network adequacy requirements. Conversely, Tufts did not report having network Emergency Service providers in any county in Massachusetts.

Behavioral Health Services

Tufts met all Behavioral Health network adequacy requirements for Outpatient, Recovery Coaching, and Recovery Support Navigator services.

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

Exhibit 5.42a. Behavioral Health Service Gaps and Corresponding Counties

County	Clinical Support Services for SUD	Community Crisis Stabilization	Community Support Programs	Intensive Outpatient Programs	Monitored Inpatient Level 3.7
Barnstable	0.0	0.0*	100	100	0.0
Bristol	100	0.0*	47.7	100	100
Essex	100	0.0*	44.6	100	100
Hampden	100	0.0	100	0.0	100
Middlesex	100	0.0*	60.8	100	100
Norfolk	100	0.0*	100	100	100
Plymouth	100	0.0*	47.1	100	100
Suffolk	100	0.0*	100	100	100
Worcester	57.8	0.0	52.6	100	57.8
Overall:	**84.2**	**0.0**	**72.5**	**88.9**	**84.2**

* No provider data were submitted by the plan

Exhibit 5.42b. Behavioral Health Service Gaps and Corresponding Counties

County	Partial Hospitalization Programs	Psychiatric Day Treatments	Residential Rehab Services for SUD	Structured Outpatient Addiction Programs
Barnstable	100	100	0.0*	100
Bristol	100	100	0.0*	100
Essex	100	100	0.0*	100
Hampden	0.0	0.0	0.0*	0.0
Middlesex	100	100	0.0*	100
Norfolk	100	100	0.0*	100
Plymouth	100	100	0.0*	100
Suffolk	100	100	0.0*	100
Worcester	100	100	0.0*	100
Overall:	**88.9**	**88.9**	**0.0**	**88.9**

* No provider data were submitted by the plan

Long-Term Services and Supports

Tufts meets all LTSS network adequacy requirements for Adult Day Health, Adult Foster Care, and Orthotics and Prosthetics. The table that follows depicts the network adequacy scores for those Long-Term Services and Supports not meeting the minimum network adequacy score.

Exhibit 5.43. Long-Term Services and Support Gaps and Corresponding Counties

County	Day Habilitation	Group Adult Foster Care	Oxygen and Respiratory Equipment	Personal Care Assistant
Barnstable	100	0.0	0.0	100
Bristol	60.6	54.5	100	100
Essex	100	0.0	45.9	100
Hampden	100	100	100	0.0
Middlesex	100	100	0.0	100
Norfolk	100	100	100	100
Plymouth	56.2	46.3	44.5	100
Suffolk	100	100	58.2	100
Worcester	54.5	57.1	0.0	62
Overall:	85.7	62.0	49.8	84.7

Findings
- Tufts did not report having Emergency Service providers in any county in Massachusetts.
- Tufts did not report having Community Crisis Stabilization providers in seven counties. Hampden and Worcester Counties did not meet either MassHealth requirements.
- Community Support Programs are only passing all MassHealth requirements in four counties. All other counties only met the servicing provider requirement.
- Tufts did not report having Residential Rehabilitation Services for SUD providers.
- Hampden County represents an opportunity for improvement for Tufts' behavioral health network.
- Day Habilitation services only met the servicing provider requirement in three counties. All other counties are passing all MassHealth requirements.
- Five counties did not meet the servicing provider requirement for Group Adult Foster Care services. Four counties passed all MassHealth requirements.
- Oxygen and Respiratory Equipment services are not passing any MassHealth requirements in Barnstable County; five other counties meet the servicing provider requirement only.

Recommendations
- Kepro recommends that Tufts contract with Emergency Service Programs as available in counties in which gaps exist.
- Kepro recommends expanding its network of Day Habilitation service providers in Hampden and Worcester Counties.
- Kepro recommends contracting additional Oxygen and Respiratory Equipment service providers as available in Barnstable County, as well as in those counties not meeting all MassHealth requirements.
- Kepro recommends contracting additional Personal Care Assistant service providers as available in Hampden and Worcester Counties.
- Kepro recommends that Tufts expands its Behavioral Health network to address network deficiencies.

Updates to 2020 Recommendations
Kepro offered no recommendations in 2020.

UNITEDHEALTHCARE COMMUNITY PLAN (UHC)

UHC enrolls beneficiaries in Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties.

Medicare Services

The plan received an overall score of 100 for Medicare services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.44. UHC Adequacy Score

100.0
Adequacy

Viewing service area results for
8 counties in 1 state
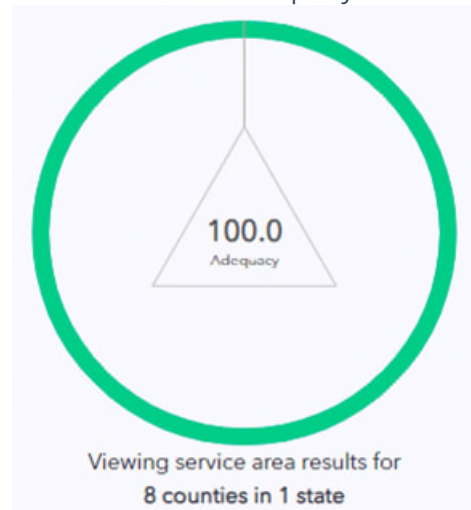
Score Wheel Percentages:
- The green bar indicates that 100% of UHC's healthcare service network fully meets Medicare requirements.

Primary Care and Medical Facilities

UHC's Primary Care and Acute Inpatient Hospital networks meet all Medicare requirements.

Behavioral Health Services

UHC's Inpatient Psychiatric Hospital network meets all Medicare requirements.

Specialty Services

UHC's specialty provider network meets all Medicare requirements.

Long-Term Services and Supports

UHC's LTSS network meets all Medicare requirements.

Medicaid Services

UHC received an overall score of 80.2 for Medicaid services. This score wheel indicates multiple scores, outlined in the bullets. These scores represent the aggregate score of the network's adequacy results based on the average across all specialties.

Exhibit 5.45. UHC Adequacy Score

80.2
Adequacy

Viewing service area results for
8 counties in 1 state
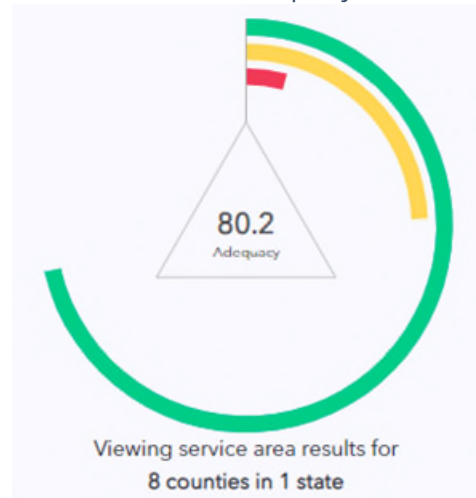
Score Wheel Percentages:
- The green bar indicates that 71.4% of UHC's Medicaid service network fully meets adequacy requirements.
- The yellow bar indicates that 23.8% of UHC's Medicaid service network meets only number of servicing provider requirements.
- The red bar indicates that 4.2% of UHC's healthcare service network does not meet either adequacy requirement.

Emergency Services and Rehabilitation Hospitals

UHC's Rehabilitation Hospital networks meet all MassHealth requirements. The table that follows depicts the network adequacy scores for Emergency Service Programs.

Exhibit 5.46. Emergency Services Gaps and Corresponding Counties

County	Emergency Service Programs
Bristol	0.0
Essex	0.0
Hampden	100
Middlesex	56.4
Norfolk	100
Plymouth	48.5
Suffolk	100
Worcester	57.1
Overall:	**57.7**

Behavioral Health Services

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

Exhibit 5.47. Behavioral Health Services with a Passing Network Adequacy Score

Behavioral Health Service	Score	Behavioral Health Service	Score
Behavioral Health Outpatient	100	Partial Hospitalization Programs	100
Intensive Outpatient Programs	100	Structured Outpatient Addiction Programs	100
Monitored Inpatient Level 3.7	94.9		

The table that follows depicts the network adequacy scores for those behavioral health services not meeting the minimum network adequacy score.

Exhibit 5.48. Behavioral Health Service Gaps and Corresponding Counties

County	Clinical Support Services for SUD	Community Crisis Stabilization	Community Support Program	Psychiatric Day Treatment	Recovery Coaching	Recovery Support Navigators	Residential Rehab Services for SUD
Bristol	0.0	44.7	0.0	0.0	55.5	55.5	44.6
Essex	100	100	0.0	47.7	50.5	0.0	60.3
Hampden	100	100	0.0	100	0.0	100	100
Middlesex	100	100	51	48.2	100	100	100
Norfolk	100	100	100	0.0	100	100	100
Plymouth	100	60.6	50.7	0.0	59.6	59.3	60.1
Suffolk	100	100	100	100	100	100	100
Worcester	58.9	100	47.7	0.0	100	100	100
Overall:	82.4	88.2	43.7	37.0	70.7	76.8	83.1

Long-Term Services and Supports

The table that follows depicts the network adequacy scores for those long-term services and supports meeting the minimum network adequacy score.

Exhibit 5.49. Long-Term Services and Supports with a Passing Network Adequacy Score

LTSS Service	Score
Adult Day Health	100
Orthotics and Prosthetics	100
Oxygen and Respiratory Equipment	100
Personal Care Assistant	100

The table that follows depicts the network adequacy scores for those long-term services and supports not meeting the minimum network adequacy score.

Exhibit 5.50. Long-Term Services and Support Gaps and Corresponding Counties

County	Adult Foster Care	Day Habilitation	Group Adult Foster Care
Bristol	0.0	0.0*	0.0
Essex	100	0.0*	100
Hampden	58.2	70.7	58.2
Middlesex	100	0.0*	100
Norfolk	100	0.0*	100
Plymouth	50.6	0.0*	50.6
Suffolk	100	0.0*	100
Worcester	56.8	0.0	56.8
Overall:	**70.7**	**8.8**	**70.7**

* No provider data were submitted by the plan

Findings

- Three counties are passing all MassHealth requirements for Emergency Service Programs. All other counties are only meeting the servicing provider requirements.
- Gaps in Psychiatric Day Treatment network coverage exist in six counties.
- Only two counties, Norfolk and Suffolk, are passing all MassHealth requirements for Community Support Programs.
- Four counties are passing all MassHealth requirements for Recovery Coaching services. All other counties are not meeting the servicing provider requirements.
- Five counties are passing all MassHealth requirements for Recovery Support Navigator services. Three counties are not meeting the servicing provider requirements.
- Five counties are passing all MassHealth requirements for Residential Rehabilitation Services for Substance Use Disorders. Three counties are not meeting the servicing provider requirements.
- Four counties are passing all MassHealth requirements for Adult Foster Care services, and four counties are not meeting the servicing provider requirements.
- UHC reported having Day Habilitation providers in two counties only, e.g., Hampden and Worcester. Worcester County, however, is not passing any MassHealth requirements. Hampden County is meeting the number of servicing provider requirements, but not time and distance standards.
- Four counties are passing all MassHealth requirements for Group Adult Foster Care services, and four counties are not meeting the servicing provider requirements.

Recommendations

- Kepro recommends contracting Emergency Service Programs as available in those counties not passing MassHealth requirements.
- Kepro suggests prioritizing Bristol County for network development for those services not meeting MassHealth network adequacy requirements.
- Kepro recommends contracting with LTSS and behavioral health service providers as necessary and available to close gaps in coverage.

Contributors

CONTRIBUTORS

PERFORMANCE MEASURE VALIDATION

Katharine Iskrant, CHCA, MPH
Ms. Iskrant is the President of Healthy People, an NCQA-licensed HEDIS audit firm. She is a member of the NCQA Audit Methodology Panel and NCQA's HEDIS Data Collection Advisory Panel. She is also featured on a 2020 NCQA HEDIS Electronic Clinical Data Systems (ECDS) podcast. 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 healthcare delivery settings. She has successfully held many positions, in both public and private sectors, utilizing her clinical background to affect change. She has contributed to the development of a multitude of quality programs from the ground up requiring her to be hands-on through implementation. She is experienced in The Joint Commission, National Committee for Quality Assurance, The Commission on Accreditation of Rehabilitation Facilities, and Accreditation Association for Ambulatory Health Care accreditation and recognition programs. She is skilled in developing workflows and using tools to build a successful process, as well as monitor accordingly. She also coaches teams through the development and implementation process of a project.

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

Wayne J. Stelk, Ph.D.
Wayne J. Stelk, Ph.D., is a psychologist with over 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 healthcare, and long-term services and supports. Other areas of expertise include implementing evidence-based interventions and treatment practices; designing systems for the measurement of treatment outcomes; and developing data-collection systems for quality metrics that are used to improve provider accountability. Dr. Stelk has lectured at conferences nationally and internationally on healthcare performance management.

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 of science degree in healthcare administration and is a Certified Professional in Healthcare Quality. She is currently pursuing a graduate certificate in Public Health Ethics at the University of Massachusetts at Amherst.

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