MassHealth

Senior Care Organizations
External Quality Review Technical Report
Calendar Year 2018

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Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid.

Contents

SECTION 1. CONTRIBUTORS

Project Management

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

Performance Measure Validation

Katharine Iskrant, CHCA, MPH
Ms. Iskrant is a member of the National Committee for Quality Assurance (NCQA) Audit Methodology Panel and has been a Certified Healthcare Effectiveness Data and Information Set (HEDIS®[1]) Compliance Auditor since 1998, directing more than 600 HEDIS® audits. She directed the consultant team that developed the original NCQA Software Certification Program℠ on behalf of NCQA. She is a frequent speaker at HEDIS® vendor and health plan conferences, such as National Alliance of State Health CO-OPs (NASHCO) conferences. Ms. Iskrant received her Bachelor of Arts from Columbia University and her Master of Public Health from UC Berkeley School of Public Health. She is a member of the National Association for Healthcare Quality (NAHQ) and is published in the fields of healthcare and public health.

Performance Improvement Project Reviewers

Bonnie L. Zell, MD, MPH, FACOG
Dr. Zell brings to KEPRO a broad spectrum of healthcare experience as a nurse, an OB/GYN physician chief at Kaiser Permanente, and a hospital medical director. She has also had leadership roles in public health and national policy. As a nurse, she worked in community hospitals, served as head nurse of a surgical ward, and was a methadone dispensing nurse at a medication-assisted treatment program. As OB/GYN chief, she developed new models of care based on patients' needs rather than system structure, integrating the department with psychologists, social workers, family medicine, and internal medicine. In public health roles as Partnerships Lead at the CDC and Senior Director for Population Health at the National Quality Forum, she advanced strategies to integrate public health and healthcare, engaging healthcare and public health leaders in joint initiatives. As an Institute for Healthcare Improvement (IHI)

[1] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

fellow, Dr. Zell led quality improvement curriculum development, coaching, and training for multiple public health and healthcare institutions.

In February 2015, Dr. Zell co-founded a telehealth company, Icebreaker Health, which developed Lemonaid Health, a telehealth model for delivering simple uncomplicated primary care accessed through an app and website. Serving as chief medical officer and chief quality officer, she built the systems, protocols, quality standards and care review processes. Her role then expanded to building partnerships to integrate this telehealth model of care into multiple health systems and study it with national academic leaders.

Dr. Zell continues to have an interest in supporting communities of greatest need. She works part-time as a physician in Medication Assisted Treatment for opiate addiction. She has published and presented extensively.

Wayne J. Stelk, Ph.D.

Wayne J. Stelk, Ph.D., is a psychologist with over 40 years of experience in the design, implementation, and management of large-scale health and human service systems. His expertise includes improving health providers' service effectiveness and efficiency through data-driven performance management systems. During his tenure as Vice President for Quality Management at the Massachusetts Behavioral Health Partnership (MBHP), Dr. Stelk designed and managed over 150 quality improvement projects involving primary care and behavioral health practices across the state. He is well-versed in creating strategies to improve healthcare service delivery that maximize clinical outcomes and minimize service costs. He also implemented a statewide outcomes management program for behavioral health providers in the MBHP network, the first of its kind in Massachusetts. After leaving MBHP in 2010, he consulted on several projects involving the integration of primary care, behavioral health care, and long-term services and supports. Other areas of expertise include implementing evidence-based intervention and treatment practices; designing systems for the measurement of treatment outcomes; and developing data-collections systems for quality metrics that are used to improve provider accountability.

SECTION 2. MASSHEALTH'S SENIOR CARE ORGANIZATIONS

Boston Medical Center HealthNet Plan (BMCHP)

BMCHP HealthNet's Senior Care Organization is a local coordinated care program (CCP) located in Charlestown, Massachusetts.

Commonwealth Care Alliance (CCA)

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

Fallon Health (FH)

Fallon Health's Senior Care Organization (SCO), NaviCare, has a service area that includes the entire state of Massachusetts, with the exception of Dukes and Nantucket Counties. It received an overall quality score of 4.0 from NCQA. Fallon Health's behavioral health partner is Beacon Health Options. Its corporate offices are located in Worcester.

Senior Whole Health (SWH)

Senior Whole Health is an SCO Special Needs Plan (SNP) and HMO SNP, with corporate offices located in Cambridge. It operates in all regions of the Commonwealth with the exception of Western Massachusetts. Its health plan is accredited by the National Committee on Quality Assurance.

Tufts Health Plan (THP)

Tufts Health Plan, Inc., is a not-for-profit health maintenance organization headquartered in Watertown serving members in Massachusetts, New Hampshire, and Rhode Island. Its private HMO/POS and Massachusetts PPO plans are rated 5 out of 5 by the National Committee for Quality Assurance (NCQA). Tufts Health Plan is the only health plan in the nation to receive the rating for both its HMO and PPO products. Tufts Medicare Preferred HMO and Senior Care Options earned 5 stars out of a possible 5 from the Centers for Medicare and Medicaid Services (CMS) for 2018, putting it in the top 4% of plans in the country. It had 5,230 SCO members as of December 2018.

UnitedHealthcare (UHC)

The Senior Care Option plan is part of UHC's Community Plan line of business. UHC started operating in the Boston region, but has since expanded its service area to include Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. As of December 31, 2017, 18,000 individuals belonged to the plan and lived either at home or in a nursing facility. CMS has assigned a 4.5 star rating to UHC's SCO. Its corporate offices are located in Waltham.

MassHealth Senior Care Organization Membership

Senior Care Organization	Membership as of December 31, 2017[2]	Percent of Total SCO Population
UnitedHealthcare	18,000	38%
Senior Whole Health	9,729	20%
Commonwealth Care Alliance	9,070	19%
Fallon Health	5,790	12%
Tufts Health Plan	4,687	10%
BMCHP HealthNet	528	1%
Total	47,804	100%

[2] SCO-reported membership figures

MassHealth Quality Strategy

SECTION 3. MASSHEALTH COMPREHENSIVE QUALITY STRATEGY

Introduction

Under the Balanced Budget Act managed care rule 42 CFR 438 subpart E, Medicaid programs are required to develop a managed care quality strategy. The first MassHealth Quality Strategy was published in 2006. An updated version, the MassHealth Comprehensive Quality Strategy which focused not only to fulfill managed care quality requirements but to improve the quality of managed care services in Massachusetts, was submitted to CMS in November 2018. The updated version broadens the scope of the initial strategy, which focused on regulatory managed care requirements. The quality strategy is now more comprehensive and serves as a framework for EOHHS-wide quality activities. A living and breathing approach to quality, the strategy will evolve to reflect the balance of agency-wide and program-specific activities; increase the alignment of priorities and goals where appropriate; and facilitate strategic focus across the organization.

MassHealth Goals

The mission of MassHealth is to improve *the health outcomes of its diverse members by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life.*

MassHealth defined its goals as part of the MassHealth Comprehensive Quality Strategy development process. MassHealth goals aim to:

1. *Deliver a seamless, streamlined, and accessible patient-centered member experience, with focus on preventative, patient-centered primary care, and community-based services and supports;*
2. *Enact payment and delivery system reforms that promote member-driven, integrated, coordinated care; and hold providers accountable for the quality and total cost of care;*
3. *Improve integrated care systems among physical health, behavioral health, long-term services and supports and health-related social services;*
4. *Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals;*
5. *Maintain our commitment to careful stewardship of public resources through innovative program integrity initiatives; and*
6. *Create an internal culture and infrastructure to support our ability to meet the evolving needs of our members and partners.*

Stakeholder Involvement

MassHealth actively seeks input from a broad set of organizations and individual stakeholders. Stakeholders include, but are not limited to, members, providers, managed care entities, advocacy groups, and sister EOHHS agencies, e.g., the Departments of Children and Families and Mental Health. These groups represent an important source of guidance for quality programs as well as for broader strategic agency. To that end, KEPRO places an emphasis on the importance of the stakeholder voice.

MassHealth Delivery System Restructuring

In November 2016, MassHealth received approval from the Centers for Medicare and Medicaid Services to implement a five-year waiver authorizing a $52.4 billion restructuring of MassHealth. The waiver included the introduction of Accountable Care Organizations (ACOs). In this model, providers have a financial interest in delivering quality, coordinated, member-centric care. Organizations applying for ACO status were required to be certified by the Massachusetts Health Policy Commissions set of standards for ACOs. Certification required that the organization met criteria in the domains of governance, member representation, performance improvement activities, experience with quality-based risk contracts, population health, and cross-continuum care. In this way, quality was a foundational component of the ACO program. Seventeen ACOs were approved to enroll members effective March 1, 2018.

Another important development during this period was the reprocurement of MassHealth managed care organizations. It was MassHealth's objective to select MCOs with a clear track record of delivering high-quality member experience and strong financial performance. The Request for Response and model contract were released in December 2016; selections were announced in October 2017. Tufts Health Public Plans and Boston Medical Center HealthNet Plan were awarded contracts to continue operating as MCOs. Contracts with the remaining MCOs (CeltiCare, Fallon Health, Health New England, and Neighborhood Health Plan) ended in February 2018.

Quality Evaluation

MassHealth evaluates the quality of its program using at least three mechanisms:

- Contract management – MassHealth contracts with plans include requirements for quality measurement, quality improvement, and reporting. MassHealth staff review submissions and evaluate contract compliance.
- Quality improvement performance programs – Each managed care entity is required to complete two Performance Improvement Projects (PIPs) annually, in accordance with 42 CFR 438.330(d).

- State-level data collection and monitoring – MassHealth routinely collects HEDIS® and other performance measure data from its managed care plans.

How KEPRO Supports the MassHealth Comprehensive Quality Strategy

As MassHealth's External Quality Review Organization, KEPRO performs the three mandatory activities required by 42 CFR 438.330:

1) Performance Measure Validation –MassHealth has traditionally asked that three measures be validated.
2) Performance Improvement Project Validation – KEPRO validates two projects per year.
3) Compliance Validation – Performed on a triennial basis, KEPRO assesses plan compliance with contractual and regulatory requirements.

The matrix that follows depicts ways in which KEPRO, through the External Quality Review (EQR) process, supports the MassHealth Comprehensive Quality Strategy:

EQR Activity	Support to MassHealth Comprehensive Quality Strategy
Performance Measure Validation	• Assure that performance measures are calculated accurately. • Offer a comparative analysis of plan performance to identify outliers and trends. • Provide technical assistance. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.
Performance Improvement Project Validation	• Ensure the inclusion of an assessment of cultural competency within interventions. • Ensure the alignment of MassHealth Priority Areas and Quality Goals with MassHealth goals. • Ensure that performance improvement projects are appropriately structured and that meaningful performance measures are used to assess improvement. • Ensure that Performance Improvement Projects incorporate stakeholder feedback. • Share best practices, both clinical and operational. • Provide technical assistance. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.
Compliance Validation	• Assess plan compliance with contractual requirements. • Assess plan compliance with regulatory requirements. • Recommend mechanisms through which plans can achieve compliance. • Facilitate the Corrective Action Plan process. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.

SECTION 4. EXECUTIVE SUMMARY

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

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

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

KEPRO conducted the following external quality review activities for MassHealth Senior Care Organizations in the CY 2018 review cycle:

1. Validation of three performance measures, including an Information Systems Capability Assessment; and
2. The validation of two Performance Improvement Projects (PIPs).

To clarify reporting periods, EQR Technical Reports that have been produced in calendar year 2018 reflect 2017 quality performance. References to HEDIS® 2018 performance reflect data collected in 2017.

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

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

In 2018, KEPRO conducted Performance Measure Validation in accordance with CMS EQR Protocol 2 on three measures that were selected by MassHealth and the Office of Elder Affairs. The measures validated were as follows:

- Care for Older Adults (COA), Advance Care Planning (ACP);
- Colorectal Cancer Screening (COL); and
- Medication Reconciliation Post-Discharge (MRP).

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

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.

All MassHealth SCOs demonstrated compliance with these requirements.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

In Calendar Year 2018, Senior Care Organizations conducted the following Performance Improvement Projects.

Domain 1: Behavioral Health

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

Domain 2: Chronic Disease Management

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

KEPRO evaluates each PIP to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. The KEPRO technical reviewer assesses project methodology. The Medical Director evaluates the clinical soundness of the interventions. The review considers the plan's performance in the areas of problem definition, data analysis, measurement, improvement strategies, and outcome. Recommendations are offered to the plan.

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

SECTION 5. PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

INTRODUCTION

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

In Calendar Year 2017, KEPRO modified the Performance Measure Validation process. SCOs that had undergone a formal HEDIS® audit uploaded documentation to the KEPRO secure File Transfer Protocol (FTP) site. KEPRO validated the performance measures based on a desk review of these documents. The desk review afforded the reviewer an opportunity to become familiar with plan systems and data flows. In addition, the reviewer conducted an independent verification of a sample of individuals belonging to the positive numerator of a hybrid measure.

For the 2018 Performance Measure Validation, SCOs submitted the following documentation:

Exhibit 1: Documentation Submitted by SCOs

Document Reviewed	Purpose of KEPRO Review
HEDIS®2018 Roadmap and attachments	Reviewed to assess health plan systems and processes related to performance measure production.
2018 Final Audit Report	Reviewed to note if there were any underlying process issues related to HEDIS® measure production that were documented in the Final Audit Report.
2018 HEDIS® Interactive Data Submission System (IDSS) and previous two years IDSS, as available	Used to compile final rates for comparison to prior years' performance and industry standard benchmarks.
Follow-up documentation as requested by the reviewer	Plan-specific documentation requested to obtain missing or incomplete information, support and validate plan processes, and verify the completeness and accuracy of information provided in the Roadmap, onsite interviews, and systems demonstrations.

COMPARATIVE ANALYSIS

In 2018, KEPRO validated three measures that were selected by MassHealth and the Office of Elder Affairs. The measures validated were as follows:

- Care for Older Adults (COA), Advance Care Planning (ACP);
- Colorectal Cancer Screening (COL); and
- Medication Reconciliation Post-Discharge (MRP).

The results of the validation follow.

Exhibit 2: Performance Measure Validation Results

Performance Measure Validation: Care for Older Adults (COA) – Advance Care Planning

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
DENOMINATOR *Population*						
SCO population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members were 66 years of age or older as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Geographic Area						
Includes only those SCO enrollees served in the plan's reporting area.	Met	Met	Met	Met	Met	Met
NUMERATOR – ADVANCE CARE PLANNING *Counting Clinical Events*						
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
Data sources used to calculate the numerators (e.g., claims files, medical records, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
Members had evidence of advance care planning as documented through either administrative data or Medical Record Review.	Met	Met	Met	Met	Met	Met
Data Quality						
Based on the Information Systems (IS) assessment findings, the data sources used were accurate.	Met	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data						
There are no exclusions for this measure.	N/A	N/A	N/A	N/A	N/A	N/A
Medical Record Review Documentation Standards						
Record abstraction tool treated each numerator accurately.	Met	Met	Met	Met	Met	Met
Hybrid Measure						
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
If the hybrid method was used, the SCO passed the NCQA Final Medical Record Review Overread component of the HEDIS® 2018 Compliance Audit.	Met	Met	Met	Met	Met	Met
SAMPLING *Unbiased Sample*						
As specified in the NCQA specifications, systematic sampling method was utilized.	N/A Min. Required Sample Size Not 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						

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors.	Met	Met	Met	Met	Met	Met
Substitutions were made for properly excluded records, and the percentage of substituted records was documented.	N/A – Minimum Required Sample Size Not Met	Met	N/A	N/A	N/A	N/A

Performance Measure Validation: Colorectal Cancer Screening (COL)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
DENOMINATOR *Population*[						
SCO population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members were 51 to 75 years of age as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Geographic Area						
Includes only those SCO enrollees served in the plan's reporting area.	Met	Met	Met	Met	Met	Met
NUMERATOR *Counting Clinical Events*						
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
Data sources used to calculate the numerators (e.g., claims files, medical records, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met	Met	Met	Met	Met
Members had evidence of colorectal cancer screening as documented through either administrative data or medical record review.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
Data Quality						
Based on the IS assessment findings, the data sources used were accurate.	Met	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
Proper Exclusion Methodology in Administrative Data						
Colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
Medical Record Review Documentation Standards						
Record abstraction tool treated each numerator accurately.	Met	Met	Met	Met	Met	Met
Hybrid Measure						
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
If the hybrid method was used, the SCO passed the NCQA Final Medical Record Review Over-read component of the HEDIS® 2018 Compliance Audit.	Met	Met	Met	Met	Met	Met
SAMPLING *Unbiased Sample*						
As specified in the NCQA specifications, systematic sampling method was utilized.	N/A Minimum Required Sample Size Not 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						

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors.	Met	Met	Met	Met	Met	Met
Substitutions were made for properly excluded records, and the percentage of substituted records was documented.	N/A Minimum Required Sample Size Not Met	Met	Met	N/A	N/A	N/A

Performance Measure Validation: Medication Reconciliation Post-Discharge (MRP)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
DENOMINATOR *Population*						
SCO population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members were age 18+ as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Members had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year.	Met	Met	Met	Met	Met	Met
Geographic Area						
Includes only those SCO enrollees served in the plan's reporting area.	Met	Met	Met	Met	Met	Met
NUMERATOR *Counting Clinical Events*						
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
Enrollment status, continuous enrollment, and enrollment gaps were correctly verified.	Met	Met	Met	Met	Met	Met
Data sources and decision logic used to calculate the numerators (e.g., claims files, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met	Met	Met	Met	Met
Members had a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, or registered nurse on or within 30 days of discharge.	Met	Met	Met	Met	Met	Met
Data Quality						
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
Proper Exclusion Methodology in Administrative Data						
If the discharge is followed by readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, only the readmission or transfer discharge is counted. Exclude if the readmission/direct transfer discharge occurs after December 1 of the measurement year or if the member remains in the facility through December 1 of the measurement year.	Met	Met	Met	Met	Met	Met
Medical Record Review Documentation Standards						
Record abstraction tool requires notation of the date of medication reconciliation.	Met	Met	Met	Met	Met	Met
Data Quality						
The eligible population was properly identified.	Met	Met	Met	Met	Met	Met
Based on the IS assessment findings, data sources used for this numerator were accurate.	Met	Met	Met	Met	Met	Met
Hybrid Measure						
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
If the hybrid method was used, the SCO passed the NCQA Final Medical Record Review Overread component of the HEDIS® 2018 Compliance Audit.	Met	Met	Met	Met	Met	Met
SAMPLING *Unbiased Sample*						
As specified in the NCQA specifications, systematic sampling method was utilized.	N/A Min. Required Sample Size Not 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

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
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.	Met	Met	Met	Met	Met	Met
Substitutions were made for properly excluded records, and the percentage of substituted records was documented.	N/A Minimum Required Sample Size Not Met	Met	Met	Met	N/A	Met

RESULTS

Care for Older Adults (COA) – Advanced Care Planning (ACP). The chart and table that follow depict COA Advanced Care Planning (ACP) rates for each of MassHealth's SCOs. The CMS PUF 90th percentile rate is included for comparison purposes. Both Senior Whole Health and Tufts perform above the CMS PUF 90th percentile. The weighted average performance is 78.18%.

Exhibit 3: 2017 COA Advanced Care Planning Rates for all SCOs

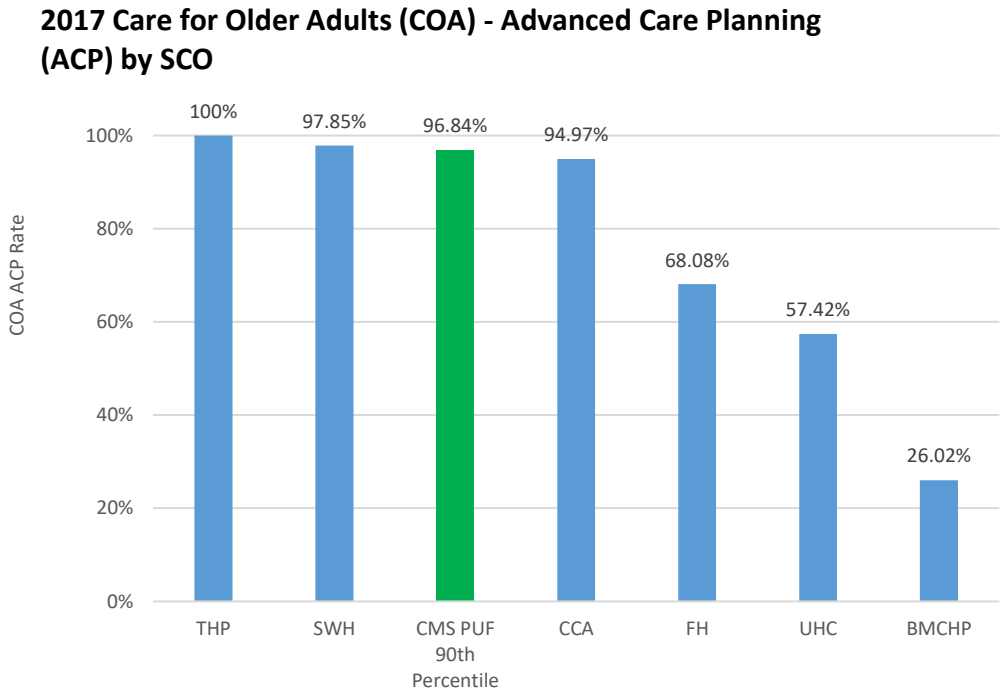
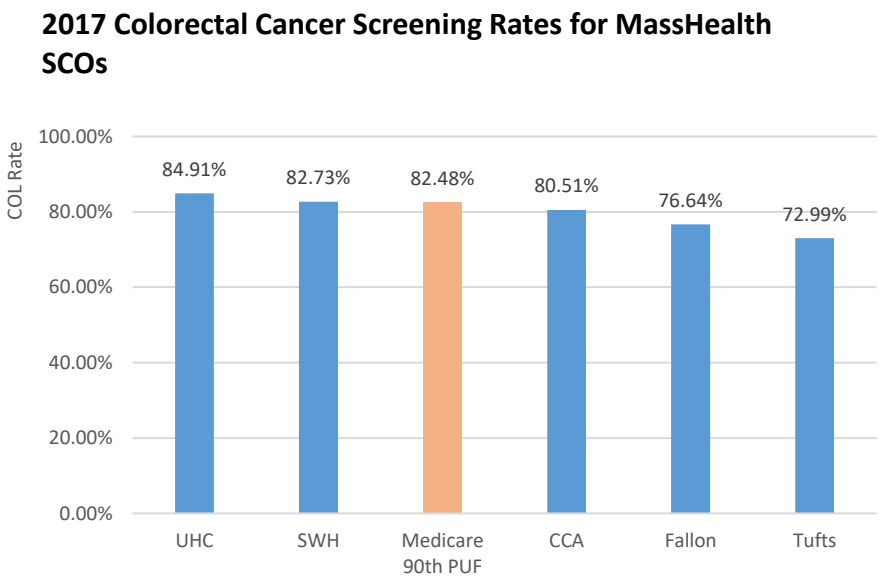


Exhibit 4: Trended COA ACP Data for MassHealth SCOs

		2013	2014	2015	2016	2017	Linear Performance Trend Line
COA ACP	**Medicare PUF 90th**					96.84%	
	BMCHP	NR	NR	NR	NR	26.02%	n/a
	CCA	84.72%%	90.20%	83.65%	90.42%	94.97%	↑
	Fallon	76.74%	79.67%	75.27%	81.47%	68.08%	↓
	SWH	47.93%	89.29%	84.88%	99.51%	97.85%	↑
	Tufts	NR	44.48%	100%	97.00%	100%	↑
	UHC	55.32%	67.99%	62.27%	76.80%	57.42%	↑

Colorectal Cancer Screening (COL). In previous years, KEPRO had validated the measure, Annual Monitoring for Patients on Persistent Medications (MPM). Medicare retired this measure in 2018. KEPRO replaced it with the Colorectal Cancer Screening measure. In general, plans performed well on this measure. Two plans performed above the 90th percentile of the Medicare Public Use Files, i.e., UnitedHealthcare and Senior Whole Health. The rate of the lowest-performing plan, Tufts Health Plan's 72.99% rate, ranked between the 33rd and 50th percentiles. The weighted average performance is 80.82%, 1.5 percentage points below the CMS Public Use File 90th percentile. In accordance with NCQA's reporting rules, BMCHP's rate was not reportable because its denominator was less than 30.

Exhibit 5: 2017 Colorectal Cancer Screening (COL) by SCO



Medication Reconciliation Post-Discharge. The chart and table that follow depict MassHealth SCO performance in the Medication Reconciliation Post-Discharge rate. Fallon's performance exceeded the Medicare Public Use File 90th percentile. The weighted average performance rate is 60.03%.

Exhibit 6: 2017 Medication Reconciliation Post-Discharge Rates for MassHealth SCOs

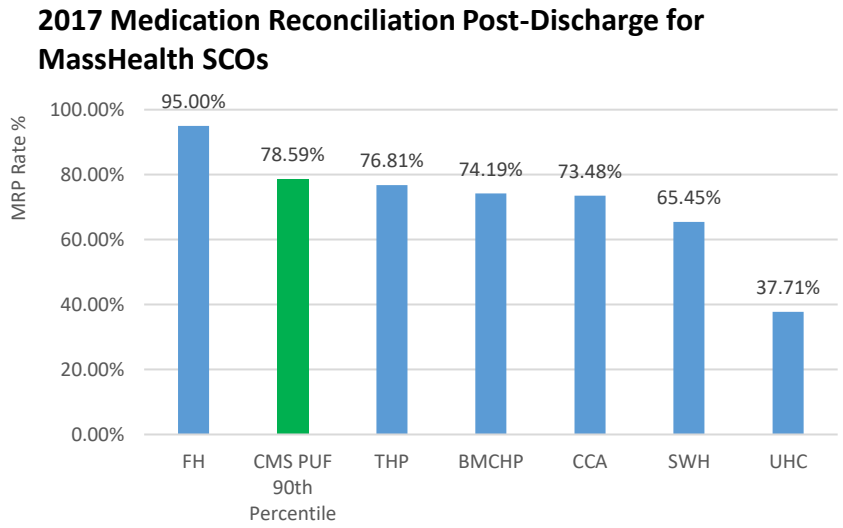


Exhibit 7: Trended MRP Data for MassHealth SCOs

		2013	2014	2015	2016	2017	Linear Performance Trend Line
MRP	**CMS PUF 90th**					78.59%	
	BMCHP	NR	NR	NR	NR	74.19%	-
	CCA	70.83%	82.47%	70.80%	85.97%	73.48%	↑
	Fallon	45.00%	52.80%	88.54%	79.08%	95.00%	↑
	SWH	62.04%	35.52%	43.07%	69.83%	65.45%	↑
	Tufts	NR	56.88%	70.14%	86.94%	76.81%	↑
	UHC	32.64%	53.24%	38.84%	28.95%	37.71%	↑

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

CMS regulations require that each managed care entity also undergo an annual Information Systems Capability Assessment. The focus of the review is on components of SCO information systems that contribute to performance measure production. This is to ensure that the system can collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system or other methods. The system must be able to ensure that data received from providers are accurate and complete and verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate. The findings of this assessment follow.

Exhibit 8: Information Systems Capability Assessment Findings

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

RECOMMENDATIONS & ANALYSIS

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

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION AND INFORMATION SYSTEM CAPABILITY ASSESSMENT

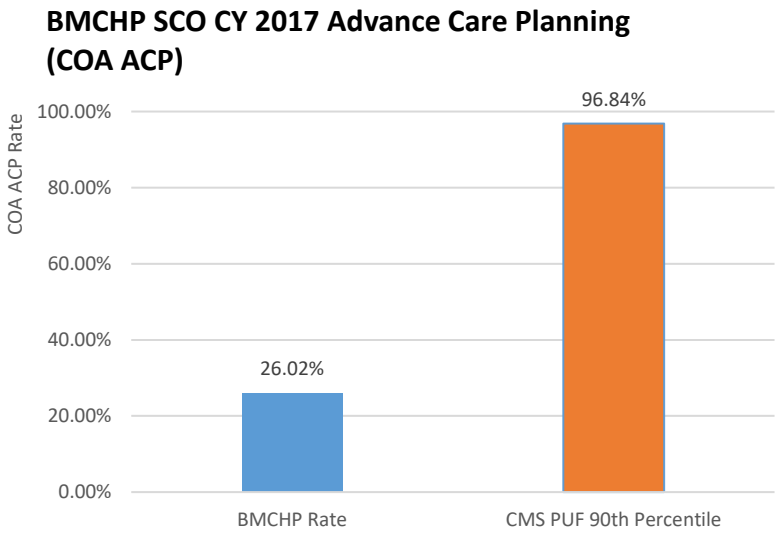
BOSTON MEDICAL CENTER HEALTHNET (BMCHP)

Performance Measure Results

The charts that follow depict BMCHP's Senior Care Options' performance in the three measures selected by MassHealth for validation. The Medicare Public Use File (PUF) 90th percentile is provided for comparison purposes.

Care for Older Adults (COA) – Advance Care Planning (ACP) – BMCHP became operational on January 1, 2016. In accordance with CMS Medicare HEDIS® reporting rules, it did not have a sufficient number of members in 2016 to report performance measures. Calendar Year 2017, therefore, is the first year for which an Advance Care Planning rate is available. BMCHP's 26.02% rate falls under the CMS Public Use File 10th percentile.

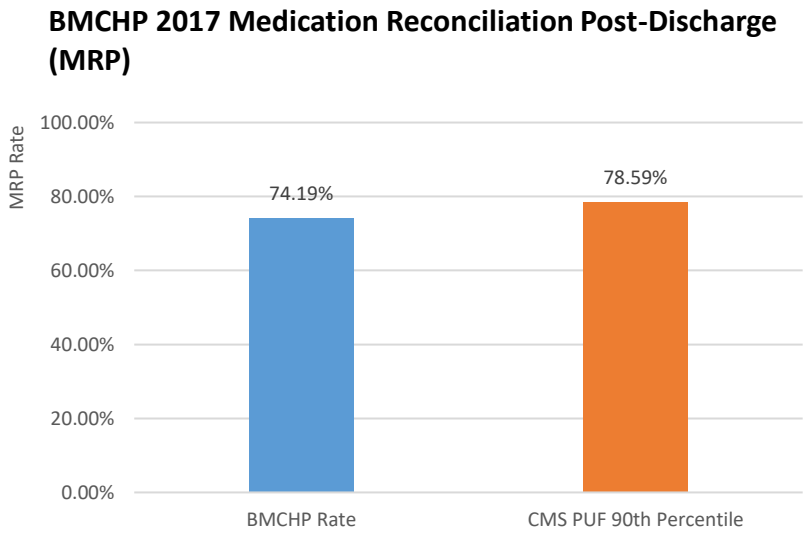
Exhibit 9: BMCHP SCO CY 2017 Advance Care Planning



Colorectal Cancer Screening (COL) – 2017 was the first year in which the Colorectal Cancer Screening measure was validated. BMCHP's denominator was less than 30 and thus is not to be publicly reported in accordance with NCQA HEDIS rate reporting rules.

Medication Reconciliation Post-Discharge (MRP) – Because the 2016 denominator for the MRP was less than 30, this measure was not publicly reported. BMCHP's 2017 74.19% MRP rate is between the Medicare Public Use File 75th and 90th percentiles.

Exhibit 10: Medication Reconciliation Post-Discharge (MRP)



Information Systems Capability Assessment

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

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

- Enrollment Data
  BMCHP used Facets to process enrollment data. Facets captured all necessary enrollment fields for HEDIS® reporting. There were no issues identified with enrollment processes.

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

- Supplemental Data
  BMCHP used a lab results supplemental data source for HEDIS reporting, but this did not affect any of the three measures validated.

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

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

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Boston Medical Center HealthNet Plan's SCO, the results of which were distributed on July 10, 2018.

Exhibit 11: BMCHP Final Audit Results

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

Follow Up to Calendar Year 2017 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on the PMV recommendation for 2017 follows.

Calendar Year 2017 Recommendations	2018 Update
The Final HEDIS® Audit Report indicated that there were some issues with chart abstraction accuracy for exclusion cases prior to the plan corrective actions that were taken. KEPRO recommended, as did the HEDIS® audit firm, that 100% of exclusions be reviewed prior to the closure of Medical Record Review.	BMCHP successfully reported hybrid exclusions for HEDIS® 2018 reporting.

Strengths

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

Opportunities

- The Advance Care Planning numerator of the Care for Older Adults measure is under the 50th percentile compared to the CMS Medicare HEDIS® Public Use File benchmark data.

Recommendations

- Focus on quality improvement initiatives for the Advance Care Planning numerator of the Care for Older Adults measure.

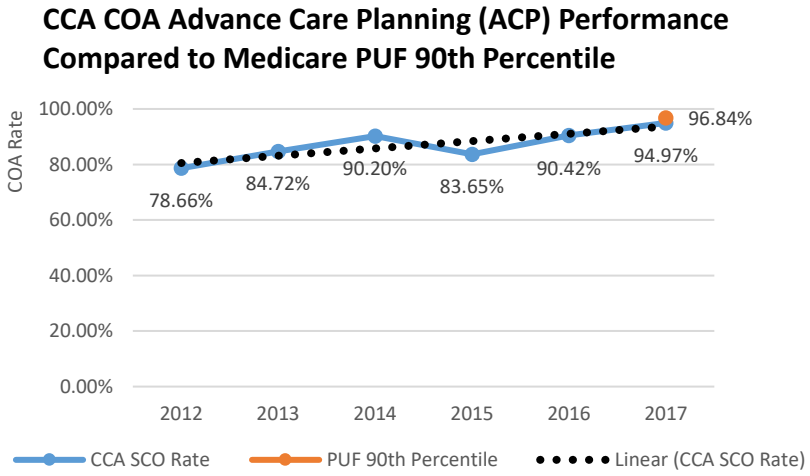
COMMONWEALTH CARE ALLIANCE (CCA)

Performance Measure Results

The charts that follow depict CCA Senior Care Organization's performance in the three measures selected for validation.

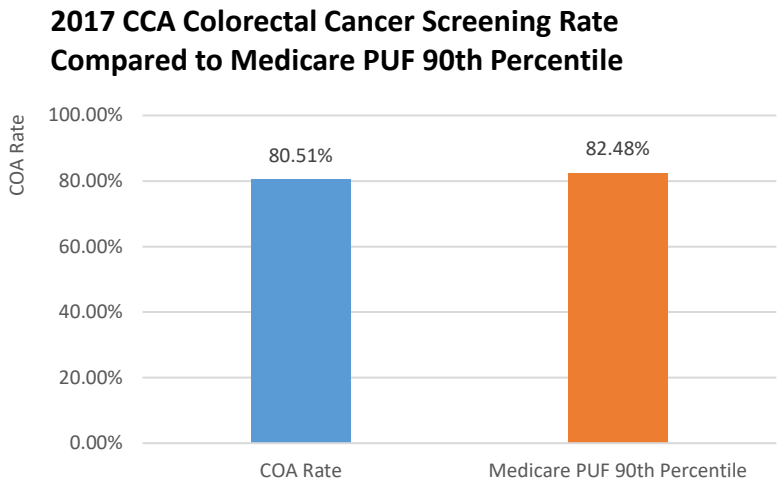
Care for Older Adults (COA), Advance Care Planning — CCA's Advance Care Planning rate increased 4.55 percentage points, from 90.42% in 2016 to 94.97% in 2017. The plan's performance is between the 75th and 90th percentiles of the CMS Public Use Files.

Exhibit 12: CCA Care for Older Adults (COA) Advance Care Planning (ACP) Performance Rates



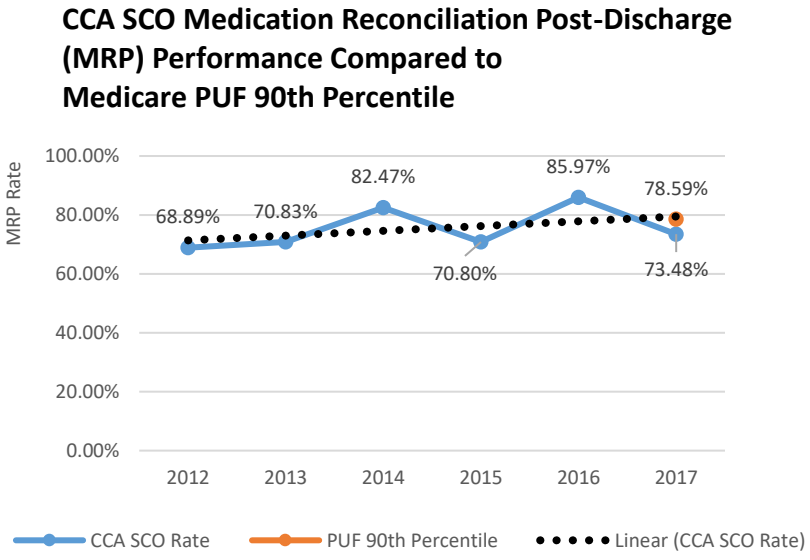
Colorectal Cancer Screening (COL) – 2017 was the first year in which the Colorectal Cancer Screening measure was validated. CCA's 80.51% COL rate ranks between the 75th and 90th percentiles compared to the CMS Public Use Files.

Exhibit 13: CCA 2017 Colorectal Cancer Screening



Medication Reconciliation Post-Discharge (MRP) — CCA's MRP rate decreased a statistically significant 12.49 percentage points, from 85.97% to 73.48%. CCA's rate falls between the Medicare Public Use Files' 75th and 90th percentiles.

Exhibit 13: CCA MRP Performance Rates



Information Systems Capability Assessment

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

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

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

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

- Supplemental Data
  CCA's eClinical Works electronic medical record (EMR) supplemental data source was successfully used for all three performance measures under review. CCA provided complete supplemental data documentation, and no concerns were identified.

- Data Integration
  CCA's performance measures were produced using Inovalon software. Inovalon hosts and runs the software for CCA. Inovalon-compliant extracts were produced from the plan's data warehouse. Inovalon then loaded the data and produced rates for the plan's review and approval. Data transfers to the Inovalon repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. Inovalon's repository

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

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

HEDIS® Roadmap and Final Audit Report

A summary follows of the findings of the Advent Advisory Group, which performed a HEDIS® Compliance Audit on Commonwealth Care Alliance Senior Care Options, the results of which were distributed on July 15, 2018.

Audit Element	Findings
Medical Data	CCA met requirements for timely and accurate claims data capture.
Enrollment Data	Enrollment data processing met all HEDIS® standards.
Practitioner Data	Practitioner data related to performance measure production is adequate to support reporting.
Medical Record Review	Medical record tools, training materials, medical record process, and quality monitoring met requirements. CCA passed Medical Record Review validation.
Supplemental Data	CCA's eClinical Works EMR supplemental data source was successfully used for all three performance measures under review.
Data Integration	Data integration processes were adequate to support data completeness and performance measure production.

Medical Record Review Validation

CCA passed the NCQA Final Medical Record Review Overread component of the HEDIS® 2018 Compliance Audit. There were no measure reportability risks stemming from the chart reviews. Further Medical Record Review accuracy determinations were deemed unnecessary.

Follow Up to Calendar Year 2017 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on the PMV recommendation for 2017 follows.

Calendar Year 2017 Recommendations	2018 Update
Continue to map eClinical Works supplemental data to the Inovalon-certified software format to better leverage supplemental data used for HEDIS® reporting.	CCA continued to map eClinical Works supplemental data to the Inovalon-certified software format to better leverage supplemental data use for HEDIS® reporting.

Strengths

- CCA used an NCQA-certified vendor.
- Thorough documentation was supplied for the review.
- CCA has a strong process for reviewing and verifying preliminary and final rates.
- CCA's three PMV rates were above the national average.

Opportunities

- None identified.

Recommendations

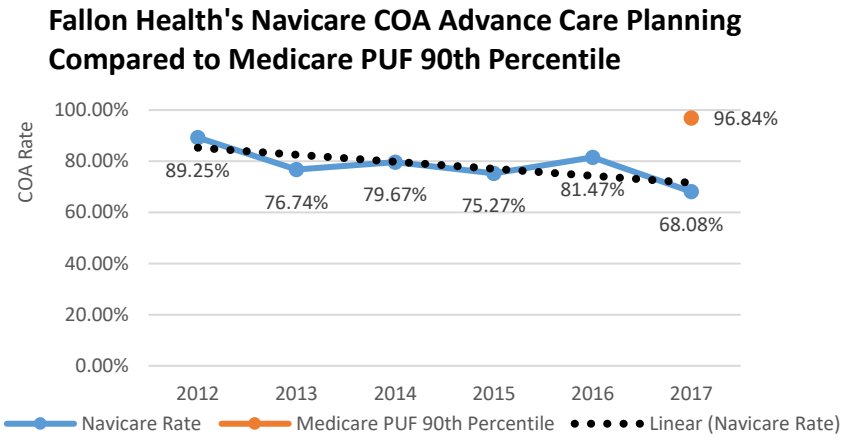
- None identified.

Performance Measure Results

The charts that follow depict Fallon Health's performance in the three measures selected by MassHealth for validation. The Medicare Claims Public Use File 90th[3] percentile is included for comparison purposes.

Care for Older Adults (COA), Advance Care Planning — Fallon Health's Advance Care Planning rate decreased a statistically significant 13.39 percentage points. The 2016 81.47% rate dropped to 68.08% in 2017. Performance is trending down. The plan now ranks between the 50th and 66th percentiles of the Medicare Public Use Files.

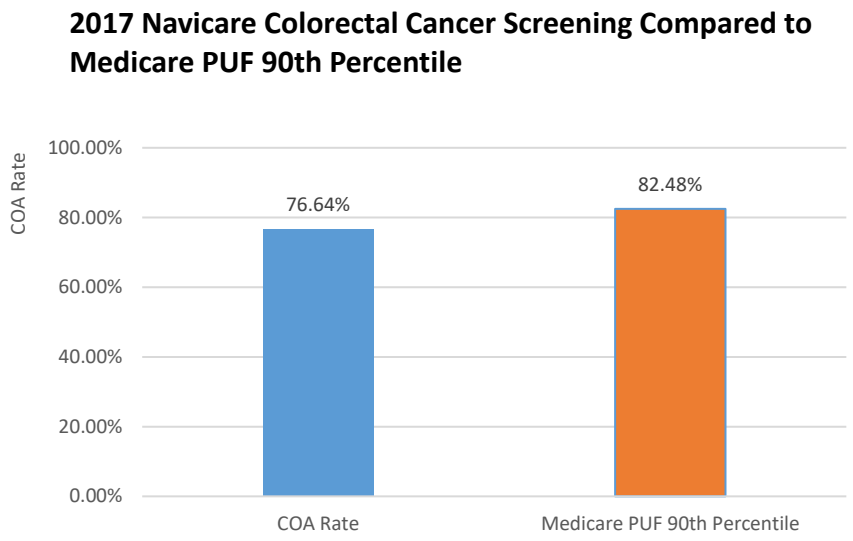
Exhibit 16: Fallon Health's COA Advance Care Planning Performance Rates



Colorectal Cancer Screening (COL) – 2018 was the first year in which the Colorectal Cancer Screening measure was validated. Fallon Health's rate of 76.64% ranks between the 66th and 75th percentiles compared to the CMS Public Use Files.

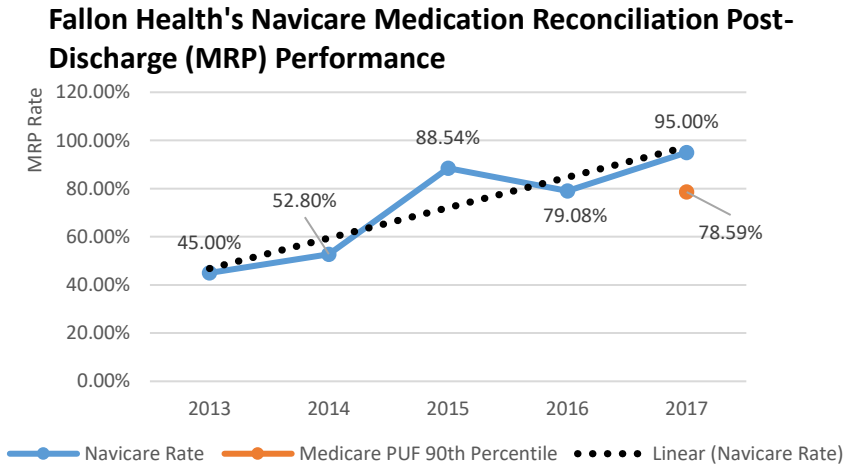
[3] The HEDIS® 2017 Medicare percentiles benchmarks for all reported measures were calculated using data from the Medicare Special Needs Plan Claims Public Use Files (PUF).

Exhibit 16: Fallon Health's 2017 Colorectal Cancer Screening Rate



Medication Reconciliation Post-Discharge (MRP) — Fallon Health's MRP rate increased a statistically insignificant 3.36 percentage points, from 79.08% in 2016 to 82.44% in 2017. The five-year trend line is up. Fallon Health's performance lies above the Medicare PUF's 90th percentile.

Exhibit 17: Fallon Health's MRP Performance Rates



Information Systems Capability Assessment

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

- Claims and Encounter Data
  Claims were processed using the QNXT system. All necessary fields were captured for HEDIS® reporting. Standard coding was used, and there was no use of non-standard codes. Lab claims were processed internally using standard codes. 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 used a vendor, Smart Data Solutions, to both scan and enter claims. The plan maintained adequate oversight of the vendor. Internal claims quality monitoring processes were also adequate. Fallon received encounters on a daily basis from its pharmacy benefits manager, CVS Health. The plan maintained adequate oversight of CVS Health. There were no issues identified with claims or encounter data processing. Fallon delegated behavioral health claims processing to Beacon Health Options. Beacon captured all required fields for claims processing and only accepted standard codes on standard claims forms. Fallon conducted adequate oversight of Beacon Health Options.

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

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

- Supplemental Data
  Fallon successfully used nonstandard supplemental data sources for HEDIS® 2018 reporting. Fallon provided complete supplemental data documentation. There were no issues with the supplemental data used to produce performance measures.

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

- Source Code
  Fallon used NCQA-certified Verscend HEDIS® software to produce performance measures. There were no source code issues identified.

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on Fallon Health Navicare, the results of which were distributed on July 2, 2018.

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

Medical Record Review Validation

Fallon passed the NCQA Final Medical Record Review Over-Read component of the HEDIS® 2018 Compliance Audit. There were no measure reportability risks stemming from the chart reviews. Further Medical Record Review accuracy determinations were deemed unnecessary.

Follow Up to Calendar Year 2017 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2017 PMV recommendation follows.

Calendar Year 2017 Recommendation	2018 Update
The Final Audit Report indicated that the internally developed performance measure source code should have had more thorough plan review, and that more of the plan review should have occurred before data submission to NCQA versus after.	Fallon used a certified HEDIS® vendor for HEDIS® 2018 reporting as opposed to using internally developed measure source code.

Strengths

- Fallon staff have excellent understanding of HEDIS® processes.
- Thorough documentation was supplied for review.
- The data warehouse is refreshed daily.

Opportunities

- None identified.

Recommendations

- None identified.

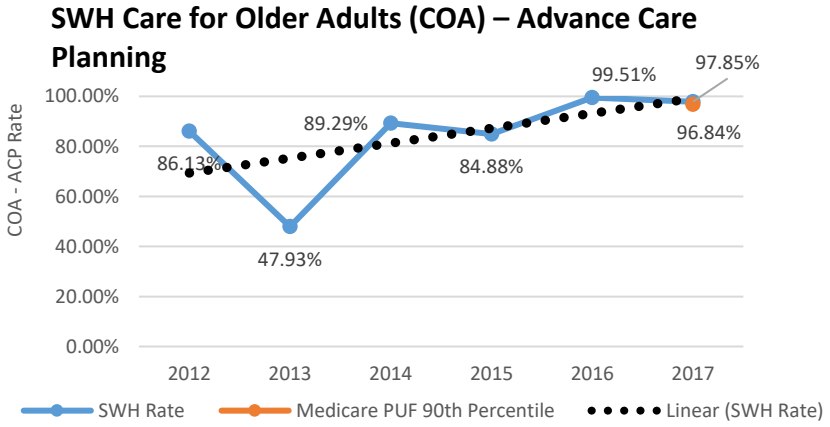
SENIOR WHOLE HEALTH (SWH)

Performance Measure Results

The chart below depicts SWH's performance in the three measures validated by KEPRO. The Medicare Claims Public Use File 90th[4] percentile is included for comparison purposes.

Care for Older Adults (COA), Advance Care Planning (ACP) — Senior Whole Health's ACP rate decreased a statistically insignificant 1.66 percentage points, from 99.51% in 2016 to 97.85% in 2017. The plan ranks above the 90th percentile of the CMS Medicare Public Use Files.

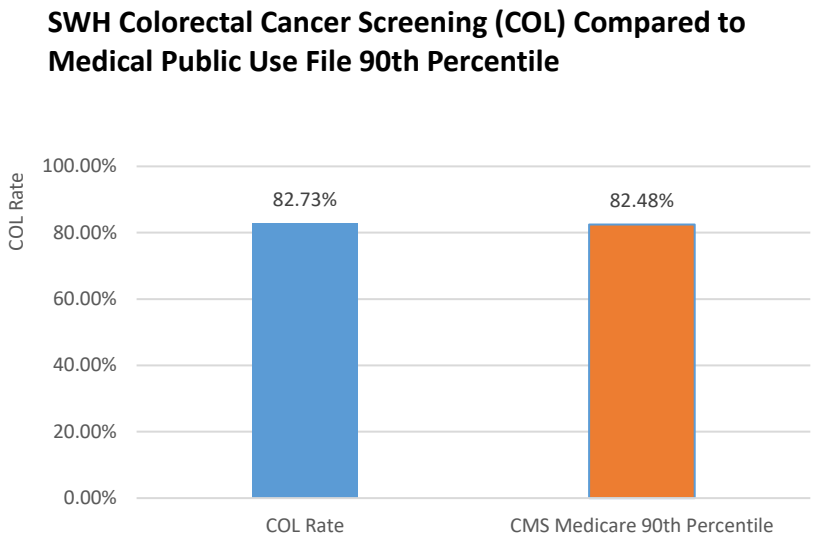
Exhibit 18: SWH COA Performance Rates



SWH Colorectal Cancer Screening – 2018 was the first year in which the Colorectal Cancer Screening measure was validated. Senior Whole Health's 82.73% performance rate is above the Medicare Public Use files' 90th percentile.

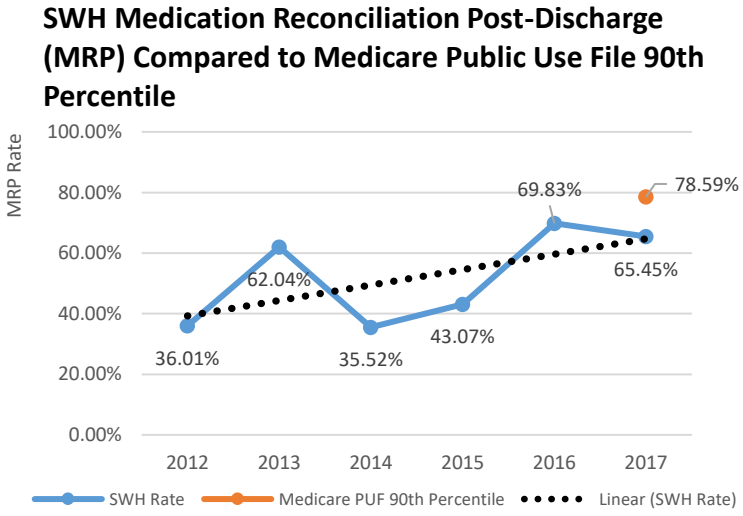
[4] The HEDIS® 2018 Medicare percentiles benchmarks for all reported measures were calculated using data from the Medicare Special Needs Plan Claims Public Use Files (PUF).

Exhibit 19: SWH 2017 COL Performance Rates



Medication Reconciliation Post-Discharge (MRP) — Senior Whole Health's 65.45% performance on the MRP measure decreased a statistically insignificant 4.38 percentage points from 2016. The plan ranks between the 66th and 75th percentiles of the CMS Public Use Files, and performance is trending up.

Exhibit 20: SWH MRP Performance Rates



Information Systems Capability Assessment

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

- Claims and Encounter Data
  SWH used the QNXT system to process claims, including lab claims. All necessary fields were captured for HEDIS® reporting. Standard coding was used, and there was no use of non-standard codes. SWH used a scanning and optical character recognition vendor, WCEDI. SWH had adequate processes to monitor claims data quality and conducted strong oversight of WCEDI. The plan had adequate processes to monitor claims data completeness. Pharmacy encounters containing standard codes were received on a weekly basis from the plan's pharmacy benefit manager, Express Scripts, over which the plan maintained adequate oversight. There were no issues identified with claims or encounter data processing. SWH delegated the processing of behavioral health claims to Beacon Health Options. Beacon captured all required fields for claims processing and accepted only standard codes on standard claims forms. SWH conducted adequate oversight of Beacon Health Options.

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

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

- Supplemental Data
  SWH successfully used both standard and nonstandard supplemental data sources for HEDIS® 2018 reporting. The supplemental data assisted the PMV performance rates under review. SWH provided complete supplemental data documentation. There were no issues with the supplemental data used to produce performance measures.

- Data Integration
  SWH's performance measures were produced using DST software. The plan's ODS data warehouse is updated nightly with data from the transactions system. Data were extracted from the ODS data warehouse and loaded into DST's CareAnalyzer. SWH had adequate processes for ensuring data completeness and referential integrity at each transfer point. Preliminary rates were reviewed and any variances investigated. There were no issues identified with data integration processes. Data transfers to the DST repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. DST's repository structure was compliant. HEDIS® measure report production was managed effectively. The DST software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. SWH maintains adequate oversight of its vendor, DST. There were no issues identified with data integration processes.

- Source Code
  SWH used NCQA-certified DST HEDIS® software to produce performance measures. There were no source code issues identified.

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

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of the HealthcareData Company, which performed a HEDIS® Compliance Audit on SWH, the results of which were distributed on July 11, 2018:

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

Medical Record Review Validation

SWH passed the NCQA Final Medical Record Review Overread component of the HEDIS® 2018 Compliance Audit. There were no measure reportability risks stemming from the chart reviews. Further Medical Record Review accuracy determinations were deemed unnecessary.

Follow Up to Calendar Year 2017 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on calendar year 2017 PMV recommendation follows.

Calendar Year 2017 Recommendation	2018 Update
Continue to improve on the Medication Reconciliation Post-Discharge measure.	The 2017 Medication Reconciliation Post-Discharge rate was not statistically different from the 2016 rate.

Strengths

- SWH used an NCQA-certified vendor.
- The plan supplied thorough documentation for review.
- SWH conducted excellent oversight of its medical record vendor.
- The plan has a strong process for reviewing and verifying preliminary and final rates.

Opportunities

- None identified.

Recommendations

- None identified.

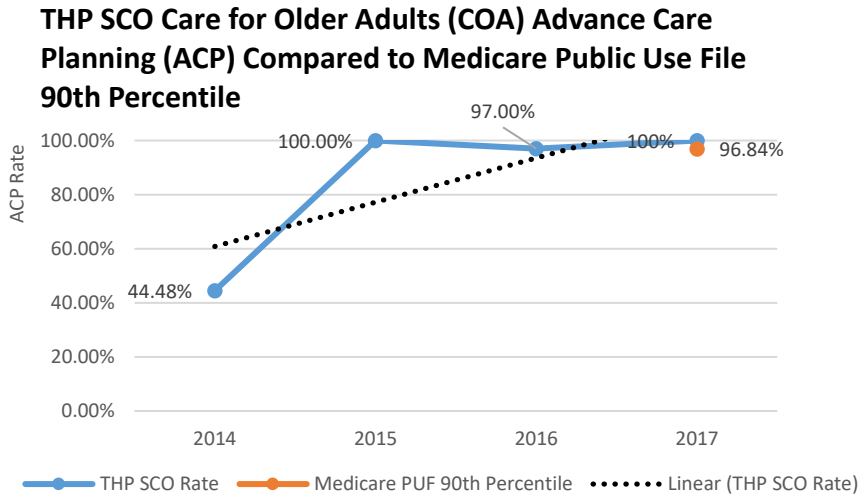
TUFTS HEALTH PLAN (THP)

Performance Measure Results

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

Care for Older Adults (COA), Advance Care Planning — Tufts' Advance Care Planning rate increased a statistically significant 3.0 percentage points. The 2016 rate of 97% returned to its 2015 levels of 100% in 2017. This performance exceeds the Medicare Public Use File's 90th percentile.

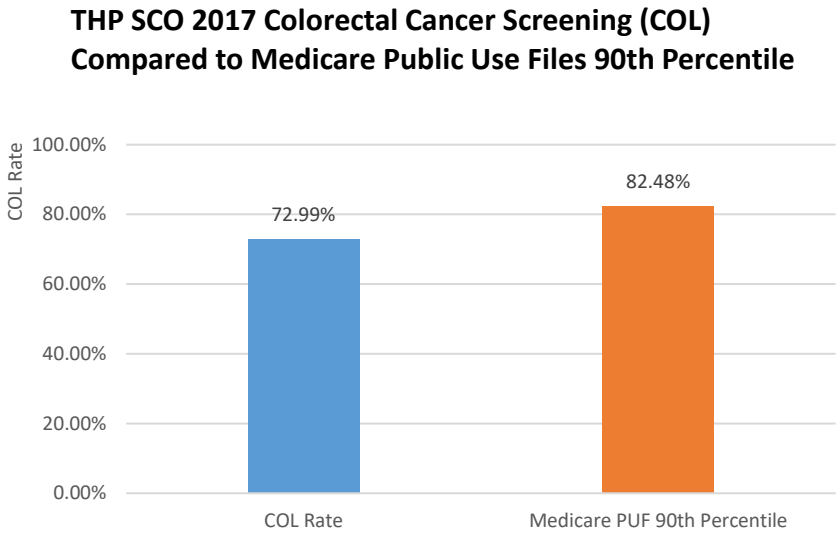
Exhibit 21: THP COA ACP Performance Rates



Colorectal Cancer Screening (COL) – 2018 was the first year in which validation was performed on the Colorectal Cancer Screening rate. Tufts Health Plan's 77.60% performance is between the 66th and 75th percentile compared to the Medicare Public Use Files.

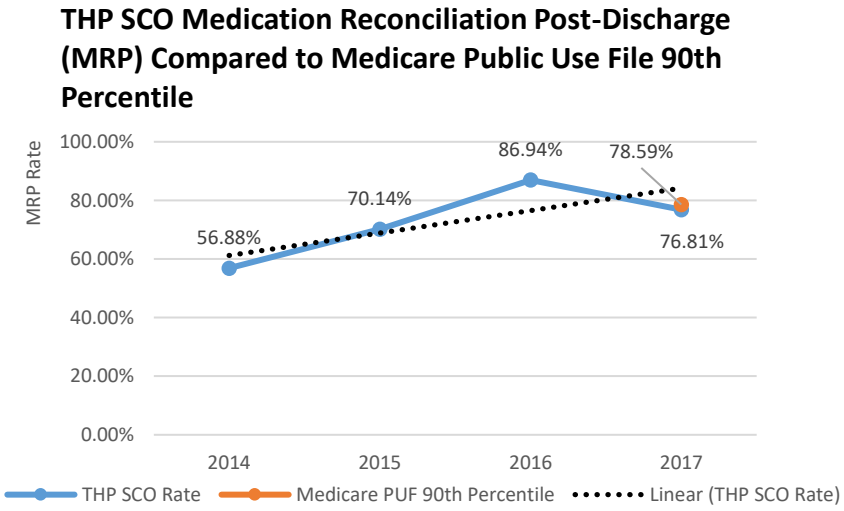
[5] The percentiles for all reported measures were calculated using data from the Medicare Special Needs Plan Claims Public Use Files (PUF).

Exhibit 22: THP COL Performance



Medication Reconciliation Post-Discharge (MRP) — Tufts Health Plan's MRP performance decreased a statistically significant 7.71 percentage points. The 2016 rate of 86.94% decreased to 79.23% in 2017. Nonetheless, the plan's performance is trending up and ranks above the 90th percentile of the Medicare Public Use Files.

Exhibit 23: THP's MRP Performance Rates



Information Systems Capability Assessment

- Claims and Encounter Data
  THP processed claims using the Diamond system. All necessary fields were captured for HEDIS® reporting. Standard coding was used, and there was no use of non-standard codes. Most claims were submitted electronically to THP, and there were adequate monitoring processes in place, including daily electronic submission summary reports to identify issues. THP had robust claims editing and coding review processes. For the small volume of paper claim submissions, THP managed scanning of paper claims in-house using optical character recognition (OCR) software, Sun Guard. There was adequate monitoring of the OCR scanning software.

  THP processed all claims within Diamond except for pharmacy claims which were handled by THP's pharmacy benefit manager, CVS Caremark. Pharmacy claims data were received on a regular basis from the pharmacy vendor, and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

- Enrollment Data
  THP used Market Prominence and Diamond to process the enrollment data. Both systems captured all necessary enrollment fields for HEDIS® reporting. THP provided daily enrollment files to CVS Caremark. There were no issues identified with enrollment processes.

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

- Medical Record Review
  THP used internally-developed abstraction tools and training manual for the hybrid measures. THP's abstraction tools and training manual were compliant with the HEDIS® technical specifications. THP had processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the Medical Record Review process. No issues were identified with the Medical Record Review process.

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

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

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

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on THP's SCO, the results of which were distributed on July 10, 2018:

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

Medical Record Review Validation

THP passed the NCQA Final Medical Record Review Over-read component of the HEDIS® 2018 Compliance Audit. There were no measure reportability risks stemming from the chart reviews. Further Medical Record Review accuracy determinations were deemed unnecessary. KEPRO

therefore did not sample any medical records for the three PMV hybrid measures under evaluation.

Follow Up to Calendar Year 2017 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on calendar year 2017 PMV recommendations follows:

Calendar Year 2017 Recommendation	2018 Update
Not applicable. No recommendations were made.	

Strengths

- THP had several initiatives aimed at managing the SCO population, including alignment of cost/quality/member satisfaction goals, an interdisciplinary House Call program, provider network narrowing toward providers of higher quality and aligned incentives, use of a geriatric consult team model, and integrated disease and case management programs.
- THP's measure rates rank very well nationally.

Opportunities

- None identified.

Recommendations

- None identified.

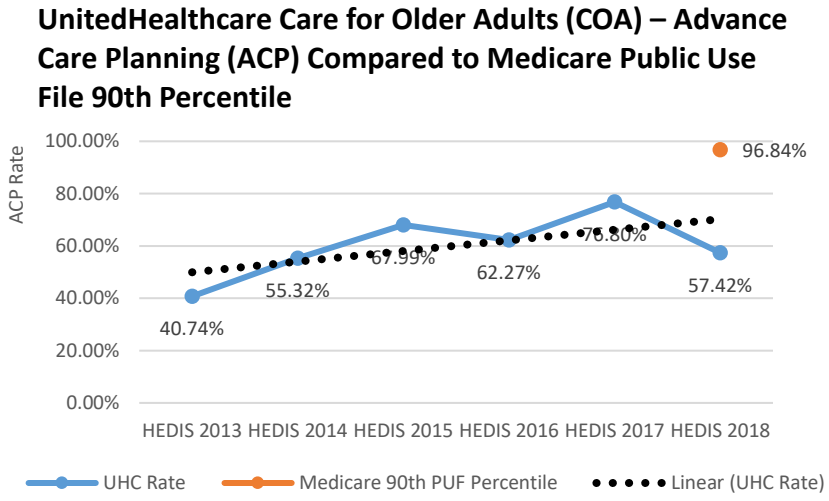
UNITEDHEALTHCARE (UHC)

Performance Measure Results

The charts below depict UHC's performance in the three measures selected for validation. The Medicare Claims Public Use File 90th[6] percentile is included for comparison purposes.

Care for Older Adults (COA), Advance Care Planning — UnitedHealthcare experienced a significant decrease of 19.38 percentage points between HEDIS® 2017 (76.80%) and HEDIS® 2018 (57.42%). The plan's performance ranks between the 25th and 50th percentiles of the Medicare Public Use File.

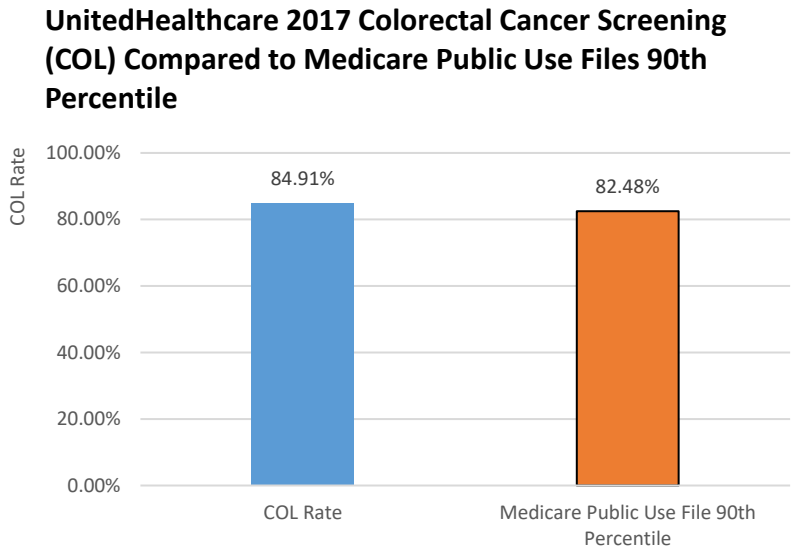
Exhibit 24: UHC's COA ACP Performance Rates



Colorectal Cancer Screening (COL) – 2018 was the first year in which KEPRO validated the Colorectal Cancer Screening measure. UnitedHealthcare's 84.91% ranks above the 90th Medicare Public Use Files' percentile.

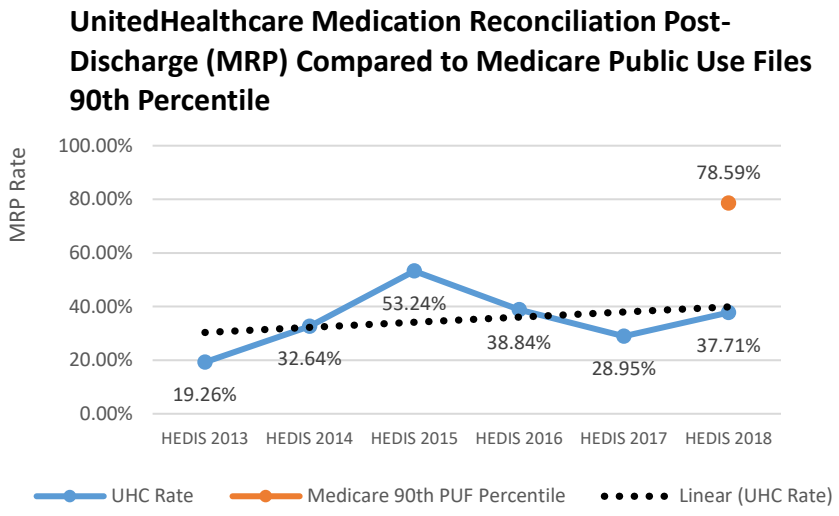
[6] Percentiles for all reported measures were calculated using data from the Medicare Special Needs Plan Claims Public Use Files (PUF).

Exhibit 25: UHC Colorectal Cancer Screening (COL)



Medication Reconciliation Post-Discharge (MRP) — UnitedHealthcare's MRP rate increased a statistically significant 8.76 percentage points, from 28.96% in HEDIS® 2017 to 37.71% in HEDIS® 2018. Although trending up, the plan's rate is between the 10th and 25th percentiles of the Medicare Public Use File.

Exhibit 26: UHC's MRP Performance Rates



Information Systems Capability Assessment

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

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

- Enrollment Data
  UHC used CSP Facets to process enrollment data. CSP Facets captured all necessary enrollment fields for HEDIS® reporting. There were no issues identified with enrollment processes.

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

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

- Data Integration
  UHC's performance measures were produced using GDIT software. UHC formatted medical record data received by Altegra into the GDIT format and had adequate processes to review the mapping. UHC had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. There were no issues identified with data integration processes. Data transfers to the GDIT repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. GDIT's repository structure was compliant. HEDIS® measure report production was managed effectively. The GDIT software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed, and any variances investigated. UHC maintains adequate oversight of its vendor, GDIT. There were no issues identified with data integration processes.

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

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

HEDIS® Roadmap and Final Audit Report

Below is a summary of the findings of Attest Health Care Advisors, which performed a HEDIS® Compliance Audit on UnitedHealthcare, the results of which were distributed on July 10, 2018:

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

Medical Record Review Validation

UnitedHealthcare passed the NCQA Final Medical Record Review Over=read component of the HEDIS® 2018 Compliance Audit. There were no measure reportability risks stemming from the chart reviews. Further Medical Record Review accuracy determinations were deemed unnecessary.

Follow Up to Calendar Year 2017 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2017 PMV recommendation follows:

Calendar Year 2017 Recommendation	2018 Update
UHC should conduct root-cause analysis for the MRP measure and explore development of interventions that can increase performance.	UHC took action on this recommendation. UHC conducted the analysis and implemented an MRP intervention.

SECTION 6. PERFORMANCE IMPROVEMENT PROJECT VALIDATION

INTRODUCTION

THE PERFORMANCE IMPROVEMENT PROJECT LIFE CYCLE

In 2018, MassHealth introduced a new approach to conducting Performance Improvement Projects (PIPs). In the past, plans submitted their annual project report in July to permit the use of the project year's HEDIS® data. KEPRO's evaluation of the project was not complete until October. Plans received formal project evaluations ten months or more after the end of the project year. The lack of timely feedback made it difficult for the plans to make changes in interventions and project design that might positively affect project outcomes.

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

Baseline/Initial Implementation Period: January 1, 2018 – December 31, 2018

Planning Phase: *January - March 2018*
During this period, the SCOs developed detailed plans for interventions. SCOs conducted a population analysis, a literature review, and root cause and barrier analyses, all of which contributed to the design of appropriate interventions. SCOs reported on this activity in March 2018. These reports described planned activities, performance measures, and data collection plans for initial implementation. Plans were subject to review and approval by MassHealth and KEPRO.

Initial Implementation: March 2018 - December 2018
Incorporating feedback received from MassHealth and KEPRO, the SCOs undertook the implementation of their proposed interventions. The SCOs submitted a progress report in September. In this report, the SCOs provided baseline data for the performance measures that had been previously approved by MassHealth and KEPRO.

Mid-cycle Implementation Period: January 1, 2019 – December 31, 2019

Mid-Cycle Progress Reports: *March 2019*
SCOs will submit progress reports detailing changes made as a result of feedback or lessons learned in the previous cycle as well as updates on the current year's interventions.

Mid-Cycle Annual Report: September 2019
SCOs submit annual reports describing current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including success and challenges.

Final Implementation Period: (January 1, 2020 – December 31, 2020)

Final Implementation Progress Reports: *March 2020*
SCOs will submit another progress report that describes current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including success and challenges.

Final Implementation Annual Report: September 2020
SCOs will submit a second annual report that describes current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including success and challenges, and describe plans for the final quarter of the initiative.

All of these reports will be reviewed by KEPRO (the 2018 reports are discussed herein). Each project is evaluated to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. KEPRO also determines whether the projects have achieved or are likely to achieve favorable results. KEPRO distributes detailed evaluation criteria and instructions to the SCOs to support their efforts.

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

1) *PIP Questionnaire*. The SCO submits a completed questionnaire for each PIP. This questionnaire is stage-specific. The Baseline Report 1 asks the SCO to provide a project rationale; member and provider goals; a barrier analysis; a description of stakeholder involvement; a description of the intervention and implementation plans; plans for small tests of change and effectiveness analysis; anticipated barriers to implementation and plans to address those barriers; and proposed performance indicators. Baseline Report 2 asks the SCO to provide a population analysis of the affected population; a strategy for member and/or provider engagement; updates to project goals; an update on intervention implementation progress; the use of small tests of change; plans to improve the intervention(s); plans for data analysis; a description of performance indicators; and baseline performance rates. The 2019 questionnaires will focus on remeasurement.

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

3) *Conference with the Plan*. The Technical Reviewer and Medical Director meet telephonically with representatives selected by the plan to obtain clarification on identified issues as well as to offer recommendations for improvement. The plan is

offered the opportunity to resubmit the PIP questionnaire within ten calendar days, although it is not required to do so.

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

PERFORMANCE IMPROVEMENT PROJECT TOPICS

MassHealth SCOs conduct two contractually required PIPs annually. In accordance with Appendix L of the three-way contract, SCOs must propose to MassHealth and the Office of Elderly Affairs one PIP from each of the two domains:

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

In Calendar Year 2018, Senior Care Organizations conducted the following Performance Improvement Projects (PIPs).

Domain 1: Behavioral Health

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

Domain 2: Chronic Disease Management

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

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

COMPARATIVE ANALYSIS

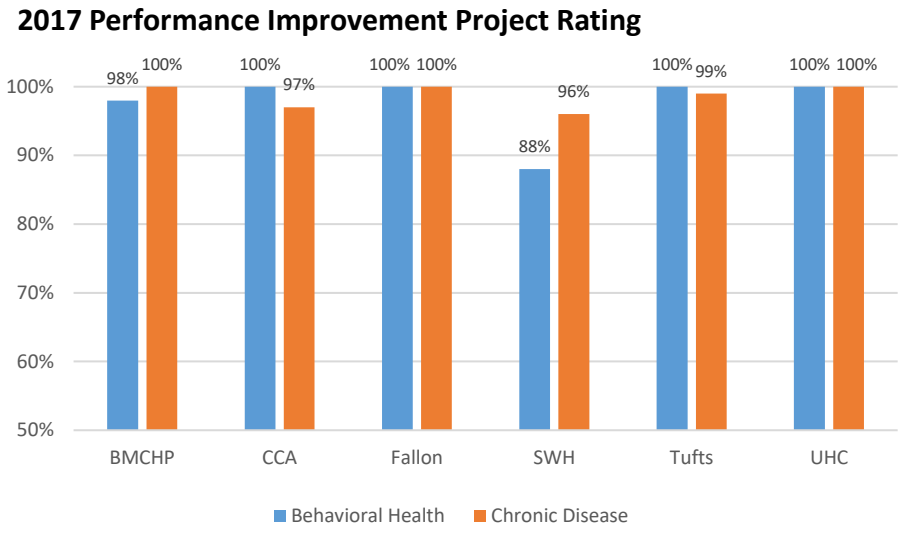
Speaking generally, the technical quality of the Performance Improvement Projects submitted by MassHealth Senior Care Organizations exceeded that of the past. Almost all plans had carefully thought out small tests of change built into their interventions and had considered the measurement of intervention effectiveness prior to implementation. Plan interventions were more robust than in previous years. There were no projects involving only member or provider education. The following interventions are of note:

- Fallon Health offers in-home retinal eye exams to members otherwise unable or unwilling to receive this test.
- Tufts Health Plan behavioral health care managers conduct a root cause analysis of individual instances of readmissions for presentation and problem-solving at Interdisciplinary Care Team meetings.
- Spanish-speaking UnitedHealthcare members discharged from Lowell General Hospital who have been prescribed oral diabetes medications receive medication instructions and labels in Spanish. A UnitedHealthcare pharmacist engages with local pharmacies on behalf of the member to facilitate the distribution of medications with instructions and labels printed in Spanish.

KEPRO hypothesizes that the quality of the 2017 Performance Improvement Projects is due in part to the increased ability of plans to select project topics that align with plan priorities and populations. Prevalent conditions in the SCO population were addressed including, but not limited to, dementia, diabetes, and chronic obstructive pulmonary disease.

The chart that follows depicts the Performance Improvement Project evaluation ratings received by each Senior Care Organization.

Exhibit 27: PIP Ratings by SCO and Domain



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

Exhibit 28: Interventions by Domain

	Behavioral Health	Chronic Disease
Care Management	5	5
Member Education	1	4
Provider Education	2	2
Screening	2	1
Staff Education	1	3
Provider Reports	2	2

In general, care management interventions were more complex than in prior years and involved multiple staff roles, including nurse care managers, pharmacists, and paraprofessionals. For example, positive screening findings were followed up with tighter hand-offs and closer follow-up. Plans used more approaches to contact members, and some plans implemented protocols for updating missing contact information.

KEPRO looks forward to the results of the first remeasurement for these interesting projects in March 2019.

DOMAIN 1: BEHAVIORAL HEALTH

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

Note: Beacon Health Options is BMC HealthNet Plan's behavioral health partner.

Project Rationale

"Beacon analyzed utilization of behavioral services for BMCHP SCO members and concluded only 76 unique members filed claims. The low volume of service utilization included only one claim for inpatient level of care and 75 claims for outpatient therapy services with a primary diagnosis of depression. The claims analysis suggests extremely low utilization and possible underreporting of depression in the SCO membership."

Project Goals

Member-Focused

- Improve the number of completed PHQ-2 questionnaires.
- Increase the number of referrals to Beacon care management.
- Improve the total number of members engaged in and accepting behavioral health care management programs.
- Improve access to behavioral health services such as outpatient therapy, psychopharmacology consultations, and inpatient treatment.
- Increase SCO member use of behavioral health self-management tools.
- Increase BMCHP SCO care manager confidence in administering the PHQ-2.
- Increase BMCHP SCO member referrals to Beacon Health Options for PHQ-2 scores ≥ 3.

Provider-Focused

- Improve primary care and behavioral health provider knowledge and awareness of depression and issues related to depression in the elderly population such as identification, contributing factors, precipitant events, and members' resistance to treatment.
- Improve primary care behavioral health provider knowledge and awareness of issues related to treating elderly members for depression such as stigma, mobility, cognition barriers, and member financial concerns.

Interventions

- BMCHP care management will administer the PHQ-2 questionnaire to each SCO member. If the member's score is ≥ 3, the member will be referred to Beacon, who will administer the PHQ-9. If the member's score is ≥ 10, the member will be referred to the indicated level of care.
- Beacon will provide provider education by means of an email blast and a webinar.

Performance Indicators

- *Depression Diagnosis Penetration Rate*, which is defined as the ratio of the number of unique SCO members with a depression diagnosis on an unduplicated claim to the number of unique enrolled SCO members. BMCHP's baseline performance is 5.1%. BMCHP has not established a goal for the first remeasurement.

- *Depression Treatment Rate*, which is defined as a ratio of the number of SCO members receiving depression treatment to the number of unique SCO utilizers with a depression diagnosis. The denominator parameter does not meet the rating criteria for this item. Baseline data are not yet available. BMCHP has not established a goal for the first remeasurement.

- *PHQ-9 Depression Score*, which is defined as the number of members age 65 and older with a diagnosis of depression and an elevated PHQ-9 score who receive a follow up PHQ-9 and experience remission or response within 4 to 8 months to the number of BMCHP SCO members who complete the PHQ-9. BMCHP's goal is a ≥ 50% reduction in the initial elevated score. Baseline data are not yet available. BMCHP has not established a goal for the first remeasurement.

Performance Improvement Project Evaluation

KEPRO evaluates an 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 98% on this Performance Improvement Project.

Summary Results of Validation Ratings for 3, 2, or 1 values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	3.0	9.0	8.3	92%
B12: Baseline Indicator Performance Rates	4.0	12.0	11.0	92%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**24**	**72**	**70.3**	**98%**

Plan & Project Strengths

- KEPRO commends BMCHP for focusing on the education of its provider networks (primary care and behavioral health) in the screening and treatment of elderly members with depression. Soliciting feedback from providers as stakeholders will be critically important in improving the effectiveness of its educational interventions for providers.

Opportunities for Improvement

- KEPRO's concern regarding the design of this project is its explicit focus on referring members with elevated PHQ-2 scores to Beacon for further evaluation and referral to a BH specialist. This protocol should be matched by an equally explicit protocol that supports the referral of members to their PCPs if that is their preference.

Recommendations

- KEPRO suggests that BMCHP consider supplementing provider education with practice- and member-specific gap reports that give providers real-time data about their rates of assessment rates and depression treatment.
- BMCHP needs to be more explicit in its goals regarding referrals of members to its Beacon behavioral health provider network compared to referring members to behavioral health services available through its primary care network.

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

Project Rationale

CCA chose this project because of the relatively high prevalence of dementia among SCO members. Preliminary qualitative data indicate that CCA has not defined or consistently implemented best practices for screening, evaluating, or developing dementia-focused care plans for members with dementia. CCA estimates that 20% of its SCO population has a diagnosis of depression.

Project Goals

Member-Focused

- Improve the rate of early detection of dementia or of less severe but impactful cognitive impairments.
- Improve care for members with recently diagnosed dementia or less severe but impactful cognitive impairment.
- Enhance knowledge of local resources to assist caregivers for those with recently diagnosed dementia or less severe but impactful cognitive impairment.

Provider-Focused

- Activate CCA clinical staff to more reliably and effectively complete periodic formal screenings of SCO members for dementia using the Mini-Cog©.
- Refer members that screen positive on the Mini-Cog© for a more comprehensive cognitive assessment by a CCA behavioral health provider or advanced practice clinician.
- Increase CCA behavioral health specialist or advanced practice clinician timely completion of the cognitive assessment of all members referred after positive screening using the MoCA, MoCA-Basic, MoCA-Blind, and MMSE.
- Improve/increase the development and implementation of a robust care plan for those members identified with dementia or less severe but impactful cognitive impairment.

CCA modified its member- and provider-focused goals from Report 1 relative to specificity and scope.

Interventions

- CCA has implemented periodic, routine, formal screening for cognitive impairment by CCA clinical staff. This intervention involves the development and implementation of templates and documentation tools in the care management system; the development of training materials and protocols; the training of clinical staff; the implementation of a process for referrals to the behavioral health provider; and the development of an outreach script in both English and Spanish.
- A related intervention is the cognitive assessment of members screening positive for cognitive impairment by CCA behavioral health clinicians or advanced practice clinicians.

- CCA reviews the cases of members who have recently had a positive Mini-Cog© screening or who screened positive on a cognitive assessment at its inter-professional team meetings. The team reviews the member's care plan and makes changes as necessary to address evaluation, treatments, services, and support for dementia-related needs. A referral to a dementia specialist is considered.

Performance Indicators

- *The Mini-Cog© Screening Rate,* which is defined as a ratio of the number of members without a diagnosis of dementia in CY2017 that received a Mini-Cog© screening at least once during the measurement period to the number of members without a diagnosis of dementia in the measurement period. CCA's baseline rate was 2%. Its goal for the first remeasurement is 35%.

- *The Timely Cognitive Assessment Rate,* which is defined as a ratio of the number of members with a positive Mini-Cog© screening during the measurement year who had a cognitive assessment by a CCA behavioral health provider or advanced practice clinician within 90 days of the date of the positive Mini-Cog© screening but did not have a diagnosis of dementia in the measurement year to the number of members that had a positive Mini-Cog© screening during the measurement year without a diagnosis of dementia but did not have a cognitive assessment. CCA's baseline rate was 0%. Its goal for the first remeasurement is 25%.

Performance Improvement Project Evaluation

KEPRO evaluates an 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.

Summary Results of Validation Ratings for 3, 2, or 1 values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	3	9	9	100%
B11: Performance Indicator Parameters	3.0	9.0	9.0	100%
B12: Baseline Indicator Performance Rates	4.0	12.0	12.0	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**25**	**75**	**75**	**100%**

Project & Plan Strengths

- CCA presents an excellent population analysis that, in many Appendix 1 tables, compares members with dementia to those with no diagnosis of dementia.
- CCA is commended for applying small tests of change as a quality improvement strategy for three of its intervention activities.
- CCA is commended for the expansion and increased specificity of its member- and provider-focused goals.
- CCA is addressing the needs of members who are at risk for dementia, as well as members who have a diagnosis of dementia.

Opportunities for Improvement

- In its next EQR report, CCA should describe its protocol for ensuring inter-rater reliability among its medical records data abstraction team.

Recommendations

- CCA's population analysis could be used to identify sub-groups of members with no diagnosis of dementia but who have greater probabilities of dementia and should be prioritized for screening outreach.

- KEPRO suggests that CCA consider whether it has the resources for both improved early detection of dementia and improved care planning for members with dementia. If its staff resources are strained, CCA might consider which focus is a priority.

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

Note: Beacon Health Options is Fallon Health's behavioral health partner.

Rationale

"The NaviCare program is designed to maintain members in the least restrictive setting, functioning at the highest level possible. Members with behavioral health issues may be at high risk of readmission due to psychosocial factors, as well as the presence of comorbid health conditions. Outreach to members following hospitalization for mental illness can help facilitate timely receipt of behavioral health, medical, and other support services in an appropriate setting, reducing the likelihood of readmission. Conversely, a decline in mental health status may result in increased utilization of emergency mental health services and decreased quality of life for the member."

Project Goals

Member-Focused

- Create a personalized aftercare assistance program in order to increase members' likelihood of engaging in post-hospitalization (outpatient) behavioral health care.
- Increase the engagement of NaviCare members in follow-up care with outpatient behavioral health providers following hospitalization for mental illness.

Provider-Focused

- Design and implement an aftercare and provider quality program to encourage coordination of care and discharge planning with inpatient providers.
- Design and implement an aftercare and provider quality program that promotes and encourages best practices regarding the provision of follow-up care post-hospitalization through outpatient providers.

Interventions

- To minimize the disruption of inpatient facility internal operations, Beacon obtains discharge information using its eServices portal. Discharge appointments are confirmed with the outpatient provider. Aftercare Coordinators secure appointments as needed. They also contact the member to confirm appointment information and ensure that the member understands medications and other discharge information.
- Aftercare Coordinators generate a no-show letter to members who miss their 7-day follow-up appointment. Aftercare Coordinators continue follow-up care coordination activities within the 30-day post-discharge window. They also collaborate with the inpatient facility to obtain accurate member contact information.
- Beacon plans to encourage outpatient providers to engage in best practices. A number of reports are planned, including Hospitalization Follow-Up, member attendance, and member engagement reports. These reports will be shared with providers to help the provider

develop strategies. Also planned is the creation of educational materials about aftercare best practices and expectations.

Performance Indicators

- The HEDIS® measure, *Follow-Up After Hospitalization for Mental Illness – 7-day Follow-up Rate.* Fallon Health's baseline performance for this measure was 45.8%. The benchmark is the Quality Compass®[7] 2017 75th percentile.
- The HEDIS® measure, *Follow-Up After Hospitalization for Mental Illness – 30-day Follow-up Rate.* Fallon Health's baseline performance for this measure was 79.2%. The benchmark is the Quality Compass 2017 75th percentile.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings for 3, 2, or 1 Values	**No. of Items**	**Total Available Points**	**Points Scored**	**Rating Averages**
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	4.0	12.0	12.0	100%
B12: Baseline Indicator Performance Rates	4.0	12.0	12.0	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**25**	**75**	**75**	**100%**

[7] Quality Compass® is a registered trademark of NCQA.

Plan & Project Strengths

- Fallon Health presents an excellent population analysis and is commended for applying the findings from its population analysis to outreach strategies toward members with the greatest risks.
- Fallon Health is commended for making available to individual providers data specific to their practices. The data presented are compared to peer practices. Also commendable is the availability of nurse care managers for home visits upon request.
- Fallon Health is commended for using the root cause analysis method as a standardized process.
- Fallon Health is commended for obtaining feedback about this intervention from its Consumer Advisory Council to offer feedback on this intervention.

Opportunities for Improvement

None identified.

Recommendations

- KEPRO suggests that other care team members engage with behavioral health providers following hospitalization as well as with the member's family, as appropriate.
- Fallon Health noted provider resistance to what is perceived as an unfunded mandate. KEPRO recommends that Fallon explore this issue with providers as stakeholders. The views of providers who are willing to engage would be particularly interesting.

SENIOR WHOLE HEALTH: IMPROVING TREATMENT FOR DEPRESSION

Note: Beacon Health Options is Senior Whole Health's behavioral health provider.

Rationale

"The Senior Whole Health membership has a high prevalence of depression and this prevalence has increased (25% of members had depression in 2015; 29% had the condition in 2016; and 28% in 2017). Senior Whole Health members are considered a high-risk population due to age (the average member age is 72), fragility, low socio-economic status, and multiple chronic health conditions."

Goals

Member-Focused

- Improve identification of members with depression.
- Improve member understanding of depression.
- Improve member compliance with depression treatment.

Provider-Focused

- Improve treatment of depression in the primary care and behavioral health provider settings.

Interventions

- Senior Whole Health distributes educational material by mail to members who have been diagnosed with depression and are enrolled in the Depression Health Management program. Members with depression are referred to Beacon case management as indicated. These case managers provide education and make provider referrals as appropriate. The Senior Whole Health nurse care manager will educate the Geriatric Services Support Coordinators about depression.
- Senior Whole Health nurse care managers will receive lists of member gap rosters. The nurse care manager will discuss non-adherence with the member at home visits. Gap lists will also be provided to Beacon Health Options so that its care managers can conduct outreach to non-adherent members engaged in its care management program.
- Senior Whole Health will ask primary care providers to screen members determined to be at risk for depression. Using gap lists generated by Senior Whole Health, Beacon will ask some of its network providers to counsel members identified as being non-adherent with medication. Senior Whole Health will also provide general provider education.

Performance Indicators

- The *HEDIS® Antidepressant Medication Management (AMM) Acute Treatment Rate.* Senior Whole Health's baseline performance rate was 68.1%; its goal is 80%.
- The *HEDIS® Antidepressant Medication Management (AMM) Continuous Treatment Rate.* Senior Whole Health's baseline performance rate was 59.1%; its goal is 68%.

- The CMS Health Outcome Survey (HOS) measure, *Improving or Maintaining Mental Health.* Its baseline performance was 79%. Its goal for the first remeasurement is 86%.

Performance Improvement Project Evaluation

KEPRO evaluates an SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Senior Whole Health received a rating score of 88% on this Performance Improvement Project.

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Score	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	8	89%
B7: Update to PIP Topic and Goals	3	9	8	89%
B8: Progress in Implementing Interventions	5.0	15.0	10.0	67%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	4.0	12.0	12	100%
B12: Baseline Indicator Performance Rates	4.0	12.0	12	100%
B13: Conclusions and Planning for Next Cycle	2	6	4	67%
Overall Validation Rating Score	**25**	**75**	**66**	**88%**

Project & Plan Strengths

- KEPRO commends Senior Whole Health for using nurse care managers for home visits.
- KEPRO commends Senior Whole Health for its plan to make medication adherence gap reports available to providers.

Opportunities for Improvement

- KEPRO notes abundant literature showing that member and provider education does not work well when it is offered through mass distribution formats, such as newsletters. KEPRO suggests that SWH develop interventions that will be integrated into provider workflows

and take advantage of whatever is most appropriate in terms of educational outreach to members.

- The project goal, "improve member treatment for depression," is non-specific with respect to "treatment for depression." As defined by its performance indicators, the scope of this project is to improve adherence to antidepressant medication for members newly diagnoses with depression. This focus on medication management is not made sufficiently clear in this topic discussion.
- KEPRO advised SWH in March 2018 to clarify how its provider interventions will apply to primary care providers compared to behavioral health specialists and how depression treatment will be coordinated between members' primary care and behavioral health providers. This issue of care integration should be more explicitly addressed.
- SWH does not offer a sufficient rationale for not using quality improvement strategies in the development of this intervention.
- KEPRO advises SWH to explain how a sample of members' improvement on a composite health outcomes survey will speak to the issue of members' improved adherence to antidepressant medications.

<u>Recommendations</u>

- KEPRO advises SWH to identify which of the varied activities in this intervention will be the focus of its intervention outcome evaluation that will be presented in the first remeasurement report. The three possible outcomes for this intervention, as currently configured, are:
    1. Improved member understanding of depression
    2. Improved member agreement to treatment
    3. Improved member adherence to treatment plans for depression and co-morbidities

  SWH should prioritize one of these three outcomes for evaluation in its first remeasurement report.
- KEPRO recommends that SWH identify in future EQR reporting the criteria by which members are referred to Beacon.
- KEPRO recommends that providers use all available opportunities to conduct a screening, such as when a member is in the reception area or having the assessment performed by a medical assistant, nurse, or even receptionist.

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

Project Rationale

"Given the complexity of the SCO membership's clinical profile and a steadily growing membership, proper screening and outpatient follow-up after hospitalization are important indicators of quality. Tufts Health Plan is looking to focus these activities to help reduce the likelihood of re-hospitalization to inpatient behavioral health facilities."

Project Goals

Member-Focused

- Increase the rate of members who receive transition of care services.
- Reduce readmission to behavioral health inpatient facilities.
- Reduce psychosocial barriers to receiving psychotherapy through the identification and resolution of barriers to timely aftercare attendance.

Provider-Focused

- Identify and begin to address provider variables related to behavioral health readmissions.
- Reinforce the importance of the seven-day follow-up after discharge from a mental health admissions appointment as an important component of transitions management in helping to prevent readmissions.

Interventions

- Tufts Health Plan has implemented a four-pronged approach to transition of care services. While the member is still hospitalized, the Tufts behavioral health care manager collaborates with the facility to initiate the discharge planning process. Within two business days of discharge, the care manager contacts the member and performs a standardized transitions assessment and intervenes where needed. Weekly contact is made for thirty days post-discharge. Within seven days of discharge, a Tufts nurse care manager performs a medication reconciliation. If additional support is required, a consultation is requested with a Tufts Geriatric Psychiatry Advanced Practice Nurse.
- A behavioral health care manager conducts a root cause analysis of instances of readmissions for presentation and problem-solving at the Interdisciplinary Care Team meeting.

Performance Indicators

- Tufts is using a *modified version of the HEDIS® Plan All-Cause Readmission (PCR)* rate. Tufts' baseline performance was 0%. Its goal for Remeasurement 1 is 11.7%, a 10% improvement over baseline performance.
- Tufts is also using the HEDIS® *Follow-Up after Hospitalization for Mental Illness (*FUH*)* measure to assess performance. Its baseline performance on the 7-day rate was 46.7%, and its goal for the first remeasurement is 51.4%. Its baseline performance on the 30-day rate was 33.3%, and its goal for the first remeasurement is 51.4%.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	4.0	12.0	12.0	100%
B12: Baseline Indicator Performance Rates	5.0	15.0	15.0	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**26**	**78**	**78**	**100%**

Project & Plan Strengths

- Tufts Health Plan is commended for its comprehensive population analysis.
- Because of a low member count for members readmitted because of depression, Tufts has expanded the focus of this PIP to include members readmitted for any behavioral health diagnosis. KEPRO regards this as a positive expansion of this project's scope.
- Tufts is commended for a novel use of the root-cause analysis method to identify a variety of factors related to each member's readmission. This process for detailed analysis of each member's reasons for readmission for behavioral health conditions might be generalized to understanding the reasons for readmission related to members with medical diagnoses.

Opportunities for Improvement
None identified.

Recommendations
- Although the number of eligible members in this PIP is small, Tufts should consider how the model of outreach for this population could be generalized to managing the needs of members with other medical diagnoses.

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

Project Rationale

"With the number of comorbidities and challenges an SCO member may be facing, this project aims to reiterate the importance of such screenings to aid in the identification of depression in older adults and thereby improve treatment, including medication adherence and management of the condition. SCO members' ability to manage medication is often compromised due to language or health literacy-driven misunderstanding of instructions, functional disabilities, the inability to juggle multiple tasks, and memory issues. The Plan offers a prescription benefit with no copay, and one of the goals of the project will be to re-educate members that this is available to them and that prescription costs should not create a barrier to medication adherence."

Project Goals

Member-Focused

- Increase the HEDIS® Antidepressant Medication Management Acute Treatment rate to the Quality Compass 2017 95th percentile.
- Increase the HEDIS® Antidepressant Medication Management Continuous Treatment rate to the Quality Compass 2017 95th percentile.

Provider-Focused

- Increase the HEDIS® Antidepressant Medication Management Acute Treatment rate of members in their panel to the Quality Compass 2017 95th percentile.
- Increase the HEDIS® Antidepressant Medication Management Continuous Treatment rate of members on their panel to the Quality Compass 2017 95th percentile.

Interventions

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

Performance Indicators

The *HEDIS® Antidepressant Medication Management (AMM) Acute Treatment Rate.* UnitedHealthcare's baseline performance rate was 65.26%; its goal is the Quality Compass 2017 95th percentile.

The *HEDIS® Antidepressant Medication Management (AMM) Continuous Treatment Rate.* UnitedHealthcare's baseline performance rate was 50.53%; its goal is the Quality Compass 2017 95th percentile.

Performance Improvement Project Evaluation Results

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

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	5.0	15.0	15.0	100%
B12: Baseline Indicator Performance Rates*	5.0	15.0	15.0	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**27**	**81**	**81**	**100%**

Project & Plan Strengths

- For each member characteristic identified in the population analysis, UnitedHealthcare is commended for identifying member characteristics that could be barriers to achieving indicator goals and might be improved through intervention activities that address these

member characteristics. UHC is also commended for stratifying its members according to those who might benefit the most from its interventions. KEPRO also commends UHC's intent to share the findings of its population analysis with stakeholders.

- UHC is commended for its active and ongoing involvement of providers as stakeholders for the continuous improvement of this intervention.
- UHC's commitment to continuous quality improvement is evident in efforts to improve the members' experience with outreach, especially with respect to member's preferred language.

Opportunities for Improvement

None identified.

Recommendations

- KEPRO suggests UHC consider utilizing other practice staff for the assessment when a member is in a face-to-face encounter with staff such as medical assistants, nurses, and receptionists.
- KEPRO suggests that UHC use its excellent barrier list to ensure that its intervention activities mitigate these barriers to the extent possible.

DOMAIN 2: CHRONIC DISEASE MANAGEMENT PERFORMANCE IMPROVEMENT PROJECTS

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

Project Rationale

Diabetes is the most prevalent diagnosis among BMCHP SCO members. Approximately 36% of SCO members have an associated medical claim for diabetes. This rate is substantially higher when compared to national benchmarks with disease prevalence of about 25% (*National Diabetes Statistics Report, 2017*). Diabetes in older adults is associated with higher mortality, reduced functional status, and increased risk of institutionalization.

Goals

Member-Focused

- Increase SCO member engagement in the care management program.
- Include a diabetes assessment in the member's individual care plan and link it to care management problems, interventions, and goals.
- Increase the distribution of culturally and linguistically appropriate education materials to SCO members. Assess SCO members' values and preferences regarding diabetes self-management.

The third goal was modified in Report 2 to include the assessment of diabetic members' values and preferences.

Provider-Focused

- Increase awareness of care gaps and the use of care gap reports.
- Increase awareness of medication adherence issues.

Interventions

- BMCHP conducted care manager trainings on Motivational Interviewing and the use of glucometers. Staff were also trained on the glucometer benefit and procurement process.
- A new diabetes assessment tool was added to the Centralized Enrollee Record.
- BMCHP actively sought input from stakeholders. Members gave input on BMCHP's diabetes educational materials at a focus group and at a Member Advisory Council meeting. Useful feedback was received. BMCHP also sought provider input on care gap reports.

Performance Indicators

Note: BMCHP provided baseline rates and performance goals for three SCO subpopulations: dually eligible Medicare members with continuous enrollment (the HEDIS® hybrid rate); dually eligible Medicare/Medicaid members without continuous enrollment; and Medicaid only members without continuous enrollment. This report will focus on the HEDIS® rate.

BMCHP is using the following *HEDIS® Comprehensive Diabetes Care* performance indicators to measure the success of this project:

- *HbA1c Testing* – BMCHP's baseline rate is 97.3%. Its stated goal for the first remeasurement is 93%.
- *HbA1c >9.0%, Poor Control* – For this measure in which a lower number reflects better performance, BMCHP's rate is 27.03%. Its goal for the first remeasurement is 27.00%.
- *Retinal Eye Exam* – BMCHP's baseline rate is 86.49%. Its goal for the first remeasurement is 72%.
- *Medical Attention for Nephropathy* – BMCHP's baseline rate is 94.59%, and its goal for the first remeasurement is 96%.
- *Diabetes Medication Adherence* (CMS measure) – The baseline rate is 80%. The first remeasurement goal is 81%.

Performance Improvement Project Evaluation

KEPRO evaluates an 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 100% on this Performance Improvement Project.

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	4	12	12	100%
B11: Performance Indicator Parameters	6.0	18.0	18.0	100%
B12: Baseline Indicator Performance Rates	5.0	15.0	15.0	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**30**	**90**	**90**	**100%**

Project & Plan Strengths

- BMCHP's plan for using its population analysis for project planning is well done.
- BMCHP is especially commended for convening its Member Advisory Committee whose membership includes six members with diabetes. BMCHP is commended for its excellent work to integrate members early in the project for their feedback and engagement regarding their diabetes educational materials.
- BMCHP is commended for staff training in MI and glucometer usage.
- BMCHP is commended for identifying and attempting to resolve important issues related to the roles of nurses versus care managers and questions related to direct care (completed by nurses) and care planning (completed by care managers).

Opportunities for Improvement

None identified.

Recommendations

- KEPRO suggests that BMCHP consider utilizing ancillary staff, such as medical assistants, nurses, and diabetes educators in addition to primary care providers and care managers to engage members for education and support during face-to-face encounters. For medication adherence, BMCHP should consider including pharmacists in the team to outreach to members since they can track medication utilization through refills.
- KEPRO suggests incorporating reminders of all outstanding preventive screening tests for each patient in the electronic medical record. This would facilitate ordering all appropriate screening tests during each face-to-face encounter from anywhere in the delivery system. Ancillary staff, such as receptionists, medical assistants, or others, can be trained to either schedule members for tests or screenings directly or serve as the link to providers who can then place the orders.

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

Note: CCA received permission from MassHealth to continue this project, which was initiated in 2017.

Project Rationale

Tens of millions of Americans do not have access to preventive dental care. These challenges are pronounced among people with a low income and racial and ethnic minorities. For people with disabilities, the degree and severity of oral health problems are often worse than those of the general population. Low-income seniors, particularly frail seniors, face challenges unique to aging. Although seniors in general are retaining their teeth longer than in the past, the prevalence of root caries, periodontal disease, and dry mouth continues to be alarmingly high. Barriers related to aging, such as physical, sensory, and cognitive impairments, further complicate seniors' challenges, making utilization of preventive care visits and self-care even more difficult.

Project Goals

Member-Focused

- Increase utilization of preventive dental visits by SCO members.

Provider-Focused

- Increase the number of preventive care oral exams performed on SCO members.

Interventions

- CCA is using multiple modalities to encourage members to schedule dental appointments. Members are contacted by text message and mail with reminders to schedule a preventive dental visit and maintain oral health. Articles are also placed in the member newsletter.
- CCA is using a three-pronged approach to activate CCA clinicians to have conversations with members to increase member engagement and facilitate access to a dentist. A dental awareness document was developed and posted periodically to the CCA intranet. This document is intended to raise awareness among staff about the importance of preventive dental care. A webinar was developed and also posted to the CCA intranet. The webinar's training goal is to increase provider knowledge of the health implications of poor oral health, the barriers members face receiving this care, oral health benefits, and the importance of integrating oral health into care management. The project team also presented oral health information at clinical staff meetings.

Performance Measure Indicator

- CCA measures performance by calculating *a rate for members that had one or more dental care visits in which preventive dental care services were provided during the measurement year.* This rate is defined as the ratio of dental claims containing a preventive dental care

service code to the total number of SCO members. CCA's baseline performance was 29%. Its goal for the first remeasurement is 32%.

Rating Score

KEPRO evaluates an 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 97% on this Performance Improvement Project.

Summary Results of Validation Ratings for 3, 2, or 1 values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	8	89%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	14.0	93%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	4	12	12	100%
B12: Baseline Indicator Performance Rates	4	12	12	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**25**	**75**	**73**	**97%**

Plan & Project Strengths

- CCA has provided a summary of the importance of promoting good and timely dental care for its elderly SCO members. CCA's summary is accompanied by excellent references.

Opportunities for Improvement

- CCA has not presented a population analysis of baseline data that is specific to the members eligible for inclusion in this project. CCA could strengthen this analysis by differentiating the population characteristics of the 2,369 members in the numerator (those who scheduled a dental visit) compared to the 5,801 members in the denominator who did not schedule a dental visit.

Recommendations

- KEPRO suggests CCA consider adding intervention activities that are embedded within the flow of care to facilitate referrals. This could include utilizing others in the care team to initiate dental appointments when members have face-to-face encounters within an office setting. Ancillary staff such as receptionists, nurses, care managers, or medical assistants could initiate scheduling of dental appointments when interacting with patients.
- CCA is relying on staff training to ensure a comprehensive discussion with the member. CCA should create a script for the member interview and a checklist of discussion topics, one of which is the topic of dental care. Topics discussed can be checked-off, and this can become a source of data for quality improvement purposes.
- KEPRO recommends testing additional outreach strategies, such as text messages to engage members, mailed postcards with a number to call, and a website for education and appointment scheduling.
- CCA should consider other venues for educational outreach and dental appointment scheduling, such as church gatherings, barbershops, and senior centers.

Update on Calendar Year 2017 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2017 to CCA follows.

Exhibit 21: Update on Calendar Year 2017 CCA PIP Recommendations

Calendar Year 2017 Recommendation	2018 Update
KEPRO recommends that CCA consider stratifying its members by risk level, such as those members whose physical or emotional health declined compared to the previous year; who have mobility disabilities; or who have three or more ADL impairments. Members at higher risk levels may need more personalized interventions to improve their service access rates.	CCA did not provide evidence of such an analysis.
The lack of literature on best practices to increase the rates of routine dental care visits underscores the importance of CCA soliciting structured feedback from both members and providers about these interventions.	CCA is commended for convening two advisory groups whose focus has a direct bearing on this project.
KEPRO recommends that, to reinforce the content of the material, CCA find ways to personalize the member mailings or ensure that care mangers review the materials with the member.	CCA did not provide evidence of such an intervention.

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

Project Rationale

"Overall, about one-third of the NaviCare population is diabetic. It is recommended that individuals with diabetes receive a retinal eye exam annually in order to test for diabetic retinopathy, which, left untreated, could lead to serious vision loss and even blindness."

Project Goals

Member-Focused

- Increase the rate of retinal eye exams among NaviCare enrollees with diabetes.
- Increase engagement of diabetic NaviCare enrollees who are identified as being unable to contact (UTC) and/or are non-adherent to diabetes care management plans, i.e., receipt of a retinal eye exam.

Provider-Focused

- Increase primary care provider engagement in the management of the care of enrollees with diabetes.
- Increase primary care provider education related to the use of telemedicine and point-of-care testing for diabetic retinopathy screening.

Interventions

- Fallon intends to engage providers at a local community health center and offer an onsite eye health clinic at which the health educator will provide point of care retinal screenings. Providers will be able to refer a member to point-of-care screening, e.g., at the member's home.
- The Centralized Enrollee Record was updated to include a Health Risk Assessment containing the HEDIS® Comprehensive Diabetes Care measures. Because an analysis revealed that Fallon had not identified all members with diabetes, NaviCare Clinical Management provided reeducation and training on the HRA process. Staff will use this information to determine whether appointment assistance or a referral to the Health Educator for an in-home retinal eye exam is needed.
- Based on a gap report, Fallon assessed member interest in receiving a referral to the Health Educator to receive an in-home diabetic retinal eye test. Test results are shared with the member and his or her primary care provider.

Performance Indicators

The *HEDIS® Comprehensive Diabetes Care (CDC) Retinal Eye Exam Rate*. Fallon Health's baseline rate for this measure was 85.6%. The 2018 CMS 5-Star cut point is > 81.0%.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	4	12	12	100%
B11: Performance Indicator Parameters	5	15	15	100%
B12: Baseline Indicator Performance Rates	4	12	12	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**28**	**84**	**84**	**100%**

Plan & Project Strengths

- Fallon Health is commended for the quality of its population analysis. KEPRO especially recognizes the comparisons between two member cohorts: members with diabetes included in the numerator (that is, those who received a retinal eye exam) compared to members with diabetes who did not receive a retinal eye exam.
- Fallon Health is commended for assessing differential eye exam performance rates among providers, as well as for documenting the high prevalence of behavioral health disorders as a co-occurring group of disorders among its members.
- KEPRO commends Fallon Health for pursuing the development of eye health clinics. KEPRO suggests that the plan provides updates on this initiative in future EQR reports.
- Fallon Health is further commended for working to institute in-home exams and exams in community clinics. Fallon is noted for its use of excellent strategies for addressing the challenges associated with hand-offs and the integration of eye care providers in primary care. Its in-home exams are an excellent initiative to test, especially since this intervention

responds to feedback from the members about the difficulty in accessing clinic appointments due to physical, mental, and transportation challenges.

Opportunities for Improvement
None identified.

Recommendations
KEPRO recommends that Fallon Health include all structured efforts to improve its interventions through the use of stakeholder feedback as examples of small tests of change.

SENIOR WHOLE HEALTH: CARDIAC DISEASE MANAGEMENT

Rationale

Senior Whole Health (SWH) members have a high prevalence of heart disease, including hypertension and cardiovascular disease. In 2017, 79% of members had hypertension; 47% had coronary artery disease (CAD). CAD is the number one cause of death globally; high blood pressure, high LDL cholesterol, and smoking are key risk factors. SWH has historically not done well with controlling blood pressure—the most recent HEDIS® results for this measure were in the bottom two-thirds of all health plans (Quality Compass 2018, all lines of business). All these factors make improving treatment of this condition a priority for SWH.

Project Goals

Member-Focused

- Improve member understanding of the importance of good blood pressure control.
- Improve member adherence with hypertension treatment.

Provider-Focused

- Improve hypertension treatment in the primary care setting.

Interventions

- Senior Whole Health has implemented four activities under the umbrella of improving member education for maintaining good blood pressure control. New Coronary Artery Disease (CAD) Management Program members receive a welcome letter and educational materials that speak to smoking cessation, nutrition, and weight management, flu vaccines, physical activity, and medication compliance. Outbound educational calls are made by the Community Service Coordinators. Nurse care managers provide coaching during scheduled home visits. Healthy Living Chronic Disease self-management classes are offered to members.
- Nurse Care Managers receive lists of members who are not adherent with their hypertension medication regimens. Member service staff also reach out to these members. A mailing describing the importance of medication compliance in the five most prevalent languages spoken by Senior Whole Health members is distributed annually. Outcomes MTM, a pharmacy vendor, provides coaching to certain members on medication compliance with CAD statins.
- Senior Whole Health offers provider training on medication compliance by means of gap reports and articles placed in the plan newsletter.

Performance Indicators

- The HEDIS® measure, Controlling Blood Pressure (CBP). Senior Whole Health's baseline performance was 72.51%. Its goal for the first remeasurement is 82%.
- The CMS Stars measure, ACE/ARB Medication Compliance. Senior Whole Health's baseline performance was 84%. Its goal for the first remeasurement is 88%.

- The CMS Stars measure, Medication Adherence for Statin. Senior Whole Health's baseline performance was 83%. Its goal for the first remeasurement is 87%.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	12.0	80%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	3	9	9	100%
B11: Performance Indicator Parameters	3.0	9.0	9.0	100%
B12: Baseline Indicator Performance Rates	4.0	12.0	12.0	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**25**	**75**	**72**	**96%**

Project & Plan Strengths

- SWH's population analysis is well done. SWH is commended for its detailed analysis of the preferred languages among members with coronary artery disease (CAD).
- SWH is commended for addressing the preferred languages of its members, as well as the challenges of limited health literacy. KEPRO also notes that SWH is using team members who are, to the extent possible, cultural matches with the members to whom they outreach.

Opportunities for Improvement

- SWH is commended for its outreach home visits, which are a great opportunity to demonstrate food preparation activities for low-fat, low-carbohydrate, and low-salt recipes.

Recommendations

- Regarding member outreach protocols, KEPRO suggests that SWH consider using methods to do outreach that acknowledge the low education level and health literacy of the population they are targeting. KEPRO further suggests it use media such as texting through smart phone and the distribution of videos that are age and culturally appropriate, and therefore different for different cohorts.
- KEPRO recommends that SWH solicit feedback from a culturally diverse member advisory panel regarding the content skills that should be included in its care manger development training.
- KEPRO suggests that SWH incorporate pharmacists into the flow of work of compliance coaching for members. This might be a better use of resources than sending educational materials to a cohort that has been acknowledged as having limited health literacy and educational levels.
- KEPRO supports SWH's plan to continue with staff training and development. KEPRO recommends that more detail regarding staff development be included in the 2019 remeasurement report.

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

Project Rationale

"Chronic Obstructive Pulmonary Disease (COPD) is a diagnosis that is frequently misunderstood despite the fact that it is the second leading cause of disability in the United States. It is also a prevalent condition for the Tufts Health Plan Senior Care Options (SCO) population and is among the top diagnoses driving admissions. Tufts Health Plan reviewed the effect that depression has on the management of COPD and found that members that are co-morbid with depression have higher morbidity, utilization, and cost than members with COPD alone. Undetected and untreated depression can be a barrier to effective COPD treatment, exacerbate existing conditions, and negatively affect outcomes. Based on 2017 data, COPD has surpassed Congestive Heart Failure as the leading admission driver for SCO members. Therefore, addressing COPD disease management with the co-morbidity of depression for high-risk frail elders has been identified as an urgent need."

Project Goals

Member-Focused

- Increase the percentage of SCO members with COPD being managed in the SCO disease management program.
- Identify members with COPD that may have undiagnosed depression.
- Facilitate depression diagnoses and treatment.

Provider-Focused

- Encourage providers to document diagnosis of depression for members who screen positive using a PHQ-9.
- Support primary care referral to outpatient depression treatment.

Interventions

- Tufts will ensure that members who have screened positive on a PHQ-2 receive behavioral health clinician support. If the member screens positive on the PHQ-9, the member will be referred to the primary care provider.
- Educational materials will be sent to members.
- Tufts will conduct outreach to primary care providers with members with co-occurring COPD and depression to ensure appropriate referrals are made and antidepressants prescribed.
- Provider education will be provided to the network at a medical directors meeting.

Performance Indicators

Tufts will use the *COPD Admission Rate*, a modified version of the AHRQ PQI-5, to measure project performance. Tufts baseline performance in this measure is 22.8 admissions per 1000 members per year. Its goal for the first remeasurement is a 10% reduction to 20.5 admissions per 1000 members per year.

Also used is the *COPD or Asthma Potentially Avoidable Admission Rate*. Tufts baseline performance in this measure is 24.2 admissions per thousand members per year. Its goal for the first remeasurement is 21.8 admissions per thousand members per year.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	14.5	97%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	3.0	9.0	9.0	100%
B12: Baseline Indicator Performance Rates	4.0	12.0	12.0	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**24**	**72**	**71.5**	**99%**

Project & Plan Strengths

- Tufts Health Plan has presented an excellent population analysis of its members with a history of COPD. It identified a number of factors associated with groups of members having a high risk for hospitalization.
- Tufts is commended for its staff development for this PIP, including training staff in Motivational Interviewing.
- KEPRO commends Tufts for its plans to solicit member and provider feedback regarding this PIP's interventions. KEPRO notes that provider stakeholders should include primary care providers and behavioral health specialists. Such a panel could be helpful in developing care

management protocols that maximize primary-behavioral health care coordination and integration.

Opportunities for Improvement

- In its next PIP report, KEPRO recommends that Tufts add depression to its population analysis as a confounding factor in rates of hospitalization due to COPD. This analysis of depression should explicitly identify the percentage of members with a co-morbid COPD/depression diagnosis in support of the topic for this PIP.
- In its next EQR report, KEPRO advises Tufts to address KEPRO's concern that the respective roles of primary care and behavioral health providers are not well-delineated in this PIP. In this regard, Tufts will need to better define these two roles, consider the interface between primary care and behavioral health providers, as mediated by Tufts, and include a protocol for members who decline a referral to a behavioral health provider for depression treatment.

Recommendations

- KEPRO notes that Tufts' depression screening protocol involves a hand-off from nurse care managers to Senior Product care managers for those members who screen positive for depression on the PHQ-2. Tufts should consider that this hand-off protocol can pose risks for members whose willingness to engage in depression management may be challenging. Tufts should offer more intensive care management support to members who may be unwilling or reluctant to accept the hand-off to a behavioral health provider.
- A PCP referral protocol should be developed by Tufts for members who decline treatment by behavioral health providers.
- KEPRO recommends that, in future EQR reporting, Tufts include an indicator that measures the effect of depression on rates of hospitalization for members with COPD.

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

Project Rationale

UnitedHealthcare selected this PIP topic because of the prevalence of diabetes in its population and the effects of poor medication adherence on the development of complications, hospitalizations and readmissions, member co-morbidities, and death. At the time of the PIP selection in 2017, the prevalence of diabetes was 47%.

Project Goals

Member-Focused

- Increase the rate of medication adherence for non-insulin diabetes medications for SCO members diagnosed with diabetes through encouraging member engagement in one or more clinical or pharmaceutical initiatives. *(Revised September 2018)*

Provider-Focused

- Increase the rate of medication adherence for non-insulin diabetes medications for SCO members diagnosed with diabetes through provider participation in one or more clinical or pharmaceutical initiatives. *(Added in September 2018)*

Interventions

- UnitedHealthcare has implemented the Diabetes RxMonitor program/Gaps in Care - Diabetes Program. The objective of this program is to promote the use of statin medications, a class of cholesterol-lowering drugs, in members with diabetes by promoting provider engagement with members and the completion of a thorough medication review. UnitedHealthcare conducts a retrospective review of pharmacy and claims data to identify members diagnosed with diabetes with no pharmacy claims for statin therapy. Once members have been identified as having a diagnosis of diabetes that could benefit from statin therapy, the plan faxes the member's provider a letter describing the opportunity to evaluate the member for appropriate treatment. Providers are encouraged to discuss the importance of medication adherence with members. In addition, providers receive a practice-specific report of members who could benefit from a statin regimen.
- Targeted to high-risk, Spanish-speaking members with diabetes discharged from Lawrence General Hospital, UnitedHealthcare has implemented an intervention in which these members who have been prescribed oral diabetes medications receive medication instructions and labels in Spanish. If the member has been prescribed oral diabetic medications, UnitedHealthcare helps him or her obtain medication instructions and labels in Spanish. Clinical care information, including the importance of medication adherence, medication instructions, and possible side effects, is provided in Spanish. A UnitedHealthcare pharmacist engages with local pharmacies on behalf of the member to facilitate the distribution of medications with instructions and labels printed in

Spanish. Nurse care managers distribute educational materials about diabetes and medication management, as appropriate, to this population in Spanish during home visits.

- The 90-Day Conversion Program focuses on providing members with a 90-day supply of oral diabetic medications. UnitedHealthcare identifies members with diabetes who are either non-adherent or at risk of becoming non-adherent. The hypothesis is that the reduced number of trips to the pharmacy and three-month medication supply will contribute to increased adherence. Retail pharmacists have face-to-face or telephonic interactions with targeted members who currently are either non-adherent or at risk of becoming non-adherent and may benefit from a 90-day fill. Many language barriers can be addressed at the pharmacy level as many of the local pharmacies are locally owned and embedded in the community.

Performance Indicator

- UnitedHealthcare is using the CMS measure, *Medication Adherence for Oral Diabetes* (MAD). Its goal is the five-star threshold, 86.01%. Its baseline performance is 84%.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings for 3, 2, or 1 Values	No. of Items	Total Available Points	Points Scored	Rating Averages
B6: Population Analysis and Participant Engagement	3	9	9	100%
B7: Update to PIP Topic and Goals	3	9	9	100%
B8: Progress in Implementing Interventions	5.0	15.0	15.0	100%
B9: Performance Indicator Data Collection	2	6	6	100%
B10: Capacity for Indicator Data Analysis	2	6	6	100%
B11: Performance Indicator Parameters	5	15	15	100%
B12: Baseline Indicator Performance Rates	5	15	15	100%
B13: Conclusions and Planning for Next Cycle	2	6	6	100%
Overall Validation Rating Score	**27**	**81**	**81**	**100%**

Plan & Project Strengths

- UHC has presented a population analysis with a commendable amount of detail and has effectively linked this analysis to its interventions.
- UHC is commended for focusing on the needs of Spanish-speaking members and making information available in Spanish. KEPRO also notes that UHC's plan to share the results of its population analysis with stakeholders is a positive strategy.
- UHC has added gap reports and revisions to other protocols for interface between UHC's Clinical Practice Consultants (CPCs) and providers. UHC is commended for involving its Provider Advisory Committee to give feedback on these protocols.
- UHC has identified a positive strategy for using small tests of change.
- UHC is commended for expanding the number of languages in which the Medication Adherence TIPS sheets will be made available to members.
- UHC is commended for the involvement of its member and provider advisory panels as stakeholders in this PIP.

Opportunities for Improvement

None identified.

Recommendations

None identified.