

MassHealth

Senior Care Organizations External Quality Review Technical Report Calendar Year 2019



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

Contents

Section 1. Executive Summary	
Scope of the External Quality Review Process	6
Performance Measure Validation & Information Systems Capability Assessment.....	6
Performance Improvement Project Validation	7
Section 2. MassHealth Comprehensive Quality Strategy	10
Section 3. MassHealth’s Senior Care Organizations	15
Section 4. Performance Measure Validation & Information Systems Capability Assessment.....	
Performance Measure Validation Methodology	18
Comparative Analysis.....	20
Results	26
Information Systems Capability Assessment.....	28
Plan-Specific Performance Measure Validation and Information System Capability Assessment	30
Boston Medical Center HealthNet Plan (BMCHP)	30
Commonwealth Care Alliance (CCA)	35
Fallon Health.....	40
Senior Whole Health (SWH)	45
Tufts Health Plan (THP).....	50
UnitedHealthcare (UHC)	55
Section 5. Performance Improvement Project Validation.....	
Introduction	61
The Performance Improvement Project Life Cycle	61
Performance Improvement Project Topics	63
Comparative Analysis.....	65
Summary of SCO-Specific Performance Improvement Projects.....	67
Domain 1: Behavioral Health	69
BMC HealthNet Plan: Improving SCO Member Access to Behavioral Health Depression Services	69
Commonwealth Care Alliance: Project REMIND: Recognizing Early Memory Impairment and Needs Assessment for Dementia	73

Fallon Health: Increasing Rates of Follow-Up after Hospitalization for Mental Illness among Fallon Enrollees.....	77
Senior Whole Health: Improving Treatment for Depression	81
Tufts Health Plan: Decrease Readmissions to Inpatient Behavioral Health Facilities by Better Managing Transitions of Care.....	85
UnitedHealthcare: Improving Antidepressant Medication Management (AMM) for Members Diagnosed with Depression	88
Domain 2: Chronic Disease Management Performance Improvement Projects	92
BMC HealthNet Plan: Improving Health Outcomes for SCO Members with Diabetes	92
Commonwealth Care Alliance (CCA): Increasing the rate of annual preventive dental care visits among CCA SCO members.....	97
Fallon Health: Increasing the Rate of Retinal Eye Exams among Diabetic Fallon Enrollees	100
Senior Whole Health: Cardiac Disease Management.....	103
Tufts Health Plan: Reducing the COPD Admission Rate through Identification and Management of COPD and Co-Morbid Depression	107
UnitedHealthcare: Improving SCO Member Adherence to Medication Regimens for Managing Their Diabetes.....	111
Appendix: Contributors.....	114

SECTION 1. 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, the Commonwealth has entered into an agreement with the KEPRO to perform EQR services for 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 (SCOs) in the CY 2019 review cycle:

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

Compliance validation must be conducted by the EQRO on a triennial basis. SCO compliance validation was last conducted in 2017 and will be repeated in 2020.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2019 reflect 2018 quality measurement performance. References to HEDIS® 2019 performance reflect data collected in 2018. Performance Improvement Project reporting is inclusive of activities conducted in CY 2019.

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

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

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 2019, KEPRO conducted Performance Measure Validation in accordance with CMS EQR protocols 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);
- Controlling High Blood Pressure Control (CBP) and
- Use of High-Risk Medications in the Elderly (DAE).

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.

KEPRO determined that all MassHealth SCOs followed specifications and reporting requirements and produced valid measures.

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 late-2017, the plans submitted proposed topics for three-year projects to MassHealth for its review and approval and initiated their implementation in 2018. The plans' work on these projects continued through 2019, the second of the three-year quality cycle.

In Calendar Year 2019, Senior Care Organizations continued the implementation of the following Performance Improvement Projects begun in 2018:

Domain 1: Behavioral Health

- Improving SCO Member Access to Behavioral Health Depression Services (BMCHP);
- Cognitive Impairment and Dementia: Detection and Care Improvement (CCA);
- Increasing Rates of Follow-Up After Hospitalization for Mental Illness Among Fallon Enrollees (Fallon);
- Improving Treatment for Depression (Senior Whole Health);

- Decrease Readmissions to Inpatient Behavioral Health Facilities by Better Managing Transitions of Care (Tufts Health Plan); and
- Improving Antidepressant Medication Management (AMM) for Members Diagnosed with Depression (UnitedHealthcare).

Domain 2: Chronic Disease Management

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

KEPRO evaluates each PIP to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocols. 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 2. MassHealth Comprehensive Quality Strategy



SECTION 2. 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 3. MASSHEALTH SENIOR CARE ORGANIZATIONS



SECTION 3. 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. Its corporate parent is Boston Medical Center Health System, Inc. Its enrollment area includes Barnstable, Bristol, Hampden, Plymouth, and Suffolk counties. As a relatively new SCO, it has not been assigned a Star rating by CMS due to lack of adequate information. Beacon Health Options is BMCHP's behavioral health partner. Additional information is available at www.seniorsgetmore.org.

Commonwealth Care Alliance (CCA)

Commonwealth Care Alliance is a community-based, not-for-profit healthcare organization headquartered in Boston. Beneficiaries throughout Massachusetts can enroll in CCA with the exception of residents of Berkshire, Dukes, and Nantucket counties. CCA will be expanding into Barnstable County in 2020. It received 4 out of 5 possible stars for 2020, according to the U.S. Centers for Medicare & Medicaid Services Star Ratings. More information about CCA is available at www.commonwealthcare.org.

Fallon Health (FH)

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

Senior Whole Health (SWH)

Senior Whole Health's corporate offices are located in Cambridge. It was acquired by its corporate parent, Magellan Complete Care, in 2017. It operates in Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. Its health plan is accredited by the National Committee on Quality Assurance for both Medicaid and Medicare and received a 3.5 Star Rating from CMS. Additional information is available at www.seniorwholehealth.com.

Tufts Health Plan (THP)

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

UnitedHealthcare (UHC)

Headquartered in Waltham, the Senior Care Option plan is part of UHC's Community Plan line of business. Beneficiaries in twelve Massachusetts counties are eligible to enroll. It has received 4.5 CMS Star rating. Its behavioral health partner is OPTUM Health. Additional information is available at www.uhccommunityplan.com.

MassHealth Senior Care Organization Membership

Exhibit 1: MassHealth SCO Membership

Senior Care Organization	Abbreviation Used in this Report	Membership as of December 31, 2018 ¹	Percent of Total SCO Population
UnitedHealthcare	UHC	20,212	34.35%
Senior Whole Health	SWH	15,199	25.83%
Commonwealth Care Alliance	CCA	10,440	17.74%
Fallon Health	Fallon	6,515	11.07%
Tufts Health Plan	THP	5,319	9.04%
BMCHP HealthNet	BMCHP	1,159	1.97%
Total		58,844	100.00%

¹ SCO-reported membership figures

PERFORMANCE MEASURE VALIDATION METHODOLOGY

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 in comparison to national benchmarks, as well as any interventions the plan has in place to improve upon reported rates and health outcomes. KEPRO validates three performance measures annually for SCOs.

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

For 2019 Performance Measure Validation, SCOs submitted the documentation that follows.

Exhibit 2: Documentation Submitted by SCOs

Document Reviewed	Purpose of Review
HEDIS 2019 Roadmap	Reviewed to assess health plan systems and processes related to performance measure production.
2019 HEDIS Final Audit Report	Reviewed to determine if there were any underlying process issues related to HEDIS measure production.
HEDIS 2019 IDSS	Used to compile rates for comparison to prior years' performance and industry standard benchmarks.

Note: HEDIS® 2019 rates reflect the calendar year 2018 measurement period.

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

In order to review the quality of the source data and the PMV measure calculation accuracy, KEPRO reviews the HEDIS Record of Administration, Data Management and Processes (Roadmap), the HEDIS 2019 Final Audit Report, and PMV measure data. KEPRO evaluates whether the plan passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit and if there are any possible reporting risks stemming from the

chart reviews conducted for the PMV hybrid measure under evaluation. Performance is compared to historical rates if the measures have been validated in the past.

Exhibit 3: Performance Measures Validated in 2019

HEDIS Measure Name and Abbreviation	Measure Description
Care for Older Adults (COA) – Advance Care Planning <i>Rationale for Selection:</i> <i>SCO variation in performance</i>	The percentage of members 66 years and older who had advance care planning during the measurement year.
Controlling High Blood Pressure (CBP) <i>Rationale for Selection:</i> <i>SCO variation in performance</i>	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Use of High-Risk Medications in the Elderly (DAE) <i>Rationale for Selection:</i> <i>SCO low performance</i>	The percentage of Medicare members 66 years of age and older who had at least two dispensing events for the same high-risk medication.

COMPARATIVE ANALYSIS

The tables that follow contain the criteria by which performance measures are validated as well as KEPRO's determination as to whether or not the plans met these criteria. Results are presented for both plans reviewed in order to facilitate comparison across plans. In 2019, KEPRO validated three measures that were selected by the Lead Performance Measurement Validation Reviewer. The results of the validation follow

Exhibit 4: 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						
<u>Population</u>						
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
Members were continuously enrolled during the measurement year, with no more than a one-month gap.	Met	Met	Met	Met	Met	Met
<u>Geographic Area</u>						
Includes only those SCO enrollees served in the plan's reporting area.	Met	Met	Met	Met	Met	Met
NUMERATOR – ADVANCE CARE PLANNING						
<u>Counting Clinical Events</u>						
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 advance care planning as documented through either administrative data or medical record review.	Met	Met	Met	Met	Met	Met
<u>Data Quality</u>						
Based on the IS assessment findings, the data sources used were accurate.	Met	Met	Met	Met	Met	Met
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
<u>Proper Exclusion Methodology in Administrative Data</u>						
There are no exclusions for this measure.	n/a	n/a	n/a	n/a	n/a	n/a
<u>Medical Record Review Documentation Standards</u>						
Record abstraction tool treated the numerator accurately.	Met	Met	Met	Met	Met	Met
<u>Hybrid Measure</u>						
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	Met	Met	Met	Met	Met
If the hybrid method was used, the SCO passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit.	Met	Met	Met	Met	Met	Met
SAMPLING						
<u>Unbiased Sample</u>						
As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	Met	Met	Met	Met	Met	Met
<u>Sample Size</u>						
After exclusions, the sample size was equal to 1) 411, 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or 3) the total population.	Met	Met	Met	Met	Met	Met
<u>Proper Substitution Methodology in Medical Record Review</u>						
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors, if applicable.	Met	Met	Met	Met	Met	Met
Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	Met	Met	Met	Met	Met

Performance Measure Validation: Controlling High Blood Pressure (CBP)

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

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
DENOMINATOR						
<u>Population</u>						
SCO population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members 18-85 years of age or older as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Members were continuously enrolled during the measurement year, with no more than a one-month gap.	Met	Met	Met	Met	Met	Met
<p>Members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (count services that occur over both years). Visit type need not be the same for the two visits. Any of the following code combinations meet criteria:</p> <ul style="list-style-type: none"> • Outpatient visit (<u>Outpatient Without UBREV Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). • A telephone visit (<u>Telephone Visits Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). • An online assessment (<u>Online Assessments Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). <p>Only one of the two visits may be a telephone visit, an online assessment or an outpatient telehealth visit. Identify outpatient telehealth visits by the presence of a telehealth modifier (<u>Telehealth Modifier Value Set</u>) or the presence of a telehealth POS code (<u>Telehealth POS Value Set</u>) associated with the outpatient visit.</p>	Met	Met	Met	Met	Met	Met
<u>Geographic Area</u>						
Includes only those SCO enrollees served in the plan's reporting area.	Met	Met	Met	Met	Met	Met

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
NUMERATOR – BLOOD PRESSURE RATE						
<u>Counting Clinical Events</u>						
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, 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 adequately controlled blood pressure as documented through either administrative data or medical record review.	Met	Met	Met	Met	Met	Met
<u>Data Quality</u>						
Based on the IS assessment findings, the data sources used were accurate.	Met	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
<u>Proper Exclusion Methodology in Administrative Data</u>						
<p><i>(Edited for brevity)</i></p> <p>Exclude members who meet any of the following criteria:</p> <ul style="list-style-type: none"> Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: <ul style="list-style-type: none"> Enrolled in an Institutional SNP (I-SNP) any time during the measurement year or Living long-term in an institution any time during the measurement year. Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty and advanced illness. <p>Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (<i>Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set</i>) during the measurement year.</p>	Met	Met	Met	Met	Met	Met

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

Performance Measure Validation: Use of High-Risk Medications in the Elderly (DAE)

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

Review Element	BMCHP	CCA	Fallon	SWH	THP	UHC
DENOMINATOR						
<u>Population</u>						
SCO population was appropriately segregated from other product lines.	Met	Met	Met	Met	Met	Met
Members 18-85 years of age or older as of December 31 of the measurement year.	Met	Met	Met	Met	Met	Met
Members were continuously enrolled during the measurement year, with no more than a one-month gap.	Met	Met	Met	Met	Met	Met
<u>Geographic Area</u>						
Includes only those enrollees served in the SCO's reporting area.	Met	Met	Met	Met	Met	Met
<u>Data Quality</u>						
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	Met	Met	Met	Met	Met
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	Met	Met	Met	Met	Met
<u>Proper Exclusion Methodology in Administrative</u>						
Not Applicable	n/a	n/a	n/a	n/a	n/a	n/a
NUMERATOR						
<u>Administrative Data: Counting Clinical Events</u>						
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	Met	Met	Met	Met	Met
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	Met	Met	Met	Met	Met	Met
Members were counted only once.	Met	Met	Met	Met	Met	Met
Members with two or more dispensing events (any days supply) for the same high-risk medication on different dates of service during the measurement year are numerator compliant.	Met	Met	Met	Met	Met	Met
Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	Met	Met	Met	Met	Met

RESULTS

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 Special Needs Plan (SNP) Public Use File (PUF) 90th percentile rate is included for comparison purposes. The weighted average SCO performance is 82.21%, 16.27 percentage points below the 90th percentile. KEPRO has validated this measure in previous years and the range of performance continues to be wide, i.e., 27.80 percentage points.

Exhibit 5: 2018 COA Advanced Care Planning Rates for all SCOs

2018 Care for Older Adults (COA) - Advanced Care Planning (ACP) by SCO

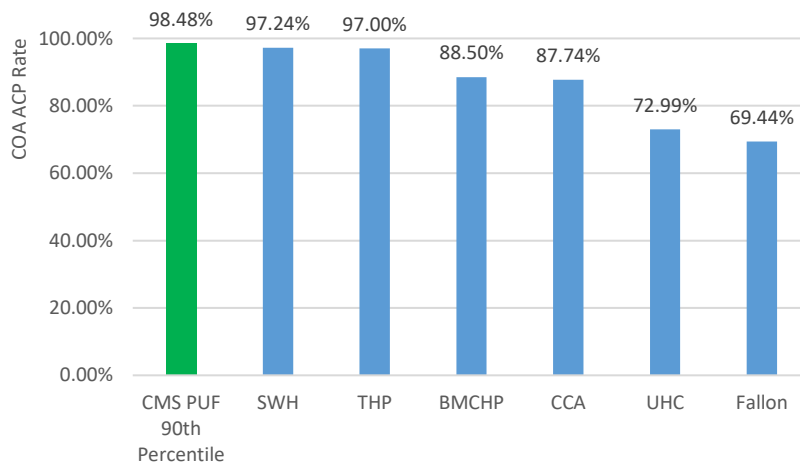
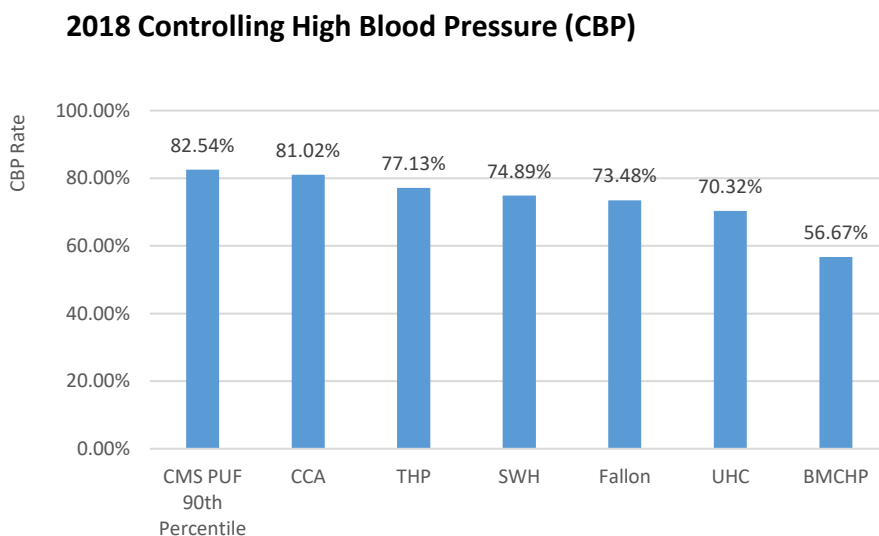


Exhibit 6: Trended COA ACP Data for MassHealth SCOs

		2013	2014	2015	2016	2017	2018	Linear Performance Trend Line
COA ACP	Medicare PUF 90th						98.48%	
	BMCHP	NR	NR	NR	NR	26.02%	88.50%	↑
	CCA	84.72%	90.20%	83.65%	90.42%	94.97%	87.74%	↑
	Fallon	76.74%	79.67%	75.27%	81.47%	68.08%	69.44%	↓
	SWH	47.93%	89.29%	84.88%	99.51%	98.06%	97.24%	↑
	Tufts	NR	44.48%	100%	97.00%	100%	97.00%	↑
	UHC	55.32%	67.99%	62.27%	76.80%	57.42%	72.99%	↑

Controlling High Blood Pressure. The chart and table that follow depict MassHealth's SCO performance in the Controlling High Blood Pressure rate. No plan's performance exceeded the Medicare SNP Public Use File 90th percentile and the range was 24.35 percentage points. The weighted average performance rate was 72.98%, 9.56 percentage points below the 90th percentile. The rate of the highest-performing SCO, CCA, was between the 75th and 90th percentiles. The rate of BMCHP, the lowest-performing SCO, was between the 10th and 25th percentiles.

Exhibit 7: 2018 Controlling High Blood Pressure (CBP) for MassHealth SCOs



Use of High-Risk Medications in the Elderly (DAE)

KEPRO identified that all SCOs performed under the CMS Medicare Public Use File 50th percentile in the measure, Use of High-Risk Medications in the Elderly (DAE), KEPRO chose this measure for validation. Tufts Health Plan was the highest-performing plan with a rate between the 33rd and 50th percentiles. Fallon was the lowest-performing plan with a rate between the fifth and tenth percentiles. The weighted average performance is 15.71%, 9.11 percentage points unfavorably above the CMS Public Use File 90th percentile.

Exhibit 8: 2018 Use of High-Risk Medications in the Elderly (DAE) for MassHealth SCOs

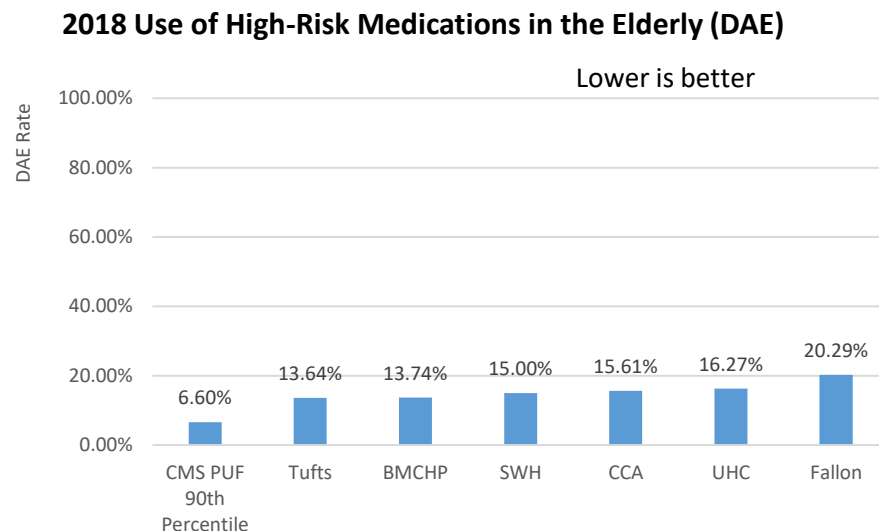
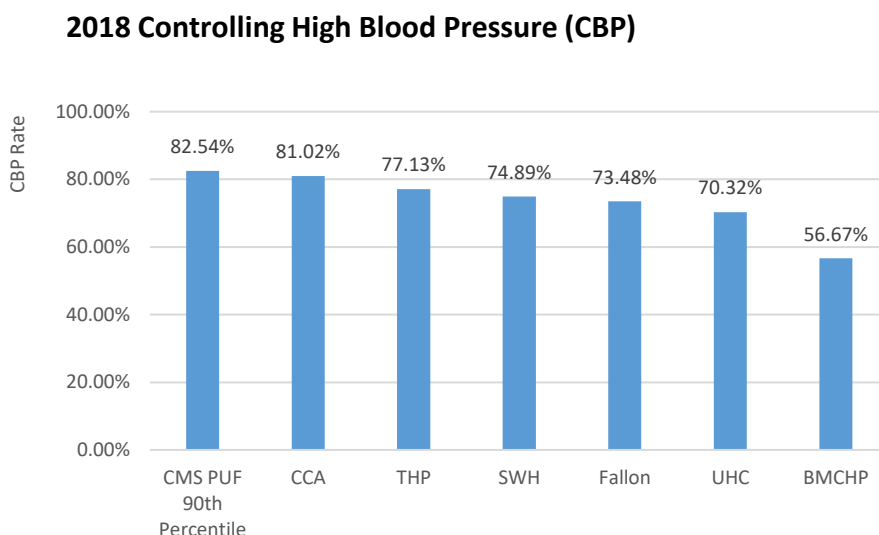


Exhibit 9: 2018 Controlling High Blood Pressure (CBP) for MassHealth SCOs



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. All SCOs'

information systems were found to be compliance with the criteria as described in the table that follows.

Exhibit 10: Information Systems Capability Assessment Findings

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

KEPRO did not identify any issues related to Performance Measure Validation.

PLAN-SPECIFIC PERFORMANCE MEASURE VALIDATION AND INFORMATION SYSTEM CAPABILITY ASSESSMENT

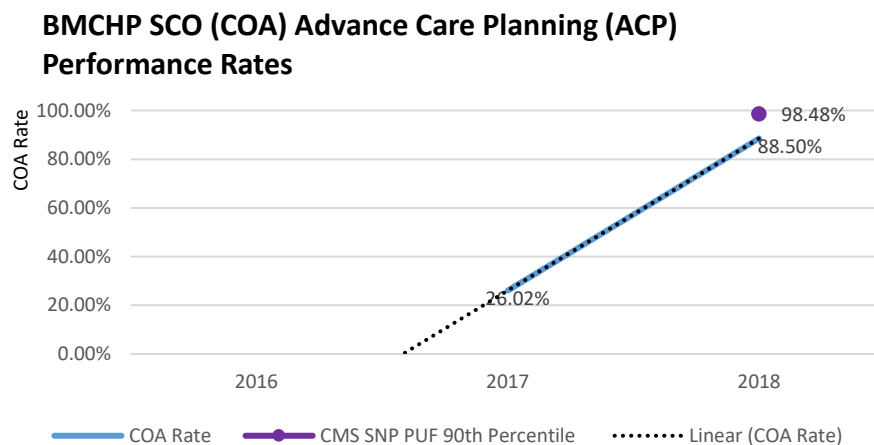
Note: Although the rates for Controlling High Blood Pressure (CBP) and the Use of High-Risk Medications in the Elderly (DAE) were validated in 2019 only, unvalidated historical rates are provided for comparison purposes.

BOSTON MEDICAL CENTER HEALTHNET PLAN (BMCHP)

Performance Measure Results

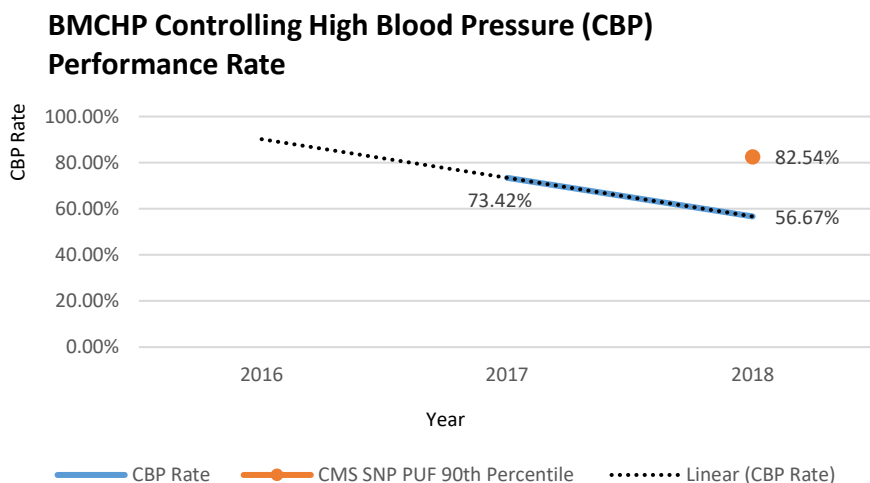
Care for Older Adults (COA) – Advance Care Planning (ACP) – BMCHP’s ACP rate increased a statistically significant 62.48 percentage points between 2017 and 2018. Its 88.50% performance ranks between the 66th and 75th percentiles of the CMS SNP Public Use Files.

Exhibit 11. BMCHP ACP Performance Rates



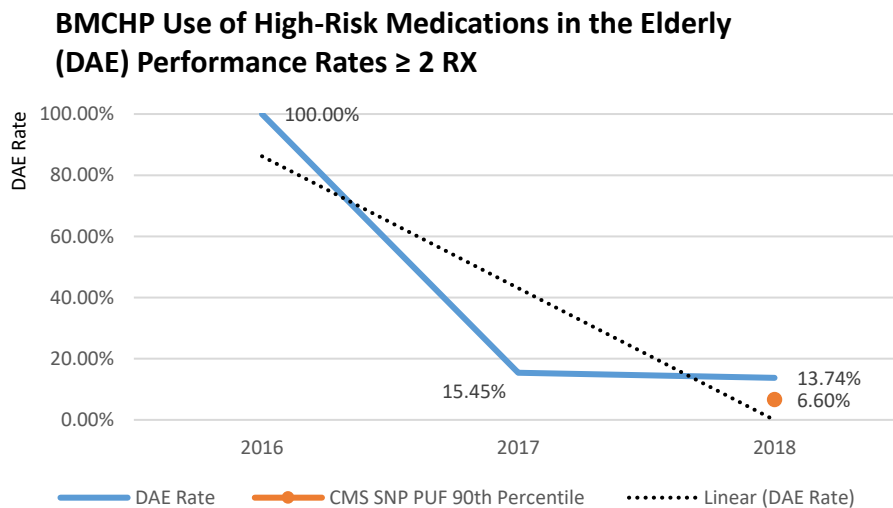
Controlling High Blood Pressure (CBP) – 2019 is the first year in which the Controlling Blood Pressure measure was validated. BMCHP’s 2018 CBP rate was 56.67%. This rate is between the 10th and 25th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 82.54%.

Exhibit 12. BMCHP CBP Performance Rates



Use of High-Risk Medications in the Elderly (DAE) – 2019 is the first year in which the DAE measure was validated. For this measure, a lower rate is better. BMCHP’s 2018 rate of 13.74% is between the 33rd and 50th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 6.60%.

Exhibit 13. BMCHP DAE 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 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. The plan had high rates of both electronic claims submission and auto-adjudication. BMCHP had adequate quality control and monitoring of claims processing. BMCHP received encounters on a weekly basis from both its pharmacy benefit manager, Envision Rx, and its behavioral health vendor, Beacon. The plan maintained adequate oversight of both. There were no issues identified with claims or encounter data processing.
- **Member Enrollment Data.** BMCHP used Facets to process member enrollment data. Facets captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.
- **Medical Record Review.** Medical record review data for COA and CBP were collected using Inovalon's data abstraction tools for hybrid measure abstraction. BMCHP monitored the accuracy of its internal chart abstraction work. 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 it did not affect any of the measures under review. KEPRO recommends that BMCHP use additional supplemental data sources in future reporting years to improve HEDIS rates.
- **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 were investigated. BMCHP maintains adequate oversight of Inovalon. There were no issues identified with data integration processes.
- **Source Code.** BMCHP used NCQA-certified Inovalon HEDIS software to produce performance measures. Inovalon received NCQA measure certification to produce the 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 June 18, 2019.

Exhibit 14: 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.
Medical Record Review	Medical record tools, training materials, medical record process, and quality monitoring met requirements.
Supplemental Data	Supplemental data processes and procedures were adequate and met technical specifications. Supplemental data were only used for lab results and did not affect the three measures under review.
Data Integration	Data integration processes were adequate to support data completeness and performance measure production.

Medical Record Validation

BMCHP passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit. There were no risks to measure reportability originating from chart reviews. Further medical record review accuracy determinations were deemed unnecessary. KEPRO, therefore, did not sample any medical records for the two PMV hybrid measures under evaluation.

Exhibit 15. BMCHP Compliance with NCQA Specifications

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
Care for Older Adults (COA) – Advanced Care Planning	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Controlling High Blood Pressure (CBP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Use of High-Risk Medications in the Elderly (DAE)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.

Strengths:

- BMCHP staff demonstrated a thorough understanding of the HEDIS process.

Opportunities:

- BMCHP's performance in the Controlling High Blood Pressure measure is under the 25th percentile compared to CMS SNP Public Use File benchmark data.
- BMCHP's performance in the Use of High-Risk Medications in the Elderly measure is under the 50th percentile compared to CMS SNP Public Use File benchmark data.

Recommendations:

- Implement quality improvement initiatives for the Controlling High Blood Pressure and Use of High-Risk Medications in the Elderly measures.
- To improve reporting rates, KEPRO recommends the use of supplemental data sources in addition to laboratory data.

Follow Up to Calendar Year 2018 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 2018 follows.

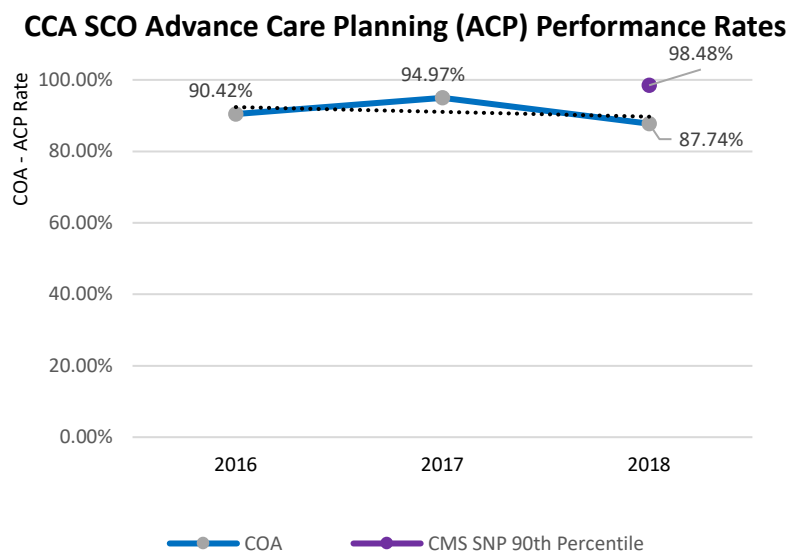
Calendar Year 2018 Recommendations	2019 Update
Focus on quality improvement initiatives for the Advance Care Planning numerator of the Care for Older Adults measure.	BMCHP demonstrated improvement in this measure.

COMMONWEALTH CARE ALLIANCE (CCA)

Performance Measure Results

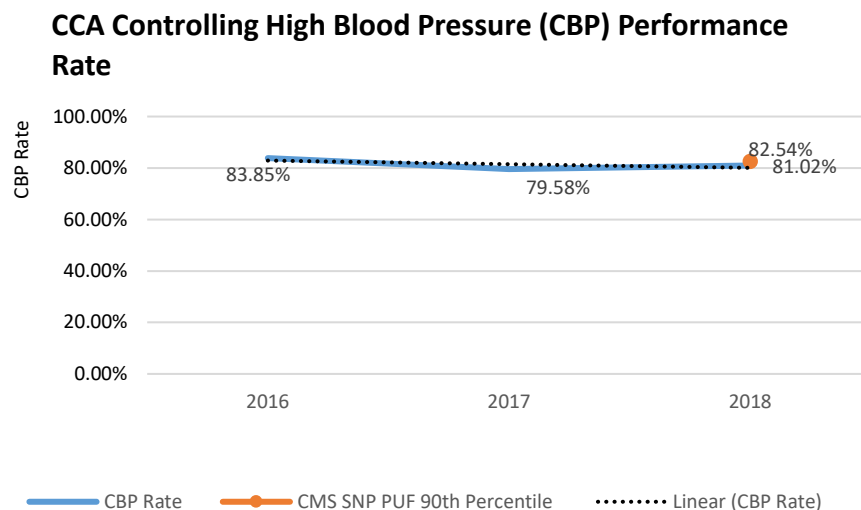
Care for Older Adults (COA), Advance Care Planning — CCA's Advance Care Planning rate decreased 7.23 percentage points, from 94.97% in 2017 to 87.74% in 2018. The plan's performance is between the 66th and 75th percentiles of the CMS SNP Public Use Files. Despite the 2018 decreased rate, CCA's performance is trending favorably up.

Exhibit 16: CCA ACP Performance Rates



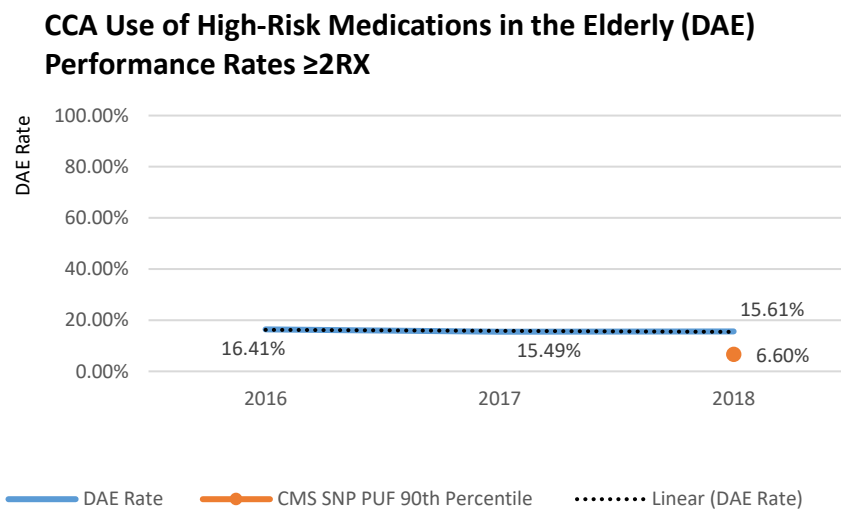
Controlling High Blood Pressure (CBP) – 2019 is the first year in which the Controlling Blood Pressure measure was validated. CCA's 2018 CBP rate was 81.02%. This rate is between the 75th and 90th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 98.48%.

Exhibit 17. CCA CBP Performance Rates



Use of High-Risk Medications in the Elderly (DAE) – 2019 is the first year in which the DAE measure was validated. For this measure, a lower rate is better. CCA's 15.61% rate is between the 10th and 15th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 6.60%.

Exhibit 18. CCA DAE 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 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 were submitted. CCA's pharmacy benefit manager, Navitus Health Solutions, fully met standards in the processing of pharmacy data for the plan. There were no issues identified with claims or encounter data processing.
- **Member Enrollment Data.** CCA enrollment data are housed in the Market Prominence system. All necessary enrollment fields are captured for HEDIS reporting. CCA had adequate processes for data quality monitoring and reconciliation. The plan had processes to combine data for members with more than one member ID. There were no issues identified with enrollment processes.
- **Medical Record Review.** Medical record review data for the COA and CBP hybrid measures 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 the medical record review.
- **Supplemental Data.** CCA successfully used supplemental data for HEDIS reporting. CCA provided complete supplemental data documentation and no concerns were identified.
- **Data Integration.** CCA's performance measures were produced using Inovalon software. Data transfers to the Inovalon repository from source transaction systems were accurate as were file consolidations, derivations, and extracts. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. CCA maintains adequate oversight of Inovalon. There were no issues identified with data integration processes.
- **Source Code.** CCA used NCQA-certified Inovalon HEDIS software to produce performance measures. Inovalon received NCQA measure certification to produce the 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 18, 2019.

Exhibit 19. CCA HEDIS Final Audit Report Results

Audit Element	Findings
Medical Data	CCA met all requirements for timely and accurate claims data capture.
Enrollment Data	Enrollment data processing met all HEDIS standards.
Medical Record Review	Medical record tools, training materials, medical record processes, and quality monitoring met requirements. The plan passed Medical Record Review Validation and the NCQA Final Medical Record Review Over-Read component of the HEDIS® 2018 Compliance Audit. There were no measure reportability risks originating in the chart reviews. Further Medical Record Review accuracy determinations were deemed unnecessary.
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.

Exhibit 20. CCA Compliance with NCQA Specifications

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
Care for Older Adults (COA) – Advanced Care Planning	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Controlling High Blood Pressure (CBP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Use of High-Risk Medications in the Elderly (DAE)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.

Plan Strengths

- CCA used supplemental data for HEDIS reporting.
- CCA has a strong process for reviewing and verifying preliminary and final rates.
- CCA scored above the CMS SNP Public Use File 75th percentile for the measure, Controlling High Blood Pressure.

Opportunities

- CCA's performance on the Use of High-Risk Medications in the Elderly measure is under the 25th percentile of the CMS SNP Public Use File benchmark data.

Recommendations

- Implement quality improvement initiatives to improve the Use of High-Risk Medications in the Elderly rate.

Follow Up to Calendar Year 2018 Recommendations

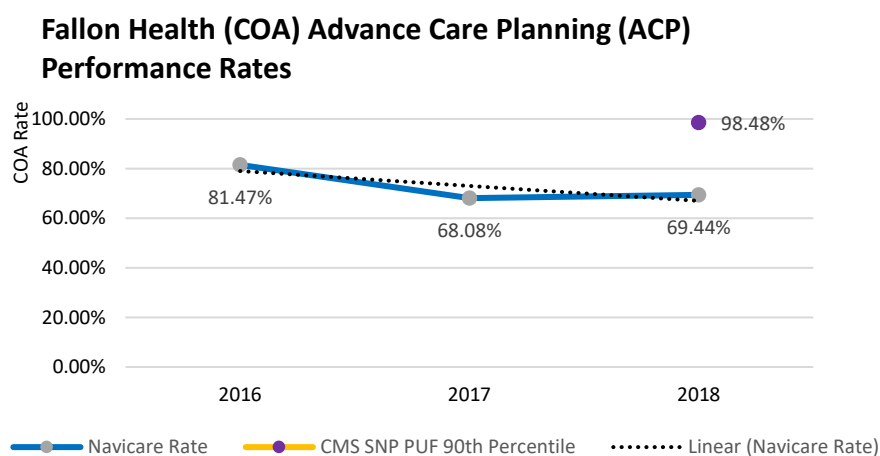
CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. No recommendations, however, were made to CCA in 2018.

FALLON HEALTH

Performance Measure Results

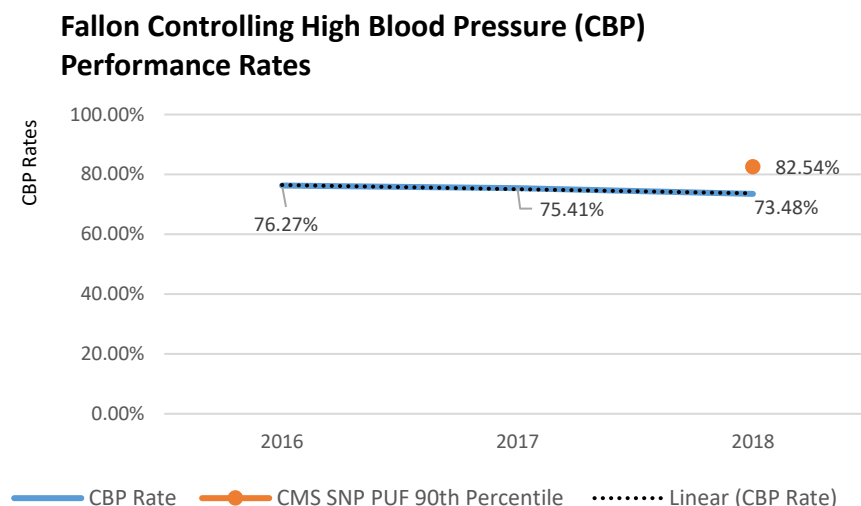
Care for Older Adults (COA), Advance Care Planning — Fallon Health's Advance Care Planning rate increased a statistically insignificant 1.36 percentage points. The 2017 68.08% rate increased to 69.44% in 2018. Performance is trending down. The plan now ranks between the 33rd and 50th percentiles of the CMS SNP Public Use Files.

Exhibit 21: Fallon Health's ACP Performance Rates



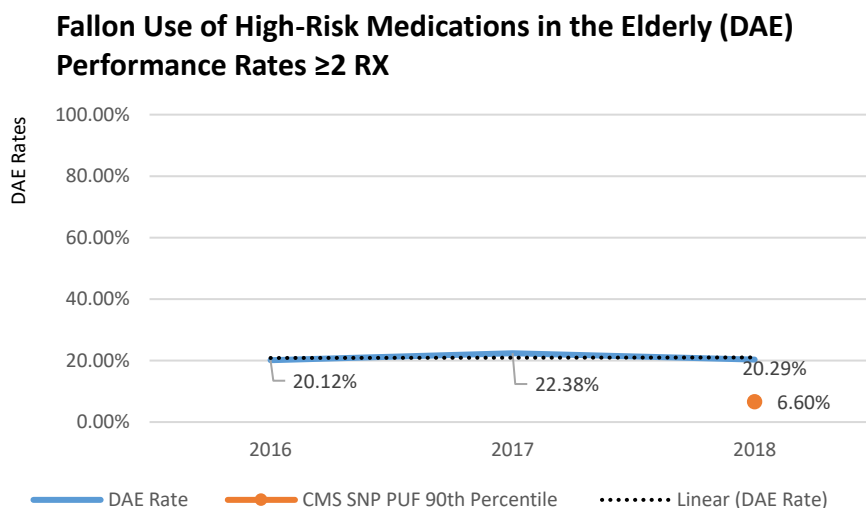
Controlling High Blood Pressure (CBP) – 2019 is the first year in which the Controlling Blood Pressure measure was validated. Fallon's 2018 CBP rate was 73.48%. This rate is between the 50th and 66th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 82.54%.

Exhibit 22. Fallon Health's CBP Performance Rates



Use of High-Risk Medications in the Elderly (DAE) – 2019 is the first year in which the DAE measure was validated. For this measure, a lower rate is better. Fallon's 20.29% rate is between the 5th and 10th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 6.60%.

Exhibit 23. Fallon Health's DAE 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. Fallon had processes in place to closely monitor encounter submission to ensure complete data receipt. Lag reports also demonstrated that claims were submitted in a timely manner. Fallon received encounters on a daily basis from its pharmacy benefit manager, CVS. The plan maintained adequate oversight of CVS. There were no issues identified with claims or encounter data processing. Fallon's behavioral health partner, Beacon Health Options, processed behavioral health claims. Beacon captured all required fields for claims processing and accepted standard codes only on standard claim forms. Fallon had adequate oversight of Beacon.
- **Member Enrollment Data.** Fallon processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. There were adequate data quality monitoring and reconciliation processes, including the ability to combine data for members with more than one member identification number. There were no issues identified with enrollment processes.
- **Medical Record Review.** Fallon conducted medical record review using Cotiviti 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 supplemental data sources for HEDIS 2019 reporting. Fallon provided complete supplemental data documentation. There were no issues with the supplemental data used to produce the HEDIS performance measures.
- **Data Integration.** Fallon performance measures were produced using Cotiviti software. Cotiviti-compliant extracts were produced from the plan's data warehouse. Cotiviti then loaded the data and produced rates for the plan's review and approval. Data transfers to the Cotiviti repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. Cotiviti's repository structure was compliant. HEDIS measure report production was managed effectively. The Cotiviti software was compliant with development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. Fallon maintained adequate oversight of its vendor, Cotiviti. There were no issues identified with data integration processes.

- **Source Code.** Fallon used NCQA-certified Cotiviti HEDIS software to produce performance measures. 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, the results of which were distributed on June 17, 2019.

Exhibit 24. Fallon Health's HEDIS Final Audit Results

Audit Element	Findings
Medical data	Fallon met all requirements for timely and accurate claims data capture.
Enrollment data	Enrollment data processing met all HEDIS standards.
Medical record review	Medical record tools, training materials, medical record processes, and quality monitoring met requirements. Fallon passed the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit. There were no reportability risks stemming from the chart reviews. Further medical record review accuracy determinations were deemed unnecessary.
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.

Exhibit 25. Fallon Health's Compliance with NCQA Specifications

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
Care for Older Adults (COA) – Advanced Care Planning	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Controlling High Blood Pressure (CBP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Use of High-Risk Medications in the Elderly (DAE)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.

Follow Up to Calendar Year 2018 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. No recommendations, however, were made to Fallon in 2018.

Plan Strengths

- Fallon staff have excellent understanding of HEDIS processes.
- Fallon used supplemental data for HEDIS reporting.

Opportunities

- Fallon's performance on the Use of High-Risk Medications in the Elderly measure is under the 10th percentile compared to the CMS SNP Public Use File benchmark data.
- Fallon scored below the CMS SNP Public Use Files 50th percentile on the Advance Care Planning rate.

Recommendations

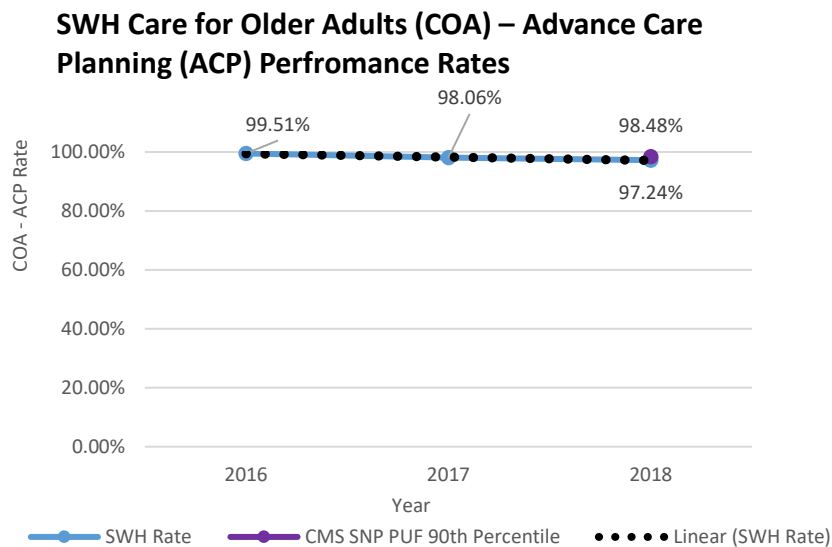
- Implement quality improvement initiatives to improve performance on the Use of High-Risk Medications in the Elderly rate.
- Implement quality improvement initiatives to improve performance on the Advance Care Planning rate.

SENIOR WHOLE HEALTH (SWH)

Performance Measure Results

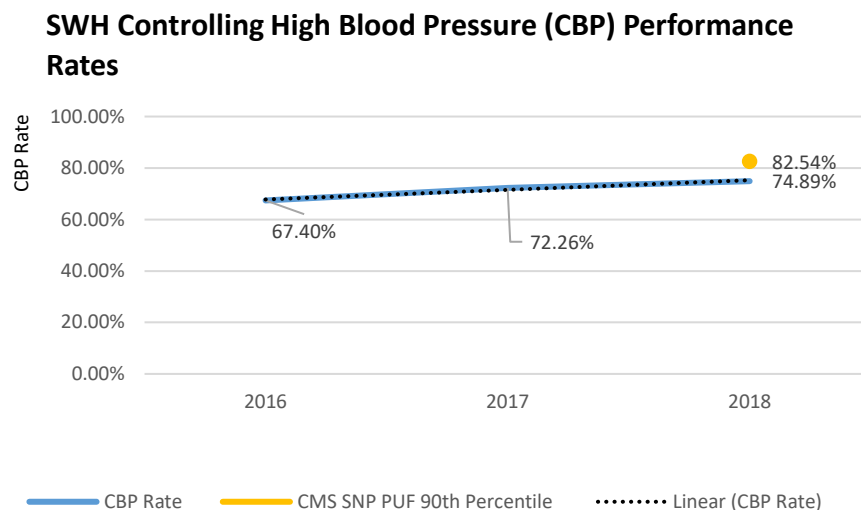
Care for Older Adults (COA), Advance Care Planning (ACP) — Senior Whole Health's ACP rate decreased a statistically insignificant 0.82 percentage points, from 98.06% in 2017 to 97.24% in 2018. The plan ranks between the 75th and 90th percentiles of the CMS SNP Public Use Files. Performance continues to trend favorably up.

Exhibit 26: SWH COA Performance Rates



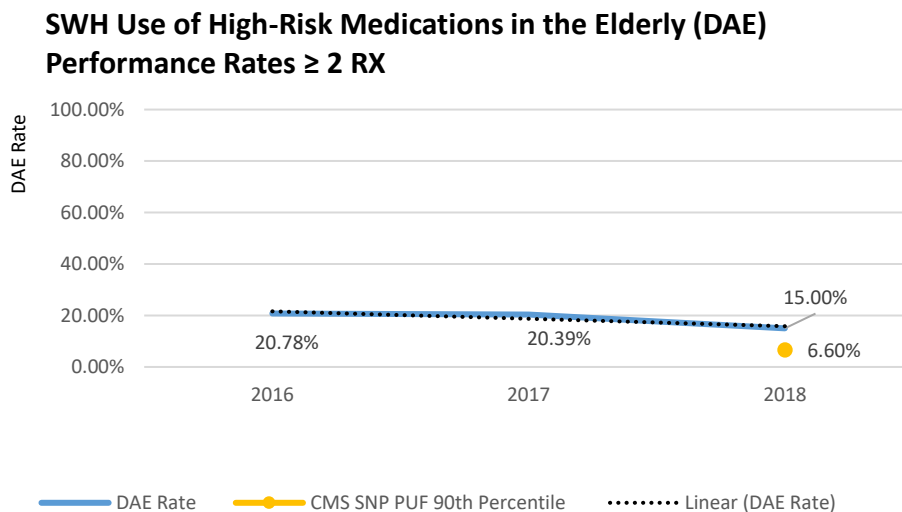
Controlling High Blood Pressure (CBP) – 2019 is the first year in which the Controlling Blood Pressure measure was validated. Senior Whole Health's 2018 CBP rate was 74.89%. This rate is between the 66th and 75th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 82.54%.

Exhibit 27. SWH's CBP Performance Rates



Use of High-Risk Medications in the Elderly (DAE) – 2019 is the first year in which the DAE measure was validated. For this measure, a lower rate is better. SWH's 15.00% rate is between the 25th and 33rd percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 6.60%.

Exhibit 28. SWH's DAE 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. All necessary fields were captured for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. SWH had adequate processes to monitor claims data quality and completeness. Pharmacy encounters containing standard codes were received on a weekly basis from the plan's pharmacy benefits manager, Express Scripts. There were no issues identified with claims or encounter data processing. SWH's behavioral health partner, Beacon Health Options, processed behavioral health claims. Beacon Health Options captured all required fields for claims processing and accepted standard codes on standard claim forms only. SWH had adequate oversight of Express Scripts and Beacon Health Options.
- **Member Enrollment Data.** SWH processed enrollment data using the QNXT system. All necessary enrollment fields were captured for HEDIS reporting. SWH had adequate processes to ensure enrollment data quality, including regular reconciliations with both MassHealth and CMS. SWH had procedures to prevent members from being entered under more than one identification number. There were no issues identified with enrollment processes.
- **Medical Record Review.** Medical record review data for the COA and CBP hybrid measures were collected by Health Data Vision (HDVI). HDVI's training materials and HEDIS processes were compliant with HEDIS technical specifications. No issues were identified with the medical record review.
- **Supplemental Data.** SWH successfully used both standard and nonstandard supplemental data sources for HEDIS 2019 reporting. There were no issues with the supplemental data used to produce performance measures.
- **Data Integration.** SWH's performance measures were produced using DST software. The plan's ODS data warehouse is updated nightly with data from the transactions system. Data were extracted from the ODS data warehouse and loaded into DST's CareAnalyzer. SWH had adequate processes for ensuring data completeness and referential integrity at each transfer point. Preliminary rates were reviewed and any variances investigated. There were no issues identified with data integration processes. 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. SWH maintains adequate oversight of this vendor. There were no issues identified with data integration processes.
- **Source Code.** SWH used NCQA-certified DST HEDIS software to produce performance measures. DST received NCQA measure certification to produce the performance measures under the scope of this review. There were no source code issues identified.

Based on the Information Systems Capability 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 June 24, 2019:

Exhibit 29. SWH HEDIS Final Audit Report Findings

Audit Element	Findings
Medical Data	SWH met all requirements for timely and accurate claims data capture.
Enrollment Data	Enrollment data processing met all HEDIS standards.
Medical Record Review	Medical record tools, training materials, medical record processes, and quality monitoring met requirements. There were no measure reportability risks stemming from the chart reviews. Further medical record review accuracy determinations were deemed unnecessary.
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.

Exhibit 30. SWH Compliance with NCQA Specifications

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
Care for Older Adults (COA) – Advanced Care Planning	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Controlling High Blood Pressure (CBP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Use of High-Risk Medications in the Elderly (DAE)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.

Follow Up to Calendar Year 2018 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. No recommendations, however, were made to SWH in 2018.

Strengths:

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

Opportunities:

- The Use of High-Risk Medications in the Elderly measure is under the 33rd percentile compared to CMS SNP Public Use File benchmark data.

Recommendations:

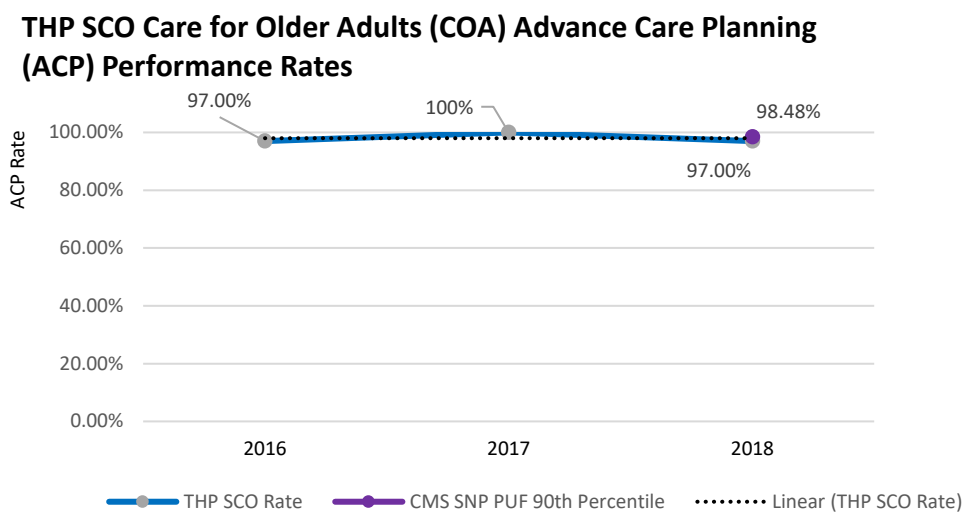
- Implement quality improvement initiatives to improve Use of High-Risk Medications in the Elderly rates.

TUFTS HEALTH PLAN (THP)

Performance Measure Results

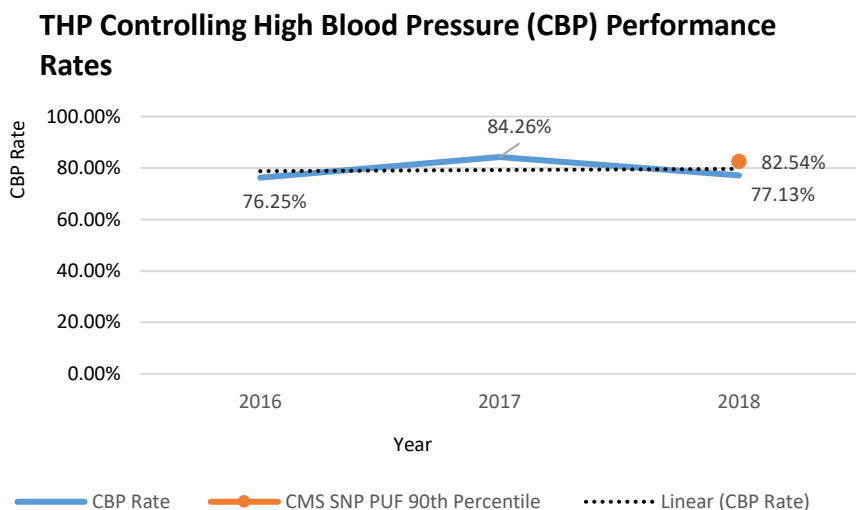
Care for Older Adults (COA), Advance Care Planning — Tufts' Advance Care Planning rate decreased a statistically significant 3.0 percentage points. The 2017 rate of 100% returned to its 2016 levels of 97% in 2018. This performance is between the CMS SNP Public Use File 75th and 90th percentiles.

Exhibit 31: THP COA ACP Performance Rates



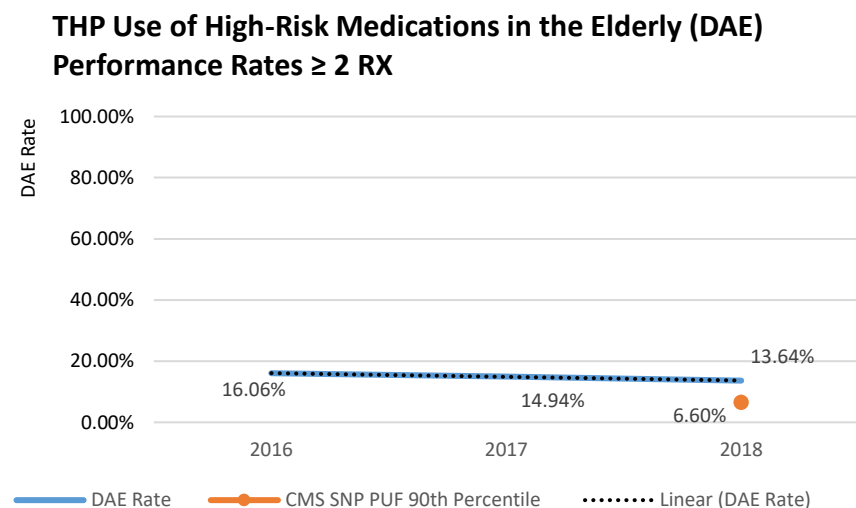
Controlling High Blood Pressure (CBP) – 2019 is the first year in which the Controlling Blood Pressure measure was validated. Tufts Health Plan's 2018 CBP rate was 77.13%. This rate is between the 75th and 90th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 82.54%.

Exhibit 32. Tufts' CBP Performance Rates



Use of High-Risk Medications in the Elderly (DAE) – 2019 is the first year in which the DAE measure was validated. For this measure, a lower rate is better. Tufts' 13.64% rate is between the 33rd and 50th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 6.60%.

Exhibit 33. Tufts' DAE Performance Rates



Information Systems Capability Assessment

- **Claims and Encounter Data.** THP processed claims using the Diamond system. Most claims were submitted electronically to THP and there were adequate monitoring processes in place, including daily electronic submission summary reports, to identify issues. THP had robust claim editing and coding review processes. THP processed all claims within Diamond except for pharmacy claims, which were handled by THP's pharmacy benefit manager, CVS Health. Pharmacy claims data were received on a regular basis from the pharmacy vendor and there were adequate processes in place to monitor pharmacy encounter volume by month. There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.
- **Member Enrollment Data.** THP used Market Prominence and Diamond to process the enrollment data. Both systems captured all necessary enrollment fields for HEDIS reporting. There were no issues identified with enrollment processes.
- **Medical Record Review.** THP used internally-developed abstraction tools and training manuals for the hybrid measures. THP's abstraction tools and training manual were compliant with HEDIS technical specifications. THP had processes in place for medical record abstraction activities and demonstrated adequate processes for inter-rater reliability and ongoing quality monitoring throughout the medical record review process. No issues were identified with the medical record review process.
- **Supplemental Data.** THP used multiple standard and non-standard supplemental databases for HEDIS reporting. No concerns were identified with any of the supplemental data sources. The supplemental data sources were approved for HEDIS reporting.
- **Data Integration.** All performance measure rates were produced internally by THP using internally-developed source code. Data from the transaction system were loaded into THP's data warehouse, Red Brick, which 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 an internally developed source code. The source code was compliant with 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 June 21, 2019:

Exhibit 34. Tufts' HEDIS Final Audit Report Findings

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 and the NCQA Final Medical Record Review Over-Read component of the HEDIS 2019 Compliance Audit. Further medical record review accuracy determinations were deemed unnecessary.
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.

Exhibit 35. Tufts' Compliance with NCQA Specifications

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
Care for Older Adults (COA) – Advanced Care Planning	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Controlling High Blood Pressure (CBP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Use of High-Risk Medications in the Elderly (DAE)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.

Follow Up to Calendar Year 2018 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. KEPRO, however, offered no recommendations to Tufts Health Plan in 2018.

Plan Strengths

- THP used supplemental data for HEDIS reporting.
- THP scored above the CMS SNP Public Use File 75th percentile for the Advance Care Planning rate for the measure, Care for Older Adults.
- THP scored above the CMS SNP Public Use File 75th percentile for the measure, Controlling High Blood Pressure.

Opportunities

- THP's performance on the measure, Use of High-Risk Medications in the Elderly, is under the 50th percentile compared to CMS SNP Public Use File benchmark data.

Recommendations

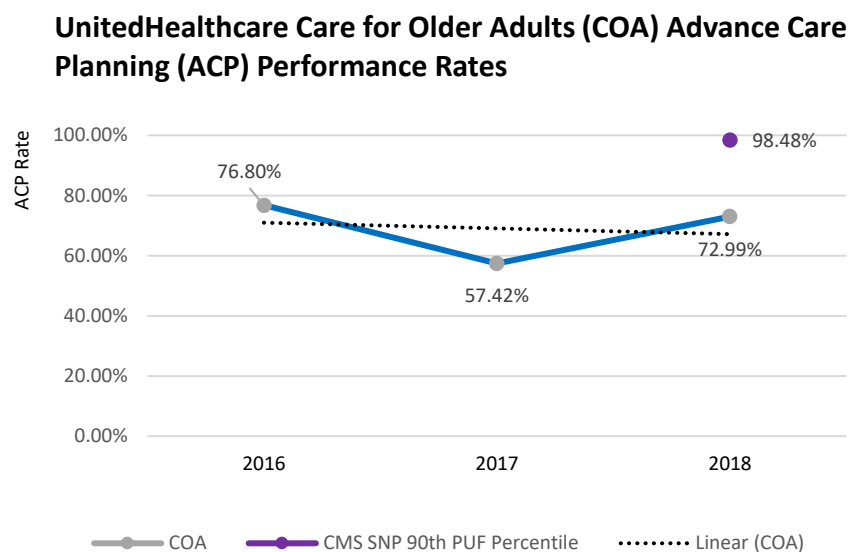
- Implement quality improvement initiatives to improvement performance in Use of High-Risk Medications in the Elderly rates.

UNITEDHEALTHCARE (UHC)

Performance Measure Results

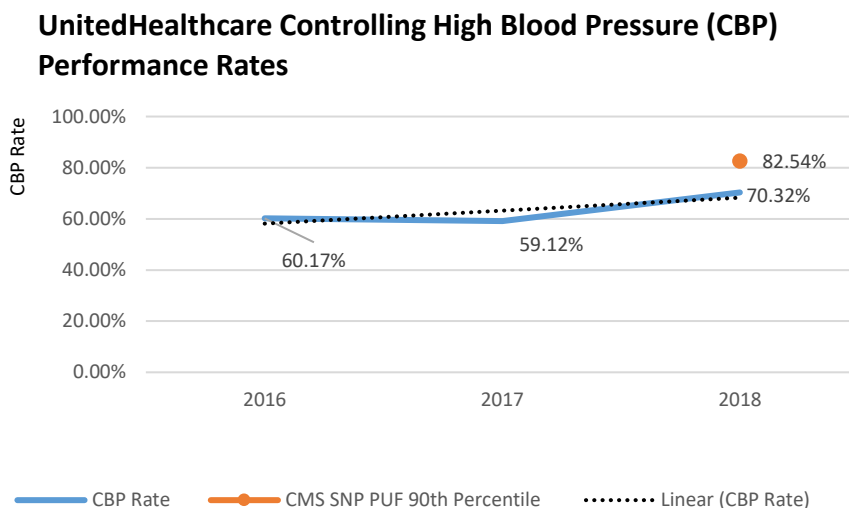
Care for Older Adults (COA), Advance Care Planning — UnitedHealthcare experienced a statistically significant increase of 15.57 percentage points between 2017 (57.42%) and 2018 (72.99%). The plan's performance ranks between the 50th and 66th percentiles of the Medicare Public Use File. Performance is trending favorably up.

Exhibit 40: UnitedHealthcare's COA ACP Performance Rates



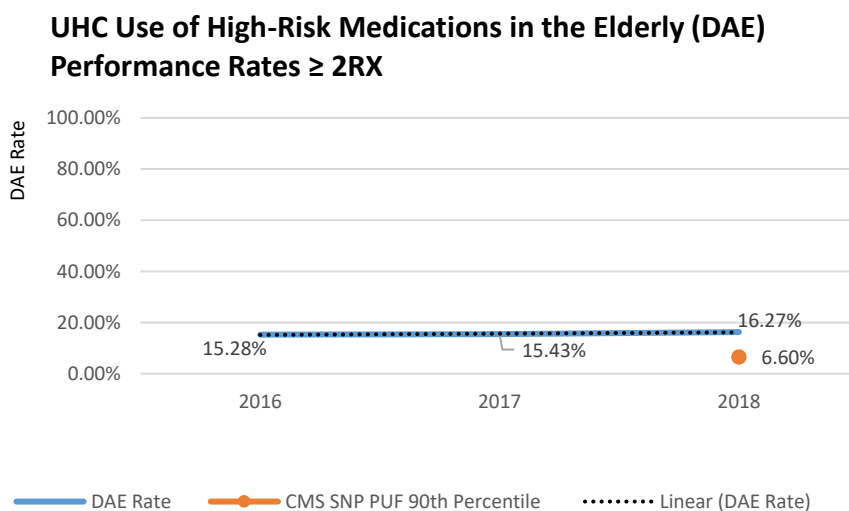
Controlling High Blood Pressure (CBP) – 2019 is the first year in which the Controlling Blood Pressure measure was validated. UHC's 2018 CBP rate was 70.32%. This rate is between the 50th and 75th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 82.54%.

Exhibit 41. UnitedHealthcare's CBP Performance Rates



Use of High-Risk Medications in the Elderly (DAE) – 2019 is the first year in which the DAE measure was validated. For this measure, a lower rate is better. UHC's 16.27% rate is between the 10th and 25th percentiles of the CMS SNP Public Use Files, the 90th percentile of which is 6.60%.

Exhibit 43. UnitedHealthcare's DAE 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 accepted standard codes only. There was no need for mapping or review of non-standard or internally developed codes. UHC processed claims timely and there was no backlog. Most claims were submitted to UHC electronically through a clearinghouse. There were adequate monitoring processes in place, including batch counts and receipts. UHC had adequate claims editing and coding review processes. UHC used OptumBehavioralHealth as its vendor to handle the processing of behavioral health claims. OptumBehavioralHealth captured all required fields for claims processing and accepted only standard codes on standard claim forms. UHC had adequate oversight of OptumBehavioralHealth including 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.

- **Member 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.** Medical record review data for the COA and CBP hybrid measures were collected using Change HealthCare's data abstraction tools and training materials. Change HealthCare's tools and training manual was compliant with the HEDIS technical specifications. UHC monitored results from Change HealthCare related to inter-rater reliability testing and conducted its own inter-rater reliability testing of the vendor. These processes demonstrated adequate vendor oversight and ongoing quality monitoring throughout the medical record review process. No issues were identified with 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.
- **Data Integration.** UHC's performance measures were produced using Inovalon software. UHC had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. There were no issues identified with data integration processes. Data transfers to the Inovalon repository from source transaction systems were accurate. File consolidations, derivations, and extracts were accurate. Inovalon's repository structure was compliant. HEDIS measure report production was managed effectively. The Inovalon software was compliant with regard to development, methodology, documentation, revision control, and testing. Preliminary rates were reviewed and any variances investigated. UHC

maintains adequate oversight of its vendor, Inovalon. There were no issues identified with data integration processes.

- **Source Code.** UHC used NCQA-certified Inovalon HEDIS software to produce performance measures. 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 15, 2019:

Exhibit 44. UnitedHealthcare HEDIS Final Audit Report Results

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

Exhibit 45. Compliance with NCQA Specifications

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
Care for Older Adults (COA) – Advanced Care Planning	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Controlling High Blood Pressure (CBP)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.
Use of High-Risk Medications in the Elderly (DAE)	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid.

Plan Strengths:

- UHC used supplemental data for HEDIS reporting.
- UHC demonstrated strong local organizational accountability for SCO population performance.

Opportunities:

- The Use of High-Risk Medications in the Elderly measure is under the 25th percentile compared to the CMS SNP HEDIS Public Use File benchmark data.

Recommendations:

- Implement quality improvement initiatives to increase the Use of High-Risk Medications in the Elderly rate.

Follow Up to Calendar Year 2018 Recommendations

CMS requires that EQROs follow up on the status of recommendations made in the prior reporting year. An update on Calendar Year 2018 PMV recommendation follows:

Calendar Year 2018 Recommendation	2019 Update
Focus on quality improvement initiatives for the Advance Care Planning numerator of the Care for Older Adults measure.	UHC's ACP performance increased a statistically significant 15.57 percentage points in the ACP measure.

SECTION 5. PERFORMANCE IMPROVEMENT PROJECT VALIDATION



INTRODUCTION

THE PERFORMANCE IMPROVEMENT PROJECT LIFE CYCLE

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

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

Baseline/Initial Implementation Period: Calendar Year 2018

Planning Phase: January - March 2018

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

Initial Implementation: March 2018 - December 2018

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

Mid-cycle Implementation Period: Calendar Year 2019

Mid-Cycle Progress Reports: March 2019

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

Mid-Cycle Annual Report: September 2019

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

Final Implementation Period: Calendar Year 2020

Final Implementation Progress Reports: March 2020

SCOs 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.

Each of these reports is reviewed by KEPRO. The 2019 Progress and Annual 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.* Plans submit a completed reporting questionnaire for each PIP. This questionnaire is stage-specific. In 2019, plans submitted questionnaires for the Mid-Cycle Progress and the Mid-Cycle Annual Reports. The Progress Report asks SCOs to provide a barrier analysis and associated mitigation strategies; project goals; intervention status including the results of small tests of change and future direction; a description of stakeholder involvement; and proposed performance indicators. The Annual Report asks for a description and rationale for any changes made to the topic, method, goals, interventions, and cultural competence strategies; an updated population analysis; intervention updates; planned changes; and the Remeasurement of selected performance indicators.
- 2) *Desktop Review.* A desktop review is conducted for each PIP. The Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plan. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the project. The Medical Director's focus is on clinical 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 points received by the sum of all available points. The Medical Director documents his or her findings, and in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report.

PERFORMANCE IMPROVEMENT PROJECT TOPICS

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

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

In Calendar Year 2019, Senior Care Organizations continued work on the following Performance Improvement Projects (PIPs):

Domain 1: Behavioral Health

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

Domain 2: Chronic Disease Management

- Improving Health Outcomes for SCO Members with Diabetes (BMCHP)
- Increasing the Rate of Annual Preventive Dental Care Visits among CCA Senior Care Options Members (CCA)
- Increasing the Rate of Retinal Eye Exams among Diabetic Fallon Enrollees (Fallon Health)
- Cardiac Disease Management (Senior Whole Health)

- Reducing the COPD Admission Rate through Identification and Management of COPD and Co-Morbid Depression (Tufts Health Plan)
- Improving SCO Member Adherence to Medication Regimens for Managing Their Diabetes (UnitedHealthcare)

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

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

COMPARATIVE ANALYSIS

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

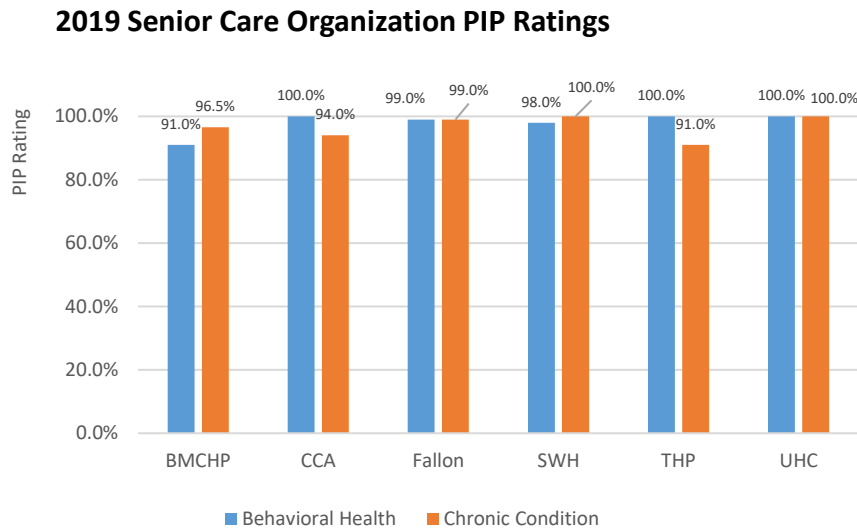
The chart that follows depicts SCO average performance on the components of the PIP Mid-Cycle Annual Report:

Exhibit 46: Average PIP Score by Rating Component

Rating Component	Behavioral Health PIPs	Chronic Disease Management PIPs
Updates to Project Topic and Scope	100%	100%
Population Analysis Update	97%	95%
Assessing Intervention Outcomes	87%	94%
Performance Indicator Data Collection	100%	100%
Capacity for Indicator Data Analysis	99%	100%
Performance Indicator Parameters	99%	100%
Remeasurement Performance Indicator Rates	100%	100%
Conclusions and Planning for Next Measurement Cycle	91%	100%

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

Exhibit 47: PIP Ratings by SCO and Domain



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

Exhibit 48: Interventions by Domain

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

SUMMARY OF SCO-SPECIFIC PERFORMANCE IMPROVEMENT PROJECTS

Summaries of SCO performance improvement projects follow. The section below is intended to provide the reader with a reference for how the project description content was derived.

Project Title	The project title is assigned by the managed care plan.
Rationale for Project Selection	In their project proposals, managed care plans are required to provide a rationale for the project's selection. The language in this section is extracted from the project proposal submitted by the plan to MassHealth in November 2018.
Project Goals	Managed care plans articulated project goals in the Planning Report and in the Initial Implementation Report. To eliminate the possibility of misinterpretation, KEPRO has provided these goals exactly as stated by the managed care plan. SCOs first reported on this project in 2018. Updates from the 2018 are noted accordingly.
Performance Indicators	This section identifies the performance indicators by which the managed care plan intends to evaluate the success of the performance improvement project. Baseline (2018) performance is provided as is the plan's goal for the 2019 remeasurement period. SCOs first reported on this project in 2018. Updates from the 2018 are noted accordingly.
Interventions	<p>Here, KEPRO summarizes at a high level the interventions the plan has or plans to implement to achieve its goals. SCOs first reported on this project in 2018. Updates from the 2018 are noted accordingly.</p> <p>Plan interventions are often complex, multi-layered initiatives with many moving parts. Space limitations preclude providing detailed, comprehensive descriptions of each intervention.</p>
Performance Improvement Project Evaluation	KEPRO evaluates projects against a set of pre-determined criteria that speak to the strength of the interventions as well as the overall project design. Elements of project design include, but are not limited to, the size of the affected population; analyses of the member population and barriers; barrier mitigation strategies; and intervention effectiveness. These criteria are summarized in the first column of the accompanying table. The managed care plan's success at meeting the criteria are summarized in the 2019 final rating score.

Plan and Project
Strengths

In this section, KEPRO recognizes the managed care plan's efforts as they relate to project design. It also recognizes organizational structures that contribute to the overall quality improvement process.

Recommendations
and Opportunities
for Improvement

In this section, KEPRO offers suggestions for improving the design of the quality improvement project including both intervention design and the overall construct of the project.

DOMAIN 1: BEHAVIORAL HEALTH

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

Rationale for Project Selection

“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 under-reporting of depression in the SCO membership.”

2019 Update: As of October 1, 2019, BMCHP staff assumed responsibility for this project’s management, quality improvement, reports, data analytics, and demographic data. Beacon Health Options, BMCHP’s behavioral health vendor, will conduct the care management, provider education, and data analytics.

Project Goals

Member-Focused

- Improve the number of completed PHQ-2 questionnaires;
- Increase the number of referrals to Beacon Health Options care management;
- Increase 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; and
- 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; and
- 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 administers the PHQ-2 questionnaire to each SCO member. If the member’s score is ≥ 3 , the member is referred to Beacon, who administers the PHQ-9. If the member’s score is ≥ 10 , the member will be referred to the indicated level of care.

2019 Update: BMCHP reported a change in approach on obtaining member feedback. Originally, the plan was to use Beacon Case Managers to complete the outreach for feedback about its own performance. To eliminate potential bias, BMCHP is now using its Consumer Advisory Council to gather feedback. BMCHP has reported that, as a result of an updated population analysis, it has identified male members as being more difficult to engage. It plans to conduct a gap analysis to determine if the behavioral health network is culturally aligned with members in this sub-population. A need to increase the number of patients screened by the PHQ-2 has been prioritized in order to initiate the cascade of activities that follow a positive screen. BMCHP has reported that the delayed implementation of the interventions has affected its ability to assess whether interventions had an effect on the performance indicators.

- Beacon will provide provider education by means of an email blast and a webinar.

2019 Update: Beacon Health Options presented a webinar on Geriatric Depression in early-2019. Supplemental written materials were also offered to attendees. A pre- and post-test was administered to the providers in attendance. A qualitative survey was administered thirty days after the training.

Performance Indicators

1. *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 2017 baseline performance was 5.10%.
 - Its performance in the 2018 remeasurement period was 5.09%, essentially unchanged from baseline. Its goal was 10.0%, which it did not meet.
2. *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.
 - BMCHP's 2017 baseline performance was 12.79%.
 - Its performance in the 2018 remeasurement period was 40.28%. This rate represents a statistically significant increase of 214.90% ($p < 0.005$).
3. *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. Baseline and Remeasurement data are not yet available.

Performance Improvement Project Evaluation

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

on this Performance Improvement Project.

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	5	83%
Assessing Intervention Outcomes	4.0	12.0	8.0	67%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	4	12	11	92%
Performance Indicator Parameters	5.0	15.0	14.3	96%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Planning for Next Measurement Cycle	3	9	8	89%
Overall Validation Rating Score	27	84	76.3	91%

Plan & Project Strengths

- BMCHP and Beacon Health Options are commended for convening a discussion of the treatment of elderly members with depression with a panel of behavioral health providers.

Opportunities for Improvement

- KEPRO recommends further detailing the clinical characteristics of this population to better inform the activities associated with this project.
- BMCHP's case management system does not capture reportable PHQ-2 results. The ensuing manual process requires a much-needed resource. KEPRO recommends that resolution of this issue be prioritized in order to adequately understand baseline results for this intervention.
- KEPRO recommends that BMCHP find ways to amend workflows for providers to increase PHQ-2 testing and appropriate follow up for positive screens occurs.

Update on 2018 Recommendations

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

2018 Recommendation	2019 Update
KEPRO suggested that BMCHP consider supplementing provider education with practice- and member-specific gap reports that give providers real-time data about their rates of assessment and depression treatment.	BMCHP does not speak to this recommendation in its submission.
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.	BMCHP does not speak to this recommendation in its submission.

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

Rationale for Project Selection

“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; and
- 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; and
- Improve/increase the development and implementation of a robust care plan for those members identified with dementia or less severe but impactful cognitive impairment.

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.

2019 Update: CCA SCO describes tracking the percentage of eligible members screened with the Mini-Cog tool for cognitive impairment through the CCA Care Management System or manual Case Management Database. The testing is conducted by a CCA Care Partner or Behavioral Health Service provider. The initial implementation of this Mini-Cog screening shows that nearly half of members with no prior diagnosis of dementia are reporting

positive screens. CCA is planning to expand the implementation of the brief screening to the entire population of eligible members.

- A related intervention is the cognitive assessment of members screening positive for cognitive impairment by CCA behavioral health clinicians or advanced practice clinicians.

2019 Update: Of those members who had comprehensive evaluations as a follow-up to a positive Mini-Cog screen, all scored positive for cognitive impairment, although there were wide variances in the severity of the impairment. All members testing positive were further evaluated by clinicians and were reviewed by CCA's inter-disciplinary teams.

- 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.

2019 Update: Due to significant resource constraints, CCA narrowed the focus of Project: REMIND to the early detection of cognitive impairment. The care-planning intervention originally planned was excluded from the scope of this project.

Performance Indicators

1. *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 2017 baseline rate was 1.70%. Its goal for the 2019 remeasurement period was 35%.
 - Its rate for the 2018 remeasurement period was 8.10%, which reflects a statistically significant increase of 377.05% ($p < 0.005$).
2. *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 2017 baseline rate was 0%.
 - Its rate for the 2018 remeasurement period was 96%. This performance exceeded the 80% goal.

Performance Improvement Project Evaluation

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

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

Project & Plan Strengths

- CCA is commended for its efforts to ensure that the activities of this PIP result in culturally competent screenings.
- The screening protocol is identifying members not previously screened and who are at identified as being at risk of greater impairment. CCA is commended for its positive work and commitment to this important project.
- This PIP has many strengths and its primary challenge is the lack of care management resources to fully implement the screening protocols across the entire CCA member population.

Recommendations & Opportunities for Improvement

- KEPRO recommends that CCA's PIP leadership team use the early findings from this project to create a high-level presentation of its positive project outcomes and distribute this presentation to CCA's senior management team. This PIP is an important project that deserves resources in a timely fashion. Publicizing the positive outcomes from this project might be instrumental in securing additional care management resources.

Follow Up to 2018 Recommendations

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

2018 Recommendation	2019 Update
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.	CCA reports that, based on its population analysis, it will focus its efforts on Western region members who are nursing home-certifiable and have some form of cognitive impairment based on their most recent long-term care minimum data set (MDS) assessment.
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.	Due to significant resource constraints, CCA narrowed the focus of Project: REMIND to the early detection of cognitive impairment. The care-planning intervention was excluded from the scope of this project.

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

Rationale for Project Selection

“The Fallon 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 Fallon 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.

2019 Update: Fallon has reported that it has leveraged its eService portal to facilitate communication between inpatient facilities and Beacon’s Aftercare team. Fallon’s Provider Quality Managers (PQMs) are using the feedback gathered through this process to improve the eServices platform. Some inpatient providers continue to use Beacon’s aftercare program by telephone. Fallon is working with these providers to better understand barriers and is offering them hands-on education. Fallon reported it plans to track provider appointment scheduling to ensure it occurs within the desired windows of 7 and 30 days.

- 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.

2019 Update: Fallon is monitoring the rate at which members are contacted by the Aftercare team. Fallon concluded that, overall, the comparison between partial year 2018 and 2019 indicated that the results of outreach efforts (both with letter and after care coordinator contact) are consistent for both members with and without scheduled appointments over time. Based on these results, the intervention activities did not have a positive effect on member outcomes.

- Beacon plans to encourage outpatient providers to engage in best practices. A number of reports are planned, including Hospitalization Follow-Up, member attendance, and member engagement reports. These reports will be shared in a pilot with providers to help the provider develop strategies. Also planned is the creation of educational materials about aftercare best practices and expectations.

2019 Update: Fallon identified Community Health Link as the provider most suited to participate in the pilot. Despite initially agreeing to partner with Fallon, Community Health Link did not respond to outreach attempts. Fallon has modified the intervention to include working with Aftercare Coordinators to improve performance in connecting with outpatient providers, evaluating current processes, and exploring alternatives to the pilot program.

Performance Indicators

1. The HEDIS® measure, *Follow-Up After Hospitalization for Mental Illness – 7-day Follow-up Rate*.

- Fallon Health's 2017 baseline performance for this measure was 45.8%.
- Its performance for the 2018 remeasurement period was 46.0%, a statistically insignificant increase of 0.36%. It did not achieve its goal of 46.4%.

2. The HEDIS® measure, *Follow-Up After Hospitalization for Mental Illness – 30-day Follow-up Rate*.

- Fallon Health's 2017 baseline performance for this measure was 79.2%.
- Its performance for the 2018 remeasurement period was 72.0%. This rate represents a statistically insignificant decrease of 9.05%. It did not achieve its goal of 78.8%.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	3	9	9	100%
Performance Indicator Parameters	5.0	15.0	15.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Planning for Next Measurement Cycle	3	9	8	89%
Overall Validation Rating Score	27	81	80	99%

Plan & Project Strengths

- Fallon Health presents an excellent population analysis and is commended for applying the findings from its population analysis to outreach strategies toward members with the greatest risks.
- KEPRO commends Fallon Health for determining that automating the provider performance reporting process would result in more valid, reliable, and actionable data in a timely manner.

Recommendations & Opportunities for Improvement

- None identified.

Follow Up to 2018 Recommendations

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

2018 Recommendation	2019 Update
KEPRO suggested that other care team members engage with behavioral health providers following hospitalization as well as with the member's family, as appropriate.	Fallon Health did not speak to this issue in its submission.
Fallon Health noted provider resistance to what is perceived as an unfunded mandate. KEPRO recommended that Fallon explore this issue with providers as stakeholders. The views of providers who are willing to engage would be particularly interesting.	Fallon Health did not speak to this issue in its submission.

SENIOR WHOLE HEALTH: IMPROVING TREATMENT FOR DEPRESSION

Rationale for Project Selection

“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 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.
- SWH plans multiple new interventions to monitor referrals, provide additional training, coordinate Beacon case management with pharmacy, enhance outreach efforts to members, and include member feedback and concerns in the planning of all interventions. SWH has made initial steps to provide medication assistance trainings by the pharmacy with the plan to assess effectiveness of these activities.
- SWH will ask primary care providers to screen members determined to be at risk for depression. Using gap lists generated by Senior Whole Health, Beacon will ask some of its network providers to counsel members identified as being non-adherent with medication. SWH will also provide general provider education.
- SWH is providing education to its providers about depression management. SWH has provided a gap list to highlight members at risk of low medication adherence and those at risk for depression to ensure they are screened, as well as providing PCP guidelines to providers.

- SWH also reached out to high-volume providers in a survey to obtain feedback on its educational flyer and guidance on outreach in the future. SWH is providing trainings to promote outreach among the PIP-eligible geriatric population. It is testing specific interventions, such as pill organizing products, to determine if this has an effect on adherence.

Performance Indicators

- The *HEDIS® Antidepressant Medication Management (AMM) Acute Treatment Rate*.
 - Senior Whole Health's 2017 baseline performance rate was 68.1%.
 - Its rate for the 2018 remeasurement 1 was 72.54%, a statistically insignificant increase of 6.52%. It did not achieve its goal of 80%.
- The *HEDIS® Antidepressant Medication Management (AMM) Continuous Treatment Rate*.
 - Senior Whole Health's 2017 baseline performance rate was 59.1%.
 - Its rate for the 2018 remeasurement period remained unchanged at 59.1%. It did not achieve its 68% goal.
- The CMS Health Outcome Survey (HOS) measure, *Improving or Maintaining Mental Health*. Update: Senior Whole Health discontinued the use of this measure in assessing performance.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	10.7	89%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	6.0	18.0	18.0	100%
Remeasurement Performance Indicator Rates	5.0	15.0	15.0	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	28	84	82.7	98%

Project & Plan Strengths

- KEPRO commends SWH for the restatement of its topic description. SWH has more clearly focused the mission and methodology of this project and its key strategies. KEPRO commends SWH for its efforts to improve the operations of this PIP going forward and to address the deficiencies noted by KEPRO in the baseline reports.
- SWH is commended for its promotion of clinical practice guidelines for depression with its network PCPs.
- The reconfigured PIP team is clearly working hard to improve the effectiveness of this project, as evidenced by the quality improvement activities that were described relative to its three interventions. The SWH PIP team is to be congratulated on its work in 2019.

Recommendation and Opportunities for Improvement

- KEPRO advises SWH to develop a methodology for evaluating whether intervention activities result in improved rates of medication adherence for members who engage in care management support compared to members who do not engage in care management.

Follow Up to 2018 Recommendations

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

2018 Recommendation	2019 Update
KEPRO advised 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.	The SWH 2019 Remeasurement Report 1 discontinued HOS as recommended by KEPRO due to the generality of the survey.
The project goal, "improve member treatment for depression," is non-specific with respect to "treatment for depression."	SWH provided a detailed operational definition of "depression treatment 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.	KEPRO suggests that SWH's member education campaign consider strategies for more personalized educational messaging than can be provided through a generic educational newsletter.
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 provided an explanation of the care management pathways that can be followed dependent on a member's preference or acceptance of management services.

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

Rationale for Project Selection

“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.

2019 Update: Behavioral health care managers’ report that their use of the transitions management protocols and tools was instrumental in preventing readmission. Tufts is attempting to obtain electronic medical record access for some high-volume, low-performing facilities. The Premanage Admit Discharge Transfer message system is to be implemented for senior products in late-2019 which will assist with more timely notification of discharge dates. In addition, a system enhancement has been requested to enable an electronic record of the completion of a post-discharge medication reconciliation.

- 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.

2019 Update: The care managers found the root cause analysis process to be useful. Because the tool format was challenging, it has now been placed in a Survey Monkey-like application and is in the process of being piloted.

Performance Indicators

- 1) Tufts is using a *modified version of the HEDIS® Plan All-Cause Readmission (PCR)* rate.
 - Tufts' 2017 baseline performance was 0%.
 - Its rate for the 2018 remeasurement period was 15%. In this performance indicator, lower figures represent better performance. It did not achieve its goal of 11.7%.
- 2) Tufts is also using the HEDIS® *Follow-Up after Hospitalization for Mental Illness (FUH)* measure to assess performance.
 - Tufts' 2017 baseline performance on the 7-day rate was 46.7%.
 - Its 7-day rate for the 2018 remeasurement period was 30%, which represents a statistically insignificant decrease of 35.71%. It did not achieve its 51.4% goal.
 - Tufts' 2017 baseline performance on the 30-day rate was 73.33%.
 - Its rate for the 2018 remeasurement period was 45.0%, a statistically significant decrease of -38.64% ($p < 0.05$). Tufts did not achieve its goal of 80.6%.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	8.0	67%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4.0	12.0	12.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Planning for Next Measurement Cycle	3	9	6	67%
Overall Validation Rating Score	25	75	68	91%

Project & Plan Strengths

- The changes to the activities of this intervention are reasonable. THP should be considering, however, the reasons for the substantial decline in its performance rates for follow-up aftercare.

Opportunities for Improvement

- KEPRO advises THP to meet with a sample of providers to conduct a barrier analysis regarding the reasons for the delay in discharge notifications.
- Tufts analyses were not consistently thorough. For example, an important question that doesn't get addressed in the population analysis is whether the three members who were readmitted to a behavioral health facility received follow-up services within seven or 30 days after their first admission.

Update to 2018 Recommendations

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

2018 Recommendation	2019 Update
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.	It would appear that organizational complexities represent a barrier to the generalization of the outreach model to the larger Tufts population.

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

Rationale for Project Selection

“With the number of comorbidities and challenges a 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.

2019 Update: The pharmacists have been able to engage about 30 members to date. A new database is being utilized as of August 2019 that will provide pharmacists with the necessary data for future outreach efforts. The outreach protocol has been amended such that pharmacists will contact the member as soon as possible in their acute phase of treatment regardless of adherence to address members’ need for health literacy teaching and side effect support.

- 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.

2019 Update: Overall, only two of 33 practices being followed have billed for the behavioral health screening. There was a slight increase in acute phase medication adherence in 17 of 33 practices that treated members with prescribed antidepressant medication, but UHC was unable to determine an intervention effect from its provider education. UHC will continue to improve and roll out its provider education activities with a two-fold focus on improving rates of behavioral health screening and enhancing the acute phase of adherence to antidepressant medications.

Performance Indicators

- 1) The *HEDIS® Antidepressant Medication Management (AMM) Acute Treatment Rate*.
 - UnitedHealthcare's 2017 baseline performance rate was 65.26%.
 - Its performance in the 2018 remeasurement period was 68.6%, a statistically insignificant increase of 2.00%. UHC surpassed its goal of 66.7%.
- 2) The *HEDIS® Antidepressant Medication Management (AMM) Continuous Treatment Rate*.
 - UnitedHealthcare's 2017 baseline performance rate was 50.53%.
 - Its performance in 2018 remeasurement period was 57.3%, a statistically significant increase of 13.33% ($p < 0.05$). UHC surpassed its goal of 55.2%.
- 3) Update: UHC added the performance indicator, Claims Data for Brief, Behavioral Health Screening Administrations. This measure is a count of the total number of claims billed for CPT 96127 for unique SCO members in the calendar year.
 - In 2017, members were screened with a behavioral health instrument at a rate of 0.4%.
 - This rate increased to 1.1% in 2018. UHC surpassed its goal of 1.0%.

Performance Improvement Project Evaluation Results

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

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

Project & Plan Strengths

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

Recommendations and Opportunities for Improvement

- None identified.

Update to 2018 Recommendations

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

2018 Recommendation	2019 Update
KEPRO suggested 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 again suggests that the use of other practice staff, e.g., receptionists or medical assistants, be considered for initiating screening.

DOMAIN 2: CHRONIC DISEASE MANAGEMENT PERFORMANCE IMPROVEMENT PROJECTS

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

Rationale for Project Selection

“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.

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.

2019 Update: Training was completed, but due to staffing constraints, BMCHP will rely on Aging Service Access Points (ASAPs) to support its goals for this project. Interventions relying on care management staff support will resume when the SCO care management department restructuring is complete and the department is fully staffed.

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

2019 Update: BMCHP reported this intervention had been eliminated due to ineffectiveness. In its stead, BMCHP is collaborating with highest-volume ASAPs and provider sites to engage and motivate members with diabetes care gaps. BMCHP developed care gap lists for these ASAPs and intends to meet with them to train them in the use of the list and to provide educational materials for targeted members.

- 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.

2019 Update: BMCHP received member input on the BMCHP SCO diabetes calendar that had been distributed in 2018 and 2019. It has plans to further engage with community partners for messaging with a focus on sharing practical tips.

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

Update: The analysis showed that SCO members with SMI are more likely to have diabetes than the general SCO population and are less likely to have key diabetes screenings than their counterparts without SMI diagnoses. Members with diabetes and comorbid SMI will thus be targeted for additional outreach and education.

- To improve diabetes medication adherence, BMCHP is expanding and enhancing its Medication Therapy Management program.

2019 Update: The plan issues letters to the providers of medication non-adherent members. If the member is a Boston Medical Center (BMC) patient, they are referred to the BMC My Medicine Health program. BMCHP will routinely monitor member adherence to diabetes medication through 2020.

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 focuses on BMCHP's HEDIS®-reported rates.

2019 Update: BMCHP has reported that, after a review of each of the indicators, it confirmed that the largest number of BMCHP SCO member care gaps are in HbA1c testing and eye exams. Additionally, non-adherence to diabetes medications is a strong predictor of non-adherence to appropriate diabetes screenings. As a result, BMCHP will narrow the focus of this PIP to track only those three measures

1) *HbA1c Testing*

- BMCHP's 2017 baseline rate was 97.3%.
- Its performance rate for the 2018 remeasurement period is 95.43%. This reflects a statistically insignificant decrease of 1.95%. BMCHP achieved its 93% goal.

2) *HbA1c >9.0%, Poor Control*

- For this measure in which a lower number reflects better performance, BMCHP's 2017 baseline rate was 27.03%.
- Its performance rate for the 2018 remeasurement period was 28.74%, a statistically insignificant unfavorable 6.32% increase. BMCHP did not achieve its 27.00% goal.

3) *Retinal Eye Exam*

- BMCHP's 2017 baseline rate was 86.49%.
- Its performance rate for the 2018 remeasurement period was 79.31%, a statistically insignificant decrease of 8.30%. It achieved its 72% goal.

4) *Medical Attention for Nephropathy*

- BMCHP's 2017 baseline rate was 94.59%.
- Its performance rate for the 2018 remeasurement period was 94.25%, a statistically insignificant decrease of 0.36%. It did not attain its goal of 96%.

5) *Diabetes Medication Adherence (CMS measure)*

- BMCHP's 2018 baseline rate was 80%.
- Its performance rate for the 2018 remeasurement period was 81.74% which represents a statistically insignificant 2.18% increase. BMCHP exceeded its goal of 81%.

Performance Improvement Project Evaluation

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of available points. This ratio is presented as a percentage. BMCHP received a rating score of 96.5% on this Performance Improvement Project.

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	5.5	16.5	14.6	89%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	4	12	12	100%
Performance Indicator Parameters	6.0	18.0	18.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	30.5	91.5	89.6	96.5%

Project and Plan Strengths

- BMCHP is commended for establishing a welcome call from the Customer Care Department's concierge staff to each SCO member to confirm preferred spoken and written language.
- KEPRO commends BMCHP for working toward forming alliances with key community centers and aligning messaging with the City of Boston's Age Strong program its familiarity with the SCO population.

Recommendations and Opportunities for Improvement

- KEPRO would recommend that, in the future, intervention activities be more frequently tracked to be able to intervene timelier and to better understand barriers in utilization prior to ending an intervention.

Update to 2018 Recommendations

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

2018 Recommendation	2019 Update
KEPRO suggested 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.	BMCHP is enhancing and expanding its Medication Therapy Management program. It is also using ASAPs to provide member education.

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

Rationale for Project Selection

“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.

2019 Update: CCA intends to build a database of available cell phone numbers and collect this information from relevant internal departments. IVR calls will be completed as an alternative method to texting.

- CCA is using a three-pronged approach to prompt CCA clinicians to have conversations with members to increase member engagement and facilitate access to a dentist. A dental awareness document was developed and posted periodically to the CCA intranet. This document is intended to raise awareness among staff about the importance of preventive dental care. A webinar was developed and also posted to the CCA intranet. The webinar’s training goal is to increase provider knowledge of the health implications of poor oral health, the barriers members face receiving this care, oral health benefits, and the importance of integrating oral health into care management. The project team also presented oral health information at clinical staff meetings.

2019 Update: CCA SCO implemented a new care management platform that it characterizes as "holistic." Dental care had not been included as a component of the conversation. CCA reports it has recently added dental intervention-related questions in this

platform. CCA anticipates that clinicians utilizing one platform in which dental questions are incorporated will facilitate these conversations that are intended to promote dental visits by members.

Performance Measure Indicator

- 1) 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 2017 baseline performance was 29.00%. Its goal for the first Remeasurement was 32%.
 - The rate for the 2018 remeasurement period was 27.58%. This represents a statistically significant decrease of 4.90% ($p < 0.05$). CCA attributes this decrease to members' transition to dentures.

Rating Score

KEPRO evaluates a SCO's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. CCA received a rating score of 94% on this Performance Improvement Project.

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	4	67%
Assessing Intervention Outcomes	4.0	12.0	10.0	83%
R8: Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4	12	12	100%
Remeasurement Performance Indicator Rates	3	9	9	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	24	72	68	94%

Plan and Project Strengths

- CCA is commended for the cultural and linguistic diversity of its clinicians.

Recommendations and Opportunities for Improvement

- The population analysis contains analytic and descriptive insufficiencies that should be corrected in CCA's next submission.
- KEPRO requests source information about how CCA calculated its 47% edentulism (toothlessness) prevalence rate.

Update on Calendar Year 2018 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2018 to CCA follows.

Calendar Year 2018 Recommendation	2019 Update
KEPRO suggested CCA consider adding intervention activities that are embedded within the flow of care to facilitate referrals.	It is assumed that the inclusion of dental care in the new care management system will provide a framework for discussing referrals.
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.	It is assumed that the inclusion of dental care in the new care management system will provide a reportable framework for discussions with members.
KEPRO recommended 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 implemented text-messaging and IVR technologies to engage members.
CCA should consider other venues for educational outreach and dental appointment scheduling, such as church gatherings, barbershops, and senior centers.	CCA did not speak to this issue in its submission.

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

Rationale for Project Selection

“Overall, about one-third of the Fallon 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 SCO enrollees with diabetes.
- Increase engagement of diabetic Fallon enrollees who are identified as being unable to be contacted (UTC) and/or are non-adherent to diabetes care management plans, i.e., receipt of a retinal eye exam.

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 has been working to implement provider in-home retinal screenings.

2019 Update: Fallon is commended for doing a pilot of this technology and process. The findings indicated that it was difficult to capture the images needed for ophthalmologists to interpret confidently. Patient-specific conditions as well as equipment-related difficulties were revealed. Fallon has selected a new camera (the RV700 Imager), which is budgeted to be acquired in 2020. Fallon will make a change in methodology upon implementation of the new equipment. Eligibility criteria will be developed for home-based eye exams.

- Fallon has engaged primary care providers in eliminating care gaps for members with diabetes.

2019 Update: Fallon's PCP engagement includes gaps in care report letters for approximately 335 Fallon members sent to 236 unique providers for action. Fallon has reported the closure rate on gaps in care is approximately 16.9% to date. Fallon is commended for the additional outreach it conducted to determine what the reason was for the remaining outstanding 75 patients identified as needing retinal eye exams. Fallon modified the gap in care letter to include all outstanding gaps rather than issue one letter per gap.

- The Centralized Enrollee Record was updated to include a Health Risk Assessment (HRA) containing the HEDIS® Comprehensive Diabetes Care measures. Because an analysis revealed that Fallon had not identified all members with diabetes, Fallon Clinical Management provided reeducation and training on the HRA process.

2019 Update: Staff conducted clinical reminders. The number of members requiring eye exams was reduced from 377 to 75 members, 23 of whom received an exam but were excluded from the rate for administrative reasons, e.g., claims lag.

Performance Indicators

1) The *HEDIS® Comprehensive Diabetes Care (CDC) Retinal Eye Exam Rate*.

- Fallon Health's 2017 baseline rate for this measure was 85.6%.
- Its rate for the 2018 remeasurement period was 87.3%. This reflects a statistically insignificant increase of 2.00%. Its goal is the 2018 CMS 5-Star cut-point, > 81.0%, which it achieved.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	11.0	92%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	4	12	12	100%
Performance Indicator Parameters	6	18	18	100%
Remeasurement Performance Indicator Rates	5	15	15	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	30	90	89	99%

Plan & Project Strengths

- Fallon impressively described the various tools and processes it uses to continuously monitor PIP activities to further understand and interpret results.
- Fallon is commended for completing a lessons-learned exercise on this intervention in order to better inform implementation once the new equipment is acquired.

Recommendation and Opportunities for Improvement

- None identified.

Update on Calendar Year 2018 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2018 to Fallon Health follows.

Calendar Year 2018 Recommendation	2019 Update
KEPRO recommended that Fallon Health include all structured efforts to improve its interventions through the use of stakeholder feedback as examples of small tests of change.	Fallon did not speak to this recommendation in its submission.

SENIOR WHOLE HEALTH: CARDIAC DISEASE MANAGEMENT

Rationale for Project Selection

“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 hypertension and coronary artery disease. New Coronary Artery Disease (CAD) Management Program members receive a welcome letter and educational materials that speak to smoking cessation, nutrition, and weight management, flu vaccines, physical activity, and medication compliance. Outbound educational calls are made by the Community Service Coordinators. CSC nurse care managers provide coaching during scheduled home visits. Healthy Living Chronic Disease self-management classes are offered to members.

2019 Update: SWH plans to enhance its gap reports as a care coordination tool for nurse care managers to use for targeted outreach. The CSC team made script-based outbound calls in which members were offered educational material to 2,891 members with claims related to cardiovascular disease. CSCs were unable to contact the majority of members and those members who were reached were more likely to decline the material. The intervention has been revised in 2019 to include a more health literate welcome to the Heart Health care management program. The hypertension educational material was revised to enhance the infographics and offer a 30-day blood pressure log. SWH intends to continue collaboration with ASAPs on the improvement of the Heart Health Program.

- SWH implemented a pharmacy-based intervention with the goal of increased member medication adherence.

Update: SWH engaged a pharmacy vendor for coaching and tracking medication refill compliance. SWH describes an improved adherence rate in members receiving specialized packaging compared to those that did not.

- SWH is implementing a wide-ranging intervention designed to change how providers manage their practices relative to cardiac disease management.

2019 Update: Among many other activities, Senior Whole Health offered provider training on medication compliance by means of gap reports and articles placed in the plan newsletter. SWH attempted to obtain feedback from PCPs about the effectiveness of the newsletter but were not able to do so due to practice staff and PCPs being too busy. SWH is commended for offering a provider incentive program, even though this did not improve the rate of providers' feedback. SWH sent a gap list containing members at risk for low medication adherence and those with cardiovascular disease needing a statin to PCP office managers. SWH is offering ideas to providers such as offering pill organizing products to enhance adherence.

Performance Indicators

1. The HEDIS® measure, Controlling Blood Pressure (CBP).
 - Senior Whole Health's 2017 baseline performance was 72.51%.
 - Its performance for the 2018 remeasurement period was 75.91%, a statistically insignificant increase of 4.70%. It did not achieve its goal of 82%.
2. The CMS Stars measure, ACE/ARB Medication Compliance.
 - Senior Whole Health's 2017 baseline performance was 84.06%.
 - Its performance for the 2018 remeasurement period was 86.06%, a statistically significant increase of 2.38% ($p < 0.005$). It did not achieve its goal of 88%.
3. The CMS Stars measure, Medication Adherence for Statin.
 - Senior Whole Health's 2017 baseline performance was 83.02%.
 - Its performance for the 2018 remeasurement period was 84.50%, a statistically significant increase of 1.78% ($p < 0.01$). It did not achieve its goal of 87%.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	5.7	17.0	17.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4	12	12	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	26.7	80	80	100%

Project and Plan Strengths

- KEPRO commends SWH for its changes to its quality department leadership, its commitment to the continued implementation of this project, and its overall excellent work with this project.

Recommendations and Opportunities for Improvement

- KEPRO recommends considering other forms of both educating and connecting with members to share what works for them at influencing their cardiovascular disease and hypertension management outcomes, such as text messaging, member forums, and dietary classes at which meals are cooked together at the community level.
- KEPRO recommends that SWH inform providers about proven strategies to adopt, such as repetitive text messaging to patients with small bits of information about the importance of adhering to prescriptions or brief remote check-ins with patients via teleconference visits.

Update on Calendar Year 2018 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2018 to Fallon Health follows.

Calendar Year 2018 Recommendation	2019 Update
Regarding member outreach protocols, KEPRO suggested that SWH consider using methods to do outreach that acknowledge the low education level and health literacy of the population it is targeting. KEPRO further suggested 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.	SWH amended its member materials enhancing its use of infographics. It also revised the welcome letter to the Heart Healthy program for health literacy.
KEPRO recommended that SWH solicit feedback from a culturally diverse member advisory panel regarding the content of its care manager development training.	SWH did not speak to this issue in its submission.
KEPRO suggested that SWH incorporate pharmacists into the flow of work of compliance coaching for members.	SWH has engaged a Medication Therapy Management organization to provide coaching to members.
More detail regarding staff development should be included in the 2019 Remeasurement report.	SWH spoke to numerous efforts at CSC and nurse care manager training including training in motivational interviewing. SWH Quality, Pharmacy, and Clinical Trainers will be collaborating in the planning of 2020 nurse care manager training that addresses evidence-based practice, tools, case studies, and culturally competent information and material.

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

Rationale for Project Selection

“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

- Members who have screened positive on a PHQ-2 receive behavioral health clinician support. If the member screens positive on the PHQ-9, the member will be referred to the primary care provider. Member educational materials are shared with members.

2019 Update: In 2018, Tufts implemented the PHQ-2 and PHQ-9 screening and referral process. When appropriate, the SCO care manager added treatment for depression to the member’s care plan in order to improve care coordination. It also sent disease-specific educational materials to members. A care manager reviewed the materials’ content with the member upon subsequent contact to ensure comprehension. In 2019, Tufts focused on referrals to E-fit and prospective prescriptions of steroids and antibiotics to head off emergency department or inpatient utilization. In addition, pulmonary rehabilitation center information and referral criteria will be made available to care managers and network medical directors in late-2019.

- Tufts will conduct outreach to primary care providers with members with co-occurring depression and COPD to ensure appropriate referrals are made and antidepressants prescribed.

2019 Update: Tufts instructed primary care providers to include depression as a diagnosis for this member cohort. Medical directors received education as a group and geriatric advanced practice nurses and geriatric psychiatrists were made available for one-to-one PCP education as needed.

Performance Indicators

1) *COPD Admission Rate*, a modified version of the AHRQ PQI-5.

- Tufts 2017 baseline performance in this measure for which lower rates reflect higher performance was 22.8 admissions per 1000 members per year.
- Its performance for the 2018 remeasurement period was 17.9 admissions per 1000 members per year. It achieved its goal of 20.5 admissions per 1000 members per year.

2) *COPD or Asthma Potentially Avoidable Admission Rate*.

- Tufts 2017 baseline performance in this measure for which lower rates reflect higher performance is 24.2 admissions per thousand members per year.
- Its performance for the 2018 remeasurement period was 19.2 admissions per thousand member per year. It achieved its goal of 21.8 admissions per thousand members per year.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	4.0	12.0	12.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	3.0	9.0	9.0	100%
Remeasurement Performance Indicator Rates	4.0	12.0	12.0	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	24	72	72	100%

Project & Plan Strengths

- THP is commended for making available in several languages its COPD and Depression health education materials which has been reviewed twice by its Consumer Advisory Group. It is commended for hiring staff with cultural and linguistic characteristics that match those of its members. It is also commended for its summary population analysis
- THP is commended for its many activities related to the ongoing education of care management staff, improving access to pulmonary rehabilitation center information and referral, and project oversight through its ongoing quality improvement workgroup.
- THP is commended for its work with 13 provider medical directors to solicit feedback on its provider education activities.

Recommendations and Opportunities for Improvement

- KEPRO recommends that THP develop protocols and workflows for each of the project management plan challenges noted. One strategy for developing these challenge-mitigating protocols is to meet with stakeholders (providers and members) to conduct a barrier analysis related to each challenging factor. The barrier analysis can become the foundation for improved intervention strategies.

Update on Calendar Year 2018 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. An update on recommendations made in 2018 to Tufts Health Plan follows.

2018 Recommendation	2019 Update
<p>KEPRO noted 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.</p>	<p>See first recommendation above. Member refusal to accept behavioral health treatment was identified by Tufts Health Plan in 2019 as a challenge of its project management plan.</p>
<p>A PCP referral protocol should be developed by Tufts for members who decline treatment by behavioral health providers.</p>	<p>See first recommendation above. Member refusal to accept behavioral health treatment was identified by Tufts Health Plan in 2019 as a challenge of its project management plan.</p>

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

Rationale for Project Selection

“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.

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.

2019 Update: Out of 1014 members who were eligible for this intervention and whose providers were outreached, 39.5% members subsequently were prescribed and filled a statin. UHC will continue to administer and monitor this intervention.

- Targeted to high-risk, Spanish-speaking members with diabetes discharged from Lawrence General Hospital, UnitedHealthcare implemented an intervention in which these members who have been prescribed oral diabetes medications receive medication instructions and labels in Spanish.

2019 Update: An analysis showed that there was no significant difference in the readmission rate of English-speaking members taking diabetes medications to those who are Spanish-speaking. After comparing year-over-year data of Spanish-speaking members, no improvements were identified. The intervention and data were discussed at the Utilization Management Committee. The Committee unanimously voted to discontinue the process.

- 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 are either non-adherent or at risk of becoming non-adherent and may benefit from a 90-day fill. Many language barriers can be addressed at the pharmacy level as many of the pharmacies are locally owned and embedded in the community.

2019 Update: Members who participated in the 90-day conversion program had a 4.1% higher adherence rate with their diabetes medications. UHC will continue to administer and monitor this intervention.

Update: At the recommendation of its Consumer Advisory Council, UHC added an intervention in which an event promoting holistic self-care for members with diabetes was sponsored at the Greater Lawrence Community Health center. This intervention went well beyond traditional passive member education by engaging members in community events and by distributing food to them in the context of a community event. UHC plans to conduct a pre-test and a post-test written in Spanish to participating members.

Performance Indicator

1. UnitedHealthcare is using the CMS measure, *Medication Adherence for Oral Diabetes* (MAD). Its goal is the five-star threshold, 86.01%.
 - UHC's 2017 baseline performance was 84.3%.
 - Its performance rate for the 2018 remeasurement period was 85.5%, a statistically insignificant increase of 1.42%. UHC notes that this rate is preliminary.

Performance Improvement Project Evaluation

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

Summary Results of Validation Ratings	No. of Items	Total Available Points	Points Scored	Rating Averages
Updates to Project Topic and Scope	4	12	12	100%
Population Analysis Update	2	6	6	100%
Assessing Intervention Outcomes	5.7	17.0	17.0	100%
Performance Indicator Data Collection	2	6	6	100%
Capacity for Indicator Data Analysis	2	6	6	100%
Performance Indicator Parameters	4	12	12	100%
Remeasurement Performance Indicator Rates	4	12	12	100%
Conclusions and Planning for Next Measurement Cycle	3	9	9	100%
Overall Validation Rating Score	26.7	80	80	100%

Plan and Project Strengths

- KEPRO commends UHC for maintaining momentum in this performance improvement project despite leadership turnover.
- UHC is highly commended for the depth and breadth of its population analysis.
- KEPRO commends UHC for its work with Spanish-speaking members served by the Greater Lawrence Family Health Center, which has a programmatic focus of improving healthy lifestyles among its members with diabetes.
- UHC is commended for its commitment to improving the cultural competence of its provider network, as well as making educational materials available to members in their preferred languages. Of the many strategies that UHC offers to ensure the cultural competence of its member services, its Physician Cultural Education Library is a notable accomplishment, as is UHC's offering courses to providers with continuing education credits.

Recommendations and Opportunities for Improvement

- In future PIP reporting, KEPRO advises UHC to provide greater detail about its method for evaluating members' response to the Gaps in Care outreach.

Update to 2018 Recommendations

KEPRO is required by CMS to determine the status of recommendations made in the previous reporting year. No recommendations, however, were made in 2018.

APPENDIX: CONTRIBUTORS

Performance Measure Validation

Katharine Iskrant, CHCA, MPH

Ms. Iskrant is a member of the National Committee for Quality Assurance (NCQA) Audit Methodology Panel and has been a Certified Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Auditor since 1998. She directed the consultant team that developed the original NCQA Software Certification ProgramSM on behalf of NCQA. She is a frequent speaker at national HEDIS® 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) 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 has published and presented extensively. Currently, Dr. Zell is serving as a healthcare quality coach for Sutter Health and is Chief Medical Officer of Pill Club providing telehealth care for women.

Chantal Laperle, MA, CPHQ, NCQA CCE

Chantal Laperle has over 25 years of experience in the development and implementation of quality initiatives in a wide variety of health care delivery settings. She has successfully held many positions in both public and private sectors using her clinical background to effect change. She has contributed to the development of a multitude of quality programs from the ground up requiring her to be hands on through implementation. She is experienced in The Joint Commission (TJC), National Committee for Quality Assurance (NCQA), the Commission on Accreditation of Rehabilitation Facilities (CARF) and Accreditation Association for Ambulatory Health Care (AAAHC) accreditation and recognition programs. She is skilled in the development of workflows and the use of tools to monitor and succeed within a process as well as coaching teams through the development and implementation process of a project.

Ms. Laperle holds both a Bachelors and a Masters Degree in Psychology. She is a Certified Professional in Health Care Quality (CPHQ) and Certified in Health Care Risk Management. She is also certified in Advanced Facilitation and the 7 Tools of Quality Control through GOAL/QPC, holds a certification as an Instructor for Nonviolent Crisis Intervention (CPI) and is a Certified Content Expert (CCE) through NCQA.

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 the effectiveness and efficiency of managed health services through data-driven performance management systems.

During his tenure as Vice-President for Quality Management and Analytics 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 with behavioral health care, and improving access to long-term services and supports for health plan members with complex medical needs. 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.

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. She is a Certified Professional in Healthcare Quality.