Primary Care Accountable Care Organizations
External Quality Review Technical Report

Calendar

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Contents

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 children with special needs) 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 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.

In November 2016, MassHealth received approval from the Centers for Medicare and Medicaid Services to implement a five-year waiver authorizing a 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. Three ACO models were implemented in Massachusetts:

Exhibit 1: Massachusetts Accountable Care Organization Models

ACO Model	Description
Accountable Care Partnership Plans (ACPPs), also referred to as "Model A ACOs" (N=13)	Groups of primary care providers (PCPs) who work with just one managed care organization to create a full network that includes PCPs, specialists, behavioral health providers, and hospitals.
Primary Care Accountable Care Organizations (PCACOs), also referred to as "Model B ACOs" (N=3)	Groups of primary care providers who form an ACO that is responsible for treating the member and coordinating their care. Primary Care ACO Plans work with the MassHealth network of specialists and hospitals and may have certain providers in their "referral circle." The "referral circle" provides direct access to certain other providers or specialists without the need for a referral.
Lahey-MassHealth Primary Care Organization, also referred to as the "Model C ACO" (N=1)	The Lahey MassHealth ACO is comprised of 16 primary care practice sites. The ACO has contracted with the MassHealth managed care organizations to administer claims and manage membership.

CMS has determined that ACPPs are considered managed care organizations and, as such, are required to participate in all mandatory External Quality Review activities, i.e., Performance Improvement Project Validation, Performance Measure Validation, and Compliance Validation. Primary Care Accountable Care Organizations are considered primary care case management plans and are required to participate in performance measure and compliance validation. 2019 ACPP external quality review activities are described in a separate technical report.

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

KEPRO conducted the validation of three performance measures, including an Information Systems Capability Assessment, in the CY 2019 review cycle.

Compliance validation must be conducted by the EQRO on a triennial basis. PCACO compliance validation will be conducted in 2021.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2019 reflect 2018 quality measurement performance.

The MassHealth Primary Care Accountable Care Organizations are listed in the table that follows.

Exhibit 2. MassHealth Primary Care Accountable Care Organizations

PCACO	Abbreviation Used in this Report
Community Care Choice	CCC
Partners HealthCare Choice	Partners
Steward Health Choice	Steward
Total	

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 Protocol #2 on three measures that were selected by MassHealth:

- Asthma Medication Ratio Less than or Equal to .50;
- Seven-Day Follow Up After Hospitalization for Mental Illness; and
- Initiation and Engagement in Alcohol and Other Drug Treatment.

The focus of the Information Systems Capability Assessment is on components of 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 PCACOs followed specifications and reporting requirements and produced valid measures.*

SECTION 2. THE MASSHEALTH COMPREHENSIVE QUALITY STRATEGY

<u>Introduction</u>

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.

<u>MassHealth Goals</u>

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 variety of stakeholders to identify quality improvement priorities in pursuit of its goals related to Comprehensive Quality Strategy Development. These 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. Toward that end, KEPRO expects ACPPs to include members and providers as stakeholders in the design and implementation of its Performance Improvement Projects.

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 ACPPs. 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. ACOs were approved to enroll members effective March 1, 2018.

Another important development during this period was the re-procurement 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 managed care 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 Managed Care 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 Managed Care Quality Strategy. 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 below depicts ways in which KEPRO, through the External Quality Review (EQR) process, supports the MassHealth Managed Care Quality Strategy:

EQR Activity	Support to MassHealth Quality Strategy
Performance Measure Validation	• Assure that performance measures are calculated accurately. • Offer a comparative analysis of plan performance to identify outliers and trends. • Provide technical assistance. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.
Performance Improvement Project Validation	• Ensure the inclusion of an assessment of cultural competency within interventions. • Ensure the alignment of MassHealth priority areas and quality goals with MassHealth goals. • Ensure that Performance Improvement Projects are appropriately structured and that meaningful performance measures are used to assess improvement. • Ensure that Performance Improvement Projects incorporate stakeholder feedback. • Share best practices, both clinical and operational. • Provide technical assistance. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.

Compliance Validation	- Assess plan compliance with contractual requirements. - Assess plan compliance with regulatory requirements. - Recommend mechanisms through which plans can achieve compliance. - Facilitate the Corrective Action Plan process. - Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.

SECTION 3. PERFORMANCE MEASURE VALIDATION

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. KEPRO validated three PCACO performance measures in 2019.

KEPRO's PCACO performance measure validation audit methodology assesses both the quality of the source data that fed into the measures under review and the accuracy of their calculation. As part of source data review, five numerator-compliant cases per measure were verified. Enrollment data were reviewed for accuracy. Measure calculation review included reviewing the logic and analytic framework for determining the measure numerator, denominator, and exclusion cases, if applicable.

In 2018, MassHealth contracted with CareSeed for the calculation of PCACO performance measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual PCACOs did not participate in or contribute to the PMV process. The following documents and files were provided by MassHealth and CareSeed in support of the performance measure validation process:

- A completed Information Systems Capability Assessment Tool (ISCAT) from CareSeed for performance measure creation and measure data validation protocols;
- A completed Information Systems Capability Assessment Tool (ISCAT) from MassHealth for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to CareSeed;
- Performance measure data reports from CareSeed for each of the three measures selected for validation that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;
- An Excel spreadsheet containing numerator-compliant data from CareSeed for each of the three selected measures for primary source verification purposes;
- Primary source verification information from MassHealth for the three selected measures;
- A copy of all enrollment data provided to CareSeed by MassHealth;
- Enrollment data for 30 members selected at random by the auditor; and
- Enrollment data for the same 30 members from CareSeed to ensure the enrollment data matches the MassHealth primary source enrollment data after CareSeed enrollment data processing.

The table below presents the three measures selected for performance measure validation (PMV) for Measurement Year 2018 as well as each measure's description as provided by NCQA:

Exhibit 3. Measures Selected for Performance Measure Validation

Measure Name and Abbreviation	Measure Description
AMR – Asthma Medication Ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
FUH - Follow-Up After Hospitalization for Mental Illness (7 days)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 7 days after discharge.
IET - Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • *Initiation of AOD Treatment.* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

COMPARATIVE ANALYSIS

The tables that follow contain the criteria through which performance measures were validated as well as KEPRO's determination as to whether or not the PCACOs met these criteria. In summary, all three PCACOs satisfied the requirements of each criterion.

Performance Measure Validation: Asthma Medication Ratio (AMR)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	CCC	Partners	Steward
DENOMINATOR			
Population			
PCACO population was appropriately segregated from other product lines.	Met	Met	Met
Members identified as having persistent asthma who were enrolled during the measurement year and the year prior to the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment.	Met	Met	Met
Geographic Area			
Includes only those Medicaid enrollees served in the PCACO's reporting area.	Met	Met	Met
Age & Sex: Enrollment Calculation			
Ages 5–64 as of December 31 of the measurement year.	Met	Met	Met
Data Quality			
Based on the IS assessment findings, the data sources for this denominator were accurate.	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
Proper Exclusion Methodology in Administrative			
Exclude members who had any diagnosis below any time during the member's history through December 31 of the measurement year: — Emphysema — COPD — Obstructive Chronic Bronchitis — Chronic Respiratory Conditions Due to Fumes or Vapors — Cystic Fibrosis — Acute Respiratory Failure	Met	Met	Met
Members who had no asthma controller or reliever medications dispensed during the measurement year.	Met	Met	Met
NUMERATOR			
Administrative Data: Counting Clinical Events			
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	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
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

Performance Measure Validation: Follow-Up After Hospitalization for Mental Illness (FUH) – Seven-Day Rate

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	CCC	Partners	Steward
DENOMINATOR			
Population			
PCACO population was appropriately segregated from other product lines.	Met	Met	Met
Enrolled on the date of discharge through 30 days after discharge.	Met	Met	Met
An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 1 of the measurement year.	Met	Met	Met
Geographic Area			
Includes only those Medicaid enrollees served in the PCACO's reporting area.	Met	Met	Met
Age & Sex: Enrollment Calculation			
Members 6 years and older as of the date of discharge.	Met	Met	Met
Data Quality			
Based on the IS assessment findings, the data sources for this denominator were accurate.	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
Proper Exclusion Methodology in Administrative			
Exclude discharges followed by readmission or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.	Met	Met	Met
NUMERATOR – 7 DAY FOLLOW-UP RATE			
Administrative Data: Counting Clinical Events			
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	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
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

Performance Measure Validation: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid

Review Element	CCC	Partners	Steward
DENOMINATOR			
Population			
PCACO population was appropriately segregated from other product lines.	Met	Met	Met
Members enrolled 60 days (2 months) prior to the new episode of Alcohol or Other Drug (AOD) abuse or dependence through 48 days after the episode.	Met	Met	Met
Geographic Area			
Includes only those Medicaid enrollees served in the PCACO's reporting area.	Met	Met	Met
Age & Sex: Enrollment Calculation			
Members 13 years and older as of December 31 of the measurement year.	Met	Met	Met
Data Quality			
Based on the IS assessment findings, the data sources for this denominator were accurate.	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
Proper Exclusion Methodology in Administrative			
Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication dispensing event during the 60 days (2 months) before the new episode of AOD abuse or dependence.	Met	Met	Met
NUMERATORS			
Administrative Data: Counting Clinical Events			
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	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
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

COMPARATIVE PERFORMANCE MEASURE RESULTS

Because NCQA has not developed benchmarks specific to accountable care organizations, one is not provided for comparison purposes.
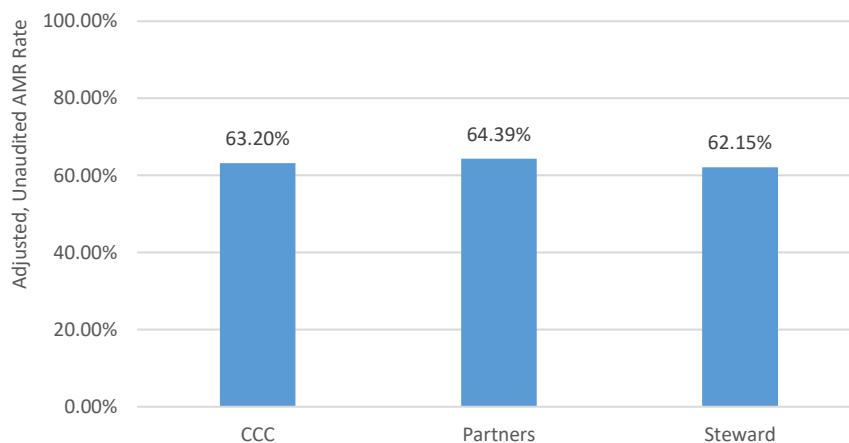
Measure 1. 2018 Asthma Medication Ratio ≥ 0.5 (AMR)

The range of 2018 AMR performance rates was 2.24 percentage points. The lowest performing PCACO was Steward at 62.15%. The highest performing plan was Partners at 64.39%. Please note that these rates are reported as adjusted, unaudited, and uncertifiable HEDIS rates.

Exhibits 4 and 5: Asthma Medication Ratio Rates

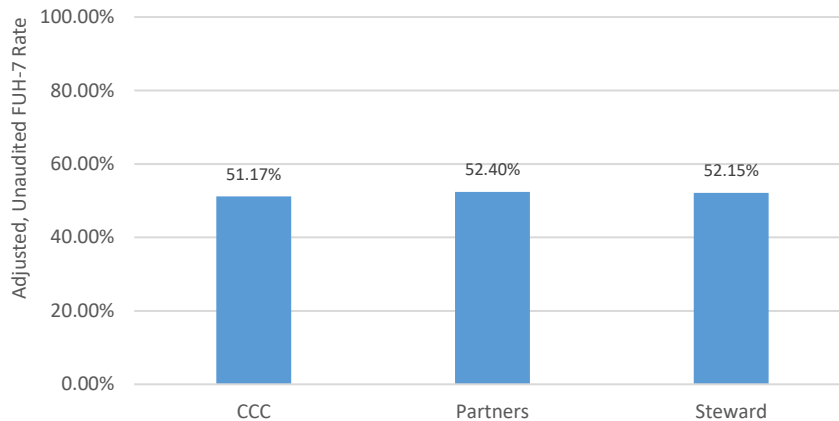| 2018 Adjusted, Unaudited, and Uncertifiable Rate	CCC	Partners	Steward
Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater	63.20%	64.39%	62.15%

2018 PCACO AMR Rates

Measure 2. Seven-Day Follow-Up After Hospitalization for Mental Illness (FUH)

The range of 2018 Seven-Day FUH performance rates was only 1.23 percentage points. The lowest performing PCACO was CCC at 51.17%. The highest performing plan was Partners at 51.17%. Please note that these rates are reported as adjusted and unaudited.

Exhibits 6 and 7: Seven-Day Follow-Up After Hospitalization for Mental Illness Rates

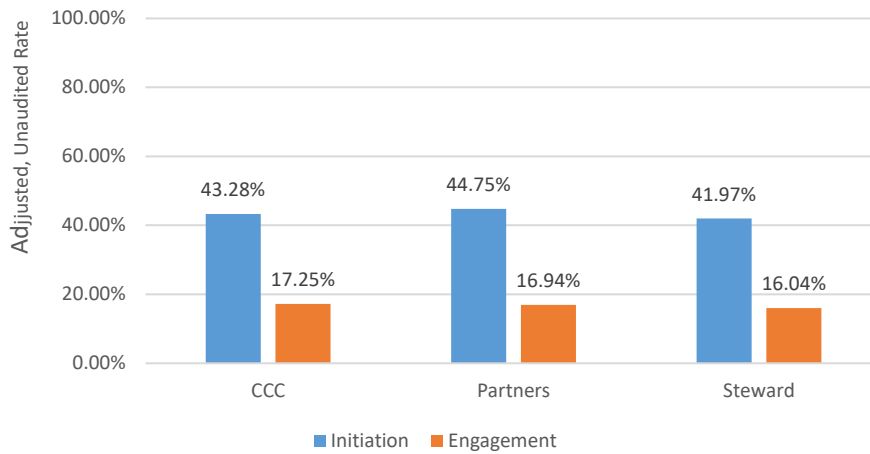| 2018 Adjusted, Unaudited, and Uncertifiable HEDIS Rate	CCC	Partners	Steward
Seven-Day Follow-Up After Hospitalization for Mental Illness	51.17%	52.40%	52.15%

2018 PCACO FUH 7-Day Rates

Measure 3. Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment (IET)

The range of 2018 IET Initiation performance rates was 2.78 percentage points. The lowest-performing PCACO was Steward at 41.97%. The highest performing plan was Partners, 44.75%. The range of the Engagement rate was only 1.21 percentage points. The lowest-performing PCACO on the Engagement rate was again Steward, 16.04%. The highest-performing PCACO was CCC at 17.25%. Please note that these rates are reported as adjusted, unaudited, and uncertifiable HEDIS rates.

Exhibits 8 and 9: 2018 PCACO Adjusted, Unaudited IET Rates

2018 Adjusted, Unaudited, and Uncertifiable HEDIS Rate	CCC	Partners	Steward
Initiation of AOD Treatment	43.28%	44.75%	41.97%
Engagement of AOD Treatment	17.25%	16.94%	16.04%

2018 PCACO IET Rates

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

The focus of the Information Systems Capability Assessment is on the components of information systems that contribute to performance measure production. This is to ensure that the system can collect data on the enrollee, on provider characteristics, and on services furnished to enrollees through an encounter data system or other methods. The systems must be able to:

- Ensure that data received from providers are accurate and complete;
- 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.

Claims and Encounter Data. PCACO claims and encounters are processed in the Massachusetts Medicaid Management Information System (MMIS). MMIS captures all necessary fields for reporting. Standard coding was used and there was no use of non-standard codes. Most claims are submitted electronically and there are adequate monitoring processes in place to identify issues. MMIS has sufficient claims editing and coding review processes. For the small volume of paper claim submissions, MassHealth's Customer Service Vendor, Maximus, is responsible for the direct data entry of paper claims. There are no concerns with the processing of electronic or manual claims.

The Massachusetts Behavioral Health Partnership (MBHP) processed behavioral health claims. MBHP processed claims using all standard codes, standard claim forms, and the capture of all required fields.

MassHealth contracted with DXC, a Xerox company, to process pharmacy claims. DXC processed the pharmacy claims through the pharmacy online payment system (POPS). There were adequate processes in place to monitor pharmacy data including processes to reconcile pharmacy reversals.

There were no concerns identified with data completeness. There were no issues identified with claims or encounter data processing.

The reviewed reviewed five numerator-compliant cases from each PCACO for each measure being validated to ensure that claims numerator data met the measure numerator requirements. The following claims numerator data were requested from MassHealth:

Exhibit 10: Documentation Requested from MassHealth

Measure	Numerator Documentation Requested
AMR	• Inbound member prescription claims showing asthma controller medications, asthma reliever medications, and the dispensing date (including injections); or • Pharmacy Benefit Manager (PBM) records showing asthma controller medications, asthma reliever medications, and the dispensing date (including injections).
FUH	• Evidence that the follow-up visit occurred with a behavioral health provider and that the visit medical billing code met the measure requirements.
IET	• Copies of treatment records corresponding to the initial and follow-up visits; or • Inbound claims from the treating provider(s).

The primary source documentation established that PCACO claims numerator data met the measure numerator requirements.

Enrollment Data. MassHealth processed enrollment data using the MMIS system. All necessary enrollment fields were captured for reporting. Member enrollment data were housed within the MMIS. Enrollment data were fed into MMIS by the Health Insurance Exchange (HIX), which processed incoming applications and determined eligibility. MAXIMUS served as the customer service center and updated eligibility information directly into the live system.

Enrollment data for 30 members were selected at random by the reviewer. Enrollment data for the same 30 members was provided by CareSeed to the reviewer to ensure the enrollment data matched the MassHealth primary source enrollment data after CareSeed enrollment data processing. The reviewer determined that the enrollment data for the sample of 30 members successfully matched. There were no issues identified with enrollment processes.

Data Integration. PCACO performance measure rates were produced using CareSeed software. Data from the MassHealth transaction system, MMIS, were formatted into CareSeed-compliant extracts and loaded into the CareSeed measure production software. MassHealth had adequate processes to track completeness and accuracy of data at each transfer point.

Source Code. NCQA-certified CareSeed software was used to produce the performance measures. There were no source code issues identified. The performance measures are not eligible for certification under NCQA's Measure Certification Program. The PCACO PMV measure rates are referred to as "Adjusted, Unaudited, Uncertifiable HEDIS Rates" because PCACO enrollment was assigned to MassHealth members who were enrolled in a PCACO prior to the ACO program start date, and who were also PCACO members in 2018.

MEASURE-SPECIFIC VALIDATION DESIGNATION

Exhibit 11. Measure-Specification Validation Designation

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
AMR – Asthma Medication Ratio	Valid measure (no bias)	Measure data were compliant with NCQA specifications and the data, as reported, were valid. The measure is not eligible for certification under NCQA's Measure Certification Program. The rate is designated or referred to as an "Adjusted, Unaudited, Uncertifiable HEDIS Rate" because enrollment was assigned to MassHealth members who were enrolled in a PCACO prior to the ACO program start date, and who were also members of the same PCACO in 2018.
FUH - Follow-Up After Hospitalization for Mental Illness (7 days)		
IET - Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment		

STRENGTHS

- MassHealth used an NCQA-certified vendor, CareSeed, for measure calculation.
- In its first external quality review, the PCACO program successfully completed performance measure validation.

OPPORTUNITIES & RECOMMENDATIONS

- None identified.

CONCLUSION

In summary, KEPRO's validation review of the selected performance measures indicates that the MassHealth's Primary Care Accountable Care Organizations' measurement and reporting processes were fully compliant with specifications and were methodologically sound.

SECTION 4. CONTRIBUTORS

Performance Measure Validation

Katharine Iskrant, MPH, CHCA, CPHQ
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 Program[SM] 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.

Project Management

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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 the 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 and is a Certified Professional in Healthcare Quality.