

TECHNICAL REPORT

# Primary Care Clinician (PCC) Plan External Quality Review

Calendar Year 2020



**MassHealth**

Massachusetts Executive Office  
of Health & Human Services



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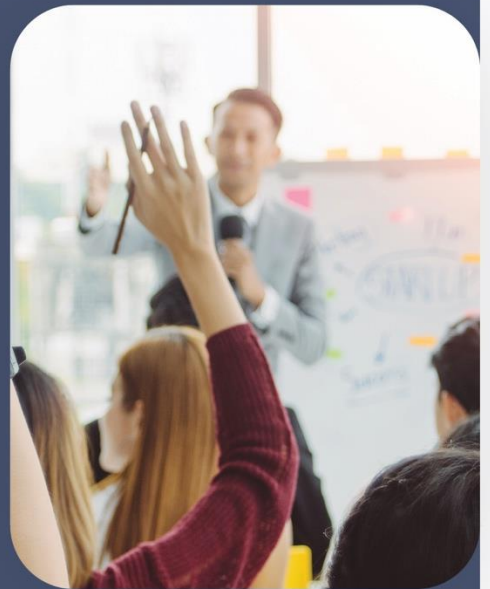
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Section 1:

# Introduction

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# SECTION 1: INTRODUCTION

## **PRIMARY CARE CLINICIAN (PCC) PLAN DESCRIPTION**

The MassHealth Primary Care Clinician (PCC) Plan is a primary care case management managed care program administered by the Executive Office of Health and Human Services (EOHHS). As of December 31, 2020, 101,203 individuals statewide were enrolled in the PCC Plan. Members' behavioral health services are managed by the Massachusetts Behavioral Health Partnership (MBHP), a Beacon Health Options company.

Section 2:

# Executive Summary

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## SECTION 2. EXECUTIVE SUMMARY

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

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 (CMS). It is also posted to the Medicaid agency website.

### SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

The Primary Care Clinician Plan voluntarily participates in the performance measure validation process, which Kepro conducted in the CY 2020 review cycle. Kepro validated one administrative performance measure and two hybrid measures for the PCC Plan in the CY 2020 review cycle. It also conducted an Information Systems Capability Assessment.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2020 reflect 2019 quality measurement performance.

### PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

#### Exhibit 2.1: Performance Measure Validation Process Overview

Topic	Description
Objectives	To assess the accuracy of performance measures in accordance with 42 CFR § 438.358(b)(ii) reported by the managed care plan and to determine the extent to which the managed care plan follows state specifications and reporting requirements.
Technical methods of data collection and analysis	Kepro's Lead Performance Measure Validation Auditor conducted this activity in accordance with 42 CFR § 438.358(b)(ii).

Data obtained	A Data Acquisition Questionnaire, the source code used to produce the validated performance measures, a list of numerator positives for the hybrid measure, medical records for the samples identified by the auditor, and follow-up documentation as requested by the auditor.
Conclusions	Kepro's validation review of the selected performance measure indicates that the PCC Plan's measurement and reporting processes were fully compliant with specifications and were methodologically sound.

The Performance Measure Validation process assesses the accuracy of performance measures. In 2020, Kepro conducted Performance Measure Validation in accordance with CMS EQR Protocol 2 on three measures that were selected by MassHealth and Kepro. The measures validated were as follows:

- Well Child Visits in the First 15 Months of Life (W15): Six or more visits;
- Adolescent well-Care Visits (AWC); and
- Controlling High Blood Pressure (CBP).

Kepro also conducted an Information Systems Capability Assessment, the focus of which is on components of plan 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 that the accuracy and timeliness of reported data are verified; that the data has been screened for completeness, logic, and consistency; and that service information is collected in standardized formats to the extent feasible and appropriate.

## HIGH-LEVEL RECOMMENDATIONS

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

### **Improve the quality of race, ethnicity, and language (REL) data provided to the managed care plans.**

A key MassHealth Quality Strategy goal is the identification and resolution of health disparities to provide equitable care. From conducting population analyses to designing interventions,



managed care plans feel challenged by the quality of REL data they receive from MassHealth. A shared concern is the overwriting of plan REL updates by the MassHealth enrollment files. Kepro strongly encourages MassHealth to resolve this issue as these data are required to better measure and address disparities in care and access.

## **QUALITY STRATEGY EVALUATION**

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

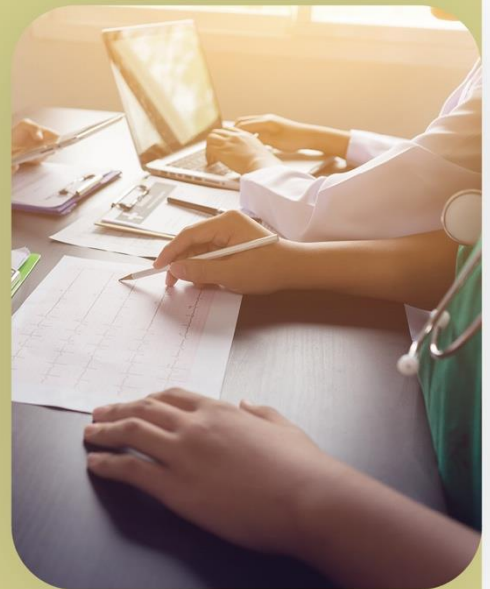
The first MassHealth Quality Strategy was published in 2006. An updated version, the MassHealth Comprehensive Quality Strategy is focused not only on fulfilling managed care quality requirements but on improving the quality of managed care services in Massachusetts, was submitted to CMS in November 2018. As is required by CMS, the strategy will be updated in 2021 and will be made available to the public on the MassHealth website.

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

**Section 3:**

# **Performance Measure Validation**

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## SECTION 3. PERFORMANCE MEASURE VALIDATION

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

### METHODOLOGY

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

Kepro's 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.

The two-step Performance Measure Validation (PMV) process consists of a desk review of documentation submitted by the managed care organization. The desk review affords the reviewer an opportunity to become familiar with plan systems and data flows. For plans that do not undergo a formal HEDIS® audit, as is the case with the PCC Plan, an onsite review is conducted. At the onsite review, which is conducted virtually, the reviewer confirms information contained in the Data Acquisition Questionnaire, inspects information systems, and by interviewing staff, obtains clarification about performance measurement and information transfer processes.

Kepro bases the results of Performance Measure Validation on the quality of source data and the calculation of the measures, including data management structure, sources and collection, and logic and the analytic framework for determining numerators and denominators. Kepro conducts a Medical Record Review validation to verify the accuracy of the hybrid measures Medical Record Review.

MassHealth requested the validation of three HEDIS® performance measures for the PCC Plan. Kepro chose one hybrid pediatric measure, one hybrid adult measure, and one administrative pediatric measure.

The table that follows presents the three HEDIS measures selected for performance measure validation (PMV) for Measurement Year 2019 as well as each measure’s description as provided by NCQA.

**Exhibit 3.1. CY 2020 Validated Performance Measures**

<b>HEDIS Measure Name and Abbreviation</b>	<b>Measure Description</b>
Well-Child Visits in the First 15 Months of Life (W15): Six or More Visits  <i>Hybrid Measure</i>	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.
Adolescent Well-Care Visits (AWC)  <i>Administrative Measure</i>	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Controlling High Blood Pressure (CBP)  <i>Hybrid Measure</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.

The PCC Plan submitted the documentation that follows in support of the performance measure validation process.

### Exhibit 3.2. Submitted Documentation

Document Reviewed	Purpose of Kepro Review
Data Acquisition Questionnaire (DAQ)	Reviewed to assess health plan systems and processes related to performance measure production.
List of numerator positives for the hybrid measures, and medical records for randomly selected sample as requested by auditor, if medical records were reviewed	Used to generate a random sample of medical records for independent review to confirm accuracy of medical record review process.
Source code used to produce performance measures	For those measures that were not produced using NCQA certified measure software, reviewed software program/code to determine accuracy of programming and compliance with measure specifications.
Follow-up documentation, as requested by the auditor, during the course of PMV review	Plan-specific documentation requested to obtain missing or incomplete information, support and validate plan processes, and verify the completeness and accuracy of information provided in the DAQ or during onsite interviews and systems demonstrations.

## PERFORMANCE MEASURE RESULTS

### 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>MassHealth Primary Care Clinician (PCC) Plan</b>
Performance measure name: <b>Well-Child Visits in the First 15 Months of Life (W15): Six or More Visits</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) As described below. <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: There were eight numerator-positive cases for <i>Well-Child Visits in the First 15 Months of Life (W15): Six or More Visits</i> and each case was reviewed during the virtual onsite review. All records were found to be in full compliance with HEDIS specifications.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): Members who turned 15 months old during the measurement year
Definition of numerator (describe): Members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2019 – December 31, 2019

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

<b>Numerator</b>	199
<b>Denominator</b>	219
<b>Rate</b>	90.87%

### 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

None.

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

*Claims and Encounter Data.* PCCP claims and encounters are processed in the Massachusetts Medicaid Management Information System (MMIS). MMIS captures all necessary fields for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Most claims were submitted electronically and there were adequate monitoring processes in place to identify issues. MMIS had sufficient claims editing and coding review processes. For the small volume of paper claim submissions, MassHealth's Customer Service Vendor, Maximus, was responsible for the direct data entry function of paper claims. There were no concerns with the processing of electronic or manual claims. The PCC Plan contracted with the Massachusetts Behavioral Health Partnership (MBHP) to process behavioral health claims. MBHP processed claims using all standard codes, standard claims forms, and the capture of all required fields. The PCC Plan had robust processes in place for tracking and reporting of MBHP data. MassHealth contracts with Conduent to process pharmacy claims for the PCC Plan. Conduent processed the pharmacy claims through the pharmacy online payment system (POPS) and MassHealth paid the pharmacy claims. 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.

*Enrollment Data.* The PCCP processes enrollment data using the MMIS system. All necessary enrollment fields are captured for HEDIS reporting. Member enrollment data were housed within MMIS. Enrollment data was fed into MMIS by the Health Insurance Exchange (HIX), which processed incoming applications and determined eligibility. In addition, the MA-21 system was used to capture disability and long-term needs eligibility. MAXIMUS served as the customer service center and updated eligibility information directly into the live system. Eligibility information from these sources updated within 24 hours. The PCC Plan used eligibility information within MMIS and used the member Medicaid identification (ID) number. There were no issues identified with enrollment processes.

*Supplemental Data.* The PCC Plan did not use supplemental data sources.

*Data Integration.* The PCC Plan's performance measure rates were produced using CareSeed software. Data from the transaction system, MMIS, were loaded to the PCCP data warehouse. Vendor data feeds from MBHP and POPS were also loaded to the warehouse. Data were then formatted into CareSeed-compliant extracts and loaded into the measure production software. The PCC Plan had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. During the onsite, the CareSeed software was reviewed. There were no issues identified with HEDIS data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

There were only eight numerator-positive cases for *Well-Child Visits in the First 15 Months of Life (W15): Six or More Visits* and each of cases were reviewed during the onsite review. All records were found to be in full compliance with HEDIS specifications.

☐ Not applicable (medical record review not conducted)

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

None identified.



## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>MassHealth Primary Care Clinician (PCC) Plan</b>
Performance measure name: <b>Adolescent Well-Care Visits</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records:  <input checked="" type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): Members 12–21 years of age
Definition of numerator (describe): Members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2019 – December 31, 2019

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

<b>Numerator</b>	13,488
<b>Denominator</b>	18,806
<b>Rate</b>	71.72%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None identified.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.  <i>Claims and Encounter Data.</i> PCCP claims and encounters are processed in the Massachusetts Medicaid Management Information System (MMIS). MMIS captures all necessary fields for HEDIS reporting. Standard

coding was used and there was no use of non-standard codes. Most claims were submitted electronically and there were adequate monitoring processes in place to identify issues. MMIS had sufficient claims editing and coding review processes. For the small volume of paper claim submissions, MassHealth's Customer Service Vendor, Maximus, was responsible for the direct data entry function of paper claims. There were no concerns with the processing of electronic or manual claims. The PCC Plan contracted with the Massachusetts Behavioral Health Partnership (MBHP) to process behavioral health claims. MBHP processed claims using all standard codes, standard claims forms, and the capture of all required fields. The PCC Plan had robust processes in place for tracking and reporting of MBHP data. MassHealth contracts with Conduent to process pharmacy claims for the PCC Plan. Conduent processed the pharmacy claims through the pharmacy online payment system (POPS) and MassHealth paid the pharmacy claims. 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.

**Enrollment Data.** The PCCP processes enrollment data using the MMIS system. All necessary enrollment fields are captured for HEDIS reporting. Member enrollment data were housed within MMIS. Enrollment data was fed into MMIS by the Health Insurance Exchange (HIX), which processed incoming applications and determined eligibility. In addition, the MA-21 system was used to capture disability and long-term needs eligibility. MAXIMUS served as the customer service center and updated eligibility information directly into the live system. Eligibility information from these sources updated within 24 hours. The PCC Plan used eligibility information within MMIS and used the member Medicaid identification (ID) number. There were no issues identified with enrollment processes.

**Medical Record Review.** Two of the three PMV measures were calculated using medical records in addition to claims and encounter data, i.e., *Controlling High Blood Pressure* and *Well-Child Visits in the First 15 Months of Life (W15): Six or More Visits*. The medical record review that was conducted for these two PMV measures was accurate. A sample of 30 numerator-positive hybrid cases were reviewed during the site visit for *Controlling High Blood Pressure*. There were only eight numerator-positive cases for *Well-Child Visits in the First 15 Months of Life (W15): Six or More Visits* and each of cases were reviewed during the webinar meeting. All records were found to be in full compliance with HEDIS specifications.

**Supplemental Data.** The PCC Plan did not use supplemental data sources.

**Data Integration.** The PCC Plan's performance measure rates were produced using CareSeed software. Data from the transaction system, MMIS, were loaded to the PCCP data warehouse. Vendor data feeds from MBHP and POPS were also loaded to the warehouse. Data were then formatted into CareSeed-compliant extracts and loaded into the measure production software. The PCC Plan had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. During the onsite, the CareSeed software was reviewed. There were no issues identified with HEDIS data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

☒ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

None identified.

## 1. Overview of Performance Measure

Managed Care Plan (MCP) name: <b>MassHealth Primary Care Clinician (PCC) Plan</b>
Performance measure name: <b>Controlling High Blood Pressure</b>
Measure steward: <input type="checkbox"/> Agency for Healthcare Research and Quality (AHRQ) <input type="checkbox"/> Centers for Disease Control and Prevention (CDC) <input type="checkbox"/> Centers for Medicare & Medicaid Services (CMS) <input checked="" type="checkbox"/> National Committee for Quality Assurance (NCQA) <input type="checkbox"/> The Joint Commission (TJC) <input type="checkbox"/> No measure steward, developed by state/EQRO <input type="checkbox"/> Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) <input checked="" type="checkbox"/> HEDIS® <input checked="" type="checkbox"/> CMS Child or Adult Core Set <input type="checkbox"/> Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) <input checked="" type="checkbox"/> Administrative data (describe) HEDIS auditor-approved data sources <input checked="" type="checkbox"/> Medical records (describe) _____ <input type="checkbox"/> Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: A sample of 30 numerator-positive hybrid cases were reviewed during the site visit for <i>Controlling High Blood Pressure</i> . All records were found to be in full compliance with HEDIS specifications.  <input type="checkbox"/> Not applicable (hybrid method not used)
Definition of denominator (describe): Members 18–85 years of age who had a diagnosis of hypertension
Definition of numerator (describe): Members 18–85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Program(s) included in the measure: <input checked="" type="checkbox"/> Medicaid (Title XIX) only <input type="checkbox"/> CHIP (Title XXI) only <input type="checkbox"/> Medicaid and CHIP
Measurement period (start/end date) January 1, 2019 – December 31, 2019

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

<b>Numerator</b>	246
<b>Denominator</b>	366
<b>Rate</b>	67.21%

## 3. Performance Measure Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).  None.
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Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results.

*Claims and Encounter Data.* PCCP claims and encounters are processed in the Massachusetts Medicaid Management Information System (MMIS). MMIS captures all necessary fields for HEDIS reporting. Standard coding was used and there was no use of non-standard codes. Most claims were submitted electronically and there were adequate monitoring processes in place to identify issues. MMIS had sufficient claims editing and coding review processes. For the small volume of paper claim submissions, MassHealth's Customer Service Vendor, Maximus, was responsible for the direct data entry function of paper claims. There were no concerns with the processing of electronic or manual claims. The PCC Plan contracted with the Massachusetts Behavioral Health Partnership (MBHP) to process behavioral health claims. MBHP processed claims using all standard codes, standard claims forms, and the capture of all required fields. The PCC Plan had robust processes in place for tracking and reporting of MBHP data. MassHealth contracts with Conduent to process pharmacy claims for the PCC Plan. Conduent processed the pharmacy claims through the pharmacy online payment system (POPS) and MassHealth paid the pharmacy claims. 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.

*Enrollment Data.* The PCCP processes enrollment data using the MMIS system. All necessary enrollment fields are captured for HEDIS reporting. Member enrollment data were housed within MMIS. Enrollment data was fed into MMIS by the Health Insurance Exchange (HIX), which processed incoming applications and determined eligibility. In addition, the MA-21 system was used to capture disability and long-term needs eligibility. MAXIMUS served as the customer service center and updated eligibility information directly into the live system. Eligibility information from these sources updated within 24 hours. The PCC Plan used eligibility information within MMIS and used the member Medicaid identification (ID) number. There were no issues identified with enrollment processes.

*Supplemental Data.* The PCC Plan did not use supplemental data sources.

*Data Integration.* The PCC Plan's performance measure rates were produced using CareSeed software. Data from the transaction system, MMIS, were loaded to the PCCP data warehouse. Vendor data feeds from MBHP and POPS were also loaded to the warehouse. Data were then formatted into CareSeed-compliant extracts and loaded into the measure production software. The PCC Plan had adequate processes to track completeness and accuracy of data at each transfer point. Preliminary rates were thoroughly reviewed by the plan. During the onsite, the CareSeed software was reviewed. There were no issues identified with HEDIS data integration processes.

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

☐ Not applicable (ISCA not reviewed)

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

The medical record review that was conducted for CBP was accurate. A sample of 30 numerator-positive hybrid cases were reviewed during the onsite review. All records were found to be in full compliance with HEDIS specifications.

☐ Not applicable (medical record review not conducted)

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

None identified.

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

EQRO recommendations for improvement of performance measure calculation:

Kepro recommends that the PCC Plan consider using supplemental data.

## PCC PLAN STRENGTHS

The PCC Plan:

- The PCC Plan used an NCQA-certified vendor for the HEDIS code.
- The PCC Plan collects, reports, and undergoes an audit of performance measures on a voluntary basis which provides transparency and accountability of performance.
- The PCC Plan staff members were knowledgeable and proficient in performance measure data collection and reporting processes.
- The PCC Plan scored well above the Quality Compass 95th percentile for the HEDIS measure, *Well-Child Visits in the First 15 Months of Life: Six or More Visits*.
- The PCC Plan scored between the Quality Compass 90th and 95th percentiles for the HEDIS measure, *Adolescent Well-Care Visits*.

## RECOMMENDATIONS

- Kepro recommends that the PCC Plan consider using supplemental data for performance measure reporting.

## FOLLOW UP TO CALENDAR YEAR 2019 RECOMMENDATIONS

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

### Exhibit 3.3. Update on PCC Plan 2019 Recommendations

Recommendations Made in 2019	2020 Follow Up
Kepro recommends that the PCC Plan consider using supplemental data for performance measure reporting.	This recommendation stands.

## CONCLUSION

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

## PERFORMANCE MEASURE VALIDATION WORKSHEETS

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. The results of the validation follow.

Kepro uses the following ratings for Performance Measure Validation review elements:

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

Comments apply only if the review element criteria are not met.

**Performance Measure Validation: Well-Child Visits in the First 15 Months of Life (W15): Six or More Visits**

<b>Methodology for Calculating Measure:</b>	Administrative	Medical Record Review	<b>Hybrid</b>
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Review Element	Rating	Comments
<b>DENOMINATOR</b>		
<u>Population</u>		
Medicaid population was appropriately segregated from other product lines.	Met	
Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.	Met	
Members continuously enrolled from 31 days–15 months of age, allowing a one-month gap in coverage. Calculate 31 days of age by adding 31 days to the child's date of birth. The member must also be enrolled on the day that they turn 15 months old.	Met	
<u>Geographic Area</u>		
Includes only those Medicaid enrollees served in PCCP's reporting area.	Met	
<b>NUMERATOR – SIX OR MORE VISITS</b>		
<u>Counting Clinical Events</u>		
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	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	
Members had evidence of six or more visits with a PCP as documented through either administrative data or medical record review.	Met	
<u>Data Quality</u>		
Based on the IS assessment findings, the data sources used were accurate.	Met	
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	
<u>Proper Exclusion Methodology in Administrative Data</u>		
Not Applicable.	N/A	
<u>Hybrid Measure</u>		
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	
If the hybrid method was used, PCCP passed the EQRO Medical Record Review Over-Read component of the PMV Audit.	Met	
<b>SAMPLING</b>		
<u>Unbiased Sample</u>		
As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	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	



<i>Proper Substitution Methodology in Medical Record Review</i>		
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	
Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	

Performance Measure Validation: Adolescent Well-Care Visits (AWC)

Methodology for Calculating Measure:	Administrative	Medical Record Review	Hybrid
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Review Element	Rating	Comments
<b>DENOMINATOR</b>		
<u>Population</u>		
Medicaid population was appropriately segregated from other product lines.	Met	
Members were continuously enrolled during the measurement year, with no more than a one-month gap. Members must also be enrolled on December 31 of the measurement year.	Met	
<u>Geographic Area</u>		
Includes only those Medicaid enrollees served in PCCP's reporting area.	Met	
<u>Age &amp; Sex: Enrollment Calculation</u>		
Members aged 12-21 years of age as of December 31 of the measurement year.	Met	
<u>Data Quality</u>		
Based on the IS assessment findings, the data sources for this denominator were accurate.	Met	
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	
<u>Proper Exclusion Methodology in Administrative</u>		
Not Applicable	N/A	
<b>NUMERATOR – WELL-CARE VISIT RATE</b>		
<u>Administrative Data: Counting Clinical Events</u>		
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	
All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant.	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	
At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the member. Do not count visits billed with a telehealth modifier) or billed with a telehealth POS code.	Met	

## Performance Measure Validation: Controlling High Blood Pressure (CBP)

<b>Methodology for Calculating Measure:</b>	Administrative	Medical Record Review	<b>Hybrid</b>
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Review Element	Rating	Comments
<b>DENOMINATOR</b>		
<u>Population</u>		
Medicaid population was appropriately segregated from other product lines.	Met	
Members 18-85 years of age or older as of December 31 of the measurement year.	Met	
Members were continuously enrolled during the measurement year, with no more than a one-month gap.	Met	
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: <ul style="list-style-type: none"> <li>• Outpatient visit with any diagnosis of hypertension.</li> <li>• A telephone visit with any diagnosis of hypertension.</li> <li>• An online assessment with any diagnosis of hypertension</li> </ul> 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 or the presence of a telehealth POS code associated with the outpatient visit.	Met	
<u>Geographic Area</u>		
Includes only those Medicaid enrollees served in PCCP's reporting area.	Met	
<b>NUMERATOR – BLOOD PRESSURE RATE</b>		
<u>Counting Clinical Events</u>		
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	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	
Members had evidence of adequately controlled blood pressure as documented through either administrative data or medical record review.	Met	
<u>Data Quality</u>		
Based on the IS assessment findings, the data sources used were accurate.	Met	
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	Met	

Review Element	Rating	Comments
<u>Proper Exclusion Methodology in Administrative Data</u>		
<p>Exclude members who meet any of the following criteria:</p> <ul style="list-style-type: none"> <li>Members 66–80 years of age as of December 31 of the measurement year with frailty and advanced illness. Members must meet <i>both</i> of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> <li>At least one claim/encounter for frailty during the measurement year.</li> <li>Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ol style="list-style-type: none"> <li>At least two outpatient visits, observation visits, ED visits, nonacute inpatient encounters or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: <ol style="list-style-type: none"> <li>Identify all acute and nonacute inpatient stays.</li> <li>Confirm the stay was for nonacute care based on the presence of a nonacute code on the claim.</li> <li>Identify the discharge date for the stay.</li> </ol> </li> </ol> </li> <li>At least one acute inpatient encounter with an advanced illness diagnosis.</li> <li>At least one acute inpatient discharge with an advanced illness diagnosis. To identify an acute inpatient discharge: <ol style="list-style-type: none"> <li>Identify all acute and nonacute inpatient stays.</li> <li>Exclude nonacute inpatient stays.</li> <li>Identify the discharge date for the stay.</li> </ol> </li> <li>A dispensed dementia medication.</li> <li>Members 81 years of age and older as of December 31 of the measurement year with frailty during the measurement year.</li> </ol></li></ul>	Met	
<u>Hybrid Measure</u>		
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	
If the hybrid method was used, PCCP passed the EQRO Medical Record Review Over-Read component of the PMV Audit.	Met	
<b>SAMPLING</b>		
<u>Unbiased Sample</u>		
As specified in the NCQA specifications, systematic sampling method was utilized, if sampling occurred.	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	
<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	
Substitutions were made for properly excluded records and the percentage of substituted records was documented, if applicable.	Met	



Section 4:

# Appendices

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# APPENDIX. CONTRIBUTORS

## PERFORMANCE MEASURE VALIDATION REVIEWER

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

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

## PROJECT MANAGEMENT

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

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

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

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