The Primary Care Clinician (PCC) Plan
A Primary Care Case Management Plan
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. CONTRIBUTORS

PERFORMANCE MEASURE VALIDATION REVIEWER

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PROJECT MANAGEMENT

Cassandra Eckhof, M.S., CPHQ

Ms. Eckhof has over 25 years 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 and is certified in healthcare quality.

SECTION 2: INTRODUCTION

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

The MassHealth Primary Care Clinician Plan is considered to be a primary care case management plan. Because it is a state-operated plan, it is not subject to the external quality review requirements of the Balanced Budget Act. The state voluntarily participates in the Performance Measure Validation process.

KEPRO's report on the Primary Care Clinician Plan follows.

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

KEPRO validated two administrative performance measures and one hybrid measure for the PCC Plan in the CY 2018 review cycle. It also conducted an Information Systems Capability Assessment.

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, 2018, 115,933 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 3. THE 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.*

<u>Stakeholder Involvement</u>

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.

<u>MassHealth Delivery System Restructuring</u>

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.

<u>Quality Evaluation</u>

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 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 4. 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 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, 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 measure Medical Record Review. Finally, for each measure validated, KEPRO determines any changes in performance over time, including whether any improvement was sustained or statistically significant.

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

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

Exhibit 1. 2018 Validated Performance Measures

HEDIS Measure Name and Abbreviation	Measure Description
Comprehensive Diabetes Care (CDC) - HbA1c poor control (>9.0%)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had poor HbA1c control (>9.0%).
Childhood Immunization Status (CIS) – Combination 2	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), and one chicken pox (VZV) vaccine by their second birthday.
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 day rate	The percentage of emergency department (ED) visits for members 6 years of age and older with a principle diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit.

Documents and Files Provided by the Primary Care Clinician Plan in Support of the PMV Process

Exhibit 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
HEDIS measure Certification Report produced by Care Seed, LLC	Reviewed for performance measure results
List of interventions related to performance measures	Reviewed to help explain changes in performance measure rates
List of numerator positive incidents 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
Follow-up documentation, as requested by the auditor, during the course of 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, and/or onsite interviews and systems demonstrations.

INFORMATION SYSTEMS CAPABILITY ASSESSMENT

The focus of the Information Systems Capability Assessment is on the components of the PCC Plan's 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 system 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.

1. **Claims and Encounter Data.** Primary Care Clinician Plan (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 PCCP contracted with the Massachusetts Behavioral Health Partnership (MBHP) to process behavioral health claims. MBHP processed claims using all standard codes, standard claim forms, and the capture of all required fields. The PCCP had robust processes in place for tracking and reporting MBHP data.

   The PCCP contracted with DXC, a Xerox company, to process pharmacy claims. DXC processed the pharmacy claims through the pharmacy online payment system (POPS) and the PCCP 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.

2. **Enrollment Data.** The PCCP processed enrollment data using the MMIS system. All necessary enrollment fields are captured for HEDIS reporting. PCCP member enrollment data were housed within MMIS. Enrollment data were 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

PCCP used eligibility information within MMIS and used the member Medicaid identification (ID) number. There were no issues identified with enrollment processes.

3. **Medical Record Review.** Two of the three measures validated were calculated using medical records in addition to claims or encounter data, i.e., Comprehensive Diabetes Care - HbA1c Poor Control and Childhood Immunization Status - Combination 2. A sample of 30 numerator positive hybrid cases were reviewed during the onsite visit for each hybrid measure. All records were found to be in full compliance with the HEDIS specifications.

4. **Supplemental Data.** The PCCP did not use supplemental data sources. Therefore, this section is not applicable.

5. **Data Integration.** The PCCP'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 PCCP 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 audit, PCCP staff members provided a system demonstration of Cognos, the front-end view of the data warehouse. There were no issues identified with the HEDIS data integration processes.

6. **Source Code.** The PCCP used NCQA-certified CareSeed HEDIS software to produce performance measures. There were no source code issues identified.

PERFORMANCE MEASURE RESULTS

Exhibit 3.
Measure 1. Comprehensive Diabetes Care (CDC) - HbA1c poor control (>9.0%)

Rate	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
HbA1c Poor Control	35.52%	35.28%	For this measure, a lower rate reflects better performance. There was a favorable decrease of 0.24 percentage points. The rate change is not statistically significant. The PCCP ranks between the 50th and 66th percentiles compared to Quality Compass 2019.

Exhibit 4.

Measure 2. Childhood Immunization Status (CIS) – Combination 2

Rate	HEDIS 2018	HEDIS 2019	Change 2018 to 2019
Childhood Immunization Status - Combination 2	75.67%	78.10%	The rate increase of 2.43 percentage points is not statistically significant. The PCCP ranks between the 75th and 90th percentiles compared to the Quality Compass 2019.

Exhibit 5.

Measure 3. Follow Up After Emergency Department Visit for Mental Illness (FUM)

Rate	HEDIS 2018	HEDIS 2019	% Change 2018 to 2019
Follow Up After Emergency Department Visit for Mental Illness - 7-Day Follow-up Rate	82.56%	81.56%	The rate decrease of 1.0 percentage points is not statistically significant. The PCC Plan's performance is above the Quality Compass 2019 95th percentile.

MEASURE-SPECIFIC VALIDATION DESIGNATION

The table below depicts the validation designation for each of the measures validated by KEPRO in Calendar Year 2019.

Exhibit 6.

Measure-Specification Validation Designation

Measure-Specific Validation Designation		
Performance Measure	Validation Designation	Definition
Comprehensive Diabetic Care (CDC) Poor Control (>9.0).	Valid measure (no bias)	Measure data were compliant with NCQA specifications, and the data, as reported, were valid.
Childhood Immunization Status (CIS) Combo 2	Valid measure (no bias)	Measure data were compliant with NCQA specifications, and the data, as reported, were valid.
Seven-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Valid measure (no bias)	Measure data were compliant with NCQA specifications, and the data, as reported, were valid.

PCC PLAN STRENGTHS

The PCC Plan:

- Uses an NCQA-certified vendor for the HEDIS® code.
- Collects, reports, and undergoes an audit of performance measures on a voluntary basis, which provides transparency and accountability of performance.
- Has staff who are knowledgeable and proficient in performance measure data collection and reporting processes.
- Scored well above the Quality Compass 95th percentile for the HEDIS® measure, Follow-Up After Emergency Department Visit for Mental Illness (7-day numerator).

OPPORTUNITIES

- None identified.

RECOMMENDATIONS

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

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 recommendations follows:

Exhibit 7: Update on PCC Plan 2018 Recommendations

Recommendations Made in 2018	2019 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.

APPENDIX. PERFORMANCE MEASURE VALIDATION WORKSHEETS

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.

Performance Measure Validation: Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%)

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

Rating Categories: Met, Needs Improvement, Not Met, Not Applicable (N/A)
Comments apply only if review element is rated needs improvement or not met.

Review Element	Rating	Comments
DENOMINATOR		
Population		
Medicaid population was appropriately segregated from other product lines.	Met	
Members aged 18–75 years as of Dec. 31 of the measurement year.	Met	
Members enrolled all of the measurement year allowing for a one-month break, but not in December.	Met	
Diabetics were appropriately identified using both specified methods. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. PCCP must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.	Met	
Geographic Area		
Includes only Medicaid enrollees served in PCCP's reporting area.	Met	
NUMERATOR – HBA1C POOR CONTROL		
Counting Clinical Events		
Standard codes listed in NCQA specifications or properly mapped internally developed codes were used.	Met	
Data sources and decision logic used to calculate the numerators (e.g., claims files, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	
Members whose most recent HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.	Met	
Data Quality		
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	
Proper Exclusion Methodology in Administrative Data		
Members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year. (Optional Exclusion).	Not Applicable	
Medical Record Review Documentation Standards		
Record abstraction tool required notation of all key numerator fields.	Met	
Data Quality		
The eligible population was properly identified.	Met	

Review Element	Rating	Comments
Based on the IS assessment findings, data sources used for this numerator were accurate.	Met	
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	
If the hybrid method was used, PCCP passed auditor review for the accuracy of 30 randomly selected abstracted charts for good HbA1c control.	Met	
SAMPLING		
Unbiased Sample		
As specified in the NCQA specifications, systematic sampling method was utilized.	Met	
Sample Size		
After exclusions, the sample size was equal to 1) 411, 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or 3) the total population.	Met	
Proper Substitution Methodology in Medical Record Review		
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors.	Met	
Substitutions were made for properly excluded records and the percentage of substituted records was documented.	Met	

Performance Measure Validation: Childhood Immunization Status (CIS) – Combination 2

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

Rating Categories: Met, Needs Improvement, Not Met, Not Applicable (N/A)
Comments apply only if review element is rated needs improvement or not met.

Review Element	Rating[1]	Comments
DENOMINATOR		
Population		
Medicaid population was appropriately segregated from other product lines.	Met	
Children who turn 2 years of age during the measurement year and were enrolled with PCCP on their second birthday.	Met	
Children enrolled 12 months prior to their second birthday with no more than a one-month gap in enrollment during this time period.	Met	
NUMERATOR – COMBINATION 2		
Counting Clinical Events		
Standard codes listed in the NCQA specifications or properly mapped internally developed codes were used.	Met	
Data sources and decision logic used to calculate the numerator (e.g., claims files, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate.	Met	
Members meeting the measure requirements for DTap, IPV, MMR, HiB, HepB, and VZV vaccinations.	Met	
Data Quality		
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	
Proper Exclusion Methodology in Administrative Data		
Exclude children who had a contraindication for a specific vaccine only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety. (Optional exclusion).	Met	
Medical Record Review Documentation Standards		
Record abstraction tool required notation of all key numerator fields for Combination 2.	Met	
Data Quality		
The eligible population was properly identified.	Met	
Based on the IS assessment findings, data sources used for this numerator were accurate.	Met	
Hybrid Measure		
If hybrid measure was used, the integration of administrative and medical record data was adequate.	Met	
If the hybrid method was used, PCCP passed auditor review for the accuracy of 30 randomly selected abstracted charts for Combination 2.	Met	

SAMPLING		
Unbiased Sample		
As specified in the NCQA specifications, systematic sampling method was utilized.	Met	
Sample Size		
After exclusions, the sample size was equal to 1) 411, 2) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or 3) the total population.	Met	
Proper Substitution Methodology in Medical Record Review		
Excluded only members for whom MRR revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by NCQA, or 2) data errors.	Met	
Substitutions were made for properly excluded records and the percentage of substituted records was documented.	Met	

Performance Measure Validation: Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 Day Rate

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

Rating Categories: Met, Needs Improvement, Not Met, Not Applicable (N/A)
Comments apply only if review element is rated needs improvement or not met.

Review Element	Rating[1]	Comments
DENOMINATOR		
Population		
Medicaid population was appropriately segregated from other product lines.	Met	
Members continuously enrolled on or before the date of the ED visit that had a principal diagnosis of mental illness on or between January 1 and December of the measurement year.	Met	
The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period.	Met	
Geographic Area		
Includes only those Medicaid enrollees served in PCCP's reporting area.	Met	
Age & Sex: Enrollment Calculation		
Members 6 years and older as of the date of the ED visit.	Met	
Members continuously enrolled on or before the date of the qualifying ED visit that had a principal diagnosis of mental illness on or between January 1 and December of the measurement year.	Met	
Data Quality		
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	
Proper Exclusion Methodology in Administrative		
Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission.	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	
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	