Affinia Health Network

MEMBERSHIP GUIDE

Publicaiton Date: 10/16/2020

Publication Information

Publication Release Notes

10/16/2020:

- Section 3: Data sent to payers updated

5/20/2020:

- 100% electronic via AffiniaHealth.com (Members – Resource – Membership Guide)
- PDF form available for download
- Changes from 2019
  - General Information Section has expanded and now includes
    - Calendars and schedules
    - Informational Sheets
    - MHPP – How to find: Epic job aids (Quality and PCMH)
  - Quality Measure Specification Section
    - Updated quality specifications
    - Updated participating prayers
    - Updated AHN Target
    - Removal of UDS measures
  - Wellcentive workflows section has been renamed Registry: Wellcentive and been revamped to now include the following sub sections
    - Definitions
    - Wellcentive Reports
    - Data sent to payers
    - Measure supported
    - Measures with limited support
    - Measure not supported
  - Attribution Handbook section has been reformatted and updated
  - NEW Section – Population Health Performance Reports
  - Retired Section - Calendars and Schedule
    - Material has not been removed it has been moved to the appropriate section such as registry or general information
  - Retired Section - Informational Sheets

- Material has not been removed it has been moved to the appropriate section or to general information.

- Retired Section - Athena Job Aids

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GENERAL INFORMATION

Section 1

Affinia Health Network

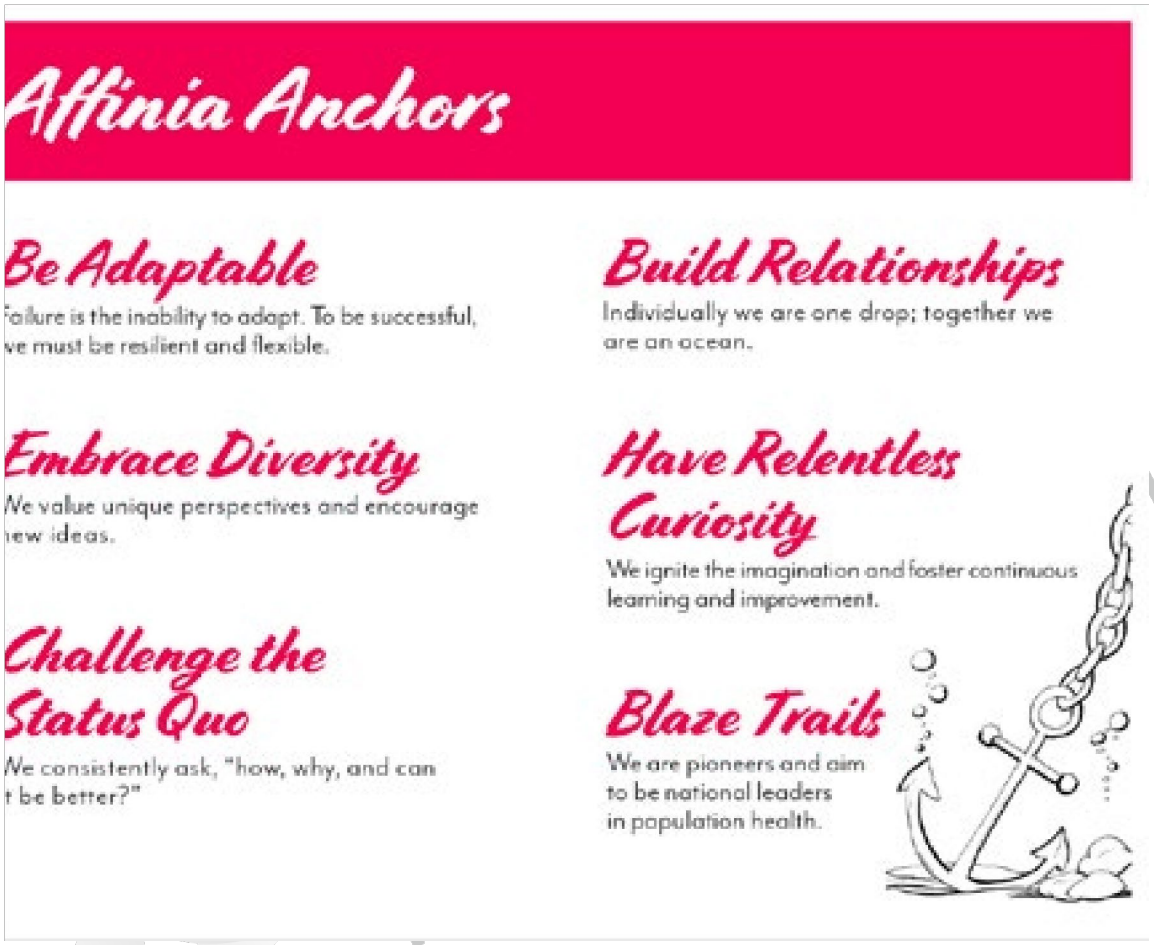
Section 1: General Information

Affinia Health Contact Information

Affinia Health Main Phone Number.....231.728.3882
Affinia Health Fax – Muskegon.....231.672.6786
Affinia Health Fax – Grand Rapids.....616.685.8550
Affinia Health Website.....AffiniaHealth.com

General Email Address.
Network Relations.....affinianetworkrelations@mercyhealth.com

Affinia Anchors



Population Health Incentives

Overview

Affinia Health Network participates in various payer contracts that allow additional opportunity to earn incentive dollars. These incentives vary by program and fall into 4 different categories. The 4 incentive methods are pay for performance, value-based reimbursement, gain share and infrastructure.

Pay for Performance

Pay for performance incentive programs reward for clinical performance by providing additional funds for meeting clinical goals in the areas of quality and utilization. These rewards are separate from the normal fee for service payment and paid out within timeframes set by each individual program.

Examples of Pay for Performance: BCN Performance Recognition Program (PRP) & Priority Health's Performance Incentive Program (PIP)

Value Based Reimbursement

Value Based Reimbursement (VBR) is an incentive methodology that allows additional percentage beyond the 100% standard fee schedule that can be added to enhance the base fee schedule payment. The VBR programs enhance fee schedules at varying amounts based on the reward program. This could include clinical initiatives & cost of care performance.

Examples of VBR: BCBSM Specialist VBR program & BCBSM Clinical Quality Initiative (Primary Care)

Gain share

Gain share is an incentive reward used in risk-based contracts that reward a dollar amount based on quality, cost and utilization performance. Gain share typically is rewarded to the Clinically Integrated Network for effectively managing patient population costs through a determined time period. Gain share rewards are typically distributed one time a year based on the measurement year performance.

Examples of Gain share: Medicare ACO & BCN settlement

Infrastructure

Infrastructure is incentive that rewards incentives for implementation of staff, education or processes. Infrastructure rewards can consist of a onetime payment or an ongoing payment based around the number of patients impacted by the program.

Examples of Infrastructure: BCBSM PCMH capability implementation & Priority Health PCMH PIP payment

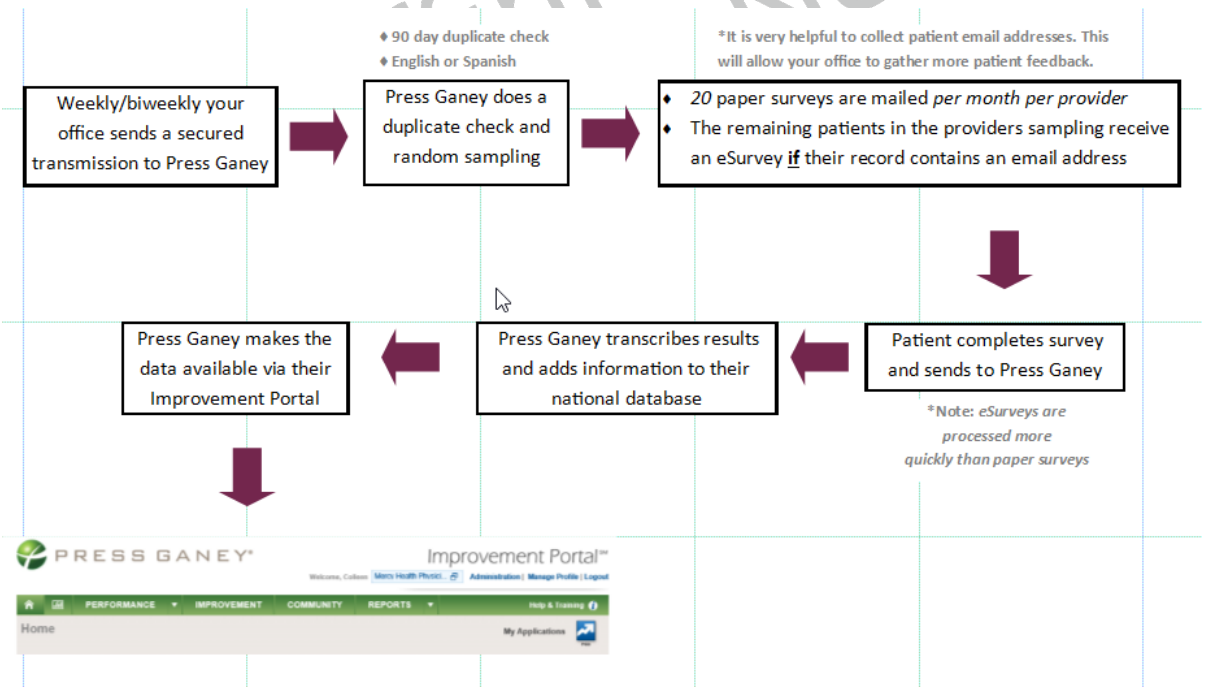
Patient Experience: Press Ganey

Transforming the care experience and delivering safe, high-quality, patient-centered care requires continuous evolution of practices and processes to meet patient needs. Affinia Health Network uses the Clinician & Group Consumer Assessment of Healthcare Providers & Systems (CG-CAHPS) survey. This survey is based on rigorous scientific development and testing, as well as stakeholder input. It focuses on topics for which patients are the best or only source of information. In addition, it is the most widely accepted version for payer quality incentive programs.

CG-CAHPS collects feedback from patients in the following categories:

- Global
  - Recommend this Provider Office
  - Rate Provider 0-10
- Physician Communication Quality
- Office Staff Quality
- Access to Care
- Care Coordination

Below is the workflow used to gather patient satisfaction data:



Press Ganey: Affinia Supported

- Affinia Health Network Covers the cost of the Press Ganey Tool for applicable member providers. Saving member practices $500 per provider per year!
- Press Ganey Improvement Portal trainings and application support
- Quarterly "*Rate the Provider"* Performance Reports
- Monthly "Patient Experience" Performance Reports
- Patient Experience Marketing Materials
- Tools to support patient experience discussion with patients

Reach out to your assigned Affinia Health Representative by emailing affinianetworkrelations@mercyhealth.com to learn more details about how your office can utilize Press Ganey to increase patient satisfaction.

Press Ganey: MDA 2020 Reporting Schedule

Refresh Month	Report Period Ending	45-Day Run Out	MDA Approximate Run Date	Release Date
March	12/31/2019	2/14/2020	2/26/2020	3/10/2020
April	1/31/2020	3/16/2020	3/28/2020	4/10/2020
May	2/29/2020	4/14/2020	4/26/2020	5/10/2020
June	3/31/2020	5/15/2020	5/27/2020	6/10/2020
July	4/30/2020	6/14/2020	6/26/2020	7/10/2020
August	5/31/2020	7/15/2020	7/27/2020	8/10/2020
September	6/30/2020	8/14/2020	8/26/2020	9/10/2020
October	7/31/2020	9/14/2020	9/26/2020	10/10/2020
November	8/31/2020	10/15/2020	10/27/2020	11/10/2020
December	9/30/2020	11/14/2020	11/26/2020	12/10/2020
January 2021	10/31/2020	12/15/2020	12/27/2020	1/10/2021
February 2021	11/30/2020	1/14/2021	1/26/2021	2/10/2021
March 2021	12/31/2020	2/14/2021	2/26/2021	3/10/2021
April 2021	1/31/2021	3/17/2021	3/29/2021	4/10/2021
May 2021	2/28/2021	4/14/2021	4/26/2021	5/10/2021
June 2021	3/31/2021	5/15/2021	5/27/2021	6/10/2021

HCC Coding Overview

Background:

First implemented by the Centers of Medicare and Medicaid Services (CMS) in 2004, risk adjustment is an actuarial tool used to predict healthcare costs based on health status and relative risk of plan enrollees. Though initially only relevant for Medicare Advantage plans, risk adjustment methodology now also determines, in part, reimbursement for accountable care organizations, Affordable Care Act exchange plans, value-based purchasing, and can augment population health efforts.

Under this model, a risk adjustment factor (RAF) score is assigned to each patient that reflects their corresponding clinical complexity. Risk or RAF scores allow CMS to make appropriate and accurate payments according to an individual's predicted annual healthcare spend. RAF scores are derived from a patient's demographic information and volume of billed diagnoses associated with Hierarchical Condition Categories (HCCs).

The HCC Risk Model is dependent upon accurate and complete diagnosis coding. Each diagnosis code carries an assigned RAF value based on the severity and complexity of the illness or injury, with higher values being assigned to more serious conditions. It's important to note that not all diagnosis codes are assigned a RAF value. There are over 9,500 ICD-10 diagnosis codes that map to 79 identified condition categories.

Accurate diagnosis coding and complete clinical documentation by the provider increases the precision of member risk scores resulting in appropriate (and often appropriately higher) reimbursement. Providers who fail to capture relevant conditions will receive lower reimbursement rates. Accurate coding also creates a more precise estimate of disease burden that allows us to stratify patients by risk and target clinical initiatives to specific high prevalence disease states. Finally, accurate risk scores can also be leveraged as a metric when considering panel size, productivity, access, and coding education effort.

Risk Score Calculation:

Two sources of data are used to determine a patient's RAF or risk score – demographic information and health status defined by ICD-10-CM diagnosis codes.

Figure 1: CMS HCC Calculation

Demographics Include:

- Age
- Gender
- Dual eligibility status
- Disability status
- Living situation (skilled nursing facility or community)

Health Status:

- Diagnoses are recorded using HCC codes based off specific ICD-10 codes

RAF Score:

- RAF values are assigned to HCCs
- If a RAF score is high, the patient has a higher disease burden; if low, the patient is assumed to be less complex
- RAF values are additive
- The HCC process includes a prospective review of health status in a base year to predict costs in the following year
- RAF values are recalculated each year

Process:

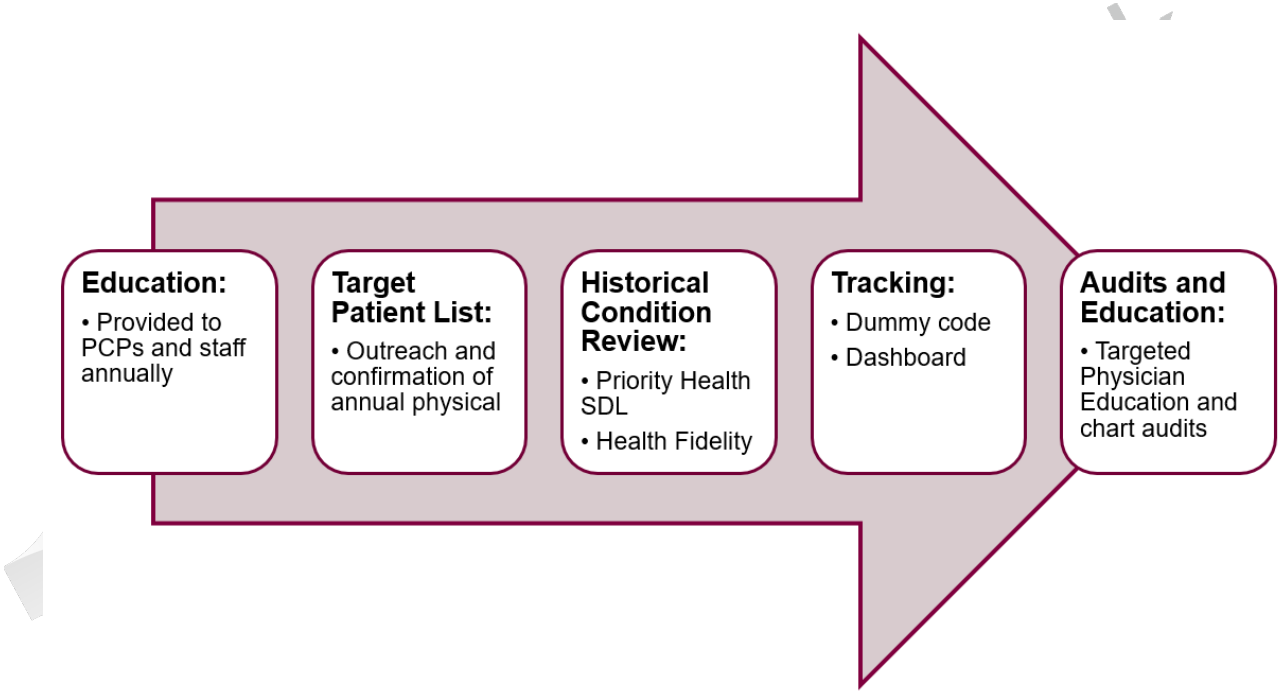


Figure 2: CCV Process

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Medicare Coverage of Physical Exams

Welcome to Medicare Visit (Initial Preventive Physical Exam / IPPE G0402)	Annual Wellness Visit (G0438 initial / G0439 subsequent)	Routine Physical Examination (99387 new / 99397 established)
Review of medical and social health history, preventive services education, and referrals, as appropriate • Covered only once in lifetime, with-in first 12 months of Part B enrollment • Patient pays nothing (if provider accepts assignment) • Patient must be within the first 12 months of Medicare Part B enrollment to receive this service. Not all patients receive a Welcome to Medicare visit • Must include a visual acuity screen • Must be performed by an MD, DO, PA, NP, or certified clinical nurse specialist • A typical review of systems or physical examination is not an inherent component of this service	Visit to develop or update a personalized prevention plan, and perform a health risk assessment • Covered once every 12 months • Patient pays nothing (if provider accepts assignment) • An MD, DO, PA, NP, CNS, or medical professionals including health educators, registered dietitians, other li-censed practitioners may perform this service • Includes a Health Risk Assessment • A typical review of systems or physical examination is not an inherent component of this service • Does not replace a complete head-to-toe physical exam • An Initial AWV is a once in a lifetime benefit for patients no longer within the first 12 months of Medicare Part B enrollment • A Subsequent AWV is for patients no longer within the first 12 months of Medicare Part B enrollment and have already received an Initial AWV more than 12 months prior	Age and gender appropriate exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury. These visits include counseling / anticipatory guidance / risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination • Not covered by traditional Medicare; prohibited by statue • Patient pays 100% out of pocket • Some Medicare Advantage plans will cover this service

Initial Preventative Physician Exam (IPPE)

The IPPE is also known as the "Welcome to Medicare" preventive visit. The goals of the IPPE are health promotion, disease prevention, and detection. Medicare pays for one beneficiary IPPE per lifetime no later than the first 12 months after the beneficiary's eligibility date for Medicare Part B benefits. Medicare may pay for the additional service if a significant, separately identifiable, medically necessary E/M service (99201 - 99215) is performed with the IPPE and supported separately in the documentation. That portion of the visit must be medically necessary to treat the patient's illness or injury.

Annual Wellness Visits (AWV)

The purpose of the Annual Wellness Visit under Medicare is to establish the state of the patient's health and to create a baseline for future care. Medicare may pay for the additional service if a significant, separately identifiable, medically necessary E/M service (99201 - 99215) is performed with the AWV and supported separately in the documentation. That portion of the visit must be medically necessary to treat the patient's illness or injury. Keep in mind, the AWV is not a head-to-toe-physical.

Medicare covers an AWV for all beneficiaries who are no longer within 12 months after the eligibility for Medicare Part B benefits, and who have not had either an IPPE or an AWV within the past 12 months. Medicare pays for only one initial AWV per beneficiary per lifetime and one subsequent AWV per year thereafter.

During a Medicare Annual Wellness Visit, the provider will measure height, weight, body mass index (BMI), and blood pressure. Through a series of questions, the provider will also go over the patient's medical history, family medical history, check any potential risk factors for preventable diseases such as Type II diabetes and depression, recommend tests and screenings such as mammograms and vaccinations, offer the option of discussing end-of-life issues, and provide counseling and referrals as appropriate.

The AWV includes health assessments but not a typical head-to-toe physical examination, unless warranted by results of the past medical and family medical history.

Routine Physician Examination

Traditional Medicare does not cover annual physical examinations. An annual physical consists of an age and gender appropriate history and physical exam, anticipatory guidance and/or counseling, as appropriate. Any blood work or lab tests that may be part of a physical exam may not be included under a Medicare Annual Well-ness Visit.

Please reference the *Welcome to Medicare Checklist and Billing Requirements* and *AWV Checklist and Billing Requirements* for additional information.

Care Management

Care Management is the collaborative process of assessment, evaluation, planning, coordination, and advocacy to assist patients and their support systems in managing complex medical and psychosocial conditions. The aim is to improve health status, enhance the coordination of care, and eliminate the duplication of services to improve quality, increase patient satisfaction, and reduce health care costs.

Core Responsibilities

- Identify patients with complex chronic conditions who are at high-risk for negative health outcomes, care fragmentation, and/or high-cost of care that are likely to benefit from care management services
- Monitor hospital admission, discharge, and transfer reports to identify patients with transitions of care needs
- Perform comprehensive health assessments to identify the risk and needs of patients and develop patient-centered plans of care
- Assist patients and caregivers in managing complex chronic conditions through self-management support
- Provide resource support, education, and care coordination during transitions between health care settings
- Assess psychosocial needs to connect patients with resources in the community

Key Deliverables

- Standardized work protocols to drive efficient and effective care management services
- Hiring, training, and embedment of care management staff into practice teams
- Payer and Government care management program tracking to ensure service alignment and compliance
- Population Health tools for the risk stratification of patient populations to identify patients appropriate for care management services
- Care Management billing support and ongoing claims and documentation monitoring to ensure compliance and revenue optimization
- Care management data and analytics tracking to ensure program productivity and alignment with standards

Team Measurements

- Care Management Productivity, Caseload, and Payer Mix
- Care Management Quality and Utilization Outcomes
- Incentive Program Performance

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Priority Health Medication Therapy Management PCP Incentive

What is Medication Therapy Management (MTM)?

MTM is an umbrella term used to capture a wide variety of clinical services, typically provided by a pharmacist, varying from medication review activities to chronic disease management services.

Why did Priority Health include MTM as a PCP Incentive Program (PIP) measure?

In 2003, the Medicare Modernization Act required Medicare Advantage plans, like Priority Health, to offer MTM services to eligible Medicare patients. Priority Health partnered with a company called OutcomesMTM to provide lists of MTM eligible patients to pharmacists who then completed MTM services and documented the care provided in the OutcomesMTM platform.

Given improved outcomes & total cost of care reductions seen in the Medicare patients that met with a pharmacist for an MTM service, Priority Health, in 2017, introduced the MTM PIP measure to enable pharmacists to provide these same services across all Priority Health populations (Medicare, Medicaid and Commercial) and for primary care providers to earn incentive dollars if their patients participated in the MTM service.

What changes did Priority Health implement for the 2019 for the MTM PIP measure?

In 2017 and 2018, MTM work completed and documented in OutcomesMTM by *any* pharmacist would fulfill the requirements on the MTM PIP measure without additional prerequisites. In 2019, Priority Health required the following for a provider to be eligible to earn incentive dollars for MTM:

- The pharmacist providing the MTM service must have access to the practice EHR
- The provider and the pharmacist must enter into a collaborative practice agreement (an official document, signed by the provider(s) & pharmacist clearly defining the relationship, outlining the duties and responsibilities of both parties)
- A Comprehensive Medication Review (CMR) must be documented in the OutcomesMTM platform by the pharmacist

The changes implemented in 2019 continue into 2020, but a key difference in 2020 is the dollars on the table for MTM. Priority Health is now offering 3 incentive tiers ($40, $60 or $75 per measured member) based on CMR completion rates by product (i.e. HMO/POS, ASO/PPO, Medicare).

What is the Affinia Health Network (AHN) plan to capture MTM PIP Incentive dollars in 2020?

AHN has worked with Mercy Health leadership and affiliate practices to ensure eligible & interested offices have access to pharmacy resources to complete MTM activities. The available pharmacist resource for each office will vary, but may include: retail, office-based and/or AHN pharmacists. These pharmacists will work with eligible Priority Health patients and complete CMRs as well as other MTM activities.

If you have questions about this measure or the requirements to earn the incentive, please contact AHN's Pharmacy Manager: Tiffany Jenkins at 616-685-7740 or Tiffany.Jenkins@mercyhealth.com

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Affinia Health Network Incentive Tracker

Overview

The Affinia Health Network Incentive tracker was designed to aid offices in prioritizing quality measures based on financial incentive. The incentive tracker utilizes quality measure performance numbers taken from each payer program to create an aggregated view of quality incentive opportunities. This report includes payer summaries form the following programs:

- Performance Recognition Program (PRP) - BCN, BCNA, BCBSM MA
- Patient Centered Medical Home (PCMH) & Clinical Quality (VBR)- BCBSM
- PCP Incentive Program (PIP) – Priority Health

The incentive tracker prioritizes measures at 2 levels, the aggregation of all the quality incentive programs and each program broken down by payer. This tool utilizes the methodology behind each payer quality incentive program to create an estimated dollar amount per measure. This estimated dollar amount is the prioritized through a priority index to display the top measures for and estimated financial opportunity.

Background

The main objective of the Affinia Health Network Incentive Tracker is to provide a report that can be used to prioritize quality metrics with the goal of maximizing quality incentive program performance.

Current Status

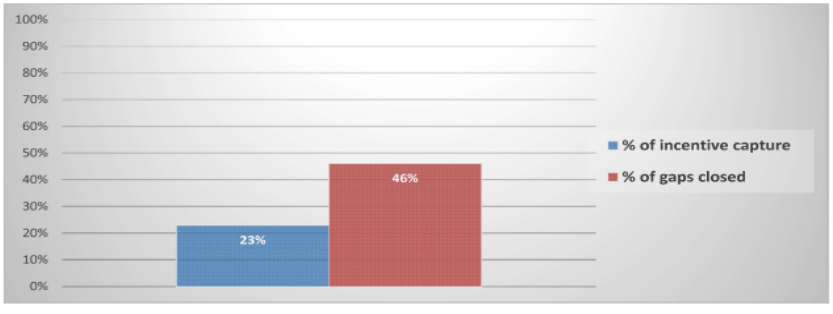
In June 2020 the AHN incentive tracker will be updated with the current year quality measures and incentive program changes. The AHN Incentive Tracker will be updated with the most current numbers on a monthly basis.

AHN Incentive Tracker example

For further details please contact your practice coach or submit your questions to Affinianetworkrelations@mercyhealth.com

Practice ABC	Through 11/30/2017					
BCN Commercial	Num	Denom	Rate	Est Opportunity	Est Reward	Est Left on Table
Breast Cancer Screening - Mammogram	20	29	69%	$ 2,625.00	$ -	$ 2,625.00
Retinal or Dilated Eye Exam by an Eye Care Professional	9	16	56%	$ 275.00	$ 100.00	$ 175.00
A1c control (<8 %)	11	16	69%	$ 4,000.00	$ 2,750.00	$ 1,250.00
Monitoring for Nephropathy	12	16	75%	$ 2,400.00	$ -	$ 2,400.00
PHQ9 Questionnaire (Period 2 Followup)	0	0		$ -	$ -	$ -
PHQ9 Questionnaire (Period 1 Followup)	0	0		$ -	$ -	$ -
BMI Percentile, height and weight documented in the medical record	10	20	50%	$ 1,000.00	$ -	$ 1,000.00
Counseling for Nutrition documented in the medical record	0	20	0%	$ 1,000.00	$ -	$ 1,000.00
Counseling for Physical Activity documented in the medical record	0	20	0%	$ 2,000.00	$ -	$ 2,000.00
Use of Imaging Studies for Low Back Pain - 2016 Spec	1	1	100%	$ 150.00	$ 150.00	$ -
Well Child Visits Within the First 15 Months (6 or more visits)	1	1	100%	$ 100.00	$ 100.00	$ -
Follow-Up Care for Children Prescribed ADHD Medications:Initiation Phase	0	0		$ -	$ -	$ -
Total	64	139	46%	$ 13,550.00	$ 3,100.00	$ 10,450.00

Priority Index		
Measure	Left on Table	Open gaps
Breast Cancer Screening - Mammogram	$ 2,625.00	9
Monitoring for Nephropathy	$ 2,400.00	4
Counseling for Physical Activity documented in the medical record	$ 2,000.00	20
A1c control (<8 %)	$ 1,250.00	5
Counseling for Nutrition documented in the medical record	$ 1,000.00	20



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Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor

Patient-Centered Medical Home (PCMH) is a team-based health care delivery model led by a primary health care provider to provide comprehensive and continuous medical care to patients with a goal to obtain maximal health outcomes. Patient Centered Medical Home Neighbor (PCMH-N) focuses on the specialist role. PCMH-N focuses on processes that ensure effective communication, coordination and integration with PCMH practices, efficient flow of information, including timely consultations and referrals, guide the determination of responsibility in co-management situations, and support enhanced access and patient-centered high-quality care.

The provision of medical homes is intended to allow better access to health care, increase satisfaction with care, and improve overall health.

PCMH & PCMH-N Principles:

Patient Centered Medical Home & Patient Centered Medical-Neighbor has five key principles:

- Recognizing the Primary Care Provider as the patient's designated *Medical Home*
- Timely consultations and referrals within your Clinically Integrated Network
- Shared responsibility of clinical interactions between Primary and Specialty Care
- Development and utilization of standard processes
- Utilization of population health registries to assist in management of chronic and preventive services.

PCMH deliverables

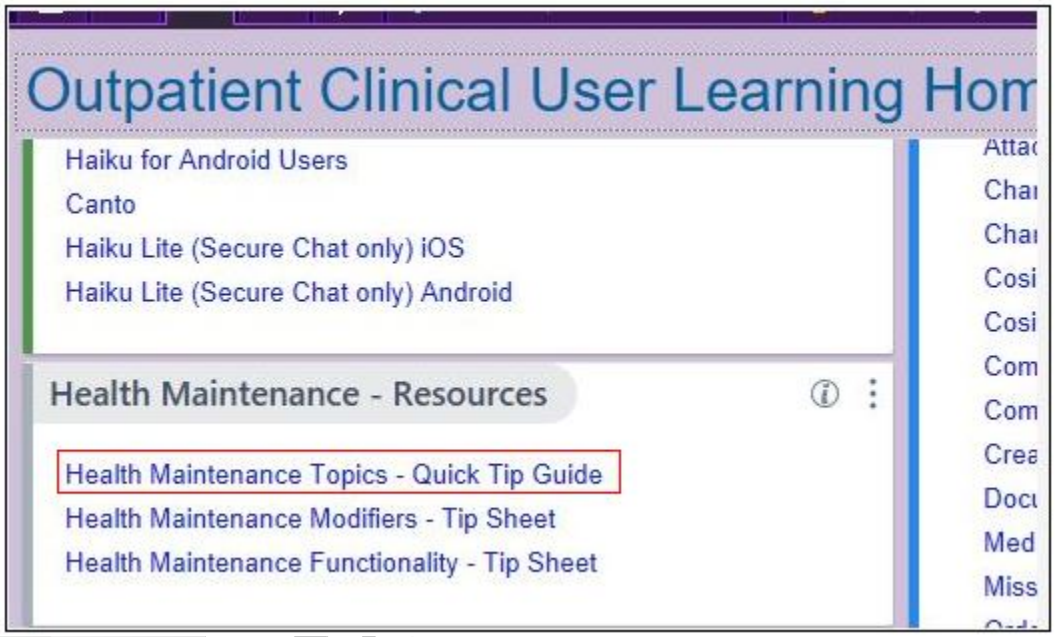
In order obtain the primary care PCMH designation a practice must implement a sub set of PCMH capabilities that are attested for by the CIN. These capabilities are broken down into 13 domains that are a road map for the PCMH principles. These capabilities are submitted 2 times a year by the CIN to BCBSM to be considered for PCMH designation.

PCMH Designation

PCMH designation is awarded on a calendar year and is based on three measurement categories: quality, use and PCMH capabilities. PCMH designation is also a prerequisite to access additional up to an additional 50% Value Based Reimbursement rewarded by BCBSM.

MHPP Quality Measure Satisfier Job Aid

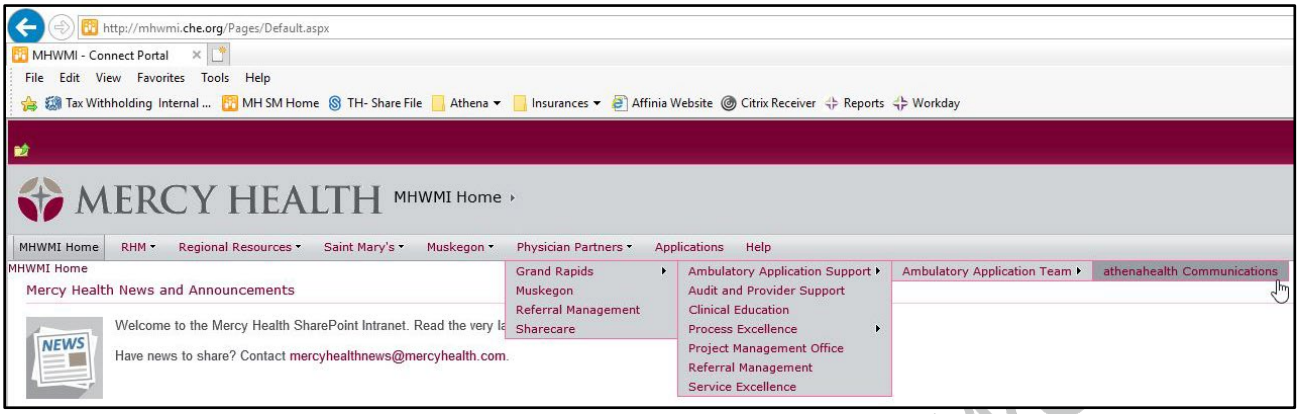
- The best place to find ways to satisfy quality measures is to visit the "Outpatient Clinical User Learning Home Dashboard" within the Epic application.
- The job aid can be found under *Health Maintenance – Resources* and is titled "Health Maintenance Topics – Quick Tip Sheet"
    - The job aid houses 37 pages worth of information on how to do multiple things for Health Maintenance and embedded is quality measures.



NOTE: If unsure how to locate the Outpatient Clinical User Learning Home Dashboard or have any questions regarding workflow please contact your local informatics team for guidance.

MHPP Job Aids for PCMH

- Open up Internet Explorer, it should open to the Mercy Health Share Point page.
- Under *Physician Partners* hover over Grand Rapids – Ambulatory Application Support – Ambulatory Application Team – athenahealth Communication



When the page opens click on "PCMH Job Aids"

- When the page opens select the job aid by clicking on the red link of the job aid desired.

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QUALITY MEASURE SPECIFICATIONS

Section 2

Affinia Health Network

Section 2: Quality Measure Specifications

Glossary

Measurement Year: 1/1/2020 to 12/31/2020

Multi-Year Lookback:

- 2-Year (during the measurement year or prior year) – 1/1/2019 to 12/31/2020
- 3-Year (during the measurement year or 2 years prior) – 1/1/2018 to 12/31/2020
- 4-Year (during the measurement year or 3 years prior) – 1/1/2017 to 12/31/2020
- 5-Year (during the measurement year or 4 years prior) – 1/1/2016 to 12/31/2020
- 10-Year (during the measurement year or 9 years prior) – 1/1/2011 to 12/31/2020

Affinia Health Network Target: Affinia Health Network selects the most stringent target performance rate of all payers for each clinical quality measure

Description: Explains the measure, usually measured as a percentage of patients who are compliant or noncompliant (for inverted measures)

Initial Population (Denominator): Criteria for the number of patients eligible for the measure

Numerator: Criteria for the number of patients who satisfy the measure

Denominator Exclusions: Criteria for the number of patients who are excluded from the Initial Population (Denominator) prior to looking for the numerator criteria; not all measures have exclusion criteria

Denominator Exceptions: Criteria for the number of patients who are excluded from the Initial Population (Denominator) when they do not meet the numerator criteria for specified reasons; not all measures have exception criteria

Tips and Tricks: Additional information on the measure

Continuous Enrollment: Most payers factor continuous enrollment when determining whether a patient falls into the Initial Population (Denominator)

Hospice: Generally, patients in hospice are excluded from the denominator population

Behavioral Health

Depression Screening and Follow-Up Plan

Payer/Program

- ACO
- Priority Health Commercial
- Priority Health Medicare
- Priority Health Medicaid

Affinia Health Network Target

- 90%

Description

- The percentage of patients 12 years of age and older who had a billed preventive evaluation and management (E&M) visit with a participating PCP and were screened for clinical depression using a standardized tool AND if screened positive, received appropriate follow-up care.
- ACO: 12 years of age and older at the beginning of the measurement period
- Priority Health: 12 years of age and older on or before the end of the measurement period

Initial Population (Denominator)

- All patients 12 years of age and older on or before the last day of the measurement year with at least one encounter on or before November 30th of the measurement year

Numerator

- ACO patients screened for depression on the date of the encounter using an age-appropriate standardized tool AND if positive, the follow-up plan is documented on the date of the positive screen
- Priority Health Patients who had a billed preventive E&M visit during the measurement year and were screened for depression and for those who were screened positive for clinical depression, were provided follow-up care within 30 calendar days after the positive screen with one or more of the following:
  - Dispensed an antidepressant medication
  - A follow-up encounter in behavioral health, including assessment, therapy, medication management or acute care
  - A follow-up outpatient visits with a diagnosis of depression
  - Follow-up with a care manager with a documented assessment for depression symptoms (any encounter that addresses depression symptoms) or a diagnosis of depression or other behavioral health condition: care management encounters on the same day as the positive screen do NOT count as follow-up care
  - Assessment on the same day as the positive screen with included documentation of additional depression assessment indicating no depression

Denominator Exclusions

- Patients with a diagnosis of Depression during the year prior to the measurement year
- Patients with an active diagnosis of Bipolar Disorder during the year prior to the measurement year

Denominator Exceptions

- ACO: Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of depression screen (e.g.: court appointed cases or case of delirium)
- Are in urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status

Tips and Tricks

- A depression screen must be completed on the date of a qualifying encounter.
- The name of the screening tool must be documented in the medical record.
- The depression screen must be reviewed and addressed in the office of the provider billing the code on the date of the encounter.
- Behavioral health encounters on the same day as the positive screen count as follow-up care.
- Outpatient encounters outside behavioral health on the same day as the positive screen do not count as follow-up care. For example, a PCP visit with a diagnosis of depression or dysthymia on the same day as the positive screen does not meet the criteria for follow-up care.
- If the provider who completed the depression screening is no longer a participating PCP, that screening and the corresponding visit will not count towards the incentive measure.
- The PHQ-9M: Modified for Teens is an accepted screening tool.
- A practice must bill a PCP office visit code and if the PHQ score for that office visit date is less than 10, submit the supplemental PHQ value.
- If the PHQ score is greater than 10 (screened positive for clinical depression), a follow-up code will need to be billed within 30 calendar days of the positive PHQ screen.

Depression Remission at Twelve Months

Payer/Program

- ACO

Affinia Health Network Target

- Reporting Only

Description

- The percentage of patients 12 years of age or older with a diagnosis of Major Depression or Dysthymia who reached remission 12 months (+/- 60 days) after an index event within the denominator identification period of 11/1/2017 and 10/31/2018.

Initial Population (Denominator)

- Patients 12 years of age and older with a diagnosis of Major Depression or Dysthymia AND an initial PHQ-9 score >9 within the denominator identification period of 11/1/2017 and 10/31/2018

Numerator

- Patients who achieved remission at twelve months (+/- 60 days) after an index event as demonstrated by a PHQ-9 score <5

Denominator Exclusions

- Diagnosis of Bipolar Disorder
- Diagnosis of Personality Disorder
- Diagnosis of Schizophrenia or Psychotic Disorder
- Diagnosis of Pervasive Developmental Disorder
- Patients who were permanent nursing home residents

Denominator Exceptions

- None

Tips and Tricks

- The patient must have an active diagnosis of Major Depression or Dysthymia on the same date of the PHQ-9 score >9 to be identified in the initial population (denominator).
- An active diagnosis of Major Depression or Dysthymia is defined as a diagnosis that is either on the patient's problem list, a diagnosis code description listed on the encounter, or is documented in a progress note indicating that the patient is being treated or managed for the disease or condition.
- A permanent nursing home resident is defined as a patient who is residing in a long-term residential facility any time during the denominator identification period or before the end of the measurement assessment period. This does NOT include patients who are receiving short-term rehabilitative services following a hospital stay. This also does NOT include patients residing in assisted living or group home settings.
- The measurement assessment period is defined as the twelve months (+/- 60 days) after an index event within the denominator identification period of 11/1/2017 and 10/31/2018.

Chronic Disease Measures: Diabetes

Diabetes: Dilated Retinal Exam

Payer/Program

- BCBSM Commercial
- BCN Commercial
- BCN Medicare Advantage
- Meridian Medicaid
- Molina Medicaid
- Molina Medicare Advantage
- Priority Health Commercial
- Priority Health Medicaid
- Priority Health Medicare

Affinia Health Network Target

- 85%

Description

- The percentage of patients 18 to 75 years of age with diabetes (Type I or II) who had a retinal or dilated eye exam by an eye care professional any time during the measurement year or had a negative retinal exam (no evidence of retinopathy) any time during the measurement year or year prior.

Initial Population (Denominator)

- Patients 18 to 75 years of age at the end of the measurement period with diabetes (Type I or II)
  - Priority Health defines diabetes by the following:
    - Two face-to-face encounters with a diagnosis of diabetes:
    - On different dates of service
    - In an outpatient setting, observation visit, ED visit, or non-acute inpatient encounter during the measurement year or year prior **OR**
  - One face-to-face encounter with a diagnosis of diabetes:
    - In an acute inpatient encounter without telehealth in the year prior or measurement year
    - One acute inpatient discharge with a diagnosis of diabetes on the discharge claim, **OR**
  - Pharmacy data, insulin or oral hyperglycemic/anti-hyperglycemic filled script with a diagnosis of diabetes during the measurement year or year prior

Numerator

- Patients with an eye screening for diabetic retinal disease which includes diabetics who have one of the following eye exams by an eye care professional:
  - A retinal eye exam anytime during the measurement year, OR
  - A negative retinal exam (no evidence of retinopathy) any time during the measurement year or year prior

Denominator Exclusions

- Medicare patients 66 years of age and older during the measurement year who meet one of the following:
  - Enrolled in an Institutional SNP (I-SNP) during the measurement year
  - Living long-term in an institution any time during the measurement year
  - Frailty and advanced illness

- Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with a diagnosis of diabetes during the measurement year or year prior

Denominator Exceptions

- None

Tips and Tricks

- Only patients with a diagnosis of diabetes (Type I or Type II) should be included in the measure's denominator
- The eye exam must be performed by an Ophthalmologist or Optometrist
- Eye exam results read by a system that provides an artificial intelligence (AI) interpretation meets criteria.

Controlled Less Than 8.0%

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Molina Medicaid
- Priority Health Commercial
- Priority Health Medicare
- Priority Health Medicaid
- United Healthcare

Affinia Health Network Target

- 78%

Description

- The percentage of patients 18 to 75 years of age with a diagnosis of diabetes (Type I or II) and with a documented HbA1c <8.0%. This measure considers the most recent HbA1c test performed during the measurement year.

Initial Population (Denominator)

- Patients 18 to 75 years of age at the end of the measurement period with diabetes (Type I or II)
  - Priority Health defines diabetes by the following:
    - Two face-to-face encounters with a diagnosis of diabetes:
    - On different dates of service
    - In an outpatient setting, observation visit, ED visit, or non-acute inpatient encounter during the measurement year or year prior, **OR**
  - One face-to-face encounter with a diagnosis of diabetes:
    - In an acute inpatient encounter without telehealth in the year prior or measurement year
    - One acute inpatient discharge with a diagnosis of diabetes on the discharge claim, **OR**
  - Pharmacy data, insulin or oral hyperglycemic/anti-hyperglycemic filled script with a diagnosis of diabetes during the measurement year or year prior

Numerator

- Diabetic patients whose most recent HbA1c value during the measurement year is <8.0%

Denominator Exclusions

- Medicare patients 66 years of age and older during the measurement year who meet one of the following:
  - Enrolled in an Institutional SNP (I-SNP) during the measurement year
  - Living long-term in an institution any time during the measurement year
  - Frailty and advanced illness
  - Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with a diagnosis of diabetes during the measurement year or year prior

Denominator Exceptions

- None

Tips and Tricks

- This measure considers the most recent lab test performed during the measurement year. If no HbA1c test was performed during the measurement year, the level is considered to be greater than 8.0% and NOT meeting the measure.
- Screening documentation and result MUST be obtained and, in the PCP's, medical record

Controlled Less Than or Equal to 9.0%

Payer/Program

- BCN Medicare Advantage
- Humana Medicare Advantage
- Molina Medicare Advantage
- Priority Health Commercial
- Priority Health Medicare
- Priority Health Medicaid

Affinia Health Network Target

- 89%

Description

- The percentage of patients 18 to 75 years of age with a diagnosis of diabetes (Type I or II) and with a documented HbA1c ≤ 9.0%. This measure considers the most recent HbA1c test performed during the measurement year.
- Humana: HbA1c value is < 9.0%

Initial Population (Denominator)

- Patients 18 to 75 years of age at the end of the measurement period with diabetes (Type I or II)
  - Priority Health defines diabetes by the following:
    - Two face-to-face encounters with a diagnosis of diabetes:
    - On different dates of service
    - In an outpatient setting, observation visit, ED visit, or non-acute inpatient encounter during the measurement year or year prior, **OR**
  - One face-to-face encounter with a diagnosis of diabetes:
    - In an acute inpatient encounter without telehealth in the year prior or measurement year
    - One acute inpatient discharge with a diagnosis of diabetes on the discharge claim, **OR**
  - Pharmacy data, insulin or oral hyperglycemic/anti-hyperglycemic filled script with a diagnosis of diabetes during the measurement year or year prior

Numerator

- Diabetic patients whose most recent HbA1c value during the measurement year is ≤ 9.0%
- Humana: HbA1c value is < 9.0%

Denominator Exclusions

- Medicare patients 66 years of age and older during the measurement year who meet one of the following:
  - Enrolled in an Institutional SNP (I-SNP) during the measurement year
  - Living long-term in an institution any time during the measurement year
  - Frailty and advanced illness
  - Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with a diagnosis of diabetes during the measurement year or year prior

Denominator Exceptions

- None

Tips and Tricks

- This measure considers the most recent lab test performed during the measurement year.
- If no HbA1c test was performed during the measurement year, the level is considered to be greater than 9.0% and NOT meeting the measure
- Screening documentation and result MUST be obtained and, in the PCP's, medical record

Poor Control More Than 9.0%

Payer/Program

- ACO

Affinia Health Network Target

- 39.63%

Description

- The percentage of patients 18 to 75 years of age with a diagnosis of diabetes (Type I or II) and with a documented HbA1c >9.0%. This measure considers the most recent HbA1c test performed during the measurement year.

Initial Population (Denominator)

- Patients 18 to 75 years of age at the end of the measurement period with diabetes (Type I or II) and with a visit during the measurement period

Numerator

- Diabetic patients whose most recent HbA1c value during the measurement year is >9.0%

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Only patients with a diagnosis of Type I or Type II diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.
- The measure is an inverted measure, meaning noncompliant patients will be included in the numerator. Lower performance rates on this measure are better.
- This measure considers the most recent lab test performed during the measurement year.
- If no HbA1c test was performed during the measurement year, the patient is considered compliant and meets the measure (will NOT be included in the numerator).
- Screening documentation and results MUST be obtained and, in the PCP's, medical record

Diabetes: Hemoglobin A1C (HbA1c) Testing

Payer/Program

- Blue Cross Complete
- Meridian Medicaid
- Molina Medicaid

Affinia Health Network Target

- 60th percentile

Description

- The percentage of patients ages 18 to 75 years of age with a diagnosis of diabetes and with a documented HbA1c test performed during the measurement year.

Initial Population (Denominator)

- Patients 18 to 75 years of age at the end of the measurement period with diabetes (Type I or II)
  - Two face-to-face encounters with a diagnosis of diabetes:
  - On different dates of service
  - In an outpatient setting, observation visit, ED visit, or non-acute inpatient encounter during the measurement year or year prior, **OR**
- One face-to-face encounter with a diagnosis of diabetes:
  - In an acute inpatient encounter without telehealth in the year prior or measurement year
  - One acute inpatient discharge with a diagnosis of diabetes on the discharge claim, **OR**
- Pharmacy data, insulin or oral hyperglycemic/anti-hyperglycemic filled script with a diagnosis of diabetes during the measurement year or year prior

Numerator

- Diabetic patients who had an HbA1c performed during the measurement year

Denominator Exclusions

- Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face to face encounters with a diagnosis of diabetes during the measurement year or year prior

Denominator Exceptions

- None

Tips and Tricks

- Documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding.
- An HbA1c test could be listed as any of the following; A1c, HbA1c, HgbA1c, Hemoglobin A1c, Glycohemoglobin A1c, Glycohemoglobin, Glycated hemoglobin, Glycosylated hemoglobin.
- Screening documentation and results MUST be obtained and, in the PCP's, medical record

Diabetes: Monitoring for Nephropathy

Payer/Program

- BCBSM Commercial
- BCN Commercial
- BCN Medicare Advantage
- Humana Medicare Advantage
- Meridian Medicaid
- Molina Medicaid
- Molina Medicare Advantage
- Priority Health Commercial
- Priority Health Medicaid
- Priority Health Medicare

Affinia Health Network Target

- 98%

Description

- The percentage of patients 18 to 75 years of age with diabetes (Type I or II) who have had one of the following:
  - A nephropathy screening – micro-albumin lab during the measurement year
  - Medical treatment for nephropathy during the measurement year
  - Diagnosis of nephropathy during the measurement year
  - Visit with a nephrologist during the measurement year
  - At least one dispending event of ACE/ARB medication during the measurement year
  - Evidence of nephrectomy or kidney transplant
  - Evidence of End-Stage Renal Disease (ESRD)
  - Evidence of Stage 4 Chronic Kidney Disease

Initial Population (Denominator)

- Patients 18 to 75 years of age at the end of the measurement period with diabetes (Type I or II)
- Priority Health defines diabetes by the following:
  - Two face-to-face encounters with a diagnosis of diabetes:
  - On different dates of service
  - In an outpatient setting, observation visit, ED visit, or non-acute inpatient encounter during the measurement year or year prior, **OR**
  - One face-to-face encounter with a diagnosis of diabetes:
    - In an acute inpatient encounter without telehealth in the year prior or measurement year
    - One acute inpatient discharge with a diagnosis of diabetes on the discharge claim, **OR**
  - Pharmacy data, insulin or oral hyperglycemic/anti-hyperglycemic filled script with a diagnosis of diabetes during the measurement year or year prior

Numerator

- Patients with diabetes who have had one of the following:
  - A nephropathy screening –micro-albumin lab during the measurement year
  - Medical treatment for nephropathy during the measurement year
  - Diagnosis of nephropathy during the measurement year
  - Visit with a nephrologist during the measurement year

- At least one dispensing event of ACE/ARB medication during the measurement year
- Evidence of kidney transplant
- Evidence of End-Stage Renal Disease (ESRD)
- Evidence of Stage 4 Chronic Kidney Disease

Tips and Tricks

- None

Diabetes: Optimal Care of Diabetic Patients

Payer/Program

- Molina Medicaid
- Priority Health Commercial
- Priority Health Medicaid

Affinia Health Network Target

- 35%

Description

- The percentage of patients 18 to 75 years of age with diabetes (Type I or II) who have met all standards defined in each of the following measures:
  - Diabetes Care: Controlled HbA1c less than 8%
  - Diabetes Care: Annual retinal eye exam
  - Diabetes Care: Monitoring for nephropathy
  - Diabetes Care: Controlled blood pressure (>140/90)

Initial Population (Denominator)

- Patients 18 to 75 years of age at the end of the measurement period with diabetes (Type I or II)
  - Priority Health defines diabetes by the following:
    - Two face-to-face encounters with a diagnosis of diabetes:
    - On different dates of service
    - In an outpatient setting, observation visit, ED visit, or non-acute inpatient encounter during the measurement year or year prior, **OR**
  - One face-to-face encounter with a diagnosis of diabetes:
    - In an acute inpatient encounter without telehealth in the year prior or measurement year
    - One acute inpatient discharge with a diagnosis of diabetes on the discharge claim, **OR**
  - Pharmacy data, insulin or oral hyperglycemic/anti-hyperglycemic filled script with a diagnosis of diabetes during the measurement year or year prior

Numerator

- The number of patients with diabetes who have met EACH of the standards in the following diabetes measures:
  - Controlled HbA1c less than 8%
  - Annual retinal eye exam
  - Monitoring for nephropathy
  - Controlled blood pressure

Denominator Exclusions

- Medicare patients 66 years of age and older during the measurement year who meet one of the following:
  - Enrolled in an Institutional SNP (I-SNP) during the measurement year
  - Living long-term in an institution any time during the measurement year

- Frailty and advanced illness
- Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with a diagnosis of diabetes during the measurement year or year prior

Denominator Exceptions

- None

Tips and Tricks

- This measure considers the most recent lab test(s) performed during the measurement year.
- Screening documentation and results MUST be obtained and, in the PCP's, medical record

Chronic Disease Measures: COPD

Chronic Obstructive Pulmonary Disease (COPD) – Pharmacotherapy

Payer/Program

- BCN Commercial

Affinia Health Network Target

- Flat Fee

Description

- The percentage of COPD exacerbations for patients 40 year of age and older who had an acute inpatient discharge or ED visit on or between the Intake Period of January 1 – November 30 of the measurement year and who were dispensed appropriate medications.

Initial Population (Denominator)

- Patients 40 years of age and older by the first day of the measurement year who had either of the following during the Intake Period of January 1 – November 30 of the measurement year
- An ED visit with a principal diagnosis of COPD, emphysema, or chronic bronchitis
- Do NOT include ED visits that result in an inpatient stay
- An acute inpatient discharge with a principal diagnosis of COPD, emphysema, or chronic bronchitis, which is determined by:
- Identifying all acute and non-acute inpatient stays
- Excluding non-acute inpatient stays
- Identifying the discharge date for the stay

Numerator

- Dispensed prescription for systemic corticosteroid on or 14 days after the episode date, **OR**
- Dispensed prescription for a bronchodilator on or 30 days after the episode date

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- None

Chronic Disease Measures: Hypertension

Hypertension (HTN): Controlling High Blood Pressure

Payer/Program

- ACO
- BCBSM Commercial
- BCN Commercial
- BCN Medicare Advantage
- Priority Health Commercial
- Priority Health Medicare
- Priority Health Medicaid

Affinia Health Network Target

- 82%

Description

- The percentage of members 18 to 85 years of age who had two diagnoses of hypertension (HTN) during the measurement year or year prior to the measurement year AND whose **MOST RECENT** blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Initial Population (Denominator)

- Patients 18 to 85 years of age who had two diagnoses of hypertension during the measurement year or 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 combinations meet criteria:
- Outpatient visit with or without a telehealth modifier, with any diagnosis of hypertension
- A telephone visit with any diagnosis of hypertension
- An online assessment with any diagnosis of hypertension

Numerator

- The number of members who had a diagnosis of hypertension (HTN) and whose **MOST RECENT** BP was adequately controlled (<140/90 mm Hg) during the measurement year

Denominator Exclusions

- Patients with hypertension who have had or who fall under one of the following:
  - End-Stage Renal Disease (ESRD)
  - Kidney transplant
  - Dialysis or renal transplant before or any time during the measurement year
  - A diagnosis of pregnancy any time during the measurement year
- Patients 66 years of age and older in Institutional SNP (I-SNP) or residing in long-term care with a POS code 32, 33, 34, 54, or 56 any time during the measurement year
- Members 66 to 80 years of age at the end of the measurement period with frailty and advanced illness during the measurement year

Denominator Exceptions

- None

Tips and Tricks

- The patient must have a diagnosis of hypertension to be identified in the initial population (denominator).
- The initial date of the hypertension diagnosis must be documented.
- If no blood pressure is recorded any time during the measurement year, the patient's blood pressure is considered not controlled and NOT meeting the measure.
- If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading as the BP values for that date.
- BP readings from remote monitoring devices which are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, the results were digitally stored and transmitted to the provider and interpreted by the provider

Efficiency

Use of Imaging Studies for Low Back Pain

Payer/Program

- BCBSM Commercial
- BCN Commercial

Affinia Health Network Target

- 84%

Description

- The percentage of patients 18 to 50 years of age with a primary diagnosis of low back pain who did not

Initial Population (Denominator)

- Patients 18 to 50 years of age with a primary diagnosis of low back pain

Numerator

- Number of patients 18 to 50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Not applicable

Medication Management

Antidepressant Treatment Effective Acute Phase

Payer/Program

- BCBSM Commercial

Affinia Health Network Target

- 80th percentile

Description

- Assesses patients 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medication for at least 84 days (12 weeks).

Initial Population (Denominator)

- Patients 18 years of age and older as of April 30th of the measurement year

Numerator

- At least 84 days (12 weeks) of treatment with antidepressant medication, beginning on the Index Prescription State Date (IPSD) through 114 days after the IPSD (115 total days); this allows gaps in medication treatment up to a total of 31 days during the 115-day period; gaps can include either washout period gaps to change medication or treatment gaps to refill the same medications

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Not Applicable

Antidepressant Treatment Effective Continuation Phase

Payer/Program

- BCBSM Commercial
- BCN Commercial

Affinia Health Network Target

- 80th percentile

Description

- Assesses patients 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medication for at least 180 days (6 months)

Initial Population (Denominator)

- Patients 18 years of age and older as of April 30th of the measurement year

Numerator

- At least 180 days (6 months) of treatment with antidepressant medication, beginning on the Index Prescription State Date (IPSD) through 231 days after the IPSD (232 total days); this allows gaps in medication treatment up to a total of 52 days during the 232-day period; gaps can include either washout period gaps to change medication or treatment gaps to refill the same medications

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Not Applicable

Appropriate Testing for Children with Pharyngitis

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Meridian Medicaid
- Molina Medicaid
- United Healthcare

Affinia Health Network Target

- Flat Fee

Description

- The percentage of children 3 to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus test for the episode.

Initial Population (Denominator)

- Children 3 years of age as of July 1st of the prior year to 18 years as of June30th of the measurement year

Numerator

- A group A streptococcus test in the seven-day period from the three days prior to the day of the diagnose though three days after the date of diagnosis.

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- A higher rate indicated better performance
- Ensure antibiotics are being used only in cases where they are needed. This prevents antibiotic resistance and unnecessary side effects.
- Educate patients on:
  - Symptomatic treatments
  - Preventing the spread of illness through good hygiene and frequent hand washing
  - Importance of completing a full course of antibiotics, if needed

Appropriate Testing for Children with URI

Payer/Program

- BCBSM Commercial
- BCN Commercial

Affinia Health Network Target

- 80th percentile

Description

- The percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were NOT dispensed an antibiotic prescription.

Initial Population (Denominator)

- Children 3 years of age as of July 1st of the prior year to 18 years as of June30th of the measurement year with a diagnosis of upper respiratory infection (URI)

Numerator

- Children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Not applicable

Asthma – Medication Management

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Meridian Medicaid
- Molina Medicaid
- United Healthcare

Affinia Health Network Target

- Flat Fee

Description

- The percentage of patients 5 to 64 years of age with a diagnosis of persistent asthma (mild, moderate, severe) who were dispensed appropriate medication AND remained on for at least 75% of their treatment period during the measurement year

Initial Population (Denominator)

- 5 to 64 years of age by the last day of the measurement year

Numerator

- Patients 5 to 64 years of age with a diagnosis of persistent asthma (mild, moderate, severe) who were dispensed appropriate medication AND remained on for at least 75% of their treatment period during the

Denominator Exclusions

- Emphysema
- Chronic Obstructive Pulmonary Disease (COPD)
- Cystic Fibrosis
- Acute respiratory failure during the measurement year or year prior

Denominator Exceptions

- None

Tips and Tricks

- Not applicable

Attention Deficit Hyperactivity Disorder (ADHD) – Initiation Phase

Payer/Program

- BCBSM Commercial
- Meridian Medicaid

Affinia Health Network Target

- 80th percentile

Description

- The percentage of patients 6 to 12 years of age with a diagnosis of ADHD and were prescribed an ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase

Initial Population (Denominator)

- All patients 6 to 12 years of age as of the last day of the measurement year with a diagnosis of ADHD and dispensed medication for ADHD.

Numerator

- Patients 6 to 12 years of age with a diagnosis ADHD and were prescribed an ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase

Denominator Exclusions

- Diagnosis of narcolepsy any time during the child's history through 12/31/2019

Denominator Exceptions

- None

Tips and Tricks

- Not applicable

Attention Deficit Hyperactivity Disorder (ADHD) – Continuation and Maintenance Phase

Payer/Program

- BCBSM Commercial

Affinia Health Network Target

- 80th percentile

Description

- The percentage of patients 6 to 12 years of age with a diagnosis of ADHD and were prescribed an ADHD medication AND remained on the medication for at least 210 days, and who had at least two follow-up visits with a practitioner in the 9 months after the initiation phase.

Initial Population (Denominator)

- All patients 6 to 12 years of age as of the last day of the measurement year with a diagnosis of ADHD and dispensed medication for ADHD.

Numerator

- Patients 6 to 12 years of age with a diagnosis ADHD and were prescribed an ADHD medication AND remained on the medication for at least 210 days, and who had at least two follow-up visits with a practitioner in the 9 months after the initiation phase.

Denominator Exclusions

- Diagnosis of narcolepsy any time during the child's history through 12/31/2019

Denominator Exceptions

- None

Tips and Tricks

- An ADHD diagnosis must be billed at the follow-up visit.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Meridian Medicaid

Affinia Health Network Target

- 80th percentile

Description

- The percentage of adults 18 to 64 years of age with a diagnosis of acuter bronchitis who were NOT dispensed an antibiotic prescription.

Initial Population (Denominator)

- Patients 18 years to 64 years of age as of the last day of the measurement year.

Numerator

- Dispensed prescription for an antibiotic medication on or three days after the episode start date

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- A lower rate indicates better performance
- If prescribing antibiotics to treat a bacterial infection or comorbid condition in a patient with acute bronchitis be sure to include the diagnosis code for the bacterial infection or comorbidity.

Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Payer/Program

- BCN Medicare Advantage

Affinia Health Network Target

- 89%

Description

- The percentage patients 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMAED).

Initial Population (Denominator)

- Patients 18 years of age and older as of the last day of the measurement year diagnosed with rheumatoid arthritis

Numerator

- Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year

Denominator Exclusions

- Medicare patients 66 years of age and older during the measurement year who meet one of the following:
  - Enrolled in an Institutional SNP (I-SNP) during the measurement year
  - Living long-term in an institution any time during the measurement year
  - Frailty and advanced illness

Denominator Exceptions

- None

Tips and Tricks

- There are two ways to identify patients who received a DMARD:
  - By claim/encounter data
  - By pharmacy data

Medication Adherence for Diabetes Medications

Payer/Program

- BCBSM Commercial
- Priority Health Medicare Advantage

Affinia Health Network Target

- 88%

Description

- The percentage of patients 18 year and older with a billed prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Initial Population (Denominator)

- Patients 18 years and older, with at least two fills of diabetes medication(s) on unique dates of service during the measurement year.

Numerator

- Number of patients with a proportion of day covered (PDC) at 80% or higher across all classes of diabetes medication during the measurement year.

Denominator Exclusions

- Patients with 1 or more fills of insulin with a service date in the measurement year
- Patients with a diagnosis of end-stage renal diseases (ESRD)
- Patients enrolled in inpatient or skilled nursing facilities within the measurement year.

Denominator Exceptions

- None

Tips and Tricks

- Note: this measure is based on billed pharmacy claims.
- Patients are only included in the measure if the first fill of their medication occurs at least 91 days before the end of the enrollment period

Medication Adherence for Cholesterol

Payer/Program

- Priority Health Medicare

Affinia Health Network Target

- 89%

Description

- The percentage of patients 18 year and older with a billed prescription for cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Initial Population (Denominator)

- Patients 18 years and older, with at least two fills of blood pressure medication(s) on unique dates of service during the measurement year.

Numerator

- Number of patients with a proportion of day covered (PDC) at 80% or higher for statin cholesterol medication(s) during the measurement year.

Denominator Exclusions

- Patients with a diagnosis of end-stage renal diseases (ESRD)
- Patients enrolled in inpatient or skilled nursing facilities within the measurement year.

Denominator Exceptions

- None

Tips and Tricks

- Note: this measure is based on billed pharmacy claims.
- Patients are only included in the measure if the first fill of their medication occurs at least 91 days before the end of the enrollment period

Medication Adherence for Hypertension

Payer/Program

- Priority Health Medicare

Affinia Health Network Target

- 90%

Description

- The percentage of patients 18 year and older with a billed prescription for blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Initial Population (Denominator)

- Patients 18 years and older, with at least two fills of blood pressure medication(s) on unique dates of service during the measurement year.

Numerator

- Number of patients with a proportion of day covered (PDC) at 80% or higher for blood pressure medication(s) during the measurement year.

Denominator Exclusions

- Patients with a diagnosis of end-stage renal diseases (ESRD)
- Patients enrolled in inpatient or skilled nursing facilities within the measurement year.
- Patients with one or more prescription for sacubitril/valsartan

Denominator Exceptions

- None

Tips and Tricks

- Note: this measure is based on billed pharmacy claims.
- Patients are only included in the measure if the first fill of their medication occurs at least 91 days before the end of the enrollment period

Opioid Utilization (Use of Opioids at High Dosage)

Payer/Program

- Priority Health Commercial
- Priority Health Medicare
- Priority Health Medicaid

Affinia Health Network Target

- Reporting Only

Description

- The proportion of patients 18 years of age and older, receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average milligram morphine dose [MME] ≥90 mg); the proportion will be calculated and displayed as a permillage (multiplied by 1,000) instead of a percentage in reports.

Initial Population (Denominator)

- Patients 18 years of age and older as of the beginning of the measurement year with
  - At least two or more opioid dispensing event on different dates of service (HDO-A Opioid Medication list)

    AND
  - ≥15 total day covered by opioids

Numerator

- Patients whose average MME was ≥ 90 mg MME during the treatment period

Denominator Exclusions

- Patients who had only a single opioid medication dispensing event
- Patients with a diagnosis of cancer or sickle cell disease

Denominator Exceptions

- None

Tips and Tricks

- A lower rate indicates better performance.

Statin Therapy for Patients with Diabetes

Payer/Program

- BCBSM Commercial
- Humana Medicare Advantage
- Priority Health Medicare Advantage

Affinia Health Network Target

- 83%

Description

- The percentage of patients 40 to 75 years of age during the measurement year with diabetes who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement year.

Initial Population (Denominator)

- Patients 40 to 75 years of age with at least two diabetes medication filled during the measurement period.
  - Priority Health defines diabetes by the following:
    - Two face-to-face encounters with a diagnosis of diabetes:
    - On different dates of service
    - In an outpatient setting, observation visit, ED visit, or non-acute inpatient encounter during the measurement year or year prior
    - Only one of the two visits may be telehealth visit, telephone visit or an online assessment, **OR**
  - One face-to-face encounter with a diagnosis of diabetes:
    - In an acute inpatient encounter without telehealth in the year prior or measurement year
    - One acute inpatient discharge with a diagnosis of diabetes on the discharge claim, **OR**
  - Pharmacy data, insulin or oral hyperglycemic/anti-hyperglycemic filled script with a diagnosis of diabetes during the measurement year or year prior

Numerator

- Patients who had at least one dispensing event for high-intensity, moderate intensity, or low-intensity statin mediation during the measurement year

Denominator Exclusions

- Medicare patients 66 years of age and older during the measurement year who meet one of the following:
- Enrolled in an Institutional SNP (I-SNP) during the measurement year
- Living long-term in an institution any time during the measurement year
- Frailty and advanced illness
- Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with a diagnosis of diabetes during the measurement year or year prior

- Members with cardiovascular disease by the following event or diagnosis the year prior to the measurement year:
- Event during 2018
- Discharged from an inpatient setting with a myocardial infarction (MI)
- Patients who had a coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI), or revascularization procedure in any setting
- Diagnosis in 2019 or 2020
- Patients diagnosed as having ischemic vascular disease (IVD), end-stage renal diseases (ESRD) without telehealth or cirrhosis
- Female patients with a diagnosis of pregnancy or in vitro fertilization
- Dispensed as least on prescription for clomiphene
- Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year

Denominator Exceptions

- None

Tips and Tricks

- Not applicable

Statin Therapy for Patients with Cardiovascular Disease

Payer/Program

- BCBSM Commercial
- BCN Commercial
- BCN Medicare Advantage
- Priority Health Commercial
- Priority Health Medicare

Affinia Health Network Target

- 87%

Description

- The percentage of male patients 21 to 75 years of age and female patient 40-75 year of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

Initial Population (Denominator)

- Male patient 21 to 75 year of age and female patient 40-75 years of age on or before the measurement year with a patient encounter any time in 2020 and identified as having clinical atherosclerotic cardiovascular disease (ASCVD) by the following event or diagnosis:
  - Discharged from an inpatient setting with a myocardial infarction (MI) during the year prior to the measurement year
  - Had a coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI), or revascularization procedure in any setting during the year prior to the measurement year
- Diagnosis of ischemic vascular disease (IVD) and one of the following in the measurement year or year prior:
  - At least one outpatient visit, telephone visit, or online assessment with an IVD diagnosis
  - At least one acute inpatient encounter with an IVD diagnosis without telehealth
  - At least one acute inpatient discharge with a principle diagnosis of IVP

Numerator

- Number of patients who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year

Denominator Exclusions

- A diagnosis of pregnancy during the measurement year
- A diagnosis of in vitro fertilization
- Patients diagnosed as having end-stage renal diseases (ESRD) or cirrhosis
- Dispensed at least one prescription for clomiphene.
- A diagnosis of rhabdomyolysis, myalgia, myositis, or myopathy during the measurement year.
- Medicare patients 66 years of age and older during the measurement year who meet one of the following:
  - Enrolled in an Institutional SNP (I-SNP) during the measurement year
  - Living long-term in an institution any time during the measurement year
  - Frailty and advanced illness

- Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with a diagnosis of diabetes during the measurement year or year prior

Denominator Exceptions

- None

Tips and Tricks

- Note: this measure is based on billed pharmacy claims.

Statin Therapy for Patients with Cardiovascular Disease – ACO

Payer/Program

- ACO

Affinia Health Network Target

- 87%

Description

- The percentage of patients identified as being high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period.

Initial Population (Denominator)

- All patients who meet one or more of the following criteria:
- Patients 21 years of age and older at the beginning of the measurement period with clinical atherosclerotic cardiovascular disease (ASCVD) diagnosis
- Patients 21 years of age and older at the beginning of the measurement period who have ever had a fasting or direct lab result of LDL-C >=190 mg/dL OR were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia
- Patients 40 to 75 years of age at the beginning of the measurement period with Type I or Type II diabetes AND with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct lab result in the measurement year or two years prior

Numerator

- Patients who are prescribed or actively using stating therapy at any point during the measurement period

Denominator Exclusions

- Patients who have a diagnosis of pregnancy
- Patients who are breastfeeding
- Patients who have a diagnosis of rhabdomyolysis

Denominator Exceptions

- Patients with adverse effect, allergy, or intolerance to statin medication
- Patients with active liver disease or hepatic disease or insufficiency
- Patients with end-stage renal disease (ESRD)
- Patients with diabetes who have a recent fasting or direct LDL-C < 70mg/dL and are NOT taking statin therapy

Tips and Tricks

- Clinical Atherosclerotic Cardiovascular Disease (ASCVD) includes:
- Acute Coronary Syndromes
- History of Myocardial Infarction
- Stable or Unstable Angina
- Coronary or another Arterial Revascularization

- Stroke or Transient Ischemic Attack (TIA)
- Peripheral Arterial Disease of Atherosclerotic Origin
- Elevated cholesterol alone does NOT count toward the familial or pure hypercholesterolemia diagnoses criteria.

Preventative Measures: For Adults

Adult BMI Screening and Follow-Up

Payer/Program

- Trinity Health

Affinia Health Network Target

- 80%

Description

- The percentage of adult patients 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year; for individuals outside the normal BMI range, a follow-up plan was developed.

Initial Population (Denominator)

- All adult patients 18 to 74 years of age

Numerator

- Adult patients who had an outpatient visit and whose BMI was documented during the measurement year; for individuals outside the normal BMI range, a follow-up plan was developed.

Denominator Exclusions

- Patients who were pregnant during the measurement year
- Patients receiving palliative care

Denominator Exceptions

- Patients 65 years of age or older whom weight reduction/weight gain would complicate other underlying health conditions such as:
  - Illness or physical disability
  - Mental Illness
  - Dementia
  - Confusion
  - Nutritional deficiency such as vitamin/mineral deficiency

Tips and Tricks

- Patient self-reported values (height, weight, and/or BMI) do NOT satisfy the measure.
- A follow-up plan may include, but is not limited to:
- Documentation of education
- Referral (for example a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon)
- Pharmacological interventions
- Dietary supplements
- Exercise counseling or nutrition counseling
- A follow-up plan must be based on the most recent documented BMI outside of normal parameters.

Colorectal Cancer Screening

Payer/Program

- ACO
- BCBSM Commercial
- BCN Medicare Advantage
- Humana Medicare Advantage
- Molina Medicare Advantage
- Priority Health Commercial
- Priority Health Medicare

Affinia Health Network Target

- 84%

Description

- The percentage of patients 50 to 75 years of age who received the appropriate colorectal cancer screening.

Initial Population (Denominator)

- Patients 50 to 75 years of age during the measurement period
- ACO: Patients 50 to 75 years of age with a medical visit during the measurement period

Numerator

- Patients with one or more appropriate screenings for colorectal cancer:
  - Fecal Occult Blood Test (FOBT) any time during the measurement year
  - Flexible sigmoidoscopy any time during the measurement year or 4 years prior
  - Colonoscopy any time during the measurement year or 9 years prior
  - CT Colonography any time during the measurement year or 4 years prior
  - Cologuard (FIT-DNA) any time during the measurement year or 2 years prior

Denominator Exclusions

- Patients with a diagnosis or history of total colectomy or colorectal cancer
- Patients 66 years of age and older as of December 31 who are
  - Enrolled in an Institutional Special Needs Plans (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year. C
  - Patients with frailty and advanced illness (members must be both frailly and advance illness to be excluded)

Denominator Exceptions

- None

Tips and Tricks

- Screening documentation and results MUST be obtained and, in the PCP's, medical record.
- Long Term institution are those facilities with a POS code 32, 33, 34, 54, or 56

Falls: Screening for Future Fall Risk

Payer/Program

- ACO

Affinia Health Network Target

- 90.73%

Description

- The percentage of patients 65 years of age and older who were screened for future fall risk at least once any time during the measurement year

Initial Population (Denominator)

- Patients 65 years of age and older with and visit during the measurement year

Numerator

- Patients 65 years of age and older who were screened for future fall risk at least once any time during the measurement year

Denominator Exclusions

- Patients who were assessed to be non-ambulatory any time during the measurement year

Denominator Exceptions

- None

Tips and Tricks

- CMS defines Screening for Future Fall Risk as an assessment of whether an individual has experienced a fall or has a problem with gait or balance
- A specific screening tool is not required this measure.
- A gait or balance assessment meets the intent of the measure.
- Screening for future fall risk may be completed during a telehealth encounter.
- Documentation of no falls is sufficient.
- Any history of fall screening any time during the measurement year is acceptable as meeting he intent of the measure.
- A musculoskeletal assessment does NOT meet the measure.
- The medical record must include documentation identifying a fall risk screening was performed any time in during the measurement year.

Initial Visit with PCP and Completed HRA

Payer/Program

- Meridian Healthy Michigan Plan
- Molina Healthy Michigan Plan

Affinia Health Network Target

- Flat Fee

Description

- The percentage of patients with an initial visit and who have completed and HRA within 150 days of member enrollment.

Initial Population (Denominator)

- Patients 19 to 64 years of age during the measurement year

Numerator

- Patients who had an initial visit and have completed an HRA
  - Molina: Annual HRAs completed during a PCP visit are also incentivized

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Not applicable

Tobacco Use Assessment and Cessation Intervention

Payer/Program

- ACO
- United Healthcare

Affinia Health Network Target

- 92.31%

Description

- The percentage of patients in the appropriate age range who were screened for tobacco use one or more times during the measurement year or year prior AND who received tobacco cessation intervention if identified as a tobacco user
- ACO: Patient population is 18 years of age and older during the measurement year
- United Healthcare: Patient population is 14 years of age and older during the measurement year

Initial Population (Denominator)

- All patients in the appropriate age range seen for at least two visits or at least one preventative visit during the measurement year

Numerator

- Patients in the appropriate age range who were screened for tobacco use one or more times during the measurement year or year prior and who received tobacco cessation intervention if identified as a tobacco user

Denominator Exclusions

- None

Denominator Exceptions

- Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)

Tips and Tricks

- Tobacco Products Include:
- Cigarettes, Cigars, and/or Pipe
- Dissolvable tobacco
- Smokeless tobacco (i.e., Chew, Dip, Snuff)

Preventative Measures: For Children

Immunizations – Adolescent Combo 2

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Meridian Medicaid
- Priority Health Commercial
- Priority Health Medicaid

Affinia Health Network Target

- 72%

Description

- The percentage of adolescents 13 years of age as of the last day of the measurement year who had the following vaccines:
  - **1 Meningococcal:** after the 11th AND before the 13th birthday
  - **1 TdaP / DTP:** after the 10th birthday AND before the 13th birthday
  - **2 HVP:** after the 9th birthday AND before the 13th birthday (must be at least 146 days apart)

Initial Population (Denominator)

- The number of adolescents who turn 13 years of age during the measurement year

Numerator

- Adolescents who have had the following vaccines during the appropriate timeframe by the age of 13:
  - **1 Meningococcal:** after the 11th AND before the 13th birthday
  - **1 TdaP / DTP:** after the 10th birthday AND before the 13th birthday
  - **2 HVP:** after the 9th birthday AND before the 13th birthday (must be at least 146 days apart)

Denominator Exclusions

- Children who are documented in MCIR as having certain health condition for which vaccines are contraindicated.

Denominator Exceptions

- None

Tips and Tricks

- Pull a MCIR on every patient at every visit.
- If a parent/guardian refuses to have their child vaccinated, the parent/guardian must sign an immunization waiver form yearly.
- Update the Michigan Care Improvement Registry (MCIR).

Immunizations – Childhood Combo 10

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Meridian Medicaid
- Molina Medicaid
- United Healthcare

Affinia Health Network Target

- 80th percentile

Description

- The percentage of children 2 years of age as of the last day of the measurement year who had the following vaccines:
  - **4 DTaP/DTP**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **3 Hepatitis B**: On or before the 2nd birthday with different DOS
  - **3 H Influenza Type B (HIB)**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 MMR**: On or before 2nd birthday
  - **3 IPV:** All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 Varicella:** On or before 2nd birthday, or history of disease on or before the 2nd birthday
  - **4 Pneumococcal Conjugate:** All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 Hepatitis A:** On or before the 2nd birthday with different DOS
  - **2-3 Rotavirus:** All at least 42 days after birth with different DOS, & on or before the 2nd birthday
  - **2 Influenza:** On or before the 2nd birthday

Initial Population (Denominator)

- The number of children who turn 2 years of age during the measurement year

Numerator

- Patients who have had the following vaccines during the appropriate timeframe by the age of 2:
  - **4 DTaP/DTP**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **3 Hepatitis B**: On or before the 2nd birthday with different DOS
  - **3 H Influenza Type B (HIB)**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 MMR**: On or before 2nd birthday
  - **3 IPV:** All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 Varicella:** On or before 2nd birthday, or history of disease on or before the 2nd birthday
  - **4 Pneumococcal Conjugate:** All at least 42 days after birth with different DOS, and on or before the 2nd birthday

- **1 Hepatitis A:** On or before the 2nd birthday with different DOS
- **2-3 Rotavirus:** All at least 42 days after birth with different DOS, & on or before the 2nd birthday
- **2 Influenza:** On or before the 2nd birthday

Denominator Exclusions

- Children who are documented in MCIR as having certain health condition for which vaccines are contraindicated.

Denominator Exceptions

- None

Tips and Tricks

- Pull a MCIR on every patient at every visit.
- If a parent/guardian refuses to have their child vaccinated, the parent/guardian must sign an immunization waiver form yearly.
- Update the Michigan Care Improvement Registry (MCIR).

Immunizations – Childhood Combo 3

Payer/Program

- Blue Cross Complete
- Molina Medicaid
- Priority Health Commercial
- Priority Health Medicaid
- United Healthcare

Affinia Health Network Target

- 87%

Description

- The percentage of children 2 years of age who had the following vaccines:
  - **4 DTaP/DTP**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **3 Hepatitis B**: On or before the 2nd birthday with different DOS
  - **3 H Influenza Type B (HIB)**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 MMR**: On or before the 2nd birthday
  - **3 IPV**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 Varicella**: On or before second birthday, or history of disease on or before the 2nd birthday
  - **4 Pneumococcal Conjugate**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday

Initial Population (Denominator)

- The number of children who turn 2 years of age during the measurement year

Numerator

- Patients who have had the following vaccines during the appropriate timeframe by the age of 2:
  - **4 DTaP/DTP**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **3 Hepatitis B**: On or before the 2nd birthday with different DOS
  - **3 H Influenza Type B (HIB)**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 MMR**: On or before the 2nd birthday
  - **3 IPV**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday
  - **1 Varicella**: On or before second birthday, or history of disease on or before the 2nd birthday
  - **4 Pneumococcal Conjugate**: All at least 42 days after birth with different DOS, and on or before the 2nd birthday

Denominator Exclusions

- Children who are documented in MCIR as having certain health condition for which vaccines are contraindicated.

Denominator Exceptions

- None

Tips and Tricks

- Pull a MCIR on every patient at every visit.
- If a parent/guardian refuses to have their child vaccinated, the parent/guardian must sign an immunization waiver form yearly.
- Update the Michigan Care Improvement Registry (MCIR).

Influenza Immunization

Payer/Program

- ACO

Affinia Health Network Target

- 90%

Description

- The percentage of patients 6 months of age and older seen for a visit between 10/1/2019 to 3/31/2020 AND who received an influenza immunization or who reported previous receipt of an influenza immunization between 8/1/2019 to 3/31/2020.

Initial Population (Denominator)

- All patients 6 months of age and older seen for a visit between 10/1/2019 and 3/31/2020

Numerator

- Patients who received an influenza immunization between 10/1/2019 and 3/31/2020 or who reported previous receipt of an influenza immunization between 8/1/2019 and 3/31/2020

Denominator Exclusions

- None

Denominator Exceptions

- Documentation of medical reason(s) for not receiving influenza immunization (e.g., patient allergy, other medical reasons)
- Documentation of patient reason(s) for not receiving influenza immunization (e.g., patient declined, other patient reasons)
- Documentation of system reason(s) for not receiving influenza immunization (e.g., vaccine not available, other system reasons)

Tips and Tricks

- Pull a MCIR on every patient at every visit.
- Documentation is required if a patient declines the administration of the influenza vaccine to meet the intent of the measure.
- Documentation is required if a patient had the influenza vaccine administered at another location.

Lead Screening

Payer/Program

- Blue Cross Complete
- Meridian Medicaid
- Molina Medicaid
- Priority Health Medicaid
- United Healthcare

Affinia Health Network Target

- 86%

Description

- The percentage of children 2 years of age who had one or more capillary or venous blood screening(s) for lead poisoning on or before their 2nd birthday.

Initial Population (Denominator)

- All children 2 years of age as of the last day of the measurement year

Numerator

- Children 2 years of age who had one or more capillary or venous blood screening(s) for lead poisoning on or before their 2nd birthday.

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Pull a MCIR on every patient at every visit.
- Update the Michigan Care Improvement Registry (MCIR).

Pediatric Weight Assessment and Counseling – BMI Percentile

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Molina Medicaid

Affinia Health Network Target

- 80th percentile

Description

- The percentage of patients 3 to 17 years of age who had an office visit with a PCP or OB-GYN during the measurement year and had a height, weight, and BMI percentile recorded during the measurement year.

Initial Population (Denominator)

- Patients 3 to 17 years of age as of the last day of the measurement year.

Numerator

- Patients 3 to 17 years of age who had an height, weight, and BMI percentile recorded during the measurement year.

Denominator Exclusions

- Patients who have a diagnosis of pregnancy during the measurement year.

Denominator Exceptions

- None

Tips and Tricks

- Patients and/or parent/legal guardian- reported data does NOT satisfy the measure.
- The following Z-codes are for the appropriate BMI percentiles:
  - Z68.51: BMI pediatric, less than 5th percentile for age
  - Z68.52: BMI pediatric, 5th percentile to LESS than 85th percentile for age
  - Z68.53: BMI pediatric, 85th percentile to LESS than 95th percentile for age
  - Z68.54: BMI pediatric, greater than or equal to 95th percentile for age
  - If sending one of the 4 BMI Z-codes via billing, ensure the clinical documentation supports the Z-code. The clinical content can be the growth chart and/or the calculated BMI percentile within the vitals section of the medical record.

Pediatric Weight Assessment and Counseling – Nutrition Counseling

Payer/Program

- BCBSM Commercial
- Molina Medicaid

Affinia Health Network Target

- 80th percentile

Description

- The percentage of patients 3 to 17 years of age who had an office visit with a PCP or OB-GYN during the measurement year and received counseling for nutrition during the measurement year.

Initial Population (Denominator)

- Patients 3 to 17 years of age as of the last day of the measurement year.

Numerator

- Patients 3 to 17 years of age who received counseling for nutrition and the counseling was documented in eh medical record during the measurement year

Denominator Exclusions

- Patients who have a diagnosis of pregnancy during the measurement year.

Denominator Exceptions

- None

Tips and Tricks

- Patients and/or parent/legal guardian- reported data does NOT satisfy the measure.
- Document all education materials provided to the patient and/or parent/legal guardian during the visit
- Document any counseling or referral for nutrition education

Pediatric Weight Assessment and Counseling – Physical Activity Counseling

Payer/Program

- BCBSM Commercial
- Molina Medicaid

Affinia Health Network Target

- 80th percentile

Description

- The percentage of patients 3 to 17 years of age who had an office visit with a PCP or OB-GYN during the measurement year and received counseling for physical activity during the measurement year.

Initial Population (Denominator)

- Patients 3 to 17 years of age as of the last day of the measurement year.

Numerator

- Patients 3 to 17 years of age who received counseling for physical activity and the counseling was documented in eh medical record during the measurement year

Denominator Exclusions

- Patients who have a diagnosis of pregnancy during the measurement year.

Denominator Exceptions

- None

Tips and Tricks

- Patients and/or parent/legal guardian- reported data does NOT satisfy the measure.
- Document all education materials provided to the patient and/or parent/legal guardian during the visit
- Document any counseling or referral for physical activity.

Well-Care Visits – Adolescents 12 to 21 Years

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Blue Cross Complete
- Meridian Medicaid
- Molina Medicaid
- United Healthcare

Affinia Health Network Target

- 91%

Description

- The percentage of patients 12 to 21 years of age who received one or more well-care visit with a primary care physician during the measurement year.

Initial Population (Denominator)

- Patients 12 to 21 years of age as of the last day of the measurement year.

Numerator

- Patients 12 to 21 years of age who received one or more well-care visit with a primary care physician during the measurement year.

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Pull a MCIR on every patient at every visit.
- One or more well-care visits with a primary care physician or OB/GYN practitioner during the measurement period.
- Document any health and development history, physical exam, and anticipatory.
- Do sports physicals during well child visit.
- Tips for coding: Codes to identify Well-Care Visits:
  - ICD10CM: Z00.00, Z00.01, Z00.5, Z00.8, Z00.110, Z00.111, Z00.121, Z00.129, Z02.0-Z02.6, Z02.71, Z02.82, Z76.1, Z76.2
  - CPT® codes**: 99381-99385, 99391-99395, 99461
  - HCPCS: G0438, G0439

Well-Child Visits – 0 to 15 Months

Payer/Program

- BCBSM Commercial
- Blue Cross Complete
- BCN Commercial
- Meridian Medicaid
- Molina Medicaid
- Priority Health Commercial
- Priority Health Medicaid
- United Healthcare

Affinia Health Network Target

- 91%

Description

- The percentage of patients turning 15 months of age during the measurement year who had six or more well-care visits (14 days apart) with a primary care physician in the first 15 months of life with different dates of service.

Initial Population (Denominator)

- Patients turning 15 months of age during the measurement year.

Numerator

- Number of patients with at least 6 well-child visits before turning 15 months of age.

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Recommendations:
  - Newborn: 1 visit 3-5 days after discharge
  - 0-2 years: 1 visit at 2, 4, 6, 9, and 12 months
- Pull a MCIR on every patient at every visit.
- Document any health and development history, physical exam, and anticipatory guidance provided: including all health education materials provided during the encounter.

Well-Child Visits – 3 to 6 Years

Payer/Program

- BCBSM Commercial
- Blue Cross Complete
- Meridian Medicaid
- Molina Medicaid
- Priority Health Commercial
- Priority Health Medicaid
- United Healthcare

Affinia Health Network Target

- 92%

Description

- The percentage of patients 3 to 6 years of age who received one or more well-care visits with a primary care physician during the measurement year.

Initial Population (Denominator)

- Patients 3 to 6 years of age as of the last day of the measurement year.

Numerator

- Patients 3 to 6 years of age who received one or more well-care visit with a primary care physician during the measurement year.

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Recommendations: 1 visit every year for children 3 to 6 years of age.
- Pull a MCIR on every patient at every visit.
- Document any health and development history, physical exam, and anticipatory guidance provided: including all health education materials provided during the encounter.

Women's Care

Breast Cancer Screening / Mammography

Payer/Program

- ACO
- BCN Commercial
- BCN Medicare Advantage
- BCBSM Commercial
- BCBSM Medicare Advantage
- Humana Medicare Advantage
- Meridian Medicaid
- Molina Medicaid
- Molina Medicare Advantage
- Priority Health Commercial
- Priority Health Medicare
- Priority Health Medicaid
- United Healthcare

Affinia Health Network Target

- 83%

Description

- The percentage of women 50 to74 years of age who had a mammogram to screen for breast cancer during the measurement year or the year prior to the measurement year.

Initial Population (Denominator)

- Women 50 to 74 years of age during the measurement year.

Numerator

- Women with one or more mammograms during the measurement year or the year prior to the measurement year

Denominator Exclusions

- Women who had a bilateral mastectomy or who have a documented history of bilateral mastectomy, or who have had 2 counts of unilateral mastectomies (left and right)
- Patients age 65 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54, or 56 any time during the measurement year

Denominator Exceptions

- None

Tips and Tricks

- This measure evaluates primary screening. Do not count biopsies, breast US, or MRIs; they are not appropriate methods for primary breast cancer screening.
- Patient self-reporting data does not satisfy the measure.
- Mammogram documentation and results MUST be obtained and, in the PCP's, medical record.

Cervical Cancer Screening

Payer/Program

- BCBSM Commercial
- BCN Commercial
- Meridian Medicaid
- Molina Medicaid
- Priority Health Commercial
- Priority Health Medicaid
- United Healthcare

Affinia Health Network Target

- 83%

Description

- The percentage of women 21 to 64 years of age with a cervical cancer screening according to the following schedule:
  - 21 to 64 years of age: cervical cancer screening every 3 years
  - 30 to 64 years of age: cervical cancer screening and human papillomavirus (HVP) co-testing performed every 5 years

Initial Population (Denominator)

- Women 21 to 64 years of age during the measurement year.
  - Priority Health: Women 24 to 64 years of age during the measurement year.

Numerator

- Women 21 to 64 years of age with a cervical cancer screening according to the following schedule:
  - 21 to 64 years of age: with cervical cancer screening during the measurement year or 2 years prior.
  - 30 to 64 years of age: with cervical cancer screening and human papillomavirus (HVP) co-testing during the measurement year or 4 years prior.

Denominator Exclusions

- Women who have had a complete, total or radical abdominal or vaginal hysterectomy on or before the last day of the measurement period

Denominator Exceptions

- None

Tips and Tricks

- Patient self-reported data does not satisfy the measure.
- Pap Smear and HVP testing documentation and results MUST be obtained and, in the PCP's, medical record.
- Transgender (male to female) members would need to have appropriate coding submitted indicating the absence of cervix.

Chlamydia Screening

Payer/Program

- Blue Cross Complete
- Meridian Medicaid
- Molina Medicaid
- Priority Health Medicaid
- United Healthcare

Affinia Health Network Target

- 72%

Description

- The percentage of women 16 to 24 years of age identified as sexually active with at least one chlamydia screening during the measurement year.

Initial Population (Denominator)

- Sexually active female patients 16 to 24 years of age as of the last day of the measurement year

Numerator

- Females 16 to 24 years of age with at least one or more chlamydia tests during the measurement year

Denominator Exclusions

- Not sexually active women 16 to 24 years of age

Denominator Exceptions

- A billed pregnancy test during the measurement year and a filled prescription for isotreinoin (Accutane)
- An x-ray on the same day as the pregnancy test or six days after the pregnancy test

Tips and Tricks

- To ensure coverage by insurance order the test under diagnosis codes Z11.3 or Z11.8
- Sexual activity is identified though billed diagnosis codes, procedure codes and pharmacy claims

Early Entry into Prenatal Care

Payer/Program

- Blue Cross Complete
- Meridian Medicaid
- Molina Medicaid
- United Healthcare

Affinia Health Network Target

- 60th percentile

Description

- The percentage of deliveries that received prenatal care during their first trimester (through the end of the 13th week after conception)
    - Meridian, Molina Marketplace, and Molina Medicaid: OR within 42 days of enrollment

Initial Population (Denominator)

- Women seen for prenatal care any time during the measurement year

Numerator

- Women beginning prenatal care at the health center, OR with a referral provider, OR with another prenatal provider during their first trimester
    - Meridian, Molina Marketplace, and Molina Medicaid: OR within 42 days of enrollment

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- First trimester: report women who were prenatal patients during the reporting period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after their last menstrual period.
- Second trimester: report women who were prenatal patients during the reporting period whose first visit occurred when they were estimated to be between the start of the 14th week and the end of the 17th week after their last menstrual period.
- Third Trimester: report women who were prenatal care patients during the reporting period and whose first visit occurred when they were estimated to be 28 weeks or more after their last menstrual period.

Osteoporosis Management in Women Who Had a Fracture

Payer/Program

- BCN Medicare Advantage
- Molina Medicare Advantage

Affinia Health Network Target

- 78%

Description

- The percentage of women 65 to 85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the six months after the fracture.

Initial Population (Denominator)

- Women ages 67 to 85 years of age by the end of the measurement year

Numerator

- Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:
- A BMD test, in any setting, on the Index Episode Start Date (IESD) or in the 108-day (6-month) period after the IESD
- If the IESD was an inpatient stay, A BMD test during the inpatient stay
- Osteoporosis therapy on the IESD or in the 180-day (6-month) period after the IESD
- If the IESD was inpatient stay, long-acting osteoporosis therapy during the inpatient stay
- A dispensed prescription to treat osteoporosis on the IESD or in the 180-day (6-month) period after the IESD

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- Not Applicable.

Postpartum Care

Payer/Program

- Meridian Medicaid
- United Healthcare

Affinia Health Network Target

- Flat Fee

Description

- The percentage of deliveries of live births on or between November 6, 2019 to November 5, 2020. For these women, the measure assesses the following:
  - Had a postpartum visit on or between 21 and 56 days after delivery

Initial Population (Denominator)

- Women who had a delivery of a live birth on or between November 6, 2019 to November 5, 2020

Numerator

- A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

Denominator Exclusions

- None

Denominator Exceptions

- None

Tips and Tricks

- The following meet the numerator criteria:
  - A postpartum visit
  - Cervical Cytology
  - A bundle services where the organization can identify the date when postpartum care was rendered.

Affinia
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MEMBER

REGISTRY: WELLCENTIVE

Section 3

Section 3: Registry: Wellcentive

Definitions

Affinia Health Network

Wellcentive Active Patient Definition

PURPOSE: The purpose of the Wellcentive active patient definition is to clearly articulate and accurately define a meaningful active patient population within Wellcentive. Having a clearly defined population will allow practice unit teams to more efficiently manage quality for their defined population. The definition will also provide structure to the defined population used in Affinia Health population health reports produced from Wellcentive.

Inclusion criteria (active)	1. Any patient that is on a payer eligibility file, regardless of timing of last office visit to attributed practice
	• Priority Health
	  ○ Medicare
	  ○ HMO
	  ○ PPO
	  ○ Medicaid
	• BCBSM
	• BCBSM MA
	• BCN
	• BCNA
	• TH ACO
	• Humana
	• Meridian
	• Molina
	• Aetna
	• Blue Cross Complete
	AND
	2. Patients not on payer eligibility file but having office visit within past 24 months, inclusive of annual wellness visits

Exclusionary criteria (inactive)	1. Patient's not on payer eligibility file and not having office visit within past 24 months. 2. All deceased patients
Measure time period	Monthly update of eligibility files and rolling 24 months for office visit eligibility
Calculation	1. All patients on an eligibility file will be included as an active patient **even if the patient has not had an office visit with the past 24 months** 2. The office visit parameters only apply to patients **not** on an eligibility file
Additional Notes	Any patients that have been manually marked as inactive or active are subject to change when the attribution calculation is applied

Wellcentive Reports

For additional job please visit
https://affiniahealth.com/members/library/job-aids/

Scorecards / Dashboards

Description

- These reports are designed for monitoring performance reports. Best report to identify patient in need of services, for most measures.

Capabilities of scorecards

- Ability to view patient population
  - Patients eligible for the measure
  - Patients meeting the measure
  - Patients not meeting the measure
  - Patients with and exception and/or exclusion
- Ability to drill down to patient level data
- Default settings
  - All payer
- Filtering options
  - Payer
  - Timeframe
  - Provider Relationship
  - Provider
- Supports PCMN Domains 2 and 3

Summary Reports

Description

- These reports are designed to be used for counts and rates of patients for defined criteria. Some reports just return counts of patients such as panel size, where there are other reports created to be used to monitor performance for defined criteria.

Count Reports

- Returns a count of patient for a defined criteria
- Default settings
  - All payer
- Can drill down to patient level for each column

Performance Reports

- Monitor Performance at the provider, office, and network levels
  - Displays numerator, denominator and completion percentage
  - Not designed to provide patient level detail or patient list
- Default settings
  - All payer
  - 365 day look back period, unless noted otherwise
- Supports PCMH Domain 3

Patient Complicate Reports

Description

- These reports are designed to return a list of patients meeting the defined criteria. The criteria can be disease or preventive care specific. These reports are often referred to as patient registries.

Capabilities

- Used for registries
  - Will return all patients meeting the defined criteria (typically a measure denominator or full list of all patients with the stated disease)
  - Patients **may or may not** have open gaps in care
- Displays relevant clinical data elements supping the disease or preventive care measures
  - Displays last value for each data element
  - n/a represent that Wellcentive foes not have any data for that element
- Can be utilized for a gap in care list
- Supports PCMH domain 2

Wellcentive vs. Payer Report Differences

Affinia Health Network (AHN) has built and implemented a new registry validation plan as we are committed to ensuring the quality and validity of the data within the registry. The most recent steps involved the review of 795 patients' performance data and over 100 hours certifying data accuracy, conducted by nine AHN staff members. AHN is committed to ongoing data validation and working to close data gaps. Below are common reasons as to why Wellcentive and payer quality reports may not match:

Common Reasons Across All Measures:

- Timing of data flow to payer
- Payer refresh dates (refer to payer refresh calendar for specific dates)
- Continuous Enrollment
    - Patients must be continuously enrolled with the payer for "x" timeframe to be in the denominator.
        - Wellcentive is unable to calculate the enrollment time

Measure Specific Reasons:

Controlling Blood Pressure

- Continuously enrolled in 2019, with no more than a 45-day gap
- Priority Health
    - 1 Face-2-face outpatient encounter between Jan 1 and June 30 with a diagnosis of HTN
- Do not receive diagnosis codes from all office's EMR; Wellcentive is reliant on claims

HbA1C < 8

- Continuously enrolled in 2019, with no more than a 45-day gap
- Priority Health
    - 2 Face-2-face encounter with diagnosis of diabetes in an outpatient setting or 1 face-2-face visit with diagnosis of diabetes in an acute inpatient encounter
- Do not receive diagnosis codes from all office's EMR; Wellcentive is reliant on claims

Breast Cancer Screening

- Continuously enrolled in 2017, 2018, and 2019, no more than a 45-day gap
- Not receiving this information from Spectrum or Kent Rad.
- Payers may close the gap with claims data
- Not approved to send mammograms to the Blues

Retinal Eye Exam

- Continuously enrolled in 2019, with no more than a 45-day gap
- Only source of truth is Shoreline Vision
- No source data for GR patients
- Do not receive diagnosis codes from all office's EMR; Wellcentive is reliant on claims

Monitoring for Nephropathy

- Continuously enrolled in 2019, with no more than a 45-day gap
- Payers closed gaps with any one of the following
  - Microalbuminuria lab in 2019
  - DX of treatment for neph in 2019
  - Pharmacy claim for ACE/ARB in 2019
  - Visit with nephrologist in 2019
  - Evidence of ESRD
  - Evidence of stage 4 CKD
  - Evidence of kidney transplant
- Wellcentive does not have the following data to support gap closer
  - Pharmacy claims
  - Visits with nephrologist
  - Kidney transplant
- Per the payers, patients must have 2 or more visits with a diagnosis of diabetes; Wellcentive looks for patients with a diagnosis of diabetes and a count of office visits. Does not have the ability to link office visits with diagnosis
- Do not receive diagnosis codes from all office's EMR; Wellcentive is reliant on claims

Colorectal Cancer Screening

- Continuously enrolled in 2018 and 2019 with no more than a 45-day gap
- Cologuard is claims based only

Well Child 3-6 Years

- Continuously enrolled during 2019 with no more than a 45-day gap
- Calculation of age
  - Payers denominator is based on the age of the child as of December 31 of the reporting period
  - Wellcentive calculated the age based on the date the report is pulled

Weight & Counseling: BMI Percentile

- Continuously enrolled during 2019 with no more than a 45-day gap
- The Blues will not take an auto-calculated value from Wellcentive
- Several EMRs do not have the BMI percentile as a discrete/structured field, therefore the data cannot be sent to Wellcentive (ie. Athena)
- AHN received billing G-codes from some EMRs (ie. Athena)
- Wellcentive will auto-calculate value with a height and weight; this does not mean a corresponding G-code was received

Weight & Counseling: Nutritional

- Continuously enrolled during 2019 with no more than a 45-day gap
- Not all EMRs store this data in a discrete/structured field, therefore the data cannot be sent to Wellcentive

- Providers not following the approved workflow set forth by the EMR vendor and/or their leadership to capture the data to be sent to Wellcentive

Weight & Counseling: Physical Activity

- Continuously enrolled during 2019 with no more than a 45-day gap
- Not all EMRs store this data in a discrete/structured field, therefore the data cannot be sent to Wellcentive
- Providers not following the approved workflow set forth by the EMR vendor and/or their leadership to capture the data to be sent to Wellcentive

Childhood Imms Combo 3

- Children continuously enrolled for a 12-month period preceding their 2nd birthday, no more than a 45-day gap in coverage
- Calculation of age
  - Payers denominator is based on the age of the child as of December 31 of the reporting period
  - Wellcentive calculated the age based on the date the report is pulled

Well Child 15-Month

- Continuously enrolled from 31-days of age to 15-months with no more than a 45-day gap
- Calculation of age
  - Payers denominator is based on child being 15-months of age during the measurement year
  - Wellcentive calculated the age based on the date the report is ran

Data Sent to Payers

Data Elements Sent to Payers

Measure	PH	BCBSM/BCN	Meridian	Molina	Humana
BMI	Y	Y	Y	Y	Y
BMI, Pediatric, < 5th Percentile	Y	Y	Y	Y	N
BMI, Pediatric, >= 95th Percentile	Y	Y	Y	Y	N
BMI, Pediatric, 5th Percentile - < 85th Percentile	Y	Y	Y	Y	N
BMI, Pediatric, 85th Percentile < 95th percentile	Y	Y	Y	Y	N
Bone Densitometry (Bone Mineral Density Test)	Y	N	Y	Y	N
BP Diastolic	Y	Y	Y	Y	Y
BP Systolic	Y	Y	Y	Y	Y
Cervical Cancer Screening: Pap Smear	Y	N	Y	Y	N
Chlamydia Screening	Y	Y	Y	Y	Y
CKD Stage 4 - Medical Attention for Nephropathy	na	Y	na	na	na
Colon Cancer Screening: FOBT	Y	na	Y	Y	Y
Colon Cancer Screening: Colonoscopy	Y	N	Y	Y	N
Colon Cancer Screening: FIT-DNA (Cologurad)	Y	N	na	N	N
Colonoscopy Cancer	N	N	N	N	N
Depression Follow-Up Palan	na			Y	
Depression Screening: Other	Y			Y	
Depression Screening: PHQ2 Administered	Y	na	na	Y	
Depression Screening: PHQ9 Administered	Y	Y	na	Y	N
Diabetic Retinal Exam - Negative		Y	N	Y	N
Diabetic Retinal Exam - Positive	na	Y	N	Y	N
Evidence Of Nephropathy: Micro Albumin / Creatinie Ratio	Y	Y	na	Y	Y
Evidence Of Nephropathy: Urine Micro Albumin	Y	Y	Y	Y	Y
Group A Streptococcus Test	Y	Y	Y	Y	Y
HBA1C Test	Y	Y	Y	Y	Y
HDL	Y	na	Y	Y	Y

Measure	PH	BCBSM/BCN	Meridian	Molina	Humana
Height	Y	Y	Y	Y	Y
HPV Tests	Y	Y	na	Y	Y
HPV Vaccine	Y	Y	Y	Y	N
Hysterectomy With No Residual Cervix	Y	N	N	N	N
Influenza Vaccine	Y	Y	Y	Y	N
LDL	Y	na	Y	Y	Y
Mammogram	Y	N	N	Y	N
MMA: Exclusions - COPD	na	Y	Y	na	na
Nephropathy Treatment - Medcal Attention for Nephropathy	na	Y	na	na	na
Nutrition Counseling	Y	Y	Y	Y	N
Physical Activity Counseling	Y	Y	Y	Y	N
Pneumococcal Vaccine (Pneumovax 23)	Y	Y	Y	Y	N
Pneumococcal Vaccine (Prevnar 13)	N	Y	Y	Y	N
Postpartum Care Visit	Y	Y	Y	Y	N
Prenatal Care Visit	Y	Y	Y	N	N
Prostate Cancer	na	Y	N	na	na
Serum Creatinine	Y	Y	na	Y	Y
Serum Lead	Y	Y	Y	Y	N
Serum Potassium	Y	Y	na	Y	Y
Sigmoidoscopy	N	Y	N	N	N
Smoking Status: Current Tobacco User	Y	Y	na	Y	N
Smoking Status: Never Used Tobacco	Y	N	na	Y	N
Smoking Status: Past Tobacco User	N	N	na	Y	N
Urine Protein Test	na	Y	N	Y	Y
Weight	Y	Y	Y	Y	Y
Well Child Visit	Y	Y	Y	Y	N

KEY:

Sending Data — Y

Not Approved to send data — N

Payer does not allow this data to be sent VIA supplemental date

Last updated: 10/16/2020

****Subject to change though out the year based on audit results.

*****Manually entered date will not be sent to payers

2020 BCBSM MA PPO Supplemental Data Refresh Schedule

Refresh Month	Payer Retrieval Date	Refresh Data Thru	Data Sent from Wellcentive to Payer	Date Data Needs to be Written in Wellcentive	Results Reflected in HeB on
March	*3/1/2020	1/31/2020	1/31/2020	1/30/2020	3/9/2020
April	*4/1/2020	2/29/2020	2/28/2020	2/27/2020	4/9/2020
May	*5/1/2020	3/31/2020	3/27/2020	3/26/2020	5/8/2020
June	*6/1/2020	4/30/2020	4/24/2020	4/23/2020	6/9/2020
July	*7/1/2020	5/31/2020	5/29/2020	5/28/2020	7/9/2020
August	*8/1/2020	6/30/2020	6/26/2020	6/25/2020	8/7/2020
September	*9/1/2020	7/31/2020	7/31/2020	7/30/2020	9/9/2020
October	*10/1/2020	8/31/2020	8/28/2020	8/27/2020	10/9/2020
November	*11/1/2020	9/30/2020	9/25/2020	9/24/2020	11/9/2020
December	*12/1/2020	10/31/2020	10/30/2020	10/29/2020	12/9/2020
January	TBA	TBA	TBA	TBA	TBA
Year End Historical	TBA	TBA	TBA	TBA	TBA

*Estimated Date: Payer has not released official date

Data is sent to The Blues every Friday.

All dates are subject to change by the payer and / or Wellcentive

Note: Most electronic (CCDA) interfaces will not send data electronically to Wellcentive until the encounter has been closed

2020 BCBSM Commercial Supplemental Data Refresh Schedule

Refresh Month	Payer Retrieval Date	Refresh Data Thru	Data Sent from Wellcentive to Payer	Date Data Needs to be Written in Wellcentive	Results Reflected in HeB on
March	*3/1/2020	2/7/2020	1/31/2020	1/30/2020	3/10/2020
April	*4/1/2020	2/29/2020	2/28/2020	2/27/2020	4/10/2020
May	*5/1/2020	3/31/2020	3/27/2020	3/26/2020	5/10/2020
June	*6/1/2020	4/30/2020	4/24/2020	4/23/2020	6/10/2020
July	*7/1/2020	5/31/2020	5/29/2020	5/28/2020	7/10/2020
August	*8/1/2020	6/30/2020	6/26/2020	6/25/2020	8/10/2020
September	*9/1/2020	7/31/2020	7/24/2020	7/23/2020	9/10/2020
October	*10/1/2020	8/31/2020	8/28/2020	8/27/2020	10/10/2020
November	*11/1/2020	9/30/2020	9/25/2020	9/24/2020	11/10/2020
December	*12/1/2020	10/31/2020	10/30/2020	10/29/2020	12/10/2020
January	*1/1/2021	11/30/2020	11/27/2020	11/26/2020	1/10/2021
Year End Historical	TBA	TBA	TBA	TBA	TBA

*Estimated Date: Payer has not released official date

Data is sent to The Blues every Friday.

All dates are subject to change by the payer and / or Wellcentive

Note: Most electronic (CCDA) interfaces will not send data electronically to Wellcentive until the encounter has been closed

2020 BCN Commercial Supplemental Data Refresh Schedule

Refresh Month	Payer Retrieval Date	Refresh Data Thru	Data Sent from Wellcentive to Payer	Date Data Needs to be Written in Wellcentive	Results Reflected in HeB on
March	*3/1/2020				
April	*4/1/2020	3/27/2020	3/20/2020	3/19/2020	4/26/2020
May	*5/1/2020	4/24/2020	4/17/2020	4/16/2020	5/24/2020
June	*6/1/2020	5/22/2020	5/15/2020	5/14/2020	6/21/2020
July	*7/1/2020	6/26/2020	6/19/2020	6/18/2020	7/26/2020
August	*8/1/2020	7/24/2020	7/17/2020	7/16/2020	8/23/2020
September	*9/1/2020	8/21/2020	8/14/2020	8/13/2020	9/20/2020
October	*10/1/2020	9/25/2020	9/18/2020	9/17/2020	10/25/2020
November	*11/1/2020	10/23/2020	10/16/2020	10/15/2020	11/22/2020
December	*12/1/2020	11/20/2020	11/13/2020	11/12/2020	12/20/2020
January	*1/1/2021	TBA	TBA	TBA	TBA
Year End Historical	TBA	TBA	TBA	TBA	TBA

*Estimated Date: Payer has not released official date

Data is sent to The Blues every Friday.

All dates are subject to change by the payer and / or Wellcentive

Note: Most electronic (CCDA) interfaces will not send data electronically to Wellcentive until the encounter has been closed

2020 Priority Health Commercial Supplemental Data Refresh Schedule

Refresh Month	Payer Retrieval Date	Refresh Data Thru	Data Sent from Wellcentive to Payer	Date Data Needs to be Written in Wellcentive	Results Reflected in Patient Portal and Payer Reports
March	3/1/2020	2/28/2020			
April	4/1/2020	3/31/2020	3/27/2020	3/26/2020	4/15/2020
May	5/1/2020	4/30/2020	4/24/2020	4/23/2020	5/15/2020
June	6/1/2020	5/31/2020	5/29/2020	5/28/2020	6/15/2020
July	7/1/2020	6/30/2020	6/26/2020	6/25/2020	7/15/2020
August	8/1/2020	7/31/2020	7/31/2020	7/30/2020	8/15/2020
September	9/1/2020	8/31/2020	8/28/2020	8/27/2020	9/15/2020
October	10/1/2020	9/30/2020	9/25/2020	9/24/2020	10/15/2020
November	11/1/2020	10/31/2020	10/30/2020	10/29/2020	11/15/2020
December	12/1/2020	11/30/2020	11/27/2020	11/26/2020	12/15/2020
January	1/1/2021	12/31/2020	12/31/2020	12/30/2020	TBA
Year End Historical	TBA	TBA	TBA	TBA	TBA

Data is sent to Priority Health every Friday.

All dates are subject to change by the payer and / or Wellcentive

Note: Most electronic (CCDA) interfaces will not send data electronically to Wellcentive until the encounter has been closed

Measures Supported

Depression Screening and Follow Up Plan

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Depression Screening (PHQ2) OR
- Depression Screening (PHQ9)

  AND
- Depression Follow Up Plan or Suicide Risk Assessment (in care)

Alerts

- Preventative Care: Depression Screening and Follow up plan (ACO Patients whose depression screening was positive, and they did not have a follow up completed on the same day of service)

Reports

- Scorecards
  - ACO – 2020
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Screening for Depression
- Summary/Provider Reports
  - AHN Performance Reports – Screening for Clinical Depression

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Diabetes: Dilated Retinal Exam

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Dilated Retinal Exam (in care).

Alerts

- Diabetes: Retinal Exam > 1 yr or Not Documented – (Patients with diabetes whose dilated retinal exam has not been recorded in the past year)
- Patients with HTN or Diabetes with Overdue Office Visit – (Patients with HTN or Diabetes whose office visit has not been recorded in the past year).

Reports

- Scorecards
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Diabetes
- Summary/Provider Repots
  - AHN Performance Report – Diabetes

* *The only data interfaced into Wellcentive for this measure comes from Shoreline Vision and Claims.*

Diabetes: Hemoglobin A1C (HbA1C) Controlled Less Than 8.0%

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- A1c (in labs)

Alerts

- Diabetes: HbA1c > 6 months or Not Documented – (Patients whose HbA1c has not been recorded in the past 6 months)
- Diabetes: HbA1c > 8 (Last Value) – (patients only whose last HbA1c recorded in the past year has a value that is > 8)
- Diabetes: HbA1c > 9 (Last Value) – (patients only whose last HbA1c recorded in the past year has a value this is of > 9)
- Patients with HTN or Diabetes with Overdue Office Visit – (Patients with HTN or Diabetes whose office visit has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Diabetes
- Summary/Provider Reports
  - AHN Performance Report – Diabetes

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Trinity, Spectrum, Metro, Quest.*

Diabetes: Hemoglobin A1C (HbA1C) Controlled Less Than or Equal To 9.0%

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- A1c (in labs)

Alerts

- Diabetes: HbA1c > 6 months or Not Documented – (Patients whose HbA1c has not been recorded in the past 6 months)
- Diabetes: HbA1c > 8 (Last Value) – (patients only whose last HbA1c recorded in the past year has a value that is > 8)
- Diabetes: HbA1c > 9 (Last Value) – (patients only whose last HbA1c recorded in the past year has a value this is of > 9)
- Patients with HTN or Diabetes with Overdue Office Visit – (Patients with HTN or Diabetes whose office visit has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
- Patient Compliance Reports
  - AHN – Diabetes
- Summary/Provider Reports
  - AHN Performance Report – Diabetes

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Trinity, Spectrum, Metro, Quest.*

Diabetes: Hemoglobin A1c (HbA1C) Poor Control Greater Than 9.0%

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- A1c (in labs)

Alerts

- Diabetes: HbA1c > 6 months or Not Documented – (Patients whose HbA1c has not been recorded in the past 6 months)
- Diabetes: HbA1c > 8 (Last Value) – (patients only whose last HbA1c recorded in the past year has a value that is > 8)
- Diabetes: HbA1c > 9 (Last Value) – (patients only whose last HbA1c recorded in the past year has a value this is of > 9)
- Patients with HTN or Diabetes with Overdue Office Visit – (Patients with HTN or Diabetes whose office visit has not been recorded in the past year)

Reports

- Scorecards
  - ACO – 2020
  - AHN – Quality Report
- Patient Compliance Reports
  - AHN – Diabetes
- Summary/Provider Reports
  - AHN Performance Report – Diabetes

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Trinity, Spectrum, Metro, Quest.*

Diabetes: Hemoglobin A1C (HbA1C) Testing

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- A1c (in labs)

Alerts

- Diabetes: HbA1c > 6 months or Not Documented – (Patients whose HbA1c has not been recorded in the past 6 months)
- Patients with HTN or Diabetes with Overdue Office Visit – (Patients with HTN or Diabetes whose office visit has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Diabetes
- Summary/Provider Reports
  - AHN Performance Report – Diabetes

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Trinity, Spectrum, Metro, Quest.*

Diabetes: Monitoring for Nephropathy

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Microalbumin (in lab)

Alerts

- Diabetes: Urine Microalbumin > 1 yr or Not Documented (excludes Nephropathy Dx) – (Patients with diabetes who have not had a microalbumin recorded in the past year)
- Patient with HTN or Diabetes with Overdue Office Visit – (Patients with HTN or Diabetes whose office visit has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Diabetes
- Summary/Provider Reports
  - AHN Performance Report – Diabetes

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Trinity, Spectrum, Metro, Quest.*

Hypertension (HTN): Controlling High Blood Pressure

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Blood Pressure (in vitals)

Alerts

- HTN: BP > 140/90 or not documented in past 365 days – (Patient with HTN who does not have a BP recorded OR who does not have a BP recorded in the past year OR whose last recorded BP was > 140 or > 90)
- Patient with HTN or Diabetes with Overdue Office Visit – (Patients with HTN or Diabetes whose office visit has not been recorded in the past year)

Reports

- Scorecards
  - ACO – 2020
  - AHN – Quality Report
  - AHN - PHPR
- Summary/Provider Reports
  - AHN Performance Report – HTN
  - MHPP – TH M.A.AP BP – Performance Report
- Patient Compliance Reports
  - AHN – HTN
  - AHN – M.A.P BP – Gap List (patients with no BP OR last BP is more than 6 months OR last BP is > 140/90)
  - MHPP – Target BP Initiative – Priority 1 (patients whose last BP was > 160/100)
  - MHPP – Target BP Initiative Gap List (patients with no BP OR last BP is more than 6 months OR last BP is > 140/90)

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Statin Therapy For The Prevention and Treatment of Cardiovascular Disease

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Appropriate medication (in active medication)

Reports

- Scorecards
  - ACO – 2020

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Adult BMI – Assessment

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- BMI (in vitals)

Alerts

- Preventive Care: BMI > 1 yr or Not Documented (Patients whose BMI has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
- Patient Compliance Reports
  - AHN – Adult BMI
- Summary/Provider Reports
  - AHN Performance Report – Preventative Care Adult

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Adult BMI – Screening and Follow-Up

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- BMI (in vitals)

  AND

- BMI Plan (in care)

Alerts

- Preventive Care: BMI > 1 yr or Not Documented (Patients whose BMI has not been recorded in the past year)
- Preventive Care: BMI Screenings and Follow up – ACO (ACO patients only; Patients who has not had a BMI or their BMI is out of range and they do not have a follow up. Follow-up must be related to the last BMI and done on the same date or 6 months prior to qualify).

Reports

- Scorecards
  - AHN – Quality Report
  - AHN – PHPR
- Patient Compliance Reports
  - AHN – Adult BMI
- Summary/Provider Reports
  - AHN Performance Report – Preventative Care Adult

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Colorectal Cancer Screening

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Colonoscopy **OR**
- Flex sig **OR**
- FOBT **OR**
- CT Colonography **OR**
- Cologaurd **OR**

Alerts

- Preventive Care: Colorectal Cancer Screening Due: Ages 50-75 (Patient's whose screening test has not been recorded in the approved timeframe)

Reports

- Scorecards
  - ACO – 2020
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Report
  - AHN – Screening for Colon Cancer
- Summary/Provider Reports
  - AHN Performance Report – Preventive Care Adult

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Mercy and St. Mary's*

Falls: Screening for Future Fall Risk

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Fall Risk Screening (in care)

Alerts

- Preventive Care: Fall Risk – ACO – (ACO Patients only – Patients whose fall risk assessment has not been recorded in the past year)

Reports

- Scorecards
  - ACO – 2020

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Tobacco Use Assessment and Cessation Intervention

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Tobacco assessment completed

  AND

- Tobacco cessation intervention (in care or in other history)

  AND

- Smoking Status (in other history)

Alerts

- Preventive Care: Tobacco Cessation Counseling >1 yr or Not Documented (Patients positive for tobacco use or an unknown status that has not had tobacco cessation intervention recorded in the past year)

Reports

- Scorecards
  - ACO – 2020
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Tobacco Assessment and Counseling
- Summary/Provider Reports
  - AHN Performance Report – Preventive Care Adult

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Immunizations – Adolescent Combo 2

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Vaccines (in immunizations)
  - Meningococcal
  - Tdap
  - Td
  - HPV

Reports

- Scorecards (monitor performance ***only,*** Not Met list ***cannot*** be work to close gaps)
  - AHN – Quality Report
- Patient Compliance Reports (registry displays immunization administered dates, ***can be*** used to identify gaps in care)
  - AHN – Adolescent Immunizations

Data needed to satisfy this measure is only collect for immunizations administer in an office and is interfaced into Wellcentive via a direct interface. Wellcentive **DOES NOT receive data from MCIR.*

**Payer relay on MCIR and claims data to close gaps in care related to this measure.*

Immunizations – Childhood Combo 10

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Vaccines (in immunizations)
  - DTap/DTP
  - Hepatitis B
  - HIB
  - MMR
  - IPV
  - Varicella
  - Pneumococcal
  - Hepatitis A
  - Rotavirus
  - Influenza

Reports

- Scorecards (monitor performance ***only,*** Not Met list ***cannot*** be work to close gaps)
  - AHN –Quality Report
  - AHN - PHPR
- Patient Compliance Reports (registry displays immunization administered dates, ***can be*** used to identify gaps in care)
  - AHN – Childhood Immunizations

* *Data needed to satisfy this measure is only collect for immunizations administer in an office and is interfaced into Wellcentive via a direct interface. Wellcentive* ***DOES NOT*** *receive data from MCIR.*

**Payer relay on MCIR and claims data to close gaps in care related to this measure.*

Immunizations – Childhood Combo 3

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Vaccines (in immunizations)
  - DTap/DTP
  - Hepatitis B
  - HIB
  - MMR
  - IPV
  - Varicella
  - Pneumococcal

Reports

- Scorecards (monitor performance ***only,*** Not Met list ***cannot*** be work to close gaps)
  - AHN –Quality Report
  - AHN - PHPR
- Patient Compliance Reports (registry displays immunization administered dates, ***can be*** used to identify gaps in care)
  - AHN – Childhood Immunizations

* *Data needed to satisfy this measure is only collect for immunizations administer in an office and is interfaced into Wellcentive via a direct interface. Wellcentive* ***DOES NOT*** *receive data from MCIR.*

**Payer relay on MCIR and claims data to close gaps in care related to this measure.*

Influenza Immunization

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Influenza (in immunizations)

Alerts

- Preventive Care: Influenza Vaccine Ages (6 months+) Flu shot not completed – (Patients > 1 year of age whose influenza vaccine has not been recorded in the past year)

Reports

- Scorecards
  - ACO – 2020

Data needed to satisfy this measure is only collect for immunizations administer in an office and is interfaced into Wellcentive via a direct interface. Wellcentive **DOES NOT receive data from MCIR.*

**Payer relay on MCIR and claims data to close gaps in care related to this measure.*

Lead Screening

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Lead, Blood (in care)

Alerts

- Pediatric Preventative Care: Children Age 6 months – 2 yrs: Primary Lead Screening Not Documented – (Patients whose lead screening has not been recorded in the past year)

Reports

- Scorecard
  - AHN – Quality Report
- Patient Compliance Reports
  - AHN – Lead Screening

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Trinity, Spectrum, Metro, Quest.*

Pediatric Weight Assessment and Counseling: BMI Percentile

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Vitals (in vitals)
  - Height
  - Weight
  - BMI Percentile

Alerts

- Preventive Care: BMI >1 yr or Not Documented – (Patients 3-74 whose BMI has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Weight Assessment and Counseling
- Summary/Provider Reports
  - AHN Performance Report – Preventive Care Pediatric
  - AHN Performance Report – Screening for Pediatric Obesity

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Pediatric Weight Assessment and Counseling: Nutrition Counseling

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Counseling (nutrition counseling)
  - Counseling-Dietary
  - Dietary Consult

Alerts

- Preventive Care: Nutrition Counseling > 1 yr or Not Documented (Children) – (Patients 3-17 whose nutritional counseling has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Weight Assessment and Counseling
- Summary/Provider Reports
  - AHN Performance Report – Preventive Care Pediatric
  - AHN Performance Report – Screening for Pediatric Obesity

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Pediatric Weight Assessment and Counseling: Physical Activity Counseling

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Physical activity counseling (in care)

Alerts

- Preventive Care: Physical Activity Counseling > 1 yr or Not Documented (Children) – (Patients 3-17 whose physical activity counseling has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Weight Assessment and Counseling
- Summary/Provider Reports
  - AHN Performance Report – Preventive Care Pediatric
  - AHN Performance Report – Screening for Pediatric Obesity

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Well-Care Visits – Adolescence 12 to 21 Years

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Well Child Visit (in care)

Alerts

- Preventive Care: Children Age 12-21: Well Care Exam >1 yr or Not Documented – (Patients ages 12-21 whose well child visit has not been recorded in the past year)

Reports

- Patient Compliance Reports
  - AHN – Well Child Ages 12-21
  - AHN – Weight Assessment and Counseling
- Summary/Provider Reports
  - AHN Performance Report - Preventive Care Pediatric

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Well-Child Visits – 0 to 15 Months

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Well Child Visit (in care) to 12 months of age with <5 well child visits recorded OR Patients 12 months to 15 months of age with <6 well child visits recorded)

Alerts

- Preventive Care Children Age 0-15mo – 6 Well Care Exams by 15 months of age (Patients <1 month of age with <1 well child visit recorded OR Patients 6 months

Reports

- Scorecards
  - AHN – PHPR (Provides rate for children 15 months of age **(nMet list is not a workable list)**
- Patient Compliance Reports
  - AHN – Well Child 0-15 Months
- Summary/Provider Reports
  - AHN – Well Child 0-15 Months

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Well-Child Visits – 3 to 6 Years

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Well Child Visit (in care)

Alerts

- Preventive Care: Children Age 3-6: Well Care Exam >1 yr or Not Documented – (Patients ages 3-6 whose well child visit has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Reports
  - AHN – Well Child Ages 3-6
  - AHN – Weight Assessment and Counseling
- Summary/Provider Reports
  - AHN Performance Report - Preventive Care Pediatric

* *Data needed to satisfy this measure comes from EMR sources either via a direct interface or supplemental data file.*

Breast Cancer Screening / Mammography

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Mammogram

Alerts

- Preventative Care: Female Age 52-74: Mammogram >2 yrs. or Not Documented (Patient whose mammogram has not been recorded in the 2 past years)
- Preventative Care: Female Age 50-74: Mammogram >15 months or Not Documented **(ACO ONLY)** (ACO Patient whose mammogram has not been recorded in the past 15 months)

Reports

- Scorecards
  - ACO – 2020
  - AHN – Quality Report
  - AHN - PHPR
- Patient Compliance Report
  - AHN – Screening for Breast Cancer
- Summary/Provider Reports (monitors performance at provider, office, AFFINIA levels)
  - AHN Performance Report – Preventative Care Adult

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Mercy and St. Mary's*

Cervical Cancer Screening

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- PAP Smear (in care)

  AND

- HPV Testing (in lab)

Alerts

- Preventive Care: Female 21-64: PAP Smear needed (excludes hysterectomy) (Patients whose PAP Smears have not been recorded in the past 3 years)

Reports

- Scorecards
  - AHN – Quality Report
- Patient Compliance Reports
  - AHN – Screening for Cervical Cancer
- Summary/Provider Reports
  - AHN Performance Report – Preventive Care Adult

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Mercy and St. Mary's*

Chlamydia Screening

The Wellcentive items(s)/field(s) that are required to satisfy the measure are

- Chlamydia Screening (in care) **OR**
- Chlamydia (in lab)

Alerts

- Preventive Care: Female 16-24: Chlamydia Screening > 1 year or not documented (Patients whose chlamydia screening has not been recorded in the past year)

Reports

- Scorecards
  - AHN – Quality Report
- Summary/Provider Reports
  - AHN Performance Report – Preventative Care Adult
  - AHN Performance Report – Preventive Care Pediatric

* *The majority of data needed to satisfy this measure is interfaced into Wellcentive from source lab systems such as Trinity, Spectrum, Metro, Quest.*

Measures with Limited Support

Diabetes: Optimal Care of Diabetic Patients

Alerts related to components of this measure

- Diabetes: HbA1c > 6 months or Not Documented – (Patients whose HbA1c has not been recorded in the past 6 months)
- Diabetes: HbA1c > 8 (Last Value) – (patients only whose last HbA1c recorded in the past year has a value that is > 8)
- Diabetes: HbA1c > 9 (Last Value) – (patients only whose last HbA1c recorded in the past year has a value this is of > 9)
- Patients with HTN or Diabetes with Overdue Office Visit – (Patients with HTN or Diabetes whose office visit has not been recorded in the past year)
- Diabetes: Urine Microalbumin > 1 yr or Not Documented (excludes Nephropathy Dx) – (Patients with diabetes who have not had a microalbumin recorded in the past year)
- Diabetes: Retinal Exam > 1 yr or Not Documented – (Patients with diabetes whose dilated retinal exam has not been recorded in the past year)

Reports related to components of this measure

- Scorecards
  - AHN – Quality Report
- Patient Compliance Reports
  - AHN – Diabetes
- Summary/Provider Reports
  - AHN Performance Report – Diabetes

Asthma – Use of Appropriate Medication

Reports to *identify* patients

- Patient Compliance Reports
  - AHN - Asthma
- Summary/Provider Reports
  - AHN Performance Report - Asthma

Asthma – Medication Management

Reports to *identify* patients

- Patient Compliance Reports
  - AHN - Asthma
- Summary/Provider Reports
  - AHN Performance Report - Asthma

Attention Deficit Hyperactivity Disorder (ADHD) - Initiation Phase

Reports to *identify* patients

- Patient Compliance Reports
  - AHN - ADHD
- Summary/Provider Reports
  - AHN Performance Report - ADHD

Attention Deficit Hyperactivity Disorder (ADHD) – Continuation and Maintenances Phase

Reports to *identify* patients

- Patient Compliance Reports
  - AHN - ADHD
- Summary/Provider Reports
  - AHN Performance Report - ADHD

Statin Therapy for Patients with Diabetes

Reports related to components of this measure

- Patient Compliance Reports
  - AHN – Diabetes

Coronary Artery Disease (CAD): Lipid Therapy

Reports related to components of this measure

- Patient Compliance Reports
  - AHN - CAD

Chronic Obstructive Pulmonary Disease (COPD) - Pharmacotherapy

Reports to *identify* patients

- Patient Compliance Reports
  - AHN - COPD
- Summary/Provider Reports
  - AHN Performance Reports – COPD

Measures Not Supported

Measures where Wellcentive cannot support performance or identify the population via reports/alerts.

- Annual Monitoring for Patients on Persistent Medications (Diuretics & ACE/ARB)
- Antidepressant Treatment Effective Acute Phase
- Antidepressant Treatment Effective Continuation Phase
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with URI
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Depression Remission at Twelve Months
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Early Entry Into Prenatal Care
- Follow-Up After Hospitalization, Medical 7 Days
- Human Immunodeficiency Virus (HIV) Linkage to Care
- Initial Visit with PCP and Completed HRA
- Low Birth Weight
- Opioid Utilization (Use of Opioids at High Dosage)
- Osteoporosis Management in Women Who Had a Fracture
- Postpartum Care
- Proportion of Days Covered
- Use of Imaging Studies for Low Pack Pain

Affinia
Health Network
MEMBER

POPULATION HEALTH PERFORMANCE REPORTS (PHPR)

Section 4

Section 4: Population Health Performance Reports (PHPR)

Guiding principles

PURPOSE: The purpose of the Population Health Performance Report's (PHPR) Performance Methodology is to enhance value to the regions and communities served by the Affinia Health Network (AHN) through improved quality and outcomes, patient experience and to reduce healthcare costs. The Affinia Performance Methodology strategies will be explored throughout this document and includes guiding principles, key definitions, scorecard layouts that will link measures to Affinia Health Network, practice, and provider performance.

GUIDING PRINCIPLES:

Guiding Principles describe the organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

- **Transparency:** At least annually**,** the methodology will be reviewed by the Affinia's Ambulatory Quality Steering Committee and Data Reporting Workgroup who in turn will clearly communicate both to the Network and Physicians respectively the prevailing model for the upcoming year, as appropriate.
- **Simplicity:** Utilize best-practice design. It will be replicable, minimize resource requirements and promote Network and Physician engagement.
- **Value Alignment:** Will recognize clinical efficiency, fiscal responsibility, Network engagement and quality improvement.
- **Balance:** Will strike a balance between clinical quality, efficiency and cost effectiveness.
- **Compliance:** Fully compliant with all Federal and state laws and regulations that govern Clinically Integrated Networks.
- **Approval:** The Methodology must be approved by the Mercy Health Physician Partners (MHPP) Regional Scorecard Committee, Affinia's Ambulatory Quality Steering Committee and Data Reporting Workgroup at least annually.
- **Attainable:** The performance threshold should be achievable and feasible by each provider within the clinical transformational model year.
- **Evidence Based:** The Methodology should take into account external national benchmarks when available.
- **Transformational:** Should be related to and create positive impact to the Affinia Board of Manager approved clinical priorities and objectives.
- **Measurable:** The Methodology must have the ability to be qualitatively measured at the Affinia, practice and provider level.

Wellcentive Active Patient Definition

PURPOSE: The purpose of the Wellcentive active patient definition is to clearly articulate and accurately define a meaningful active patient population within Wellcentive. Having a clearly defined population will allow practice unit teams to more efficiently manage quality for their defined population. The definition will also provide structure to the defined population used in Affinia Health population health reports produced from Wellcentive.

Inclusion criteria (active)	1. Any patient that is on a payer eligibility file, regardless of timing of last office visit to attributed practice
	• Priority Health
	  ○ Medicare
	  ○ HMO
	  ○ PPO
	  ○ Medicaid
	• BCBSM
	• BCBSM MA
	• BCN
	• BCNA
	• TH ACO
	• Humana
	• Meridian
	• Molina
	• Aetna
	• Blue Cross Complete
	AND
	2. Patients not on payer eligibility file but having office visit within past 24 months, inclusive of annual wellness visits

Exclusionary criteria (inactive)	1. Patient's not on payer eligibility file and not having office visit within past 24 months. 2. All deceased patients
Measure time period	Monthly update of eligibility files and rolling 24 months for office visit eligibility
Calculation	1. All patients on an eligibility file will be included as an active patient **even if the patient has not had an office visit with the past 24 months** 2. The office visit parameters only apply to patients **not** on an eligibility file
Additional Notes	Any patients that have been manually marked as inactive or active are subject to change when the attribution calculation is applied

Measure unique ID definition

PURPOSE: The purpose of this document is to define the policy for creating a unique identification for population health measures used by Affinia Health Network. The purpose of the unique identification show a relationship to specific measure name with the aligned technical specifications used to generate the numerator and denominator.

Measure ID structure:

Two letters followed by the next number in chronological order to be added to a domain: example: XX01

Letter 1 (***X***X01): measure domain

The measure domain is the category in which the measure falls, currently AHN has 5 domains:

1. Quality Performance - Q
2. Utilization Management - U
3. Cost and efficiency - C
4. Safety - S
5. Patient Centeredness – P

Letter 2 (X***X***01): measure specific

The measure specific is a letter that relates directly to the measure and can fall into one of 2 areas:

1. Sub category
    a. Example (P=preventive, D = diabetes, E = Emergency department)
2. First letter unique with no defined sub category
    a. Example (N=Network Integrity)

Last 2 numbers (XX***01***):

The chronological order a measures has been added to a domain/sub category.

Primary Care Provider Definition

PURPOSE: The purpose of this document is to define the specialties that are assigned to be categorized as a primary care provider.

Inclusion criteria	1. Pediatrics 2. Family Medicine 3. Internal Medicine 4. Geriatrics
Exclusionary criteria	All other specialties
Source	The specialty for a provider will be pulled from the Affinia Health Network Provider Index Tool

Population Definition

PURPOSE: The purpose of this definition is to clearly outline the patient population included in the population health performance report.

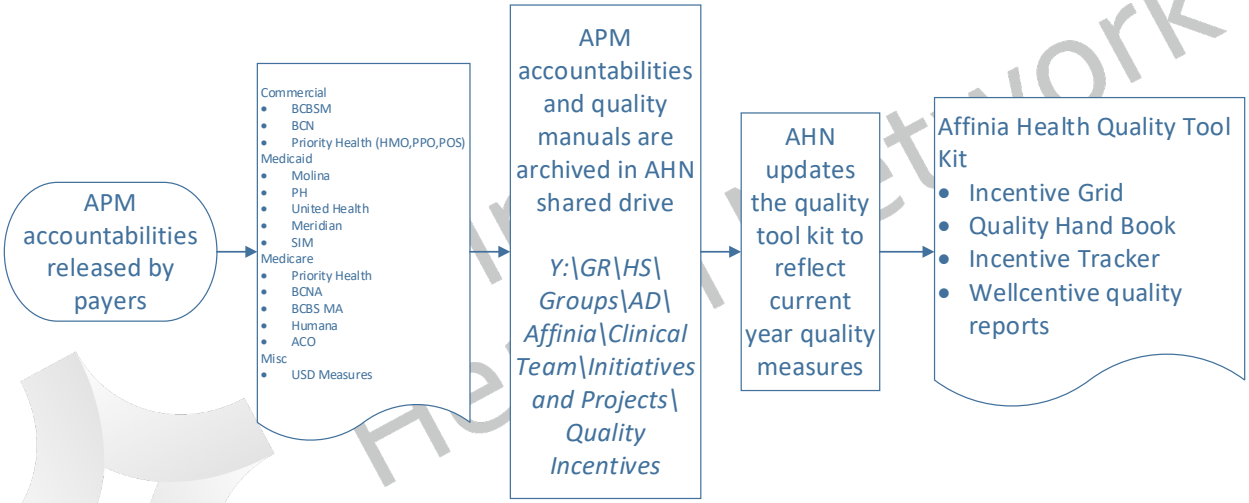
Inclusion criteria	• BCBSM (VBK) • BCN • BCBSM – MAPPO • Priority Health Medicare • BCN – My Choice Wellness • NG ACO (THACO) • Priority Health – HMO & PPO • BCNA • Priority Health Medicaid
Exclusionary criteria	• US Health & Life (Together Health) • Aetna • Humana • Meridian Health Plan of MI • Access Health • ASR • Molina (Exchange) • Cofinity • Cigna • Meridian MA • Molina MA • Blue Cross Complete • Molina Medicaid • United Health Care • No Payer listed
Source	Payer Eligibility files

Quality Measure Definitions and Performance Methodology

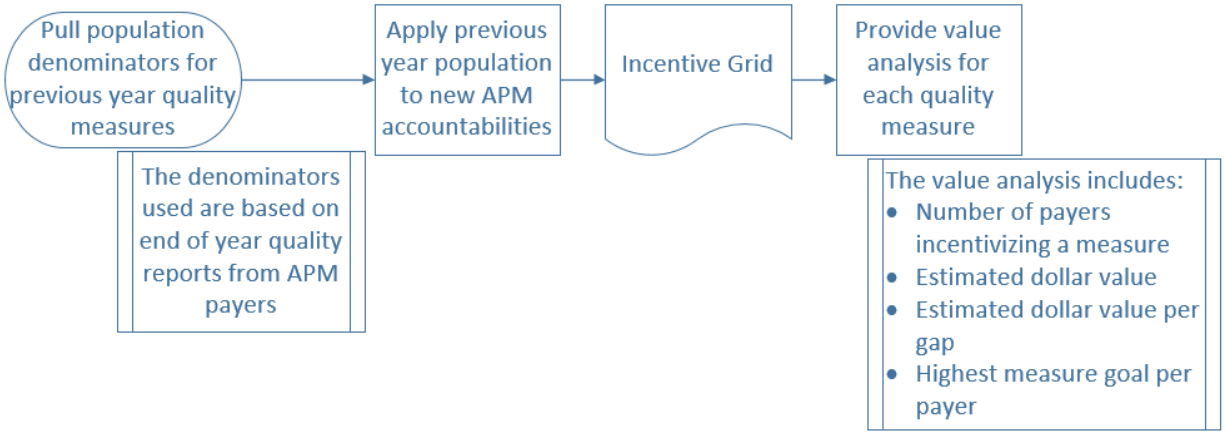
PURPOSE: The purpose of this document is to define the quality measures and performance methodology.

Selection quality measures: The quality measures for the Population Health Performance Report (PHPR) are selected through the annual quality measure assessment which takes into account Advanced Payment Model (APM) accountabilities, Trinity Health strategic goals, and current community health assessment results. This process consists of 5 steps that take place within the first quarter of each performance year.

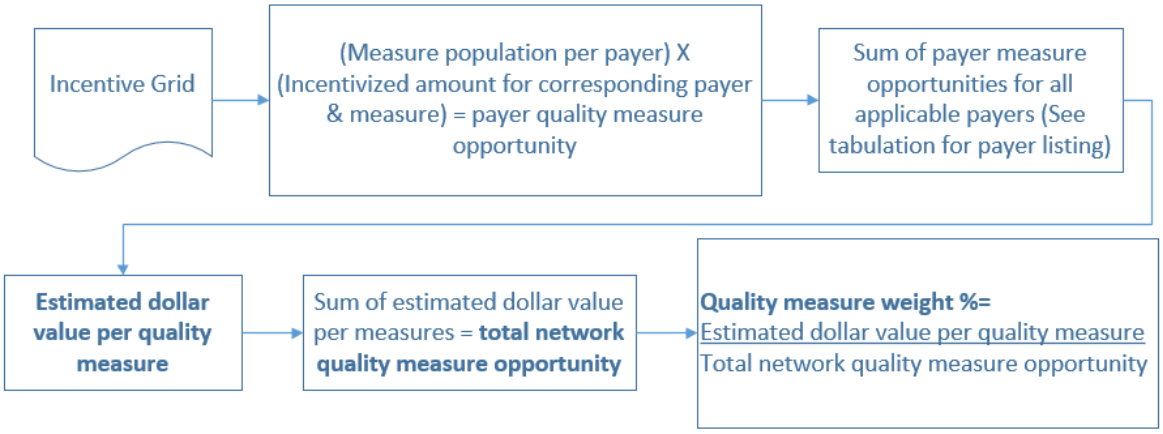
1. **Tabulation:** During this process Affinia Health Network (AHN) does an analysis of all the changes and updates to the payer APM accountabilities in conjunction with the Trinity Health Strategic goals in relation to quality measures. This analysis takes places as information is released by the payer programs during the first quarter of each year.



2. **Analysis:** Utilizing the previous year patient population, AHN applies the new quality measure program changes in order to stratify the population for the new calendar year.



3. **Weighting:** All APM quality measures are weighted and prioritized based on this calculation. The weighting takes into account the combination of the population volume and APM accountabilities.



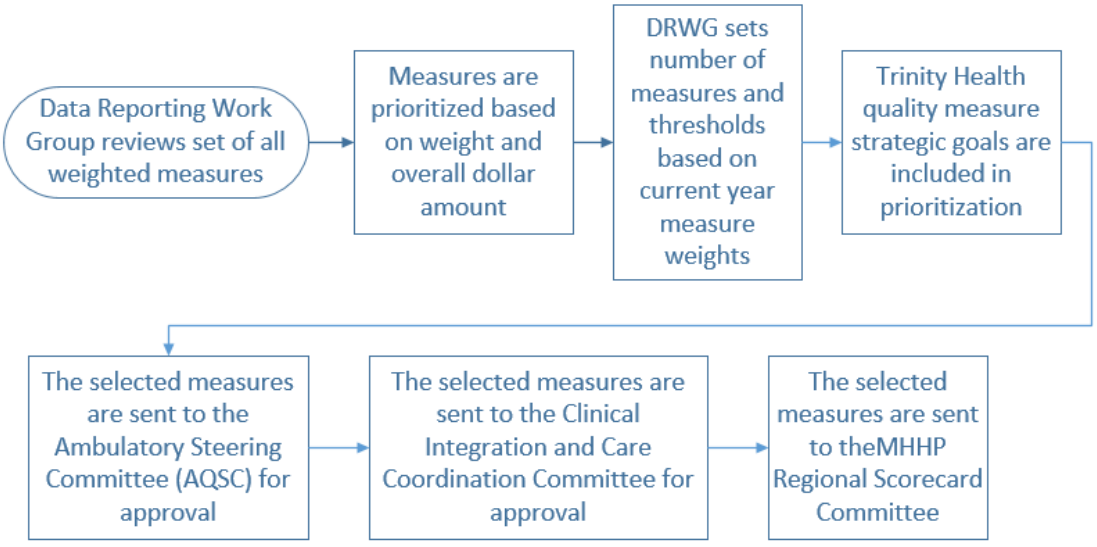
Example:

Measure	Number of plans that incentivize	Est incentive Reward	Quality measure weight %
Controlled Blood Pressure < 1	8	$ 965,941.26	13.37%
HgbA1C <8%:	7	$ 717,147.35	9.93%
Breast Cancer Screening:	9	$ 664,032.96	9.19%
Retinal Eye Exam:	10	$ 509,687.35	7.06%
Monitoring for Nephropathy:	10	$ 500,581.26	6.93%

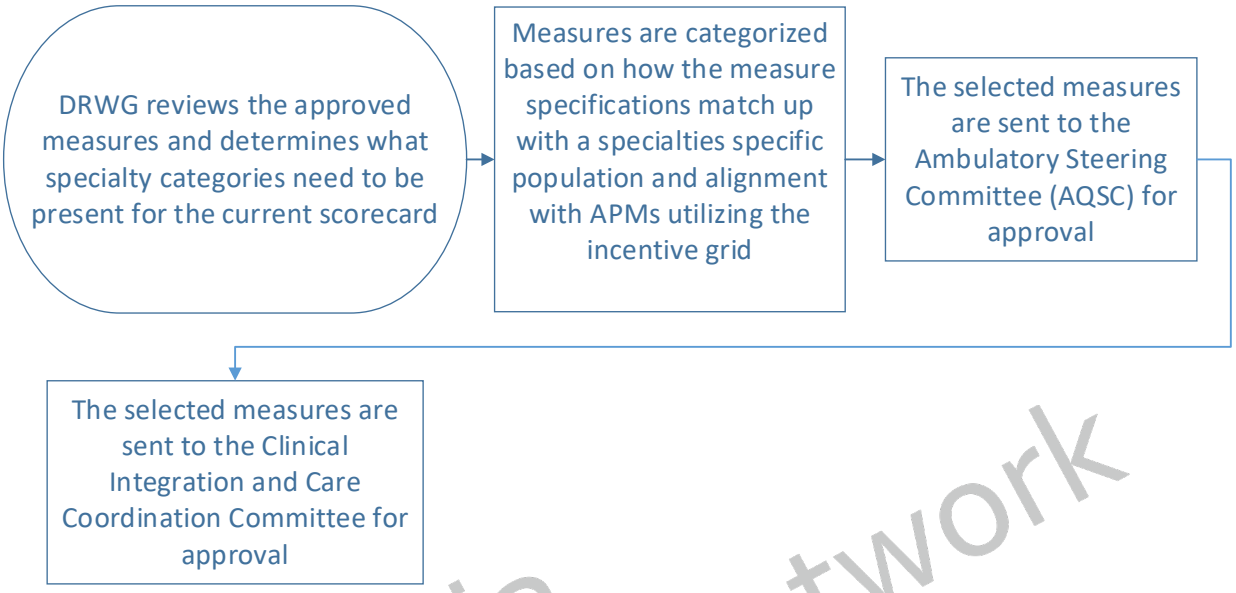
Measure		
HgbA1C <8%:	*Estimated dollar value per quality measure*	$ 717,147.35
	Total network quality measure opportunity	$ 7,223,898.89

= 9.93%

4. **Prioritization:** The quality measures are then prioritized based on weighting. This process also determines the threshold for identifying the core quality metrics.



5. **Categorization**: In conjunction with the Trinity Health strategic goals the weighted quality measures are then categorized into their respective specialties.



Quality Measures Definitions:

All quality measures use specifications from either NCQA HEDIS or CMS ACO specifications. The selected definitions are reviewed by the Data Reporting Work Group (DRWG) during the "Categorization" process and sent through the same approval process as the selected quality measures. The specification align with the current year quality programs and are reviewed on an annual basis.

HEDIS 2018 specifications:

Measure	AHN ID
Well Child Visits: 3-6 years	QP22
Weight Assessment and Counseling: BMI Percentile	QP16
Weight Assessment and Counseling: Nutrition	QP17
Weight Assessment and Counseling: Physical Activity	QP18
Childhood Imm: Combo 3	QP13
Well Child Visits: 15 months	QP21
Well-Care Visits – Adolescence 12 to 21 Years	QP36
Breast Cancer Screening	QP23
Colorectal Cancer Screening	QP32
Cervical Cancer Screening	QP37
Controlled Blood Pressure < 140/90	QH01
HgbA1C <8%	QD03
Monitoring for Nephropathy	QD05

Quality performance methodology overview:

The quality performance methodology utilizes APM accountabilities to provide specialty specific weights and determines quality measure point allocation by specialty.

Quality measure goal selection:

The quality goals are selected through an analysis of both payer goals and the NCQA 90%ile. As stated by our guiding principles:

"Attainable: The performance threshold should be achievable and feasible by each provider within the clinical transformational model year."

For the first PHPR year the goals will all be set at the NCQA 90%ile. The 90th%ile will allow the measures to correlate with plan benchmarks as well as peer to peer quality programs.

If a measure does not have an NCQA 90th%ile, the goal will be substituted with the highest payer goal.

The measure goals will be evaluated on an annual basis to determine if the goals are aligning with our guiding principles.

Quality Data Reporting Calendar

Calendar Month	Time Frame For Reports	Reporting Year	Registry Run Date	Tableau Refresh Date	Day
Jan-20	1/1/2020 - 12/31/2020	2019	1/11/2020	1/11/2020	Saturday
Feb-20			N/A		
Mar-20	1/1/2020 - 12/31/2020	2019	3/10/2020	3/10/2020	Tuesday
Attribution Update starting new year 2121			3/15/2020		
May-20	1/1/2020 - 4/30/2020	2020	5/11/2020	5/11/2020	Monday
Jun-20	1/1/2020 - 5/31/2020	2020	6/10/2020	6/10/2020	Wednesday
Jul-20	1/1/2020 - 6/30/2020	2020	7/10/2020	7/10/2020	Friday
Aug-20	1/1/2020 - 7/31/2020	2020	8/12/2020	8/12/2020	Wednesday
Sep-20	1/1/2020 - 8/31/2020	2020	9/10/2020	9/12/2020	Thursday
Oct-20	1/1/2020 - 9/30/2020	2020	10/10/2020	10/11/2020	Monday
Nov-20	1/1/2020 - 10/31/2020	2020	11/11/2020	11/11/2020	Wednesday
Dec-20	1/1/2020 - 11/30/2020	2020	12/10/2020	12/10/2020	Thursday
Jan-21	1/1/2020 - 12/31/2020	2020	1/11/2021	1/11/2021	Monday
Feb-21			N/A		
Mar-21			N/A		
Apr-21	1/1/2020 - 12/31/2020	2020	4/1/2021	4/1/2021	Thursday
Attribution Update starting new year 2021 (est)			4/6/2021	4/7/2021	

Quality Timeline:

Quarter 1

- **January -Febuary**: Affinia receives incentives from current contracts
- PHPR utilizes prior performance year defintions and tools

Quarter 2

- **April:** Affinia runs Tabulation to identify priority and weighting for points in performance methodology
- **April-May**: Update AHN tools (Quality hand book, Incentive Tracker, Outreach Calendar)
- Gain Committee review and approval of any performance measure changes
- **May:** Launch of quality tools and performance reports. Updated performance reports will be distrubuted on the ***4th Monday of each month after May***

Quarter 3

- Monthly Distribution on 4th Monday of the month
- Practice Coach rounding to reveiw performance

Quarter 4

- Continued distribution and rounding monthly
- December 31st last day for services to be completed for current year PHPR

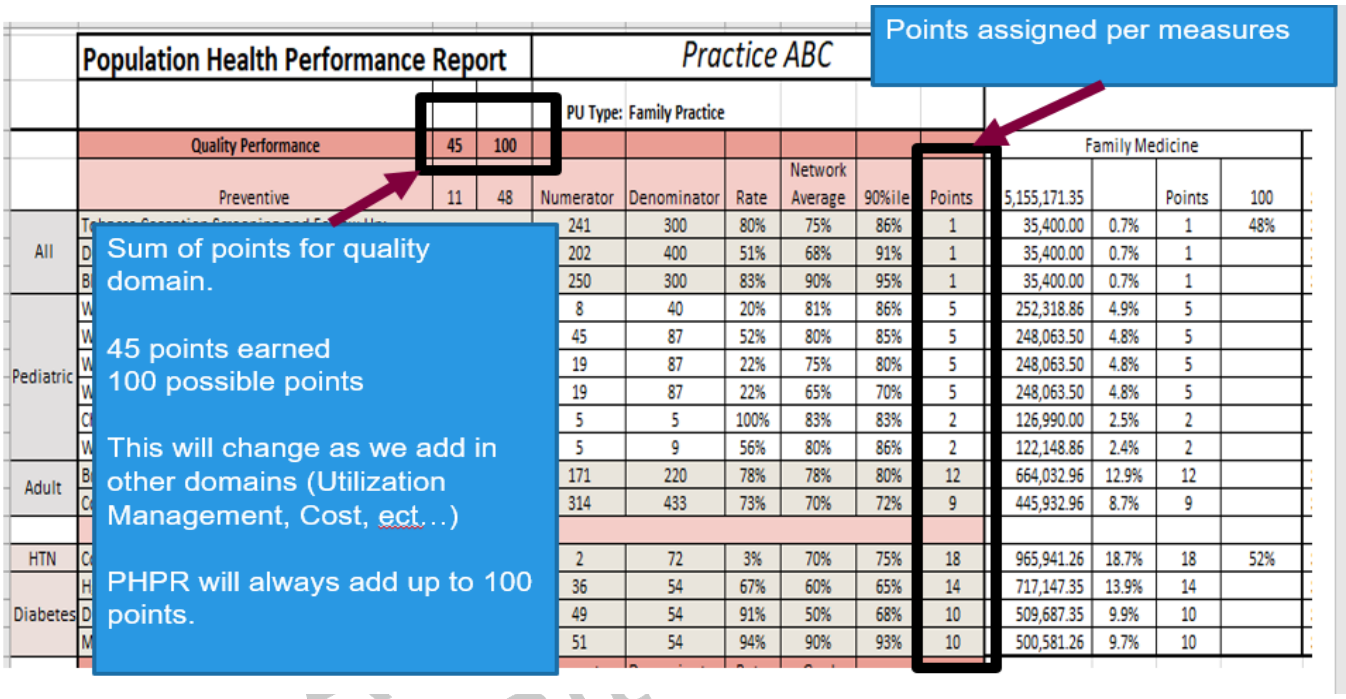
Quarter 1 (next performance year)

- March: PHPR final score

Quality Performance Methodology:

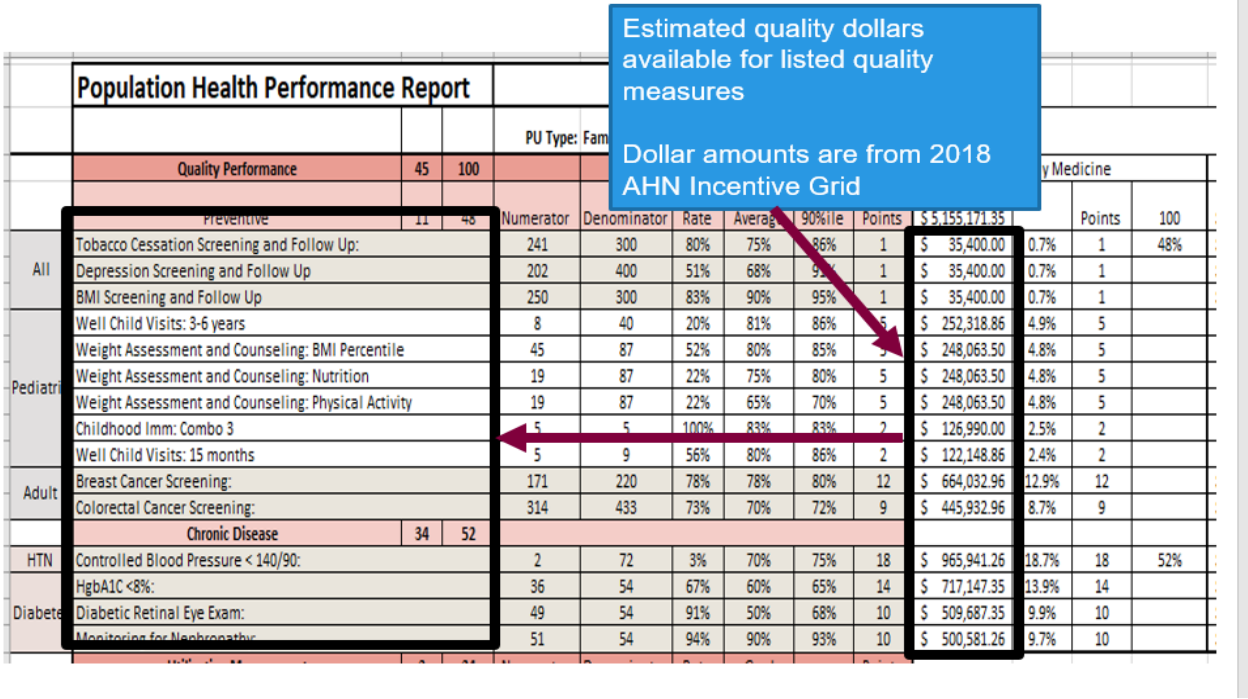
The process steps and calculations below outline the process for producing a quality composite score.

1. Overall point system



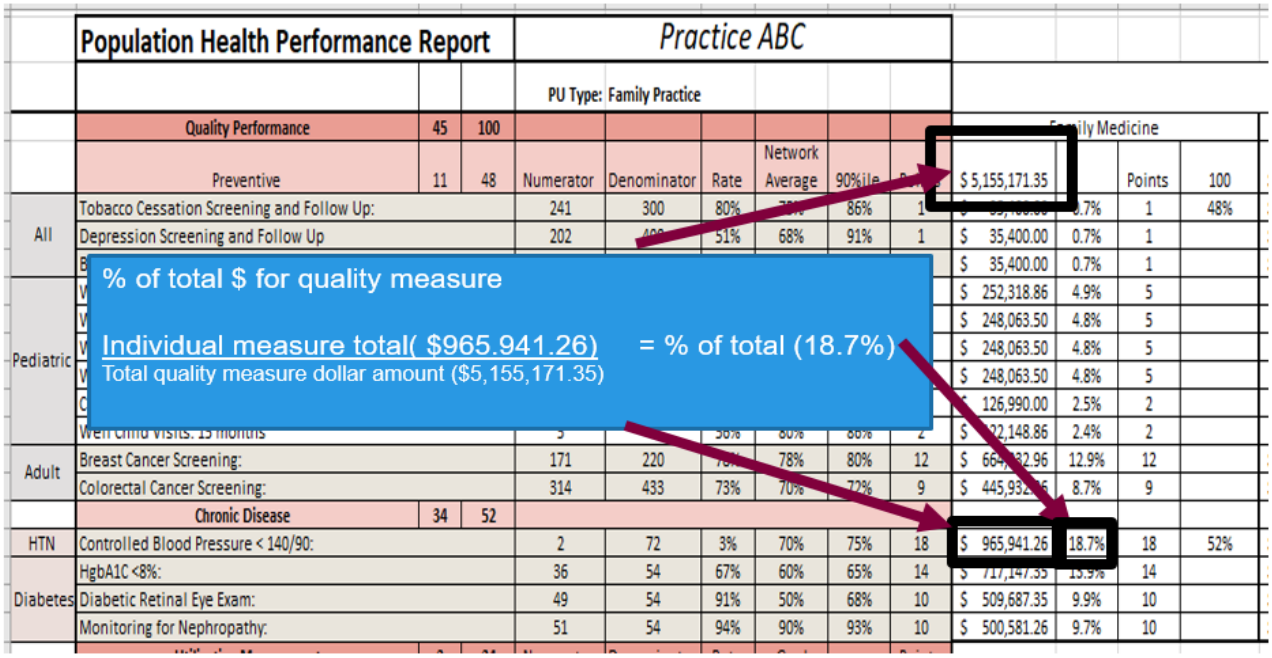
Population Health Performance Report			Practice ABC									
			PU Type: Family Practice									
Quality Performance	45	100								Family Medicine		
Preventive	11	48	Numerator	Denominator	Rate	Network Average	90%ile	Points	5,155,171.35		Points	100
All			241	300	80%	75%	86%	1	35,400.00	0.7%	1	48%
			202	400	51%	68%	91%	1	35,400.00	0.7%	1	
			250	300	83%	90%	95%	1	35,400.00	0.7%	1	
Pediatric			8	40	20%	81%	86%	5	252,318.86	4.9%	5	
			45	87	52%	80%	85%	5	248,063.50	4.8%	5	
			19	87	22%	75%	80%	5	248,063.50	4.8%	5	
			19	87	22%	65%	70%	5	248,063.50	4.8%	5	
			5	5	100%	83%	83%	2	126,990.00	2.5%	2	
			5	9	56%	80%	86%	2	122,148.86	2.4%	2	
Adult			171	220	78%	78%	80%	12	664,032.96	12.9%	12	
			314	433	73%	70%	72%	9	445,932.96	8.7%	9	
HTN			2	72	3%	70%	75%	18	965,941.26	18.7%	18	52%
Diabetes			36	54	67%	60%	65%	14	717,147.35	13.9%	14	
			49	54	91%	50%	68%	10	509,687.35	9.9%	10	
			51	54	94%	90%	93%	10	500,581.26	9.7%	10	

2. Quality measure point assignment



Population Health Performance Report												
			PU Type: Fam									
Quality Performance	45	100								y Medicine		
Preventive	11	48	Numerator	Denominator	Rate	Averag	90%ile	Points	$ 5,155,171.35		Points	100
All	Tobacco Cessation Screening and Follow Up:		241	300	80%	75%	86%	1	$ 35,400.00	0.7%	1	48%
	Depression Screening and Follow Up		202	400	51%	68%	9	1	$ 35,400.00	0.7%	1	
	BMI Screening and Follow Up		250	300	83%	90%	95%	1	$ 35,400.00	0.7%	1	
Pediatri	Well Child Visits: 3-6 years		8	40	20%	81%	86%	5	$ 252,318.86	4.9%	5	
	Weight Assessment and Counseling: BMI Percentile		45	87	52%	80%	85%	5	$ 248,063.50	4.8%	5	
	Weight Assessment and Counseling: Nutrition		19	87	22%	75%	80%	5	$ 248,063.50	4.8%	5	
	Weight Assessment and Counseling: Physical Activity		19	87	22%	65%	70%	5	$ 248,063.50	4.8%	5	
	Childhood Imm: Combo 3		5	5	100%	83%	83%	2	$ 126,990.00	2.5%	2	
	Well Child Visits: 15 months		5	9	56%	80%	86%	2	$ 122,148.86	2.4%	2	
Adult	Breast Cancer Screening:		171	220	78%	78%	80%	12	$ 664,032.96	12.9%	12	
	Colorectal Cancer Screening:		314	433	73%	70%	72%	9	$ 445,932.96	8.7%	9	
	Chronic Disease	34	52									
HTN	Controlled Blood Pressure < 140/90:		2	72	3%	70%	75%	18	$ 965,941.26	18.7%	18	52%
Diabete	HgbA1C <8%:		36	54	67%	60%	65%	14	$ 717,147.35	13.9%	14	
	Diabetic Retinal Eye Exam:		49	54	91%	50%	68%	10	$ 509,687.35	9.9%	10	
	Monitoring for Nephropathy:		51	54	94%	90%	93%	10	$ 500,581.26	9.7%	10	

3. Quality measure point assignment



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	Depression Screening and Follow Up		202		51%	68%	91%	1	$ 35,400.00	0.7%	1	
	B								$ 35,400.00	0.7%	1	
Pediatric	W								$ 252,318.86	4.9%	5	
	W								$ 248,063.50	4.8%	5	
	W								$ 248,063.50	4.8%	5	
	W								$ 248,063.50	4.8%	5	
	C								$ 126,990.00	2.5%	2	
	Well child visits: 15 months		5		36%	80%	86%	2	$ 22,148.86	2.4%	2	
Adult	Breast Cancer Screening:		171	220	78%	78%	80%	12	$ 664,032.96	12.9%	12	
	Colorectal Cancer Screening:		314	433	73%	70%	72%	9	$ 445,932.96	8.7%	9	
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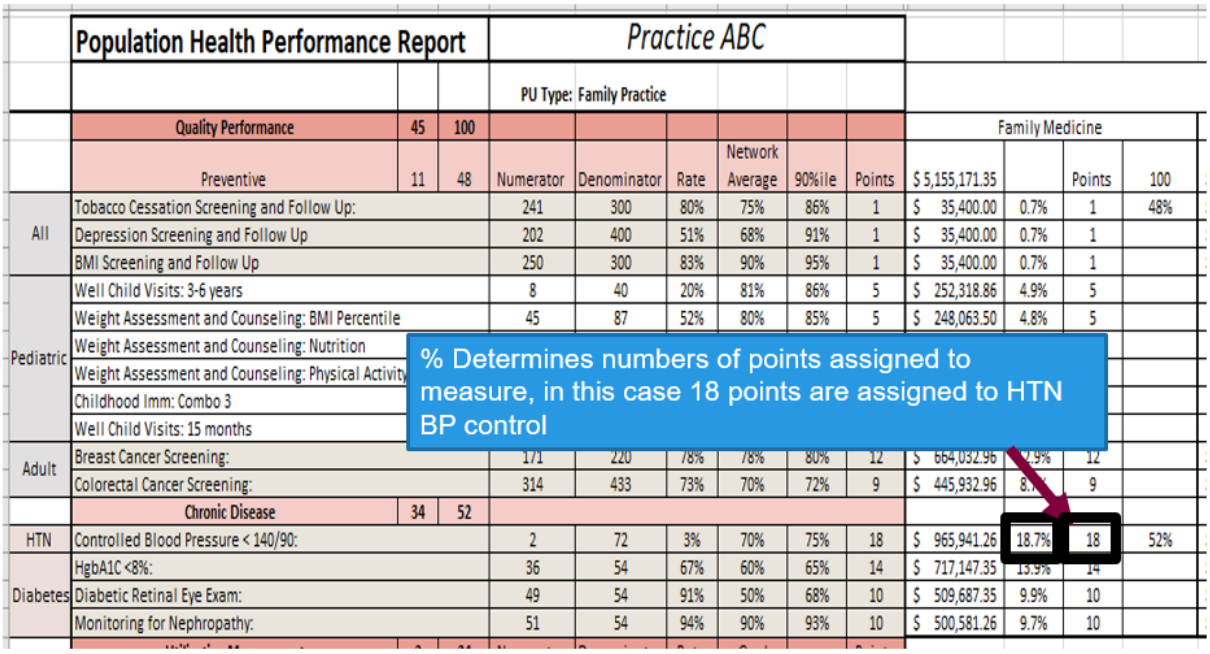
HTN	Controlled Blood Pressure < 140/90:		2	72	3%	70%	75%	18	$ 965,941.26	18.7%	18	52%
Diabetes	HgbA1C <8%:		36	54	67%	60%	65%	14	$ 717,147.35	13.9%	14	
	Diabetic Retinal Eye Exam:		49	54	91%	50%	68%	10	$ 509,687.35	9.9%	10	
	Monitoring for Nephropathy:		51	54	94%	90%	93%	10	$ 500,581.26	9.7%	10	

% of total $ for quality measure

Individual measure total($965,941.26) = % of total (18.7%)
Total quality measure dollar amount ($5,155,171.35)

4. Quality measure point assignment



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	Childhood Imm: Combo 3											
	Well Child Visits: 15 months											
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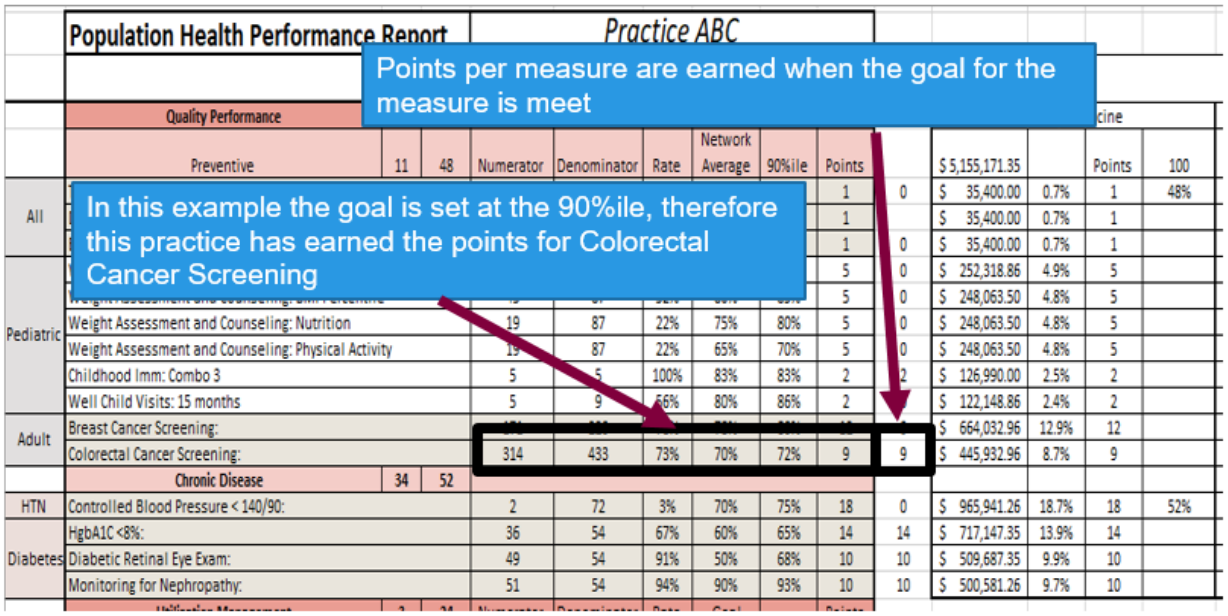
	Colorectal Cancer Screening:		314	433	73%	70%	72%	9	$ 445,932.96	8.7%	9	
	Chronic Disease	34	52									
HTN	Controlled Blood Pressure < 140/90:		2	72	3%	70%	75%	18	$ 965,941.26	18.7%	18	52%
Diabetes	HgbA1C <8%:		36	54	67%	60%	65%	14	$ 717,147.35	13.9%	14	
	Diabetic Retinal Eye Exam:		49	54	91%	50%	68%	10	$ 509,687.35	9.9%	10	
	Monitoring for Nephropathy:		51	54	94%	90%	93%	10	$ 500,581.26	9.7%	10	

% Determines numbers of points assigned to measure, in this case 18 points are assigned to HTN BP control

5. Quality measure scoring



	Population Health Performance Report			Practice ABC											
	Quality Performance														
	Preventive	11	48	Numerator	Denominator	Rate	Network Average	90%ile	Points		$ 5,155,171.35		Points	100	
All									1	0	$ 35,400.00	0.7%	1	48%	
									1		$ 35,400.00	0.7%	1		
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	Weight Assessment and Counseling: Physical Activity			19	87	22%	65%	70%	5	0	$ 248,063.50	4.8%	5		
	Childhood Imm: Combo 3			5	5	100%	83%	83%	2	2	$ 126,990.00	2.5%	2		
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	Diabetic Retinal Eye Exam:			49	54	91%	50%	68%	10	10	$ 509,687.35	9.9%	10		
	Monitoring for Nephropathy:			51	54	94%	90%	93%	10	10	$ 500,581.26	9.7%	10		

Quality measure Validation Process

PURPOSE: The purpose of this document is to define the validation process for the data within the Population Health Performance Report. The validation processes includes multiple levels of validation which spans the continuum of the data flow process.

1. **Population Health Performance Report query validation** – This validation is completed to ensure that all internal queries and data processes are accurate and functioning correctly.

2. **Payer validation** – This validation process is completed to ensure that the data reflected in the Population Health Performance Report is appropriately reflected in the payer data.

Glossary

PHPR (Population Health Performance Report)

Standard scorecard that can be used to measure key performance indicators that are essential to the successes of Affinia Health Network in Advanced Payment Model contracts.

Guiding Principles

Organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

Active Patient

The active patient is a term for a patient who is currently attributed to an Affinia Health Network provider.

Measure ID

A unique identification for population health metrics used within Affinia Health Network. The unique identification is used to ensure the technical specification of a measure are correctly aligned with the associated metric. The unique identification also ensures that metric updates are tracked and accounted for.

PCP (Primary Care Practitioner) Definition

The PCP (Primary Care Practitioner) Definition is used to classify a provider into the specialty that will receive patient attribution and be assigned a set of quality measures the provider is responsible for.

Reporting Population Definition

The reporting population definition is a subset of patients that will be used for the purposes of the population health performance report.

Domains & Measures with Definitions

The definitions for the domains and measures provide details and structural build behind the corresponding categories with in the population health performance report. These definitions call out the technical specifications and details on the categories being measured.

Performance Methodology

The performance methodology is the procedure that is followed to analyze system quality performance and for the purposes of this document will be the procedure used for the population health Population Health Performance Report.

PHPR Timeline

The population health performance (PHPR) report timeline is a graphical representation of the chronological order of the process used to create the PHPR.

Tabulation

The first step in selecting the quality measures. Encompasses processing information from the payer quality programs and putting this information in a consolidated table.

Weighting

The second step in selecting the quality measures. This process applies additional information, specific to Affinia Health Network, to the payer quality programs. The result is a measurement that takes into account the patient population and payer quality program.

Prioritization

The third step in selecting the quality measures. The quality measures are ranked in order of importance relative to each of the other quality metrics.

Categorization

The third step in quality measures selecting the quality measures. Encompasses placing the quality measures into groups based on the clinical weight in relation to each specialty used in the PHPR.

Incentive Tracker

A tool that can be used to track quality incentive program performance and prioritizes quality measures based on financial opportunity.

The current tool includes:

- BCN – Performance Recognition Program (PRP)
- BCNA - Performance Recognition Program (PRP)
- BCBSM – Patient Centered Medical Home (PCMH) & Clinical Quality (VBR)
- Priority Health – PCP Incentive Program (PIP)

Quality Handbook

The quality hand book is a comprehensive guide to clinical documentation for associated quality measures. The quality handbook outlines these the clinical details for all APM accountabilities, and HEDIS clinical technical specifications.

Outreach Calendar

The outreach calendar is yearly schedule that outlines the recommended quality measure outreach activity for the calendar year. The calendar takes into account APM accountabilities, Patient Centered Medical Home (PCMH) capabilities and clinical technical specifications.

Incentive Grid

The Incentive Grid is a table of all the quality measures that Affinia Health Network is accountable for through all advanced payment models, payer quality programs and regulatory agencies.

Practice Coach

A Practice Coach is are individuals who work with primary care practices to make meaningful changes designed to improve patient outcomes. Practice coaches are trained professionals who collaborate with practices throughout the challenging—and rewarding—process of change.

Wellcentive

Affinia Health Network's regional web-based electronic patient registry for quality and performance reporting.

Affinia Health Network
MEMBER

ATTRIBUATION HANDBOOK

Section 5

Affinia Health Network

Section 5: Attribution Handbook

Definitions

Attribution Methods Glossary

Attribution

The process of assigning patients to physicians in population health programs determined by either a prospective, retrospective, or self-selective process.

Prospective

Prospective attribution assigns members based on historical claim data. This method allows both patient and provider notification. Prospective attribution assumes the patient will use the same provider in the future they have used in the past.

Retrospective

Retrospective attribution is based on actual utilization. Reporting of these patients is not always timely. Under retrospective attribution providers do not always know who will be assigned to them.

Self-Selective

Self-Selective attribution allows the patient to choose their provider, usually during a certain period of time.

Payers

Aetna

Attribution Method

- Commercial: Self-Selective
- Medicare: Self-Selective
- Medicaid: N/A

Member Alignment/ Member Attribution Process

If no PCP is selected by the member, the system will default to auto-select based on claims. Patient will be attribute to the PCP seen most in most recent 12-months.

Claim-attributed member remains frozen for the year unless the member selects a PCP. Member PCP selection always trumps claim-based attribution.

Member Realignment

Claim-attributed member remains frozen for the year unless the member selects a PCP. Member PCP selection always trumps claim-based attribution.

Patient Discharge by PCP

Refer to provider manual or payer website for more detail.

Blue Cross Complete

Attribution Method

- Commercial: N/A
- Medicare: N/A
- Medicaid: Self-Selective

Member Alignment/ Member Attribution Process

If no PCP is selected by the member, the system will default to auto-select.

Dual-Eligible members: When an individual is enrolled as a dual-eligible member, the Blue Cross Complete secondary plan selects a primary care physician affiliated with Blue Cross Complete and sends the member a notification letter. The primary care physician selected by Blue Cross Complete may or may not be the physician the member is used to seeing under the primary Medicare plan. Dual-eligible members are not required to see the primary care physician selected by Blue Cross Complete. These members may continue to receive Medicare-covered services from their current physician. Note: If the physician the member is used to seeing under Medicare is affiliated with Blue Cross Complete, Blue Cross Complete will select that physician as the member's primary care physician of record for Blue Cross Complete. If the physician the member is used to seeing under Medicare is not affiliated with Blue Cross Complete, Blue Cross Complete will select another physician as the member's primary care physician of record for Blue Cross Complete.

Member Realignment

A member may change their PCP at any time via mibluecrosscomplete.com or by calling customer service at 800.228.8554.

Patient Discharge by PCP

Providers do not have the option of disenrolling or removing a member from their practice.

BCBSM PPO

Attribution Method

- Commercial: Retrospective
- Medicare: Retrospective
- Medicaid: N/A

Member Alignment/ Member Attribution Process

Claim review to define attribution relationship, 48-month review of claims.

Member Realignment

Realignment occurs during the claims review process.

Patient Discharge by PCP

Refer to provider manual or payer website for more detail.

BCN

Attribution Method

- Commercial: Self-Selective
- Medicare: Self-Selective
- Medicaid: N/A

Member Alignment/ Member Attribution Process

If no PCP is selected by the member, the system will default to auto-select based on zip code of the member and provider availability to take on new members.

If a provider has their panel closed (limited or current patients only), they will not be assigned new members. A loop hole to this is if the member contacts customer service and requests a PCP who has a closed panel status, customer service will reach out to the provider office to confirm if that PCP will take on a new patient.

Member Realignment

Members can ask to change their PCP via the Blues portal at BCBSM.com or by calling member services at 888.417.3479.

Patient Discharge by PCP

Blue Care Network has changed the process a primary care physician should use when requesting that a member be removed from his or her practice and assigned to another primary care physician.

The primary care physician the member is currently assigned to must complete the Member Transfer Request Form and submit it to BCN. The form can be found at the following link:

https://provider.bcbsm.com/therecord/bcn/documents/forms/bcn-member-transfer-faq-form.pdf

Humana

Attribution Method

- Commercial: N/A
- Medicare: Retrospective
- Medicaid: N/A

Member Alignment/ Member Attribution Process

Claim review to determine attribution, 24 months of retrospective claims; evaluated on a quarterly basis. Data used by Humana to attribute patients to PCPs:

- Evaluation/management (E/M) visits,
- Wellness visits,
- Physical assessments and some OB/GYN visits
- Visits within the last year take priority
- Total visits, most recent visit date and total claim dollars are used in the event of a tie
- Humana-covered patients must have three or more visits to cause a change in PCP

Member Realignment

In the event that a Humana-covered patient disagrees with the PCP change made as a result of this process, he/she can call Humana customer service and change PCPs at any time.

Patient Discharge by PCP

Refer to provider manual or payer website for more detail.

Meridian

Attribution Method

- Commercial: N/A
- Medicare: N/A
- Medicaid: Self-Selective

Member Alignment/ Member Attribution Process

If no PCP is selected by the member, the system will default to auto-select a PCP within 30 minutes or 30 miles from your home address.

Member Realignment

Members can ask to change their PCP via the MY MHP (member portal) or by calling member services at 888.437.0606.

Patient Discharge by PCP

PCP's must give reasonable notice to a member of his/her intent to discharge the member from care. Meridian considers ***reasonable notice to be at least a 30-day prior written notice.*** This notice must be given by certified mail. Meridian must also be notified of this process concurrently in writing. Failure to give reasonable notice may result in allegations of patient abandonment against the treating physician. PCP must provide 30 days of emergent care and referrals. A letter is sent to the member. The letter is then faxed to Meridian Customer Experience. Please ensure the letter includes the member's name and member ID. Fax number is: 313-202-0007.

https://corp.mhplan.com/ContentDocuments/default.aspx?x=XYFRtcGF1z7t1mzprB35XjfZWv/d0aIoVwRAKT8alCPn+sbrV1W6e8Lao+UCzmdGDI1R3eO/cBN7/xuelFxKsQ

Molina

Attribution Method

- Commercial: N/A
- Medicare: N/A
- Medicaid: Self-Selective

Member Alignment/ Member Attribution Process

If no PCP is selected by the member in the first 30-days, the system will default to auto-select a PCP within 30 minutes or 30 miles from your home address.

Newborns – Automatically enrolled in mother's enrolled health plan on the date of delivery. Parents may choose a different plan for the newborn within the first 90 days of life. CHAMPS may not reflect HMO coverage for 30-60 days.

Provider Initiated via member signed form

Member Realignment

A member may change their PCP at any time and the change will that effect immediately. They can make their PCP change request via MyMolina.com or by calling member service at 888.898.7969.

Patient Discharge by PCP

There may be times when a PCP requests a member be transferred to a different PCP. If this situation occurs, the current PCP must inform the member in writing of the reason(s) for terminating the current physician/patient relationship and must also inform the member they have thirty 30 days to choose another PCP. The written correspondence must be mailed by certified or registered letter to the member. A copy of the correspondence must be sent to:

Molina Healthcare Attn: Enrollment

84 NE Loop 410 Suite #180

San Antonio, TX 78216

Fax: (855) 714-2414

Providers should use the Provider Request to Change PCP Form to notify Member Services of their desire to initiate a member transfer. The form is located in the Forms section of Molina Healthcare's website at www.molinahealthcare.com. A Member Services Representative can assist the member in reviewing the Provider Directory for available PCP choices.

Requests made on or before the 15th day of the month will be reflected the 1st day of the next month. Requests after the 15th of the month will be reflected 45 days later. For example, a request made on July 14th will be reflected August 1. A request made on July 20 will be reflected September 1.

When the PCP believes an immediate transfer is necessary, the PCP should contact Member Services at (888) 898-7969 for assistance.

***Other information found in manual.**

Priority Health

Attribution Method

- Commercial: Self-Selection
- Medicare: Self-Selection
- Medicare: Self-Selection

Member Alignment/ Member Attribution Process

Member alignment occurs annually, and attribution is based first on PCP selection by patient and if patient does not select a PCP it is determined based on claims history.

See Diagram Below or for more detail refer to the Provider Manual – PIP

Member Realignment

Patients may change his or her own PCP through the member portal. A PCP seeing a patient at their practice may also change the patient's through the provider portal.

Patient Discharge by PCP

Reasons for discharge include: unpaid balances, repeated no shows, threatening behavior, doctor shopping to obtain scripts, failed drug screen, and/or fraudulent behavior. Specifications related to the reason for discharge along with the process for discharging can be found by following the link : https://www.priorityhealth.com/provider/manual/standards/provider-patient-relationship/discharge.

*Non-Compliant Patients

Please note that Priority Health has also expanded their process for identifying non-adherence (not discharge) to include those who fail to establish care and those who are non-compliant. Although patients WILL still be attributed to the practice, they can be removed from the denominator of ALL PIP measures by following the outlined process:

Three outreach attempts (phone, email, letter, in-person visit) MUST be documented

Document in patient profile last outreach attempt

Submit by 11/8/19 – if approved will be removed from numerator and denominator of ALL measures at settlement (you can send discharge letter to patient prior to receiving approval from PH but patient will remain attributed).

https://www.priorityhealth.com/provider/center/incentives/pip/nonadherent-members

*log-in will be required for Payer Websites

Trinity Health Next Generation ACO (Medicare Part B)

Attribution Method

Prospective

Alignment

Each Performance Year (PY) is associated with two alignment-years. The first alignment year for Performance Year is the 12-month period ending 18 months prior to the start of the Performance Year. The second alignment year is the 12-month period ending 6 months prior to the start of the Performance Year.

PY3 (01/01/2018 – 12/31/2018) - Alignment Year 1 07/01/2015 – 6/30/2016
Alignment Year 2 07/01/2016 – 06/30/2017

Alignment – eligible Beneficiary

A beneficiary is alignment-eligible for a Performance Year if:

1. During the related 2-year alignment period the beneficiary had at least one paid claim for a Qualified Evaluation and Management (QEM) service and
2. During the Performance Year the beneficiary
    1. Was covered under Part A in January
    2. Has no months of coverage under Part A only
    3. Has no months of coverage under Part B only
    4. Has no months of coverage under a Medicare Advantage or other Medicare managed care plan
    5. Has no months in which Medicare was the secondary payer
    6. Was a resident of the United States

Member Attribution Process

Providers are submitted for participation six months prior to the Performance Year (June). Once providers are processed and accepted into the program, claims data is processed to determine beneficiaries/attribution. This process is done for the entire Trinity Health ACO (THACO). CMS sends the attribution file to Trinity Health System Office who then separates out by chapter and provider. The attribution file is then loaded into Wellcentive.

Member Realignment

ACO beneficiaries are assigned to an ACO using the prospective attribution model. There may be patients who have switched providers and are no longer being cared for by the provider they are attributed to. The ACO can create a process to realign these patients.

United Health Care

Attribution Method

- Commercial: N/A
- Medicare: N/A
- Medicare: Self-Selective

Member Alignment/ Member Attribution Process

If no PCP is selected by the member, the system will default to auto-select.

Member Realignment

Members may change their network PCP at any time. Change are generally effective on the first day of the following month. The changes does not affect referrals previously submitted by there PCP as long as the member remains in the same network.

Patient Discharge by PCP

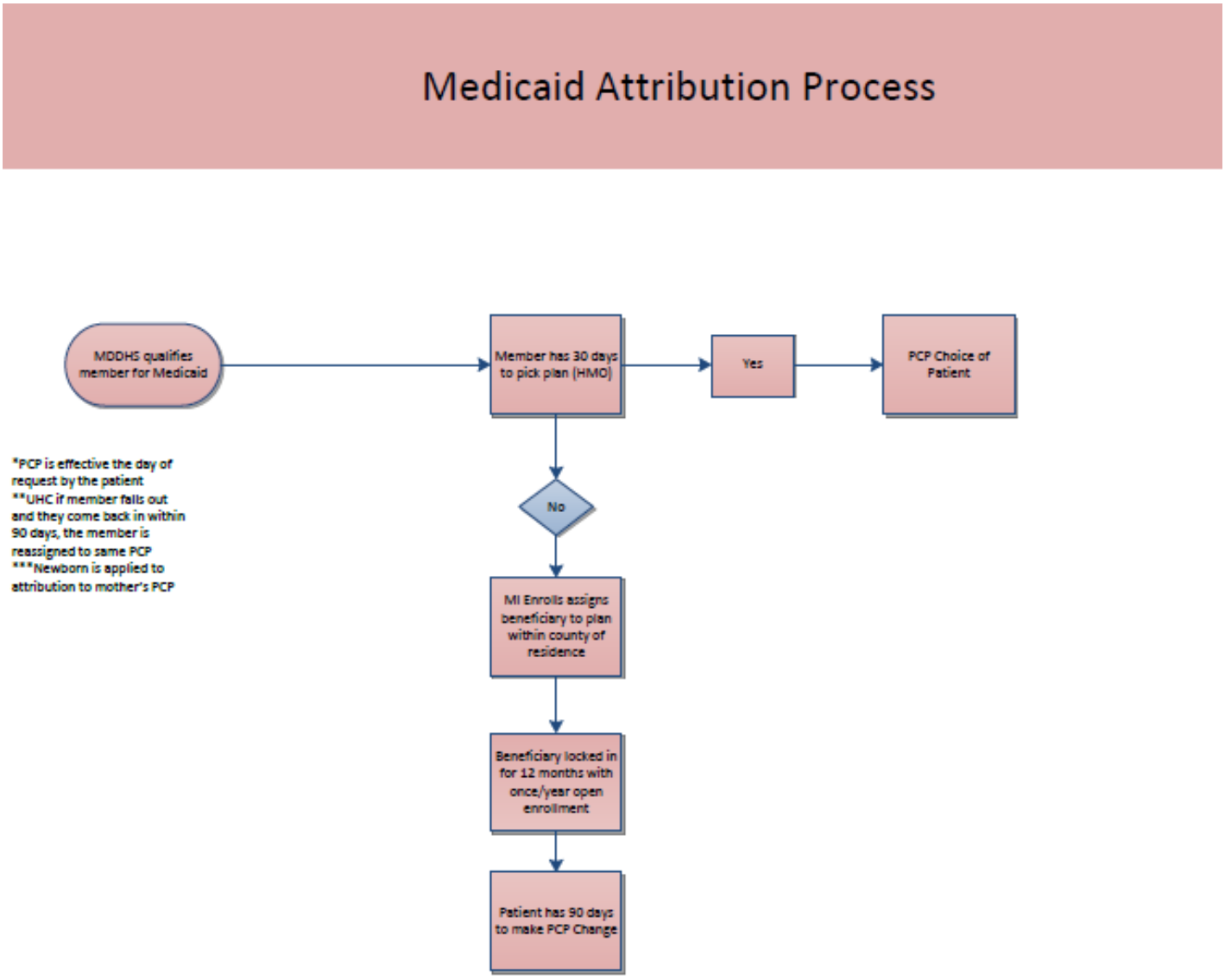
Refer to provider manual or payer website for more detail.

Medicaid Plan / PCP Selection

Medicaid Attribution Process

Upon state qualification, member has 30 days to choose a plan. If the member does not choose a plan within the 30-day opportunity, Michigan Enrolls will assign the member to a plan within their county of residence. Member is locked into the plan for 12 months. Annually there will be an open enrollment period in which the member has 90 days to a new plan if desired.

The last digit of their case number will determine the open enrollment month.



*log-in will be required for Payer Websites