2018 Primary Care Program

Released April 2018

HMSA Payment Transformation

P R O G R A M G U I D E

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Thank you for your commitment to providing high quality, patient-centered care to HMSA members. Your dedication is essential to the continual improvement of the health and well-being of Hawaii residents.

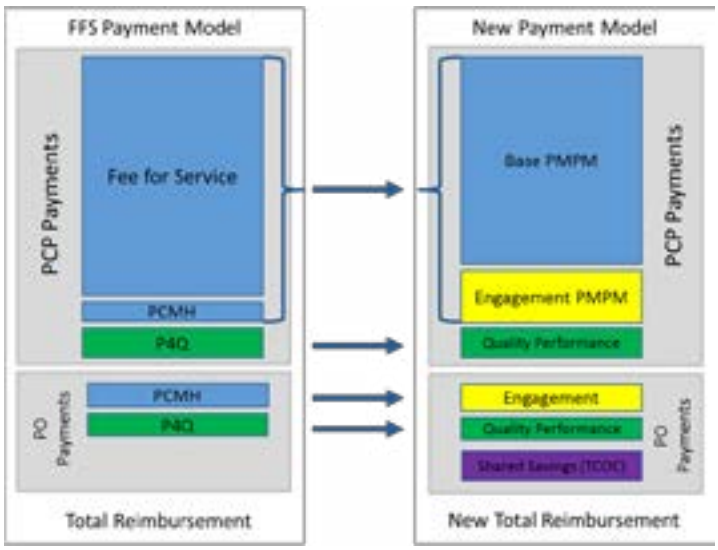
Beginning in 2016, HMSA worked with select physician organizations (POs) and their primary care providers (PCPs) to implement a new reimbursement model called the Payment Transformation program (PT program). This reimbursement model moves away from the fee-for-service (FFS) payment model to a per-member-per-month (PMPM) payment model.

The PT program replaced HMSA's payments that were based on existing fee schedules, pay-for-quality (P4Q) programs, and patient-centered medical home (PCMH) programs.

This *Payment Transformation Program Guide* includes information for PCPs and POs.

The patient-PCP relationship is the foundation of a successful health care system and is essential to advancing the well-being of Hawaii. The FFS reimbursement system allows providers to bill for each service provided to patients, but doesn't incentivize patient-centered, high-value care.

HMSA's PT program for PCPs moves away from FFS to a base PMPM rate for each attributed HMSA member. Eighty percent of the base PMPM payment is guaranteed; 20 percent is at-risk, but paid as long as PCPs meet engagement measures that are foundational to the PT program. PCPs can earn additional incentives based on performance (i.e., quality) measures. PCPs with high quality scores will be eligible to earn a shared savings bonus based on their PO's Total Cost of Care (TCOC) performance. TCOC will be scored at the PO level and paid annually to the PO for distribution to member PCPs. Details about each of these components and how they evolve annually are included in this *PT Program Guide*. Here's a graphic overview of the PT program's compensation framework:



Under the new payment model, **it's essential that PCPs continue submitting accurately coded claims to HMSA in a timely manner.** This allows HMSA to:

- Accurately risk-adjust TCOC performance and PMPM rates.
- Credit PCPs for performance on quality measures.
- Comply with regulatory and financial requirements such as reporting to the Centers for Medicare & Medicaid Services (CMS), employer groups, state of Hawaii, etc.

Program Guide

Program Years

April 1 through December 31, 2016, was the pilot program period (Year Zero) where a limited number of POs and PCPs were eligible to participate in the PT program. Each subsequent program year may range from 12 to 15 months depending on contracting cycles. Year One began on January 1, 2017 and will end on June 30, 2018.

Summary of Changes - April 2018

Updated Patient Attribution to PCPs section to explain Coreo processes. (p. 7)

Updated Base PMPM Payments section to explain value-based PMPM methodology. (pp. 11-17)

Updated 2018 supplemental data audit methodology. (p. 48)

Updated dates for Target Dates and Deliverables: PO Engagement Measures. (p. 51)

Added three appendices:

- Appendix A - PMPM Methodology for Year One (2017- June 2018). (p. 52)
- Appendix B - Facility-based Place of Service Codes. (p. 53)
- Appendix C - Standardized Base PMPM Methodology. (pp. 54-56)

Added new numerator code [90756] to Appendix D: Immunization Codes Carved out of PMPM Bands. (p.58)

Clarified numerator logic for the EPSDT completion rate measure. (p. 60)

Clarified that Td (tetanus and diphtheria toxoids vaccine) is not accepted for numerator credit in the Immunizations for Adolescents measure. (p. 71)

Updated Facilitating Timely Access for New Patients measure in the PO Engagement measure set. (p. 80)

Changed due date for Avoidable ED Visits, Quarter 1 submission from April 5, 2018 to May 5, 2018. (p. 84)

Updated the eligible population in the Total Cost of Care Shared Savings Methodology (Appendix I). (pp. 88-96)

Replaced references to Cozeva with Coreo, HMSA's new population management tool.

The following sections of the *PT Program Guide* apply to PCPs.

Program Eligibility

To participate in the PT program, a provider must meet all of the following criteria:

- Be a participating HMSA provider for HMSA's commercial, QUEST Integration, or Medicare Advantage lines of business.
- Be a PCP who is credentialed with HMSA as an internist, general practitioner, family physician, pediatrician, naturopathic physician, advanced practice registered nurse (APRN) or physician assistant (PA) under the supervision of a PT program-eligible PCP.
- Be a member of a PO contracted with HMSA to participate in the PT program. All PCPs in a PO are required to participate in the PT program. PCP membership with a PO must follow the PO and PCP Rules of Engagement in this guide.
- PCPs may only be contracted with one PO for the purposes of PT program participation.

If a PCP in HMSA's provider network is a member of a PO that's participating in the PT program and the PCP wants to opt out of the program:

- The PCP must leave their PO, but can continue to be an HMSA participating provider. The PCP will revert to FFS reimbursement based on a frozen HMSA fee schedule.
  - Quality bonuses won't be available (e.g., no P4Q or PCMH incentives).
  - HMSA reserves the right to request a refund of any base PMPM overpayments or advance performance payments.

OR

- [1] The PCP must leave their PO and become a nonparticipating HMSA provider (i.e., will no longer be in HMSA's provider network).

Providers who are solely contracted with HMSA as specialists and urgent care providers are ineligible to participate in the PT program.

Pediatricians aren't eligible to participate in the PT Medicare Advantage program.

Program Eligibility FQHCs/RHCs

Beginning in 2018, PCPs in Federally Qualified Health Centers or Rural Health Clinics whose only payee is the FQHC/RHC are eligible to participate in a separate quality program and aren't eligible for this primary care payment transformation program.

PCP Membership in a PO – Rules of Engagement

For purposes of participation in HMSA's PT Program, all PCPs may only be contracted with one PO. HMSA attributes PCPs to a PO based on PCP membership information from each PO:

PCPs - Established Providers Unattached to a PO

- PCPs unattached to a PO may join a PO in the timeframe in Table 1. A fully executed Payment Transformation amendment is also required.

Table 1. Unattached providers

CHANGE DECLARATION DEADLINE	EFFECTIVE DATE
May 1	July 1
November 1	January 1

PCPs – New providers to HMSA's network

Eligibility for participation in the PT program:

- New providers are those who signed a participating agreement with HMSA during the measurement year.
- New PCPs may join a PO any time. POs must notify HMSA 60 days in advance for a PCP to be effective from the first day of the intended month for starting in Payment Transformation. A fully executed Payment Transformation amendment is also required.
- PCPs will be subject to program requirements and eligible for payments based on the effective date of their affiliation with their PO.

PCPs – Currently attached to a PO

Transferring between POs:

- PCPs are only allowed to transfer from one PO to another during the period designated in Table 2.

Table 2. Timeframe for PCPs transferring POs

CHANGE DECLARATION DEADLINE	EFFECTIVE DATE
May 1	July 1
November 1	January 1

- See PCP Performance Payments section and PO Performance Payments section for details on quality payment eligibility by line of business.
- PCPs transferring POs may not have access to their Coreo UI while their dashboards are being configured and until their access is provisioned.

Open enrollment period doesn't apply to providers who become employed by a medical group.

[1] Provision not applicable to specified PCPs whose HMSA participating provider agreement requires participation in the payment transformation program.

Patient Attribution to PCPs

The goal of the attribution process is to assign a member to their preferred PCP. The role and expectations for providers acting as PCPs builds on the principles of HMSA's Patient Centered Medical Home program. In an attribution-based payment model, a defined panel of patients is critical to the implementation of population health management approaches and accountability for patients regardless of how much, how often, or where they get care.

HMSA continues to refine its attribution model and PCP selection processes to support the development of strong patient-provider relationships and aims to provide transparent and timely feedback to PCPs about their panel.

HMSA's attribution process is comprised of two major components: member selection and PCP panel management. Here are details on the process and expectations for PCPs.

Member selection

Members with commercial HMO, QUEST Integration, or Medicare Advantage plans are encouraged to select a PCP when they enroll. Members may change their PCP at any time by simply calling HMSA. Commercial HMO members must choose a PCP in their selected HMO health center. QUEST Integration members who don't choose a PCP will be assigned to a PCP by HMSA. Members with these plans have their PCP's name (and health center for HMO plans) printed on their HMSA membership card. Any changes to a PCP or health center will generate a new HMSA membership card, which may take up to 10 business days.

HMSA's enrollment databases maintain PCPs for members with a commercial HMO, QUEST Integration, or Medicare Advantage plan. On the last day of each month, PCP assignments in the enrollment databases are pulled and fed into the attribution algorithm. Requests to change a PCP that aren't processed before the end of the month won't impact attribution for that month. If the change is processed the following month and there are no other changes, the member will be attributed the following month.

Commercial PPO members don't need to select a PCP when they enroll. Historically, these members were attributed to the provider they saw most frequently and recently in the last 16 months based on claims data. In September 2017, HMSA stopped attributing members based on claims history to allow all future assignments to be based on member choice. While HMSA doesn't currently ask for or store the preferred PCP for commercial PPO members, selected PCPs may communicate changes to historical PCP assignments to HMSA on the members' behalf. See the next section for details on the PCP's role in the attribution process.

PCP panel management through Coreo

Members may choose a new PCP on any given day. To ensure that member preferences are honored in a timely manner and to ensure that providers don't face barriers to care (e.g., delayed access to a patient's care history or care gaps), PCPs may request that HMSA add, remove, or transfer members from their panel in Coreo.

Attribution is a snapshot of PCP assignments as of the end of the previous month. All changes requested between months are considered tentative and are inputs to the next attribution run. During the first business week of each month, HMSA runs attribution for the previous month and sends the data to Coreo to upload. Coreo displays all actively enrolled and attributed HMSA members on the PCPs panel, plus any members added or transferred onto the PCPs panel or removed from the PCP's panel since the end of the previous month by Coreo users.

Adding members to panel in Coreo

1. Have a discussion with the member

Before adding members to their panel, PCPs are required to:

- Confirm that they are the member's preferred PCP.
- Discuss the expectations for the patient-PCP relationship.
- Ensure the member or member's authorized representative understands that they have the option to choose another PCP at any time.
- For commercial HMO members, make sure that the member's health center matches the PCP's health center affiliation. If the member is in a health center that the PCP isn't affiliated with, confirm if the member is willing to change health centers. Members should be warned that each health center may have different affiliated providers and facilities from which the member can receive care. Members may call HMSA at the phone number on their HMSA membership card if they need help choosing a health center.

As add requests in Coreo can't be canceled or reversed, it's critical for these discussions and the member's choice to be confirmed before the patient is added to the panel.

2. Search for the member in Coreo

From the All Patient Registry in the Panel Management module in Coreo, users may search for patients to add to their panel. Providers will be able to see all members attributed to PCPs in their practice. To add a member who's attributed to another PCP in the practice, search for the member by name or member ID. To find members attributed to PCPs outside of the practice, search by name, date of birth, gender, and member ID. Users must check "break the glass" to search for members outside of their practice.

3. Complete the Add Patient Request form

Once the member is found in the system, click add patient. This will generate a form pre-populated with the member's and provider's information. Providers should fill in any missing information. To add a patient with a commercial HMO plan, the PCP must confirm the member's preferred HMO health center. Select one of the health centers in the drop-down menu, which is based on the PCP's current health center affiliations.

When the form is submitted, the provider or Coreo user on behalf of the provider will attest to the following statements:

- I have a medical need to access this patient's record.
- I understand that the member will be added to my panel and a request to attribute the patient to me will be submitted to HMSA.
- I/my practice had a discussion with the member about their choice to designate me as their PCP.
- I/my practice printed and distributed or emailed the attached notice ("Confirmation of Primary Care Provider Designation") to the member that confirms the information that will be sent to HMSA.

4. Print the patient notification form

While HMSA no longer requires providers to collect a signed attestation from members they're adding to their panel, providers must confirm the member's choice. Add requests in Coreo are considered requests to HMSA on behalf of the member. Providers must print a pre-filled notification after submitting an add request in Coreo. The notification documents the request that was submitted to HMSA and provides additional information about if/when members can expect a new HMSA membership card and that they may change their PCP at any time. The notification is available in several different languages. Providers should distribute the notification to the member within three business days of submitting an add request.

PCPs will be able to access new patient data in Coreo within 24 hours. All add requests submitted in Coreo for commercial PPO members will be sent to HMSA on the last day of the month for inclusion in the attribution run for that month. If more than one add request was submitted, **the most recent request on or before the last day of the month will be used.** Add requests submitted in Coreo for commercial HMO, QUEST Integration, and Medicare Advantage members will be sent to HMSA's membership teams daily for database updates. Processing these requests and issuing new HMSA membership cards may take up to 10 business days.

All attribution changes initiated via Coreo are subject to audit.

Transferring or removing members from the panel in Coreo

Whether members request to be removed from the PCP's panel or PCPs decide they cannot provide care for the member, the following expectations should be factored into the PCP's workflow.

1. Determine why the member needs to be removed from the panel

- In most situations and for continuity of care, providers should transfer members to another PCP of the member's choice. If members need help finding a new PCP, they can call HMSA at the phone number on the back of their HMSA membership card. Transfers can be initiated once members confirm their choice. If the member can't be reached by the PCP or the practice, attempts to contact the member should be documented. Members may select a specific PCP when they enroll in a plan, so it's important to reach out to these members before removing them from the panel.
- If PCPs confirm that a member is deceased, the PCP can request to remove the member from their panel.
- If a member has moved off island or out of state, PCPs can request to remove the member from their panel. While a transfer in Coreo may not be possible if the provider isn't in our network, the PCP must still ensure that the member's care is transferred appropriately.
- If the provider can't transfer the member's care to another PCP or the circumstances are such that an immediate discharge is necessary, the provider may request to discharge the member from the practice. Providers must communicate to members about their plan to discharge them. If the provider can't reach the member, the provider's attempts to contact the member must be documented.

2. Submit the remove patient request in Coreo

From the All Patient Registry in the Panel Management module in Coreo, search for and select the member who will be removed. The remove patient form will be populated with the member's and provider's information. Select one of the remove reasons:

- The member is deceased.
- The member has moved out of state or off island.
- Member was discharged from practice.
- Member's care was transferred to another provider.

For transfer requests, the user will be prompted to search by name and select the provider who the member is being transferred to.

3. Completion of a transfer request

Once the releasing provider submits a transfer request, the receiving provider will have at least 30 days to accept or decline the request. The member will remain on the releasing provider's panel during this time with a "pending transfer" status. If the request is accepted, the receiving provider will be prompted to submit an Add Patient Request. If the request is declined, the member will remain on the releasing provider's panel. If a member is pending transfer and Coreo loads an HMSA attribution file that either assigns the member to the receiving provider or a third provider, the transfer will be canceled and the member will be assigned accordingly.

All inbound and outbound transfer requests can be managed in the Transfer Registry in the Panel Management module in Coreo.

Similar to add patient requests generated in Coreo, remove patient requests for members who are reportedly deceased, have moved out of state or off island, or are being discharged, will be sent to HMSA for processing. Remove requests for members with a commercial HMO, Medicare Advantage, or QUEST Integration plan will be sent to HMSA's membership teams daily for database updates, which will feed the attribution run at the end of the month. In the case of a discharge, HMSA's membership teams may either call the member or send the member a letter to inform the member of the discharge request and to help connect the member with a new PCP. QUEST Integration members must have an assigned PCP, so the discharge request may not be processed until HMSA can assign the member to another provider. Remove requests for commercial PPO members will be sent to HMSA at the end of each month for the monthly attribution run.

Providers can monitor the addition and removal of all members from their panel in the Attribution Activity Log in the Panel Management module of Coreo.

Dual members

Members with more than one HMSA plan may be attributed to only one provider. The attribution algorithm will assign the member to one PCP based on information in HMSA's enrollment databases or panel management requests from Coreo.

Attribution to self and immediate family members

HMSA plans don't provide benefit payment or cover services rendered by medical practitioners to themselves or to their immediate family.

HMSA defines immediate family members as:

- Parent
- Child
- Spouse

As an extension of this policy, PCPs in the HMSA Payment Transformation Program may not add themselves or their immediate family members to the PCP's own patient panel or accept patient attribution for themselves or immediate family members. That's because HMSA makes benefit payment in the form of the base PMPM payment for each attributed patient. Accepting a PMPM payment for yourself or immediate family members is a violation of this policy. PCPs should not add themselves or their immediate family members to Coreo or select themselves as their PCP or allow immediate family members to select them as their PCP when enrolling in HMSA plans.

Access to primary care

Access to primary care is an important principle of the PT program. While it is fully within a PCP's right to not accept or schedule visits with patients as he/she deems appropriate, HMSA's PT program or the fact that the member is attributed to another PCP should not be the reason for denying member access to care. HMSA monitors member complaints about PCPs regarding access to care and will initiate a corrective action process for the PCP and their PO when we receive the first complaint. Members should not be coerced to select a provider as their PCP as a condition for receiving care.

PCP Payments Available in the PT Program

PCPs in the PT program will receive payments based on the schedule and criteria outlined below. These payments replace FFS payments, PCMH payments, and P4Q payments.

PAYMENT TYPE	FREQUENCY/TIMING OF PAYMENT	CRITERIA FOR PAYMENT
Base PMPM payment (PMPM rate x attributed members, by LOB)	Monthly, around the 15th of each month.	• Part 1: For each LOB, 80 percent of the base PMPM rate is guaranteed. • Part 2: For each LOB, 20 percent of the base PMPM rate is at-risk based on annual performance on PCP engagement measures during the previous measurement year. • HMSA makes base PMPM payment around the 15th of the month in the PCP's first month of participation in the PT program; this is considered an advance payment. If the PCP leaves the PT program, HMSA reserves the right to request a refund of this advance payment.
PCP Performance (Quality) Payments	Advances at the end of each quarter; annual true-up on quality performance by May of the following year.	• At the end of each quarter, PCPs will receive an advance payment based on the amount they earned the previous year for quality incentives. • At the end of the calendar year, each PCP's annual performance on quality measures will be scored and payments will be trued-up. Any additional incentive that HMSA owes will be paid by the end of May of the following year. Any incentive that the provider received in advance but didn't earn will be deducted from the PCP's quality payment(s) the following year. • PCPs who leave the PT program prior to the end of a year must return advance payments for that year.
Total Cost of Care Shared Savings	Annually; scored and distributed at the PO level.	• TCOC will be based on the PO's calendar year performance. • A PO is eligible for TCOC savings if the PO's risk-adjusted TCOC trend (i.e., comparing each PO's trend against themselves for the measurement year to the prior year) falls below the cost-trend target and the PO meets the performance (quality) target score. • TCOC scores and payments will be distributed to POs by July of the following year.

Base PMPM Payments

Base PMPM Rate

Reimbursements in the HMSA Payment Transformation Program provide flexibility in the delivery of primary care and enable population health management and patient-centered care across the continuum of health. HMSA pays each PCP a monthly PMPM base payment for their attributed HMSA members. While reimbursement is no longer determined by claims billed against HMSA's primary care fee schedule, it's essential that PCPs continue to submit accurately coded claims in a timely manner.

The amount of the base PMPM payment is based on the PMPM rate for which the PCP qualifies. A PCP's PMPM is adjusted every 12-15 months depending on the program year. We notify PCPs of their PMPM rate at least 60 days before the new rate is effective. The base PMPM is compensation in full for all covered services for all members with a few exceptions outlined in the PMPM Payment Exclusions section. A PCP or their PO is responsible for compensating other PT program PCPs when the PT program PCPs provide covered services to the PCP's attributed members.

A PCP's base PMPM payment will reflect the PCP's PMPM rate multiplied by the number of members attributed to that PCP as of the last day of the preceding month.

Line of Business

PMPM rates for each PCP will vary for each HMSA line of business (LOB). PCPs receive a PMPM rate and payment for each LOB they participate in. For example, if a PCP participates with HMSA in all LOBs (commercial, which includes HMO and PPO members; QUEST Integration; and Medicare Advantage), the PCP's base PMPM payments are calculated using these formulas:

1. PCP's commercial PMPM rate x number of attributed commercial HMSA members = $A/month.
2. PCP's QUEST Integration (QI) PMPM rate x number of attributed QI HMSA members = $B/month.
3. PCP's Medicare Advantage PMPM rate x number of attributed Medicare Advantage members = $C/month.
4. PCP's base PMPM revenue from HMSA = $A + $B + $C per month.

PMPM Rate Determination

The base PMPM band rates in Year 1 (effective 2017 – June 2018) were based on each PCP's historical fee for service (FFS) reimbursements and PCMH PMPM rates. The Year 1 PMPM methodology, detailed in Appendix A, was designed to keep providers' reimbursements relatively whole during their first year in the PT program. However, the FFS-based PMPMs reflected practice patterns shaped by the FFS model, which accounted for the volume of services delivered, but not necessarily the variation in patient complexity, cost, and quality outcomes. Over three years, HMSA will transition PCP compensation and the variation in PMPM rates to be increasingly value-based. A standardized base PMPM for each LOB will be modified based on each PCP's relative panel risk, quality measure performance, their PO's TCOC[1], and scope of service for eligible providers[2]. To ensure that PCPs have a glide path to transition from their Year 1 FFS-based PMPM band rate to a completely value-based PMPM in Year 4, the Year 2 and Year 3 PMPMs will be blended as described in the table below.*

	FFS-based PMPM rate	Value-based PMPM rate
Year 1 (2017 – Jun 2018)	1	0
Year 2 (Jul 2018 – Sept 2019)	2/3	1/3
Year 3 (Oct 2019 - Sept 2020)	1/3	2/3
Year 4 (Oct 2020 - Sept 2021)	0	1

[1] Adjustments for TCOC won't be applied in Year 2.

[2] Eligibility for the scope of service modifier will be discussed with POs.

* Exceptions to the start date for Year 2 may vary by PO, and is defined in each PCP's contract.

FFS-based PMPM

Each PCPs FFS-based PMPM rate will be equal to their Year 1 contracted PMPM band rate, less the PMPM cost of facility-based services, and with an additional PMPM amount added to their Year 1 commercial PMPM to account for the state General Excise Tax (GET) previously collected from eligible commercial PPO members in the FFS model.

Carve out for facility-based services

Facility-based services identified by place of service (POS) codes in Appendix B and reported in field 24B on professional claims will be paid FFS beginning in Year 2 for dates of service on or after July 1, 2018. A PMPM rate representative of the historic revenue from facility-based services was removed from each PCP's Year 1 PMPM band rates for each LOB as described below:

- Facility PMPM = [Facility-based service reimbursements for three-year period] / [Attributed member-months for three-year period]
- FFS-based PMPM = [Year 1 PMPM band rate] – [Facility PMPM]

The three-year period used to calculate the Facility PMPM aligned with the three years of FFS reimbursements and member months used to calculate each PCP's Year 1 PMPM band rate. For PCPs who joined the PT program in 2016, the three-year period was 2012-2014. For PCPs who joined the PT program in 2017, the three-year period was 2013-2015.

Adjustment for General Excise Tax

In the PT program, providers cannot collect state GET on base PMPM payments from their members. To replace the GET liability that PCPs would've been able to collect from eligible HMSA commercial PPO members in a FFS model, a prorated PMPM adjustment will be added to each PCP's commercial FFS-based PMPM as described below:

- GET Adjustment (PMPM) = [Commercial FFS-based PMPM – PCMH PMPM] x [Percentage of commercial panel that are PPO members where tax is not a benefit[2]] x [Tax rate based on practice location[3]] x [21 months / 15 months[4]]
- (GET-adjusted) commercial FFS-based PMPM = [Year 1 PMPM band rate] – [Facility PMPM] + [GET Adjustment PMPM]

An adjustment for GET will also be factored into the value-based PMPM rate by building additional dollars into the standardized PMPM rate for the commercial LOB each year.

Providers may continue to collect GET from members who pay copayments, deductibles, and coinsurance, as well as FFS payments. The PT program amendment characterizes the PMPM payment as "compensation in full for all covered services" (excluding the cost share and FFS exceptions mentioned in the PMPM Payment Exclusions section).

Value-based PMPM

A standardized base PMPM rate was determined for each line of business. The standardized base PMPM was derived from modeling that would allow the median PCP's overall revenue from HMSA, including the value-based PMPM, to align approximately with the 50th percentile MGMA salary. See Appendix C for more details on how the standardized base PMPM was derived.

In Year 2, each PCP's value-based PMPM rate will be derived from adjustments to the standardized PMPM based on the PCP's panel risk and quality.

The standardized base PMPM rates are listed in the table below.

	Standardized PMPM rates
Commercial	$18.25
QUEST Integration	$18.50
Medicare Advantage	$31.75

Each of the value-based modifiers will be calculated as a PMPM rate that will be added or deducted from the Year 2 standardized PMPM rates. The maximum potential adjustments are listed in the table below.

VALUE MODIFIER	POTENTIAL ADJUSTMENT (PMPM)
Risk	$0 to +$15
Quality	-$2 to +$2

[2] The percentage of an individual PCP's commercial panel or medical group members' aggregated commercial panels that were PPO members where tax is not a benefit in December 2017.

[3] 4.712% for practices on Oahu. 4.167% for practices on the Neighbor Islands.

[4] The GE Tax PMPM is prorated for 21-months-worth of coverage (January 2018 – September 2019), paid out over 15 months (July 2018 – September 2019).

Risk modifier (PMPM)

The risk modifier intends to adjust revenue based on the quantifiable risk of the PCP's panel relative to other providers in the network. Providers with a relatively low risk panel will receive a smaller PMPM adjustment than providers with a higher risk panel. Each PCP's risk modifier PMPM for Year 2 is calculated across their entire attributed panel for a defined measurement period, as detailed below, to ensure equity in the value of the risk modifier between each LOB. This ensures that changes in a PCP's LOB-mix or their LOB-mix relative to other providers won't be factored into their risk adjustment.

	RISK MODIFIER PMPM BASED ON MEMBER ATTRIBUTION, ERG RISK SCORES, GENDER, AND AGE OF PANEL FOR RISK MEASUREMENT PERIOD
Year 2 (July 2018-September 2019)	August 2016 – July 2017

To quantify the risk modifier, a predictive primary care spending model was created and calibrated on member data from 2013-2015. At the individual member level, the model allows us to understand the average amount of primary care resources it takes to care for a particular member based on their age, gender, and Episode Risk Group (ERG) category. The model doesn't account for differences in practice patterns and unexplainable variation.

To derive the predicted panel PMPM for an individual provider, we first derive the predicted PMPM for each member based on their ERG category, age, and gender as of the final month of the risk modifier measurement period. The members' predicted PMPMs are then summed and averaged to the members' attributed PCP as of the final month of the risk modifier measurement period.

Each PCP's predicted panel PMPM is then indexed against the network-predicted PMPM. The network-predicted PMPM is an aggregation of patient level data, as opposed to an average of provider level PMPMs, to ensure that PCPs with large panels don't have a disproportional impact on the network rate. Each PCP's indexed score is mapped to a risk PMPM modifier ranging from $0 to $15.

The amount of the risk PMPM modifier, $15, was derived from historical data. When calculating the predicted primary care panel PMPMs for PCPs using data from 2013-2015, the difference between the 5th and 95th percentile PMPMs was approximately $15. This means that the amount of primary care spending (PMPM) that could be explained by quantifiable risk factors alone for the average PCP panel in 2013-2015 was $15.

Providers without data to calculate a risk modifier will receive the median risk modifier of $7.50 PMPM.

Quality modifier (PMPM)

The quality modifier adds a positive PMPM adjustment to PCPs with quality performance above the network average and a negative adjustment to those below the network average. The quality modifier is based on each PCP's performance on a sub-set of quality measures common to HMSA's pay-for-quality program and the PCP Performance Measure Set for payment transformation.

LOBs[5]	QUALITY METRIC
C A	Advanced Care Planning
C Q A	Body Mass Index Assessment
C Q A	Breast Cancer Screening
C Q A	Cervical Cancer Screening
C Q A	Colorectal Cancer Screening
C Q A	Diabetes Care - Eye Exam
C Q A	Diabetes Care - Nephropathy
C Q A	Diabetes Care - BP Control < 140/90
C A	Diabetes Care I HbA1c In Control (<=9.0)
A	Review of Chronic Conditions
C Q	Childhood Immunization Status
C Q	Immunizations for Adolescents
C Q	Well-child Visits in the First 15 Months of Life
C Q	Well-child Visit in the Third, Fourth, Fifth and Sixth Years of Life

A quality score (%) for each LOB is calculated as the total percentage of the maximum potential dollars earned on the sub-set of comparable quality measures in HMSA's pay-for-quality and PT program in the 2016 measurement period.

- Quality Score (LOB) = [∑dollars earned for sub-set of quality measures in 2016[6] (LOB)] / [∑maximum potential dollars for sub-set of quality measures in 2016 (LOB)]

The Quality Score (LOB) is then indexed against the network weighted (by attributed member months) average quality score for the respective LOB.

- Indexed Quality Score (LOB) = [PCP's Quality Score (LOB)] / [Network Average Quality Score (LOB)]

An aggregated quality index is then computed as a weighted average of the PCP's indexed quality scores for each LOB divided by the PCP's total member-months across all LOBs. Member-months for each LOB are based on the member-months used for quality/performance payment calculations in 2016 in HMSA's pay-for-quality or PT program.

- Aggregated Quality Index = [(Commercial Indexed Quality Score * member-months from commercial members) + (QUEST Integration Indexed Quality Score * member-months from QUEST Integration members) + (Medicare Advantage Indexed Quality Score * member-months from Medicare Advantage members)] / [(Total commercial member months) + (Total QUEST Integration member months) + (Total Medicare Advantage member months)]

[5] C= commercial; Q= QUEST Integration; A= Medicare Advantage

[6] In Year 3, quality data from the 2018 measurement period will be used to calculate the quality modifier.

Each PCP's Quality PMPM will be based on their Aggregated Quality Index percentile ranking, as described in the table below.

AGGREGATED QUALITY INDEX	QUALITY PMPM
>75th percentile	$2
<75th percentile and >25th percentile	Variable, between -$2 and $2
<25th percentile	-$2

Providers with an Aggregated Quality Index between the 25th and 75th percentile will receive an incremental Quality PMPM amount, between -$2 and $2 PMPM, as follows:

Starting from the 25th through the 75th percentile (not inclusive), every increase of 0.01 in the Aggregated Quality Index percentile will adjust a provider's PMPM, on average, upwards by approximately $0.10.

Providers without quality performance data for the 2016 measurement period will be given a $0 quality modifier PMPM.

Year Two Base PMPM[7]

Individual Providers

To determine the maximum potential Year 2 base PMPM rate for an individual provider, add the risk modifier and quality modifier to the standardized base PMPM for each LOB:

- Year 2 value-based PMPM (LOB) = [Standardized PMPM (LOB)] + [Risk modifier PMPM] ± [Quality modifier PMPM]
- Blend the FFS-based PMPM with the Year 2 value-based PMPM for each LOB
- Year 2 PMPM rate (LOB) = (2/3) [FFS-based PMPM (LOB)] + (1/3) [Year 2 value-based PMPM (LOB)]

Medical Groups

To determine the maximum potential Year 2 base PMPM rate for a medical group, calculate a Year 2 value-based PMPM by LOB for each individual provider. Take a weighted average of the value-based PMPM rates by member-months and then blend with the group's FFS-based PMPM for each LOB.

If an HMSA member is attributed to a payment transformation PCP who's part of a medical group, FFS payments for services shall not be made to non-payment transformation PCPs who are contracted or employed by the same group for the attributed member. HMSA reserves the right to recoup any overpayments made in error.

If a group member is dissatisfied with the revenue, they may appeal to their group or may contractually leave the group to receive an individually calculated and paid rate.

Cap PMPM Reduction

To ensure that providers or medical groups don't experience significant reductions in their revenue, the Year 2 (blended) PMPM for each LOB will be capped at 90 percent of the FFS-based PMPM. In other words, providers cannot be adjusted to a PMPM rate more than 10 percent below their FFS-based PMPM (i.e., excluding facility-based services and including the GET adjustment for the commercial PMPM).

PMPM Payment Exclusions

PMPM payments are intended to cover all the care that a PCP delivers to both attributed and unattributed HMSA members, except for cost-based immunizations and facility-based services that HMSA continues to pay on a FFS basis. This is because the cost of vaccines varies each year, possibly rendering the PMPM inadequate to cover the cost. While codes for the vaccines (Appendix E) are carved out of the PMPM and paid FFS for all PCPs, administration fees are included in the PMPM rates. Care delivered by PCPs in facilities, such as newborn care in the hospital and checkups at skilled nursing facilities and rehabilitation facilities, often fill critical gaps in access and provide value especially with regard to patient experience. Reference to Appendix B. Thus these services will be paid on a FFS basis for service dates on or after July 1, 2018.

The HMSA members in the following plans are also excluded from the PT program PMPM payment. Claims for these members will continue to be paid FFS and the PCPs they're attributed to won't receive a PMPM payment for them. HMSA members in these plans are excluded:

- Federal Employee Program® (FEP)[8].
- QUEST Integration – aged, blind, and disabled (ABD).
- Members of another health plan operating under a license with the Blue Cross Blue Shield Association and entitled to benefits under the Global Core Program.

[7] The Year Two base PMPM methodology described in this section will apply to PCPs who sign a Year Two Payment Transformation contract amendment. The Year Two PMPM rate for all other providers will be equal to their FFS-based PMPM rate as described on page 12.

[8] FEP members are part of a national account enrolled through BCBSA.

Example Calculations for Year Two base PMPM

Dr. Aloha Wong is an individual practitioner, on Oahu, and participates in the commercial, Medicare Advantage and QUEST Integration LOBs. To calculate Dr. Wong's Year Two PMPM rates follow the steps below.

Dr. Wong's Year One (2017) PMPM band rates are listed in the table below.

LINE OF BUSINESS	YEAR ONE (2017) PMPM BAND RATE
Commercial	$20.61
Medicare Advantage	$39.44
QUEST Integration	$23.40

Step 1: Calculate Facility PMPM, by LOB.

LINE OF BUSINESS	FACILITY-BASED SERVICE REIMBURSEMENTS, 2013-2015	/	ATTRIBUTED MEMBER-MONTHS, 2013-2015	=	FACILITY PMPM
Commercial	$5,114	/	23,679	=	$0.22
Medicare Advantage	$5,623	/	2,607	=	$2.15
QUEST Integration	$2,361	/	6,074	=	$0.39

Step 2: Calculate GET Adjustment (PMPM) for the commercial LOB.

LINE OF BUSINESS	[YEAR ONE (2017) PMPM BAND RATE – PCMH PMPM]	X	PERCENTAGE OF COMMERCIAL PANEL THAT ARE PPO MEMBERS	X	TAX RATE FOR OAHU	X	(21 MONTHS / 15 MONTHS)	=	GET PMPM
Commercial	$20.61 - $3.50	x	80%	x	4.712%	x	(21/15)	=	$0.90

Step 3: Calculate FFS-based PMPM Rate.

Line of Business	Year One (2017) PMPM Band Rate	-	Facility PMPM	+	GET PMPM	=	FFS-based PMPM Rate
Commercial	$20.61	-	$0.22	+	$0.90	=	$21.29
Medicare Advantage	$39.44	-	$2.15	+	N/A	=	$37.29
QUEST Integration	$23.40	-	$0.39	+	N/A	=	$23.01

The FFS-based PMPM rates above will be blended with Dr. Wong's Year Two value-based PMPM rates, as calculated below.

Step 4: Calculate Risk Modifier PMPM.

Predicted Panel PMPM	/	Network-predicted PMPM	=	Risk Index	⟶	Risk Modifier (PMPM)
$18.32	/	$18.26	=	1.00	⟶	$7.50

Step 5: Calculate Quality Modifier PMPM.

First calculate a Quality Score for each LOB.

LINE OF BUSINESS	DOLLARS EARNED FOR SUB-SET OF QUALITY MEASURES IN 2016	/	MAX POTENTIAL DOLLARS FOR SUB-SET OF QUALITY MEASURES IN 2016	=	QUALITY SCORE
Commercial	$3,110	/	$3,113	=	100%
Medicare Advantage	$1,087	/	$1409	=	77%
QUEST Integration	$110	/	$222	=	50%

Second, calculate the Indexed Quality Score for each LOB.

LINE OF BUSINESS	QUALITY SCORE	/	NETWORK AVERAGE QUALITY SCORE	=	INDEXED QUALITY SCORE
Commercial	100%	/	91%	=	110%
Medicare Advantage	77%	/	82%	=	94%
QUEST Integration	50%	/	82%	=	61%

Third, calculate the Aggregated Quality Index, across all LOBs.

[(COMMERCIAL INDEXED QUALITY SCORE X MM)	+	(MEDICARE ADVANTAGE INDEXED QUALITY SCORE X MM)	+	(QUEST INTEGRATION INDEXED QUALITY SCORE X MM)]	/	(COMMERCIAL MM + MEDICARE ADVANTAGE MM + QUEST INTEGRATION MM)	=	AGGREGATED QUALITY INDEX
110% x 4,697	+	94% x 335	+	61% x 451	/	(4,697+335+451) = 5,483	=	1.05

AGGREGATED QUALITY INDEX	QUALITY MODIFIER PMPM
1.05	$0.63

Step 6: Calculate Year Two Value-Based PMPM

Line of Business	Standardized PMPM	+	Risk Modifier PMPM	+	Quality Modifier PMPM	=	Year Two Value-based PMPM
Commercial	$18.25	+	$7.50	+	$0.63	=	$26.38
Medicare Advantage	$31.75	+	$7.50	+	$0.63	=	$39.88
QUEST Integration	$18.50	+	$7.50	+	$0.63	=	$26.63

Step 7: Calculate Year Two (blended) PMPM rates

Line of Business	(2/3) x (FFS-based PMPM)	+	(1/3) x (Year Two Value-based PMPM)	=	Year Two (blended) PMPM
Commercial	(2/3) x ($21.29)	+	(1/3) x (26.38)	=	$22.99
Medicare Advantage	(2/3) x ($37.29)	+	(1/3) x (39.88)	=	$38.15
QUEST Integration	(2/3) x ($23.01)	+	(1/3) x (26.63)	=	$24.22

Step 8: Ensure Year 2 (blended) PMPM is not less than 90% of FFS-based PMPM

Line of Business	(90%) x (FFS-based PMPM)	<	Year Two (blended) PMPM	Cap?
Commercial	(90%) x ($21.29) = $19.16	<	$22.99	No
Medicare Advantage	(90%) x ($37.29) = $33.56	<	$38.15	No
QUEST Integration	(90%) x ($23.01) = $20.71	<	$24.22	No

Dr. Wong's Year Two base PMPM rates are $22.99 for Commercial, $38.15 for Medicare Advantage, and $24.22 for QUEST Integration.

PCP Engagement Payments and Measures

Engagement Measures Overview

Each year, 20 percent of a PCP's base PMPM rate for each line of business will be at risk based on the PCP's performance on a limited set of foundational engagement measures. Engagement measures are intended to outline key behaviors or activities that will help PCPs succeed in the new payment model. Engagement measures will be scored annually, which will determine the portion of the following year's base PMPM rate at risk that the PCP will earn for each line of business. Whenever possible, measures will be displayed in Coreo for tracking purposes.

Since engagement measures will evolve over time, HMSA reserves the right to change these measures at the start of each measurement year.

Engagement Measures

LINE OF BUSINESS	MEASURE NAME	HIGH-LEVEL DESCRIPTION
C Q M	Access to and Use of Coreo	PCPs and/or their office staff or delegate will use Coreo at least once a month. Coreo lets providers manage their member panel, monitor care gaps, and view their performance and payment potential.
C Q M	Panel Management	PCPs will check on the well-being of attributed members in their panel at least once per measurement year. This requirement will be measured using an annual member survey administered to a sample of each provider's attributed members at the end of the measurement year.
C Q M	Engagement with Ecosystem	PCPs will refer patients to programs in the ecosystem, such as HMSA's Care Model, HMSA health education workshops, and Dr. Ornish's Program for Reversing Heart Disease®.
Q	EPSDT completion rate	PCPs with participating provider agreements for QUEST Integration will submit EPSDT (Early and Periodic, Screening, Diagnostic, and Treatment) exam forms DHS 8015 or DHS 8016 for attributed QUEST Integration members under age 21 who had an EPSDT visit due during the measurement year. The number of members who are expected to have a visit will be based on the EPSDT periodicity schedule and the number of members attributed to the provider at the end of the measurement year.

C = COMMERCIAL; Q = QUEST INTEGRATION; M = MEDICARE ADVANTAGE

Healthways, Inc.® is an independent company that provides well-being programs to engage members on behalf of HMSA.

Engagement Measure Scoring

For each engagement measure, PCPs will either earn all or none of the credit across all lines of business. The measure weights are listed in the table below. Requirements for each measure are in Appendix E.

ENGAGEMENT MEASURE	MEASURE WEIGHT		
	COMMERCIAL	MEDICARE ADVANTAGE	QUEST INTEGRATION
Access to and Use of Coreo	6%	6%	5%
Panel Management	7%	7%	5%
Engagement with Ecosystem	7%	7%	5%
EPSDT Completion Rate			5%
Total	**20%**	**20%**	**20%**

For example, Dr. Wong met all of the engagement measures in Year Two (2018), except the Engagement with Ecosystem measure. In Year Three (October 2019-September 2020), Dr. Wong's potential base PMPM rates are $22 for commercial, $20 for Medicare Advantage, and $16 for QUEST Integration; however, 20 percent of her actual PMPM band rate will be adjusted based on her Year Two (2018) performance in the engagement measures: $20.46 for commercial, $18.60 for Medicare Advantage, and $15.20 for QUEST Integration.

LINE OF BUSINESS	YEAR THREE: PMPM GUARANTEED (80%)	YEAR TWO: ENGAGEMENT MEASURES PERFORMANCE (20%)				YEAR THREE: PERCENT PMPM EARNED	YEAR THREE: BASE PMPM RATE POTENTIAL	YEAR THREE: EARNED BASE PMPM RATE
		ACCESS TO AND USE OF COREO	PANEL MANAGEMENT	ENGAGEMENT WITH THE ECOSYSTEM	EPSDT FORM COMPLETION			
Commercial	80%	+6%	+7%	0%		93%	$22.00	$20.46
Medicare Advantage	80%	+6%	+7%	0%		93%	$20.00	$18.60
QUEST Integration	80%	+5%	+5%	0%	+5%	95%	$16.00	$15.20

Performance (Quality) Payments

PCPs will be eligible to earn incentives in addition to their base PMPM revenue based on their performance on an applicable set of performance measures. The measures will be scored annually on an individual PCP basis by line of business.

Measurement Responsibility

All participating PCPs (regardless of specialty type) are scored on all measures for which their member panels are eligible. Performance measures were selected for clinical importance and focus on meeting new goals for patient care, including prevention, well-being, access, patient-centeredness, and population health management. A summary of all performance measures and the lines of business that they apply to are in the table below. Details of the performance measures are in Appendix F.

PCP Performance Measures

LINE OF BUSINESS	MEASURE	HIGH-LEVEL DEFINITION
C M	Advance Care Planning	The percentage of attributed members 65 years and older at the end of the measurement year who had an advance care plan and/or an advance care planning discussion with a provider documented during the measurement year.
C Q	Adolescent Well-care Visits	The percentage of attributed members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an ob-gyn during the measurement year.
C Q M	Body Mass Index (BMI) Assessment	The percentage of attributed members 18–74 years of age who had an outpatient visit and whose body mass index was documented during the measurement year.
C Q M	Breast Cancer Screening	The percentage of attributed member women 52–74 years of age who had one or more mammograms during the 27 months prior to the end of the measurement year.
C Q M	Cervical Cancer Screening	The percentage of attributed member women 24–64 years of age who were screened for cervical cancer using either cervical cytology during the measurement year or the two years prior. If age 30–64, a cervical cytology and a human papillomavirus (HPV) test with service dates four or less days apart during the measurement year or the four prior measurement years are also accepted.
C Q	Childhood Immunization Status	Percentage of attributed member children having all of the following immunizations on or before their second birthday: • At least four DTaP vaccinations with different dates of service on or before the child's second birthday. DTaP administered prior to 42 days after birth can't be counted. • At least three Hib vaccinations with different dates of service on or before the child's second birthday. Hib administered prior to 42 days after birth can't be counted. • At least two outpatient HepB vaccinations with different dates of service on or before the child's second birthday. • At least three IPV vaccinations with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth can't be counted. • At least one MMR vaccination with a date of service on or before the child's second birthday. • At least four PCV vaccinations with different dates of service on or before the child's second birthday. PCV administered prior to 42 days after birth can't be counted. • At least one VZV vaccination with a date of service on or before the child's second birthday.
C Q M	Colorectal Cancer Screening	The percentage of attributed members 51–75 years of age who had appropriate screening for colorectal cancer through one of these measures: fecal occult blood test (FOBT) during the current measurement year, FIT-DNA test during the measurement year or the two prior measurement years, flexible sigmoidoscopy during the measurement year or the four prior measurement years, CT colonography during the measurement year or the four prior measurement years, or colonoscopy during the current measurement year or the nine prior measurement years.

C = COMMERCIAL; Q = QUEST INTEGRATION; M = MEDICARE ADVANTAGE

LINE OF BUSINESS	MEASURE	HIGH-LEVEL DEFINITION
C Q M	Diabetes Care – Blood Pressure Control (<140/90)	The percentage of attributed members with diabetes 18–75 years of age whose most recent blood pressure reading during the measurement year was <140/90 mm Hg.
C Q M	Diabetes Care – Eye Exam	The percentage of attributed members with diabetes 18–75 years of age who received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the current measurement year or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the prior measurement year. (American Diabetes Association guideline.)
C Q M	Diabetes Care – HbA1c Control (≤9)	The percentage of attributed members with diabetes age 18–75 years whose most recent HbA1c test during the measurement year is ≤9.0 percent.
C Q M	Diabetes Care – Medical Attention for Nephropathy	The percentage of attributed members with diabetes 18–75 years of age who had at least one test for microalbumin during the current measurement year or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microal-buminuria or albuminuria; ACE inhibitor/ARB therapy during the measurement year is also acceptable evidence). (American Diabetes Association guideline.)
C Q	Developmental Screening in the First Three Years of Life	Percentage of attributed member children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, and third birthdays.
C Q	Immunizations for Adolescents	Percentage of attributed member adolescents having all of the following immunizations on or before their 13th birthday: • One meningococcal vaccine on or between the adolescent's seventh and 13th birthdays. • One Tdap between the adolescent's seventh and 13th birthdays. Percentage of attributed adolescent members who received the HPV vaccine on or between their seventh and 13th birthdays. Note: The HPV vaccine will not be included in the measure for scoring in 2018.
C Q M	Influenza Vaccine (Adult)	Percentage of attributed members 18 years and older who received an influenza vaccine during the measurement year.
M	Review of Chronic Conditions	The percentage of chronic condition groupings or codes that were identified in the two years prior that are persistent during the measurement year as confirmed by claims or disconfirmed by provider attestation. See page 61 for details.
C Q M	Screening for Symptoms of Clinical Depression and Anxiety	Percentage of attributed members 12 years of age and older who had an office visit with an eligible PCP type during the measurement year and who were screened for symptoms of depression using an approved screener.
C	Sharecare RealAge Assessment	The percentage of members 18 years of age and older who completed the RealAge assessment at least once during the measurement period.
C Q M	Tobacco Screening and Cessation Counseling	The percentage of attributed members 18 years of age and older who had an outpatient visit with an eligible PCP type during the measurement year, were screened for tobacco use, and had tobacco cessation if screened positive for tobacco use.
C Q	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	The percentage of attributed members 3–17 years of age who receive BMI assessment, nutrition, and physical activity counseling during the measurement year.

C = COMMERCIAL; Q = QUEST INTEGRATION; M = MEDICARE ADVANTAGE

LINE OF BUSINESS	MEASURE	HIGH-LEVEL DEFINITION
C Q	Well-child Visits in the First 15 Months of Life	The percentage of attributed members who turned 15 months old during the measurement year and had six or more well-child visits with a PCP.
C Q	Well-child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	The percentage of attributed members 3–6 years of age who received one or more well-child visits with a PCP during the current measurement year.

C = COMMERCIAL; Q = QUEST INTEGRATION; M = MEDICARE ADVANTAGE

Patient Population and Member Eligibility

Patient Population Identification

COMMERCIAL

Members enrolled in HMSA's commercial plans (HMO and PPO), will be included in the performance measures. FEP members will not be included in the PCP Performance Measures.

QUEST INTEGRATION

Members enrolled in HMSA's QUEST Integration plan will be included in the performance measures. This includes QUEST Integration's aged, blind, and disabled (ABD) members.

If a member is enrolled in HMSA QUEST Integration and another plan, the member can be counted for only one of the performance measure sets as follows:

- If an HMSA QUEST Integration member also has coverage under an HMSA commercial plan, the member will be counted for the commercial performance measure set.
- If an HMSA QUEST Integration member also has coverage under a Medicare Advantage plan, the member will be counted for the Medicare Advantage performance set.

MEDICARE ADVANTAGE

Except for Essential Advantage plan members, members enrolled in Medicare Advantage will be included in the performance measures.

If a member is enrolled in Medicare Advantage and another plan, the member can be counted for only one of the performance measure sets as follows:

- If a Medicare Advantage member also has coverage under an HMSA commercial plan, the member will be counted for the commercial performance measure set.
- If a Medicare Advantage member also has coverage under QUEST Integration, the member will be counted for the Medicare Advantage plan performance measure set.

Members of another Blue Cross and Blue Shield Association plan who are entitled to benefits of the BlueCard program will be excluded from the performance measures.

Member Eligibility

To be included in a PCP's scored performance rate calculations, members must be attributed to the PCP's member panel and be eligible HMSA members for at least three consecutive months during the 12-month measurement year. If a member is attributed to more than one PCP for three consecutive months during a measurement year, the most recent PCP meeting this criterion as of December 31 of the measurement year will have the member included in their performance rate calculations.

All members who are eligible for a measure, whether or not they meet this requirement, will contribute to a PCP's maximum performance payment potential for each month they're attributed to the PCP. For example, if a member is attributed to PCP A's panel for two months but is then attributed to PCP B's panel for the remainder of the year, PCP A's maximum performance payment potential will include the two months for which the member was attributed. See Step 1 on page 18 for details.

Payment Conditions

To be eligible for performance payments, a PCP must meet the following criteria:

- Have an executed Payment Transformation Program amendment to their participating provider agreements for:
  - HMSA's commercial line of business at the end of the measurement year for commercial performance payments.
  - HMSA's QUEST Integration line of business at the end of the measurement year for QUEST Integration performance payments.
  - Medicare Advantage at the end of the measurement year for Medicare Advantage performance payments.
- Submit at least one claim to HMSA that indicates a face-to-face encounter with an HMSA member during the measurement year. For example, at least one such Medicare Advantage claim must be submitted during the measurement year for a provider to be eligible to earn any performance payment for Medicare Advantage.

If the PCP or group administrator is eligible to receive a performance payment, the performance payment check and remittance report will be sent to the payee(s) that the provider or group administrator designated for HMSA Payment Transformation payments.

Electronic Funds Transfer (EFT)

If a PCP or medical group has an EFT account for claims payment, HMSA will direct all payment transformation payments to that EFT account. HMSA will not allow a provider to have an EFT account for claims payment and also receive check payments for the payment transformation program.

Performance Payments Overview

Performance payments are based on a PCP's cumulative performance during the measurement year. Performance measure scoring methodology rewards PCPs both for attainment of a measure's target threshold, and improvement on any measure as compared to that PCP's baseline. In total, PCPs can earn up to 110 percent of each measure's maximum payment potential by performing above the target threshold.

A PCP's maximum payment potential per line of business is based on the number of members attributed to their panel throughout the measurement year. Details on how to calculate total maximum performance payment potential and how to calculate maximum payment potential per performance measure are included in this section. The portion that each PCP earns — the annual performance payment — is based on each PCP's performance rate relative to a minimum and target threshold for each measure (performance component) and performance relative to his or her baseline measurement for each measure (improvement component). For details on the measurement year and baseline period, see the table below. Details on how to calculate the performance payment earned per measure are included later in this section.

Performance Measure Scoring and Payment Timeframes for 2018

PERFORMANCE MEASURE	MEASUREMENT PERIOD	SUPPLEMENTAL DATA ENTRY DEADLINE	BASELINE PERIOD	PERFORMANCE PAYMENT TRUE-UP
All Performance Measures except Review of Chronic Conditions (RCC)	January 1 through December 31, 2018	January 31, 2019	January 1 through December 31, 2017	May 2019
Review of Chronic Conditions (RCC)	January 1 through September 30, 2018	October 31, 2018	January 1 through December 31, 2017	May 2019

PCPs will receive quarterly performance payment advances throughout the measurement year. The scoring schedule allows for one month of claims run-out, one month for validation, and one month for processing following the annual measurement year; thus the annual true-up for performance payments will be paid in the second quarter of the following measurement year. Any performance payments that the PCP was advanced and didn't earn in the year will be deducted from the PCP's quality payment(s) the following year. PCPs who terminate their participation in the PT program prior to the end of the year must return advance performance payments for that year. See the Performance Measure Scoring and Payment Timeframes table above for more details.

Due to the time needed to validate scoring, the baseline rate displayed in Coreo during the first quarter of the measurement year will be set at the target threshold for the measures if a baseline doesn't exist, but will be updated by the end of May each year.

Performance Payment Formula

The performance payment formula is based on:

- Attributed member panel count.
- Performance payment PMPM budget for each line of business.
- Measure weighting.
  - Individual measure attributed member panel count (i.e., measure denominator).
  - Individual measure adjustment factor.
- Measure thresholds.
  - Minimum performance threshold.
  - Target performance threshold.
  - Baseline period performance.
- Portion of the potential award amount is based on performance and improvement relative to measure thresholds.

PMPM Performance Budget

LINE OF BUSINESS	MAXIMUM PMPM
Commercial	$4.50
QUEST Integration	$3.00
Medicare Advantage	$8.00

The steps in the following sections explain how HMSA will calculate the total maximum payment potential and maximum payment potential per measure, as well as the payment earned after measures are scored at the end of the measurement period.

STEP 1: TOTAL MAXIMUM POTENTIAL PAYMENT BY LINE OF BUSINESS

The eligible members in the PCP's attributed member panel will be counted at the end of each month for each line of business. Member months will be attributed to a PCP starting from the first month the PCP participates in the PT program. At the end of the measurement year, the monthly counts are added to generate an annual total member months (MM) count. Those counts are multiplied by the PMPM performance budgets for each line of business to calculate the total maximum payment potential for that year.

Total Max Pay Potential =
Member Months x Maximum PMPM Rate

Example: In January 2018, Dr. Wong had 801 eligible commercial members, 150 eligible QUEST Integration members, and 45 eligible Medicare Advantage members. In February 2018, Dr. Wong had 799 eligible commercial members, 148 eligible QUEST Integration members, and 44 eligible Medicare Advantage members. At the end of the measurement year, Dr. Wong's estimated annual MM is 9,605 MM for commercial, 1,782 MM for QUEST Integration, and 538 MM for Medicare Advantage. The maximum annual potential payment for Dr. Wong's commercial panel is $43,222.50 (9,605 x $4.50), her QUEST Integration panel is $5,346.00 (1,782 x $3), and her Medicare Advantage panel is $4,304.00 (538 x $8).

	COMMERCIAL			QUEST INTEGRATION			MEDICARE ADVANTAGE		
MONTH	PATIENT COUNT	PMPM	TOTAL MONTHLY POTENTIAL	PATIENT COUNT	PMPM	TOTAL MONTHLY POTEN-TIAL	PATIENT COUNT	PMPM	TOTAL MONTHLY POTEN-TIAL
January	801	$4.50	$3,604.50	150	$3.00	$450.00	45	$8.00	$360.00
February	799	$4.50	$3,595.50	148	$3.00	$444.00	44	$8.00	$352.00
March	800	$4.50	$3,600.00	148	$3.00	$444.00	42	$8.00	$336.00
April	800	$4.50	$3,600.00	146	$3.00	$438.00	46	$8.00	$368.00
May	802	$4.50	$3,609.00	149	$3.00	$447.00	46	$8.00	$368.00
June	803	$4.50	$3,613.50	153	$3.00	$459.00	46	$8.00	$368.00
July	801	$4.50	$3,604.50	150	$3.00	$450.00	45	$8.00	$360.00
August	799	$4.50	$3,595.50	149	$3.00	$447.00	44	$8.00	$352.00
September	800	$4.50	$3,600.00	150	$3.00	$450.00	45	$8.00	$360.00
October	800	$4.50	$3,600.00	147	$3.00	$441.00	46	$8.00	$368.00
November	799	$4.50	$3,595.50	147	$3.00	$441.00	44	$8.00	$352.00
December	801	$4.50	$3,604.50	145	$3.00	$435.00	45	$8.00	$360.00
Annual Total	**9,605**		**$43,222.50**	**1,782**		**$5,346.00**	**538**		**$4,304.00**

STEP 2: MAXIMUM PAYMENT POTENTIAL PER MEASURE

To calculate the maximum payment potential for each measure in each line of business, the following will be applied:

a. Calculate Measure Weight

Measure Weight =
Measure Denominator x Measure Adjustment Factor

See PCP Performance Measure Adjustment Factors table on page 21.

Example: Dr. Wong had 460 patients in the cervical cancer screening measure for the commercial line of business. The adjustment factor for the cervical cancer screening measure is 1. The measure weight for Dr. Wong's cervical cancer screening measure for the commercial line of business is 460 x 1 = 460.

b. Total All Measure Weights

$$\text{Total Measure Weights} = \sum_{(m=1)}^{(\#\ of\ Measures)} \text{Measure Weight}$$

Example: The total of all measure weights for Dr. Wong's commercial measure set is 2,723.

c. Normalize Measure Weight

$$\text{Normalized Weight} = \frac{(\text{Measure Weight})}{(\text{Total Measure Weights})}$$

Example: Dr. Wong's cervical cancer screening normalized weight factor is 460/2,723= 0.168931326.

d. Calculate Maximum Payment Potential for Each Measure

Max Payment Potential for Measure =
Normalized Weight x Total Max Pay Potential for that line of business

Example: Dr. Wong's maximum payment potential for the cervical cancer screening measure for the commercial population is 0.168931326 x $43,222.50 = $7,301.63.

Calculations for Dr. Wong's maximum payment potential per measure for the commercial population are in the following table.

Example: Dr. Wong's maximum payment per measure for the COMMERCIAL population

MEASURE NAME	ADJUSTMENT FACTOR	DENOMINATOR	NUMERATOR	MEASURE WEIGHT	NORMALIZED WEIGHT	MAX PAYMENT PER MEASURE
Advance Care Planning	1	20	11	20	0.00734484	$317.46
Adolescent Well Care Visits	1	12	12	12	0.004406904	$190.48
Body Mass Index Assessment	0.25	600	456	150	0.055086302	$2,380.97
Breast Cancer Screening	1	443	390	443	0.162688212	$7,031.79
Cervical Cancer Screening	1	460	359	460	0.168931326	$7,301.63
Childhood Immunization Status	1	5	4	5	0.00183621	$79.37
Colorectal Cancer Screening	1	721	526	721	0.264781491	$11,444.52
Diabetes Care- Blood Pressure Control (<140/90)	1	90	75	90	0.033051781	$1,428.58
Diabetes Care- Eye Exam	1	90	60	90	0.033051781	$1,428.58
Diabetes Care- HbA1c Control (≤9)	1	90	78	90	0.033051781	$1,428.58
Diabetes Care- Medical Attention for Nephropathy	1	90	86	90	0.033051781	$1,428.58
Developmental Screening in the First 3 Years of Life	1	14	12	14	0.005141388	$222.22
Sharecare RealAge Assessment	0.1	700	195	70	0.025706941	$1,111.12
Immunizations for Adolescents	1	3	2	3	0.001101726	$47.62
Influenza Vaccine	0.25	440	298	110	0.040396621	$1,746.04
Screening for Symptoms of Clinical Depression and Anxiety	0.25	700	627	175	0.064267352	$2,777.80
Tobacco Cessation and Follow Up	0.25	650	644	162.5	0.059676827	$2,579.38
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0.25	30	24	7.5	0.002754315	$119.05
Well-Child Visits in the First 15 Months of Life	1	2	2	2	0.000734484	$31.75
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1	8	7	8	0.002937936	$126.98
			TOTAL MEASURE WEIGHTS:	**2723**	**MAX POTENTIAL PYMT:**	**$43,222.50**

PCP Performance Measures Adjustment Factors

Adjustment factors apply for all lines of business in which a measure is included.

MEASURE NAME	ADJUSTMENT FACTOR
Advance Care Planning	1
Adolescent Well-care Visits	1
Body Mass Index Assessment	0.25
Breast Cancer Screening	1
Cervical Cancer Screening	1
Childhood Immunization Status	1
Colorectal Cancer Screening	1
Diabetes Care – Blood Pressure Control (<140/90)	1
Diabetes Care – Eye Exam	1
Diabetes Care – HbA1c Control (≤9)	1
Diabetes Care – Medical Attention for Nephropathy	1
Developmental Screening in the First Three Years of Life	1
Immunizations for Adolescents	1
Influenza Vaccine (Adult)	0.25
Review of Chronic Conditions	1
Screening for Symptoms of Clinical Depression and Anxiety	0.25
Sharecare RealAge Test	0.10
Tobacco Screening and Cessation Counseling	0.25
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0.25
Well-child Visits in the First 15 Months of Life	1
Well-child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1

STEP 3: PERCENTAGE OF MAXIMUM PAYMENT PER MEASURE EARNED

A PCPs' performance rate for each measure will be measured against a minimum threshold and a target threshold. Achievement of the minimum threshold will earn the provider 40 percent of the maximum payment potential for the measure; achievement of the target threshold will earn the provider 100 percent of the maximum payment potential for the measure. A performance rate between the minimum and target threshold will be paid incrementally based on the formula described below. PCPs may also earn up to 50 percent of the maximum payment potential per measure for improvement in their performance rate from their baseline period performance rate.

In total, PCPs can earn up to 110 percent of their maximum payment potential per measure for performance above the target threshold.

Measure Thresholds apply to all lines of business

MEASURE	MINIMUM THRESHOLD	TARGET THRESHOLD	IPR[1]	IIR[2]	BASELINE[3]
Advance Care Planning	45.00%	65.00%	3.00	2.50	P4Q or 0% or PT
Adolescent Well-care Visits	45.00%	65.00%	3.00	2.50	0% or PT
Body Mass Index Assessment	85.00%	95.00%	6.00	5.00	P4Q or 0% or PT
Breast Cancer Screening	75.00%	85.00%	6.00	5.00	P4Q or 0% or PT
Cervical Cancer Screening	75.00%	85.00%	6.00	5.00	P4Q or 0% or PT
Childhood Immunization Status	85.00%	95.00%	6.00	5.00	P4Q or 0% or PT
Colorectal Cancer Screening	65.00%	80.00%	4.00	3.33	P4Q or 0% or PT
Diabetes Care – Blood Pressure Control (<140/90)	75.00%	85.00%	6.00	5.00	P4Q or 0% or PT
Diabetes Care – Eye Exam	65.00%	80.00%	4.00	3.33	P4Q or 0% or PT
Diabetes Care – HbA1c Control (≤9)	75.00%	85.00%	6.00	5.00	P4Q or 0% or PT
Diabetes Care - Medical Attention for Nephropathy	85.00%	95.00%	6.00	5.00	P4Q or 0% or PT
Developmental Screening in the First Three Years of Life	65.00%	80.00%	4.00	3.33	0% or PT
Immunizations for Adolescents	85.00%	95.00%	6.00	5.00	P4Q or 0% or PT
Influenza Vaccine (Adult)	45.00%	65.00%	3.00	2.50	0% or PT
Review of Chronic Conditions	85.00%	95.00%	6.00	5.00	P4Q or 0% or PT
Screening for Symptoms of Clinical Depression and Anxiety	85.00%	95.00%	6.00	5.00	0% or PT
Sharecare RealAge Test	5.00%	10.00%	12.00	10.00	0%
Tobacco Screening and Cessation Counseling	45.00%	65.00%	3.00	2.50	0% or PT
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	75.00%	85.00%	6.00	5.00	P4Q or 0% or PT
Well-child Visits in the First 15 Months of Life	75.00%	85.00%	6.00	5.00	P4Q or 0% or PT
Well-child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.00%	85.00%	6.00	5.00	P4Q or 0% or PT

[1] IPR= Incremental performance rate: The percentage of maximum payment per measure earned for every 1 percent increase in performance rate above the minimum and target threshold.

[2] IIR= Incremental improvement rate: The percentage of maximum payment per measure earned for every 1 percent increase in performance rate above the baseline period performance rate.

[3] All PCPs who were scored and eligible for payment on the PT Performance Measures in 2017 will have their 2018 measure baselines set at their 2017 PT Performance rates (PT). PCPs who were scored on Pay for Quality (P4Q) measures in 2017 will have their 2018 measure baselines set at their Quarter 4, 2017, P4Q performance rates (for measures that are included in both P4Q and PT). For any measure that a PCP does not have a historic performance rate for a specific LOB, the measure baseline will be set equal to 0% for that measure.

To calculate the percentage of the maximum payment per measure earned, these steps will be applied.

a. Calculate Performance Component

The performance component is capped at 100 percent.

Performance Rate < Minimum Threshold,
Performance Component = 0

Performance Rate ≥ Minimum Threshold,
Peformance Component = 40% + IPR x
(Performance Rate-Minimum Threshold)

Example: Dr. Wong's cervical cancer screening performance rate for her commercial panel is 78.04 percent. The minimum threshold for cervical cancer screening is 75 percent; the IPR is 6.00. Dr. Wong's cervical cancer screening performance component is 40.00% + 6.00 x (78.04%-75.00%) = 58.26%.

b. Calculate Improvement Component

The improvement component is capped at 50 percent.

Performance Rate ≤ Baseline Rate,
Improvement Component = 0

Performance Rate > Baseline Threshold,
Improvement Component = IIR x
(Performance Rate-Baseline Rate)

Example: Dr. Wong's cervical cancer screening performance rate for her commercial panel is 78.04 percent. Dr. Wong's cervical cancer screening baseline rate for her commercial panel was 72.00 percent. The IIR for the cervical cancer screening measure is 5.0. Dr. Wong's cervical cancer screening improvement component is 5.0 x (78.04% - 72.00%) = 30.22%.

c. Compute Payment Percentage

The payment percentage is capped at 100 percent.

Payment Percentage =
Performance Component + Improvement Component

Example: Dr. Wong's payment percentage is 58.26% + 30.22% = 88.48%.

d. Calculate Bonus Component

The bonus component is capped at 10 percent.

Performance Rate ≤ Target Threshold,
Bonus Component = 0

Performance Rate>Target Threshold,
Bonus Component = IPR x (Performance Rate-Target Threshold)

Example: Dr. Wong's cervical cancer screening performance rate was less than the target threshold for the measure (85 percent); as a result, Dr. Wong didn't earn the bonus component.

e. Compute Total Payment Percentage per Measure

Total Payment Percentage =
Payment Percentage + Bonus Component

Example: Dr. Wong's cervical cancer screening total payment percentage is 88.48% + 0% = 88.48%.

f. Payment per Measure Earned

Payment for Measure =
Total Payment Percentage x Maximum Payment for Measure

Example: Dr. Wong's cervical cancer screening payment is 88.48% x $7,301.63 = $6,460.36

Calculations for Dr. Wong's payment earned per measure for the **commercial** population are in the following table. Dr. Wong earned $40,282.40 for the commercial measure set; 93.20 percent of the total maximum payment potential for her commercial measure set.

MEASURE NAME	DENOMINATOR	NUMERATOR	PERFORMANCE RATE	BASELINE	PERFORMANCE COMPONENT	IMPROVEMENT COMPONENT	BONUS COMPONENT	TOTAL PAYMENT PERCENTAGE	MAX PAYMENT PER MEASURE	PAYMENT EARNED
Advance Care Planning	20	11	55.00%	45.00%	70.00%	25.00%	0.00%	95.00%	$317.46	$301.59
Adolescent Well Care Visits	12	12	100.00%	45.00%	205.00%	137.50%	105.00%	110.00%	$190.48	$209.53
Body Mass Index Assessment	600	456	76.00%	78.00%	0.00%	0.00%	0.00%	0.00%	$2,380.97	$0.00
Breast Cancer Screening	443	390	88.04%	85.00%	118.22%	15.18%	18.22%	110.00%	$7,031.79	$7,734.97
Cervical Cancer Screening	460	359	78.04%	72.00%	58.26%	30.22%	0.00%	88.48%	$7,301.63	$6,460.36
Childhood Immunization Status	5	4	80.00%	100.00%	0.00%	0.00%	0.00%	0.00%	$79.37	$0.00
Colorectal Cancer Screening	721	526	72.95%	60.50%	71.82%	41.51%	0.00%	100.00%	$11,444.52	$11,444.52
Diabetes Care- Blood Pressure Control (<140/90)	90	75	83.33%	80.80%	90.00%	12.67%	0.00%	100.00%	$1,428.58	$1,428.58
Diabetes Care- Eye Exam	90	60	66.67%	70.35%	46.67%	0.00%	0.00%	46.67%	$1,428.58	$666.67
Diabetes Care- HbA1c Control (≤9)	90	78	86.67%	85.00%	110.00%	8.33%	10.00%	110.00%	$1,428.58	$1,571.44
Diabetes Care- Medical Attention for Nephropathy	90	86	95.56%	94.10%	103.33%	7.28%	3.33%	103.33%	$1,428.58	$1,476.20
Developmental Screening in the First 3 Years of Life	14	12	85.71%	65.00%	122.86%	69.05%	22.86%	110.00%	$222.22	$244.45
Sharecare RealAge Assessment	700	195	27.86%	1.00%	314.29%	268.57%	214.29%	110.00%	$1,111.12	$1,222.23
Immunizations for Adolescents	3	2	66.67%	100.00%	0.00%	0.00%	0.00%	0.00%	$47.62	$0.00
Influenza Vaccine	440	298	67.73%	45.00%	108.18%	56.82%	8.18%	108.18%	$1,746.04	$1,888.90
Screening for Symptoms of Clinical Depression and Anxiety	700	627	89.57%	85.00%	67.43%	22.86%	0.00%	90.29%	$2,777.80	$2,507.95
Tobacco Cessation and Follow Up	650	644	99.08%	45.00%	202.23%	135.19%	102.23%	110.00%	$2,579.38	$2,837.32
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	30	24	80.00%	75.00%	70.00%	25.00%	0.00%	95.00%	$119.05	$113.10
Well-Child Visits in the First 15 Months of Life	2	2	100.00%	100.00%	190.00%	0.00%	90.00%	110.00%	$31.75	$34.92
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	8	7	87.50%	60.00%	115.00%	137.50%	15.00%	110.00%	$126.98	$139.68

MEASURE NAME	DENOMINATOR	NUMERATOR	PERFORMANCE RATE	BASELINE	PERFORMANCE COMPONENT	IMPROVEMENT COMPONENT	BONUS COMPONENT	TOTAL PAYMENT PERCENTAGE	MAX PAYMENT PER MEASURE	PAYMENT EARNED
TOTAL									**$43,222.50**	**$40,282.40**

To calculate the total annual performance payment earned, Step 2: Maximum Payment per Measure and Step 3: Percentage of Maximum Payment per Measure Earned must be repeated for each line of business.

Advance Payment for PCP Performance Measures

PCP performance measures will be scored annually following the end of the measurement year. To help cash flow in the measurement year, PCPs will receive quarterly advance payments. If the PCP's performance exceeds the amount they received in advance payments, the remainder of the award (true-up amount) will be in May of the following year. Any performance payments that the PCP was advanced and didn't earn in the year will be deducted from the PCP's performance payment(s) the following year. PCPs who terminate their participation in the PT program before the end of the year must return advance performance payments for that year.

MEASUREMENT PERIOD	QUARTERLY ADVANCE PAYMENT	TRUE-UP PAYMENT
January 1-December 31, 2018	June 2018	
	September 2018	
	December 2018	
		May 2019

Advance Payment Formula

The amount of the quarterly advance payment will be based on the PCP's earnings on the PCP performance measures in the previous year, their attributed member months for the quarter, and the PCP performance measure budget (PMPM) for the current measurement year.

Quarterly advance payment = 80% x Previous Earnings (%) x Attributed member months (Quarter) x PMPM

For each PCP's first year in the PT program, the previous earnings amount will be the percentage of the maximum potential payment earned in HMSA's P4Q program in the fourth quarter of the previous year. For each PCP's second year and beyond in the PT program, the previous earnings will be based on the percentage of maximum potential payment earned in the PT program for the PCP performance measures the previous year.

PCPs who are new to the PT program or who didn't have performance payments in the previous year for a line of business will have their previous earnings percentage set at 50 percent of their PO's earning percentage (on the PO performance measure set) or 50 percent if the PO has no earning history.

Example: In 2017, Dr. Wong earned 85 percent of the maximum potential payment for the commercial line of business. Her first quarterly advance payment for 2018 will be paid in June and will be based on the number of attributed member months she had in January, February, and March 2018. Dr. Wong's advance payment for June will be 80% x 85% x (801 + 799 + 800) x $4.50 = $7,344.00.

See the following tables for quarterly advance payments Dr. Wong will receive in 2018 for each line of business.

Example: Dr. Wong's attributed member months count for 2018

MONTH	ATTRIBUTED MEMBER MONTHS (2018)		
	COMMERCIAL	QUEST INTEGRATION	MEDICARE ADVANTAGE
January	801	150	45
February	799	148	44
March	800	148	42
April	800	146	46
May	802	149	46
June	803	153	46
July	801	150	45
August	799	149	44
September	800	150	45
October	800	147	46
November	799	147	44
December	801	145	45

Example: Dr. Wong's advance payments for 2018

QUARTERLY ADVANCE PAYMENT DATE (2018)	COMMERCIAL				QUEST INTEGRATION				MEDICARE ADVANTAGE			
	PREVIOUS EARNINGS (%) (2017)	ATTRIBUTED MEMBER MONTHS (2018)	PMPM (2018)	ADVANCE PAYMENT AMOUNT (2018)	PREVIOUS EARNINGS (%) (2017)	ATTRIBUTED MEMBER MONTHS (2018)	PMPM (2018)	ADVANCE PAYMENT AMOUNT (2018)	PREVIOUS EARNINGS (%) (2017)	ATTRIBUTED MEMBER MONTHS (2018)	PMPM (2018)	ADVANCE PAYMENT AMOUNT (2018)
June	85%	2,400 (Jan-Mar)	$4.50	$7,344.00	90%	446 (Jan-Mar)	$3.00	$963.36	78%	131 (Jan-Mar)	$8.00	$653.95
September	85%	2,405 (Apr-Jun)	$4.50	$7,359.30	90%	448 (Apr-Jun)	$3.00	$967.68	78%	138 (Apr-Jun)	$8.00	$688.90
December	85%	2,400 (Jul-Sept)	$4.50	$7,344.00	90%	449 (Jul-Sept)	$3.00	$969.84	78%	134 (Jul-Sept)	$8.00	$668.93

Dr. Wong's quarterly advance payments for all lines of business in 2018, are $26,959.96. After the end of the measurement year, Dr. Wong's performance for 2018 is scored for earnings of $48,070.93 (annual performance payment amount). As a result, in May 2019, Dr. Wong will be paid the difference of the amount she was advanced versus what she earned: $21,110.97.

Example: Dr. Wong's performance (quality) payments for 2018

LOB	QUARTERLY ADVANCE PAYMENT TOTAL	MAX POTENTIAL PAYMENT	PAYMENT EARNED (ANNUAL PERFORMANCE PAYMENT)	TRUE-UP PAYMENT (MAY 2019)
Commercial	$22,047.30	$43,222.50	$40,368.93 (93 percent of max)	$18,321.63
QUEST Integration	$2,900.88	$5,346.00	$4,202.00 (79 percent of max)	$1,301.12
Medicare Advantage	$2,011.78	$4,304.00	$3,500.00 (81 percent of max)	$1,488.22
Total	**$26,959.96**	**$52,872.50**	**$48,070.93**	**$21,110.97**

Total Cost of Care Shared Savings Incentive

PCPs who participate in a PO that meets a defined PO performance (quality) target established by HMSA for the measurement year will be eligible to earn shared savings on a total cost of care incentive calculation through their PO. Total cost of care (TCOC) is defined as all costs incurred in the health care system by a PCP's attributed patients, with exceptions outlined below and in Appendix I. While Coreo will display information about the cost, utilization patterns, and risk of individual PCP's attributed panels, scoring for this measure will occur at the PO level as PCPs' panels are too small to protect them from the impact of a single member's cost in a year on their trend.

Eligibility for TCOC shared savings incentive

To be eligible for TCOC, a PO must have an aggregate performance (quality) score (across all LOBs and all member PCPs in the PO) equivalent to earning at least 50 percent of the total maximum potential performance payments for the PCP performance measures during the measurement year. POs that don't meet this performance (quality) score threshold won't be eligible for any TCOC shared savings regardless of their TCOC trend.

Claims exclusions from TCOC calculation

In 2018, TCOC calculations won't include drug costs associated with drug plan riders and behavioral health services. The TCOC performance will only be calculated on a PCP's medical spending trend for HMSA commercial plan members. There will be no other "outlier" exclusions applied to the calculation.

Scoring of TCOC

TCOC will be measured and scored annually at the PO level based on the performance of its PCPs in the measurement year. To earn TCOC shared savings, HMSA will use the methodology described in Appendix I.

PO distribution of earned TCOC payments to PCPs

TCOC is measured and scored at the PO level. HMSA will distribute any earned TCOC shared savings to the PO. Each PO must then determine how to distribute these payments among the eligible member PCPs. HMSA recommends that POs share a portion of any shared savings earned with their PCPs. If the PO would like HMSA to distribute the payments to their PCPs, the PO must provide HMSA with written instructions.

TCOC score impact on PCP's individual PMPM band rates

An individual PCP's base PMPM rate (beginning in Year Three, October 1, 2019) will also be impacted by the PCP's PO's TCOC performance in the previous measurement period. The methodology described above and more fully in Appendix I describes how HMSA will calculate TCOC.

PO PT Program Model

With a much stronger emphasis on population health management, well-being, and patient-centered high-value care, PCPs in HMSA's PT program require the infrastructure and support of strong, high-functioning, and innovative physician organizations (POs). In the PT program, successful POs need to:

- Lead PO transformation, including management and sustainability.
- Plan for business needs to manage funds and resources.
- Ensure strong organizational communication.
- Address outlier physicians.
- Help their providers use data to ensure patient-centered care and manage the total cost of care of their patients.
- Facilitate best-practice sharing and care coordination among providers.
- Develop innovative strategies and tools to manage the health and well-being of their patients.

This enhanced PO role builds on the essential role of the PO created in the patient-centered medical home (PCMH) program.

PO Program Eligibility

To participate in HMSA's PT program, POs must have a signed Payment Transformation Program Physician Organization Agreement with HMSA.

PO Membership and Attribution

PO Provider Membership – Rules of Engagement

POs are responsible for notifying HMSA of all changes to their provider members. POs must notify HMSA when a provider joins or leaves the PO. HMSA will use the most current list the PO provides to calculate PO scoring and payment. POs and PCPs must abide by the rules of engagement for adding and/or transferring PCP membership in a PO, as detailed in the PCP Membership in a PO – Rules of Engagement section on page 6.

Physician Organizations

PCP membership:

- PCPs may be a member of only one PO for the purposes of PT program participation.
- POs are responsible for PCP-PO membership contracts.
- POs are responsible for maintaining and submitting PCP membership lists to HMSA. POs should notify HMSA of any changes to PO membership in a timely manner because of the complexity of data and payment processing. PCPs added to the PO by the 15th of the current month will have an effective date of the first of the following month. For example, a PCP added on December 13, will have an effective date of January 1; a PCP added on December 20, will have an effective date of February 1. Notice of PCPs who are terminating from the PO and PT program must be communicated to HMSA at least 60 days in advance of the intended effective termination date.
- POs may only add PCPs to their PO according to the PCP rules described on page 6. Failure to comply with the notification deadlines will impact the PCP's effective or termination date with the PO and base PMPM payments.
- PCPs' performance will be included in the POs scores in the PT program.

PO Member Attribution

The number of members attributed to a PO will be calculated using the total number of attributed members for the PO's PCP members. Although a PO's membership may include specialists, their patient panel counts **aren't** included in PO calculations for the PT program.

PO Payments in the PT Program

POs in the PT program will be eligible to earn payments based on their performance on 11 measures. These amounts replace all amounts previously available in HMSA's PCMH and P4Q programs. POs will also have the opportunity to earn a shared savings bonus to share with their member providers based on their providers' collective performance on TCOC.

The following amounts are available to POs:

PAYMENT TYPE	FREQUENCY/ TIMING OF PAYMENT	FREQUENCY OF MEASURE SCORING	OVERVIEW OF PAYMENT
PO Engagement Payments	Monthly	Quarterly	• Engagement amounts will be paid based on performance from two quarters prior. (For example, Year Two (2018) Quarter 1 engagement amount levels will be based on a PO's performance in Year One (2017) Quarter 3).
PO Performance Payments	Quarterly	Annually	• PO performance measures will be scored on an annual, calendar-year basis. To help with cash flow, POs will receive quarterly advance payments. • At the end of the year, POs will be scored on the performance measures. If the PO's performance exceeds the amount they received in advance payments, the remainder of the award (true-up amount) will be paid after the end of the measurement year. Any additional amounts owed to the PO based on their performance will be paid by May of the following year (annual true-up). If the quarterly advances represent overpayments to the PO when compared to their earned performance payment, the difference between the advances and the earned amounts will be deducted from the following year's performance payments.
Total Cost of Care Shared Savings	Annually; scored and distributed at the PO level	Annually	• TCOC will be scored based on calendar year performance. • A PO is eligible for TCOC savings if the PO's risk-adjusted TCOC trend (i.e., comparing each PO's trend against themselves for the measurement year to the prior year) falls below the cost-trend target and the PO meets the performance (quality) target score. • TCOC scores and payments will be distributed to POs by June of the following year. It is within each PO's discretion to determine how to distribute any TCOC shared savings with member providers.

PMPM Amounts – PO Engagement and Performance Measures

The maximum potential PMPM amounts available to POs by each line of business are shown in the following table.

LOB	ENGAGEMENT PMPM	PERFORMANCE PMPM
COMMERCIAL	$ 0.90	$ 0.60
QUEST INTEGRATION	$ 0.50	$ 0.20
MEDICARE ADVANTAGE	$ 0.60	$ 0.40

PO Engagement Payments

POs will receive engagement payments on a monthly basis for each LOB. The amount of the monthly payment will be based on the PO's attributed HMSA members for each line of business multiplied by the engagement PMPM for each line of business.

The PO's attributed member count is based on the sum of the PO's PCPs' attributed members that are eligible for base PMPM payment in the immediately preceding month. HMSA will reconcile PO engagement payments as necessary.

PMPM Engagement Budget for POs

LINE OF BUSINESS	PMPM
Commercial	$0.90
QUEST Integration	$0.50
Medicare Advantage	$0.60

Example: A physician organization, Oahu Care Providers, has 10 PCPs. The PCPs attributed member panel counts for October 2018 are shown in the following table. Oahu Care Providers' monthly engagement payment for November 2018 will be $7,248.20 ($6,040.80 for commercial, $611.00 for QUEST Integration, and $596.40 for Medicare Advantage).

PO: Oahu Care Providers

Payment Month: November 2018

Attribution Month: October 2018

	DR. A	DR. B	DR. C	DR. D	DR. E	DR. F	DR. G	DR. H	DR. I	DR. J	TOTAL	PMPM	ENGAGEMENT PAYMENT
Commercial	664	541	758	812	671	754	843	321	458	890	6712	$0.90	$6,040.80
QUEST Integration	0	143	100	75	84	257	215	119	212	17	1222	$0.50	$611.00
Medicare Advantage	231	58	0	132	121	0	54	215	69	114	994	$0.60	$596.40
Total													**$7,248.20**

Engagement Payment Adjustments

POs will receive 100 percent of their monthly engagement payment as long as they continue to demonstrate adequate performance on the PO engagement measures, which will be measured quarterly. POs that score less than 100 percent on the engagement measures during any particular quarter will have their engagement payments adjusted two quarters later. See the PO Engagement Payments Schedule table below.

Example: Oahu Care Providers' December 2018 PO engagement payment will be $7,248.20 if they scored 100 percent on the Engagement Measure set during Quarter 2 (April 1 to June 1, 2018). If they scored less than 100 percent on the Engagement Measure set in Quarter 2, their December payment would be adjusted accordingly. See Engagement Measure Scoring.

PO Engagement Payments Schedule

ATTRIBUTION PERIOD	PAYMENT DATE	ENGAGEMENT MEASURE EVALUATION PERIOD
January 2018	February 2018	Quarter 3 July 1 – September 30, 2017
February 2018	March 2018	
March 2018	April 2018	
April 2018	May 2018	Quarter 4 October 1-December 31, 2017
May 2018	June 2018	
June 2018	July 2018	
July 2018	August 2018	Quarter 1 January 1-March 31, 2018
August 2018	September 2018	
September 2018	October 2018	
October 2018	November 2018	Quarter 2 April 1-June 30, 2018
November 2018	December 2018	
December 2018	January 2019	
January 2019	February 2019	Quarter 3 July 1- September 30, 2018
February 2019	March 2019	
March 2019	April 2019	
April 2019	May 2019	Quarter 4 October 1- December 31, 2018
May 2019	June 2019	
June 2019	July 2019	

PO Engagement Measures

Descriptions of the engagement measures are shown in the following table.
For details on the measures and thresholds, see Appendix G.

LINE OF BUSINESS	MEASURE	HIGH-LEVEL DEFINITION
C Q M	Access: Facilitating timely access for new members	POs will be responsible for facilitating timely access to PCPs for new members. POs will send a list of its member PCPs who will accept new members each month.
C Q M	Access: Facilitating timely access for existing members	POs will be responsible for facilitating timely access to PCPs for all attributed members. Data collected via monthly and quarterly patient surveys.
C Q M	Access: Facilitating timely access for members across all lines of business	POs will be responsible for ensuring access to PCPs for members in all lines of business (e.g., commercial, Medicare Advantage, and QUEST Integration).
C Q M	Access: Providing 24/7 coverage for attributed members	POs will be responsible for ensuring 24/7 coverage for attributed members. This may include phone access to a live provider (PCP or another provider in the PO) or access to HMSA's Online Care.
C Q M	Collaboration: Participation in HMSA PO meetings	POs will be required to participate in quarterly PO leadership meetings.
C Q M	Population Health: Social determinants of health data collection *Note: This measure will be introduced in 2019.*	POs will be responsible for collecting key demographic information for attributed members.

C = COMMERCIAL; Q = QUEST INTEGRATION; M = MEDICARE ADVANTAGE

PO Engagement Measures Scoring

POs will be evaluated on the engagement measures on a quarterly basis. Measure requirements and thresholds are listed in Appendix G. Each quarter, HMSA will determine whether the PO meets or doesn't meet the requirements for the engagement measures. For each measure, no partial credit will be awarded and credit for the measure will be applied to all lines of business.

The measures will all be weighted equally within each line of business as indicated in the table below. POs monthly engagement payments will be adjusted on a quarterly basis if the PO fails to meet any of the measures (see PO Engagement Payments Schedule).

ENGAGEMENT MEASURE	MEASURE WEIGHT		
	COMMERCIAL	QUEST INTEGRATION	MEDICARE ADVANTAGE
Access: Facilitating timely access for new members	20.00%	20.00%	20.00%
Access: Facilitating timely access for existing members	20.00%	20.00%	20.00%
Access: Facilitating timely access for members across all lines of business	20.00%	20.00%	20.00%
Access: Providing 24/7 coverage for attributed members	20.00%	20.00%	20.00%
Collaboration: Participation in HMSA PO meetings	20.00%	20.00%	20.00%
Total	**100%**	**100%**	**100%**

Example: For Quarter 2, 2018, if Oahu Care Providers meets the requirements for four out of the five engagement measures, the PO would lose 20 percent of their total monthly engagement payments for each line of business for October, November, and December 2018. If the PO meets all of the engagement measures the following quarter (Quarter 3, 2018) it'll receive 100 percent of their monthly engagement payments for January, February, and March 2019.

Performance Measures

POs are eligible to receive performance payments based on the measures described below and in Appendix H. Some of the measures evaluate the cumulative performance of the PCPs in the PO (e.g., access and utilization measures) while some measures evaluate the POs activities and infrastructure as an organization (e.g., collaboration measures). The PO performance measures don't overlap with the PCP performance measures.

LINE OF BUSINESS	MEASURE	HIGH-LEVEL DEFINITION
C M	Access and utilization: Hospitalization for Potentially Preventable Complications (HPC) – Chronic ACSC	For attributed members 65 years of age and older, the rate of discharges for chronic ambulatory care sensitive conditions (ACSC) per 1,000 members. An ACSC is a chronic health condition that can be managed or treated in an outpatient setting.
C Q M	Access and utilization: Avoidable Emergency Department Visits	The rate of avoidable emergency department (ED) visits for members attributed to a PO. A lower performance rate is better. Note: This measure won't be scored based on performance in 2018. POs will earn measure credit for analyzing their current performance and developing a performance improvement plan.
C Q	Population Health: Children with Special Health Care Needs Screener© (CSHCN)	The percentage of members 3-17 years of age who were screened for special health care needs using the CSHCN Screener© during the measurement year or the two years prior.
C Q M	Population Health: Controlling Blood Pressure	The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria: • Patients 18-59 years of age whose BP was <140/90 mm Hg • Patients 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Patients 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.
C Q M	Population Health: PO Engagement with Ecosystem	The percentage of a PO's PCPs who report that their PO provided them with the information, training, resources, and support necessary to understand how to effectively use ecosystem programs. Measured via annual provider survey.
C Q M	Collaboration: Accountability for PCP Communication	The percentage of a PO's PCPs who report that their PO provided them with the information, training, and support necessary to understand how to succeed in HMSA's PT program. Measured via annual provider survey.

C = COMMERCIAL; Q = QUEST INTEGRATION; M = MEDICARE ADVANTAGE

Performance Payments Overview

A PO's maximum payment potential per line of business is based on the number of members attributed to their PO (via member PCPs) in the measurement period. Details on how to calculate total maximum payment potential and how to calculate maximum payment per measure are included in this section. The portion the PO earns — a PO's annual performance payment — is based on its performance rate relative to a minimum and target threshold for each measure (performance component) and is also based on the PO's performance relative to the PO's baseline period performance for each measure (improvement component). For details on the measurement period and baseline period, see the table below.

Scoring and Payment Timeframes

PERFORMANCE MEASURE	MEASUREMENT PERIOD	SUPPLEMENTAL DATA ENTRY DEADLINE	BASELINE PERIOD	PERFORMANCE PAYMENT TRUE-UP
All PO Performance Measures	January 1 through December 31, 2018	January 31, 2019	January 1 through December 31, 2017	May 2019

All PO performance measures will be scored on an annual calendar-year basis. The scoring schedule allows for a one-month claims run-out, one month for validation, and one month for processing. Annual true-up for performance payments will be paid by the end of May of the following measurement year. Due to the time needed to validate scoring, the baseline rate displayed in Coreo during the first quarter of the measurement year will be an estimate, but will be updated by the end of April of each measurement year.

To help POs with cash flow, POs will receive an advance performance payment at the end of each quarter.

At the end of the year, POs will be scored on their performance during the 12-month measurement year as detailed below. Any additional amount owed to the PO based on performance will be paid by May of the following measurement year. If the quarterly advances represent overpayments to the PO when compared to actual performance/earned amounts, the difference between the advances and the earned amounts will be deducted from the following measurement year's performance payments.

PMPM Performance Measure Budget for POs

LINE OF BUSINESS	PMPM
Commercial	$0.60
QUEST Integration	$0.20
Medicare Advantage	$0.40

Performance Measure Scoring and Payment

The following sections explain how the total maximum payment potential and maximum payment potential per measure will be calculated and the payment earned after measures are scored at the end of the year.

STEP 1 – TOTAL MAXIMUM POTENTIAL PAYMENT BY LINE OF BUSINESS

The eligible members in each PCP's primary care panel will be counted at the end of each month for each line of business. At the end of the measurement year, the monthly values are added to generate an annual total member months (MM) count. The annual MM count for all of the PO's PCPs will be added to determine total PO MM. If a PCP leaves the PO mid-year, the PO will retain all member months accumulated by that PCP during the measurement year. Similarly, if a PCP joins the PO mid-year, the PO will have that PCP's member months added to its maximum potential payment beginning with the month the PCP's membership in the PO is effective. Those counts are multiplied by the PO's PMPM performance measure budgets for each line of business to calculate the total maximum payment potential for that year.

Use the following formula for each line of business:

$$\text{Total PO MM} = \sum_{(m=1)}^{(\#\ of\ PCPs)} \text{Annual total MM}$$

Total Maximum Pay Potential = Total PO MM x PMPM Rate

STEP 2 – MAXIMUM PAYMENT POTENTIAL PER MEASURE

Each of the PO performance measures is weighted equally within each LOB.

PERFORMANCE MEASURE	MEASURE WEIGHT		
	COMMERCIAL	MEDICARE ADVANTAGE	QUEST INTEGRATION
Access and utilization: Hospitalization for Potentially Preventable Complications (HPC) – Chronic ACSC	16.67%	20%	
Access and utilization: Avoidable Emergency Department Visits	16.67%	20%	20%
Population Health: Children with Special Health Care Needs Screener (CSHCN)	16.67%		20%
Population Health: Controlling Blood Pressure	16.67%	20%	20%
Population Health: PO Engagement with Ecosystem	16.67%	20%	20%
Collaboration: Accountability for PCP Communication	16.67%	20%	20%

To determine the maximum payment potential per measure by line of business, use the following formula:

Maximum Payment Potential for Measure (LOB) = Measure Weight (LOB) x Total Maximum Pay Potential (LOB)

STEP 3 – PERCENTAGE OF MAXIMUM PAYMENT PER MEASURE EARNED

POs' performance rate for each performance measure will be measured against a minimum threshold and a target threshold. Achievement of the minimum threshold will earn the PO 40 percent of the maximum payment for the measure; achievement of the target threshold will earn the PO 100 percent of the maximum payment for the measure. A performance rate between the minimum and target threshold will be rewarded incrementally. POs may also earn up to 50 percent of the maximum payment per measure for improvement in their performance rate when compared to their baseline rate.

In total, POs can earn up to 110 percent of their maximum payment per measure for performance above the target threshold.

PO Performance Measure Thresholds

MEASURE	MINIMUM THRESHOLD	TARGET THRESHOLD	IPR[1]	IIR[2]	BASE-LINE[3]
Access and utilization: Hospitalization for Potentially Preventable Complications (HPC) – Chronic ACSC	40.00 discharges/ 1,000 members	16.00 discharges/ 1,000 members	-2.50	-2.08	Min or PT
Access and utilization: Avoidable Emergency Department Visits	N/A[4]	N/A[4]	N/A[4]	N/A[4]	N/A[4]
Population Health: Children with Special Health Care Needs Screener (CSHCN)	40.00%	75.00%	1.71	1.43	Min or PT
Population Health: Controlling Blood Pressure	65.00%	80.00%	4.00	3.33	P4Q or Min or PT
Population Health: PO Engagement with Ecosystem	50.00%	85.00%	1.71	1.43	Min or PT
Collaboration: Accountability for PCP Communication	75.00%	90.00%	4.00	3.33	Min or PT

1 IPR = Incremental Performance Rate: The percentage of maximum payment per measure earned for every 1 percent increase in performance rate above the minimum threshold and target threshold.

2 IIR = Incremental Improvement Rate: The percentage of maximum payment per measure earned for every 1 percent increase in performance rate above the baseline measurement.

3 All POs that joined the PT Program in 2017 will have their 2018 measure baselines set at their 2017 PT performance rates (PT). POs that join the PT Program in 2018 will have their measure baselines set at the Minimum Threshold (Min) for that measure, except for the Controlling Blood Pressure measure, which will be set at their Quarter 4 2017 performance rate in HMSA's Pay for Quality program (P4Q).

4 Scoring for the Avoidable Emergency Department Visits Measure won't be based on the PO's performance relative to measure thresholds or a baseline rate in 2018. See measure specifications in Appendix H for scoring requirements for 2018.

To calculate the percentage of the maximum payment per measure earned, follow the methodology for scoring the PCP performance measures.

Advance Payment for PO Performance Measures

POs will be scored and paid for their performance on the PO performance measures annually following the end of the measurement year. To help with cash flow, POs will receive quarterly advance payments. If a PO's performance exceeds the amount they received through the advance payments, the remainder of the award (true-up amount) will be paid following the end of the measurement year.

MEASUREMENT PERIOD	QUARTERLY ADVANCE PAYMENT	TRUE-UP PAYMENT
January 1 - December 31, 2018	June 2018	
	September 2018	
	December 2018	
		May 2019

Advance Payment Formula

The amount of the quarterly advance payment will be based on the PO's earnings on the performance measures in the previous year, its attributed member months for the quarter, and the PO performance measure budget (PMPM) for the current measurement year.

Quarterly advance payment =
80% x Previous Earnings (%) x Attributed member months (Quarter) x PMPM

For each PO's first year in the PT program, the previous earnings amount will be the percentage of maximum potential amounts earned in HMSA's P4Q program during the previous year's fourth quarter. For each PO's second year and beyond in the PT program, the previous earnings will be based on the percentage of maximum potential amounts earned in the PT program for the PO performance measures the previous year.

Data Sources

The PT program uses claims data as the primary source to identify patients who meet the numerator and denominator criteria for the Performance (Quality) Measures.

Claims data, on occasion, may not be adequate to meet numerator criteria or identify denominator exclusions.

For example, claims data may indicate that a woman needs a breast cancer screening when the medical record indicates that she has had a bilateral mastectomy.

As a result, providers are able to submit supplemental data for certain measures via Coreo to provide evidence from the patient's medical record for services that were rendered. Supplemental data submissions should be used when requesting that a patient be given numerator credit for a measure.

Additionally, a provider can also submit a Request for Reconsideration to provide evidence that a patient isn't eligible for a given measure. See the Additional Information section in this guide.

Supplemental Data Audit

The PT program includes a supplemental data audit to ensure the integrity of the supplemental data that the PCP submits during the program year. The audit includes a sample of supplemental data submissions and requests medical records to support those supplemental data submissions. HMSA's Quality Improvement (QI) unit will conduct the supplemental data audits for measures, excluding the Review of Chronic Conditions (RCC) measure.

PCPs are asked to provide any requested medical records by mail or fax by the date indicated in the request. HMSA won't pick up records or perform on-site chart reviews. All self-reported information in Coreo must be consistent with the information that was recorded in the patient's medical record and must include the exact service and the date on which the service was performed.

Appendices F and H identify the supplemental data submission opportunities and requirements for each performance (quality) measure.

Supplemental Data Audit: Methodology for the QI Review

The supplemental data audit for measures (excluding the RCC measure) is conducted by HMSA's Quality Improvement team unit once a year. All providers who submit supplemental data will be included in the audit. All measures for which a provider has submitted entries will be audited. HMSA applies a randomized process, selecting 5 percent of entries per measure for review. Requests are then sent via fax to the PCP to provide medical record documentation that supports each supplemental data entry that is selected for audit. The audit team will send two reminders via fax requesting the supporting documentation.

For PCPs who don't respond to a request for documentation during the initial review, all supplemental data entries for the audited measure are deleted and no credit is awarded. For PCPs who are found to have 10 percent of the audited entries (per measure) unsupported by medical record documentation, such as when the date of service in the medical record doesn't match the date of service provided in the entry, HMSA will conduct a second review to validate the accuracy of a larger sample of supplemental data entries for the same measure that was found to be unsupported. Requests for the second review are sent via fax to the PCP. For the second review, 10 percent or 10 entries (whichever is less) are selected.

If the PCP doesn't respond to a request in the second review or if 10 percent of the audited entries (per measure) are found to be unsupported, all of the PCP's supplemental data entries for that measure are removed and the PCP's performance (quality) score and payment will be adjusted for the scoring period of these entries.

If a PCP disagrees with the audit results, they can complete the Request for Reconsideration - Scoring and Payment form (available online at https://hmsa.com/portal/provider/zav_pel.aa.PAY.100.htm). The form must be submitted to HMSA within 10 days of the date that the audit results notification was sent by HMSA.

Supplemental Data Audit: Methodology for the Review of Chronic Conditions (RCC) Measure

MEDICARE ADVANTAGE

The RCC measure allows providers to disconfirm conditions via supplemental data entries. The supplemental data audit for the Medicare Advantage RCC measure may be conducted by HMSA annually, following the measure's deadline for supplemental data submission.

If conducted, the review will identify supplemental data entries that cannot be confirmed or denied through research of claims history, past chart reviews, and other data sources. These supplemental data entries will be subject to a review of the supporting documentation.

Each supplemental data entry that is found to be invalid will be deleted and the PCP's performance score and payment will be adjusted for the scoring period in which the entry was submitted.

Member Benefits

Providers must continue to submit accurately coded claims to HMSA for services provided in a timely manner. These claim submissions will be essential for the provider to continue to collect payments that the member owes the provider directly, such as a copayment or coinsurance.

Member benefits **aren't** impacted by the new PCP payment model in the PT program. The value of the service and benefit to the member haven't changed.

Providers should continue to use HMSA's HHIN system to obtain information about member eligibility and benefits.

Appeals

HMSA will maintain a formal appeals process. PCPs and POs who don't agree with HMSA's determination of their program eligibility, base PMPM band rate, scoring on engagement and performance measures, and scoring on TCOC, must use this appeals process.

All appeals requests must be made in writing using the PT Request for Reconsideration forms found on HMSA's Provider Resource page. Completed forms may be faxed to 948-6887 on Oahu
or mailed to:

HMSA
Attn: Provider Services - POA
P.O. Box 860
Honolulu, HI 96808-0860

After receiving the completed form, HMSA's Payment Transformation Review Committee will issue a written determination within 60 business days. Any issue that cannot be submitted via the defined appeals process should be communicated in writing to the PO's HMSA provider engagement lead.

Request for Reconsideration - Excluding a Member from the Performance (Quality) Measures

Overview

A request for reconsideration is a request for HMSA to change a decision on a PCP's reported scores and/or payment.

If a service is incomplete in a PCP's care planning registry, Coreo lets the PCP submit supplemental data (for some measures) that shows the service was performed. When available, use this option for numerator credit.

If a PCP believes there's an additional reason to exclude a patient from the measure denominator, the PCP may request reconsideration for measure exclusion.

If HMSA approves a Request for Reconsideration, the adjustment is made during the scoring process and may not be reflected in Coreo until the end of the measurement period.

Requirements

Submit requests for reconsideration in Coreo to HMSA by December 31, 2018. HMSA won't accept verbal requests.

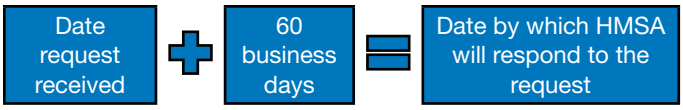
Requests must include:

- Clinical rationale and supporting citations for denominator exclusion.
- Measure.
- Patient.
- Medical record information to support denominator exclusion such as:
  - Service/procedure.
  - Date of service.
  - Diagnosis.
  - Lab result.

Include supporting data, if available.

Target Dates and Deliverables

Requests for reconsideration must be made during the measurement period from May 1 to December 31, 2018. HMSA's Review Committee will evaluate the requests and make a decision within 60 business days.



DATE	MILESTONES
May 1, 2018	Requests for reconsideration accepted for the 2018 meaurement period.
December 31, 2018	Deadline for HMSA to receive requests for reconsideration that will be included in performance and payment.
March 28, 2019	Deadline for HMSA to send decisions on requests for reconsideration that were received by December 31, 2018.

HMSA may ask the PCP for additional information to complete the review and evaluation of the request for reconsideration. PCPs must provide the additional information within two weeks so that HMSA may complete the review. PCPs should regularly log in to Coreo and check their R4R status to ensure timely notification of any requests for additional information from HMSA.

Request for Reconsideration - Scoring and Payment

Overview

A request for reconsideration is a request for HMSA to change a determination on a PO's or PCP's reported scores and/or payment.

If POs or PCPs believe that their score and/or payment in the Engagement or Performance Measures is inaccurate, the PO or PCP may submit a request for reconsideration for scoring and payment.

Requirements

Submit reconsideration requests in writing to HMSA no later than 30 days after the final performance report is posted on Coreo. Use the forms available from the Payment Transformation section on the HMSA Provider Resource Center (https://hmsa.com/portal/provider/zav_pel.aa.PAY.100.htm). HMSA won't accept verbal requests. See the Target Dates and Deliverables sections below for details.

Reconsideration requests for scoring and payment may be made for the following situations:

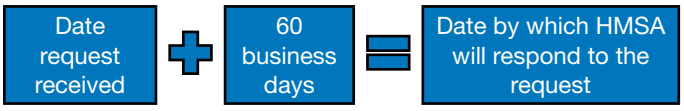
- Payment reports on Coreo don't match the check you received.
- You believe an error was made in scoring your performance relative to measure thresholds.
- You believe a systematic error in the measure logic affected your performance score (e.g., measure is awarding credit for a particular code or members were incorrectly pulled into the denominator).

Requests must include:

- Measure.
- Patient (if applicable).
- Information to support the request, such as calculations to support the assertion that the scoring is inaccurate.

Include supporting data, if available.

HMSA will review and respond to your request no later than 60 business days after the submission is received.



Target Dates and Deliverables: PCP Performance Measures, PCP Engagement Measures, and PO Performance Measures

DATE	MILESTONES
May 2019	Annual 2018 performance report and payment. Note: Reconsideration requests for the PCP Performance Measure scoring won't be accepted prior to posting of the annual performance report on Coreo.
June 30, 2019	Final deadline for reconsideration requests.
July 31, 2019	HMSA will send determinations for reconsideration requests that were received on June 30, 2019. If adjustments in scoring are warranted, a reconciliation check will be issued.

Target Dates and Deliverables: PO Engagement Measures

DATE	MILESTONES
September 2018	Q2 2018 performance report. Note: Reconsideration requests for scoring and payment won't be accepted prior to posting of the quarterly performance report on Coreo.
October 1, 2018	Final deadline for reconsideration requests for Q2 2018 performance.
October 20, 2018	HMSA will send determinations for all scoring and payment reconsideration requests that were received on October 1, 2018. If adjustments in scoring are warranted, they will be reflected in the monthly PO Engagement payments.
December 2018	Q3 2018 performance report. Note: Reconsideration requests for scoring and payment won't be accepted prior to posting of the quarterly performance report on Coreo.
December 31, 2018	Final deadline for reconsideration requests for Q3 2018 performance.
January 18, 2019	HMSA will send determinations for reconsideration requests that were received on December 31, 2018. If adjustments in scoring are warranted, they will be reflected in the monthly PO Engagement payments.
March, 2019	Q4 2018 performance report. Note: Reconsideration requests won't be accepted prior to posting of the quarterly performance report on Coreo.
April 1, 2019	Final deadline for reconsideration requests for Q4 2018 performance.
April 19, 2019	HMSA will send determinations for all scoring and payment reconsideration requests that were received on April 1, 2019. If adjustments in scoring are warranted, they will be reflected in the monthly PO Engagement payments.

Target Dates and Deliverables: Total Cost of Care

DATE	MILESTONES
July 2019	TCOC for 2018 measurement period paid and reported.
August 2019	Deadline for TCOC request for reconsideration submission.
September 2019	HMSA will send determinations for reconsideration requests that were recieved within 30 days of the payment and distribution of the results.

Submitting Requests

1. Complete one request for reconsideration form per measure, or per measure set. Requests that don't include supporting documents, as described in the Requirements section above, won't be processed or evaluated.

2. Submit the form to HMSA.

   Fax: 948-6887 on Oahu

   Mailing address: HMSA
   Attn: Provider Services – POA
   P.O. Box 860
   Honolulu, HI 96808-0860

Appendix A- PMPM Methodology for Year One (2017-June 2018)

Individual Providers

Each PCP's Year 1 PMPM rate for each LOB was determined in the following manner:

[The PCP's total HMSA FFS reimbursements for each LOB for all members (not just attributed members) for a three-year period[8]] / [The total number of attributed member-months for the same three-year period] + [The PCP's PCMH PMPM[9] based on their PCMH level[10]] = PMPM rate.

Reimbursements for immunizations were not included in the calculation of the Year 1 PMPM rates as they'll continue to be paid on a FFS basis. For a list of cost-based immunization services carved out, see Appendix E. Reimbursements for all other services during the three-year period, including claims submitted for unattributed members, were included. A provider's exact Year 1 PMPM rate was aligned to the nearest PMPM band in HMSA's band rate table and is listed at the end of this section.

Providers in a Medical Group

PCPs in a medical group will receive the group's base PMPM rate. The group's base PMPM rate is calculated using the total FFS reimbursements and member-months for all of the group's PCPs for the three-year period and the weighted average of their PCMH PMPMs based on their PCMH levels. The medical group receives the individual PCPs' base PMPM rates that were used to determine the group's rate.

BAND	COMMERCIAL	MEDICARE ADVANTAGE	QUEST INTEGRATION
Band 01	$ 12.80	$ 18.40	$ 8.20
Band 02	$ 14.08	$ 20.24	$ 9.02
Band 03	$ 15.49	$ 22.26	$ 9.92
Band 04	$ 17.04	$ 24.49	$ 10.91
Band 05	$ 18.74	$ 26.94	$ 12.01
Band 06	$ 20.61	$ 29.63	$ 13.21
Band 07	$ 22.68	$ 32.60	$ 14.53
Band 08	$ 24.94	$ 35.86	$ 15.98
Band 09	$ 27.44	$ 39.44	$ 17.58
Band 10	$ 30.18	$ 43.39	$ 19.34
Band 11	$ 33.20	$ 47.72	$ 21.27
Band 12	$ 36.52	$ 52.50	$ 23.40*
Band 13	$ 40.17	$ 57.75	$ 25.74
Band 14	$ 44.19	$ 63.52	$ 28.31
Band 15		$ 69.87	$ 31.14
Band 16			$ 34.25
Band 17			$ 37.68
Band 18			$ 41.45
Band 19			$ 45.59
Band 20			$ 50.15
Band 21			$ 55.17

- Average for adult providers
- Average for pediatric providers

** Note: For QUEST Integration, the average band rate is the same for adult and pediatric providers.*

Providers with Limited Member Months

PCPs may have had a low number of member-months for several reasons, such as the PCP is new to the HMSA network or the PCP was previously functioning in a different capacity and is transitioning to full-time primary care. If a PCP didn't meet the minimum number of member-months required to calculate a base PMPM rate (shown in the table below), the PCP received either:

- The medical group's PMPM rate for each LOB (if the PCP belongs to a medical group).
- The network average base PMPM band rate based on their PCP type (adult or pediatric) for each LOB.

The minimum number of member-months required to be eligible for the PMPM rate formula detailed previously is as follows:

HMSA LINE OF BUSINESS	MINIMUM NUMBER OF MEMBER-MONTHS (FOR THREE-YEAR PERIOD)
Commercial	3,600
QUEST Integration	1,800
Medicare Advantage	1,000

[8] The PMPM for PCPs who joined the PT program in 2016, was based on FFS reimbursements and attribution from 2012-2014. The PMPM for PCPs who joined the PT program in 2017 was based on FFS reimbursement and attribution from 2013-2015.

[9] The PCMH rates from 2015 were applied. For commercial PCMH, $1.00 for Level 1, $3.00 for Level 2, and $3.50 for Level 3. For QUEST Integration PCMH, $1.00 for Level 1, $1.50 for Level 2, and $2.00 for Level 3.

[10] PCPs who joined the PT program in 2016 had their November 2015 PCMH level applied. PCPs who joined the PT program in 2017 had their December 2016 level applied.

Appendix B – Facility-based Place of Service Codes

POS CODE	PLACE OF SERVICE NAME
13	Assisted Living Facility
19	Off Campus – Outpatient Hospital
21	Inpatient Hospital
22	On Campus – Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Individuals with Intellectual Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
61	Comprehensive Inpatient Rehab Facility
62	Comprehensive Outpatient Rehab Facility
65	End-Stage Renal Disease Treatment Facility

Appendix C – Standardized base PMPM methodology

The methodology below details the steps HMSA used to calculate the standardized base PMPM for each line of business.

1. Start with a simple average between the median compensation reported for MGMA and AMGA for the specialties of internal medicine, family practice, and pediatrics.

TABLE 1 - MGMA/AMGA MEDIAN COMPENSATION	
Internal Medicine	$251,899.50
Family Practice	$236,028.00
Pediatrician	$240,669.50

2. Compute the gross income amount by using a 60 percent practice overhead by specialty. Divide the median compensation in Table 1 by (1 - 0.60) to derive the gross income in Table 2.

TABLE 2 - GROSS INCOME BY SPECIALTY	
Internal Medicine	$629,748.75
Family Practice	$590,070.00
Pediatrician	$601,673.75

3. Use historical HMSA primary care data from 2013-2015 to break down the gross income by LOB.

TABLE 3 - GROSS INCOME BY LOB AND BY SPECIALTY			
	Commercial	QUEST Integration	Medicare
Internal Medicine	$476,926.53	$46,012.69	$106,809.53
Family Practice	$446,876.69	$43,113.56	$100,079.75
Pediatrician	$432,095.85	$169,577.90	

4. Calculate a gross income PMPM rate by LOB using a total panel size of 1,600 for internal medicine and family practice and 1,200 for pediatrics while having a panel composition of 80% commercial/10% QUEST Integration/10% Medicare for internal medicine and family practice and 60% commercial/40% QUEST Integration for pediatrics.

TABLE 4A - GROSS INCOME PMPM BY LOB, INTERNAL MEDICINE			
Internal Medicine	**Commercial**	**QUEST Integration**	**Medicare**
Gross Income	$476,926.53	$46,012.69	$106,809.53
Panel Size ÷	1280	160	160
Months ÷	12	12	12
Gross PMPM by LOB	**$31.05**	**$23.96**	**$55.63**

TABLE 4B - GROSS INCOME PMPM BY LOB, FAMILY PRACTICE			
Family Practice	**Commercial**	**QUEST Integration**	**Medicare**
Gross Income	$446,876.69	$43,113.56	$100,079.75
Panel Size ÷	1280	160	160
Months ÷	12	12	12
Gross PMPM by LOB	**$29.09**	**$22.45**	**$52.12**

TABLE 4C - GROSS INCOME PMPM BY LOB, PEDIATRICIAN		
Pediatrician	**Commercial**	**QUEST Integration**
Gross Income	$432,095.85	$169,577.90
Panel Size ÷	720	480
Months ÷	12	12
Gross PMPM by LOB	**$50.01**	**$29.44**

TABLE 4D - GROSS INCOME PMPM BY LOB SUMMARY			
	Commercial	**QUEST Integration**	**Medicare Advantage**
Internal Medicine	$31.05	$23.96	$55.63
Family Practice	$29.09	$22.45	$52.12
Pediatrician	$50.01	$29.44	

5. Use historical HMSA primary care reimbursements from 2013-2015 and the same panel sizes in Table 4 to derive a PMPM carve-out for immunizations, member copayments, and quality revenue.

TABLE 5 - GROSS INCOME PMPM CARVE OUT			
	Commercial	**QUEST Integration**	**Medicare**
Internal Medicine	$7.32	$1.77	$17.30
Family Practice	$6.80	$1.47	$15.21
Pediatrician	$18.84	$2.28	

6. Subtract the PMPM for immunizations, member copayments, and quality revenue in Table 5 from Table 4D to derive the MGMA/AMGA PMPM by specialty and LOB.

TABLE 6 - MGMA/AMGA PMPM BY SPECIALTY AND BY LOB			
	Commercial	**QUEST Integration**	**Medicare**
Internal Medicine	$23.73	$22.19	$38.33
Family Practice	$22.29	$20.98	$36.91
Pediatrician	$31.17	$27.16	

7. Calculate a weighted average PMPM across specialties and by LOB using attributed member months across the HMSA PCP network.

TABLE 7 - AGGREGATE MGMA/AMGA PMPM		
Commercial	**QUEST Integration**	**Medicare**
$25.06	$24.99	$37.98

8. For commercial LOB, a GET adjustment gets factored into the target median PMPM. For QUEST Integration & Medicare LOBs, the target median PMPM is set based on budget and our desire to put more investment into primary care.

TABLE 8 - TARGET MEDIAN PMPM		
Commercial	**QUEST Integration**	**Medicare**
$25.75	$26.00	$39.25

9. The standardized base PMPM for each LOB is then set by subtracting the median risk modifier PMPM ($7.50) from the target median PMPM by LOB from Table 8 above.

TABLE 9 – STANDARDIZED BASE PMPM BY LOB		
Commercial	**QUEST Integration**	**Medicare Advatage**
$18.25	$18.50	$31.75

Appendix D – Immunization Codes Carved Out of PMPM Bands

CODE ID	DESCRIPTION
90296	0151 DIPHTHERIA ANTITOXIN
90371	0151 HEP B IG IM
90375	0151 RABIES IG IM/SC
90376	0151 RABIES IG HEAT TREATED
90378	0151 RSV MAB IM 50MG
90379	0151 RSV IG IV
90476	0134 ADENOVIRUS VACCINE TYPE 4
90477	0134 ADENOVIRUS VACCINE TYPE 7
90581	0134 ANTHRAX VACCINE SC OR IM
90585	0134 BCG VACCINE PERCUT
90620	0134 MENB RP W/OMV VACCINE IM
90621	0134 MENB RLP VACCINE IM
90630	0134 FLU VACC IIV4 NO PRESERV ID
90632	0134 HEPA VACCINE ADULT IM
90633	0134 HEPA VACC PED/ADOL 2 DOSE IM
90634	0134 HEPA VACC PED/ADOL 3 DOSE
90636	0134 HEP A/HEP B VACC ADULT IM
90644	0134 HIB-MENCY VACCINE 4 DOSE IM
90645	0134 HIB VACCINE HBOC IM
90646	0134 HIB VACCINE PRP-D IM
90647	0134 HIB PRP-OMP VACC 3 DOSE IM
90648	0134 HIB PRP-T VACCINE 4 DOSE IM
90649	0134 4VHPV VACCINE 3 DOSE IM
90650	0134 2VHPV VACCINE 3 DOSE IM
90651	0134 9VHPV VACCINE 3 DOSE IM
90653	0134 IIV ADJUVANT VACCINE IM
90654	0134 FLU VACC IIV3 NO PRESERV ID
90655	0134 IIV3 VACC NO PRSV 6-35 MO IM
90656	0134 IIV3 VACC NO PRSV 3 YRS+ IM
90657	0134 IIV3 VACCINE 6-35 MONTHS IM
90658	0134 IIV3 VACCINE 3 YRS+ IM
90660	0134 LAIV3 VACCINE INTRANASAL
90661	0134 CCIIV3 VAC IM CULT PRSV FREE
90662	0134 IIV NO PRSV INCREASED AG IM
90663	0134 FLU VACC PANDEMIC H1N1
90664	0134 LAIV VACC PANDEMIC INTRANASL
90666	0134 FLU VAC PANDEM PRSRV FREE IM
90667	0134 IIV VACC PANDEMIC ADJUVT IM
90668	0134 IIV VACCINE PANDEMIC IM
90669	0134 PCV7 VACCINE IM
90670	0134 PCV13 VACCINE IM
90672	0134 LAIV4 VACCINE INTRANASAL
90673	0134 RIV3 VACCINE NO PRESERV IM

CODE ID	DESCRIPTION
90674	0134 CCIIV4 VAC NO PRSV 0.5 ML IM
90675	0134 RABIES VACCINE IM
90676	0134 RABIES VACCINE ID
90680	0134 RV5 VACC 3 DOSE LIVE ORAL
90681	0134 RV1 VACC 2 DOSE LIVE ORAL
90685	0134 IIV4 VACC NO PRSV 6-35 M IM
90686	0134 IIV4 VACC NO PRSV 3 YRS+ IM
90687	0134 IIV4 VACCINE 6-35 MONTHS IM
90688	0134 IIV4 VACCINE 3 YRS PLUS IM
90690	0134 TYPHOID VACCINE ORAL
90691	0134 TYPHOID VACCINE IM
90692	0134 TYPHOID VACCINE H-P SC/ID
90693	0134 TYPHOID VACCINE AKD SC
90696	0134 DTAP-IPV VACCINE 4-6 YRS IM
90697	0134 DTAP-IPV-HIB-HEPB VACCINE IM
90698	0134 DTAP-IPV/HIB VACCINE IM
90700	0134 DTAP VACCINE LT 7 YRS IM
90701	0134 DTP VACCINE IM
90702	0134 DT VACCINE UNDER 7 YRS IM
90703	0134 TETANUS VACCINE IM
90704	0134 MUMPS VACCINE SC
90705	0134 MEASLES VACCINE SC
90706	0134 RUBELLA VACCINE SC
90707	0134 MMR VACCINE SC
90708	0134 MEASLES-RUBELLA VACCINE SC
90710	0134 MMRV VACCINE SC
90712	0134 ORAL POLIOVIRUS VACCINE
90713	0134 POLIOVIRUS IPV SC/IM
90714	0134 TD VACC NO PRESV 7 YRS+ IM
90715	0134 TDAP VACCINE 7 YRS/ GT IM
90716	0134 VAR VACCINE LIVE SUBQ
90717	0134 YELLOW FEVER VACCINE SUBQ
90718	0134 TD VACCINE GT 7 IM
90719	0134 DIPHTHERIA VACCINE IM
90720	0134 DTWP-HIB VACCINE IM
90721	0134 DTAP/HIB VACCINE IM
90723	0134 DTAP-HEP B-IPV VACCINE IM
90725	0134 CHOLERA VACCINE INJECTABLE
90732	0134 PPSV23 VACC 2 YRS+ SUBQ/IM
90733	0134 MPSV4 VACCINE SUBQ
90734	0134 MENACWY VACCINE IM
90735	0134 ENCEPHALITIS VACCINE SC
90736	0134 HZV VACCINE LIVE SUBQ

Appendix D – Immunization Codes Carved Out of PMPM Bands (continued)

CODE ID	DESCRIPTION
90738	0134 INACTIVATED JE VACC IM
90739	0134 HEPB VACC 2 DOSE ADULT IM
90740	0134 HEPB VACC 3 DOSE IMMUNSUP IM
90743	0134 HEPB VACC 2 DOSE ADOLESC IM
90744	0134 HEPB VACC 3 DOSE PED/ADOL IM
90746	0134 HEPB VACCINE 3 DOSE ADULT IM
90747	0134 HEPB VACC 4 DOSE IMMUNSUP IM
90748	0134 HIB-HEPB VACCINE IM
90749	0134 VACCINE TOXOID
90756	0134 CCIIV4 VACC ABX FREE IM
G9142	0134 INFLUENZA A H1N1, VACCINE
J1670	0151 TETANUS IMMUNE GLOBULIN INJ
Q2033	0134 INFLUENZA VACCINE, (FLUBLOK)
Q2034	0134 AGRIFLU VACCINE
Q2035	0134 AFLURIA VACC, 3 YRS & GT , IM
Q2036	0134 FLULAVAL VACC, 3 YRS & GT , IM
Q2037	0134 FLUVIRIN VACC, 3 YRS & GT , IM
Q2038	0134 FLUZONE VACC, 3 YRS & GT , IM
Q2039	0134 NOS FLU VACC, 3 YRS & GT , IM
S0195	0134 PNEUMO VACCINE 5-9 YRS

Appendix E – PCP Engagement Measure Details

Access to and Use of Coreo

Description

PCPs and/or their office staff or Coreo delegate will use Coreo at least once a month. Coreo enables providers to manage their member panel, monitor care gaps, and displays the PCPs performance and payment potential on performance measures.

Requirements for Compliance

PCP or a Coreo user affiliated with the PCP's practice location must have logged on to the PCP's Coreo profile at least once a month for all 12 months during the measurement year. This requirement will be tracked via the Coreo login history. In 2018, PCPs will only be held accountable for logging in beginning with the month Coreo is made available to the HMSA provider network.

Panel Management

Description

PCPs will check on the well-being of all individual members in their panel at least once a measurement year. This requirement will be measured using an annual member survey administered to a sample of each provider's attributed members at the end of the measurement year.

- In the last 12 months, did this provider or someone else from their office contact you about your health and well-being? (Check all that apply.)

  - ☐ Had an in-person visit. (1)
  - ☐ Called me. (2)
  - ☐ Emailed me. (3)
  - ☐ Provider interacted with me via HMSA's Online Care. (4)
  - ☐ Texted me. (5)
  - ☐ Sent me a letter, postcard, or brochure/pamphlet. (6)
  - ☐ No contact. (7)

Numerator

Members without any visit-based claims in the measurement year who responded to the survey with 2, 3, 4, 5 or 6, and members who had at least one visit with the provider (claim filed) during the measurement year. Members will be counted only once in the numerator.

Denominator

Members without any visit-based claims in the measurement year who responded to the survey and members who had a claim filed by their attributed PCP. Members will be counted only once in the denominator.

Exclusions

None.

Requirements for Compliance

To meet the requirement for this measure, the performance rate must be greater than or equal to 75 percent.

Engagement with Ecosystem

Description

PCPs will refer patients to programs in the ecosystem (including programs such as HMSA Care Model, HMSA health education workshops, Dr. Ornish's Program for Reversing Heart Disease™, etc.).

Requirements for Compliance

Confirmation and description of referrals to programs in the ecosystem submitted via an attestation form in Coreo by the end of the measurement year including:

- Identifying and describing which programs the patients were referred to.
- Approximate number of members that was referred to programs.

EPSDT Completion Rate

QUEST Integration

Description

PCPs with participating provider agreements for QUEST Integration will submit EPSDT exam forms (DHS 8015 or DHS 8016) for attributed QUEST Integration members under the age of 21 who had an EPSDT visit due during the measurement year. The number of members expected to have a visit will be calculated based on the EPSDT periodicity schedule and the number of patients attributed to the provider.

Denominator

The number of members age 6 months less one day to 21 years less one day of age on the last day of the measurement period.

Numerator

The number of members who completed all EPSDT screenings that are due during the current measurement year, and within the eligible screening period. The eligible screening period start date and due date are relative to each members' birth date. See table below. If the member has no screenings due during the current measurement period, the compliance status from the previous measurement period will be carried over.

EPSDT SCREENING VISIT	ELIGIBLE SCREENING PERIOD START	ELIGIBLE SCREENING PERIOD END (DUE DATE)
6 months	6 months	9 months less 1 day
9 months	9 months	12 months less 1 day
12 months	12 months	15 months less 1 day
15 months	15 months	18 months less 1 day
18 months	18 months	2 years less 1 day
2 years	2 years	3 years less 1 day
3 years	3 years	4 years less 1 day
4 years	4 years	5 years less 1 day
5 years	5 years	6 years less 1 day
6 years	6 years	8 years less 1 day
8 years	8 years	10 years less 1 day
10 years	10 years	12 years less 1 day
12 years	12 years	14 years less 1 day
14 years	14 years	16 years less 1 day
16 years	16 years	18 years less 1 day
18 years	18 years	20 years less 1 day
20 years	20 years	21 years less 1 day

Click the icon below for allowable numerator codes.

Requirements for compliance

To meet the requirement for this measure, the performance rate must be greater than or equal to 70 percent.

Members Excluded from the PCP Performance Measures

Members who received hospice care at any time during the measurement year are not included in the PCP Performance Measures.

Click the icon below for allowable exclusion codes:

Members who are living long term in an institution (e.g., skilled nursing facility) for at least six months (does not need to be consecutive) during the measurement year may be excluded from all PCP Performance Measure denominators. To have the member excluded, providers must submit a Request for Reconsideration and include documents with supporting evidence of the following:

- Name of institution.
- Dates that patient is/was living at the institution.
- Physician at institution (e.g., SNF medical director) who is overseeing patient's care.
- Copies of notes/updates (e.g., discharge plan and instructions) from institution.

Requests for Reconsideration for members living long term in institutions will be accepted beginning July 2018. Refer to page 42 for more information regarding submitting exclusion requests.

Advance Care Planning

COMMERCIAL • MEDICARE ADVANTAGE

Description

The percentage of members 65 years of age and older at the end of the measurement year who had an advance care plan and/or an advance care planning discussion with a provider documented during the measurement year.

Numerator

Advance care discussion or plan documented in the medical record and a CPT code submitted during the measurement year.

Acceptable documentation:

1. Examples of an advance care plan:
   a. Advance directive. Directive about treatment preferences and the designation of a representative who can make medical decisions for a patient who's unable to make them (e.g., living will, power of attorney, health care proxy).
   b. Actionable medical orders. Written instructions regarding initiating, continuing, withholding, or withdrawing specific forms of life-sustaining treatment (e.g., Physician Orders for Life Sustaining Treatment [POLST], Five Wishes).
   c. Living will. Legal document denoting preferences for life-sustaining treatment and end-of-life care.
   d. Authorized representative. A written document designating someone other than the member to make medical decisions.

   Documents completed by another provider (e.g., upon discharge) can be used to fulfill numerator criteria as long as there was evidence of review and validation of the content in the medical record.

2. Examples of an advance care planning discussion:
   a. Notation in the medical record of a discussion with a provider during the measurement year.
   b. Conversations with relatives or friends about life-sustaining treatment and end-of-life care documented in the medical record. Patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be noted in the medical record during the measurement year.
   c. If your patient is uncomfortable or not ready to create an advance care plan, the patient's chart should document the patient's current thinking about at least one of the following:
      i. CPR.
      ii. Goals of care for cardiopulmonary failure, including hospitalization.
      iii. Artificial nutrition and hydration.
      iv. Comfort care option.
      v. Advance directive decisions.
      vi. Durable power of attorney for health care/designated representative.
      vii. The patient's key questions for further discussion.
      viii. The progression of their illness.
      ix. Potential complications.
      x. Specific life-sustaining treatments that may be required if their illness progresses.
   d. If your patient can't participate in the conversation (e.g., patient has Alzheimer's or isn't legally capable of making decisions), document their status.

Providers can submit either through a CPT code during the measurement year or supplemental data.

Click the icon below for allowable numerator codes:

Denominator

Members 65 years of age and older at the end of the measurement year.

Exclusions

None.

Supplemental Data Option Documentation Requirements

To attest that a member has an advance care plan or has had an advance care planning discussion, acceptable documentation (listed in the numerator) must be documented in the medical record.

Adolescent Well-care Visit

COMMERCIAL • QUEST INTEGRATION

Description

The percentage of members 12-21 years of age who had at least one comprehensive well-care visit with an eligible PCP type**, ob-gyn or geriatrician during the measurement year.

The American Academy of Pediatrics (aap.org) and Bright Futures (brightfutures.aap.org) recommend well-care visits for patients aged 11 to 21. Such visits include history, height and weight, body mass index, blood pressure, vision and hearing screening, developmental/behavioral assessment (including depression screening), physical examination, immunizations, and anticipatory guidance. (aap.org/en-us/Documents/periodicity_schedule.pdf)

Numerator

Members with at least one well-care visit with an eligible PCP type**, ob-gyn or geriatrician during the measurement year. The visit doesn't need to be completed by the patient's attributed PCP.

Click the icon below for allowable numerator codes:

Denominator

Members 12-21 years of age at the end of the measurement year.

Exclusions

None.

Supplemental Data Option Documentation Requirements

To attest that a patient had a well-care visit, medical record evidence of all of the following is required:

- Health and developmental history (physical and mental).
- Physical exam.
- Health education/anticipatory guidance.

Body Mass Index (BMI) Assessment

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

The percentage of members 18-74 years of age who had an outpatient visit with any provider and whose body mass index (BMI) was documented during the measurement year.

The U.S. Preventive Services Task Force recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions. (uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-screening-and-management)

Numerator

The number of members whose BMI was reported either through claims or through supplemental data. For claims, use the following codes that indicate numerator compliance.

For members 21 years of age or older on the date of service, BMI value during the measurement period.

For members 20 years of age and younger on the date of service, BMI percentile during the measurement period.

Click the icon below for allowable numerator codes:

Denominator

Members 18-74 years of age who had an outpatient visit with any provider during the measurement year. Telehealth visits billed with a POS 02 don't qualify as outpatient visits.

Click the icon below for allowable denominator codes:

Exclusions

Members who have a diagnosis of pregnancy during the measurement year.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that the BMI assessment was performed, medical record evidence of the following is required:

For members 20 years of age and younger on the date of service, documentation must indicate the height, weight, and BMI percentile dated during the measurement year. The height, weight, and BMI percentile must be from the same data source.

For BMI percentile, the following documentation is needed:

- BMI percentile documented as a value (e.g., 85th percentile).
- BMI percentile plotted on an age-growth chart.

For members 21 years of age and older: Medical note that indicates the date the BMI assessment was performed and the BMI value with weight documented in the same record during the measurement year.

Note: A distinct BMI value or percentile, if applicable, is required to meet the criteria of the numerator.

**Eligible PCP types include general or family practice physicians; general internal medicine physicians and pediatricians; primary care nurse practitioners, physician assistants, and advanced practice registered nurses; and naturopathic physicians.

Documentation Required for Request for Reconsideration

To attest that a member should be excluded, medical record evidence of the following is required:

- A note indicating diagnosis of pregnancy during the measurement year.

Breast Cancer Screening

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

The percentage of women 52–74 years of age as of the end of the measurement year who had one or more mammograms during the measurement year or the 15 months prior to the measurement year. The purpose of this measure is to evaluate primary screening; claims for biopsies, breast ultrasounds, or MRIs won't count toward this measure because they aren't considered appropriate methods for primary breast cancer screening. This measure currently follows 2002 recommendations from the U.S. Preventive Services Task Force (USPSTF) (uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/breast-cancer-screening).

Numerator

Members who had one or more mammograms during the measurement year or the 15 months prior to the measurement year. The following codes identify services that satisfy the measure:

Click the icon below for allowable numerator codes:

Denominator

Women 52–74 years of age as of the end of the measurement year.

Exclusions

Women who had a bilateral mastectomy and for whom administrative data doesn't indicate that a mammogram was performed. Look for evidence of bilateral mastectomy as far back as possible in the patient's history through either administrative data or medical record review. The bilateral mastectomy must have occurred by the end of the measurement year. (Exclusionary evidence in the medical record must include a note indicating a bilateral mastectomy.)

If there's evidence of two unilateral mastectomies, this patient may be excluded from the measure. The unilateral mastectomies must have two separate occurrences on two different dates that are 14 days or more apart from each other. This measure will use the billing codes from submitted claims to identify exclusions.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that a breast cancer screening was performed, medical record evidence of the following is required:

- Mammogram: one or more mammograms in the measurement year or the 15 months prior to the measurement year.

Documentation Required for Request for Reconsideration

To attest that a member should be excluded, medical record evidence of one of the following is required:

- Bilateral mastectomy: operative note indicating the date that a bilateral mastectomy was completed.
- Unilateral mastectomy: operative note indicating two different occurrences on two different dates of service that are 14 days or more apart from each other.
- Unilateral mastectomy with a bilateral modifier.

Measure Status
NQF # 0031
Status: Endorsed
Original Endorsement Date: August 10, 2009
Steward(s): NCQA

Cervical Cancer Screening

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

The percentage of women 24–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women ages 24–64 who had cervical cytology performed every three years.
- Women ages 30–64 who had cervical cytology and human papillomavirus (HPV) co-testing performed every five years.

This measure follows the USPSTF guidelines for cervical cancer screening (uspreventiveservicestaskforce.org/uspstf/uspscerv.htm).

Numerator

Members who were screened for cervical cancer using either of the following criteria:

- Members 24–64 years of age who had cervical cytology during the measurement year or the two years prior to the measurement year.
- Members 30–64 years of age who had cervical cytology and an HPV test with service dates four or less days apart during the measurement year or the four prior measurement years.

The measure will use the billing codes from submitted claims to identify cervical cancer screening.

Click the icon below for allowable numerator codes:

Denominator

Women 24–64 years of age at the end of the measurement year.

Exclusions

Evidence of a hysterectomy with no residual cervix at any time in the patient's history. The hysterectomy must have occurred by the end of the measurement year.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that a cervical cancer screening was performed, medical record evidence of one of the following is required.

- Cervical cytology:
  - A note indicating the date when the cervical cytology was performed.
  - The result or finding.
- Cervical cytology and HPV screening:
  - A note indicating the date when the cervical cytology and the HPV test were performed.
  - The result or finding.

Note: Lab results that explicitly state that the sample was inadequate or that "no cervical cells were present" isn't appropriate screening. Biopsies aren't accepted because they're diagnostic and therapeutic only and aren't valid for primary cervical cancer screening.

Documentation Required for Request for Reconsideration

To attest that a patient should be excluded, medical record evidence of one of the following is required:

- Documentation of complete, total, or radical abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.
- Documentation of vaginal Pap smear in conjunction with documentation of hysterectomy meets the exclusion criteria, but documentation of hysterectomy alone doesn't meet the criteria because it doesn't indicate that the cervix was removed.

Measure Status
NQF # 0032
Original Endorsement Date: August 10, 2009
Status: Endorsed
Steward(s): NCQA

Childhood Immunization Status (All individual immunizations)

COMMERCIAL • QUEST INTEGRATION

Description

Percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenzae type b (Hib); two hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) by their second birthday.

This measure follows the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations. The measure implements changes to the guidelines (e.g., new vaccine recommendations) after three years to account for the measure's retrospective period and to allow the industry time to adapt to new guidelines.

Numerator

For all antigens, count any of the following:

- Evidence of the antigen or combination vaccine.
- Documented history of the illness.
- A seropositive test result.

This measure will use the billing codes from submitted claims data to identify immunizations.

Click the icon below for allowable numerator codes:

Denominator

Children who turn 2 years of age during the measurement year.

Exclusions

Children who had a contraindication for a specific vaccine will be excluded. Exclude patients for contraindication only if the administrative data doesn't indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the second birthday.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

For MMR, hepatitis B, and VZV, medical record evidence of one of the following is required:

- Evidence of the antigen or combination vaccine.
- Documented history of the illness.
- A seropositive test for each antigen.

For DTaP, IPV, Hib, and pneumococcal conjugate, medical record evidence of the following is required:

- Evidence of the antigen or combination vaccine.

Documentation Required for Request for Reconsideration

To attest that a member should be excluded, medical record evidence of the following is required:

- Contraindications: a medical record note about contraindications specific to applicable immunizations that occurred before the patient's second birthday. Documentation should also describe tests performed and the results.

Measure Status
NQF # 0038
Status: Endorsed
Original Endorsement Date: August 10, 2009
Steward(s): NCQA

Colorectal Cancer Screening

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

Percentage of adults 51–75 years of age who had appropriate screening for colorectal cancer. The colorectal cancer screening measure follows USPSTF guidelines (uspreventiveservicestaskforce.org/uspstf/uspscolo.htm).

Numerator

Members who had one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the five criteria below:

- Fecal occult blood test (FOBT) during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four prior measurement years.
- Colonoscopy during the measurement year or the nine prior measurement years.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA test during the measurement year or the two years prior to the measurement year.

This measure will use the billing codes from submitted claims to identify colorectal cancer screening. The following codes identify services that satisfy the measure:

Click the icon below for allowable numerator codes:

Denominator

Members 51–75 years of age at the end of the measurement year.

Exclusions

Members with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history through either administrative data or medical record review. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy, which must have occurred by the end of the measurement year.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that a colorectal cancer screening was performed, medical record evidence of one of the following is required:

- FOBT: lab results/report for guaiac (gFOBT) or immunochemical (iFOBT). Depending on the type of FOBT test, the following is the required number of samples:

  1. gFOBT: three consecutive stools.

  2. iFOBT: one stool.

- Flex sigmoidoscopy: performed during the measurement year or four years prior to the measurement year.
- Colonoscopy: performed during the measurement year or nine years prior to the measurement year.

Note: A result isn't required if the documentation is clearly part of the medical history section of the record. However, if this isn't clear, the result or finding must also be present to ensure that the screening was performed and not merely ordered. A digital rectal exam doesn't count as evidence of a colorectal screening because it isn't specific or comprehensive enough to screen for colorectal cancer.

Documentation Required for Request for Reconsideration

To attest that a patient should be excluded, medical record evidence of one of the following is required:

- Colorectal cancer.
- Total colectomy, including the date of the procedure.

Measure Status

NQF # 0034
Status: Endorsed
Original Endorsement Date: August 10, 2009
Steward(s): NCQA

Comprehensive Diabetes Care – Blood Pressure Control (<140/90)

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

Percentage of patients with diabetes 18–75 years of age whose blood pressure was adequately controlled (less than 140/90) during the measurement year based on the most recent blood pressure reading during the measurement year.

The comprehensive diabetes care/blood pressure controlled measure is approved by NQF (qualityforum.org) and follows American Diabetes Association guidelines (care.diabetesjournals.org/content/33/Supplement_1/S11.full.pdf).

Numerator

The number of members in the denominator whose blood pressure is adequately controlled during the measurement year. For a patient's blood pressure to be controlled, both systolic and diastolic values must be less than 140/90 (adequate control). PCP must report the actual blood pressure reading to satisfy reporting requirements.

To describe systolic and diastolic blood pressures, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic values on that date as the representative blood pressure.

Medical records must support the diagnosis for the denominator and identify the actual blood pressure reading for the numerator.

The following blood pressure readings don't meet the criteria for the numerator:

- Blood pressure reading from an acute inpatient stay or an emergency department visit.
- Blood pressure reading from an outpatient visit, the sole purpose of which was to have a diagnostic test or surgical procedure performed.
- Blood pressure reading done on the same day as a major diagnostic or surgical procedure.
- Blood pressure reading reported or taken by the patient.

If there are no blood pressure readings that meet the criteria after the diagnosis of hypertension, the patient cannot be included in the numerator.

Click the icon below for allowable numerator codes:

Denominator

Patients 18–75 years of age at the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) by a provider qualified to make the diagnosis of diabetes for this measure. Patients with diabetes can be identified during the measurement year or the prior measurement year through:

- Pharmacy data: Prescriptions that identify members with diabetes include insulin prescriptions (drug list available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list available). Note: Glucophage/metformin isn't included because it's used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis codes only.
- At least two visits with an eligible provider type where diabetes is listed as a diagnosis. Eligible provider types include advanced practice registered nurse (APRN), endocrinology, pediatric endocrinology, family physician, general practice, internal medicine, naturopath, nephrology, pediatrics, pediatric endocrinology, pediatric nephrology, physician assistant. Telehealth visits billed with a POS 02 don't qualify as outpatient visits.

Click the icon below for allowable denominator codes:

Exclusions

Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.

For the exclusion to apply, the patient must not have a face-to-face encounter in any setting with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that the patient's blood pressure is controlled, medical record evidence of the following is required:

- Blood pressure test – medical note that indicates the date the blood pressure test was performed and the systolic and diastolic values that were collected.

Documentation Required for Request for Reconsideration

To attest that a member should be excluded, medical record evidence of the following is required:

For the exclusion to apply, the patient must not have a face-to-face encounter in any setting with a diagnosis of diabetes during the measurement year or the prior measurement year and must have one of the following diagnoses:

- Gestational or steroid-induced diabetes – note indicating a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the prior measurement year.

Measure Status
NQF # 0061
Status: Endorsed
Original Endorsement Date: August 10, 2009
Steward(s): NCQA

Comprehensive Diabetes Care – Eye Exam

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

Percentage of patients with diabetes 18–75 years of age who received a retinal or dilated eye exam, by an ophthalmologist or optometrist, during the measurement year. A negative retinal eye exam (no evidence for retinopathy) in the prior measurement year also meets criteria for the eye exam indicator.

The eye exam measure is approved by the National Quality Forum (qualityforum.org/) and follows American Diabetes Association guidelines (care.diabetesjournals.org/content/33/Supplement_1/S11.full.pdf).

Numerator

This measure will use the billing codes from submitted claims to identify eye exams. The following codes identify services that satisfy the measure:

Click the icon below for allowable numerator codes:

Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there's no administrative way to determine that a dilated exam was performed.

Denominator

Members 18–75 years of age at the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) by a provider qualified to make the diagnosis of diabetes for this measure. Patients with diabetes can be identified during the measurement year or the prior measurement year through:

- Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).
  Note: Glucophage/metformin isn't included because it's used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.
- At least two visits with an eligible provider type where diabetes is listed as a diagnosis. Eligible provider types include advanced practice registered nurse (APRN), endocrinology, pediatric endocrinology, family physician, general practice, internal medicine, naturopath, nephrology, pediatrics, pediatric endocrinology, pediatric nephrology, physician assistant. Telehealth visits billed with a POS 02 don't qualify as outpatient visits.

Exclusions

Blindness isn't an exclusion for a diabetic eye exam because it's difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore don't require an exam.

Exclude patients with gestational diabetes or steroid-induced diabetes on the problem list during the measurement year. For the exclusion to apply, the patient must not have a face-to-face encounter in any setting with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that an eye exam screening was performed, medical record evidence of one of the following is required:

- Dilated eye exam: documentation of a retinal or dilated eye exam by an optometrist or ophthalmologist during the measurement year.
- Negative retinal eye exam: documentation of a negative eye exam (no evidence of retinopathy) from an ophthalmologist/optometrist in the year prior to the measurement year.

Documentation Required for Request for Reconsideration

To attest that a member should be excluded, medical record evidence of the following is required:

For the exclusion to apply, the patient must not have a face-to-face encounter in any setting with a diagnosis of diabetes during the measurement year or the prior measurement year and must have one of the following diagnoses:

- Gestational or steroid-induced diabetes: note indicating a diagnosis of gestational or steroid-induced diabetes in any setting during the measurement year or the prior measurement year.

Measure Status
NQF # 0055
Status: Endorsed
Original Endorsement Date: August 10, 2009
Steward(s): NCQA

Comprehensive Diabetes Care – HbA1c Control (≤9)

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

Percentage of patients with diabetes 18–75 years of age whose most recent HbA1c level was less than or equal to 9.0 percent (in control).

The comprehensive diabetes care/blood sugar controlled measure is approved by NQF (qualityforum.org) and follows American Diabetes Association guidelines (care.diabetesjournals.org/content/33/Supplement_1/S11.full.pdf).

Numerator

The number of members whose most recent HbA1c test performed during the measurement year had a result less than or equal to 9.0 percent. If the result for the most recent HbA1c test during the measurement year is greater than 9.0 percent or if the member didn't have a test in the measurement year, the member won't be included in the numerator.

Actual lab values for the most recent HbA1c test must be provided to satisfy measure reporting requirements.

Click the icon below for allowable numerator codes:

Denominator

Member 18–75 years of age as of the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) by a provider qualified to make the diagnosis of diabetes for this measure. Patients with diabetes can be identified during the measurement year or the prior measurement year through pharmacy data or diagnosis.

- Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available). Note: Glucophage/metformin isn't included because it's used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.
- At least two visits with an eligible provider type where diabetes is listed as a diagnosis. Eligible provider types include advanced practice registered nurse (APRN), endocrinology, pediatric endocrinology, family physician, general practice, internal medicine, naturopath, nephrology, pediatrics, pediatric endocrinology, pediatric nephrology, physician assistant. Telehealth visits billed with a POS 02 don't qualify as outpatient visits.

Click the icon below for allowable denominator codes:

Exclusions

Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year or prior measurement year.

For the exclusion to apply, the patient must not have a face-to-face encounter in any setting with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that the patient's HbA1c is in control, medical record evidence of the following is required:

- HbA1c test: a lab report, medical note, or in-house lab printout that indicates the date the HbA1c test was performed and the value that was collected.

Documentation Required for Request for Reconsideration

To attest that a member should be excluded, medical record evidence of the following is required:

For the exclusion to apply, the member must not have a face-to-face encounter in any setting with a diagnosis of diabetes during the measurement year or the prior measurement year and must have one of the following diagnoses:

- Gestational or steroid-induced diabetes: note indicating a diagnosis of gestational or steroid-induced diabetes in any setting during the measurement year or the prior measurement year.

Measure Status
NQF # 0059
Status: Endorsed
Original Endorsement Date: August 10, 2009
Steward(s): NCQA

Comprehensive Diabetes Care - Medical Attention for Nephropathy

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

Percentage of diabetes patients 18–75 years of age with at least one test for microalbumin during the measurement year or evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria).

This measure is approved by the National Quality Forum (qualityforum.org/) and follows American Diabetes Association guidelines (care.diabetesjournals.org/content/33/Supplement_1/S11.full.pdf).

Numerator

Patients who had any one of the following:

- Screening for nephropathy.
- Evidence of nephropathy.
- Evidence of ACE inhibitor/ARB therapy.
- Evidence of stage 4 chronic kidney disease.
- Evidence of ESRD.
- Evidence of kidney transplant.
- A visit with a nephrologist, as identified by the organization's specialty provider codes.

This measure will use pharmacy claims data to identify evidence of ACE inhibitor or ARB therapy. This measure will also use the billing codes from claims to identify screening for nephropathy and evidence of nephropathy.

Click the icon below for allowable numerator codes:

Denominator

Patients 18–75 years of age at the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) by a provider qualified to make the diagnosis of diabetes for this measure. Patients with diabetes can be identified during the measurement year or the prior measurement year through:

- Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available). Note: Glucophage/metformin isn't included because it's used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis codes only.
- At least two visits with an eligible provider type where diabetes is listed as a diagnosis. Eligible provider types include advanced practice registered nurse (APRN), endocrinology, pediatric endocrinology, family physician, general practice, internal medicine, naturopath, nephrology, pediatrics, pediatric endocrinology, pediatric nephrology, physician assistant. Telehealth visits billed with a POS 02 don't qualify as outpatient visits.

Exclusions

Patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year. For the exclusion to apply, the patient must not have a face-to-face encounter in any setting with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that the patient has a diagnosis of nephropathy, medical record evidence of one of the following is required:

- Diabetic nephropathy screening test: lab report or medical record note indicating the date when a urine microalbumin test was performed and the results.
- Evidence of nephropathy: documentation of a visit to a nephrologist, renal transplant, or medical attention for diabetic nephropathy, ESRD, CRF, CKD, renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure (ARF), or dialysis.
- Positive urine microalbumin test: lab report or medical record note indicating the date when the microalbumin test was performed and a positive result. Trace urine microalbumin test results aren't considered valid documentation for this measure.
- Evidence of ACE inhibitor/ARB medication therapy: at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

Documentation Required for Request for Reconsideration

To attest that a member should be excluded, medical record evidence of the following is required:

For the exclusion to apply, the patient must not have a face-to-face encounter in any setting with a diagnosis of diabetes during the measurement year or the prior measurement year and must have one of the following diagnoses:

- Gestational or steroid-induced diabetes: note indicating a diagnosis of gestational or steroid-induced diabetes in any setting during the measurement year or the prior measurement year.

Measure Status
NQF # 0062
Status: Endorsed
Original Endorsement Date: August 10, 2009
Steward(s): NCQA

Developmental Screening in the First Three Years of Life

COMMERCIAL • **QUEST INTEGRATION**

Description

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, and third birthdays.

The American Academy of Pediatrics (aap.org) and Bright Futures (brightfutures.aap.org) recommends developmental screening at 9 months, 18 months, and 30 months for early identification of developmental disorders.

aap.org/en-us/Documents/periodicity_schedule.pdf

Developmental screening in the first three years of life is also part of the CMS core set of children's health care quality measures for Medicaid.

Numerator

Patients who were screened once in the 12 months preceding each of their first, second, and third birthdays, for risk of developmental, behavioral, and social delays using one of the approved standardized screening tools:

- Ages and Stages Questionnaire (ASQ).
- Ages and Stages Questionnaire – 3rd Edition (ASQ-3).
- Battelle Developmental Inventory
- Bayley Infant Neuro-developmental Screen (BINS).
- Brigance Screens – III
- Child Development Inventory (CDI).
- Infant Development Inventory.
- Parents' Evaluation of Developmental Status (PEDS).
- Parents' Evaluation of Developmental Status- Developmental Milestones (PEDS-DM).
- Other tool approved by PCP's Physician Organization (Supplemental Data required).

Click the icon below for allowable numerator codes:

Denominator

Patients who turn 1, 2, or 3 years of age during the measurement year.

Exclusions

None

Supplemental Data Option Documentation Requirements

To attest that a developmental screening was completed, medical record evidence of the following is required:

- Date screening was administered.
- Name of standardized screening tool used.
- Screening result or score.
- If "other tool" is selected, provider will be prompted to attest to the following statement:

  The tool I administered has been approved by my physician organization and meets all of the following criteria:

  1. Includes the following developmental domains: motor, language, cognitive, and social-emotional.
  2. Established reliability of approximately 0.70 or above.
  3. Validity scores of approximately 0.70 or above when measured against an appropriate standardized developmental or social-emotional assessment instrument(s) tested for a significant number of children.
  4. Established sensitivity/specificity scores of approximately 0.70 or above.

Immunizations for Adolescents (All individual immunizations)

COMMERCIAL • **QUEST INTEGRATION**

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria, and acellular pertussis vaccine (Tdap) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Numerator

Adolescents who receive both:

- One meningococcal conjugate vaccine on or between their seventh and 13th birthdays.
- One Tdap on or between their seventh and 13th birthdays.

Click the icon below for allowable numerator codes:

Denominator

Adolescents who turn 13 years of age during the measurement year.

Exclusions

Adolescents who have a contraindication for one of these vaccines. Exclusion must have occurred before the adolescent's 13th birthday.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that a patient received the proper vaccinations, medical record evidence must include the following:

- A medical record documentation showing evidence of the antigen or combination vaccine for meningococcal vaccine and Tdap.

Documentation Requirements for Request for Reconsideration

To attest that a patient should be excluded, medical record evidence of the following is required:

- Contraindications – a medical record note about contraindications specific to applicable immunizations that occurred before the patient's 13th birthday. Documentation should also describe tests performed and the results.

Measure Status
NQF # 1407
Status: Endorsed
Original Endorsement Date: August 15, 2011
Steward(s): NCQA

Immunizations for Adolescents HPV Vaccine (HPV)

COMMERCIAL • **QUEST INTEGRATION**

NOTE: Coreo will display this measure in 2018, but PCPs will not be scored on their performance rate until 2019.

Description

Percentage of attributed adolescent members who received the HPV vaccine on or between their seventh and 13th birthdays.

Numerator

At least two HPV vaccines with different service dates on or between the member's seventh and 13th birthdays. Note: The first and second doses must be administered at least 146 days apart

OR

At least three HPV vaccines with different dates of service on or between the member's seventh and 13th birthdays.

Click the icon below for allowable numerator codes:

Denominator

Adolescents who turn 13 years of age during the measurement period.

Exclusions:

Adolescents who have a contraindication for one of these vaccines. Exclusion must have occurred before the adolescent's 13th birthday.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that a patient received the proper vaccinations, medical record evidence must include the following:

- A medical record documentation showing evidence of either the two dose or three dose HPV vaccine series.

Documentation Requirements for Request for Reconsideration.

To attest that a patient should be excluded, medical record evidence of the following is required:

- Contraindications – a medical record note about contraindications specific to applicable immunizations that occurred before the patient's 13th birthday. Documentation should also describe tests performed and the results.

Influenza Vaccine (Adult)

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

Percentage of members 18 years and older who received an influenza vaccine during the measurement year.

The Advisory Committee on Immunization Practices (ACIP) recommends routine annual influenza vaccination for all persons aged ≥6 months who don't have contraindications.

(cdc.gov/mmwr/preview/mmwrhtml/mm6430a3.htm)

Numerator

Members who received an influenza vaccine during the measurement year. The vaccine doesn't need to be administered by the patient's attributed provider.

Click the icon below for allowable numerator codes:

Denominator

Members 18 years of age and older as of the end of the measurement year.

Exclusions

Members who have a contraindication to the vaccine or a component of the vaccine.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that a patient received the proper vaccinations, medical record evidence must include the following:

- Name and title of the individual who administered the vaccine.
- The date of administration.
- Vaccine product name and administration route.

Documentation Requirements for Request for Reconsideration

To attest that a patient should be excluded, medical record evidence of the following is required:

- Contraindications – a medical record note about contraindications specific to applicable immunizations. Documentation should also describe tests performed and the results.

Review of Chronic Conditions

MEDICARE ADVANTAGE

- The Review of Chronic Conditions (RCC) measure will be subject to a measurement period of January 1, 2018, to September 30, 2018, with supplemental data due by October 31, 2018, and a one-month claims run-out through October 31, 2018.
- Measure will be displayed in the Review of Chronic Conditions Registry on Coreo.

Description

Medicare Advantage patients often have conditions that persist from year to year. The RCC measure encourages you to review each of your patients' persistent conditions and care plans. The measure groups patient diagnoses identified over two calendar years prior to the measurement period into clinically meaningful condition groupings or codes called Hierarchical Condition Categories (HCC). You must review and confirm or disconfirm the persistence of each clinical condition group or code every calendar year. HMSA will audit provider reviews because they will be used for Risk Adjustment Processing System (RAPS) and Encounter Data Processing System (EDPS) submissions.[6] See Table 1 for a list of the persistent conditions included in this measure.

The RCC measure will be scored based on the persistent conditions, which are identified in the Review of Chronic Conditions Registry. Persistent conditions are defined as chronic conditions coded in the previous two years by a patient's attributed PCP and treating specialist(s).

Numerator

The cumulative number of persistent conditions that were confirmed by medical claims (from both providers and facilities) submitted with dates of service within the measurement period.

To receive credit for the confirmation, you must have a face-to-face visit with your patient during the measurement period. If an audit finds that you didn't have a face-to-face visit with your patient, the patient won't be counted toward your maximum payment potential and all confirmed conditions for the patient will be removed from the numerator and denominator.

Claims processing logic will also give providers credit for coding conditions of greater severity to a higher level of specificity. When a more severe diagnosis is reported, any gap(s) on a condition of lesser severity will automatically be closed.

[6] CMS instituted a Risk Adjustment Payment Model in 2004 to align payment to health plans with the disease burden and associated otential cost of the plan's beneficiaries. Data collected from this measure will be used to supplement our risk adjusted score through RAPS/EDPS submissions to CMS.

Denominator

The cumulative number of persistent conditions for all Medicare Advantage members in the PCP's patient panel identified during the 24 months prior to the start of the measurement period. Persistent conditions are identified through diagnosis codes in medical claims from the PCP and/or from the specialty types on the inclusion lists in Table 2a. These lists exclude specialty and facility types that would submit medical claims that aren't used for RAPS/EDPS submissions.

Exclusions

In the final performance scoring, all numerator negative conditions that were exclusively coded by ED physicians, the hospital, and hospitalists during the two year look-back period for the measure will be removed. If these exclusions eliminate all chronic conditions of any given member, that member won't contribute to the PCP's scoring or max potential for the measure.

New manifestations or complications of persistent conditions for medical claims received in 2018 won't be included in the denominator for this measure.

Supplemental Data & Disconfirmations

Primary care providers may request that the persistent condition be excluded from the measure denominator for one of the rationales listed below. These requests for measure exclusion must be submitted once every measurement period. Providers are able to upload documentation that contains supporting evidence for the disconfirmation of a chronic condition.

- **Disconfirm – Condition has improved** (e.g., the patient has been diagnosed with a condition of lesser severity)
  - The patient's pertinent medical record.
  - Documentation must include a face-to-face visit in the calendar year (service date) that clearly demonstrates that the patient's condition has been managed/monitored, evaluated, assessed, or treated and that the patient's symptoms, labs, medication, and treatment are consistent with a condition of lesser severity (diagnosis and diagnosis code) than what is currently reported on Coreo.
- **Disconfirm – Condition has resolved** (e.g., the patient's care is no longer affected by the condition)
  - The patient's pertinent medical record.
  - Documentation must include a face-to-face visit in the calendar year (service date) that clearly demonstrates that the patient's symptoms, labs, and other diagnostic work indicate that the condition no longer needs to be managed/monitored, evaluated, assessed, or treated.
- **Disconfirm – Insufficient evidence of the condition**
  - An attestation (e.g., note or memo uploaded into Coreo or text entered into Coreo).
  - The attestation must demonstrate that the provider reviewed the pertinent clinical information (such as medical record notes, consult reports, lab results, or imaging over the past two years) and on the basis of those results, finds:
    - Insufficient evidence to support the diagnosis; OR
    - Clinical information to the contrary of the diagnosis.
  - The attestation should be specific to the patient and condition, and provide clinical rationale to the extent possible. Example attestation: "I, Dr. Aloha Lee, do hereby attest that this patient does not have the diagnosis of chronic renal disease. The patient has had normal creatinine levels seen over the past two years. Based on this history and my physical examination, this patient does not have the diagnosis of chronic renal disease."
  - A PCP may choose to allow office staff (e.g., Coreo delegate users) to complete the attestation and submit the supplemental data for disconfirmation on the PCP's behalf. Example attestation: "I, [staff member name], report that Dr. Aloha Lee attests that the patient does not have the diagnosis of chronic renal disease. Dr. Lee has reviewed the pertinent medical information and finds that the patient has had normal creatinine levels over the past two years."

All disconfirmations and supplemental data are subject to audit. Providers will be held accountable for all submissions by Coreo delegate users. All disconfirm submissions that pass audit will result in the removal of the condition from the denominator, which will be reflected in your Coreo registry automatically.

All disconfirmations and supplemental data for the Review of Chronic Conditions measure must be submitted by October 31, 2018.

Table 1: Persistent Conditions

HCC	DESCRIPTION
1	HIV/AIDS
2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
6	Opportunistic Infections
8	Metastatic Cancer and Acute Leukemia
9	Lung and Other Severe Cancers
10	Lymphoma and Other Cancers
11	Colorectal, Bladder, and Other Cancers
12	Breast, Prostate, and Other Cancers and Tumors
17	Diabetes with Acute Complications
18	Diabetes with Chronic Complications
19	Diabetes without Complication
21	Protein-Calorie Malnutrition
22	Morbid Obesity
23	Other Significant Endocrine and Metabolic Disorders
27	End-Stage Liver Disease
28	Cirrhosis of Liver
29	Chronic Hepatitis
33	Intestinal Obstruction/Perforation
34	Chronic Pancreatitis
35	Inflammatory Bowel Disease
39	Bone/Joint/Muscle Infections/Necrosis
40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
46	Severe Hematological Disorders
47	Disorders of Immunity
48	Coagulation Defects and Other Specified Hematological Disorders
54	Drug/Alcohol Psychosis
55	Drug/Alcohol Dependence
57	Schizophrenia
58	Major Depressive, Bipolar, and Paranoid Disorders
70	Quadriplegia
71	Paraplegia
72	Spinal Cord Disorders/Injuries
73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
74	Cerebral Palsy
75	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
76	Muscular Dystrophy
77	Multiple Sclerosis
78	Parkinson's and Huntington's Diseases

HCC	DESCRIPTION
79	Seizure Disorders and Convulsions
80	Coma, Brain Compression/Anoxic Damage
82	Respirator Dependence/Tracheostomy Status
83	Respiratory Arrest
84	Cardio-Respiratory Failure and Shock
85	Congestive Heart Failure
86	Acute Myocardial Infarction
87	Unstable Angina and Other Acute Ischemic Heart Disease
88	Angina Pectoris
96	Specified Heart Arrhythmias
99	Cerebral Hemorrhage
100	Ischemic or Unspecified Stroke
103	Hemiplegia/Hemiparesis
104	Monoplegia, Other Paralytic Syndromes
106	Atherosclerosis of the Extremities with Ulceration or Gangrene
107	Vascular Disease with Complications
108	Vascular Disease
110	Cystic Fibrosis
111	Chronic Obstructive Pulmonary Disease
112	Fibrosis of Lung and Other Chronic Lung Disorders
114	Aspiration and Specified Bacterial Pneumonias
115	Pneumococcal Pneumonia, Empyema, Lung Abscess
122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
124	Exudative Macular Degeneration
134	Dialysis Status
135	Acute Renal Failure
136	Chronic Kidney Disease (Stage 5)
137	Chronic Kidney Disease, Severe (Stage 4)
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
158	Pressure Ulcer of Skin with Full Thickness Skin Loss
161	Chronic Ulcer of Skin, Except Pressure
162	Severe Skin Burn or Condition
166	Severe Head Injury
167	Major Head Injury
169	Vertebral Fractures without Spinal Cord Injury
170	Hip Fracture/Dislocation
173	Traumatic Amputations and Complications
176	Complications of Specified Implanted Device or Graft
186	Major Organ Transplant or Replacement Status
188	Artificial Openings for Feeding or Elimination
189	Amputation Status, Lower Limb/Amputation Complications

Table 2a. Acceptable Specialty Types for Risk Adjustment Data Submission

ALLERGY	GASTROENTEROLOGY	NON-SUBMIT PROVDR	PODIATRY
ANESTHESIOLOGY	GENERAL HOSPITAL	NURSE PRACTITIONE	PSYCHIATRY
APRN	GENERAL PRACTICE	OB/GYN	PSYCHOLOGY
AUDIOLOGY	HB AMB SURG CNTR	OCCUP THERAPY	PULMONARY DISEASE
CARDIAC REHAB	HB DIALYSIS FACIL	ONCOLOGY	RHEUMATOLOGY
CARDIOLOGY	HOME HEALTH AGEN	OPHTHALMOLOGY	SLEEP MEDICINE CLINIC
CHILD PSYCHIATRY	HOME IV THERAPY	OPTOMETRY	SOCIAL WORKER
CHIROPRACTOR	HOSP OUTPT MEDICL	OSTEOPATHY	SPEECH LANG PATH
CLINIC	HOSPICE	OTHER M.D.	SUBSTANCE ABUSE
CLINIC EMERG SVCS	HOSPITAL PSYCH	OTHER FS FACILITY	SURGERY
CLINIC PSYCH	IN VITRO	OTOLARYNGOLOGY	SURG-ORAL
CRNA	INFECT DISEASES	OUTPT CLINIC SVCS	SURG-ORTHOPEDIC
DERMATOLOGY	INTERNAL MEDICINE	PATHOLOGY	SURG-PLASTIC
DIET/NUTRTNL PROF	LONG TERM CARE	PED NEUROLOGY	URGENT CARE CLINIC
EMERGENCY MED	MARRGE FAM THRPST	PED ONCOLOGY	UROLOGY
ENDOCRINOLOGY	MENTAL HLTH CNSLR	PED SPECIALIST	
FACILITY SERVICES	MIDWIFE	PEDIATRICS	
FAMILY PHYSICIAN	NEPHROLOGY	PHYS MED/REHAB	
FS AMB SURG CNTR	NEUROLOGY	PHYSCN ASSISTANT	
FS DIALYSIS FACIL	NEUROSURGERY	PHYSICAL THERAPY	

Screening for Symptoms of Clinical Depression and Anxiety

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

Percentage of members 12 years of age and older who had an outpatient visit with an eligible PCP type** during the measurement year and who were screened for symptoms of depression using an approved screener. The screening does not need to be completed on the same day as the outpatient visit that made the member eligible for the measure.

The U.S. Preventive Services Task Force recommends screening for depression in the general adult population, including pregnant and postpartum women, and adolescents age 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1?ds=1&s=depression) (http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1?ds=1&s=depression)

Numerator

Members 12-17 years of age as of December 31 of the measurement year who were screened for symptoms of depression during the measurement year using one of the following approved tools:

- Acceptable tools for the adolescent population:
  - Patient Health Questionaire-2 (PHQ-2).
  - Patient Health Questionnaire- 4 (PHQ-4).
  - Patient Health Questionnaire for Adolescents (PHQ-A).
  - Patient Health Questionnaire (PHQ-9).
  - Patient Health Questionnaire Modified for Teens(PHQ-9M).
  - PRIME MD-PHQ2®.
  - Beck Depression Inventory-Fast Screen (BDI-FS)®*.
  - Mood Feeling Questionnaire (MFQ)*.
  - Center for Epidemiologic Studies Depression Scale (CES-D).
  - PROMIS Depression.

Members 18 years of age and older who were screened for symptoms of depression and anxiety during the measurement year using the Patient Health Questionnaire-4 (PHQ-4) or, one of the acceptable screening tools for depression and one acceptable tool for anxiety listed below:

- Acceptable depression and anxiety screening tools for the adult population:
  - Patient Health Questionnaire- 4 (PHQ-4).
- Acceptable depression screening tools for the adult population:
  - Patient Health Questionnaire (PHQ-9).
  - PRIME MD-PHQ2.
  - Beck Depression Inventory (BDI-II or BDI-FS)®*.
  - Center for Epidemiologic Studies Depression Scale (CES-D).
  - Depression Scale (DEPS).
  - Duke Anxiety-Depression Scale (DADS)®.
  - Geriatric Depression Scale (GDS).
  - Cornell Scale for Depression in Dementia (CSDD).
  - Edinburgh Postnatal Depression Scale (EPDS).
  - My Mood Monitor (M-3)®.
  - PROMIS Depression.
  - Clinically Useful Depression Outcome Scale (CUDOS).
  - Montgomery-Asberg Depression Scale (MADRS).
- Acceptable anxiety screening tools for the adult population:
  - Generalized Anxiety Disorder 7-item (GAD-7).
  - Hamilton Anxiety Rating Scale (HAM-A)®.
  - Beck Anxiety Inventory®*.

*Proprietary tool. May have a cost or licensing requirement associated with use.

Click the icon below for allowable numerator codes:

Denominator

Patients 12 years of age or older at the end of of the measurement year who had an outpatient visit with an eligible PCP type.

Telehealth visits billed with a POS 02 don't qualify as outpatient visits.

Click the icon below for allowable denominator codes:

Exclusions

Members with a diagnosis of depression or anxiety during the measurement period or year prior.

Click the icon below for for exclusions for depression and anxiety:

Supplemental Data Option Documentation Requirements

To attest that a screening was completed, medical record evidence of the following is required:

- For members 12-17 years of age as of December 31 of the measurement year, documentation in the medical record must indicate the result of a screening using the PHQ-2, PHQ-4, PHQ-9, or PHQ-A, and the date the screening was administered.
- For members 18 years of age or older as of December 31 of the measurement year, documentation in the medical record must indicate the result of a screening using the PHQ-4 and the date the screening was administered.

Sharecare RealAge® Assessment

COMMERCIAL

Description

The percentage of members 18 years of age and older who completed the RealAge assessment at least once during the measurement period.

Numerator

Members who completed the RealAge assessment during the measurement period.

Denominator

Members 18 years of age and older as of the end of the measurement year.

Exclusions

None

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

Tobacco Screening and Cessation Counseling

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

Patients 18 years of age and older who had an outpatient visit with an eligible PCP type** during the measurement year who were screened for tobacco use and had tobacco cessation counseling if screened positive for tobacco use. The tobacco screening and cessation counseling (if appropriate) do not need to occur on the same day as the outpatient visit that made the member eligible for the measure. If a member is screened more that once during the measurement year, the most recent screening status will be applied.

The U.S. Preventive Services Task Force recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and pharmacotherapy for cessation approved by the U.S. Food and Drug Administration (FDA) to adults who use tobacco.

(uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1?ds=1&s=tobacco)

Numerator

Members whose most recent screening for tobacco use during the measurement year was negative and members whose most recent screening for tobacco use during the measurement year was positive and received tobacco cessation counseling during the measurement year.

Click the icon below for allowable numerator codes:

Denominator

Members 18 years of age or older as of the end of the measurement year who had an outpatient visit with an eligible PCP type.**

Telehealth visits billed with a POS 02 don't qualify as outpatient visits.

Click the icon below for allowable denominator codes:

Exclusions

None

Data Option Documentation Requirements

To attest that a patient was screened for tobacco use and cessation counseling (if applicable), medical record evidence must include all of the following:

- Documentation that the member was screened for tobacco use during the measurement year.
- Tobacco use status (i.e. tobacco user, not a tobacco user).
- If member is a tobacco user, documentation that cessation counseling was completed.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

COMMERCIAL • QUEST INTEGRATION

Description

Percentage of patients 3 to 17 years of age who had an outpatient visit with an eligible PCP type**, ob-gyn or geriatrician and who had evidence of the following during the measurement year:

- BMI percentile documentation.***
- Counseling for nutrition.
- Counseling for physical activity.

The U.S. Preventive Services Task Force recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral intervention to promote improvement in weight status.

** Eligible PCP types include general or family practice physicians; general internal medicine physicians and pediatricians; primary care nurse practitioners, physician assistants, and advanced practice registered nurses; and naturopathic physicians.

*** Because BMI norms for youth vary with age and gender, this measure evaluates whether the BMI percentile is assessed rather than an absolute BMI value.

uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-children-and-adolescents-screening)

The American Academy of Pediatrics (aap.org) and Bright Futures (brightfutures.aap.org) recommend that children and adolescents be screened for overweight and obesity and that body mass index be calculated from age 24 months to 21 years. Recommended anticipatory guidance includes encouraging proper nutrition and balanced diet and promoting physical activity.

Numerator

Patients age 3 to 17 years of age who had a recorded BMI, counseling for nutrition, and counseling for physical activity. Each of these components must occur at least once during the measurement period to receive numerator credit for this measure. This measure will use the billing codes from claims to identify credit for this measure.

Click the icon below for allowable numerator codes:

Denominator

Children 3 to 17 years of age who had an outpatient visit with an eligible PCP type**, ob-gyn or geriatrician during the measurement year.

Telehealth visits billed with a POS 02 don't qualify as outpatient visits.

Click the icon below for allowable denominator codes:

Exclusions

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that a patient had BMI percentile documentation, counseling for nutrition, and counseling for physical activity, medical record evidence of all of the following is required:

BMI, any of the following:

- BMI percentile.
- BMI percentile plotted on an age-growth chart.

Counseling for Nutrition

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

Counseling for Physical Activity

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child's physical activity.
- Weight or obesity counseling.

Well-child Visits in the First 15 Months of Life

COMMERCIAL • QUEST INTEGRATION

Description

Percentage of patients who turned 15 months old during the measurement year and who had six or more well-child visits with an eligible PCP type**, ob-gyn or geriatrician during their first 15 months of life. This measure is based on the Centers for Medicare & Medicaid Services (CMS) and American Academy of Pediatrics guidelines for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visits.

Refer to the American Academy of Pediatrics Guidelines for Health Supervision at aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (published by the National Center for Education in Maternal and Child Health) at brightfutures.org for details on what constitutes a well-child visit.

Numerator

The six well-child visits must occur with an eligible PCP type**, ob-gyn or geriatrician, but the PCP doesn't have to be the provider assigned to the child. This measure will use the billing codes from claims to identify well-child visits.

Click the icon below for allowable numerator codes:

Denominator

Children who turned 15 months old during the measurement year.

Exclusions

None

** Eligible PCP types include general or family practice physicians; general internal medicine physicians and pediatricians; primary care nurse practitioners, physician assistants, and advanced practice registered nurses; and naturopathic physicians.

*** Because BMI norms for youth vary with age and gender, this measure evaluates whether the BMI percentile is assessed rather than an absolute BMI value.

Supplemental Data Option Documentation Requirements

To attest that a patient had a well-child visit, medical record evidence of all of the following is required:

- Health and developmental history (physical and mental).
- Physical exam.
- Health education/anticipatory guidance.

Note: In accordance with HEDIS definitions, the 15th month birth date will be calculated as the patient's first birthday plus 90 days.

Well-child Visit in the Third, Fourth, Fifth and Sixth Years of Life

COMMERCIAL • QUEST INTEGRATION

Description

Percentage of patients 3 to 6 years of age as of the end of the measurement year who received one or more well-child visits with an eligible PCP type**, ob-gyn or geriatrician during the measurement year. This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits.

Refer to the American Academy of Pediatrics Guidelines for Health Supervision at aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (published by the National Center for Education in Maternal and Child Health) at brightfutures.org fordetails on what constitutes a well-child visit.

Numerator

Children 3 to 6 years of age who received at least one well-child visit with an eligible PCP type**, ob-gyn or geriatrician during the measurement year. The well-child visit must occur with a an eligible PCP type**, ob-gyn or geriatrician, but the PCP doesn't have to be the provider assigned to the child. This measure will use billing codes from claims to identify well-child visits.

Click the icon below for allowable numerator codes:

Denominator

Patients at least 3 years old and not more than 6 years old as of the end of the measurement year.

Exclusions

None

Supplemental Data Option Documentation Requirements

To attest that a patient had a well-child visit, medical record evidence of all of the following is required:

- Health and developmental history (physical and mental).
- Physical exam.
- Health education/anticipatory guidance.

Note: The annual well-child visit is generally scheduled every 12 months. HMSA recognizes that families and providers need flexibility in scheduling well-child visits and will cover well-child visits that are at least nine months apart.

**Eligible PCP types include general or family practice physicians; general internal medicine physicians and pediatricians; primary care nurse practitioners, physician assistants, and advanced practice registered nurses; and naturopathic physicians.

Access: Facilitating Timely Access for New Patients

Description

POs will be responsible for facilitating timely access for new patients. Verifying the accuracy of PCP demographic data and ensuring that the provider directory is up to date is critical to enabling HMSA members to contact PCPs in the community and establish care with a PCP who is accepting new patients.

This measure has two parts:

Section A: Timely access for new patients

POs must send a list of its member-PCPs who will accept new patients throughout the upcoming month. PCPs must have appointment availability within 30 days to be considered as accepting new patients. POs should detail any restrictions that PCPs have for accepting new patients (e.g., only newborn patients). Additionally, POs should indicate which PCPs are building their panels and which providers HMSA should prioritize member assignment and referrals to. To qualify for member assignment prioritization, PCPs must accept all patients without restrictions. These PCPs will be given priority when matching members to a PCP.

Additional PO reporting options will be available effective with the July 5, 2018, report. POs may send a delta file of changes only from the prior month's report with the changes for specific PCPs clearly communicated. If there are no changes, POs may send an email indicating the measure, "Timely Access," the reporting month in the subject line, and "NO CHANGES" in the body of the email to PSInquiries@hmsa.com. Monthly verification of the data remains an expectation for this measure and the timely report or email response will be required for credit.

HMSA reserves the right to do audits to ensure that PCPs are truly accepting new patients during the month for which the PO submitted the list. The PO won't receive numerator credit for this measure if it doesn't pass the audit or if customer relations discovers a high rate of discrepancies when contacting PCP offices.

Section B: Accurate Provider Directory data
(effective April 1, 2018)

To ensure that members have timely access to primary care, the HMSA provider directory must offer close-to-real-time accuracy.

HMSA will provide a quarterly file to the PO of PCPs with their practice addresses and contact phone numbers. POs must conduct outreach to each PCP in the PO at least once per quarter. Any changes to practice address, contact phone number, and email address must be reported to HMSA. POs must attest that outreach was conducted when the file is submitted each quarter. Information reported by the PO will be used to update HMSA's provider database and provider directory, so accurate information is paramount.

The PO will have the discretion to determine how it will confirm PCP demographic data, e.g., through visits, email, phone call, or a posting on the website that allows PCPs to individually confirm their data. The PO is required to submit an action plan of the steps it will take to address this measure by April 5, 2018. The written plan must describe the PO's policies and procedures to validate which providers are accepting new members and their addresses, phone numbers, and email addresses. The written plan will be used as documentation for audits in which HMSA may be obligated to participate.

If provider demographic data changes (e.g., practice location is closed) and isn't reported by the PO, the quarter's file will be considered to be non-compliant.

Numerator

Total number of timely lists submitted by the PO for that quarter listing all of its member PCPs and indicating which providers are accepting new patients that month. In the third month of the quarter, the PO will additionally report confirmation or changes of the PCP demographics data. The list must be submitted to HMSA via email (PSInquiries@hmsa.com) by the due dates indicated for each month on the chart below.

For each of HMSA's lines of business, at least one PCP in the PO must be accepting new patients during the month.

Denominator

HMSA requires three lists from the PO during the measurement quarter - two monthly lists addressing Section A only and one quarterly list addressing Sections A and B. The monthly lists are worth one point each and the quarterly list is worth three points, for a maximum of five points per quarter.

Exclusions

None

Threshold

100 percent

Note: File must be submitted by the due date for each month and the action plan is due by April 5. If at any time there are no PCPs in your PO accepting new patients, no points will be earned for this measure. If the file isn't returned by the deadline, no points will be earned.

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

Due Date Schedule

MONTH	REPORT DUE	DUE DATE
January	Accepting New Patients file	January 15, 2018
February	Accepting New Patients file	February 5, 2018
March	Accepting New Patients file	March 5, 2018
April	Action Plan and Section A Accepting New Patients file	April 5, 2018
May	Section A Accepting New Patients file	May 7, 2018
June	Section A (Accepting New Patients) and B (Demographics data)	June 5, 2018
July	Section A Accepting New Patients file	July 5, 2018
August	Section A Accepting New Patients file	August 6, 2018
September	Section A (Accepting New Patients) and B (Demographics Data)	September 5, 2018
October	Section A Accepting New Patients file	October 5, 2018
November	Section A Accepting New Patients file	November 5, 2018
December	Section A (Accepting New Patients) and B (Demographics Data) file	December 5, 2018

Access: Facilitating Timely Access to PCPs for Existing Patients

Description

POs will be responsible for facilitating timely access to PCPs for all attributed members.

This will be measured using the following survey question, which will be sent to a sample of members attributed to each PCP, each quarter:

- In the last three months, how often was it easy to get the care, tests, or treatment you needed?
  - ☐ Never. (1)
  - ☐ Sometimes. (2)
  - ☐ Usually. (3)
  - ☐ Always. (4)
  - ☐ I did not need care in the last three months. (5)

Numerator

Members who responded with 2 through 4.

Denominator

Members who replied to the survey with responses 1 through 4.

Exclusions

None

Threshold

75 percent.

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

Access: Facilitating Timely Access to PCPs for Patients Across All Lines of Business

Description

POs will be responsible for ensuring access to PCPs for members in all lines of business (e.g., commercial, Medicare Advantage, and QUEST Integration).

This will be measured using PCP members' participating provider agreements.

HMSA reserves the right to do secret shopper/audits to ensure that PCPs are accepting patients from all lines of business.

Note: In Years Zero and One, a PO doesn't need to ensure that all PCP members accept all LOBs. The PO must ensure that a patient from any LOB may be seen by any appropriate provider in the PO.

Numerator

The number of PCPs in the PO who accept QUEST Integration patients based on their HMSA participating provider agreement.

Denominator

The number of PCPs in the PO with any HMSA participating agreement, as of the last month in the measurement quarter.

Exclusions

None

Threshold

10 percent of PCPs in the PO must have a QUEST Integration participating provider agreement.

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

Access: Providing 24/7 Coverage for Attributed Members

Description

POs will be responsible for ensuring 24/7 coverage for attributed members. This may include or be met with phone access to a live provider (PCP or another provider in a PO) or with access to HMSA's Online Care. Attestation must be submitted once per measurement quarter.

This will be measured using PO attestation.

HMSA reserves the right to do secret shopper/audits to ensure that PCPs are providing sufficient 24/7 coverage.

Requirement for compliance

Attestation submitted via Coreo that confirms and explains how a PO is supporting their PCPs to cover patients 24/7 (HMSA's Online Care, phone, coverage schedules, etc.). One attestation submission is required per quarter.

Exclusions

None

Threshold

If no attestation is provided or the secret shopper/audit yields negative results, no points will be earned for this measure.

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

Collaboration: Participation in HMSA PO Meetings

Description

POs will be required to participate in quarterly PO leadership meetings. HMSA will designate the meetings that will count toward this requirement.

This will be measured using meeting attendee lists.

Numerator

The number of times both a PO administrator(s) and a medical director(s), or appropriate delegate(s), attend PO leadership meetings. POs are responsible for informing HMSA when a delegate will be sent in place of a PO administrator or medical director.

Denominator

The number of scheduled PO leadership meetings.

Exclusions

None

Threshold

100 percent

Note: Both an administrator/manager and medical/clinical representative must be present to receive credit for attending the meeting.

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

Population Health: Social Determinants of Health (SDoH) Data

NOTE: This measure will be introduced in 2019.

Description

POs will be responsible for collecting key demographic information for attributed members.

This will be measured based on the completeness of demographic information submitted to HMSA.

POs will be required to facilitate the collection of demographic information for PCP's attributed members and to report that information in a standard format acceptable to HMSA. Demographic data elements for each member could include:

1. Age.
2. Gender.
3. City.
4. ZIP code.
5. Ethnicity.
6. Education level.
7. Income level.
8. Occupation.
9. Housing.
10. Household size.
11. Marital status.

Numerator

1. The number of members with at least five data elements collected in the report.
2. The number of members with one or more of the #5 – 11 data elements collected in the report.

Denominator

1. The total number of attributed members in a PO.
2. The total number of attributed members in a PO.

Exclusions

None

Threshold

1. 85 percent.
2. 20 percent.

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

Members excluded from the PO Performance Measures.

Members who received hospice care at any time during the measurement year aren't included in the following PO Performance Measure denominators:

- CSHCN© Screener.
- Controlling Blood Pressure.
- Avoidable ED Utilization.
- Hospitalization for Potentially Preventable Complications – Chronic ACSC for Members 65 years and older.

Click the icon below for allowable exclusion codes:

Members who are living long-term in an institution (e.g., skilled nursing facility) for at least six months (doesn't need to be consecutive) during the measurement period may also be excluded from the following PO Performance Measure denominators:

- CSHCN© Screener.
- Controlling Blood Pressure.
- Avoidable ED Utilization.
- Hospitalization for Potentially Preventable Complications – Chronic ACSC for Members 65 years and older.

To have the member excluded, providers must submit a Request for Reconsideration and include documentation with supporting evidence of the following:

- Name of institution.
- Dates that patient is/was living at the institution.
- Physician at institution (e.g., SNF medical director) who is overseeing patient's care.
- Copies of notes/updates (e.g., discharge plan and instructions) from institution.

Requests for Reconsideration for members living long term in institutions will be accepted beginning July 2018. Refer to page 42 for more information regarding submitting exclusion requests.

Access and Utilization: Hospitalization for Potentially Preventable Complications (HPC) – Chronic Ambulatory Care Sensitive Conditions (ACSC)

COMMERCIAL • MEDICARE ADVANTAGE

Description

For attributed members 65 years of age and older, the rate of discharges for chronic ambulatory care sensitive conditions (ACSC) per 1,000 members. An ACSC is a chronic health condition that can be managed or treated in an outpatient setting.

Numerator

Attributed members 65 years of age as of December 31 of the measurement year who were discharged from an inpatient facility with a primary diagnosis or procedure code identifying chronic ACSC. Members attributed to the same PCP during the month of January and December will be counted. The chronic ACSCs included in this measure are:

Click the icon below for allowable numerator codes:

ACSCS	IDENTIFICATION OF DISCHARGES	EXCLUSIONS
Diabetes short-term complications	Primary diagnosis: ketoacidosis, hyperosmolarity or coma	None
Diabetes long-term complications	Primary diagnosis: renal, eye, neurological, circulatory or unspecified complications	None
Uncontrolled diabetes	Primary diagnosis	None
Lower-extremity amputation among patients with diabetes	Procedure code for lower-extremity amputation and any diagnosis for diabetes	Any discharge with diagnosis for traumatic amputation or lower extremity or tie amputation procedure
COPD	Primary diagnosis	Any discharge with a diagnosis for cystic fibrosis and anomalies of the respiratory system
Asthma	Primary diagnosis	Any discharge with a diagnosis for cystic fibrosis and anomalies of the respiratory system
Acute bronchitis and COPD	Primary diagnosis	Any discharge with a diagnosis for cystic fibrosis and anomalies of the respiratory system
Hypertension	Primary diagnosis	Excluding any discharge with a cardiac procedure or diagnosis of Stage I-IV kidney disease with a dialysis procedure
Heart failure	Primary diagnosis	Any discharges with a cardiac procedure

Denominator

Attributed members 65 years of age and older as of December 31 of the measurement year. Members must be attributed to the same PCP during the month of January and December of the measurement year.

Exclusions

Members who are enrolled in an Institutional Special Needs Plan (iSNP) anytime during the measurement year.

Rate Calculation

The count of inpatient stays with a discharge date during the measurement year for chronic ACSC divided by the number of total attributed members 65 years of age and older (as of December 31 of the measurement year), multiplied by 1,000.

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

NOTE: Coreo will display the following performance rates for informational purposes only (not scored):

- *Population < 65 years of age.*
- *Population ≥ 65 years of age rate for acute ACSCs (bacteria pneumonia, urinary tract infection, cellulitis, pressure ulcer).*
- *Population < 65 years of age rate for acute ACSCs (bacteria pneumonia, urinary tract infection, cellulitis, pressure ulcer).*

Access and Utilization: Avoidable Emergency Department Visits

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

The rate of avoidable emergency department (ED) visits for members attributed to a PO. This measure follows the classification of ED visits specified by the New York University ED Algorithm (wagner.nyu.edu/faculty/billings/nyued-background). A lower performance rate is better. Note: This measure will not be scored based on performance in 2018. POs will earn measure credit for analyzing their current performance and developing a performance improvement plan.

Numerator

For ED visits in the denominator, the count of avoidable ED visits as identified by the primary diagnosis code. ED visits that result in an inpatient admission are considered unavoidable.

Click the icon below for allowable numerator codes:

Denominator

Total count of ED visits for members attributed to a PO who had the same PCP in January and December of the measurement year. ED visits that result in an inpatient stay are counted in the denominator.

Click the icon below for allowable denominator codes:

Exclusions

None

Supplemental Data Option Documentation Requirements

Supplemental data is not accepted for this measure.

Requirements for Compliance (2018 measurement period)

The PO Performance measure, Avoidable ED Visits, will be a process measure in 2018. POs will not be scored on their performance rates until 2019. This will allow focus on the action steps that will ultimately lead to improved performance. POs will instead be scored on timely submission and completion of three performance improvement plan forms. All three forms must be complete and on time to receive compliance for this measure; no partial credit will be awarded. A completed form is defined as all questions being answered satisfactorily at the discretion of HMSA.

The structure of the forms is designed to follow the standard Plan-Do-Study-Act (PDSA) method for quality improvement. The PDSA stages represent planning, testing, observing results, and acting on lessons learned.

The process is designed to help POs assess their performance and collaborate on improvement strategies. In addition, POs will share lessons learned and successful interventions with other POs. Submission deadlines are intended to serve as check points for POs to stay on track. The goal of each submission phase is as follows:

1) Quarter 1 (Identify the problem): Analyze the avoidable ED visits data on SureMetrics both from a condition and member perspective. Identify which conditions and members should be targeted for intervention based on frequency or potential to be effectively impacted. Form must be submitted by May 5, 2018.

2) Quarter 2 (Plan): Develop a strategy and plan for reducing avoidable ED visits for the targeted conditions/members reported for Quarter 1. Begin to implement specific interventions. Form must be submitted by July 5, 2018.

3) Quarter 3 + Quarter 4 (Do, Study, Act): Fully implement the interventions proposed in Quarter 2. Describe and assess the results of those interventions. Report on the effectiveness of the strategies employed, lessons learned, and continuity of those strategies. Form must be submitted by December 31, 2018.

In addition to submitting all three improvement plan forms, at least one representative from each PO must attend a workgroup meeting to be held in June 2018, to receive compliance for the measure. PO representatives are expected to provide feedback and propose enhancements to the measure specifications or code sets for the next measurement period. During the workgroup meeting, POs will also be asked to propose a methodology for deriving performance thresholds for 2019.

Improvement plan forms can be found on the payment transformation page of the HMSA Provider Resource Center.

Controlling Blood Pressure

COMMERCIAL • QUEST INTEGRATION • MEDICARE ADVANTAGE

Description

The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria:

- Patients 18 to 59 years of age whose BP was <140/90 mm Hg.
- Patients 60 to 85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Patients 60 to 85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Numerator

The number of members in the denominator whose most recent blood pressure is adequately controlled during the measurement year as reported from an office visit.

Click the icon below for allowable numerator codes:

PCPs must report the actual blood pressure reading to satisfy measure reporting requirements. To describe systolic and diastolic blood pressures, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

Medical records must support the diagnosis for the denominator and identify the representative blood pressure reading for the numerator.

The following blood pressure readings don't meet the criteria for the numerator:

- Blood pressure reading from an acute inpatient stay or an ED visit.
- Blood pressure reading from an outpatient visit, the sole purpose of which was to have a diagnostic test or surgical procedure performed.
- Blood pressure reading done on the same day as a major diagnostic or surgical procedure.
- Blood pressure reading reported or taken by the patient.

If there are no blood pressure readings that meet the criteria after the diagnosis of hypertension, the patient cannot be included in the numerator.

Note: There are no procedure codes to describe a systolic pressure of 140 to 149 mm Hg. That means controlled blood pressure for a patient between 60 to 85 years of age (i.e., one with a systolic pressure of 140 to 149 mm Hg and a diastolic pressure of <90 mm Hg) must be reported using Coreo supplemental data.

Denominator

Members 18 to 85 years of age who had a diagnosis of hypertension. Patients are considered hypertensive if they have at least one outpatient encounter with a diagnosis of hypertension during an 18-month window (the 12 months prior to the start of the measurement year and the first six months of the measurement year).

Click the icon below for allowable denominator codes:

Exclusions

All members who have evidence of ESRD (including dialysis or renal transplant), are pregnant, or who had a non-acute inpatient admission during the measurement year.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

To attest that the patient's blood pressure is controlled, medical record evidence of the following is required:

- Blood pressure test: medical note that indicates the date the blood pressure test was performed and the systolic and diastolic values that were collected.

Documentation Requirements for Request for Reconsideration

To attest that a patient should be excluded, medical record evidence of one of the following is required:

- A note indicating a diagnosis of ESRD during the measurement year. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.
- A note indicating a diagnosis of pregnancy during the measurement year.
- A note indicating a non-acute inpatient admission during the measurement year.

Measure Status
NQF # 0018
Status: Endorsed
Original Endorsement Date: August 10, 2009
Steward(s): NCQA

Collaboration: Accountability for PCP Communication

Description

POs will be accountable for sharing and discussing information with their PCPs (e.g., payment transformation, care coordination programs, etc.).

This will be measured using an annual survey question sent to PCPs:

- Did your PO provide you with the information, training, and support necessary to understand how to succeed in HMSA's Payment Transformation Program?

  ☐ Yes.

  ☐ No.

Numerator

The number of PCP members from the PO who responded positively (Yes) to the annual survey question.

Denominator

The number of PCP members from the PO who responded to the annual survey question.

Exclusions

None

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

Population Health: Children with Special Health Care Needs (CSHCN) Screener

COMMERCIAL • QUEST INTEGRATION

Description

The percentage of members 3 to 17 years of age who were screened for special health care needs using the CSHCN Screener every three years.

The CSHCN Screener is a tool developed by the Child and Adolescent Health Measurement Initiative (CAHMI) to identify children with special health care needs for quality assessment and population-based health applications.

Numerator

Attributed members 3 to 17 years of age as of December 31 of the measurement year who were screened for special health care needs using the CSHCN Screener during the measurement year or two years prior.

- An HA modifier (child/adolescent program) appended to E&M CPT codes 99201-99499 that indicates screening was completed on specific visit date.
  - Positive:

    HA modifier appended to E&M CPT code for specific visit on the screening date; and ICD-10-CM diagnosis code Z87.898 (Personal history of other specified conditions).
  - Negative:

    HA modifier appended to E&M CPT code for specific visit on the screening date.

Click the icon below for allowable numerator codes:

Denominator

Attributed members 3 to 17 years of age and older as of December 31 of the measurement year.

Exclusions

None

Supplemental Data Option Documentation Requirements

To attest that a member was screened for special health care needs medical record evidence of the following is required:

- Date of service.
- Report of one of the following:
  - Administration of the CSHCN Screener resulted in positive findings for chronic or special health care needs.
  - Administration of the CSHCN Screener resulted in negative findings for chronic or special health care needs.

Population Health: Engagement with the Ecosystem

Description

POs will be responsible for helping their PCPs to:

- Identify available ecosystem programs.
- Refer patients.
- Follow-up with patients to determine if they're enrolled.

This will be measured using an annual survey question sent to all PCP members:

- Did your PO provide you with the information, training, resources, and support necessary to understand how to effectively use ecosystem programs (e.g., Care Model, Dr. Ornish's Program for Reversing Heart Disease, patient health education activities, etc.)?

  ☐ Yes.

  ☐ No.

Numerator

The number of PCP members from the PO who responded positively (Yes) to the annual survey question.

Denominator

The number of PCP members from the PO who responded to the annual survey question.

Exclusions

None

Supplemental Data Option Documentation Requirements

Supplemental data won't be accepted for this measure.

[7] Exclusions to the TCOC calculation are listed in this appendix.

Appendix I – Total Cost of Care (TCOC) Shared Savings Methodology

Payment Transformation Total Cost of Care (TCOC) Methodology

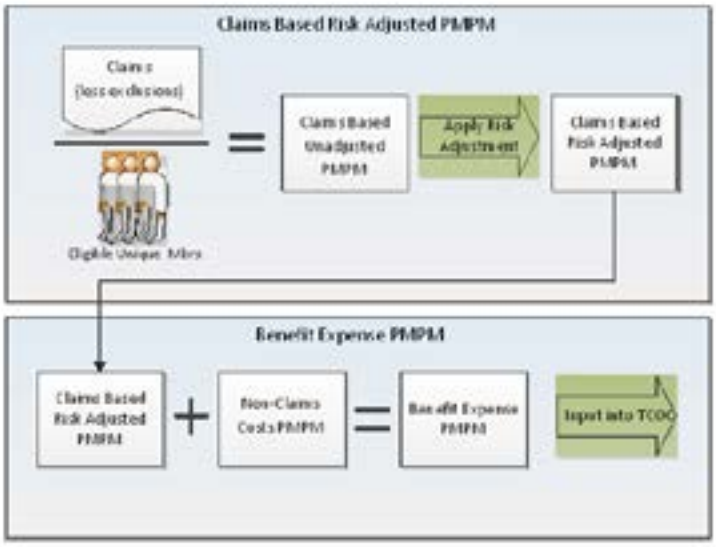
Document Contents

Overview

This methodology document describes how the total cost of care (TCOC) is calculated under HMSA's Payment Transformation program.

All POs who meet defined performance (quality) targets established by HMSA will be eligible to earn shared savings on a total cost of care incentive that is paid to their PO each year (see Total Cost of Care Shared Savings Incentive section).TCOC is defined as all costs incurred in the health care system by a PCP's attributed patients.[7] While Coreo will display information about an individual PCP's TCOC performance for his/her attributed members, scoring for this measure must occur at the PO level, as PCPs' panels are too small to protect a PCP from having a single patient's cost for a year disproportionately impact the individual provider's trend.

The Benefit Expense (BE) — which is an input into the TCOC — will be the product of several steps that are detailed in this document. The following diagram summarizes the overall BE calculation process:



Document Organization

This methodology document is organized into two main sections: (1) Definitions and (2) Methodology, the latter split into three sub-sections: (a) Calculation of Claims Based Risk Adjusted PMPM, (b) Calculation of Non-claims Based Benefit Expense, and (c) Calculation of TCOC and Shared Savings.

Section I. Definitions

1. **Reporting Period and Baseline Period:** Calculations on members identified with the defined Reporting Period are compared with calculations on matching members identified with a prior, comparison one-year period, referred to as Baseline Period.
2. **Target and Comparison Groups:** For each report, the methodology establishes Benefit Expense PMPM from the combination of Claims Based Risk Adjusted PMPM and Non-Claims Based Costs for two groups of members, Target Group (identified by **PO**) and Comparison Group (identified as **Network** and consisting of all allowed members). These cost calculations are specific to each report's associated reporting period and baseline period. The primary objective of the TCOC calculation is to determine if the change in cost between the reporting and the baseline period for the PO is at or below the established target that is based on the Network change in cost for the same two periods.
3. **PCP Affiliation and Member Attribution:** For each report, both target and comparison groups consist of distinct sets of affiliated primary care providers (PCPs) identified as of the ending month of the reporting period. Only PCPs located in the state of Hawaii are eligible.
4. **Member Attribution:** As of the ending month of the reporting period, members are assigned to one and only one PCP by a procedure called Member Attribution. Thus, given the distinct assignment of members to PCPs and distinct assignment of PCPs to target or comparison groups, all qualified attributed members are assigned to either target or comparison group as of the ending month of the reporting period. Members so assigned are referred to as either a PO member or as a network member.
5. **Unique Member and Member Coverage:** All calculations and data processing for Claims Based PMPM and Risk Adjusted PMPM are done with respect to unique persons, for whom claims payments are aggregated and distinct months of plan coverage or enrollment are tallied. Unique persons are referred to as unique members in this methodology. Unique members are distinctly identified to the best of HMSA technology by an identifier termed Member Unique ID. Unique members (persons or individuals) enrolled in HMSA plans are assigned coverage/plan-specific member IDs (based on subscriber number and dependent code). Most unique members are enrolled in a single HMSA coverage/plan in any given month. Some unique members may be enrolled in two or more HMSA coverage/plans in any given month and are termed dual member. Unique members

with at least one qualified (non-excluded) coverage/plans as of the ending month of the reporting period are included in PMPM calculations; only medical reimbursement dollars and only distinct months of enrollment associated with qualified plans are included in these calculations.

6. **Member Population Universe:** The universe of members for each report consists of all qualified and uniquely identified members (identified by HMSA MbrUID) in allowed commercial plans (PPO and HMO) as of the ending month of the reporting period. Any unique member whose only coverage is in an excluded plan or product (see section 8) as of the end of the reporting period will not be included in the PMPM calculations.
7. **Member Matching Across Periods:** Members assigned to member reporting cohorts are filtered to ensure that members are retained for a report's BE calculations only if they're identified in the reporting period and are also identified in the baseline period for any report. Required data assembled on each unique member in a member reporting cohort reflects data from both the reporting period and baseline periods.
8. **Member Exclusions – Criteria:** For each report, members are excluded from the member population universe by determination of member qualifications for the ending month of the reporting period. Any member meeting one or more exclusion qualifications will result in the member being excluded from the member universe and from any member reporting cohort and all calculations of PMPM and BE and TCOC. The exclusion criteria include:[8]
    a. Members of the Federal Employee Plan ("FEP").[9]
    b. Members of a Medicare Advantage plan.
    c. Members of the QUEST Integration plan.
    d. Members of another health plan operating under a license with the Blue Cross Blue Shield Association and entitled to benefits under the Blue Card Program.
    e. Individuals identified in a report's reporting period who aren't matched in the report's baseline period.

Section II. TCOC Methodology

Part A. Calculation of Claims-based Risk-adjusted PMPM

Overview

The methodology for calculating and comparing the Claims Based Risk Adjusted PMPM **(CBRA PMPM)** expense of providing benefits to members attributed to the target group (PO) and to members attributed to comparison group (network) for each of two benefit product lines (PPO and HMO) for each of two periods (the reporting period and the baseline period) is described below.

In short, four benefit product cohorts (as defined below) of the CBRA PMPM are required to produce the necessary outputs to enable calculation of the BE, the resulting TCOC, and the applicable eligible shared savings.

Step 1. Establish Provider Affiliation and Create PO/Network Provider and Attributed Member Groupings

1. **Identify Target and Comparison Group PCPs:** Identify two sets of PCPs affiliated with the target group (PO) and PCPs affiliated with the comparison group (network {not including target PO}) as of the ending month of the reporting period.
2. **Define the Member Universe:** The member universe is defined as the set of HMSA members identified by unique member identifier (member UID) who are:
    a. Enrolled as of the ending month of the reporting period.
    b. Attributed to one of the PCPs identified with PO or with network.
    c. Assigned the member benefit product of PPO or HMO.
    d. Not excluded by any of the member exclusion criteria.

Step 2. Segregate PO Member and Network Member subpopulations

1. **Identify Member Reporting Cohorts:** Split the qualified Member Universe into two member reporting cohorts, based on member categorization by group (PO or network).
2. **Create Source Member Lists and Member Data:** Create two initial source lists of members (unique member ID) and associated attributed benefit product for the ending month of the reporting period.

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[8] Some distinct members (identified by member unique ID) may be associated with one or more member contracts and termed dual member. Such a member may be enrolled in a qualified plan (HMO or PPO) and also enrolled in a nonqualified plan (Medicare or QUEST Integration). In such cases, a member unique ID's major product is determined by payment transformation attribution product and the only allowable products are qualified plans in HMO and PPO.

[9] Note: FEP members are part of a national account enrolled through BCBSA; FEP members cannot be enrolled through HMSA and are thus automatically excluded.

[10] In reports for interim reporting periods, ERG risk scores may not be available for members as of the ending month of the reporting period, in which cases the ERG risk scores for the most recent ERG-run month available will be employed.

[11] In reports for interim as well as final report, ERG risk scores will be available for members as of the ending month of the baseline period.

a. Create the PO Source Member List for the Reporting Period: For the ending month of the reporting period, collect all unique members (unique ID and attributed benefit product) attributed to any of the PCPs affiliated with PO group, as long as the attributed benefit product is either HMO or PPO.

b. Create the Network Source Member List for the Reporting Period: For the ending month of the reporting period, collect all unique members (unique ID and attributed benefit product) attributed to any of the PCPs affiliated with network group, as long as the attributed benefit product is either HMO or PPO.

(Note: for both source member lists created, the set of unique members is larger than will be used in calculations because they haven't been edited for completeness or attributes, exclusions, or matching data from baseline period.)

Step 3. Assemble Data for Member Reporting Cohorts

1. **Assemble Required Data for Member Attributes for Reporting Period:** For each group (PO and network), for the reporting period, extract the following member related data for each member subject to specified exclusions:

   a. Member unique identifier.

   b. Member benefit product (PPO or HMO).

   c. Member age (for risk adjustment).

   d. Member gender (for risk adjustment).

   e. Member risk-morbidity category (for risk adjustment), based on member assignment to symmetry episode risk group **("ERG")** retrospective risk category as of the ending month of reporting period.

   f. Apply Initial Exclusions: Data are assembled for attributes (a) through (g) for those unique members in the initial listing who don't meet one of the following initial exclusion criteria as of the ending month of the report period:[7]

      i. Members of the Federal Employee Plan ("FEP").

      ii. Members of a Medicare Advantage plan.

      iii. Members of the QUEST Integration plan.

      iv. Members of another health plan operating under a license with the Blue Cross Blue Shield Association and entitled to benefits under the Blue Card Program.

2. **Assemble Required Data for Member Attributes for Baseline Period:** For each group (PO and network), for the baseline period, extract the following member related data for each member subject to specified exclusions:

   a. Member unique identifier

   b. Member age (for risk adjustment).

   c. Member gender (for risk adjustment).

   d. Member risk-morbidity category (for risk adjustment), based on member assignment to symmetry episode risk group **("ERG")** retrospective risk category as of the ending month of baseline period.[8]

   e. Apply Initial Exclusions: Data are assembled for attributes (a) through (g) for those unique members in the initial listing provided that they don't meet one of the following initial exclusion criteria:

      i. Members of the Federal Employee Plan ("FEP").

      ii. Members of a Medicare Advantage plan.

      iii. Members of the QUEST Integration Plan.

      iv. Members of another health plan operating under a license with the Blue Cross Blue Shield Association and entitled to benefits under the Blue Card Program.

Step 4. Calculate Member Total Enrolled Months and Total Medical Reimbursement

1. **Calculate Enrolled Months per Unique Member:** Calculate the total number of active enrolled months per unique member (enrolled months)

   a. Calculate the enrolled months of each unique member in the reporting period.

   b. Calculate the enrolled months of each unique member in the baseline period.

   Note: Enrolled months for either period consist of the number of distinct months in the period that a unique member had coverage, regardless of the number of plan contracts or contract-specific member IDs a unique member was associated with. (For example, a unique member with dual qualified HMSA plans [dual member] in a given month is counted as having one enrolled month.)

2. **Qualified Claims Reimbursement:** Calculate the total medical benefits reimbursement for qualified claims detail for each unique member. (For unique members with dual qualified HMSA plans, medical claims reimbursement is the summation of primary and secondary payments.)

   a. Calculate the total qualified claims reimbursement for medical benefits per unique member in the reporting period.

   Note: For this period, qualified claims are claims for services covered under a member's commercial HMO or PPO medical benefit plan, excluding:

      1) Services rendered by and paid to out-of-state providers.

      2) BlueCard, out-of-state, and out-of-country claims.

      3) Drug claims.

      4) Behavioral health service claims (see definition below).

b. Calculate the total qualified claims reimbursement for medical benefits per unique member in the baseline period.

Note: For this prior period, qualified claims are claims for services covered under a member's commercial HMO or PPO medical benefit plan, excluding:

1) Services rendered by and paid to out-of-state providers.
2) BlueCard, out-of-state, and out-of-country claims.
3) Drug claims.
4) Behavioral health service claims (see definition below).

3. Behavioral Health Services Exclusion Definition:

Click the icon below for details:

Step 5. Clean and Standardize Member Data

1. **Create separate member calculation data sets for group and period.**
   a. Create complete calculation data set for the following member cohorts:
      - PO-reporting period.
      - Network-reporting period.
      - PO-baseline period.
      - Network-baseline period.
   b. Complete calculation data set fields per cohort consist of the following:
      - Member UID.
      - Member group (target=PO, comparison=network).
      - Member age.
      - Member gender.
      - Member ERG retro risk category.
      - Member total distinct enrolled months.
      - Member total medical benefit reimbursement.
2. **Clean and standardize data values.**
   a. Set member net medical benefit reimbursement to 0 if null.
3. **Remove member records with missing or inadmissible data in required data fields.**
   a. Remove member records with missing data in required data fields:
      - Member UID.
      - Member group (PO, network).
      - Member age group (<1,1-19,20-39,40-49,50-64,65+).
      - Member gender (male, female).
      - Member ERG retro risk category (0,...,25).
      - Member total distinct enrolled months (non-null numeric value > 0).
      - Member net medical benefit reimbursement (non-null numeric value ≥ 0).
   b. Remove unmatched member records:
      - Remove baseline period member records where MbrUID not matched in reporting period.
      - Remove reporting period member records where MbrUID not matched in baseline period.
4. **Split and recombine benefit product cohorts per period**
   a. Starting with the following source datasets with data variables as described above:
      - PO-reporting period.
      - Network-reporting period.
      - PO-baseline period.
      - Network-baseline period.

Step 6. Calculate the Claims Based Unadjusted PMPM

1. **Calculate claims based unadjusted PMPM amounts.**

   a. Definitions:

   - PO PMPM = claims based unadjusted PMPM amounts for the PO members.
   - Network PMPM = claims based unadjusted PMPM amounts for network members.
   - Calculation: Claims based unadjusted PMPM amounts are calculated within each analytic dataset as total qualified claims reimbursement divided by total enrolled months.

   b. Generate the following unadjusted claims based PMPM amounts:

   - Reporting period.
     1. PO PMPM.
     2. Network PMPM.
   - Baseline period.
     1. PO PMPM.
     2. Network PMPM.

Example Table

	cohort	mbrmos	prod	age	agegrp	sex	expmnowk	expmnal	expmnwk	agegrpsex	asexg	asex
1	HPN	4933	HMO	32	Age 20 - 39	M	0.0000	00	0	Age20-39M	Age20-39M00	Age20-39M0
2	HPN	20704	HMO	28	Age 20 - 39	F	0.0000	00	0	Age20-39F	Age20-39F00	Age20-39F0
3	HPN	82499	HMO	32	Age 20 - 39	F	0.0000	00	0	Age20-39F	Age20-39F00	Age20-39F0
4	HPN	178251	HMO	17	Age 1 - 19	M	0.0000	00	0	Age1-19M	Age1-19M00	Age1-19M0

and

treimb	tmbrmo
0.00	12
0.00	9
33.62	12
394.00	12

Step 7. Calculate Risk-Adjusted PMPM to Account for Age/Sex/Morbidity Differences between Attributed Members and Network Members

1. **Risk adjustment definitions and approach.**

   a. *Risk-adjusted PMPM rationale:* Claims based non-risk-adjusted PO PMPM is risk-adjusted with respect to claims based network PMPM in order to ensure the most appropriate comparison of PMPM medical dollars accounting for differences in risk due to member risk factors.

   b. *Risk-adjustment risk factors:* The member risk factors selected for use in risk-adjusted PMPM calculation reflect key systematically measurable sources of risk: individual age, gender, and morbidity (illness burden).

   c. *Symmetry ERG risk classification:* HMSA uses the ERG retrospective risk category as the best measure of member morbidity.

   d. *Member risk stratification:* Risk-adjusted PMPM calculations require attributed members to be stratified by specified risk factors. For this methodology, risk strata are defined as combinations of age group, gender category, and morbidity risk category for each member for each period.

      - *Member age group:* HMSA will use six age groups defined by mutually exclusive age intervals as follows: <1, 1-19, 20-39, 40-49, 50-64, and 65+. A member's (maximum) age as of the ending month of the reporting period determines the age group to which he/she is assigned for risk stratum assignment.

      - *Member gender category:* There are two genders, male and female. A member's gender as of the ending month of the reporting period determines the gender for risk stratum assignment.

      - *Member morbidity-risk category*

         1) *Symmetry ERG risk classification:* HMSA will use the ERG software installed at HMSA and run monthly to assign ERG risk scores to each HMSA enrolled member. ERG retrospective risk scores identify a numeric value of relative morbidity risk for an individual (unique member) for a 12-month historical experience period identified by ending-month-and-year.

         2) *Symmetry ERG risk categories:* Defined mutually exclusive intervals of risk score define distinct ERG retrospective risk categories. There are 26 ERG retrospective risk categories, numbered 0 through 25. A member is assigned to only one morbidity-risk category for a 12-month experience period indicated by ending month.

      - Member risk strata: Risk strata are distinct combinations of age, gender and ERG risk categories (for example: male, age 40-49, ERG Risk Category 15).

         1) There are a maximum of 312 unique risk strata possible as defined for this methodology.

         2) Risk strata are retained for use in overall PO risk-adjusted PMPM calculation if there are positive count of members from both PO and network cohorts.

   e. *Member benefit product assignment:* Identify and assign members to benefit product as of the ending month of the reporting period.

   f. *Member risk stratum assignment:* Assign members to risk strata based on age category, gender, and ERG morbidity/risk category as described above.

   g. *Member months:* Identify the total of distinct enrolled months per member for both reporting and baseline periods.

   h. *Reimbursements:* Identify the sum of qualified claims reimbursements per member for both reporting and baseline periods.

   i. *Risk-adjusted rates method:* Risk-adjusted rates can be calculated in two ways: direct method or indirect method. Both methods require calculation of a target group's expected value per risk stratum. The indirect method offers more generality and is more applicable to situations where data gaps exist in data for target (PO) group's risk strata. The indirect method is used in this TCOC methodology.

   j. *Risk-adjusted rate calculation:* Target (PO) group's risk adjusted PMPM is calculated as an adjustment of comparison (network) group's unadjusted PMPM. The adjustment is made using a PO adjustment factor, which is the ratio of PO actual total reimbursement to PO expected total reimbursement (simply stated as a ratio of observed over expected). The expected total reimbursement for PO under the indirect method of risk adjustment is the product of PO member months times network's unadjusted PMPM; this calculation reflects the adjustment assumption that PO members have the same PMPM as network members.

2. **Generate risk strata labels: Create risk strata labels per member record per analytic dataset.**

   a. Risk strata labels are created as the concatenation of distinct labels for age groups, gender categories, and ERG retro risk categories.

   b. For each distinct member record in each analytic dataset, generate the risk strata label (e.g., Age20M00, Age20-39M12) as the concatenation of age group label, gender label, and ERG risk category label.

3. **Create risk strata tables from the analytic datasets.**

   a. Definition:

      - Risk strata tables are the set of analytic rows resulting from the permutation of maximum allowed age groups, gender categories and ERG risk categories (n=312 rows as defined above).

   b. Create four risk strata tables, one for each combination of product and period.

      - The two risk strata tables are:

        1) Risk strata table for reporting period (PO & network).

        2) Risk strata table for baseline period (PO & network).

      - Each table consists of a maximum of 312 rows.

      - Each table contains 10 columns: RiskStratum, T_TotMbrs, T_TotMbrMo, T_TotReimb, T_TotExpReimb, T_TotPMPM, and B_TotMbrs, B_TotMbrMo, B_TotReimb, B_TotPMPM

      - Columns are labelled and defined as follows:

        1) T_ = target group = PO.

        2) B_ = benchmark group = network.

        3) TotMbrs = count of total distinct members per group.

        4) TotMbrMo = sum of enrolled months per group.

        5) TotReimb= sum of claims based benefit reimbursement dollars.

        6) TotExpReimb = blank field initially to hold calculation of risk-adjusted expected reimbursement dollars per group.

        7) TotPMPM = (TotReimb / TotMbrMo) per group.

   c. Populate each risk strata table from data in the analytic datasets as follows:

      - Per risk stratum in a specified risk strata table:

        1) Assign total count of distinct member records per group to T_TotMbrs (for PO group) and to B_TotMbrs (for network group) for members labeled with the specified risk stratum.

        2) Assign sum of MbrMo (member months) per unique member across all member records per group to T_TotMbrMo (for PO group) and to B_TotMbrMo (for network group) for members labeled with the specified risk stratum.

        3) Assign sum of total reimbursement per unique member across all member records per group to T_TotReimb (for PO group) and to B_TotReimb (for network group) for members labeled with the specified risk stratum.

        4) Assign the result of (T_TotReimb / T_TotMbrMo) to T_TotPMPM, and assign the result of (B_TotReimb / B_TotMbrMo) to B_TotPMPM.

        5) Finally, assign the product (B_TotPMPM * T_TotMbrMo) to T_TotExpReimb.

Example Risk Strata Table for a specified Product and Period (partial set of rows)

	aserg	t_nmbrs	t_mbrmo	t_ttreimb	t_exptreimb	t_pmpm	b_nmbrs	b_ttreimb	b_mbrmo	b_pmpm
1	Age1-19F00	543	6098	125228.24	92018.82	20.54	1950	328746.13	21782	15.09
2	Age1-19F01									
3	Age1-19F02									
4	Age1-19F03									
5	Age1-19F04	249	2966	90122.00	75217.76	30.39	940	281777.76	11109	25.36
6	Age1-19F05	178	2102	76378.02	75356.70	36.34	584	247316.48	6898	35.85
7	Age1-19F06	137	1614	82223.56	73517.70	50.94	601	321135.66	7060	45.55
8	Age1-19F07	167	1938	84866.97	102888.42	43.79	613	381630.13	7186	53.09

4. **Create a set of four risk summary tables.**

   a. Definition: The risk summary table per product-period summarizes totals, ratios, and rates required in calculating the PO claims based risk-adjusted PMPM for each period (reporting and baseline). A total of two risk summary tables are generated for each report.

   b. Create a risk summary table per product-period

   - The two risk summary tables are:
     1) Risk summary table reporting period (PO & network).
     2) Risk summary table baseline period (PO & network).
   - Each risk summary table consists of one row.
   - Each risk summary table contains 11 columns: Peer_TMbrs, Peer_TMbrMo, Peer_TReimb, Tgt_TMbrs, Tgt_TMbrMo, Tgt_TReimb_obs, CR_Peer, CR_Tgt, Tgt_TReimb_exp, AF_Tgt, AdjRate_Tgt.
   - Columns are labeled and defined/populated as follows:
     1) Peer_TMbrs = total distinct members for peer group (network).
     2) Peer_TMbrMo = total member months for peer group (network).
     3) Peer_TReimb = total reimbursement for peer group (network).
     4) Tgt_TMbrs = total distinct members for target group (PO).
     5) Tgt_TMbrMo = total member months for target group (PO).
     6) Tgt_TReimb_obs = total actual (observed) reimbursement for target group (PO).
     7) CR_Peer = crude rate of peer group = unadjusted PMPM of network = (Peer_TReimb / Peer_TMbrMo).
     8) CR_Tgt = crude rate of target group = unadjusted PMPM of PO = (Tgt_TReimb_obs / Tgt_TMbrMo).
     9) Tgt_TReimb_exp = sum of expected reimbursement for target group (PO) = sum of risk strata table T_TotExpReimb values across all risk strata.
     10) AF_Tgt = adjusted factor for target group (PO) = observed total reimbursement divided by expected total reimbursement for PO = (Tgt_TReimb_obs / Tgt_TReimb_exp).
     11) AdjRate_Tgt = risk adjusted rate for target group (PO) = risk adjusted claims based reimbursement PMPM for PO = (CR_Peer * AF_Tgt).

Example table:

Peer_TReim	Tgt_TMbrs	Tgt_TMbrMo	Tgt_TReim_obs	CR_Peer	CR_Tgt	Tgt_TReim_exp	AF_Tgt	AdjRate_Tgt
195748101.32	16674	191142	42484426.08	211.37	222.27	37970870.99	1.118869	236.50

5. **Summary of Claims Based PO and Network Rates and Factors.**

   a. Results of the above steps and calculations saved in the four risk summary tables include all required and supporting data for claims based risk-adjusted medical reimbursement PMPM.

   b. Risk summary tables for each period (reporting & baseline) provide required calculated values:

      - Overall network PMPM.
      - Overall PO PMPM.
      - Overall PO risk-adjusted PMPM (claims based risk-adjusted PO PMPM).

   c. The risk summary tables each period (reporting & baseline) also provide supporting calculated values:

      - Total PO reimbursement (observed or actual dollars).
      - Total PO expected reimbursement (expected dollars).
      - PO risk adjustment factor (calculation of the ratio of observed dollars to expected dollars, the factor applied to overall network PMPM to yield the PO risk-adjusted PMPM).

6. **Claims Based Risk-Adjusted PMPM Amounts:** As a recap of the above step, the following CBRA PMPM amounts will be generated and saved to risk summary tables:

   a. Reporting period:

      - Claims based network PMPM.
      - Claims based risk-adjusted PO PMPM.

   b. Baseline period:

      - Claims based network PMPM.
      - Claims based risk-adjusted PO PMPM.

Part B. Calculation of Non-claims Based Benefit Expense

Step 8. Include Non-Claims Based Benefit Expense Costs

1. The following non-claims based benefit expense costs will be added to the CBRA PMPM amounts on a PMPM basis:

   a. PCP bundled rate of care (monthly PMPM payment).

   b. Fees (PCMH PCP, PO, ACO, HMO, etc.), if any.

   c. PCP & PO patient management fees including PT Engagement Measure payments.

   d. Quality payments (PCP, provider organization, hospital, etc.).

   e. Payments to HMSA vendors.

In situations where the actual amount (quality settlement with the specific hospital facility, for example) hasn't yet been settled by the time the yearly reconciliation is due, an estimated settlement amount will be developed/used.

2. The following benefit expense PMPM amounts (CBRA PMPM, adjustments for non-claims based benefit expense costs, and patient management fees) will be generated:

   a. Total reporting period.

      - PO BE PMPM.
      - Network BE PMPM.

   b. Total baseline period

      - PO BE PMPM.
      - Network BE PMPM.

Part C. Calculation of the TCOC and Shared Savings

The following TCOC amounts and percentages will be calculated:

PO TCOC = ((Reporting Period PO BE PMPM/ Baseline Period PO BE PMPM)-1).

PO shared savings = PO BE PMPM x (Target TCOC – PO TCOC) x 40% x attributed member months.


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