2018 Primary Care Provider Quality Improvement Program (PCP QIP)
Measurement Specifications

FAMILY MEDICINE PRACTICES

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II. Program Overview

The PCP Quality Improvement Program (QIP), designed in collaboration with PHC providers, offers sizable financial incentives and technical assistance to primary care providers so that they can make significant improvements in the following areas:

- Prevention and Screening
- Chronic Disease Management
- Appropriate Use of Resources
- Primary Care Access and Operations
- Patient Experience
- Advance Care Planning

Although the PCP Quality Improvement Program evaluates performance on PHC’s Medi-Cal line of business, PHC encourages quality, cost-efficient care for all your patients. Incentives are based on meeting specific performance thresholds in measures that address the above areas (see p.6-10 for a Summary of Measures).

Guiding Principles

The QIP uses nine guiding principles for measure development and program management to ensure our members have high quality care and our providers are able to be successful within the program.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable measures
4. Feasible data collection
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measurement set
8. Align measures that are meaningful
9. Stable measures

The guiding principles outlined above are used to select measures for improvement. These measures are selected in areas that are not addressed under PCP contracts, such as population-level screening targets and other population-level preventive care services. The QIP serves to increase health plan operational efficiencies by prioritizing areas that drive high quality care and have potential to reduce overall healthcare costs.

Program Timeline: 2018

Historically, the PCP QIP has run on an annual program period beginning July 1 and ending June 30. The PCP QIP is transitioning to an annual program period aligned with the calendar year, beginning 2018. A 6-month “transition period” was conducted at the conclusion of the 2016-2017 year, from July 1, 2017 to December 31, 2017. After the transition period, the calendar year cycle begins, and the 2018 measurement year begins on January 1, 2018 and ends on December 31, 2018. The PCP QIP will continue on an annual, calendar-year basis thereafter.

Payment is sent out 120 days after the program period ends, on April 30, 2019. In order to maintain a stable measurement set, measure development occurs on a two-year cycle; major changes are only made every other year.
Eligibility Criteria
All current primary care providers, including pediatric, family, and internal medicine sites, that have capitated Medi-Cal only members and are contracted with PHC for at least six months during the measurement year are enrolled in the QIP, and all new primary care providers contracted with PHC for the full 12 months during the measurement year are enrolled in the QIP.

If a provider site is contracted for at least nine out of 12 months during the measurement year, it reports on all applicable measures. If a provider site is contracted for more than six but less than 11 months during the measurement year, it only reports on measures that rely on administrative data; the Clinical and Patient Experience measures in the Core Measurement Set do not apply. If a contract is terminated during the measurement year, eligibility will be reviewed on a case-by-case basis. In order to offer comprehensive QIP data, sites are required to report to the QIP at the PCP-ID level.

Eligible Population
The eligible population used to calculate the final scores for all measures is defined as capitated Medi-Cal members. For measures in the Clinical domain, the member also has to be continuously enrolled with a PCP site, with continuous enrollment defined as being assigned for nine out of the 12 months between 1/1/2018 and 12/31/2018. Medi-Medi or dually eligible members are excluded from all measures.

Payment
The PCP QIP is comprised of two measurement sets each with its own payment methodology.

The PCP QIP Core Measurement Set includes measures in the Clinical, Appropriate Use of Resources, Operations and Access, and Patient Experience domains. For these measures, performance is rewarded based on the points earned and the number of member months accumulated throughout the year. There is a fixed per member per month (PMPM) amount for all sites. The number of member months is multiplied by the PMPM to determine the maximum amount an individual site can earn. That amount is then multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

Example: The PMPM amount is illustratively set at $10.

- A site that earns 100% of their QIP Core Measurement Set points would earn 100% of the site’s potential amount. If the site had an average of 1,000 members, that would result in a total of 12,000 member months. The $10 is then multiplied by 12,000, equaling a payment of $120,000. This breaks down to a realized $10.00 PMPM.

- A site that earns 55% of their QIP Core Measurement Set points would earn 55% of the site’s total potential amount. If the site had 1,000 members and 12,000 member months, this would equal a final payment amount of $66,000. This breaks down to a realized $5.50 PMPM.

The PMPM amount may change annually based on the plan’s financial performance. It is announced annually at the beginning of the measurement year and may change mid-year pending unforeseen State budget impacts to the plan.

For the Unit of Service measures, the payment is independent of and distinct from the financial incentives a site receives from the Core Measurement Set. A site receives payment according to the measure specifications if the requirements for one or more Unit of Service measures are met.

Billing
The QIP often uses administrative data to evaluate performance on clinical and non-clinical measures. The codes that will trigger automatic inclusion for evaluation are listed in our Code List and specified within each measure. These claims may not be wholly representative of reimbursable codes of PHC. Please review the code list for any potential billing discrepancies.
eReports

eReports, an online system built for the QIP Clinical measures, is the mechanism by which providers can monitor their performance and submit supplemental data to PHC. The eReports portal may be accessed at https://qip.partnershiphp.org/. The launch date of eReports falls within the first quarter of the measurement year to ensure availability of data throughout the measurement year; the exact date may vary from year to year and is announced via the QI Newsletter. Providers have access to eReports for the reporting measurement year from the launch date through the end of the grace period. The grace period is defined as the period between the close of the measurement year and the close of eReports, i.e. January 31 following the measurement year, and is intended to allow for final data collection and uploads.

All providers, regardless of denominator size, will be held against the established thresholds. We are aware that small denominators may negatively impact the overall performance on that measure. Therefore, if a provider 1) has fewer than 10 members in the denominator for any clinical measure after continuous enrollment is applied and 2) does not meet the threshold, there will be an additional opportunity to submit evidence of outreach efforts to non-compliant members conducted during the measurement year. Providers with denominators of less than 10 members must provide evidence of three targeted outreach attempts when requesting a member be excluded from the denominator. Outreach information must be submitted to the QIP team by 5 p.m. on the last day of the grace period.

Non-Clinical Reports

In addition to the eReports system, the QIP Team produces site-specific Non-Clinical Reports on a bimonthly basis, containing performance data on the Non-Clinical measures (i.e. measures in the Appropriate Use of Resources, Access & Operations, and Patient Experience domains). These reports provide a retrospective look at a site’s performance based on available data. They will be distributed via e-mail to the preferred contacts at each QIP participating site.

Payment Dispute Policy

Data accessible by providers prior to payment is considered final. You can access performance data throughout the measurement year and, during the validation period at the end of the measurement year, review data on which your final point earnings will be based. Dispute of final data described below will not be considered:

1. QIP scores on eReports

   eReports refreshes data on a daily basis and providers have access to eReports through the well-published grace period (30 days after the end of the measurement year, through January 31) to check for data disparities. Additionally, providers have access to eReports for during the one-week validation period, after the grace period closes, to verify that all data manually submitted correctly corresponds to resulting scores. Each site is responsible for its own data entry and for validating the outcome of uploads. At the discretion of the QIP team, PHC may assist a provider with uploading data before the close of the grace period, if prior attempts have failed. In these cases, providers are still responsible for verifying successful uploads. If a provider does not alert the QIP of any potential issues, data shown in eReports at the end of this validation period will be used to calculate final payment. After this period, post-payment disputes specific to eReports data will not be considered.

2. Exclusions on eReports

   Some exclusions from denominators, when approved, involve a manual process by PHC staff. Since the QIP receives a large volume of exclusion requests, providers are responsible for checking that members are correctly excluded. Post-payment disputes related to member eligibility for specific measures will not be considered. Exclusion requests must be submitted to the QIP team via email by 5 p.m. on the last day of the grace period (January 31 following the measurement year, unless otherwise announced).

3. Data reported on the Year-End Preliminary Report
At the end of the measurement year, before payment is issued, QIP will send out a Preliminary Report detailing the final point earnings for measures that are tracked manually, such as Patient Experience and Practice Open to PHC Members. Providers will be given one week to review this report for potential discrepancies. If a provider does not alert the QIP of any issues during the validation period, data on the Preliminary Report will be reflected in the final payment. Post-payment disputes on data on the Preliminary Report will not be considered.

4. Practice type designations
   Each PCP site is categorized as either: Internal Medicine, Family Practice, or Pediatric Practice. Each practice type is responsible for different QIP measures. Criteria regarding these designations is available in the PCP QIP Measurement Specification Documents. The QIP team is available throughout the measurement year to answer questions about these designations as defined in the QIP. Requests to change a designation post-payment cannot be addressed for the measurement year reflected in the payment.

5. Thresholds
   Network-wide and site-specific thresholds can be reviewed in the QIP measurement specification document and on eReports throughout the measurement year. The QIP may consider adjusting thresholds mid-year based on provider feedback. However, post-payment disputes related to thresholds cannot be accommodated.

Should a provider have a concern that does not fall in any of the categories above (i.e. the score on your final report does not reflect what was in eReports), a Payment Dispute Form must be filled out within 60 days of receiving the final statement. All conversations regarding the dispute will be documented and reviewed by PHC. All payment adjustments will require approval from PHC’s Executive Team.

**Governance Structure**

The QIP and its measurement set are developed collaboratively with internal and external stakeholders and receive feedback and approval from the following parties:

**Provider Network:** Providers provide feedback on program structure and measures throughout the measurement year. During the measure development cycle, proposed changes are released to the network for public comment.

**QIP Technical Workgroup:** The QIP internal workgroup consisted of representatives from Finance, Provider Relations, and IT Departments reviews program policies and proposes measure ideas.

**QIP Advisory Group:** The QIP external advisory group comprised of physicians and administrators from all practice types and counties provides recommendations on measures and advises on QIP operations.

**PHC Physician Advisory Committee:** The Brown Act committee with board certified physicians is responsible for approving measures.

**Board of Commissioners:** The PHC Board approves the financial components of the QIP.
III. Summary of Measures

For the tables below, please refer to these notes:

1: For all existing clinical measures, the full-point target is set at the 90th percentile performance of all Medicaid health plans. Sites have the opportunity to receive half points on measures if the 75th percentile performance is met. For all new clinical measures, the full-point target is set at the 50th percentile performance, and no partial points are available.

2: For existing clinical measures, sites can also earn partial points based on relative improvement (RI). Relative improvement measures the percentage of the distance the provider has moved from the previous year’s rate toward a goal of 100 percent. The method of calculating relative improvement is based on a *Journal of the American Medical Association* authored by Jencks et al in 2003, and is as follows:

\[
\frac{(\text{Current year performance}) - (\text{previous year performance})}{(100 - \text{Previous year performance})}
\]

The formula is widely used by the Integrated Healthcare Association commercial pay for performance program as well as by the Center for Medicare and Medicaid Services.

- A site’s performance on a measure must meet the 25th percentile target, also known as the minimum performance level (MPL), in order to be eligible for RI points on the measure.
- A minimum of 15% RI will be needed to earn partial points.

3: Site specific and practice type risk adjusted targets are sent with the first Non-Clinical Reports in 2018, to be released in March 2018.

4: All clinical measures except Colorectal Cancer Screening use as targets the performance percentiles obtained from the NCQA national averages for Medicaid health plans reported in 2017. The Colorectal Cancer Screening targets are based on the 75th and 90th percentile plan-wide performance from the 2016-17 QIP, as data for Medicaid is not available.
<table>
<thead>
<tr>
<th>Measures</th>
<th>Targets</th>
<th>Points</th>
<th>Risk Adjusted?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL DOMAIN (65 Points Total)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Monitoring Patients on Persistent Medications</td>
<td>-Full Points: TBD¹</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Partial Points: TBD, or, if performance meets MPL, 15% Relative Improvement²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Well Child Visits (3-6 yrs)</td>
<td>-Full Points: TBD¹</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Partial Points: TBD¹, or, if performance meets MPL, 15% Relative Improvement²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Controlling High Blood Pressure (18-85 yrs)</td>
<td>-Full Points: TBD¹</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Partial Points: TBD¹, or, if performance meets MPL, 15% Relative Improvement²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Cervical Cancer Screening (21-64 yrs)</td>
<td>-Full Points: TBD¹</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Partial Points: TBD¹, or, if performance meets MPL, 15% Relative Improvement²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Colorectal Cancer Screening (51-75 yrs)</td>
<td>-Full Points: TBD⁴</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Partial Points: TBD⁴, or, if performance meets MPL, 15% Relative Improvement²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Diabetes Management: HbA1C good control (18-75 yrs)</td>
<td>-Full Points: TBD¹</td>
<td>5</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>-Partial Points: TBD¹, or, if performance meets MPL, 15% Relative Improvement²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Diabetes Management: Retinal Eye Exams (18-75 yrs)</td>
<td>-Full Points: TBD¹</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Partial Points: TBD¹, or, if performance meets MPL, 15% Relative Improvement²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Diabetes Management: Nephropathy (18-75 yrs)</td>
<td>-Full Points: TBD¹</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Partial Points: TBD¹ or, if performance meets MPL, 15% Relative Improvement²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Breast Cancer Screenings</td>
<td>-Full Points: TBD¹</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-No partial point is available for this measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Childhood Immunization Combo-3</td>
<td>-Full Points: TBD¹</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-No partial point is available for this measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Immunizations for Adolescents</td>
<td>-Full Points: TBD¹</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-No partial point is available for this measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Admissions/1000</td>
<td>-Full Points: &lt; 110% of site-specific target³</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>-Partial Points: 111-119% of site-specific target³</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>7.5</td>
<td>Yes: By PCP/Site³</td>
<td></td>
</tr>
<tr>
<td>13. Readmission Rate</td>
<td>-Full Points: &lt;110% of target³</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Partial Points: 111-119% of site-specific target³</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.5</td>
<td>Yes: By Practice Type³</td>
<td></td>
</tr>
</tbody>
</table>

### ACCESS & OPERATIONS (10 Points Total)

| 14. Primary Care Utilization: ED Visits and PCP Office Visits | -Full Points: At or below target for ED visits AND at or above target for PCP office visits³ |
|                                                             | -Partial Points: At or below target for ED visits³ |
|                                                             | 10 | Yes: By plan and PCP/site³ |

### PATIENT EXPERIENCE (10 Points Total)

| 15. CAHPS Survey for qualified sites, or Survey Option for all other sites |
| CAHPS surveys will be paid based on site’s Access and Communication composites according to the following targets: |
| -Full Points: Re-survey result > PHC 50th percentile score |
| -Partial Points: Re-survey result between PHC 25th and 50th percentile scores |
| Access Median: 45.0%  |
| Access 25<sup>th</sup> Percentile: 41.1%  |
| Communication Median: 70.3%  |
| Communication 25<sup>th</sup> Percentile: 67.0%  |
| 10 | No |
## Unit of Service Measures – All Practice Types

<table>
<thead>
<tr>
<th>Measure</th>
<th>Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning attestations</td>
<td>$5,000 for 50-99 attestations; $10,000 for 100+ attestations; in addition, $5,000 for 50-99 advance directives/POLST; $10,000 for 100+ advance directives/POLST for Medi-Cal members 18 years and older.</td>
</tr>
<tr>
<td>Access/Extended Office Hours</td>
<td>10% of Capitation for sites that 1) earned at least 35 points in previous QIP year and 2) open for extended office hours as defined as eight hours beyond normal business hours per week.</td>
</tr>
<tr>
<td>PCMH Certification</td>
<td>$1000 yearly for achieving or maintaining PCMH accreditation</td>
</tr>
<tr>
<td>Peer-led self-management support groups (both new and existing)</td>
<td>$1000 per group (Maximum of five groups per site)</td>
</tr>
<tr>
<td>SBIRT</td>
<td>$5 per screening for screening a minimum of 10% of eligible adult members</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>One time $2500 incentive for signing on with a local or regional health information exchange</td>
</tr>
<tr>
<td>Initial Health Assessment</td>
<td>$2000 for submitting both parts of improvement plan</td>
</tr>
<tr>
<td>Timely Data Submission via eReports</td>
<td>1% of the site’s potential earning pool, or $1000, whichever is higher, for uploading 60% of data on eReports before December 1 of the measurement year.</td>
</tr>
</tbody>
</table>
IV. Clinical domain

Measure 1. Annual Monitoring for Patients on Persistent Medications

Description
The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report as a total rate:

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on diuretics.

Studies show that adverse drug events cause more than 700,000 visits to the ER each year, and the more medications people take, the higher their risk of having an adverse drug event.1 These adverse drug events can contribute to patient injury and increased health care costs. For patients on persistent medications, appropriate monitoring can reduce the occurrence of preventable adverse drug events.

Meeting and exceeding targets for kidney function screenings for all patients on persistent medications is a challenge. Routine PCP contracts do not account for this. However, the QIP sees these screenings as vitally important for preventing adverse drug events which can add to future costs.

Thresholds

- Full points: 90th percentile (TBD)
- Half Points: 75th percentile (TBD) or, if performance meets MPL, 15% Relative Improvement

**Beginning 2018, a site’s performance must meet the Minimum Performance Level (MPL), defined as the 25th percentile performance across all Medicaid plans, in order to earn points based on relative improvement.**

- MPL: 25th percentile (TBD)

Denominator
The number of continuously enrolled Medi-Cal members 18 years of age or older as of December 31, 2018 (DOB on or before December 31, 2000) who, during the measurement year, received at least 180 treatment days of ACE inhibitors or ARBs or at least 180 treatment days of Diuretics.

Members may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days’ supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition). Separately, members may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days’ supply for those medications count toward the total 180 treatment days. The 180 treatment days must come from therapies within one table. Having 180 treatment days from treatments across two tables will not count towards the denominator.

Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e. a prescription of 90 days’ supply dispensed on December 1, 2018 counts as 30 treatment days).
Sum the days’ supply for all medications and subtract any day’s supply that extends beyond December 31, 2018 of the measurement year.

Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

### Numerator

At least one serum potassium and a serum creatinine therapeutic monitoring test during the measurement year, between January 1, 2018 and December 31, 2018. Any of the following during the measurement year meet criteria:

- A lab panel test.
- A serum potassium test and a serum creatinine test.

The tests do not need to occur on the same service date, only within the measurement year.

### Codes Used

**Denominator:**
- Codes to identify ACE inhibitors or ARBs: ACE Inhibitor/ARB Medications Value Set.
- Codes to identify Diuretics: Diuretic Medications Value Set.

**Numerator:**
- Codes to identify lab panel test: Lab Panel Value Set.
- Codes to identify serum creatinine test: Serum Creatinine Value Set.
- Codes to identify serum potassium: Serum Potassium Value Set.

### Exclusions (only if not numerator hit)

Exclude members from each eligible population rate who had an acute inpatient encounter (Acute Inpatient Value Set) or non-acute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

Each member can only be counted in a provider’s denominator once. If a member has 180 treatment days on ACE inhibitors or ARBs, as well as 180 treatment days on Diuretics, he or she will only appear once in the denominator list.
IV. CLINICAL DOMAIN

MAXIMUM NUMBER OF POINTS: 5

Measure 2. Well Child Visits

Description
The percentage of continuously enrolled Medi-Cal members 3-6 years of age who received one or more well child visits with a PCP during the measurement year.

Assessing physical, emotional and social development is important at every stage of life, particularly with children and adolescents. Behaviors established during childhood or adolescence, such as eating habits and physical activity, often extend into adulthood. Well-care visits provide an opportunity for providers to influence health and development and they are a critical opportunity for screening.

Meeting and exceeding targets for annual well child visits is a challenge. Routine PCP contracts do not account for this. The QIP leverages this burden due in order to establish habitual preventive care for children.

Thresholds

- Full points: 90\(^{\text{th}}\) percentile (TBD)
- Half Points: 75\(^{\text{th}}\) percentile (TBD) or, if performance meets MPL, 15% Relative Improvement

Beginning 2018, a site’s performance must meet the Minimum Performance Level (MPL), defined as the 25\(^{\text{th}}\) percentile performance across all Medicaid plans, in order to earn points based on relative improvement.

- MPL: 25\(^{\text{th}}\) percentile (TBD)

Denominator
The number of continuously enrolled Medi-Cal members 3-6 years of age as of December 31, 2018 (i.e. DOB between January 1, 2012 and December 31, 2015).

Numerator
The number of children in the eligible population with at least one well child visit with a PCP during the measurement year, between January 1, 2018 and December 31, 2018.

NOTE: To be eligible for eReports data entry, documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.
Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners considered PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified by the measure.

### Codes Used

**Denominator:** No codes applicable as eligibility is solely defined by age.

**Numerator:** Codes to identify Well Child Visits from claims/encounter data: Outpatient Value Set.

### Exclusions (only if not numerator hit)

N/A
Measure 3. Controlling High Blood Pressure

**Description**

The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose most recent BP reading, taken during the measurement year, was adequately controlled.

Known as the “silent killer,” high blood pressure, or hypertension, increases the risk of heart disease and stroke, which are the leading causes of death in the United States. Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions. Some studies also indicate that failure to achieve blood pressure targets contribute to avoidable costs and the number of cardiovascular events. Health care providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity and smoking cessation.

Due to the size of the hypertensive population, meeting and exceeding targets for controlling high blood pressure readings can be a challenge for providers. Routine PCP contracts do not account for this. The QIP incentivizes this measure in order to combat a chronic health condition as well as reduce costs that accompany it.

**Thresholds**

- Full points: 90th percentile (TBD)
- Half Points: 75th percentile (TBD) or, if performance meets MPL, 15% Relative Improvement

**Beginning 2018, a site’s performance must meet the Minimum Performance Level (MPL), defined as the 25th percentile performance across all Medicaid plans, in order to earn points based on relative improvement.**

- MPL: 25th percentile (TBD)

**Denominator**

The number of continuously enrolled Medi-Cal members 18-85 years of age as of December 31, 2018 (i.e. DOB between January 1, 1933 and December 31, 2000) with at least one outpatient visit, with a diagnosis of hypertension, during the six months prior to the measurement year (i.e. July 1, 2017 – December 31, 2017).

**Numerator**

The number of eligible population in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age as of December 31, 2018 whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31, 2018 and flagged with a diagnosis of diabetes (see note below) whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31, 2018 and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.
To determine if the member’s BP is adequately controlled, the representative BP must be identified. Representative BP is defined as the most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g. sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g. stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the patient.

Members who met any of the following criteria during the measurement year or the year prior to the measurement year (January 1, 2017 – December 31, 2018) are identified as diabetic:

- At least two outpatient visits, observation visits, ED visits or non-acute inpatient encounters on different dates of service, with a diagnosis of diabetes. The visit types do not need to be the same for the two visits.
- At least one acute inpatient encounter with a diagnosis of diabetes.
- Dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis.

Members who met any of the following criteria are identified as not diabetic:

- Do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year (January 1, 2017 – December 31, 2018).
- A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year (January 1, 2017 – December 31, 2018).

Note: Members classified as diabetic in Step one based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are re-classified as not diabetic in this step.

**Codes Used**

**Denominator:**
- Codes to identify outpatient visits: Outpatient Without UBREV Value Set.
- Codes to identify Hypertension: Essential Hypertension Value Set.

**Numerator:** See codes below to identify diabetic and non-diabetic members.

**Diabetic Members:**
- Codes to identify outpatient visits: Outpatient Value Set.
- Codes to identify observation visits: Observation Value Set.
- Codes to identify ED visits: ED Value Set.
- Codes to identify non-acute inpatient encounters: Nonacute Inpatient Value Set.
- Codes to identify acute inpatient encounters: Acute Inpatient Value Set.
Codes to identify diabetes diagnosis: Diabetes Value Set.
Codes to identify insulin or hypoglycemics/antihyperglycemics: Diabetes Medications Value Set.

**Non-diabetic Members:**
Codes to identify gestational or steroid-induced diabetes diagnosis: Diabetes Exclusions Value Set.

Please use eReports to upload data for most recent BP readings.

<table>
<thead>
<tr>
<th>Exclusions (only if not numerator hit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.</td>
</tr>
<tr>
<td>• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set.) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31, 2018. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.</td>
</tr>
</tbody>
</table>
| • Exclude from the eligible population all members who had a non-acute inpatient admissions during the measurement year. To identify non-acute inpatient admissions:
  o Identify all acute and non-acute inpatient states (Inpatient Stay Value Set).
  o Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim.
  o Identify the discharge date for the stay. |
IV. CLINICAL DOMAIN

Measure 4. Cervical Cancer Screening

**Description**
The percentage of continuously enrolled Medi-Cal women 21-64 years of age who were screened for cervical cancer according to the evidence-based guidelines:

- Women age 21-64 who had cervical cytology performed every three years.
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Cervical cancer is a disease in which cells in the cervix (the lower, narrow end of the uterus) grow out of control. Cervical cancer used to be one of the most common causes of cancer death for American women; effective screening has reduced the mortality rate by more than 50 percent over the last 30 years. Cervical cancer is preventable in most cases because effective screening tests exist. If detected early, cervical cancer is highly treatable.11

Meeting and exceeding targets for population-level screenings for cervical cancer is a challenge for providers. Routine PCP contracts do not account for this. The QIP leverages this burden because improvements in screening rates have been associated with decreased morbidity and mortality from cervical cancer, with reduced proximal health care costs.

**Thresholds**

- Full points: 90th percentile (TBD)
- Half Points: 75th percentile (TBD) or, if performance meets MPL, 15% Relative Improvement

**Beginning 2018,** a site’s performance must meet the Minimum Performance Level (MPL), defined as the 25th percentile performance across all Medicaid plans, in order to earn points based on relative improvement.

- MPL: 25th percentile (TBD)

**Denominator**
The number of continuously enrolled Medi-Cal women 24-64 years of age as of December 31, 2018 (DOB between January 1, 1954 and December 31, 1994).

**Numerator**
The number of women in the eligible population who were appropriately screened according to evidence-based guidelines. Please refer to the steps and flow chart below.

**Step one:**
Identify women 24-64 years of age (DOB between January 1, 1954 and December 31, 1994) as of December 31, 2018 who had cervical cytology in the measurement year or the two years prior (January 1, 2016 – December 31, 2018).

Documentation in the medical record must include:
A note indicating the date when the cervical cytology was performed.

**Step two:**
From the women who did not meet Step one criteria, identify women 30-64 years of age (DOB between January 1, 1954 and December 31, 1988) as of December 31, 2018 who had cervical cytology and an HPV test on the same date of service* during the measurement year or the four years prior to the measurement year (January 1, 2014 – December 31, 2018) and who were 30 years or older on the date of both tests. Documentation in the medical record must include:

- A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.

*For administrative data, due to potential claims lag, services delivered within four days apart may count toward numerator compliance. For example, if the service date for Pap test and HPV test was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year. However, for eReports data upload, the tests must occur on the same date.

**Step three:**
Add the numbers from Steps one-two to obtain a total rate for women who were identified with appropriate screening for cervical cancer.

NOTE: For Steps one and two, count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening. Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

### Codes Used
Denominator: No codes applicable as eligibility is defined by age and gender.

Numerator:
- Codes to Identify Cervical Cancer Screening from Claims/Encounter Data: **Cervical Cytology Value Set**.
- Codes to Identify HPV test from Claims/Encounter Data: **HPV Tests Value Set**.

### Exclusions (only if not numerator hit)
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Value Set) any time during the member’s history through December 31, 2018.

Documentation of “complete,” “total” or “radical” abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria:

- Documentation of a “vaginal Pap smear” in conjunction with documentation of “hysterectomy”.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.
Monitoring for Appropriate Cervical Cancer Screening of Eligible Members

Step 1: Is there a Pap test in the measure year or the two years prior (January 1, 2016 – December 31, 2018)?

YES → Member is compliant

NO

Step 2a: Is the member 30-64 years of age?

NO → Member is not compliant

YES

Step 2b: Is there a Pap test and HPV test with the same service date during the measurement year or the four years prior to the measurement year (January 1, 2014 – December 31, 2018) and who were 30 years or older on the date of both tests?

YES → Member is compliant

Step 3: Add the numbers from Step 1 and Step 2b to obtain a total rate
IV. CLINICAL DOMAIN

Maximum Number of Points: 5

Measure 5. Colorectal Cancer Screening

Description
The percentage of members 51–75 years of age as of December 31, 2018 who had appropriate screening for colorectal cancer.

Treatment for colorectal cancer in its earliest stage can lead to a 65 percent survival rate after five years. However, screening rates for colorectal cancer lag behind other cancer screening rates—only about half of people age 50 or older, for whom screening is recommended, have been screened. Colorectal cancer screening in asymptomatic adults between the ages of 50 and 75 can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.\textsuperscript{12,13}

Meeting and exceeding targets for colorectal cancer screenings is outside the parameters of routine PCP contracts. The QIP incentivizes this measure in order to ensure patients receive life-saving preventive care that can reduce the costs of future treatments.

Thresholds

- Full points: 90\textsuperscript{th} percentile (TBD)
- Half Points: 75\textsuperscript{th} percentile (TBD) or, if performance meets MPL, 15\% Relative Improvement

\textit{Beginning 2018, a site’s performance must meet the Minimum Performance Level (MPL), defined as the 25\textsuperscript{th} percentile performance across all Medicaid plans, in order to earn points based on relative improvement.}

- MPL: 25\textsuperscript{th} percentile (TBD)

Denominator
The number of continuously enrolled Medi-Cal members 51-75 years of age by December 31, 2018 (\textit{DOB between January 1, 1943 and December 31, 1967}).

Numerator
The percentage of members 51–75 years of age who had one or more screenings for colorectal cancer. Any of the following meet the criteria:

- Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- 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.

Codes Used
Denominator: No codes applicable as eligibility is solely defined by age.
Numerator:
   Fecal immunochemical test: FOBT Value Set.
   Flexible sigmoidoscopy: Flexible Sigmoidoscopy Value Set.
   Colonoscopy: Colonoscopy Value Set.
   CT colonoscopy: CT Colonography Value Set.
   FIT-DNA: FIT-DNA Value Set.

Exclusions (only if not numerator hit)

Either of the following any time during the member’s history through December 31, 2018 of the measurement year:

- Colorectal cancer: Colorectal Cancer Value Set.
- Total colectomy: Total Colectomy Value Set.
IV. CLINICAL DOMAIN

Measure 6. Diabetes Management – HbA1c Good Control (≤9%)

Description
The percentage of members 18-75 years of age who had a diagnosis of diabetes with evidence of HbA1c levels at or below the threshold.

Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body’s inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life, and reduce healthcare costs. The QIP includes three measures for diabetes management.

Achieving outstanding levels of population control of HbA1c is a challenging endeavor, not expected as part of the routine PCP contract. Improvements in Hemoglobin A1c Control have been associated with decreased morbidity and mortality from treatment of diabetic complications, and as a result, reduced proximal health care costs.

Thresholds

- Full points: 90th percentile (TBD)
- Half Points: 75th percentile (TBD) or, if performance meets MPL, 15% Relative Improvement

Beginning 2018, a site’s performance must meet the Minimum Performance Level (MPL), defined as the 25th percentile performance across all Medicaid plans, in order to earn points based on relative improvement.

- MPL: 25th percentile (TBD)

Denominator
The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1943 and December 31, 2000) with diabetes identified as of December 31, 2018.

There are two ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior, i.e. January 1, 2017 –December 31, 2018.

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, January 1, 2017 – December 31, 2018).

- At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters, on different dates with service, with a diagnosis of diabetes. The visit types do need not be the same for the two visits.

- At least one acute inpatient encounter with a diagnosis of diabetes.

Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.
### Numerator

The number of diabetics in the eligible population with evidence of the most recent measurement (during the measurement year) at or below the threshold for HbA1c ≤9.0%.

### Denominator:

- Codes to identify outpatient visits: **Outpatient Value Set**.
- Codes to identify observation visits: **Observation Value Set**.
- Codes to identify ED visits: **ED Value Set**.
- Codes to identify non-acute inpatient encounters: **Nonacute Inpatient Value Set**.
- Codes to identify acute inpatient encounters: **Acute Inpatient Value Set**.
- Codes to identify diabetes diagnosis: **Diabetes Value Set**.
- Codes to identify insulin or hypoglycemics/antihyperglycemics: **Diabetes Medications Value Set**.

### Numerator:

- Codes to identify HbA1c good control: **HbA1c Level Greater Than 9.0 Value Set**.
- Codes to identify HbA1c test: **HbA1c Tests Value Set**.

### Exclusions (only if not numerator hit)

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2017 – December 31, 2018), and who meet either of the following criteria:

- A diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set) in any setting, during the measurement year or the year prior to the measurement year.
- Have a current lab value indicating no diabetes that is less than 12 months old and more recent than the last diabetic triggering event (as visible on eReports). See **Appendix VII** for the diabetes management table that includes lab value ranges eligible as proof for exclusions and **Appendix VIII** for the Diabetes Exclusions Flow Chart.
### IV. CLINICAL DOMAIN

**Measure 7. Diabetes Management – Retinal Eye Exam**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of members 18-75 years of age who had a diagnosis of diabetes who have had regular retinal eye exams.</td>
</tr>
</tbody>
</table>

Meeting and exceeding targets for population-level retinal eye exams is challenging: providers often do not have the time or equipment necessary to conduct retinopathy exams. These challenges are not addressed as part of routine PCP contracts. This measure encourages more retinal eye exams, which some studies indicate reduce complications of diabetes and associated health care costs. One study found that screening and treatment for eye disease in patients with type II diabetes generates annual savings of $24.9 billion to the federal government.\(^{16}\)

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Full points: 90(^{th}) percentile (TBD)</td>
</tr>
<tr>
<td>- Half Points: 75(^{th}) percentile (TBD) or, if performance meets MPL, 15% Relative Improvement</td>
</tr>
</tbody>
</table>

**Beginning 2018, a site’s performance must meet the Minimum Performance Level (MPL), defined as the 25\(^{th}\) percentile performance across all Medicaid plans, in order to earn points based on relative improvement.**

- MPL: 25\(^{th}\) percentile (TBD)

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1943 and December 31, 2000) with diabetes identified as of December 31, 2018.</td>
</tr>
</tbody>
</table>

There are two ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior (January 1, 2017 – December 31, 2018).

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, January 1, 2017 – December 31, 2018).

- At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters, on different dates with service, with a diagnosis of diabetes. The visit types do not need not be the same for the two visits.

- At least one acute inpatient encounter with a diagnosis of diabetes.

Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (January 1, 2017 – December 31, 2018).
**Numerator**

An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following.

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist or teleoptometry service such as EyePACs) in the measurement year.

\[\text{OR}\]

- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year (January 1, 2017 – December 31, 2017).

**Codes Used**

**Denominator:**

Codes to identify outpatient visits: Outpatient Value Set.

Codes to identify observation visits: Observation Value Set.

Codes to identify ED visits: ED Value Set.

Codes to identify non-acute inpatient encounters: Nonacute Inpatient Value Set.

Codes to identify acute inpatient encounters: Acute Inpatient Value Set.

Codes to identify diabetes diagnosis: Diabetes Value Set.

Codes to identify insulin or hypoglycemics/antihyperglycemics: Diabetes Medications Value Set.

**Numerator:**

Codes to identify diabetic retinal screening: Diabetic Retinal Screening Value Set, billed by an eye care professional during the measurement year.

Codes to identify diabetic retinal screening with eye care professional: Diabetic Retinal Screening With Eye Care Professional Value Set, billed by any provider type, during the measurement year.

Codes to identify negative diabetic retinal screening: Diabetic Retinal Screening Negative Value Set, billed by any provider type, during the measurement year.

Codes to identify diabetic retinal screening: Diabetic Retinal Screening Value Set, billed by an eye care professional (specialty code 18 and 59), with a diagnosis of Diabetes Mellitus without complications (Mellitus Without Complications Value Set).

For exams performed with a negative result in the year prior to the measurement year (January 1, 2017 – December 31, 2017), a result must be available.

**Exclusions (only if not numerator hit)**

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2017 – December 31, 2018), and who meet either of the following criteria:

- A diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set) in any setting, during the measurement year or the year prior to the measurement year.

- H Have a current lab value indicating no diabetes that is less than 12 months old and more recent than the last diabetic triggering event (as visible on eReports). See Appendix VII for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix VIII for the Diabetes Exclusions Flow Chart.
IV. CLINICAL DOMAIN

Measure 8. Diabetes Management – Nephropathy Screening Test or Evidence of Nephropathy

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
</table>
The percentage of members 18-75 years of age who had a diagnosis of diabetes with a recent nephropathy screening test or evidence of nephropathy.

Meeting and exceeding targets for nephropathy screenings among diabetics is an additional task requested of providers outside of their normal PCP contracts. Nephropathy screenings are a time consuming yet important preventive service for diabetic patients, and one that is oftentimes not included in a patient's normal scope of care. The QIP focuses on this measure to reduce the complications of diabetes as well as associated health care costs. 14,15

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
</table>
- Full points: 90th percentile (TBD)
- Half Points: 75th percentile (TBD) or, if performance meets MPL, 15% Relative Improvement

Beginning 2018, a site’s performance must meet the Minimum Performance Level (MPL), defined as the 25th percentile performance across all Medicaid plans, in order to earn points based on relative improvement.

- MPL: 25th percentile (TBD)

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
</table>
The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1943 and December 31, 2000) with diabetes identified as of December 31, 2018.

There are two ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior, i.e. January 1, 2017 – December 31, 2018.

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, January 1, 2017 – December 31, 2018).

- At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters, on different dates with service, with a diagnosis of diabetes. The visit types do need not be the same for the two visits.
- At least one acute inpatient encounter with a diagnosis of diabetes.

Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
</table>
The number of diabetics in the eligible population with a nephropathy screening or monitoring test or evidence of nephropathy, including diabetics who had one of the following during the measurement year.

Any of the following meet the criteria for a nephropathy screening or monitoring test or evidence of nephropathy.
• A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
  o 24-hour urine for albumin or protein.
  o Timed urine for albumin or protein.
  o Spot urine for albumin or protein.
  o Urine for albumin/creatinine ration.
  o 24-hour urine for total protein.
  o Random urine for protein/creatinine ratio.

• Documentation of a visit to a nephrologist.

• Documentation of a renal transplant.

• Documentation of medical attention for any of the following (no restriction on provider type):
  o Diabetic nephropathy.
  o ESRD.
  o Chronic renal failure (CRF).
  o Chronic kidney disease (CKD).
  o Renal insufficiency.
  o Proteinuria.
  o Albuminuria.
  o Renal dysfunction.
  o Acute renal failure (ARF).
  o Dialysis, hemodialysis or peritoneal dialysis.

• Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include, at a minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

A process flow diagram is included below to help implement this specification.

<table>
<thead>
<tr>
<th>Codes Used</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
</tr>
<tr>
<td>Codes to identify outpatient visits: Outpatient Value Set.</td>
</tr>
<tr>
<td>Codes to identify observation visits: Observation Value Set.</td>
</tr>
<tr>
<td>Codes to identify ED visits: ED Value Set.</td>
</tr>
<tr>
<td>Codes to identify non-acute inpatient encounters: Nonacute Inpatient Value Set.</td>
</tr>
<tr>
<td>Codes to identify acute inpatient encounters: Acute Inpatient Value Set.</td>
</tr>
<tr>
<td>Codes to identify diabetes diagnosis: Diabetes Value Set.</td>
</tr>
<tr>
<td>Codes to identify insulin or hypoglycemics/antihyperglycemics: Diabetes Medications Value Set</td>
</tr>
</tbody>
</table>

| **Numerator:** |
| Codes to identify evidence of ESRD: ESRD Value Set. |
| Codes to identify evidence of kidney transplant: Kidney Transplant Value Set. |
| Codes to identify a nephropathy screening or monitoring test: Urine Protein Tests Value Set. |
| Codes to identify evidence of treatment for nephropathy or ACE/ARB therapy: Nephropathy treatment Value Set. |
| Codes to identify evidence of Stage 4 chronic kidney disease: CKD Stage 4 Value Set. |
| Codes to identify ACE inhibitor or ARB dispensing event: ACE Inhibitor/ARB Medications Value Set. |

| **Exclusions (only if not numerator hit)** |
| Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2017 – December 31, 2018), and who meet either of the following criteria: |
- A diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set) in any setting, during the measurement year or the year prior to the measurement year.
- Have a current lab value indicating no diabetes that is less than 12 months old and more recent than the last diabetic triggering event (as visible on eReports). See Appendix VII for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix VIII for the Diabetes Exclusions Flow Chart.

### Monitoring for Diabetic Nephropathy

**STEP 1:**
Is there documentation of ESRD, chronic or acute renal failure, renal insufficiency, diabetic nephropathy or dialysis or renal transplant?

- **YES**
  - STOP! Member is compliant.
- **NO**

**STEP 2:**
Was a urine test for albumin or protein performed during the measurement year?

- **YES**
  - STOP! Member is compliant
- **NO**

**STEP 3:**
Review for evidence of ACE inhibitor/ARB therapy. Is there evidence of therapy in the measurement year?

- **YES**
  - STOP! Member is compliant
- **NO**
  - STOP! Member is not compliant
IV. CLINICAL DOMAIN

**Measure 9. Breast Cancer Screening**

**Description**

The percentage of continuously enrolled Medi-Cal women 50-74 years of age who had a mammogram to screen for breast cancer.

Breast cancer is a leading cause of premature mortality among US women. Breast cancer is the most common cancer among women in California, regardless of race and ethnicity. Early detection by mammography has been shown to be associated with reduced breast cancer morbidity and mortality. A mammogram can detect any cancer sign even before any lump can be felt in the breast. Studies have shown that routine mammograms are associated with 10% to 25% less chance of dying of breast cancer. Routine PCP contracts do not account for this. Therefore, the QIP incentivizes these screenings that can prevent breast cancer development and result in huge healthcare cost savings from late-stage treatment.

**Thresholds**

- Full points: 50th percentile (TBD)
- No partial point is available for this measure

**Denominator**

The number of continuously enrolled (October 1, 2016 through December 31, 2018, no gap allowed from October 1, 2016 to December 31, 2016, one month gap allowed from January 1, 2017 to December 31, 2017, and January 1, 2018 to December 31, 2018) Medi-Cal women 50-74 years of age as of December 31, 2018 (DOB between January 1, 1944 and December 31, 1968).

**Numerator**

The number of eligible population in the denominator with one or more mammograms any time on or between October 1, 2016 and December 31, 2018.

**Codes Used**

Denominator: No codes applicable as eligibility is solely defined by age.

Numerator: Codes to identify Mammogram: Mammography Value Set.

**Exclusions** (only if not numerator hit)

Bilateral mastectomy any time during the member’s history through December 31, 2018. Any if the following meet criteria for bilateral mastectomy:

- Bilateral Mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Mastectomy Value Set). Codes must be on the same claim.
- Two unilateral mastectomies ((Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1, 2018, the service date for the second unilateral mastectomy must be on or after February 15.
- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
- Any combination of codes that indicate a mastectomy on both the left and right side on the same different dates of service.
<table>
<thead>
<tr>
<th>Left Mastectomy (Any of the following)</th>
<th>Right Mastectomy (Any of the following)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same claim)</td>
<td>• Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Left Modifier Value Set) (same claim)</td>
</tr>
<tr>
<td>• Absence of the left breast (Absence of Left Breast Value Set)</td>
<td>• Absence of the right breast (Absence of Right Breast Value Set)</td>
</tr>
<tr>
<td>• Left Unilateral mastectomy (Unilateral Mastectomy Left Value Set)</td>
<td>• Right Unilateral mastectomy (Unilateral Mastectomy Right Value Set)</td>
</tr>
</tbody>
</table>
**IV. CLINICAL DOMAIN**

**Measure 10. Childhood Immunization Combo 3**

**Description**

The percentage of continuously enrolled Medi-Cal children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV). The measure calculates a rate of each vaccine and the combination rate.

Nowadays, the drop in disease rates in relies heavily on vaccination. The primary benefit of vaccination is that it prevents disease and saves lives. Immunization is considered one of the greatest public health achievements of the 20th century. Studies have showed that vaccines prevent 33,000 deaths in the U.S. annually, and between two and three million deaths worldwide. Managing the ratio of childhood immunization is a challenge for providers that falls outside of general PCP contracts. The QIP incentivizes this measure to reduce costly treatment for sickness that can be prevented by utilizing the above vaccines.

**Thresholds**

- Full points: 50\(^{th}\) percentile (TBD)
- No partial point is available for this measure

**Denominator**

The number of continuously enrolled Medi-Cal members who turn two years of age between January 1, 2018 and December 31, 2018 (DOB between January 1, 2016 and December 31, 2016).

**Numerator**

The number of eligible population in the denominator with the following:

For MMR, hepatitis B, and VZV, count any of the following:
- Evidence of the antigen or combination vaccine, or
- Documented history of the illness, or
- A seropositive test result for each antigen.

For DTap, IPV, HiB, and PCV count only:
- Evidence of the antigen or combination vaccine.

For combination vaccines that require more than one antigen (i.e., DTap and MMR), evidence of all the antigens must be found.

**DTap:** At least four DTaP vaccinations, with different dates of service, on or before the child’s 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

**IPV:** At least three IPV vaccinations, with different dates of service, on or before the child’s 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

**MMR:** Any of the following on or before the child’s 2\(^{nd}\) birthday meet criteria:
- At least one MMR vaccination
- At least one measles and rubella vaccination and at least one mumps vaccination or history of the illness on the same date of service or on different dates of service.
• At least one measles vaccination or history of the illness and at least one mumps vaccination or history of the illness and at least one rubella vaccination or history of the illness on the same date of service or on different dates of service.

Note: General Guideline 39 (i.e. the 14-day rule) does not apply to MMR.

HiB: At least three HiB vaccinations, with different dates of service, on or before the child’s 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

Hepatitis B: Any of the following on or before the child’s 2nd birthday meet criteria:
• At least three HepB vaccinations with different dates of service
  - One of the three vaccinations can be a newborn HepB vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member’s date of birth is December 1, the newborn HepB vaccination must be on or between December 1 and December 8.
  - History of hepatitis illness

VZV: Either of the following on or before the child’s 2nd birthday meet criteria:
• At least one VZV vaccination, with a date of service on or before the child’s second birthday.
• History of varicella zoster (e.g. chicken pox) illness.

PCV: At least four PCV vaccinations, with different dates of service, on or before the child’s 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:
• A note indicating the name of the specific antigen and the date of the immunization.
• A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.

For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member’s 2nd birthday.

Notes in the medical record indicating that the member received the immunization “at delivery” or “in the hospital” may be counted toward the numerator only for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the “member is up to date” with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for QIP reporting.

Immunizations documented using a generic header or “DTaP/DTP/DT” can be counted as evidence of DTaP. The burden on PCPs to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

### Codes Used

**Denominator:** No codes applicable as eligibility is solely defined by age.

**Numerator:**
- Codes to identify DTaP vaccination: DTaP Vaccine Administered Value Set.
- Codes to identify IPV vaccination: Inactivated Polio Vaccine (IPV) Administered Value Set.
- Codes to identify MMR vaccination: Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set.
- Codes to identify measles and rubella vaccination: Measles/Rubella Vaccine Administered Value Set.
Codes to identify mumps vaccination or history of the illness: Mumps Vaccine Administered Value Set; Mumps Value Set.
Codes to identify measles vaccination or history of the illness: Measles Vaccine Administered Value Set; Measles Value Set.
Codes to identify rubella vaccination or history of the illness: Rubella Vaccine Administered Value Set; Rubella Value Set.
Codes to identify HiB vaccination: Haemophilus Influenzae Type B (HiB) Administered Value Set.
Codes to identify HepB vaccination: Hepatitis B Vaccine Administered Value Set.
Codes to identify newborn hepatitis B vaccination: Newborn Hepatitis B Vaccine Administered Value Set.
Codes to identify history of hepatitis illness: Hepatitis B Value Set.
Codes to identify VZV vaccination: Varicella Zoster (VZV) Vaccine Administered Value Set.
Codes to identify history of VZV illness: Varicella Zoster Value Set.
Codes to identify PCV vaccination: Pneumococcal Conjugate Vaccine Administered Value Set.

Exclusions (only if not numerator hit)

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.
- Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

Any of the following on or before the member’s 2nd birthday meet optional exclusion criteria:

**Any particular vaccine:** Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set).

**DTap:** Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).

**MMR, VZV:** Immunodeficiency (Disorders of the Immune System Value Set); HIV (HIV Value Set; HIV Type 2 Value Set); Lymphoreticular cancer, multiple myeloma or leukemia; Anaphylactic reaction to neomycin (Malignant Neoplasm of Lymphatic Tissue Value Set).

**IPV:** Anaphylactic reaction to streptomycin, polymyxin B or neomycin.

**Hepatitis B:** Anaphylactic reaction to common baker’s yeast.
IV. CLINICAL DOMAIN

Measure 11. Immunizations for Adolescents

**Description**

The percentage of continuously enrolled Medi-Cal adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and two doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Receiving recommended vaccinations is the best defense against vaccine-preventable diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough) and human papillomavirus.\(^{19,20}\) These are serious diseases that can cause breathing difficulties, heart problems, nerve damage, pneumonia, seizures, cervical cancer and even death.\(^ {21}\)

Meeting and exceeding targets for immunizations is great challenge for providers. Routine PCP contracts do not account for this. The QIP leverages the additional burden as a matter of public health and avoidance of costs associated with preventable illnesses.

**Thresholds**

- Full points: 50th percentile (TBD)
- No partial point is available for this measure

**Denominator**

The number of continuously enrolled Medi-Cal members who turn 13 years of age between January 1, 2018 and December 31, 2018 (DOB between January 1, 2005 and December 31, 2005).

**Numerator**

The number of eligible population in the denominator who are numerator compliant for all three indicators (meningococcal, Tdap, HPV):

For meningococcal conjugate, Tdap and HPV, count only evidence of the antigen or combination vaccine.

- **Meningococcal**: At least one meningococcal conjugate vaccine, with a date of service on or between the member’s 11th and 13th birthdays.

- **Tdap**: At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, with a date of service on or between the member’s 10th and 13th birthdays.

- **HPV**: At least two HPV vaccines, with different dates of service on or between the member’s 9th and 13th birthdays.
  - There must be at least 146 days between the first and the second dose of the HPV vaccine. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.

For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:

- A note indicating the name of the specific antigen and the date of the immunization.

- A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.
For meningococcal conjugate, do not count meningococcal polysaccharide or meningococcal recombinant (serogroup B) (MenB) vaccines. Generic documentation that the “meningococcal vaccine” was administered meets criteria.

Immunization documented using a generic header or “Tdap/Td” can be countered as evidence of Tdap. The burden on PCPs to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.

### Codes Used

**Denominator:** No codes applicable as eligibility is solely defined by age.

**Numerator:** Codes to identify meningococcal conjugate: Meningococcal Vaccine Administered Value Set. Codes to identify Tdap: Tdap Vaccine Administered Value Set. Codes to identify HPV: HPV Vaccine Administered Value Set.

### Exclusions (only if not numerator hit)

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Either of the following meet optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member’s 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.
V. Appropriate Use of Resources

Measure 12. Admissions/1000 members

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of admissions in an acute care hospital during the measurement year per 1000 members per year.</td>
</tr>
</tbody>
</table>

Reducing the number of admissions in acute care settings is a difficult challenge for primary care providers. It is not part of routine PCP contracts. The QIP incentivizes this measure so patients’ problems can be managed early and intensively by primary care physicians in the hope of reducing the need for hospital admissions.

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Full points: 110% or less than target</td>
</tr>
<tr>
<td>- Half points: 111-119% of target</td>
</tr>
</tbody>
</table>

Targets are set using plan-wide mean, adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets were sent with March 2018 Non-Clinical Reports.

<table>
<thead>
<tr>
<th>Data Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>A three month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30. PHC will calculate the total number of admissions using PHC allowable claims and encounter data from acute care hospitals for services provided to the physician’s assigned members.</td>
</tr>
</tbody>
</table>

Step one: Identify all acute inpatient stays in an acute facility during the measurement Year. Include admissions in inpatient hospital, inpatient rehab or inpatient psychiatry (indicated by Service Location on claims).

Step two: Acute-to-acute transfers: An acute-to-acute transfer counts as one stay.

Step three: Assign each acute inpatient stay to the assigned PCP when the discharge occurred.

Calculation:

\[
\text{Admissions/1000} = \left( \frac{\text{Total # of admissions}}{\text{Total member months}} \right) \times 12,000
\]

<table>
<thead>
<tr>
<th>Codes Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes to identify service location as acute facility: AD Inclusion – Location Code on Code List</td>
</tr>
<tr>
<td>Codes to identify acute-to-acute transfers: AD Inclusion – Discharge Code on Code List</td>
</tr>
<tr>
<td>Codes to identify diagnosis of pregnancy or diagnosis of a condition originating in the perinatal period: AD Exclusion - Primary Diagnosis ICD9/10 on Code List</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclude hospital stays for the following reasons:</td>
</tr>
<tr>
<td>- A principal diagnosis of pregnancy</td>
</tr>
<tr>
<td>- A principal diagnosis of a condition originating in the perinatal period</td>
</tr>
</tbody>
</table>
V. APPROPRIATE USE OF RESOURCES

MAXIMUM NUMBER OF POINTS: 7.5

Measure 13. Readmission Rate

Description
Ratio of acute hospital admissions that are within 30 days of a discharge to total number of inpatient stays that meet Continuous Plan enrollment criteria.

A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs.23

Similar to Admissions, reducing readmissions is not part of routine PCP contracts. The QIP leverages this burden in order to incentivize providers to optimize post-discharge care to prevent hospital readmission, which carried significant health care costs.

Thresholds

- Full points: 110% or less than target
- Half points: 111-119% of target

Targets are set by practice type using plan-wide mean. Practice type risk adjusted targets were sent with March 2018 Non-Clinical Reports.

Data Criteria

A three month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30.

Using paid claim and capitated encounter data, PHC will identify all acute inpatient stays not subject to the exclusion criteria with a discharge date within the measurement period. The denominator is the count of all continuous stays (discharge date on or between January 1 and November 30 of the measurement year); the numerator is the count of all 30-day readmissions (admission date on or between January 1 and December 31 of the measurement year).

For acute-to-acute transfers, the original admission date is the admission date for the entire stay and the transfer's discharge date is the discharge date for the entire stay.

Transfers to rehabilitation, sub-acute, or nursing facilities will be counted as discharges.

Definitions:

<table>
<thead>
<tr>
<th>IHS</th>
<th>Index hospital stay. An acute inpatient stay with a discharge on or between January 1, 2018 and December 31, 2018. Exclude stays that meet the exclusion criteria in the denominator section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index Admission Date</td>
<td>The IHS admission date.</td>
</tr>
</tbody>
</table>

2018 PCP QIP Measurement Specifications: FAMILY PRACTICE
<table>
<thead>
<tr>
<th>Index Discharge Date</th>
<th>The IHS discharge date. The index discharge date must occur on or between January 1, 2018 and December 31, 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index Readmission Stay</td>
<td>An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.</td>
</tr>
<tr>
<td>Index Readmission Date</td>
<td>The admission date associated with the Index Readmission Stay.</td>
</tr>
</tbody>
</table>

**Denominator**

Denominator: Start with eligible population, i.e. Medi-Cal only members who do not have Medicare or other source of insurance and who are 18 years or older as of the Index Discharge Date.

Step 1: Identify all acute inpatient stays in an acute facility with a discharge date on or between January 1, 2018 and November 31, 2018. Include admissions in inpatient hospital, inpatient rehab or inpatient psychiatry (indicated by Service Location on claims). Identify the discharge date for the stay.

Step 2: Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date for the entire stay.

Step 3: Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Apply continuous enrollment at the health plan level, i.e. enrolled with PHC 90 days prior to the Index Admission Date, through 30 days after Index Admission Date.

Step 5: Assign each acute inpatient stay to the PCP where the discharge occurred.

**Numerator**

Numerator: At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1: Identify all acute inpatient stays with an admission date on or between January 2, 2018 and December 31, 2018.

Step 2: Acute-to-acute transfers: Keep the original admission date is the Index Admission Date for the entire stay, but use the transfer's discharge date as the Index Discharge Date for the entire stay.

Step 3: Exclude acute inpatient hospital admissions with a principal diagnosis of pregnancy or a principal diagnosis for a condition originating in the perinatal period.

Step 4: For each Index Hospital Stay, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

**Codes Used**

Codes to identify service location as acute facility: AD Inclusion – Location Code on Code List
Codes to identify acute-to-acute transfers: AD Inclusion – Discharge Code on Code List
Codes to identify diagnosis of pregnancy or diagnosis of a condition originating in the perinatal period: AD Exclusion - Primary Diagnosis ICD9/10 on Code List

**Exclusions**
Exclude hospital stays for the following reasons:

- A principal diagnosis of pregnancy
- A principal diagnosis of a condition originating in the perinatal period
- The member died during the stay
VI. ACCESS AND OPERATIONS

Maximum Number of Points: 10

Measure 14. Primary Care Utilization

**Description**
Two part measure rewarding low ED usage as well as high primary care access as measured by the number of PCP office visits.

Providers are often empaneled with a large number of patients for whom they are expected to establish care. Controlling the number of avoidable ED visits requires addressing patient access to care and influencing an individual's health behaviors, both of which are external to routine PCP contracts. Additionally, routine PCP contracts do not demand a certain number of visits each year. This measure exists to encourage providers to focus on this access issue, and to help curb the high costs associated with preventable ED visits. Providers are incentivized to integrate ED visit prevention into a strategy to make sure patients are establishing care with their assigned PCP.

**Thresholds**

- Full points: At or below target for ED visits AND at or above target for PCP office visits
- Partial points: At or below target for ED visits

Targets are set using a plan-wide mean adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets will be sent with March 2018 Non-Clinical Reports.

**Data Criteria**
A three month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30.

PHC will calculate the total eligible non-dual capitated member months after the month-end eligibility reconciliation load from the State. Member months are calculated by counting the total number of members who are eligible at the end of each month.

**ED Visits:** PHC will extract facility or professional claims with a location code indicating an Emergency Department, using allowable PHC claim and encounter data, for services provided to the PCP site's assigned members. Only claims with at least one of the diagnoses codes included in the Avoidable ED tab in the Code List will be included. The presence of at least one diagnosis code not considered avoidable will deem the visit as not avoidable.

**Step 1:** Identify total members assigned to PCP during each month.

**Step 2:** For those members, obtain all ED facility claims and professional claims.

**Step 3:** An ED visit is avoidable if every diagnosis code associated with an ED episode (both professional and facility claims) is included in the list of avoidable diagnoses codes.

**Calculation**

\[
\text{Avoidable ED Visits per 1000} = \frac{\text{Avoidable ED visits}}{\text{Non-Dual Capitated Member Months} \times 12,000}
\]
**PCP Office Visits**: PHC will extract the total number of PHC office visits using allowable PHC claim and encounter data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site. An estimate for incurred but not yet paid/processed claims data will be included.

Step 1: Identify total members assigned to PCP during each month.

Step 2: For those members, identify all their PCP office visits by procedure codes during that month, regardless of who the provider of the visit is, that occur in the following locations: office, home or private residence of patient, FQHC, State or local health clinic, or Rural Health Clinic.

Step 3: To calculate monthly performance for a specific provider site, divide the total number of PCP office visits by assigned members that month by the total number of non-dual capitated member months that month.

Step 4: To calculate YTD performance for a specific provider site, add up all the monthly numerators (visits by assigned members) and monthly denominators (non-dual capitated member months).

Note: it is possible that the numerator may contain visits for members who are not in the denominator, because of retroactive enrollment changes.

Calculation:

\[
PCP \text{ Office Visits PMPY} = \left( \frac{\# \text{ Office Visits}}{\text{Non-Dual Capitated Member Months}} \right) \times 12
\]

**Codes Used**

- Codes to identify service location as ED: Avoidable ED Inclusion – Location Code on Code List
- Codes to identify ED claims type (facility or professional): Avoidable ED Inclusion – ED Claims Type on Code List
- Codes to identify ED Avoidable Diagnosis Codes: Avoidable ED Inclusion – Primary Diagnosis ICD9/10 on Code List
- Codes to identify office visits location: OV Inclusion – Location Code on Code List
- Codes to identify office visits: OV Inclusion – Procedure Code on Code List
- Codes to identify void or denied claims in exclusions: OV Exclusion – Explain Code on Code List

**Exclusions**

- Members age <1 for Avoidable ED Visits
- Void claims and denied claims with certain explanation codes (See Code List – OV Exclusion) for PCP office visits
VII. Patient experience

Measure 15. Patient Experience

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>This measure aims to improve the patient experience. There are two ways in which to earn points:</td>
</tr>
<tr>
<td>- PHC contracts with a vendor to conduct the Consumer Assessment of Healthcare Providers and System (CAHPS) survey once during the measurement year;</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>- PCP conducts a survey to understand the patient experience and reports results and findings using the submission template</td>
</tr>
</tbody>
</table>

CAHPS: Providers that have sufficient PHC patient volume can earn up to a maximum of 10 points on their performance on the Access and Communication composites in the Clinician-Group CAHPS survey.

Survey Option: This option allows providers to fulfill the requirements by soliciting feedback from patients and implementing changes to improve the patient experience.

Refer to the Thresholds section below for detailed specifications.

Patient feedback can help providers capture the patient’s voice, gain more understanding of the patient population, and target specific improvement areas to improve the overall quality of health service delivery. PCP contracts do not account for this. This measure can incentivize providers to understand more about patients’ need and save future costs by identifying the right patient concerns and utilizing resources efficiently.

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) <strong>CAHPS</strong></td>
</tr>
<tr>
<td>Providers that have sufficient PHC patient volume can earn up to a maximum of 10 points for meeting performance thresholds in key measures in the Clinician &amp; Group CAHPS 3.0 survey. The validated tool can be found here: <a href="http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/downloadsurvey3.0.html">http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/downloadsurvey3.0.html</a>.</td>
</tr>
</tbody>
</table>

For sites to be measured in 2018, a baseline survey is conducted between May and July 2017 and a re-measurement survey between May and July 2018. Sites will be notified by May 1, 2017 whether they meet sufficient volume for inclusion in the CAHPS survey. A third-party vendor hired by PHC will conduct the survey independently. A site would only participate in this measure with this option (as opposed to the submission-based options) if both the baseline survey and the re-measurement survey are conducted, i.e. a site needs to be part of the CAHPS survey in both the measurement year and the year prior to the measurement year.

Sufficient patient volume is defined as having at least 1200 unique visits by PHC members between April 1, 2017 and March 31, 2018 at the parent organization level. If a site does not belong to any parent organization, it is considered a parent organization for this measure. The survey results will be analyzed at the parent organization level. Eligible population includes assigned members with at least one unique visit or special members with at least two visits during this period. Members 13-17 years of age are excluded. Adults and children will be surveyed separately.
Payment methodology: Providers will earn points by meeting the performance targets set based on the baseline survey conducted in 2017. If both the adult and child CG-CAHPS surveys are conducted at your site, you will be paid based on the higher of the two results. We will pay for the Access and Communication composites according to the following targets:

- Full points (5 points for each composite): Re-survey result > PHC 50th percentile score
- Half points (2.5 points for each composite): Re-survey result between PHC 25th and 50th percentile scores

The 2018 targets will be based on 2017 survey results:

<table>
<thead>
<tr>
<th></th>
<th>Access</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Survey Median</td>
<td>45.0%</td>
<td>70.3%</td>
</tr>
<tr>
<td>2017 Survey 25th Percentile</td>
<td>41.1%</td>
<td>67.0%</td>
</tr>
</tbody>
</table>

OR

2) Survey Option

Sites that do not meet the patient volume threshold can conduct an internal survey and report results and findings on eReports. There are two parts to this option. Please follow the steps below accordingly. Sites can describe existing survey efforts, such as the NCQA PCMH survey.

Part I (5 points):

1) Implement a survey which must include at least two questions regarding access to care (questions do not need to come from the CAHPS survey, although we encourage using CAHPS or another well vetted survey). Collect at least 100 responses per site.

2) Analyze baseline data, select measures from survey to target for improvement, identify change(s) to implement, and report on successes and challenges in the Survey Option Part I submission template.

Part II (5 points):

3) Implement change(s) for improvement.

4) Re-measure patient experience using the same survey at least once after implementing changes.

Submission Process

Only sites that use the Survey Option (i.e. sites that do not meet the patient volume threshold) are required to submit data. Beginning 2018, submission must be completed via eReports; submission via email or fax will not be considered. Part I is due on July 31, 2018 and Part II January 31, 2019.

Exclusions

N/A
Measure 16. Advanced Care Planning

Description
This measure pays for both the process and the outcome of advance care planning discussions.

The purpose of this measure is to encourage providers to integrate these important planning discussions with patients into their standard practices. Advanced care planning is valuable across the spectrum of needs. Planning for end of life care has been shown to reduce offered yet sometimes unwanted treatments. Ultimately, ACP helps ensure that unnecessary treatments are not conducted, and can result in a large cost savings. A study published in JAMA on October 5, 2011, showed that a patient dying with an advanced directive had $5585 less in hospital cost than a patient who dies without an advanced directive.

Measure Requirements
Providers will receive payment for facilitating advanced care planning (ACP) with eligible Medi-Cal only PHC members over the age of 18 after a threshold is met. Providers will receive $5000 for completing 50-99 attestations to ACP conversations. Providers will receive $10,000 for completing 100 or more ACP attestations.

In addition, providers will receive $5000 for completing 50-99 advanced directives or Physician Orders for Life-Sustaining Treatment (POLST) forms. Providers will receive $10,000 for completing 100 or more advanced directives or POLST forms. The counts of POLST and advanced directive completion will be combined, while the ACP attestations are separate.

All submissions are through eReports indicating completion of the forms; the actual forms and documentation indicating the conversation occurred during the measurement year need to be kept on file in case of an audit. ACP discussions must take place between January 1, 2018, and December 31, 2018 in order to be eligible for this measure.

Note that ACP is a covered benefit and can be reimbursed. If an ACP discussion is billed using CPT codes, that discussion is not eligible for the QIP incentive. The QIP will work with PHC’s Claims Department to identify conversations that have been reimbursed. Also note that this measure is not exclusive to patients with a life-limiting disease or condition.

Advance Directive and/or POLST:
Only one submission of each form per patient per measurement year. If a patient has a previously completed form and does not wish to make any changes, documentation of a conversation during the measurement period confirming that no change will qualify.

Attestation:
Only one attestation per patient per measurement. In addition to patient identification information including name, CIN, and date of birth, the following components are required to be documented in the chart for a provider to attest to the completion of an ACP discussion:

- Conversation about patient goals, general preferences around end of life, and prognosis (if appropriate)
- Documentation of conversation with family or recommendation for patient to talk with family
• Status of the Advance Directive:
  o Discussed
  o Given to patient
  o Completed
  o Copy in chart
  o Patient refused

• Summary of patient wishes, whether from conversation or from an Advanced Directive. Some options include:
  o Full treatment
  o Comfort care
  o Hospice
  o DNR
  o DNI
  o Other (tube feeds and blood transfusion and transfer to hospital are common items)

• If a POLST is appropriate, some status options include:
  o Discussed
  o Given to patient
  o Completed
  o Copy in chart
  o Patient refused

• Plan for next conversation.

---

**Submission Process**

Beginning 2018, submission must be completed via eReports; submission via email or fax will not be considered. Please keep the completed attestations, medical record evidence, Advance Directives, and/or POLST forms on file in case of an audit.

Submissions are due to Partnership no later than January 31, 2019. Payments will be made on an annual basis.

---

**Exclusions**

If an ACP discussion is billed using CPT codes, that discussion is not eligible for the QIP incentive. The QIP will work with PHC’s Claims Department to identify conversations that have been reimbursed.
VIII. UNIT OF SERVICE

Measure 17. Extended Office Hours

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>For PCP sites that earned a minimum of 35 points in the prior QIP measurement period, providers receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter. PCP sites that are part of a large organization and within a five mile radius of each other are eligible for the increased cap. Example 1: A parent organization has two sites within five miles of each other (Site A and Site B). Site A meets the criterion for holding extended office hours. Site B does not hold extended office hours. Since Site B is within a five mile radius, patients who are seen at Site B can easily access Site A during the extended hours of service. Both Site A and Site B are eligible for the payment. Example 2: Site A and Site B are located 15 miles apart. Only Site A holds extended office hours and meets the criterion. In this scenario, Site A is eligible for the payment but Site B is not eligible for the payment. Continuity of care is a central goal of primary care improvement efforts nationwide, because physician’s offices with office hours during the weekends and evenings allow patients more opportunities to be seen, yielding opportunities for improved health outcomes, more patient satisfaction, and lower healthcare costs. Efforts in this area are not addressed in routine PCP contracts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP sites must have earned a minimum of 35 points in the 2017 QIP measurement period in order to be eligible for this measure. PCP site must be open an additional eight hours per week or more, beyond the normal business hours, defined as Monday-Friday, 8:00 a.m. to 5:00 p.m., for the entire quarter. No award if, during a quarter, the practice site no longer offers extended office hours or reduces the hours and no longer meets the eight hour minimum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Submission Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership’s Provider Relations department keeps track of extended office hours. No submission is required for this measure. Payment is in accordance with information listed on the Provider Directory.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>An exception to this measure is made for any PHC site with less than 2000 members and more than 30 minute drive to the nearest ED. They would need to demonstrate the following:</td>
</tr>
<tr>
<td>- Have on-call arrangements available where by the on-call physicians come to the office to see urgent problems (arrangement to be submitted in writing annually to the PR representative of your county, including what types of urgent issues will be seen in the office) after hours. Deadline to submit arrangement is March 30, 2019.</td>
</tr>
<tr>
<td>- Demonstrate the use of arrangement with at least three PHC members seen in the office after hours per quarter, to be submitted quarterly by the site to their Provider Relations representative of your county. Deadlines are as follows:</td>
</tr>
</tbody>
</table>
- Q1: March 31, 2018
- Q2: June 30, 2018
- Q3: September 30, 2018
- Q4: December 31, 2018

Please note this measure is subject to an audit by the Provider Relations department.
Measure 18. Patient-Centered Medical Home Recognition

Description
$1000 yearly incentive for achieving or maintaining PCMH accreditation from NCQA, or equivalent from AAAHC or JCAHO.

Accomplishing excellent levels of service, care integration, and panel management are goals external to routine PCP contracts. This measure incentivizes providers to improve standards of care across their panels of patients, achieve recognition from established quality organizations, and maintain accreditation.

Refer to Appendix I for submission template for this measure.

Measure Requirements
Primary care provider sites with a minimum of 50 assigned Partnership members. Sites must receive accreditation, maintain accreditation, or re-certify within the measurement year. Documentation of PCMH recognition, accreditation maintenance, re-certification from NCQA, AAAHC, or JCAHO must be faxed or emailed to QIP@partnershiphp.org by January 31, 2019.

Submission Process
You may refer to (Appendix I) for the documentation template, which can be faxed or emailed to QIP@partnershiphp.org by January 31, 2019.

Exclusions
Primary care provider sites with fewer than 50 assigned Partnership members.
### Measure 19. Peer-Led Self-Management Support Groups

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for starting or continuing a peer-run self-management support group at a contracted primary care provider site ($1,000 per group).</td>
</tr>
</tbody>
</table>

Hosting and leading support groups for various health needs is not part of routine PCP contracts. They are not considered a routine part of primary care. Incentivizing this measure allows for patients to receive additional support for needs that affect their overall health and overall health expenditures.

Refer to [Appendix II](#) for submission template for this measure.

<table>
<thead>
<tr>
<th>Measure Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider sites with a minimum of 50 assigned Partnership members.</td>
</tr>
</tbody>
</table>

Qualifying peer groups must meet at least four times in the 2018 calendar year and have a peer-facilitation component and a self-management component. Group can serve both PHC and non-PHC members, but must include at least 16 PHC total member visits per year (For example, if there are four PHC members in the group and the group meets for four sessions, the group will meet this criterion). The groups may be general, for patients with a variety of conditions, or focused on specific diseases or conditions, such as: Diabetes, Rheumatoid Arthritis, Chronic Pain, Hepatitis C, Cancer, Congestive Heart Failure, COPD, Asthma, Depression, Anxiety/Stress, Substance use, Pregnancy.

The following components have to be submitted in order to qualify for this incentive:

1. Name of group
2. Name and background information/training of group facilitator
3. Site where group visits took place
4. Narrative on the group process that includes: location and frequency of the group meetings
5. List of major topics/themes discussed at each meeting
6. A description of the way that self-management support is built into the groups
7. An assessment of successes and opportunities for improvement of the group
8. Documentation of minimum of 16 PHC patient visits, via list of attendees with DOB and dates of meetings

Maximum number of groups eligible for payment:

- two per credentialed Partnership provider
- Up to a maximum of 10 per site
Documentation will be reviewed and approved by the CMO or physician designee. Proposed groups may submit elements 1-7 above prospectively for review and feedback at any time in the year, before groups start, to ensure program will be eligible for bonus.

Examples of the curriculum and evidence base for this approach can be found at: http://patienteducation.stanford.edu/programs/

### Submission Process

All documentation must be submitted on the Peer-led Self-Management Support Group template (Appendix II) by January 31, 2019, and can be faxed or emailed to QIP@partnershipphp.org.

### Exclusions

Primary care provider sites with fewer than 50 assigned Partnership members.
Measure 20. Screening, Brief Intervention, Referral, and Treatment (SBIRT)

**Description**

This measure incentivizes providers to screen patients for alcohol abuse using standardized tools. Providers receive the incentive provided that they screen a minimum of 10% of eligible members.

Substance abuse is associated with additional adverse health outcomes and costs. Screening for abuse is not a part of routine PCP contracts. However, the QIP leverages this incentive in order to ensure providers are identifying a potential need that could be tied to other risky behaviors.

**Measure Requirements**

Primary care provider sites with a minimum of 50 assigned Partnership members.

The following code will be used to pull the total number of screenings:

- H0049 (Alcohol screening)

PHC’s claim system will validate and pay for up to two screenings for an individual every six months. Sites that hit the 10% target will earn a site-specific incentive.

We use the following formula to determine each site’s screening rate:

\[
\frac{\text{Number of screenings billed with HCPCS code H0049}}{\text{Number of assigned adult members}}
\]

We use the following formula to determine the financial incentive the site is eligible for:

Number of Screenings* $5

**Submission Process**

PHC will extract this data three months after the end of the reporting year (i.e. March 31, 2019) by identifying claims for H0049 submitted through the claims department.

**Exclusions**

Primary care provider sites with fewer than 50 assigned Partnership members.

Claims submitted in excess of two screenings per individual patient within a six month time frame.
**VIII. Unit of Service**

Measure 21. *Health Information Exchange Participation*

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sites will be reimbursed for participating in a local or regional health information exchange (HIE). The reimbursement will be a one-time $2,500 payment per contracted site.</td>
</tr>
</tbody>
</table>

Electronic HIE allows doctors, nurses, pharmacists, and other health care providers to appropriately access and securely share a patient’s vital medical information electronically. Providing physicians with information regarding their patients’ significant hospital events allows for more streamlined follow-up care, considering access to this information via claims data can potentially take anywhere from 60-90 days after an episode of care is delivered. HIE interface has been associated with not only an improvement in hospital admissions and overall quality of care, but also with other improved resource use: studies found statistically significant decreases in imaging and laboratory test ordering in EDs directly accessing HIE data. In one study population, HIE access was associated with an annual cost savings of $1.9 million for a hospital.²⁴

Establishing and maintaining a connection with a local health information exchange can be costly and is outside the parameters of routine PCP contracts. The measure seeks to make important health information available to local health care systems in order to reduce duplicative care and potentially risky care decisions.

<table>
<thead>
<tr>
<th>Measure Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to qualify for the incentive, linkage with the HIE has to be established by:</td>
</tr>
</tbody>
</table>

- Sending an HL7 Patient Visit Information to the HIE
  - The HL7 PV1 segment contains basic inpatient or outpatient encounter information and consists of various fields with values ranging from assigned patient location, to admitting doctor, to visit number, to servicing facility.

  OR

- Sending CCD document to the HIE
  - The Continuity of Care Document summarizes a patient’s medical status for the purpose of information exchange. The content may include administrative (e.g., registration, demographics, insurance, etc.) and clinical (problem list, medication list, allergies, test results, etc.) information. This component defines content in order to promote interoperability between participating systems such as Personal Health Record Systems (PHRs), Electronic Health Record Systems (EHRs), Practice Management Applications and others.

  OR

- Retrieving clinical information (such as labs, images, etc.) from the HIE.

Recognized Community Health Information Exchange organizations include the following:

- Sac Valley Med Share
- North Coast Clinical Information Network
- Redwood Med Net
• Connect Healthcare
• Jefferson HIE

Linkage to other HIEs may also qualify for the incentive; submission of justification will be reviewed on a case-by-case basis.

<table>
<thead>
<tr>
<th>Submission Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit the HIE Attestation form (<a href="#">Appendix III</a>) by January 31, 2019. PHC will validate the data exchange by working directly with the specified HIE.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>
VIII. UNIT OF SERVICE

Measure 22. Initial Health Assessment

Description

Providers are mandated by the state of California to schedule patients within 120 days of becoming a PHC member for an IHA (Initially Health Assessment) including the following criteria:

- Physical and mental history
- Identification of high-risk behaviors
- Assessment of need for preventative screenings or services, and health education
- Diagnosis and plan for treatment of any diseases
- A completed SHA (Staying Healthy Assessment)
- Providers that have sufficient PHC patient volume can earn an annual Unit of Service measure payout of $2000 based on submission of template form outlining data collection plan and documentation of process to improve site compliance for the IHA. The intent in this introductory year is to encourage IHA improvement plan development. Expect this measure to evolve in future iterations to include a reporting element, demonstrating impact of implementing an approved plan.

Refer to the Thresholds section below for detailed specifications.

Completion of the IHA will help providers to determine current, acute, chronic and preventative needs in a comprehensive and timely manner, potentially addressing problems sooner and lowering overall healthcare costs.

Refer to Appendix IV for submission template for this measure.

Measure Requirements

Providers that have sufficient PHC patient volume can earn a one-time annual payment based on points given for completing and turning in an IHA Template Form.

Sufficient patient volume to participate is defined as having at least 1200 unique visits by PHC members between April 1, 2017 and March 31, 2018 at the entity level. If a site does not belong to any entity, it is considered an entity for this measure. This criterion mirrors the eligibility requirement for the Patient Experience – CAHPS survey, which means that a site is eligible to participate if it received CAHPS results from PHC in 2017.

Submission Process

Submit completed template via fax or email to QIP@partnershipphp.org. Submissions are due to Partnership no later than 1/31/2019. Payments will be made on an annual basis. Refer to Appendix IV for IHA template.

Exclusions

Sites with a patient volume less than 1200 unique visits by PHC members.
### Measure 23. *Timely Data Submission via eReports*

#### Description

Sites will be reimbursed for entering the majority of their relevant data records before the end of the measurement year. The incentive amount is 1% of the site’s potential earning pool, or $1000, whichever is higher.

Some sites do not submit data to PHC until the end of the measurement year. A key component to performance improvement is to monitor data on an ongoing basis. This measure incentivizes PCPs to upload and track their performance on the QIP clinical measures regularly, to minimize the “data rush” at the end of the year.

This measure is not expected as part of the routine PCP contract. Meeting this measure would give PHC more time to analyze data, identify trends and make improvement for providers resulting in more efficient resource usage and reduced overall cost.

#### Measure Requirements

This measure calculates the number of records entered into eReports across all applicable clinical measures.

Target: 70%

Calculation:

\[
\frac{\text{Number of uploads by December 1st of measurement year}}{\text{Number of all uploads by end of grace period (in general January 31 following the measurement year)}}
\]

#### Submission Process

Sites upload data into eReports, PHC will validate the number of uploaded records through eReports.

#### Exclusions

N/A
IX. APPENDICES

Appendix I: Patient-Centered Medical Home Documentation Template

Quality Improvement Program
Patient Centered Medical Home Recognition Template

Please complete all of the following fields on this form by January 31, 2019 and send to:

☐ Email: QIP@partnershiphp.org
☐ Fax: 707-863-4316
☐ Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

1. Name of Recognition entity (NCQA, JCAHO or AAAHC):

2. Recognition status (First time, Maintenance or Re-certification):

3. Date of recognition received:

4. Level accomplished (if applicable):

5. How often is recognition obtained?

6. Attach a copy of PCMH recognition documentation provided by the recognizing entity (must contain a date of recognition within the measurement year).

Additional Notes/Comments:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

4665 Business Center Dr.
Fairfield, CA 94534
Quality Improvement Program
Peer-led Self-Management Support Group Template

Please complete all of the following fields on this form by **January 31, 2019** and send to:

- Email: QIP@partnershiphp.org
- Fax: 707-863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

You may submit elements 1-7 prospectively for review and feedback before groups start, to ensure program will be eligible for the bonus.

1. **Name of group**

2. **Name and background information/training of group facilitator**

3. **Site where group visits took place**

4. **Narrative on the group process that includes: location and frequency of the group meetings**

5. **List of major topics/themes discussed at each meeting**

6. **A description of the way that self-management support is built into the groups**

7. **An assessment of successes and opportunities for improvement of the group**

8. **Documentation of minimum of 16 PHC patient visits, via list of attendees with DOB and date of group**
Appendix III: Submission Template for HIE

Quality Improvement Program
Health Information Exchange (HIE) Reporting Template

If you intend to participate in the HIE measure for the 2018 PCP QIP, please complete all of the following fields on this form and submit by **January 31, 2019** and send to:

- **Email:** QIP@partnershiphp.org
- **Fax:** 707-863-4316
- **Mail:** Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

PHC will verify the following information with the HIE specified. Please refer to the Measure Specifications for details.

1. **Name of practice linked to the HIE:** ________________________________

2. **Type of linkage established (check at least one that applies):**
   - ☐ Sending HL7/ Patient Visit Information history to the HIE
   - ☐ Sending CCD document to the HIE
   - ☐ Retrieving clinical information such as labs from the HIE

3. **Date of registration:** ________________________________

4. **Name of the HIE linked to (check the option that applies):**
   - ☐ Sac Valley Med Share
   - ☐ North Coast Clinical Information Network
   - ☐ Redwood Med Net
   - ☐ Connect Healthcare
   - ☐ Jefferson HIE

Submitted by: ________________________________ Date: ________________________________
Title: ________________________________ Phone: ________________________________
Email: ________________________________
1. Attach a plan or report on how you are determining eligible patients. (How is your site running reports, or retrieving information to determine the eligible population?)

2. Provide documentation of the process in which the site is reaching out the newly assigned members (i.e. mailers/phone calls etc.)

3. Provide a data collection plan to demonstrate how many members keep IHA appointments within the plan’s timeframe AND the capture of the minimum necessary documentation. This includes:
   - A physical and mental history
   - Identification of high risk behavior
   - Assessment of need for preventative screenings or services, and health education
   - Diagnosis and plan for treatment of any disease
   - A completed Staying Health Assessment (SHA) form

4. Provide data collection plan for measuring any declinations to come in for an IHA appointment as well as completion of the SHA.

5. Has this been on a recent MRR CAP? If so, provide documentation/plan implementation of what you have done since the accepted CAP date to increase compliance with the IHA.
## Appendix V: 2018 PCP QIPS Submission Timeline

<table>
<thead>
<tr>
<th>DUE DATE</th>
<th>QIP MEASURE</th>
<th>REPORTING TEMPLATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 31, 2019</td>
<td>Patient Experience – Survey Option</td>
<td>eReports</td>
</tr>
<tr>
<td>January 31, 2019</td>
<td>Advance Care Planning</td>
<td>eReports</td>
</tr>
<tr>
<td>January 31, 2019</td>
<td>PCMH Recognition</td>
<td>Appendix I</td>
</tr>
<tr>
<td>January 31, 2019</td>
<td>Peer-led Self-Management Support Group</td>
<td>Appendix II</td>
</tr>
<tr>
<td>January 31, 2019</td>
<td>Health Information Exchange</td>
<td>Appendix III</td>
</tr>
</tbody>
</table>
**Appendix VI: Data Source Table**

*For any measure, if “Provider” is listed as the only data source, that means a site will not get credit unless data is submitted. These are measures where data from health plan sources (e.g. Claims, Pharmacy, Provider Directory) is not available.*

<table>
<thead>
<tr>
<th>PCP QIP Core Measures</th>
<th>Data Source*</th>
<th>System Used for Data Monitoring</th>
<th>System Used for Data Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Care: Pediatric Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Nutrition Counseling (ages 3-17)</td>
<td>PHC and Provider</td>
<td>eReports</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Physical Activity Counseling (ages 3-17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Well Child Visits (ages 3-6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Immunizations for Adolescents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Childhood Immunization Combo-3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Asthma Medication Ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Care: Family Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Monitoring Patients on Persistent Medications</td>
<td>PHC and Provider</td>
<td>eReports</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Well Child Visits (ages 3-6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Controlling High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Cervical Cancer Screening (ages 24-65)</td>
<td></td>
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<td></td>
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<tr>
<td>5. Colorectal Cancer Screening (ages 50-75)</td>
<td></td>
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</tr>
<tr>
<td>6. HBA1C Good Control</td>
<td></td>
<td></td>
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<tr>
<td>7. Retinal Eye Exam</td>
<td></td>
<td></td>
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<tr>
<td>8. Screening for Nephropathy</td>
<td></td>
<td></td>
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<tr>
<td>9. Breast Cancer Screening</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. Childhood Immunization Combo-3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Immunization for Adolescents</td>
<td></td>
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<tr>
<td><strong>Clinical Care: Internal Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Monitoring for Patients on Persistent Medications</td>
<td>PHC and Provider</td>
<td>eReports</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Controlling High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Cervical Cancer Screening (ages 24-65)</td>
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</tr>
<tr>
<td>4. Colorectal Cancer Screening (ages 50-75)</td>
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<td></td>
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</tr>
<tr>
<td>5. HbA1C Good Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Retinal Eye Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Nephropathy Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Breast Cancer Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appropriate Use of Resources: Family and Internal Medicine

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>System Used for Data Monitoring</th>
<th>System Used for Data Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admissions/ 1000</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Readmission Rate</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Access/Operations Measures: All Practice Types

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>System Used for Data Monitoring</th>
<th>System Used for Data Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary Care Utilization</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Patient Experience: All Practice Types

- **Survey Option (sites not qualified for CAHPS)**
  - Data Source: Provider
  - System Used for Data Monitoring: Monthly Reports
  - System Used for Data Submission: eReports
- **CAHPS Survey (for qualified sites)**
  - Data Source: PHC Vendor
  - System Used for Data Monitoring: Year-End Report
  - System Used for Data Submission: eReports

### Unit of Service Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>System Used for Data Monitoring</th>
<th>System Used for Data Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advance Care Planning</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Access/Extended Office Hours</td>
<td>PHC</td>
<td>Year-End Report</td>
<td>Provider Relations Department</td>
</tr>
<tr>
<td>3. PCMH Certification</td>
<td>PHC and Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
<tr>
<td>4. Peer-led self-management support groups</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
<tr>
<td>5. SBIRT: $5 per screening</td>
<td>PHC</td>
<td>Year-End Report</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Health Information Exchange</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
<tr>
<td>7. Initial Health Assessment</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
<tr>
<td>8. Timely Data Submission via eReports</td>
<td>Provider</td>
<td>eReports</td>
<td>eReports</td>
</tr>
</tbody>
</table>
Appendix VII: Diabetes Management Table

The table below indicates lab values that the QIP accepts as proof that the member is not diabetic and thus should be excluded from the diabetes management measures. In addition to the values, please refer to the flow chart on the next page to understand the exclusion protocol. For this measure, members may only be excluded by presenting lab values indicating no Diabetes, and only labs that take place after the date of diagnosis will be considered.

<table>
<thead>
<tr>
<th>Lab</th>
<th>Description</th>
<th>Value accepted for diabetes exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c value (%)</td>
<td>-</td>
<td>&lt; 6.5%</td>
</tr>
<tr>
<td>Random blood sugar test (mg/dL or mmol/L)</td>
<td>Blood sample taken at a random time regardless of when the patient last ate.</td>
<td>&lt;126 mg/dL</td>
</tr>
<tr>
<td>Fasting blood sugar test (mg/dL or mmol/L)</td>
<td>Blood sample taken after an overnight fast.</td>
<td>&lt; 126 mg/dL or 7 mmol/L</td>
</tr>
<tr>
<td>Oral glucose tolerance test</td>
<td>Overnight fast, and the fasting blood sugar is measured, then the patient drinks a sugary liquid, blood sugar levels tested periodically for the next two hours.</td>
<td>&lt; 200 mg/dL or 11.1 mmol/L after two hours</td>
</tr>
</tbody>
</table>
Appendix VIII: QIP Diabetes Exclusion Flow Chart
Appendix IX: Works Cited for All Practice Types