2020 Primary Care Provider Quality Improvement Program (PCP QIP)
Measurement Specifications

FAMILY MEDICINE PRACTICES

Developed by: The QIP Team

QIP@partnershiphp.org

AMENDED MEASUREMENT SET
IN RESPONSE TO COVID-19 PANDEMIC

Published: December 2, 2019

Updated: July 22, 2020

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I. Quality Improvement Program Contact Information

Email: QIP@partnershiphp.org
Fax: (707) 863-4316
Website: Primary Care Provider Quality Improvement Program

II. Program Overview

The Primary Care Provider Quality Improvement Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California (PHC) providers, offers sizable financial incentives and technical assistance to primary care providers so 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 high quality, cost-efficient care for all your patients. Incentives are based on meeting specific performance thresholds in measures that address the above areas (see pages 8-13 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: 2020

The 2020 measurement year begins on January 1, 2020, and ends on December 31, 2020. Please see Appendix V for details on deadlines specific to any measures. Payment is sent out 120 days after the program period ends, on April 30, 2021.

Definitions

Parent Organization (PO): A health providing organization (e.g. a health center, an integrated health system, or a health care administrative entity that owns and oversees the operations of

one or more sites in a defined administrative region) that may or may not operate multiple sites.

Primary Care Provider Site (PCP Site): A clinic location that has been designated with a unique PCP ID with members actively assigned by Partnership HealthPlan of California. Eligibility and requirements for Primary Care Provider sites are listed in the PHC Policy MPQP1023, (Access Standards and Monitoring), subject to California Health and Safety Code 1206(h) and HRSA regulations on intermittent sites. All Primary Care Provider Sites are listed in the Provider Directory.

Provider: A term that may refer to a PCP PO, a PCP Site, a PCP Clinician, or any other entity or professional that is contracted to provide health care services to PHC members.

PCP Site QIP Eligibility Criteria

All current primary care sites, including pediatric, family, and internal medicine sites, that have capitated, Medi-Cal members assigned and are contracted with PHC for nine (9) out of 12 months of the measurement year are automatically enrolled in the QIP. A PCP PO must be enrolled in the program as of December 1 of the measurement year in order to be eligible for incentive payments. Eligibility criteria for specific measures and measure domains vary.

If a contract is terminated during the measurement year, eligibility for payment will be reviewed on a case-by-case basis. In order to offer comprehensive QIP data, performance and payment are calculated at the PCP site level.

Clinical Measures

PCP sites that join PHC's network mid-year are eligible for payment for the Clinical Measures of the QIP under the following circumstances:

- PCP sites joining Partnership without affiliation to an existing QIP participant site (standalone new practice or new PCP PO):
    - Must be contracted with members assigned for at least nine (9) months.

- PCP sites joining Partnership as part of a PCP PO where members from an existing QIP participant (an existing primary care site) are potentially being reassigned to the new site (example – new site opens within multi-site FQHC model)
    - Must be contracted with members assigned by October 1.
    - New PCP sites enrolled by October 1 will be eligible for the clinical measures. Member enrollment at other sites within the PCP parent organization will be used to support continuous enrollment requirements for Clinical Measures.

Non-Clinical Measures

PCP sites that join PHC's network mid-year are eligible for measures in the Non-Clinical domains under the following circumstances:

- All PCP sites, regardless of any affiliation with a PCP PO:
    - Must be contracted with members assigned for at least nine (9) months of the measurement year.

Eligible Member Population

The eligible population used to calculate the final scores for all measures is defined as capitated Medi-Cal members. In addition, members qualified under California Children Services (CCS) will be assigned to PCP sites without capitation, and certain Native Americans will be assigned and capitated to PCP sites while keeping their special member designation. These members are eligible to be included in PCP sites' denominator lists assuming other

denominator criteria are met. Member month assignments will also count towards the member month totals used for payment calculations.

For measures in the Clinical domain, the member must be continuously enrolled within a PCP parent organization, with continuous enrollment defined as member assignment for nine (9) out of the 12 months between January 2020 and December 2020 (assignment to a site occurs on the first of the month). For multi-site PCP parent organizations, the continuous enrollment criterion is applied at the parent organization level. The anchor date of assignment within a PCP site's final denominator is December 1st. This means that members must be assigned as of December 1 to be included in the final denominator lists used to calculate payment. Members who are dually enrolled in Medicare and Medi-Cal (Medi-Medi members) are excluded from all measures. Cases in which continuous enrollment criteria negatively affect a site's final rate should be presented to the QIP Team.

For measures in the Non-Clinical domain, continuous enrollment criteria are detailed within each measure's specifications.

Measure Development and Selection

The measurement set for the QIP is reviewed and developed annually. In order to maintain a stable measurement set, major changes occur only when significant changes are made in DHCS measure sets. With input from the network, the Provider Advisory Group, and internal departments, the measurement set requires approval from the Physician Advisory Committee. Once approved, the finalized set for the next year is shared with the network and specifications are developed. It is possible for the measurement set to change slightly during the measurement year due to new information becoming available (i.e. a measure's retirement from the Department of Health Care Services Managed Care Accountability Set, evaluation of the previous program year, or a change in financial performance). Any mid-year changes to the measurement set will be communicated through e-mail to all providers as well as through the program's monthly newsletter.

Measures may evaluate a PCP site's utilization of a certain service or provision of treatment. PHC recognizes the potential for underutilization of care and services and takes appropriate steps to monitor for this. The processes utilized for decision making are based solely on the appropriateness of care and services and existence of coverage. PHC does not offer incentives or compensation to providers, consultants, or health plan staff to deny medically appropriate services requested by members, or to issue denials of coverage.

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: ***For illustrative purposes only***, assume the PMPM for the 2020 year is $10.00.

- 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 a monthly 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 an average of 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 Measurement Set, the payment is independent of, and distinct from, the financial incentives a site receives from the Core Measurement Set. A PCP site receives payment according to the measure specifications if the requirements for at least one Unit of Service measure are met.

Billing

The QIP uses administrative (claims and encounter) data to identify denominator and numerator inclusion for clinical and non-clinical measures. The specific codes are listed in the Code List and specified within each measure. These codes are not wholly representative of reimbursable codes of PHC but codes outside of the Code List are not used for measure evaluation.

eReports

eReports, an online application built for the QIP Clinical measures, is the mechanism by which PCP sites can monitor 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 year. Typically eReports is available in early March and is announced via the QI Newsletter. PCP sites 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 membership size, will have measures compared against the specified measure thresholds. We are aware that small denominators may negatively impact the overall performance on a particular 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 January 15, 2021.

Partnership Quality Dashboard

In addition to eReports, the Partnership Quality Dashboard (PQD) can be used for Non-Clinical measure performance tracking. PQD is accessible via hyperlink on the eReports user menu. The PQD offers additional dashboard views, designed to enable performance trending, data stratification, and QIP payout potential. Please review the PQD Overview Webinar for detailed instructions, and contact the QIP Team with questions.

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 after the end of the measurement year, review data on which your final point earnings will be based. If during the Preliminary Report review period or eReports validation period a provider does not inform PHC of a calculation or point attribution error that would result in potential under or over payment, the error may be corrected by PHC post-payment. This means PHC may recoup overpaid funds any time after payment is distributed. Dispute of final data described below will not be considered:

1. QIP scores on eReports
   eReports refreshes data on a weekly 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. The deadline for exclusion requests that need to be executed by the QIP Team is January 15, 2021.

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 earnings for manually tracked measures (i.e. PCMH Certification, Initial Health Assessment, etc.). Providers will be given one week, hereafter referred to as Preliminary Report Review Period, to review this report for performance discrepancies and calculation or point attribution errors.

4. Practice type designations
   Each PCP site is categorized as either: Internal Medicine, Family Practice, or Pediatric Practice according to the accepted age groupings listed in the Provider Directory and a historical review of member months. Each practice type is responsible for different QIP measures. 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. Post-payment disputes related to thresholds, however, 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 completed within 30 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:

PCP Provider Network: PCP 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 comprised 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

2020 Primary Care Provider Quality Improvement Program Summary of Measures[1]

Measurement Set – Family Medicine

Core/Monitoring	Measure	Targets[2]	Points	Risk Adjusted?
CLINICAL DOMAIN – Core Measures (85 Points Total)				
Core	1. Well-Child Visits (1st 15 Months)	-Full Points: 65.83% (50th percentile)	15	No
Core	2. Controlling High Blood Pressure (18-85 yrs)	-Full Points: 61.04% (50th percentile)	15	
Core	3. Colorectal Cancer Screening (51-75 yrs)	-Full Points: 32.24% (25th percentile)[3]	12.5	
Core	4. Diabetes Management: HbA1C good control (18-75 yrs)	-Full Points: 50.97% (50th percentile)	12.5	

[1] This final Measurement Set for the 2020 Measurement Year (MY) is significantly modified from previously released versions and from the previous MY in response to the Covid-19 pandemic. DHCS and PHC recognize that the pandemic puts constraints on providers making more rigorous measure targets very difficult to achieve. Therefore, the measurement set is reduced in numbers of accountable measures, measurement targets are set lower, and the planned Gateway Measure will not be implemented.

[2] Measure full-point targets are set at the 50th percentile performance benchmark, based on National Committee for Quality Assurance (NCQA) National Medicaid Benchmarks. Partial points are not available for measurement year 2020.

[3] Colorectal Cancer Screening full-points target is based on the 25th percentile of plan-wide performance from the 2019 QIP measurement year, as NCQA Medicaid National Benchmarks are not available.

Core	5. Childhood Immunization Combo -10	-Full Points: 34.79% (50th percentile)	15	
Core	6. Asthma Medication Ratio (5 – 64 yrs)	-Full Points: 65.58% (50th percentile)	15	
NON-CLINICAL DOMAIN - ACCESS & OPERATIONS (15 Points Total)				
Core	7. PCP Office Visits	Full Points: TBD	15	Yes: By plan and PCP/site[4]
CLINICAL DOMAIN – Monitoring Measures (Points Not Applicable)[5]				
Monitoring	1. Adolescent Well Care (12 – 21 yrs)	-54.26% (50th percentile)	N/A	
Monitoring	2. Breast Cancer Screening (50 – 74 yrs)	-58.67% (50th percentile)	N/A	
Monitoring	3. Cervical Cancer Screening (21 – 65 yrs)	-60.65% (50th percentile)	N/A	No
Monitoring	4. Diabetes Management - Retinal Eye Exam (18 – 75 yrs)	-58.88% (50th percentile)	N/A	
Monitoring	5. Immunizations for Adolescents	-34.43% (50th percentile)	N/A	

[4] Site specific and practice type risk adjusted targets will be posted in Partnership Quality Dashboard (PQD) for each participating site by end of spring 2020.

[5] *April, 2020 Update: Due to circumstances related to the 2020 Covid-19 pandemic, clinical measures marked as “Monitoring” are removed from the 2020 QIP measurement set. Monitoring measures will continue to be displayed in eReports and Partnership Quality Dashboard (PQD) throughout the measurement year, but performance does not contribute to the QIP score. The 50th percentile National Medicaid Benchmarks are included for reference.

Monitoring	6. Well Child Visits (3 – 6 yrs)	-72.87% (50th percentile)	N/A	
Monitoring	7. Ambulatory Care Sensitive Admissions		N/A	
	8. Avoidable ED Visits/1000 Members per Year		N/A	

Unit of Service Measures – All Practice Types

Measure	Incentive
Advance Care Planning Attestations	Minimum 1/1000th (0.01%) of the sites assigned monthly membership18 years and older for: • $100 per Attestation, maximum payment $10,000. • $100 per Advance Directive/POLST, maximum payment $10,000
Extended Office Hours	10% of Capitation for sites that are open for extended office hours: • **Quarter 1 (January –March 31 2020):** PCP sites must be open for the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification). • **Quarter 2 (April-June 2020):** PCP sites must be open for the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification). • **Quarter 3 (July-September 2020):** PCP sites must be open for the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification). • **Quarter 4 (October-December 2020):** Will likely be similar to Quarter 3, but will be finalized towards the end of September.
PCMH Certification	$1000 yearly for achieving or maintaining PCMH accreditation.

Peer-led Self-Management Support Groups (both new and existing)	$1000 per group (Maximum of 10 groups per parent organization).
Alcohol Misuse Screening and Counseling	$5 per screening for screening a minimum of 5% of eligible adult members.
Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. The incentive is available once per parent organization.
Initial Health Assessment	$2000 per parent organization for submitting all required parts of improvement plan regardless of visit volume.

IV. Clinical Domain

IV. CLINICAL DOMAIN — MAXIMUM NUMBER OF POINTS: 15

Measure 1. *Well-Child Visits in the First 15 Months of Life*

Description

The percentage of continuously enrolled Medi-Cal members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life.

These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.

The QIP encourages providers to establish habitual preventative care for children.

Thresholds

- Full points: 65.83% (50th percentile)

Denominator

The number of continuously enrolled (from age of 31 days and for 9 out of 12 months during the measurement period) Medi-Cal members who turned 15 months old between January 1, 2020 and December 31, 2020 (i.e. DOB between October 3, 2018 and October 2, 2019).

- Calculate 31 days of age by adding 31 days to the child's date of birth.
- Calculate the 15-month birthday as the child's first birthday plus 90 days.

Numerator

The number of children in the eligible population with at least six (6) well-child visits (Well-Care Value Set) with a PCP by the date of age 15 months.

NOTE: To be eligible for a well-child visit, visit documentation must include 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 the assessment or treatment of an acute or chronic condition do not count toward the measure.

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: Well-Care Value Set.

Exclusions (only if not numerator hit)

N/A

IV. CLINICAL DOMAIN — MAXIMUM NUMBER OF POINTS: 15

Measure 2. *Controlling High Blood Pressure*

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

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.[1] 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.[2] Some studies also indicate that failure to achieve blood pressure targets contribute to avoidable costs and the number of cardiovascular events.[3] 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.

Thresholds

- Full points: 50th percentile (61.04%)

Denominator

The number of continuously enrolled Medi-Cal members 18-85 years of age as of December 31, 2020 (i.e. DOB between January 1, 1935 and December 31, 2002) who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (i.e. January 1, 2019 – December 31, 2020). Visit type need not be the same for the two visits. Only one of the two visits may be a telephone visit, an online assessment, or a telehealth visit. Any of the following code combinations meet criteria:

- Outpatient visit with any diagnosis of hypertension.
- A telephone visit with any diagnosis of hypertension.
- An online assessment with any diagnosis of hypertension.

Numerator

The number of members in the eligible population whose most recent BP reading taken during an outpatient visit, a nonacute inpatient encounter, or remote monitoring event was <140/90 mm Hg during the measurement year.

The BP reading must occur on or after the date of the second diagnosis of hypertension.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Administrative Specifications:
To become numerator compliant, the member must have a compliant code for both diastolic and systolic on the same claim number, and the same non-compliant code for both diastolic and systolic

to fall back to a denominator. The most recent occurrence should always be counted, which means a member can turn from a numerator to a denominator if a non-compliant code is the most recent.

Medical Record Specifications:

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension occurred.

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 second 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. The systolic and diastolic results do not need to be from the same reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

The member is not compliant if the BP reading is ≥140/90 mm Hg or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider, and interpreted by the provider.

BP readings from a virtual video visit may be captured if:

- The physician witnessed the patient taking his/her blood pressure with an appropriate home blood pressure monitor device.
- The electronic result was shown to the provider and entered into the medical record.
- This is not an option for virtual telephone visits.

We will accept blood pressure readings recorded at a dental visit, provided the dental EHR and medical EHR for the reporting practice is integrated.

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the test or procedure, with the exception of fasting blood tests.
- Reported by or taken by the patient.
- Member-reported results to the provider from a remote monitoring device are not acceptable.

Codes Used

Denominator:

- Codes to identify outpatient visits: Outpatient Without UBREV Value Set
- Codes to identify Hypertension: Essential Hypertension Value Set
- Codes to identify telephone visit: Telephone Visits Value Set

- Codes to identify online assessment: Online Assessments Value Set

Numerator:

- Codes to identify outpatient visits: Outpatient Without UBREV Value Set
- Codes to identify nonacute inpatient visits: Nonacute Inpatient Value Set
-
- Codes to identify remote blood pressure monitoring: Remote Blood Pressure Monitoring Value Set

- Code to identify Diastolic and Systolic Numerator Compliance:
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Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than/Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than/Equal To 90 Value Set	Diastolic not compliant

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

Exclusions (only if not numerator hit)

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.

- Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

- Exclude from the eligible population all members who had a non-acute inpatient admission during the measurement year. To identify non-acute inpatient admissions:
  1. Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for non-acute care based on the presence of a non-acute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the admission date for the stay.

IV. CLINICAL DOMAIN — MAXIMUM NUMBER OF POINTS: 12.5

Measure 3. *Colorectal Cancer Screening*

Description

The percentage of members 51–75 years of age as of December 31, 2020 who had appropriate screening for colorectal cancer.

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.[4] 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.

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: 25th percentile (32.24%)

Targets are set using a plan-wide mean adjusted for each site based on age, gender, and Medi-Cal Aid Code mix.

Denominator

The number of continuously enrolled Medi-Cal members 51-75 years of age by December 31, 2020 (DOB between January 1, 1945 and December 31, 1969).

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 (e.g., Cologuard®) 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:

- Code to identify Fecal immunochemical test: FOBT Value Set.
- Code to identify Flexible sigmoidoscopy: Flexible Sigmoidoscopy Value Set.
- Codes to identify Colonoscopy: Colonoscopy Value Set.
- Codes to identify CT colonoscopy: CT Colonography Value Set.
- Codes to identify 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, 2020 of the measurement year:

- Colorectal cancer: Colorectal Cancer Value Set.
- Total colectomy: Total Colectomy Value Set.

IV. CLINICAL DOMAIN — MAXIMUM NUMBER OF POINTS: 12.5

Measure 4. *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.[5,6] The QIP includes three measures for diabetes management.

Thresholds

- Full points: 50th percentile (50.97%)

Denominator

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1945 and December 31, 2002) with diabetes identified as of December 31, 2020.

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, 2019 –December 31, 2020).

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, 2019 – December 31, 2020).

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

  OR

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

  OR

- Members who were dispensed insulin or hypoglycemics/antihyperglycemics, per pharmacy data, 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 at or below the threshold for HbA1c ≤9.0% during the measurement year.

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.
- Code to identify telephone visit: Telephone Visit Value Set

Numerator:

- Codes to identify HbA1c good control:
  - HbA1c Level Greater Than 7.0
  - Less Than 8.0, HbA1c Level Greater Than or Equal to 8.0
  - Less than or Equal to 9.0.

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, 2019 – December 31, 2020), 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 VIII for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix IX for the Diabetes Exclusions Flow Chart.

IV. CLINICAL DOMAIN — MAXIMUM NUMBER OF POINTS: 15

Measure 5. *Childhood Immunization Status (Combination 10)*

Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three *haemophilus* influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Maintaining low rates of childhood communicable diseases 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 all-time. Studies show that vaccination prevents 33,000 deaths in the U.S annually, and between two and three million deaths worldwide.[7]

Thresholds

- Full points: 50th percentile (34.79%)

Denominator

The number of continuously enrolled Medi-Cal members who turn two years of age between January 1, 2020 and December 31, 2020 (DOB between January 1, 2018 and December 31, 2018).

Numerator

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

14 Day Rule:
For each subset of vaccinations, there must be at least 14 days between each vaccination when multiple doses are required, excluding the MMR vaccination. i.e., for DTaP:
If the first vaccination was given on 12/1, the next vaccination from any data source to count towards the measure, would have to be 12/15 or later. A vaccination with a date of service on 12/14, wouldn't qualify as an additional vaccination.

DTap: At least four DTaP vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

IPV: At least three IPV vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

MMR: Any of the following meet criteria:

- At least one MMR vaccination on or between the child's first and second birthdays.
- 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. Only count vaccinations that are on or between the child's first and second birthdays. History of illness can occur on or before the child's second birthday.

- Any combination of codes from the table below that indicates evidence of all three antigens (on the same or different date of service).

Measles (any of the following)	Mumps (any of the following)	Rubella (any of the following)
At least one measles vaccination administered on or between the child's first and second birthdays.	At least one mumps vaccination administered on or between the child's first and second birthdays.	At least one rubella vaccination administered on or between the child's first and second birthdays.
History of measles illness anytime on or before the child's second birthday.	History of mumps illness anytime on or before the child's second birthday.	History of rubella illness anytime on or before the child's second birthday.

HiB: At least three HiB vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis B: Any of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations with different dates of service.
  One of the three vaccinations can be a newborn hepatitis B 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 hepatitis B vaccination must be on or between December 1 and December 8.

- Or History of hepatitis B illness

VZV: At least one VZV vaccination with a date of service on or between the child's first and second birthdays.

- Or history of varicella zoster, i.e. chicken pox, illness on or before the child's second birthday.

PCV: At least four pneumococcal conjugate vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination Procedure or Immunization prior to 42 days after birth.

Hepatitis A: Either of the following meets criteria:

- At least one hepatitis A vaccination with a date of service on or between the child's first and second birthdays.
- Or, history of hepatitis A illness on or before the child's second birthday.

Rotavirus: Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.

- At least two doses of the two-dose rotavirus vaccine) on different dates of service.
- Or at least three doses of the three-dose rotavirus vaccine on different dates of service.
- Or at least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine all on different dates of service.

Influenza: At least two influenza vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months or180 days after birth.

For immunization information obtained from the medical record, count members where there is evidence that the where there is documentation that the vaccine was given.

- Documentation indicating the name of the specific vaccine 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.

Documentation 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., prior to 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 vaccines does not constitute sufficient evidence of immunization for QIP reporting.

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.
- Codes to identify Hepatitis A vaccination: Hepatitis A Vaccine Administered
- Codes to identify history of hepatitis illness: Hepatitis A Value Set
- Codes to identify Rotavirus 2 Dose Schedule: Rotavirus 2 Dose Schedule Vaccine Administered
- Codes to identify Rotavirus 3 Dose Schedule: Rotavirus 3 Dose Schedule Vaccine Administered
- Codes to identify Influenza vaccine: Influenza Vaccine Administered
- In addition, immunization data obtained through the California Immunization Registry (CAIR) will be used to meet this measure. **Important Note**: PHC WILL BE MOVING TOWARDS LIMITING UPLOADING FOR THIS MEASURE. To prepare for this, we recommend all PCP sites develop robust systems for entering data for current and past vaccines into CAIR.

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.

Any of the following on or before the member's second birthday meet optional exclusion criteria for any of the vaccines:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set).
- Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).
- Immunodeficiency (Disorders of the Immune System Value Set).
- HIV (HIV Value Set; HIV Type 2 Value Set).
- Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set).
- Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set).
- History of intussusception (Intussusception Value Set).

V. CLINICAL DOMAIN — MAXIMUM NUMBER OF POINTS: 15

Measure 6. *Asthma Medication Ratio*

Description

The percentage of continuously enrolled Medi-Cal members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater between January 1, 2020 and December 31, 2020.

The Asthma Medication Ratio is a measure to help providers assess the quality of asthma care received by their patients with persistent/chronic asthma. Studies have shown that the AMR to be a better predictor of acute asthma exacerbations than any prior measure of controller medication use.[8] Routine PCP contracts do not account for this. The QIP incentivizes this measure to increase the quality of asthma care and reduce the cost of asthma exacerbations.

Thresholds

- Full points: 50th percentile (63.58%)

Definition

Oral Medication Dispensing Event:
One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30) = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days' supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.

Inhaler Dispensing Event:
When identifying the eligible population, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Injection Dispensing Event:
Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three

dispensing events.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Allocate dispensing events to the appropriate year based on the date on which the prescription is filled.

Units of Medications:
When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication. For example, two inhalers canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event

Use the package size and units columns in the NDC list to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10g and pharmacy data indicates the dispensed amount is 30g, this indicates three inhalers canisters were dispensed.

Denominator

The number of continuously enrolled Medi-Cal members 5-64 years of age as of December 31, 2020 (DOB between January 1, 1956 and December 31, 2015).

Follow the steps below to identify the eligible population:

Step 1: Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit with a principal diagnosis of asthma (Asthma Value Set).
- At least one acute inpatient encounter with a principal diagnosis of asthma.
- At least four outpatient visits) or observation visits or telehealth visits; on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events for any controller medication or reliever medication. Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events for any controller medication or reliever medication.

Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

Step 3: Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year.
    - Emphysema
    - Other Emphysema
    - COPD

- Obstructive Chronic Bronchitis
- Chronic Respiratory Conditions Due To Fumes/Vapors
- Cystic Fibrosis
- Acute Respiratory Failure

- Members who had no asthma medications (controller or reliever) dispensed during the measurement year.

Numerator

The number of members in the eligible population in the denominator who have a medication ratio of 0.50 or greater between January 1, 2020 and December 31, 2020. Following these steps to calculate the ratio:

Step 1: For each member, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of Units of Medications.

Step 2: For each member, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of Units of Medications.

Step 3: For each member, sum the units calculated in step 1 and step 2 to determine Units of Total Asthma Medications.

Step 4: For each member, calculate the ratio of controller medications to total asthma medications using the following formula.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Asthma Medications (step 3)}}$$

Step 5: Sum the total number of members who have a ratio of 0.50 or greater in step 4.

Table: Asthma Controller Medications

ASTHMA CONTROLLER MEDICATIONS			
Description	**Prescriptions**	**Medication Lists**	**Route**
Antiasthmatic combinations	Dyphylline-guaifenesin	Dyphylline Guaifenesin Medications List	Oral
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Subcutaneous
Anti-interleukin-5	Benralizumab	Benralizumab Medications List	Subcutaneous
Anti-interleukin-5	Mepolizumab	Mepolizumab Medications List	Subcutaneous
Anti-interleukin-5	Reslizumab	Reslizumab Medications List	Intravenous
Inhaled steroid combinations	Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation

Inhaled steroid combinations	Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	Zileuton	Zileuton Medications List	Oral
Methylxanthines	Theophylline	Theophylline Medications List	Oral

Table: Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Codes Used

Denominator:

- Codes to identify ED visit: ED Value Set.
- Codes to identify a principal diagnosis of asthma: Asthma Value Set.
- Codes to identify acute inpatient encounter: Acute Inpatient Value Set.
- Codes to identify outpatient visit: Outpatient Value Set.
- Codes to identify observation visit: Observation Value Set.
- Codes to identify telehealth: Telehealth Modifier Value Set and Telehealth POS Value Set
- Codes to identify Telephone Visits: Telephone Visit Value Set
- Codes to identify Online Assessment: Online Assessment Value Set
- Codes to identify Asthma Controller Medication List: Asthma Controller Medication List
- Codes to identify Asthma Reliever Medication List: Asthma Reliever Medication List

Numerator: No codes applicable as eligibility is solely based on medication ratio. No eReports data entry for this measure.

Exclusions (only if not numerator hit)

N/A

V. ACCESS AND OPERATIONS — MAXIMUM NUMBER OF POINTS: 15

Measure 7. *PCP Office Visits*

Description

The average number of assigned members' visits to a PCP per member, per year.

PHC will extract the total number of PHC office visits, telephone visits, and video visits from claims and encounter claims data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site.

Steps to identify PCP Office Visits:

1. Identify total members assigned to PCP during each month
2. For those members, add up all PCP office visits during that month, *regardless of which PCP office location the visit occurred* (i.e. in the following locations: office, home or private residence of patient, FQHC, State or local health clinic, Rural Health Clinic, and newly added Telephone and video encounters).
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
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)

Telephone and Video Encounters:
For the first time, PHC will count phone and video encounters as part of this calculation. Encouraging providers to record and submit claims for these visits will move PHC and providers toward an alternative payment methodology that is value-based, not volume-based.

- The codes for phone or video visits for FQHCs and Rural Health Centers is G0071; here is the description:
  "Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only."

- The code for other (non-FQHC or RHC) providers is G2012; here is the description:
  "Brief communication technology-based service by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment, 5 – 10 minutes of medical discussion"

Calculation:

*PCP Office Visits PMPY= (# Office Visits/ Non-Dual Capitated Member Months)*12*

Thresholds

- Full Points: At or above target (TBD)

Target is set using a plan-wide mean adjusted for each site based on age, gender, and Medi-Cal Aid Code mix.

Codes Used

- 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).

VI. Unit of Service $20,000 Maximum Per Site

Measure 8. *Advanced Care Planning*

Description

This measure pays for both the process and the outcome of advance care planning discussions. Providers will receive payment for facilitating advanced care planning (ACP) with 1/1000 (0.01%) of the eligible Medi-Cal only PHC members 18 years or older.

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 costs than a patient who dies without an advanced directive.

Thresholds

Minimum 1/1000th (0.01%) of the sites assigned monthly membership 18 years and older for:

- $100 per Attestation, maximum payment $10,000.
- $100 per Advance Directive/POLST, maximum payment $10,000

Measure Requirements

Providers will receive payment for facilitating advanced care planning (ACP) with eligible Medi-Cal only PHC members 18 years of older after the threshold is met.

Providers will receive payment for facilitating advanced care planning (ACP) with eligible Medi-Cal only PHC members 18 years or older. Providers will receive $100 for each submitted attestation to ACP conversations (100 per year limit). In addition, providers will receive $100 for each submitted advanced directive OR a Physician Orders for Life-Sustaining Treatment (POLST) form (combined 100 per year limit).

ACP discussions must take place between January 1, 2020 and December 31, 2020 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. Note that this measure is not exclusive to patients with a life-limiting disease or condition.

<u>Advance Directive and/or POLST:</u>
Only one record 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 changes are needed will qualify.

<u>Attestation:</u>

Only one conversation per patient per measurement year. 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:
    - Discussed
    - Given to patient
    - Completed
    - Copy in chart
    - Patient refused
- Summary of patient wishes, whether from conversation or from an Advanced Directive. Some options include:
    - Full treatment
    - Comfort care
    - Hospice
    - DNR
    - DNI
    - Other (tube feeds and blood transfusion and transfer to hospital are common items)
- If a POLST is appropriate, some status options include:
    - Discussed
    - Given to patient
    - Completed
    - Copy in chart
    - Patient refused
- Plan for next conversation.

Submission Process

Providers must utilize the templates found within eReports to submit documentation for individual patients. Faxed or e-mailed attestation forms will not be accepted. Submissions are due to Partnership no later than January 31, 2020. 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. If a member's eligibility status changes during the measurement year, the site's count of accepted attestations may change.

VI. Unit of Service 10% of Capitation

Measure 9. *Extended Office Hours*

Description

Providers will receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.

Continued efforts to maintain continuity of care during COVID-19 and social distance protocols, the provider network is highly encouraged to include telehealth visits as part of the extended hour services. Expanding primary care access during non-conventional business hours to include 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.

Measure Requirements

Important Note: To accommodate statewide shelter-in-place orders across California, as a response to the Covid-19 pandemic, the 1st Quarter requirements are different than the remaining calendar year quarters. Starting in the 2nd Quarter measures have been adjusted to meet the needs of both the providers and members through the end of this measurement year.

Quarter 1 (January –March 31 2020): PCP sites must be open for the entire quarter an additional **8** hours per week or more beyond the normal business hours (defined below).

- Data from January to February 2020, excluding March 2020, will be used to determine the site's payment for 2020 Quarter 1.
- Exception: If no data is found for January to February 2020, we will use 2019 Quarter 4 data to determine the site's payment for 2020 Quarter 1.
- Exclusion: If the extended office hours was discontinued by way of a Provider Directory updated before February 29, 2020, the site becomes not eligible for 2020 Quarter 1 payment.

Quarter 2 (April 1 – June 2020): After-hours care may include any combination of in-person, video and telephone visits for at least **8** hours/week beyond the normal business hours (defined below)

- Due to COVID-related changes, the month of April may be excluded.
- On-call hours may count towards the extended hours if the provider has live or real-time access to member's medical records and documents the encounter at the time of the virtual visits.
- Visits completed by phone or video must be documented by clinicians as visits in the medical record.
- Scheduled extended hours for virtual visits may be scheduled at the parent organization level, which will then count for all sites within the parent organization, regardless of the location of the site (even if in different counties). In person extended hours may count for other sites with the same parent organization if the two sites are within 5 miles of each other.
- Submission of schedule is due by June 30th, 2020

Quarter 3 (July 1 – September 30 2020): After-hours care may include any combination of in-person, video and telephone visits for at least **8** hours/week beyond the normal business hours (defined below)

- Starting on August 1, 2020, the after-hours virtual visits must have the capacity to offer video visits to members who have the internet or cellular bandwidth to do video visits. A PCP that offers only phone visits during the after-hours period may not count these towards the extended hours QIP incentive
- On-call hours may count towards the extended hours if the provider has live or real-time access to member's medical records and documents the encounter at the time of the virtual visits.
- Visits completed by phone or video must be documented by clinicians as visits in the medical record.
- Scheduled extended hours for virtual visits may be scheduled at the parent organization level, which will then count for all sites within the parent organization, regardless of the location of the site (even if in different counties). In person extended hours may count for other sites with the same parent organization if the two sites are within 5 miles of each other.
- Submission of schedule is due by September 30th, 2020

Quarter 4 (October 1 -- December 31 2020): Will likely be similar to Quarter 3, but will be finalized towards the end of September.

Revised definition of extended hours, effective Q1, 2020.

Regular business hours are defined as up to 9 hours between the hours of 8am and 6pm, Monday through Friday. Being open and seeing patients during lunch does not count toward the extended hours.

Larger groups (more than 4 PCP providers) are expected to be staffed for at least 40 hours per week during these regular business hours. Smaller groups are expected to be staffed at least 32 hours per week during these regular business hours.
Assuming these minimum hours requirements are met:

1. Any hours before 8am and after 6pm on weekdays, and any hours on weekends will count towards the 8 extended hours.
2. An office with scheduled visits from 8am to 6pm (10 hours) may count one of those hours towards the extended hours.

If a provider feels they are providing extended access, but their hours do not meet this definition, they may present their explanation in writing for consideration by the PHC administration.

EXAMPLES:

1. Long hours every weekday.

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours Open	7am-6pm	7am-6pm	7am-6pm	7am-6pm	7am-5pm	Closed	Closed
Regular business hours	9	9	9	9	9		
Extended hours	2	2	2	2	1	0	0

Regular business hours open: 45 hours **Extended hours: 9 hours**

2. Small practice shifting hours

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours Open	9am-5pm	9am-5pm	Noon-9pm	11am-8pm	9am-5pm	9am-noon	Closed
Regular business hours	8	8	6	7	8		
Extended hours	0	0	3	2	0	3	

Regular business hours open: 37 hours **Extended hours: 8 hours**

3. Saturday (mainly) extended hours

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours Open	8am-5pm	8am-5pm	8am-6pm	8am-5pm	8am-5pm	8am-noon, 1pm-4pm	Closed
Regular business hours	9	9	9	9	9		
Extended hours	0	0	1	0	0	7	

Regular business hours: 45 hours **Extended hours: 8 hours**

Submission Process

Partnership's Provider Relations (PR) department keeps track of extended office hours.

- Quarter 1 (Jan – Mar 31 2020): No submission required. PR will collect data from the Provider Directory.
- Quarter 2 (Apr 1 – Jun 2020): Copy of the after-hours clinician call schedule. Send submission to PHC's QIP Team via email, qip@partnershiphp.org , or fax to (707) 863-4316.
- Quarters 3 and 4 (Jul – Dec 2020): Copy of the after-hours clinician call schedule. Send submission to PHC's QIP Team via email, qip@partnershiphp.org , or fax to (707) 863-4316.

Exclusions

N/A

VI. Unit of Service $1,000 per site

Measure 10. *Patient-Centered Medical Home Recognition (PCMH)*

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, or re-certification from NCQA, AAAHC, or JCAHO must be faxed or emailed to QIP@partnershiphp.org by January 31, 2021.

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, 2021.

Exclusions

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

VI. UNIT OF SERVICE $10,000 MAXIMUM PER PARENT ORGANIZATION

Measure 11. *Peer-Led Self-Management Support Groups*

Description

Payment for starting or continuing a peer-run self-management support group at a contracted primary care provider site. The incentive will pay $1,000 per group, maximum 10 groups, to the parent organization.

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.

Measure Requirements

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

Qualifying peer groups must meet at least four times in the 2020 calendar year and have a peer-facilitation component and a self-management component via face-to-face, telephonic, or video meetings. 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:

- Up to a maximum of 10 per parent organization

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, 2021, and can be faxed or emailed to QIP@partnershiphp.org.

Exclusions

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

VI. UNIT OF SERVICE — INCENTIVE AMOUNT VARIES BY SITE

Measure 12. *Alcohol Misuse Screening and Counseling*

Description

This measure incentivizes providers to screen and counsel patients for alcohol misuse using standardized tools. Providers receive the incentive provided that they screen a minimum of 5% 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:

- G0442 (Alcohol screening)
- G0443 (Alcohol counseling)

PHC's claim system will validate and pay for up to two screenings for an individual every six months. Sites that hit the 5% target will earn a site-specific incentive.

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

$$\frac{Number\ of\ screenings\ billed\ with\ HCPCS\ codes\ G0442\ and\ G0443}{Number\ of\ assigned\ adult\ members}$$

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, 2021) by identifying claims for G0442 and G0443 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.

VI. UNIT OF SERVICE MAXIMUM OF $3,000 PER PARENT ORGANIZATION

Measure 13. *Health Information Exchange Participation*

Description

Parent Organizations will be reimbursed for participating in a local or regional health information exchange (HIE). Parent Organizations that first establish linkage during the 2020 measurement year are eligible to earn $3,000. Parent Organizations that can show continued linkage and utilization of an HIE prior to the 2019 measurement year are eligible to earn $1,500.

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.[9]

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.

Measure Requirements

Parent Organizations must specify on the Submission Template when linkage was established. In order to qualify for the incentive, linkage with the HIE has to be established by:

- 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
- Jefferson HIE

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

Submission Process

Submit the HIE Attestation form (Appendix III) by January 31, 2021. PHC will validate the data exchange by working directly with the specified HIE.

Exclusions

N/A

VI. UNIT OF SERVICE $2,000 MAXIMUM PER PARENT ORGANIZATION

Measure 14. *Initial Health Assessment Improvement Plan*

Description

DHCS requires the health plans to ensure that all new Medi-Cal beneficiaries have an initial health assessment (a first visit, including a health screening with the DHCS's Staying Healthy Assessment questionnaire. Normally this assessment includes an examination and must occur within 120 days of enrollment into Medi-Cal Managed care. Since a new Medi-Cal member has 1 month to select a PCP, the assigned PCP has about 90 days to complete this assessment. Most recent update, DHCS permitted to defer the completion of the IHA for these members until the COVID-19 emergency declaration is rescinded; however, DHCS will require the completion of the IHA for these members once the public health emergency is over (DHCS, 2020, page 9, para 4).

Our interpretation of the telehealth flexibilities is that an initial health assessment may be done through a video visit, if it includes all the elements of a comprehensive initial visit.

The IHA (Initial Health Assessment) includes the following criteria:

- Medical and Behavioral Health histories
- 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)

Parent Organizations 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.

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 can earn a one-time annual payment based on points earned for completing and turning in an IHA Improvement Plan.

Submission Process

Submit completed template via fax or email to QIP@partnershiphp.org. Submissions are due to Partnership no later than January 31, 2021. Payments will be made on an annual basis once per parent organization. Refer to Appendix V for IHA template.

Exclusions

N/A

VII. APPENDICES

Appendix I. Patient-Centered Medical Home Documentation Template

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Patient Centered Medical Home Recognition Template

Please complete all of the following fields on this form by **January 31, 2021** 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:

Appendix II: Submission Template for Peer-led Self-Management Support Group

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, 2021** 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 paid to the parent organization, not the individual sites.

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

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program
Health Information Exchange (HIE) Reporting Template

If your organization is linked to an HIE during or prior to the 2020 Measurement year, you may qualify for an incentive for the 2020 PCP QIP. Please complete all of the following fields on this form and submit by **January 31, 2021** 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. The parent organization, not the individual sites, will qualify for an incentive based on **either** HIE linkage (as a first time user) or HIE maintenance (as a continuing user). 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. Type of incentive
   - ☐ Linkage: First joined HIE *during* 2020 (list date)
     _____
   - ☐ Maintenance: First joined HIE *prior to* 2020 (list date)
     _____

4. Name of the HIE linked to (check the option that applies):

☐Sac Valley Med Share
☐North Coast Clinical Information Network
☐Redwood Med Net
☐Jefferson HIE
☐Other: _____

Submitted by: _____ Date: _____
Title: _____ Phone: _____
Email: _____

Appendix IV: Initial Health Assessment (IHA) Improvement Plan Template

PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Initial Health Assessment (IHA) Improvement Plan Template

The parent organization will qualify for an incentive based on approved Initial Health Assessment Plan. Please refer to the Measure Specifications for details.

Please complete the form and follow instructions below. Submit material by **January 31, 2021** to:

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

Organization Name: _____
Practice Address: _____
Contact Name: _____ Contact Email:_____

Improvement Plans should be a minimum of 400 words.

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 to 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: 2020 PCP QIP Submission and Exclusion Timeline

2020 QIP Submissions		
DUE DATE	**QIP MEASURE**	**REPORTING TEMPLATE**
January 31, 2021	All Clinical Domain Measures and Advanced Care Planning	Find on eReports
January 31, 2021	PCMH Recognition	Appendix I
January 31, 2021	Peer-led Self-Management Support Group	Appendix II
January 31, 2021	Health Information Exchange	Appendix III
January 31, 2021	Initial Health Assessment Improvement Plan	Appendix IV

2020 QIP Exclusions	
LAST DAY TO SUBMIT (ACCEPTED ALL YEAR)	**APPLICABLE MEASURES**
January 15, 2021	A1C Good Control
January 31, 2021	All other measures from the Clinical Domain

Appendix VI: Data Source Table

*For any measure, if "PHC" is the only data source, Providers may not submit uploads for the measure through eReports. PHC uses administrative data (Claims/Encounter/RxClaims) for these measures only.

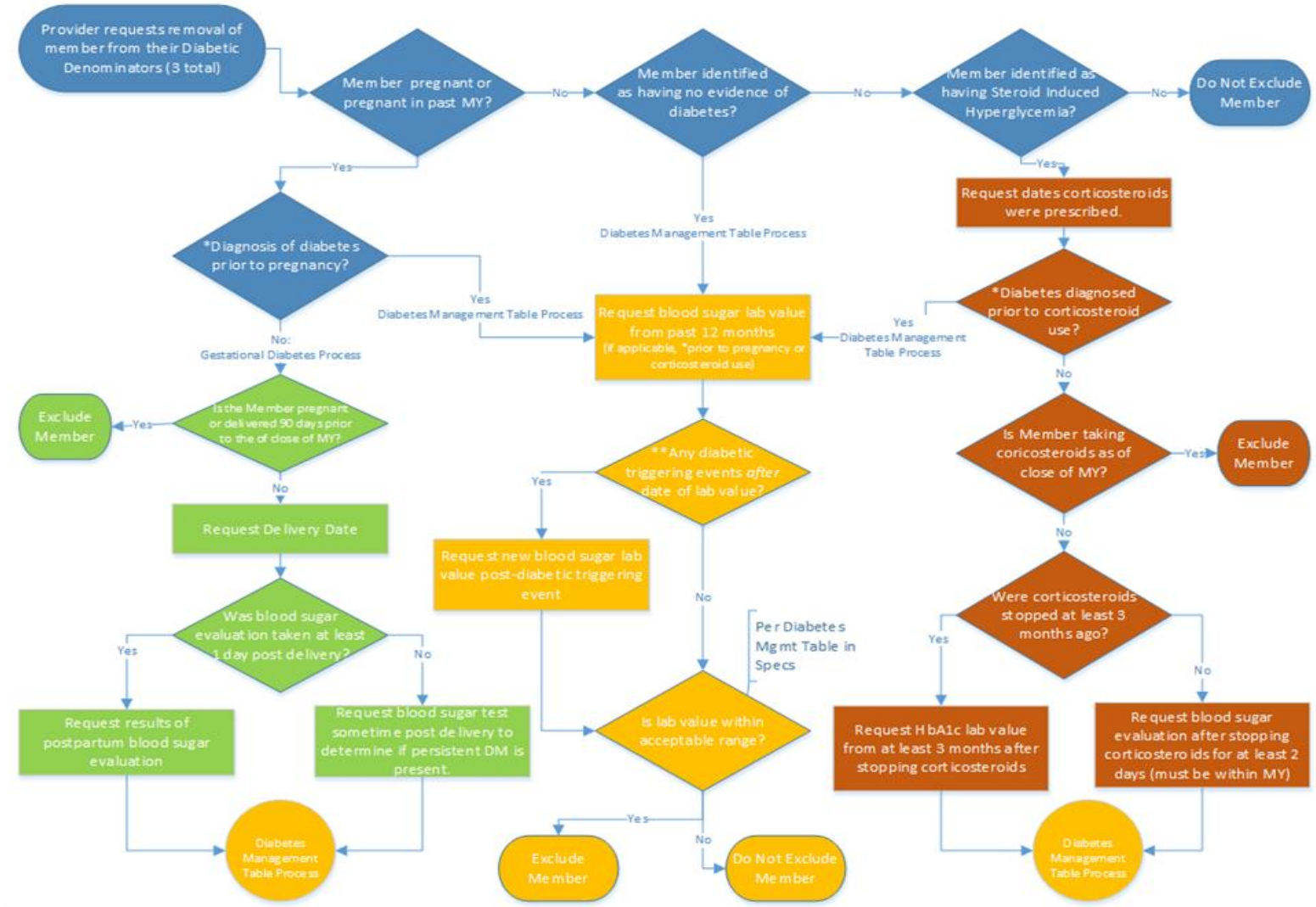
PCP QIP Core Measures	Data Source*	System Used for Data Monitoring	System Used for Data Submission
Clinical Care: Pediatric Medicine			
1. Well-child Visits in the First 15 Months of Life	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Childhood Immunization Combo-10			eReports
3. Asthma Medication Ratio	PHC		Claims
Clinical Care: Family Medicine			
1. Well-child Visits in the First 15 Months of Life	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Controlling High Blood Pressure			eReports
3. Colorectal Cancer Screening			
4. HBA1C Good Control			
5. Childhood Immunization Combo-10			eReports
6. Asthma Medication Ratio	PHC		Claims
Clinical Care: Internal Medicine			
1. Controlling High Blood Pressure	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
3. Colorectal Cancer Screening			
4. HbA1C Good Control			
5. Asthma Medication Ratio	PHC		Claims
Access/Operations Measures: All Practice Types			
1. PCP Office Visits	PHC	Partnership Quality Dashboard	Claims

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.

Lab	**Description**	**Value accepted for diabetes exclusions**
HbA1c value (%)	-	< 6.5%
Random blood sugar test (mg/dL or mmol/L)	Blood sample taken at a random time regardless of when the patient last ate.	<126 mg/dL
Fasting blood sugar test (mg/dL or mmol/L)	Blood sample taken after an overnight fast.	< 126 mg/dL or 7 mmol/L
Oral glucose tolerance test	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.	< 200 mg/dL or 11.1 mmol/L after two hours

Appendix VIII: QIP Diabetes Exclusion Flow Chart



VII. Monitoring Measurement Set for the MY2020

As stated above, the final QIP Measurement Set for the MY2020 is significantly modified and reduced from previously released versions and from the previous MY in response to the Covid-19 pandemic. DHCS and PHC recognize that the pandemic puts constraints on providers making more rigorous and numerous measure targets very difficult to achieve. **PHC wants to emphasize that the measures not included in the payment group remain clinically important.** Therefore, we are including this Monitoring Measurement Set.

The Monitoring Measurement Set is a separate and distinct measurement set that **does not have any points assigned to each measure**. The intent of this set is to provide visibility to your performance and access to the member gap-in-care list throughout the measurement year.

Data Source Table:

Monitoring Measures	Data Source*	System Used for Data Monitoring	System Used for Data Submission
Clinical Care: Pediatric Medicine			
1. Well-child Visits (ages 3-6)	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Adolescent Well Care Visits			
3. Immunizations for Adolescents			
Clinical Care: Family Medicine			
1. Well-child Visits (ages 3-6)	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Adolescent Well Care Visits			
3. Cervical Cancer Screening			
4. Retinal Eye Exam			
5. Breast Cancer Screening			
6. Immunization for Adolescents			
Clinical Care: Internal Medicine			
1. Cervical Cancer Screening	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Retinal Eye Exam			
3. Breast Cancer Screening			
Appropriate Use of Resources: Family and Internal Medicine			
1. Ambulatory Care Sensitive Admissions	PHC	Partnership Quality Dashboard	Claims
2. Plan-All Cause Readmission Rate			

Access/Operations Measures: All Practice Types			
1. Avoidable ED Visits/1000 Members Per Year	PHC	Partnership Quality Dashboard	Claims

VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

Monitoring Measure 1. *Adolescent Well-Care Visits (12 – 21 Years Old)*

Description

The percent of continuously enrolled Medi-Cal members 12–21 years of age and who received at least one well-care visit with a PCP during the measurement year.

Regular check-ups by adolescents provide an opportunity for health teaching and for the adolescents / parents to raise any potential concerns. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health. This is a time of transition between childhood and adult life and is accompanied by dramatic changes including accidents, homicide and suicide, which are the leading causes of adolescent deaths. Sexually transmitted diseases, substance abuse, pregnancy and antisocial behavior are important causes of—or result from—physical, emotional and social adolescent problems [28].

The QIP encourages providers to establish habitual preventative care for children.

Thresholds

- Points Not Applicable
- 50th percentile (54.26%)

Denominator

The number of continuously enrolled Medi-Cal members 12-21 years of age as of December 31, 2020 (i.e. DOB between January 1, 1999 and December 31, 2008).

Numerator

The number of members in the eligible population with a comprehensive well-care visit with a PCP during the measurement year, between January 1, 2020 and December 31, 2020.

Note: To be eligible for a well-care visit, visit documentation must include 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 the assessment or treatment of 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 provider does not have to be the member's assigned PCP.

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: Well-Care Value Set.

Exclusions (only if not numerator hit)

N/A

VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

Monitoring Measure 2. *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 signs of cancer even before any lump can be felt in the breast. Studies have shown that routine mammograms are associated with a 10% to 25% less chance of dying of breast cancer.[25]

Thresholds

- Points Not Applicable
- 50th percentile (58.67%)

Denominator

The number of continuously enrolled (October 1, 2018 through December 31, 2020, no gap allowed from October 1, 2018 to December 31, 2018, one month gap allowed from January 1, 2019 to December 31, 2019, and one month gap allowed from January 1, 2020 to December 31, 2020) Medi-Cal women 50-74 years of age as of December 31, 2020 (DOB between January 1, 1946 and December 31, 1970).

Numerator

The number of members from the eligible population in the denominator with one or more mammograms any time on or between October 1, 2018 and December 31, 2020.

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, 2020.

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, 2019, 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 or different dates of service.

Left Mastectomy (Any of the following)	Right Mastectomy (Any of the following)
• Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Left Modifier Value Set) (same claim)	• Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Left Modifier Value Set) (same claim)
• Absence of the left breast (Absence of Left Breast Value Set)	• Absence of the right breast (Absence of Right Breast Value Set)
• Left Unilateral mastectomy (Unilateral Mastectomy Left Value Set)	• Right Unilateral mastectomy (Unilateral Mastectomy Right Value Set)

VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

Monitoring Measure 3. *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 and human papillomavirus (HPV) co-testing performed every five years.
- Women age 30-64 who had high-risk human papillomavirus (hrHPV) 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]

Thresholds

- Points Not Applicable
- 50th percentile (60.65%)

Denominator

The number of continuously enrolled Medi-Cal women 24-64 years of age as of December 31, 2020 (DOB between January 1, 1956 and December 31, 1996).

Numerator

The number of women in the eligible population who were appropriately screened according to evidence-based guidelines.

Women 24-64 years of age as of December 31, 2020 (DOB between January 1, 1956 and December 31, 1996) who had cervical cytology in the measurement year or the two years prior (January 1, 2018 – December 31, 2020).

Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed.
- The result or finding.

  Do not count biopsies because they are diagnostic and therapeutic and are not valid for primary cervical cancer screening.

  Note: *Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.*

Women 30-64 years of age as of December 31, 2020 (DOB between January 1, 1956 and December 31, 1990) who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year (High Risk HPV Lab Test Value Set) or the four years prior to the measurement year (January 1, 2016 – December 31, 2020) and who were 30 years or older on the date of both tests.

Documentation in the medical record must include both of the following:

- 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, i.e., on the same claim number.
- The result or finding.

  Do not count biopsies because they are diagnostic and therapeutic and are not valid for primary cervical cancer screening.

Note: *Evidence of hrHPV testing within the last five years also captures patients who had co-testing. Reflex testing (Pap w/HPV if needed) or primary hrHPV within the past five years for 30 – 64 year old women is now compliant.*

NOTE: For any age group, 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 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 hrHPV Test: High Risk HPV Tests Value Set

Exclusions (only if not numerator hit)

These are based on:

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Value Set; Hysterectomy with No Residual Cervix Value Set) any time during the member's history through December 31, 2020.

- Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy date meets the criteria for hysterectomy with no residual cervix any time during the member's history through December 31, 2020.

- Documentation of a "vaginal Pap smear" in conjunction with documentation of "hysterectomy" date any time during the member's history through December 31, 2020.

- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening date any time during the member's history through December 31, 2020.
- Transgender members (Male to Female) with the use of the cervical agenesis code from the Absence of Cervix Value Set.

Important Note:

1. Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.
2. If the doctor is willing to attest and document permanently in the patient's chart a "complete," "total" or "radical" abdominal or vaginal hysterectomy date and the patient provides limited date information, please use the following for uploading the date into eReports:
    a. Year - (01/01/YYYY) or (12/31/YYYY)
    b. Month and Year – (MM/01/YYYY) or (MM/30 or 31/YYYY)

    If the doctor diagnosis the patient no residual cervix, cervical agenesis or acquired absence of cervix, please upload into eReports:
    Date of Diagnosis – (MM/DD/YYYY)

VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

Monitoring Measure 4. *Diabetes Management – Retinal Eye Exam*

Description

The percentage of members 18-75 years of age who had a diagnosis of diabetes who have had recommended retinal eye exams, screening for diabetes related retinopathy.

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 vision loss related to 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]

Thresholds

- Points Not Applicable
- 50th percentile (58.88%)

Denominator

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1945 and December 31, 2002) with diabetes identified as of December 31, 2020.

Members with diabetes are identified throughpharmacy 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 will count services that occur during the measurement year or the year prior (i.e. January 1, 2019 –December 31, 2020).

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, 2019 – December 31, 2020).

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

  OR

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

OR

- Members who were dispensed insulin or hypoglycemics/antihyperglycemics, per pharmacy data, on an ambulatory basis during the measurement year or the year prior to the measurement year.

Numerator

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

- A retinal or dilated eye exam (Diabetic Retinal Screening Value Set) by an eye care professional (optometrist or ophthalmologist or teleoptometry service such as EyePACs) in the measurement year.
- A negative retinal or dilated eye exam (negative for retinopathy) (Diabetic Retinal Screening Negative Value Set) by an eye care professional during the measurement year or the year prior. For exams performed with a negative result in the year prior to the measurement year (January 1, 2019 – December 31, 2019), a result must be available.
- Unilateral eye enucleation with a bilateral modifier.).
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) and right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.

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 (Diabetes Mellitus Without Complications Value Set).
- Codes to identify a unilateral eye enucleation: Unilateral Eye Enucleation Value Set
- Codes to identify a unilateral eye:
  - Unilateral Eye Enucleation Left Value Set
  - Unilateral Eye Enucleation Right 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, 2019 – December 31, 2020), 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 VIII for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix IX for the Diabetes Exclusions Flow Chart.

VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

Monitoring Measure 5. *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]

Thresholds

- Points Not Applicable
- 50th percentile (34.43%)

Denominator

The number of continuously enrolled Medi-Cal members who turn 13 years of age between January 1, 2020 and December 31, 2020 (DOB between January 1, 2007 and December 31, 2007).

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 serogroups A, C, W, Y vaccine with a date of service on or between the members' 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's10th 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 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 documentation that the vaccine was given from either of the following:

- Documentation indicating the name of the specific vaccine 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.

Codes Used

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

Numerator:

- Codes to identify meningococcal conjugate: Meningococcal Vaccine Administrated Value Set.
- Codes to identify Tdap: Tdap Vaccine Administrated Value Set.
- Codes to identify HPV: HPV Vaccine Administrated Value Set.
- In addition, immunization data obtained through the California Immunization Registry (CAIR) will be accessed to meet this measure. **Important Note:** PHC WILL BE MOVING TOWARDS LIMITING UPLOADING FOR THIS MEASURE. To prepare for this, we recommend all PCP sites develop robust systems for entering data for current and past vaccines into CAIR.

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 given.

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.

VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

Monitoring Measure 6. *Well-Child Visits (3 – 6 Years Old)*

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.[2] Behaviors established during childhood or adolescence, such as eating habits and physical activity, often extend into adulthood.[3] Well-care visits provide an opportunity for providers to influence health and development and they are a critical opportunity for screening.

The QIP encourages providers to establish habitual preventative care for children.

Thresholds

- Points Not Applicable
- 50th percentile (72.87%)

Denominator

The number of continuously enrolled Medi-Cal members 3-6 years of age as of December 31, 2020 (i.e. DOB between January 1, 2014 and December 31, 2017).

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, 2020 and December 31, 2020.NOTE: To be eligible for a well-child visit, visit documentation must include 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 the assessment or treatment of 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 provider does not have to be the member's assigned PCP..

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: Well-Care Value Set.

Exclusions (only if not numerator hit)

N/A

VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

Monitoring Measure 7. *Ambulatory Care Sensitive Admissions*

Description

The rate of assigned members who have had ambulatory care sensitive admissions (ACSA) during the measurement year.

ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.[10]

Thresholds

- Points Not Applicable
- Full points: TBD

Targets are set using the plan-wide mean, adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets will be posted in Partnership Quality Dashboard by the end of Spring 2020.

Data Criteria

Sites must have a minimum of 100 eligible members on the last day of the measurement period (December 31, 2020). The list of ambulatory care sensitive conditions is obtained from the Agency for Health Care Research and Quality's (AHRQ) Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). PHC will calculate the number of admissions related to these diagnoses using PHC allowable claims and encounter data from acute care hospitals for services provided to the site's assigned members.

Denominator

Total hospital days for all admissions for eligible population during the measurement period.

Numerator

Total hospital days for inpatient admissions with a qualifying diagnosis from the provided list of PDIs and PQIs.

Calculation:

ACSA Rate = Total # of ACSC / Total # of All Inpatient Admissions

Codes Used

Preventive Quality Indicators:
https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2018.aspx
PQI 01 – Diabetes Short-term Complications
PQI 03 – Diabetes Long-term Complications
PQI 05 – COPD or Asthma in Older Adults Admission Rate
PQI 07 – Hypertension
PQI 08 – Heart Failure
PQI 10 – Dehydration

PQI 11 – Community Acquired Pneumonia Admission Rate
PQI 12 – Urinary Tract Infection
PQI 14 – Uncontrolled Diabetics
PQI 15 – Asthma in Younger Adults
PQI 16 – Lower-Extremity Amputation among Patients with Diabetes

Pediatric Quality Indicators:
https://www.qualityindicators.ahrq.gov/Archive/PDI_TechSpec_ICD10_v70.aspx
PDI 14 – Asthma Admissions Rate
PDI 15 – Diabetes Short-term Complications
PDI 16 – Gastroenteritis
PDI 18 – Urinary Tract Infection

Exclusions

Exclude hospital stays for the following reasons:

- A principal diagnosis of pregnancy
- A principal diagnosis of a condition originating in the perinatal period
- Admissions associated with organ transplants
- Transfers from acute health care facilities

VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

Monitoring Measure 8. *Avoidable ED Visits/1000 Members per Year*

Description

This measure rewards providers for having a low number of Emergency Room Department (ED) 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.

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

- Points Not Applicable
- Full points: TBD

Targets are set using the plan-wide mean, adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets will be posted on thePartnership Quality Dashboard by end of Spring 2020.

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:

Avoidable ED Visits per 1000 =
Avoidable ED visits /
*Non-Dual Capitated Member Months)*12,000*

Codes Used

- Codes to identify service location as ED: Avoidable ED Inclusion – Location Code
- Codes to identify ED claims type (facility or professional): Avoidable ED Inclusion – ED Claims Type
- Codes to identify ED Avoidable Diagnosis Codes: Avoidable ED Inclusion – Primary Diagnosis ICD9/10

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

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