2020 PRIMARY CARE PROVIDER
QUALITY INCENTIVE PROGRAM

IT'S WHAT WE LIVE FOR

Blue Cross Blue Shield of Rhode Island

Dear Provider,

Blue Cross & Blue Shield of Rhode Island (BCBSRI) is committed to improving the health of our members and all Rhode Islanders, by supporting access to high-quality, cost-effective healthcare. An important component of our commitment is our continued efforts to reward primary care providers (PCPs) for improving quality and closing gaps in care, such as through our PCP Quality Incentive Program (PQIP). In this letter, I am pleased to share details about our 2020 program.

Each year, BCBSRI is evaluated by a number of organizations – including the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) – on the health outcomes of our members. We recognize that as a primary care provider, you have much more influence than BCBSRI in affecting improvement on many of the measures identified in this program, specifically those related to closing potential gaps in care.

For the 2020 PCP Quality Incentive Program, we have introduced enhancements that incorporate feedback we received from the provider community, as well as improvement efforts to reduce gaps in care. In addition, targets for Medicare Advantage measures will align with the most up-to-date CMS Star Rating cut points. Commercial measures will align with the most up-to-date NCQA Quality Compass percentile benchmarks.

Incentive payments will be based on a holistic view that leverages an overall composite achievement score, shifting from the measure-by-measure approach used in previous years. The scoring methodology will now also include a Star rating, which will provide you with a means of understanding your performance relative to your peers.

If you have questions about the 2020 PCP Quality Incentive Program, please contact your quality concierge team representative, or send an email to QualityHEDIS@bcbsri.org.

Thank you for your support of the 2020 PCP Quality Incentive Program.

Sincerely,

Matthew Collins, M.D., MBA

Executive Vice President, Chief Medical Officer

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Introduction

Blue Cross & Blue Shield of Rhode Island (BCBSRI) is pleased to offer the 2020 PCP Quality Incentive Program, which rewards PCPs for improving quality and closing gaps in care. As in past years, BCBSRI will make incentives available to PCPs to support improvements in quality, as outlined by nationally recognized programs and measures.

This 2020 PCP Quality Incentive Program handbook includes detailed information regarding:

- Specific measurement attributes of the program
- Access to data to assist in meeting benchmarks
- Bonus earning opportunities to maximize earning potential

The 2020 PCP Quality Incentive Program is open to all PCPs participating in the BCBSRI network. This program includes Medicare Advantage and Commercial BCBSRI populations. The program is based on the State Innovation Model (SIM) Measure Alignment measure set and the Centers for Medicare and Medicaid Services (CMS) Star Rating program, which are composed of nationally accepted quality measures developed and/or endorsed by a number of organizations, including:

- National Committee for Quality Assurance
- Oregon Pediatric Improvement Partnership
- National Quality Forum

BCBSRI evaluates performance measures yearly. Categories and benchmarks are adjusted based on feedback from BCBSRI's providers and health system partners, as well as the healthcare industry.

Reporting and Payment Schedule

2020 Incentive Payment Schedule

Program Year	Communication to providers	Measurement Period	Anticipated Payment & Reporting Date
2020	4th Quarter 2019	January 2020 – December 2020	4th Quarter 2021

HIGHLIGHTED PROGRAM UPDATES

Although many program components remain the same, there are some key changes:

INCENTIVES

- To align with performance standards expected of BCBSRI, providers must score an aggregated Star Rating of at least a 4 Star to receive each population's base payment. For example, if a provider receives a 4.5 star for Medicare Advantage and a 3 star for both Commercial Adult and Pediatric, they will only be eligible to receive the base payment for Medicare Advantage.
- Providers and Systems of Care are eligible for a bonus in addition to their Medicare Advantage base payment. Bonuses focus on practice Star ratings, CAHPS and HOS, and yearly improvement. See page 12 for details.

ADMINISTRATIVE REQUIREMENTS

- Systems of Care and Contracted Groups are required to use standard file format for supplemental data no later than July 1, 2020. If not implemented, a 10% penalty on the total payment (Medicare Advantage + Commercial) will be applied. See page 7 for details.
- Systems of Care and contracted groups are required to use CPT II codes, when applicable, by December 31, 2021. See page 7 for details.
- Glide paths will be discontinued for performance year 2020 and beyond. See page 7 for details on how to submit supplemental data in an accurate and accepted way.

PERFORMANCE MEASUREMENT

- Measure Benchmarks, as outlined in page 8, are based on BCBSRI's prediction of how CMS and NCQA will set the benchmarks for applicable performance measures for the applicable program year.
- Adult BMI Assessment, Tobacco Screening, Transitions of Care and Adolescent Immunization Status will not be included in the 2020 program.
- Exclusions for advanced illness/frailty, as defined by NCQA, are continued in the 2020 program. Criteria to identify advanced illness/frailty is provided by NCQA; exclusions are made using claims data only and must be assessed on an annual basis.

QUALITY INCENTIVE PROGRAM BASE PAYMENT MEASURES

For detailed measure descriptions, please see page 18 of this document.

MEDICARE ADVANTAGE PROGRAM

1. Breast Cancer Screening
2. Colorectal Cancer Screening
3. Comprehensive Diabetes Care – Eye Exam
4. Comprehensive Diabetes Care – Nephropathy Screening
5. Comprehensive Diabetes Care – Hemoglobin A1c Control < = 9%
6. Controlling High Blood Pressure
7. Osteoporosis Management in Women Who Had a Fracture
8. Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
9. Medication Reconciliation Post Discharge

COMMERCIAL PROGRAM

Commercial – Adult

1. Breast Cancer Screening
2. Colorectal Cancer Screening
3. Comprehensive Diabetes Care – Eye Exam
4. Comprehensive Diabetes Care – Hemoglobin A1c Control < 8%
5. Controlling High Blood Pressure

Commercial – Pediatric

1. Well-Child – Counseling for Nutrition
2. Well-Child – Counseling for Physical Activity
3. Well-Child – BMI Assessment
4. Developmental Screening in the First Three Years of Life – 1st Year
5. Developmental Screening in the First Three Years of Life – 2nd Year
6. Developmental Screening in the First Three Years of Life – 3rd Year

PERFORMANCE MEASUREMENT

Providers participating in the PCP Quality Incentive Program must have the appropriate technology to exchange data with BCBSRI. Systems of Care, Contracted Groups, and individual providers will be expected to expand Electronic Health Record capabilities to include the ability to transmit quality data extracts.

SUPPLEMENTAL DATA

BCBSRI continues aligning efforts with NCQA measure standards for clinical data collection. Therefore, glide paths (Excel spreadsheets) have been eliminated. Providers will have the opportunity to submit data in the standard file format for certain quality measures in which gaps are not closed through the claims submission process.

STANDARD FILE FORMAT

Beginning with the 2020 PQIP program, Systems of Care and Contracted Groups are required to submit data in the standard file format for applicable measures by July 1, 2020. Independent practices are responsible for submitting data in an acceptable format that will be subject to an audit. Any data submitted in a different format will not receive credit in the 2020 incentive calculation. BCBSRI reserves the right to withhold payments from practices that do not adhere to the data submission guidelines. Glide paths will not be accepted in 2020.

IF SYSTEMS OF CARE AND CONTRACTED GROUPS FAIL TO SUBMIT DATA IN THE STANDARD FILE FORMAT BY JULY 1, 2020, A 10% PENALTY WILL BE APPLIED TO THE TOTAL BASE PAYMENT.

GAP IN CARE REPORTS

Providers can request monthly gap in care reports starting in January 2020. Providers are expected to reconcile these reports to ensure gaps are closed. All program measures will be included in the report except Osteoporosis Management in Women Who Had a Fracture and Medication Reconciliation Post Discharge. Gap in care data follows the member and date panels are frozen October 1, 2020 through the end of the year. Therefore, the calculated score reflecting member compliance (whether negatively or positively) will impact the payout for the provider attributed to that member when the panel locked on October 1, 2020.

If you would like to be added to the distribution list to receive the monthly reports, please email QualityHEDIS@bcbsri.org.

CPT CATEGORY II CODES

Providers are strongly encouraged to use CPT Category II Codes for applicable measures in which the gap can be closed through coding. CPT Category II Codes are not required for the 2020 program but may be tied to additional incentives in future programs. Appropriate CPT Category II Codes are outlined in the measure descriptions starting on page 18. Codes listed are not all inclusive; codes may be added, changed, or removed.

Measure Benchmarks

Measures are weighted in the 2020 program. For Medicare Advantage measures, BCBSRI aligned the weighting with the Centers for Medicare and Medicaid 2020 Stars weighting. For Commercial measures, BCBSRI weighted all measures equally.

2020 MEDICARE ADVANTAGE BENCHMARKS AND WEIGHTING

Count	Measure	3 Star Rating	4 Star Rating	5 Star Rating	Weight
1	Breast Cancer Screening	74%	82%	88%	1
2	Colorectal Cancer Screening	68%	77%	83%	1
3	Diabetes – Eye Exam	73%	77%	85%	1
4	Diabetes – Nephropathy Screening	90%	97%	98%	1
5	Diabetes – Hemoglobin A1c Control < = 9%	72%	82%	91%	3
6	Controlling High Blood Pressure	62%	75%	82%	1
7	Osteoporosis Management in Women Who Had a Fracture	47%	60%	81%	1
8	Rheumatoid Arthritis Management	80%	87%	93%	1
9	Medication Reconciliation	66%	75%	88%	1

2020 COMMERCIAL BENCHMARKS AND WEIGHTING: ADULT MEASURES

Count	Measure	3 Star Rating Equivalent	4 Star Rating Equivalent	5 Star Rating Equivalent	Weight
1	Breast Cancer Screening	74%	78%	85%	1
2	Colorectal Cancer Screening	65%	71%	80%	1
3	Diabetes – Eye Exam	54%	63%	75%	1
4	Diabetes – Hemoglobin A1c Control <8%	61%	66%	71%	1
5	Controlling High Blood Pressure	62%	70%	80%	1

2020 COMMERCIAL BENCHMARKS AND WEIGHTING: PEDIATRIC MEASURES

Count	Measure	3 Star Rating Equivalent	4 Star Rating Equivalent	5 Star Rating Equivalent	Weight
1	Well-Child Counseling for Nutrition	68%	78%	90%	1
2	Well-Child Counseling for Physical Activity	64%	73%	87%	1
3	Well-Child BMI Assessment	73%	83%	94%	1
4	Developmental Screening in the First Three Years of Life – 1^{s} Year	77%	82%	87%	1
5	Developmental Screening in the First Three Years of Life –2nd Year	77%	82%	87%	1
6	Developmental Screening in the First Three Years of Life –3rd Year	77%	82%	87%	1

Scoring and Base Payout Methodology

The following methodology is used to determine final incentive base payments.

A. Establish Weighted Achievement Star Score

1. Calculate the compliance rate (numerator/denominator) for each individual measure.
2. Determine the Star Rating equivalent for each individual measure using the target grids by product and population as shown on the previous page. If the compliance rate falls below 3 Star, the Star score = 2.
3. Calculate a weighted star (Star Rating x Weight = Weighted Star Rating) for each individual measure. Calculate an Aggregated Star Rating across all measures (SUM of Weighted Star Rating ÷ SUM of Weight = Aggregated Star Rating).

To align with performance standards expected of BCBSRI, providers must score an aggregated Star Rating of at least 4 Stars to receive each population's base payment. For example, if a provider receives 4.5 stars for Medicare Advantage and 3 stars for both Commercial Adult and Pediatric, they will only be eligible to receive the base payment for Medicare Advantage.

Example using Medicare Advantage:

Measure	Denominator	Numerator	Compliance Rate	Star Rating	Weight	Weighted Star Rating
Breast Cancer Screening	397	350	88.2%	5	1	5
Colorectal Cancer Screening	145	112	77.2%	4	1	4
Diabetes – Eye Exam	236	189	80.1%	4	1	4
Diabetes – Nephropathy Screening	236	230	97.5%	4	1	4
Diabetes – Hemoglobin A1c Control < = 9%	236	200	84.7%	4	3	12
Controlling High Blood Pressure	125	112	89.6%	5	1	5
Osteoporosis Management in Women Who Had a Fracture	4	3	75%	4	1	4
Rheumatoid Arthritis Management	5	4	80%	3	1	3
Medication Reconciliation	27	25	92.6%	5	1	5
				Sum:	11	46
				Aggregated Star Rating:	4.1818182	

B. Establish Per Member Per Month (PMPM) Rate

Using the Aggregated Star Rating calculated in Step A select the corresponding PMPM rate for the product line.

Aggregated Star Rating	Medicare PMPM	Commercial Adult PMPM	Commercial Pediatric PMPM
5.00	$14.00	$7.00	$5.25
4.75 – 4.99	$13.00	$6.50	$4.88
4.5 – 4.74	$10.00	$5.00	$3.75
4.25 – 4.49	$9.00	$4.50	$3.38
4.00 – 4.24	$6.00	$3.00	$2.25

In the above example, the provider's Medicare PMPM rate = $6.00.

C. Establish Average Denominator Stratification

Step 1: Assign a stratification number to each individual measure based on the denominator size according to the following table:

Denominator Size by Measure	Stratification
1 – 9 members	.25
10 – 19 members	.50
20 – 29 members	.75
30+ members	1.00

Step 2: Calculate the average denominator stratification across all eligible measures.

Measure	Denominator	Numerator	Compliance Rate	Star Rating	Weight	Agg. Star Rating	Denominator Stratification
Breast Cancer Screening	397	350	88.2%	5	1	5	1
Colorectal Cancer Screening	145	112	77.2%	4	1	4	1
Diabetes – Eye Exam	236	189	80.1%	4	1	4	1
Diabetes – Nephropathy Screening	236	230	97.5%	4	1	4	1
Diabetes – Hemoglobin A1c Control < = 9%	236	200	84.7%	4	3	12	1
Controlling High Blood Pressure	125	112	89.6%	5	1	5	1
Osteoporosis Management in Women Who Had a Fracture	4	3	75%	4	1	4	0.25
Rheumatoid Arthritis Management	5	4	80%	3	1	3	0.25
Medication Reconciliation	27	25	92.6%	5	1	5	0.75
						Average Denominator Stratification	0.78

D. Establish Member Months

Using the October 1, 2020 frozen patient panel for each provider, BCBSRI will calculate unique member months following an appropriate claims runout for 2020.

Note: Dual eligible members are only counted once, defaulting to Medicare Advantage for program measures and PMPM payout rates.

E. Calculate Final Payout

PMPM Rate for Aggregate Star Rating (from Step B) × **Average Denominator Stratification** (from Step C) × **Member Months** (from Step D)

Follow steps A-E to calculate Medicare Advantage, Commercial Adult, and Commercial Pediatric measures. Then calculate the Final Quality Base Payment using the formula below.

Final Quality Base Payment =

Medicare Advantage Payout + Commercial Adult Payout + Commercial Pediatric Payout

ELIGIBLE BONUSES

In addition to the base payments, Systems of Care, Contracted groups and individual providers are eligible to receive bonuses on the Medicare Advantage population in the 2020 program. Dependent on practice affiliation, providers are eligible to receive the following bonuses:

Bonus	Practice Affiliation	Requirements	Payment
Overall High Performance	Systems of Care & Contracted Groups	At least 50% of providers achieve an overall 4.5 Star rating or above.	Additional 10% of Medicare Advantage base payment
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Systems of Care & Contracted Groups	Development of CAHPS action plan and improvement in measures/areas.	Additional 10% of Medicare Advantage base payment
Health Outcomes Survey (HOS)	Systems of Care & Contracted Groups	Development of HOS action plan and improvement in measures/areas.	Additional 10% of Medicare Advantage base payment
Year Over Year Improvement	Independent Practices	Practice shows improvement in overall Stars rating.	Additional 10% of Medicare Advantage base payment

BCBSRI calculates all eligible bonuses and will include any additional payment with the base payment. If you need more information about what practice affiliation you fall into, see the Glossary on page 38 for provider definitions, contact your quality concierge team representative, or send an email to QualityHEDIS@bcbsri.org.

OVERALL HIGH PERFORMANCE BONUS

Systems of Care and Contracted Groups are eligible to receive an additional 10% of their Medicare Advantage base payment based on individual providers' performance. To receive this bonus, 50% of the providers affiliated to the SOCs or contracted groups must achieve an overall aggregated Star rating of 4.5 Stars or above for their Medicare Advantage performance.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) BONUS

In the 2020 PCP Quality Incentive Program, Systems of Care and Contracted Groups are eligible to receive an additional 10% of their Medicare Advantage base payment based on the development of actions that will lead to improvement on the Medicare CAHPS survey.

The CAHPS survey provides information to Medicare beneficiaries on the quality of health services provided through Medicare Advantage programs. Consumer evaluations of health care, such as those collected through the Medicare CAHPS surveys, measure important aspects of a patient's experience that cannot be assessed by other means. As part of the 2020 program, Medicare Advantage members attributed to Systems of Care and Contracted Groups will be surveyed to determine performance in the following CAHPS measures, which are referenced in greater detail on page 36:

- Getting needed care
- Getting appointments and care quickly
- Rating of health care quality
- Care coordination.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

BCBSRI will measure and distribute CAHPS baselines in 2020 that will be used for benchmark setting in future incentive programs.

In order to receive the designated bonus for CAHPS in the 2020 program, Systems of Care and Contracted Groups will be expected to develop an action plan that will lead to improvement in these areas. This action plan must be communicated to BCBSRI no later than Q2 2020, with work expected to begin by July 2020 with influence on patient experience beginning no later than Q4 2020 to align with CMS measurement periods for the CAHPS data source.

HEALTH OUTCOMES SURVEY (HOS) BONUS

In the 2020 PCP Quality Incentive Program, Systems of Care and Contracted Groups are eligible to receive an additional 10% of their Medicare Advantage base payment based on their performance in the Health Outcomes Survey (HOS).

Medicare HOS collects patient-reported outcomes measures from beneficiaries enrolled in Medicare Advantage plans. The Medicare HOS program collects health status data for use in quality improvement activities, plan accountability documentation, and health improvement activities in a base survey and two-year follow-up survey. BCBSRI will provide Systems of Care and Contracted Groups with a baseline of HOS data as received through Health Risk Assessments.

To receive a bonus for the 2020 PCP Quality Incentive Program, Systems of Care and Contracted Groups will be expected to meet two criteria. The first will be to develop an assessment template and process for delivery that is auditable at the request of BCBSRI for all Medicare Advantage member visits by Q1 of 2020. In order to reflect improvement in HOS measures, these assessment templates should address the following topics, which are referenced in greater detail on page 38:

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Monitoring Physical Activity
- Reducing Risk of Falling
- Improving Bladder Control

The second criteria will be to develop an action plan that will lead to improvement in the areas listed above. This action plan must be communicated to BCBSRI no later than Q2 2020, with work expected to begin by July 2020 with influence on patient experience beginning no later than Q4 2020 to align with CMS measurement periods for the HOS data source.

YEAR-OVER-YEAR IMPROVEMENT BONUS

Individual practices not affiliated with a System of Care or Contracted Group are eligible to receive an additional bonus based on year-over-year improvement. The year-over-year improvement will be calculated based on the overall unweighted compliance rate across selected Medicare Advantage measures as shown below (i.e., sum of numerators ÷ sum of denominators).

- Breast Cancer Screening
- Colorectal Cancer Screening
- Comprehensive Diabetes Care – Eye Exam
- Comprehensive Diabetes Care – Nephropathy Screening
- Comprehensive Diabetes Care – Hemoglobin A1c Control < = 9%
- Controlling High Blood Pressure

Providers that show 20% or more year-over-year improvement between 2019 and 2020 will be eligible to receive an additional 10% of their Medicare Advantage base payment.

Example of year-over-year improvement bonus:

	2019		2020	
	Denominator	**Numerator**	**Denominator**	**Numerator**
Breast Cancer Screening	110	88	102	93
Colorectal Cancer Screening	81	61	82	72
Diabetes – Eye Exam	32	22	23	20
Diabetes – Nephropathy Screening	32	23	23	19
Diabetes – Hemoglobin A1c Contol < = 9%	32	18	23	21
Controlling High Blood Pressure	56	35	43	38
Sum of Measures	**343**	**247**	**296**	**263**
Overall Compliance Rate	**72%**		**89%**	

Conclusion: This provider has shown >20% year-over-year improvement and is qualified for MA bonus payment in 2020.

Provider Affiliation

Incentives will be calculated at the individual provider level based on the provider's affiliation in BCBSRI's internal databases as of October 1, 2020. Systems of Care, Contracted Groups, and individual practices are required to notify BCBSRI, via a Practitioner Change Form, when a provider joins or leaves a practice. There are no appeals of the incentive calculation if notification to BCBSRI did not occur prior to October 1, 2020. If a provider leaves the BCBSRI network between October 2, 2020 and December 31, 2020, no payment will be made.

If a provider belongs to Systems of Care or Contracted Groups that have contractual responsibilities for quality, the incentive payment and all reporting will be sent to the System of Care or Contracted Groups. The System of Care or Contracted Groups will be responsible for paying the incentive to its providers, in accordance with the terms of the contract between the System of Care/Contracted Groups and the provider.

Provider information (e.g., System of Care affiliation, Contracted Group affiliation, practice site affiliation, NPI1, NPI2, tax ID, address, etc.) from the frozen patient panel will be used for rate calculations and payments.

Member Attribution

The patient panel for each provider will be frozen as of October 1, 2020. Members or providers cannot be added to, or removed from a frozen patient panel after that date.

ATTRIBUTION METHODOLOGY

A member's PCP is determined through BCBSRI's attribution process, as listed below:

- Self-selection (i.e., a member selects their PCP). This step is only used when:
  - The member's plan requires PCP selection, and
  - The PCP's name appears on the member's ID card.
- If no PCP has been self-selected, then:
  - Using the most recent 24 months of claims data, the PCP with the most recent well visit (CPT codes: 99381–99387, 99391–99397) is attributed as the PCP.
- If there is no well visit, then:
  - Using the most recent 24 months of claims data, the PCP with the greatest number of sick visits (CPT codes: 99201–99205, 99211–99215) is attributed as the PCP. In the event of two or more PCPs having the same number of sick visits, the PCP with the most recent sick visit will be attributed as the PCP.

EXCLUDED MEMBERS

Members excluded from the 2020 PCP Quality Incentive Program include:

- Members participating in BCBSRI's Federal Employee Program
- Classic Blue members
- New England Health Plan Home members with a PCP outside of Rhode Island
- New England Health Plan Host members
- Medicare Advantage members residing in a long term-care facility
- Members actively receiving hospice care (hospice care defined as members who begin home-based or facility-based hospice coverage)
- Medicare Supplemental

Attribution of members and PCP assignments cannot be appealed. Members and providers cannot be added to, or removed from, a patient panel once the panel has been frozen on October 1, 2020.

Payment Guidelines

1. Providers must be active and participating within BCBSRI's network as of October 1, 2020 to receive an incentive payment.
2. Payments will be made via electronic funds transfer based on tax ID, if banking information is on file with BCBSRI. Otherwise, payment will be issued by check.
3. BCBSRI reserves the right to recover overpayment, should we discover that we have overpaid on an incentive payment.
4. Should payments be made later than the documented payment date found in this handbook, BCBSRI will not pay interest on incentives.
5. BCBSRI reserves the right to implement financial penalties for any discrepancies found upon review or audit.
6. BCBSRI will not allow for any deadline extensions. BCBSRI will not analyze, create, write, and/or run programs for specific shared savings/contracted groups to accommodate early or late payment calculations.
7. BCBSRI will not accept appeals.
8. Payment analysis will be conducted with data that is submitted by the provider or through claims. Errors in data submission that are not corrected before the deadline (January 31, 2021) will not be available for correction after the deadline.
9. Payments cannot be split when a new System of Care relationship has occurred after the patient panel has been frozen.

Detailed Measure Descriptions

BCBSRI reserves the right to remove or modify a measure that is part of this program if the measure is removed or retired by the entity that is the source of the measure (the measure steward – CMS, NCQA, etc.).

Breast Cancer Screening	
Measure Definition	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for numerator compliance. This measure does not count MRIs, ultrasounds, or biopsies toward the numerator for this measure.
Measure Source	HEDIS® 2020
Age Criteria	Women 52–74 years as of December 31, 2020
Qualifying Event Criteria	N/A
Measurement Period	Date of service between October 1, 2018– December 31, 2020
Exclusions	Medicare members 66 years of age and older as of December 31, 2020 who meet either of the following: • Enrolled in an Institutional SNP any time in 2020 • Living long-term in an institution any time in 2020 Members 66 years of age and older as of December 31, 2020 with frailty **and** advanced illness. Members in hospice in 2020. Bilateral mastectomy at any time during the member's history through December 31, 2020. Any of the following meet criteria for bilateral mastectomy: • Bilateral mastectomy • Unilateral mastectomy with bilateral modifier • Unilateral mastectomy found in clinical data with a bilateral modifier • History of bilateral mastectomy • Both of the following on the same or different dates of service: - Unilateral mastectomy with a left-sided modifier - Unilateral mastectomy with a right-sided modifier
Line(s) of Business	Medicare Advantage, Commercial Adult
Codes	Claim for mammogram from the radiology facility.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Colorectal Cancer Screening	
Measure Definition	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer. Appropriate screenings: • Fecal Occult Blood Test during 2020 • Flexible sigmoidoscopy in 2020 or the four years prior to 2020 • Colonoscopy in 2020 or the nine years prior to 2020 • CT colonography in 2020 or the four years prior to 2020 • FIT-DNA in 2020 or the two years prior to 2020
Measure Source	HEDIS 2020
Age Criteria	51–75 years as of December 31, 2020
Qualifying Event Criteria	N/A
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Medicare members 66 years of age and older as of December 31, 2020 who meet either of the following: • Enrolled in an Institutional SNP any time in 2020 • Living long-term in an institution any time in 2020 Members 66 years of age and older as of December 31, 2020 with frailty **and** advanced illness criteria to be excluded. Members in hospice in 2020. Either of the following any time during the member's history through December 31, 2020: • Colorectal cancer • Total colectomy
Line(s) of Business	Medicare Advantage, Commercial Adult
Codes	Codes to identify Fecal Occult Blood Screening: • CPT Codes: 82270, 82274 • HCPCS Codes: G0328 Codes to identify FIT-DNA Test: • CPT Code: 81528 • HCPCS Code: G0464

Diabetes – Eye Exam	
Measure Definition	Members ages 18–75 with diabetes (type 1 and type 2) who had an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2020 • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2019 • Bilateral eye enucleation any time during the member's history through December 31, 2020
Measure Source	HEDIS 2020
Age Criteria	18–75 years as of December 31, 2020
Qualifying Event Criteria	Members who met any of the following criteria in 2019 or 2020: • At least one acute inpatient encounter with a diagnosis of diabetes • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: - Outpatient - Emergency Department - Observation - Non-acute inpatient *One of these visits may be a telehealth visit • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Medicare members 66 years of age and older as of December 31, 2020 who meet either the following: • Enrolled in an Institutional SNP any time in 2020 • Living long-term in an institution any time in 2020 Members 66 years of age and older as of December 31, 2020 with frailty **and** advanced illness criteria to be excluded. Members are excluded if they do not have a diagnosis of diabetes, in any setting, in 2019 or 2020 **and** have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, in 2019 or 2020. Members in hospice in 2020.
Line(s) of Business	Medicare Advantage, Commercial Adult

Codes	CPT Category II Codes to identify Diabetic Retinal Screening with an eye care professional: • 2022F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed during the measurement year; with evidence of retinopathy • 2023F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed during the year prior to the measurement year; without evidence of retinopathy • 2024F – Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy • 2025F – Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy • 2026F – Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy • 2033F - Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy CPT Category II Codes to identify Diabetic Retinal Screenings Negative for Retinopathy • 3072F – Low risk for retinopathy (no evidence of retinopathy in the prior year)

Diabetes – Nephropathy Screening	
Measure Definition	Members ages 18–75 with diabetes (type 1 and type 2) who had a nephropathy screening test or evidence of nephropathy during 2020. This included members who had one of the following: • A urine test for albumin or protein including: - 24-hour urine for albumin or protein - Timed urine for albumin or protein - Spot urine (e.g. urine dipstick or test strip) for albumin or protein - Urine for albumin/creatinine ratio - 24-hour urine for total protein - Random urine for protein/creatinine ratio • Evidence of treatment for nephropathy for ACE/ARB therapy • Evidence of stage 4 chronic kidney disease • Evidence of end-stage renal disease • Evidence of kidney transplant • A visit with a nephrologist (no restriction on the diagnosis or procedure code submitted) • At least one ACE inhibitor or ARB dispensing event
Measure Source	HEDIS 2020
Age Criteria	18–75 years as of December 31, 2020
Qualifying Event Criteria	Members who met any of the following criteria in 2019 or 2020: • At least one acute inpatient encounter with a diagnosis of diabetes • At least two of the following visit types*, on different dates of service, with a diagnosis of diabetes: - Outpatient - Emergency Department - Observation - Non-acute inpatient *One of these visits may be a telehealth visit • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Medicare members 66 years of age and older as of December 31, 2020 who meet either the following: • Enrolled in an Institutional SNP any time in 2020 • Living long-term in an institution any time in 2020 Members 66 years of age and older as of December 31, 2020 with frailty **and** advanced illness criteria to be excluded. Members are excluded if they do not have a diagnosis of diabetes, in any setting, in 2019 or 2020 **and** have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, in 2019 or 2020. Members in hospice in 2020.
Line(s) of Business	Medicare Advantage

Codes	Code to identify Stage 4 Chronic Kidney Disease: • ICD-10 CM Code: N18.4 Code to identify ESRD: • ICD-10 CM Codes: N18.5, N18.6, Z99.2 Codes to identify Kidney Transplant: • CPT Codes: Z94.0 Nephropathy Screening: • CPT Codes: 8100 – 81005, 82042 – 82044, 84156 • CPT Category II Codes: 3060F, 3061F, 3062F Nephropathy Treatment: • CPT Category II Codes: 3066F, 4010F • ICD-10 CM Codes: E08.21, E08.22, E08.29, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0 – N08, N14.0 – N14.4, N17.0 – N19, N25.0 – N25.9, N26.1 – N26.9, Q60.0 – Q60.0, Q61.00 – Q61.02, Q61.11, Q61.19, Q61.2 – Q61.9, R80.0 – R80.9

Diabetes – Hemoglobin A1c Control ≤ 9% – Medicare	
Measure Definition	Members ages 18–75 with diabetes (type 1 and type 2) whose A1c was documented as ≤ 9% as of the end of 2020. All lab values should be documented regardless of whether the gap in care is closed, as these codes provide valuable quality information.
Measure Source	HEDIS 2020
Age Criteria	18–75 years as of December 31, 2020
Qualifying Event Criteria	Members who met any of the following criteria in 2019 or 2020: • At least one acute inpatient encounter with a diagnosis of diabetes • At least two of the following visit types*, on different dates of service, with a diagnosis of diabetes: - Outpatient - Emergency Department - Observation - Non-acute inpatient *One of these visits may be a Telehealth visit • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Medicare members 66 years of age and older as of December 31, 2020 who meet either the following: • Enrolled in an Institutional SNP any time in 2020 • Living long-term in an institution any time in 2020 Members 66 years of age and older as of December 31, 2020 with frailty **and** advanced illness criteria to be excluded. Members are excluded if they do not have a diagnosis of diabetes, in any setting, in 2019 or 2020 **and** have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, in 2019 or 2020. Members in hospice in 2020.
Line(s) of Business	Medicare Advantage
Codes	CPT Category II Codes to identify Hemoglobin A1c Levels: • 3044F – A1c level less than 7.0 • 3051F – A1c level greater than or equal to 7.0 and less than 8.0 • 3052F – A1c level greater than or equal to 8.0 and less than or equal to 9.0 • 3046F – A1c level greater than 9.0

Diabetes – Hemoglobin A1c Control < 8% – Commercial	
Measure Definition	Members ages 18 – 75 with diabetes (type 1 and type 2) whose HbA1c was documented as < 8% as of the end of 2020. All lab values should be documented regardless of whether the gap in care is closed, as these codes provide valuable quality information.
Measure Source	HEDIS 2020
Age Criteria	18–75 years as of December 31, 2020
Qualifying Event Criteria	Members who met any of the following criteria in 2019 or 2020: • At least one acute inpatient encounter with a diagnosis of diabetes • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: - Outpatient - Emergency Department - Observation - Non-acute inpatient *One of these visits may be a telehealth visit • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Members 66 years of age and older as of December 31, 2020 with frailty **and** advanced illness criteria to be excluded. Members are excluded if they do not have a diagnosis of diabetes, in any setting, in 2019 or 2020 **and** have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, in 2019 or 2020. Members in hospice in 2020.
Line(s) of Business	Commercial Adult
Codes	CPT Category II Codes to identify Hemoglobin A1c Levels: • 3044F – A1c level less than 7.0 • 3051F – A1c level greater than or equal to 7.0 and less than 8.0 • 3052F – A1c level greater than or equal to 8.0 and less than or equal to 9.0 • 3046F – A1c level greater than 9.0

Controlling High Blood Pressure	
Measure Definition	The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled as of the end of 2020. Results must be from the last blood pressure reading in 2020. Adequate blood pressure control is defined as less than 140/90. However, all values should be documented regardless of whether the gap in care is closed, as these codes provide valuable quality information.
Measure Source	HEDIS 2020
Age Criteria	18–85 years as of December 31, 2020
Qualifying Event Criteria	Members who had at least two visits on different dates of service with a diagnosis of hypertension in 2019 or 2020. *One of these visits may be a telehealth visit.
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Medicare members 66 years of age and older as of December 31, 2020 who meet either the following: • Enrolled in an Institutional SNP any time in the measurement year • Living long-term in an institution any time in the measurement year Members 66–80 years of age and older as of December 31, 2020 with frailty **and** advanced illness criteria to be excluded. Members ages 81 and older as of December 31, 2020 with frailty are excluded. Members in hospice in 2020. The following members are excluded: • All members with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to December 31 of the measurement year (Medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis) • Female members with a diagnosis of pregnancy during the measurement year • All members who have a non-acute inpatient admission in 2019
Line(s) of Business	Medicare Advantage, Commercial Adult
Codes	CPT Category II Codes to identify Blood Pressure Results: • 3074F – Most recent systolic blood pressure less than 130 • 3075F – Most recent systolic blood pressure 130–139 • 3077F – Most recent systolic blood pressure greater than or equal to 140 • 3078F – Most recent diastolic blood pressure less than 80 • 3079F – Most recent diastolic blood pressure between 80–89 • 3080F – Most recent diastolic blood pressure greater than or equal to 90

Osteoporosis Management in Women Who Had a Fracture	
Measure Definition	The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. Intake Period is defined as a 12-month window that begins on July 1, 2019 and ends on June 30, 2020. The Intake Period is used to capture the first fracture. Episode Date is defined as the date of service for an eligible encounter during the Intake Period with a diagnosis of fracture.
Measure Source	HEDIS 2020
Age Criteria	Women 67–85 years as of December 31, 2020
Qualifying Event Criteria	Members who had either of the following during the Intake Period with a fracture : • Outpatient Visit • Emergency Department Visit • Acute or non-acute inpatient discharge
Measurement Period	Date of service between July 1, 2019 – December 31, 2020
Exclusions	Medicare members 66 years of age and older as of December 31, 2020 who meet either the following: • Enrolled in an Institutional SNP any time in 2020 • Living long-term in an institution any time in 2020 Members 66-80 years of age and older as of December 31, 2020 with frailty **and** advanced illness criteria to be excluded. Members ages 81 and older as of December 31, 2020 with frailty are excluded. Members in hospice in 2020. Exclude fractures where either of the following occurred for a fracture during the 60-day period prior to the episode date: • Outpatient visit • Telephone visit • Online assessment • Observation visit • Emergency Department visit • Acute or non-acute inpatient discharge Exclude episodes where any of the following are met: • Members who had a BMD test prior to the episode date • Members who had a claim/encounter for osteoporosis therapy during the 12 months prior to the episode date • Members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the episode date
Line(s) of Business	Medicare Advantage

Codes	CPT Codes to identify Bone Mineral Density Tests: • 76977, 77078, 77080, 77081, 77082, 77085, 77086 HCPCS Codes to identify Osteoporosis Medications: • J0897, J1740, J3489, J0897, J3110

Rheumatoid Arthritis Management	
Measure Definition	The percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).
Measure Source	HEDIS 2020
Age Criteria	18 years and older as of December 31, 2020
Qualifying Event Criteria	At least two of the following visit types* on or between January 1, 2020 and November 30, 2020, on different dates of service, with a diagnosis of rheumatoid arthritis: - Outpatient - Telephone visit - Online assessment - Non-acute inpatient *One of these visits may be a telehealth visit
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Medicare members 66 years of age and older as of December 31, 2020 who meet either the following: • Enrolled in an Institutional SNP any time in 2020 • Living long-term in an institution any time in 2020 Members 66–80 years of age and older as of December 31, 2020 with frailty **and** advanced illness criteria to be excluded. Members ages 81 and older as of December 31, 2020 with frailty are excluded. Members in hospice in 2020.
Line(s) of Business	Medicare Advantage
Codes	HCPCS Codes to identify DMARDs: • J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515, J7516, J7517, J7518, J9250, J9260, J9310, J9311, J9312, Q5102, Q5103, Q5104, Q5109

Medication Reconciliation	
Measure Definition	The percentage of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Measure Source	HEDIS 2020
Age Criteria	18 years and older as of December 31, 2020.
Qualifying Event Criteria	An acute or non-acute inpatient discharge on or between January 1, 2020 and December 1, 2020. The denominator for this measure is based on discharges, not members. If members have more than one discharge, include all discharges on or between January 1, 2020 and December 1, 2020. If the discharge is followed by a readmission or direct transfer for an acute or non-acute inpatient care setting on the date of discharge through 30 days after discharge (31 days), count only the last discharge.
Measurement Period	Date of service between January 1, 2020 – December 1, 2020
Exclusions	Members in hospice in 2020.
Line(s) of Business	Medicare Advantage
Codes	Codes to identify Medication Reconciliation: • CPT Codes: 99483, 99495, 99496 • CPT II Codes: 1111F

Well-Child Counseling for Nutrition	
Measure Definition	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition documented in 2020. Documentation must include a note indicating the date and at least one of the following: • Discussion of current nutrition behaviors (e.g. eating habits, dieting behaviors) • Checklist indicating nutrition was addressed • Counseling or referral for nutrition education • Member received education materials on nutrition during a face-to-face visit • Anticipatory guidance for nutrition • Weight or obesity counseling Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is preset, regardless of the primary intent of the visit. Services specific to assessment or treatment of an acute or chronic condition do not count toward this measure. Documentation related to a member's appetite or an observation such as well-nourished alone is not compliant because it does not indicate counseling for nutrition.
Measure Source	HEDIS 2020
Age Criteria	3- 17 years as of December 31, 2020
Qualifying Event Criteria	An outpatient visit with a PCP or OB/GYN in 2020.
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Female members who have a diagnosis of pregnancy in 2020. Members in hospice in 2020.
Line(s) of Business	Commercial Pediatric
Codes	Codes to identify Well-Child Counseling for Nutrition: • CPT Codes: 97802 – 97804 • HCPCS Codes: G0270, G0271, G0447, S9449, S9452, S9470 • ICD-10 CM Codes: Z71.3

Well-Child Counseling for Physical Activity	
Measure Definition	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity documented in 2020. Documentation must include a note indicating the date and at least one of the following: • Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation) • Checklist indicating physical activity was addressed • Counseling or referral for physical activity • Member received educational materials on physical activity during a face-to-face visit • Anticipatory guidance specific to the child's physical activity • Weight or obesity counseling Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is preset, regardless of the primary intent of the visit. Services specific to assessment or treatment of an acute or chronic condition do not count toward this measure. A notation of "cleared for gym class" alone without documentation of a discussion is not compliant. A notation of anticipatory guidance related solely to the safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations is not compliant. A notation related solely to screen time (computer or television) without specific mention of physical activity is not compliant.
Measure Source	HEDIS 2020
Age Criteria	3-17 years as of December 31, 2020
Qualifying Event Criteria	An outpatient visit with a PCP or OB/GYN in 2020.
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Female members who have a diagnosis of pregnancy in 2020. Members in hospice in 2020.
Line(s) of Business	Commercial Pediatric
Codes	Codes to identify Well-Child Counseling for Physical Activity: • HCPCS Codes: G0447, S9451 • ICD-10 CM Codes: Z02.5, Z71.82

Well-Child BMI Assessment	
Measure Definition	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had a **BMI percentile** documented in 2020. Because BMI norms for youths vary with age and gender, this measure evaluates whether the **BMI percentile** is assessed rather than an absolute BMI value. Documentation **must include height, weight, and BMI percentile**. The height, weight, and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile: • BMI percentile documented as a value (e.g., 85th percentile) • BMI percentile plotted on an age-growth chart Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of > 99% or < 1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).
Measure Source	HEDIS 2020
Age Criteria	3-17 years as of December 31, 2020
Qualifying Event Criteria	An outpatient visit with a PCP or OB/GYN in 2020.
Measurement Period	Date of service between January 1, 2020 – December 31, 2020
Exclusions	Female members who have a diagnosis of pregnancy in 2020. Members in hospice in 2020.
Line(s) of Business	Commercial Pediatric
Codes	Codes to identify Well-Child BMI Percentile: • ICD-10 CM Codes: Z68.51, Z68.52, Z68.53, Z68.54

Developmental Screening in the First Three Years of Life	
Measure Definition	Members who are screened for risk developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, and third birthday. This measure identifies children who were screened for risk of developmental, behavioral, or social delays using a standardized tool. Tools must meet the following criteria: • *Developmental domains* – The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional. • *Established reliability* – Reliability scores must be approximately 0.70 or above. • *Established findings regarding the validity* – Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and use an appropriate standardized developmental or social-emotional assessment instrument(s). • *Established sensitivity/specificity* – Sensitivity and specificity scores must be approximately 0.70 or above. Current recommended tools that meet these criteria: • Ages and Stages Questionnaire (ASQ): 2 months to 5 years • Ages and Stages Questionnaire (ASQ-3) • Battelle Developmental Inventory Screening Tool (BDI-ST): Birth to 95 months • Brigance Screens II: Birth to 90 months • Child Development Inventory (CDI): 18 months to 6 years • Infant Developmental Inventory: Birth to 18 months • Parents' Evaluation of Developmental Status (PEDS): Birth to 8 years • Parents' Evaluation of Developmental Status: Development Milestones (PEDS-DM) • Survey of Well-being of Young Children (SWYC)
Measure Source	Oregon Pediatric Improvement Partnership at Oregon Health and Science University
Age Criteria	Member turns 1, 2, or 3 years of age in 2020. Three separate rates are calculated, once for each age category.
Qualifying Event Criteria	None
Measurement Period	The 12 month period preceding the member's 1st, 2nd, or 3rd birthday, up to December 31, 2020.
Exclusions	None
Line(s) of Business	Commercial Pediatric
Codes	Codes to Identify Developmental Screening • CPT-4 Codes: 96110

CAHPS Measures	
Getting Needed Care	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • Never • Sometimes • Usually • Always In the last 6 months, how often was it easy to get the care, tests, or treatment that you needed? • Never • Sometimes • Usually • Always
Getting Appointments and Care Quickly	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • Never • Sometimes • Usually • Always In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed? • Never • Sometimes • Usually • Always Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? • Never • Sometimes • Usually • Always
Rating of Health Care Quality	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? • Scale from 0-10

Care Coordination	In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • Never • Sometimes • Usually • Always In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • Never • Sometimes • Usually • Always In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them? • Never • Sometimes • Usually • Always In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • Never • Sometimes • Usually • Always In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • Yes, definitely • Yes, somewhat • No In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists? • Never • Sometimes • Usually • Always • I do not have a personal doctor • I did not visit my personal doctor in the last 6 months • My personal doctor is a specialist

HOS Measures	
Improving or Maintaining Physical Health	How would you rate your physical health? • Excellent • Very Good • Good • Fair • Poor Compared to one year ago, how would you rate your physical health in general now? • Much Better • Slightly Better • About the Same • Slightly Worse • Much Worse
Improving or Maintaining Mental Health	How would you rate your mental health? • Excellent • Very Good • Good • Fair • Poor Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed, or irritable) in general now? • Much Better • Slightly Better • About the Same • Slightly Worse • Much Worse
Monitoring Physical Activity	In the past 12 months, did a doctor or other health provider advise you to start, increase, or maintain your level of exercise or physical activity? • Yes • No
Reducing Risk of Falling	Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? • Yes • No
Improving Bladder Control	Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine? • Yes • No Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? (e.g., bladder training, exercises, medication, surgery) • Yes • No

GLOSSARY

Systems of Care (SOCs): A System of Care is an organized group of providers who holistically care for a population of patients while maintaining financial accountability for the total medical expense and population heath of those patients they serve.

Contracted groups: a group of providers who have come together contractually or in partnership for the purpose of managing a practice and sharing the care of patients.

Independent practices: providers who practice autonomously.

Supplemental data: electronically generated files that come from service providers (providers who rendered the service). Production of these files follows clear policies and procedures; standard file layouts remain stable from year to year.