



2019 PCP Quality Incentive Program



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 through 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. In this letter, I'm pleased to share details about our 2019 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, specifically those related to closing potential gaps in care.

As in past years, we have selected key measures used by CMS and NCQA to evaluate health plans for performance incentive and accreditation programs. One new measure specific to Medicare Adults is Transitions of Care, which will look for notification of inpatient admission and receipt of discharge information. We are also including exclusions for advanced illness/frailty.

For the 2019 PCP Quality Incentive Program, we've introduced enhancements that incorporate feedback we've received from the provider community, as well as improve efforts to increase closure of gaps in care. Now, 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 more 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 2019 PCP Quality Incentive Program, please contact your quality concierge team representative, or send an email to PQIP@bcbsri.org.

Thank you for your support of the 2019 PCP Quality Incentive Program.

Sincerely,



Gus Manocchia, M.D.
Executive Vice President & Chief Medical Officer

Table of Contents

- I. Introduction 4**
- II. Reporting and Payment Schedule..... 5**
- III. PCP Quality Incentive Program Measures 6**
- IV. Highlighted Program Enhancements 7**
- V. Supplemental Data..... 8**
- VI. Participation Rules, Requirements and Reference Guide 9**
- VII. Measure Targets 11**
- VIII. Scoring and Payout Methodology 13**
- IX. Attribution Methodology 19**
- X. Detailed Measure Descriptions 20**
- XI. FAQs 40**

I. Introduction

BCBSRI is pleased to offer the 2019 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. BCBSRI's continued investment in quality incentives underscores our plan to support primary care, limit fee-for-service rate increases, and offer payments to PCPs through incentives to improve quality of care.

This 2019 PCP Quality Incentive Program handbook includes detailed information regarding:

- Specific measurement attributes of the program
- Access to data to assist in meeting targets
- Expectations for providers, so you can maximize your earning potential

BCBSRI's transformation to digital quality reporting includes the redesign of our PCP Quality Incentive Program (PQIP) to a composite scoring methodology. It's important to note that BCBSRI has invested a maximum of \$9 million in the 2019 program. However, providers who exceed performance achievement scores may be eligible for additional quality incentives.

The 2019 PCP Quality Incentive Program is open to all PCPs. This program includes BlueCHiP for Medicare and Commercial BCBSRI populations. The program is based on the State Innovation Model (SIM) Measure Alignment measure set composed of nationally accepted quality measures developed and/or endorsed by a number of organizations, including:

- National Committee for Quality Assurance
- Centers for Medicare & Medicaid Services
- Oregon Pediatric Improvement Partnership
- National Quality Forum

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

II. Reporting and Payment Schedule

2019 Incentive Payment Schedule

Measurement Period	Supplemental Data	Anticipated Payment & Reporting Date
January – December 2019	BCBSRI must receive supplemental data no later than January 31, 2020	4 th Quarter 2020

III. PCP Quality Incentive Program Measures

For detailed descriptions of these measures, please see Section IX of this document.

Adult Program Measures

BlueCHiP for Medicare

1. Breast Cancer Screening
2. Adult BMI Assessment
3. Diabetes – Hemoglobin A1c Control $\leq 9\%$
4. Diabetes – Nephropathy Screening
5. Diabetes – Eye Exam
6. Controlling High Blood Pressure
7. Colorectal Cancer Screening
8. Transitions of Care (TRC) – *New for 2019**
 - a. Notification of Inpatient Admission
 - b. Receipt of Discharge Information

Commercial

1. Breast Cancer Screening
2. Adult BMI Assessment
3. Diabetes – Hemoglobin A1c Control $< 8\%$
4. Diabetes – Nephropathy Screening
5. Diabetes – Eye Exam
6. Controlling High Blood Pressure
7. Colorectal Cancer Screening
8. Tobacco Use: Screening and Cessation Intervention

Pediatric Program Measures

Commercial

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

*Not included in Achievement Star Score calculation

IV. Highlighted Program Enhancements

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

- One new Medicare Adult measure was added to the incentive program:
 - Transitions of Care (TRC)*
 - Notification of inpatient admission
 - Receipt of discharge information

Both admission and discharge notifications must be present in the same medical record to be eligible for payout. See pages 38-39 for medical record requirements.
- New exclusions for advanced illness/frailty have been applied to the 2019 program. Criteria to identify advanced illness and frailty is provided by NCQA, and exclusions are made using claims data only and must be assessed on an annual basis. If a member meets the criteria for advanced illness and frailty, and falls into the age ranges and measures listed below, they will be excluded from the measure and will not appear with a gap in care for those measures.
 - Members age 66 and older with advanced illness and frailty are excluded from the Breast Cancer Screening, Colorectal Cancer Screening and Comprehensive Diabetes Care measures.
 - Members between 66-80 years of age with advanced illness and frailty and members age 81 and older with frailty only are excluded from the Controlling High Blood Pressure measure.
- Medicare Advantage measure targets will align with the most up-to-date CMS Star Rating cut points that will become available and applied in time for the Q3/Q4 2019 score calculations. See Section VII, Measure Targets.
- Commercial measure targets will align with the most up-to-date NCQA Quality Compass percentile benchmarks that will become available and applied in time for the Q3/Q4 2019 score calculations.
- Payment calculation design has shifted away from a measure-by-measure approach toward a more holistic approach, leveraging an overall composite achievement score and PMPM rate system for both Commercial and Medicare Advantage products.
- In support of EHR integration/transformation evolution within the industry, supplemental data submission through glide paths has been discontinued for performance year 2019 and beyond.
 - The process for submitting supplemental data for certain measures are outlined in Section V.
 - Questions related to supplemental data submissions or EHR integration/transformation should be directed to our Quality Analytics team via email at: PQIP@bcbsri.org.
- Base payments for each gap in care that is closed will no longer be part of the payout methodology.

*Not included in Achievement Star Score calculation

V. Supplemental Data

Beginning with the 2019 PQIP program, BCBSRI will be aligning efforts with NCQA measure standards for clinical data collection. Therefore, glide paths (Excel spreadsheets) will be eliminated.

Instead, providers will have the opportunity to submit medical records for the quality measures listed below that may not close gaps through the claims submission process.

BCBSRI will accept medical records for the following measures:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Diabetes – Eye Exam
- Diabetes – Hemoglobin A1c <8% (Commercial only)
- Transitions of Care (Medicare)
 - Notification of Inpatient Admission
 - Notification of Patient Discharge

Both admission and discharge notifications must be present in the same medical record to be eligible for payout. See pages 38-39 for medical record requirements.

Medical records will not be accepted for any other measures.

Instructions for submitting medical records:

- Medical records may be emailed to PQIP@bcbsri.org or faxed to Quality Analytics at (401) 459-5567. If faxing, please write PQIP on the cover sheet.
- Medical records will be accepted from January 1, 2019 through January 31, 2020.
- Medical records must contain the member's name and date of birth, as well as documentation of the procedure, including the date of service that the procedure occurred. **Order dates will not be accepted.** Services must be performed to be eligible for PQIP incentive. Providers should refer to the Detailed Measure Descriptions (Section X.) of the 2019 PCP Quality Incentive Program booklet for the services needed to close gaps in care.
- Services that are determined to be compliant will be incorporated into the PQIP incentive calculation.

VI. Participation Rules, Requirements and Reference Guide

1. The 2019 PQIP Program does **not** include members participating in BCBSRI's Federal Employee Plan (FEP), Classic Blue plan, New England Health Plan Home with a PCP outside of Rhode Island, New England Health Plan Host, Plan 65 Medicare supplement plans, or Blue Cross plans from states other than Rhode Island.
2. Providers must be active and participating within BCBSRI's network as of October 1, 2019 to receive an incentive payment.
3. Incentives will be calculated at the individual provider level based on that provider's affiliation in BCBSRI's internal databases as of October 1, 2019. Systems of care (SOCs) and practice sites 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, 2019. **If a provider leaves the BCBSRI network between October 2, 2019 and December 31, 2019, no payment will be made.**
 - a. 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.
4. The patient panel for each provider will be frozen as of October 1, 2019. Members or providers cannot be added to or removed from a frozen patient panel after that date.
5. If a provider belongs to a SOC that has contractual responsibilities for quality, or a contracted group, the incentive payment and all reporting will be sent to the SOC or contracted group. The SOC or contracted group will be responsible for paying the incentive to its providers, in accordance with the terms of the contract between the SOC/contracted group and the provider.
6. Payments will be made via electronic funds transfer, if banking information is on file with BCBSRI. Otherwise, payment will be made by check.
7. Medical records that you provide to BCBSRI for applicable measures (see page 8) will be used for calculating scores in the 2019 PCP Quality Incentive Program.
8. BCBSRI reserves the right to recover overpayment, should we discover that we have overpaid on an incentive payment.
9. BCBSRI will not pay interest on incentives, should the payment be made later than the documented payment date found in this handbook.
10. 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 – i.e., CMS, NCQA, etc.).
11. **BCBSRI reserves the right to implement financial penalties for any discrepancies found upon review or audit.**
12. Providers can request to receive monthly gap in care reports starting in June 2019. Providers are expected to reconcile these reports to ensure gaps are closed, focusing on the date panels are frozen (October 1, 2019) through the end of the year. If you would like to be added to the distribution list to receive the monthly reports, please email PQIP@bcbsri.org.
13. Gap in care data follows the member. Therefore, the calculated score reflecting member compliance (whether negatively or positively) will impact the payout for the provider attributed to that member and locked on October 1, 2019.
14. 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.
15. BCBSRI will not accept appeals.

16. 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, 2020) will not be available for correction after the deadline.
17. Payments cannot be split when a new relationship with a SOC has occurred, after the patient panel has been frozen
18. Compliance rates are calculated at two decimal places. There is no rounding when determining the payment levels.
19. Participants of the PQIP program must have appropriate technology to exchange data and communication with BCBSRI. As healthcare data transitions to a bi-directional platform, Systems of Care (SOCs) and providers will be expected to expand EHR/EMR capabilities to include the ability to transmit quality data extracts.

VII. Measure Targets

The minimum Star Rating achievement score a provider is eligible for payout is a 3 Star. For example, using the table below, the minimum score for BlueCHiP for Medicare Breast Cancer Screening is 68% (3 Star).

The following target setting grids by product and population are *illustrative only*, using the benchmarks currently available.

- Medicare uses Star Rating cut points from CMS.
- Commercial uses Quality Compass (National All Lines of Business) percentiles, which are then correlated to Star Rating equivalents:
 - 50th percentile = 3 Star
 - 75th percentile = 4 Star
 - 95th percentile = 5 Star

All targets will be updated when refreshed benchmarks become available prior to the Q3 and Q4 2019 score calculations.

2019 BlueCHiP for Medicare Targets (*Illustrative*)

Count	Measure	3 Star Rating	4 Star Rating	5 Star Rating
1	Breast Cancer Screening	68%	76%	82%
2	Adult BMI Assessment	84%	93%	98%
3	Diabetes – Hemoglobin A1c Control ≤9%	68%	78%	87%
4	Diabetes – Nephropathy Screening	87%	95%	97%
5	Diabetes – Eye Exam	64%	73%	80%
6	Controlling High Blood Pressure	62%	75%	82%
7	Colorectal Cancer Screening	63%	72%	79%
8	Transition of Care (TRC)	N/A	N/A	N/A

2019 Commercial Targets: Adult Measures (*Illustrative*)

Count	Measure	3 Star Rating Equivalent	4 Star Rating Equivalent	5 Star Rating Equivalent
1	Breast Cancer Screening	71.25%	75.59%	81.28%
2	Adult BMI Assessment	80.56%	88.32%	94.78%
3	Diabetes – Hemoglobin A1c Control <8%	56.93%	62.04%	68.04%
4	Diabetes – Nephropathy Screening	89.51%	91.00%	93.80%
5	Diabetes – Eye Exam	50.36%	60.17%	73.20%
6	Controlling High Blood Pressure	57.77%	66.39%	78.83%
7	Colorectal Cancer Screening	61.07%	67.19%	76.35%
8	Tobacco Use: Screening and Cessation Intervention	60.00%	65.00%	70.00%

2019 Commercial Targets: Pediatric Measures (*Illustrative*)

Count	Measure	3 Star Rating Equivalent	4 Star Rating Equivalent	5 Star Rating Equivalent
1	Well-Child Counseling for Nutrition	63.75%	72.75%	86.06%
2	Well-Child Counseling for Physical Activity	58.90%	67.49%	81.02%
3	Well-Child BMI Assessment	68.76%	78.55%	89.78%
4	Adolescent Immunization Status – Combination 2	20.68%	25.79%	35.04%
5	Developmental Screening in the First Three Years of Life – Age 1	70.00%	75.00%	80.00%
6	Developmental Screening in the First Three Years of Life – Age 2	70.00%	75.00%	80.00%
7	Developmental Screening in the First Three Years of Life – Age 3	70.00%	75.00%	80.00%

VIII. Scoring and Payout Methodology

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 (see pages 13-15). For example, the Star Rating for BlueCHiP for Medicare Adult BMI compliance score of 94.92% = 4 Star.
3. Calculate a weighted numerator (numerator * Star Rating) for each individual measure.
 - a. Note: If the compliance score in Step 2 falls below 3 Stars, the weighted numerator = 0.
4. Calculate a weighted achievement Star score across all measures (aggregate weighted numerator/aggregate denominator).

Example using BlueCHiP for Medicare:

	#1			#2	#3	
Measure	Compliance Rate (N/D)	Denominator	Numerator	Star Rating	Weighted Numerator (N * Star Rating)	
Adult BMI	94.92%	59	56	4	224	
HbA1c Control <= 9	91.67%	12	11	5	55	
Breast Cancer Screening	75.00%	32	24	3	72	
Colorectal Cancer Screening	86.96%	69	60	5	300	
Controlling High Blood Pressure	97.96%	49	48	5	240	
Eye Exam	83.33%	12	10	5	50	
Nephropathy	100.00%	12	12	5	60	
Aggregate Totals	90.20%	245	221		1,001	#4

Weighted Achievement Star Score = 1,001 / 221 = 4.52

B. Establish Per Member Per Month (PMPM) Rate

Using the Weighted Achievement Star Score calculated in Step A, select the corresponding PMPM rate for the product line.

Weighted Achievement Star Score	Commercial \$PMPM	Medicare \$PMPM
5.00	\$7.00	\$14.00
4.75 – 4.99	\$6.50	\$13.00
4.50 – 4.74	\$5.00	\$10.00
4.25 – 4.49	\$4.50	\$9.00
4.00 – 4.24	\$3.00	\$6.00
3.75 – 3.99	\$2.50	\$5.00
Transition of Care (TRC) – Medicare Only for compliant medical record	<i>*Compliance with this measure will result in a flat \$15.00 rate for records where both components are compliant.</i>	

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	Compliance Rate (N/D)	Denominator	Numerator	Star Rating	Weighted Numerator (N * Star Rating)	Denominator Payout Stratification
Adult BMI	94.92%	59	56	4	224	1
HbA1c Control <= 9	91.67%	12	11	5	55	.5
Breast Cancer Screening	75.00%	32	24	3	72	1
Colorectal Cancer Screening	86.96%	69	60	5	300	1
Controlling High Blood Pressure	97.96%	49	48	5	240	1
Eye Exam	83.33%	12	10	5	50	.5
Nephropathy	100.00%	12	12	5	60	.5
Aggregate Totals	90.20%	245	221		1,001	.785

D. Establish Member Months

Using the October 1, 2019 frozen panel for each provider, BCBSRI will calculate unique member months following an appropriate claims runout for CY 2019.

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

E. Calculate Final Payout

Aggregate Compliance Score (from Step A.1) * PMPM Rate for Aggregate Weighted Star Score (from Step B) * Average Denominator Stratification (from Step C) * Member Months (from Step D)

Examples of Scoring and Payout Calculations

Medicare – 92 members with 1,079 member months during 2019

Step 1: Determine a Weighted Achievement Star Score (*Achievement score is calculated as a weighted average of all members' scores across all measures*)

Measure	Compliance Rate (N/D)	Denominator	Numerator	Star Rating	Weighted Numerator (N * Star Rating)	Denominator Payout Stratification
Adult BMI	94.92%	59	56	4	224	1
HbA1c Control <= 9	91.67%	12	11	5	55	.5
Breast Cancer Screening	75.00%	32	24	3	72	1
Colorectal Cancer Screening	86.96%	69	60	5	300	1
Controlling High Blood Pressure	97.96%	49	48	5	240	1
Eye Exam	83.33%	12	10	5	50	.5
Nephropathy	100.00%	12	12	5	60	.5
Aggregate Totals	90.20%	245	221		1,001	.785

Step 2: Determine PMPM Rate and Payout By Weighted Achievement Star Score

Achievement Score	Medicare PMPM
5.0	\$14.00
4.75	\$13.00
4.50	\$10.00
4.25	\$9.00
4.00	\$6.00
3.75	\$5.00

Weighted Achievement Star Score: 4.52
(1001/221)

PMPM Rate: \$10.00

Panel Size - 92 (1,079 member months)

Payout Formula
($\$10 * 90.20% * 0.785 * 1079$)

Potential Payout: \$7,640

Commercial Adult - 506 members with 6,069 member months during 2019

Step 1: Determine a Weighted Achievement Star Score (*Achievement score is calculated as a weighted average of all members' scores across all measures*)

Measure	Compliance Rate (N/D)	Denominator	Numerator	Star Rating	Weighted Numerator (N * Star Rating)	Denominator Payout Stratification
Adult BMI	99.00%	502	497	5	2,485	1
HbA1c Control < 8	63.89%	36	23	4	92	1
Breast Cancer Screening	79.01%	81	64	4	256	1
Colorectal Cancer Screening	88.14%	194	171	5	855	1
Controlling High Blood Pressure	87.84%	74	65	5	325	1
Eye Exam	50.00%	36	18	0	0	1
Nephropathy	91.67%	36	33	4	132	1
Tobacco Screening	99.01%	505	500	5	2,500	1
Aggregate Totals	93.65%	1,464	1,371		6,645	1.00

Step 2: Determine PMPM Rate and Payout By Weighted Achievement Star Score

Achievement Score	Commercial PMPM
5.0	\$7.00
4.75	\$6.50
4.50	\$5.00
4.25	\$4.50
4.00	\$3.00
3.75	\$2.50

Weighted Achievement Star Score: 4.8
(6,645/1,371)

PMPM Rate: \$6.50

Panel Size - 506 (6,069 member months)

Payout Formula

(\$6.50 * 93.65% * 1.00 * 6069)

Potential Payout: \$36,944

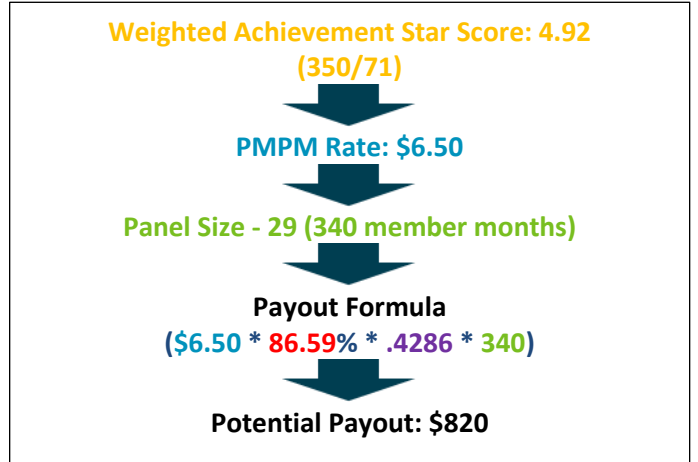
Commercial Pediatric – 29 members with 340 member months during 2019

Step 1: Determine a Weighted Achievement Star Score (*Achievement score is calculated as a weighted average of all members' scores across all measures*)

Measure	Compliance Rate (N/D)	Denominator	Numerator	Star Rating	Weighted Numerator (N * Star Rating)	Denominator Payout Stratification
Well Child Nutrition Counseling	96.00%	25	24	5	120	.75
Well Child Physical Activity	84.00%	25	21	5	105	.75
Well Child BMI	100.00%	25	25	5	125	.75
Adolescent Immunizations Combo 2	0.00%	2	0	0	0	.25
Developmental Screening 1	0.00%	0	0	0	0	0
Developmental Screening 2	0.00%	3	0	0	0	.25
Developmental Screening 3	50.00%	2	1	0	0	.25
Aggregate Totals	86.59%	82	71		350	.4286

Step 2: Determine PMPM Rate and Payout By Weighted Achievement Star Score

Achievement Score	Commercial PMPM
5.0	\$7.00
4.75	\$6.50
4.50	\$5.00
4.25	\$4.50
4.00	\$3.00
3.75	\$2.50



IX. 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 2019 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.)
- Members enrolled in Blue Cross Blue Shield plans outside of Rhode Island (e.g., Blue Cross Blue Shield of California, Blue Cross Blue Shield of Texas)

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, 2019.

X. Detailed Measure Descriptions

Breast Cancer Screening	
Measure Definition	Female members aged 50–74 who had a mammogram to screen for breast cancer between October 1, 2017 and December 31, 2019. All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for numerator compliance.
Measure Source	HEDIS 2019
Age Criteria	Member is female and is 52–74 years old as of December 31, 2019.
Qualifying Event Criteria	N/A
Measurement Period	Date of service between October 1, 2017 – December 31, 2019
Exclusions	<p>Bilateral mastectomy at any time during the member’s history through December 31, 2019. Any of the following meet the criteria:</p> <ul style="list-style-type: none"> • Bilateral mastectomy • Unilateral mastectomy with a bilateral modifier • Two unilateral mastectomies on different dates of service with service dates 14 or more days apart • Both of the following on the same or different dates of service: <ul style="list-style-type: none"> - Unilateral mastectomy with a left-side modifier - Unilateral mastectomy with a right-side modifier <p>Members age 66 and older as of December 31, 2019 with frailty in 2019 <u>and</u> advanced illness in 2019 or 2018 are excluded.</p> <p>Members in hospice in 2019.</p> <p>Exclusions for Medicare members age 66 and older as of December 31, 2019 only:</p> <ul style="list-style-type: none"> • Enrolled in an institutional SNP anytime in 2019 • Living long-term in an institution any time during 2019
Line(s) of Business	Medicare Adult, Commercial Adult
Additional Information	Does not count biopsies, breast ultrasounds, or MRIs toward the numerator for this measure.

Adult BMI Assessment

Measure Definition	<p>Members aged 18–74 who had an outpatient visit during 2019 or the year prior, and whose body mass index (BMI) was documented during 2019 or 2018.</p> <p>For members 20 years and older on the date of service, documentation must indicate the height, weight, and BMI value dated during 2019 or 2018. The weight and BMI must be from the same data source.</p> <p>For members younger than 20 years on the date of service, documentation must include the height, weight, and BMI percentile dated during 2019 or 2018. The height, weight, and BMI percentile must be from the same data source. For BMI percentile, the following documentation meets criteria:</p> <ul style="list-style-type: none"> • BMI percentile documented as a value (e.g., 85th percentile) • BMI percentile plotted on an age-growth chart <p>Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident.</p>
Measure Source	<p>HEDIS 2019</p>
Age Criteria	<p>Member is 18 years as of January 1, 2018 to 74 years as of December 31, 2019.</p>
Qualifying Event Criteria	<p>Member has a claim for an outpatient visit during 2019 or 2018.</p>
Measurement Period	<p>Date of service between January 1, 2018 – December 31, 2019</p>
Exclusions	<p>Female members who have a diagnosis of pregnancy during 2019 or 2018. Members in hospice in 2019.</p>
Line(s) of Business	<p>Medicare Adult, Commercial Adult</p>
Codes	<p>ICD-10CM® Codes to Identify BMI</p> <ul style="list-style-type: none"> • Adult BMI Value: Z68.1–Z68.45 • BMI Percentile: Z68.51–Z68.54

Diabetes – Hemoglobin A1c Control ≤ 9% – Medicare

Measure Definition	Members aged 18–75 with diabetes (type 1 and type 2) whose HbA1c was documented as ≤9% as of the end of 2019. 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 2019
Age Criteria	Member is 18–75 years as of December 31, 2019.
Qualifying Event Criteria	<p>Member meets any of the following criteria during 2019 or 2018:</p> <ul style="list-style-type: none"> • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: <ul style="list-style-type: none"> - Outpatient - Emergency department - Observation - Non-acute inpatient * <i>One of these visits may be a Telehealth visit</i> • At least one acute inpatient encounter with a diagnosis of diabetes • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	Date of service between January 1, 2019 – December 31, 2019
Exclusions	<p>Members are excluded if they do not have a diagnosis of diabetes, in any setting, during 2019 or 2018 and have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2019 or 2018.</p> <p>Members age 66 and older as of December 31, 2019 with frailty in 2019 and advanced illness in 2019 or 2018 are excluded.</p> <p>Members in hospice in 2019.</p> <p>Exclusions for Medicare members age 66 and older as of December 31, 2019 only:</p> <ul style="list-style-type: none"> • Enrolled in an institutional SNP anytime in 2019 • Living long-term in an institution any time during 2019
Line(s) of Business	Medicare Adult
Codes	<p>CPT Category II Codes to Identify Hemoglobin A1c Levels</p> <ul style="list-style-type: none"> • A1c <7: 3044F • A1c 7–9: 3045F • A1c >9: 3046F

Diabetes – Hemoglobin A1c Control <8% – Commercial

Measure Definition	Members aged 18–75 with diabetes (type 1 and type 2) whose HbA1c was documented as <8% as of the end of 2019. 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 2019
Age Criteria	Member is 18–75 years as of December 31, 2019.
Qualifying Event Criteria	<p>Member meets any of the following criteria during 2019 or 2018:</p> <ul style="list-style-type: none"> • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: <ul style="list-style-type: none"> - Outpatient - Emergency department - Observation - Non-acute inpatient *One of these visits may be a Telehealth visit • At least one acute inpatient encounter with a diagnosis of diabetes • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	Date of service between January 1, 2019 – December 31, 2019
Exclusions	<p>Members are excluded if they do not have a diagnosis of diabetes, in any setting, during 2019 or 2018 <u>and</u> have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2019 or 2018.</p> <p>Members in hospice in 2019.</p> <p>Members age 66 and older as of December 31, 2019 with frailty in 2019 <u>and</u> advanced illness in 2019 or 2018 are excluded.</p>
Line(s) of Business	Commercial Adult
Codes	<p>CPT Category II Codes to Identify Hemoglobin A1c Levels</p> <ul style="list-style-type: none"> • A1c <7: 3044F • A1c >9: 3046F <p>Do not use code 3045F for Commercial members. That code does not designate that the HbA1c was less than 8%.</p>

Diabetes – Nephropathy Screening

Measure Definition	<p>Members aged 18–75 with diabetes (type 1 and type 2) who had a nephropathy screening test or evidence of nephropathy during 2019. This includes members who had one of the following:</p> <ul style="list-style-type: none"> • A urine test for albumin or protein including: <ul style="list-style-type: none"> - 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 or 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 2019
Age Criteria	Member is 18–75 years as of December 31, 2019.
Qualifying Event Criteria	<p>Member meets any of the following criteria during 2019 or 2018.</p> <ul style="list-style-type: none"> • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: <ul style="list-style-type: none"> - Outpatient - Emergency department - Observation - Non-acute inpatient - *One of these visits may be a Telehealth visit • At least one acute inpatient encounter with a diagnosis of diabetes • Dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	Date of service between January 1, 2019 – December 31, 2019
Exclusions	<p>Members are excluded if they do not have a diagnosis of diabetes, in any setting, during 2019 or 2018 <u>and</u> have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2019 or 2018.</p> <p>Members age 66 and older as of December 31, 2019 with frailty in 2019 <u>and</u> advanced illness in 2019 or 2018 are excluded.</p> <p>Members in hospice in 2019.</p> <p>Exclusions for Medicare members age 66 and older as of December 31, 2019 only:</p> <ul style="list-style-type: none"> • Enrolled in an institutional SNP anytime in 2019 • Living long-term in an institution any time during 2019

Line(s) of Business	Medicare Adult, Commercial Adult
Codes	<p>Code to Identify Stage 4 Chronic Kidney Disease</p> <ul style="list-style-type: none"> • ICD-10 CM Code: N18.4 <p>Codes to Identify ESRD</p> <ul style="list-style-type: none"> • ICD-10 CM Codes: N18.5, N18.6, Z91.15, Z99.2 <p>Codes to Identify Kidney Transplant</p> <ul style="list-style-type: none"> • ICD-10 CM Code: Z94.0 <p>Nephropathy Screening</p> <ul style="list-style-type: none"> • CPT Codes: 81000–81005, 82042–82044, 84156 • CPT Category II Codes: 3060F, 3061F, 3062F <p>Nephropathy Treatment</p> <ul style="list-style-type: none"> • CPT Category II Codes: 3066F, 4010F <p>ICD-10 CM Codes: E08.21, E08.22, E08.29, E09.21, 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–Q60.6, Q61.00–Q61.02, Q61.11, Q61.19, Q61.2–Q61.9, R80.0–R80.9</p>

Diabetes – Eye Exam	
Measure Definition	Members aged 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: <ul style="list-style-type: none"> • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2019 • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2018 • Bilateral eye enucleation any time during the member's history through December 31, 2019.
Measure Source	HEDIS 2019
Age Criteria	Member is 18–75 years as of December 31, 2019.
Qualifying Event Criteria	Member meets any of the following criteria during 2019 or 2018. <ul style="list-style-type: none"> • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: <ul style="list-style-type: none"> - Outpatient - Emergency department - Observation - Non-acute inpatient - *One of these visits may be a Telehealth visit • At least one acute inpatient encounter with a diagnosis of diabetes • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	Date of service between January 1, 2019 – December 31, 2019
Exclusions	Members are excluded if they do not have a diagnosis of diabetes, in any setting, during 2019 or 2018 and have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2019 or 2018. Members age 66 and older as of December 31, 2019 with frailty in 2019 <u>and</u> advanced illness in 2019 or 2018 are excluded. Members in hospice in 2019. Exclusions for Medicare members age 66 and older as of December 31, 2019 only: <ul style="list-style-type: none"> • Enrolled in an institutional SNP anytime in 2019 • Living long-term in an institution any time during 2019
Line(s) of Business	Medicare Adult, Commercial Adult
Codes	CPT Category II Codes to Identify Diabetic Retinal Screening with an Eye Care Professional <ul style="list-style-type: none"> • 2022F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed • 2024F – Seven standard field stereoscopic photos with interpretation by an ophthalmologist documented and reviewed • 2026F – Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and

	<p>reviewed</p> <p>CPT Category II Code to Identify Diabetic Retinal Screenings Negative for Retinopathy</p> <ul style="list-style-type: none">• 3072F – Low risk for retinopathy (no evidence of retinopathy in the prior year)
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Controlling High Blood Pressure	
Measure Definition	<p>Members aged 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled as of the end of 2019. Results must be from the last blood pressure reading in 2019.</p> <p>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.</p>
Measure Source	HEDIS 2019
Age Criteria	Member is 18–85 years as of December 31, 2019.
Qualifying Event Criteria	Members are identified as hypertensive if there are at least two visits with different dates of service with a diagnosis of hypertension in 2019 or 2018. One of the visits may be a Telehealth visit.
Measurement Period	Date of service between January 1, 2019 – December 31, 2019
Exclusions	<p>The following members are excluded:</p> <ul style="list-style-type: none"> • All members with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to December 31, 2019 (Medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis.) • Female members with a diagnosis of pregnancy during 2019 • All members who had a non-acute inpatient admission during 2019 <p>Members age 66-80 years of age as of December 31, 2019 with frailty in 2019 <u>and</u> advanced illness in 2019 or 2018 are excluded. Members age 81 and older as of December 31, 2019 with frailty are excluded.</p> <p>Members in hospice in 2019.</p> <p>Exclusions for Medicare members age 66 and older as of December 31, 2019 only:</p> <ul style="list-style-type: none"> • Enrolled in an institutional SNP anytime in 2019 • Living long-term in an institution any time during 2019
Line(s) of Business	Medicare Adult, Commercial Adult
Codes	<p>CPT Category II Codes to Identify Blood Pressure Results:</p> <ul style="list-style-type: none"> • 3074F - Most recent systolic blood pressure less than 130 • 3075F - Most recent systolic blood pressure between 130-139 • 3077F - Most recent systolic blood pressure greater than/equal to 140 • 3078F - Most recent diastolic blood pressure less than 80 • 3079F - Most recent diastolic blood pressure between 80-89

	<ul style="list-style-type: none"> • 3080F - Most recent diastolic blood pressure greater than or equal to 90
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Colorectal Cancer Screening	
Measure Definition	Members aged 50–75 who had appropriate screening for colorectal cancer. Any of the following are compliant: <ul style="list-style-type: none"> • Fecal occult blood test during 2019 • Flexible sigmoidoscopy during 2019 or the four years prior to 2019 • Colonoscopy during 2019 or the nine years prior to 2019 • CT colonography during 2019 or the four years prior to 2019 • FIT-DNA (Cologuard) test during 2019 or the two years prior to 2019
Measure Source	HEDIS 2019
Age Criteria	Member is 51–75 years as of December 31, 2019
Qualifying Event Criteria	N/A
Measurement Period	Date of service between January 1, 2019 – December 31, 2019
Exclusions	<p>Either of the following at any time in the member’s history through December 31, 2019:</p> <ul style="list-style-type: none"> • Colorectal cancer • Total colectomy <p>Members age 66 and older as of December 31, 2019 with frailty in 2019 <u>and</u> advanced illness in 2019 or 2018 are excluded.</p> <p>Members in hospice in 2019.</p> <p>Exclusions for Medicare members age 66 and older as of December 31, 2019 only:</p> <ul style="list-style-type: none"> • Enrolled in an institutional SNP anytime in 2019 • Living long-term in an institution any time during 2019
Line(s) of Business	Medicare Adult, Commercial Adult
Codes	<p>Codes to Identify Fecal Occult Blood Screening</p> <ul style="list-style-type: none"> • CPT Codes: 82270, 82274 • HCPCS Code: G0328 <p>Codes to Identify FIT-DNA Test</p> <ul style="list-style-type: none"> • CPT Code: 81528 • HCPCS Code: G0464

Well-Child Counseling for Nutrition

Measure Definition	<p>Members aged 3 to 17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition documented during 2019. Documentation must include a note indicating the date and at least one of the following:</p> <ul style="list-style-type: none"> • Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors) • Checklist indicating nutrition was addressed • Counseling or referral for nutrition education • Member received educational materials on nutrition during a face- to-face visit • Anticipatory guidance for nutrition • Weight or obesity counseling <p>Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to assessment or treatment of an acute or chronic condition do not count toward the measure.</p> <p>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.</p>
Measure Source	<p>HEDIS 2019</p>
Age Criteria	<p>Member is 3 to 17 years of age as of December 31, 2019.</p>
Qualifying Event Criteria	<p>Member has a claim for an outpatient visit with a PCP or OB/GYN during 2019.</p>
Measurement Period	<p>Date of service between January 1, 2019 – December 31, 2019</p>
Exclusions	<p>Female members who have a diagnosis of pregnancy during 2019.</p> <p>Members in hospice in 2019.</p>
Line(s) of Business	<p>Commercial Pediatric</p>
Codes	<p>Identification of Well-Child Counseling for Nutrition</p> <ul style="list-style-type: none"> • CPT Codes: 97802–97804 • HCPCS Codes: G0270, G0271, G0447, S9449, S9452, S9470 • ICD-10CM Codes: Z71.3

Well-Child Counseling for Physical Activity	
Measure Definition	<p>Members aged 3 to 17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity documented during 2019. Documentation must include a note indicating the date and at least one of the following:</p> <ul style="list-style-type: none"> • 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 <p>Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to assessment or treatment of an acute or chronic condition do not count toward the measure.</p> <p>A notation of "cleared for gym class" alone without documentation of a discussion is not compliant.</p> <p>A notation related solely to screen time (computer or television) without specific mention of physical activity is not compliant.</p> <p>A notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations is not compliant.</p>
Measure Source	HEDIS 2019
Age Criteria	Member is 3 to 17 years of age as of December 31, 2019.
Qualifying Event Criteria	Member has a claim for an outpatient visit with a PCP or OB/GYN during 2019.
Measurement Period	Date of service between January 1, 2019 – December 31, 2019
Exclusions	<p>Female members who have a diagnosis of pregnancy during 2019.</p> <p>Members in hospice in 2019.</p>
Line(s) of Business	Commercial Pediatric
Codes	<p>Identification of Well-Child Counseling for Physical Activity</p> <ul style="list-style-type: none"> • HCPCS Codes: G0447, S9451 • ICD-10CM Code: Z02.5, Z71.82

Well-Child BMI Assessment	
Measure Definition	<p>Members aged 3 to 17 who had an outpatient visit with a PCP or OB/GYN and who had a BMI percentile documented during 2019. Because BMI norms for youth vary with age and gender, this measure evaluates whether 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.</p> <p>Either of the following meets criteria for BMI percentile:</p> <ul style="list-style-type: none"> • BMI percentile documented as a value (e.g., 85th percentile) • BMI percentile plotted on age-growth chart <p>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%).</p>
Measure Source	HEDIS 2019
Age Criteria	Member is 3 to 17 years of age as of December 31, 2019.
Qualifying Event Criteria	Member has a claim for an outpatient visit with a PCP or OB/GYN during 2019.
Measurement Period	Date of service between January 1, 2019 – December 31, 2019.
Exclusions	<p>Female members who have a diagnosis of pregnancy during 2019.</p> <p>Members in hospice in 2019.</p>
Line(s) of Business	Commercial Pediatric
Codes	<p>Codes to Identify Well-Child BMI Assessment</p> <ul style="list-style-type: none"> • ICD-10 CM BMI Percentile Codes: Z68.51, Z68.52, Z68.53, Z68.54

Adolescent Immunization Status – Combination 2

Measure Definition	<p>Adolescents 13 years of age who had the following vaccinations by their 13th birthday:</p> <ul style="list-style-type: none"> • One meningococcal serogroups A, C, W, Y vaccine between the member's 11th and 13th birthdays, and • One tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap), between the member's 10th and 13th birthdays. • Completed the HPV vaccine series by receiving EITHER at least 2 HPV vaccines with dates of service at least 146 days apart between the member's 9th and 13th birthdays; OR at least 3 HPV vaccines between the member's 9th and 13th birthdays
Measure Source	HEDIS 2019
Age Criteria	Adolescents who turn 13 years of age during 2019
Qualifying Event Criteria	Turned 13 years of age during 2019
Measurement Period	Age 9 to 13
Exclusions	<p>Anaphylactic reaction to the vaccine or its components.</p> <p>Members in hospice in 2019.</p>
Line(s) of Business	Commercial Pediatric
Codes	<p>Codes for Immunizations</p> <ul style="list-style-type: none"> • Meningococcal: 90734 • Tdap: 90715 • HPV: 90649, 90650, 90651

Developmental Screening in the First Three Years of Life

<p>Measure Definitions</p>	<p>Members who are screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.</p> <p>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:</p> <ul style="list-style-type: none"> • <i>Developmental domains.</i> The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional. • <i>Established reliability.</i> Reliability scores must be approximately 0.70 or above. • <i>Established findings regarding the validity.</i> 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). • <i>Established sensitivity/specificity.</i> Sensitivity and specificity scores must be approximately 0.70 or above. <p>Current recommended tools that meet these criteria:</p> <ul style="list-style-type: none"> • 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 • Bayley Infant Neuro-developmental Screener (BINS): 3 months to 2 years • 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: Developmental Milestones (PEDS-DM) • Survey of Wellbeing of Young Children (SWYC)
<p>Measure Source</p>	<p>Oregon Pediatric Improvement Partnership at Oregon Health and Science University</p>
<p>Age Criteria</p>	<p>Member turns 1, 2, or 3 years of age during 2019. Three separate rates are calculated, one for each age category.</p>
<p>Qualifying Event Criteria</p>	<p>None</p>
<p>Measurement Period</p>	<p>The 12 month period preceding the member's 1st, 2nd, or 3rd birthday, up to December 31, 2019.</p>
<p>Exclusions</p>	<p>None</p>

Line(s) of Business	Commercial Pediatric
Codes	Codes to Identify Developmental Screening <ul style="list-style-type: none">• CPT-4 Codes: 96110

Tobacco Use: Screening and Cessation Intervention

Measure Definition	<p>The percentage of members age 18 and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user.</p> <p><i>Tobacco Use</i> – includes any type of tobacco <i>Tobacco Cessation Intervention</i> – Includes brief counseling (3 minutes or less) and/or pharmacotherapy</p>
Measure Source	National Quality Forum
Age Criteria	18 years of age or older as of December 31, 2019.
Qualifying Event Criteria	Had encounter during the measurement period.
Measurement Period	Date of service between January 1, 2018 – December 31, 2019
Exclusions	Members for whom tobacco screening was not performed for medical reasons.
Line(s) of Business	Commercial Adult
Codes	<p>CPT Category II code to identify tobacco use screening and cessation intervention:</p> <ul style="list-style-type: none"> • 4004F <p>CPT Category II code to identify tobacco use screening and identified as non-user of tobacco:</p> <ul style="list-style-type: none"> • 1036F <p>CPT Category II code to identify tobacco screening not performed for medical reasons (Exclusion):</p> <ul style="list-style-type: none"> • 4004F with modifier 1P

Transitions of Care – Notification of Inpatient Admission and Receipt of Discharge Information	
Measure Definitions	<p>The percentage of discharges for members age 18 and older that had the following:</p> <ul style="list-style-type: none"> • Notification of Inpatient Admission – documentation in the PCP’s record of receipt of notification of inpatient admission on the day of admission or the following day. • Receipt of Discharge Information – documentation in the PCP’s record of receipt of discharge information on the day of discharge or the following day.
Measure Source	HEDIS 2019
Age Criteria	Members 18 and older as of December 31, 2019.
Qualifying Event Criteria	An acute or nonacute inpatient discharge on or between January 1 and December 31, 2019.
Measurement Period	Date of service between January 1, 2019 – December 31, 2019
Exclusions	Members in hospice in 2019.
Line(s) of Business	Medicare
Additional Information	<p>This measure is not part of the PQIP achievement score. A flat fee of \$15 will be paid for medical records that are compliant for both Notification of Inpatient Admission and Receipt of Discharge Information.</p> <p>For Notification of Inpatient Admission documentation in the PCP’s record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when documentation was received. Receipt of notification must be on the day of admission or the following day.</p> <p>For Receipt of Discharge Information, documentation in the PCP’s record must include evidence of receipt of discharge information on the day of discharge or the following day with evidence of the date that the documentation was received.</p> <p>Please note: The denominator is based on discharges, not on members. Members may appear more than once in the sample.</p> <p>Please refer to page 8 for information on how to submit medical records for this measure.</p>

Transitions of Care – Notification of Inpatient Admission and Receipt of Discharge Information

Medical Record Criteria	<p>Only one outpatient medical record can be used for both indicators. The record selected may be from the member’s PCP or ongoing care provider.</p> <p>Notification of Inpatient Admission - Documentation must include evidence of receipt of notification of inpatient admission on the day of admission or the following day.</p> <ul style="list-style-type: none"> • Admission refers to the date of inpatient admission or date of admission for an observation stay that turns into an inpatient admission. <p>Documentation must include evidence of receipt of notification of inpatient admission with a date stamp. Any of the following examples meet criteria:</p> <ul style="list-style-type: none"> • Communication between inpatient providers or staff and the member’s PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission between emergency department and the member’s PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission to the member’s PCP or ongoing care provider through a health information exchange; an automated admission, discharge and transfer (ADT) alert system; or a shared electronic medical record system. • Communication about admission to the member’s PCP or ongoing care provider from the member’s health plan. • Indication that the member’s PCP or ongoing care provider admitted the member to the hospital. • Indication that a specialist admitted the member to the hospital and notified the member’s PCP or ongoing care provider. • Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member’s inpatient stay. • Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission or the following day; documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the denominator event. <p>Receipt of Discharge Information - Documentation of receipt of discharge information on the day of discharge or the following day.</p> <p>Documentation must include evidence of receipt of discharge information on the day of discharge or the following day. Discharge information may be included in a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information should include all of the following:</p>
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	<ul style="list-style-type: none">• The practitioner responsible for the member’s care during the inpatient stay.• Procedures or treatment provided.• Diagnoses at discharge.• Current medication list• Testing results, or documentation of pending tests or no tests pending.• Instructions to the PCP or ongoing care provider for patient care. <p>Note: The following notations or examples of documentation <u>do not</u> count as numerator compliant:</p> <ul style="list-style-type: none">• Notification of Inpatient Admission and Notification of Inpatient Discharge• Documentation that the member or the member’s family notified the member’s PCP or ongoing care provider of the admission or discharge• Documentation of notification that does not include a time frame or date/time stamp
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XI. FAQs

What if I don't submit data by the date required (January 31, 2020)?

No exceptions will be made for data submission after January 31, 2020. Please note that the actual date of service must be reported for all services. The order date for a test or procedure will not be accepted.

When will we receive payment?

We will need time for claims to process before we can provide accurate information and missing data elements. Then we will need to tabulate responses from providers who submit supplemental data. We expect that payment will be made in 4th quarter 2020.

Please be advised that if you are in a system of care (SOC), payment distribution may be different, based on contractual terms.

How do you determine who our patients are?

For BlueCHiP for Medicare and plans that require PCP selection, we use the member self-selection. If the member's plan does not require PCP selection, we use claims to attribute the member to a PCP. Year-end results will be based on attribution as of October 1, 2019. This allows the notified provider to be aware of their panel. Please see Section IV on page 19 for details on our attribution methodology.

What if the patient refuses to do what we order/request?

We recognize that many factors influence patient adherence to recommendations. There may be clinical reasons why some patients may not receive the services suggested by the general guidelines. Patient choice and patient-specific clinical judgment remain essential. Payout targets reflect these factors as they are benchmarked against national comparisons.

We do hope, however, that you will address barriers to care with your patients. As appropriate, seek assistance addressing these barriers by contacting BCBSRI's Care Coordination program by calling (401) 459-CARE (2273) or emailing triage_group@bcbsri.org.

What if I take height and weight, but did not calculate a BMI and record it at the visit?

The measure requires a BMI documented in the record. Documentation in the medical record for the Adult BMI measure must indicate the height, weight and BMI value, dated during 2018 or 2019. For the Well-Child BMI Assessment, measure documentation must include height, weight, and BMI percentile documented in 2019. This is consistent with documentation and coding guidelines.

If your practice has an electronic health record (EHR), please ensure it is calculating and recording the BMI after entering the patient's height and weight. In many (EHRs), this is a function that needs to be turned on in order to calculate BMI. In practices that routinely perform well on these measures, the clinical workflow includes obtaining and documenting a BMI at every visit, including sick visits, and submitting the appropriate ICD-10CM Codes (see page 16 for codes).

Will I get credit if the gynecologist or surgeon orders a mammogram or an endocrinologist does an A1c?

Yes, controlled A1c levels will need to be in your record, unless supplied to BCBSRI by the lab. BCBSRI will not be contacting hospitals, specialists, or other healthcare professionals with data requests.

What if the measure does not make sense for my patient? For example, a 70-year-old woman with advanced lung cancer does not need a mammogram.

The measures are methods designed to evaluate, generally, evidence-based care. Individual clinician judgment is important. Measures are not guidelines. For example, many clinicians order screening mammography annually, yet the measure accepts one study in the two calendar years. A case like the one described in the question is unlikely to be material in the overall results of any clinician with more than a few members. As mentioned in a previous answer, payout targets take these sort of instances into consideration.

Will we get credit if we can send you a test result even if you did not pay for it? For example, could we send an HbA1c from a hospital stay or a mammogram report?

Yes, you may use data from any source documented in your record (for example, if the service was provided at a Veteran's Administration hospital), or service was rendered while a member had non-BCBSRI coverage.