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Introduction

Thank you for your hard work and dedication to providing care to our members. Your clinical and engagement efforts are appreciated and continue to improve the health and well-being of the communities you serve.

In 2018, HMSA recognized that the new primary care Payment Transformation Model didn’t fully align with care delivery of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). HMSA worked collaboratively with FQHCs/RHCs and other stakeholders in Hawaii to develop a new quality incentive model that would more appropriately account for the variety of services and support that FQHCs/RHCs provide to their patients and communities.

The 2019 P4Q program for FQHCs/RHCs intends to better align clinical quality metrics. The program also includes evolved engagement measures that aim to advance collaboration in data sharing and continue the progress made toward addressing social determinants of health and well-being.

Program Overview

Provider Eligibility

Primary care providers (PCP) whose payee is a FQHC/RHC will be eligible to participate in the program.

If a provider is contracted with HMSA as a non-PCP marketing specialty type at a non-FQHC/RHC location, that provider may still be eligible for program participation if the provider also practices at an FQHC/RHC as a PCP.

Payment Conditions

Payment will be divided into two components: 1) an engagement PMPM and 2) a quality PMPM.

Engagement payments will be made monthly based on the following calculation:

- Engagement PMPM x # of attributed members per line of business (LOB) for that month.

Quality payment will be made annually (following the end of the measurement period) based on the calculations outlined in Appendix B (Quality Measure Scoring Example).

2019 Rates

<table>
<thead>
<tr>
<th>LINE OF BUSINESS</th>
<th>ENGAGEMENT PMPM</th>
<th>QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>$3.00</td>
<td>$4.25</td>
</tr>
<tr>
<td>QUEST Integration</td>
<td>$2.00</td>
<td>$2.75</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>N/A</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

Scoring Period

The 2019 program will have an annual (12-month) measurement period.

<table>
<thead>
<tr>
<th>MEASUREMENT PERIOD</th>
<th>BASELINE PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1 to December 31, 2019</td>
<td>January 1 to December 31, 2018</td>
</tr>
</tbody>
</table>
### Summary of Engagement Measures

<table>
<thead>
<tr>
<th>MEASUREMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Sharing and Integration</td>
<td>Continue to collaborate with HMSA on development of a strategy and implementation to accomplish timely and accurate bidirectional data sharing between HMSA and FQHCs/RHCs.</td>
</tr>
<tr>
<td>Social Determinants of Health (SDoH) Initiatives</td>
<td>Design outcomes reporting and evaluation for a social determinants-related initiative.</td>
</tr>
</tbody>
</table>

### Summary of Quality Measures

The 2019 program will include measures based on 2018 Healthcare Effectiveness Data and Information Set (HEDIS) specifications and the State of Hawaii Med-QUEST Division specification for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) completion.

<table>
<thead>
<tr>
<th>MEASUREMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td>Percentage of attributed members 18-74 years of age who had an outpatient visit and whose body mass index was documented during the measurement year or year before the measurement year.</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Percentage of women members 52-74 years of age who had one or more mammograms during the measurement year or the 15 months before the measurement year.</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Percentage of attributed members 51-75 years of age who had an appropriate screening for colorectal cancer through one of these measures: Fecal occult blood test (FOBT) during the measurement year, FIT-DNA test during the measurement year or the two prior measurement years, CT colonography during the measurement year or the four prior measurement years, or colonoscopy during the current measurement year or the nine before the measurement year.</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Percentage of women members 24-64 years of age who were screened for cervical cancer using either cervical cytology during the measurement year or the two years prior. If age 30-64, a cervical cytology and human papillomavirus (HPV) test with service dates four or less days apart during the measurement year or the four prior measurement years are also accepted.</td>
</tr>
<tr>
<td>Diabetes Care - HbA1c &lt;8%</td>
<td>Percentage of attributed members with diabetes 18-75 years of age whose most recent HbA1c level was less than 8.0%.</td>
</tr>
<tr>
<td>Childhood Immunizations – Combo 3</td>
<td>Percentage of attributed member children having all of the following immunizations on or before their second birthday:</td>
</tr>
<tr>
<td></td>
<td>• At least four DTaP vaccinations with different dates of service on or before the child’s second birthday.</td>
</tr>
<tr>
<td></td>
<td>• DTaP administered before 42 days after birth can’t be counted.</td>
</tr>
<tr>
<td></td>
<td>• At least three Hib vaccinations with different dates of service on or before the child’s second birthday.</td>
</tr>
<tr>
<td></td>
<td>• Hib administered before 42 days after birth can’t be counted.</td>
</tr>
<tr>
<td></td>
<td>• At least two outpatient HepB vaccinations with different dates of service on or before the child’s second birthday.</td>
</tr>
<tr>
<td></td>
<td>• At least three IPV vaccinations with different dates of service on or before the child’s second birthday.</td>
</tr>
<tr>
<td></td>
<td>• IPV administered before 42 days after birth can’t be counted.</td>
</tr>
<tr>
<td></td>
<td>• At least one MMR vaccination with a date of service on or before the child’s second birthday.</td>
</tr>
<tr>
<td></td>
<td>• At least four PCV vaccinations with different dates of service on or before the child’s second birthday.</td>
</tr>
<tr>
<td></td>
<td>• PCV administered before 42 days after birth can’t be counted.</td>
</tr>
<tr>
<td></td>
<td>• At least one VZV vaccination with a date of service on or before the child’s second birthday.</td>
</tr>
<tr>
<td>Well-child Visits in the First 15 Months of Life</td>
<td>Percentage of attributed members who turned 15 months old during the measurement year and had six or more well-child visits with a PCP.</td>
</tr>
<tr>
<td>Well-child Visits in the 3rd, 4th, 5th, and 6th Years of Life</td>
<td>The percentage of attributed members 3-6 years of age who received one or more well-child visits with a PCP during the current measurement year.</td>
</tr>
<tr>
<td>Adolescent Well-care Visit</td>
<td>The percentage of attributed members 12-21 years of age who had at least one comprehensive well-care visit with a PCP during the measurement year.</td>
</tr>
<tr>
<td>Prenatal and Postpartum – Timeliness of Prenatal Care</td>
<td>The percentage of pregnant members who had a prenatal visit in the first trimester, on the enrollment, start date or within 42 days of enrollment.</td>
</tr>
<tr>
<td>Prenatal and Postpartum – Postpartum Care</td>
<td>The percentage of pregnant members who had a postpartum visit or a pelvic exam between 21-56 days after delivery.</td>
</tr>
<tr>
<td>EPSDT Completion</td>
<td>The percentage of attributed members who completed all EPSDT screenings that are due during the current measurement year and within the eligible screening period.</td>
</tr>
</tbody>
</table>
**Quality Measure Targets**

The measure targets for the 2019 program year will be based on 2018 National Committee for Quality Assurance (NCQA) Quality Compass or CMS Medicare Star Ratings benchmark rates for each measure.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>COMMERCIAL</th>
<th>QUEST INTEGRATION</th>
<th>MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LOWER TARGET</td>
<td>UPPER TARGET</td>
<td>LOWER TARGET</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>80.56%</td>
<td>88.32%</td>
<td>--</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>71.25%</td>
<td>75.59%</td>
<td>--</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>61.07%</td>
<td>67.19%</td>
<td>--</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c&lt;8%</td>
<td>56.93%</td>
<td>62.04%</td>
<td>51.34%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>74.44%</td>
<td>76.49%</td>
<td>60.10%</td>
</tr>
<tr>
<td>Childhood Immunizations – Combo 3</td>
<td>76.46%</td>
<td>82.00%</td>
<td>70.80%</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care – Timeliness of Prenatal Care</td>
<td>84.92%</td>
<td>89.80%</td>
<td>83.21%</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care – Postpartum Care</td>
<td>75.27%</td>
<td>82.22%</td>
<td>65.21%</td>
</tr>
<tr>
<td>Well-child Visit in the First 15 Months of Life</td>
<td>80.75%</td>
<td>85.71%</td>
<td>66.23%</td>
</tr>
<tr>
<td>Well-child Visits in the 3rd, 4th, 5th, and 6th Months of Life</td>
<td>77.26%</td>
<td>82.95%</td>
<td>73.89%</td>
</tr>
<tr>
<td>Adolescent Well-care Visit</td>
<td>45.70%</td>
<td>53.97%</td>
<td>54.57%</td>
</tr>
<tr>
<td>EPSDT Completion</td>
<td>--</td>
<td>--</td>
<td>70.00%</td>
</tr>
</tbody>
</table>
Providers covered under an FQHC/RHC medical group agreement will be enrolled in the 2019 pay-for-quality program if the FQHC/RHC returned a signed letter of agreement for the 2019 pay-for-quality program. Note: Exceptions to eligibility criteria may be made at HMSA’s sole discretion.

Universal Eligibility and Enrollment Criteria

The following universal eligibility criteria are applied across commercial, QUEST Integration, and Medicare Advantage lines of business:

1. Practice in one of the following primary care specialties:
   - Family medicine.
   - General practice.
   - Internal medicine.
   - Naturopathic medicine.
   - Advanced practice registered nurses (primary care).
   - Physician assistants under the supervision of a program-eligible primary care provider.
   - Pediatrics (commercial and QUEST Integration).

2. PCPs whose payee is a FQHC/RHC will be eligible to participate in the program.

If a provider is contracted with HMSA as a non-PCP marketing specialty type at a non-FQHC/RHC location, that provider may be eligible for program participation if the provider also practices at a FQHC/RHC as a PCP.

HMSA reserves the right to exclude other non-primary care specialists in accordance with CMS standards.

Enrollment Conditions

Providers must agree to the following:

- Participate fully in the pay-for-quality program and the quality improvement activities necessary to evaluate their performance and improvement.
- Accept HMSA’s determination of the pay-for-quality score and understand that the score will serve as the basis for any pay-for-quality award from HMSA. Providers may request reconsideration of their score and/or award, but must follow established procedures for reconsideration (see Inquiries and Requests for Reconsideration section on page 8).
- Providers, at their sole cost and expense, will maintain adequate records related to their obligations under the pay-for-quality program. Providers agree that the Department of Health and Human Services, the comptroller general, and/or their designees will have the right of access and entry to this information and to providers’ facilities, including computer and other electronic systems, that pertain to any aspect of providers’ performance that results in payments from HMSA for the purposes of audit, evaluation, and/or inspection.1

Additional Eligibility Criteria

COMMERCIAL

1. Participation in HMSA’s PPO and/or HMO plan at the end of the measurement period.

QUEST INTEGRATION

1. Participation in HMSA’S QUEST Integration plan at the end of the measurement period.

MEDICARE ADVANTAGE

1. Participation in a Medicare Advantage plan at the end of the measurement period.

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1 Required by regulations promulgated under the Affordable Care Act, 45 C.F.R § 158.501.
As a pay-for-quality initiative, this program translates accepted evidence-based medicine into standards that can be objectively measured through analyses of claims and other verifiable data. Establishing measurable quality standards is a constantly evolving process as new clinical evidence is discovered.

**Measurement Responsibility**

All providers (regardless of specialty) are scored on all measures for which their patient panels are eligible.

**Key Dates and Deliverables**

**Engagement Measures**

**Data Sharing and Integration**

<table>
<thead>
<tr>
<th>DEADLINE</th>
<th>MILESTONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 30, 2019</td>
<td>FQHC/RHC to implement at least one ongoing quarterly scheduled data file that supports quality measures.</td>
</tr>
</tbody>
</table>

**SDOH Initiatives (first-year SDOH participant)**

<table>
<thead>
<tr>
<th>DEADLINE</th>
<th>MILESTONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 31, 2019</td>
<td>FQHC/RHC to submit description and plan for SDOH initiative.</td>
</tr>
<tr>
<td>June 30, 2019</td>
<td>FQHC/RHC to submit outcomes and measures of success for SDOH initiative.</td>
</tr>
<tr>
<td>December 31, 2019</td>
<td>FQHC/RHC to submit progress report for SDOH initiative.</td>
</tr>
<tr>
<td>March 31, 2020</td>
<td>FQHC/RHC to submit evaluation for SDOH initiative.</td>
</tr>
</tbody>
</table>

**SDOH Initiatives (second-year SDOH participant)**

<table>
<thead>
<tr>
<th>DEADLINE</th>
<th>MILESTONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 31, 2019</td>
<td>FQHC/RHC to submit update of SDOH initiative.</td>
</tr>
<tr>
<td>July 31, 2019</td>
<td>FQHC/RHC to submit Q1-Q2 2019 progress report for SDOH initiative.</td>
</tr>
<tr>
<td>October 31, 2019</td>
<td>FQHC/RHC to submit Q3 2019 progress report for SDOH initiative.</td>
</tr>
</tbody>
</table>

**Quality Measures**

**Supplemental Data Submissions**

<table>
<thead>
<tr>
<th>SERVICE PERIOD</th>
<th>DEADLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 (January 1 to March 31, 2019)</td>
<td>April 30, 2019</td>
</tr>
<tr>
<td>Quarter 2 (April 1 to June 30, 2019)</td>
<td>July 31, 2019</td>
</tr>
<tr>
<td>Quarter 3 (July 1 to September 30, 2019)</td>
<td>October 31, 2019</td>
</tr>
<tr>
<td>Quarter 4 (October 1 to December 31, 2019)</td>
<td>February 28, 2020</td>
</tr>
</tbody>
</table>

**Engagement Measures Payment Schedule**

Payments will be issued at the end of the month listed in the Payment Date column.

<table>
<thead>
<tr>
<th>ATTRIBUTION PERIOD</th>
<th>PAYMENT DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2019</td>
<td>February 2019</td>
</tr>
<tr>
<td>February 2019</td>
<td>March 2019</td>
</tr>
<tr>
<td>March 2019</td>
<td>April 2019</td>
</tr>
<tr>
<td>April 2019</td>
<td>May 2019</td>
</tr>
<tr>
<td>May 2019</td>
<td>June 2019</td>
</tr>
<tr>
<td>June 2019</td>
<td>July 2019</td>
</tr>
<tr>
<td>July 2019</td>
<td>August 2019</td>
</tr>
<tr>
<td>August 2019</td>
<td>September 2019</td>
</tr>
<tr>
<td>September 2019</td>
<td>October 2019</td>
</tr>
<tr>
<td>October 2019</td>
<td>November 2019</td>
</tr>
<tr>
<td>November 2019</td>
<td>December 2019</td>
</tr>
<tr>
<td>December 2019</td>
<td>January 2020</td>
</tr>
</tbody>
</table>
Data Sources

The quality measures included in the 2019 pay-for-quality program align with areas of focus for the State of Hawaii Medicaid-QUEST Division, CMS Medicare Star Ratings, and NCQA.

Following HEDIS specifications, HMSA will identify eligible members for each measure through enrollment, claims and provider data. HMSA will calculate measure rates using claims and supplemental data available to HMSA. Supplemental data available to HMSA includes Clinical Labs of Hawaii and Diagnostic Laboratory Services lab data, as well as EPSDT form data.

Claims data, on occasion, may not be adequate to exclude a patient from the denominator. For example, claims data may indicate that the woman needs a breast cancer screening when the medical record indicates that she has had a bilateral mastectomy. HMSA will allow FQHCs/RHCs to submit supplemental data and attest to the validity of the data in order to exclude a patient from a measure denominator or satisfy the criteria for a favorable numerator.

FQHC/RHC supplemental data should only be used for services that aren’t captured through claims and should only include information supported by a medical record. For additional details, see the “Supplemental Data Option Documentation Requirements” for each measure in Appendix A.

Submitting Supplemental Data

Supplemental data may be submitted through various channels:

- Email – Quality-FQHC@hmsa.com
  - o When sending a patient gap list file and/or medical records via email, please ensure the subject line includes the following statement: HMSASECURE: [FQHC Name]
- Fax – (808) 948-5680 or (808) 948-6381
  - o ATTN: Quality - FQHC Program
- FTP – HMSA will work individually with FQHCs that wish to submit data via a FTP.

Supplemental Data Submission Deadlines

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>April 30, 2019</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>July 31, 2019</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>October 31, 2019</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>February 28, 2020</td>
</tr>
</tbody>
</table>

Patient Care Gap Lists

Quarterly, HMSA will provide a patient care gap list to each FQHC/RHC via an Excel spreadsheet. Patients contained in the spreadsheet have been attributed to the FQHC/RHC based on member selection or auto assignment. To attest/request that a member be attributed, a PCP must contact HMSA at Quality-FQHC@hmsa.com to request an attestation form.

The spreadsheet contains the following patient information:

- FQHC name
- Line of business (Commercial, QUEST Integration, Medicare)
- Measure name
- Measure description
- Patient name (last, first)
- Date of birth
- Subscriber number with dependent number
- Contact information

The spreadsheet also contains the following fields that can be populated to note how the gaps are closed:

- Medical Record: Mark this field with an “X” if submitting a medical record.
- Date of Service: Enter the date the service was completed.
- Notes: Enter any additional information.

Data Audit

HMSA reserves the right to conduct an audit of patient medical records to verify that the measure data submitted by the FQHC/RHC was accurate. HMSA will notify the FQHC/RHC in writing with details about the audit process and requirements before the audit.
Inquiries and Requests for Reconsideration

Inquiries

An inquiry is defined as a request for additional information about the FQHC/RHC pay-for-quality program.

General inquiries about the program (not specific to scores or results) will be answered at any time throughout the year.

Send inquiries by:

- Letter. Mail to: HMSA
  Attn: Quality Management – 9-KB-QM
  P.O. Box 860
  Honolulu, HI 96808-0860

- Email. Send to Quality-FQHC@hmsa.com.

- Phone. Call HMSA. For help identifying your contact, please call 948-6820 on Oahu or 1 (877) 304-4672 toll-free on the Neighbor Islands.

Requests for Reconsideration

Reconsideration is defined as a request for HMSA to change a determination it has made regarding a provider's reported scores and/or payment.

Requests for reconsideration will be accepted only in writing up through May 31, 2020.

A request for reconsideration submitted within the criteria explained below should include supporting data. If a request is approved, the FQHC’s/RHC’s final quality score and payment will be adjusted accordingly. Requests for reconsideration must communicate:

- Measure.
- Patient.
- Clinical rationale and supporting citations for denominator exclusion or numerator credit.
- Medical record information to support denominator exclusion or numerator credit such as:
  - Service/procedure.
  - Date of service.
  - Diagnosis.
  - Lab result.
- Documentation including calculations and rationale to support adjustments to quality performance scores.

Request for Reconsideration Process

1. Submit the necessary documents and information to HMSA.

   Fax: 948-5680 on Oahu

   Email: Quality-FQHC@hmsa.com

   Mailing address:
   HMSA
   Attn: Quality Management – 9-KB-QM
   P.O. Box 860
   Honolulu, HI 96808-0860

2. HMSA will review and respond to your request within 60 business days from the date that HMSA receives the request.

3. If you’re dissatisfied with HMSA’s response to your request for reconsideration, additional dispute resolution remedies are available to you under your HMSA participating provider agreement.
Patient Population and Member Eligibility

**Patient Population Identification**

**COMMERCIAL**
HMSA's commercial plans (HMO and PPO) are eligible for the program.

**QUEST INTEGRATION**
HMSA QUEST Integration is eligible for the program.

**MEDICARE ADVANTAGE**
HMSA Medicare Advantage is eligible for the program.

**Engagement Measures - Member Eligibility**

To be included in a provider’s monthly engagement payment calculations, the member must be assigned to the provider for that month.
Payment Details

Payment Conditions
To be eligible, an FQHC/RHC provider must meet all of the following criteria:

- Participate in:
  - HMSA’s PPO and/or HMO plan at the end of the measurement period for commercial quality.
  - An HMSA Medicare Advantage plan at the end of the measurement period for Medicare Advantage quality.
  - HMSA QUEST Integration plan at the end of the measurement period for QUEST Integration.
- Practice in the state of Hawaii at the end of each measurement period.
- Submit claims to HMSA that indicate a face-to-face encounter, during the measurement period.

See also, details under the Program Eligibility and Enrollment sections on page 5.

If the provider is eligible to receive an award, the award check and remittance report will be sent to the payee(s) that the provider or group administrator designated for HMSA claims payments as of the end of each measurement period.

Providers must be participating in the 2018 FQHC/RHC pay-for-quality program at the end of the measurement period to receive their quality payment earned in that program. If a provider ends FQHC/RHC pay-for-quality program participation and begins participating in HMSA’s Payment Transformation Performance Quality Measures before the end of the FQHC/RHC quality measurement period, the provider forgoes any FQHC/RHC quality award earned and won’t receive payment for that FQHC/RHC quality measurement period.

Engagement Payments
FQHCs/RHCs will receive a monthly payment for their participation in the engagement measures. A summary report will be provided with each monthly payment. The summary report will include attributed member counts and the total engagement payment for each provider who belongs to the FQHC/RHC. The monthly payment is based on the following formula:

Engagement PMPM x # of attributed members per LOB per month.

See the Engagement Measures Payment Schedule on page 6 for more details.

If a provider hasn’t sufficiently satisfied the requirements for any of the engagement measures, HMSA reserves the right to recoup these payments.

Quality Payments
FQHC/RHC quality payments are based on the FQHC’s/RHC’s cumulative performance during the measurement period compared to measure targets, as well as performance during the corresponding baseline period.

Final performance quality reports will be available on completion of the annual scoring and payment process in April 2020. For detailed program schedules, see the Key Dates and Deliverables table on page 6.

Under the 2019 FQHC/RHC pay-for-quality program, payment varies predictably with the provider’s performance and improvement within the quality measures based on a predetermined formula. The provider is paid for performance as well as improvement in a given measure.

Payment Rates

<table>
<thead>
<tr>
<th>LOB</th>
<th>ENGAGEMENT PMPM</th>
<th>QUALITY PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>$3.00</td>
<td>$4.25</td>
</tr>
<tr>
<td>QUEST Integration</td>
<td>$2.00</td>
<td>$2.75</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>N/A</td>
<td>$3.00</td>
</tr>
</tbody>
</table>
Quality Measure Scoring

Measure Targets
The measure targets for the 2019 program year are based on 2018 National Committee for Quality Assurance (NCQA) Quality Compass or CMS Medicare Star Ratings benchmark rates for each measure.

Measure Weightings
The weightings for the quality measures are below.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>COMMERCIAL</th>
<th>QUEST</th>
<th>MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
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<tr>
<td>Breast Cancer Screening</td>
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<tr>
<td>Colorectal Cancer Screening</td>
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<td>$0.75</td>
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<tr>
<td>Comprehensive Diabetes Care - HbA1c&lt;8%</td>
<td>$0.38</td>
<td>$0.35</td>
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<tr>
<td>Cervical Cancer Screening</td>
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<td>Childhood Immunizations – Combo 3</td>
<td>$0.38</td>
<td>$0.35</td>
<td>--</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care – Timeliness of Prenatal Care</td>
<td>$0.38</td>
<td>$0.25</td>
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<tr>
<td>Prenatal and Postpartum Care – Postpartum Care</td>
<td>$0.38</td>
<td>$0.25</td>
<td>--</td>
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<tr>
<td>Well-child Visit in the First 15 Months of Life</td>
<td>$0.38</td>
<td></td>
<td>$0.35</td>
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<tr>
<td>Well-child Visits in the 3rd, 4th 5th, and 6th Years of Life</td>
<td>$0.38</td>
<td>$0.35</td>
<td>--</td>
</tr>
<tr>
<td>Adolescent Well-care Visit</td>
<td>$0.38</td>
<td>$0.35</td>
<td>--</td>
</tr>
<tr>
<td>EPSDT Completion</td>
<td>- -</td>
<td>$0.15</td>
<td>--</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$4.25</td>
<td>$2.75</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

Measure Scoring
For each LOB, for each applicable measure:

Full credit is awarded for achieving the measure target (Upper Target).

If the target isn’t achieved, partial credit may be awarded for improving over baseline and/or reaching designated thresholds.

- Improvement is awarded proportionally based on the actual amount the provider has improved from the baseline relative to the target (Continuous Improvement).

- Bonuses are awarded for reaching the following thresholds:
  - Achieving the second-tier measure target (Lower Target Bonus).
  - Narrowing the gap between the baseline and the Upper Target by at least 10% (10% Gap Bonus).
  - Narrowing the gap between the baseline and the Upper Target by at least 25% (25% Gap Bonus).

<table>
<thead>
<tr>
<th>Continuous Improvement</th>
<th>75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Target Bonus</td>
<td>10%</td>
</tr>
<tr>
<td>10% Gap Bonus</td>
<td>10%</td>
</tr>
<tr>
<td>25% Gap Bonus</td>
<td>15%</td>
</tr>
<tr>
<td>Total</td>
<td>110%</td>
</tr>
</tbody>
</table>

Note: Although it is possible to achieve 110%, a maximum of 100% will be awarded per LOB per measure.

See Appendix B for detailed scoring examples.
Appendix A - Measure Detail

Engagement Measures
Engagement Measure: Data Sharing and Integration .......................................................... 13
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Data Sharing and Integration

Description
Continue to collaborate with HMSA on the development of a strategy and implementation to accomplish timely and accurate bidirectional data sharing between HMSA and FQHCs/RHCs.

Requirements
To fulfill this measure, FQHCs/RHCs must participate in the following activities. FQHCs/RHCs are asked to respond in a timely manner to help facilitate continued collaboration and partnership.

• Participate in collaborative discussions and meetings, including site visits with HMSA staff (ongoing).
• Provide input on technical processes and requirements, including potential barriers to systems integration (ongoing).
• Share plans for implementation of new systems, data processing, and data feeds, etc. (ongoing).
• Milestone 1: Implement at least one ongoing quarterly scheduled data file that supports quality measures (no later than September 30, 2019).*

SDOH Initiatives

Description
Design outcomes, reporting, and evaluation for a social determinants-related initiative. For FQHCs/RHCs that participated in the SDOH Initiative component of the 2018 pay-for-quality program, 2019 activities will build on 2018 activities.

Requirements
First-Year SDOH Participant
Milestone 1: Describe the social determinants of health and plans for the initiative (no later than March 31, 2019).*

• Provide responses to the following questions in five pages or less:
  o What’s the problem that you’re trying to solve?
  o Who’s your target population?
  o What’s your intervention or activity to address the problem?
  o What are the desired outcomes of your intervention or activity? How are you achieving these outcomes?
  o Please include a high-level plan and timeline of how your intervention or activity will be/have been implemented.
Milestone 2: Identify potential outcomes and measurements of success for the initiative (no later than June 30, 2019).*

• Provide responses to the following questions in five pages or less:
  o How are you measuring the impact of your intervention or activity? Please include a description of any products or deliverables that result from the intervention or activity. For example, an intervention targeted at patients who are unemployed might measure impact by the number of unemployed patients that complete resume writing and job interviewing classes.
  o How are you measuring the desired outcomes of your intervention or activity? Please describe specific data that’s collected and how the data is used to track progress toward outcomes and performance. For example, an outcome measure for an activity that targets childhood obesity might be a 30-percent increase in the number of children that regularly engage in physical activity.
Milestone 3: Share progress report of your initiative (no later than December 31, 2019).*

• Share any preliminary outcomes data and progress on products or deliverables from your intervention or activities.
Milestone 4: Evaluate your initiative (no later than March 31, 2020).*

• Provide responses to the following in five pages or less:
  o Describe your experiences with implementing your intervention or activities. Did you have to modify your plan and timeline? Are there any lessons learned from this experience?
  o What are the next steps for your intervention or activities? Will you modify the design and/or outcomes measurement of your intervention or activities?
Second-Year SDOH Participant
Milestone 1: In conjunction with Milestone 4 of the 2018 pay-for-quality program SDOH initiative, update or reaffirm initiative based on 2018 evaluation (no later than March 31, 2019).*
Milestone 2: Report Q1-Q2 2019 initiative progress, including identification of targeted patients participating and not participating in intervention or activity (no later than July 31, 2019).*
Milestone 3: Report Q3 2019 initiative progress, including identification of targeted patients participating and not participating in intervention or activity (no later than October 31, 2019).*
Milestone 4: Report Q4 2019 initiative progress, including identification of targeted patients participating and not participating in intervention or activity (no later than January 31, 2020).*

* To receive full credit for this measure, each FQHC must submit the information outlined for each milestone to HMSA by the deadline. Please submit the information in a Word document (or other similar format) by email to Quality-FQHC@hmsa.com.
Members Excluded from the PCP Performance Measures

Members who received hospice care at any time during the measurement year aren’t included in the PCP Performance Measures.

Click the icon below for allowable exclusion codes:

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

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

Members who received hospice care at any time during the measurement year are not included in the PCP Performance Measures. Members who are also identified with advanced illness and frailty will also not be included in the PCP performance measures.

Requests for Reconsideration for members living long term in institutions will be accepted beginning July 2018. Refer to page 8 for more information regarding submitting exclusion requests.

Body Mass Index (BMI) Assessment

**COMMERCIAL • MEDICARE ADVANTAGE**

**Description**

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

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

**Numerator**

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

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

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

Click the icon below for allowable numerator codes:

**Denominator**

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

Click the icon below for allowable denominator codes:

**Exclusions**

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

Click the icon below for allowable exclusion codes:

**Supplemental Data Option Documentation Requirements**

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

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

For BMI percentile, the following documentation is needed:

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

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

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

**Documentation Required for Request for Reconsideration**

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

- A note indicating diagnosis of pregnancy during the measurement year or the year before the measurement year.
Breast Cancer Screening

COMMERICAL • MEDICARE ADVANTAGE

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

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

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

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

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

Supplemental Data Option Documentation Requirements
To attest that a breast cancer screening was performed, medical record evidence of the following is required:

• Mammogram: One or more mammograms in the measurement year or the 15 months before the measurement year.

Documentation Required for Request for Reconsideration
To attest that a member should be excluded, medical record evidence of one of the following is required:

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

Childhood Immunization Status (All individual immunizations)

COMMERICAL • QUEST INTEGRATION

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

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

Numerator
For all antigens, count any of the following:

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

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

Denominator
Children who turn 2 years of age during the measurement year.
Exclusions
Children who had a contraindication for a specific vaccine will be excluded. Exclude patients for contraindication only if the administrative data doesn’t indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the second birthday.

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements
For MMR, hepatitis B, and VZV, medical record evidence of one of the following is required:

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

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

- Evidence of the antigen or combination vaccine.

Documentation Required for Request for Reconsideration
To attest that a member should be excluded, medical record evidence of the following is required:

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

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

- FOBT: Lab results/report for guaiac (gFOBT) or immunochromatoc (iFOBT). Depending on the type of FOBT test, the following is the required number of samples:
  1. gFOBT: Three consecutive stools.
  2. iFOBT: One stool.

- Flex sigmoidoscopy: Performed during the measurement year or four years before the measurement year.

- Colonoscopy: Performed during the measurement year or nine years before the measurement year.

- CT colonography: Performed during the measurement year or the four years before the measurement year.

- FIT-DNA: Performed during the measurement year or the two years before the measurement year.

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

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

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

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

Comprehensive Diabetes Care – HbA1c Control (<8)

Commercial • Quest Integration • Medicare Advantage

Description
Percentage of patients with diabetes 18–75 years of age whose most recent HbA1c level was less than 8.0 percent (in control).

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

Numerator
The number of members whose most recent HbA1c test performed during the measurement year had a result less than 8.0 percent. If the result for the most recent HbA1c test during the measurement year is greater than 8.0 percent or if the member didn’t have a test in the measurement year, the member won’t be included in the numerator.

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

Click the icon below for allowable numerator codes:

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

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

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements

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

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

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

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

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

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

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

- Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available). Note: Glucophage/metformin isn’t included because it’s used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

- At least two visits with an eligible provider type where diabetes is listed as a diagnosis. Eligible provider types include advanced practice registered nurse (APRN), endocrinology, pediatric endocrinology, family physician, general practice, internal medicine, naturopath, nephrology, pediatrics, pediatric endocrinology, pediatric nephrology, physician assistant. Telehealth visits billed with a POS 02 don’t qualify as outpatient visits.
Well-child Visits in the First 15 Months of Life

**COMMERCIAL • QUEST INTEGRATION**

**Description**
Percentage of patients who turned 15 months old during the measurement year and who had six or more well-child visits with an eligible PCP type**, ob-gyn, or geriatrician during their first 15 months of life. This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits.

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

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

Click the icon below for allowable numerator codes:

**Denominator**
Children who turned 15 months old during the measurement year.

**Exclusions**
None

**Supplemental Data Option Documentation Requirements**
To attest that a patient had a well-child visit, medical record evidence of all of the following is required:

- Health and developmental history (physical and mental):
  - A health history. Health history is an assessment of the member’s history of disease or illness. Health history can include past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization), and family health history.
  - A physical developmental history. Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
  - A mental developmental history. Mental developmental history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
  - Physical exam.
- Health education/anticipatory guidance: Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

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

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

**COMMERCIAL • QUEST INTEGRATION**

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

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

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

Click the icon below for allowable numerator codes:

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

**Exclusions**
None

**Supplemental Data Option Documentation Requirements**
To attest that a patient had a well-child visit, medical record evidence of all of the following is required:

- Health and developmental history (physical and mental):
  - A health history. Health history is an assessment of the member’s history of disease or illness. Health history can include past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization), and family health history.
  - A physical developmental history. Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
  - A mental developmental history. Mental developmental history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
  - Physical exam.
- Health education/anticipatory guidance: Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

**Eligible PCP types include general or family practice physicians; general internal medicine physicians and pediatricians; primary care nurse practitioners, physician assistants, and advanced practice registered nurses; and naturopathic physicians.**
• A physical developmental history. Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.

• A mental developmental history. Mental developmental history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.

• Physical exam.

• Health education/anticipatory guidance: Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

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

## EPSDT Completion Rate
### QUEST INTEGRATION

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

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

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

<table>
<thead>
<tr>
<th>EPSDT SCREENING VISIT</th>
<th>ELIGIBLE SCREENING PERIOD START</th>
<th>ELIGIBLE SCREENING PERIOD END (DUE DATE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months</td>
<td>6 months</td>
<td>9 months less 1 day</td>
</tr>
<tr>
<td>9 months</td>
<td>9 months</td>
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<tr>
<td>20 years</td>
<td>20 years</td>
<td>21 years less 1 day</td>
</tr>
</tbody>
</table>

Click the icon below for allowable numerator codes.

#### Requirements for compliance
To meet the requirement for this measure, the performance rate must be greater than or equal to 70 percent.
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care

**COMMERCIAL • QUEST INTEGRATION**

**Description**

The percentage of deliveries of live births on or between November 6 of the year before the measurement year and November 5 of the measurement year that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.

**Denominator**

The percentage of deliveries of live births on or between November 6 of the year before the measurement year and November 5 of the measurement year.

**Numerator**

A prenatal visit in the first trimester, on the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy. Include only visits that occur while the member was enrolled.

The following codes identify services that satisfy the measure:

Click the icon below for allowable numerator codes:

**Exclusions**

None

---

**Supplemental Data Option Documentation Requirements**

**Medical record**

Prenatal care visit to an ob/gyn or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following.

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: Hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or
  - TORCH antibody panel alone, or
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
  - Ultrasound of a pregnant uterus.
- Documentation of LMP, EDD or gestational age in conjunction with either of the following.
  - Prenatal risk assessment and counseling/education.
  - Complete obstetrical history.

Note: For women whose last enrollment segment was after 219 days before delivery (i.e., between 219 days before delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an ob/gyn, family practitioner, or other PCP with a diagnosis of pregnancy.

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Prenatal and Postpartum Care (PPC) – Postpartum Care

**COMMERCIAL • QUEST INTEGRATION**

**Description**

The percentage of deliveries of live births on or between November 6 of the year before the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.
Denominator
The percentage of deliveries of live births on or between November 6 of the year before the measurement year and November 5 of the measurement year.

Numerator
A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

The following codes identify services that satisfy the measure:
Click the icon below for allowable numerator codes:

Exclusions
None

Supplemental Data Option Documentation Requirements
Medical record
Postpartum visit to an ob/gyn practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:
- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
- Notation of postpartum care, including:
  - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
  - A preprinted “Postpartum Care” form in which information was documented during the visit.

Cervical Cancer Screening
COMMERCIAL • QUEST INTEGRATION
Description
The percentage of women 24–64 years of age who were screened for cervical cancer using either of the following criteria:
- Women ages 24–64 who had cervical cytology performed every three years.
- Women ages 30–64 who had cervical cytology and human papillomavirus (HPV) co-testing performed every five years.

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

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

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

Click the icon below for allowable exclusion codes:

Supplemental Data Option Documentation Requirements
To attest that a cervical cancer screening was performed, medical record evidence of one of the following is required.
- Cervical cytology:
  - A note indicating the date when the cervical cytology was performed.
  - The result or finding.
- Cervical cytology and HPV screening:
  - A note indicating the date when the cervical cytology and the HPV test were performed.
  - The result or finding.

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

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

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

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

Adolescent Well-care Visits

COMMERCIAL • QUEST INTEGRATION

Description
The percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an ob/gyn practitioner during the measurement year.

Numerator
At least one comprehensive well-care visit with a PCP or an ob/gyn practitioner during the measurement year as documented through either administrative data or medical record review. The PCP doesn’t have to be assigned to the member.

Click the icon below for allowable numerator codes:

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

Supplemental Data Option Documentation Requirements

To attest that an Adolescent Well-care Visit was performed, medical record evidence of one of the following is required:

- A health history. Health history is an assessment of the member’s history of disease or illness. Health history can include past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization), and family health history.
- A physical developmental history. Physical developmental history includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult.
- A mental developmental history. Mental developmental history includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult.
- A physical exam.
- Health education/anticipatory guidance. Health education/anticipatory guidance is given by the health care provider to the member and/or parents or guardians in anticipation of emerging issues that a member and family may face.
Appendix B - Quality Measure Scoring Example

Given the following:
- Upper Target: 85.00%
- Lower Target: 80.00%
- Baseline rate: 65.00%
- Performance rate: 68.00%
- Attributed members: 3,000
- Measure weight ($/PMPM): $0.35 PMPM

### TABLE 1: SCORING CALCULATIONS

<table>
<thead>
<tr>
<th>Calculation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Difference between the improvement target and the baseline rate yields maximum improvement potential.</td>
<td>85.00% – 65.00% = 20.00%</td>
</tr>
<tr>
<td>b. The difference between the performance and baseline rates yields actual improvement.</td>
<td>68.00% – 65.00% = 3.00%</td>
</tr>
<tr>
<td>c. The quotient of the actual improvement to the maximum improvement potential is the proportion of the maximum potential dollar amount (Continuous Improvement) to be awarded for this measure.</td>
<td>3.00% = 15.00% 20.00%</td>
</tr>
<tr>
<td>d. The product of the maximum improvement potential and 10 percent, then added to the baseline rate yields the threshold for narrowing the gap between the baseline and Upper Target by 10 percent (10% Gap Bonus).</td>
<td>(20.00% x 10.00%) + 65.00% = 67.00%</td>
</tr>
<tr>
<td>e. The product of the maximum improvement potential and 25 percent, then added to the baseline rate yields the threshold for narrowing the gap between the baseline and Upper Target by 10 percent (25% Gap Bonus).</td>
<td>(20.00% x 25.00%) + 65.00% = 70.00%</td>
</tr>
</tbody>
</table>

### TABLE 2: ACHIEVED PERCENTAGE CALCULATIONS

<table>
<thead>
<tr>
<th>Achievement Available</th>
<th>Available %</th>
<th>Achieved %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous Improvement</td>
<td>75.00%</td>
<td>15.00% (d) x 75% = 11.25%</td>
</tr>
<tr>
<td>Lower Target Bonus</td>
<td>10.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>10% Gap Bonus</td>
<td>10.00%</td>
<td>10.00%</td>
</tr>
<tr>
<td>25% Gap Bonus</td>
<td>15.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>110.00%</strong></td>
<td><strong>21.25%</strong></td>
</tr>
</tbody>
</table>

### TABLE 3: ACHIEVED DOLLARS CALCULATIONS

- The product of the attributed members and the weight of the measure over 12 months yield the maximum potential dollars for this measure for this LOB. 3,000 x $0.35 x 12 = $12,600.00
- The product of the maximum potential dollars and the achieved percentage yields the actual dollars earned for this measure for this LOB. $12,600.00 x 21.25% = $2,677.50

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65.00%  67.00%  70.00%  80.00%  85.00%
Base  10% Gap (d) 25% Gap (e) (Lower Target) (Upper Target)

3.00% improvement potential (a)

20.00% actual improvement (a)