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In 2011, we introduced HMSA Akamai Advantage, our Medicare Advantage health plan, to better serve our senior members. This year, we are introducing the Akamai Advantage Primary Care Pay-for-Quality Program. The program is based on the Medicare Stars Rating System, a quality scoring system created by the Centers for Medicare & Medicaid Services (CMS).

CMS created the rating system in 2007 to help beneficiaries choose between Medicare Advantage medical and drug plans. Plans are rated on how well they perform on 53 measures related to preventive care, chronic disease management, and patient experience. In 2010, CMS linked bonus payments to Stars ratings to encourage quality during a time of constricted CMS payments.

The Stars ratings are:
- Five stars = Excellent
- Four stars = Above Average
- Three stars = Average
- Two stars = Below Average
- One star = Poor

The measures are organized by domains. For medical plans, they include: staying healthy, managing chronic conditions, plan responsiveness, and care. For drug plans, they include member experience, drug pricing, and patient safety. Measures are based on data from various sources, including the Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems, Health Outcomes Survey, and a variety of drug claims and administrative information.

HMSA has selected 12 of the 53 measures – you may recognize the measures with asterisks as the same measures in the commercial primary care pay-for-quality program – for additional payments based on performance:

- Breast cancer screening*
- Colorectal cancer screening*
- Cholesterol management for patients with cardiovascular conditions – LDL-C screening*
- Comprehensive diabetes care – eye exam*
- Comprehensive diabetes care – medical attention for nephropathy*
- Comprehensive diabetes care – blood sugar controlled
- Comprehensive diabetes care – cholesterol controlled
- Controlling blood pressure
- Comprehensive diabetes treatment
- Part D medication adherence for oral diabetes medications
- Part D medication adherence for hypertension (ACEI or ARB)
- Part D medication adherence for cholesterol (statins)

HMSA-recognized primary care providers (PCPs) are eligible to participate in this program.

Performance will be measured beginning Jan. 1, 2012. The annual pay-for-quality payment will be calculated based on the number of gaps, or relevant measures, attributable to each member in a provider's panel. Each gap will be worth $2 or $4 per member per month. Potential pay-for-quality payments will vary depending on the type and number of gaps attributed to each member.

In this first year of the program, there will be a patient management fee to recognize the effort made by practices to use Cozeva, a new web-based platform that supports HMSA's pay-for-quality programs. In addition, to encourage providers to use Cozeva and engage their patients, providers who meet certain requirements will be guaranteed, at a minimum, a portion of their yearly maximum payment potential.

Our pay-for-quality program seeks to reward you for the excellent care you provide to our members who are most vulnerable and have the most health complexities. This guide explains the rules of the road for the program and demonstrates how improved quality of care translates to increased revenue for individual providers.

Welcome to the 2012 Akamai Advantage Primary Care Pay-for-Quality Program. We look forward to reaching the stars with you!

Sincerely,

Rae Seitz, M.D.
Medical Director
Quality Management
Introduction to Cozeva

The launch of HMSA's Akamai Advantage Primary Care Pay-for-Quality Program will coincide with the statewide rollout of Cozeva, our new web-based platform for the presentation of quality information. Cozeva has the ability to tie all health care stakeholders and participants together into a more coordinated, efficient, and effective system.

Cozeva, developed by Applied Research Works (ARW), is more than just a web-based platform for data presentation. Its true strength lies in its ability to foster deeper provider-patient, provider-care extender, and even provider-health plan engagement.

HMSA tested Cozeva with ARW in the East Hawaii Independent Physicians Association Model Office Pilot, which launched in November 2011. The physicians and practice staff who participated have embraced it. The physicians were pleased that their staff adapted to Cozeva with ease. The practice managers continue to report that learning to use Cozeva has been much simpler than other platforms and appreciate how easily they can act on the quality data displayed. Practices welcome the immediate feedback loop and real-time recalculation of their performance.

As practices begin to understand the value and ease of using Cozeva, they are asking about the patient engagement features, working to register their patients more quickly, and involving them more actively in the system. The pendulum is swinging toward true engagement with patients, promising immense benefits especially as engagement moves beyond the walls of the practice.

We hope that you find Cozeva to be an indispensable tool and asset in your continuous journey to increasing the quality of health care delivery in Hawaii.

Sincerely,

Michael B. Stollar
Vice President
Health Systems Development

Paul K. Schnur
Vice President
Provider Services
Program Eligibility and Enrollment

Eligibility Criteria

Providers who meet the following eligibility criteria are automatically enrolled in the Akamai Advantage Primary Care Pay-for-Quality Program:


2. As reflected by the provider's designation in HMSA Akamai Advantage, practice as one of the following:
   - A family practitioner.
   - A general practitioner.
   - An internal medicine provider.
   - An advanced practice registered nurse.
   - A physician assistant under the supervision of an Akamai Advantage Primary Care Pay-for-Quality Program-eligible PCP.

Exclusions

Providers with the aforementioned specialties who are practicing as hospitalists or emergency care providers are excluded from the program. In addition, 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 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 Inquiry and Request for Reconsideration section, page 8).
As a pay-for-quality initiative, this program uses CMS-determined measures that will be assessed through analyses of claims and other verifiable data. Establishing measurable quality standards is a constantly evolving process as new clinical evidence is discovered and new treatments are developed. The care standards adopted for the program are reviewed and updated regularly to reflect new advances.

**Measurement Responsibility**

You will be responsible for all adult Akamai Advantage primary care pay-for-quality clinical measures. Please see Appendix A on page 18 for a detailed description of measures.

**Target Dates & Deliverables**

<table>
<thead>
<tr>
<th>DATE</th>
<th>MILESTONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2012</td>
<td>2012 Akamai Advantage Primary Care Pay-for-Quality Program is launched on Cozeva.</td>
</tr>
<tr>
<td>May 2012</td>
<td>Baseline quality report.</td>
</tr>
<tr>
<td>February-March 2013</td>
<td>Processing and scoring for annual pay-for-quality payment.</td>
</tr>
<tr>
<td>April 2013</td>
<td>Annual performance quality report. Annual pay-for-quality payment or alternative payment.</td>
</tr>
<tr>
<td></td>
<td>A patient management fee will be paid to a provider the month after they sign up for Cozeva.</td>
</tr>
</tbody>
</table>

**2012 Scoring Periods**

<table>
<thead>
<tr>
<th>SCORING PERIOD</th>
<th>MEASUREMENT PERIOD</th>
<th>BASELINE PERIOD</th>
</tr>
</thead>
</table>

**Payment Philosophy**

Under the program, payment varies predictably with your performance and improvement within the measures based on a predetermined formula. You are paid for performance as well as improvement in a given measure. Points scored for performance and points scored for improvement determine total points, which translate into monetary awards.

The variable payment formula calculation will be based on:

- Patient panel count per measure.
- The amount budgeted per member per measure for pay-for-quality – $2 or $4 per member per month (PMPM) depending on the measure.
- Current-period performance compared to prior-period performance and national performance percentile levels. This determines the points earned per measure.
- Points earned, which determine the actual portion of the maximum payment potential earned.

For a more detailed explanation, see Pay-for-Quality Scoring Calculations section on page 13.
The Cozeva platform is a dynamic population health management tool that allows providers to access their data in a meaningful, actionable, and supportive manner. HMSA strongly encourages use of Cozeva to help you maximize the quality of your care and your pay-for-quality awards.

The use of Cozeva over time gives you an integrated approach to managing each of your patient’s chronic conditions and co-morbidities. Cozeva allows standards of care delivered by any and all providers caring for your patient to be reported and monitored accurately. It provides a care planning registry that identifies gaps in care in accordance with the best standards of care. You can track medication adherence by identifying prescriptions filled, display lab results when available, and add data from the medical record to demonstrate care in accordance with standards. Your ability to identify gaps in care and manage visits allows better engagement with your patients.

These and other tools and reports are described below:

- Patient Panel: A monthly list of patients attributed to you by HMSA from all lines of business.

- Care Planning Registry: A platform that you and your care teams can use to identify patients who may benefit from additional care as related to pay-for-quality program metrics. The Care Planning Registry is refreshed every week.

- Supplemental Data: Allows you to supplement claims-based data with information from your clinical records and immediately updates your Care Planning Registry.

- Member Engagement: Helps you deliver appointment reminders, alerts, and secure messages to your patients. You can also collaborate with your patients’ designated family members and friends to encourage better health care.

- Baseline Quality Report: A report of performance measured during the baseline period. The report shows you where you currently rank in comparison to national standards and presents the basis of comparison to determine improvement.

- Performance Quality Report: A report to measure your performance for each quarter and for the year as a whole. Provides access to a detailed view of each measure, including National Percentile Target Rate and Estimated Quality Pay by percentile ranking.
The program will use claims data as the primary source to identify patients who meet the criteria to be in the denominator for a given measure. The program will also use claims data and clinical data as the primary sources to identify patients who meet the numerator criteria or satisfy the underlying care opportunity.

Claims data, on occasion, may not be adequate to exclude a patient from the denominator. Claims data may identify patients as needing a service when they do not. For example, claims data may indicate that a woman needs a breast cancer screening when the medical record indicates that she had a bilateral mastectomy.

The program will allow you to submit supplemental data and attest to the validity of the data to exclude a patient from your measure patient panel or satisfy the criteria for a favorable numerator score.

The program will include a supplemental data audit plan. The audit plan will select supplemental data submissions using various methods and request medical records to support supplemental data submissions. Failure to comply with audit requests will mean that the data will not be used toward your pay-for-quality results. You must submit the requested medical records by mail or fax by the date indicated on the request. HMSA will not pick up records or perform onsite chart reviews. Appendix A identifies the supplemental data submission opportunities and requirements for each measure.

All self-reported information must be consistent with that recorded in the patient's medical record and must include the exact service and the date performed. The date is important as different care standards have different frequency and time period requirements. The medical record should meet all standards for acceptable documentation. (For more information, visit HMSA's Provider E-Library at hmsa.com/portal/provider/zav_pel.aa.med.500.htm or the American Medical Association's website at www.ama-assn.org/ama/pub/physician-resources/practice-management-center/claims-revenue-cycle/clinical-documentation.page.) The patient's medical record is subject to audit.

For example, a patient's medical record may show that a flexible sigmoidoscopy has been performed. To satisfy the colorectal cancer screening measure, the flexible sigmoidoscopy procedure must have occurred during the measurement period or the four prior measurement periods. If the procedure occurred before that time, the measure will not be satisfied. Additionally, the medical record must include a result to show that a test has been ordered and performed.

Some measures, such as cholesterol management for patients with cardiovascular conditions – LDL-C screening, do not require an actual lab value result to be reported. Other measures, such as comprehensive diabetes care – blood sugar controlled, do require an actual lab value result. The documentation for the supplemental submission process will make the submission requirements clear.

You can submit requests for updates to information in the Care Planning Registry to allow for:

- Evidence of services that were rendered in the PCP’s medical record.
- Evidence that a patient is not eligible for a given measure.

As provided for in your participating provider agreements with HMSA, you or your medical group can submit an inquiry or official request for reconsideration of your pay-for-quality score and/or payment by HMSA.
Inquiry and Request for Reconsideration of Pay-for-Quality Payment and Methodology

Inquiries
An inquiry is defined as a request for additional information about HMSA’s Akamai Advantage Primary Care Pay-for-Quality Program.

General inquiries about the program (not specific to pay-for-quality scores or results) will be answered at any time throughout the year. HMSA also welcomes any suggestions for program changes throughout the year with the understanding that there is no guarantee the proposed change will be implemented.

Inquiries will be initiated by:

- **Letter.** Mail to HMSA Provider Services, Room 511, P.O. Box 860, Honolulu, HI 96808-0860.
- **Email** to PSInquiries@hmsa.com.
- **Phone.** Please call HMSA Provider Services. For assistance 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 your reported pay-for-quality scores and/or payment.

**Note:** When a particular service is shown as incomplete in your Care Planning Registry, Cozeva enables you to submit supplemental data to show that the service was performed. When a situation does not match one of the supplemental data options listed on Cozeva, you may submit a Supplemental Data Request for Reconsideration. Please submit the request within 30 days following the posting of performance quality reports.

A request for reconsideration submitted within the criteria explained below should include supporting data, if available. (A request for reconsideration will not be accepted verbally.) Requests for reconsideration must communicate:

- Why the online supplemental data process did not enable you to record supplemental data that satisfies denominator exclusion criteria or numerator inclusion criteria.
- Clinical rationale and supporting citations for denominator exclusion or numerator inclusion.
- Measure.
- Patient.
- Medical record information to support denominator exclusion or numerator inclusion such as:
  - Service/procedure.
  - Date of service.
  - Diagnosis.
  - Lab result.

**Request for Reconsideration Process**
The following describes the process for Supplemental Data Requests for Reconsideration:

1. Please submit one Supplemental Request for Reconsideration form per patient. The form is located on Cozeva.
2. HMSA will review and respond to your request no later than 30 days after receipt of your request. An HMSA medical director will always be included in the review of your requests.
3. If you are dissatisfied with HMSA’s response to your request for reconsideration, additional dispute resolution remedies are available to you under your HMSA participating provider agreement.

Submit the form to Provider Services by:

- **Fax:** (808) 948-6887
- **Email:** PSInquiries@hmsa.com
- **Mail:**
  Provider Services Operations and Administration, Rm. 503
  HMSA
  P.O. Box 860
  Honolulu, HI 96808-0860

**Questions**
If you have questions, please contact HMSA Provider Services. For assistance identifying your contact, please call 948-6820 on Oahu or 1 (877) 304-4672 toll-free on the Neighbor Islands.
## Staying Healthy

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>HIGH-LEVEL DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>The percentage of women 40-69 years of age who had one or more mammograms during the current measurement period or the prior measurement period. (U.S. Preventive Services Task Force (USPSTF) 2002 Guideline)</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>The percentage of patients 50-75 years of age who had one or more appropriate screenings for colorectal cancer through one of these measures: fecal occult blood test (FOBT) during the current measurement period, flexible sigmoidoscopy during the measurement period or the four prior measurement periods, or colonoscopy during the current measurement period or the nine prior measurement periods. (USPSTF Guideline)</td>
</tr>
</tbody>
</table>

## Managing Chronic Conditions

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>HIGH-LEVEL DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol management for patients with cardiovascular conditions – LDL-C screening</td>
<td>The percentage of patients 18-75 years of age who were discharged alive for acute myocardial infarction, coronary artery bypass graft, or percutaneous coronary interventions between the 1st and 305th days of the prior measurement period, or who had a diagnosis of ischemic vascular disease during the current measurement period and the prior measurement period, and who also had an LDL-C screening during the measurement period.</td>
</tr>
<tr>
<td>Comprehensive diabetes care - eye exam</td>
<td>The percentage of patients with diabetes 18-75 years of age who received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the current measurement period, or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the prior measurement period. (American Diabetes Association (ADA) Guideline)</td>
</tr>
<tr>
<td>Comprehensive diabetes care – medical attention for nephropathy</td>
<td>The percentage of patients with diabetes 18-75 years of age who had at least one test for microalbumin during the current measurement period or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria; angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) therapy during the measurement period is also acceptable evidence). (ADA Guideline)</td>
</tr>
<tr>
<td>Comprehensive diabetes care – blood sugar controlled</td>
<td>The percentage of patients with diabetes 18-75 years of age whose most recent HbA1c level during the measurement period was &lt;9.0 percent.</td>
</tr>
<tr>
<td>Comprehensive diabetes care – cholesterol controlled</td>
<td>The percentage of patients with diabetes 18-75 years of age whose most recent LDL-C level during the measurement period was &lt;100 mg/dL.</td>
</tr>
<tr>
<td>Controlling blood pressure</td>
<td>The percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90) during the measurement period.</td>
</tr>
</tbody>
</table>

## Pharmacy Plan Measures

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>HIGH-LEVEL DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive diabetes treatment</td>
<td>The percentage of Medicare Part D beneficiaries 18 years of age or older who were dispensed appropriate medication for diabetes, medication for hypertension (other than ACEI or ARB), and ACEI or ARB medication.</td>
</tr>
<tr>
<td>Part D medication adherence for oral diabetes medications</td>
<td>The percentage of Medicare Part D beneficiaries 18 years of age or older who adhered to their prescribed drug therapy across four classes of oral diabetes medications – biguanides, sulfonylureas, thiazolidinediones, and dipeptidyl peptidase-IV (DPP-IV) inhibitors – by meeting the proportion of days covered (PDC) threshold of 80 percent during the measurement period.</td>
</tr>
<tr>
<td>Part D medication adherence for hypertension (ACEI or ARB)</td>
<td>The percentage of Medicare Part D beneficiaries 18 years of age or older who adhered to their prescribed drug therapy for ACEI or ARB medication by meeting the PDC threshold of 80 percent during the measurement period.</td>
</tr>
<tr>
<td>Part D medication adherence for cholesterol (statins)</td>
<td>The percentage of Medicare Part D beneficiaries 18 years of age or older who adhered to their prescribed drug therapy for statin cholesterol medications by meeting the PDC threshold of 80 percent during the measurement period.</td>
</tr>
</tbody>
</table>
Maximum Payment Potential

The health status of individual HMSA Akamai Advantage members varies widely. You may have more patients with chronic diseases or co-morbidities and therefore have more challenges in keeping your patients healthy. To align pay-for-quality payments with the unique number of care opportunities for your practice, the program counts the number of members in your primary care panel (the patient panel count) who meet the criteria for each measure at the end of each month. This number is multiplied by a PMPM amount to calculate your monthly maximum payment potential for each measure. PMPM amounts are based on the approximate relative value of each measure for the current measurement period.

To take into account your most recent patient panel and your associated performance in 2011, your estimated yearly maximum payment potential for 2012 will be calculated by multiplying your actual monthly maximum payment potential for the month of March 2012 by 12. The figures will be reported on your baseline quality report posted on Cozeva in May 2012.

Your actual monthly maximum payment potential for a measure may vary each month as the number of members eligible for it vary based on several factors, including enrollment, PCP selection, chronic conditions, and treatments. The calculation process will be repeated every month to determine your actual yearly maximum payment potential.

Below is an example of the estimated yearly maximum payment potential for one PCP based on one month.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>PATIENT PANEL COUNT</th>
<th>PMPM AMOUNT</th>
<th>MONTHLY MAXIMUM PAYMENT POTENTIAL</th>
<th>EST. YEARLY MAXIMUM PAYMENT POTENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>6</td>
<td>$2</td>
<td>$12</td>
<td>$144</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>17</td>
<td>$2</td>
<td>$34</td>
<td>$408</td>
</tr>
<tr>
<td>Cholesterol management for patients with cardiovascular conditions – LDL-C screening</td>
<td>4</td>
<td>$2</td>
<td>$8</td>
<td>$96</td>
</tr>
<tr>
<td>Comprehensive diabetes care – eye exam</td>
<td>10</td>
<td>$2</td>
<td>$20</td>
<td>$240</td>
</tr>
<tr>
<td>Comprehensive diabetes care – medical attention for nephropathy</td>
<td>10</td>
<td>$2</td>
<td>$20</td>
<td>$240</td>
</tr>
<tr>
<td>Comprehensive diabetes care – blood sugar controlled</td>
<td>10</td>
<td>$4</td>
<td>$40</td>
<td>$480</td>
</tr>
<tr>
<td>Comprehensive diabetes care – cholesterol controlled</td>
<td>10</td>
<td>$4</td>
<td>$40</td>
<td>$480</td>
</tr>
<tr>
<td>Controlling blood pressure</td>
<td>18</td>
<td>$4</td>
<td>$72</td>
<td>$864</td>
</tr>
<tr>
<td>Comprehensive diabetes treatment</td>
<td>10</td>
<td>$2</td>
<td>$20</td>
<td>$240</td>
</tr>
<tr>
<td>Part D medication adherence for oral diabetes medications</td>
<td>10</td>
<td>$4</td>
<td>$40</td>
<td>$480</td>
</tr>
<tr>
<td>Part D medication adherence for hypertension (ACEI or ARB)</td>
<td>17</td>
<td>$4</td>
<td>$68</td>
<td>$816</td>
</tr>
<tr>
<td>Part D medication adherence for cholesterol (statins)</td>
<td>18</td>
<td>$4</td>
<td>$72</td>
<td>$864</td>
</tr>
<tr>
<td>TOTAL</td>
<td>140</td>
<td>$446</td>
<td></td>
<td>$5352</td>
</tr>
</tbody>
</table>
Patient Management Fee

To encourage improved patient health outcomes and patient safety through use of our new provider and patient engagement tool, we are offering a one-time patient management fee of $1,000. This is an award you can earn in addition to your annual pay-for-quality payment. You will receive payment after you sign up to use Cozeva and discontinue access to and use of HBIOnline™.

**Requirements**

<table>
<thead>
<tr>
<th>REQUIREMENTS</th>
<th>DEADLINE TO MEET REQUIREMENTS</th>
<th>PAYMENT AMOUNT</th>
<th>PAYMENT DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient management fee</td>
<td>Sign up to use Cozeva and agree to discontinue access to and use of HBIOnline.</td>
<td>15th of the month for payment at the end of the following month. Final deadline: Dec. 31, 2012.</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**Pay-for-Quality Payments**

Pay-for-quality payments are based on your cumulative performance during the measurement period compared to your performance during a baseline period. This year, your pay-for-quality payment will be based on your performance during calendar year 2012 compared to your performance in calendar year 2011 (the baseline period for 2012).

Your performance is calculated at the end of each quarter and scored at the end of the year. For details, see the Target Dates & Deliverables table and Scoring Periods table on page 5.

The program establishes a maximum payment potential (see Maximum Payment Potential section, page 10). The portion you earn — your annual pay-for-quality payment — is determined by a threshold scoring model. This program allocates points based on your performance compared to national percentile levels (see National Percentile Threshold Rates, page 14) and improvement over the percentile level achieved during the baseline period.

To encourage member engagement and the use of Cozeva, if you meet the following requirements, you will receive the greater of your actual pay-for-quality payment or 35 percent of your yearly maximum payment potential. If these requirements are not met, your pay-for-quality payment will be based solely on your performance and improvement points. The requirements are as follows:

- Ensure Cozeva contains the last value of the year for HbA1c, LDL-C, and blood pressure levels for 75 percent of your total patient gaps.
- Achieve three star level on three of the 10 chronic disease measures. (Chronic disease measures include all of the measures listed on page 9, except for breast cancer screening and colorectal cancer screening.)

Performance quality reports are delivered three months after the end of each quarter. The patient management fee will be paid after you sign up for Cozeva. The annual pay-for-quality payment or alternative payment, whichever is greater, will be sent four months after the close of the year to allow time for run out and processing. For a detailed program schedule, see the Target Dates & Deliverables table on page 5.

**Payment Conditions**

To be eligible, you must be participating in HMSA Akamai Advantage and practicing in the state of Hawaii by Dec. 31, 2012. For details, refer to the Program Eligibility and Enrollment section on page 4.

If you are eligible to receive a pay-for-quality payment, the payment check and remittance report will be sent to the payee(s) that you or your medical group designates for HMSA claims payments as of the end of the measurement period.
## Akamai Advantage Primary Care Pay-for-Quality – Baseline Quality Report

**Measurement Period:** 1/1/2012 to 12/31/2012  
**Baseline Period:** 1/1/2011 to 12/31/2011  
**Provider:** LEE, ALOHA  
**Specialty:** INTERNAL MEDICINE  
**Est. Yearly Maximum Payment Potential:** $5,352  
**Est. Eligible Members:** 140

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>YOUR ESTIMATED MEASURE PATIENT PANEL COUNT</th>
<th>YOUR BASELINE PERIOD’S NUMERATOR COUNT</th>
<th>YOUR BASELINE PERIOD’S PERFORMANCE RATE</th>
<th>YOUR BASELINE PERIOD’S STAR LEVEL</th>
<th>NUMBER OF ADDITIONAL PATIENTS TO ACHIEVE FIVE STAR LEVEL</th>
<th>EST. YEARLY MAXIMUM PAYMENT POTENTIAL</th>
<th>EST. SHARE OF MAXIMUM PAYMENT POTENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>6</td>
<td>5</td>
<td>83.33%</td>
<td>5</td>
<td>0</td>
<td>$144</td>
<td>2.69%</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>17</td>
<td>15</td>
<td>88.24%</td>
<td>5</td>
<td>0</td>
<td>$408</td>
<td>7.62%</td>
</tr>
<tr>
<td>Cholesterol management for patients with cardiovascular conditions - LDL-C screening</td>
<td>4</td>
<td>2</td>
<td>50.00%</td>
<td>&lt;1</td>
<td>2</td>
<td>$96</td>
<td>1.79%</td>
</tr>
<tr>
<td>Comprehensive diabetes care - eye exam</td>
<td>10</td>
<td>6</td>
<td>60.00%</td>
<td>2</td>
<td>3</td>
<td>$240</td>
<td>4.48%</td>
</tr>
<tr>
<td>Comprehensive diabetes care - medical attention for nephropathy</td>
<td>10</td>
<td>6</td>
<td>60.00%</td>
<td>&lt;1</td>
<td>4</td>
<td>$240</td>
<td>4.48%</td>
</tr>
<tr>
<td>Comprehensive diabetes care - blood sugar controlled</td>
<td>10</td>
<td>-</td>
<td>65.63%</td>
<td>2*</td>
<td>-</td>
<td>$480</td>
<td>8.97%</td>
</tr>
<tr>
<td>Comprehensive diabetes care - cholesterol controlled</td>
<td>10</td>
<td>-</td>
<td>43.98%</td>
<td>2*</td>
<td>-</td>
<td>$480</td>
<td>8.97%</td>
</tr>
<tr>
<td>Controlling blood pressure</td>
<td>18</td>
<td>-</td>
<td>54.99%</td>
<td>2*</td>
<td>-</td>
<td>$864</td>
<td>16.14%</td>
</tr>
<tr>
<td>Comprehensive diabetes treatment</td>
<td>10</td>
<td>6</td>
<td>60.00%</td>
<td>&lt;1</td>
<td>3</td>
<td>$240</td>
<td>4.48%</td>
</tr>
<tr>
<td>Part D medication adherence for oral diabetes medications</td>
<td>10</td>
<td>6</td>
<td>60.00%</td>
<td>1</td>
<td>3</td>
<td>$480</td>
<td>8.97%</td>
</tr>
<tr>
<td>Part D medication adherence for hypertension (ACEI or ARB)</td>
<td>17</td>
<td>2</td>
<td>11.76%</td>
<td>&lt;1</td>
<td>12</td>
<td>$816</td>
<td>15.25%</td>
</tr>
<tr>
<td>Part D medication adherence for cholesterol (statins)</td>
<td>18</td>
<td>5</td>
<td>27.78%</td>
<td>&lt;1</td>
<td>9</td>
<td>$864</td>
<td>16.14%</td>
</tr>
</tbody>
</table>

**Total Care Opportunities:** 140  
**Cumulative Yearly Maximum Payment Potential:** $5,352  
**Total:** 100.0%

* In 2012, the baseline period’s star level for the three in-control measures will be set at the two star level for all providers to account for incomplete data. For details, see the second note on page 13.
Step 1: Calculation of Maximum Payment Potential for Each Measure

To calculate your monthly maximum payment potential for each measure, multiply the number of patients eligible for each measure at the end of each month by the designated PMPM amount listed in the table below. Repeat this calculation every month to determine your yearly maximum payment potential for each measure. For details, see the Maximum Payment Potential section on page 10.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>PMPM AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>$2</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>$2</td>
</tr>
<tr>
<td>Cholesterol management for patients with cardiovascular conditions – LDL-C screening</td>
<td>$2</td>
</tr>
<tr>
<td>Comprehensive diabetes care – eye exam</td>
<td>$2</td>
</tr>
<tr>
<td>Comprehensive diabetes care – medical attention for nephropathy</td>
<td>$2</td>
</tr>
<tr>
<td>Comprehensive diabetes care – blood sugar controlled</td>
<td>$4</td>
</tr>
<tr>
<td>Comprehensive diabetes care – cholesterol controlled</td>
<td>$4</td>
</tr>
<tr>
<td>Controlling blood pressure</td>
<td>$4</td>
</tr>
<tr>
<td>Comprehensive diabetes treatment</td>
<td>$2</td>
</tr>
<tr>
<td>Part D medication adherence for oral diabetes medications</td>
<td>$4</td>
</tr>
<tr>
<td>Part D medication adherence for hypertension (ACEI or ARB)</td>
<td>$4</td>
</tr>
<tr>
<td>Part D medication adherence for cholesterol (statins)</td>
<td>$4</td>
</tr>
</tbody>
</table>

Step 2: Performance and Improvement Points Earned

To calculate performance and improvement points and the portion of the yearly maximum payment potential you earn for each measure, follow these steps. The figures below will use numbers from three measures in Dr. Lee’s sample baseline quality report on page 12.

Note: New PCPs without a pre-existing patient panel will be eligible for performance points only, because there is no baseline to compare against for improvement points.

a. Look up your baseline period’s performance rate on your baseline quality report.

b. Consult the following table of national percentile threshold rates, which are also the star level thresholds for adult Akamai Advantage primary care pay-for-quality clinical measures. Where you fall, based on your baseline period’s performance rate, determines your baseline period’s star level: below one star, one star, two stars, three stars, four stars, or five stars.

c. Your baseline period’s star level indicates which of the six tables on the following pages you should use to determine your performance and improvement points.

Note: This year, the baseline period’s star level for the three control measures (i.e., comprehensive diabetes care – blood sugar controlled, comprehensive diabetes care – cholesterol-controlled, controlling blood pressure) will be set at the two star level for all providers to account for a lack of data to accurately determine actual baseline period performance. The premise is that to earn improvement points, you must perform at the three star level at a minimum.
National Percentile Threshold Rates –
Adult Akamai Advantage Primary Care Pay-for-Quality Clinical Measures

National percentile threshold rates are based on National Committee for Quality Assurance (NCQA) HEDIS 2011 and CMS Medicare Advantage Stars program performance levels.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BELOW ONE STAR</th>
<th>ONE STAR</th>
<th>TWO STARS</th>
<th>THREE STARS</th>
<th>FOUR STARS</th>
<th>FIVE STARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>&lt;55.47%</td>
<td>55.47%</td>
<td>61.76%</td>
<td>68.56%</td>
<td>77.13%</td>
<td>82.92%</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>&lt;40.05%</td>
<td>40.05%</td>
<td>48.66%</td>
<td>56.94%</td>
<td>70.71%</td>
<td>77.57%</td>
</tr>
<tr>
<td>Cholesterol management for patients with cardiovascular conditions – LDL-C screening</td>
<td>&lt;81.21%</td>
<td>81.21%</td>
<td>85.42%</td>
<td>89.27%</td>
<td>93.22%</td>
<td>95.40%</td>
</tr>
<tr>
<td>Comprehensive diabetes care – eye exam</td>
<td>&lt;49.67%</td>
<td>49.67%</td>
<td>56.19%</td>
<td>64.72%</td>
<td>74.66%</td>
<td>80.28%</td>
</tr>
<tr>
<td>Comprehensive diabetes care – medical attention for nephropathy</td>
<td>&lt;84.67%</td>
<td>84.67%</td>
<td>86.81%</td>
<td>89.09%</td>
<td>92.56%</td>
<td>94.92%</td>
</tr>
<tr>
<td>Comprehensive diabetes care – blood sugar controlled</td>
<td>&lt;54.97%</td>
<td>54.97%</td>
<td>65.63%</td>
<td>76.74%</td>
<td>84.89%</td>
<td>89.69%</td>
</tr>
<tr>
<td>Comprehensive diabetes care – cholesterol controlled</td>
<td>&lt;36.98%</td>
<td>36.98%</td>
<td>43.98%</td>
<td>53.05%</td>
<td>62.10%</td>
<td>68.00%</td>
</tr>
<tr>
<td>Controlling blood pressure</td>
<td>&lt;47.69%</td>
<td>47.69%</td>
<td>54.99%</td>
<td>63.37%</td>
<td>69.86%</td>
<td>75.42%</td>
</tr>
<tr>
<td>Comprehensive diabetes treatment</td>
<td>&lt;61.88%</td>
<td>61.88%</td>
<td>82.50%</td>
<td>84.20%</td>
<td>87.00%</td>
<td>88.30%</td>
</tr>
<tr>
<td>Part D medication adherence for oral diabetes medications</td>
<td>&lt;51.30%</td>
<td>51.30%</td>
<td>68.40%</td>
<td>71.70%</td>
<td>76.90%</td>
<td>80.80%</td>
</tr>
<tr>
<td>Part D medication adherence for hypertension (ACEI or ARB)</td>
<td>&lt;50.48%</td>
<td>50.48%</td>
<td>67.30%</td>
<td>71.10%</td>
<td>76.80%</td>
<td>79.90%</td>
</tr>
<tr>
<td>Part D medication adherence for cholesterol (statins)</td>
<td>&lt;46.95%</td>
<td>46.95%</td>
<td>62.60%</td>
<td>68.40%</td>
<td>72.80%</td>
<td>77.20%</td>
</tr>
</tbody>
</table>

Examples:

- Dr. Lee’s baseline period’s performance rate for comprehensive diabetes treatment was 60.00 percent, which is at the below one star level. Use Table 1.

- Dr. Lee’s baseline period’s performance rate for comprehensive diabetes care - eye exam was 60.00 percent, which is at the two star level. Use Table 3.

- Dr. Lee’s baseline period’s performance rate for colorectal cancer screening was 88.24 percent, which is at the five star level. Use Table 6.
**Performance and Improvement Points by Performance Level Tables**

The following tables correspond to the six levels of prior-period performance and detail the performance and improvement points earned based on current-period performance. Select the table that corresponds to your prior-period performance level for each measure. Locate the row that describes your current-period star level and note the total points earned for each measure.

**Table 1: Prior-Period Performance: Below One Star Level**

<table>
<thead>
<tr>
<th>CURRENT-PERIOD PERFORMANCE</th>
<th>PERFORMANCE POINTS</th>
<th>IMPROVEMENT POINTS</th>
<th>TOTAL POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below one star level</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>One star level</td>
<td>1.5</td>
<td>1.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Two star level</td>
<td>2.5</td>
<td>2.0</td>
<td>4.5</td>
</tr>
<tr>
<td>Three star level</td>
<td>5.0</td>
<td>3.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Four star level</td>
<td>7.5</td>
<td>3.5</td>
<td>11.0</td>
</tr>
<tr>
<td>Five star level</td>
<td>10.0</td>
<td>2.5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

**Table 2: Prior-Period Performance: One Star Level**

<table>
<thead>
<tr>
<th>CURRENT-PERIOD PERFORMANCE</th>
<th>PERFORMANCE POINTS</th>
<th>IMPROVEMENT POINTS</th>
<th>TOTAL POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below one star level</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>One star level</td>
<td>1.5</td>
<td>0</td>
<td>1.5</td>
</tr>
<tr>
<td>Two star level</td>
<td>2.5</td>
<td>1</td>
<td>3.5</td>
</tr>
<tr>
<td>Three star level</td>
<td>5.0</td>
<td>3.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Four star level</td>
<td>7.5</td>
<td>3.5</td>
<td>11.0</td>
</tr>
<tr>
<td>Five star level</td>
<td>10.0</td>
<td>2.5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

**Table 3: Prior-Period Performance: Two Star Level**

<table>
<thead>
<tr>
<th>CURRENT-PERIOD PERFORMANCE</th>
<th>PERFORMANCE POINTS</th>
<th>IMPROVEMENT POINTS</th>
<th>TOTAL POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below one star level</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>One star level</td>
<td>1.5</td>
<td>0</td>
<td>1.5</td>
</tr>
<tr>
<td>Two star level</td>
<td>2.5</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>Three star level</td>
<td>5.0</td>
<td>3.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Four star level</td>
<td>7.5</td>
<td>2.5</td>
<td>10.0</td>
</tr>
<tr>
<td>Five star level</td>
<td>10.0</td>
<td>2.5</td>
<td>12.5</td>
</tr>
</tbody>
</table>
Table 4: Prior-Period Performance: Three Star Level

<table>
<thead>
<tr>
<th>CURRENT-PERIOD PERFORMANCE</th>
<th>PERFORMANCE POINTS</th>
<th>IMPROVEMENT POINTS</th>
<th>TOTAL POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below one star level</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>One star level</td>
<td>1.5</td>
<td>0</td>
<td>1.5</td>
</tr>
<tr>
<td>Two star level</td>
<td>2.5</td>
<td>0</td>
<td>2.5</td>
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<tr>
<td>Three star level</td>
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<td>0</td>
<td>5.0</td>
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<tr>
<td>Four star level</td>
<td>7.5</td>
<td>2.5</td>
<td>10.0</td>
</tr>
<tr>
<td>Five star level</td>
<td>10.0</td>
<td>2.5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Table 5: Prior-Period Performance: Four Star Level

<table>
<thead>
<tr>
<th>CURRENT-PERIOD PERFORMANCE</th>
<th>PERFORMANCE POINTS</th>
<th>IMPROVEMENT POINTS</th>
<th>TOTAL POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below one star level</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>One star level</td>
<td>1.5</td>
<td>0</td>
<td>1.5</td>
</tr>
<tr>
<td>Two star level</td>
<td>2.5</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>Three star level</td>
<td>5.0</td>
<td>0</td>
<td>5.0</td>
</tr>
<tr>
<td>Four star level</td>
<td>7.5</td>
<td>0</td>
<td>7.5</td>
</tr>
<tr>
<td>Five star level</td>
<td>10.0</td>
<td>2.5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Table 6: Prior-Period Performance: Five Star Level

<table>
<thead>
<tr>
<th>CURRENT-PERIOD PERFORMANCE</th>
<th>PERFORMANCE POINTS</th>
<th>SUSTAINED EXCELLENCE</th>
<th>TOTAL POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below one star level</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>One star level</td>
<td>1.5</td>
<td>0</td>
<td>1.5</td>
</tr>
<tr>
<td>Two star level</td>
<td>2.5</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>Three star level</td>
<td>5.0</td>
<td>0</td>
<td>5.0</td>
</tr>
<tr>
<td>Four star level</td>
<td>7.5</td>
<td>0</td>
<td>7.5</td>
</tr>
<tr>
<td>Five star level</td>
<td>10.0</td>
<td>2.5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Examples:
- Assume Dr. Lee’s measurement period performance for comprehensive diabetes treatment is at the two star level. On Table 1, this earns 2.5 performance points, 2.0 improvement points, and 4.5 total points.
- Assume Dr. Lee’s measurement period performance for comprehensive diabetes care - eye exam was at the four star level. On Table 3, this earns 7.5 performance points, 2.5 improvement points, and 10.0 total points.
- Assume Dr. Lee’s measurement period performance for colorectal cancer screening was at the five star level. On Table 6, this earns 10.0 performance points, 2.5 sustained excellence points, and 12.5 total points.
Step 3: Calculation of Payment for Each Measure

To calculate the actual payment you earn for each measure, note the points earned for your current-period performance (Step 2, page 13) and follow the steps below.

**Note:** Each measure has a budget of 10 points. You may exceed your budgeted points and, thus, your yearly maximum payment potential for an individual measure. However, you may not exceed your cumulative yearly maximum payment potential (across all measures).

Multiply the total points earned for each measure by the yearly maximum payment potential for each measure and divide by 10 to determine the payment for each measure.

**Examples:**

- Dr. Lee earned 4.5 total points for comprehensive diabetes treatment, with a yearly maximum payment potential of $240. For this measure, the payment earned would be $240 \times \frac{4.5}{10} = $108.

- Dr. Lee earned 10.0 total points for comprehensive diabetes care - eye exam, with a yearly maximum payment potential of $240. For this measure, the payment earned be $240 \times \frac{10.0}{10} = $240.

- Dr. Lee earned 12.5 total points for colorectal cancer screening, with a yearly maximum payment potential of $408. For this measure, the payment earned would be $408 \times \frac{12.5}{10} = $510. Note that Dr. Lee can earn more than the yearly maximum payment potential for a single measure, but cannot earn more than the cumulative yearly maximum payment potential.

Member Eligibility for Specific Measures

Members who meet the following criteria will be eligible for all measures: members must be assigned to your patient panel and be eligible HMSA members for at least nine of the 12 months in the measurement period.

Patient Population Identification

Only HMSA Akamai Advantage regional and local medical plans are currently eligible for the program.

If a member participates in another plan in addition to HMSA Akamai Advantage, the member can only be counted under one of the pay-for-quality programs, as follows:

- If a member under HMSA Akamai Advantage also has coverage under HMSA’s commercial plan, the member will be counted under the commercial pay-for-quality program.

- If a member under HMSA Akamai Advantage also has coverage under The HMSA Plan for QUEST Members, the member will be counted under the Akamai Advantage Primary Care Pay-for-Quality Program.
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Breast Cancer Screening

Description
Percentage of women 40-69 years of age as of the end of the measurement period who had one or more mammograms to screen for breast cancer during the measurement period or the prior measurement period. The purpose of this measure is to evaluate primary screening; claims for biopsies, breast ultrasounds, or MRIs will not count toward this measure because they are not considered appropriate methods for primary breast cancer screening.


Numerator
Patients who had one or more mammograms during the measurement period or the prior measurement period. This measure will use the billing codes from submitted claims to identify breast cancer screening.

The following codes* identify services that satisfy the measure:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4</td>
<td>77055-77057</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0202, G0204, G0206</td>
</tr>
<tr>
<td>ICD-9-CM Procedure</td>
<td>87.36, 87.37</td>
</tr>
<tr>
<td>UB Revenue</td>
<td>0401, 0403</td>
</tr>
</tbody>
</table>

Denominator
Women 42-69 years of age as of the end of the measurement period.

Exclusion
Exclude women who had a bilateral mastectomy and for whom administrative data does not 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. (Exclusionary evidence in the medical record must include a note indicating a bilateral mastectomy.) If there is evidence of two unilateral mastectomies, a patient may be excluded from the measure. A woman must have had two separate occurrences on two different dates of service to be excluded. The bilateral mastectomy must have occurred by the end of the measurement period. This measure will use the billing codes from submitted claims to identify exclusions.

The following codes* identify bilateral mastectomy exclusions:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4</td>
<td>19180, 19200, 19220, 19240, 19303-19307 with modifier 50 or modifier code 09950</td>
</tr>
<tr>
<td>ICD-9-CM Procedure</td>
<td>85.42, 85.44, 85.46, 85.48</td>
</tr>
</tbody>
</table>

*  All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.

**Note:** Modifier codes 50 and 09950 indicate the procedure was bilateral and performed during the same operative session.

The following codes* identify two unilateral mastectomy exclusions:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4</td>
<td>19180, 19200, 19220, 19240, 19303-19307</td>
</tr>
<tr>
<td>ICD-9-CM Procedure</td>
<td>85.41, 85.43, 85.45, 85.47</td>
</tr>
</tbody>
</table>

Supplemental Data Option Documentation Requirements

Identify Breast Cancer Screening from Medical Records
A physician’s practice may attest that a breast cancer screening was performed by identifying the date, procedure, findings, and performing provider from the patient's medical record.

Patient Exclusion via Medical Records
Records indicate evidence that the patient had a bilateral mastectomy or two unilateral mastectomies.

Measure Status
National Quality Form (NQF) # 0031
Status: Endorsed
Original Endorsement Date: Aug. 10, 2009
Steward(s): NCQA
Colorectal Cancer Screening

**Description**
The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

The colorectal cancer screening measure follows USPSTF guidelines (www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm).

**Numerator**
Patients who had one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the three criteria below:

- Fecal occult blood test (FOBT) during the measurement period.
- Flexible sigmoidoscopy during the measurement period or the four prior measurement periods.
- Colonoscopy during the measurement period or the nine prior measurement periods.

This measure will use the billing codes from submitted claims to identify colorectal cancer screening. The following codes* identify services that satisfy the measure:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4</td>
<td>82270, 82274, 45330-45335, 45337-45342, 45345, 44388-44394, 44397, 45355, 45378-45387, 45391, 45392</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0328, G0104, G0105, G0121</td>
</tr>
<tr>
<td>ICD-9-CM Procedure</td>
<td>45.22, 45.23, 45.24, 45.25, 45.42, 45.43</td>
</tr>
</tbody>
</table>

**Denominator**
Patients 50-75 years of age during the measurement period.

**Exclusion**
Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient’s history through either administrative data or medical record review. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy, which must have occurred by the end of the measurement period.

Use the following codes* to identify allowable exclusions:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4</td>
<td>44150-44153, 44155-44158, 44210-44212</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0213-G0215, G0231</td>
</tr>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>153, 154.0, 154.1, 197.5, V10.05</td>
</tr>
<tr>
<td>ICD-9-CM Procedure</td>
<td>45.8</td>
</tr>
</tbody>
</table>

Cholesterol Management for Patients with Cardiovascular Conditions – LDL-C Screening

**Description**
Percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) between the 1st and 305th days of the prior measurement period, or who had a diagnosis of ischemic vascular disease during the measurement period and the prior measurement period, and who had an LDL-C screening during the measurement period.

**Numerator**
LDL-C screening: Patients who had an LDL-C test performed any time during the measurement period as identified by claims/encounter or automated laboratory data. This measure will use the billing codes from submitted claims to identify LDL-C screening.

The following codes* identify services that satisfy the measure:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4</td>
<td>80061, 83700, 83701, 83704, 83721</td>
</tr>
<tr>
<td>CPT Category II</td>
<td>3048F, 3049F, 3050F</td>
</tr>
</tbody>
</table>

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
Denominator

Patients are identified for the eligible population by event or diagnosis.

Both event and diagnosis are used to identify the eligible population, but a patient only needs to be identified by one to be included in the measure.

Event: Discharged alive for AMI, CABG, or PCI on or between the 1st and 305th days of the prior measurement period. All cases of PCI should be included, regardless of setting (e.g., inpatient, outpatient, emergency department).

Measure Status

NQF # 0075
Status: Endorsed (undergoing endorsement maintenance)
Original Endorsement Date: Aug. 10, 2009
Steward(s): NCQA

Comprehensive Diabetes Care – Eye Exam

Description

The percentage of diabetes patients 18-75 years of age who received a dilated eye exam, seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, or imaging validated to match diagnosis from these photos during the measurement period (or the prior measurement period if patient is at low-risk for retinopathy). Patient is considered low-risk if there is no evidence of retinopathy in the prior measurement period.

The comprehensive diabetes care – eye exam measure is approved by the NQF (www.qualityforum.org) and follows American Diabetes Association Guidelines (http://care.diabetesjournals.org/content/33/Supplement_1/S11.full.pdf).

Numerator

This measure will use the billing codes from submitted claims to identify eye exams. The following codes* identify services that satisfy the measure:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4</td>
<td>67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245, 2022F, 2024F, 2026F</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S0620, S0621, S0625**, S3000</td>
</tr>
<tr>
<td>ICD-9-CM Procedure</td>
<td>14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16</td>
</tr>
</tbody>
</table>

** Code is not limited to optometrist or ophthalmologist.

Eye exams provided by eye care professionals are a proxy for dilated eye exams because there is no administrative way to determine that a dilated exam was performed.

Denominator

Patients 18-75 years of age as of the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement period or the prior measurement period through:

- 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 is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.
- A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.

Exclusion

Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement period or prior measurement period. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement period.

The following codes* identify available exclusions:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>249, 251.8, 256.4, 648.8, 962.0</td>
</tr>
</tbody>
</table>

**Measure Status**

NQF # 0055  
Status: Endorsed  
Original Endorsement Date: Aug. 10, 2009  
Steward(s): NCQA

**Comprehensive Diabetes Care – Medical Attention for Nephropathy**

**Description**

The percentage of diabetes patients 18-75 years of age with at least one test for microalbumin during the measurement period or evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria).

The comprehensive diabetes care – medical attention for nephropathy measure is approved by NQF (www.qualityforum.org) and follows American Diabetes Association Guidelines (http://care.diabetesjournals.org/content/33/Supplement_1/S11.full.pdf).

**Numerator**

Patients who had any one of the following:

- Screening for nephropathy.
- Evidence of nephropathy.
- Evidence of ACE inhibitor/ARB therapy.

This measure will use pharmacy claims data to identify evidence of ACE inhibitor or ARB therapy. This measure will also use the billing codes from submitted claims to identify screening for nephropathy and evidence of nephropathy.

The following codes* identify services that satisfy the measure:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4</td>
<td>82042, 82043, 82044, 84156, 81000-81003, 81005, 36145, 36147, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512</td>
</tr>
<tr>
<td>CPT Cat II</td>
<td>3060F, 3061F, 3062F, 3066F, 4009F</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0257, G0392, G0393, S9339</td>
</tr>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1</td>
</tr>
<tr>
<td>ICD-9-CM Procedure</td>
<td>38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6</td>
</tr>
</tbody>
</table>

**Denominator**

Patients 18-75 years of age as of the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement period or the prior measurement period through:

- 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 is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

- A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>250, 357.2, 362.0, 366.41, 648.0</td>
</tr>
</tbody>
</table>

**Exclusion**

Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement period or the prior measurement period. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement period.

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
The following codes* identify allowable exclusions:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>249, 251.8, 256.4, 648.8, 962.0</td>
</tr>
</tbody>
</table>

**Measure Status**

NQF # 0062  
Status: Endorsed  
Original Endorsement Date: Aug. 10, 2009  
Steward(s): NCQA

**Comprehensive Diabetes Care – Blood Sugar Controlled**

**Description**

Percentage of patients with diabetes 18-75 years of age whose most recent HbA1c level was less than or equal to 9.0 percent (in control).

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

**Numerator**

This measure will use the most recent HbA1c test performed during the measurement period with a result less than or equal to 9.0 percent. If the result for the most recent HbA1c test during the measurement period is greater than 9.0 percent or is missing, or if an HbA1c test was not performed during the measurement period, the member cannot be included in the numerator.

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

**Denominator**

Patients 18-75 years of age as of the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement period or the prior measurement period through:

- 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 is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

- A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>250, 357.2, 362.0, 366.41, 648.0</td>
</tr>
</tbody>
</table>

**Exclusion**

Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement period or the prior measurement period. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement period.

**Measure Status**

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

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
Comprehensive Diabetes Care – Cholesterol Controlled

Description
The percentage of patients 18-75 years of age with diabetes whose most recent LDL-C test result during the measurement period was less than 100 mg/dL.

The comprehensive diabetes care – cholesterol controlled measure is approved by NQF (www.qualityforum.org) and follows American Diabetes Association Guidelines (http://care.diabetesjournals.org/content/33/Supplement_1/S11.full.pdf).

Numerator
This measure will use tests with results of LDL-C less than 100 mg/dL as the most recent LDL-C test during the measurement period. If the result for the most recent LDL-C test during the measurement period is ≥100 mg/dL or is missing, or if an LDL-C test was not performed during the measurement period, the member cannot be included in the numerator.

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

Denominator
Patients 18-75 years of age as of the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement period or the prior measurement period through:

- 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 is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.
- A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.

Exclusion
Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement period or the prior measurement period. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement period.

The following codes* identify allowable exclusions:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>249, 251.8, 256.4, 648.8, 962.0</td>
</tr>
</tbody>
</table>

Measure Status
NQF # 0064
Status: Endorsed
Original Endorsement Date: Aug. 10, 2009
Steward(s): NCQA

Controlling Blood Pressure

Description
The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90) during the measurement period based on the most recent blood pressure reading during the measurement period (after diagnosing hypertension).

The controlling blood pressure measure is approved by NQF (www.qualityforum.org) and follows The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (www.nhlbi.nih.gov/guidelines/hypertension).

Numerator
The number of members in the denominator whose most recent blood pressure is adequately controlled during the measurement period. For a member’s blood pressure to be controlled, both the systolic and diastolic blood pressure must be less than 140/90 (adequate control). You must report actual blood pressure to satisfy measure reporting requirements.

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>250, 357.2, 362.0, 366.41, 648.0</td>
</tr>
</tbody>
</table>

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
Your medical records must support the diagnosis for the denominator and identify the representative blood pressure level for the numerator.

The following blood pressure readings do not meet the criteria to be considered for the numerator:

- Blood pressure reading from an acute inpatient stay or an emergency department visit.
- Blood pressure reading from an outpatient visit, the sole purpose of which was to have a diagnostic test or surgical procedure performed.
- Blood pressure reading done on the same day as a major diagnostic or surgical procedure.
- Blood pressure reading reported by or taken by the patient.

If there are no blood pressure readings that meet the criteria after the diagnosis of hypertension, the member cannot be included in the numerator.

**Denominator**

Patients 18-85 years of age who had a diagnosis of hypertension. A patient is considered hypertensive if they have at least one outpatient encounter with a diagnosis of hypertension (ICD-9-CM diagnosis code 401) during an 18-month window (the 12 months prior to the start of the measurement period and the first six months of the measurement period).

**Exclusion**

Exclude all patients who have evidence of end-stage renal disease (ESRD) (including dialysis or renal transplant), are pregnant, or who were admitted to a non-acute inpatient setting on or prior to December 31 of the measurement period.

The following codes* identify ESRD exclusions:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>585.5, 585.6, V42.0, V45.1</td>
</tr>
</tbody>
</table>

The following codes* identify pregnancy exclusions:

<table>
<thead>
<tr>
<th>CODE TYPE</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis</td>
<td>630-679, V22, V23, V28</td>
</tr>
</tbody>
</table>

**Measure Status**

NQF # 0018
Status: Endorsed
Original Endorsement Date: Aug. 10, 2009
Steward(s): NCQA

**Comprehensive Diabetes Treatment**

**Description**

The percentage of adult Medicare Part D beneficiaries (18 years of age or older) who were dispensed appropriate medication for diabetes, medication for hypertension, and an ACEI or ARB medication recommended for people with diabetes.

**Numerator**

Number of patients who received an ACEI or ARB medication during the measurement period.

**Denominator**

Number of patients who were dispensed at least one prescription for an oral hypoglycemic agent or insulin (see the following Table A) and at least one prescription for an antihypertensive agent (see the following Table B) other than ACEI or ARB medication during the measurement period.

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
**Diabetes and hypertension medications, including ACEI and ARB medications, from the Pharmacy Quality Alliance measure specifications:**

**Table A: Oral Hypoglycemic, Insulin, and Incretin Mimetics**

Biguanides and biguanide combination products
- metformin
- pioglitazone & metformin
- rosiglitazone & metformin
- repaglinide & metformin
- sitagliptin & metformin
- saxagliptin & metformin SR
- glyburide & metformin
- glipizide & metformin

Sulfonylureas and sulfonylurea combination products
- acetohexamide
- chlorpropamide
- glipizide & metformin
- glimepiride
- glipizide
- glyburide & metformin
- glyburide
- rosiglitazone & glimepiride
- pioglitazone & glimepiride
- tolazamide
- tolbutamide

Meglitinides and meglitinide combination products
- nateglinide
- repaglinide
- repaglinide & metformin

Alpha-glucosidase inhibitors
- acarbose
- miglitol

Thiazolidinediones and thiazolidinedione combination products
- pioglitazone
- pioglitazone & glimepiride
- pioglitazone & metformin
- rosiglitazone
- rosiglitazone & glimepiride
- rosiglitazone & metformin

**Incretin mimetic agents**
- exenatide
- liraglutide

**Amylin analogs**
- pramlintide

**DPP-IV inhibitors and DPP-IV inhibitor combination products**
- sitagliptin
- saxagliptin
- sitagliptin & metformin
- saxagliptin & metformin SR

**Insulins**
- insulin aspart
- insulin aspart Protamine & Aspart
- insulin detemir
- insulin glargine
- insulin glulisine
- insulin isophane & regular human insulin
- insulin isophane (human N)
- insulin lispro
- insulin lispro Protamine & Insulin lispro
- insulin regular (human R)
- insulin regular (human) buffered
- insulin regular inhalation powder
- insulin zinc (Lente)
- insulin zinc extended (human Ultralente)

**Table B: Antihypertensive Agents**

Beta-blocker medications
- acebutolol HCL
- atenolol
- betaxolol HCL
- bisoprolol fumarate
- carteolol HCL
- carvedilol
- labetalol HCL
- metoprolol succinate
- metoprolol tartrate
- nadolol
- nebivolol
- penbutolol sulfate
- pindolol
Part D Medication Adherence for Oral Diabetes Medications

Description
The percentage of adult Medicare Part D beneficiaries (18 years of age or older) who adhered to their prescribed drug therapy across the following classes of oral diabetes medications: biguanides, sulfonylureas, thiazolidinediones, and DPP-IV inhibitors.

Numerator
Number of patients with a proportion of days covered (PDC) of 80 percent or over across the classes of oral diabetes medications during the measurement period. A beneficiary with a PDC threshold of at least 80 percent is considered to be adherent. The steps used to calculate the numerator are below.

Step 1: Determine the beneficiary’s measurement period in days, starting at the date of the first fill and ending at the end of the measurement period, disenrollment, or death.

Step 2: Within the measurement period, count the number of days the beneficiary was “covered” by at least one drug in the therapeutic area based on the prescription fill date and days of supply. If prescriptions for the same drug (same generic code number) overlap, adjust the prescription start date to be the day after the previous fill ends.

Step 3: Divide the number of days found in Step 2 by the number of days found in Step 1 to determine the PDC.

Step 4: Count the number of beneficiaries who had a PDC greater than or equal to 0.80.

Note: Patients taking antiglycemic medication and only ACEI or ARB will be not included the measure.

Measure Status
NQF # 0546
Status: Endorsed
Original Endorsement Date: Aug. 5, 2009
Steward(s): Pharmacy Quality Alliance

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
Oral diabetes medications:

Biguanide medications
- metformin
- glipizide & metformin
- glyburide & metformin
- rosiglitazone & metformin
- pioglitazone & metformin
- repaglinide & metformin
- sitagliptin & metformin
- saxagliptin & metformin SR

Note: Active ingredients are limited to oral formulations only (includes all dosage forms).

Sulfonylurea medications
- acetohexamide
- chlorpropamide
- glimepiride
- glipizide
- glyburide
tolazamide
tolbutamide
glipizide & metformin
glucurid & metformin
rosiglitazone & glimepiride
pioglitazone & glimepiride

Note: Active ingredients are limited to oral formulations only (includes all salts and dosage forms).

Thiazolidinedione medications
- pioglitazone rosiglitazone
- pioglitazone & metformin
- rosiglitazone & metformin
- pioglitazone & glimepiride
- pioglitazone & glimepiride

DPP-IV inhibitor medications
- sitagliptin
- linagliptin
- saxagliptin
- sitagliptin & metformin
- saxagliptin & metformin SR

Note: Active ingredients are limited to oral formulations only (includes all dosage forms).

Denominator
Number of patients with at least two fills of medication(s) in any of the drug classes during the measurement period.

Exclusion
Exclude patients who were prescribed one or more prescriptions for insulin during the measurement period.

Measure Status
NQF # 0541
Status: Endorsed
Original Endorsement Date: Aug. 5, 2009
Steward(s): Pharmacy Quality Alliance

Part D Medication Adherence for Hypertension (ACEI or ARB)

Description
The percentage of adult Medicare Part D beneficiaries (18 years of age or older) who adhered to their prescribed drug therapy for ACEI or ARB medications.

Numerator
Number of patients with a PDC of 80 percent or over for ACEI or ARB medications during the measurement period. A beneficiary with a PDC threshold of at least 80 percent is considered to be adherent. The steps used to calculate the numerator are below.

Step 1: Determine the beneficiary's measurement period in days, starting at the date of the first fill and ending at the end of the measurement period, disenrollment, or death.

Step 2: Within the measurement period, count the number of days the beneficiary was “covered” by at least one drug in the therapeutic area based on the prescription fill date and days of supply. If prescriptions for the same drug (same generic code number) overlap, adjust the prescription start date to be the day after the previous fill ends.

Step 3: Divide the number of days found in Step 2 by the number of days found in Step 1 to determine the PDC.

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
Step 4: Count the number of beneficiaries whose PDC was greater than or equal to 0.80.

**ACEI and ARB hypertension medications**
- candesartan
- eprosartan
- irbesartan
- losartan
- olmesartan
- telmisartan
- valsartan

**ACE inhibitor medications**
- benazepril
- captopril
- enalapril
- fosinopril
- lisinopril
- moexipril
- perindopril
- quinapril
- ramipril
- trandolopril

**ACE inhibitor combination products**
- amlodipine & benazepril
- benazepril & HCTZ
- captopril & HCTZ
- enalapril & HCTZ
- enalapril & felodipine
- fosinopril & HCTZ
- lisinopril & HCTZ
- moexipril & HCTZ
- lisinopril & nutritional supplement
- quinapril & HCTZ
- trandolopril-verapamil HCL

**ARB combination products**
- candesartan & HCTZ
- eprosartan & HCTZ
- telmisartan & amlodipine
- irbesartan & HCTZ
- losartan & HCTZ
- amlodipine & olmesartan
- olmesartan & HCTZ
- telmisartan & HCTZ
- aliskiren & valsartan
- olmesartan & amlodipine & HCTZ
- valsartan & HCTZ
- amlodipine & valsartan
- amlodipine & valsartan & HCTZ

**Note:** Active ingredients are limited to oral formulations only.

**Denominator**
Number of patients with at least two fills of either the same medication or medications in the same drug class during the measurement period.

**Measure Status**
NQF # 0541
Status: Endorsed
Original Endorsement Date: Aug. 5, 2009
Steward(s): Pharmacy Quality Alliance

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
Part D Medication Adherence for Cholesterol (Statins)

Description
The percentage of adult Medicare Part D beneficiaries (18 years or age or older) who adhered to their prescribed drug therapy for statin cholesterol medications.

Numerator
Number of patients with a PDC of 80 percent or over for statin cholesterol medications during the measurement period. A beneficiary with a PDC threshold of at least 80 percent is considered to be adherent. The steps used to calculate the numerator are below.

Step 1: Determine the beneficiary’s measurement period in days, starting at the date of the first fill and ending at the end of the measurement period, disenrollment, or death.

Step 2: Within the measurement period, count the number of days the beneficiary was “covered” by at least one drug in the therapeutic area based on the prescription fill date and days of supply. If prescriptions for the same drug (same generic code number) overlap, adjust the prescription start date to be the day after the previous fill ends.

Step 3: Divide the number of days found in Step 2 by the number of days found in Step 1 to determine the PDC.

Step 4: Count the number of beneficiaries whose PDC was greater than or equal to 0.80.

Statin cholesterol medications
- lovastatin
- rosuvastatin
- fluvastatin
- atorvastatin
- pravastatin
- pitavastatin
- simvastatin

Statin combination products
- niacin & lovastatin
- atorvastatin & amlodipine
- niacin & simvastatin
- pravastatin & aspirin
- ezetimibe & simvastatin

Note: Active ingredients are limited to oral formulations only (includes all dosage forms).

Denominator
Number of patients with at least two fills of either the same statin medication or medications in the same drug class during the measurement period.

Measure Status
NQF # 0541
Status: Endorsed
Original Endorsement Date: Aug. 5, 2009
Steward(s): Pharmacy Quality Alliance

* All codes and drugs listed under various headings in Appendix A are a summary set for each measure and do not comprise an exhaustive list applicable to the Akamai Advantage Primary Care Pay-for-Quality Program, which by default adheres to HEDIS and PQA specifications.
Appendix B - Patient Attribution Process

The patient attribution process aims to reflect our members’ preference for a provider as a PCP based on the member’s choice of PCP and member’s office visit pattern. HMSA Akamai Advantage and HMSA’s HMO and QUEST members are included in the PCMH patient panel of the PCP they selected upon enrolling. All other HMSA members are attributed to a PCP based on the provider they’ve seen most frequently or most recently, which is determined by a review of HMSA claims for a specified period.

The attribution process includes members of HMSA’s plans including The HMSA Plan for QUEST Members, 65C Plus and Medicare Advantage plans, and The HMSA Children’s Plan.

An initial attribution, using the process described below, was completed when HMSA launched its PCMH and commercial primary care pay-for-quality programs. Thereafter, the same attribution process has been completed at the close of every calendar month after HMSA has posted all the claims processed and eligible members for that month.

1. Keep the PCP selection for the members who have selected a PCP.

2. For all other members, attribute the member to a PCP using a 16-month claims window. (A 37-month claims window was used for the initial attribution.) For eligible PCP specialties, the claims used represent face-to-face encounters between the provider and patient.

3. Select the PCP who was most frequently seen or, in cases of a tie, most recently seen.

4. Confirm that the member has valid eligibility for that month.

If there is no change to the attribution for a patient, the previous month’s attribution results will apply for the current month. Attribution results will be available as an updated patient panel on Cozeva. You are encouraged to view your patient panel and follow the update process described on Cozeva.

You may add patients to your patient panel through Cozeva. Patients will need to sign an attestation to complete the process. Their attestations will supersede all prior attributions.