2012 MiPCT 12 Month Performance Incentive Metrics

Data Sources for 12 Month Metrics

1. Claims Data: All participating health plans will submit claims data to the Michigan Data Collaborative which can be used to calculate utilization and cost metrics. Claims data will be calculated for each Health Plan and aggregated across all contracted plans. Confidence intervals at 95% will be provided.
2. MiPCT Quarterly Reports: The report will document progress to date in developing PCMH infrastructure capabilities and carrying out MiPCT clinical initiatives.
3. Self-Reported Data (SRD): PGIP POs currently report to BCBSM twice a year on their practice's PCMH capabilities. BCBSM applies accuracy, validity and inter-rater reliability checks and balances to the reports. They impose financial penalties on POs for inaccurate reporting of capabilities.
4. Practice Clinical Registry Data: (1) Electronic submission of a clinical data file in the specified format. (2) PO summary reports of MiPCT clinical metrics.

Metric	Data Source	Numerator	Denominator	Maximum Points
Enhanced Access				
1. 30% same day appointments	SRD report (5.7)	Number of practices in PO with capability	Number of practices in PO	**10** N/D x 10
2. Access outside regular hours: 12 hrs/week	SRD report (5.5)	Number of practices in PO with capability	Number of practices in PO	**10** N/D x 10
All Patient Registry Functionality				
3. Electronic patient registry functionality: Tracking chronic illness care and preventive services	a. MDC attestation b. Electronic report of clinical metrics	Sum of points earned for ability to transmit clinical data to MDC Sum of points earned for summary reports of clinical measures for all practices	Number of practices in PO x 5 Number of practices in PO x 20	**5** N/D **20** N/D
Care Managers				
4. Moderate care managers (MCMs) trained and working*	MiPCT Quarterly report	Number of MCMs trained and providing services to practices in PO**	Number of attributed MiPCT members in PO as of June 30, 2012 divided by 5000	**15** N/D x 15
5. Complex care managers (CCMs) trained and working*	MiPCT Quarterly report	Number of CCMs trained and providing services to practices in PO**	Number of attributed MiPCT members in PO as of June 30, 2012 divided by 5000	**15** N/D x 15
		Transitions of Care		
6. Notification of hospital admissions and discharges for	MiPCT Quarterly	Number of practices reporting capability	Number of Practices in PO	**15** N/D x 15

at least 50% of MiPCT beneficiaries	Report			
Utilization				
7. Primary care sensitive ED visits (NYU algorithm)	Claims Data	Change in PO PCS ED visits/1000 (Baseline Rate – 2012 rate	PO Baseline Rate (Mean of 2010 & 2011 ED visits/1000)	**10** Change/D***

* Hybrid care managers will be attributed to Moderate and Complex categories according to their FTE assignment.

** Pediatric practices are expected to have 2 care managers/5000 MiPCT beneficiaries, but the ratio of moderate to complex care managers may vary between settings. For calculation of this metric, 50% of the POs total pediatric care managers will be attributed to the moderate care manager category and 50% to the complex care category.

***Calculation methodology and assignment of points will be adjusted after preliminary data is available to accommodate POs with lower baseline rates and/or those with smaller numbers of beneficiaries.

Metric Descriptions

ENHANCED ACCESS

1. 30% Same Day Appointments (SRD 5.7)

Advanced access scheduling is in place, reserving at least 30% of appointments for same-day appointments for acute and routine care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients).

A. 30% of the day's appointments should be available at the start of business for same-day appointments for both acute and routine care needs.
   - In unusual, extenuating circumstances (such as a solo primary care practice in a rural or urban under-served area), primary care practice units may meet the requirements by having a routine, systematic procedure that practice unit clinicians remain after-hours as necessary to see the majority of patients requesting routine or acute care.

B. Written policy for advanced access is available.
   - Patients are aware of policy and do not feel that they must self-screen to avoid imposing on primary care practice unit staff.

C. Patients can be accommodated throughout the day (not only during lunch or after-hours).

D. Patients are seen on a timely basis with no excessive waiting time.

E. Patients can be seen by PAs/NPs or by any physician in primary care practice.

F. Primary care practices that do not have an approach to scheduling that closely follows the structure and process of formal open access scheduling consistent with the sources cited herein, must have a documented policy and procedures demonstrating that the practice's advanced access approach has the following attributes referenced at the following sites:
   - http://www.aafp.org/fpm/20000900/45same.html .
   - Reference Institute for Healthcare Improvement articles at http://www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/IH for information on implementing advanced access.

2. Appointments Outside Regular Hours - 12 hours per week (SRD 5.5)

Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 12 after-hours per week and, if different from the PCP office, after-hours provider has a feedback loop within 24 hours or next business day to the patient's PCMH.

- After-hours is defined as office visit availability during weekday evening (e.g., 5-8 pm) and/or early morning hours (e.g., 7-9 am) and/or weekend hours (e.g., Saturday 9-12), sufficient to reduce patients' use of ED for non-ED care.
- After-hours provider may be at Primary care practice Unit site or may be in a physically separate location (e.g., an urgent care location or a separate physician office) as long as it is within 30 minutes travel time of the PCMH.
- Services provided by the after-hours provider must be billable as an office visit or an urgent care visit, not as an ER visit.
- After-hours services provided in a different setting (e.g. urgent care center or a physician who shares on-call responsibilities) requires an established arrangement for after-hours coverage, and feedback to the PCP by the next business day regarding the care received.
- Primary care practice Units may team with other practice units/physicians to provide after-hours urgent care.

ALL PATIENT REGISTRY FUNCTIONALITY

3. Electronic Patient Registry Functionality

The registry is being used to track and manage chronic illness and preventive services and can report the MiPCT Clinical Metrics (MiPCT Quarterly Report).

A. Up to 5 points will be awarded for the PO or practice capacity to send a test file of clinical data from the registry/EHR. Specifications for each metric can be found beginning on page 9 here: http://mipctdemo.files.wordpress.com/2011/09/mipct-clinical-metrics.pdf. POs will receive 0.5 points for providing a complete and acceptable test data file to MDC by January 31, 2012 for each of the metrics below. The file can be in the form of a BCN extract or in Standard HL7, and can contain all patients or just MiPCT patients and at least one month of data.

Measures to Send to MDC
1. Diabetes: Poor Control A1c>9
2. Diabetes: Control A1c< 8
3. Diabetes: LDL-C Controlled < 100 mg/dl
4. Diabetes: BP <140/90
5. Persistent Asthma: Self-Management Plan or Asthma Action Plan (ages 5-50)
6. Hypertension: Controlled BP <140/90 (age 18-85)
7. Cardiovascular Disease: Blood Pressure Management <140/90 mmHg
8. Cardiovascular Disease: LDL Cholesterol Management <100 mg/dl
9. Obesity: Adult or Child Weight Screening (Meaningful Use)
10. Tobacco: Assessment and Cessation Intervention (Meaningful Use)

B. Up to 20 points for a practice level summary report of the clinical measures (e.g. % of patients in a population that meet metric criteria) generated by the registry or EHR. The format for these reports is flexible; you can submit actual reports generated by the EHR or registry, or screenshots of reports. If a PO has practices with the same EHR or registry, only one report per unique EHR/registry is required as long as all practices using the EHR/registry appear on the report.

i. 2 points (1 point each). 1 point for a table or chart showing a trend for at least two months for the number of patients in the practice with an AIC<8. 1 point for an outreach report of de-identified patients that could be used at the practice (for example, a list of males aged 40-50 with diabetes and A1C>9).

ii. Up to 18 points for a summary report of the clinical metrics (see tables below).

a. Practice has Adult Patients Only

1 point is awarded for each of the measures below tracked in the registry

Adult Chronic and Preventive Care Measures
Diabetes Measures: (ages 18-75 years with type 1 or 2 diabetes)
1. Diabetes: A1C Test
2. Diabetes: Poor Control A1c>9
3. Diabetes: Control A1c< 8
4. Diabetes: LDL-C Test
5. Diabetes: LDL-C Controlled < 100 mg/dl
6. Diabetes: BP <140/90
7. Diabetes: Retinal Eye Exam
8. Diabetes: Nephropathy Screen or Evidence of Nephropathy
9. Asthma: Self-Management Plan or Asthma Action Plan (ages 5-50)
10. Hypertension: Controlled BP <140/90 (age 18-85)
Cardiovascular Disease Measures: (ages 18-75)
11. Cardiovascular Disease: Blood Pressure Management <140/90 mmHg
12. Cardiovascular Disease: LDL Cholesterol Management <100 mg/dl
13. Obesity: Adult Weight Screening (Meaningful Use)
14. Tobacco: Assessment and Cessation Intervention (Meaningful Use)
15. Breast Cancer Screening (ages 40-69)
16. Cervical Cancer Screening (ages 21-64)
17. Colorectal Cancer Screening (ages 50-75)
18. Chlamydia Screening (women ages 16–24)

b. Practice has Pediatric Patients Only

2 Points are awarded for each metric below tracked in the registry

Pediatric Chronic and Preventive Care Measures
1. Persistent Asthma: Self- management plan or asthma action plan
2. Obesity: Child Weight Assessment (Meaningful Use, ages 2-17yrs)*
3. Lead Screening by Age 2: HEDIS (Medicaid only)*
4. Tobacco Use: Assessment and Cessation Intervention (Meaningful Use, ages 13 and older)
5. Chlamydia Screening: Women ages 16–24
6. Childhood (age 2) and Adolescent (age 13) Immunizations*
7. Well Child Visits by 15 Months
8. Well Child Visits 3-6 Years

9. Well Child Visits 12-21 Years

* A MCIR report may count for this measure if the practice routinely checks patient's immunization status with visits and periodically generates lists of patients due for services for outreach.

c. Practice has Both Adult and Pediatric Patients

1 point for each metric or group of metrics below tracked in the registry

Adult and Pediatric Chronic and Preventive Care Measures
Diabetes Measures: (ages 18-75 years with type 1 or 2 diabetes) 1. Diabetes: A1C Test + Control A1c > 9 = Control A1c < 8 2. Diabetes: LDL-C Test + LDL-C Controlled < 100 mg/dl 3. Diabetes: BP <140/90 4. Diabetes: Retinal Eye Exam 5. Diabetes: Nephropathy Screen or Evidence of Nephropathy 6. Persistent Asthma: Self-Management Plan or Asthma Action Plan (ages 5-50) 7. Hypertension: Controlled BP <140/90 (age 18-85) Cardiovascular Disease Measures: (ages 18-75) 8. Cardiovascular Disease: Blood Pressure Management <140/90 mmHg 9. Cardiovascular Disease: LDL Cholesterol Management <100 mg/dl 10. Obesity: Adult Weight Screening (Meaningful Use) 11. Tobacco: Assessment and Cessation Intervention (Meaningful Use) 12. Breast Cancer Screening (ages 40- 69) 13. Cervical Cancer Screening (ages 21-64) 14. Colorectal Cancer Screening (ages 50-75) 15. Chlamydia Screening (Women ages 16–24) 16. Childhood (age 2) Immunization* 17. Adolescent (age 13) Immunizations* 18. Well Child Visits:15 Months, 3-6 years and 12-21 years

* A MCIR report may count for this measure if the practice routinely checks patient's immunization status with visits and periodically generates lists of patients due for services in order to do outreach

CARE MANAGERS

MiPCT recognizes two categories of care managers: moderate and complex. The two roles have different responsibilities, qualifications and training and are typically performed by different individuals.

- The number of care managers to be engaged in a PO is approximately 1 moderate care manager and 1 complex care manager for each 5000 MiPCT covered lives that are seen in internal medicine and family medicine settings. Pediatric practices typically see fewer complex patients and are expected to engage 2 care managers per 5000 MiPCT beneficiaries, but the ratio of moderate to complex care managers may be greater.
- In unique circumstances, such as practices with a relatively small number of MiPCT patients and/or pediatric practices, one individual may assume both care manager roles. For performance incentive purposes, these "hybrid" care managers are counted as a partial FTE in

both the moderate and complex care manager categories. For example, 0.5 FTE is reported as a moderate care manager and 0.5 FTE is reported as a complex care manager.

4. Moderate Care Managers Trained and Working

The number of employed/contracted moderate care managers reported to be trained and in place in the MiPCT Fourth Quarter Report. Trained means completion of the required self-management course. The target number of moderate care managers is 1:5000 covered lives. The number of pediatric moderate care managers may exceed this ratio. For this metric, 50% of total pediatric care managers will be attributed to the moderate care manager category.

5. Complex Care Managers Trained and Working

The number of complex care managers reported in the MiPCT Fourth Quarter Report to be trained and working. Trained means the individual has completed the required MiPCT CCM training. This will be self-reported by the PO and verified by the complex care manager training center. The target number of complex care managers is 1:5000 covered lives. The number of pediatric moderate care managers may be less this ratio. For this metric, 50% of total pediatric care managers will be attributed to the complex care manager category.

TRANSITIONS OF CARE

6. Notification of Hospital Admissions and/or Discharges

A process is in place for the MiPCT practice to obtain daily notification of hospital admissions and/or discharges and transfers for more than 50% of their MiPCT patients. In the MiPCT Quarterly report POs will indicate the hospitals for each practice where notification processes are in place. Credit will be awarded to the practice if the sum of the admissions to those hospitals represents >50% of the total MiPCT admissions for their practice.

UTILIZATION

7. Primary Care Sensitive ED Visits

Percent change in PO's Primary Care Sensitive ED Visits/1000 patients during measurement year compared to PO's rate for prior year(s).

The NYU Algorithm for ED Visit classification will be used. ED visits will be sorted into four categories. The first three categories are collectively referred to as preventable/avoidable or primary care sensitive (PCS) conditions/visits.

- Non-emergent. Cases where immediate (within 12 hours) care is not required (e.g., sore throat, back pain, ingrown toenail, eczema, and attention to dressings).
- Emergent, but primary care treatable. Care is needed within 12 hours, but care could be provided in a typical primary care setting (e.g., infant with a 102° fever, nosebleed, abdominal pain, acute bronchitis, painful breathing).
- Emergent, ED care needed but preventable/avoidable. Immediate care in an ED setting is needed, but the condition potentially could have been prevented or avoided with timely and effective ambulatory care (e.g., asthma, cellulitis, emphysema, pelvic inflammatory disease, diabetic ketoacidosis, etc.).
- Emergent, ED care needed, not preventable/avoidable. Immediate care in an ED setting is

needed and the condition could not have been prevented/avoided even with effective ambulatory care (e.g., heart attack, appendicitis, kidney stone, multiple trauma, and chest pain). This category includes visits with a principal diagnosis relating to injury, mental health, alcohol and drug related, and visits with an unclassified diagnosis that does not fall into one of the other categories.

This classification is then used to calculate rates of preventable/avoidable/PCS visits per 1000 patients. Rates are known to vary by patient demographics, health plan source, and geography. Points will be allotted to POs whose rates remain stable or decrease.

Appendix: MiPCT 12 Month Registry Metric Crosswalk

High-level program references in PCMH validation and Medicare incentive programs that support the MiPCT incentivized activities.

Metric	BCBSM PCMH Capability	NCQA Measure / Capability	URAC Element/ Capability	Meaningful Use
The practice is using the registry or EHR registry functionality to identify, track, and manage patients with one or more of the following 5 conditions: • Diabetes • Asthma • Hypertension • Cardiovascular Disease • Obesity	2.1 2.10 N/A 2.11 2.17 (Peds)	2-B	PR-1	Core Req.8 Menu Req.3
The registry or EHR registry functionality incorporates preventive services guidelines and is being used to generate routine, systematic communication to all patients in the practice regarding needed preventive services.	2.14	2-D	PR-3	Menu Req. 4
The practice is using the preventive guidelines embedded within the registry or EHR in a systematic approach to provide and track preventive services for the following: **1.** Tobacco Control Guidelines (both adult and child) **2.** Breast Cancer Screening (ages 40-69) HEDIS **3.** Cervical Cancer Screening (ages 21-64) HEDIS **4.** Colorectal Cancer Screening (ages 50-75) HEDIS **5.** Chlamydia Screening (sexually active women ages 16-24) HEDIS **6.** Obesity- BMI (adult and child > age 2) Meaningful Use **7.** Lead Screening (Medicaid only) **8.** Childhood Immunizations (age 2) HEDIS **9.** Well Child Visits by 15 months, HEDIS **10.** Well Child Visits 3-6 years, HEDIS **11.** Well Child Visits – Adolescent (Ages 12-21) HEDIS **12.** Adolescent Immunizations (Age 13) HEDIS	9.2	2-D	PR-2 PR-3	Core Req. 8 Core Req. 9