Michigan Data Collaborative

CPC+ Measure Definitions: Technical Guide

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Contents

Introduction

This guide includes technical definitions for the measures and chronic conditions included in the CPC+ Dashboard.

It includes the following sections:

Overview

Measures are calculated across the payers that are participating in CPC+. Results are designed to help organizations improve overall performance as well as allow analysis across payers.

Eligibility

Continuous enrollment is a requirement for the denominator for many measures. MDC receives eligibility from all payers participating in CPC+ and determines continuous enrollment across payers. For example, a patient could be in a commercial plan for 6 months and in a Medicare plan for 6 months. Since continuous enrollment is based upon multiple payer data, this patient would be considered as continuously enrolled for 12 months.

Patient Attribution

Patients are included in measures when they are attributed to a CPC+ Primary Care Provider (PCP) during the final month of the reporting period. This is accomplished differently by payer.

Medicare: Centers for Medicare & Medicaid Services (CMS) provides quarterly files that attribute beneficiaries to a practice.

- MDC attributes beneficiaries to a PCP using the CMS claims-based attribution algorithm.
- MDC only includes active beneficiaries from the CMS attribution file.
- BCBSM provider hierarchy has more recent information and is used to identify active practices.

BCBSM: BCBSM provides monthly files that attribute members to PCPs. BCBSM also provides a quarterly provider hierarchy that identifies active CPC+ practices.

Priority Health: Priority Health provides monthly eligibility files with some members' PCPs. Claims-based attribution is used for members without an attributed PCP.

If multiple payers include the same patient in attribution, the following hierarchy is used for dashboard assignment: Medicare, Priority Health, then BCBSM. Commercial payer Medicare Advantage patients are excluded.

Claims Attribution

MDC utilizes the CMS algorithm to attribute patients to PCPs based on claims as defined below. Assign beneficiaries' (or members') provider based on a two-year lookback and in the following order:

1. Most recent Chronic Care Management service.
2. Most recent Annual Wellness Visits/Welcome to Medicare Visits.
3. Plurality of primary care services.

If a PCP cannot be identified in claims, the member/beneficiary is included in the "Unassigned" category. Members/Beneficiaries attributed to more than one payer's data are assigned to a single payer in the following order: Medicare, Priority Health, Blue Cross Blue Shield of Michigan (BCBSM).

Quality Measure Descriptions

Currently all quality measures are based on claims data only.

Breast Cancer Screening

Source:	HEDIS 2018 Breast Cancer Screening
Definition:	Percentage of women aged 50-74 who were screened for breast cancer.
Numerator:	The number of eligible female members who had one or more mammograms any time between two years prior to the measurement year and the end date of the measurement year.
Denominator:	Women aged 52-74 at the report end date of the measurement year. (An age of 52 years accommodates the 2 years prior to the measurement period). **Exclusions** Women who: • had a bilateral or two unilateral mastectomies. • use hospice services during the measurement year. • are Medicare members aged 65 and older and enrolled in an institutional skilled nursing facility (SNF) or living long-term in an institution during the measurement year.
Value Sets:	Mammography, Bilateral Mastectomy, History of Bilateral Mastectomy, Unilateral Mastectomy, Bilateral Modifier, Right Modifier, Left Modifier, Unilateral Mastectomy Left, Unilateral Mastectomy Right, Absence of Right Breast, Absence of Left Breast, Hospice

Chlamydia Screening in Women

Source: HEDIS 2018 Chlamydia Screening.

Definition: The percentage of females aged 16–24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Numerator: The number of female members aged 16-24 in the eligible population who had at least one chlamydia test during the measurement year.

Denominator: The number of currently attributed sexually active female patients aged 16-24.

- Claims used to identify sexual activity
- Pharmacy used to identify contraceptive prescriptions

Exclusions

Members who:

- requalified for the denominator only based on pregnancy test and a prescription of isotretinoin or an x-ray within 7 days.
- use hospice services any time during the measurement year.

Diabetes Eye Exam

Source: HEDIS 2018 Comprehensive Diabetes Care-Eye Exam

Definition: Identify the diabetic population aged 18-75 who have had a screening for diabetic retinal disease with a qualified professional (optometrist/ophthalmologist).

Numerator: An eye screening for diabetic retinal disease as identified by administrative data or clinical/ EHR data (measures will not include clinical data until a later release). This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- Bilateral eye enucleation anytime during the member's history through the end of the measurement year.

Eye care professionals are identified by first using the provider specialty code on the claim. If the provider specialty code is not populated, then the National Provider Identifier (NPI) on the claim is linked to the National Plan and Provider Enumeration System (NPPES) to determine the provider specialty.

Denominator: Members aged 18-75 years qualify for the denominator if they meet at least one of the following requirements any time during the current or prior measurement year:

- At least 2 outpatient, observation, ED, or nonacute inpatient (any combination) visits with different dates of service with any diagnosis of diabetes.

Source: HEDIS 2018 Comprehensive Diabetes Care-Eye Exam

- An acute inpatient visit with any diagnosis of diabetes.
- At least 1 insulin or hypoglycemic/antihyperglycemics ambulatory drug dispensed in the current or prior year.

Exclusions

- Members who use hospice services any time during the measurement year.
- If identified for the denominator by pharmacy claims only, exclude patients with gestational or steroid-induced diabetes in the current or prior year who do not have a diabetes diagnosis in any setting.

Value Sets: Diabetes, Observation, ED, Nonacute Inpatient, Outpatient, Acute Inpatient, Diabetes Exclusions, Diabetic Retinal Screening, Diabetic Retinal Screening with Eye Care Professional, Diabetic Retinal Screening Negative, Diabetes Mellitus Without Complications, Unilateral Eye Enucleation, Bilateral Modifier, Unilateral Eye Enucleation Left Value Set, Unilateral Eye Enucleation Right Value Set, Hospice, MDC-EYE

Diabetes Medications List (Pharmacy)

MDC uses the CMS Taxonomy crosswalk to identify eye care professionals.

Diabetes Medical Attention for Nephropathy

Source: HEDIS 2018 Comprehensive Diabetes Care-Medical Attention for Nephropathy

Definition: Identify the diabetic population aged 18-75 who have had a nephropathy screening test claim or evidence of nephropathy during the measurement year.

Numerator: A nephropathy screening test or evidence of nephropathy as documented through administrative data. This includes diabetics who had **one** of the following during the measurement year:

- A nephropathy screening Test (Urine Protein Test) or Evidence of nephropathy
- Treatment by a Nephrologist
- ACE/ARB Therapy in pharmacy claims

Denominator: See Diabetes Eye Exam and denominator exclusions. The denominator is identical for all diabetes measures.

Value Sets: Diabetes, Observation, ED, Nonacute Inpatient, Outpatient, Acute Inpatient, Diabetes Exclusions, Nephropathy Treatment, Urine Protein Tests, Kidney Transplant, ESRD, CKD Stage 4, Hospice.

Diabetes Medications List and ACE Inhibitor/ARB Medications (Pharmacy)

MDC uses the CMS Taxonomy crosswalk to identify treatment by a nephrologist.

Utilization Measure Descriptions

Acute Hospital Admissions

Source: HEDIS 2019 Acute Hospitalization Utilization (AHU)

Definition: The number of acute hospital admissions per 1,000 adult attributed members.

Numerator: Count of acute admissions that have occurred during the 12-month measurement year for the current attributed members.

Admissions are created by evaluating claims:

1. Identify all acute inpatient and observation discharges during the reporting period.
2. **Exclude** records in the following value sets:
   - Nonacute Inpatient Stay
   - Mental and Behavioral Disorders
   - Maternity
   - Deliveries Infant
   - Newborn/Neonates
   - Discharge status of death
3. Determine if a transfer occurred and extend the time window if it occurred.
4. MDC aggregates information associated with the admission: financial fields, length of stay, provider assignment, and admission diagnosis. Assign admission and discharge dates.

Denominator: All adult (aged 18 and older) members of the population with continuous enrollment for the current and previous reporting periods.

Exclusions

Members who use hospice services any time during the measurement year.

Value Sets: Hospice, Inpatient Stay, Observation Stay, Nonacute Inpatient Stay, Mental and Behavioral Disorders, Maternity, Maternity Diagnosis, Deliveries Infant Record

Emergency Department Visits

Source: HEDIS 2019 Emergency Department Utilization

Definition: Emergency Department (ED) visits are defined as each service date visit to an ED that does not result in an inpatient hospital admission. Events are counted once per service date, regardless of the intensity or duration of the visit. The resulting measure is the number of ED Visits per 1,000 attributed members.

Numerator: ED Events within the measurement period for eligible population. Multiple service dates occurring on the same date are counted as one event. ED visits are identified by claims in the ED Value Set or with procedure code in ED Procedure Code Value Set with an ED Place of Service.

Exclusions

- ED visits that result in a hospital admission
- ED visits for mental health or chemical dependency, psychiatry, or electroconvulsive therapy

Denominator: All adult (aged 18 and older) members of the population with continuous enrollment for the current and previous reporting period.

Exclusions

Members who use hospice services any time during the measurement year.

Value Sets: ED, ED Procedure Code, ED POS, Hospice, Inpatient Stay, Mental and Behavioral Disorders, Psychiatry, Electroconvulsive Therapy

Chronic Condition Descriptions

Asthma

Source: Custom MDC measure with a numerator based on HEDIS 2018 *Medication Management for People with Asthma (MMA)*, and *Asthma Medication Ratio (AMR)* definitions of asthma population and denominator.

Definition: Measure the percentage of members who have chronic asthma.

Numerator: The numerator includes members who are defined as having persistent asthma by meeting at least one of the following criteria:

- One Emergency Department visit with asthma as the principal diagnosis
- One Acute Inpatient encounter with asthma as the principal diagnosis
- At least four outpatient or observation visits with asthma as any diagnosis
- At least four asthma medication dispensing events. (If all prescriptions are for leukotriene modifiers or antibody inhibitors, the patient must also have an asthma diagnosis.)

Exclusions

- Members who had a diagnosis from any of the following value sets any time during the member's history through end of the current measurement year:
  - Emphysema
  - Other Emphysema
  - COPD
  - Obstructive Chronic Bronchitis
  - Chronic Respiratory Conditions Due to Fumes/Vapors
  - Cystic Fibrosis
  - Acute Respiratory Failure
- Members who have only leukotriene modifier pharmacy events and no diagnosis of Asthma.

Denominator: All members of the CPC+ population regardless of eligibility, enrollment, age, or diagnosis.

Exclusions

Members who use hospice services any time during the measurement year.

Value Sets: ED, Asthma, Acute Inpatient, Observation, Outpatient, Emphysema, Other Emphysema, COPD, Obstructive Chronic Bronchitis, Chronic Respiratory Conditions Due To Fumes/Vapors, Cystic Fibrosis, Acute Respiratory Failure, Hospice

Asthma Controller Medications and Asthma Reliever Medications (Pharmacy)

Diabetes

Source: Based on HEDIS 2018 Comprehensive Diabetes Care measures.

Definition: Measure the percentage of members who have diabetes.

Numerator: Members qualify for the numerator if they meet at least one of the following requirements in all available data received by MDC:

- At least 2 Outpatient, Observation, ED, or Nonacute Inpatient (any combination) visits with different dates of service with any diagnosis of diabetes.
- An Acute Inpatient visit and any diagnosis of diabetes.
- Dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis.

Denominator: All members of the CPC+ population.

Exclusions
Members who use hospice services any time during the measurement year.

Value Sets: Outpatient, Observation, ED, Nonacute Inpatient, Diabetes, Acute Inpatient, Diabetes Medication List, Hospice

Hypertension

Source: Custom MDC measure based on the HEDIS 2018 Controlling Blood Pressure specifications (CBP). However, unlike the HEDIS specification, it includes ALL members with hypertension rather than limiting based on age.

Definition: Measure the percentage of adults who were ever told they have hypertension or high blood pressure.

Numerator: Patients who had any diagnosis of hypertension before the end of the reporting period.

Note: Only Current Procedural Terminology (CPT) codes are used to identify outpatient visits.

Exclusions

- Members who have had a kidney transplant
- Female members who are pregnant (if patient did not have any diagnosis for Essential Hypertension in the reporting year prior to the measurement year)
- Members with End Stage Renal Disease (ESRD)

Denominator: All members of the CPC+ population.

Exclusions
Members who use hospice services any time during the measurement year.

Value Sets: Outpatient Without UBREV, Essential Hypertension, Kidney Transplant, Pregnancy, ESRD, Hospice

Obesity

Source: Custom MDC measure based on definitions from the CDC, Center for Health and Research Transformation (CHRT), and the American Congress of Obstetricians and Gynecologists.

Definition: Track all patients who are outside of the range of healthy weight, including overweight and obese patients. The measure assigns patients to the following categories: Overweight, Moderate Obesity, and Severe Obesity.

Numerator: A patient is defined as overweight /obese if a diagnosis includes any of the related ICD-9 or ICD 10-CM Diagnostic codes in the most recent measurement year.

The following BMI definitions are used to categorize patients:

Adult Patients:

- BMI of 25.0 - 29.9 (Overweight)
- BMI of 30.0 – 34.9 (Moderate Obesity)
- BMI of 35.0 or greater (Severe Obesity)

Pediatric Patients:

- BMI at or above the 85th percentile and below the 95th percentile (Overweight)
- BMI at or above 95th percentile (Obese)

Denominator: All members of the CPC+ population.

Exclusions

This measure includes only the data for the most recent 12 months.

Value Sets: MDC-Overweight, MDC-Moderate Obesity, MDC-Severe Obesity

Cost Measure Description

Currently, there is one cost measure included on the dashboard.

Risk-Adjusted PMPM Costs

Source:	MDC utilizes the Health Partners Total Cost of Care tool and Johns Hopkins Adjusted Clinical Groups (ACGs) to generate this measure.
Definition:	Risk-adjusted average medical costs per member per month. The Total Cost of Care tool creates standardized costs based on Allowed Amounts (payer payment plus patient payment) and ACG risks and reports commercial and Medicare populations separately.
MSM Adjusted Average Rescaled Concurrent ACG Score:	Represents the average risk in the population based on the Johns Hopkins ACG risk score and utilizes the Health Partners Measure Stabilization Module (MSM) to adjust for smaller group sizes (<600). If the score is greater than 1.0, it indicates the rating population is sicker than the Michigan CPC+ reference group. If the mean is less than 1.0, it indicates the rating population is healthier. Different reference groups are used for the Commercial and Medicare populations.
Resource Utilization Bank (RUBS):	A RUB is a morbidity category that the ACG system assigns based on six levels: Invalid, Healthy Users, Low Morbidity, Moderate, High, Very High. You can drill into your data to see the risk categories for the population of interest.
Numerator:	Risk-adjusted total medical costs
Denominator:	Qualifying Patients are separated out between Commercial (aged 0-65) or Medicare (aged 65+) populations. For example, when selecting Commercial, only the patients aged 0-65 with commercial coverage qualify for the measure.