QUALITY+

2024 Medical Home Partnership

A Program Guide to Rewarding Quality Outcomes

of Tennessee

Table of Contents

Medical Home Partnership (MHP) Aim:

Better outcomes and value for BlueCross BlueShield of Tennessee members and customers through partnerships with selected primary care providers to establish the three components:

1. Care coordination
2. Quality improvement
3. Utilization management

In 2009, BlueCross began working with primary care practices to implement the Patient-Centered Medical Home (PCMH) program. A PCMH is a team-based model of providing care, designed to support providers in improving and maintaining the health of their patients, or BlueCross members. The model of care highlights the individuals on the health care team and the importance of the patients' role in their own health. Additionally, the goal is to improve coordination of care among the medical system, community, family and patient resulting in better outcomes and patient satisfaction.

From 2009 to 2018, the BlueCross PCMH program emphasized disease management and primary prevention screenings. Specific chronic conditions such as diabetes, heart disease, respiratory conditions and cancer screenings were the primary focus for outreach and engagement. Currently, the BlueCross PCMH program is the largest in the state with 19 primary care partners, approximately 500 individual locations, 2,200 providers and 374,500 attributed members seeking care within a PCMH primary care practice.

In 2020, the PCMH program became the Medical Home Partnership (MHP), a population health management program designed to improve care coordination, quality, and utilization. The MHP program emphasizes a population approach to prevention (primary, secondary and tertiary), wellness/health promotion and disease management.

Key Principles of the Medical Home Partnership:

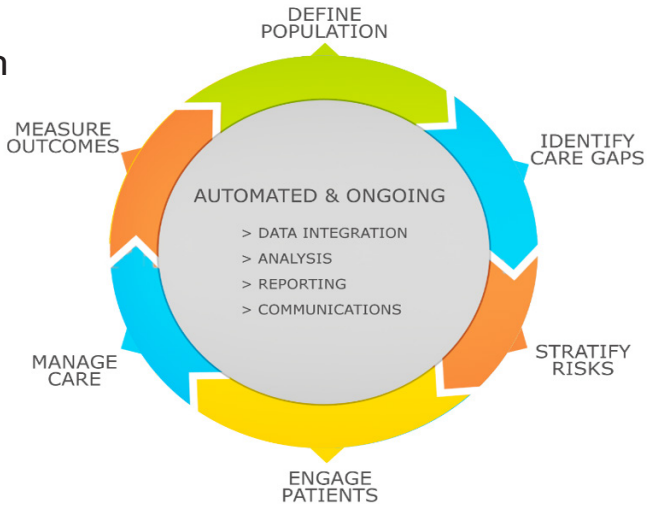
The principles of the Medical Home Partnership align with the patient-centered model of care, developed by the American Academy of Pediatrics (AAP), and include:

- **Physician-directed medical practice:** The personal physician leads a practice team to take responsibility for the ongoing care of the patient.
- **Care that's coordinated and integrated across all elements of the health care system:** Care is facilitated by data registries and information technology, such as EMR or Health Information Exchange platforms, to ensure that patients receive the best quality care when and where they need it (hospitals, health agencies, nursing homes, etc.).
- **Quality and safety:** Evidence-based medicine and clinical outcomes are measured and monitored to check for continuous quality improvement in patient care.
- **Enhanced access to care:** Access is enhanced through open scheduling, expanded hours, and email/telephone consultations.

Population Health Management

According to the National Institute of Health, Population Health Management is the shift in care provided at an individual level to improve managing and paying for health care services for a defined population. The MHP model of care focuses on an attributed, risk stratified population in which care gaps are identified and managed by an embedded nurse care coordinator. BlueCross' proprietary analytics and reporting capabilities allow for better care coordination and chronic disease identification to ensure education, self-management and decision support skills are taught and transferred to the BlueCross member. Program outcomes include quality and utilization improvement, measured by practice scorecards and an annual program evaluation. Member satisfaction is measured annually with a survey.

Population Health Management Diagram



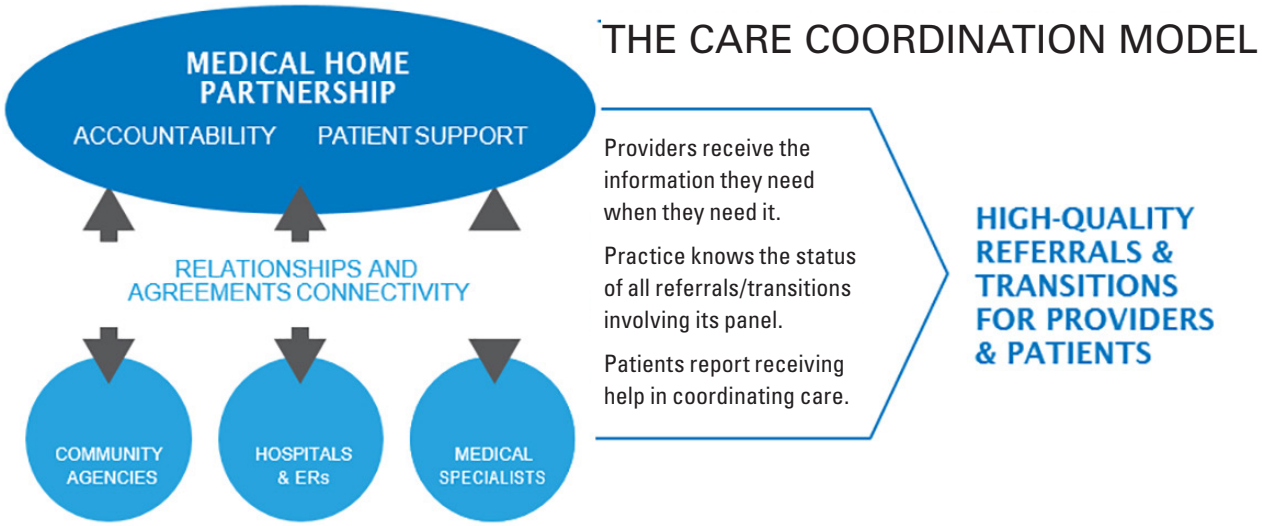
Care Coordination Model

Care coordination is the foundation of the Medical Home Partnership. It involves organizing patient care activities and sharing information among all participants involved in the patient's care to achieve safe, appropriate and effective quality care. The main goal of care coordination is to satisfy the patient's needs and preferences while delivering high-quality health care in a cost-effective manner. The result is a highly engaged patient.

The Care Coordination Model, developed by Group Health Cooperative, looks at care coordination from the perspective of a patient-centered model of care. It considers the major external providers and organizations with which the patient interacts: medical specialists, community service agencies, and hospital and emergency facilities. These providers and organizations contribute to successful referrals and transitions in care.

All patient referrals and transitions should meet the six Institute of Medicine goals of high-quality health care, including care that is:

- **Timely**: Transitions and consultative services are provided without delays.
- **Safe**: Planned and managed referrals and transitions prevent harm to patients.
- **Effective**: Referrals and transitions are centered around scientific knowledge and properly executed.
- **Patient-centered:** Patient needs and preferences are met through responsive referrals and transitions.
- **Efficient**: Referrals and transitions avoid unnecessary or duplicative services.
- **Equitable**: Quality of service does not vary by the personal characteristics of patients.



BlueCross-embedded care coordinators have the unique opportunity to help coordinate care for patients who are BlueCross members. Care coordinators are integrated and should be considered part of the practice health care team. They assist with coordinating services, such as specialist appointments and community resources, as well as, transitions in care.

Program Evaluations: Quality and Cost Improvement

Over the past ten-years, collaboration with the participating providers in the Patient-Centered Medical Home Program has resulted in significant quality and cost improvement. The annual PCMH results, outlined below, are the result of a collaborative partnership between the practices and BlueCross. With the addition of the MHP Utilization Management Program in 2020, additional improvements in the health outcomes of BlueCross members are expected.

2022 Evaluation Results

- An average 8.08 return on investment (ROI) compared to non-MHP practices
- 6.21% reduction in medical claims
- 3.2% reduction in Commercial inpatient visits per 1000
- 2.7% reduction in Commercial ER visits per 1000

2021 Evaluation Results

- An average 6.21 return on investment (ROI) compared to non-PCMH practices
- An average 6.1% reduction in inpatient (IP) admissions per 1,000
- Statistically significant higher quality compliance scores on 15 out of 25 key HEDIS® measures

2020 Evaluation Results

- An average 7.51 return on investment (ROI) compared to non-PCMH practices
- Approximately $5.1M in cost savings
- An average 2.1% reduction in inpatient (IP) admissions per 1,000 and 1.6% reduction in ER visits per 1000
- Statistically significant higher quality compliance scores on 12 out of 25 key HEDIS® measures

MHP Benefits to the Practice

Better data

- Access to more comprehensive, actionable data on patients
- Data-driven models to enable better integration across care settings

Best practices

- Enables sharing of best practices across the state
- Support and resources to aid in transformation to a patient-centered model

More sustainable reimbursement methods

- Opportunities to be reimbursed for quality care
- Opportunities to be reimbursed for improvement in utilization
- Financial opportunities for coordinated care

MHP Benefits to the Patient

Simplified, personalized health care

- Care coordination brings more personal and continuous interaction with providers, so patients get the care they need to stay healthy.

Improved quality of outcomes

- Care is tailored for the patients' needs and preferences.
- Care coordination results in fewer ineffective or redundant tests and procedures.

Greater member satisfaction

- Patients have expanded access to care and better access to their own information.
- There are multiple mechanisms for communicating with their provider through new technology.

Practice Responsibilities

1. The practice will identify a physician champion whose responsibilities include, but aren't limited to:

   - Providing visible and sustained leadership to lead specific strategies to improve quality, lower medical cost and improve patient satisfaction
   - Ensuring that the MHP utilization effort has the time and resources needed to be successful
   - Distributing provider scorecards and discussing best practices among colleagues
   - Educating providers and staff on care coordination and the role of the BlueCross MHP care coordinator
   - Attending and participating in joint quarterly MHP program meetings with the BlueCross MHP medical director and clinical team
   - Monitoring and tracking performance data and outcomes of the MHP program initiatives
   - Supporting collaborative care activities to improve quality

2. The practice agrees to use the BlueCross technology platform to identify the targeted population.

   - Stipend Care Coordinators are required to complete BlueCross compliance training annually. Failure to comply will result in loss of funding for the stipend care coordinator resource(s).
   - Failure to use the Care Coordination platform may result in termination of the MHP contract.

3. The practice agrees to participate in collaborative quality and cost initiatives (e.g. utilization reduction) through joint meetings and process improvement activities.

4. The practice will provide a workstation, including a desk and chair, for the MHP care coordinator within a clinical space of the practice. Clinical space isn't considered administrative space or off-site locations where BlueCross members aren't seeing the providers.

   The entity employing the care coordinator will be responsible for supplying the following:

   - Practice desktop computer or laptop computer
   - Two monitors (BlueCross can provide, if needed)
   - Keyboard (BlueCross can provide, if needed)
   - EMR access and training on EMR
   - Remote access to EMR
   - Access to printer within practice
   - Access to fax within practice
   - Practice phone

5. The practice will allow the MHP stipend care coordinator to attend onboarding training, monthly care coordinator meetings and the BlueCross annual meeting.
6. The practice will agree to share data for purposes of improving quality (HEDIS) outcomes, including sharing member level race, ethnicity and language data through the BlueCross Clinical Data Exchange (CDE).

BlueCross Responsibilities

1. BlueCross provides an MHP clinical team to work with the practice team.

   - BlueCross has a clinical team consisting of a Clinical Operations Manager and Corporate Medical Director that partners with practices to improve quality outcomes.

2. BlueCross provides a technology platform that supports the Medical Home Partnership.

   - BlueCross provides a care coordination, reporting and analytical platform for the MHP program. Through a defined attribution process, BlueCross members are attributed to a specific provider panel based on claims history. The technology allows care coordinators to review a patient population by practice, provider, chronic condition and/or utilization triggers such as ER visits. The technology platform also allows the MHP care coordinators to read notes and care plans, and refer members to internal BlueCross complex case managers needing additional support.

3. BlueCross provides an employed or stipend MHP care coordinator for the practice.

Care coordinator responsibilities include, but aren't limited to:

- Assisting with coordination of patient care needs and education on chronic conditions (telephonic and face-to-face).
  - Patients
  - Caregivers
- Building relationships and trust with PCPs and their clinical teams as well as other specialists within the MHP practice
- Focusing on moderate and high IP/ER utilizers
- Care transition management
- Ensuring medications prescribed at discharge have been filled and patient is taking medications properly
- Coordinating care for symptom management
- Coordinating preventive care
- No PCP visit within the year – reaching out to schedule appointment and ensure visit completed
- Completing a comprehensive assessment to determine plan of care

4. BlueCross provides New Employee Orientation and Training.

BlueCross provides training support for all employed and stipend care coordinators. The education program focuses on:

- New Employee Orientation (for hired employees only)
- The Care Coordination Model
- The Chronic Care Model
- Transitions in Care
- BlueCross Quality Program – HEDIS® 101
- Communication Techniques and Strategies:
  - Motivational interviewing
  - Shared decision-making
- Chronic Condition management training
- Annual BlueCross Compliance Training
- Quarterly BlueCross Security Training

5. BlueCross provides a Care Coordination Fee to the Practice.

- BlueCross runs claims data monthly to attribute patients to a specific provider within the MHP practice. BlueCross pays a monthly Care Coordination fee to the practice. The amount is based on the Exhibit 4 in the MHP Agreement.

MHP Provider and Network Participation

BlueCross recognizes that certain administrative functions are necessary to run the operations of the MHP program. These functions include patient attribution, data exchange, analytics and reporting. MHP is a program designed to include primary care providers exclusively.

Primary Care Physician (PCP) Classification

For purposes of the MHP Program, PCP classification includes the following provider specialties whose primary credentialing by BlueCross is as a primary care provider:

- Family Medicine
- Family Medicine – Adolescent Medicine
- Family Medicine – Adult Medicine
- Family Medicine – Geriatric Medicine
- Family Medicine – Sports Medicine
- Family Practice
- General Practice
- Internal Medicine
- Internal Medicine – Adolescent Medicine
- Internal Medicine – Geriatric Medicine
- Internal Medicine – Sports Medicine
- Nurse Practitioner
- Nurse Practitioner – Adult Acute Care
- Nurse Practitioner – Adult Health
- Nurse Practitioner – Family
- Nurse Practitioner – Gerontology
- Nurse Practitioner – Pediatrics
- Nurse Practitioner – Primary Care
- Pediatrics
- Pediatrics – Adolescent Medicine
- Pediatrics – Sports Medicine
- Physician Assistant
- Physician Assistant – Medical

Note: The PCP classification may differ by MHP component. For QCPI, please refer to the QCPI Addendum and QCPI Program Guide for PCP Classification.

MHP Provider Network Participation

The BlueCross MHP program applies to the networks according to the Exhibit 1 of the MHP Agreement.

MHP Attribution

Patient Attribution Methodology

Attribution. The BlueCross attribution methodology differs by MHP component; for instance, attribution to one component of MHP doesn't always mean a member will be attributed to all components. The attribution methodology for each MHP Program component is set forth below. BlueCross will apply the attribution methodology consistently among providers participating in the MHP program.

Attribution is at the member level and is based on face-to-face office or telehealth visits over an 18-month look-back period. Members are attributed to the provider with whom they've had the most visits during the look-back period. If there is a tie, then the member is attributed to the provider they've seen most recently.

A. Quality Component. BlueCross BlueShield of Tennessee members[1] who receive health benefits through a Commercial network (i.e., Blue Network PSM, Blue Network SSM, Blue Network LSM, or other future commercial networks) will be attributed to a PCP for the purposes of the QCPI.

Attribution is at the member measure level. Members are identified and attributed to a single PCP who meets one of the QCPI PCP Classified Provider Types and who's seen the member the most within an 18-month look-back period. If there's a tie, the member will be attributed to the PCP they've seen most recently.

Four measures, Appropriate Treatment for Children with Upper Respiratory Infection (URI), Appropriate Testing for Children w/Pharyngitis (CWP), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB), and Use of Imaging Studies for Low Back Pain (LBP) will be attributed to the provider within the practice who's responsible for the event that caused the member to be included in the measure. For example, a member that was diagnosed with Upper Respiratory Infection (URI) would be attributed to the PCP-classified provider who diagnosed the URI. Women's measures are attributed based on a hierarchy. They're attributed to the OB/GYN PCP provider they've seen the most during the look-back period. If they've not seen an OB/GYN PCP provider, those measures will be attributed to the primary care provider they've seen the most.

Pediatric members are also attributed based on a hierarchy, with the pediatric PCP provider taking precedence over primary care provider. These member measures will be attributed to the pediatric PCP provider with whom they had the most office visits during the look-back period. If they've not seen a pediatric PCP provider during the look-back period, the member will be attributed to a primary care provider. All other measures will be attributed to a primary care provider. Members that can't be attributed to any type of primary care provider won't be included in the QCPI. If a merger and/or acquisition of a new practice occurs during the performance year, any new PCP meeting the PCP classification will be added to the program and members will be attributed.

[1] BlueCard® membership is currently excluded from the QCPI attribution methodology because some data for this membership may be incomplete according to HEDIS®* specifications. BlueCross may add BlueCard membership to the QCPI attribution methodology if data sufficiency for this membership meets HEDIS specifications. BlueCross will provide notice to QCPI providers prior to including BlueCard membership in the QCPI attribution methodology.

B. Care Coordination Component. Member attribution methodology for the Care Coordination Component of the MHP Program and calculation of the Care Coordination Payment is as follows:

I. Care Coordination Component:

1. Members must have primary coverage with BlueCross to be included in attribution
2. Commercial members are attributed by Medical Claims history
3. PCPs, as defined in the above section of this MHP Program Guide, are eligible to have members attributed to them
4. Members who access the Commercial network according to Exhibit 1 A. of the MHP Agreement, may be attributed to a Professional Provider
5. Members who have received services from a PCP during an eighteen (18) month* look-back period

II. Care Coordination Fee:

1. Using the above attribution methodology, we will apply the following filters to identify eligible members for the care coordination fee:
   - *Commercial:* Age Filter Applied
     - Care coordination fee for commercial members will be for all adult members 19 years and older

C. Utilization Management Component. Member attribution methodology for the Utilization Management Component of the MHP Program is as follows:

I. For purposes of evaluating performance of Primary Care Provider for the Utilization Metrics:

1. Members must have primary coverage with BlueCross to be included in attribution.
2. Line of Business:
   a) *Commercial:* Members attributed via Medical Claims history
   b) *BlueCard:* BlueCard members will be included in the MHP attribution methodology
3. PCPs, as defined in the above section of this MHP Program Guide, are eligible to have members attributed to them
4. Members who access the Commercial Network(s), according to Exhibit 1 A. of the MHP Agreement, may be attributed to a Professional Provider
5. Members who have received services from a PCP during an eighteen (18) month* look-back period
6. Age Ranges:
   a) *Commercial:* Members 19 years and older during the look-back period may be attributed to Professional Provider

II. For purposes of calculating the Utilization Management Payment:

1. Using the above attribution methodology, we will apply the following filters to identify eligible members for the utilization management payment:
   a) Line of Business:
      - *Commercial:* Age Filter Applied
        - Utilization payment for commercial members will be for all adult members 19 years and older

For purposes of the MHP program the following (E&M) CPT-4 codes are used in the Attribution methodology:

59426, 59430, 93784, 96116, 96127, 96156, 96158, 96159, 96160, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99421, 99422, 99423, 99441, 99442, 99443, G0442, G0443, G0444

BlueCross will review the list of codes provided by NCQA on an annual basis and make revisions as needed.

* 18 month attribution model based on American Academy of Family Physicians and NCQA Recommendations

MHP Care Coordination Fee

Care Coordination Fees are based off the MHP attribution methodology and will be paid on per attributed member per month (PaMPM) according to Exhibit 4 of the MHP Agreement.

MHP Utilization Management Program

1. Practice Participation Requirements

The following requirements must be met for a practice to participate in the MHP Utilization Management Program:

- Achieved a minimum of four Stars on Commercial QCPI Scorecard in previous performance year.
- Actively participating in the Commercial Quality Care Partnership Initiative (QCPI) Program

2. Participating Lines of Business and Networks

The MHP Utilization Management Program is for our Commercial lines of business, including BlueCard Host members. All current and future participating Commercial networks, including Networks P, S, and L, are included in the MHP Utilization Management Program.

3. MHP Utilization Scorecard

Practices participating in the MHP Utilization Management Component will receive a Utilization Scorecard that is based on a 100 "Points Available" scale. The practice's scores are calculated for all attributed members within measurement year and are risk adjusted for the attributed member population. Each utilization metric is weighted and the total across all utilization metrics will equal 100%. "Points Earned" for a provider group is calculated on each metric and will be measured and compared to an established risk-adjusted regional benchmark.

- Practices achieving a four or five star rating in the MHP utilization management component will earn additional PaMPM fees according to Exhibit 2 of the MHP Agreement.

4. Benchmark Calculation

Utilization benchmarks are set at the provider group's regional comparison PCP population level. Provider groups with fewer than 225 attributed members are excluded from benchmark calculations. Additionally, provider groups with an overall risk score outside of three standard deviations from statewide average are excluded from benchmark calculations. Members who are non-attributable to a PCP are excluded from all benchmark calculations.

Appendix

A. 2024 QCPI Quality Measures

Quality Measure	Description
AAB Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event. The measurement period for this measure is a 12-month window that begins on July 1 of the year prior to the current year and ends on June 30 of the current year.
AIS Adult Immunization Status - Influenza 2024 Bonus Measure	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza.
AIS Adult Immunization Status - Zoster 2024 Bonus Measure	The percentage of members 50 years of age and older who are up to date on recommended routine Zoster vaccines.
AMM Antidepressant Medication Management - Effective Continuation Phase Treatment	The percentage of members 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (six months).
AMR Asthma Medication Ratio	The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
BCS Breast Cancer Screening	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer during the measurement year or the year prior.
BPD Blood Pressure Control for Patients with Diabetes <140/90	The percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) whose most recent documented BP was adequately controlled (<140/90) during the measurement year.
CBP Controlling High Blood Pressure	The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose most recent documented BP was adequately controlled (<140/90) during the measurement year.

Quality Measure	Description
CCS Cervical Cancer Screening	The percentage of women 21-64 years of age who were screened for cervical cancer using any of the following criteria: Women 21-64 years of age who had cervical cytology performed every three years. Women 30-64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years. Women 30–64 years of age who had hrHPV performed every 5 years.
CHL Chlamydia Screening in Women	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
CIS Childhood Immunization Status - Combo 10 (Dtap, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, Influenza)*	The percentage of members 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
COL Colorectal Cancer Screening New 2024 QCPI Measure	The percentage of members 45–75 years of age who were screened for colorectal cancer using any of the following criteria: Colonoscopy during the measurement year or the nine years prior Flexible sigmoidoscopy during the measurement year or the four years prior. CT colonography during the measurement year or the four years prior. FIT-DNA Test during the measurement year or the two years prior. Fecal occult blood testing (FOBT), including fecal immunochemical testing (FIT) annually.
CWP Appropriate Testing for Pharyngitis	The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. The measurement period for this measure is a 12-month window that begins on July 1 of the year prior to the current year and ends on June 30 of the current year.
EED Eye Exam for Patients with Diabetes	The percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) who had an eye exam (retinal) performed.

Quality Measure	Description
ECM Ethnicity Completeness Measure 2024 Bonus Measure	The count and percentage of members enrolled any time during the measurement year by ethnicity.
HBD Hemoglobin A1c Control for Patients with Diabetes <8%	The percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) whose most recent documented HbA1c was adequately controlled (<8.0%) during the measurement year.
IMA Immunizations for Adolescent - Combo 2 (Meningococcal, Tdap, HPV)*	The percentage of members 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.
KED Kidney Health Evaluation for Patients With Diabetes - Total	The percentage of members 18–85 years of age with diabetes (Type 1 and Type 2) whose most recent documented HbA1c was adequately controlled (<8.0%), during the measurement year.
LBP Use of Imaging Studies for Low Back Pain New 2024 QCPI Measure	The percentage of members 18-75 with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance).
RCM Racial Completeness Measure 2024 Bonus Measure	The count and percentage of members enrolled any time during the measurement year by race.
SPC Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy	The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: Received Statin Therapy - Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
SPC Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%	The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: Statin Adherence 80% - Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Quality Measure	Description
SPD Statin Therapy for Patients with Diabetes - Received Statin Therapy 2024 Bonus Measure	The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria: Received Statin Therapy - Members who were dispensed at least one statin medication of any intensity during the measurement year.
SPD Statin Therapy for Patients with Diabetes - Statin Adherence 80% 2024 Bonus Measure	The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria: Statin Adherence 80% - Members who remained on a statin medication of any intensity for at least 80% of the treatment period.
URI Appropriate Treatment for Upper Respiratory Infection	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.
W30 Well-Child Visits in the First 30 Months of Life - Age 15 Months-30 Months	Patients turning 30 months old during the year should have at least two or more well-visits between 15 months old and before 30 months old.
W30 Well-Child Visits in the First 30 Months of Life - First 15 Months	Patients turning 15 months old during the year should have at least 6 or more well-visits before turning 15 months old.
WCC Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents - BMI Percentile	Percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value. Ranges and thresholds do not meet criteria for this measure. Documentation must include height and weight. A distinct BMI percentile, if applicable, is required for compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).
WCV Child and Adolescent Well-Care Visits	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Bonus Measures

Quality Measure	Description
ECM Ethnicity Completeness Measure	Count and percentage of members enrolled any time during the measurement period by ethnicity. Completeness factor of 75%
RCM Racial Completeness Measure	Count a percentage of members enrolled any time during the measurement period by race. Completeness factor of 75%
AIS Adult Immunization Status – Influenza	Percentage of members 19 years of age and older who are up to date on recommended routine vaccine for influenza.
AIS Adult Immunization Status – Zoster	Percentage of members 19 years of age and older who are up to date on recommended routine vaccine for zoster.
AIS Adult Immunization Status – Tdap	Percentage of members 19 years of age and older who are up to date on recommended routine vaccine for Tdap.
SPD Statin Therapy for Patients with Diabetes – Received Statin Therapy	The percentages of members ages 40-75 who have diabetes and who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and who met the following criteria: Received Statin Therapy Members who were dispensed at least one statin medication of any intensity during the measurement year.
SPD Statin Therapy for Patients with Diabetes – Statin Adherence 80%	The percentages of members ages 40-75 who have diabetes and who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and who met the following criteria: Statin Adherence 80% - members who remained on statin medication of any intensity for at least 80% of the treatment period.

Measures for Monitoring Status Only

Quality Measure	Description
AWV Annual Wellness Visit	75% of members ages 22 and older who had an ambulatory or preventive visit with their primary care provider during the measurement period.
CWP-C Custom Appropriate Testing for Pharyngitis	The percentage of episodes for members ages 3 and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.*
URI-C Custom Appropriate Treatment for Upper Respiratory Infection	The percentage of episodes for members 3 months and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.*
AAB-C Custom Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	The percentage of episodes for members 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.*

*A custom BlueCross measure that allows for providers to have antibiotic dispensing information beginning in July of the prior year through June in the measurement year.

B. Sample Provider Scorecard

Commercial QCPI

Reporting Period Jan - Dec 2024

Benchmark	1 Star	2 Stars	3Stars	4 Stars	5 Stars
Points Needed	<=39	>=40	>=56	>=73	>=89

Measure	Eligible Population	Number Compliant	Compliance Rate	<25th	25th	50th	75th	90th	Points Earned	Points Available
Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment	199	137	69%	57%	57%	61%	65%	69%	3.03030	3.03030
Appropriate Testing for Pharyngitis (CWP)	291	195	67%	62%	62%	70%	75%	79%	1.21212	3.03030
Appropriate Treatment for Upper Respiratory Infection (URI)	275	231	84%	80%	80%	87%	90%	93%	1.21212	3.03030
Asthma Medication Ratio (AMR)	55	49	89%	81%	81%	84%	88%	91%	2.66667	3.03030
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	84	21	25%	43%	43%	49%	56%	65%	0.60606	3.03030
Blood Pressure Control for Patients With Diabetes (BPD) <140/90	1,683	1,254	75%	57%	57%	65%	72%	76%	8.00000	9.09091
Breast Cancer Screening (BCS)	3,982	3,238	81%	70%	70%	73%	77%	80%	3.03030	3.03030
Cervical Cancer Screening (CCS)*	9,449	7,502	79%	70%	70%	74%	78%	81%	2.66667	3.03030
Child and Adolescent Well-Care Visits (WCV)	2,185	1,154	53%	49%	49%	56%	64%	72%	1.21212	3.03030
Childhood Immunization Status (CIS) - Combo 10 (Dtap, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, Influenza)*	62	43	69%	45%	45%	56%	64%	71%	8.00000	9.09091
Chlamydia Screening in Women (CHL)	702	325	46%	40%	40%	45%	52%	62%	2.06061	3.03030

Measure	Eligible Population	Number Compliant	Compliance Rate	<25th	25th	50th	75th	90th	Points Earned	Points Available
Colorectal Cancer Screening (COL)	7,621	5,231	69%	52%	52%	57%	62%	67%	3.03030	3.03030
Controlling High Blood Pressure (CBP)*	3,725	2,670	72%	56%	56%	64%	70%	74%	8.00000	9.09091
Eye Exam For Patients with Diabetes (EED)	2,027	873	43%	43%	43%	50%	58%	64%	1.21212	3.03030
Hemoglobin A1c Control For Patients with Diabetes (HBD) <8	2,027	1,375	68%	55%	55%	61%	66%	69%	8.00000	9.09091
Immunizations for Adolescents (IMA) - Combo 2 (Meningococcal, Tdap, HPV)*	108	37	34%	26%	26%	32%	39%	46%	6.18182	9.09091
Kidney Health Evaluation for Patients with Diabetes (KED) - Total	2,031	885	44%	38%	38%	43%	49%	56%	2.06061	3.03030
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Received Statin Therapy	105	76	72%	80%	80%	83%	86%	88%	0.60606	3.03030
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Statin Adherence 80%	76	64	84%	76%	76%	80%	83%	86%	2.66667	3.03030
Use of Imaging Studies for Low Back Pain (LBP)	124	92	74%	72%	72%	76%	80%	83%	1.21212	3.03030
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC) - BMI Percentile	1,358	440	32%	63%	63%	76%	82%	88%	0.60606	3.03030
Well-Child Visits in the First 30 Months of Life (W30) - Age 15 Months-30 Months	75	67	89%	85%	85%	88%	92%	95%	2.06061	3.03030
Well-Child Visits in the First 30 Months of Life (W30) - First 15 Months	64	55	86%	78%	78%	83%	87%	90%	2.06061	3.03030
								*Hybrid Measure	71	100

Bonus Measures

Measure	Eligible Population	Number Compliant	Compliance Rate	Goal Compliance Rate	Goal Reached	Bonus Pts Available	Bonus Pts Earned
Ethnicity Completeness Measure	20,556	1350	7%	75%	N	1	0
Racial Completeness Measure	20,556	15622	76%	75%	N	1	1
Adult Immunization Status (AIS)- Influenza	12,042	1,898	16%	29%	N	0.5	0
Adult Immunization Status (AIS)- Zoster	5171	248	5%	21%	N	0.5	0
Adult Immunization Status (AIS) - Tdap	6010	2824	47%	46%	Y	0.5	0.5
Statin Therapy for Patients with Diabetes (SPD) - Statin Adherence 80%	263	232	88%	79%	Y	0.5	0.5
Statin Therapy for Patients with Diabetes (SPD)- Received Statin Therapy	430	263	61%	68%	N	0.5	0
					Total	4.5	2.0

Measures for Monitoring Status Only

Benchmark	Eligible Population	Number Compliant	Compliance Rate
Annual Wellness Visit (AWV)	0	0	0%
Custom Appropriate Testing for Pharyngitis (CWP-C)	0	0	0%
Custom Appropriate Treatment for Upper Respiratory Infection (URI-C)	0	0	0%
Custom Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-C)	0	0	0%

C. Utilization Measures

Utilization Measures	Description
Risk Adjusted Emergency Room visits per 1,000	For members 19 years of age and older, the regionally risk-adjusted per 1,000 rate of Emergency Department visits during the measurement year. Excludes Emergency Department visits that end up as hospital admission.
Risk Adjusted Inpatient Admissions per 1,000	For members 19 years of age and older, the regionally risk-adjusted per 1,000 rate of Inpatient Admissions in an Acute Care Hospitals, Skilled Nursing Facility (SNF), and/or Rehabilitation Facility during the measurement year. This measure only includes visits with POS 21.
Risk Adjusted Specialist visits per 1,000	For members 19 years of age and older, the regionally risk-adjusted per 1,000 rate of specialist visits during a measurement year. Include only outpatient visit counts and four categories of specialists: radiology, cardiology, orthopedic and gastroenterology. Excludes facility specialist visits and Primary Care Provider (Family Practice, Internal Medicine, General Practice and Pediatrics). Measure excludes the following: CT Heart/Coronary Calcium Scoring, CT Thorax/lung cancer screening, colonoscopies, mammograms, osteoporosis screenings, and bone density testing.

Note: Regional Benchmarks for MHP measures will be determined using data from July 2022 - June 2023. Non-Attributed members won't be considered in the risk score normalization process.

D. Medical Home Partnership Utilization Scorecard - 2024 Program Specifications

ABC Group SAMPLE

Incurred 1/1/2024 through 12/31/2024

Attributed Members: 3,897 **Member Months:** 28,721 **Risk Score:** 0.988

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Benchmark	1 Star	2 Stars	3Stars	4 Stars	5 Stars
Points Needed	39	40	56	73	89

Metric	Non Adjusted Group Utilization	Risk Adjusted Metric Per 1K	1 Star	2 Stars	3 Stars	4 Stars	5 Stars	Star Earned	Potential Points	Points Earned
Risk Adjusted Specialist Visits Per 1K	1,676	708.8	745.0	745.0	647.8	550.7	485.9	2	30	15.0
Risk Adjusted Emergency Room Visits Per 1K	417	176.4	225.8	225.8	196.3	166.9	147.3	3	30	21.0
Risk Adjusted Admits Per 1K	81	34.3	47.4	47.4	41.2	35.0	30.9	4	40	35.2
								Total	**100**	**71.2**

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1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

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