# 2024 Quality Performance Metrics Program

## Guide to Calculations and Metrics – Internal & Family Medicine

**In 2024, MSHP will continue to extract quality performance data directly from claims** to reduce the burden of reporting on primary care providers (PCPs)**.** This guide reviews 2024 adult quality measures and describes how providers can submit supplemental data to support and reconcile quality measurement.

While claims data will be used to measure quality for purposes of calculating the CI Index, MSHP may request supplemental clinical data on value-based patients to support contract performance. **If you are asked to provide additional data, the expectation is that this information will be provided to MSHP within two weeks of the request.**

Provider performance in Mount Sinai Health Partners' 2024 Quality Performance Metrics (QPM) program accounts for 40% of your Clinical Integration (CI) Index score. The CI Index score is used to calculate your annual incentive payment under the MSHP Clinical Integration Program.

### 2024 Adult Quality Measures

| Quality Measure | CIN Benchmark 2024 (HEDIS 4star) | QPM Points |
|---|---|---|
| Breast Cancer Screening | 71% | 3 |
| Colorectal Cancer Screening | 71% | 3 |
| Diabetic Eye Exam | 73% | 3 |
| Diabetic Kidney Health Evaluation | 50% | 3 |
| Medication Adherence – Oral Diabetes Medications (MA) | 89% | 3 |
| Medication Adherence ACE/ARBs for HTN (MA) | 89% | 3 |
| Medication Adherence – Statins (MA) | 89% | 3 |
| Percent of panel with PCP visit (seen anytime within the calendar year 2024) | 70% | 6 |

Total QPM points = 27

- Patient panels may vary throughout the year based on payer PCP attribution.
- **Benchmarks may be adjusted downward if Health Plans and/or CMS adjust quality measures, or at the discretion of MSHP Leadership.**
- Medication adherence is calculated for members in value-based contracts (VBCs) where medication adherence data is provided, but CI Index payment is across total CIN panel.
- Denominators will not be locked in Q4, meaning that if a patient joins your panel in October through December, they will be included in your denominator. This will more closely align your rolling 12-month reports to your current attribution and performance.
- If you have no patients that qualify for a measure denominator, the measure and associated points will be removed from the calculation. The remaining measures will be weighted more heavily in your total QPM score.

## Claims data and HEDIS guidelines are used to calculate quality metric performance

In 2024, we are using a claims-based approach to calculate quality performance. MSHP receives medical and pharmacy claims for attributed patients as part of our value-based contracts (VBCs) with payers. Payers assign their members to a PCP and we use this payer PCP assignment to determine which patients to include in a PCP's QPM measurement. Patient attribution methodology differs by line of business (see payer attribution table in appendix).

***Cancer Screenings and Diabetes Care Measurement***

We are using medical and pharmacy claims along with guidelines from the Healthcare Effectiveness Data and Information Set (HEDIS) to calculate quality measure rates and compliance for cancer screenings and diabetes care. HEDIS specifications are developed by the National Committee for Quality Assurance (NCQA) and used by payers to measure our performance in value-based contracts.

The HEDIS specifications provide quality measure inclusion criteria that contain visit types, age ranges, and diagnoses that are accounted for via CPT codes, ICD-10 codes, among other billing code sets. These guidelines also include specifications to calculate quality measure compliance, and what to include for credit for each measure using medical billing codes. Accordingly, the patient group for inclusion (i.e. denominator) and determination of those for whom the quality measure satisfied (i.e. numerator) are both calculated via medical codes on claims. The final rate calculation for each measure equals your numerator/denominator.

## Performance Reports

In January (week of January 22, 2024), April (week of April 1, 2024), and October (week of October 1, 2024), you will receive reports to help you track your performance and identify patients to target for needed care.

- In January 2024, PCPs received a full panel report that included 2023 attribution for all Commercial, Medicaid, and Medicare Advantage payers. The report includes 2024 attribution for Mount Sinai's Medicare ACOs.
- The **Value-Based Care (VBC) Performance Profile Report (April and October)** includes metrics on the percentage of patients who have been seen, quality gaps, accurate coding and documentation opportunities, and risk-adjusted cost and utilization information.
- The **Patient Opportunity Report (POR) (April and October)** identifies patients who have not been seen in the last 12 months. This report identifies open care gaps and patients with chronic diseases to help you target and manage your value-based care panel.
- The **In-Network Integration Performance Bonus Opportunity Report (April and October)** includes practice-level measures on new office visits to CIN specialists.

*Which patients are included in my reports?*

All VBC patients will be included in your performance reports. This includes patients insured by Healthfirst Medicaid, Healthfirst Medicare, and Empire Medicaid, as well as those participating with Mount Sinai's Medicare ACOs.

- While we will include all VBC patients in these performance reports, your final CI Index measurement will only include patients from MSHP's Clinically Integrated Network (CIN) value-based contracts. *See appendix, "CIN VBC Contracts" for a listing of payers included in the denominator.*

*What is the timing of the report lookbacks?*

Metrics are based on rolling 12-month data, with the exception of medication adherence and clinical documentation, which report year-to-date information.

*How will reports be distributed?*

Reports will be delivered to your OneDrive account**.** Please review these reports and schedule your patients for an appointment or necessary services to close care gaps.

*What should I do if I've reviewed my report and it shows care gaps as open that I know are closed?*

If you have proof that a care gap is closed, you will need to attest to the closure by uploading a historical report (such as cancer screenings or diabetic eye exam for adult patients) to your OneDrive account during the discrepancy review period. Please be aware that it may take at least 3-4 months for MSHP to receive claims data from payers, so patients who have recently closed a care gap may still appear on your report as non-compliant.

## Requests from MSHP for Supplemental Quality Data

Although MSHP uses claims data to evaluate quality performance, MSHP may ask you to supply supplemental data to support payer contract performance. As specified in the Clinical Integration Program requirements, this information must be provided within two weeks of the request.

Use CPT Category II codes on claims to help supplement performance measurement – and reduce the need to submit additional information for payers.

***Patient Exclusions***

The quality measures calculated using the HEDIS specifications (diabetes care and cancer screenings) take into account denominator exclusion criteria for frailty and advanced illness. **These include patients in palliative and hospice care along with those 66 years of age and older with frailty and advanced illness.** Patients must meet both the frailty and advanced illness criteria to be excluded. Examples include patients with ESRD, oxygen dependent patients with cancer, and Alzheimer's patients prescribed dementia medications.

There are also measure-specific exclusions such as gestational diabetes, bilateral mastectomy, and total colectomy. Note that conditions must be captured via diagnoses codes on claims during the measurement period or in some cases the year prior, in order for the patient to be excluded from a denominator. MSHP does not accept supplemental medical documentation from providers for patient exclusion.

## Numerator and Denominator Details

| MSHP 2024 Clinical Integration Program Quality Performance Metrics Internal & Family Medicine | |
|---|---|
| **Breast Cancer Screening** | |
| **Denominator:**<br><br>Women 52–74 years as of December 31 of the measurement period (timeframe is a rolling 12 months of measurement.)<br><br>*Note: We recommend **starting to screen at age 50** so that the patient is compliant with the quality measure when they enter your denominator.* | **Numerator:**<br>Women with one or more mammograms during the 27 months prior to the end of the measurement period |
| **Colorectal Cancer Screening** | |
| **Denominator:**<br>Patients 45 to 75 years of age as of December 31 of the measurement period (timeframe is a rolling 12 months of measurement.) | **Numerator:**<br>Patients with one or more screenings for colorectal cancer.<br>- Fecal occult blood test (FOBT) during the measurement period. |

| | |
|---|---|
| | - Flexible sigmoidoscopy during the measurement period or the 4 years prior.<br>- Colonoscopy during the measurement period or the 9 years prior.<br>- Computed tomography (CT) colonography during the measurement period or the 4 years prior.<br>- Fecal immunochemical DNA test (FIT- DNA) during the measurement period or the 2 years prior to the measurement period |
| **Percent of Panel with PCP visit (telehealth or in person anytime in 2024)** | |
| **Denominator:**<br>Adult patients attributed to a provider in a CIN value-based contract. (measurement is calendar year to date) | **Numerator:**<br>1 telehealth or in-person visit with the attributed PCP or another provider in the same PCP practice completed anytime in the 2024 calendar year<br><br>**Preventive Medicine Services:**<br>*Medicare AWV*<br>- IPPE - G402<br>- Initial AWV - G0438<br>- Subsequent AWV - G0439<br><br>*New Patients*<br>- Age 18 – 39 - 99385<br>- Age 40 – 64 - 99386<br>- Complete Physical Exams or Well Checks for 65 and older - 99387<br>*Established Patients*<br>- Age 18 – 39 years - 99395<br>- Age 40 - 64 years - 99396<br>- 65 years and older - 99397<br><br>**E&M Visits:**<br>*New Patient*<br>- Level 2 – 99202<br>- Level 3 – 99203<br>- Level 4 – 99204<br>- Level 5 – 99205<br><br>*Established Patient*<br>- Level 1 – 99211<br>- Level 2 – 99212<br>- Level 3 – 99213<br>- Level 4 – 99214<br>- Level 5 – 99215 |
| **Diabetes: Eye Exam** | |

| | |
|---|---|
| **Denominator:**<br>Patients 18 to 75 years of age on date of encounter AND diagnosis for diabetes (ICD-10-CM) | **Numerator**:<br>Diabetics with an eye screening for diabetic retinal disease who had one of the following:<br>- Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed (G2102)<br>- Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed (G2103)<br>- Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed (G2104)<br>- Low risk for retinopathy (no evidence of retinopathy in the prior year) (CPT II code 3072F) |
| **Diabetes: Kidney Health Evaluation** | |
| **Denominator:**<br>Patients aged 18 years to 85 years on date of encounter AND diagnosis for diabetes (ICD-10) | **Numerator:**<br>Kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.<br><br>Patients can receive an eGFR and a uACR during the measurement year on the same or different dates of service. |
| **Medication Adherence for Diabetes Medications** | |
| **Denominator:**<br>Patients with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (measurement is calendar year to date)<br>Patients who use insulin are excluded. | **Numerator:**<br>Number of patients with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period. |
| Measure description: | |

- Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
- Diabetes medication means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic drug, a meglitinide drug, or an SGLT2 inhibitor. Patients who take insulin are not included.

## Medication Adherence for Cholesterol (Statins)

| **Denominator:** | **Numerator:** |
|---|---|
| Patients with at least two statin cholesterol medication fills on unique dates of service during the measurement period (year to date measurement.) | Number of patients with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period. |

Measure description:

- Patients with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
- Statins include: atorvastatin (+/- amlodipine, ezetimibe), fluvastatin, lovastatin (+/- niacin), pitavastatin, pravastatin, rosuvastatin, simvastatin (+/-ezetimibe, niacin, sitagliptin)

## Medication Adherence for Hypertension (RAS antagonists)

| **Denominator:** | **Numerator:** |
|---|---|
| Patients with at least two ACE/ARB fills on unique dates of service during the measurement period (measurement is year to date.) | Number of patients with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period. |

Percent of Medicare Advantage members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Blood pressure medication means an ACE (angiotensin converting enzyme) inhibitor, an ARB (angiotensin receptor blocker), or a direct renin inhibitor drug.

| **ARBs** | **ACE Inhibitors** | **Direct Renin Inhibitor** |
|---|---|---|
| azilsartan (+/- chlorthalidone) candesartan (+/- hydrochlorothiazide) eprosartan (+/- hydrochlorothiazide) irbesartan (+/- hydrochlorothiazide) losartan (+/- hydrochlorothiazide) olmesartan (+/- amlodipine, hydrochlorothiazide) telmisartan (+/- amlopdipine, hydrochlorothiazide) valsartan (+/- amlodipine, hydrochlorothiazide nebivolol) | benazepril (+/- amlodipine, hydrochlorothiazide) captopril (+/- hydrochlorothiazide) enalapril (+/- hydrochlorothiazide) fosinopril (+/- hydrochlorothiazide) lisinopril (+/- hydrochlorothiazide) moexipril (+/- hydrochlorothiazide) perindopril (+/- amlodipine) quinapril (+/- hydrochlorothiazide) ramipril trandolapril (+/- verapamil) | aliskiren (+/- amlodipine, hydrochlorothiazide) |

**Questions?** Please contact your Population Health Manager or Population Health Specialist. You can also email us at mshp@mountsinai.org or call 877-234-6667.

# APPENDIX: Denominator Inclusion/Exclusion by Payer

| Quality Measures | Eligible Population |
|---|---|
| Medication Adherence Measures | CIN Medicare Advantage Contracts |
| Breast Cancer Screening<br>Colorectal Cancer Screening<br>Diabetic Eye Exam<br>Diabetic Nephropathy Screening<br>Percent of panel with PCP visit | CIN VBC Payer Contracts |

## CIN VBC Payer Contracts **Included** in Final CI Index Calculation

- Aetna Commercial and Aetna Medicare Advantage
- Cigna Commercial
- Empire Commercial and Empire Medicare Advantage
- Humana Medicare Advantage

## Payer Contracts **Excluded** from Final CI Index Calculation

- Centivo Commercial
- EmblemHealth GHI Medicare & Commercial
- EmblemHealth HIP Commercial, Medicare, and Medicaid
- Empire BlueCross BlueShield Medicaid
- Healthfirst Medicaid and Medicare Advantage
- MSSP (Medicare ACO) and ACO REACH
- Oscar Commercial