Care Network Value Based Contract Metric Specifications Guide-2026

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AETNA AVOIDABLE ER VISITS PER 1,000 MEMBERS PER YEAR	
DEFINITION	This measure calculates the rate of avoidable emergency room visits per 1,000 members per year. This measure excludes ER visits for cancer management, maternity care, major trauma and other conditions where it is unlikely that an ER visit can be avoided.
NUMERATOR	ER visits to an acute care facility or children's hospital, for members > age 5 for specific conditions that have a potential for office-based management.
DENOMINATOR	Members as defined by reporting package. The definition of a member month is being effective on the 16th of a given month. If member month count >=12 then 12. If the measurement period is less than 12 months the rate is annualized.
EXCLUSIONS	This measure excludes ER visits for cancer management, maternity care, major trauma and other conditions where it is unlikely that an ER visit can be avoided.
TIPS	• Educate families to always call your office before heading to emergency department or urgent care • Engage with patients who have chronic conditions (e.g., asthma) to help prevent and minimize exacerbations and complications. • Contact patients seen for preventable ED or urgent care visits and bring them in for follow-up • Orient all new patients/families to your office hours, how to reach you after hours, and what kinds of conditions you will see urgently • Remind patients who have used the ED for things better cared for in the primary care office about your office hours, how to reach you after hours, and what kinds of conditions you will see urgently • Work with our Care Network team to identify high utilizers of the ED and schedule appointments, review their problem list, and encourage them to call your office before going to the ED

AETNA CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)	
DEFINITION	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.
NUMERATOR	Members who had one or more well-care visits during the measurement year.
DENOMINATOR	Members 3-21 years as of December 31 of the measurement year.
EXCLUSIONS	Members in hospice care
TIPS	• It is possible to improve this measure in the short term since it is dependent on a patient receiving an annual preventive visit any time during the measurement year. • Whenever possible (and indicated) convert sports pre-participation physical exams or dental clearance exams into well visits. Train staff to identify families who call for sports physicals and dental clearance exams who need well visits. • Use gaps in care process and reports.

	• Schedule next visit at the end of each appointment. Institute a reminder system to make sure well visits are scheduled. • Have a reminder or call-back system to increase the number of appointments that are kept. • Recruit office staff to help with reminders for well visits	
COMMON CODES:	**CPT**	99382-99385, 99392-99395
	ICD-10	Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

AETNA CHILDHOOD IMMUNIZATION STATUS-COMBO 10 (CIS)		
DEFINITION	The percentage of children 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.	
NUMERATOR	Children who received the recommended vaccines by their second birthday	
DENOMINATOR	Children turning 2 years of age during the measurement year	
EXCLUSIONS	• Members with immunodeficiency may be excluded from MMR, VZV, and influenza • Members with anaphylactic reaction to a vaccine or its components can be excluded from that vaccine • Members in hospice care	
TIPS	• Document the date of the first hepatitis B vaccine given at the hospital. • Include child's immunization history from all sources (e.g., hospitals, health department, previous providers). • Document contraindications or allergies. • Schedule subsequent vaccine visits before parents leave the office • Check at each visit (well or sick) for any missing immunizations. • Missing the fourth doses of DTaP and PCV vaccines are primary barriers for CIS compliance. Ensure timeliness in administering first doses and follow up for additional doses before the patient's second birthday. • Check each child's immunization status at 12 months of age to allow time to catch up by second birthday. • Missing second influenza vaccination is a primary barrier to CIS compliance. Develop standard process to recall patients for second influenza vaccination. • Use your electronic medical record system for pre-visit planning and to set alerts to indicate when the immunizations are due.	
COMMON CPT CODES	**DTaP**	90696, 90697, 90698, 90700, 90723
	IPV	90696, 90697, 90698, 90713, 90723
	MMR	90707
	MMRV	90710

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	Hib	90647, 90648, 90697, 90698
	Hepatitis B	90697, 90723, 90740, 90744, 90747
	Varicella – VZV	90710, 90716
	Pneumococcal Conjugate	90670, 90671
	Hepatitis A	90633
	Rotavirus (2 doses)	90681
	Rotavirus (3 doses)	90680
	Influenza	90674, 90685, 90686, 90687, 90688, 90756

AETNA
CT/MRI VISITS PER 1,000

DEFINITION	Total paid CT and MRI procedures in the outpatient setting per 1,000 attributed members.
NUMERATOR	Total CT and MRI procedures in the outpatient setting. Procedure count = distinct count of Member, Date of Service and Procedure Code.
DENOMINATOR	Members as defined by reporting package. The definition of a member month is being effective on the 16th of a given month. If member month count >=12 then 12. If the measurement period is less than 12 months, the rate is annualized.
EXCLUSIONS	None
TIPS	• This metric is focused on the total number of CTs and MRIs in the attributed population • Avoid unnecessary scans

AETNA
IMMUNIZATIONS FOR ADOLESCENTS-COMBO 2 (IMA)

DEFINITION	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.
NUMERATOR	Adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.
DENOMINATOR	Adolescent members who turn 13 years of age during the measurement year
EXCLUSIONS	• Members with anaphylactic reaction to vaccine or its components can be excluded from that vaccine • Members with encephalopathy due to Tdap vaccine • Members in hospice or using hospice services anytime during the measurement year
TIPS	• Check at each visit (well or sick) for any missing immunizations.

	• Include child's immunization history from all sources (e.g., hospitals, health department, previous providers).
	• Document contraindications or allergies.
	• Schedule appointments for your patient's next vaccination before they leave your office.
	• Reschedule appointments for those who were no-shows for a vaccine visit.
	• There must be at least 146 days between the first and second dose of the HPV vaccine.
	• Recommend immunizations to parents and address common misconceptions. They are more likely to agree with vaccinations when supported by the provider.
	• Use normalizing or opt out language with patients
	  ○ "Now that Miguel is 11, he is due for vaccinations to help protect against meningitis, cancer caused by HPV, and whooping cough. We'll give those shots during today's visit. Do you have any questions about these vaccines?"
	• Advice from your Care Network colleagues
	  ○ Use the word "vaccine" instead of "shot"
	  ○ Choose careful scripting, avoid phrase "and optional HPV vaccine" at 11yr old check-up
	  ○ List HPV in the middle of the vaccine sequence when talking with parents and kids
	  ○ For parents that opt out at the 11yr old check-up, schedule a nurse-only visit for HPV vaccine at another date/time.	

COMMON CODES:	**CPT**	• **Meningococcal conjugate:** 90619, 90734 • **Tdap:** 90715 • **HPV:** 90651

AETNA IMPACTABLE ACUTE INPATIENT ADMISSIONS PER 1,000 MEMBERS PER YEAR	
DEFINITION	This measure calculates the number of potentially impactable acute inpatient admissions per 1,000 members per year. This measure includes cases that, with improved patient management, potentially could be avoided.
NUMERATOR	Acute inpatient hospitalizations for specific DRG codes
DENOMINATOR	Members as defined by reporting package. The definition of a member month is being effective on the 16th of a given month. If member month count >=12 then 12. If the measurement period is less than 12 months, the rate is annualized.
EXCLUSIONS	• Admission for cancer management, maternity care, trauma, transplant, behavioral health conditions and other conditions where it is unlikely that an inpatient admission can be avoided based on the DRG on the admission. • Readmission cases identified within 1-30 days because this indicator is profiled in the 30-day readmission measure.
TIPS	• Ensure engagement with patients who have chronic diseases (e.g., asthma, diabetes) to review action plans, medication use and understanding, status of chronic disease, connection to specialist care. • Contact patients seen for preventable ED or urgent care visits and bring them in for follow-up, to prevent future admissions

AETNA LABORATORY STEERAGE PREFERRED SETTING	
DEFINITION	This measure calculates the percentage of laboratory services performed in participating free-standing laboratory.
NUMERATOR	Laboratory studies performed in a participating provider office or free-standing laboratory
DENOMINATOR	Laboratory studies performed in a participating outpatient setting: hospital outpatient, provider office or participating free-standing laboratory: • Chemistry studies • Hematology studies • Laboratory studies - other • Microbiology studies
EXCLUSIONS	The measure excludes surgical pathology tests
TIPS	• Utilize outpatient laboratories (i.e., Labcorp, Quest) as often as possible

AETNA OUTPATIENT STEERAGE PREFERRED SETTING	
DEFINITION	This measure calculates for selected outpatient procedures performed in an outpatient hospital or free-standing ambulatory surgery center, the percentage of cases that are performed in a free-standing ambulatory surgery center.
NUMERATOR	Selected surgical procedures performed in a free-standing ambulatory surgery center
DENOMINATOR	Selected surgical procedures performed in a hospital outpatient surgery setting or free-standing ambulatory surgery center
EXCLUSIONS	None
TIPS	• This metric is focused on increasing the number of surgeries that can appropriately be done at an ambulatory surgery center (to reduce cost)

AETNA RADIOLOGY STEERAGE PREFERRED SETTING	
DEFINITION	This measure calculates the percentage of outpatient radiology MRI, CT scan, PET scan and ultrasound services performed in a participating physician office or participating free- standing radiology center.
NUMERATOR	Studies performed by in a participating provider office or participating free-standing radiology.

DENOMINATOR	MRI, CT scan, PET scan and ultrasound performed in a participating hospital outpatient, physician office or participating free-standing radiology center.
EXCLUSIONS	None
TIPS	• Utilize outpatient radiology centers (e.g., Jefferson) as often as possible, when appropriate

AETNA **READMIT RATE (30-DAY READMISSION RATE)**	
DEFINITION	This measure calculates the percentage of acute care inpatient hospitalizations followed by a subsequent acute care inpatient hospitalization within 1-30 days of the discharge date of the first hospitalization.
NUMERATOR	Readmission is defined as the proportion of acute care inpatient hospitalizations followed by a subsequent acute care inpatient hospitalization within 1 to 30 days of the original discharge date. This measure excludes counting readmissions that would have been expected based on the clinical nature of the case such as elective surgery (where the DRG on the case is designated as surgical by CMS) or the DRG represents maternity, newborn, behavioral health, rehabilitation, sequential care like chemotherapy, or acute injury that, by nature, cannot be related to a previous admission.
DENOMINATOR	All acute care inpatient hospitalizations
EXCLUSIONS	This measure excludes counting admissions in any of the following conditions: • The age of the members is <1 year, • The length of stay of the primary admission is an outlier • The discharge status indicates the member expired, a transfer to an acute inpatient facility or discharge against medical advice.
TIPS	• Obtain and review patients’ discharge summaries • Obtain any test results that were not available when patients were discharged and track tests that are still pending • If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed • When scheduling the post-discharge visit, ask patients to bring in all their prescription medications, over-the-counter medications and supplements so that medication reconciliation can be performed • Discuss the discharge summary with patients/caregivers and ask if they understand the instructions and filled the new prescriptions • Complete a thorough medication reconciliation and ask patients and caregivers to recite their new medication regimen back to you • Provide the patient/caregiver with a current list of medications • Develop an action plan for chronic conditions (e.g., asthma). • Have patients and caregivers repeat the care plan back to you to demonstrate understanding. • Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.

	• Ask patients/caregivers if they completed or scheduled prescribed outpatient follow-up or other services. This could include specialists, physical therapy, home health care visits and obtaining durable medical equipment

AETNA RX STEERAGE - GENERIC UTILIZATION (TOP 12)	
DEFINITION	This measure calculates the percentage of generic prescriptions filled for the top 12 drug groups.
NUMERATOR	The number of prescription 30-day equivalents in the top 12 drug groups that are generic at the time of claim adjudication.
DENOMINATOR	The total number of prescription 30-day equivalents in the top 12 drug groups for both preferred (generic) and non-preferred drugs (brand).
DRUG GROUPS INCLUDED	Drug groups are identified by Generic Product Identifier (GPI) group code and include: • Antianginal agents • Antianxiety agents • Antidepressants • Antidiabetics • Antihyperlipidemics • Antihypertensives • Beta blockers • Calcium channel blockers • Dermatologicals • Diuretics • Thyroid agents • Ulcer drugs
TIPS	• As often as possible, prescribe generic formulations of medications • Configure EHR to default to generic medications • Do not check of the DAW box, if brand medication is not required.

AETNA WELL CHILD VISITS AGES 0-30 MONTHS (W30)	
DEFINITION	Percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months-30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

NUMERATOR	Rate 1. Children in the denominator with 6 or more well visits on different dates of service on or before the 15-month birthday Rate 2. Children in the denominator with 2 or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.	
DENOMINATOR	Rate 1. Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days. Rate 2. Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days Exclude children in hospice.	
TIPS	• This metric is two separate metrics, Well Child Visits Ages 0-15 Months and Well Child Visits 15-30 Months • Improvement on these measures measure take a significant amount of time since performance is evaluated based on six visits over 0-15 months and two visits over 15-30 months. • Whenever possible (and indicated) convert simple acute visits into preventive visits. • Use gaps in care process and reports. • Schedule next visit at the end of each appointment. • Institute a reminder system to make sure well visits are scheduled. • Have a reminder/call back system to increase the number of appointments that are kept. • Recruit office staff to help with reminders for well visits.	
COMMON CODES:	**CPT:**	99381, 99382, 99391, 99392, 99461
	ICD-10:	Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.82, Z02.89, Z02.9, Z76.1, Z76.2

ANTHEM ALL CAUSE 30 DAY READMISSION - ADULT	
DEFINITION	This measure identifies, for 18-64 years of age, the number of acute inpatient or observation discharges during the measurement period that were followed by an unplanned acute readmission for any diagnosis within 30 days adjusted for the predicted probability of an acute readmission.
NUMERATOR	The number of unplanned readmissions within 30 days of an index hospital stay
DENOMINATOR	All acute inpatient and observation discharges for members 18-64 who had one or more discharges at least 30 days before the last day of the Measurement Period
EXCLUSIONS	Numerator • Nonacute inpatient stays • Inpatient stays for a principal diagnosis of pregnancy or

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	• Inpatient stays for a principal diagnosis of pregnancy perinatal conditions or • Inpatient stays followed within 30 days by planned readmissions. • Principal diagnosis of chemotherapy or rehabilitation; kidney transplant, bone marrow transplant, or other organ transplant; or readmission for potentially planned procedures without a principal acute diagnosis Denominator • Index Hospital Stay (IHS) with the same start and end date • IHS where member died during the stay • IHS with a principal diagnosis of pregnancy or perinatal conditions • Exclude commercial members with 3 or more index hospital or observation stays during the measurement period
TIPS	• Obtain and review patients' discharge summaries • Obtain any test results that were not available when patients were discharged and track tests that are still pending • If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed • When scheduling the post-discharge visit, ask patients to bring in all their prescription medications, over-the-counter medications and supplements so that medication reconciliation can be performed • Discuss the discharge summary with patients/caregivers and ask if they understand the instructions and filled the new prescriptions • Complete a thorough medication reconciliation and ask patients and caregivers to recite their new medication regimen back to you • Provide the patient/caregiver with a current list of medications • Develop an action plan for chronic conditions (e.g., asthma). • Have patients and caregivers repeat the care plan back to you to demonstrate understanding. • Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future. • Ask patients/caregivers if they completed or scheduled prescribed outpatient follow-up or other services. This could include specialists, physical therapy, home health care visits and obtaining durable medical equipment

ANTHEM BRAND FORMULARY COMPLIANCE RATE	
DEFINITION	This measure identifies the overall percentage of brand prescriptions filled as formulary based on the prescriptions filled for Attributed members with an Anthem prescription drug benefit during the applicable Data Collection period.
NUMERATOR	The total number of denominator prescribing events that are dispensed for a formulary drug (defined by claim formulary indicator).
DENOMINATOR	Total number of brand prescriptions with fill dates in the Measurement Period. • Note: Each 30-day supply of drug counts as one denominator event. So 90 day supply is 3 denominator events of a non-formulary brand medication

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EXCLUSIONS	• **Specialty Drugs:** requires frequent dosing adjustments and intensive clinical monitoring; special handling requirements, limited distribution, High-cost- $500 for a 30-day supply, e.g. Antiretroviral, growth hormones, multiple sclerosis agents • **Drug and Alcohol Treatment:** e.g. buprenorphine, naloxone
TIPS	• As often as appropriate, default to a generic medication • When a brand medication is needed, understand which formulary the patient has and default to the brand medication that is on the formulary, as appropriate. • Links to formularies can be found in every biweekly Care Network Update

ANTHEM
CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

DEFINITION	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.	
NUMERATOR	Members who had one or more well-care visits during the measurement year.	
DENOMINATOR	Members 3-21 years as of December 31 of the measurement year.	
EXCLUSIONS	Members in hospice care	
TIPS	• It is possible to improve this measure in the short term since it is dependent on a patient receiving an annual preventive visit any time during the measurement year. • Whenever possible (and indicated) convert sports pre-participation physical exams or dental clearance exams into well visits. Train staff to identify families who call for sports physicals and dental clearance exams who need well visits. • Use gaps in care process and reports. • Schedule next visit at the end of each appointment. Institute a reminder system to make sure well visits are scheduled. • Have a reminder or call-back system to increase the number of appointments that are kept. • Recruit office staff to help with reminders for well visits	
COMMON CODES:	**CPT**	99382-99385, 99392-99395
	ICD-10	Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

ANTHEM
EMERGENCY DEPARTMENT UTILIZATION (EDU)-18Y+

DEFINITION	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year Rate = (Numerator ÷(Denominator/1000)/ riskadjustment factor

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NUMERATOR	Number of ED visits during the measurement year for members in the denominator. Exclude visits with principal diagnosis of mental or behavioral disorders and visits followed directly by an inpatient stay
DENOMINATOR	• Age 18 or older • Current member eligibility • Continuous member eligibility for the 730 days before the end of the Measurement Period

EXCLUSIONS	• ED visits that result in an inpatient or observation stay
	• ED visits with any of the following:
	  ○ A principal diagnosis of mental health or chemical dependency
	  ○ Psychiatry
	  ○ Electroconvulsive therapy
	• Members in hospice
	• Members with 4 or more ED visits in the measurement year

TIPS	• Encourage patients to engage with their PCP for annual wellness visits, screenings, and care coordination • Engage with patients who are diagnosed with chronic conditions to help prevent and minimize exacerbations and complications • Educate patients about appropriate ED use and other options available such as same-day appointments, urgent care, nurse lines, and telehealth • Engage the Care Network care coordination team for patients with high ED utilization • Consider extended clinic and telehealth hours and addition of a nurse line • Offer/coordinate support services for patients diagnosed with chronic conditions or experiencing exacerbations. • Work closely with the Care Network care coordination team for care coordination support

ANTHEM FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (FUM)	
DEFINITION	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness **within 7 days** of the latest ED visit
NUMERATOR	Members in the denominator who had a follow-up mental health visit within 7 days of the emergency department visit (8 total days). A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit. • An outpatient visit ***with*** a principal diagnosis of a mental health disorder • An outpatient visit ***with*** a principal diagnosis of a mental health disorder • An intensive outpatient encounter or partial hospitalization ***with*** POS code 52 ***with*** a principal diagnosis of a mental health disorder

	• An intensive outpatient encounter or partial hospitalization a principal diagnosis of a mental health disorder • A community mental health center visit ***with*** POS code 53 ***with*** a principal diagnosis of a mental health disorder • Electroconvulsive therapy ***with*** a principal diagnosis of a mental health disorder • A telehealth visit ***with*** a principal diagnosis of a mental health disorder • A telephone visit ***with*** a principal diagnosis of a mental health disorder • An e-visit or virtual check-in ***with*** a principal diagnosis of a mental health disorder • An outpatient visit ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • An outpatient visit ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • An intensive outpatient encounter or partial hospitalization ***with*** POS code 52 ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • An intensive outpatient encounter or partial hospitalization ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • A community mental health center visit ***with*** POS code 53 ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • Electroconvulsive therapy ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • A telehealth visit ***with*** Telehealth POS Value Set ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • A telephone visit ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • An e-visit or virtual check-in ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder
DENOMINATOR	An ED visit with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members
EXCLUSIONS	• Members in hospice or using hospice services anytime during the measurement year • ED visits followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days)
TIPS	• Ensure there is an efficient office workflow for reviewing ED reports timely and reach out to members/parents promptly to schedule follow-up visits • Identify and address any barriers to the patient attending the appointment • Encourage the patient to bring their discharge paperwork to their follow up appointment • Provide reminder calls to confirm appointments and reach out within 24 hours to patients who cancel appointments to reschedule as soon as possible • Telephone, telehealth, e-visits, and virtual visits are included in follow-up visit types as long as a claim is submitted and a code for a behavioral health diagnosis is included • Follow-up visits that occur on the same date as the ED visit count • 7-day time frames include weekends • Follow-up visits can be with any practitioner type

	• Discuss with the patient the importance of seeking follow up with a behavioral health provider • Submit claims and encounter data in a timely manner and ensure accurate and complete coding • A non-mental illness diagnosis code will not fulfill this measure • Work closely with the Care Network care coordination team for care coordination support

ANTHEM KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)		
DEFINITION	This measure identifies diabetic members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement period.	
NUMERATOR	Members in the denominator who received both of the following during the measurement period on the same or different dates of service: • At least 1 claim for an estimated glomerular filtration rate and • At least one uACR identified by both a quantitative urine albumin test and a urine creatinine test with service dates within four or less days apart	
DENOMINATOR	• Age 18-85 as of the last day of the Measurement Period. • Member eligibility in the 365 days before the end of the measurement period, with no more than 1 gap of no more than 45 days • Member eligibility on the last day of the measurement period. • Meets the following criteria ○ Any of the following in the 730 days before the end of the measurement period: • At least 1 claim for diabetes from an acute inpatient setting • At least 2 claims for diabetes from an outpatient, observation, telephone visit, online assessment, ED visit, or nonacute inpatient setting or inpatient stay • OR at least 1 prescription claim for diabetes medication dispensed	
EXCLUSIONS	• Members with gestational diabetes, medication-induced diabetes, or condition-induced diabetes • Members with a palliative care assessment, encounter, or intervention	
COMMON CODES:	**CPT:**	• Estimated glomerular filtration rate lab test: 80047; 80048; 80050; 80053; 80069; 82565 • Quantitative urine albumin lab test: 82043 • Urine creatinine lab test: 82570
	ICD-10:	• Diabetes: E10.9, E11.9, E13.9
TIPS	• Identify, early in the year, patients 18 years of age or older with diabetes who need testing and coordinate with endocrinology to set them up for testing • Coordinate patient care with endocrinologists and/or nephrologists, as needed. • If patient has transitioned to an adult endocrinologist not affiliated with Connecticut Children’s, you may need to order testing and communicate with patient and their endocrinologist. • **Quest’s Kidney Profile test includes both the eGFR blood test and the urine albumin-to-creatinine ratio (uACR) test; Quest test code is 39165**	

	• **Labcorp's Kidney Profile test includes both the eGFR blood test and the urine albumin-to-creatinine ratio (uACR) test; Labcorp test number is 140301** • Educate patients on how diabetes can damage blood vessels which can lead to loss of kidney function. • A urine albumin test is not sufficient

ANTHEM POTENTIALLY AVOIDABLE EMERGENCY ROOM VISITS (<18)	
DEFINITION	This measure identifies members under age 18 years who visited the ER for a diagnosis that likely could have been treated in an ambulatory care setting excluding those ER visits followed by an inpatient admission and those with a patient reason for visit considered potentially avoidable.
NUMERATOR	The number of potentially avoidable emergency room visits for the eligible population for the designated time period. Potentially avoidable emergency room visits are identified by primary ICD-10 diagnosis codes
DENOMINATOR	The count of eligible members for each month of eligibility for the designated time period.
EXCLUSIONS	Emergency room visits that resulted in: 1) an inpatient admission OR 2) visits with a patient reason for visit considered potentially unavoidable
TIPS	• Educate families to always call your office before heading to emergency department or urgent care • Engage with patients who have chronic conditions (e.g., asthma) to help prevent and minimize exacerbations and complications. • Contact patients seen for preventable ED or urgent care visits and bring them in for follow-up • Orient all new patients/families to your office hours, how to reach you after hours, and what kinds of conditions you will see urgently • Remind patients who have used the ED for things better cared for in the primary care office about your office hours, how to reach you after hours, and what kinds of conditions you will see urgently • Work with our Care Network team to identify high utilizers of the ED and schedule appointments, review their problem list, and encourage them to call your office before going to the ED

ANTHEM WELL CHILD VISITS: AGES 15-30 MONTHS	
DEFINITION	This measure identifies members who turned 30 months old and who had at least 2 well-child visits between 15 and 30 months of life
NUMERATOR	Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP

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	does not have to be the practitioner assigned to the child. Visits within 6 days' interval will be counted as one visit.	
DENOMINATOR	• Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days. • AND Continuously enrolled with no more than one gap in enrollment of up to 45 days from 31 days through 15 months of age (calculate 31 days of age by adding 31 days to the date of birth). • Exclude children in hospice.	
TIPS	• Improvement on this measure takes significant amount of time since performance is evaluated based on six visits over 15 months. • Whenever possible (and indicated) convert simple acute visits into preventive visits. • Use gaps in care process and reports. • Schedule next visit at the end of each appointment. • Institute a reminder system to make sure well visits are scheduled. • Have a reminder/call back system to increase the number of appointments that are kept. • Recruit office staff to help with reminders for well visits.	
COMMON CODES:	**CPT**	• 99382, 99391, 99392
	ICD-10	• Z00.121, Z00.129, Z00.2, Z00.8, Z02.6, Z76.1, Z76.2

ANTHEM-CT
ALL CAUSE 30 DAY READMISSION - ADULT

DEFINITION	This measure identifies, for 18-64 years of age, the number of acute inpatient or observation discharges during the measurement period that were followed by an unplanned acute readmission for any diagnosis within 30 days adjusted for the predicted probability of an acute readmission.
NUMERATOR	The number of unplanned readmissions within 30 days of an index hospital stay
DENOMINATOR	All acute inpatient and observation discharges for members 18-64 who had one or more discharges at least 30 days before the last day of the Measurement Period
EXCLUSIONS	Numerator • Non-acute inpatient stays • Inpatient stays for a principal diagnosis of pregnancy or • Inpatient stays for a principal diagnosis of pregnancy perinatal conditions or • Inpatient stays followed within 30 days by planned readmissions. • Principal diagnosis of chemotherapy or rehabilitation; kidney transplant, bone marrow transplant, or other organ transplant; or readmission for potentially planned procedures without a principal acute diagnosis Denominator • Index Hospital Stay (IHS) with the same start and end date • IHS where member died during the stay

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	• IHS with a principal diagnosis of pregnancy or perinatal conditions • Exclude commercial members with 3 or more index hospital or observation stays during the measurement period
TIPS	• Obtain and review patients' discharge summaries • Obtain any test results that were not available when patients were discharged and track tests that are still pending • If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed • When scheduling the post-discharge visit, ask patients to bring in all their prescription medications, over-the-counter medications and supplements so that medication reconciliation can be performed • Discuss the discharge summary with patients/caregivers and ask if they understand the instructions and filled the new prescriptions • Complete a thorough medication reconciliation and ask patients and caregivers to recite their new medication regimen back to you • Provide the patient/caregiver with a current list of medications • Develop an action plan for chronic conditions (e.g., asthma). • Have patients and caregivers repeat the care plan back to you to demonstrate understanding. • Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future. • Ask patients/caregivers if they completed or scheduled prescribed outpatient follow-up or other services. This could include specialists, physical therapy, home health care visits and obtaining durable medical equipment

ANTHEM-CT CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)	
DEFINITION	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.
NUMERATOR	Members who had one or more well-care visits during the measurement year.
DENOMINATOR	Members 3-21 years as of December 31 of the measurement year.
EXCLUSIONS	• Members in hospice care
TIPS	• It is possible to improve this measure in the short term since it is dependent on a patient receiving an annual preventive visit any time during the measurement year. • Whenever possible (and indicated) convert sports pre-participation physical exams or dental clearance exams into well visits. Train staff to identify families who call for sports physicals and dental clearance exams who need well visits. • Use gaps in care process and reports. • Schedule next visit at the end of each appointment. Institute a reminder system to make sure well visits are scheduled. • Have a reminder or call-back system to increase the number of appointments that are kept. • Recruit office staff to help with reminders for well visits

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COMMON CODES	**CPT:** 99382-99385, 99392-99395 **ICD-10:** Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

ANTHEM-CT CHLAMYDIA SCREENING (CHL)	
DEFINITION	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.
NUMERATOR	Female members aged 16–24 years of age who were identified as sexually active (by a pregnancy test or diagnosis, sexually activity, or contraceptive prescriptions being captured via claims) and who had at least one test for chlamydia during the measurement year
DENOMINATOR	Female members aged 16-24 years of age who were identified as sexually active (by a pregnancy test or diagnosis, sexually activity, or contraceptive prescriptions being captured via claims)
EXCLUSIONS	• Women who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray. • Women who were in hospice or using hospice services during the measurement year

TIPS	• Document every patient’s sexual history. This normalizes discussing sexual behavior and allows providers to identify issues that jeopardize a patient’s sexual health.
	• Systematize the collection of a specimen from patients. Consider collecting urine sample from adolescent and young adult patients before they enter the exam room. Test the specimens of those patients identified during the sexual history as being sexually active or due for screening. Post instructions on how patients should properly collect a urine sample to avoid contamination
	• Establish a reminder system in your EHR to notify patients when they are due to be screened or retested
	• Use normalizing or opt out language with patients
	  ○ “I recommend testing for Chlamydia to all my patients under 25. Let’s test you today while you’re here.”
	  ○ “Chlamydia often has no symptoms. It is a good idea for us to screen today”
	  ○ “We recommend routine screening”
	  ○ “Untreated chlamydia can lead to infertility or the inability to have children. The test is quick and easy.”
	  ○ “We test everyone your age for chlamydia.”
	  ○ “To keep you healthy, I recommend testing for chlamydia. It’s a common infection that usually has no symptoms. We test all of our patients your age.”

COMMON CODES	**CPT:** 87110, 87270, 87320, 87490-87492, 87810

<table>
<tr><th colspan="2">ANTHEM-CT
DEPRESSION SCREENING AND FOLLOW UP PLAN (12Y+)</th></tr>
<tr><td>DEFINITION</td><td>Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool <u>AND</u> if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter</td></tr>
<tr><td>NUMERATOR</td><td>Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool <u>AND</u> if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter</td></tr>
<tr><td>DENOMINATOR</td><td>All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period</td></tr>
<tr><td>EXCLUSIONS</td><td>• Patients who have been diagnosed with depression
• Patients who have been diagnosed with bipolar disorder</td></tr>
<tr><td>TIPS</td><td>• This is an entirely different metric with entirely different expectations of coding from the Cigna depressions screening metric
• Use a standardized depression screener, such as those below
  ○ Patient Health Questionnaire 9 item (PHQ-9)
  ○ Patient Health Questionnaire 2 item (PHQ-2)
  ○ Patient Health Questionnaire - 9: modified for teens
• Use standardized clinical depression screening templates in electronic health records (EHRs)
• Ensure that your EHR maps the LOINC code for the depression screener that you use AND ensure that you document the score of the screener so that the EHR can map the score as well
• LOINC codes
  ○ Patient Health Questionnaire 9 item (PHQ-9) LOINC: 44261-6
  ○ Patient Health Questionnaire 2 item (PHQ-2) LOINC: 55758-7
  ○ Patient Health Questionnaire 9 item: modified for teens LOINC: 89204-2
• Ensure that your EHR can generate a report that includes all key information to submit to Anthem to get credit for this metric
    ○ Member ID
    ○ Last Name of Patient
    ○ First Name of Patient
    ○ Date of Birth
    ○ Rendering Provider NPI
    ○ Date of Service
    ○ Procedure Code (96127)
    ○ LOINC Code (specific to the screener you used)
    ○ Result Value (score of the screener)
• If the screening result is negative, and the data are submitted, member is compliant
• If the screening result is positive, member must meet one of the criteria for follow up within 30 days of the assessment:
  ○ An outpatient, telephone, e-visit or virtual check-in visit with a diagnosis of depression or other behavioral health condition</td></tr>
</table>

	○ A depression case management encounter ○ A behavioral health encounter ○ A dispensed anti-depression medication OR ○ Documentation of additional depression screening on same date as positive screen that indicates no depression or symptoms (i.e., a PHQ-9 after a PHQ-2) • Make sure there is documentation of a referral or the need for further evaluation on the encounter date, where applicable • Schedule follow-up appointment within 30-day timeframe after a positive PHQ-9 assessment • Reschedule any canceled appointment and consider offering telehealth visits if in-person visit is not suitable for the patient • Ensure necessary releases are in place to include Parents/Caregivers and enable key providers (Psychiatrists, Therapist/Counselor, etc.) to collaborate on overall patient care and patient's ability to improve/maintain physical and emotional health • Work closely with the Care Network care coordination team for care coordination support
COMMON CODES	(see table below)

Instruments for Adolescents (≤17 years)	LOINC Code
Patient Health Questionnaire (PHQ-9)®	44261-6
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9
Edinburgh Postnatal Depression Scale (EPDS)	99046-5
PROMIS Depression	71965-8

ANTHEM-CT
DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE

DEFINITION	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday
NUMERATOR	Members who had a claim with CPT code 96110 in the 12 months preceding or on their 1st, 2nd, or 3rd birthday
DENOMINATOR	Members who turned 1, 2, or 3 years of age during the measurement year
EXCLUSIONS	None
TIPS	• Example developmental screening tools that meet criteria for the measure ○ Ages and Stages Questionnaire - 3rd Edition (ASQ-3) ○ Modified Checklist for Autism in Toddlers – (MCHAT) ○ Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8 ○ Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) ○ Survey of Well-Being in Young Children (SWYC)

	• Documentation in the medical record must include all of the following: o A note indicating the date on which the test was performed, and o The standardized tool used, and o Evidence of a screening result or screening score • AAP suggests developmental screening take place at the 9-month, 18-month, and 30-month well visits. • Avoid missed opportunities by taking advantage of all visits to complete developmental screening • Provide time for the parent to fill out the screening tool, either before or during the visit • Score the tool and document the score in the medical record • Refer child to the appropriate resource (Birth To Three) or specialist based on screening tool outcome for follow up and a more formal evaluation.	
COMMON CODES:	**CPT**	96110

ANTHEM-CT **FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (FUM)**	
DEFINITION	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the latest ED visit
NUMERATOR	Members in the denominator who had a follow-up mental health visit within 7 days of the emergency department visit (8 total days). A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit. • An outpatient visit ***with*** a principal diagnosis of a mental health disorder • An outpatient visit ***with*** a principal diagnosis of a mental health disorder • An intensive outpatient encounter or partial hospitalization ***with*** POS code 52 ***with*** a principal diagnosis of a mental health disorder • An intensive outpatient encounter or partial hospitalization a principal diagnosis of a mental health disorder • A community mental health center visit ***with*** POS code 53 ***with*** a principal diagnosis of a mental health disorder • Electroconvulsive therapy ***with*** a principal diagnosis of a mental health disorder • A telehealth visit ***with*** a principal diagnosis of a mental health disorder • A telephone visit ***with*** a principal diagnosis of a mental health disorder

	• An e-visit or virtual check-in ***with*** a principal diagnosis of a mental health disorder • An outpatient visit ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • An outpatient visit ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • An intensive outpatient encounter or partial hospitalization ***with*** POS code 52 ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • An intensive outpatient encounter or partial hospitalization ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • A community mental health center visit ***with*** POS code 53 ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • Electroconvulsive therapy ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • A telehealth visit ***with*** Telehealth POS Value Set ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • A telephone visit ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder • An e-visit or virtual check-in ***with*** a principal diagnosis of intentional self-harm ***with*** any diagnosis of a mental health disorder
DENOMINATOR	An ED visit with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members
EXCLUSIONS	• Members in hospice or using hospice services anytime during the measurement year • ED visits followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days)
TIPS	• Ensure there is an efficient office workflow for reviewing ED reports timely and reach out to members/parents promptly to schedule follow-up visits • Identify and address any barriers to the patient attending the appointment • Encourage the patient to bring their discharge paperwork to their follow up appointment • Provide reminder calls to confirm appointments and reach out within 24 hours to patients who cancel appointments to reschedule as soon as possible • Telephone, telehealth, e-visits, and virtual visits are included in follow-up visit types as long as a claim is submitted and a code for a behavioral health diagnosis is included • Follow-up visits that occur on the same date as the ED visit count • 7-day time frames include weekends • Follow-up visits can be with any practitioner type • Discuss with the patient the importance of seeking follow up with a behavioral health provider • Submit claims and encounter data in a timely manner and ensure accurate and complete coding • A non-mental illness diagnosis code will not fulfill this measure • Work closely with the Care Network care coordination team for care coordination support

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ANTHEM-CT GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (≤9%)	
DEFINITION	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1 (HbA1c) was at the following level during the measurement year: • HbA1c good control (<8.0%). This is an inverse measure. A lower rate indicates better performance.
NUMERATOR	Use codes to identify the most recent HbA1c test during the measurement year. The member is included if the most recent HbA1c level is <8.0%, or is missing a result, or if an HbA1c test was not done during the measurement year.
DENOMINATOR	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. A member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least one acute inpatient encounter with a diagnosis of diabetes without telehealth. • At least one acute inpatient discharge with a diagnosis of diabetes on the discharge claim. • At least two outpatient visits, observation visits, telephone visits, e-visits or virtual check-ins, ED visits, nonacute inpatient encounters, or nonacute inpatient discharges, on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two encounters. *Pharmacy data.* Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year.
EXCLUSIONS	• Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year. • Members in hospice or using hospice services anytime during the measurement year. • Members receiving palliative care during the measurement year.
TIPS	• Identify, early in the year, patients 18 years of age or older with diabetes who need A1c testing and coordinate with endocrinology to set them up for testing ○ If no HbA1c test is done, it is counted as >9% • Since the last value in the year is used, have member repeat elevated test prior to the end of the year • If patient has transitioned to an adult endocrinologist not affiliated with Connecticut Children's and has not been tested, you may need to order testing yourself and communicate with patient and their endocrinologist

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COMMON CODES	**CPT:** 83036, 83037 **HbA1c results:** 3044F, 3046F, 3041F, 3052F

ANTHEM-CT
IMMUNIZATIONS FOR ADOLESCENTS-COMBO 2 (IMA)

DEFINITION	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.
NUMERATOR	Adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.
DENOMINATOR	Adolescent members who turn 13 years of age during the measurement year
EXCLUSIONS	• Members with anaphylactic reaction to vaccine or its components can be excluded from that vaccine • Members with encephalopathy due to Tdap vaccine • Members in hospice or using hospice services anytime during the measurement year
TIPS	• Check at each visit (well or sick) for any missing immunizations. • Include child's immunization history from all sources (e.g., hospitals, health department, previous providers). • Document contraindications or allergies. • Schedule appointments for your patient's next vaccination before they leave your office. • Reschedule appointments for those who were no-shows for a vaccine visit. • There must be at least 146 days between the first and second dose of the HPV vaccine. • Recommend immunizations to parents and address common misconceptions. They are more likely to agree with vaccinations when supported by the provider. • Use normalizing or opt out language with patients ○ "Now that Miguel is 11, he is due for vaccinations to help protect against meningitis, cancer caused by HPV, and whooping cough. We'll give those shots during today's visit. Do you have any questions about these vaccines?" • Advice from your Care Network colleagues ○ Use the word "vaccine" instead of "shot" ○ Choose careful scripting, avoid phrase "and optional HPV vaccine" at 11yr old check-up ○ List HPV in the middle of the vaccine sequence when talking with parents and kids ○ For parents that opt out at the 11yr old check-up, schedule a nurse-only visit for HPV vaccine at another date/time.
COMMON CODES:	**CPT** • **Meningococcal conjugate:** 90619, 90734 • **Tdap:** 90715 • **HPV:** 90651

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<table>
<tr><th colspan="3">ANTHEM-CT
KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)</th></tr>
<tr><td>DEFINITION</td><td colspan="2">This measure identifies diabetic members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement period.</td></tr>
<tr><td>NUMERATOR</td><td colspan="2">Members in the denominator who received both of the following during the measurement period on the same or different dates of service:
• At least 1 claim for an estimated glomerular filtration rate and
• At least one uACR identified by both a quantitative urine albumin test and a urine creatinine test with service dates within four or less days apart</td></tr>
<tr><td>DENOMINATOR</td><td colspan="2">• Age 18-85 as of the last day of the Measurement Period.
• Member eligibility in the 365 days before the end of the measurement period, with no more than 1 gap of no more than 45 days
• Member eligibility on the last day of the measurement period.
• Meets the following criteria
o Any of the following in the 730 days before the end of the measurement period:
▪ At least 1 claim for diabetes from an acute inpatient setting
▪ At least 2 claims for diabetes from an outpatient, observation, telephone visit, online assessment, ED visit, or nonacute inpatient setting or inpatient stay
▪ OR at least 1 prescription claim for diabetes medication dispensed</td></tr>
<tr><td>EXCLUSIONS</td><td colspan="2">• Members with gestational diabetes, medication-induced diabetes, or condition-induced diabetes
• Members with a palliative care assessment, encounter, or intervention</td></tr>
<tr><td rowspan="2">COMMON CODES:</td><td>CPT:</td><td>• Estimated glomerular filtration rate lab test: 80047; 80048; 80050; 80053; 80069; 82565
• Quantitative urine albumin lab test: 82043
• Urine creatinine lab test: 82570</td></tr>
<tr><td>ICD-10:</td><td>• Diabetes: E10.9, E11.9, E13.9</td></tr>
<tr><td>TIPS</td><td colspan="2">• Identify, early in the year, patients 18 years of age or older with diabetes who need testing and coordinate with endocrinology to set them up for testing
• Coordinate patient care with endocrinologists and/or nephrologists, as needed.
• If patient has transitioned to an adult endocrinologist not affiliated with Connecticut Children's, you may need to order testing and communicate with patient and their endocrinologist.
• Quest's Kidney Profile test includes both the eGFR blood test and the urine albumin-to-creatinine ratio (uACR) test; Quest test code is 39165
• Labcorp's Kidney Profile test includes both the eGFR blood test and the urine albumin-to-creatinine ratio (uACR) test; Labcorp test number is 140301
• Educate patients on how diabetes can damage blood vessels which can lead to loss of kidney function.
• A urine albumin test is not sufficient</td></tr>
</table>

<table>
<tr><th colspan="3">ANTHEM-CT
WELL CHILD VISITS AGES 0-30 MONTHS (W30)</th></tr>
<tr><td>DEFINITION</td><td colspan="2">Percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. (W15) Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.

2. (W30) Well-Child Visits for Age 15 Months-30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.</td></tr>
<tr><td>NUMERATOR</td><td colspan="2">Rate 1. (W15) Children in the denominator with 6 or more well visits on different dates of service on or before the 15-month birthday

Rate 2. (W30) Children in the denominator with 2 or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.</td></tr>
<tr><td>DENOMINATOR</td><td colspan="2">Rate 1. (W15) Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.

Rate 2. (W30) Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days

Exclude children in hospice.</td></tr>
<tr><td>TIPS</td><td colspan="2">• Often the first, second or third visit is on the mother's claim. Confirm with the payer(s) the process for the first 30 days of newborn claims processing. Is the data accessible?
• Improvement on this measure takes significant amount of time since performance is evaluated based on six visits over 15 months and two additional visits over the subsequent 15 months.
• Whenever possible (and indicated) convert simple acute visits into preventive visits.
• Use gaps in care process and reports.
• Schedule next visit at the end of each appointment.
• Institute a reminder system to make sure well visits are scheduled.
• Have a reminder/call back system to increase the number of appointments that are kept.
• Recruit office staff to help with reminders for well visits.</td></tr>
<tr><td rowspan="2">COMMON CODES:</td><td>CPT:</td><td>99381, 99382, 99391, 99392, 99461</td></tr>
<tr><td>ICD-10:</td><td>Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.82, Z02.89, Z02.9, Z76.1, Z76.2</td></tr>
</table>

<table>
<tr><th colspan="3">CIGNA
ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES (AAP)</th></tr>
<tr><td>DEFINITION</td><td colspan="2">The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.</td></tr>
<tr><td>NUMERATOR</td><td colspan="2">Members who had a preventive or ambulatory care visit during the measurement year.</td></tr>
<tr><td>DENOMINATOR</td><td colspan="2">Members age 20 years of age and older as of December 31 of the measurement year.</td></tr>
<tr><td>EXCLUSIONS</td><td colspan="2">• Members in hospice care
• Members who died during the measurement year</td></tr>
<tr><td>TIPS</td><td colspan="2">• Educate patients on the importance of having at least one ambulatory or preventive care visit during each calendar year.
• Use gaps in care process and reports.
• Schedule next visit at the end of each appointment. Institute a reminder system to make sure well visits are scheduled.
• Have a reminder or call-back system to increase the number of appointments that are kept.
• Recruit office staff to help with reminders for well visits
• If patient is transitioning out of the practice, ask them to call Cigna or go online and identify their new PCP</td></tr>
<tr><td rowspan="2">COMMON CODES:</td><td>CPT</td><td>99385, 99395, 99212-5,</td></tr>
<tr><td>ICD-10</td><td>Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2</td></tr>
</table>

<table>
<tr><th colspan="2">CIGNA
CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)</th></tr>
<tr><td>DEFINITION</td><td>The percentage of members 3-11 years of age who had at least one comprehensive well-care visit with a PCP during the measurement year.</td></tr>
<tr><td>NUMERATOR</td><td>Members who had one or more well-care visits during the measurement year. Well-child visits must occur with a PCP, but does not have to be the assigned PCP.</td></tr>
<tr><td>DENOMINATOR</td><td>Members 3-11 years as of December 31 of the measurement year.</td></tr>
<tr><td>EXCLUSIONS</td><td>• Members in hospice care
• Members who died during the measurement year</td></tr>
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• Use gaps in care process and reports.
• Schedule next visit at the end of each appointment. Institute a reminder system to make sure well visits are scheduled.
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</table>

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	• Recruit office staff to help with reminders for well visits	
COMMON CODES:	**CPT**	99382-99383, 99392-99393
	ICD-10	Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

CIGNA
DEPRESSION SCREENING AND FOLLOW UP (12Y+)

DEFINITION	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool and, if screened positive, received follow-up care.
NUMERATOR	1. Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool 2. Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: a. An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. b. A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. c. A behavioral health encounter, including assessment, therapy, collaborative care or medication management. d. A dispensed antidepressant medication. e. A diagnosis of encounter for exercise counseling. OR f. Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.
DENOMINATOR	All patients 12 years of age or older before the beginning of the measurement period with at least one eligible (any E/M office visit CPT code) encounter with a PCP during the measurement period.
EXCLUSIONS	• Patients who have been diagnosed with depression • Patients who have been diagnosed with bipolar disorder
TIPS	• This is an entirely different metric with entirely different expectations of coding from the Anthem-CT depressions screening metric • In order to be successful in this metric, you must **code** for the depression screen using 96127 **AND** you must code whether the depression screen was positive (G8431) or negative (G8510)

	• There is no expectation of a CPT code for a follow up visit (as required in the Anthem-CT metric) • Cigna has clarified that a **charge** of $0.01 for the G8431 or G8510 will trigger compliance for the metric • Cigna allows up to 10 diagnosis codes and 10 procedure codes, enabling providers to capture all necessary information to close a measure.
COMMON CODES	**CPT:** 96127 **<u>AND</u>** G8510: Screening for depression is negative OR G8431: Screening for depression is documented as being positive and a follow-up plan is documented **AND** Charge $0.01 for the G8510 or G8431

CIGNA DIABETES CARE-HBA1C RESULT ≤ 8.0	
DEFINITION	Percentage of members with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] was ≤ 8.0
NUMERATOR	Member is numerator compliant if the most recent HbA1c was <8.0. The member is not numerator compliant if the result of the most recent HbA1c is ≥8.0 or is missing a result, or if a HbA1c was not done during the measurement year.
DENOMINATOR	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data: • Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year • Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year
EXCLUSIONS	• Members in hospice care • Members who died during the measurement year
TIPS	• This metric includes all patients who have a diagnosis of diabetes. It is not limited to 18y+ • Encourage all patients with diabetes to have regular follow ups with their endocrinologist • Patients who are 18 years or older may be transitioning from pediatric endocrinology to adult endocrinology and may fall through the gaps. Ensure they have made a connection and met with an adult endocrinologist.

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	• If a patient has not had a hemoglobin A1c done by their endocrinologist, you may need to order it. • If multiple tests were performed in the measurement year, the result from the last test is used.
COMMON CODES	**CPT II:** 3044F-HbA1c Level Less than 7.0; 3051F-HbA1c Level Greater than/Equal to 7 and Less than 8

CIGNA **EYE EXAM FOR PATIENTS WITH DIABETES (EED)**	
DEFINITION	Percentage of members 18-75 years of age with diabetes (types 1 and 2) who had an annual retinal eye exam
NUMERATOR	Members who had an annual screening test for diabetic retinopathy.
DENOMINATOR	There are two ways to identify members 18-75 with diabetes: by claim/encounter data and by pharmacy data: • Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year • Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year
EXCLUSIONS	• Members in hospice care • Members who died during the measurement year
TIPS	• This metric is focused only on patients with diabetes who are age 18y or older. • Patients who are 18 years or older may be transitioning from pediatric endocrinology to adult endocrinology and may fall through the gaps. Ensure they have made a connection and met with an adult endocrinologist. • Encourage all members 18y and older who have diabetes to have an annual retinal exam by an ophthalmologist • If a patient has not had a retinal exam done, you may need to order it and make a referral to ophthalmology.
COMMON CODES	**CPT II:** 3072F, 2022F, 2023F, 2024F, 2025F, 2033F

CIGNA **PATIENT EXPERIENCE**	
DEFINITION	AHRQ CAHPS® question, "Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?"

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NUMERATOR	Report number of patients surveyed, number of 9 and 10 responses (or 4 and 5 depending on the scale), and the promoter score.
DENOMINATOR	CIGNA patients who responded to a patient experience survey with the question: "How would you rate your provider?"
EXCLUSIONS	None
TIPS	• If your practice already implements a patient experience survey, just add the question above to your existing survey to meet CIGNA's requirement • If your practice does not implement a patient experience survey, please initiate one and include the question listed above • You will be asked to report the number of survey responses and scores at the highest levels, as noted above, at the end of the year.

CIGNA SOCIAL DETERMINANTS OF HEALTH SCREEN (18+)		
DEFINITION	Patients 18 years of age and older screened for social determinants of health on the date of the encounter using an appropriate tool	
NUMERATOR	Completion and submission of social determinants of health screening of eligible patient during an encounter	
DENOMINATOR	Patients 18 years of age or older with a provider encounter during the measurement year	
EXCLUSIONS	• None	
TIPS	• The Z13.9 code must be submitted to show Cigna that the SDoH screen was done. No additional coding is required for a negative screen. • A positive screen must have both the Z13.9 screening code and the Z code associated with the social need discovered (Z55-65) • Cigna does not require a specific assessment tool • We have provided some SDOH screening tool examples and the array of Z codes that can be used here. • Work with our QI consultants (Rui and Cabrini) to determine a process that works best for your practice • Consider providing the tool prior to the visit or in the waiting room to be filled out by the patient • Cigna allows up to 10 diagnosis codes and 10 procedure codes, enabling providers to capture all necessary information to close a measure.	
COMMON CODES	**ICD-10:**	Negative Screen: Z13.9 Positive screen: Z13.9 **AND** Z55-65 (based on the specific need)

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CIGNA TOBACCO USE: SCREENING AND CESSATION INTERVENTION		
DEFINITION	Current tobacco users who received medical assistance for tobacco use cessation.	
NUMERATOR	Current tobacco users who received medical assistance for tobacco use cessation in the last 24 reported months.	
DENOMINATOR	Patient(s) 18 years or older who are current tobacco users.	
TIPS	• We will provide you with the list of patients that Cigna identifies as tobacco users, based on prior coding for tobacco use • A patient is compliant if they receive tobacco counseling at some point during the year **and** one of the codes listed below is submitted for that counseling. This can be a specific visit for counseling or counseling taking place at a well visit.	
COMMON CODES:	**CPT:**	99406, 99407
	HCPCS:	G9458, G9906
	ICD-10:	Z71.6

CONNECTICARE CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)		
DEFINITION	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.	
NUMERATOR	Members who had one or more well-care visits during the measurement year. Well-child visits must occur with a PCP, but does not have to be the assigned PCP.	
DENOMINATOR	Members 3-21 years as of December 31 of the measurement year.	
EXCLUSIONS	Members in hospice care	
TIPS	• It is possible to improve this measure in the short term since it is dependent on a patient receiving an annual preventive visit any time during the measurement year. • Whenever possible (and indicated) convert sports pre-participation physical exams or dental clearance exams into well visits. Train staff to identify families who call for sports physicals and dental clearance exams who need well visits. • Use gaps in care process and reports. • Schedule next visit at the end of each appointment. Institute a reminder system to make sure well visits are scheduled. • Have a reminder or call-back system to increase the number of appointments that are kept. • Recruit office staff to help with reminders for well visits	
COMMON CODES:	**CPT**	99382-99385, 99392-99395
	ICD-10	Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

CONNECTICARE CHILDHOOD IMMUNIZATION STATUS-COMBO 10 (CIS)		
DEFINITION	The percentage of children 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.	
NUMERATOR	Children who received the recommended vaccines by their second birthday.	
DENOMINATOR	Children turning 2 years of age during the measurement year	
EXCLUSIONS	• Members with immunodeficiency may be excluded from MMR, VZV, and influenza • Members with anaphylactic reaction to a vaccine or its components can be excluded from that vaccine • Members in hospice care	
TIPS	• Document the date of the first hepatitis B vaccine given at the hospital. • Include child's immunization history from all sources (e.g., hospitals, health department, previous providers). • Document contraindications or allergies. • Schedule subsequent vaccine visits before parents leave the office • Check at each visit (well or sick) for any missing immunizations. • Missing the fourth doses of DTaP and PCV vaccines are primary barriers for CIS compliance. Ensure timeliness in administering first doses and follow up for additional doses before the patient's second birthday. • Check each child's immunization status at 12 months of age to allow time to catch up by second birthday. • Missing second influenza vaccination is a primary barrier to CIS compliance. Develop standard process to recall patients for second influenza vaccination. • Use your electronic medical record system for pre-visit planning and to set alerts to indicate when the immunizations are due.	
COMMON CPT CODES	**DTaP**	90696, 90697, 90698, 90700, 90723
	IPV	90696, 90697, 90698, 90713, 90723
	MMR	90707
	MMRV	90710
	Hib	90647, 90648, 90697, 90698
	Hepatitis B	90697, 90723, 90740, 90744, 90747
	Varicella – VZV	90710, 90716
	Pneumococcal Conjugate	90670, 90671
	Hepatitis A	90633
	Rotavirus (2 doses)	90681
	Rotavirus (3 doses)	90680
	Influenza	90674, 90685, 90686, 90687, 90688, 90756

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CONNECTICARE CHLAMYDIA SCREENING (CHL)	
DEFINITION	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.
NUMERATOR	Female members aged 16–24 years of age who were identified as sexually active (by a pregnancy test or diagnosis, sexually activity, or contraceptive prescriptions being captured via claims) and who had at least one test for chlamydia during the measurement year
DENOMINATOR	Female members aged 16-24 years of age who were identified as sexually active (by a pregnancy test or diagnosis, sexually activity, or contraceptive prescriptions being captured via claims)
EXCLUSIONS	• Women who qualified for the denominator based on a pregnancy test alone and who meet either of the following: pregnancy test and a prescription for Isotretinoin, or pregnancy test and an x-ray on the date of pregnancy test or six days after • Women who were in hospice or using hospice services during the measurement year
TIPS	• Document every patient’s sexual history. This normalizes discussing sexual behavior and allows providers to identify issues that jeopardize a patient’s sexual health. • Systematize the collection of a specimen from patients. Consider collecting urine sample from adolescent and young adult patients before they enter the exam room. Test the specimens of those patients identified during the sexual history as being sexually active or due for screening. Post instructions on how patients should properly collect a urine sample to avoid contamination • Establish a reminder system in your EHR to notify patients when they are due to be screened or retested • Use normalizing or opt out language with patients ○ “I recommend testing for Chlamydia to all my patients under 25. Let’s test you today while you’re here.” ○ “Chlamydia often has no symptoms. It is a good idea for us to screen today” ○ “We recommend routine screening” ○ “Untreated chlamydia can lead to infertility or the inability to have children. The test is quick and easy.” ○ “We test everyone your age for chlamydia.” ○ “To keep you healthy, I recommend testing for chlamydia. It’s a common infection that usually has no symptoms. We test all of our patients your age.”
COMMON CODES	**CPT:** 87110, 87270, 87320, 87490-87492, 87810

CONNECTICARE WELL CHILD VISITS AGES 0-30 MONTHS (W30)	
DEFINITION	Percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

	1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months-30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	
NUMERATOR	Rate 1. Children in the denominator with 6 or more well visits on different dates of service on or before the 15-month birthday Rate 2. Children in the denominator with 2 or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.	
DENOMINATOR	Rate 1. Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days. Rate 2. Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days Exclude children in hospice.	
TIPS	• This metric is two separate metrics, Well Child Visits Ages 0-15 Months and Well Child Visits 15-30 Months • Improvement on these measures measure take a significant amount of time since performance is evaluated based on six visits over 0-15 months and two visits over 15-30 months. • Whenever possible (and indicated) convert simple acute visits into preventive visits. • Use gaps in care process and reports. • Schedule next visit at the end of each appointment. • Institute a reminder system to make sure well visits are scheduled. • Have a reminder/call back system to increase the number of appointments that are kept. • Recruit office staff to help with reminders for well visits.	
COMMON CODES:	**CPT:**	99381, 99382, 99391, 99392, 99461

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