Care Network Value Based Contract
Metric Specifications Guide-2021

TABLE OF CONTENTS: ***Click on hyperlink to go directly to that section.***

Connecticut Children's

AETNA CHLAMYDIA SCREENING	
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	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	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)
TIPS	• Incorporate a sexual history into the history and physical. • Screen Members aged 6 years to 17 years diagnosed with diabetes (type 1 or type 2)all sexually active women for chlamydia through age 25. • Educate members about sexually transmitted diseases, include signs, symptoms, and treatment.
COMMON CODES:	**CPT:** 87110, 87270, 87320, 87490-87492, 87810

AETNA Comprehensive Diabetes Care-Pediatric-annual HbA1c		
DEFINITION	The percentage of members aged 6 years to 17 years with diabetes (type 1 or type 2) who had an HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data	
NUMERATOR	Members aged 6 years to 17 years who had HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data	
DENOMINATOR	Members aged 6 years to 17 years diagnosed with diabetes (type 1 or type 2)	
COMMON CODES:	**CPT**	• HbA1c: 83036, 83037 • HbA1c results: 3044F, 3045F, 3046F
	ICD-10	• Diabetes: E10.9, E11.9, E13.9

AETNA Immunizations for Adolescents-Combo 1		
DEFINITION	The percentage of adolescent members aged 13 years who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine completed by their 13th birthday	
NUMERATOR	Adolescents who are numerator compliant for both the meningococcal conjugate and Tdap indicators.	
DENOMINATOR	Adolescent members who turn 13 years of age during the measurement year	
TIPS	• Leverage state immunization records to ensure you capture patient's complete immunization record. • Whenever possible and appropriate, forecast, review status with parents and give vaccines at all visit types (beyond just well visits). • Recommend immunizations to parents and address common misconceptions. They are more likely to agree with vaccinations when supported by the provider. • Schedule appointments for your patient's next vaccination before they leave your office. • Consider targeting patients past due for adolescent immunizations who are 12-12.75 years old. Specifically address non-compliant patients who have time to receive the necessary immunization and be included in the measure for the current measurement year. • Use gaps in care process and reports. • 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**	• **Meningococcal conjugate:** 90734 • **TDAP:** 90715

AETNA Medication Management for People with Asthma		
DEFINITION	The percentage of members aged 5 years to 64 years who were identified as having persistent asthma and who were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1) The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2) The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period	
NUMERATOR	1) Medication Compliance 50%- members who achieved a PDC of at least 50% for their asthma controller medications during the measurement year. 2) Medication Compliance 75%- members who achieved a PDC of at least 75% for their asthma controller medications during the measurement year	
DENOMINATOR	Members aged 5 years to 64 years who were identified as having persistent asthma	
COMMON CODES:	**ICD-10**	• J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901- J45.902, J45.909, J45.990-J45.991, J45.998

AETNA Well Child Visits: Ages 0-15 Months		
DEFINITION	The number of members who received 6 or more well-child visits with a PCP, on different date of service, on or before the child's 15 month birthday.	
NUMERATOR	Those who had six or more well visits on different dates of service on or before the 15th month birthday. Visit must occur with a PCP but the PCP does not have to be assigned to the child.	
DENOMINATOR	• Children who turn 15 months during the measurement year (calculate the 15-month birthday as the child's first birthday plus 90 days). • 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	• A well-care visit consists of all of the following. Include the dates of each component was performed or given in the medical record.
	  ○ A health history
	  ○ A physical developmental history
	  ○ A mental developmental history
	  ○ A physical exam
	  ○ Health education/anticipatory guidance
	• The components of care can be completed at any appointment—not just a well visit— and on different dates of service. However, services specific to an acute or chronic condition are not compliant.
	• 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.
	• 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, Z76.1, Z76.2

AETNA Well Child Visits: Ages 3 – 6		
DEFINITION	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	
NUMERATOR	Members with at least one well-child visit with a PCP during the measurement year. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.	
DENOMINATOR	Members aged 3 years to 6 years as of December 31 of the measurement year	

TIPS	• A well-care visit consists of all of the following. Include the dates of each component was performed or given in the medical record.
	  ○ A health history
	  ○ A physical developmental history
	  ○ A mental developmental history
	  ○ A physical exam
	  ○ Health education/anticipatory guidance
	  ○ BMI percentile either plotted on a growth chart or as a percentile
	• Ability exists 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.
	• The components of care can be completed at any appointment—not just a well visit— and on different dates of service. However, services specific to an acute or chronic condition are not compliant.
	• 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, 99383, 99392, 99383, 99461
	ICD-10	• Z00.121, Z00.129, Z00.8, Z02.0, Z02.2, Z02.5, Z02.6, Z02.71, Z02.82

ANTHEM Appropriate Treatment for Children with Upper Respiratory Infection (URI)		
DEFINITION	This measure identifies members' age 3 months to 18 years who were given a diagnosis of upper respiratory infection (URI) and were not dispensed antibiotic prescription.	
NUMERATOR	Members in the denominator who did not receive an antibiotic prescription within 3 days after the diagnosis.	
DENOMINATOR	Children age 3 months old as of 18 months prior to the end of the Measurement Period to 18 years old 6 months prior to the end of the measurement Period who were diagnosed with URI between 545 and 180 days prior to the end of the Measurement Period.	
TIPS	• To qualify for denominator patients must not have had any antibiotic dispensed in the past 30 days. Patients on long-standing prophylactic antibiotics might be excluded from this measure. • Document a second diagnosis code for any competing diagnosis (e.g. pharyngitis, otitis media, enteritis, whooping cough, etc.) in addition to the URI code. • Episodes may qualify for the denominator based on care from by outside providers (urgent care, ED, etc.). Provide patients and families a list of preferred high-quality, after-hours facilities.	
COMMON CODES:	**Upper respiratory infection codes that do not need antibiotics**	
	ICD-10	• J00, J06.0, J06.9

ANTHEM Appropriate Testing for Children with Pharyngitis	
DEFINITION	This measure identifies children 3 months-18 years of age who were diagnosed with pharyngitis dispensed an antibiotic and had a test for group A streptococcus for the episode. A higher rate represents better performance (i.e. appropriate testing).
NUMERATOR	Members in the denominator who had a test for group A streptococcus (strep) for the episode of pharyngitis
DENOMINATOR	Children age 3-18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic within 6-18 months before the end of the measurement period.
TIPS	• To qualify for denominator patients must not have had any antibiotic dispensed in the past 30 days. Patients on long-standing prophylactic antibiotics might be excluded from this measure. • The measure is only looking for evidence of a strep test, not for a positive test. • Episodes may qualify for the denominator based on care from by outside providers (urgent care, ED, etc.). Provide patients and families with a list of preferred high-quality, after-hours facilities
COMMON CODES:	• **GROUP A STREP TEST: CPT:** 87070-71, 87081, 87430, 87650-52, 87880
	• **PHARYNGITIS: ICD-10:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80-81, J03.90-91

ANTHEM Asthma Medication Ratio (AMR)	
DEFINITION	Measure evaluates the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater.
NUMERATOR	Members in the denominator with a ratio of controller medications (oral, injectable, inhaled) to total asthma medications of 0.50 or greater during the measurement period
DENOMINATOR	Members age 5-64 years of age who were identified as having persistent asthma and who have claims for asthma medications

TIPS	• Clinical practice guidelines and field research have both illustrated the significance of adherence to medication regimens in controlling asthma. The evidence suggests that asthma patients who are adherent to their prescribed controllers and reliever medication regimens experience fewer exacerbations and thus fewer visits to the ED.
	  ○ Review proper inhaler usage during every encounter with an asthma patient.
	  ○ Review medication list to ensure member has prescriptions for both controller and reliever medications.
	  ○ Document reason for prescribed medication and member's response.
	  ○ Schedule follow-up to evaluate whether medications are taken as prescribed.
	  ○ Convert controller medication to a 90-day supply to increase adherence.
	  ○ Focus on members who have not filled prescriptions for their controller medications.
	• Patients that receive 'PRN' inhaled steroid prescriptions will qualify for the denominator but will likely not qualify for the numerator.
	• Report codes for diagnosed conditions that may exclude member from this measure.
	• Patients may qualify based on care provided outside your network or hospital (urgent care, ED, etc.).
	• Provide patients and families a list of preferred high-quality, after-hours facilities.
	• Engage community partners such as schools. For example, develop a school-based administration program for controllers instead of just rescue inhalers.
	• Consider writing a single albuterol prescription with instructions to dispense two inhalers—one for home and one for school.
	• Four or more albuterol fills on separate dispensing dates in one year is the most common qualifying inclusion criteria for this measure. Consider writing albuterol prescription with no more than three refills to encourage the patient or family to contact clinic prior to receiving more albuterol.
	
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ANTHEM Asthma Medication Ratio (AMR) *(continued)*		
COMMON ASTHMA CODES:	**Outpatient CPT**	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401- 99404, 99411-99412, 99429, 99455-99456, 99483
	Acute inpatient CPT	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
	Emergency department CPT	99281-99285
	ICD-10	J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901-J45.902, J45.909, J45.990, J45.991, J45.998
	NOTES: • For each member, count the units of asthma controller medications (Asthma Controller Medications List) dispensed during the measurement year. • For each member, count the units of asthma reliever medications (Asthma Reliever Medications List) dispensed during the measurement year. • For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications	

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: HEDIS definition of a dispensing event used- each 30-day supply of drug counts as one denominator event.
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

ANTHEM Childhood Immunizations Status - MMR		
DEFINITION	The percentage of children 2 years of age who had one measles, mumps and rubella (MMR) between their first and second birthday	
NUMERATOR	Members in the denominator who have had at least one MMR vaccination on or between their first and second birthday	
DENOMINATOR	Enrolled children who turn 2 years of age during the Measurement Period, excluding those with history of anaphylactic reaction to immunizations, malignant neoplasm of lymphatic tissue, HIV, or other disorders of the immune system	
COMMON CODES:	**ICD-10**	90707, 90710

ANTHEM Childhood Immunizations Status - VZV		
DEFINITION	The percentage of children 2 years of age during the Measurement Period who had chicken pox (VZV) shot by their second birthday	
NUMERATOR	Members in the denominator who have had at least one VZV vaccination between their first and second birthday	
DENOMINATOR	Enrolled children who turn 2 years of age during the Measurement Period, excluding those with history of anaphylactic reaction to immunizations, malignant neoplasm of lymphatic tissue, HIV, or other disorders of the immune system	
COMMON CODES:	**ICD-10**	90710, 90716

ANTHEM Chlamydia Screening		
DEFINITION	Members age 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	
NUMERATOR	Members in the denominator who had at least 1 at least 1 medical claim with a chlamydia test OR at least 1 lab result for chlamydia test during the measurement period	

DENOMINATOR	Females who are 16-24 years of age as of the last day of the measurement period:
	• AND continuous medical eligibility during the Measurement Period with no more than 1 gap of no more than 45 days
	• AND medical eligibility with no gaps on analysis date
	• AND any of the following:
	  ○ at least 1 claim with a procedure from sexual activity during the Measurement Period
	  ○ OR at least 1 claim with a diagnosis from sexual activity during the Measurement Period
	  ○ OR at least 1 claim with a diagnosis from pregnancy during the Measurement Period
	  ○ OR at least 1 prescription claim for contraceptives during the Measurement Period
	  ○ OR at least 1 claim with a procedure from pregnancy tests during the Measurement Period, excluding member from pregnancy tests set with the following:
	  ▪ at least 1 claim for pregnancy test exclusion during the Measurement Period
	  ▪ AND at least 1 claim for diagnostic radiology or chlamydia screen exclusions within 6 days after the pregnancy test	

TIPS	• Incorporate a sexual history into the history and physical. • Screen all sexually active women for chlamydia through age 25. • Educate members about sexually transmitted diseases, include signs, symptoms, and treatment.	
COMMON CODES:	**CPT CODES:**	87110, 87270, 87320, 87490-87492, 87810

ANTHEM Potentially Avoidable Emergency Room Visits	
DEFINITION	This measure identifies members 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 (PRFV) considered potentially avoidable.
NUMERATOR	Emergency room visits identified by the presence of UB revenue codes. Potentially avoidable emergency room visits are identified by primary ICD-10 diagnosis code.
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 (PRFV) considered potentially unavoidable

ANTHEM Diabetes: HbA1c Screening		
DEFINITION	This measure identifies members age 18-75 with diabetes who have had a HbA1c test during the Measurement Period.	
NUMERATOR	Members in the denominator who had at least 1 procedure claim for an HbA1c test during the Measurement Period OR at least 1 lab result for a HbA1c test during the Measurement Period	

DENOMINATOR	• Age between 18 and 75 years as of the last day of the Measurement Period
	• Members identified by the following criteria in the past 2 years:
	  ○ Any one of the following
	  ▪ At least 2 claims at least one day apart with a diagnosis of diabetes in any position from an outpatient, observation, acute inpatient ED, or non-acute inpatient setting, telehealth visit, or online assessment in the last day of the Measurement Period
	  ▪ At least 1 prescription claim for insulin or oral hypoglycemic medication dispensed in the 2 years before the last day of the Measurement Period
	  ○ Exclude members with claims for diabetes exclusions.
	  ○ Continuous medical eligibility during the Measurement Period with maximum 1 gap of no more than 45 days.
	  ○ Medical eligibility with no gaps on the last day of the Measurement Period.	

COMMON CODES:	**CPT CODES:**	• HbA1c: 83036, 83037 • HbA1c results: 3044F, 3045F, 3046F
	ICD-10:	• Diabetes: E10.9, E11.9, E13.9

ANTHEM Diabetes: Urine Protein Screening		
DEFINITION	This measure identifies diabetic members 18-75 years old who, during the Measurement Period, had at least one nephropathy screening or had evidence of medical attention for existing nephropathy (diagnosis or treatment of nephropathy).	
NUMERATOR	Any one of the following during the Measurement Period: • At least 1 procedure in any position for urine protein tests • OR at least 1 lab LOINC claim for urine protein tests • OR at least 1 procedure or diagnosis in any position for treatment for nephropathy • OR at least 1 procedure or diagnosis in any position for ESRD • OR at least 1 diagnosis in any position for CKD stage 4	

DENOMINATOR	• Age 18-75 years old as of the last day of the Measurement Period.
	• AND service eligibility during the Measurement Period with no more than 1 gap of no more than 45 days
	• AND medical eligibility with no gaps on analysis date
	• AND identified by the following criteria:
	  ○ Any one of the following
	  ▪ At least 2 claims at least one day apart with a diagnosis of diabetes in any position from an outpatient, observation, acute inpatient ED, or non-acute inpatient setting in the 2 years before the analysis date
	  ▪ At least 1 prescription claim for insulin or oral hypoglycemic medication dispensed in the 2 years before the analysis date
	  ▪ Exclude members with claims for diabetes exclusions.	

COMMON CODES:	**CPT CODES:**	• Urine Protein Test: 81000-81003, 81005, 82042-82044, 84156 • HbA1c results: 3060F, 3061F, 3062F
	ICD-10:	• Diabetes: E10.9, E11.9, E13.9

ANTHEM Well Child Visits Ages 0-15 months		
DEFINITION	Members who turned 15 months old and who had 6 well-child visits during their first 15 months of life	
NUMERATOR	Members in the denominator who have had at least 6 well-child visits during their first 15 months of life	
DENOMINATOR	Members who turned 15 months old during the measurement period AND have medical service eligibility between 31 days and 15 months of age, with no more than 1 gap of no more than 45 days.	

TIPS	• A well-care visit consists of all of the following. Include the dates of each component was performed or given in the medical record.
	  ○ A health history
	  ○ A physical developmental history
	  ○ A mental developmental history
	  ○ A physical exam
	  ○ Health education/anticipatory guidance
	• The components of care can be completed at any appointment—not just a well visit— and on different dates of service. However, services specific to an acute or chronic condition are not compliant.
	• 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, then 2 visits from 15-30 months and patients are only included after turning 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 CODES:**	99381, 99382, 99391, 99392, 99461
	ICD-10:	Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.82, Z76.1, Z76.2

ANTHEM Well Child Visits Ages 3-6 Years		
DEFINITION	Members 3-6 years of age who had one or more well-child visits during the measurement period.	
NUMERATOR	Members in the denominator who have had at least 1 claim for a well-care visit during the measurement period.	
DENOMINATOR	Members who are 3-6 years of age as of the end of the measurement period AND have service eligibility during the entire measurement period, with no more than 1 gap of no more than 45 days.	

TIPS	• A well-care visit consists of all of the following. Include the dates of each component was performed or given in the medical record.
	  ○ A health history
	  ○ A physical developmental history
	  ○ A mental developmental history
	  ○ A physical exam
	  ○ Health education/anticipatory guidance
	  ○ BMI percentile either plotted on a growth chart or as a percentile
	• Ability exists 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.
	• The components of care can be completed at any appointment—not just a well visit— and on different dates of service. However, services specific to an acute or chronic condition are not compliant.
	• 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 CODES:**	99382, 99383, 99392, 99383, 99461
	ICD-10:	Z00.121, Z00.129, Z00.8, Z02.0, Z02.2, Z02.5, Z02.6, Z02.71, Z02.82

CONNECTICARE Childhood Immunization status (CIS) Combo 10	
DEFINITION	The percentage of children who have received all recommended vaccines by their 2nd birthday.
NUMERATOR	Members in the denominator who have had the following vaccines by their 2nd birthday: • 4 diphtheria, tetanus and acellular pertussis (DTaP) • 3 polio (IPV) • 1 measles, mumps and rubella (MMR) • 3 haemophilus influenza type B (Hib) • 3 hepatitis B (HepB) • 1 chicken pox (VZV) • 4 pneumococcal conjugate (PCV) • 1 hepatitis A (HepA) • 2 or 3 rotavirus (RV) • 2 influenza (Flu)
DENOMINATOR	Children turning 2 years of age during the measurement year

TIPS	**Common chart deficiencies**
	• Immunizations received after the second birthday.
	• PCP charts do not contain immunization records if received elsewhere, such as health departments.
	• Immunizations given in the hospital at birth. Suggested solution: confirm with the payer(s) the process for newborn claims processing. Is the data accessible?
	• No documentation of contraindications or allergies.
	• No second influenza vaccination. Suggested solution: develop standard process to recall patients for second influenza vaccination.
	• Documentation of physician orders, CPT codes or billing charges will not meet compliance.
	Medical record requirements
	• Medical record must include one of the following:
	  ○ A note with the name of the specific antigen and the date of the immunization.
	  ○ An immunization record from an authorized health care provider or agency. For example, a registry including the name of the specific antigen and the date of the immunization.
	• For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the patient's second birthday.
	
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CONNECTICARE
Childhood Immunization status (CIS) Combo 10
(continued)

TIPS (CONTINUED)

Medical record requirements *(continued)*

- Notes in the medical record indicating that the child received the immunization at delivery or in the hospital may be counted toward the numerator *only* for immunizations that do not have minimum age restrictions.
- Documentation that a child is up to date with all immunizations but doesn't include a list of the immunizations and dates is not compliant.
- Patients receiving immunizations before the appropriate window do not count in the numerator (e.g. DTaP, IPV, HiB, PCV, Rotavirus should not be given prior to 42 days after birth and influenza not prior to 6 months or 180 days after birth).

Improve compliance

- Leverage state immunization records to capture the patient's complete immunization record. Inquire whether the payer(s) receives records from state immunization registries as standard part of their HEDIS reporting. If applicable, consider participating in the state's immunization registry.
- Whenever possible (and appropriate), forecast, review status with parents and give vaccines at all visit types (beyond just well visits).
- Recommend immunizations to parents and address common misconceptions. They are more likely to agree with vaccinations when supported by the provider.
- Schedule appointments for your patient's next vaccination before they leave your office.

COMMON CPT CODES:		
	DTaP	90698, 90700, 90721, 90723
	IPV	90698, 90713, 90723
	MMR	90707, 90710
	Measles and Rubella	90708
	Measles and Rubella	90708
	Measles	90705
	Mumps	90704
	Rubella	90706
	Hib	90644 – 90648, 90698, 90721, 90748
	Hepatitis B	90723, 90740, 90744, 90747, 90748
	Varicella – VZV	90710, 90716
	Pneumococcal Conjugate	90669, 90670
	Hepatitis A	90633
	Rotavirus (2 doses)	90681
	Rotavirus (3 doses)	90680
	Influenza	90655, 90657, 90661, 90662, 90673, 90685 - 90688

CONNECTICARE Immunizations for Adolescents (IMA) – Combo 2	
DEFINITION	The percentage of Members 13 years of age who have had all required immunizations
NUMERATOR	Members in the denominator who had the following vaccines by their 13th birthday: • 1 Meningococcal conjugate vaccine • 1 Tdap vaccine • 2 or 3 HPV vaccines
DENOMINATOR	All adolescents who turn 13 years of age during the measurement year
TIPS	**Common chart deficiencies** • Vaccines are not administered during the appropriate time frames. • Documentation that a child is up to date with all immunizations, but does not include a list of the immunizations and dates, is not compliant. • Documentation of physician orders, CPT codes or billing charges are not compliant **Medical record requirements** • Medical record must include one of the following: o A note with the name of the specific antigen and the date of the immunization. o An immunization record from an authorized health care provider or agency. For example, a registry including the name of the specific antigen and the date of the immunization. **Improve compliance** • Leverage state immunization records to capture the patient's complete immunization record. Inquire whether the payer(s) receives records from state immunization registries as standard part of their HEDIS reporting. If applicable, consider participating in the state's immunization registry. • Whenever possible (and appropriate), forecast, review status with parents and give vaccines at all visit types (beyond just well visits). • Recommend immunizations to parents and address common misconceptions. They are more likely to agree with vaccinations when supported by the provider. • Schedule appointments for your patient's next vaccination before they leave your office. • Consider targeting patients past due for adolescent immunizations who are 12-12.75 years old. • Specifically address non-compliant patients who have time to receive the necessary immunization and be included in the measure for the current measurement 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. ***(continued…)***

CONNECTICARE
Immunizations for Adolescents (IMA) – Combo 2
(continued)

TIPS (continued)	**Vaccine hesitancy** • Behavioral psychology literature supports listing HPV in between other vaccines being received as a pre-teen bundle. For example, Tdap, HPV then MCV. • Giving first HPV at 9-10 years old instead of later can increase compliance. • Hardwire scheduling of second HPV appointment and reminders		
COMMON CODES:	**Immunization**	**CPT Codes**	• **Notes**
	HPV	90649-51	• Dose must be administered on or between the 9th and 13th birthdays. • There must be at least 146 days between the first and second dose of HPV vaccine or at least three HPV vaccines with different dates of service. • May be given at the same time as other vaccines.
	Meningococcal conjugate	90734	• Dose must be administered on or between the 11th and 13th birthdays. • Only quadrivalent meningococcal vaccines (serogroups A, C, W, Y) are included in the measure. Do not count meningococcal recombinant (serogroup B) (MenB) vaccines
	Tdap	90715	• Dose must be administered on or between the 10th and 13th birthdays. • Optionally exclude encephalopathy with a vaccine adverse-effect code • Immunizations documented using a generic header or Tdap/Td can be counted as evidence of Tdap

CONNECTICARE Medical Management for People with Asthma (MMA)		
DEFINITION	The percentage of Members 5-64 years of age identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period	
NUMERATOR	Members in the denominator identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period 1. Members who remained on an asthma controller medication for at least 50% of their treatment period. 2. Members who remained on an asthma controller medication for at least 75% of their treatment period.	
DENOMINATOR	Members 5-64 years of age identified as having persistent asthma	
TIPS	• Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program. • Schedule follow-up visits to check progress	
COMMON CODES:	**ICD-10:**	J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901- J45.902, J45.909, J45.990-J45.991, J45.998

CONNECTICARE Chlamydia Screening		
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 current year	
NUMERATOR	Members in the denominator who have had a chlamydia screening in the current year	
DENOMINATOR	Women 16-24 years of age identified as sexually active (Women are identified as sexually active through claims encounter and pharmacy data)	
TIPS	• Incorporate a sexual history into the history and physical. • Screen all sexually active women for chlamydia through age 25. • Educate members about sexually transmitted diseases, include signs, symptoms, and treatment.	
COMMON CODES:	**CPT CODES:**	87110, 87270, 87320, 87490-87492, 87810

CONNECTICARE
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

DEFINITION	The percentage of Members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and had the following during the measurement year: 1. BMI Percentile 2. Counseling for Nutrition **3.** Counseling for Physical Activity
NUMERATOR	Members in the denominator who had an outpatient visit with the following: 1. BMI Percentile: Documented as a value or plotted on an age growth chart. 2. Counseling for Nutrition (e.g., current nutrition behaviors, checklist, weight or obesity counseling). 3. Counseling for Physical Activity (e.g., checklist of current physical activities)
DENOMINATOR	Members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN in the measurement year
TIPS	• BMI and counseling services may be performed during a visit other than a well-child visit (e.g. sick visits, sport physicals). • Services performed during a telephone visit, e-visit or virtual check-in are compliant. • Medical record must include height, weight and BMI percentile (must be from same data source) during the measurement year. Including a checklist in the medical record is a good way to make sure that all components of this measure are completed:

Requirements	Compliant	Not compliant
BMI percentile documentation	• Either of the following meets criteria for BMI percentile: ▪ BMI percentile documented as a value (e.g., 85th percentile). ▪ BMI percentile plotted on an age-growth chart. • Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%). • Member-collected biometric values (height, weight, BMI percentile) are eligible for use in reporting	• An absolute BMI value only. • Height and weight only. • Ranges and thresholds. This is true even for narrow or single ranges. For example, 15%-16%.

CONNECTICARE

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

(continued)

TIPS
(continued)

Requirements	Compliant	Not compliant
Counseling for nutrition	Must include a note of the date and at least one of the following: • Discussion of current nutrition behaviors (e.g. eating habits, dieting). • Checklist indicating nutrition was addressed. • Counseling or referral for nutrition education. • Receipt of educational materials on nutrition during a face-to-face visit. • Anticipatory guidance for nutrition. • Weight or obesity counseling. • Obesity or eating disorder related services may be used to meet criteria for Counseling for Nutrition and Physical Activity if the specified documentation is present. • Referral to Special Supplemental Nutrition for Women, Infants and Children (WIC).	• Documentation related to child's appetite. • Notation of "health education" or "anticipatory guidance" without specific mention of nutrition. • A notation of "well nourished" during a physical exam.
Counseling for physical activity	Must include a note of the date and at least one of the following: • Discussion of current physical activity behaviors (e.g. exercise, sports, exam for sports participation). • Checklist indicating physical activity was addressed. • Counseling or referral for physical activity. • Receipt of educational materials on physical activity during a face-to-face visit. • Anticipatory guidance specific to the child's physical activity. • Weight or obesity counseling. • Obesity or eating disorder related services may be used to meet criteria for Counseling for Nutrition and Physical Activity if the specified documentation is present. • Evidence of a sports physical.	• Notation of "health education" or "anticipatory guidance" without specific mention of physical activity. • Notation of anticipatory guidance related solely to safety (e.g. "wears helmet") without physical activity recommendations. • Notation solely related to screen time without mention of physical activity. • A notation of "cleared for gym class" without documentation of discussion.

(continued…)

CONNECTICARE Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) *(continued)*		
COMMON CODES:	**BMI percentiles-ICD-10**	• Z68.51 – BMI <5% • Z68.52 – BMI <85% • Z68.53 – BMI < 95% • Z68.54 – BMI ≥ 95%
	Counseling for nutrition-ICD-10	Z71.3
	Counseling for nutrition-CPT	97802-04
	Counseling for physical activity-ICD-10	Z71.82, Z02.5

CONNECTICARE Well Child Visits Ages 0-15 Months (W15)		
DEFINITION	The percentage of Members who turn 15 months old during the measurement year and have 0, 1, 2, 3, 4, 5, 6, or more well visits with a PCP during their first 15 months	
NUMERATOR	Members in the denominator with 0, 1, 2, 3, 4, 5, 6, or more well visits	
DENOMINATOR	Children who turn 15 months old during the measurement year	

TIPS	• A well-care visit consists of all of the following. Include the dates of each component was performed or given in the medical record.
	  ○ A health history
	  ○ A physical developmental history
	  ○ A mental developmental history
	  ○ A physical exam
	  ○ Health education/anticipatory guidance
	• The components of care can be completed at any appointment—not just a well visit— and on different dates of service. However, services specific to an acute or chronic condition are not compliant.
	• 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.
	• 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

PCMH+ (SCORING METRIC) Asthma Patients with One or More Asthma-Related Emergency Room Visit(s) (Ages 2-20)	
DEFINITION	Percentage of members 2-20 years of age diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits.
NUMERATOR	All patients age two through age 20, with Asthma, that have an emergency room visit during the measurement period.
DENOMINATOR	All patients age two through age 20, diagnosed with asthma during the measurement period.

PCMH+ (SCORING METRIC) Avoidable Emergency Department (ED) Visits	
DEFINITION	***Information not currently available***
NUMERATOR	
DENOMINATOR	
TIPS	

PCMH+ (SCORING METRIC) Avoidable Hospitalizations	
DEFINITION	***Information not currently available***
NUMERATOR	
DENOMINATOR	
TIPS	

PCMH+ (SCORING METRIC) Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)		
DEFINITION	The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.	
NUMERATOR	The number of dispensed antibiotic medications following an episode of acute bronchitis/bronchiolitis. The measure is reported as an inverted rate (i.e., 1 – numerator/denominator) to reflect the proportion of episodes during which an antibiotic was not dispensed (a higher rate is better)	
DENOMINATOR	Episodes for members age 3 months and older with a diagnosis of acute bronchitis or bronchiolitis during the intake period	
COMMON CODES	**ICD-10**	J20.3-J20.9, J21.0-J21.1, J21.8-J21.9

PCMH+ (SCORING METRIC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing		
DEFINITION	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year	
NUMERATOR	Patients who had an HbA1c test performed during the measurement year.	
DENOMINATOR	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	
COMMON CODES	**CPT**	• HbA1c: 83036, 83037 • HbA1c results: 3044F, 3045F, 3046F

PCMH+ (SCORING METRIC) Child & Adolescent Well-Care Visits (WCV)		
DEFINITION	Percentage of members ages 3 to 21 who had at least one comprehensive well-care visit with a primary care provider or an OB/GYN during the measurement year.	
NUMERATOR	Those who had one or more well visits with a PCP or OB/GYN during the measurement year. (Practitioner does not have to be assigned to the member.)	
DENOMINATOR	• Ages 3 to 21 as of Dec. 31 of the measurement year. Report three age stratifications and total rate: 3-11; 12-17; 18-21. • Continuously enrolled with no more than one gap of up to 45 days. • Exclude those in hospice	

TIPS	• Well-care visit consists of all of the following. Include the dates of each component was performed or given in the medical record.
	  ○ A health history
	  ○ A physical developmental history
	  ○ A mental developmental history
	  ○ A physical exam
	  ○ Health education/anticipatory guidance
	• Ability exists 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.
	• The components of care can be completed at any appointment—not just a well visit— and on different dates of service. However, services specific to an acute or chronic condition are not compliant.
	• 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.
	• Confirm the PCP and ensure the assignment is accurate. Examples of common issues are:
	  ○ If the parent doesn't elect a PCP, Medicaid assigns a PCP by default.
	  ○ Never seen the child before.
	  ○ Child moved, but not yet terminated by Medicaid.
	• For patients with Medicaid as secondary insurance, check that the well visit is billed to Medicaid instead of the primary insurance, so the child is not overlooked as counting toward the measure. This is not very common, but possible, especially with children with medical complexity.	

COMMON CODES	**CPT**	99381-85, 99391-95, 99461
	ICD-10	Z00.00, Z00.01, Z00.110, Z00.111, 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

PCMH+ (SCORING METRIC) 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. This is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.	
NUMERATOR	Children who were screened for risk of developmental, behavioral and social delays using a standardized tool.	
DENOMINATOR	All patients who turn 1, 2 or 3 years of age between January 1 and December 31 of the performance period	
REQUIRED MEDICAL RECORD DOCUMENTATION	For children who had a developmental screening using a standardized, validated tool in the 12 months preceding their birthday, the following documentation must be in the medical record: • Date of service • Documentation of the validated screening tool used (Refer to Provider Bulletin 2019-14 for validated tools for this measure) • Evidence of a screening result (positive or negative) or screening score (a numeric value associated with the validated screening tool)	
COMMON CODES	**CPT**	96110 Use modifier U3 for a positive screen and U4 for a negative screen

PCMH+ (SCORING METRIC) Emergency Department (ED) Usage	
DEFINITION	***Information not currently available***
NUMERATOR	
DENOMINATOR	
TIPS	

PCMH+ (SCORING METRIC) PCMH CAHPS	
DEFINITION	The CAHPS PCMH survey assesses patient experience along several key domains of care, including Access, Information, Communication, Coordination of care, Comprehensiveness, Self-management support, and Shared decision making.

PCMH+ (CHALLENGE METRIC) Behavioral Health Screening 1-18		
DEFINITION	The percentage of members 1-18 years of age who received an annual behavioral health screen within the 12 months prior to their birthday.	
NUMERATOR	Children in denominator who had a claim with CPT code 96110 or 96127	
DENOMINATOR	All beneficiaries age 1 year to 18 years	
REQUIRED MEDICAL RECORD DOCUMENTATION	• Date of service for the behavioral health screening • Documentation of the validated screening tool used (Refer to Provider Bulletin 2015-70 for validated tools for this measure) • Evidence of a screening result or a screening score	
COMMON CODES	**CPT**	• 96110 Use modifier U3 for a positive screen and U4 for a negative screen • 96127 Use modifier U3 for a positive screen and U4 for a negative screen

PCMH+ (CHALLENGE METRIC) Re-admissions Within 30 Days	
DEFINITION	The percentage of physical health and behavioral health hospital readmissions within 30 days of discharge for members 0-64 years of age.
NUMERATOR	Awaiting details from PCMH+
DENOMINATOR	Awaiting details from PCMH+

PCMH+ (CHALLENGE METRIC) Follow-up After ED Visit for Mental Illness (FUM)		
DEFINITION	The percentage of ED visits for members 6 years of age and older in the measurement year with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness	
NUMERATOR	Members who had a follow-up visit after an ED visit for mental illness or intentional self-harm within either: • 7 days of the ED visit. Visits that occur on the date of the ED visit are included. • 30 days of the ED visit. Visits that occur on the date of the ED visit are included.	
DENOMINATOR	Children who have an ED visit with a principal diagnosis of mental illness or intentional self-harm on or between Jan. 1 and Dec. 1 of the measurement year who are 6 years or older on the date of the visit • Continuously enrolled (no gaps) from date of the ED visit through 30 days after the ED visit (31 total days). • The denominator is based on ED visits, not on members. If a member has more than one ED visit in a 31-day period include only the first eligible ED visit for that period.	
TIPS	• This measure uses medical and behavioral health claims. • Schedule the seven-day follow-up visit within five days after the ED visit to allow flexibility in rescheduling, if necessary. • Schedule the seven-day follow-up visit with a mental health practitioner before the patient leaves the ED. • Call the patient and/or parent/guardian 24 to 72 hours after discharge to verify appointments are scheduled and address additional needs. • Review medications with patient and/or caregiver and educate on the importance of taking them with appropriate frequency. • Provide information on the importance of monitoring emotional well-being and following up with their mental health practitioner.	
COMMON CODES	**Mental Illness (ICD-10) Diagnosis Codes**	• F03.xx, F20-F53, F59-F69, F80-F99, Diagnosis of intentional self-harm (multiple possible codes) With any of the following CPT:
	Follow-up Visits (CPT)	• 98960-98962, 99078, 99201-99205, 99211-99215, 99217- 99220, 99241-99245, 99341-99345, 99347-99350, 99381- 99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510

PCMH+ (CHALLENGE METRIC) Metabolic Monitoring for Children & Adolescents on Antipsychotics (APM)		
DEFINITION	Members 1-17 years of age in the measurement year who had two or more antipsychotic prescriptions and had metabolic testing.	
NUMERATOR	Children and adolescents 1-17 years of age on antipsychotics who received blood glucose and cholesterol testing during the measurement year.	
DENOMINATOR	Children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions	

TIPS	• Ordering a blood glucose and cholesterol test every year and building care gap alerts in the electronic medical record
	• Testing blood glucose and cholesterol at a member's annual checkup or school physical to reduce additional visits
	• Encouraging shared decision-making by educating members and caregivers about the:
	  ○ Increased risk of metabolic health complications from antipsychotic medications
	  ○ Importance of screening blood glucose and cholesterol levels	

COMMON CODES	**CPT**	• Non-LDL: 82465, 83718, 83722, 84478 • LDL-C: 80061, 83700-1, 83704, 83721; 3048-50F • Glucose: 80047-8, 80050, 80053, 80069, 82947, 82950-1 • HbA1c: 83036-7; 3044F, 3046F, 3051-2F