2025 Office Manager Symposium

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Today's Agenda

1. Welcome
2. Defining Value Based Care
3. MHN Progress Report
4. Tips & Best Practices
5. Summary & Conclusion

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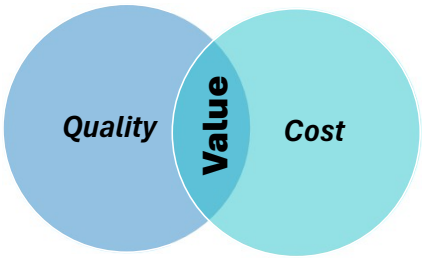
What is Value-Based Care?

Value-based care (VBC) is a system designed to focus on quality of care, provider performance, and patient experience

- **Value** = Prioritizes the results that matter to the patient; does ***not*** mean cheaper care
- **Integrated Care Delivery** = PCP and other providers work together to manage a ***whole person's health***; this includes access to transportation, healthy food, and relationship with family



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What is Value-Based Care? (continued)

- The National Academy of Medicine described a framework for quality that can be used to hold providers accountable in VBC models. These components include:
  - **Effectiveness** – Care is based on evidence
  - **Efficiency** – Only necessary resources are utilized
  - **Equity** – Care does not vary in quality based on race, income, etc.
  - **Patient centeredness** – Each patient's needs and values are respected
  - **Safety** – Treatment does not cause harm
  - **Timeliness** – Treatment is available without long delays

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Why Value-Based Care?

- VBC ties the amount earned by health care providers to the results of the care they deliver to patients
- The idea is to correct the misaligned incentives of the U.S. fee-for-service system
- Despite spending more on health care than any other developed nation in the world, the U.S. does not have the best results

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How does the Provider benefit?

- By participating in a clinically-integrated network, providers can more easily manage their patients across the health care continuum

  PCP ↔ Specialist ↔ Pharmacy ↔ Disease Management

- Financial incentives are aligned among all stakeholders, including health plans; this results in generation of shared savings
- Providers are rewarded for providing high-quality, efficient care with improved outcomes

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How does the Patient benefit?

- Person's physical, mental, behavioral, and social needs are addressed
- Person is treated as an individual rather than an organ system or a specific disease process
- Access to health education resources, including disease management and prevention programs
- Result: Healthier patients ***without*** increased costs

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MHN is Claims-Based

- Data on reports **is lagged** due to the time it takes for claims to be submitted to the payer, adjudicated, paid (or not), and then sent to MHN.
- MHN Attribution happens one of three (3) ways:
  1) A claim is received from a primary care provider (PCP)
  2) Patient selects a doctor in the network to be their PCP
  3) Payer assigns the patient to a provider

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MHN is Claims-Based (continued)

Appropriate coding and documentation results in:

- Fewer rejected claims
- Appropriate reimbursement for rendered services
- Care gap closure

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2025 MHN Reports

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MHN Reports

- **Care Gap Reports**: provided monthly beginning in June
- **Progress Reports**: provided quarterly beginning in the second quarter (Q2 through Q4)
- Both reports are from DoNotReplyMHN@mhs.net
  - ***Best Practice**: Download and save attached reports immediately upon receipt*
- Reports are claims-based, so the data are lagged by as much as ***three months***

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MHN Care Gap Reports

- A care gap indicates the patient is due for some type of follow-up, such as:
  - Wellness visit
  - Preventive screening (colorectal cancer, breast cancer, etc.)
  - Disease-related follow-up (Hemoglobin A1c, eye exam, etc.)

➢***Please note the date on the report*** – There is a delay/lag in claims-based reports

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MHN Care Gap Report

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Provider: [redacted]
[redacted] FAMILY PRACTICE

Contract Year 2024
Care Gap Provider Feedback Report as of 10/31/2024

Note the date on the report

Member ID / Name	DOB	Age	Gender	MRN	Measure	Primary Care Physician
[redacted]	[redacted]	53	M	[redacted]	CBP-Controlling High Blood Pressure	
[redacted]	[redacted]	46	F	[redacted]	COL-Colorectal Cancer Screening	
[redacted]	[redacted]	21	M	[redacted]	WCV-Well Care Visit age 3-21	
[redacted]	[redacted]	51	F	[redacted]	COL-Colorectal Cancer Screening	
[redacted]	[redacted]	65	F	[redacted]	CBP-Controlling High Blood Pressure	
[redacted]	[redacted]	24	F	[redacted]	CHL-Chlamydia Screening in Women	
[redacted]	[redacted]	55	F	[redacted]	BCS - Mammogram	
[redacted]	[redacted]	55	F	[redacted]	COL-Colorectal Cancer Screening	
[redacted]	[redacted]	50	F	[redacted]	COL-Colorectal Cancer Screening	
[redacted]	[redacted]	57	M	[redacted]	COL-Colorectal Cancer Screening	
[redacted]	[redacted]	62	F	[redacted]	CBP-Controlling High Blood Pressure	
[redacted]	[redacted]	62	F	[redacted]	COL-Colorectal Cancer Screening	

Reports are distributed at the end of the month from June through November of the performance year

HEDIS Measure Legend:

BCS = Breast Cancer Screening
CDC = Comprehensive Diabetes Care
W30 = Well Child Exam
CPB = Controlling High Blood Pressure
CHL = Chlamydia Screening
WCV = Child & Adolescent Well Exam
CCS = Cervical Cancer Screening
COL = Colorectal Cancer Screening

10/31/2024

This report contains Protected Health Information. As you and your office are Covered Entities, please ensure compliance with HIPAA Privacy and Security Rules.

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MHN Progress Report (page 1)

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Provider Progress Report

Interim Score: 47.1%
Total CI Points: 8 of 17

NAME:
SPECIALTY: FAMILY PRACTICE
NPI:
DATES EVALUATED: January – September 2024
REPORT GENERATED: Monday, November 25, 2024

Note the date on the report

Citizenship Domain

Measure Name	Points Earned	Points Available
Clinical Integration Education: Program Update	1	1
MHN Second Education Topic	1	1
Physician Survey	0	0
Office Manager Symposium	1	1
After Hours Access (BONUS)	1	0

4 of 3 Available Points

Efficiency Domain

Measure Name	Goal	Numerator	Denominator	Result	Points Earned	Points Available
Generic Medication Usage	> 90%	1015.00	1156.00	88%	0	2
ED visits/1000 - (# ED visits X 12,000)/ Member Months	< 250	558.00	21188.00	316.0	0	1
Average Length of Stay	<			No Data	0	0

0 of 3 Available Points

Readmission Measures

Measure Name	Goal	MHS Rate	Cohort Rate	MHS/Cohort Rate	Points Earned	Points Available
Adult Readmissions Ratio 30-Day All Cause (Observed / Expected)	< 1	10.69	10.16	1.05	0	1
Adult Readmissions Ratio Heart Failure (Observed / Expected)	< 1	20.21	19.31	1.05	0	1

0 of 2 Available Points

Citizenship metrics results reported as of Nov 12th, 2024
Efficiency metrics reported as of Jan-Sept 2024 except Inpatient metrics based on rolling 12 months of data
Readmission measures based on rolling 12 months of data
Quality metrics reported Jan-Sept 2024 except OB/GYN metrics based on rolling 12 months of data

Additional dates in the report footer

*Reports are distributed **quarterly** from Q2 through Q4 of the performance year*

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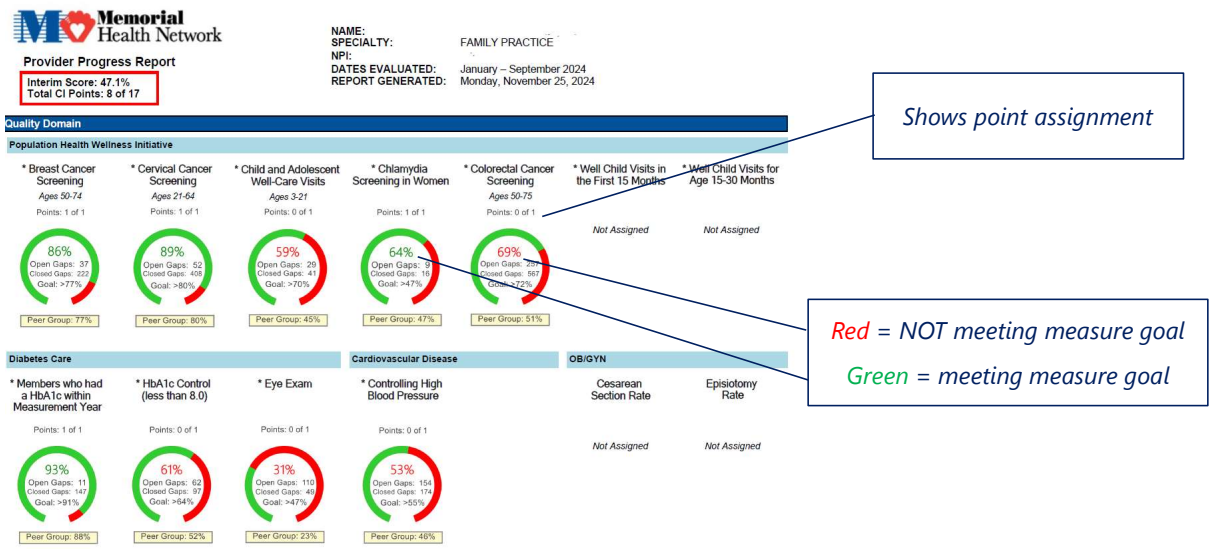
MHN Progress Report (page 2)



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MHN Progress Report Measures 2025

Progress Report measures comprise three (3) domains/sections:

1) Citizenship – **Applies to all MHN providers**
2) Quality
3) Efficiency

Assignment is based on providers' specialty

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Citizenship Measures 2025

There are three measures worth 1 point each plus one bonus point for eligible practices

1. Clinical Integration Education (CI Update)
2. MHN Second Education Topic
3. Office Manager Symposium ★
4. Extended Hours (***bonus for <u>eligible</u> providers***)

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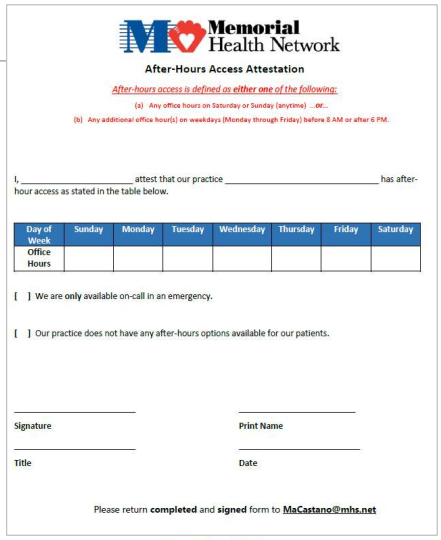
Extended Hours Access (Bonus)

- ✓ Only ***office-based*** providers are eligible for this bonus point.
- ✓ Must provide completed ***After Hours Access Attestation*** form →
  - *Appointments must be available for BOTH new and existing patients* during the times specified on the form.
  - MHN personnel may contact your office to request an appointment on behalf of a patient during the times specified on the form.



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After-Hours Access Attestation

*After-hours access is defined as **either one** of the following:*

(a) Any office hours on Saturday or Sunday (anytime) ...or...

(b) Any additional office hour(s) on weekdays (Monday through Friday) before 8 AM or after 6 PM.

I, _____ attest that our practice _____ has after-hour access as stated in the table below.

Day of Week	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Office Hours							

[ ] We are **only** available on-call in an emergency.

[ ] Our practice does not have any after-hours options available for our patients.

Signature _____ Print Name _____

Title _____ Date _____

Please return **completed** and **signed** form to MaCastano@mhs.net

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2025 Quality Measures

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HEDIS Quality Measures 2025

Changes for 2025:

1. Retired *Annual Hemoglobin A1c test* measure
2. New Measure: Use of Opioids at High Dosage

Total # HEDIS Quality Measures:	13
Total # Efficiency Measures:	3
Readmission Measures (Adult):	2
Readmission Measures (Peds):	1

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NEW Use of Opioids at High Dosage (HDO)

Measures the percentage of members 18 years of age and older who received prescription opioids at a high dosage, defined as morphine milligram equivalent **(MME) dose ≥ 90, for ≥ 15 days** during the measurement year.

- Data from pharmacy claims
- Attributed to *all providers*
- Will not be scored in 2025
- Exclusions: Cancer, sickle cell, hospice, palliative care

Opioid	MME Conversion
Codeine sulfate	0.15
Fentanyl patch (mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Morphine	1
Oxycodone	1.5
Tramadol	0.2

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How is MME Calculated?

Example: Patient prescribed Percocet (oxycodone) 5 mg/325 mg #120 tablets per 30 days supply. What is the MME equivalent for this Rx?

1. Calculate the total milligrams of the opioid taken each day

   *5 mg/tablet x 4 tablets/day = **20 mg** oxycodone*

2. Multiply by the MME conversion factor

   20 mg x 1.5 = 30 MMEs

Result: Rx does not meet the 90 MME threshold

Opioid	MME Conversion
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Fentanyl patch (mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Morphine	1
Oxycodone	1.5
Tramadol	0.2

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Well-Child Visits in the First 30 Months of Life (W30)

Two (2) age stratifications:

1) Children who turn 15 months during measurement year: Must have had **6 or more** well visits during this timeframe
2) Children who turn 30 months during measurement year: Must have had **2 or more** well visits between 15 -30 months of age

Description	CPT	ICD-10-CM
Infant (Younger than 1 year)	**99381** New patient **99391** Established	• **Z00.110** Health supervision for newborn under 8 days old • **Z00.111** Health supervision for newborn up to 28 days old • **Z00.121** Routine child health exam with abnormal findings • **Z00.129** Routine child health exam without abnormal findings
Early Childhood (Ages 1 to 4 years)	**99382** New Patient **99392** Established	

** As of 1/1/2025: Telehealth visits no longer count towards measure compliance **

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Child & Adolescent Well Care Visits Ages 3-21 (WCV)

Measures the percentage of members 3-21 years of age who had **at least one** comprehensive well-care visit with a PCP or OB/GYN **during the measurement year**

Description	CPT	ICD-10-CM
Early childhood (Ages 1 to 4 years)	**99382** New patient **99392** Established	• **Z00.121** Routine child health exam with abnormal findings • **Z00.129** Routine child health exam without abnormal findings
Late childhood (Ages 5 to 11 years)	**99383** New patient **99393** Established	
Adolescent (Ages 12 to 17 years)	**99384** New patient **99394** Established	
Adult (Ages 18 years and up)	**99385** New patient **99395** Established	• **Z00.00** General adult medical exam without abnormal findings • **Z00.01** General adult medical exam with abnormal findings

** As of 1/1/2025: Telehealth visits no longer count towards measure compliance **

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Breast Cancer Screening Ages 50-74 (BCS)

Measures the percentage of women 50-74 years of age who have had at least one mammogram in the **previous 27 months** (10/2023 - 12/2025)

- Women who have undergone a bilateral mastectomy (Z90.13) at any time during their history are ***excluded*** from this measure

Description	CPT	ICD-10-CM	HCPCS
Mammography bilateral	**77065** - unilateral **77066** - diagnostic **77067** - screening	**Z12.31** – Encounter for screening mammogram for malignant neoplasm of breast	**G0206** – unilateral **G0204** – diagnostic **G0202** – screening **G9899** – screening results have been documented & reviewed
Exclusion: Bilateral mastectomy		**Z90.13** – Hx bilateral mastectomy	

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Cervical Cancer Screening - Ages 21-64 (CCS)

Description	CPT	ICD-10-CM	HCPCS
Women 21–64 years of age: Cervical cytology performed **every 3 years** (2023-2025)	88141-88143, 88147-88148, 88150, 88152, 88153, 88164-88167, 88174-88175		G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
Women 30–64 years of age: Cervical cytology/ HPV co-testing performed **every 5 years** (2021-2025)	87624, 87625		G0476 (must be documented in addition to PAP test as indicated above)
Exclusion: "Total", "Complete" or "Radical" hysterectomy; Hysterectomy with no residual cervix	57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 59856, 59135	Q51.5, Z90.710, Z90.712	

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Chlamydia Screening (CHL)

Measures the percentage of individuals **16 – 24** years of age who were identified as sexually active via medical claims or pharmacy data (oral contraceptives) and who had at least one test for chlamydia **during the measurement year** (2025)

Chlamydia screening can be done via urine test or vaginal swab

Exclusion: Members who were assigned male at birth

Coding: Measure compliance is assessed by CPT code submission

Chlamydia Test CPT Codes
87110, 87270, 87320, 87490-87492, 87810

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Colorectal Cancer Screening - Ages 46-75 (COL)

Measures the percentage of members 46-75 years of age who had appropriate screening for colorectal cancer as shown below:

Description	CPT	HCPCS
Colonoscopy Every 10 years (2016 – 2025)	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398	G0105, G0121
Flexible sigmoidoscopy Every 5 years (2021-2025)	45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350	G0104
CT Colonography Every 5 years (2021-2025)	74261-74263	
Cologuard or FIT-DNA (stool DNA test) Every 3 years (2023-2025)	81528	
Fecal Occult Blood Test (FOBT) Yearly (2025)	82270 82274	G0328

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Stool Tests for Colorectal Cancer Screening

There are two (2) types of stool tests:

1. **Fecal occult blood test**
   - FOBT, Guaiac test – checks for presence of hemoglobin
   - FIT test – uses antibodies to detect blood in stool
   - Must be done ***yearly***
2. **Fecal occult blood + DNA test**
   - Cologuard
   - FIT-DNA/ Stool DNA – Detects blood ***plus*** altered DNA in stool
   - Can be done ***every 3 years***

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Document Clearly & Appropriately

The following are NOT acceptable for closing care gaps:

- Tests performed in an office setting *or* from any specimen collected during a digital rectal exam
- CT scan of abdomen or pelvis

Avoid abbreviations whenever possible

- Example "COL" or "COL 2022"
  Colostomy? Colectomy? Colonoscopy? Cologuard?

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Colorectal Cancer Screening Exclusions (COL)

Required Exclusion	ICD-10-CM	CPT	HCPCS
Enrollment in palliative care	Z51.5		
Utilization of hospice services			Q5001 – Q5010
Frailty or advanced illness	R54		G2099
Living in Long Term Care/ ALF		99341 – 99345 99347 – 99350	
History of colorectal cancer diagnosis	C18.0 – C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048		
History of total colectomy		44150 – 44153, 44155 – 44158, 44210 – 44212	

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Diabetes Care: Hemoglobin A1c Control <8%

Measures the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing within the measurement year and the value returned as **below 8.0%**

- Measure performance is recorded via *CPT II coding*

CPT II Code	Hemoglobin A1c (HbA1c) Level
3044F	Less than 7.00
3051F	7.00 – 7.99
3052F	8.00 – 9.00
3046F	Greater than 9.00

The most recent test result from measurement year (2025) is the one that counts towards measure compliance

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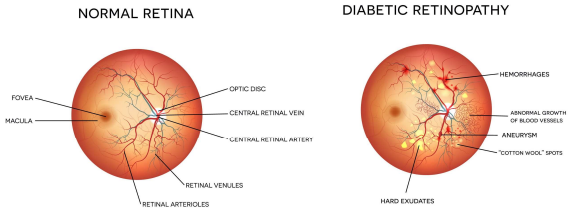
Diabetes Care: Eye Exam (CDC)

Measures the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a comprehensive eye exam to screen/monitor for diabetic retinal disease, including:

- A retinal or dilated eye exam in the measurement year (**2025**) ****OR****
- A negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement year (**2024**)



Exam must be interpreted by an eye care professional (optometrist or ophthalmologist)

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Diabetes Care: Eye Exam – Best Practices

Educate patient on the risks of Diabetic Eye Disease and encourage scheduling an **annual eye exam**

- Obtain eye exam reports. Document eye care provider name and contact information in chart
- Documentation can be in the form of a note or letter prepared by the eye care professional and must include the date of service, the test and result, and the provider's credentials
  - Example of appropriate documentation: *Diabetic retinal* or *dilated eye exam with Donald Blake, OD, June 2024, no retinopathy*
- Prior year exam results must indicate retinopathy was ***NOT PRESENT***

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Diabetes Care: Eye Exam – CPT Coding

CPT Codes document that the exam was performed (but not the result)

Description of Exam*	CPT Code
Imaging of retina for detection or monitoring of disease With remote clinical staff review and report	92227
Imaging of retina for detection or monitoring of disease With remote physician or other qualified health care professional interpretation and report	92228
Imaging of retina for detection or monitoring of disease Point of care automated analysis and report (AI Interpretation)	92229

***Date of service must be provided**

If previous year's exam is being used, then ***must include CPT II code*** to communicate that exam was negative for retinopathy!

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Diabetes Care: Eye Exam – CPT II Coding

CPT II Codes document the result of the Diabetic Eye exam.

Description	CPT II Code	CPT II Code Description
Current year (2025) Dilated retinal screening ***with*** evidence of retinopathy	2022F 2024F 2026F	- Dilated retinal exam w/interpretation by eye care professional documented & reviewed - 7 standard field stereoscopic photos w/interpretation by eye care professional documented & reviewed - Eye imaging validated to match dx from 7 standard field stereoscopic photos results documented & reviewed
Current year (2025) Dilated retinal screening ***without*** evidence of retinopathy	2023F 2025F 2033F	- Dilated retinal exam w/interpretation by eye care professional documented & reviewed - 7 standard field stereoscopic photos w/interpretation by eye care professional documented & reviewed - Eye imaging validated to match dx from 7 standard field stereoscopic photos results documented & reviewed
Prior year (2024) Dilated retinal screening ***without*** evidence of retinopathy	3072F	- Low risk for retinopathy (no evidence of retinopathy in the prior year)

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Hypertension – Controlling High Blood Pressure (CBP)

Measures the percentage of patients ages 18-85 years who have a diagnosis of hypertension and whose **most recent BP** during the measurement year is **BELOW 140/90** mmHg.

The BP reading **cannot** be used if:

- BP was taken during an acute inpatient stay or ED visit
- BP was taken on the same day as diagnostic test requiring change in diet or medication (except fasting blood test)
- BP was taken by patient using a *non-digital* device

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Blood Pressure Measurement – Best Practices

- Offer restroom facilities prior to taking BP
- Allow 5-10 minutes to sit and relax prior to any BP reading
- Provide a comfortable chair with back support
- Ensure there is an arm rest at heart level for taking BP reading
- Check to see if feet are flat on the floor with legs uncrossed
- Do not speak or ask questions during the time the reading is taken

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Measuring Accurate Blood Pressure (continued)

- Use the correctly sized cuff based on mid-arm circumference

Mid-Arm Circumference	Cuff Size
Less than 10.2 inches (26 cm)	Small Adult
10.2 – 13.4 inches (26 – 34 cm)	Regular Adult
13.4 – 17.3 inches (34 – 44 cm)	Large Adult
More than 17.3 inches (44 cm)	Extra Large Adult

  - Too small cuff size → Falsely elevated BP
  - Too large cuff size → Falsely decreased BP

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Hypertension – Controlling High Blood Pressure (CBP)

Measure performance is tracked exclusively via CPT II coding

CPT II Code	SYSTOLIC BP Value
3074F	< 130 mm Hg
3075F	130 – 139 mm Hg
3077F	≥ 140 mm Hg
CPT II Code	**DIASTOLIC BP Value**
3078F	< 80 mm Hg
3079F	80 – 89 mm Hg
3080F	≥ 90 mm Hg

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Quality Measures for Obstetrics: Cesarean Section & Episiotomy Rates

- The Leapfrog Group reports rates across the U.S. annually
- This report represents 80% of the inpatient beds in the U.S
- ***Good news:*** Episiotomy rates continue to decline
- ***Not-so-good news:*** C-section rates are (still) relatively high

➢ Rates reported on MHN Progress Report reflect deliveries across ***MHS facilities only***

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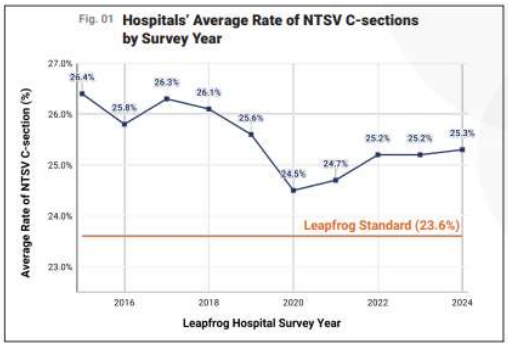
Cesarean Section Rate



NTSV = Nulliparous, Term, Singleton, Vertex

- C-section rates are *not* improving nationally
- Rates of primary C-sections have been steadily increasing at MHS facilities between 2022-2024
  - 2022 Performance = 23%
  - 2023 Performance = 25%
  - 2024 Performance = 26%

2025 Network Goal: ≤24%

Source: The Leapfrog Group, State of Maternity Care in U.S. Hospitals. Retrieved June 16, 2025, from www.leapfrog.org

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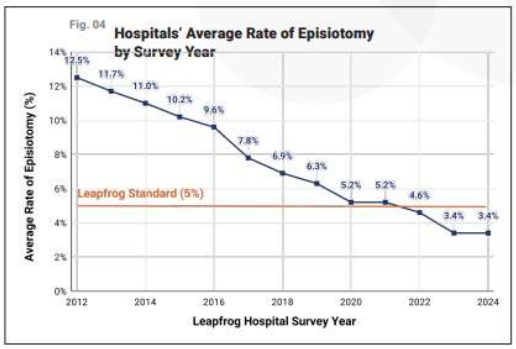
Episiotomy Rate



- Episiotomy rates have declined 73% nationally since 2012
- Rates of episiotomies have been steadily *decreasing* at MHS facilities between 2022-2024
  - 2022 Performance = 4%
  - 2023 Performance = 3%
  - 2024 Performance = 1%

2025 Network Goal: ≤7%

Source: The Leapfrog Group, State of Maternity Care in U.S. Hospitals. Retrieved June 16, 2025, from www.leapfrog.org

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2025 Efficiency Metrics

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Generic Prescribing Rate

Measures the ratio of generic prescriptions divided by the total prescriptions (brand and generic) authorized for MHN-attributed members during the measurement year (2025).

Inpatient orders are not counted towards this measure

Goal: Varies by specialty and is based upon historical (prior year) performance

Exclusions: Branded Levothyroxine products and vaccines/toxoids

Threshold: **25** total outpatient prescriptions

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Generic Prescribing Rate (continued)

Tips for improving your generic prescribing rate:

1. Prescribe generic medications whenever possible (first-line therapy)
2. Avoid routinely documenting "medically necessary" on prescriptions
3. Prescribe a 3-month supply for *eligible* maintenance (not specialty) medications
4. Request your pharmacy report to see whether you have opportunities for generic prescribing
5. Educate your patients about the benefits of generic medication

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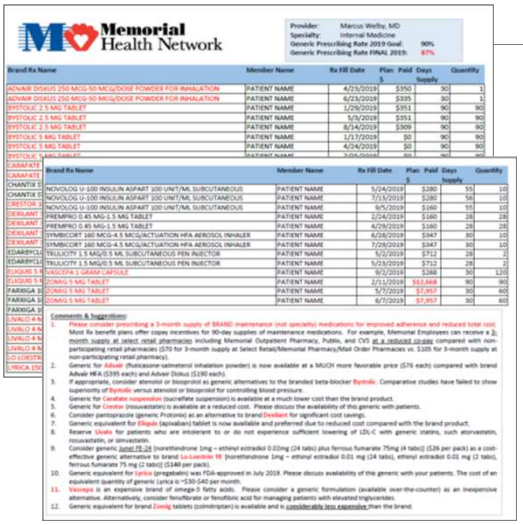
Pharmacy Report – Available upon request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Provider: Marcus Welby, MD
Specialty: Internal Medicine
Generic Prescribing Rate 2019 Goal: 90%
Generic Prescribing Rate FINAL 2019: 87%

Brand Rx Name	Member Name	Rx Fill Date	Plan $	Paid $	Days Supply	Quantity
ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION	PATIENT NAME	4/23/2019	$350		30	1
ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION	PATIENT NAME	6/23/2019	$335		30	1
BYSTOLIC 2.5 MG TABLET	PATIENT NAME	1/29/2019	$351		90	90
BYSTOLIC 2.5 MG TABLET	PATIENT NAME	5/3/2019	$351		90	90
BYSTOLIC 2.5 MG TABLET	PATIENT NAME	8/14/2019	$909		90	90
BYSTOLIC 5 MG TABLET	PATIENT NAME	1/17/2019	$0		90	90
BYSTOLIC 5 MG TABLET	PATIENT NAME	4/24/2019	$0		90	90
BYSTOLIC 5 MG TABLET	PATIENT NAME	7/25/2019	$0		90	90
CARAFATE	PATIENT NAME	1/17/2019	$0		90	90
CARAFATE	PATIENT NAME	4/24/2019	$0		90	90
CHANTIX 1	PATIENT NAME	7/25/2019	$0		90	90
CHANTIX 1	PATIENT NAME	10/24/2019	$0		90	90
CRESTOR 2	PATIENT NAME	1/17/2019	$0		90	90
DEXILANT	PATIENT NAME	4/24/2019	$0		90	90
DEXILANT	PATIENT NAME	7/25/2019	$0		90	90
DEXILANT	PATIENT NAME	10/24/2019	$0		90	90
EDARBYCLOR	PATIENT NAME	1/17/2019	$0		90	90
EDARBYCLOR	PATIENT NAME	4/24/2019	$0		90	90
EUQUIN 5	PATIENT NAME	7/25/2019	$0		90	90
EUQUIN 5	PATIENT NAME	10/24/2019	$0		90	90
FARXIGA 1	PATIENT NAME	1/17/2019	$0		90	90
FARXIGA 1	PATIENT NAME	4/24/2019	$0		90	90
LIVALO 4 M	PATIENT NAME	7/25/2019	$0		90	90
LIVALO 4 M	PATIENT NAME	10/24/2019	$0		90	90
LIVALO 4 M	PATIENT NAME	1/17/2019	$0		90	90
LO LOESTR	PATIENT NAME	4/24/2019	$0		90	90
LYRICA 150	PATIENT NAME	7/25/2019	$0		90	90
	PATIENT NAME	10/24/2019	$0		90	90

Brand Rx Name	Member Name	Rx Fill Date	Plan $	Paid $	Days Supply	Quantity
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS	PATIENT NAME	5/24/2019	$280		55	10
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS	PATIENT NAME	7/15/2019	$280		56	10
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS	PATIENT NAME	9/5/2019	$160		55	10
PREMPRO 0.45 MG-1.5 MG TABLET	PATIENT NAME	2/24/2019	$160		28	28
PREMPRO 0.45 MG-1.5 MG TABLET	PATIENT NAME	4/29/2019	$160		28	28
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER	PATIENT NAME	6/28/2019	$347		30	10
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER	PATIENT NAME	7/29/2019	$347		30	10
TRULICITY 1.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR	PATIENT NAME	5/2/2019	$712		28	2
TRULICITY 1.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR	PATIENT NAME	5/23/2019	$712		28	2
VASCEPA 1 GRAM CAPSULE	PATIENT NAME	9/2/2019	$268		30	120
ZOMIG 5 MG TABLET	PATIENT NAME	2/11/2019	$12,668		90	90
ZOMIG 5 MG TABLET	PATIENT NAME	5/7/2019	$7,957		30	60
ZOMIG 5 MG TABLET	PATIENT NAME	6/7/2019	$7,957		30	60

Comments & Suggestions:

1. Please consider prescribing a 3-month supply of BRAND maintenance (not specialty) medications for improved adherence and reduced total cost. Most Rx benefit plans offer copay incentives for 90-day supplies of maintenance medications. For example, Memorial Employees can receive a 3-month supply at select retail pharmacies including Memorial Outpatient Pharmacy, Publix, and CVS at a reduced co-pay compared with non-participating retail pharmacies ($70 for 3-month supply at Select Retail/Memorial Pharmacy/Mail Order Pharmacies vs. $105 for 3-month supply at non-participating retail pharmacy).
2. Generic for Advair (fluticasone-salmeterol inhalation powder) is now available at a MUCH more favorable price ($76 each) compared with brand Advair HFA ($395 each) and Advair Diskus ($190 each).
3. If appropriate, consider atenolol or bisoprolol as generic alternatives to the branded beta-blocker Bystolic. Comparative studies have failed to show superiority of Bystolic versus atenolol or bisoprolol for controlling blood pressure.
4. Generic for Carafate suspension (sucralfate suspension) is available at a much lower cost than the brand product.
5. Generic for Crestor (rosuvastatin) is available at a reduced cost. Please discuss the availability of this generic with patients.
6. Consider pantoprazole (generic Protonix) as an alternative to brand Dexilant for significant cost savings.
7. Generic equivalent for Eliquis (apixaban) tablet is now available and preferred due to reduced cost compared with the brand product.
8. Reserve Livalo for patients who are intolerant to or do not experience sufficient lowering of LDL-C with generic statins, such atorvastatin, rosuvastatin, or simvastatin.
9. Consider generic Junel FE 24 (norethindrone 1mg – ethinyl estradiol 0.02mg (24 tabs) plus ferrous fumarate 75mg (4 tabs)) ($26 per pack) as a cost-effective generic alternative to brand Lo-Loestrin FE (norethindrone 1mg – ethinyl estradiol 0.01 mg (24 tabs), ethinyl estradiol 0.01 mg (2 tabs), ferrous fumarate 75 mg (2 tabs)) ($1440 per pack).
10. Generic equivalent for Lyrica (pregabalin) was FDA-approved in July 2019. Please discuss availability of this generic with your patients. The cost of an equivalent quantity of generic Lyrica is ~$30-$40 per month.
11. Vascepa is an expensive brand of omega-3 fatty acids. Please consider a generic formulation (available over-the-counter) as an inexpensive alternative. Alternatively, consider fenofibrate or fenofibric acid for managing patients with elevated triglycerides.
12. Generic equivalent for brand Zomig tablets (zolmitriptan) is available and is considerably less expensive than the brand.

- Contains brand Rxs prescribed for MHN-attributed patients
- Includes only outpatient prescriptions, NOT inpatient orders
- Scroll to bottom of report for suggestions on cost-effective and/or generic alternatives

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ED Visits per Thousand

Measures the ED utilization of all members seen by the practice and is calculated by taking the number of ED visits during the measurement year (2025) divided by the number of member months per practice multiplied by 12,000

For group practices: The practice rate will be used, NOT individual physician

Attributed to **primary care providers *only***

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Average Length of Stay

Reports the arithmetic average length of stay for all cases attributed to a provider over a rolling 12-month period

Value indicates the provider's average length of stay for cases within the *Memorial Healthcare System* hospitals

Attributed only to the "responsible" physician on the case, not all providers in the practice

Threshold: 10 cases

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30-Day All-Cause Readmission Ratio: Adult & Pediatrics

Adult and pediatric rates are reported separately

Applies to patients attributed to MHN providers regardless of payer

Observed Score: Aggregate measure of network readmissions (*not* individual physician performance)

Expected Score: Measures the Crimson "Florida Hospitals" cohort readmissions

Goal: $\frac{\text{Observed score (MHN rate)}}{\text{Expected score (Cohort rate)}} \leq 1.0$

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30-Day Heart Failure Readmission Ratio

Adult patients with Heart Failure DRG attributed to MHN providers, regardless of payer

Observed Score: Aggregate measure of network readmissions for Heart Failure DRG (*not* individual physician performance)

Expected Score: Measures the Crimson "Florida Hospitals" cohort readmissions for heart failure DRG

Goal: $\frac{\text{Observed score (MHN rate)}}{\text{Expected score (Cohort rate)}} \leq 1.0$

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Top 5 Reasons for Reduced HEDIS Measure Performance

1. Patient did not follow-through on ordered service/procedure
   - Diabetic (dilated) eye exam
   - Other screening tests (labs, mammograms, etc.)
2. Service *was* provided, but claim contains incorrect or missing CPT and/or CPTII codes
3. Service was provided outside of the required time frame
4. Measure exclusion(s) were not coded properly
5. Claims were not submitted in a timely manner

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Tips and Best Practices

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Tips and Best Practices

Use your attribution list to contact patients due/overdue for an exam or those who are new to your practice

Most measure performance can be recorded via claims when complete and accurate coding is used

Take advantage of the information presented here and the MHN Fact Sheet to help your practice understand HEDIS measures

Contact your patients to remind of appointments and preventative screenings via Care Gap & Attribution Reports

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Tips and Best Practices (continued)

Most Electronic Health Records (EHRs) have functionality to create alerts for overdue screenings *and* share data with other providers	Be sure to have these prompts turned ***on*** or check with your software vendor to have these added to your EHR
Consider extending your office hours into the evening, early morning, or weekend to accommodate your patients' work schedules	Benefits include decreased ED visits, greater patient engagement, and practice growth

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Optimize your Office Workflow

Front Desk
Verify patient information, check for overdue AWV or WCE and notify MA/Nurse

MA or Nurse
Check for care gaps, Rx refills, vaccinations, recent test results

Provider / Physician
Confirm/ document relevant diagnoses, confirm orders (Rx, labs)

Check Out Desk
Verify Rx refills & final questions

IF specialist office: *refer patient back to PCP for continuity of care*

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5 Things You can do Today to Elevate Office Performance in VBC

- Maintain your panel by reaching out to patients on your attribution report that have not been to the office this past year
- Review your ED report and consider referring these patients to Care Management
- Engage your billing vendor to verify they are using current and correct codes with claims
- Order 3-month supplies of *eligible* maintenance medications to reduce costs and aid adherence
- Ask patients to write an online review for your office/provider

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MHN Website

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Questions?

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