Ohio | Governor's Office of Health Transformation

Ohio Comprehensive Primary Care (CPC) Practice Webinar #1

Attribution and Payment

April 6, 2017

www.HealthTransformation.Ohio.gov

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1. **Welcome and overview**
2. Attribution
3. Payment
4. Next steps and timeline
5. Reminders and questions

Appendix

Ohio Comprehensive Primary Care (CPC) milestones to date

- The **Ohio CPC program launched January 1, 2017** with 92 "early-entry" practices enrolled in Ohio CPC, covering more than 630,000 members
- The **first performance year** covers the period January through December, 2017
- **Patient attribution has been shared with practices for the first quarter** of the performance year via the MITS portal
- ODM issued quarterly **PMPM payments for Q1 and Q2**
- Practices will receive the **first quarterly Ohio CPC Provider Report by the end of April, 2017**

Goals for the Practice Webinars throughout 2017

- Provide an **overview of the Ohio CPC program** and **answer any operational or model design questions**
- **Discuss feedback about the Ohio CPC model**, including attribution, payment, and reporting
- **Share best practices** and learnings across Ohio CPCs

Overview of the Ohio CPC practice journey

Attribution	Payment	Reporting
Determining the patients for which an Ohio CPC practice is responsible	**Quarterly per-member-per-month (PMPM) payments**	**Summary of performance at the Ohio CPC Practice level and detailed member level**

Key Dates / Next Steps:

April 4 – Q2 attribution and payment files shared on MITS **July 6 -** Q3 attribution and payment files shared on MITS	Q2 payment for MCP members forthcoming	**End of April** Q1 CPC provider report shared

The practice journey through the Ohio CPC program is intended to transform care delivery and support primary care practices in effectively managing patients' health needs

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Overview of today's discussion on attribution

Determining the patients for which an Ohio CPC practice is responsible

- How does patient attribution work?
- Why are some patients who we have never seen attributed to our practice?
- When is attribution conducted for each quarter?
- What should we do if patients are incorrectly attributed to our practice?

Key Dates / Next Steps:

April 4 – Q2 attribution and payment files shared on MITS

July 6 - Q3 attribution and payment files shared on MITS

Attribution for the Ohio CPC program is based on three criteria

1. **First criteria: assign members based on member choice**

   Member choice is the most direct way for members to be attributed to an Ohio CPC

2. **Second criteria:** if member choice isn't expressed, attribute **member based on claims from visits**

   Claims-based attribution is based on a plurality of E&M visits with a practice

3. **Third criteria:** if neither member choice nor visit claims are available – **Assign member based on non-claims considerations**[1]

   Patients may be attributed to your practice even if you have not seen them in the past

Attribution can be changed based on member preference (i.e. member exhibits new or changed choice) or member behavior as determined through claims

1 MCPs may use other factors to conduct non-claims based attribution

Patient attribution is determined prior to each quarter

	Payment and reporting period	Attribution date	Timeframe reports are shared with CPCs
Winter (Q1)	January to March	September 1 of the prior year	April
Spring (Q2)	April to June	December 1 of the prior year	July
Summer (Q3)	July to September	March 1	October
Fall (Q4)	October to December	June 1	January of the following year

What you should do if you believe your attribution is incorrect

- **Review your patient attribution file** (available on MITS)
- **Encourage patients to update their selected primary care provider (PCP)**
- **If you believe patients were attributed to your practice in error**, contact the managed care plan responsible for the member(s)
  - For fee-for-service members, contact the Medicaid Provider Hotline at 1 (800) 686-1516

Changes in attribution are effective as of the next attribution date, and will be reflected in the subsequent payment and reporting period

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Overview of today's discussion on payment

Quarterly per-member-per-month payments for eligible practices

Next step:

Q2 payment for MCP members forthcoming

- What payments are made as part of the Ohio CPC program?
- When are payments made for each quarter?
- What should we do if we have not received payment, or payment is incorrect?
- What is required for our practice to receive payment?
- Where can we find more information about the quality and efficiency measures used to determine payment?

Ohio Comprehensive Primary Care (CPC) Program Requirements and Payment Streams

Requirements	8 activity requirements	4 Efficiency measures	20 Clinical Measures	Total Cost of Care
	▪ *Same-day appointments* ▪ *24/7 access to care* ▪ *Risk stratification* ▪ *Population management* ▪ *Team-based care management* ▪ *Follow up after hospital discharge* ▪ *Tracking of follow up tests and specialist referrals* ▪ *Patient experience*	▪ *ED visits* ▪ *Inpatient admissions for ambulatory sensitive conditions* ▪ *Generic dispensing rate of select classes* ▪ *Behavioral health related inpatient admits*	▪ *Clinical measures aligned with CMS/AHIP core standards for PCMH*	
	Must pass 100%	**Must pass 50%**	**Must pass 50%**	
Payment Streams				
PMPM	***All required***			
Shared Savings	***All required***			***Based on self-improvement & performance relative to peers***

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PMPM payments are made prospectively for each quarter

- **PMPM payments are made prospectively at the beginning of each quarter**, based on the number of attributed members for the quarter
- **If you have not received your PMPM payment**, or believe your payment amount is incorrect, **please contact the managed care plan responsible for the payment**, or for questions about payment for fee-for-service members, contact the Medicaid Provider Hotline at 1 (800) 686-1516

PER MEMBER PER MONTH (PMPM) payment calculation

The PMPM payment for a given Ohio CPC practice is calculated by multiplying the **PMPM for each risk tier** by the **number of members attributed to your practice in each risk tier**

	3M CRG health statuses	Example of 3M CRG	2017 CPC PMPM
Ohio CPC PMPM Tier 1	▪ Healthy	▪ Healthy (no chronic health problems)	**$1**
	▪ History of significant acute disease	▪ Chest pains	
	▪ Single minor chronic disease	▪ Migraine	
Ohio CPC PMPM Tier 2	▪ Minor chronic diseases in multiple organ systems	▪ Migraine and benign prostatic hyperplasia (BPH)	**$8**
	▪ Significant chronic disease	▪ Diabetes mellitus	
	▪ Significant chronic diseases in multiple organ systems	▪ Diabetes mellitus and CHF	
Ohio CPC PMPM Tier 3	▪ Dominant chronic disease in 3 or more organ systems	▪ Diabetes mellitus, CHF, and COPD	**$22**
	▪ Dominant/metastatic malignancy	▪ Metastatic colon malignancy	
	▪ Catastrophic	▪ History of major organ transplant	

- Your practice will receive payments **prospectively and quarterly**
- Risk tiers are **updated quarterly**, based on 24 months of claims history with 6 months of claims run-out

Detailed requirement definitions are available on the Ohio Medicaid website:
http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx#1600562-cpc-payments

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SHARED SAVINGS payment calculation

- **Annual retrospective payment** based on total cost of care (TCOC)
- **Activity requirements and quality and efficiency metrics must be met** for the CPC practice to receive this payment
- CPC practice must have **60,000 member months** to calculate TCOC
- CPC practice may receive **either or both** of two payments:

1. Total Cost of Care RELATIVE TO SELF	Payment based on a **practice's improvement on total cost of care** for all their attributed patients, **compared to their own baseline** total cost of care
2. Total Cost of Care RELATIVE TO PEERS	Payment **based on a practice's low total cost of care** relative to other CPC practices

CY17 Shared Savings will be determined in Q3 2018 after a 6-month claims run-out period

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Patients and services included in total cost of care

	Inclusions	Exclusions
Patients	▪ All adults and pediatrics ▪ All behavioral health members including SPMI ▪ Members with exclusively dental or vision TPL coverage	▪ Duals (included as operationally feasible, priority for MyCare) ▪ Members with limited benefits (e.g., family planning) ▪ All other members with TPL coverage
Services	▪ All non-excluded medical and prescription spend including: – Case management – DME – Home health – First 90 days of LTC	▪ Waiver ▪ Currently underutilized services (dental, vision, transportation) ▪ All spend for members: – With a NICU[1] stay – With > 90 days of LTC claims – That are outliers within each risk band (top and bottom 1%)

1 Defined as Nursery level 3 and 4

Must pass 100%

Ohio CPC Activity Requirements

Same-day appointments	• The practice provides same-day access, within 24 hours of initial request, including some weekend hours to a PCMH practitioner or a proximate provider with access to patient records who can diagnose and treat
24/7 access to care	• The practice provides and attests to 24 hour, 7 days a week patient access to a primary care physician, primary care physician assistant or a primary care nurse practitioner with access to the patient's medical record
Risk stratification	• Providers use risk stratification from payers in addition to all available clinical and other relevant information to risk stratify all of their patients, and integrates this risk status into records and care plans
Population health management	• Practices identify patients in need of preventative or chronic services and implements an ongoing multifaceted outreach effort to schedule appointments; practice has planned improvement strategy for health outcomes
Team-based care management	• Practice defines care team members, roles, and qualifications; practice provides various care management strategies in partnership with payers and ODM for patients in specific patient segments; practice creates care plans for all high-risk patients, which includes key necessary elements
Follow up after hospital discharge	• Practice has established relationships with all EDs and hospitals from which they frequently get referrals and consistently obtains patient discharge summaries and conducts appropriate follow-up care
Tests and specialist referrals	The practice has a documented process for tracking referrals and reports, and demonstrates that it: • Asks about self-referrals and requests reports from clinicians • Tracks lab tests and imaging tests until results are available, flagging and following up on overdue results • Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports • Tracks fulfillment of pharmacy prescriptions where data is available
Patient experience	• The practice assesses their approach to patient experience and cultural competence at least once annually through quantitative or qualitative means; information collected by the practice covers access, communication, coordination and whole person care and self-management support; the practice uses the collected information to identify and act on improvement opportunities to improve patient experience and reduce disparities. The practice has process in place to honor relationship continuity.

Detailed requirement definitions are available on the Ohio Medicaid website:
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Must pass 50%

Ohio CPC Clinical Quality Requirements

Category	Measure Name	Population	Population health priority	NQF #
Pediatric Health (4)	Well-Child Visits in the First 15 Months of Life	Pediatrics		1392
	Well-Child visits in the 3rd, 4th, 5th, 6th years of life	Pediatrics		1516
	Adolescent Well-Care Visit	Pediatrics		HEDIS AWC
	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	Pediatrics	Obesity, physical activity, nutrition	0024
Women's Health (5)	Timeliness of prenatal care	Adults	Infant Mortality	1517
	Live Births Weighing Less than 2,500 grams	Adults	Infant Mortality	N/A
	Postpartum care	Adults	Infant Mortality	1517
	Breast Cancer Screening	Adults	Cancer	2372
	Cervical cancer screening	Adults	Cancer	0032
Adult Health (7)	Adult BMI	Adults	Obestiy	HEDIS ABA
	Controlling high blood pressure (starting in year 3)	Adults	Heart Disease	0018
	Med management for people with asthma	Both		1799
	Statin Therapy for patients with cardiovascular disease	Adults	Heart Disease	HEDIS SPC
	Comprehensive Diabetes Care: HgA1c poor control (>9.0%)	Adults	Diabetes	0059
	Comprehensive diabetes care: HbA1c testing	Adults	Diabetes	0057
	Comprehensive diabetes care: eye exam	Adults	Diabetes	0055
Behavioral Health (4)	Antidepressant medication management	Adults	Mental Health	0105
	Follow up after hospitalization for mental illness	Both	Mental Health	0576
	Preventive care and screening: tobacco use: screening and cessation intervention	Both	Substance Abuse	0028
	Initiation and engagement of alcohol and other drug dependence treatment	Adults	Substance Abuse	0004

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Measures will evolve over time

- Measures will be refined based on learnings from initial roll-out
- Hybrid measures that require electronic health record (EHR) may be added to the list of core measures
- Hybrid measures may replace some of the core measures
- Reduction in variability in performance between different socioeconomic demographics may be included as a CPC requirement

Note: All CMS metrics in relevant topic areas were included in list except for those for which data availability poses a challenge (e.g., certain metrics requiring EHR may be incorporated in future years)

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Some quality measures may require changes to billing practices

CPC quality measure	Billing code purpose	Key billing codes
Weight Assessment and Counseling for Children / Adolescents: BMI Percentile	ICD-9 & ICD-10 codes to indicate BMI percentile *(numerator)*	ICD-10: **Z68.51-Z68.54** ICD-9[1]: V85.51-V85.54
Adult BMI Assessment	ICD-9 & ICD-10 codes to indicate BMI percentile *(numerator)*	ICD-10: **Z68.51-Z68.54, Z68.1, Z68.20-Z68.45** ICD-9[1]: V85.51-V85.54, V85.0-V85.1, V85.21-V85.25, V85.30-V85.39, V85.41-V85.45
Comprehensive Diabetes Care: Poor Control (HbA1c >9%)	CPT®-II codes to identify HbA1c levels *(numerator)*	**3044F** (HbA1c < 7%) **3045F** (HbA1c between 7-9%) **3046F** (HbA1c > 9%)
Controlling High Blood Pressure	Codes to indicate hypertension *(denominator)*	ICD-10: **I10** ICD-9[1]: 401.0, 401.1, 401.9
	CPT® and CPT®-II codes to indicate blood pressure is controlled, or recorded *(numerator)*	**3074F, 3075F, G8752**: Blood Pressure Controlled, Systolic **G8753, G8756, 3077F**: Blood Pressure Recorded, Systolic **3078F, 3079F, G8754**: Blood Pressure Controlled, Diastolic **3080F, G8755, G8756**: Blood Pressure Recorded, Diastolic
Tobacco Use: Screening and Cessation Intervention	CPT® and CPT®-II codes to indicate tobacco screening and cessation counseling provided *(numerator)*	**4004F**: Patient screened for tobacco use AND received tobacco cessation intervention **1036F**: Current tobacco non-user **99406**: Smoking/tobacco counseling 3-10 minutes **99407**: Smoking/tobacco counseling > 10 minutes

1 ICD-9 codes are applicable to dates of service prior to October, 2015

Must pass 50%

Ohio CPC Efficiency Requirements

Metric	Rationale
Generic dispensing rate (all drug classes)	▪ Strong correlation with total cost of care for large practices ▪ Limited range of year over year variability for smaller panel sizes ▪ Aligned with preferred change behavior to maximize value
Ambulatory care-sensitive inpatient admits per 1,000	▪ Strong correlation with total cost of care for large practices ▪ Metric that PCPs have stronger ability to influence, compared to all IP admissions
Emergency room visits per 1,000	▪ Limited range of year over year variability for smaller panel sizes ▪ Aligned with preferred change in behavior supporting the most appropriate site of service
Behavioral health-related inpatient admits per 1,000	▪ Reinforces desired provider practice patterns, with focus on behavioral health population ▪ Relevant for a significant number of smaller practices ▪ Stronger correlation to total cost of care than other behavioral health-related metrics
Episodes-related metric	▪ **REPORTING ONLY** (not tied to payment) ▪ Links CPC program to episode-based payments ▪ Based on CPC practice referral patterns to episodes principle accountable providers

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Next steps on reporting: Q1 Ohio CPC Provider Reports will be shared by the end of April

1 PDF Summary of practice performance

CPC Quarterly Progress Report
Provider Name (Provider ID#)

Illustrative PCMH provider report – All thresholds and performance data are illustrative 2

Performance Summary | **Jul 2016 – Jun 2017**

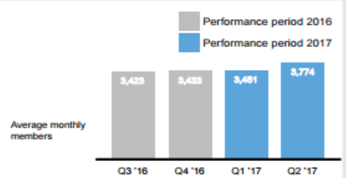
Reporting period covering services paid through 6/30/2017, with service dates between 7/1/2016 to 6/30/2017
Standard processes and operational activities status based on provider portal entries

CPC Performance Summary

Your payment eligibility

	PMPM		Shared Savings Payment
Your payment eligibility	Congratulations! You are eligible for this payment based on last year's performance		Eligibility for this payment will be determined at the end of the performance period
Your payment amounts	$45,290 Next quarter	$127,902 2017 YTD	N/A[1]

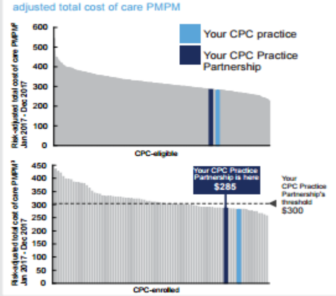
Your CPC panel composition over time



	Q3 '16	Q4 '16	Q1 '17	Q2 '17
# members gained	15	10	20	325
# members lost	1	0	2	2
Average risk score	0.88	0.91	0.95	0.95

Your risk-adjusted total cost of care performance

Distribution of CPC-eligible and CPC-enrolled practices by risk adjusted total cost of care PMPM



Requirements for payment

Requirement categories	Found on pages	PMPM		Shared Savings Payment	
		2017 performance	Goal	2017 performance	Goal
Activity requirements	*8*	N/A[1]	8/8	N/A[1]	8/8
Quality measures	*3, 4, 9*	N/A[1]	≥50%	N/A[1]	≥50%
Efficiency measures	*3, 6, 13*	N/A[1]	≥30%	N/A[1]	≥30%
Total cost of care	*3, 6, 14*	Not scored for this payment stream		N/A[1]	<$300 risk-adj. PMPM 2017

1 Not scored in this reporting period
2 Risk-adjusted TCOC PMPM does not include PMPM payment for CPC enrolled practices
3 Risk-adjusted TCOC PMPM includes PMPM payment for CPC enrolled practices

2 CSV file with detailed patient-level data

Member First Name	Member Last Name	Payer	Risk Tier	Claims Last 24 Months	Practice Medicaid ID	Practice NPI	Rendering Provider Medicaid ID
MFN 1	MLN 1	Payer1	1	Yes	0001234	1000000009	0001334
MFN 2	MLN 2	Payer2	1	No	2000239	1000000010	1111335
MFN 3	MLN 3	Payer3	1	Yes	0001236	1000000011	0001336
MFN 4	MLN 4	Payer4	1	Yes	2000237	1000000012	0001337
MFN 5	MLN 5	Payer5	1	Yes	0001238	1000000013	0001338
MFN 6	MLN 6	Payer6	1	Yes	0001239	1000000014	0001339
MFN 7	MLN 7	Payer7	1	No	0001240	1000000015	0001340
MFN 8	MLN 8	Payer8	6	Yes	0001241	1000000016	0001341
MFN 9	MLN 9	Payer9	1	Yes	0001242	1000000017	0001342
MFN 10	MLN 10	Payer10	0	Yes	2000240	1000000018	
MFN 11	MLN 11	Payer11	3	No	0001244	1000000019	0001344
MFN 5	MLN 5	Payer5	1	Yes	0001238	1000000013	0001338
MFN 6	MLN 6	Payer6	1	Yes	0001239	1000000014	0001339
MFN 7	MLN 7	Payer7	1	No	0001240	1000000015	0001340
MFN 8	MLN 8	Payer8	6	Yes	0001241	1000000016	0001341
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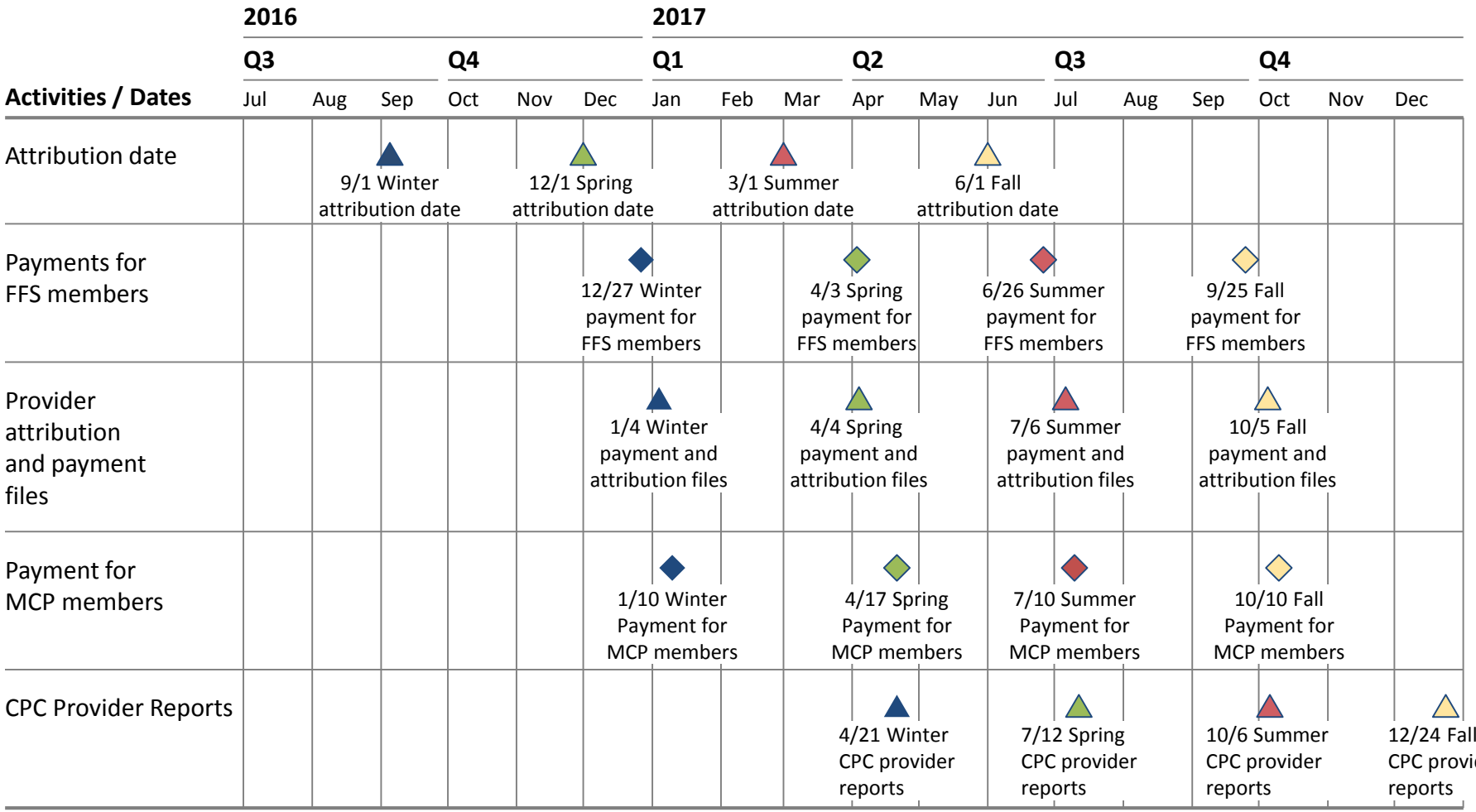
MFN 8	MLN 8	Payer8	6	Yes	0001241	1000000016	0001341
MFN 9	MLN 9	Payer9	1	Yes	0001242	1000000017	0001342

Additional detail about the content of these reports will be covered on the next Practice Webinar on April 25

Tentative

Tentative timeline of Ohio CPC activities



- Winter reflects Jan - Mar payment and reporting
- Spring reflects Apr - Jun payment and reporting
- Summer reflects Jul - Sep payment and reporting
- Fall reflects Oct - Dec payment and reporting

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Tentative

Tentative Practice Webinar dates and topics for 2017

	Webinar topic	Date
1	Attribution and payment	April 6, 2017
2	Ohio CPC Provider Reports	April 25, 2017
3	Best practices in meeting activity requirements	May 2017
4	Deep dive into shared savings under the Ohio CPC model	June 2017
5	Best practices in improving quality measure performance	July 2017
6	Behavioral health integration	August 2017
7	Practice partnerships in 2018	September 2017
8	Model design changes and supporting new enrollment for 2018	October 2018
9	Feedback on payment and reporting in 2017	November 2017
10	Feedback on year in review	December 2017

What other topics should we address in future webinars?

Note: dates and topics are preliminary and subject to change

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Reminders during the start of the Ohio CPC program

- **Your practice's patient attribution files are available now for Q2** on the MITS portal, which reflect attribution as of December 1, 2016
- Find out who within your organization is the **MITS administrator**
- If you have further **questions about the Ohio CPC program following this webinar**, including questions about your CPC reports, **contact the Medicaid Provider Hotline** at 1 (800) 686-1516

Frequently asked questions about attribution, payment, and quality measures (1/2)

Q: How can we remove inactive providers or providers who are no longer associated with our practice?

There is a self-service feature on the MITS secure portal that allows you to update your provider roster for fee-for-service providers. Please note that the provider roster is only used to determine if the provider has "active" status with Medicaid. The association between the practice billing ID and the rendering provider ID is made through claims.

Q: When and how do we attest to meeting activity requirements? How will these attestations be checked / confirmed?

A: Each practice attested via the enrollment process to meeting activity requirements within 6 months. There will be a process for monitoring practices to verify activity requirements are being met. This will include desk reviews, as well as a select number of site visits.

Q: If our practice fails to meet quality/efficiency measures, will you retroactively "claw back" the PMPM payments?

A: Suspension of payment due to failing measures will be applied to future payments only, no "claw back" is planned.

Frequently asked questions about attribution, payment, and quality measures (2/2)

Q: Is quality and efficiency measure performance based on our attributed members?

Yes. Performance is based on each practice's attributed members. As a reminder, an Ohio CPC practice is defined by the Medicaid billing ID.

Q: Does our practice have to report quality and efficiency measures?

No. All measures will be calculated by ODM using claims data. ODM is responsible for generating the measures and distributing the Ohio CPC Provider Reports.

Q: When are quality and efficiency measures calculated for purposes of determining eligibility for PMPM payments?

A: Enrolled providers will receive PMPM payments while quality and efficiency measures scores are calculated for the entire performance period of calendar year 2017, as reported in 2018 after six months of claims run-out. If providers do not pass 50% of quality and efficiency measures for which they qualify, they will receive a warning. The following year, if they still fail to pass 50% of quality and efficiency measures for which they qualify, PMPM payments will be suspended, and will not resume until providers pass 50% of the applicable quality and efficiency metrics.

Additional Questions?

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Data elements included in CPC provider CSV reports (1/7)

Field name	Description
Reporting Year	Year of the provider report (based on the release date)
Reporting Quarter	Quarter of the provider report (based on the release date)
Performance Period ID	Performance period number in the provider report
Performance Period Start Date	Start date of the performance period in the provider report
Performance Period End Date	End date of the performance period in the provider report
Reporting Practice Medicaid ID	Medicaid ID of one of the 92 practices enrolled in the CPC Program
Reporting Practice Name	Name of the enrolled practice
Member Medicaid ID	Medicaid ID of the member attributed to the practice in any quarter of the performance period
Member First Name	First name of the attributed member
Member Last Name	Last name of the attributed member
Ineligible Months	Number of months when the member did not have Medicaid eligibility
Dual Months	Number of months when the member had dual status
TPL Coverage Months	Number of months when the member had TPL status
Limited Benefits Months	Number of months when the member had limited benefits
FFS MCP Transition Months	Number of months when the member transitioned between FFS and MCP
Foster Children Exclusion Months	Number of months when the member had foster children status
Measure Exclusion Months	Number of months when the member had any of the status above (not including NICU status)
NICU Months	Number of months when the member had NICU status
TCOC Exclusion Months	Number of months when the member had any of the status above (including NICU status)
Measure Eligible Months	Number of months when the member had Medicaid eligibility and measure exclusion status = 0

Data elements included in CPC provider CSV reports (2/7)

Field name	Description
TCOC Eligible Months	Number of months when the member had Medicaid eligibility and measure exclusion status = 0 and NICU status = 0
LTC Flag	Whether the member had LTC status in the performance period
CRG Outlier Flag	Whether the member was a CRG outlier in the performance period
Fewer than 6 Months Eligibility Flag	Whether the member had TCOC eligible months < 6
TCOC Exclusion Flag	Whether the member was excluded from TCOC calculation (LTC flag = 1 or CRG outlier = 1 or Fewer than 6 months eligibility flag = 1)
Practice 6-Month Attribution Flag for Measure	Whether the member was attributed to the practice for at least 6 months when the member had measure exclusion status = 0
Practice 6-Month Attribution Flag for TCOC	Whether the member was attributed to the practice for at least 6 months when the member had TCOC exclusion status = 0
Member Date of Birth	Date of birth of the attributed member
Member Age	Age of the attributed member (age in months)
Member Gender	Gender of the attributed member
Asthma Flag	Whether the member had asthma condition in the performance period
Diabetes Flag	Whether the member had diabetes condition in the performance period
CHF Flag	Whether the member had CHF condition in the performance period
Depression Flag	Whether the member had depression condition in the performance period
Stroke Flag	Whether the member had stroke condition in the performance period
SPMI Flag	Whether the member had SPMI condition in the performance period
Risk Band	9 risk categories based on the member's CRG risk score (determined by the first digit of ConAggCrg3)
Risk Tiers	3 risk tiers based on the member's CRG risk score (high/medium/low)

Data elements included in CPC provider CSV reports (3/7)

Field name	Description
Spend Percentile Within Practice	Percentile rank of the member across all members in the attributed panel based on risk-adjusted TCOC
Member Attribution Status: Currently in Panel Flag	Whether the member was attributed to the practice in the most recent quarter
Member Attribution Status: Newly Attributed in Current Quarter	Whether the member was attributed to the practice in the most recent quarter but not in the prior quarter
Member Attribution Status: 6 or More Months in Panel Flag	Whether the member was attributed to the practice for >= 6 months in the performance period
PCP Medicaid ID	Medicaid ID of the PCP attributed for the member (populated only when row 44 = "Yes")
PCP Name	Name of the PCP attributed for the member (populated only when row 44 = "Yes")
Practice Medicaid ID	Medicaid ID of the Practice attributed for the member (populated only when row 44 = "Yes")
Practice Name	Name of the Practice attributed for the member (populated only when row 44 = "Yes")
Payer	FFS/MCP of the attributed member (populated only when row 44 = "Yes")
Payer Detail	FFS/MCP name of the attributed member (populated only when row 44 = "Yes")
Attribution Method	Method of attribution (e.g. , member choice, claim based, or GIS) (populated only when row 44 = "Yes")
W15 Den Flag	Whether the member was a denominator of W15 measure in the performance period
W15 Num Flag	Whether the member was a numerator of W15 measure in the performance period
W34 Den Flag	Whether the member was a denominator of W34 measure in the performance period
W34 Num Flag	Whether the member was a numerator of W34 measure in the performance period
WCC Den Flag	Whether the member was a denominator of WCC measure in the performance period
WCC Num Flag	Whether the member was a numerator of WCC measure in the performance period
AWC Den Flag	Whether the member was a denominator of AWC measure in the performance period

Data elements included in CPC provider CSV reports (4/7)

Field name	Description
AWC Num Flag	Whether the member was a numerator of AWC measure in the performance period
PPC_Prenatal Den Flag	Whether the member was a denominator of PPC_Prenatal measure in the performance period
PPC_Prenatal Num Flag	Whether the member was a numerator of PPC_Prenatal measure in the performance period
LBW Den Flag	Whether the member was a denominator of LBW measure in the performance period
LBW Num Flag	Whether the member was a numerator of LBW measure in the performance period
PPC_Postpartum Den Flag	Whether the member was a denominator of PPC_Postpartum measure in the performance period
PPC_Postpartum Num Flag	Whether the member was a numerator of PPC_Postpartum measure in the performance period
CCS Den Flag	Whether the member was a denominator of CCS measure in the performance period
CCS Num Flag	Whether the member was a numerator of CCS measure in the performance period
BCS Den Flag	Whether the member was a denominator of BCS measure in the performance period
BCS Num Flag	Whether the member was a numerator of BCS measure in the performance period
ABA Den Flag	Whether the member was a denominator of ABA measure in the performance period
ABA Num Flag	Whether the member was a numerator of ABA measure in the performance period
CDC_HbA1cTest Den Flag	Whether the member was a denominator of CDC_HbA1cTest measure in the performance period
CDC_HbA1cTest Num Flag	Whether the member was a numerator of CDC_HbA1cTest measure in the performance period
CDC_PoorControl Den Flag	Whether the member was a denominator of CDC_PoorControl measure in the performance period
CDC_PoorControl Num Flag	Whether the member was a numerator of CDC_PoorControl measure in the performance period
CDC_EyeExam Den Flag	Whether the member was a denominator of CDC_EyeExam measure in the performance period
CDC_EyeExam Num Flag	Whether the member was a numerator of CDC_EyeExam measure in the performance period
CBP Den Flag	Whether the member was a denominator of CBP measure in the performance period

Data elements included in CPC provider CSV reports (5/7)

Field name	Description
CBP Num Flag	Whether the member was a numerator of CBP measure in the performance period
SPC Den Flag	Whether the member was a denominator of SPC measure in the performance period
SPC Num Flag	Whether the member was a numerator of SPC measure in the performance period
MMA Den Flag	Whether the member was a denominator of MMA measure in the performance period
MMA Num Flag	Whether the member was a numerator of MMA measure in the performance period
AMM Den Flag	Whether the member was a denominator of AMM measure in the performance period
AMM Num Flag	Whether the member was a numerator of AMM measure in the performance period
FUH Den Flag	Whether the member was a denominator of FUH measure in the performance period
FUH Num Flag	Whether the member was a numerator of FUH measure in the performance period
IET Den Flag	Whether the member was a denominator of IET measure in the performance period
IET Num Flag	Whether the member was a numerator of IET measure in the performance period
TCI Den Flag	Whether the member was a denominator of TCI measure in the performance period
TCI Num Flag	Whether the member was a numerator of TCI measure in the performance period
AMB - Count of Avoidable ER Visits	Number of ER visits specified by AMB measure in the performance period
AHRQ PQI 90 - Count of IP Admits	Number of IP admissions specified by PQI 90 measure in the performance period
GDR - Number of Generic Scripts	Number of generic drugs dispensed in the performance period
GDR - Number of Total Scripts	Number of total drugs dispensed in the performance period
MPT - Count of BH-Related Admits per 1,000	Number of BH-related IP admissions specified by MPT measure in the performance period
EOC: Asthma - Total Number of Episodes	Number of asthma episodes of the member in the performance period

Data elements included in CPC provider CSV reports (6/7)

Field name	Description
EOC: Asthma - Number of Episodes with Top PAPs	Number of asthma episodes accounted by top PAP (low-cost and high-quality) of the member in the performance period
EOC: Asthma - Number of Episodes with Bottom PAPs	Number of asthma episodes accounted by bottom PAP (high-cost and low-quality) of the member in the performance period
EOC: COPD - Total Number of Episodes	Number of COPD episodes of the member in the performance period
EOC: COPD - Number of Episodes with Top PAPs	Number of COPD episodes accounted by top PAP (low-cost and high-quality) of the member in the performance period
EOC: COPD - Number of Episodes with Bottom PAPs	Number of COPD episodes accounted by bottom PAP (high-cost and low-quality) of the member in the performance period
EOC: Perinatal - Total Number of Episodes	Number of Perinatal episodes of the member in the performance period
EOC: Perinatal - Number of Episodes with Top PAPs	Number of Perinatal episodes accounted by top PAP (low-cost and high-quality) of the member in the performance period
EOC: Perinatal - Number of Episodes with Bottom PAPs	Number of Perinatal episodes accounted by bottom PAP (high-cost and low-quality) of the member in the performance period
3 or More ED Flag	Whether the member had 3 or more ED visits in the performance period
1 or More IP Admit Flag	Whether the member had 1 or more IP admissions in the performance period
No PCP Visit Flag	Whether the member any PCP visit in the performance period
Total Spend (Post Exclusions) $	Total Spend (medical cost + pharmacy cost + PMPM payments) after excluding non TCOC-related spend and excluded member months in the performance period
Quarterly PMPM Payment $	Quarterly PMPM payment (in eligible member months) in the performance period
Hospital Inpatient Care $	Hospital inpatient spend (in eligible member months) in the performance period

Data elements included in CPC provider CSV reports (7/7)

Field name	Description
ED Care $	ED care spend (in eligible member months) in the performance period
Hospital Outpatient Care $	Hospital outpatient spend (in eligible member months) in the performance period
Office and Clinic Care $	Office and clinic spend (in eligible member months) in the performance period
Institutional Care $	Institutional spend (in eligible member months) in the performance period
Home and Community-Based Care $	Home and community-based spend (in eligible member months) in the performance period
Prescription Drugs $	Prescription drugs spend (in eligible member months) in the performance period
Specialty Pharmaceuticals $	Specialty pharmaceuticals spend (in eligible member months) in the performance period
Lab and Pathology $	Lab and pathology spend (in eligible member months) in the performance period
Radiology $	Radiology spend (in eligible member months) in the performance period
Ancillary Services $	Ancillary service spend (in eligible member months) in the performance period
DME and Supplies $	DME and supplies spend (in eligible member months) in the performance period
Physical, Occupational, and Speech Therapies $	Physical, occupation and speech therapies spend (in eligible member months) in the performance period
Others $	Other spend (in eligible member months) in the performance period
Monthly TCOC $	Total spend (post exclusions) divided by eligible months
Monthly Risk-Adjusted TCOC $	Risk-adjusted total spend (post exclusions) divided by eligible months