MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

September 21, 2017

The Michigan Health Information Technology Commission is an advisory Commission to the Michigan Department of Health and Human Services and is subject to the Michigan open meetings act, 1976 PA 267, MCL 15.261 to 15.275

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

September 2017 Meeting

- Welcome and Introductions
  - Commissioner Updates
  - Introduction of New Commissioners
- Commission Business
  - Review of Minutes from the May 2017 Meeting
  - Recognition of Departing Commissioners

HIT/HIE Updates

- HIT Commission Dashboard
- Update on the Behavioral Health Consent Form
- Update on ADT Notifications for Inpatient Psychiatric Stays

2017 Goals – September HIT Commission Update

Governance Development and Execution of Relevant Agreements

- Data sharing legal agreements executed to date:
  - **119 total** Trusted Data Sharing Organizations
  - **560 total** Use Case Agreements/Exhibits
- **Michigan Peer Review Organization (MPRO)–** Qualified Data Sharing Organization Agreement (QDSOA)
- **McLaren Health Care–** Master Use Case Agreement (MUCA), Immunization History-Forecast (IHF) Use Case Exhibit (UCE)
- **NetSmart Technologies, Inc–** Admission, Discharge, Transfer Notifications (ADT) UCE, IHF UCE, Active Care Relationship Services (ACRS) UCE
- **Sav-Mor Drug Stores–** Simple Data Sharing Organization Agreement (SDSOA), MUCA, IHF UCE, Health Information for State UCE
- **Washtenaw County Community Mental Health (WCCMH)–** SDSOA, MUCA, Single Sign-On (SSO) UCE
- **Bay-Arenac Behavioral Health–** SDSOA

Technology and Implementation Road Map Goals

- **48 hospitals in full production sending Lab Results to MiHIN:**
  - **35,192,317 Statewide Labs** received since 01/11/17
- **Metro Health Hospital**- Sending Common Key Service data directly to MiHIN
- **Oaklawn Hospital**– Participating in the IHF Use Case via GLHC
- **Westlake Health Campus**- Sending ADT data via Patient Ping
- **Novi Lakes Health Campus**– Sending ADT data via Patient Ping
- **Family Tree Medical Associates**- Receiving ADTs via GLHC
- **Community Health Center of Branch County (CHCBC)**– Sending Statewide Lab Results via GLHC

2017 Goals – September HIT Commission Update

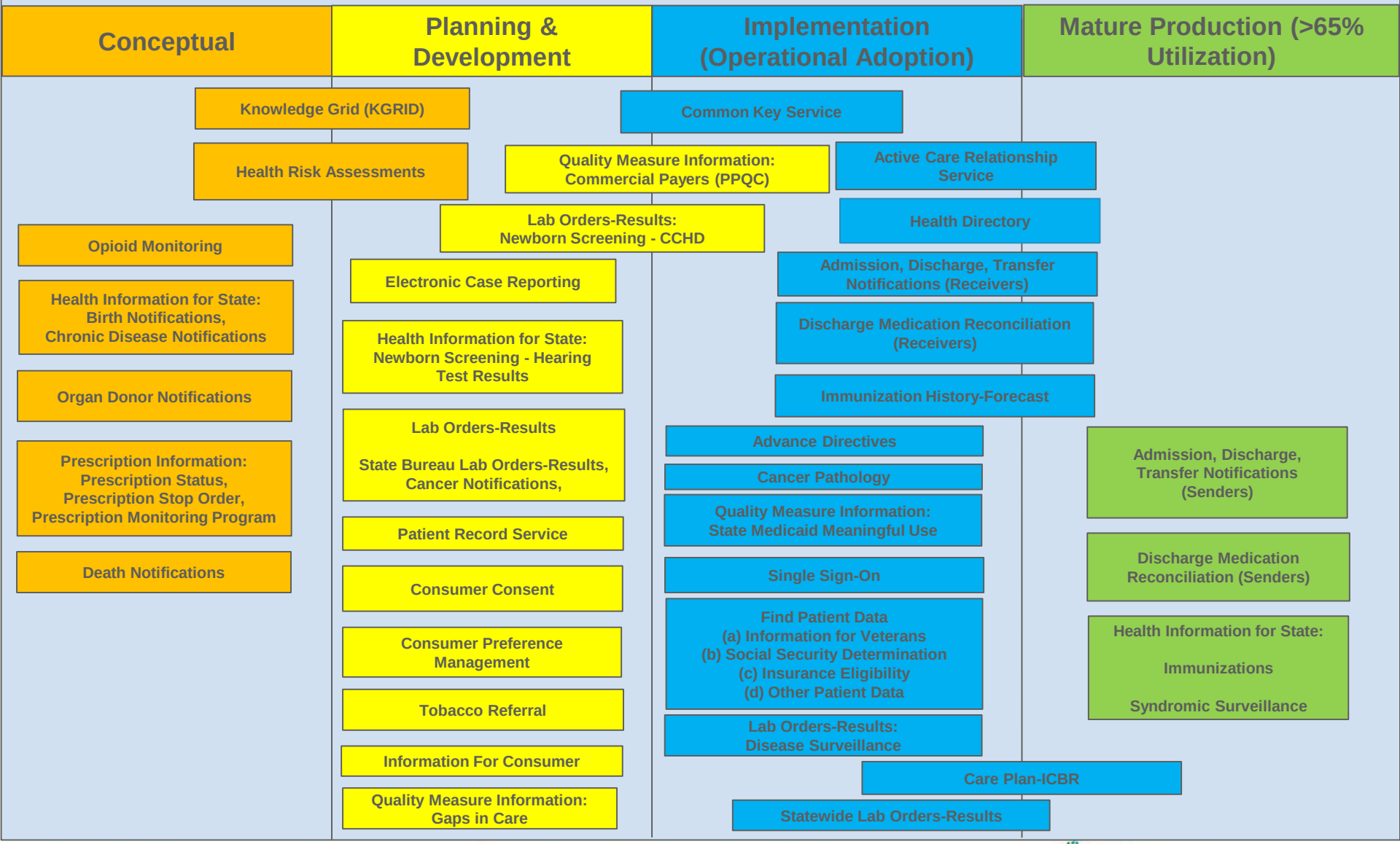
QO & VQO Data Sharing

- More than **1.44 *billion*** messages received since production started May, 2012
  - Averaging **12.8 MLN** messages/week
  - **9.2 MLN+ ADT** messages/week; **2.3 MLN+** public health messages/week
- Total 660 ADT senders, 100 receivers to date
- Sent **4.1 MLN** ADTs outbound last week (**94.57%** "exact match" rate without CKS)
- Messages received from NEW use cases in production:
  - **1,920,889 Lab results** received
  - **5,637,944 Immunization History/Forecast queries to MCIR**
  - **9,770,540 Medication Reconciliations at Discharge** received from hospitals
  - **27,807 Care Plan/Integrated Care Bridge Records** sent from ACOs to PIHPs
- **19.9 MLN** patient-provider relationships in Active Care Relationship Service (ACRS)
- **10 MLN** unique patients in ACRS
- **137,998** unique providers in statewide Health Directory
  - **39,239** total organizations
  - **92,785** total Direct addresses in HD
  - **371,265** unique affiliations between providers and entities in HD

MiHIN Shared Services Utilization

- **189** Skilled Nursing Facilities (SNFs) sending ADTs – 45% of SNFs in Michigan
- **91** MedRec senders, 75%

MiHIN Statewide Use Case and Scenario Status

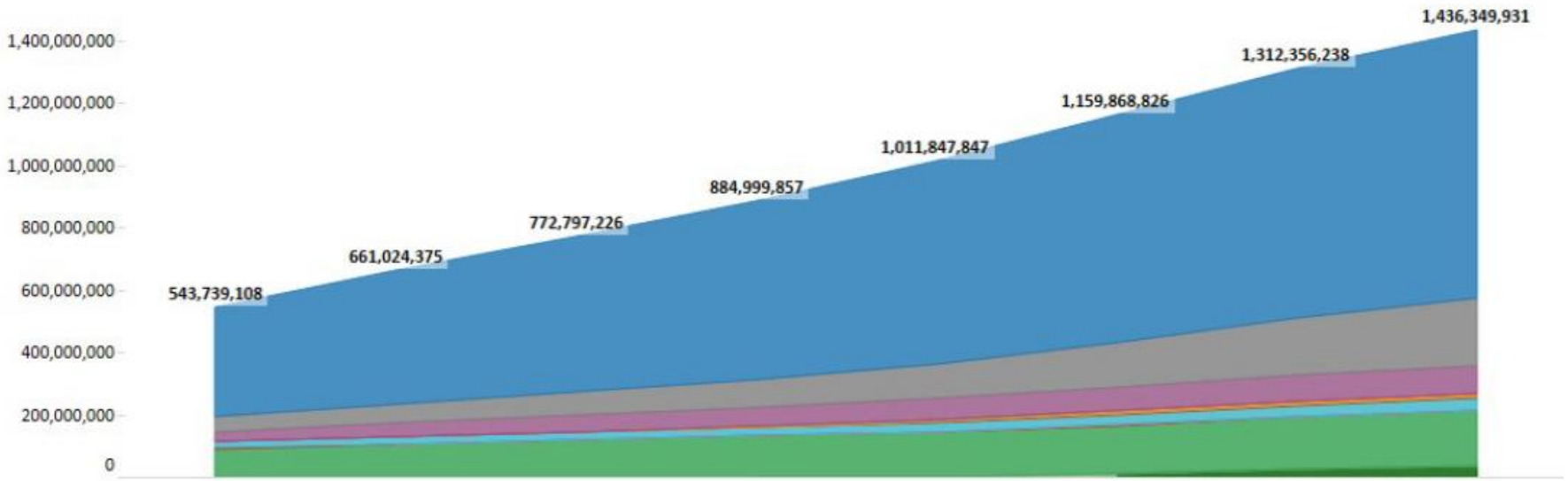


MiHIN Shared Services

MiHIN Shared Services

MiHIN M3 Report: Cumulative Totals by Quarter

MiHIN M3 Report: Cumulative Totals



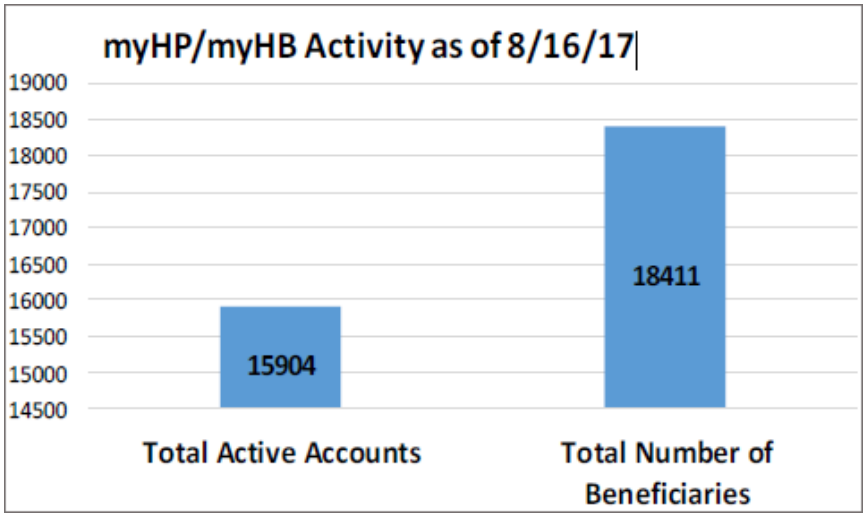
Use Case	2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3
ADT Inbound	349,613,076	428,856,636	501,941,123	572,952,331	649,229,795	727,861,806	805,510,111	862,993,540
ADT ACRS Outbound	50,395,674	60,425,845	72,405,193	87,300,522	110,932,841	144,261,924	179,918,771	214,927,981
ADT Payer Outbound	32,115,861	43,012,417	53,376,463	61,074,794	68,675,409	77,385,882	85,040,610	90,665,435
Care Plan-ICBR	2,939	4,338	4,435	7,250	16,150	19,945	24,272	27,807
Medrec Inbound	36,809	549,972	1,665,729	3,297,812	4,919,290	6,618,958	8,407,293	9,770,540
Medrec Outbound			48,274	226,012	789,702	1,363,147	1,861,864	2,472,398
Immunization History-Forecast	49,505	158,364	529,435	1,289,941	2,241,593	3,203,419	4,366,531	5,637,944
Submit Immunizations	19,153,190	21,968,194	23,823,779	26,246,330	29,758,097	32,089,266	33,870,293	36,917,854
Submit Newborn Screening		88	296	3,280	3,509	3,604	3,712	3,781
Submit Reportable Labs	1,039,026	1,274,693	1,352,059	1,430,888	1,529,120	1,654,998	1,832,346	1,920,889
Submit Syndromic Surveillance	91,333,028	104,773,828	117,650,440	131,168,929	143,749,006	156,646,713	168,195,913	175,815,052
Cancer Pathology				1,768	3,335	3,396	3,821	4,219
Statewide Labs						8,755,768	23,320,701	35,192,317
Cancer Notifications								174
Cumulative Total	543,739,108	661,024,375	772,797,226	884,999,857	1,011,847,847	1,159,868,826	1,312,356,238	1,436,349,931

Consumer Access to Immunization Information

Medicaid beneficiaries will soon be able to download and view their immunization information in the myHealthButton and myHealthPortal applications.

Consumer-driven reforms are becoming more common throughout the healthcare industry because engaging individuals in their own healthcare can lead to healthier behaviors and better health outcomes. MDHHS's goal is to empower Medicaid beneficiaries to responsibly manage their health. In support of this goal, MDHHS has sponsored a project to provide beneficiaries with the ability to download and view immunization records available in the Michigan Care Improvement Registry (MCIR).

In October 2016, we informed you that the existing MCIR query by parameter message would be expanded to include a new parameter to designate the response in a PDF format, which gets encapsulated and inserted into the HL7 response message by the Data Hub. Coming September 30, 2017, the PDF will be available to Medicaid beneficiaries within the myHealthButton (myHB) and myHealthPortal (myHP) applications. In addition, Medicaid beneficiaries will be able to access their dependents' information from myHB and myHP.



Participation Year (PY) Goals

September 2017 Dashboard

	Reporting Status	Prior # of Incentives Paid (July)	Current # of Incentives Paid (August)	PY Goal: Number of Incentive Payments	PY Medicaid Incentive Funding Expended
Eligible Professionals (EPs)	AIU 2015	1021	1021	500	$21,568,756
	AIU 2016	1039	1142	300	$24,182,504
	MU 2015	2202	2202	1702	$20,193,204
	MU 2016	1926	2143	2480	$19,673,288
	MU 2017	0	1	3500	$8,500.00
Eligible Hospitals (EHs)	AIU 2015	1	1	5	$184,905
	MU 2015	25	25	28	$5,005,313
	MU 2016	10	10	22	$1,424,018

Cumulative Incentives for EHR Incentive Program 2011 to Present		
	Total Number of EPs & EHs Paid	Total Federal Medicaid Incentive Funding Expended
AIU	7240	$ 230,579,570
MU	7722	$ 149,024,498

Key: AIU= Adopt, Implement or Upgrade MU= Meaningful Use

Michigan Medicaid Program – Sept 2017

M-CEITA | Michigan Center for Effective IT Adoption

Michigan Medicaid MU Program

Supporting providers in Michigan with high volumes of Medicaid patients in achieving Meaningful Use.

Program Goals

- Assist 600 Specialists in their first year of Meaningful Use
- Assist 1770 Providers in any year of Meaningful Use

Ongoing Program Metrics

- 3508 Sign-ups for MU Support representing 2699 unique providers
- 1434 Total Meaningful Use Attestations
  - 51% of attestations by M-CEITA Clients were for year 1 of MU
  - 49% of attestations by M-CEITA clients were for year 2+ of MU

Other program highlights:

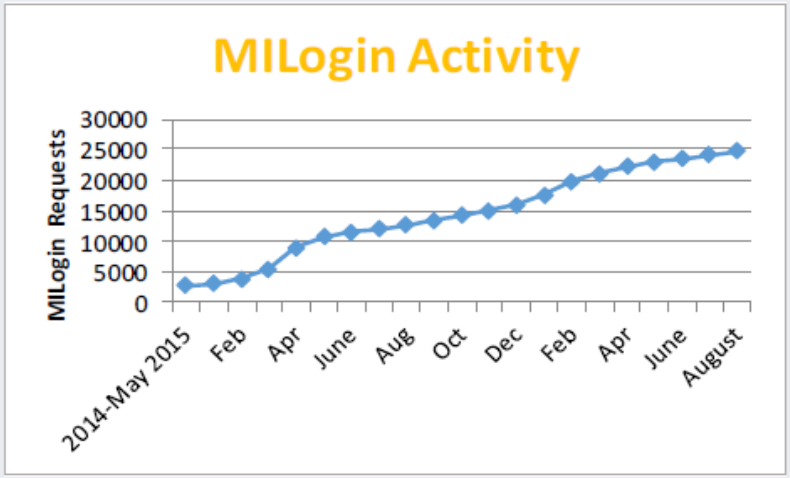
As reported last month, CMS released a final rule which modified the 2017 MU reporting requirements for Clinical Quality Measures (CQMs). As a result, M-CEITA expects most of our providers' attestations to be deferred until early 2018, after the Medicaid Attestation System has been modified to accommodate the rule changes.

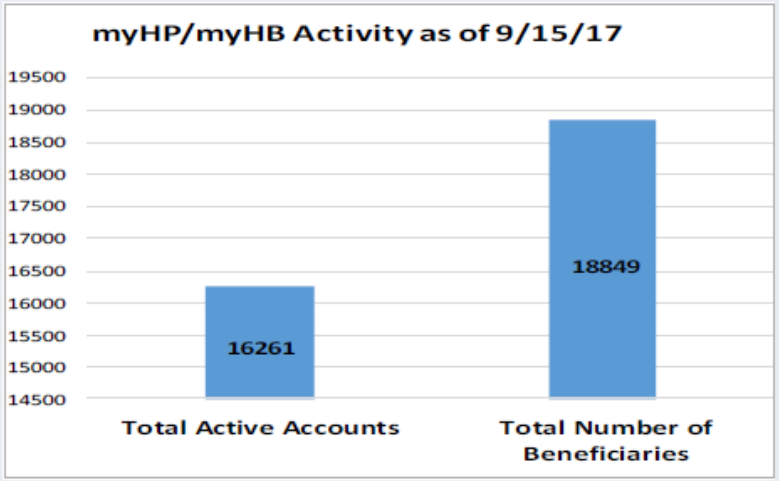
Project Contact

Project Lead: Judy Varela judith.varela@altarum.org

Funder: CMS funding administered by the Michigan Department of Health & Human Services (MDHHS)

myHealthButton/myHealthPortal Dashboard





Updates:

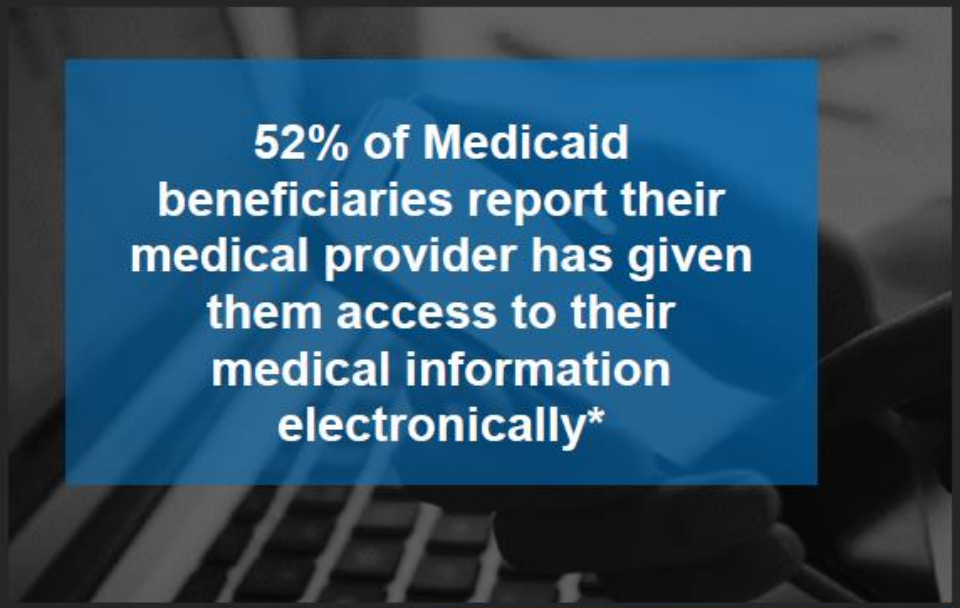
Release 6.8 (September 2017)

- Members will be able to view and download immunization records from the Michigan Care Improvement Registry (MCIR)
- MCIR will also provide information on recommended immunization schedule

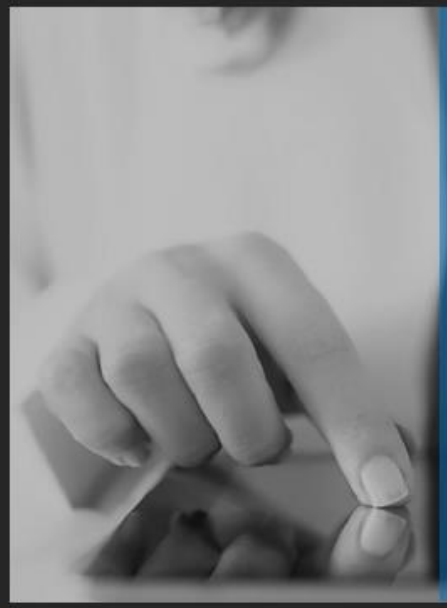
Outreach Activities

- DHHS is promoting myHealthPortal to community partners who are assisting individuals with the

CONSUMER ENGAGEMENT DASHBOARD | August 2017



52% of Medicaid beneficiaries report their medical provider has given them access to their medical information electronically*



Upcoming Presentation

Survey of Medicaid Consumers: Lessons Learned

American Public Health Association Annual Conference
Atlanta, GA

Date: November 2017

Save the Date!

Consumer Engagement Stakeholder Forum

September 20, 2017
Michigan Public Health Institute
Interactive Learning Center

Consumer Engagement Newsletter

The CEIG Newsletter offers subscribers with current content from trusted sources within Health IT, Michigan Medicaid and patient engagement.

Click Here to Join

www.MichiganHealthIT.org

* Full Survey Results at www.MiEngagement.org

HIT/HIE Updates

- HIT Commission Dashboard
- Update on the Behavioral Health Consent Form
- Update on ADT Notifications for Inpatient Psychiatric Stays

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The New Quality Payment Program and Available Support for Michigan Clinicians

Bruce Maki, MA
M-CEITA / Altarum
Regulatory & Incentive Program Analyst

September 21, 2017

ALTARUM

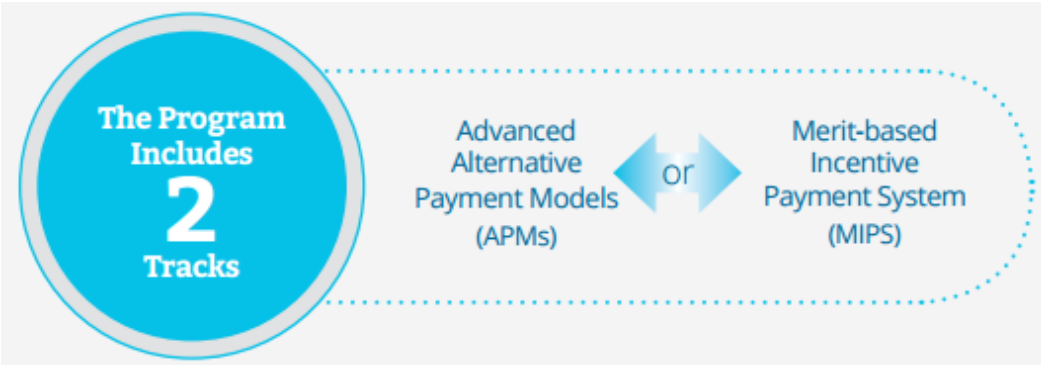
Agenda

- High-level overview of the new Quality Payment Program
- How CMS supports participation efforts
- The QPP Resource Center™ for the Midwest
- Questions & Answers

MACRA: What is it?

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Bipartisan legislation (yes, really) that replaced the flawed Sustainable Growth Rate (SGR) formula by paying clinicians for the value and quality of care they provide
- MACRA is more predictable than SGR. It will increase the number of physicians participating in alternative payment models (APMs), with those in high quality, efficient practices benefiting financially
- Extends funding for Children's Health Insurance Program (CHIP) for two years
- **And introduces us to… (imagine a drumroll here)**

The QPP is part of a broader effort from CMS towards paying for VALUE and QUALITY

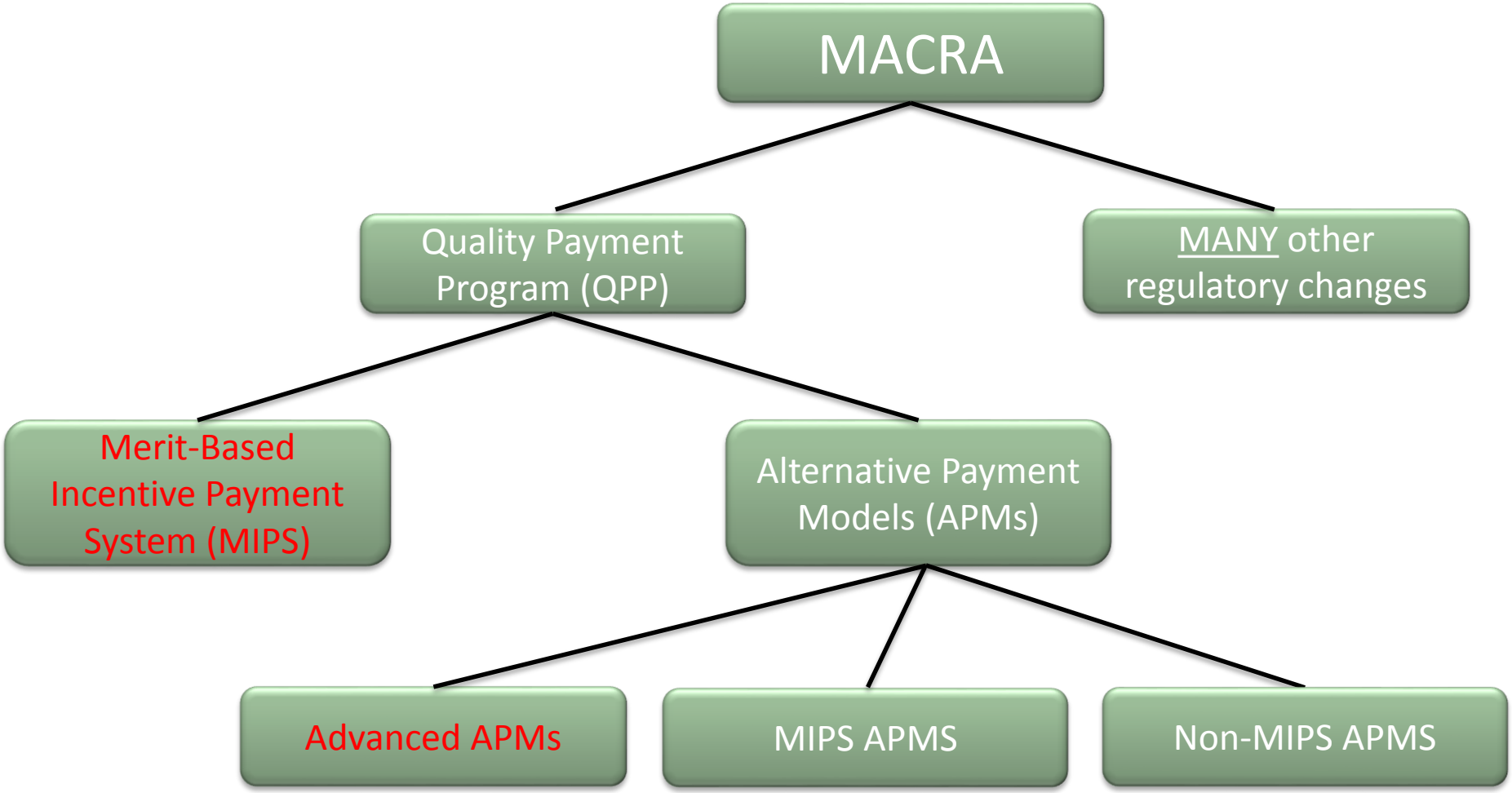


Quality Payment Program Strategic Goals

- Improve beneficiary outcomes
- Enhance clinician experience
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

Quick Tip:
For additional information on the Quality Payment Program, please visit QPP.CMS.GOV

Conceptual MACRA Diagram



For CY 2017, out of 1.3M Part B Clinicians, CMS projects:
~ 600,000 MIPS Eligible Clinicians
~ 100,000 Advanced APM Clinicians

Who Participates in the Quality Payment Program?

Who is Exempt from Participation?

First Year of Medicare Part B participation

Below **low patient volume** threshold

Certain participants in **ADVANCED** Alternative Payment Models

What is MIPS?

- The Merit-based Incentive Payment System

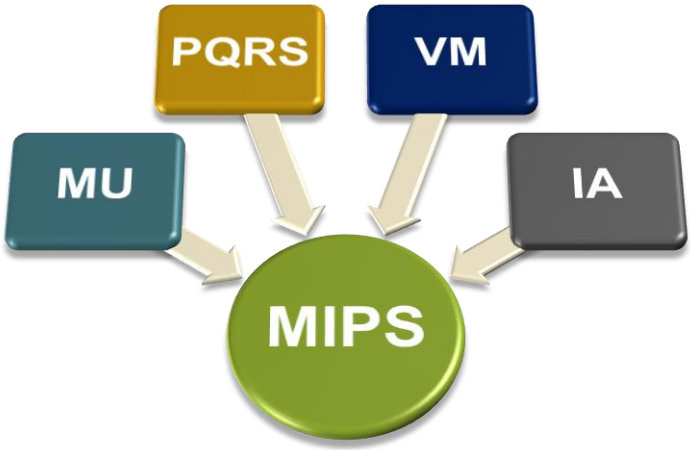
- Combines multiple Medicare Part B programs into a single program

Medicare EHR Incentive Program (MU)*

Physician Quality Reporting System (PQRS)

Value-Based Payment Modifier (VM)

- (4) MIPS Performance Categories:
  - Quality (PQRS/Value Modifier-Quality Program)
  - Cost (Value Modifier-Cost Program)
  - Advancing Care Information (ACI) (Medicare MU*)
  - Improvement Activities (IA) (new category)



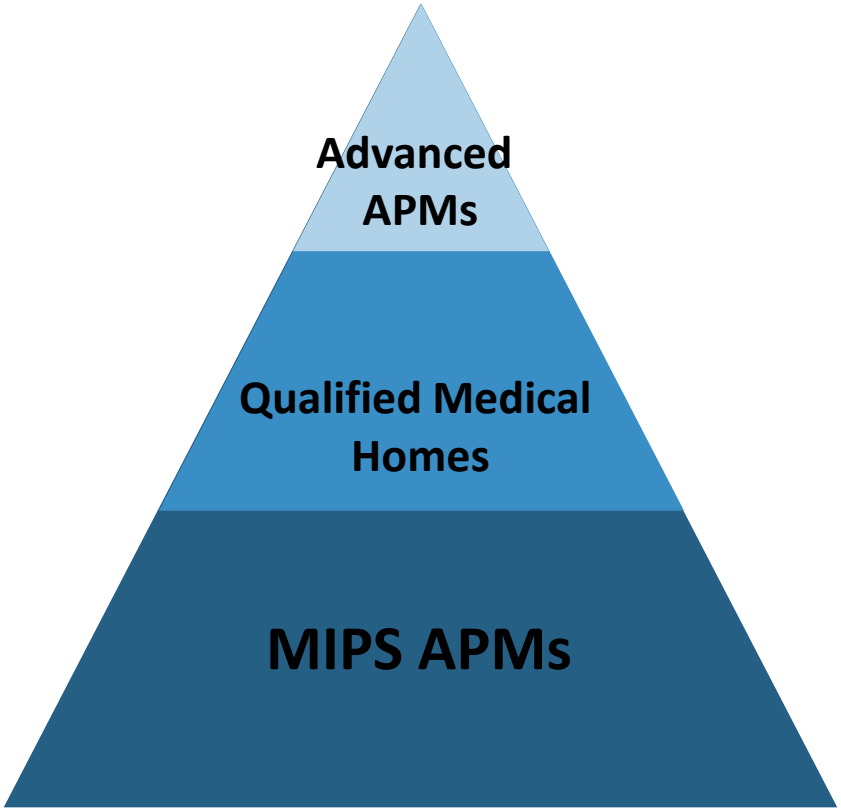
MACRA does not alter or end the Medicaid EHR Incentive Program

Alternative Payment Models (APMs)

- Alternative Payment Model or APM is a **generic term** describing a payment model in which providers take **responsibility for cost and quality performance** and **receive payments to support** the services and activities designed to achieve high value
- According to MACRA, APMs in general include:
  - Medicare Shared Savings Program (MSSP) ACOs
  - Demonstrations under the Health Care Quality Demonstration Program
  - CMS Innovation Center Models
  - Demonstrations required by Federal Law
- **MACRA does not change how any particular APM pays for medical care and rewards value; program adds incentives to existing model**
- MIPS APM participants also participating in MIPS may receive favorable scoring under certain MIPS performance categories
- Only **some** APMs are **"Advanced"** APMs

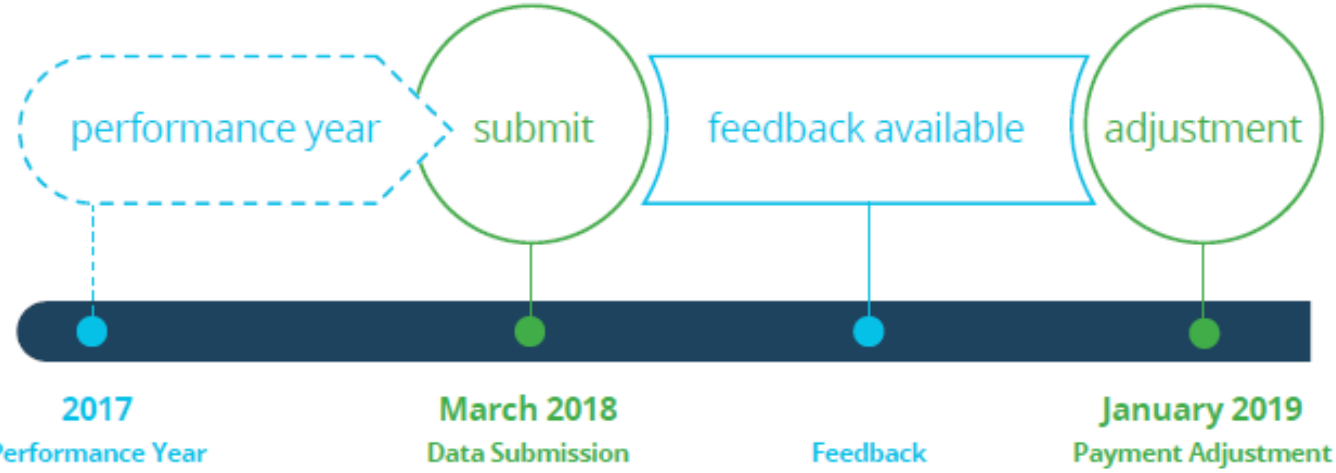
Alternative Payment Models

- **"Advanced" APMs**, a term established by CMS, have the greatest risks and offer potential for greatest rewards
- **Qualified Medical Homes** (must be expanded under CMS authority) have different risk structure but are otherwise treated as Advanced APMs
- **MIPS APMs**, which make up the majority of ACOs today, receive favorable MIPS scoring



How will the QPP Affect Medicare Payments?

- **MIPS Track**
  - Performance-based payment adjustment (+ / - / null) based on the amount and quality of data submitted (budget neutral)
- **Advanced APM Track**
  - 5% lump sum bonus payment of 2018 Medicare Part B reimbursements
- **In either track**, the first payment adjustments or bonuses based on performance in 2017 go into effect on January 1, 2019



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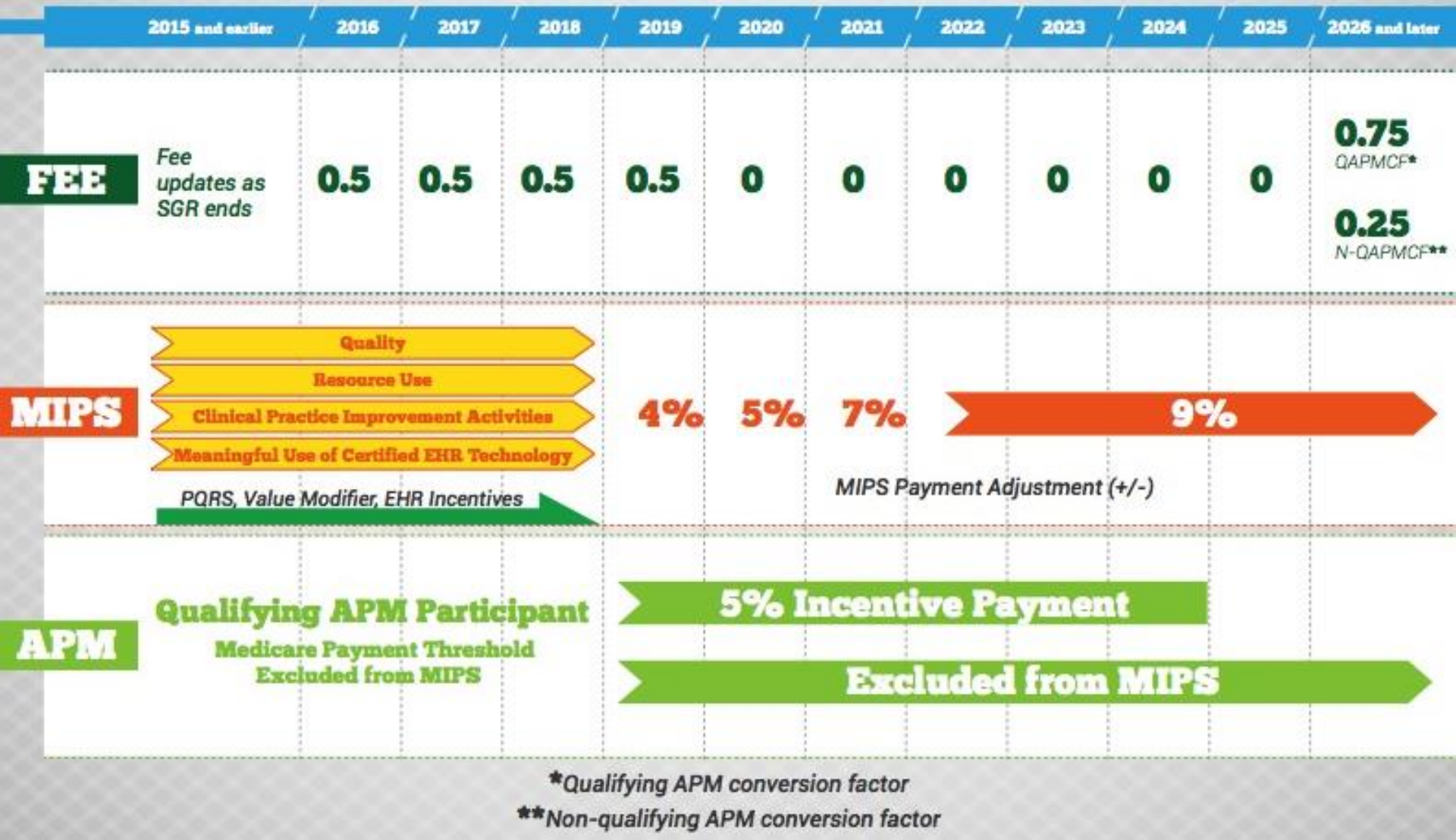
TIMELINE



*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

Technical Assistance for Clinicians

CMS has **free** resources and organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in early 2017.

LARGE PRACTICES

Quality Innovation Networks- Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

The QPP Resource Center™ for the Midwest – Supporting Small Practices with QPP Transformation

What is the QPP Resource Center™ for the Midwest?

CMS funded, seven State network of experienced technical assistance organizations providing **free** help to small & rural providers.

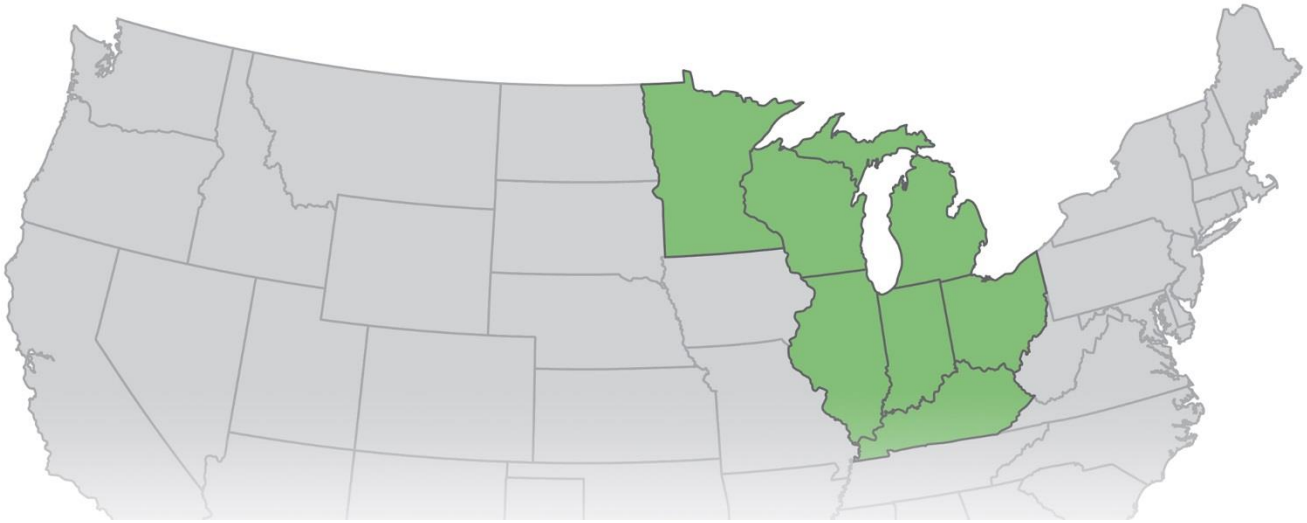
Staffed By:

- Experts on the requirements of the Quality Payment Program
- Skilled QPP Advisors who can help navigate resources, meet QPP program requirements and avoid penalties

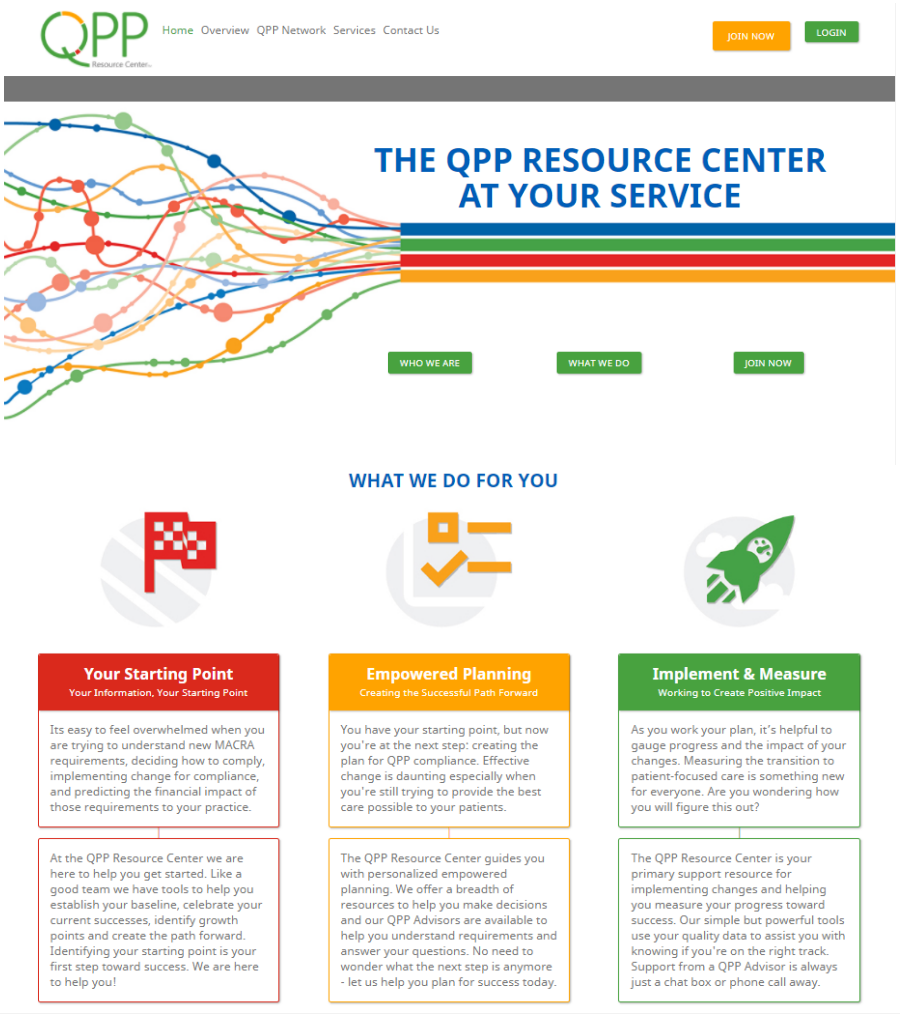
Member Organizations:

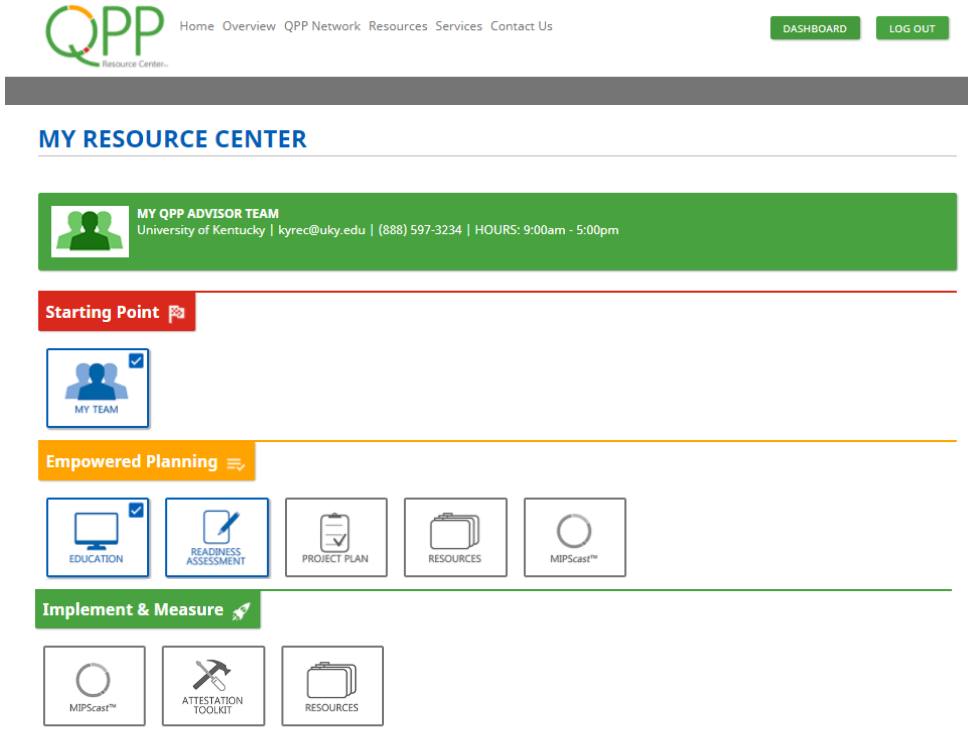
10 Organizations including top performing:

- Quality Improvement Organizations
- Regional Extension Centers for Health IT
- Practice Transformation Networks
- Universities, and
- Rural Health Associations



QPP Resource Center™ for the Midwest Web Portal

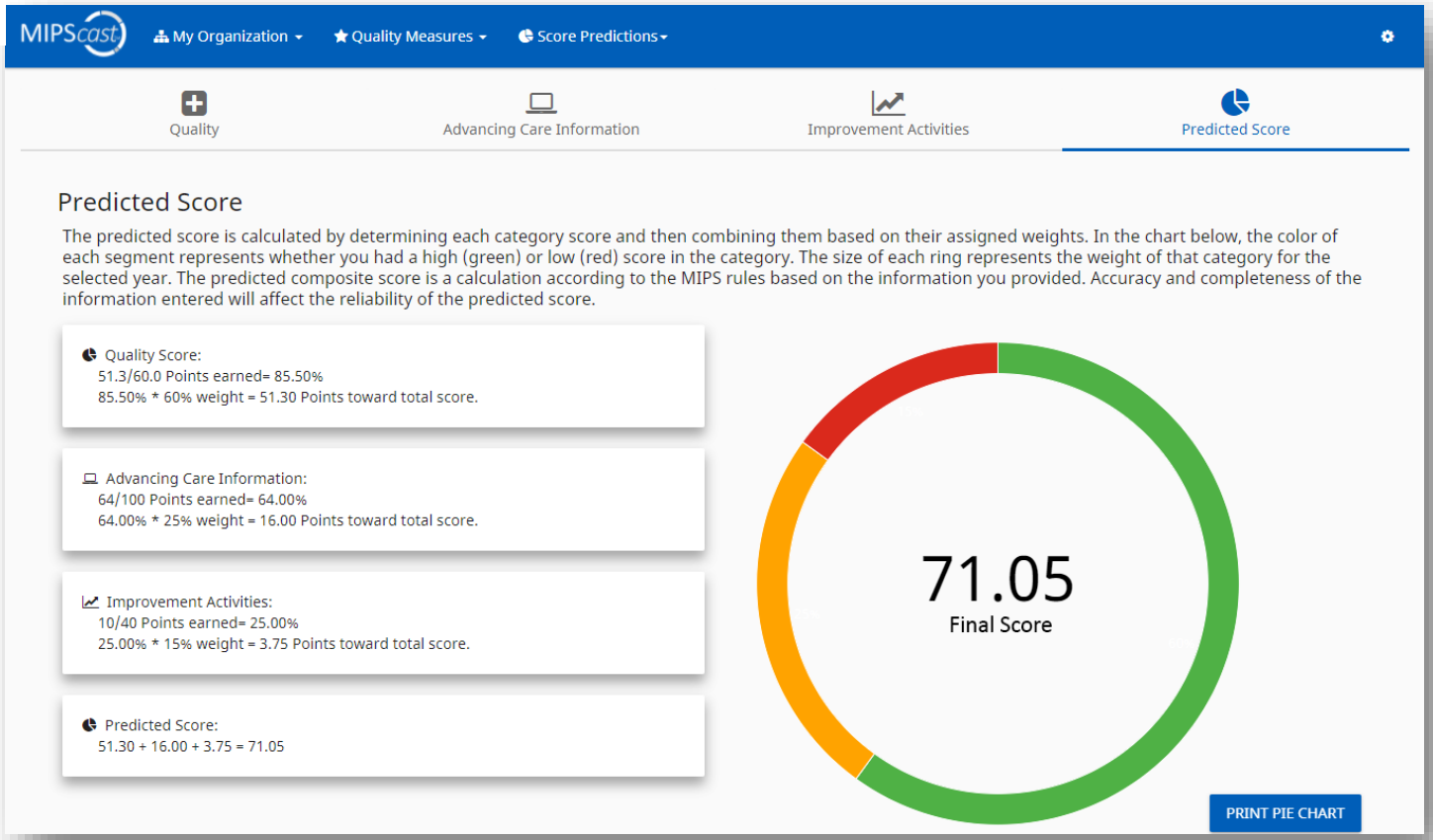




www.qppresourcecenter.com

The QPP Resource Center™: Estimating Your MIPS Final Score

MIPScast™
An Altarum Innovation



Resources

- QPP Resource Center for the Midwest: https://www.qppresourcecenter.com/
- CMS Quality Payment Program Website: https://qpp.cms.gov/
- QPP Executive Summary: https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf
- QPP Final Rule: https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm
- QPP Fact Sheet: https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf
- Comprehensive List of APMs: https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf
- Additional Webinars and Educational Programs: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html

Questions?

www.mceita.org

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MDHHS Medicaid Managed Care Plan Division

Quality Improvement and Program Development

HIT Commission Meeting – Sept 21 2017

Michigan Medicaid Managed Care Quality Strategy and Implementation

Presentation Points

- Overview of Medicaid Quality Regulatory Landscape
  - All populations need oversight
  - The need for collaboration
- How is MDHHS responding?
  - Managed care rule implementation
  - Quality measure data workgroup
  - Alternative payment methodology initiative

Overview of Medicaid Quality Regulatory Landscape

- State Legislative & Departmental Priorities
  - Population Health
  - Maternal/Child Health
  - Primary Care
- Waivers & Demonstrations
  - Healthy Michigan Plan
  - MI Health Link
  - State Innovation Model
- Centers for Medicare & Medicaid Services (CMS) Rules
  - Transparency
  - Stakeholder Engagement
  - Alignment

All Populations Need Oversight

- Consistency across all plans and programs.
  - Establish common priorities and goals
  - Identify relevant performance measures
  - Set minimum standards
  - Develop oversight processes
- Public input is required.

The Need for Broad Collaboration

- Comprehensive MDHHS Quality Strategy (must include all managed care populations)
  - Medicaid health plans
  - Integrated Care Organizations
  - Behavioral Health PIHPs
  - MI Choice Waiver Agents (AAAs)
  - Dental Vendor(s) (PAHPs)
- Heavy lift! Here's how…

How is MDHHS responding?

- Managed care rule implementation
- Quality measure data workgroup
- Alternative payment methodology initiative

Managed Care Rule Implementation

- Engage major program areas (managed care, behavioral health, long-term services and supports)
- Ensure consistency in understanding the rules
- Implement on a uniform timeline
- Collaborate with all administrations and programs to get appropriate beneficiary and stakeholder input

Quality Measure Data Workgroup

- Quality Improvement and Program Development (QIPD) Section of Medicaid managed care gives raw data to Medicaid health plans (MHPs)
- MHPs compare data from the Medicaid data warehouse with their own administrative data
- Workgroup discusses differences in performance rates
- Changes made where necessary in queries, definitions, or other elements of the process
- Rerun data from the Medicaid data warehouse for use in quality improvement initiatives

Quality Measure Data Workgroup

- Builds credibility for using data in the Medicaid data warehouse for calculating performance rates
- Ensures performance measures calculated and published using data from the Medicaid data warehouse are accurate (for both incentive and QI purposes)
- Provides a foundation for stratifying data in the Medicaid data warehouse in new ways to drive QI (for example, race/ethnicity or by prosperity region)
- Provides a foundation for pursuing new measure specifications for evaluating performance

Alternative Payment Methodology (APM) Initiative

- Definition of what constitutes an Advanced APM from the HCP LAN framework
- MHPs report medical expenditure percentages by category of APM
- Continuing to refine definitions for numerator and denominator of the measures
- MHPs submit 3-year strategic plan and targets for increasing expenditures in advanced categories of APM

Alternative Payment Methodology (APM) Initiative

- Provides framework for department to work collaboratively with Medicaid health plans
- Unifies MHPs and department to engage providers
- Pursuing standardized quality measures Statewide and by prosperity region to link to APMs
- Using payment reform as a quality improvement vehicle

Summary

- Quality improvement is a priority, and requires a comprehensive approach to do it right.
- The new Medicaid managed care regulations, MDHHS waivers, and CMS grants are leverage to prioritize doing quality improvement the right way.
- Collaboration with Medicaid health plans and their provider networks is the only way to use credible measurement and incentives to truly improve the quality of care.

Physician Payer Quality Collaborative (PPQC)

HIT COMMISSION MEETING

Dara Barrera
Manager, HIT and Practice Management
Michigan State Medical Society

MSMS
MICHIGAN STATE MEDICAL SOCIETY

What is PPQC?

- Initiative between MSMS and MiHIN to reduce the administrative burden of quality measurement and reporting
- Origins at the MSMS Executive Council of Physician Organizations back in March 2015
- True collaborative effort between Physician Organizations and Payers to achieve goals
- Pilot group for a streamlined approach to quality reporting HIT infrastructure

Why PPQC?

- Physician “death by 1,000 cuts”
  - Alphabet soup of quality reporting requirements – HEDIS, PQRS, MU, eCQMs
- Proliferation of EMR and registry vendors
  - Barriers to interoperability and lack of standardization
- Different processes across health plans
  - Patient attribution models, reporting formats, feedback timelines and incentive programs

PPQC Guiding Principles

- Vision for “Report Once” infrastructure
- All-payer, all-patient, all-measure supplemental data file
- Utilize existing file format for rapid adoption but use QRDA file format as future standard
- Develop all-patient, all-payer incentives for core measures identified by Payer and Physician Organization survey

Final Thoughts

- Change is hard, change in healthcare is exponentially hard
- Next year “report once” will be standard process for quality reporting in Michigan
- Physicians want to be accountable – need less administrative burden to focus on patient care
- Need to engage purchasers in broader incentive discussion on the core measurement set

Physician Payer Quality Collaborative (PPQC)

Health Information Technology Commission

September 21, 2017

Bo Borgnakke
Population Health Analyst
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MiHIN Shared Services

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Quality Measure Information (QMI) Use Case

Medicare / Medicaid

- Meaningful Use
- MIPS
- CPC+

Reporting Format

- Manual Attestation
- QRDA

Health Plans

- HEDIS Reporting
- Incentive Programs

Reporting Format

- Proprietary specifications

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PPQC 27 Core Set Measures

Adult BMI Assessment	Childhood Immunization Status	Well Child Visits 15 months	Well Child Visits 3-6 years
Colorectal Cancer Screening	Immunizations for Adolescents	Adolescent Well Care Visits	Follow-up for ADHD
Appropriate Treatment for URI	Appropriate testing for pharyngitis	Lead Screening	Imaging Studies for Low Back Pain
CDC: Hemoglobin A1c Testing	CDC: Hemoglobin A1c Poor Control	CDC: Eye Exam Performed	CDC: Medical Attention for Nephropathy
CDC: Blood Pressure Control	Controlling High Blood Pressure	Weight Assessment + Counseling	Tobacco Use Screening and Cessation
Screening for Depression + Follow-up	Avoidance of Antibiotics for Bronchitis	Prenatal & Postpartum Care	Cervical Cancer Screening
Breast Cancer Screening	Chlamydia Screening	Anti-depression Medication Management	

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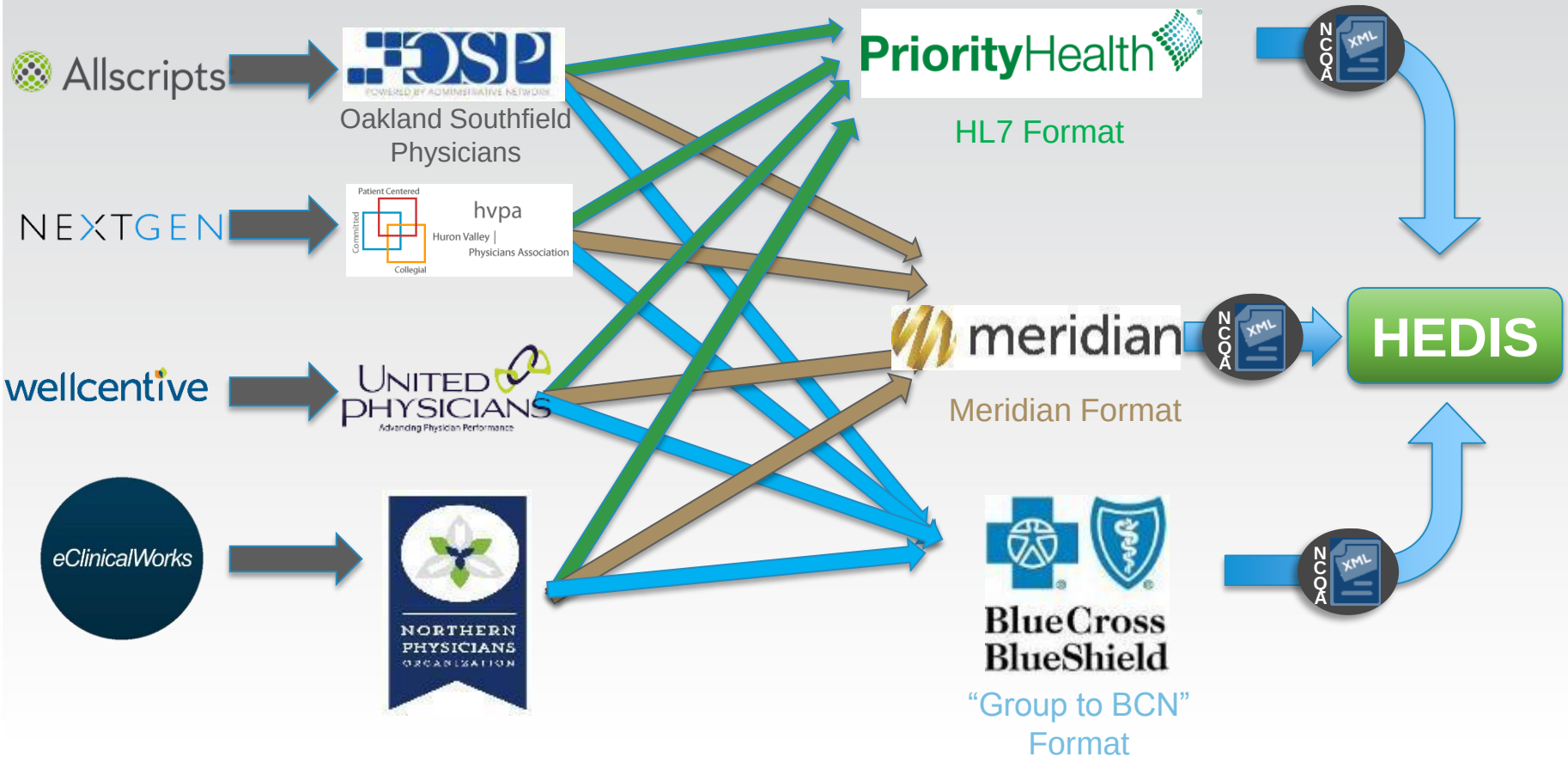
Supplemental Data – Status Quo



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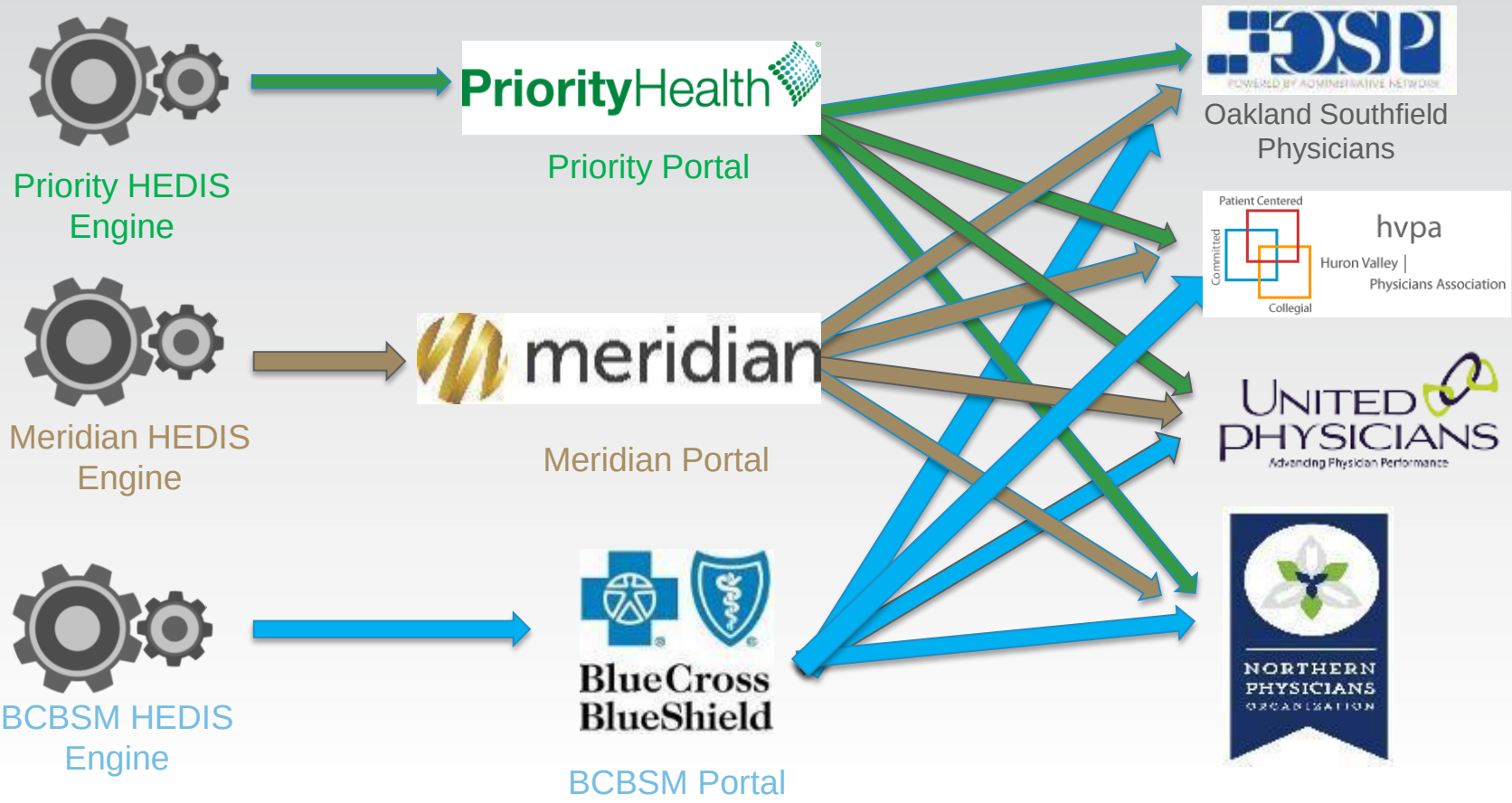
Gaps in Care Reports – Status Quo



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Quality Measure Data Flow

One format and **one location** for:

- POs to submit quality measures
- Payers to submit Gaps in Care
- POs to close Gaps in Care

Physician Organizations

Health Plans

MiHIN Shared Services

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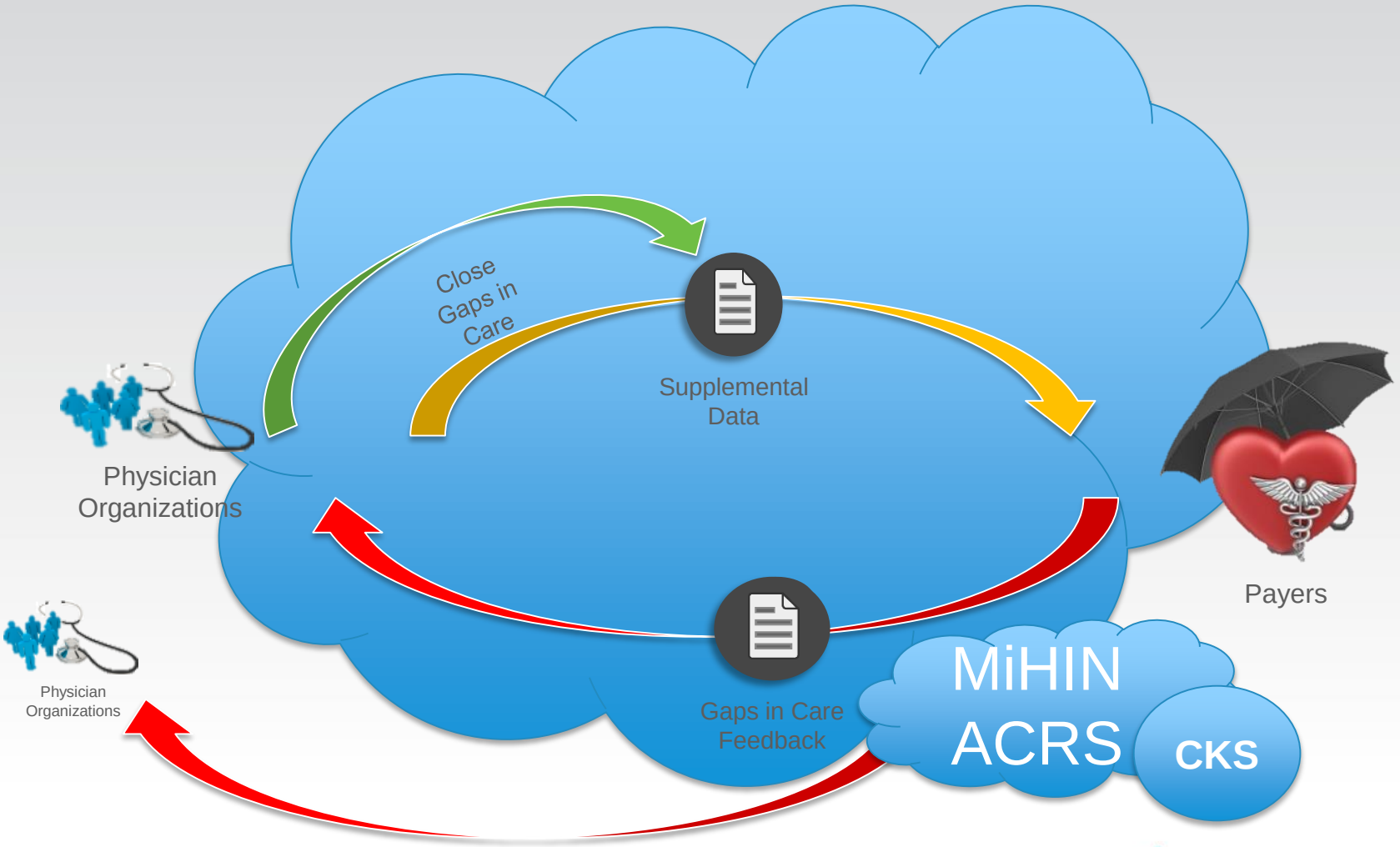
Standardizing Closing Gaps In Care



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Gaps in Care Report Specification

Required	Name	Description	Type
Y	PAYER_NAME	Name of Payer	VARCHAR2 (50)
Y	SOURCE_OID	Payer Organization OID	VARCHAR2 (50)
Y	PCP_NPI	PCP's NPI	VARCHAR2(10)
N	PCP_FIRST_NAME	PCP First Name	VARCHAR2 (50)
N	PCP_LAST_NAME	PCP Last Name	VARCHAR2 (50)
Y	MBR_ID1	Member / Contract Number (With Suffix) that POs could use to identify patient	VARCHAR2 (25)
N	MBR_ID2	Number sent in the "Unique Patient ID" field of ACRS file to MiHIN, if different than MBR_ID1	VARCHAR2 (25)
Y	MBR_FIRST_NAME	Member First Name	VARCHAR2 (50)
Y	MBR_LAST_NAME	Member Last Name	VARCHAR2 (50)
Y	MBR_ZIP_CODE	Member Zip Code	NUMERIC (5)
Y (IA)	MBR_LAST_FOUR_SSN	Member Last Four Digits of SSN	NUMERIC
Y	BIRTH_DT	Member Date of Birth	DATE (DD-MMM-YYYY)
Y	GENDER	Member Sex (M/F)	VARCHAR2 (1)
Y (IA)	COMMON_KEY	Member's Assigned Common Key	VARCHAR2 (25)
Y	HEDIS_MEASURE_CODE	HEDIS Measure Code	VARCHAR2 (3)
Y	HEDIS_SUBMEASURE_CODE	HEDIS SubMeasure Code	VARCHAR2 (3)
Y (IA)	MEASURE_DESCRIPTION	HEDIS Measure Description	VARCHAR2 (200)
Y (IA)	SUBMEASURE_DESCRIPTION	HEDIS Sub-Measure Description	VARCHAR2 (200)
Y (IA)	MEASURE_START_DATE	First date of measure data collection period	DATE (DD-MMM-YYYY)
Y (IA)	MEASURE_END_DATE	Last date of measure data collection period	DATE (DD-MMM-YYYY)
Y	NUMERATOR	Indicator of whether a member is meeting the criteria for measure compliance. Will always be 1 (yes) or 0 (no).	NUMERIC (1)
Y	DENOMINATOR	An indicator for members who are in the measure & submeasure. Will always be 1.	NUMERIC (1)
Y (IA)	EVENT_DATE	For event based measures, the date of service that qualifies the member for the measure. For example, the delivery date for Prenatal/Postpartum	DATE (DD-MMM-YYYY)
Y	AS_OF_DATE	Data Received Through Date	DATE (DD-MMM-YYYY)

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Participants to Date

Payers
Aetna
Blue Care Network of Michigan
Blue Cross Blue Shield of Michigan
Blue Cross Complete
Health Alliance Plan
McLaren Health Plan
Molina Healthcare of Michigan
Meridian Health Plan
Priority Health
Total Health Care
Upper Peninsula Health Plan
UnitedHealthcare

Physician Organizations
Affinia
Answer Health
Great Lakes OSC
Huron Valley Physicians Association
Michigan Medicine
Northern Physicians Organization
Oakland Southfield Physicians
Physician Healthcare Network
United Physicians

Other Stakeholders
Michigan Dept of Health & Human Services
Michigan Quality Improvement Consortium
Michigan Public Health Institute

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Quality Measure Information Goals

- Reduce burdens for physicians and health plans
  - **Automate** quality measure reporting workflow
  - **Report Once** and send to multiple quality programs

- **Standardize** quality data sharing
  - Working towards one unified format submitted to one place
  - Utilize national standards for export, transport, and submission

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Questions and contacts

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Other HIT Commission Business

- HIT Commission Next Steps
- Public Comment
- Adjourn