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
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

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

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%
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

### Cumulative Incentives for EHR Incentive Program 2011 to Present

<table>
<thead>
<tr>
<th>Reporting Status</th>
<th>Prior # of Incentives Paid (July)</th>
<th>Current # of Incentives Paid (August)</th>
<th>PY Goal: Number of Incentive Payments</th>
<th>PY Medicaid Incentive Funding Expended</th>
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<tbody>
<tr>
<td><strong>Eligible Professionals (EPs)</strong></td>
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<tr>
<td>AIU 2015</td>
<td>1021</td>
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<td><strong>Eligible Hospitals (EHs)</strong></td>
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<td>MU 2016</td>
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### Key:
- **AIU** = Adopt, Implement or Upgrade
- **MU** = Meaningful Use

<table>
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<tr>
<th>Total Number of EPs &amp; EHs Paid</th>
<th>Total Federal Medicaid Incentive Funding Expended</th>
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<tr>
<td>AIU</td>
<td>7240</td>
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<tr>
<td>MU</td>
<td>7722</td>
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</table>
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
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
The New Quality Payment Program and Available Support for Michigan Clinicians

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

September 21, 2017
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
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?

You’re a part of the MIPS track of the Quality Payment Program if you bill Medicare Part B more than $30,000 as an individual clinician and provide care for more than 100 Medicare Part B patients during the determination period, and are a

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

▲ (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
### TIMELINE

#### FEE Updates as SGR ends

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#### MIPS

- **Quality**
- **Resource Use**
- **Clinical Practice Improvement Activities**
- **Meaningful Use of Certified EHR Technology**

- **PQRS, Value Modifier, EHR Incentives**

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Resource Use</th>
<th>Clinical Practice Improvement Activities</th>
<th>Meaningful Use of Certified EHR Technology</th>
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<tr>
<td>2015</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
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- **MIPS Payment Adjustment (+/-)**

#### APM

- **Qualifying APM Participant**
- **Medicare Payment Threshold Excluded from MIPS**

- **5% Incentive Payment**
- **Excluded from MIPS**

---

*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.SHC@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 **small 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](#)

**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
The QPP Resource Center™: Estimating Your MIPS Final Score

**Predicted Score**

The predicted score is calculated by determining each category score and then combining them based on their assigned weights. In the chart below, the color of each segment represents whether you had a high (green) or low (red) score in the category. The size of each ring represents the weight of that category for the selected year. The predicted composite score is a calculation according to the MIPS rules based on the information you provided. Accuracy and completeness of the information entered will affect the reliability of the predicted score.

- **Quality Score:**
  - 51.3/60.0 Points earned = 85.50%
  - 85.50% * 60% weight = 51.30 Points toward total score.

- **Advancing Care Information:**
  - 64/100 Points earned = 64.00%
  - 64.00% * 25% weight = 16.00 Points toward total score.

- **Improvement Activities:**
  - 10/40 Points earned = 25.00%
  - 25.00% * 15% weight = 3.75 Points toward total score.

- **Predicted Score:**
  - 51.30 + 16.00 + 3.75 = 71.05

**Final Score:**

71.05
Resources

▲ QPP Resource Center for the Midwest: https://www.qppresourcecenter.com/

▲ CMS Quality Payment Program Website: https://qpp.cms.gov/

▲ QPP Executive Summary:


▲ QPP Fact Sheet:

▲ Comprehensive List of APMs:

▲ Additional Webinars and Educational Programs:
Questions?

www.mceita.org

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734-302-4744
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
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
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
Physician Payer Quality Collaborative (PPQC)

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
Physician Payer Quality Collaborative (PPQC)

**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
borgnakke@mihin.org

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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
# PPQC 27 Core Set Measures

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<thead>
<tr>
<th>Adult BMI Assessment</th>
<th>Childhood Immunization Status</th>
<th>Well Child Visits 15 months</th>
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<td>Adolescent Well Care Visits</td>
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<td>Appropriate Treatment for URI</td>
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<td>Lead Screening</td>
<td>Imaging Studies for Low Back Pain</td>
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<td>CDC: Eye ExamPerformed</td>
<td>CDC: Medical Attention for Nephropathy</td>
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<td>CDC: Blood Pressure Control</td>
<td>Controlling High Blood Pressure</td>
<td>Weight Assessment + Counseling</td>
<td>Tobacco Use Screening and Cessation</td>
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<td>Screening for Depression + Follow-up</td>
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<td>Prenatal &amp; Postpartum Care</td>
<td>Cervical Cancer Screening</td>
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<td>Chlamydia Screening</td>
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Supplemental Data – Status Quo

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Gaps in Care Reports – Status Quo

Priority HEDIS Engine

Meridian HEDIS Engine

BCBSM HEDIS Engine

Priority Portal

Meridian Portal

BCBSM Portal

Oakland Southfield Physicians

hvpa

Huron Valley Physicians Association

MiHIN Shared Services

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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
# Gaps in Care Report Specification

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<tr>
<td>Y</td>
<td>MBR_LAST_NAME</td>
<td>Member Last Name</td>
<td>VARCHAR2 (50)</td>
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<td>Y</td>
<td>MBR_ZIP_CODE</td>
<td>Member Zip Code</td>
<td>NUMERIC (5)</td>
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<tr>
<td>Y (IA)</td>
<td>MBR_LAST_FOUR_SSN</td>
<td>Member Last Four Digits of SSN</td>
<td>NUMERIC</td>
</tr>
<tr>
<td>Y</td>
<td>BIRTH_DT</td>
<td>Member Date of Birth</td>
<td>DATE (DD-MM-YYYY)</td>
</tr>
<tr>
<td>Y</td>
<td>GENDER</td>
<td>Member Sex (M/F)</td>
<td>VARCHAR2 (1)</td>
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<td>Y (IA)</td>
<td>COMMON_KEY</td>
<td>Member’s Assigned Common Key</td>
<td>VARCHAR2 (25)</td>
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<td>Y</td>
<td>HEDIS_MEASURE_CODE</td>
<td>HEDIS Measure Code</td>
<td>VARCHAR2 (3)</td>
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<tr>
<td>Y</td>
<td>HEDIS_SUBMEASURE_CODE</td>
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<td>MEASURE_START_DATE</td>
<td>First date of measure data collection period</td>
<td>DATE (DD-MM-YYYY)</td>
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<tr>
<td>Y (IA)</td>
<td>MEASURE_END_DATE</td>
<td>Last date of measure data collection period</td>
<td>DATE (DD-MM-YYYY)</td>
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<tr>
<td>Y</td>
<td>NUMERATOR</td>
<td>Indicator of whether a member is meeting the criteria for measure compliance. Will always be 1 (yes) or 0 (no).</td>
<td>NUMERIC (1)</td>
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<tr>
<td>Y</td>
<td>DENOMINATOR</td>
<td>An indicator for members who are in the measure &amp; submeasure. Will always be 1.</td>
<td>NUMERIC (1)</td>
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<tr>
<td>Y (IA)</td>
<td>EVENT_DATE</td>
<td>For event based measures, the date of service that qualifies the member for the measure. For example, the delivery date for Prenatal/Postpartum</td>
<td>DATE (DD-MM-YYYY)</td>
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<tr>
<td>Y</td>
<td>AS_OF_DATE</td>
<td>Data Received Through Date</td>
<td>DATE (DD-MM-YYYY)</td>
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## Participants to Date

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<thead>
<tr>
<th>Payers</th>
<th>Physician Organizations</th>
<th>Other Stakeholders</th>
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<tr>
<td>Aetna</td>
<td>Affinia</td>
<td>Michigan Dept of Health &amp; Human Services</td>
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<tr>
<td>Blue Care Network of Michigan</td>
<td>Answer Health</td>
<td>Michigan Quality Improvement Consortium</td>
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<td>Blue Cross Blue Shield of Michigan</td>
<td>Great Lakes OSC</td>
<td>Michigan Public Health Institute</td>
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<td>Blue Cross Complete</td>
<td>Huron Valley Physicians Association</td>
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<td>Health Alliance Plan</td>
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<td>McLaren Health Plan</td>
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This work made possible by funding from the Michigan Department of Health and Human Services

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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
Questions and contacts

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Rick Wilkening
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Bo Borgnakke
borgnakke@mihin.org

Dara Barrera
DJBarrera@msms.org
Other HIT Commission Business

- HIT Commission Next Steps
- Public Comment
- Adjourn