2018 MHS Quality
Agenda

- MHS Pay for Performance (P4P)
- Tools Available to Assist in Obtaining a Better P4P Payout
- Secure Web Reporting
- Patient Analytics
- My Health Direct
- Question and Answer
WHAT YOU WILL LEARN

- Measure Overviews & Specifications
- Documentation Requirements
- Administrative Measures
- Secure Web Reports
- My Health Direct
- How Payout is Calculated
2018 P4P

맹 Bonus Pay for Performance (P4P) fund is written into Primary Medical Provider contracts
맹 Measures differ for each product line
맹 Measures align with HEDIS® and NCQA
맹 Annual Payout
## 2018 HOOSIER HEALTHWISE P4P

### P4P Schedule A-2A-1

Hoosier Healthwise

<table>
<thead>
<tr>
<th>Pay-For-Performance Measures</th>
<th>Goal Rate</th>
<th>Minimum Number of Covered Persons</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children's Care (Quality)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status (CIS)COMBO 10</td>
<td>% of 2 year old Covered Persons who had the following immunizations by their second birthday: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule). 2 Flu</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase</td>
<td>% of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
</tr>
<tr>
<td>Follow-Up Care for Children Prescribed ADHD Medication - continuation phase</td>
<td>% of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life (W15)</td>
<td>% of Covered Persons turning 15 mos within the current year who had 6 or more visits with PMP before turning 15 mos old</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)</td>
<td>% of Covered Persons who turned 3–6 years old within the year who had 1 or more well-child visits within the current year</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits (AWC)</td>
<td>% of Covered Persons 12–21 years old who had at least 1 comprehensive well care visit with PMP or CB within the current year</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
</tbody>
</table>
## 2018 HOOSIER HEALTHWISE P4P

<table>
<thead>
<tr>
<th>Maternal Care (Quality)</th>
<th>Timeliness of Prenatal Care - % of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment</th>
<th>HEDIS 75th percentile</th>
<th>20 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postpartum Care (PPC)</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HEDIS 75th percentile</td>
<td>7 points</td>
</tr>
<tr>
<td>Postpartum Care - % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HEDIS 75th percentile</td>
<td>7 points</td>
</tr>
</tbody>
</table>
## 2018 HOOSIER HEALTHWISE P4P

### Women’s Care (Quality)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>HEDIS 75th percentile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia Screening in Women (CHL)</td>
<td>% of female Covered Persons age 16-24 years identified as sexually active who had at least one Chlamydia test in the current year</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

### Respiratory Care

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>HEDIS 75th percentile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED Management for People With Asthma (Med 75% rate)</td>
<td>% of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Asthma Medication Ratio (AMR) - total</td>
<td>% of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

### Ambulatory Measures

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>HEDIS 10th percentile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care (AME) – ER Utilization</td>
<td>Utilization of ambulatory care in the ED - # visits per 1,000 member months</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

### Provider Outreach (Administrative) Credit given for use of any 3 of the following 5:

- Provider-Initiated Preventive Health Outreach
- Panel Size Increase
- Training Attendance or Use of Bright Futures
- Use of Patient Satisfaction Survey
- Use of EMR or MHS Well Visit Form

Select outreach condition must be applicable to at least 20% of total panel, i.e., telephonic campaign, Covered Person mailing campaign, special well-child health check day at your office. Report of Outreach must be received by MHS by December 31 of the measurement year. At a minimum, the outreach must be described and a list of Covered Persons who received the outreach must be included.

- Increase panel size by 10%
- Physician or Office Manager attendance in one MHS training/orientation sessions during the calendar year or documented use of the AAP Bright Futures program
- Use of a practice-level patients satisfaction survey, such as the American Academy of Family Physicians model questionnaire
- Use of Electronic Medical Record or the MHS Child or Adult Health Maintenance Form for well visits

*Use of 1 = 3 points
Use of 2 = 6 points
Use of 3 or more = 10 points
2018 HOOSIER HEALTHWISE MEASURES

💖 Child and Adolescent Well-Care:
- Childhood immunization status (CIS)
- Well-child visits 0-15 months (W15)
- Well-child visits 3-6 years (W34)
- Well-care adolescent visits 12-21 years (AWC)
- Follow-up care for children prescribed ADHD medication – Acute and Continuation phases (ADD)

💖 Maternal Care:
- Timeliness/Initiation of Prenatal Care (PPC)
- Postpartum Care (PPC)
2018 HOOSIER HEALTHWISE P4P MEASURES

Women’s Care:
• Chlamydia Screening (CHL)

Respiratory Care:
• MED Management for Asthmatics (MMA)
• Asthma Medication Ratio (AMR) - total

Ambulatory Measures:
• Ambulatory Care (AMB) – ER utilization
# 2018 HIP P4P

## P4P SCHEDULE A-2B-1
Healthy Indiana Plan (HIP)

<table>
<thead>
<tr>
<th>Pay-For-Performance Measures</th>
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<th>Minimum Number of Covered Persons</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women’s Care (Quality)</strong></td>
<td>21 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening in Women (CHL)</td>
<td>% of female Covered Persons age 16-24 years identified as sexually active who had at least one Chlamydia test in the current year</td>
<td>HEDIS 75th percentile</td>
<td>5 points</td>
</tr>
<tr>
<td>Cervical Cancer Screening (CCS)</td>
<td>% of female Covered Persons age 24-64 years who received 1 or more Pap tests to screen for cervical cancer in the current year</td>
<td>HEDIS 75th percentile</td>
<td>5 points</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>% of women 50–74 years of age who had a mammogram to screen for breast cancer</td>
<td>HEDIS 75th percentile</td>
<td>5 points</td>
</tr>
<tr>
<td><strong>Maternal Care (Quality)</strong></td>
<td>20 points</td>
<td></td>
<td></td>
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<tr>
<td>Prenatal and Postpartum Care (PPC)</td>
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<td>5 points</td>
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## 2018 HIP P4P

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<thead>
<tr>
<th>Respiratory Care</th>
<th>% of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period</th>
<th>HEDIS 75th percentile</th>
<th>5</th>
<th>7 points</th>
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<tbody>
<tr>
<td>MED Management for People With Asthma (Med 75% rate)</td>
<td></td>
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<td>5</td>
<td>7 points</td>
</tr>
<tr>
<td>Pharmacotherapy Management of COPD Exacerbation (PCE) - systemic corticosteroid</td>
<td>% of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
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</table>
# 2018 HIP P4P

## Behavior Health Care

| Metric | Details | Points | HEDIS
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medication Management (AMM) – Acute Phase</td>
<td>% of members who remained on an antidepressant medication for at least 64 days (12 weeks)</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

## Diabetes Care

| Metric | Details | Points | HEDIS
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Care – Eye exam (retinal) performed</td>
<td>% of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes Care – Medical attention for nephropathy</td>
<td>% of members 18–75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy</td>
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</tr>
</tbody>
</table>

## Ambulatory Measures

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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care (AMB) – ER utilization</td>
<td>Utilization of ambulatory care in the ED - # visits per 1,000 member months</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Adults’ Access to Preventive/Ambulatory Health Services (AAP)</td>
<td>% of members 20 years and older who had an ambulatory or preventive care visit</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

## Provider Outreach (Administrative) Credit given for use of any 3 of the following 5:

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<td>Use of EMR or MHS Well Visit Form</td>
<td>Use of Electronic Medical Record or the MHS Adolescent or Adult Health Maintenance Form for well-visits</td>
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**P4P Scoring Key for Provider Outreach**

- Complete one activity above to earn 3 Points. (30% payment for this section)
- Complete two activities above to earn 6 Points. (50% payment for this section)
- Complete three or more activities above and earn 100% payment for this section.
2018 HIP P4P MEASURES

Maternal Care:
• Timeliness/initiation of prenatal care (PPC)
• Postpartum care (PPC)

Women’s Care:
• Chlamydia Screening (CHL)
• Cervical Cancer Screening (CCS)
• Breast Cancer Screening (BCS)
2018 HIP P4P MEASURES

Respiratory Care:
• MED Management for Asthmatics (MMA)
• Pharmacotherapy Management of COPD Exacerbation (PCE) - systemic corticosteroid

Behavioral Health Care:
• Antidepressant Med Management (AMM) – Acute Phase
2018 HIP P4P MEASURES

Diabetes Care (CDC):
- Diabetes Care - Eye exam (retinal) performed
- Diabetes Care - Medical attention for nephropathy

Ambulatory Measures:
- Ambulatory Care (AMB) – ER Utilization
- Adults’ Access to Preventive/Ambulatory Health Services (AAP)
## 2018 HOOSIER CARE CONNECT

### P4P

#### P4P SCHEDULE 2C-1A

**Hoosier Care Connect**

<table>
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<th>Pay-For-Performance Measures</th>
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<tr>
<td><strong>Children’s Care (Quality)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status (GIS) COMBO 10 - % of 2 year old Covered Persons who had the</td>
<td>HEDIS 75th</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>following immunizations by their second birthday: 1 DTap, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV,</td>
<td>percentile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life (W15) - % of Covered Persons turning</td>
<td>HEDIS 75th</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>15 months within the current year who had 6 or more visits with PMP before turning 15 months</td>
<td>percentile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>old</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) - % of Covered</td>
<td>HEDIS 75th</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Persons who turned 3-6 years old within the year who had 1 or more well child visits</td>
<td>percentile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>within the current year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent Well-Care Visits (AWC) - % of Covered Persons 12-21 years old who had at least</td>
<td>HEDIS 75th</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>1 comprehensive well care visit with PMP or OB within the current year</td>
<td>percentile</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MED Management for People With Asthma (Med 75% rate) - % of members 5-64 years of age during</td>
<td>HEDIS 75th</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>the measurement year who were identified as having persistent asthma and were dispensed</td>
<td>percentile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>appropriate medications and remained on an asthma controller medication for at least 75% of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>their treatment period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma Medication Ratio (AMR) - total - % of members 5-64 years of age who were identified</td>
<td>HEDIS 75th</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>as having persistent asthma and had a ratio of controller medications to total asthma</td>
<td>percentile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medications of 0.50 or greater during the measurement year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 2018 Hoosier Care Connect P4P

<table>
<thead>
<tr>
<th>Pharmacotherapy Management of COPD Exacerbation (PCE) - systemic corticosteroid</th>
<th>% of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 - November 30 of the measurement year and who were dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event</th>
<th>HEDIS 75th percentile</th>
<th>5</th>
<th>7 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>% of adults 18–84 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within three days after the diagnosis. [Members with chronic respiratory disorders such as COPD and Cystic Fibrosis are excluded from this measure.]</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
<td>6 points</td>
</tr>
<tr>
<td><strong>Diabetes Care</strong></td>
<td>14 points</td>
<td><strong>Diabetes Care - Eye exam (retinal) performed</strong></td>
<td>% of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed</td>
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</tr>
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<td><strong>Diabetes Care - Medical attention for nephropathy</strong></td>
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<td>7 points</td>
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<td><strong>Ambulatory Measures</strong></td>
<td>14 points</td>
<td><strong>Ambulatory Care (AMB) - ER utilization</strong></td>
<td>utilization of ambulatory care in the ED - # visits per 1,000 member months</td>
<td>HEDIS 10th percentile</td>
</tr>
<tr>
<td><strong>Adults' Access to Preventive/Ambulatory Health Services (AAP)</strong></td>
<td>% of members 20 years and older who had an ambulatory or preventive care visit</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
<td>7 points</td>
</tr>
<tr>
<td><strong>Behavioral Health Care</strong></td>
<td>7 points</td>
<td><strong>Antidepressant Medication Management (AMM) - Acute Phase</strong></td>
<td>% of members who remained on an antidepressant medication for at least 84 days (12 weeks)</td>
<td>HEDIS 75th percentile</td>
</tr>
</tbody>
</table>
## 2018 Hoosier Care Connect P4P

**Provider Outreach (Administrative) Credit given for use of any 3 of the following 5:**

<table>
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<tr>
<th>Activity</th>
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<tr>
<td>Provider-Initiated Preventive Health Outreach</td>
<td>Selected outreach condition must be applicable to at least 20% of the total panel, e.g., telephonic campaign, Covered Person mailing campaign, special well-child health check day at your office. Report of Outreach must be received by MHS by December 31 of the measurement year. At a minimum, the outreach must be described and a list of Covered Persons who received the outreach must be included.</td>
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<td>Panel Size Increase</td>
<td>Increase panel size by 10%</td>
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<td>Physician or Office Manager attendance in one MHS training/orientation session during the calendar year or documented use of the AAP Bright Futures program</td>
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<td>Use of Patient Satisfaction Survey</td>
<td>Use of a practice-level patient satisfaction survey, such as the American Academy of Family Physicians <a href="#">model questionnaire</a></td>
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<tr>
<td>Use of EMR or MHS Well Visit Form</td>
<td>Use of Electronic Medical Record or the MHS Child or Adult Health Maintenance Form for well-visits</td>
</tr>
</tbody>
</table>

**P4P Scoring Key for Provider Outreach**

- Complete one activity above to earn 3 Points. (30% payment for this section)
- Complete two activities above to earn 6 Points. (60% payment for this section)
- Complete three or more activities above and earn 100% payment for this section.
Child and Adolescent Well-Care:
• Childhood immunization status (CIS)
• Well-Child visits 0-15 months (W15)
• Well-Child visits 3-6 years (W34)
• Well-Care Adolescent visits 12-21 years (AWC)

Behavioral Health Care:
• Antidepressant Medication Management (AMM) – Acute Phase
2018 HOOSIER CARE CONNECT
P4P MEASURES

💖 Diabetes Care (CDC):
  • Diabetes Care - Eye exam (retinal) performed
  • Diabetes Care - Medical attention for nephropathy

💖 Ambulatory Measures:
  • Ambulatory Care (AMB) – ER Utilization
  • Adults’ Access to Preventive/Ambulatory Health Services (AAP)
Respiratory Care:

- MED Management for People With Asthma (MMA)
- Asthma Medication Ratio (AMR) – total
- Pharmacotherapy Management of COPD Exacerbation (PCE) - Systemic Corticosteroid
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
ADMINISTRATIVE MEASURES

Credit given for use of any 3 of the following 5 measures:

👩‍⚕️ Provider-Initiated Preventive Health Outreach
👩‍⚕️ Panel Size Increase by 10%
👩‍⚕️ Physician or Office Manager attendance at one MHS training/orientation session during the calendar year or documented use of the AAP Bright Futures program
👩‍⚕️ Use of Patient Satisfaction Survey
👩‍⚕️ Use of EMR or MHS Well Visit Form
MEASURE REQUIREMENTS AND CODING
Child and Adolescent Measures

Immunization Status:

🎉 Applicable age group: Children who turn two years of age in the measurement year.

🎉 Requirements: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu

- Vaccinations given prior to 42 days after birth or following the member's 2nd birthday will not be counted.
- Members must be continuously enrolled with the health plan for 12 months prior to their 2nd birthday with no more than a 45 day gap in enrollment.
Child and Adolescent Measures

Well-Child Visits 0-15 Months:

ئيس Applicable members: Children who turn 15 months old during the measurement year.

Requirement: Six or more well-child visits by 15 months of age.

* CPT – 99381-99382, 99391-99392
* ICD-10 - Z00.110, Z00.111, Z00.121, Z00.129
* Medical record documentation must include health history, physical exam, mental developmental history, physical developmental history, and anticipatory guidance/health education.
* Member must have been continuously enrolled with MHS from 31 days to 15 months of life with no more than a 45 day gap in enrollment.
Child and Adolescent Measures

Well-Child Visits 3-6 Years:

яд Applicable members: Members who turn 3-6 years of age during the measurement year.

 Requirement: At least one well-child visit during the measurement year.
- CPT – 99382, 99383, 99392, 99393
- ICD-10 - Z00.110, Z00.111, Z00.121, Z00.129
- Medical record documentation must include health history, physical exam, mental developmental history, physical developmental history, and anticipatory guidance/health education.
- Member must be continuously enrolled with MHS for 12 months with no more than a 45 day gap in enrollment.
Child and Adolescent Measures

Well-Care 12-21 Years:

눌 Applicable members: Members who turn 12-21 years of age during the measurement year.

눌 Requirement: At least one well-care visit during the measurement year.

- CPT 99384-99385, 99394-99395
- ICD-10 – Z00.121, Z00.129, Z00.5, Z00.8, Z02.0
- HCPCS - G0438, G0439
- Medical record documentation must include health history, physical exam, mental developmental history, physical developmental history, and anticipatory guidance/health education.
- Member must be continuously enrolled for 12 months with MHS with no more than a 45 day gap in enrollment.
Child and Adolescent Measures

Follow-Up Care for Children Prescribed ADHD Medication:

**Applicable members:** Members who turn 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year.

**Index Prescription Start Date (IPSD)** - The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.

*Members must be continuously enrolled 120 days (4 months) prior to the IPSD through 30 days after the IPSD with no gap in enrollment.*
Child and Adolescent Measures

Requirement:

👩‍⚕️ Initiation Phase – members with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-days after IPSD.

👩‍⚕️ Continuation Phase – members with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Adult Measures

Antidepressant Medication Management (AMM) – Acute Phase:

🌟 Applicable members: 18 years and older as of April 30 of the measurement year.

 Requirement:

- Members remained on an antidepressant medication for at least 84 days (12 weeks).
- Member must be continuously enrolled May 1 of the year prior to the measurement year through April 30 of the measurement year with MHS with no more than a 45 day gap in enrollment.
Adult Measures

Ambulatory Care (AMB) – ER Utilization:

🎉 Applicable members: all members

🎉 Requirement:
• Calculates # Visits/1,000 Member Months.
• Each visit to an ED that does not result in an inpatient encounter counts once.
• Multiple ED visits on the same date of service are counted as one visit.
**Adult Measures**

**Adults’ Access to Preventive/Ambulatory Health Services (AAP):**

👩‍⚕️ **Applicable members:** 20 years and older as of December 31 of the measurement year:

👩‍⚕️ **Requirement:**
- One or more ambulatory or preventive care visits during the measurement year.
- Members must be continuously enrolled for the measurement year with no more than one 45 day gap in enrollment.
Maternal Care

Timeliness of Prenatal Care:

🎉 Applicable members: Women who delivered between November 6 of the year prior to the measure year and November 5 of the measure year.

🎉 Requirement: Prenatal visit must occur within the first trimester or within 42 days of enrollment.
Maternal Care

Postpartum Care:

👩🏻‍⚕️ **Applicable members:** Women who delivered between November 6 of the year prior to the measure year and November 5 of the measure year.

👶🏻 **Requirement:** At least 1 postpartum visit on or between 21 and 56 days after delivery.
Women’s Care

Chlamydia Screening:

重中之重 Applicable Members: Women 16-24 years of age as of December 31\textsuperscript{st} during the measurement year.

Requirement:

• Women who were identified as sexually active and had at least 1 test for Chlamydia during the measurement year.
• Sexually active women are identified through evidence of a pregnancy test or prescription for a contraceptive.
• Members cannot be excluded for receiving prescription contraceptives for off label use.
Cervical Cancer Screening:

ือนApplicable members: Women 21-64 years of age as of December 31<sup>st</sup> of the measurement year.

ือนRequirement: Women 24-64 receive 1 Pap test during the measurement year or within 2 years prior OR women 30-64 receive cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years (must occur within 4 days of each other).

ือนWomen who have had either a complete, total or radical hysterectomy (vaginal or abdominal) with evidence that the cervix has been removed can be excluded from the measure based on medical record documentation.
Women’s Care

Breast Cancer Screening

🎉 **Applicable members:** Women 50-74 years of age as of December 31st of the measurement year.

🎉 **Requirement:** Women who have received at least 1 mammogram during the measurement year or October 1 of 2 years prior.

*Women who have had a bilateral mastectomy or two unilateral mastectomies can be excluded from this measure. Medical records will be required in order to exclude the member.*
Respiratory Care

Medication Management for People With Asthma:

🎉 **Applicable members:** Members 5-64 years of age as of December 31st of the measurement year.

🎉 **Requirements:**

- Members identified with persistent asthma who were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period.
- Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.
Respiratory Care

APPROPRIATE MEDICATIONS:

• Antiasthmatic combinations
• Antibody inhibitor
• Inhaled steroid combinations
• Inhaled corticosteroids
• Leukotriene modifiers
• Mast cell stabilizers
• Methylxanthines
Respiratory Care

Asthma Medication Ratio (AMR) – Total

❤️ Applicable members: Members 5-64 years of age as of December 31st of the measurement year.

❤️ Requirements:
• Members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
• Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.
Persistent asthma is defined as:
• 1 or more ED visits with a principal diagnosis of asthma; or
• 1 acute inpatient discharge with a principal diagnosis of asthma; or
• 4 or more outpatient visits with asthma as a diagnosis and at least 2 asthma medication events; or
• 4 or more asthma medication dispensing events
Diabetes Care

Diabetes Care – Eye Exam:

🎉 **Applicable members:** Members ages 18-75 as of December 31st of the measurement year with diabetes (types 1 & 2).

🎉 **Requirements:**
- Members identified with diabetes (types 1 & 2) who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) completed every year OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior.
- Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.
Diabetes Care

Diabetes Care – Monitoring for Nephropathy

🎉 **Applicable members:** Members ages 18-75 as of December 31st of the measurement year with diabetes (types 1 & 2).

🎉 **Requirements:**
- Members identified with diabetes (types 1 & 2) who had a nephropathy screening performed at least once per year.
- A member who is on ACE/ARBs or has nephropathy is compliant for this measure.
- Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.
MEASURE REQUIREMENTS AND CODING

🎉 You can find additional information on the measurement requirements and some tips for coding on our website located under HEDIS.

For more information, visit [www.ncqa.org](http://www.ncqa.org)
Tools Available to Assist in Obtaining a Better P4P Payout
Tools Available to Assist in Obtaining a Better P4P Payout

- Secure Web Reporting
- Patient Analytics
- My Health Direct
Secure Web Portal Reporting
P4P Scorecards

Reports updated regularly on secure portal:
• Group scorecards
• Individual scorecards
• Members in Need of Services lists

*Send email to P4P@mhsindiana.com to sign up to receive email alerts when documents are posted!
Scorecards

Updated measurement rates on scorecards include:

- Claims data (pharmacy, encounter/medical)
- CHIRP / Lab results
- Medical record documentation
- Collected annually
MHS Secure Portal

FOR MEMBERS

FOR PROVIDERS

GET INSURED

Select Your Plan Below

Ambetter From MHS
Healthy Indiana Plan
Hoosier Healthwise
Hoosier Care Connect

Find a Provider
Finding a doctor is quick and easy. Search for Primary Medical Providers, hospitals, pharmacies and more.

Get Insured
Health insurance shouldn't be stressful. Get more information on the health coverage we provide.

Coming Soon!
New health plans starting October 1!
MHS Secure Portal
# Group Scorecard Example

Group name: 
Time period covered by this report: YTD 1/1/2018 thru 7/31/2018

## Group Performance Metrics

<table>
<thead>
<tr>
<th>Prod</th>
<th>Measure</th>
<th>Minimum Applicable Members</th>
<th>Number of Applicable Members</th>
<th>Compliant Members</th>
<th>Group Average</th>
<th>NCQA 75th percentile</th>
<th>Members needed to reach MHS GOAL</th>
<th>Estimated Allocated P4P Dollars</th>
<th>Estimated P4P Dollars per Noncompliant Member</th>
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</thead>
<tbody>
<tr>
<td>HCC</td>
<td>Adolescent Well Care</td>
<td>10</td>
<td>151</td>
<td>33</td>
<td>21.85%</td>
<td>59.72%</td>
<td>58</td>
<td>$1,213.61</td>
<td>$20.32</td>
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<td>HCC</td>
<td>Adultiss' Access (AAP)</td>
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<td>429</td>
<td>325</td>
<td>75.76%</td>
<td>85.97%</td>
<td>44</td>
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<tr>
<td>HCC</td>
<td>Antidepressant Medica</td>
<td>5</td>
<td>18</td>
<td>13</td>
<td>72.22%</td>
<td>56.94%</td>
<td>0</td>
<td>$1,213.61</td>
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<tr>
<td>HCC</td>
<td>Asthma Med Ratio</td>
<td>5</td>
<td>16</td>
<td>12</td>
<td>75.00%</td>
<td>67.45%</td>
<td>0</td>
<td>$1,213.61</td>
<td>$0.00</td>
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<tr>
<td>HCC</td>
<td>Avoidance of Antibiotics</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>20.00%</td>
<td>33.74%</td>
<td>1</td>
<td>$1,213.61</td>
<td>$1,213.61</td>
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<td>HCC</td>
<td>Child Imm - Combo 10</td>
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<td>6</td>
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<td>33.66%</td>
<td>3</td>
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<td>Diabetes Care - Eye ex</td>
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<td>103</td>
<td>40</td>
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<td>63.33%</td>
<td>26</td>
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<td>$44.58</td>
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<tr>
<td>HCC</td>
<td>Diabetes Care - Neph</td>
<td>6</td>
<td>100</td>
<td>92</td>
<td>89.32%</td>
<td>91.67%</td>
<td>0</td>
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<tr>
<td>HCC</td>
<td>MED Mgmt Asthma</td>
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<td>12</td>
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<td>40.03%</td>
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<tr>
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<td>7</td>
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<td>9</td>
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<td>HHW</td>
<td>Adolescent Well Care</td>
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<td>866</td>
<td>215</td>
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<td>53.72%</td>
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<td>$13.07</td>
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<tr>
<td>HHW</td>
<td>Asthma Med Ratio</td>
<td>5</td>
<td>27</td>
<td>24</td>
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<td>67.45%</td>
<td>0</td>
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<td>$0.00</td>
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<tr>
<td>HHW</td>
<td>Child Imm - Combo 10</td>
<td>10</td>
<td>105</td>
<td>8</td>
<td>7.62%</td>
<td>33.66%</td>
<td>34</td>
<td>$3,961.22</td>
<td>$116.51</td>
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# Member Gap List Example

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
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<tbody>
<tr>
<td>TaxID</td>
<td>ProvID</td>
<td>Group Name</td>
<td>PMP Name</td>
<td>Member Name</td>
<td>Member ID</td>
<td>BIRTH Date</td>
<td>Service Nm</td>
<td>Member A Number</td>
<td>Member C Number</td>
<td>Member ST</td>
<td>Member Z</td>
<td>Member T L OB</td>
<td></td>
<td></td>
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<td>10845560</td>
<td>P1000018</td>
<td>General H. John Doe</td>
<td>KENDALL</td>
<td>105363999999</td>
<td>4/15/2003</td>
<td>Adolescer</td>
<td>872 S 100TH ST</td>
<td>NOBLESVIN</td>
<td>46360</td>
<td>(317)483-1 HHW</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10845560</td>
<td>P1000018</td>
<td>General H. John Doe</td>
<td>Stick, Crou</td>
<td>105363999999</td>
<td>8/30/2010</td>
<td>Well Child</td>
<td>554 CHERRY ST</td>
<td>NOBLESVIN</td>
<td>46360</td>
<td>(317)483-1 HHW</td>
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<td></td>
</tr>
<tr>
<td>10845560</td>
<td>P1000018</td>
<td>General H. John Doe</td>
<td>NOE, Jane</td>
<td>105363999999</td>
<td>5/26/1995</td>
<td>Chlamydia Screening - Total</td>
<td>BLOOMIN IN</td>
<td>46360</td>
<td>(317)483-1 HLP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Excel file
Sortable
Filterable
P4P Payout Calculations

Payout calculations based on final HEDIS admin rates and paid at group level.

Factors include:

- Panel size – must have at least 150 members.
- Required number of members qualified per measure.
- Funds from measures without enough members get rolled into other qualifying measures.
Patient Analytics
Patient Analytics

What is Patient Analytics?

- Patient Analytics is a web-based patient care platform that uses claims data to create a detailed patient-level and population-level reporting.
Patient Analytics

💖 Why Was Patient Analytics Created?

• Patient Analytics was created to enable providers to make more informed patient care decisions based on health histories, current diagnoses, and prescription regimens, which also supports population health views and outreach initiatives.
What Does Patient Analytics Do?

- Within Patient Analytics, each patient has a detailed clinical profile. Patients with the most care gaps are identified allowing providers to take a proactive approach to managed care.

Key Benefits:

- **Population Health**: Providers are able to manage member’s information using patient registries. The information can easily be accessed online and many elements can be printed.
- **Medical History** – Patient Analytics contains up to 24 months of medical, pharmacy, and lab claims.
- **Increased Visibility** – Primary Care Physicians (PCPs) will have access to claims history submitted by other providers.
- **Improved Outcomes**: Patient Analytics helps providers improve patient care, performance, outcomes and adherence to quality measures.
Click on Patient Analytics from Homepage.
Reports – Patient Analytics

Functionalities of the Patient Tab.

**Patients Tab**

1. **Tabs**: Allows the providers to choose between the Patients information and Reports.

2. **Logout Button**: For security purposes, logout to protect patient information. Not shown, in upper right hand corner.

3. **Search**: Allows providers to search by the patient’s name, Medicaid, Medicare or Marketplace ID number.

4. **Filters and Export Features**: Allows users to view all patients or filter by multiple criteria. The users will also have the ability to create a PDF document or export a detailed patient profile.

   4a. **Manage Filters**: Filter the patient list by business rules, subgroups, and physicians.

5. **Timeframe**: Provides the date when claims have been posted, followed by a link to contact for questions or concerns.
Each member has a detailed **Patient Profile**.

### Patient Profile

1. **Member Demographics**: Displays information about the member.
2. **All Care Opportunities**: The default landing page for patient details. Displays care opportunities or measures that indicate if a patient has or has not received treatment for a health condition.
3. **Diagnosis**: Shows primary and secondary diagnoses from claims data.
4. **Procedures**: Shows patient procedures associated with primary and secondary diagnoses.
5. **Medications**: Displays a list of medications prescribed to the patient.
6. **Lab/Observational**: Shows lab values, interpretations, and trends.
7. **Care Team**: Allows users to view the patient’s providers. Providers are labeled as Managing Doctor or Other Doctor.
Reports – Patient Analytics

Quality Measure Report by selected groups and filters.

Quality Measure Report:
Monitor Quality Measures Report
- Users are able to view reports by selected grouping and filtering options.
Creating **Saved Reports** for frequent use.

**Additional Reports**

**Saved Reports:**
- Shows reports saved by current user.
My Health Direct
MYHEALTHDIRECT

WHAT IS MYHEALTHDIRECT?

MyHealthDirect is a service sponsored by MHS to schedule healthcare appointments for MHS members. You specify the type and quantity of appointments to make available and a MHS team member schedules those appointments with your patients on your behalf.

HOW IT WORKS

- MHS contacts and schedules with your patient
- Both you and the patient get a confirmation email
- You enter the appointment into your EM system
- Automatic reminders sent to patient
- The patient attends their appointment
- Once a week you complete a simple attendance report in MyHealthDirect

Key Benefits of the Program:

- Free to you & your patients!
- More appointments with your hard-to-reach patients
- MHS outreaches to patients on your behalf
- Better attendance
- Improve Quality
- Confirmations and reminders
- Reduce administrative cost
- Option for English or Spanish
- Full control over your calendar & appointments
- No more 3-way calling!
1. How do I get started?
   One time:
   1. Complete the Clinic Setup Form and User Agreements
   2. Activate your user account
   3. Schedule and complete the training webinar (est. 45 minutes)
   Ongoing Responsibilities:
   1. Enter appointments promptly as you receive the confirmations
   2. Report attendance weekly
   3. Keep your calendar up to date

2. How do I keep from double booking?
   You always have full control over your calendar. You make appointments available in MyHealthDirect and then block them in your practice management system. When an appointment comes in through MyHealthDirect, you enter the information and change the blocked slot to a scheduled appointment. If you want to schedule an appointment for a blocked slot, it's easy to remove that slot from your MyHealthDirect inventory so it isn't double-booked.

3. I don't want appointments to go unused
   All appointments have a give-back rule known as a “restriction.” We recommend setting your appointment restrictions at 72 hours. If an appointment is still unbooked 72 hours out, it will automatically become unavailable in MyHealthDirect and your staff can fill it without concern for double-booking.

4. Can I get appointment confirmations other ways?
   Confirmation emails can be sent by email, fax, or both. Additionally, a connector is available for practices with a high volume of appointments. This connector allows MyHealthDirect to update your practice management system directly. Please contact your MyHealthDirect Account Executive for more information.

More Questions? Please feel free to contact your Provider Representative or MyHealthDirect at any time!

Danielle Curran  
Account Manager, MyHealthDirect  
dcurran@myhealthdirect.com | 312.418.9060

Caroline Larsen  
Account Specialist, MyHealthDirect  
clarson@myhealthdirect.com | 615.588.7110

myhealthdirect
P4P Payout Calculations

Payout calculations based on final HEDIS admin rates and paid at contract level.

Factors include:
- Panel size
- Required number of members qualified per measure
- Funds from measures without enough members get rolled into other qualifying measures
Provider Network Territories

Physical Health

**TAWANNA DANZIE**
Provider Performance Associate
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com
Exception to map: Franciscan Alliance

**CHAD PRATT**
Provider Performance Associate
1-877-647-4848 ext. 20484
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**TANEYA WAGAMAN**
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**KAT GIBSON**
Provider Performance Associate
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kgibson@mhsindiana.com

**ESTHER CERVANTES**
Provider Performance Associate
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ecervantes@mhsindiana.com

**JENNIFER GARNER**
Provider Performance Associate
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com
Exception to map: IU Health, Eskenazi Health

Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect
# MHS Provider Relations Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Contact Information</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candace Ervin</td>
<td>Envolve Dental Indiana Provider Relations</td>
<td>1-877-647-4848 ext. 20187</td>
<td><a href="mailto:Candace.Ervin@envolvehealth.com">Candace.Ervin@envolvehealth.com</a></td>
</tr>
<tr>
<td>Chad Pratt</td>
<td>Provider Relations Specialist – Northeast Region</td>
<td>1-877-647-4848 ext. 20454</td>
<td><a href="mailto:ripratt@mhsindiana.com">ripratt@mhsindiana.com</a></td>
</tr>
<tr>
<td>Tawanna Danzie</td>
<td>Provider Relations Specialist – Northwest Region</td>
<td>1-877-647-4848 ext. 20022</td>
<td><a href="mailto:tdanzie@mhsindiana.com">tdanzie@mhsindiana.com</a></td>
</tr>
<tr>
<td>Jennifer Garner</td>
<td>Provider Relations Specialist – Southeast Region</td>
<td>1-877-647-4848 ext. 20149</td>
<td><a href="mailto:jgarner@mhsindiana.com">jgarner@mhsindiana.com</a></td>
</tr>
<tr>
<td>Taneya Wagaman</td>
<td>Provider Relations Specialist – Central Region</td>
<td>1-877-647-4848 ext. 20202</td>
<td><a href="mailto:twagaman@mhsindiana.com">twagaman@mhsindiana.com</a></td>
</tr>
<tr>
<td>Katherine Gibson</td>
<td>Provider Relations Specialist – North Central Region</td>
<td>1-877-647-4848 ext. 20959</td>
<td><a href="mailto:kagibson@mhsindiana.com">kagibson@mhsindiana.com</a></td>
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<tr>
<td>Esther Cervantes</td>
<td>Provider Relations Specialist – South West Region</td>
<td>1-877-647-4848 ext. 20947</td>
<td><a href="mailto:Estherling.A.PimentelCervantes@mhsindiana.com">Estherling.A.PimentelCervantes@mhsindiana.com</a></td>
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<tr>
<td>LaKisha Browder</td>
<td>Behavioral Health Provider Relations Specialist - East Region</td>
<td>1-877-647-4848 ext. 20224</td>
<td><a href="mailto:lakisha.j.browder@mhsindiana.com">lakisha.j.browder@mhsindiana.com</a></td>
</tr>
</tbody>
</table>
What You Learned Today

1. Review of P4P measures
2. The Documentation Requirements
3. Reporting tools that are available for providers to review.
4. Patient Analytics tool
5. Benefits of My Health Direct
6. How Payout is Calculated
Questions?
Thank you for being our partner in care.