Physician Effectiveness and Efficiency Manual

Humana.

849904ALL1025-A
(HUMP849904)

Table of Contents

I. Overview of Care Highlight Program

Patients today have many choices when it comes to healthcare. These choices can vary greatly in terms of effectiveness (also described as clinical quality) and efficiency (also described as cost-efficiency) of care. Patients need to consider a variety of factors when making decisions around care. Care Highlight® aims to provide Humana-covered patients and participating physicians with information on physician effectiveness and efficiency in 22 specialties and 4 subspecialties (See tables A and B on page 6.) for consideration when making healthcare decisions.

Humana recognizes the industry's focus on providing high-quality and cost-efficient care. The Care Highlight methodology for evaluating effectiveness and efficiency of care is consistent with national standards and incorporates physician feedback.

Humana displays effectiveness and/or efficiency ratings for Humana-contracted physicians on its Find Care tool if the physicians meet specific criteria. Some participating physicians may not have a rating on the tool.

The primary intent of these ratings is transparency. The ratings should be used only as a guide when choosing care. Patients are encouraged to consider all relevant information and to consult with their treating physicians when selecting a specialist.

Additional relevant information could include the following:

- Decisions about treatment
- Deductibles and copayments
- Differences in costs between facilities and physicians
- Patient's condition and access to services

Provide feedback

We appreciate your input about our programs and want to hear your ideas for improvement. To give us feedback, please visit **Humana.com/CareHighlight** and select the **Physician Survey** link. Feedback received from this survey, along with feedback received from a consumer and employer group survey, is used for ongoing program improvement. At least annually, survey responses are aggregated and considered, along with data from physician reconsideration requests, physician and customer complaints, and internal analytics to improve the program. We use this data to evaluate our measures and methodology and improve our program.

In2026, Care Highlight is available in these states/geographies (availability may differ by line of business):

AL	AR	AZ	CA	CO
CT	DC	DE	FL	GA
HI	IA	ID	IL	IN
KS	KY	LA	MA	MD
ME	MI	MN	MO	MS
MT	NC	ND	NE	NH
NJ	NM	NV	NY	OH
OK	OR	PA	RI	SC
SD	TN	TX	UT	VA
VT	WA	WI	WV	WY

Note: Display of ratings for Medicaid plans is available in select states/geographies. Display of ratings for commercial plans is not available.

II. Measurement Framework

Humana uses administrative data (including Medicare Advantage, Medicaid and commercial claim data incurred over a 3-year period for efficiency and 2 measurement years for effectiveness) to assess physician performance. Data is validated continually to enhance accuracy.

Humana also considers non-claim-based information when assessing effectiveness and efficiency (See "Rating" section on page 5.).

Measurement level

Humana creates effectiveness and efficiency ratings at the group and individual physician levels. (Detailed explanations for both levels are included in the following sections.) Because our evaluation is based on Tax Identification Numbers (TINs), individual physicians may have multiple ratings if they practice under more than one TIN.

Geographic areas

Geographic areas are based on the United States government core-based statistical areas or Dartmouth Atlas' hospital referral regions. Care Highlight ratings apply only where requirements are met (when there is sufficient data volume, statistical credibility, minimum peer volume, etc.).

Peer groups

Peer groups are defined as physicians in the surrounding geographic area who, based on patients treated, practice the same specialty type or subspecialty type. Peer-group geographic areas are based on hospital referral regions, except for oncology effectiveness, which is based on hospital referral region states. In special scenarios, custom geographies have been defined based on market and clinical input. Physician groups with substantial patient volume in more than 1 geographic area may be evaluated in each geographic area. Evaluation is based on medical activities tied to all physicians in each geography, with volume and statistical credibility checks, outlined below, applied in each geography.

Frequency of evaluation

Effectiveness and efficiency ratings are updated annually. Ratings on the Find Care tool are updated annually upon completion of the physician review period.

Minimum volume requirements

Effectiveness

Effectiveness is measured for all physicians who have a minimum of 30 eligible cases and at least 11 different patients included as part of their evaluation. This approach ensures a sufficient volume of cases is reviewed for each physician who receives an effectiveness rating.

Efficiency

Efficiency is measured for all physicians with a minimum of 20 episodes of care and at least 11 different patients included as part of their evaluation. An episode of care is a longitudinal linkage of claims at the patient condition level, as determined by using Optum® Symmetry® Episode Treatment Groups® algorithms and methodologies. Episodes are formed using professional, surgical, inpatient, ancillary and pharmaceutical claim data.

Physician attribution

Eligible cases and episodes of care are assigned to physicians who significantly contribute to a patient's treatment based on these attribution rules:

- For effectiveness, physicians are assigned eligible cases according to a hierarchy, starting with greatest number of visits, most recent visit, greatest paid amount and greatest charged amount.
- For efficiency, physicians are assigned episodes when they contribute to at least 30% of the patient's professional and medical/surgical costs.

Nurse practitioners (NPs) and physician assistants (PAs) may be attributed cases and/or episodes following the approach outlined above, and their clinical activity may be included within a group's ratings.

NP and PA activity may be included in a group's evaluation for the specialties in which they primarily practice.

Ratings will not be created solely based on NP and/or PA activity.

Case-mix adjustment

Because of variations in patient age, line of business, severity and the geography of patient populations among physicians, case-mix adjustments are applied to enable accurate peer comparisons. For effectiveness, comparison to peers occurs at the measure level and considers geography, specialty, line of business and members' health equity index status[†]. For efficiency, peer comparisons are condition-specific and take into consideration geography, specialty, line of business, severity, condition treatment indicator and age-appropriateness.

[†] Health Equity Index

Beginning in 2026, Humana will introduce a health equity index adjustment to provider quality ratings as part of ongoing efforts to advance health equity. While the overall method for calculating ratings will remain unchanged, an adjustment will be made to account for patient social risk factors that are beyond the control of healthcare providers. Ratings will continue to utilize a claims-based approach, comparing providers to their peers. Integrating health equity considerations will enable fairer comparisons among providers. This adjustment supports the prioritization of health equity as a cornerstone of improving member health outcomes and empowers providers to deliver the highest quality care.

Statistical credibility

A 90% confidence interval around the performance index is calculated for each scored physician or physician group. Ratings (1 to 4 hearts/badges) are assigned to physicians based on their scored position within the peer group. One heart/badge is assigned if the physician's associated score differs statistically from his or her peers' scores and is in the bottom quartile. Four hearts/badges are assigned if the physician's associated score differs statistically from his or her peers' scores and is in the top quartile. Humana then assigns a rating to each physician who meets the evaluation criteria.

Rating

Effectiveness*, ‡

- ♥♥♥♥ Top quartile and statistically significantly higher than peers
- ♥♥♥♡ Top half, excluding highest-rated physicians or performance index greater than 1.03
- ♥♥♡♡ Bottom half, excluding lowest-rated physicians or performance index less than 0.97
- ♥♡♡♡ Bottom quartile and statistically significantly lower than peers

Efficiency*

- Top quartile and statistically significantly higher than peers
- Top half, excluding highest-rated physicians or performance index lower than 0.95

-  Bottom half, excluding lowest-rated physicians or performance index greater than 1.05
-  Bottom quartile and statistically significantly lower than peers

***Value-based care arrangements**

Internal Medicine and Family/General Practice groups in Humana value-based care arrangements that include downside risk (partial, full or global risk) will receive a 1-level upward adjustment to their effectiveness and/or efficiency rating(s) if they are in the top 2 deciles of their original rating level(s) based on performance index score(s). If received, this adjustment would be reflected in the overall effectiveness and/or efficiency rating(s) (hearts and/or badges) but would not impact the claims-based performance index score(s). Value-based care status with Humana is determined by TIN at the time of the annual rating evaluation. Lack of participation in a downside risk arrangement will not result in a lowering of a rating.

‡ Patient Experience adjustments

Internal Medicine and Family/General Practice groups will receive a 1-level upward adjustment to their effectiveness rating(s) if they are in the top 2 deciles of their patient experience survey response(s) based on Humana Patient Experience Surveys, which were closely modeled after Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) instruments from STARS program. If received, this adjustment would be reflected in the overall effectiveness rating(s) (hearts) but would not impact the claims-based performance index score(s). Lack of patient experience surveys will not result in a lowering of a rating.

Evaluated specialties

Specialties and subspecialties evaluated for effectiveness and efficiency appear in tables A and B below.

Table A: Evaluated specialties

Allergy & Immunology	Obstetrics and Gynecology
Cardiology	Oncology
Colon and Rectal Surgery	Orthopedic Surgery
Endocrinology	Pediatrics
Family/General Practice	Plastic Surgery
Gastroenterology	Psychiatry
General Surgery	Pulmonary Medicine
Internal Medicine	Rheumatology
Nephrology	Thoracic Surgery
Neurology	Urology
Neurosurgery	Vascular Surgery

Table B: Evaluated subspecialties

Specialty	Subspecialty
Cardiology	Electrophysiology
	Interventional Cardiology
Orthopedic Surgery	Hand
	Spine

Note: For effectiveness, physicians with a subspecialty of electrophysiology or interventional cardiology are evaluated within the Cardiology specialty, and physicians with a subspecialty of hand or spine surgery are evaluated within Orthopedic Surgery.

III. Effectiveness of Care

Effectiveness measurement tools

Humana relies on Optum Symmetry EBM Connect software and internal clinical measures to determine a physician group's effectiveness of care.

Optum Symmetry EBM Connect software contains a robust set of evidence-based care guidelines sourced from the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Healthcare Effectiveness Data and Information Set (HEDIS®), the Pharmacy Quality Alliance (PQA) and Optum proprietary measures.

The software uses administrative data sets that include information from Humana's member enrollment and medical, pharmacy, lab and vision claims. This information is used to generate output files that support physician reporting and transparency to our stakeholders, including plan sponsors, Humana-covered patients and physicians.

EBM Connect software is used by dozens of organizations around the country, including large and small health plans (government and commercial), healthcare decision-support vendors, disease and care management organizations, physician management groups and research organizations.

Humana internal clinical measures

In addition to EBM Connect software, Humana relies on internally developed clinical measures using administrative claim data. Clinical quality metrics alignment is a key component when selecting quality measures for physician performance at Humana. All internal clinical measures are based on evidence supported by credible organizations and internal review. Examples of these organizations include the NCQA, PQA, American Medical Association's Physician Consortium for Performance Improvement, professional medical societies, government agencies and other national experts. Humana strives to use measures that are endorsed by the National Quality Forum (NQF) and supported by credible stewards. In the absence of NQF endorsement and stewardship, measures are tested for validity and reliability in a manner consistent with the NQF process.

Our oncology assessment includes another type of Humana internal clinical measure, one that uses cancer treatment protocol compliance scores based on clinical authorization data provided by external vendors.

Methodology used for effectiveness-of-care compliance rates

Humana evaluates the effectiveness of care compliance rates for all physicians who treat Humana patients and practice at least one of the specialty types in tables A and B on page 6. Physicians are evaluated annually using a 24-month measurement period. Evaluations are based on claim and administrative data from Humana. Data includes medical, pharmacy, lab and vision claims incurred during the period.

Humana rates physicians for effectiveness only when it has a sufficient volume of eligible cases for the physician/group and data from at least 5 peers per specialty.

Effectiveness is measured for all evaluated physician groups at the group level when an adequate data sample is available. This is done by comparing each physician group's compliance rate to the overall peer group rate for each applicable specialty. When a physician actively practices with multiple medical groups, the physician's claims are evaluated separately by a legal entity to allow a comprehensive analysis.

The overall expected compliance rate is a composite value calculated for each physician. It is the sum of the expected compliance rate for each measure and is derived by multiplying the peer compliance rate by the weight of the measure based on the physician's volume for each given measure.

The expected compliance rate is used to calculate the physician's effectiveness performance index.

The effectiveness performance index of each physician is relevant to the measures assigned to the physician and calculated by dividing the actual compliance rate by the expected compliance rate.

For example, an effectiveness performance index of 1.15 indicates a physician's compliance to the effectiveness measures is 15% higher than peer compliance for comparable eligible cases. Likewise, an effectiveness performance index of 0.95 indicates a physician's compliance to the effectiveness measures is 5% lower than peer compliance for comparable eligible cases.

IV. Efficiency of Care

Efficiency measurement tools

Efficiency of care is determined using Optum Symmetry Episode Treatment Groups, a widely recognized tool that employs algorithms and methodologies that create longitudinal episodes of care at the patient level, based on professional, surgical, inpatient, ancillary and pharmaceutical claim data. This comprehensive linkage of claims enables a thorough examination of a physician group's practice patterns of treatment for a specific patient with a defined medical condition, such as asthma or hypertension. Cost-efficiency of individual physicians and physician groups is evaluated using an episode-of-care based methodology.

Methodology used for efficiency

To evaluate physician groups for efficiency, Humana compares costs for claim-based episodes of care to the expected cost for episodes of care based on the experience of the peer group and risk adjusted for the patient's condition severity and the physician case mix for each specialty.

When a physician practices with multiple medical groups, the physician's claims are evaluated separately by a legal entity to enable a comprehensive analysis.

Completed patient episodes are assigned to physicians who significantly contribute to the patient's treatment. This may include physician-submitted claims for office visits, laboratory/pathology services, diagnostic tests, and medical and surgical procedures. All prevalent and clinically relevant conditions, which are reviewed by clinicians for each applicable specialty, are included in the evaluation process. Humana rates physicians for efficiency only when it has a sufficient volume of eligible cases for the group (See "Minimum Volume Requirements" under Measurement Framework on page 4.).

V. Uses of Results

Uses of effectiveness and efficiency results

- **Find Care tool** – Physician ratings are shared on Humana's Find Care tool.
- **Referral Analytics** – Effectiveness and efficiency information may be shared with primary care physicians (PCPs) and specialists about other providers who have treated (or may treat) their Humana-covered patients.
- **Network assessment** – Continued participation in Humana networks is evaluated for physicians who do not meet effectiveness and/or efficiency standards.
- **Member enrollment** – Ratings may be shared with and used by agents (both internal and external) and vendors as well as part of internal Humana processes to help current and prospective members find the right physician for their needs.

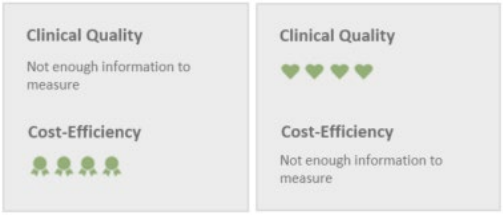
Humana Find Care tool

Users of Humana's Find Care tool have access to physician effectiveness and efficiency ratings. Individual physicians' ratings are derived from – and are the same as – their group's ratings.

Ratings appear in Find Care as symbols – hearts for effectiveness and badges for efficiency – and search results are ordered by highest to lowest ratings within the selected search area. The highest possible ratings are 4 hearts for effectiveness and 4 badges for efficiency.

Subspecialty ratings for efficiency are displayed at subspecialty level on Find Care when directory requirements, including, but not limited to, credentialing are met. Otherwise, those ratings are displayed at the higher level of specialization. For effectiveness, physicians with a subspecialty of electrophysiology or interventional cardiology are evaluated within the Cardiology specialty, and physicians with a subspecialty of hand or spine surgery are evaluated within Orthopedic Surgery.

Humana displays ratings only for specialties that have applicable effectiveness measures. If a group satisfies the criteria outlined in the Measurement Framework on page 4 needed for effectiveness but not for efficiency, Humana displays the effectiveness rating along with a note for efficiency indicating there is "Not enough information to measure." Similarly, if a group satisfies the criteria outlined in the Measurement Framework on page 4 needed for efficiency but not for effectiveness, Humana displays the efficiency rating along with a note for effectiveness indicating there is "Not enough information to measure."



Referral Analytics

Referral Analytics is a capability that uses evidence-based and cost analytics to help support improvement in care for Humana-covered patients. Humana may share effectiveness and efficiency information with PCPs and specialists about providers who have treated (or may treat) their Humana-covered patients.

.

This information is available at the physician group and individual physician level. Referral Analytics includes detailed effectiveness and efficiency information for the non-PCP Care Highlight specialties in tables A and B on page 6. Humana is collaborating with several scheduling and Electronic Medical Record (EMR) solutions to include physician ratings. In the event physicians choose one of these scheduling/EMR applications/solutions, physician ratings may be included in the display. Physicians may receive one of the following ratings:

Effectiveness*, ‡

-  Top quartile and statistically significantly higher than peers
-  Top half, excluding highest-rated physicians or performance index greater than 1.03
-  Bottom half, excluding lowest-rated physicians or performance index less than 0.97
-  Bottom quartile and statistically significantly lower than peers

Efficiency*

-  Top quartile and statistically significantly higher than peers
-  Top half, excluding highest-rated physicians or performance index lower than 0.95
-  Bottom half, excluding lowest-rated physicians or performance index greater than 1.05
-  Bottom quartile and statistically significantly lower than peers

*, ‡ See the footnote in the "Rating" section above

Network assessment

Physician effectiveness and efficiency ratings are among the factors considered when determining physician participation in Humana networks**.** Humana also considers participation in the American Board of Internal Medicine Practice Improvement Modules, as well as participation and achievement in the NCQA Physician Recognition Programs.

Member enrollment

In support of various efforts, including helping members find the right physician for their needs, ratings information may be shared with and used by agents (both internal and external) and vendors and may be used as part of related internal Humana processes. Member preferences and needs take precedence.

VI. Physician Notifications and Feedback

Care Highlight 60-day review period

At least 60 days before their effectiveness and efficiency results are posted as ratings in the Find Care tool, physicians are notified in writing about how to access their results and ratings, how to obtain a full explanation of the results and, should they wish to do so, how to request clarification/reconsideration of their ratings.

The clarification/reconsideration request process is as follows:

- Humana sends its 60-calendar day notice informing physicians they can access their rating information on www.availity.com. Humana mails this notice during the first week of January. Physicians can access results at www.availity.com.
- Upon signing in to Availity, physicians have access to their clinical quality and cost-efficiency reports, information about how to request a full explanation of their ratings, instructions for requesting a clarification/reconsideration and a Clarification/Reconsideration Request form (electronic and downloadable).
- Upon request from the provider group, new clinics/physicians not meeting the criteria to receive their own rating(s) but operating under an established TIN with ratings or wholly owned by a rated entity may have ratings extended from the provider group's established clinics/physicians for up to 24 months (subject to additional requirements). To request an extension, providers should submit a clarification request via Availity, providing the applicable TIN, name, address, and specialty. Humana will follow up with the provider group to obtain additional information as necessary. New clinics/physicians operating under an established TIN with ratings will automatically have those ratings extended if the new clinic/physician is in the same geography and has the same specialty as the established TIN with ratings.
- Physicians wishing to request reconsideration of their ratings must submit a reconsideration request to Humana within 30 calendar days of the date of initial notification so that Humana can conduct a full review prior to posting the ratings. (Physicians can continue submitting requests outside that window, but the request may not be adjudicated prior to the public display of ratings.) With the form, physicians can submit any information or documentation they would like to support their request.
- A panel of representatives (including Humana medical directors, members of our analytics staff and representatives from network management) review all reconsideration requests and supporting documents submitted by the physician. Where applicable and in accordance with state-specific laws and regulations, the panel will be comprised of external clinicians. Additional information can be found in the Panel Notice letter that is mailed to physicians who request a reconsideration.
- After reviewing all information submitted by the physician, the review panel makes a final decision to uphold or rescind the rating. The requesting physician is notified

of the decision within 30 days of Humana's receipt of the reconsideration request.

- If the decision is to rescind, under the following circumstances, Humana will reevaluate a requesting physician's ratings:
    - Chart/EMR documentation submitted by the physician group for review by the panel reflects actual higher adherence to the clinical quality measures across the evaluated patient population (affecting effectiveness ratings); or
    - Documentation submitted by the physician group for review by the panel indicates unique factors to be considered in attributing a patient to the physician group (affecting efficiency and/or effectiveness ratings); or
    - Other circumstances at the discretion of Humana's internal review panel.
- The requesting physician is notified of the outcome of the re-evaluation within 14 calendar days of the date of the panel. Updated results will be made available to the physician group in Availity and will be reflected on Find Care where applicable.

Group-level ratings are displayed on Find Care for groups and individual physicians.

Additional information and considerations for reconsideration

There may be situations where additional information could be relevant to a physician's reconsideration evaluation. For example:

- Unique service – The physician performs a unique, essential service.
- Unique treatment setting – The physician provides care in a unique setting.
- Specialty considerations – The physician has been evaluated under the incorrect specialty.

Important notes about Care Highlight

Care Highlight is intended for informational purposes only. The information it offers should be one of many factors patients consider when selecting a PCP or specialist; for example, patients may consult with their physician(s) when selecting specialists or changing PCPs. Physician ratings have a risk of error, which is another reason why patients should consider other factors when selecting a physician. Please visit **Humana.com/CareHighlight** for more information about our program and methodologies.

Care Highlight is not intended to endorse certain physicians or healthcare professionals. Humana does not provide healthcare services and does not practice medicine. Physicians are solely responsible for medical treatments provided. Ratings do not guarantee the quality of healthcare services provided or the outcome of healthcare services. Patient out-of-pocket costs are determined by the specific services they receive and their plan coverage details.

Ratings that state "not enough information to measure" do not indicate the rated physician does not provide quality services. All physicians rated have met certain minimum requirements. Patients have access to all physicians in the Humana network regardless of whether a physician has received a Care Highlight rating.

Complaints

Physicians can register complaints about Care Highlight by calling **800-626-2741**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time, or by emailing **PPM@humana.com.**

Interested in more information?

This document is meant to provide a general overview of Care Highlight. If you would like additional information or clarification on any issue discussed herein, please email Humana at **PPM@humana.com.**

MEASURE TITLE	MEASURE DESCRIPTION	SPECIALTIES
Asthma Presumed Uncontrolled or Partly Controlled: Use of Inhaled Corticosteroid or Acceptable Alternative – Pediatrics	Pediatric patient(s) with presumed uncontrolled or partly controlled asthma using an inhaled corticosteroid or acceptable alternative.	Allergy & Immunology
Asthma Presumed Uncontrolled or Partly Controlled: Use of Inhaled Corticosteroid or Acceptable Alternative	Adult(s) with presumed uncontrolled or partly controlled asthma using an inhaled corticosteroid or acceptable alternative (leukotriene modifiers).	Allergy & Immunology
Asthma – Hospitalization in Last 12 Months	Patient(s) that did not have an asthma-related hospitalization in last 12 reported months.	Allergy & Immunology, Pulmonary Medicine
Asthma – Emergency Department in Last 12 Months	Patient(s) that did not have an asthma related emergency department encounter or observation stay in last 12 reported months.	Allergy & Immunology, Pulmonary Medicine
Rheumatoid Arthritis – CBC Test	Patient(s) taking methotrexate, sulfasalazine, or leflunomide that had a CBC in last 3 reported months.	Rheumatology
Rheumatoid Arthritis – Serum ALT or AST Test	Patient(s) taking methotrexate, sulfasalazine, or leflunomide that had serum ALT or AST test in last 3 reported months.	Rheumatology
Rheumatoid Arthritis Patients Taking Hydroxychloroquine – Eye Exam in Last 12 Months	Patient(s) with rheumatoid arthritis taking hydroxychloroquine who had an eye exam in the last 12 reported months.	Rheumatology
Hypertension – Annual Monitoring for Serum Potassium	Patient(s) taking an ACE-inhibitor, angiotensin receptor blocker (ARB), diuretic, aliskiren, or aldosterone receptor antagonist-containing medication that had a serum potassium in last 12 reported months.	Cardiology, Family/General Practice, Internal Medicine
Hypertension – Annual Monitoring for Serum Creatinine	Patient(s) with hypertension that had a renal function evaluation in last 12 reported months.	Cardiology, Family/General Practice, Internal Medicine
Chronic Obstructive Pulmonary Disease – Medication Compliance	Patient(s) compliant with prescribed long-acting antimuscarinic agent (minimum compliance 80%).	Pulmonary Medicine
Chronic Obstructive Pulmonary Disease – Emergency Department	Patient(s) that did not have a COPD-related emergency department encounter or observation stay in last 12 reported months.	Pulmonary Medicine
Chronic Obstructive Pulmonary Disease – Hospitalization	Patient(s) that did not have a COPD related hospitalization in last 12 reported months.	Pulmonary Medicine
Hepatitis C	Patient(s) with cirrhosis that had a liver imaging test in last 6 reported months.	Gastroenterology

Depression – SSRI Compliance	Patient(s) compliant with prescribed selective serotonin reuptake inhibitor (minimum compliance 80%).	Psychiatry
Depression – Annual Visit	Patient(s) 18 years of age or older taking a medication for depression treatment that had an annual provider visit.	Psychiatry
Neuroimaging for Patients with Primary Headache (Overuse)	Adult(s) with a computerized axial tomography (CT) or magnetic resonance imaging (MRI) study of the head that was not medically indicated.	Neurology
Chronic Kidney Disease - Anemia	Patient(s) with stage 3 or more advanced CKD that had a hemoglobin or hematocrit in last 12 reported months.	Nephrology
Chronic Kidney Disease – ACE-inhibitor or ARB	Patient(s) with proteinuria currently taking an ACE-inhibitor or angiotensin II receptor antagonist.	Nephrology
Inflammatory Bowel Disease – CBC in last 3 reported months	Patient(s) taking methotrexate, sulfasalazine, mercaptopurine, azathioprine, or janus kinase inhibitors for IBD that had a CBC in last 3 reported months.	Gastroenterology
Inflammatory Bowel Disease – Ulcerative Colitis or Crohn's Colitis: Colonoscopy Interval	Patient(s) 18 years of age and older with ulcerative colitis or Crohn's colitis who had a colonoscopy in last 5 years.	Gastroenterology
Use of High-Risk Medications in Older Adults (DAE) – Adjusted	Patients 67 years and older who received two or more of the same high-risk medications from the same drug class or two or more of the same high-risk medications except for appropriate diagnosis in the last 12 reported months.	Family/General Practice, Internal Medicine
Asthma Medication Ratio (AMR)	Patient(s) with an asthma medication ratio >= 0.50 during the report period.	Allergy & Immunology, Pulmonary Medicine
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Patient(s) with schizophrenia or schizoaffective disorder and diabetes who had a HbA1c and LDL-C test during the report period.	Psychiatry
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	Patient(s) with cardiovascular disease and schizophrenia or schizoaffective disorder who had a LDL-C test during the report period.	Psychiatry
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Patient(s) with schizophrenia or schizoaffective disorder who were dispensed and remained on antipsychotic medication for at least 80% of their treatment period.	Psychiatry

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Patient(s) 1 - 17 years who had two or more antipsychotic medications and had blood glucose and cholesterol testing during the report period.	Psychiatry
Antipsychotic Use in Persons with Dementia (APD)	Percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	Neurology, Psychiatry
Statin Therapy for Patients with Cardiovascular Disease (SPC) – Treatment	Patient(s) with cardiovascular disease who received a high or moderate-intensity statin medication.	Cardiology
Statin Therapy for Patients with Cardiovascular Disease (SPC) – Adherence	Patient(s) with cardiovascular disease taking statin medications who adhered to the prescribed statin medication regimen (proportion of days covered) at least 80 percent during the treatment period.	Cardiology
Statin Therapy for Patients with Diabetes (SPD) – Adherence	Patient(s) with diabetes taking statin medications who adhered to the prescribed statin medication regimen (proportion of days covered) at least 80 percent during the treatment period.	Endocrinology
Statin Therapy for Patients with Diabetes (SPD) – Treatment	Patient(s) 40-75 years of age with diabetes who received a statin medication.	Endocrinology
Kidney Health Evaluation for Patients with Diabetes (KED)	Patient(s) 18-85 years of age with diabetes (Type 1 & Type 2) who received an annual kidney health evaluation, including a blood test for kidney function (eGFR) and a urine test for kidney damage (uACR) in last 12 reported months.	Endocrinology, Nephrology, Family/General Practice, Internal Medicine
Glycemic Status Assessment for Patients With Diabetes (GSD)	Patient(s) 18 - 75 years of age with diabetes whose most recent glycemic status is greater than 9.0%.	Endocrinology
Eye Exam for Patients With Diabetes (EED)	Patient(s) 18 - 75 years of age with diabetes that had an annual retinal eye exam.	Endocrinology, Family/General Practice, Internal Medicine
Follow-Up After Hospitalization for Mental Illness (FUH)	Patient(s) hospitalized for mental illness or intentional self-harm that had a follow-up encounter with a mental health practitioner within 30 days after discharge.	Psychiatry

Use of Imaging Studies for Low Back Pain (LBP)	Percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Neurosurgery, Orthopedic Surgery
Appropriate Testing for Pharyngitis (CWP)	Percentage of members 3 years of age and older with a diagnosis of pharyngitis, dispensed an antibiotic and received a group A streptococcus test for the episode.	Pediatrics
Pregnancy management	Percentage of pregnant patients that had HBsAg testing	Obstetrics & Gynecology
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Patient(s) with a diagnosis of acute bronchitis/bronchiolitis that did not have a prescription for an antibiotic on or within three days after the initiating visit	Family/General Practice, Internal Medicine
Antidepressant Medication Management (AMM) – Effective Acute Phase Treatment	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 weeks (effective acute phase treatment).	Family/General Practice, Internal Medicine, Obstetrics & Gynecology, Psychiatry
Antidepressant Medication Management (AMM) – Effective Continuation Phase Treatment	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 6 months (effective continuation phase treatment).	Family/General Practice, Internal Medicine, Obstetrics & Gynecology, Psychiatry
Osteoporosis Management in Women Who Had a Fracture (OMW)	Percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	Family/General Practice, Internal Medicine, Orthopedic Surgery
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Patient(s) 18 - 64 years with any substance use disorder event who initiated treatment within 14 days of the diagnosis.	Family/General Practice, Internal Medicine, Psychiatry
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid	Patient(s) 40 years of age and older with COPD exacerbation who received a systemic corticosteroid within 14 days of the hospital or ED discharge.	Family/General Practice, Internal Medicine, Pulmonary Medicine
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator	Patient(s) 40 years of age and older with COPD exacerbation who received a bronchodilator within 30 days of the hospital or ED discharge.	Family/General Practice, Internal Medicine, Pulmonary Medicine

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge.	Cardiology
Imaging for Transient Ischemic Attack or Ischemic Stroke (Timeliness)	Patient(s) with a recent acute cerebral ischemic event who had a head computerized axial tomography (CT) scan or magnetic resonance imaging (MRI) test soon after the acute event. (Episode start date through 7 days)	Neurology
Recent Hospitalization for an Acute Cerebral Ischemic Event – Physician Visit within 30 days of Hospital Discharge	Patient(s) with a recent hospitalization or observation stay for an acute cerebral ischemic event who had any provider visit within 30 days of hospital discharge.	Neurology
Plan All-Cause Readmissions (PCR)	Unplanned hospital readmission within 30 days of principal procedure.	Colon & Rectal Surgery, General Surgery, Neurosurgery, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery, Vascular Surgery
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Patient(s) with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a prescribing provider during the 30 days after the initial ADHD prescription.	Pediatrics, Psychiatry
Diabetes Medications-Part D Medication Adherence (National Standard)	Patient(s) compliant with all prescribed diabetes medications (minimum compliance 80 percent or higher).	Endocrinology, Family/General Practice, Internal Medicine
Renin Angiotensin System (RAS) Antagonists-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed RAS antagonist medication (minimum compliance 80% or higher).	Family/General Practice, Internal Medicine
Statins-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed statin medication (minimum compliance 80% or higher).	Family/General Practice, Internal Medicine
Prenatal and Postpartum Care (PPC) – Prenatal	Women that received a prenatal visit in the appropriate time period (excluding bundled prenatal services)	Obstetrics & Gynecology
Prenatal and Postpartum Care (PPC) – Postpartum	Women that received postpartum care (excluding bundled postpartum services).	Obstetrics & Gynecology

Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Patient(s) six years of age or older with an ED visit for mental illness or intentional self-harm that had a follow-up visit within 30 days.	Psychiatry
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Patient(s) 13 years and older with an ED visit for substance use that had a follow-up visit or pharmacotherapy dispensing event within 30 days.	Psychiatry
Follow-Up After Emergency Department Visit for Patients with Multiple Chronic Conditions (FMC)	Patient(s) 18 years and older with an ED visit and multiple high-risk chronic conditions that had a follow-up visit within 7 days.	Family/General Practice, Internal Medicine
Transitions of Care (TRC)	Patient(s) 18 years of age and older that had patient engagement within 30 days after discharge.	Family/General Practice, Internal Medicine
Controlling Blood Pressure (CBP)	Patient(s) 18 - 85 years with hypertension with most recent documented blood pressure less than 140/90 mm Hg.	Cardiology, Family/General Practice, Internal Medicine, Obstetrics & Gynecology
Blood Pressure Control for Patients With Diabetes (BPD)	Patient(s) with diabetes who had a blood pressure less than 140/90 mm Hg documented in the last 12 months.	Endocrinology, Nephrology
Chlamydia Screening in Women (CHL)	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	Family/General Practice, Internal Medicine, Obstetrics & Gynecology
Cervical Cancer Screening (CCS)	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: *Women 21–64 years of age who had cervical cytology performed every 3 years. *Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Family/General Practice, Internal Medicine, Obstetrics & Gynecology
Breast Cancer Screening (BCS)	Patient(s) 50 - 74 years of age who had a screening mammogram in last 27 reported months.	Family/General Practice, Internal Medicine, Obstetrics & Gynecology
Childhood Immunization Status (CIS)	Patient(s) 2 years old at the end of the report period who had 1) 4 diphtheria, tetanus and acellular pertussis (DTaP); 2) 3 polio (IPV); 3) 1 measles, mumps and rubella (MMR); 4) 3 haemophilus influenza type B (Hib); 5) 3 hepatitis B (HepB); 6) 1 chickenpox (VZV); 7) 4 pneumococcal conjugate (PCV); 8) 1 hepatitis A (HepA); 9) 2 or 3 rotavirus (RV); 10) and 2	Pediatrics

	influenza (flu) vaccines by their 2nd birthday	
Colorectal Cancer Screening (COL)	Patient(s) 46 - 75 years of age who had appropriate screening for colorectal cancer.	Family/General Practice, Internal Medicine, Gastroenterology
Lead Screening in Children (LSC)	Patient(s) 2 years old at the end of the report period that had at least one capillary or venous blood test on or before their 2nd birthday.	Pediatrics
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI	Patient(s) 3 - 17 years of age that had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile documentation during the report period.	Pediatrics
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Nutrition	Patient(s) 3 - 17 years of age that had an outpatient visit with a PCP or OB/GYN and had nutrition counseling during the report period.	Pediatrics
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Physical Activity	Patient(s) 3 - 17 years of age that had an outpatient visit with a PCP or OB/GYN and had physical activity counseling during the report period.	Pediatrics
Immunizations for Adolescents (IMA)	Patient(s) 13 years old at the end of the report period that had three HPV vaccinations at least 14 days apart, or two HPV vaccinations at least 146 days apart between their 9th and 13th birthdays.	Pediatrics
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Patient(s) 20 years of age and older who had a preventive or ambulatory care visit during the last 12 months of the report period.	Family/General Practice
Non-Recommended PSA-Based Screening in Older Men (PSA)	Percentage of men 70 years of age or older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening.	Urology
Developmental Screening in the First Three Years of Life	Children 1- 3 years of age at the end of the report period who were screened for risk of developmental, behavioral, and social delays using a standardized tool.	Pediatrics

Well-Child Visits in the First 30 Months of Life – 15 months (W30)	Patient(s) that had six or more well-child visits with a PCP during the first 15 months of life.	Family/General Practice, Pediatrics
Well-Child Visits in the First 30 Months of Life – 30 months (W30)	Patient(s) age 30 months that had two well-child visits with a PCP between ages 15 months and 30 months.	Family/General Practice, Pediatrics
Child and Adolescent Well-Care Visits (WCV)	Patient(s) 3 - 21 years that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner in the last 12 reported months.	Family/General Practice, Pediatrics
Hospital Admission After Hospital Outpatient Surgery	Patient(s) who had outpatient same-day surgeries performed in the hospital outpatient setting who did not have 1) an inpatient admission directly after surgery [typically unexpected for the surgeries/ procedures included in the measure]; or 2) an unplanned hospital visit [emergency department visit, observation stay, or unplanned inpatient admission] occurring after discharge and within 7 days of the surgical procedure.	Colon & Rectal Surgery, General Surgery, Neurosurgery, Plastic Surgery, Vascular Surgery, Orthopedic Surgery
Complications within 90 Days of Principal Procedure	Patient(s) 18 years of age and older who experienced complications that were not present on admission, but occurred within 90-days post index admission. Specified complications list includes acute myocardial infarction, cardiac arrest, pneumonia, sepsis/ septicemia/shock, surgical site/wound infection, surgical wound disruption, unplanned reintubation, intraoperative /postoperative bleeding, pulmonary embolism, deep venous thrombosis, progressive renal insufficiency or acute renal failure, urinary tract infection, postoperative stroke.	Colon & Rectal Surgery, General Surgery, Neurosurgery, Thoracic Surgery, Vascular Surgery
Complications within 90 days following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Patient(s) aged 18 or older who experienced complications 90-days post index admission for elective THA and/or TKA. Complications included in this measure: acute myocardial infarction, pneumonia, sepsis/septicemia/shock, surgical site bleeding, pulmonary embolism, death, mechanical complications, periprosthetic joint infection/ wound infection.	Orthopedic Surgery
Complications within 90 Days of Principal Procedure	Patient(s) 18 years of age or older who experienced complications that were not present on admission but occurred within 90 days post-index admission. Specified complications list includes acute myocardial infarction, pneumonia, sepsis/septicemia/shock, surgical site/wound infection, surgical wound disruption, intraoperative/postoperative bleeding, pulmonary embolism, deep venous thrombosis, progressive renal insufficiency or acute renal failure, urinary tract infection, postoperative stroke, and mechanical complication of breast prosthesis and implant	Plastic Surgery

Colonoscopy Interval for Patients with History of Adenomatous Polyps – Avoidance of Inappropriate Use	Patient(s) receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, which had an interval of 3 or more years since their last colonoscopy (Inappropriate use).	Gastroenterology
Heart Failure with Reduced Ejection Fraction (HFrEF): Needs ACEi/ARB/ARNi	Percentage of patients aged 18 years and older with a diagnosis of heart failure with reduced ejection fraction (HFrEF) who were prescribed and dispensed an ACEi, ARB or ARNi therapy during the last 6 months of the measurement year.	Cardiology
Heart Failure with Reduced Ejection Fraction (HFrEF): Needs Beta Blocker	Percentage of patients aged 18 years and older with a diagnosis of heart failure with reduced ejection fraction who were prescribed and dispensed an approved Beta-Blocker during the last 6 months of the measurement year.	Cardiology
Coronary Angiography (Catheterization) for Stable Coronary Artery Disease (CAD)	Patients 18 years and older with Stable Coronary Artery Disease (CAD) who received coronary angiography / catheterization (inappropriate use)	Cardiology
Percutaneous Coronary Interventions (PCI) for Stable Coronary Artery Disease	Patients with stable coronary artery disease who received percutaneous coronary intervention (inappropriate use)	Cardiology
Cardiac Stress Testing for Asymptomatic Patients	Patients 18 years and older with Stable Coronary Artery Disease (CAD) who received Cardiac Stress Testing (inappropriate use)	Cardiology
Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate	In-hospital deaths for patients 18 years of age and older who had abdominal aortic aneurysm (AAA) repair.	Vascular Surgery
Preterm Birth Rate	Percentage of total live deliveries for females between ages 8-65 who are pre-term (25 to 36 weeks of gestation)	Obstetrics & Gynecology
Overall C-section rate	Percentage of Cesarean live deliveries for females between ages 8-65.	Obstetrics & Gynecology
Nulliparous C-section Birth Rate	Percentage of Cesarean live deliveries for nulliparous females between ages 8-65.	Obstetrics & Gynecology

Cancer Treatment Protocol Compliance	Members with cancer for whom the medical oncologist's treatment plan demonstrates compliance with recognized compendia and published standards of care; and represents high quality and low toxicity care.	Oncology
Avoidable Hospitalization	Patient(s) 18 years of age or older who had an acute inpatient admission or observation stay for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection within the measurement year	Family/General Practice, Internal Medicine
Prostate Cancer Surveillance	Patient(s) with prostate cancer who had a prostate specific antigen test in last 12 reported months.	Urology