Integrated Solutions Health Network

Provider Manual

2014 - 2015

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1.0 Welcome to Integrated Solutions Health Network

1.1 History

Integrated Solutions Health Network (ISHN) was established in mid-2009 as an affiliated company of Mountain States Health Alliance (MSHA). ISHN is a provider owned regional health solutions company. Located in Johnson City, Tennessee, ISHN supports the hospitals, physicians and the communities they serve by promoting quality, efficiency and patient/member satisfaction throughout Northeast Tennessee and Southwest Virginia regions.

The ISHN network consists of approximately two thousand physicians in Northeast Tennessee, Southwest Virginia, and Western North Carolina with over two hundred and seventy five provider groups, five hundred and thirty primary care physicians, and one thousand three hundred and seventy five specialists. The ISHN network also encompasses fourteen community Hospitals, five Skilled Nursing Facilities, six Orthotic/Prosthetic providers, four Durable Medical Equipment providers, nine Home Health providers, two Hospice providers, a Laboratory provider, a Rehabilitation Facility, and four Ambulatory Surgical Centers. ISHN offers network access, along with strong aspects of medical delivery efficiency and integration.

ISHN was developed to eliminate redundancy, seek simplification and standardization, improve processes, integrate the system of care at a member/patient centric level and augment the system with an integrated community-based regional network. ISHN's goal is to create and implement a new standard of healthcare delivery and cost management to a regional population and to deliver best practice patient care and health management resulting in cost efficient care to our community. The network was created in order to coordinate and manage patient care with a "wholistic" approach.

ISHN is comprised of two main business lines:

- AnewCare Collaborative, an Accountable Care Organization (ACO) and,
- CrestPoint Health as the carrier for Mountain States Health Alliance (MSHA) team member's insurance in addition to offering two Medicare Advantage and Prescription Drug Benefit Program plans.

ISHN has partnered with selected outside entities to enable seamless service during the company start-up period. Claims Processing and Utilization Management have been delegated by contract to SummaCare, an integrated healthcare delivery system with years of experience in providing clinical care and health plan administration. Pharmacy Services and Benefit Management is delegated to MedImpact.

Integrated Solutions Health Network's vision is to transform ISHN into the premier regional Accountable Care Organization. ISHN participates in the Medicare Shared Savings Program (MSSP) with the ACO population.

Our Mission is to unlock the value of integration to advocate for

- Delivery of exceptional healthcare
- Better individual health and wellness
- Economic vitality within the communities we serve

"The first step was taken several years ago, but today the path to greatness is at our feet…it starts with us – right here, right now; it's a journey that many of us may not see to the finish, but it will be our legacy."

~ Robert Slattery, CEO, ISHN

ISHN - Our Commitment to you is to:

Strive to become the *PREMIER* Regional Community-based Accountable Care Organization…

Have integrity, transparency and sound judgment in every decision and *Relationship* we have…

Have a *Patient-Centered* approach that provides care to improve the quality and reduce the total cost of care…

Create new *Partnerships* and new *Care Delivery Models* that are integrated operationally, financially and not just contractually…

1.2 Office Reference Resources

Web-based Services
ISHN offers its providers a great deal of information that can be accessed through our website at www.ishnonline.com . On the ISHN website, the tabs along the menu bar allow access to the web-based services and programs designed for use by ISHN providers.

ISHN is dedicated to providing resources and information that promote adoption of evidence-based guidelines for quality in care and coordination to effectively meet the healthcare needs of our patients. The list of resources below includes links to national guidelines as well as tools and checklist that will help guide your practice. **This list is NOT all inclusive**. We will continue to build and update this list. Please let us know of additional resources that would be helpful.

Evidence-Based Guidelines

The Guide to Clinical Preventive Services 2014: Recommendations of the US Preventive Services Task Force in PDF format at http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/cpsguide.pdf

Adult Immunizations Schedule from the CDC at http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

Infant and Child Immunization Schedule from the CDC at http://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

The US Preventive Task Force Recommendations most recent January 2015 website: http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

National Guidelines Clearing House, a resource for evidence-based clinical practice guidelines. A searchable website at http://guideline.gov/

American College of Physicians Clinical Practice Guidelines at http://www.acponline.org/clinical_information/guidelines/

Institute for Clinical System Improvements offers a collection of evidenced based guidelines at https://www.icsi.org/guidelines__more/

National Heart Blood and Lung Institute provide these guidelines plus others:
Pediatric Cardiovascular Risk Reduction at http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm
Asthma Expert Panel Report at http://www.nhlbi.nih.gov/guidelines/asthma/index.htm

2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8) at http://www.measureuppressuredown.com/HCProf/Find/BPs/JNC8/specialCommunication.pdf

Cardiac Care

American College of Cardiology and American Heart Association guidelines, searchable website: http://my.americanheart.org/professional/StatementsGuidelines/ByTopic/TopicsA-C/ACCAHA-Joint-Guidelines_UCM_321694_Article.jsp

Diabetes Care

American Diabetes Association, a searchable resource for clinical practice recommendations: http://professional.diabetes.org/?loc=header_professional

National Diabetes Education Initiative at http://www.ndei.org/ADA-2015-Guidelines-Criteria-Diabetes-Diagnosis.aspx

Orthopedic Care

American Association of Orthopedic Surgeons searchable guidelines at
http://www.aaos.org/research/guidelines/guide.asp

Centers for Medicare and Medicaid Services (CMS) Resources

The Guide to Medicare Preventive Services from the Medicare Learning Network, Quick Reference Information:
http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf

Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (January 2012) at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

Quick Reference Information: The ABCs of Providing the Annual Wellness Visit (January 2012) at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

Quality Measures

Medicare Shared Savings

- ACO 2014 Narrative Specifications for Quality Measures at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf
- Provider Resource for MSSP - See Appendix A

Medicare Advantage Stars Program / HEDIS - See Appendix B

Meaningful Use Stage One and Two Comparison - See Appendix C

Tools

Depression Screen - See Appendix D

Fall Risk Assessment / Screening - See Appendix E

Health Risk Assessment - See Appendix F

Patient Education Resources

Men stay healthy at any age website with a downloadable PDF version
http://www.ahrq.gov/ppip/healthymen.htm

Men stay healthy over age 50 website with a downloadable PDF version
http://www.ahrq.gov/ppip/men50.htm

Women stay healthy at any age website with a downloadable PDF version
http://www.ahrq.gov/ppip/healthywom.htm

Women stay healthy over age 50 website with a downloadable PDF version.
http://www.ahrq.gov/ppip/women50.htm

Preventive Checklist for Patients- See Appendix G

ISHN Mailings Sent to Beneficiaries

ISHN mails educational materials to beneficiaries with a focus on prevention and wellness. These materials often contain checklists and tip sheets that will be available on the website for your review and use as desired.

1.3 Key Contacts

Dover, Laraine –Director of Contracts and Provider Support
Phone: 423-952-2124
Email: laraine.dover@ishnonline.com

Warrington, Dee-
Chief Compliance Officer
Phone: 423-952-2160
Email: WarringtonDJ@msha.com

Light, Sean– Credentialing and Enrollment Manager
Phone: 423-952-2162
Email: LightSM@msha.com

Hoyle, Kristina – Provider Relations Specialist
Phone: 423-952-2177
Email: Kristina.Hoyle@ISHNonline.com

Hill, Kelly- Provider Relations Specialist
Phone: 276-258-3233
Email: Kelly.Hill@ISHNonline.com

Bushell, Ian – Chief Clinical Integration Officer
President/ CEO AnewCare Collaborative
Phone: 423-952-2179
Email: LundquistTG@msha.com

Sherrill, Sylvia –
Chief Operating Officer
Phone: 423-952-2118
Email: SherrillSA@msha.com

Slattery, Rob- President and CEO of ISHN
Phone: 423-952-2115
Email: Rob.Slattery@ishnonline.com

Younkin, E. Paige – VP Clinical Integration
Phone: 423-952-2178
Email: YounkinEP@msha.com

2.0 Physician Credentialing Standards and Procedures

2.1 Credentialing Overview

Credentialing is the systematic approach and process by which the training, education and trends of a practitioner are evaluated and compared to origin specific criteria and their ability to meet the ISHN criteria.

All physicians/practitioners participating with ISHN experience a thorough review of their qualifications, including but not limited to, education and training, licensure status, board certification, hospital privileges, and malpractice history, in accordance with credentialing/re-credentialing requirements that are based on NCQA standards, and state and federal regulations. All physicians,/practitioners undergoing initial credentialing and re-credentialing are reviewed and those meeting criteria are presented to the Credentialing Committee for consideration and inclusion or continued inclusion on the network panel. The Credentialing Committee upon receipt of complaints regarding physicians and practitioners will monitor for issues which meet established thresholds. Re-credentialing is performed every three years.

2.1.1 Credentialing Scope

Physicians/practitioners requiring credentialing and re-credentialing by ISHN include:

Medical Practitioners:

- Medical doctors
- Oral surgeons
- Chiropractors
- Osteopaths
- Podiatrists
- Nurse practitioners

Behavioral healthcare practitioners:

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master lever psychologists
- Master's level social workers
- Master's level clinical nurse specialists or psychiatric nurse practitioners
- Other behavioral healthcare specialists who are licensed, certified, or registered by the state to practice independently

Allied health practitioners:

- Physical therapists
- Occupational therapists
- Practitioner Assistants
- Speech pathologists

2.1.2 Credentialing Requirements:

To become a participating ISHN provider, you must hold a current, unrestricted license by the state in which you practice. You may apply for acceptance in the ISHN Network by completing either the ISHN or the Council of Affordable Quality Health Care (CAHQ) credentialing application and must comply with ISHN credentialing criteria and submit all requested information. By signing the application, providers must attest to the accuracy of their credentials. If there are discrepancies between the application and the

information obtained during the external verification process, the ISHN Credentialing Department will investigate them. Discrepancies may be grounds for the denial of participation or the termination of an existing contractual relationship. Practitioners and providers will be notified if any information obtained during the process varies from what was submitted. The practitioner and/or provider will then be given the opportunity to correct any information.

The content of the application address practitioner demographics, (personal identification, physical location) licensure, sanctions or disciplinary actions taken on the application or licensure, education, hospital affiliations, work history, malpractice insurance limits of liability, effective and expirations dates, limits of liability, malpractice case history with detailed explanation, the ability or inability to perform within the scope of practice, history of licensure and felony activities, history of loss or limitation of privileges, disciplinary action in both licensure and/or hospital privileges, and illegal drug use.

2.1.3 The ISHN Credentialing and Recredentialing Process:
ISHN will conduct a non-discriminatory credentialing and evaluation process of its eligible practitioners and will not discriminate on the basis of race, color, creed, religion, sex, national origin, disability or age. If an applicant feels that he/she has been discriminated against, he/she has the right to file a written appeal to the CEO of ISHN. The appeal will then be investigated by the Credentials Committee.

Initial credentialing requires a completed and signed application and a primary source verification of licensure, hospital and healthcare organization privileges, Drug Enforcement Administration (DEA) registration or CDS certification, education and training, board certification, proof of professional malpractice coverage, and a review of professional liability claims history. Additional verifications include a query of the National Practitioner Data Bank (NPDB), a query for Centers for Medicare and Medicaid Services (CMS) sanctions.

Practitioners are re-credentialed every three years. Organization providers are also re-credentialed every 3 years. Recredentialing requires submission of a current application, ISHN or CAQH application with attestation, and re-verification of licensure, hospital/healthcare organization privileges, DEA or CDS registration, board certification, proof of professional malpractice coverage and a review of professional liability claims history. The recredentialing process also includes an update of physical/mental health status, a query of the NPDB, and a query of CMS sanctions. Information from quality

improvement activities and member complaints are also assessed, along with the assessments and verification which are listed above.

2.2. Rights of Providers during the Credentialing/Re-credentialing Process

2.2.1. Provider notification of status of the credentialing application
At any time during the credentialing process, an applicant has the right to contact the ISHN Credentialing/ Enrollment Department to determine the status of their credentialing or re-credentialing application.

The Credentialing Department can be reached by telephone at 423-952-2124, via fax to 423-282-1657, or by sending an email to ISHNCredentialingEnrollment@msha.com .

2.2.2 Provider rights to review and correct erroneous information

2.2.2.1 Applicants will be notified in the event that credentialing information obtained from other sources varies substantially from that provided, which may include actions/or sanctions on license, malpractice claims history and/or board certification decisions.

2.2.2.2 Applicants are also advised of their right to review information submitted (on his or her behalf) in support of their credentialing application. This does not apply to primary source certifications, peer references or NDPS as this is peer review protected.

2.2.2.3 Practitioners will be notified in writing in the event that credentialing information from verification sources varies substantially from what was provided. The practitioner will be advised to contact the entities to correct the information as well as to update the CAQH application, or complete the ISHN initial credentialing application if applicable.

2.2.3 Confidentiality of Credentialing Information
The proper handling of confidential information is a vital part of the ISHN commitment to applicants and approved practitioners. All information collected in the credentialing process is confidential in nature and protected by the peer review statues of Tennessee. Recognizing the importance of preserving the confidentiality of all provider records, paper and electronic, the ISHN credentialing office handles all information in the strictest of confidence any information in connection with fulfilling the responsibilities of the credentialing process. This confidence extends to all provider files, Credentialing Committee minutes, as well as the discussions and deliberations which take place within the confines of the Credentialing Department. The credentialing files are maintained in a locked file room within locked file cabinets. The credentialing database is password protected and authorized users are granted access to practitioner and provider information via field level security throughout the system. Access to credentialing files is

limited to those persons involved in conducting or overseeing credentialing and peer review activities.

2.2.4 Credentialing Denials and Appeals

ISHN's policy is to ensure participating providers are afforded an opportunity to appeal a recommendation by the Credentials Committee to deny, restrict or terminate a practitioner's participation. In the event that this occurs, the practitioner has the right to appeal such a decision and to request a hearing before an appeal committee which is appointed by the Credentialing Committee.

2.2.4.1. Any of the criteria below may be the basis for the Credentialing Committee to recommend to the Board of Directors that a practitioner's participation with ISHN be declined, restricted or terminated.

- Incomplete application, unable to complete verification due to lack of information
- Failure to provide proof of insurance as required by this policy
- Disqualification, suspension or other sanction with respect to license to practice
- Threatened disqualification or suspension of licensure in any state
- No longer in good standing on the medical staff of any hospital
- Professional misconduct
- Practitioner's violation of principles of professional ethics
- An excessive number of liability claims filed, resolved cases or notices of intent to file against Practitioner's malpractice insurance coverage
- Has been indicted or charged with a felony or crime of moral turpitude
- Application for participation in ISHN or any application for re-credentialing contains a deliberate misstatement or misrepresentation or omission
- Received a denial or termination of participation from a health plan

2.2.4.2 Reporting to appropriate authorities

ISHN will investigate and report adverse actions, denials and terminations to appropriate authorities for quality reasons.

- State licensing agency
- Federal State Medical Board
- National Practitioner Data Bank
- Applicable Hospital affiliations
- Medicare or Medicaid

2.2.4.3 Appeal Procedure

ISHN will provide the Chief Medical Officer of ISHN and the Appeal Committee all records, reports and materials relating to the Credential Committee decision regarding the practitioner.

- The Chief Medical Officer will review the information and respond with a decision in writing within 30 days from the date when the appeal is received.
- If the practitioner is not satisfied with the decision made by the Chief Medical Officer, the practitioner has the right to request a hearing. The practitioner must notify the Appeal Committee in writing within 30 days of the receipt of the Chief Medical Officer decision and include all documentation that the practitioner intends to use to submit for the Appeal Committee to consider.
- The practitioner may be represented by an attorney or by a person of the practitioner's choosing who participates in ISHN and practices in the same specialty.
- The Appeal Committee will review the material submitted by ISHN and by the practitioner, conduct a hearing and render a decision within 30 days following the hearing date. The practitioner will be notified of the decision, including the specific reasons, in writing.
- The Credentials Committee decision will be final upon approval by the Board of Directors and the practitioner will no longer have the right to contest such decision to decline, restrict or terminate the practitioner's participation in ISHN.

2.2.5.2. Provider Termination

ISHN notifies members affected by the termination of a practitioner or practice group in general, family and internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.

If a practitioner's contract is discontinued, ISHN will allow the affected member continued access to the practitioner as follows:

- Continuation of treatment through the current period of active treatment, or for up to 90 calendar days whichever is less, for members undergoing active treatment for a chronic or acute medical condition.
- Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

2.3 Peer Review

ISHN will maintain a peer review process to promote and monitor credentialing, quality patient care, member satisfaction, member complaints and administrative compliance with policies, procedures, rules and practices for all providers.

ISHN has established thresholds for performance measures to include but not limited to the following key areas:

- Member satisfaction
- Quality
- Member complaints and grievances

- Referrals
- Utilization
- HEDIS ®

2.4 Assessment of Organizational Providers

ISHN holds an internal network health care system, includes hospitals, urgent care facilities, skilled nursing facilities, orthopedic/prosthetic providers, durable medical equipment providers, home health providers, hospice centers, laboratory providers, a rehabilitation facility and ambulatory surgical centers. Organizational providers must meet contracting requirements and maintain credentials that include the following as appropriate:

- State licensure
- Accreditation a recognized accrediting body as applicable to the provider type
  - Joint Commission Accreditation of HealthCare Organizations (TJC)
  - Accreditation Association for Ambulatory Health Care (AAAHC)
  - Accreditation Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
  - American Osteopathic Association (AOA)
  - Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Community Health Accreditation Program (CHAP)
  - National Integrated Accreditation for HealthCare Organizations (NIAHO)
  - Accreditation Commission for Health Care (ACHC)
- Certification by Centers for Medicare and Medicaid Services (CMS)
- Current liability coverage

Initial assessment for an organizational provider is valid for 36 months, at which time the organizational provider is reassessed for continued compliance with the contracting requirements.

If an organizational provider receives any recommendations from a licensure, accreditation, or other regulatory entity, the organizational provider is required to provide the survey's findings/recommendations along with the corrective action plan to resolve the identified issue or concern.

ISHN's CVO monitors the status of the above listed accreditations, licensures, certifications etc. and upon expiration, as the organizational provider is reassessed, every 36 months.

2.5 Practitioner Office Site Quality

ISHN reserves the right to perform environmental and medical record site reviews for any provider if requested as a part of the credentialing process. This includes visits for a newly contracted provider, a new office location/relocation for an established provider, or a revisit to monitor compliance with a corrective action plan. A facility and office site

review will be completed if an office site exceeds established thresholds for a site – related member complaint pertaining to physical accessibility, physical appearance, or adequacy of waiting room and/or exam room space. Unannounced office site reviews may be conducted based on the urgency of the complaint.

2.5.1 Frequency of facility and office site reviews
Site reviews may be completed on all prospective PCPs, OB/GYN and BH provider offices prior to consideration by ISHN Credentials Committee. If an existing plan PCP, OB/GYN, or BH practitioner relocates or adds and additional practice location, a site review may be completed within 30 days of the relocation/opening for the new office.

In addition, a site review may be requested by the Credentials Committee or by the Quality Improvement Department upon receipt of an environmental complaint files by a member.

2.5.2 Guidelines for Medical Record Review

2.5.2.1 Organization and Filing

- Medical records must be organized appropriately and in an orderly fashion
- There must be a method utilized by the staff for filing of individual charts
- Staff must be able to verbalize what process is utilized
- The area must look neat and orderly.
- Records should be stored in an area inaccessible to the public only to authorized office staff

2.5.2.2 Demonstration of Charting System

- The staff must be able to locate charts and information in the chart easily

2.5.2.3 Filing and Tracking of Records

- There must be a tracking system that is used by staff to locate records if the records are not in the filing area
- There must be a policy and procedure in place to sign out medical records

2.5.2.4 Adequate Filing System

- The system in place must have adequate space and clearly defined processes for filing
- Staff must be trained on use of the filing system and processes in place
- There must be monitoring of these processes ensure compliance

2.5.2.5 Confidentiality

- Employees must sign a statement regarding confidentiality of patient and office information
- The office must have mechanisms in place and policies that safeguard patient confidentiality
- Guidelines governing the disclosure of confidential information must be clearly identified and consistently used
- Office staff must be able to explain their routine procedures

2.5.2.6 Patient Confidentiality

- Education must be provided for staff to make them aware of the necessity of confidentiality of patient information
- Policies and procedures must be in place which addresses confidentiality. Staff must be able to articulate how they maintain patient privacy and confidentiality. Confidential information should not be released without specific patient consent.

2.5.2.7 Appropriateness of Care Documentation

- Medical record documentation must meet the requirements outlines in section 7.9 of this document.

3.0 Provider Rights and Responsibilities

The following rights and responsibilities apply to all health care providers.

3.1 The right to have your application to participate in the ISHN network reviewed by a panel of health care providers, one of whom is knowledgeable in your scope of professional practice

3.2 The right to receive a written decision regarding the application to participate within 90 days of providing a complete credentialing application.

3.3 The right to request and review the factors considered by ISHN committees in reviewing credentials, complaints or standard of care issues.

3.4 The right to file complaints on your own behalf or on the behalf of your patient, with your patient's consent, without fear of retaliation, and to have those complaints resolved.

3.5 The right to communicate freely with patients about all diagnostic testing and treatment options regardless of benefit coverage.

3.6 The right to act as an advocate for your patient in seeking appropriate, medically necessary health services.

3.7 The right to speak with the doctor who, acting on behalf of the carrier, disapproves or limits approval of a request for covered services, and receive a written statement denying the approval upon request.

3.8 The right to request an exception to limited covered services or medications on behalf of your patient, with your patient's specific consent.

3.9 The right to discuss and appeal a benefit coverage decision on behalf of the patient, with the patient's consent, and obtain a written decision.

3.9.1 The right to timely notification of healthcare utilization management decisions.

- Non-urgent preservice decisions within 15 calendar days
- Urgent preservice decisions within 72 hours
- Urgent concurrent decisions within 24 hours
- Postservice decisions within 30 calendar days

3.10 The right to obtain a written decision at the conclusion of each stage of the internal appeal process explaining why the prior decision is being upheld (if that is the case), and explaining how to proceed to the next level of appeal.

3.11 The right to review and provide input in the clinical criteria and protocols adopted by ISHN.

3.12 The right to appeal claims payment issues within 90 days following a claims determination.

3.13 The right to protection and confidentiality of credentialing information.

3.14 The right to freedom from discrimination related to credentialing decisions or other plan decisions.

3.15 The right to resolution to complaints or issues brought to the plan in a timely manner.

3.16 The right to written notice of termination or denial of credentialing, and the right to request a hearing. Immediate termination may occur if the decision is based on proof that you have committed fraud, breached the terms of the contract, or are an imminent danger to a patient or the public health, safety, quality and welfare.

3.16.1 The right to request a written reason for the termination, if one is not provided with the notice of termination.

3.16.2 The right to request a hearing within 30 business days of receipt of the notice of termination, and to have the hearing held within 30 days of the request for the hearing.

3.16.3 The right to receive in writing the hearing decision within 30-days following the close of the hearing (unless an extension is necessary to completely document the issues of the requested hearing). The decision outcome must specify the reasons for decision. If conditional reinstatement is the hearing decision, the decision must include any conditions and time periods for conditional reinstatement, and the consequences for failing to meet the conditions.

3.17 The responsibility of cooperating with QI activities.

3.18 The responsibility to provide appropriate clinical documentation to support prior authorization requests.

3.18 The responsibility of allowing ISHN to use practitioner performance data in improvement activities.

3.19 The responsibility to maintain the confidentiality of member information and records.

3.20 The responsibility to assess the cultural, ethnic, racial and linguistic needs of your patients and make adjustments in practice and services to meet those needs.

3.21 The responsibility to provide adequate access to care for your patients including regular and routine care appointment.

3.21.1 Plans for urgent care and after-hours appointments are defined and communicated to your patients.

3.22 The responsibility to cooperate with processes designed to provide safe care transitions across the care continuum.

3.23 The responsibility to adopt evidence based guidelines or care models and implements them in practice.

3.24 The responsibility to cooperate with processes and procedures that are designed to promote patient safety.

3.25 The responsibility to implement recommended preventive care and wellness promotion interventions applicable to your practice.

4.0 Claims and Authorizations

For Plans that ISHN contracts with, claims and authorizations are directed back to those specific Plans following their guidelines and regulations.

As an entity of ISHN, CrestPoint Healthcare Insurance Company (CrestPoint) is a Third Party Administrator (TPA) and Insurance Company that manages the claims and authorization process for the customers directly contracted with them. The information below reflects the process for claims and obtaining authorizations through CrestPoint. Additionally, CrestPoint Health is a plan sponsor for two Medicare Advantage plans, CrestPoint Health Mind PPO and CrestPoint Health Body PPO.

4.1 Claims Submission:
Claims can be submitted through Electronic Data Interchange (EDI)
Apex Payer ID number is 34196.

Please send completed paper claim forms and supporting documentation to:
Apex
P.O. Box 3620
Akron, Ohio 44309-3620

4.2 Health Service Management*
Prior Authorization, Inpatient Concurrent Review, Case Management
Primary Phone: 330-996-2190 or 888-261-0417
After Hours Phone: 330-996-8710 or 888-996-8710
Fax: 330-996-1910
*Providers - Please fax forms to Benefits Determination Unit. Call Benefits Determination Unit for prior authorization.
*Facilities - Please contact Benefits Determination Unit with notification of hospitalization within 24 hours of admission.

4.3 Pharmacy

To obtain prior authorization and/or step therapy drug information please contact the Pharmacy Department at 1-800-910-1832. You may also view the complete formulary at www.crestpointhealth.com or in Appendix F.

For Medicare Advantage members: to obtain prior authorization and/or step therapy drug information please contact 1-888-350-7537. You may also view the complete formulary at www.yourcrestpointhealth.com or in Appendix E.

4.4 Durable Medical Equipment

Phone: 330-996-8428 or 866-728-8797
Fax: 330-996-8904

4.5 Provider Information Coordinator

To obtain access or request training on web-based products such as Plan Central and Clear Claim Connection:
Phone: 330-996-8860 or 800-996-8411
Fax: 330-996-8580
Email: mailto:rastettera@summacare.com

4.6 Prior Authorization List

4.6.1 Medicare Advantage

CrestPoint Health does NOT require prior authorization of services for Medicare Advantage inpatient hospitalizations, sub-acute hospitalizations, tests, procedures, rehab admissions, or skilled nursing admissions. However, **notification** is required and is accomplished through the submission of claims post service.

It is important for providers to be aware of and understand that CrestPoint Health may review post payment for medical necessity, to assure Medicare that services are provided appropriately. It is very important that all admissions, procedures, and services meet medical necessity regardless of the need for prior authorization in order to avoid any post payment issues of recoupment of funds.

4.6.2 CrestPoint Health Commercial Plan

For prior authorization lists for self-funded, non-Medicare Advantage groups; members should contact SummaCare Customer Service and providers should log onto Plan Central on http://www.crestpointhealth.com/provider-login/ or contact Customer Service at 423-952-2190 or toll free at 888-261-0417.

Network providers must obtain authorization **48 hours prior** to rendering service for the services listed below. For PPO members, when outside the coverage area, it is

the member's responsibility to verify that the necessary prior authorization has been obtained.

Coverage decisions are based on plan benefits and appropriateness of care and service. Prior authorization requests may be made by calling the Benefits Determination Unit at Primary Phone: 330-996-2190 or 888-261-0417
After Hours Phone: 330-996-8710 or 888-996-8710
Fax: 330-996-1910

Forms may be obtained from your provider manual or accessed online at http://www.crestpointhealth.com/resources/forms-downloads/.

4.6.3 CrestPoint Health Prior Authorization List (Non-Medicare Advantage)
Inpatient Services:
- Elective Inpatient Admissions
- Acute Inpatient Rehabilitation
- SNF, Transitional and Sub-Acute Care
- Human Organ, Bone Marrow and Stem Cell Transplants

Diagnostic Tests
- Cat Scan (CT) with exception of CT of Sinus
- Magnetic Resonance Imaging (MRI, MRA, MRV)
- PET/SPECT
- Nuclear Cardiac Stress Procedures
- Genetic Testing

Ambulatory Services
- Ambulance Services/Non-Emergent: Call 330-996-8791 or toll free 866-996-8791
- Durable Medical Equipment, Orthotics and Prosthetics: Call 330-996-8428 or toll free at 866-728-8797
- Hospice Care
- Pain Management
    - The initial request for an evaluation must be called in to the Benefits Determination Unit by the ordering physician. Additional visits must be prior authorized by the servicing provider.

Services Requiring Determination of Benefit Coverage
- Potentially Cosmetic, Experimental or Investigational Procedures
- Infertility
- Sclerotherapy
- Provider administered injectable medications and infusions
- Temporomandibular Joint Testing

CPT Coding
Please contact the Provider Support Services Unit at 330-996-8400 or the Benefits Determination Unit at 330-996-8710 for specific CPT coding inquiries.

4.6.4 Prior Authorization by Fax

- Complete the request form in its entirety. See Appendix H—make copies for your use. Include any supporting information and chart notes with your request.
- To allow for medical necessity review, please send requests at least 48 hours prior to rendering service.
- Complete clinical information will help to facilitate a quicker authorization decision.
- CrestPoint will provide prior authorization within 48 hours of receipt of request.
- After a determination has been reached, an authorization specialist will telephone you at your office to notify you of the determination outcome.

If you should have questions regarding the above process, please call the Benefits Determination Unit at 330-996-2190 or 888-261-0417.

The fax number to submit a prior authorization request is 330-996-1910.

Please call 423-952-2190 or 888-861-0417 for urgent requests.

5.0 Pharmacy Services

The pharmacy department is available to assist participating providers and members with pharmacy-related questions. A formulary is developed to optimize patient care through the rational selection and use of drugs, and to ensure quality prescribing practices based on the latest evidence. The formulary is a culmination of efforts by the Pharmacy and Therapeutics (P&T) Committee.

Medications in each therapeutic class are reviewed with respect to safety, efficacy, currently available agents and cost-effectiveness for members. The appropriate agents are then selected for inclusion in the formulary. The P&T committee continually reviews the formulary on an ongoing basis including new medications and information about existing medications. The formulary is available in printed or electronic form. Please contact the CrestPoint Health Provider Relations representative if you need assistance in obtaining access. See the contacts list in section 1.3 of this document.

5.1 Medicare Coverage
CrestPoint Health plans cover both Medicare Part B and D drugs. Medicare Part B drugs include the following types of drugs.

- Some Antigens; If they are prepared by a physician and administered by a properly instructed person under physician supervision
- Osteoporosis Drugs: Injectable osteoporosis drugs for some women
- Erythropoietin (Epoetin Alfa or Epogen): By injection if your patient has end-stage renal disease and need this drug to treat anemia
- Hemophilia Clotting Factors: Self-administered clotting factors for patients with hemophilia
- Injectable Drugs: Most injectable drugs administered incident to a physician service
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage
- Some Oral Cancer Drugs: If the same drug is available in injection form
- Oral Anti-Nausea Drugs: If part of an anti-cancer chemotherapeutic regimen
- Inhalation and Infusion Drugs administered through Durable Medical Equipment

All other drugs are covered under Part D benefits. Note: The shingles vaccination is covered by Medicare Part D, different than the flu or pneumonia vaccination which is a Medicare Part B allowable claim.

5.2 Pharmacy Network

CrestPoint Health has formed a network of pharmacies. Beneficiaries must use a network pharmacy to receive plan benefits.

For CrestPoint Commercial Members: visit
http://www.crestpointhealth.com/resources/

For CrestPoint Medicare Advantage: visit www.yourcrestpointhealth.com for a current list of in network pharmacies.

CrestPoint Heath allows members to use mail order prescriptions for a 90 day supply with MedVantx Home Delivery. Members may mail the paper prescriptions to

MedVantx Pharmacy Services
PO Box 5736
Sioux Falls, SD 57117-5736

Physicians may fax prescriptions to MedVantx to 1-888-868-8660 or electronic prescriptions may be sent through Shared Scripts NPI# 1073692745

5.3 How to use the Formulary – Medicare Advantage Plans

For Medicare Advantage members: to obtain prior authorization and/or step therapy drug information please contact 1-888-350-7537.

You may also view the complete formulary at www.yourcrestpointhealth.com. Or you may review the full Medicare Advantage formulary in Appendix I. The formulary is organized in two search formats.

- Medical Condition
  - The drugs are grouped into categories depending on the type of medical conditions that they are used to treat.
- Alphabetical Listing
  - The index provides an alphabetical list of all the drugs included in the formulary. Both brand name and generic drugs are listed here with the page number reference.

5.4 CrestPoint Health Commercial Formulary

For the CrestPoint Health commercial plan: To obtain prior authorization and/or step therapy drug information please contact the MedImpact at 1-800-910-1832.

5.5 Generic, Brand Name Drugs and Drug Tiers

CrestPoint Health covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs. Medications are assigned to a tier with tier one (1) being the most cost effective for the patient. Drug tier assignments are listed in the formulary.

- Tier 1 is Preferred Generic
- Tier 2 is Non-Preferred Generic
- Tier 3 is Preferred Brand
- Tier 4 is Non-Preferred Brand
- Tier 5 is the Specialty Tier

5.6 Restrictions to Coverage

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- Prior Authorizations
  - These drugs require approval before the prescription will be filled in order to be covered by the plan. Drugs requiring prior approval will be indicated as such in the formulary.

- Quantity Limits
  - For certain drugs, CrestPoint Health limits the amount of the drug that will be covered by the plan. For instance, Xanax is limited to 90 tablets in 30 days. Drugs with quantity limits will are indicated in the formulary.
- Step Therapy
  - In some cases, CrestPoint Health requires you to first try certain drugs to treat medical conditions before the plan will cover another drug for that condition. For example, before Prevacid (lansoprazole) will be covered by the plan, one of the tier one (1) antiulcer agents should have been tried and found to be unsuccessful in managing the condition. Medications requiring step therapy are indicated in the formulary.

5.7 Changes to the Formulary

Generally, we will not discontinue or reduce coverage of any drug that was listed in the formulary at the beginning of the year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year.

If we remove drugs from our formulary, or add prior authorization, quantity limits and /or step therapy restrictions on a drug, or move a drug to ah higher cost-sharing tier, we will notify affected members of the change at least 60 days before the change becomes effective, or at the time a member requests a refill at which time the member will receive a 60-day supply. If the FDA deems a drug on formulary to be unsafe or the manufacturer removes the drug from the market, we will immediately remove the drug from the formulary and provide notice to members who take the drug.

5.8 Drugs Not on the Formulary

If a drug is not listed in the formulary, first contact CrestPoint Health Pharmacy Services to confirm that it is not covered. If it is not covered, there are two options.

- Ask for a list of similar drugs that are covered by the plan and prescribe one of those.
- Request an exception from CrestPoint Health

5.9 Requesting a Formulary Exception

You can ask CrestPoint Health to make an exception to our coverage rules. There are several options. You can ask CrestPoint Health

- To cover a drug not on formulary

- Waive coverage restrictions or limits on a drug
- To provide a higher level of coverage for a drug

Generally, CrestPoint Health will only approve your request for an exception if the alternative drugs include in the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating the condition and/or would cause adverse medical effects. A written statement must be submitted supporting the exception request. Generally, a decision will be made within 72 hours of receiving the prescriber's supporting statement. CrestPoint Health will also accept expedited requests in the case that serious harm may be caused by waiting 72 hours. If the request to expedite is granted, a decision will be made no later than 24 hours after receipt of the request with the physician's supporting statement.

5.10 Medication Therapy Management

A Medication Therapy Management (MTM) program is provided free of service to the CrestPoint Medicare Advantage beneficiaries who meet criteria. They are automatically enrolled but have the option to opt-out. The program offers a Comprehensive Medication Review (CMR) which is one-on-one consultation with a pharmacist or licensed pharmacy intern under the direct supervision of a pharmacist. The consult is conducted by appointment by way of a telephone conference. During the CMR, the member's entire medication profile is reviewed, including prescriptions, OTCs, and samples, for appropriateness of therapy. Disease-specific goals of therapy and medication-related problems are discussed with the member, as well as any member-specific questions. After the CMR, the member is mailed the standardized post-CMR takeaway letter which includes a Personal Medication List and Medication Action Plan detailing the conversation with the pharmacist or pharmacy intern.

All members that have not opted-out of the program receive on-going Targeted Medication Reviews (TMRs) at least quarterly and with each update of prescription claims. TMRs identify opportunities for interventions based on systematic drug utilization review including cost savings, adherence to national consensus treatment guidelines, adherence to prescribed medication regimens, and safety concerns. TMRs that result in generation of alerts are categorized and triaged based on the severity of the alert. The member or physician would then be contacted via phone or mail as appropriate for review of potential therapy changes. TMR alerts that result in an outbound phone call to the member allow an additional opportunity to offer the member a CMR. Members that accept the CMR on the outbound TMR call receive the

CMR as outlined above. Interventions resulting from TMRs or CMRs may result in provider contact via phone, fax or mail when appropriate.

Criteria for CrestPoint Health Medicare Advantage member selection for MTM include the following.

- Two (2) or more of these chronic diseases
  - Chronic Heart Failure
  - Hypertension
  - Dyslipidemia
  - Diabetes
  - Asthma
  - COPD
- Six (6) or more chronic/ maintenance drugs
- Incurred one-fourth (1/4) of specified annual cost threshold in previous three months

CrestPoint Health outsources/ delegates pharmacy services to MedImpact.

6.0 Fraud, Waste, Abuse, and Compliance

All employees participate in annual educational sessions to ensure they maintain a current knowledge of and comply with these policies Fraud, Waste, and Abuse and Compliance.

Integrated Solutions Health Network (ISHN) has been, and continues to be, committed to providing high-quality health care to our members through excellent customer service, sensitivity to customer needs, and professionalism. ISHN is equally committed to conducting business with the highest integrity and in compliance with all applicable federal, state and local laws, rules, regulations, standards and other regulatory requirements.

Integrated Solutions Health Network (ISHN) is an affiliated company of Mountain States Health Alliance (MSHA). The standards of conduct for CrestPoint Health, as a division of ISHN, are those defined in the MSHA *Code of Ethics and Business Conduct* and the MSHA Compliance Plan.

6.1 Code of Ethics

Our Code of Ethics is available in its entirety online to all of our team members, Board of Directors' members, providers, vendors, contractors and volunteers at: **http://www.msha.com/uploads/pdf_files/MSHACodeofEthics.pdf.** As an affiliated company with MSHA, CrestPoint Health and ISHN team members (employees) are required to comply with MSHA's *Code of Ethics and Business Conduct* and Compliance

Plan. Team members receive training on the standards of conduct at new team member orientation on their first day of employment and annually thereafter.

6.2 Compliance Program

ISHN adopted the MSHA Compliance Program which aids in the prevention and detection of non-compliant activity. It is the responsibility of every team member, including affiliated providers operating under MSHA/ISHN's control, physicians, and other health care professionals, to proactively identify issues relating to potential fraud and abuse exposures and to comply with the policies and procedures designed to minimize such exposures.

Compliance in the health care industry is challenging due to the complex and ever changing regulatory requirements governing our business practices. To underscore and enhance its continued pledge of compliance and to better assist all team members, including physicians, contractors and vendors in ensuring compliance, MSHA and ISHN are committed to maintaining a comprehensive Compliance Program. MSHA and ISHN have adopted the directives set forth in the Office of Inspector General's Compliance Program Guidance for Hospitals in an effort to prevent and detect potential violations of law.

The adoption and implementation of MSHA/ISHN's Voluntary Compliance Program will significantly advance the prevention of potential fraud, abuse, errors, and waste while furthering the fundamental mission of MSHA/ISHN to identify and respond to the health care needs of individuals and communities in our region and to assist them in attaining their highest possible level of health. While it is imperative to respond to existing compliance issues and resolve those issues in a timely and effective manner, a primary goal of the Compliance program is to be pro-active on the front end in preventing fraud, waste, and abuse scenarios from occurring. Through its Compliance department and efforts throughout the system, MSHA/ISHN commits extensive resources to provide education and assistance to team members who empower them with the ability to be pro-active and prevent potential concerns from developing into compliance issues.

6.3 Reporting Compliance Concerns

MSHA/ISHN takes all reports of non-compliance seriously and is committed to listening and responding to team member concerns regarding potential violations of our organization's policies, *Code of Ethics and Business Conduct*, Compliance Program, and regulatory requirements. Therefore, we have established a mechanism whereby team members and agents of MSHA are able to report concerns without the fear of retribution. Reports may be made in the following manner:

- **In person** …
    - Through the team member's Supervisor,
    - Manager,
    - Department Director,
    - Administrative Staff,
    - Facility Compliance Officer,
    - Corporate Compliance Officer, or
    - Legal Counsel

- **In writing** …
    - Through the Direct Line to the President/CEO or
    - To Corporate Compliance Services
      Attn: Corporate Compliance Officer
      Mountain States Health Alliance
      400 N. State of Franklin Rd., Johnson City, TN 37604

- **Orally** …
    - To the Corporate Compliance Officer at (423) 302-3345, or
    - Through MSHA's AlertLine at 1-800-535-9057.

The AlertLine is managed and operated by an independent firm contracted by MSHA to handle calls in a confidential and secure manner 24 hours a day, seven days a week. A Communications Specialist answers the call, documents the information provided by the caller, issues the caller a unique I.D. number (so that the caller may remain anonymous, if he/she desires) and call back date, and prepares a written report to be sent to Corporate Audit and Compliance Services. After review by the Corporate Compliance Officer, calls will be assigned to the appropriate individual(s) for inquiry, investigation, and resolution.

7.0 Quality Improvement Program

ISHN maintains Quality Management (QM) programs that continually evaluate, monitor and improve the quality of care provided to its client members. ISHN coordinates with affiliated physicians, health plans and ancillary providers to improve the quality of care. We employ a Quality Management team to oversee internal quality initiatives, facilitate reporting and conduct provider credentialing and site reviews.

7.1 Purpose

The purpose of the Quality Management Program is to provide a foundation for the development of programs and activities directed towards improving the health of our members. It is designed to implement, monitor, evaluate, and improve processes that are within the scope of the Plan using the Institute of Health's Triple Aim tenants as a framework. Several committees within the organization work on Quality Improvement (QI) issues. Membership includes ISHN staff and participating practitioners and may include representatives from other organizations. Each year, ISHN develops a Quality Management Program Description and Work Plan that outlines our efforts to improve clinical care and service to our members. Providers may request a copy of the current Quality Management Program and Work Plan by calling 423-952-2111.

7.2 Activities

Activities of the QM Program include, but are not limited to:

- Preventive Care
- Evidence Based Clinical Practice
- Care and Case Management Programs
    - Chronic Care Improvement Programs (CCIP)
    - Continuity and Coordination of Care
- Clinical Care Improvement Projects
    - Quality Improvement Projects (QIPs)
- Complaints, Grievance and Appeals Resolution and Prevention Activities
- Credentialing and Re-credentialing activities
- Pharmacy Program activities
- Patient Safety activities
- Adverse event review
- Member Satisfaction
- Physician and other practitioner Satisfaction surveys
- Standard of Practice. Peer Review
- Monitoring Service Quality
- HEDIS Measures
- CMS STAR Ratings
- Medicare Shared Savings Program (MSSP) Quality Measures
- Medicare Compliance

7.3 NCQA Accreditation

As part of our commitment to quality, ISHN and its entities define functions, processes and outcomes based on National Committee for Quality Assurance (NCQA) current standards for different program accreditations, certifications and designations. NCQA is an independent, non-profit organization whose mission is to improve health care quality. For government lines of business CrestPoint Health and AnewCare Collaborative will use the appropriate CMS and state guidance. NCQA evaluates health care in three different ways: through the accreditation process (a rigorous on-site review of key clinical and administrative processes), through HEDIS® performance measures, and through a comprehensive member satisfaction survey.

7.4 HEDIS®

Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures are a part of the NCQA accreditation process. Information that is provided by HEDIS® helps employers and customers understand the value and quality of care provided by their health plan. Participating in the HEDIS® process allows the community the ability to evaluate their plan for cost and quality, and for making comparisons among other health plans. Some of the major areas of performance measured by HEDIS® are:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices
- Health Plan Descriptive Information

7.5 Clinical Guidelines

Clinical Guidelines are based on published national guidelines, literature review, and clinical experience. They offer the most current recommendations in disease management techniques. Clinical Guidelines are updated on an annual/biannual basis. They are not meant to replace clinical judgment in dealing with individual patient care decisions, but are intended to facilitate a collaborative approach between primary care physicians and consultants in the management of patient care. Clinical Guidelines are available to providers on www.ishnonline.com under Provider Resources.

7.6 Patient Appointment Access Guidelines

Access to care is recognized as a key component of quality care. As a condition of participation, all ISHN Providers agree to provide necessary Covered Services to Members on a 24-hour per day, 7-day per week basis, or arrange with physician(s) to cover patients in their absence.

- The member has access to care after normal operation hours (24 hours a day, 7 days a week), by an answering service or direct pager.

- Providers must make arrangements with another participating physician to provide coverage in their absence.
- When a PCP is unable to meet access criteria due to schedule conflicts and the member's condition warrants immediate attention, the PCP should make provisions for that member to be seen by another participating physician.

7.7 Appointment Access Standards for all Health Products

- Emergency: Immediately upon request
- Urgent: 24 hours
- Symptomatic: 1 week
- Routine/Well Care: 30 days
- Initial Prenatal Care:
  - First Trimester: 14 days
  - Second Trimester: 7 days
  - Third Trimester: 3 days
  - High-Risk: 3 days or immediately if emergency
- Behavioral Health services:
  - Emergency: 6 hours
  - Urgent: 48 hours
  - Routine: 10 days

7.8 Continuity and Coordination of Care

ISHN strives to ensure that all members receive the highest quality of care and utilizes systematic methods of detecting problems specific to continuity and coordination of care. Ongoing collaboration between primary care physicians and specialists, as well as between primary care physicians and other types of providers promotes a continuous plan of care that benefits the member. Other types of providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, and ambulatory surgical centers.

It is ISHN's policy to monitor and identify potential problems with continuity and coordination of care for all of our members. Information on continuity and coordination of care will be collected from chart reviews, from member surveys, complaints and other methods. For plans that require PCP assignment, when the PCP terminates a notice will be sent to the Member at least 30 days prior to the PCP termination with the assignment of a new PCP stated in the letter. The Member will have the option of changing to another PCP if they desire.

7.9 Medical Record Documentation Standards

Medical record audits for Practitioners may occur based on quality concerns or at the request of the Credentialing Committee.

7.9.1 Medical Record Documentation Guidelines for Appropriate Care

Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. The following elements reflect a set of commonly accepted standards for medical record documentation and will be included in audit findings.

- A current active problem list with associated supporting assessment findings, lab, and diagnostic testing results
- Allergies to medications are prominently noted in the record. If the patient has no known allergies, this is appropriately noted in the record
- Adverse reactions to medications and treatments are prominently noted in the record
- Past medical and surgical history
- If a specialist is consulted, a note from the specialist should be in the record with documentation that the PCP has reviewed their findings
- Evidence in the notes or other documentation of continuity and coordination of care between the PCP and behavioral health specialists if patient is being seen by behavioral health
- Evidence in the notes that all lab and diagnostic testing results have been reviewed by the provider and acted upon appropriately
- Evidence in the record about the patient wellness and preventive interventions including at least:
    - Vaccination record including pneumonia and annual influenza vaccination
    - BMI and counseling if needed
    - Tobacco use and counseling if needed
    - Fall Risk Assessment and intervention if needed
    - Depression screening and intervention if needed
    - Cancer screening for breast, colon, and prostate as appropriate
    - LDL screening with appropriate treatment if needed
    - Blood pressure screening an follow up as recommended by the JNC guidelines
    - Blood glucose screening to include Hemoglobin A1Cs for all know diabetics per ADA guidelines
- A current medication list including all prescribed and OTC medications, dosages and dates of initial or refill prescriptions
- Documentation of reasons for not following guidelines for treatment when there is variation from the recommendations
- Documentation from inpatient or ambulatory care admissions and transition follow up appointment to include medication reconciliation
- A treatment plan/ plan of care that documents realistic goals and patient involvement
- Documentation that care is medically appropriate according to best practice guidelines
- Documentation on whether or not the patient has executed an Advance Directive

    - If yes, is documentation of an advanced directive must be on the chart
- Each page in the record contains the patient's name and ID number and all entries are signed, timed and dated
- The record is legible to someone other than the writer
- Evidence that quality measures appropriate for this patient are being met which may include:
    - MSSP Quality Measures
    - HEDIS Quality Measures for the Stars program
    - Meaningful Use Measures
    - Satisfaction Measures
    - Health Outcome Measures

7.10 Advance Directives:
Every competent adult and emancipated minor has the right to execute an Advance Directive. As detailed below, state and federal regulations require that patient medical records must document whether or not a patient has executed an Advance Directive.

- While the participating provider's primary concern is to keep his/her patients healthy, he/she also has an important role to play in helping patients make an Advance Directive. ISHN will support the Advance Directive process to facilitate compliance with these regulations.

Tennessee law recognizes more than one written advance directive for health care decision making: 1) the "Living Will" or "Advance Care Plan" and 2) the "Medical Power of Attorney" or "Appointment of Health Care Agent." You can download the two forms and information about these directives from this State of Tennessee, Department of Health website: http://health.state.tn.us/advancedirectives/. These forms are included in each CrestPoint Health Members Handbook for the Medicare Advantage plan members.

The Patient Self-Determination Act requires that "a provider of services" must document in the individual's medical record whether or not the individual has executed an Advance Directive. The Virginia Health Care Decisions Act states "It shall be the responsibility of the declarant to provide for notification to his attending physician that an Advance Directive has been made. In the event the declarant is comatose, incapacitated or otherwise mentally or physically incapable of communication, any other person may notify the physician of the existence of an Advance Directive. An attending physician who is so notified shall promptly make the Advance Directive or a copy of the Advance Directive, if written, or the fact of the Advance Directive, if oral, a part of the declarant's medical records." Participating providers must demonstrate compliance with all applicable state and federal laws and regulations.

ISHN may participate in programs to educate the community regarding patients' rights to make health care decisions and to execute Advance Directives. The Customer Operations department will provide information regarding Advance Directives to

members upon enrollment and re-enrollment via the Member Handbook and will provide additional information and forms upon request. Network Management conducts provider staff education on Advance Directives during provider orientations along with regular updates and reminders. Quality Improvement audits physician compliance with this policy in regular medical record reviews and communicates findings as part of the recredentialing process.

7.11 CMS Stars Ratings

For Medicare Advantage plans, CMS measures Health and Drug Plan Quality and Performance levels through a "star" rating on a scale of 1 – 5 with 5 as the best. Medicare Part C-only plans are monitored for 36 measures and Medicare Part D-only plans are monitored for 17 measures. The Medicare Advantage plans with Part D coverage (MA-PD) are monitored for up to 50 individual measures. Each measure gets an individual score. Like measures are grouped by similarity into "domains." Each measure is given a weight and a star rating. A weighted average of all measures applicable to the health plan is derived to determine the overall star rating

The Star Ratings are publicly displayed on the Medicare.gov plan finder site. The rating affects plan receiving bonus payment and the data is pulled from multiple sources. For MA-PD, CMS assigns stars for each of the 50 by applying one of three different methods:

- Relative distribution and clustering
- Relative distribution and significance testing and
- CMS standard, relative distribution, and clustering

These methods are described in precise detail, complete with algorithms and Euclidean metrics, in *Medicare Health & Drug Plan Quality and Performance Ratings 2015 Part C & D Technical Notes*, updated 09/03/2014.

The multiple sources for the Star rating data pull include:

- HEDIS – Health Employer Data Information Set
- CAHPS – Consumer Assessment of Health Plan Satisfaction
- HOS – Health Outcomes Survey
- CMS Administrative Data – Medicare Plan Finder (MPF) Pricing, Prescription Drug Event (PDE) files, Independent Review Entity (IRE), Health Plan Management System (HPMS) Complaints Tracking Module (CTM), Medicare Beneficiary Database Suite of Systems, HPMS Approved Formulary Extracts

CMS requires that a contract exist for a year before submitting HEDIS because many of the individual measures have a "time enrolled" requirement. So, HEDIS 2013 can only be submitted by contracts that have an effective date ≤1/1/2012. There are higher minimum enrolled numbers for HOS (500) and CAHPS (600) which also have a "time in existence" requirement.

To achieve higher star ratings, plans and providers must:

- Provide excellent patient/member service
- Address access to care issues immediately
- Provide accurate and timely information
- Address patients'/members' complaints timely, thoroughly and with compassion
- Keep improving the patient's/member's experience and quality of care
- Provide timely outreach for preventive care
- Provide timely and comprehensive care coordination for patients/members living with chronic conditions
- Correct any identified patient safety issues as quickly as possible

7.12 Medicare Shared Savings Program

Providers participating with an Accountable Care Organization (ACO) may be participating in the Medicare Shared Savings Program (MSSP). The intent of the program is to encourage providers, suppliers, and others involved with care to create a new type of health care entity that agrees to be responsible and accountable for the care of its assigned beneficiaries. The goals of the program are congruent with the Institute of Healthcare Improvement's Triple Aim:

- Better population health management
- Better experience of care (satisfaction)
- Better management of cost of care

These goals will be achieved through better coordination of care across the continuum and implementing evidenced-based care that eliminates waste.

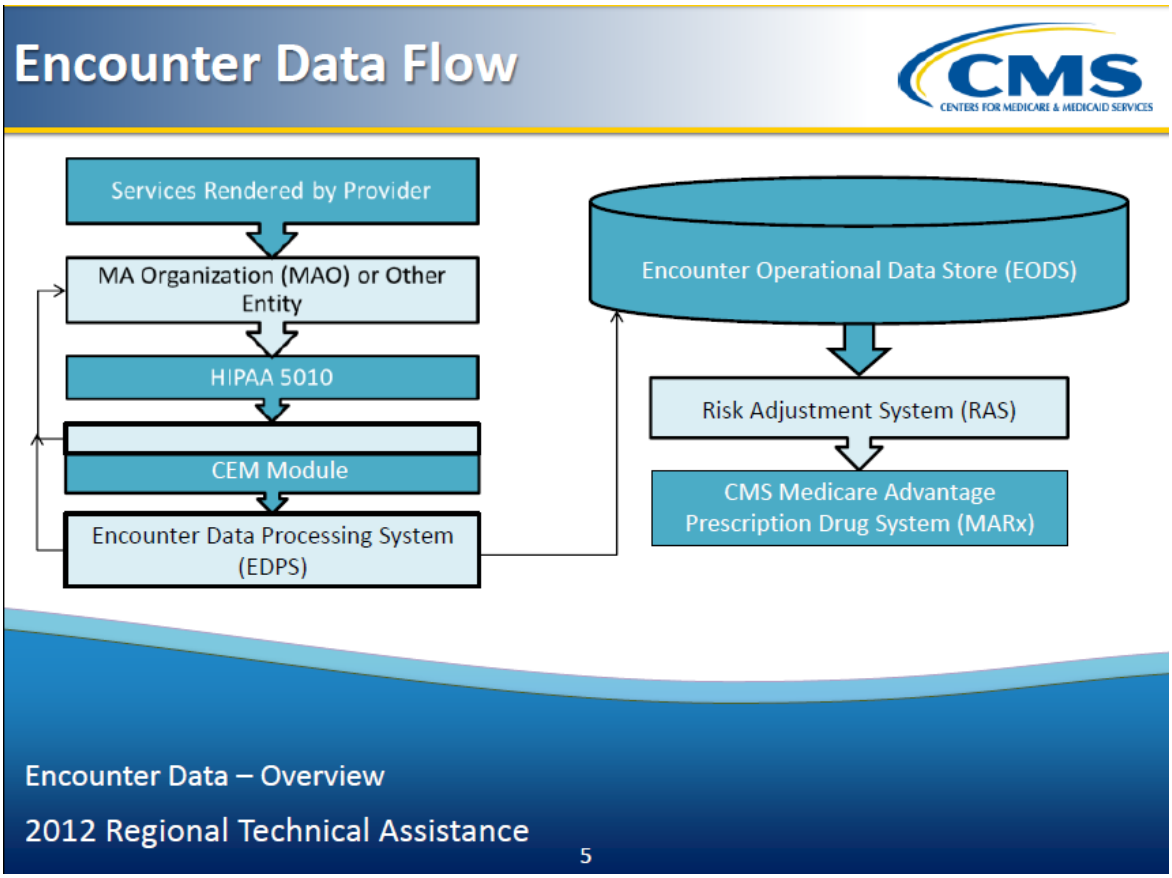
The MSSP program has a total of 33 measures. Only 22 of the measures are collected from medical records. The remaining 11 are collected directly from patient surveys and claims or administrative data. The measures are divided into four key domains:

- Patient/ Caregiver Experience (7 measures)
- Care Coordination and Patient Safety (6 measures)
- Preventive Health (8 measures)
- At-risk Populations / Disease Specific (12 measures)

For more information, see Appendix A.

8.0 Medicare Risk Adjustment

Medicare Advantage plans have Risk Adjustment programs. Risk adjustment is the process through which CMS reimburses the Medicare Advantage plans based on the individual member's health status and demographics. The diagram below from CMS illustrates the process.



The Customer Service and Support Center website is the gateway to Encounter Data System (EDS) for information, resources regarding data submission, and basic training information:
http://www.csscoperations.com/internet/cssc3.nsf/docsCatHome/CSSC%20Operations

CMS performs Data Validation audits to assure the integrity and accuracy of risk adjustment payments.

Providers need to be aware of this process because plan sponsors, such as CrestPoint Health, may request medical records to verify coding accuracy and to document conditions that may not be evident through encounter data and claims data.

9.0 Member Rights and Responsibilities

ISHN has Member Rights and Responsibility statements for each of its plans. Please see appendix L and M. These rights and responsibilities are shared with the members on enrollment, and then annually. The plan members' rights and responsibilities are also shared with providers when they join the network and annually thereafter.

9.1 Member Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT THE MEMBER MAY BE USED AND DISCLOSED AND HOW MEMBERS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CrestPoint is dedicated to protecting the confidentiality of information we have about our members. We are required by law to maintain the privacy of protected health information and to provide members with this Notice of our legal duties and privacy practices with respect to protected health information.

This Notice of Privacy Practices describes how CrestPoint may use and disclose member protected health information to facilitate treatment, carry out payment or health care operations, and for other purposes that are permitted or required by law. It also describes member rights to access and control their protected health information.

"Protected health information" is:

- Information about the member, including demographic information, that may identify the member and
- That relates to the member's past, present or future physical or mental health or condition; and
- Any health care services the member may receive and payment for those services.

Examples of protected health information include but are not limited to the notes the doctor keeps that documents information about the physician office visit, member birth date and social security number.

CrestPoint is required by law to abide by this Notice as long as the terms remain in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary. Any revisions to this Notice will apply to all the protected health information we maintain, including protected information received before the change was made. Except when required by law, CrestPoint will not implement a material change to any of the policies or terms described in this Notice prior to the effective date of the new Notice. All members enrolled with CrestPoint at the time that changes are made will receive the revised Notice 60 days prior to the effective date of the changes. Copies of the most current Notice may be obtained at any time by calling the Member Services Department or by viewing the CrestPoint web site at www.yourCrestPointHealth.com.

Members may also request a current Notice in writing by mailing a request to Member Services.

IF A MEMBER HAS ANY QUESTIONS ABOUT THIS NOTICE OR WISH TO REQUEST A COPY, THEY MAY CALL MEMBER SERVICES AT THE NUMBER LISTED ON THE MEMBER CRESTPOINT CARD

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
CrestPoint must internally use protected health information to conduct our business and to ensure members are provided with the care and services to which they are entitled as a member. In some cases we may disclose or share protected health information with external individuals or organizations. In both cases, CrestPoint limits access to the protected health information used and disclosed to the minimum amount reasonably necessary.

Upon enrollment, CrestPoint may use and disclose protected health information for these purposes without a member signed authorization. The purposes for which we may use and disclose protected health information are described below:

A. FOR TREATMENT – CrestPoint may use or disclose information about members to facilitate treatment by a physician or other health care provider. This includes the coordination or management of health care with a third party that has already obtained permission to have access to your protected health information. For example, when a member seeks the services of a physician, CrestPoint may provide information about the member to the physician so he can better treat the individual's illness or injury.

B. FOR PAYMENT – CrestPoint may use or disclose health information for payment purposes. For example, we may use information regarding medical procedures and treatment to process and pay claims, to determine whether services are medically necessary or to otherwise pre-certify services as covered under CrestPoint plan. We may also disclose such information to another health plan, which may have an obligation to process and pay claims on the member's behalf or to a health care provider from whom the member has received medical services.

C. FOR HEALTH CARE OPERATIONS – CrestPoint will use and disclose protected health information as necessary, and as permitted by law, for our health care operations. In limited situations, CrestPoint may disclose protected health information for the operations of other health plans or health care providers with which you have or had a relationship. For example, CrestPoint may share protected health information with the member's primary care physician's practice for quality improvement activities.

D. INFORMATION SENT TO YOU – CrestPoint members may occasionally receive information from us about the care and services we provide. Sometimes this includes protected health information. Examples include information about the payment of

claims, appointment reminders, or case management calls from a CrestPoint nurse. We may also send information about treatment alternatives or other health-related benefits and services that may be of interest to the member.

E. INDIVIDUALS INVOLVED IN ARRANGING FOR CARE OR PAYMENT FOR CARE – With member approval, we may disclose protected health information to designated family members or others who may be helping arrange care or payment for care. We may also disclose protected health information to an individual or individuals who are legally authorized to act on the member's behalf, such as an individual to whom the member has granted durable power of attorney. We may require the individual to furnish proof of such authorization before granting them access to information. If the member is unavailable, incapacitated, or facing an emergency medical situation, and in our professional judgment we determine that a limited disclosure may be in the member's best interest, we may share limited protected health information with such individuals without your approval. If the member has designated a person to receive information regarding payment of the premium for the policy, we will inform that person when the premium has not been paid. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts to locate a family member.

F. BUSINESS ASSOCIATES - Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to share some protected health information with one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require business associates to appropriately safeguard the privacy of information, and comply fully with the privacy practices described in this Notice.

G. OTHER USES AND DISCLOSURES - CrestPoint is permitted or required by law to make the following additional uses or disclosures of protected health information:

- As Required by Law – CrestPoint will disclose your protected health information for any purpose when required to do so by federal, state or local law.
- To the Secretary of the U.S. Department of Health and Human Services or his/her designee for investigations of HIPAA privacy compliance.
- For Public Health Activities – CrestPoint may release your protected health information for public health activities. These activities generally include the following:
    - To prevent or control disease, injury or disability;
    - To report births and deaths;
    - To report the abuse or neglect of children, elders and dependent adults;
    - To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the member agrees or when required or authorized by law.

- To the Food and Drug Administration – CrestPoint may release protected health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls.
- To the Plan Sponsor– Under certain limited circumstances, CrestPoint may release protected health information to the plan sponsor. The "plan sponsor" is generally an employer or the entity that has purchased or funded the group health plan. The plan sponsor may need your information for such things as obtaining premium bids from CrestPoint or another health plan. Before CrestPoint shares any protected health information with a plan sponsor, that sponsor must agree to a number of legally required conditions designed to ensure that information remains protected. For example, a plan sponsor must certify that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations. The plan sponsor must also describe in advance the need for information and limit access to the information to those employees who require it to perform the job function described. When feasible, the plan sponsor must return or destroy all copies of protected health information when it is no longer needed.
- Health Oversight Activities – CrestPoint may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. For example, CrestPoint may disclose information to the Tennessee/Virginia Department of Health for periodic audits of the quality of care provided to CrestPoint members.
- Lawsuits and Disputes – If a member is involved in a lawsuit or a dispute, CrestPoint may disclose protected health information in response to a court or administrative order. CrestPoint may also disclose protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell the member about the request (which may include written Notice) or to obtain an order protecting the information requested.
- Law Enforcement – CrestPoint may release protected health information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;

- If CrestPoint believes in good faith that the information constitutes evidence of criminal conduct that occurred on the premises of any CrestPoint establishment;
- As required by law to report wounds and injuries and crimes;
- In certain situations when a member is an inmate in a correctional institution.
- Coroners, Medical Examiners and Funeral Directors – CrestPoint may release your protected health information to a coroner or medical examiner to identify a deceased person or determine the cause of death. CrestPoint may also release protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

- Organ and Tissue Donation – CrestPoint may use or disclose protected health information to organ procurement organizations for the purpose of facilitating organ, eye or tissue donation and transplantation.
- Research – Under certain circumstances, CrestPoint may use and disclose protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process that evaluates a proposed research project and its use of medical information. Information for research is not disclosed until the research project is approved. We may, however, disclose medical information to people preparing to conduct a research project to help them look for patients with specific medical needs, so long as the medical information they review does not leave the possession of CrestPoint.
- Military and Veterans – CrestPoint may use and disclose protected health information if the member is obligated to the armed forces and the use and disclosure has been deemed necessary by appropriate military command authorities. CrestPoint may also release protected health information about foreign military personnel to the appropriate foreign military authority.
- National Security and Intelligence – CrestPoint may release information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. CrestPoint may disclose protected health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- Workers' Compensation – CrestPoint may release protected health information to workers' compensation agencies if necessary for workers' compensation benefit determination.

H. WITH YOUR AUTHORIZATION – CrestPoint will not use or disclose protected health information without your written authorization except as described above in this Notice.

Members may revoke their authorization in writing at any time, except to the extent that CrestPoint or one of our business associates is already taking action in reliance on the use or disclosure approved in the authorization.

II. MEMBER RIGHTS REGARDING PROTECTED HEALTH INFORMATION

A. RIGHT TO REQUEST RESTRICTIONS – Members have the right to request restrictions on the uses and disclosures of their protected health information for treatment, payment, or health care operations. Restriction request forms are available from Member Services, or from the CrestPoint web site. Requests should be mailed to the attention of Member Services at the address listed on page one of this Notice. The request must include (i) the information to limit; (ii) whether to limit our use, disclosure or both; and (iii) to whom the limits will apply, for example, disclosures to a spouse. Restrictions must be signed by the member or the authorized representative. We are not required to agree to your restriction request. We retain the right to terminate an agreed upon restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. Members also have the right to terminate, in writing or verbally, any agreed upon restriction by sending such termination Notice to the attention of Member Services.

B. RIGHT TO AN ACCOUNTING OF DISCLOSURES – Members have the right to receive an accounting of certain disclosures of protected health information. CrestPoint is not required to track and account for the following types of disclosure:

- Disclosure made for the purposes of treatment, payment or operations;
- Disclosures made to the member, or member authorized representative;
- Disclosures to an individual involved in arranging member care or arranging payment for care;
- Disclosures made in accordance with an authorization the member had previously signed and agreed to;
- Certain disclosures that we may legally be required to keep from the member, such as disclosures to law enforcement officials in response to a legally obtained warrant.

Members may request an accounting of any disclosures of their protected health information that does not fall into the categories listed above. The member must submit a written request signed by the member or their authorized representative to CrestPoint Member Services. Accounting request forms are available from Member Services, or the CrestPoint website.

C. CONFIDENTIAL AND ALTERNATIVE COMMUNICATIONS –CrestPoint members may occasionally receive information from us about the care and services we provide. Sometimes this includes protected health information specific to the member. The member has the right to request that CrestPoint make reasonable accommodations for the member to receive such communications by alternative means or at alternative

locations. For example, the member can request to have letters sent to a particular address that may be different from their normal home mailing address.

Members may also request that CrestPoint restrict access and disclosure of protected health information to specific individuals involved in arranging for care or arranging payment for care. Forms for requesting confidential communications are available from Member Services, or from the CrestPoint web site.

The member request for confidential or alternative communications must be in writing, signed by the member or their authorized representative and sent to the attention of Member Services. We are not required to agree to these requests unless the member clearly states that the disclosure of all or part of the information in question could place them or someone else in danger. The member also has the right to request that we not send you any future marketing materials, and we will use our best efforts to honor such requests.

D. RIGHT TO INSPECT AND COPY – Members have the right to copy and/or inspect most of the protected health information that we retain on their behalf. All requests for access must be made in writing and signed by the member or their authorized representative. The member may obtain an access request form by calling Member Services or at the CrestPoint website. Requests for access should be sent to the attention of Member Services. We may charge you for a copy of the information. We may also charge for postage if you request a mailed copy and may charge for preparing a summary of the requested information if requesting a summary.

E. RIGHT TO AMEND – If a member believes that the protected health information we maintain about them is incomplete or incorrect, they have the right to ask CrestPoint to amend our records. All amendment requests must be in writing and signed by the member or their authorized representative. Requests for an amendment must state why the member believes our records are incomplete or inaccurate. We are not obligated to make all requested amendments but will give each request careful consideration. We may deny the request if the member ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment, and we can confirm that the amendment is appropriate;
- Is not part of the protected health information kept by or for CrestPoint;
- Is not part of the information which the member would be permitted to inspect and copy; or
- Is accurate and complete.

CrestPoint may send a copy of the newly amended record to any business associate or other entity that may have the older, inaccurate information. Members may obtain an amendment request form from Member Services or from the CrestPoint website.

F. COMPLAINTS – If a member believes their privacy rights have been violated, the member can file a complaint. The complaint must be in writing, and sent to the attention of

CrestPoint Appeals Department
P.O. Box 3620
Akron, Ohio 44309-3620

We will investigate all complaints, and send a written response.

Members may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of their rights. CrestPoint encourages members to tell us if they believe their privacy rights were violated. By law, CrestPoint may not retaliate against a member for filing a complaint.

G. RIGHT TO A PAPER COPY OF THIS NOTICE – All members have the right to a paper copy of this Notice even if the member has agreed to receive this Notice electronically. Members may request a copy of this Notice at any time by calling Member Services department at the number located on their identification card.

PROVIDER RESOURCE

Medicare Shared Savings Program

(MSSP)

Quality Measures

Updated January 2015

What you will find in this resource:

- A description of the Medicare Share Savings Program also called MSSP
- An explanation about why it is important to providers
- An overview of the 33 quality measures
- A description of the data collection process
- Recommendations for provider success in meeting the performance measures enabling payout of the incentive

Description of MSSP

The Medicare Shared Savings Program (MSSP) is a voluntary incentive program for Accountable Care Organizations (ACOs) to reward providers that work together to lower cost of care while meeting quality performance standards. The intent of the program is to encourage providers, suppliers, and others involved with care to create a new type of health care entity that agrees to be responsible and accountable for the care of its assigned beneficiaries. The goals of the program are congruent with the Institute of Healthcare Improvement's Triple Aim:

- Better population health management
- Better experience of care (satisfaction)
- Better management of cost of care

These goals will be achieved through better coordination of care across the continuum and implementing evidenced-based care that eliminates waste.

In order to participate in MSSP, the ACO must submit an application describing how they plan to meet the program goals. CMS sets benchmark goals for the ACO in both cost and quality areas. The ACO agrees to work to meet these benchmarks. If the ACO does not meet the cost and quality goals there are no shared savings.

Importance to Providers

Provider (also includes groups of providers) participation in the program is voluntary. A provider may be part of an ACO without participating in the MSSP program. All providers will continue to get paid by Medicare at the regular fee-for-service rates regardless of their participation. If a provider or group decides to participate, they will sign an agreement of participation with the ACO and be eligible to share in the savings. Savings are distributed once a year and are based on the entire ACO meeting the benchmarks. It is important for provider practices to be aware of the measures and to work collectively to meet the goals.

Quality Measures

The quality measures are designed to promote improved outcomes for patients. They are all clinically proven practices that promote prevention and better disease management. The measures are really a way to look at processes and care that should already be in place according to the evidence-based guidelines.

The MSSP program has a total of 33 measures. Only 22 of the measures are collected from medical records. The remaining 11 are collected directly from patient surveys and claims or administrative data. The measures are divided into four key domains:

- Patient/ Caregiver Experience (7 measures)

- Care Coordination and Patient Safety (6 measures)
- Preventive Health (8 measures)
- At-risk Populations / Disease Specific (12 measures)

The first year of data collection (2012 data) is used to help set the benchmarks for performance quality. For this year, the incentive pay will be based on reporting, not how well the ACO performed. In the following years, the incentive will be based on how well the ACO actually performs on the measures. See ***Table 1*** for a list of the specific measures.

During the data collection process for 2012, opportunities for improvement in adherence to the guidelines and more importantly documentation of data elements were identified. See ***Table 2*** for a summary of the measure specifications and opportunities identified.

Inconsistency in documentation processes and methods across the ACO create challenges in accurately gathering the data for the quality measures that have to be collected from the patient medical record. Creating consistent processes with clear documentation within each practice is vital to successfully reaching the benchmark goals for future incentive pay.

Data Collection Process

The data collection process takes place once a year and is scheduled in early spring by the Centers for Medicare and Medicaid (CMS). Each ACO receives a list of patient names from CMS to be included in the sample for data collection. CMS randomly selects 616 names for each measure from claims data that have been submitted during the measurement year. The ACO is required to report the measure results on 411 consecutive names in each measure list. There are exclusions for several of the measures which make the patient ineligible for that measure creating a “skip”. A skip requires that the next patient on the list be added to meet the 411 consecutive patient requirements. There may be one or more measures that have a smaller sample size of less than 411. In this case, all patients in the sample must be reported.

Once the data is collected, it is entered in the Group Practice Reporting Option (GPRO) web interface. This may be accomplished by direct data entry or data can be imported. AnewCare uses Health Endeavors, a third party software company to compile the MSSP data and upload it in the GPRO tool. This approach provides some advantages and process checking to ensure successful reporting.

After CMS receives the data, they analyze and will later send out official performance reports to the ACO.

Table 1: The ACO GPRO Quality Measures from the Medical Record 2014 Measurement Period					
ACO #	Domain	Measure Title	Pay for Performance Phase-In R= Reporting P= Performance PY1	PY2	PY3
12	Care Coord./Pt Safety	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	R	P	P
13	Care Coord./Pt Safety	Falls: Screening for Fall Risk	R	P	P
14	Preventive Health	Influenza Immunization	R	P	P
15	Preventive Health	Pneumococcal Vaccination	R	P	P
16	Preventive Health	Adult Weight Screening and Follow-up	R	P	P
17	Preventive Health	Tobacco Use Assessment and Tobacco Cessation Intervention	R	P	P
18	Preventive Health	Depression Screening	R	P	P
19	Preventive Health	Colorectal Cancer Screening	R	R	P
20	Preventive Health	Mammography Screening	R	R	P
21	Preventive Health	Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years	R	R	P
22	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8%)	R	P	P
23	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (<100)	R	P	P
24	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Blood Pressure <140/90	R	P	P
25	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Tobacco Non Use	R	P	P
26	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Aspirin Use	R	P	P
27	At Risk Population – Diabetes	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	R	P	P
28	At Risk Population – Hypertension	Hypertension (HTN): Blood Pressure Control	R	P	P
29	At Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100 mg/dl	R	P	P
30	At Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	R	P	P
31	At Risk Population – Heart Failure	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	R	R	P
32	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Drug Therapy for Lowering LDL-Cholesterol	R	R	P
33	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	R	R	P

Table 2. Quality Measure for 2013 with Insights from the 2013 Collection

Module	2014 Measure	2014 Notes	Education Opportunities
Care 1	Medication Reconciliation within **30 days** of discharge This includes discharge from acute care, SNF, or Rehab facility CMS provides the discharge dates based on claims data Reconciliation must be done for each discharge however if there are two discharges close together, one reconciliation can satisfy both if they are within the 30 window.	Medical record must: - Indicate the physician, PA, NP, or Clinical Pharmacist was aware of the discharge - The medications were reviewed including the dosage - Documented for them to stay the same, discontinue, or change including dosage	NOTE: for 2014, med rec must occur within **30 days of discharge** for this measure It is allowable for nurses to collect the information and put it in the electronic record but a physician, PA, NP or CP has to actually perform the reconciliation or make the decisions to continue, change, or discontinue. This must be evident in the medical record. One best practice we saw was a physician note that was titled "Hospital Follow-up". The note said discharge medications reviewed the following changes made….(list meds and dose changed or discontinued) then they wrote, all others continue as listed.
Care 2	Fall Risk Assessment Required once within the measurement period. Fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level on an object, floor or ground other than as a consequence of a sudden onset of paralysis, seizure, or external force (pushed)	Medical record must show that screening was documented - Two or more falls in a year - One fall with injury in a year - No falls within the year The measure intent is that planning occurs to create safety for those at risk for falls. CMS does not require use of a specific screening tool for Fall Risk Assessment.	Documentation for fall risk screening was excellent in the hospital setting but frequently not found in Physician Office documentation unless they came to the office because they fell. Offices need to determine the best place to document the screening and have it pull (if electronically documenting) to the summary note. NOTE: Reports can be created to pull this data if it is entered in a discrete field in the electronic record.
Prev 7	Influenza Immunization Required annually for all patients unless there is a medical contraindication, the patient refuses, or a system reason for not giving such as a shortage of the vaccine.	Medical Record must show: - Documentation that the vaccine was offered AND administered OR - Documentation that patient states they received it elsewhere OR - Documentation of why it was	There is a look back period for this measure….from Fall of previous year or anytime during measurement year. Best Practice Documentation: Use of a vaccination record or flow sheet which includes documentation of receipt elsewhere (Pharmacy, Clinic, etc)

Module	2014 Measure	2014 Notes	Education Opportunities
		not administered	
Prev 8	Pneumonia Vaccination Required once in a life time after age 65	Medical Record must show: - The vaccine was administered at any time after age 65 OR - Documentation that patient states they received it elsewhere OR - Documentation of why it was not administered	Best Practice Documentation: Use of a vaccination record or flow sheet which includes documentation of receipt elsewhere (Pharmacy, Clinic, etc) Offices need to determine the best place to document the screening and have it pull (if electronically documenting) to the summary note.
Prev 9	Body Mass Index (BMI) BMI must be measured within the last 6 months or at current visit and follow up plan documented if outside of normal range. Normal: - Age 65 and older BMI greater than or equal 23 and less than 30. - Age 18 – 64, BMI greater than or equal to 18.5 and less than 25	Medical Record must show: - Documentation of the BMI - Follow up plan for any BMI outside normal and may include diet education, future appointment for weight, referral to specialist such as dietician, occupational therapy, exercise physiologist, mental health professional, surgeon, etc. Some exclusions apply but must be documented: - Patient already in treatment for weight management - Terminal illness - Pregnant - Patient Refused - Other medical reason	Ht. and Wt. alone ***do not meet*** this measure, the BMI must be calculated. NOTE: The CMS measure actually is looking for a BMI with the current visit (last in the measurement period) or within 6 months prior. So for practice purposes, if the patient was seen in January and again in October, the BMI would need to be calculated at BOTH visits to meet this measure. For data collection purposes, we are instructed by CMS to use the ***most recent visit*** in the measurement period. Best Practice: Identify the BMI as a "Problem" if outside the normal range and add it to the problem list. Document follow up plans that meet the requirements and have them pull to the summary note. Leave the BMI on the active problem list until it is resolved.
Prev 10	Tobacco Screening Tobacco screening includes smoking, chewing, dipping or any use of tobacco. Patients must be screened at least once every 24 months and if they use tobacco, cessation counseling	Medical Record Documentation must include: - Screening for use - Cessation counseling if they are a user May (not required) include other interventions such as referrals, medications to help quit, etc.	This measure has a look back period including the measurement year AND the year previous. If a user, there must be documentation about counseling and follow up. CMS has determined that RX for a medication to help them stop is adequate to meet the "counseling" requirement.

<table>
<tr><th>Module</th><th>2014 Measure</th><th>2014 Notes</th><th>Education Opportunities</th></tr>
<tr><td></td><td>provided</td><td></td><td></td></tr>
<tr><td>Prev 12</td><td>Depression Screen

Depression screening must be done annually using an age appropriate standardized screening tool. If evidence of depression is found, a follow up plan must be implemented.</td><td>Medical Record documentation must include:
- Evidence that the screening was performed
- The screening was done using an age appropriate standardized tool – tool must be referenced in the documentation
- If the screen is positive, a follow up plan is put in place which must include further evaluation and may include referrals, screening for suicide, future appointments, medications, and education.
Exclusions must be documented in the medical record and include previous dx (prior to the measurement period) and currently receiving treatment; patient refusal; severe mental or physical incapacity where the person is unable to express him/herself (i.e. delirium)</td><td>This measure requires use of a standardized tool that is appropriate for the age of the patient. CMS recommends the list below for adults 18 and older but does not require use of one of those. Providers may choose others but they must meet the guidelines as “standardized”.
- PHQ9
- Beck Depression Inventory
- CES-D
- Depression Scale (EDPS)
- Duke Anxiety-Depression Scale
- Geriatric Depression Scale
- Cornell Scale Screening
- PRIME MD-PHQ2

NOTE: Just documenting that the patient does not have depression does NOT meet the measure requirement.

For existing depression dx, be sure to document why depression medications are being continued if prescriptions are renewed.</td></tr>
<tr><td>Prev 6</td><td>Colorectal Cancer Screening

This applies to patients age 50 - 75

This may be answered using one or more of these methods:
- Annual Fecal Occult Blood test
- Flexible Sigmoidoscopy every 5 years
- Colonoscopy every 10 years</td><td>Medical record documentation must include up to date testing of one of the following:
- Annual Fecal Occult Blood test
- Flexible Sigmoidoscopy every 5 years
- Colonoscopy every 10 years
Exclusions include documented medical reasons why the test(s) were not performed including total colectomy.</td><td>Best Practice Documentation: Use of a flow sheet or checklist which includes documentation of date, test, and receipt location.

Example:
<table><tr><td>Fecal Occult Blood Test</td><td>11/20/2010 PCP Office</td><td>10/11/2011 GYN Office</td></tr><tr><td>Flexible Sigmoidoscopy</td><td>Never</td><td></td></tr><tr><td>Colonoscopy</td><td>2004 – Dr. X</td><td></td></tr></table>
This measure may be self-reported by the patient but must be noted in the record. The actual test result does NOT have to be in the record but desired for good practice management.</td></tr>
</table>

Module	2014 Measure	2014 Notes	Education Opportunities
Prev 5	Mammography for women ages 40 – 69 every 24 months	Medical record must include documentation of - The mammogram date - The results of the mammogram The only exclusions include total bilateral mastectomy or two unilateral mastectomies	Best Practice Documentation: Use of a flow sheet or checklist which includes documentation of date, test results which may be in a dictated note or other report.
Prev 11	High Blood Pressure Screening This measure requires screening of the blood pressure WITH follow up based on the initial finding.	Medical Record Documentation must include: - Date and BP result - Follow up plan based on BP result. Guidelines: - BP <120/80, no follow up plan required - BP with systolic reading of 120 – 139 or diastolic reading of 80-90 should be screened annually (must be documented as a plan) AND recommended lifestyle changes - A FIRST BP equal to or higher than 140/90 should be rescreened within one month (must be documented as a plan) AND recommended lifestyle changes - A SECOND BP equal to or higher than 140/90 should receive recommendation on Life style changes AND one or more of the following: • Anti-Hypertensive medications • Lab Tests • EKG Another appropriate action would be to refer the patient with elevated BP to an alternative or primary care provider.	CMS requires use of the most recent BP result in the measurement period. In order to meet the follow up requirement for this measure, documentation must include a note about when to recheck the BP if the BP is above 120/80, AND counseling on lifestyle changes and other follow up as defined in the Notes column. Example plan documentation: *Return in 1 month for BP check, patient educated on low salt diet and weight management.* Simply documenting "return in one month" without referencing the BP is not adequate. If the patient is screened by a specialist, the specialist needs to document a follow up. It could be referred to the PCP but it must be documented.

Module	2014 Measure	2014 Notes	Education Opportunities
		Exclusions include patients with known HTN currently being treated, over the age of 85, or patient refusal.	
DM	Diabetes Mellitus is a composite measure which means we must meet all 5 of the composite measures plus the one other for each patient or the entire module will not count for performance. These measures apply to all patients dx with diabetes between the ages of 18 – 75. Exclusions include: - Permanent Nursing Home Resident - Pregnant during the measurement period		
DM 15	Hemoglobin A1c in control less than 8%	Medical Record Documentation must include: - Active Dx of DM - Date of test - Result of test	CMS requires the measure be answered using the most recent HgA1c result in the measurement period.
DM 14	Low Density Lipoprotein (LDL-C) <100 mg/dl	Medical Record must include: - Active Dx of DM - Date of test - Result of test (Performance goal is <100)	CMS requires the measure to be answered using the most recent test in the measurement period. NOTE: When ordering a Lipid Panel, be sure the LDL-C is included in the results
DM 13	Blood Pressure Control Most recent BP <140/90	Medical Record must include: - Active Dx of DM - Date of BP reading - Result <140/90	CMS requires the measure to be answered using the most recent reading in the measurement period.
DM 17	Tobacco NON-use	Medical Record must include: - Dx of DM - Screening for NON-use of tobacco	NOTE: A look back period does not apply for this measure. Patients must be screened within the measurement period for tobacco use if they are Dx with DM. For this measure to count toward performance, the patient must be a non-user.
DM 16	Diabetes and Ischemic Vascular Disease (IVD) Patients with DM ***and*** IVD with documentation of taking daily aspirin or antiplatelet or accepted contraindication	Medical Record must include: - Dx of DM - Dx of IVD* - Documentation of ASA use or listed antiplatelet agents *(cliostazol, clopidogrel, dipridamole, prasugrel, ticlopine, enoxaprin)* OR - Documented contraindication such as allergy, Coumadin tx,	IVD* with the DM measure includes other acceptable diagnoses including: - CABG - PTCA - AMI - Carotid Stenosis - Ischemic Stroke - Atherosclerosis NOTE: NOT all diagnoses equal to IVD count in this measure. A comprehensive list of diagnosis codes available on request.

Module	2014 Measure	2014 Notes	Education Opportunities
		Lovenox, hx of GI bleed or intracranial bleed, or other medical reason.	Be sure the med list is updated to include aspirin if the patient is taking it even if it is an OTC medication.
DM 2	Hemoglobin A1c ***in poor*** control (>9.0) This measure is stand alone, not part of the composite score.	Medical Record Documentation must include: - Active Dx of DM - Date of test and result - Result of test	CMS requires the measure be answered using the most recent HgA1c result in the measurement period.
HTN 2	Controlling Blood Pressure for Patients with Hypertension Includes patients age 18 - 85 BP is controlled at <140/90	Medical Record documentation must include: - Active Dx of HTN - Date of BP reading - Result of Reading <140/90	CMS requires the measure to be answered using the most recent reading in the measurement period. If the patient BP is >140/90, this measure is not met regardless of anti-hypertensive therapy.
IVD	Ischemic Vascular Disease includes CAD, AMI, CABG, PCI, Stroke, TIA, Ischemia, and PVD		
IVD 1	IVD and Lipid Profile One ***complete*** lipid profile in 12 months and recent LDL-C in control (<100)	Medical Record documentation must include: - Active Dx of IVD* - Lipid Profile on chart including all components - LDL-C result and date IVD* there is a long list of diagnosis codes that may apply here – List available on request	CMS requires the measure to be answered using the most recent lipid profile in the measurement period. Complete Lipid Profile must include: - Total Cholesterol - HDL - LDL - Triglycerides
IVD 2	IVD and use of Aspirin or Another Antithrombotic	Medical Record must include: - Active Dx of IVD - Documented use of ASA or listed antithrombotic (clopidogrel.dipyridamole, ticlopine, prasugrel)	Be sure the med list in the patient record is updated to include aspirin if the patient is taking it ***even if it is an OTC*** medication.
HF 6	Heart Failure and Beta-Blocker Therapy All patients with heart failure with a current or prior LVEF <40% should be prescribed beta-	Medical record documentation should include: - Dx HF with evidence of a ***current or prior left ventricular ejection fraction of less than 40%***	Additional approved beta-blockers for this measure include: - Atenolol - Nadolol - Pindolol - Timolol - Penbutolol

Module	2014 Measure	2014 Notes	Education Opportunities
	blocker therapy.	- Beta-blocker therapy ordered to include one of the following • Bisoprolol • Carvedilol • Metoprolol • Others (see list in next column) OR - Documented Contraindication to beta-blocker therapy	- Betaxolol - Nebivolol - Proprandolol - Labetalol - Sotalol - Carteolol - Esmolol - Acebutolol NOTE: Be sure the LVEF is recorded in the patient primary care chart.
CAD	Coronary Artery Disease (CAD) includes dx of AMI, Angina, ASCVD, ASHD, CABG, PTCH, CHD, Myocardial Ischemia, and others. A comprehensive list of diagnosis codes available on request.		
CAD 2	Coronary Artery Disease: Lipid Control LDL-C should be measured every 12 months LDL-C < 100 *OR* LDL-C > 100 with a plan of care to decease including at a minimum an RX for statin tx	Medical Record Documentation must include: - Dx of CAD (see above) - LDL-C result and date on the chart within the measurement period - If LDL-C >100, plan of care includes, at a minimum, a prescribed statin OR - Contraindication to statin use is documented	Approved Statin List: - Fluvastatin - Simvastatin - Lovastatin - Pravastatin - Rosuvastatin - Any in combination A comprehensive list of approved medications is available on request.
CAD 7	Coronary Artery Disease with DM and/or LVSD Patients with a diagnosis of CAD who also have: - a current or prior LVEF < 40% AND/ OR - a diagnosis of Diabetes are prescribed ACE inhibitors or ARB therapy	Medical Record Documentation must include: - Dx of CAD ***and*** - Dx of LVSD ***or*** - Dx of Diabetes - Documented prescription for an ACE Inhibitor or ARB OR - Documented contraindications to the medications	Be sure to include all diagnoses in the current problem list in the medical record. The approved list of ACE inhibitors and ARB medications is long and is available on request. Essentially any ACE-I or ARB will meet the measure.

Appendix B: Quality Programs for Medicare Patients

Information for Providers

An Introduction to the Quality Programs for Medicare Patients

Recent changes in Medicare have further intensified the need for Providers and Health Plans to ensure quality of care for their patients. New financial incentives for meeting quality measures have been put in place to encourage quality and prevention. This information guide will help you in meeting the required measures to maximize patient and financial outcomes.

Enclosed in this Appendix is a guide for the Medicare and Medicaid 5-Star Rating Program. For the Medicare Advantage patients, the Stars Rating Program incorporates 37 measures divided into 5 domains. For patients also on the Prescription Drug Plan, there are 51 measures divided into 9 domains. It is important to strive for a 4 or 5 Star Rating in order to realize the best financial incentive. The measures are congruent with the Institute of Health's Triple Aim for better care, better health, and decreased costs.

Several of the measures in the Stars Rating Program are gathered by sources such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Health Outcomes Survey (HOS) in which the data is collected directly from the patient by survey. The remaining measures are gathered through medical record documentation and reported to the National Committee for Quality Assurance (NCQA) as part of Healthcare Effectiveness Data and Information Set (HEDIS) program. The HEDIS report is used in conjunction with CAHPS and HOS survey outcomes to determine the Star Rating.

One important recent focus for Medicare is on preventive care and providing an Initial Preventive Physical Exam (Welcome to Medicare Exam) in the first 12 months of Medicare eligibility followed by an Annual Wellness Visit. Costs for both of these are now covered by Medicare. One significant element includes completing a Health Risk Assessment (HRA).

We hope this information will be helpful. Please contact us with any questions.

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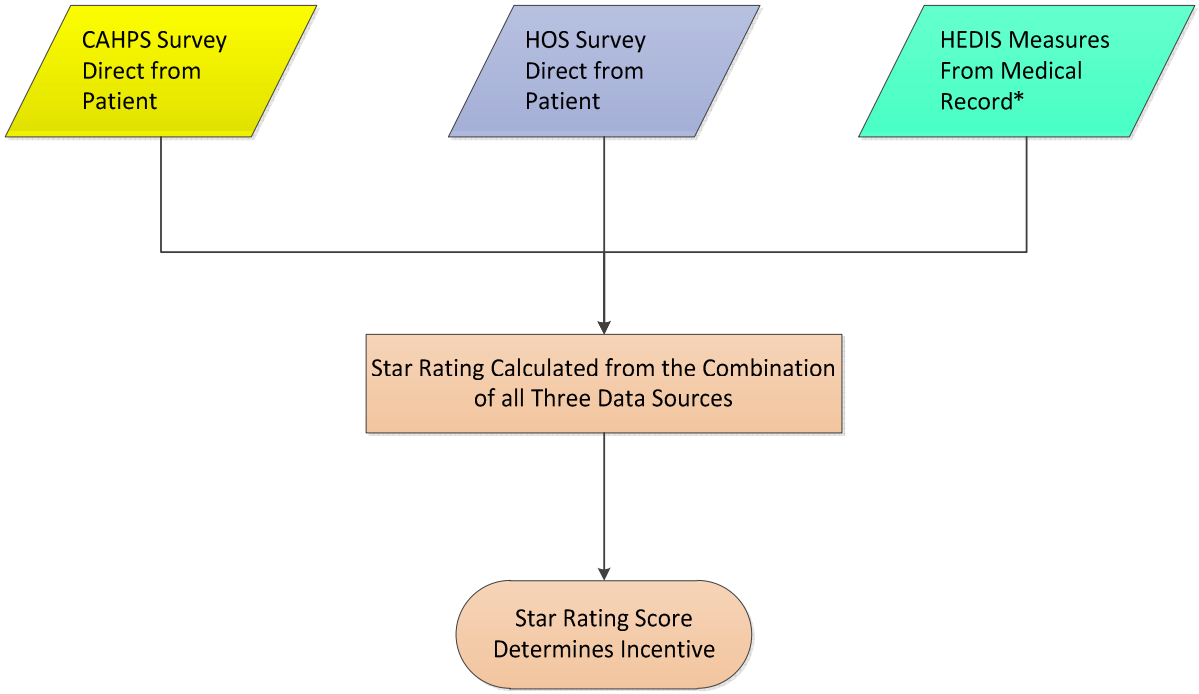
Medicare Advantage Quality Stars Ratings Process



*Refer to Stars Physician Documentation document

Stars Measures

Part	2014 ID	2015 ID	Measure	Notes	Weight
C	C02	C01	Colorectal Cancer Screening	Colonoscopy every 10 years Flexible Sigmoidoscopy every 5 years Annual Fecal Occult Blood Tests	1
C	C03	C02	Cardiovascular Care – Cholesterol Screening	LDL Value and data of test.	1
C	C04	C03	Diabetes Care – Cholesterol Screening	LDL Value and date of test.	1
C	C06	C04	Annual Flu Vaccine	Survey question – Did you have the flu vaccination?	1
C	C07	C05	Improving or Maintaining Physical Health	Survey Measure to assess patient perception of health.	3
C	C08	C06	Improving or Maintaining Mental Health	Points are awarded for improvement from year to year in the overall scores.	3
C	C09	C07	Monitoring Physical Activity	Medical record documentation of discussion with patient about physical activity and the patient answers on survey that you did discuss it with them.	1
C	C10	C08	Adult BMI Assessment	A calculated BMI on the chart (and if abnormal, a plan in place to address)	1
C	C14	C13	Osteoporosis Management in Women who had a Fracture	Females who suffered a fractured bone had either a Bone Scan and/or osteoporosis treatment started within 6 months of fracture.	1
C	C15	C14	Diabetes Care – Eye Exam	Retinal eye exam results in the medical record read by a qualified professional.	1
C	C16	C15	Diabetes Care – Kidney Disease Monitoring	Multiple things meet this measure including urine micro albumin test or treatment with an ACEI or ARB	1
C	C17	C16	Diabetes Care – Blood Sugar Controlled	The most recent in the measure year A1c result is less than 8.	3
C	C18	C17	Diabetes Care – Cholesterol Controlled	The most recent in the measure year LDL-c was less than 100. This measure is going away for 2016 due to guideline changes.	3
C	C19	C18	Controlling Blood Pressure	The most recent BP in the measure year is less than 140/90.	3
C	C20	C19	Rheumatoid Arthritis Management	Patients diagnosed with RA are on the appropriate disease modifying agents.	1
C	C21	C20	Improving Bladder Control	Survey question for all patients whose medical record documents bladder control problems.	1
C	C22	C21	Reducing the Risk of Falling	Fall risk screening is completed and documented in the medical record.	1
C	C23	C22	Plan All-Cause Readmissions	Claims data will be used to measure readmission rates.	3
C	C24	C23	Getting Needed Care	Survey Question	1.5
C	C25	C24	Getting Appointments and Care Quickly	Survey Question	1.5
C	C26	C25	Customer Service	Survey Question	1.5

C	C27	C26	Rating of Health Care Quality	Survey Question	1.5
C	C28	C27	Rating of Health Plan	Survey Question	1.5
C	C29	C28	Care Coordination	Survey Question	1.5
C	C30	C29	Complaints about the Health Plan	Medicare records of complaints filed for the health plan (CTM Module)	1.5
C	C32	C30	Members Choosing to Leave the Plan	Enrollment / disenrollment data from Medicare	1.5
C	C33	C31	Health Plan Quality Improvement	Points are awarded for improvement from year to year in the overall scores.	5
C	C34	C32	Plan Makes Timely Decisions about Appeals	Medicare Records	1.5
C	C35	C33	Reviewing Appeals Decisions	Medicare Records	1.5
C	C36	C34	Call Center – Foreign Language Interpreter and TTY Availability	Medicare secret shopper results	1.5
D	C01	D01	Call Center – Foreign Language Interpreter and TTY Availability	Medicare secret shopper results	1.5
D	D02	D02	Appeals Auto–Forward	Medicare Records	1.5
D	D03	D03	Appeals Upheld	Medicare Records	1.5
D	D04	D04	Complaints about the Drug Plan	Medicare records of complaints filed for the drug plan (CTM Module)	1.5
D	D05	D05	Members Choosing to Leave the Plan	Enrollment / Disenrollment records	1.5
D	D07	D06	Drug Plan Quality Improvement	Points are awarded for improvement from year to year in the overall scores.	5
D	D08	D07	Rating of Drug Plan	Survey Question	1.5
D	D09	D08	Getting Needed Prescription Drugs	Survey Question	1.5
D	D10	D09	MPF Price Accuracy	Medicare calculations based on bid submitted and actual drug prices charged at point of service measured by claim review.	1
D	D11	D10	High Risk Medication	Number of patients who were prescribed a high risk medication with at least one refill measured by claim review.	3
D	D12	D11	Diabetes Treatment	Diabetes patients who also have hypertension are on an ACEI or ARB as per prescription claims review.	3
D	D13	D12	Medication Adherence for Diabetes Medications	Patients are getting their oral diabetes medications refilled often enough to have at least 80% of the days covered.	3
D	D14	D13	Medication Adherence for Hypertension (RAS antagonists)	Patients are getting their ACEI or ARB medications refilled often enough to have at least 80% of the days covered.	3
D	D15	D14	Medication Adherence for Cholesterol (Statins)	Patients are getting their statin medications refilled often enough to have at least 80% of the days covered.	3

Appendix C : Meaningful Use Measures

The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

To be part of the AnewCare Collaborative ACO, providers must participate in the EHR Incentive Program and attest to meaningful use measures that qualify for stage one and two of the program.

Visit CMS website at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html

Appendix D: Depression Screen

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ Date of Birth_____

DATE Completing Form:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)	**Not at all** **0**	**Several Days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
Totals **This row to be completed by Office Staff**	0	Number ✓ =	Number ✓ *x2=*	Number ✓ *x3=*
			Add totals for grand total:	

10. If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** _____ **Somewhat difficult** _____ **Very difficult** _____ **Extremely difficult** _____

Instructions for Scoring

ATTENTION: Do not give this page to the patient with Patient Health Questionnaire
For physician or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Ask the patient to complete the PHQ-9 Quick Depression Assessment
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add the score to determine severity.

Consider Major Depressive Disorder

3. If there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

4. If there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1, More than half the days = 2, Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Continue on next page for scoring….

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

For healthcare professional use only

Scoring—add up all checked boxes on PHQ-9 by column, then multiply by the severity score

For every ✓: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score Depression Severity

0-4 = None
5-9 = Mild depression
10-14 = Moderate depression
15-19 = Moderately severe depression
20-27 = Severe depression

Appendix E: Fall Risk Assessment Tool

Place a check mark in the column labeled yes if the risk factor applies to your patient. A patient with a check in the box for a risk factor with an asterisk (*) or four or more other risk factors would be considered at risk for falls.	
Risk Factor	**Yes**
Confusion/Disorientation*	
Age over 60	
Dizziness/Imbalance	
Unsteady gait, perform "Get-Up-and-Go Test" if needed	
Problems/disease affecting weight-bearing joints	
Weakness	
Seizure Disorder	
Impairment of vision and/or hearing	
Altered elimination (bowel and/or bladder)	
Impaired Memory/Judgment/Impulsivity	
Inability to understand or follow directions	
Use of diuretics or drugs with diuretic effects	
Hypotensive	
Use of CNS suppressants (e.g., narcotic, sedative, psychotropic, hypnotic, tranquilizer, antihypertensive, antidepressant)	
Use of Ambulatory Devices (cane, crutches, walker, wheelchair, braces, geriatric (geri) chair	
History of two or more falls within last 12 months*	
History of one or more falls within last 12 months resulting in moderate or worse injury*	

An injury is defined in the terms listed below:

1. *None* indicates that the patient did not sustain an injury secondary to the fall.
2. *Minor* indicates those injuries requiring a simple intervention.
3. *Moderate* indicates injuries requiring sutures or splints.
4. *Major* injuries are those that require surgery, casting, further examination (e.g., for a neurological injury).
5. *Deaths* refers to those that result from injuries sustained from the fall.

Timed Get Up and Go Test

This test is performed with patient wearing regular footwear, using usual walking aid if needed, and sitting back in a chair with arm rest. On the word, "Go", the patient is asked to do the following:

- Stand up from the arm chair
- Walk 10 feet in a line
- Turn
- Walk back to chair
- Sit down

Repeat the test and time the second effort. Observe patient for postural stability, gait, stride length and sway.

Scoring: Normal: completes task in < 10 seconds
Abnormal: completes task in >20 seconds

Low scores correlate with good functional independence; high scores correlate with poor functional independence and higher risk of falls.

NOTE: IF the patient is at risk for a fall based on one or both of these test, a follow up plan for safety needs to be documented in the treatment plan.

Sources: www.NBCI.gov; Hendrich II Fall Risk Model; Brians LK Risk tool for fall prevention

Appendix F: Health Risk Assessment
Use this tool as a guide to collect needed information.

Member Name: _____ DOB: _____

Member ID: _____ Age: _____

DATE OF ASSESSMENT: _____ PCP: _____

Current and Past Medical Diagnoses

Date / Year	Diagnosis	Acute	Chronic	Resolved

Do you have recurring pain? ☐Yes ☐No ☐Sometimes

Please describe:

_____

Current Medication List – Rx and OTC

Medication (Dose, Route, and Frequency)	Supporting Diagnosis

Current Medication List – Rx and OTC Continued….	Supporting Diagnosis

Do you currently take all your medications daily as they are prescribed? ☐Yes ☐No

Comments:
_____

Allergies	*List Allergies*
☐ NKDA	
☐ Food / Other	
☐ Medications	

Personal and Social History

With whom do you live? ☐ Alone ☐ Spouse ☐ Child(ren) ☐Other Family ☐Other _____

Who assists you when you are not well?

_____

Do you use any medical equipment? ☐ Yes ☐ No

If yes, what equipment? _____

Do you receive assistance from any outside agencies?

☐ Homecare ☐ Passport ☐ Other _____

Do you feel safe in your home? ☐ Yes ☐ No

Advance Directives? ☐ Yes (Obtain copy for chart) ☐ No

Health Habits

Diet:
___No Restrictions __Diabetic __Low Fat __Low Salt ___DASH ___Wt Reduction ___Supplements

Tobacco Use: ☐ Yes ☐ No *If yes, how much, how long? _____

☐ *If current, instructed on smoking cessation*

Drug Abuse: ☐ Yes ☐ No

If yes, what type? Elicit_____ Prescription_____

Caffeine: ☐ Yes ☐ No

If yes, type and amount per day? _____

Alcohol: ☐ Yes ☐ No ☐ Past

Present/Amount _____

Does patient have diagnosis of Alcohol Dependency? ☐ ***Yes*** ☐ ***No***

Health Maintenance (please note dates or approximate dates)	
Eye Exam (Glaucoma screen q2 years) (Annual diabetic eye exam)	
Dental Exam	
Hearing Exam	
Colonoscopy	
Mammogram	
Breast Exam	
PAP test	
DEXA	
Prostate Exam	
PSA	

Do you see any specialists for any of your chronic medical conditions?

_____

Do you have difficulty with any of these daily tasks?

Eating ☐ Yes ☐ No Bathing ☐ Yes ☐ No Toileting ☐ Yes ☐ No

Immunizations (please note dates or approximate dates)	
Flu Shot (Annually >65 yrs)	
Pneumonia Shot (Once >65 yrs)	
Tetanus/ TDP (Booster q 10 yrs)	
Zostavax (Covered by SummaCare after age 60)	
Other	

Vital Statistics (REQUIRED)	
Height	inches
Weight	pounds
BMI	%
Blood Pressure	
Pulse	
Respirations	
Temp	

stem	**Review of Systems**	**Physical Exam**	**Provider's Assessment and Diagnosis**		
Nutrition	Poor Appetite Weight Loss Weight Gain	Cachexic Overweight Underweight Obese	799.4	☐	Cachexia
			263.9	☐	Protein Calorie Malnutrition
			273.8	☐	Hypoalbuminemia
			278.00	☐	Obesity (BMI 30.0 – 38.9)
			278.01	☐	Morbid Obesity (BMI > 39)

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
	Teeth: Dentures Edentulous Poor condition **Asymptomatic**	Albumin ___ **WNL**		☐	
Integumentary	Rash Lumps Dry Skin/ Itching Skin Break/Tear **Asymptomatic**	Pressure Ulcer - Location - Stage Ulcer - Location - Stage Change in Hair /Nails **WNL**	707.0_	☐	Pressure Ulcer: Specify Site & Stage _____
			707.1_	☐	Ulcer (not Pressure): Specify Site _____
			682._	☐	Cellulitis: Specify site _____
			692.9	☐	Eczema
			696	☐	Psoriasis
				☐	
Eyes	Change in Vision Glasses Pain	PERRLA Conjunctivitis Cataract	V45.61	☐	Cataracts - History
			366.9	☐	Cataracts - Current
			365.11	☐	Open Angle Glaucoma
			362.50	☐	Macular Degeneration
			362.00	☐	Diabetic Retinopathy
			369.00	☐	Blindness

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
	Redness Blurred Vision Floaters **Asymptomatic**	Glaucoma Diabetic Retinopathy **WNL**		☐	
ENT	Hearing impairment Ringing in ears Sinus pain Sinus drainage **Asymptomatic**	Cerumen Impaction Enlarged Thyroid Adenopathy **WNL**	380.4	☐	Cerumen Impaction
			389.9	☐	Deafness
			473.9	☐	Sinusitis
			477.9	☐	Allergic Rhinitis
				☐	
Cardiovascular	History of MI	Irregular Heart Rate Murmur	272.4	☐	Hyperlipidemia
			272.0	☐	Hypercholesterolemia
			401.1	☐	Benign Hypertension

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
	Chest pain Arrhythmia or palpitations Shortness of breath Shortness of breath with exertion Edema Orthopnea Leg pain while walking **Asymptomatic**	JVD Lipid Panel Carotid Bruit L / R Peripheral pulses - present - diminished - absent **WNL**	401.9	☐	Unspecified Hypertension
			402.90	☐	Hypertensive Heart Disease
			412	☐	Old Myocardial Infarction (> 8 weeks)
			413.9	☐	Angina
			414.01	☐	Coronary Atherosclerosis of Native Coronary Artery
			V45.81	☐	History of CABG
			414.8	☐	Chronic Ischemic Heart Disease
			425.4	☐	Cardiomyopathy
			428.0	☐	Congestive Heart Failure
			428.22	☐	Chronic Systolic Heart Failure
			428.32	☐	Diastolic Heart Failure
			428.42	☐	Combined Chronic Systolic and Diastolic Heart Failure
			428.9	☐	Heart Failure Unspecified
			429.3	☐	Cardiomegaly
			782.3	☐	Edema
			427.31	☐	Atrial Fibrillation
			426.0	☐	Complete AV Block
			427.81	☐	Sick Sinus Syndrome
			440.0	☐	Atherosclerosis of Aorta
			440.1	☐	Atherosclerosis Renal Artery
			440.20	☐	Atherosclerosis of Extremities
			441.4	☐	Abdominal Aortic Aneurysm

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
			441.9	☐	Aortic Aneurysm of unspecified
			443.9	☐	Peripheral Vascular Disease
			443.9	☐	Intermittent Claudication
			V12.51	☐	History of Venous Thrombosis and Embolism
			424._	☐	Heart Valve Disorder: ☐ Mitral ☐ Aortic ☐ Tricuspid ☐ Pulmonary
			V45.02	☐	Defribrillator/AICD in Situ – Specify reason below: ☐Ventricular Fib/Flutter ☐Ventricular Tachycardia ☐Cardiac Arrest
			429.3	☐	Cardiomegaly
			782.3	☐	Edema
				☐	
				☐	
Respiratory	Cough Sputum SOB Wheezing Hemoptysis	Lung Sounds Rhonchi Rales/ Crackles Wheezes 02 sat ___%	491.0	☐	Chronic Bronchitis
				☐	Smoker's Cough
			492.8	☐	Emphysema
			493.90	☐	Asthma
			496	☐	COPD
			518.83	☐	Chronic Respiratory Failure
			V46.2	☐	Supplemental O2 (current)
			V44.0	☐	Tracheostomy Status (current)
				☐	

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
	02 dependent? ___ **Asymptomatic**	Spirometry Test **WNL**		☐	
Gastrointestinal	Difficulty Swallowing Nausea Constipation Diarrhea Bloody Stools Hemorrhoids Heartburn GERD Bowel Incontinence **Asymptomatic**	Jaundice Ascites Abdominal Tenderness Palpable Mass Colostomy Ileostomy Guiac + / -	530.81 533.90 556.9 555.9 564.00 787.6 787.91 571.4 V44.3 V44.1 V44.4 562.10 562.11 571.2 571.5 572.8 577.1	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Esophageal Reflux (GERD) Peptic Ulcer Disease (PUD) Ulcerative Colitis Crohn's Disease Constipation Bowel Incontinence Diarrhea Chronic Hepatitis Colostomy (current) Gastrostomy (current) PEG Tube (current) Diverticulosis Diverticulitis Alchoholic Cirrhosis Cirrhosis of Liver Other End Stage Liver Disease Chronic Pancreatitis
Gen	Frequency	GFR _____	788.30	☐	Urinary Incontinence

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
			599.0	☐	Urinary Tract Infection
	Urgency	Urine Dip	607.84	☐	Impotence
			600.00	☐	BPH
	Burning	Diabetic Nephropathy	585.1	☐	Chronic Kidney Disease Stage I (GFR ≥ 90)
	Change in flow	Enlarged Prostate	585.2	☐	Chronic Kidney Disease Stage II – Mild (GFR 60-89)
	Hematuria	History Kidney Stones	585.3	☐	Chronic Kidney Disease Stage III - Moderate (GFR 30-59)
			585.4	☐	Chronic Kidney Disease Stage IV - Severe (GFR 15-29)
	Incontinence or Leaking	Testicular Mass	585.5	☐	Chronic Kidney Disease Stage V (GFR < 15)
	Pain on Urination		585.6	☐	End Stage Renal Disease (ESRD)
			585.9	☐	CKD Unspecified / Chronic Renal Insufficiency
	Urinary Catheter		V45.11	☐	Dialysis
	Asymptomatic	**WNL**	V44.50	☐	Cystostomy Status (current)
				☐	
Musculoskeletal	Joint Stiffness	Limited ROM	274.9	☐	Gout
			714.0	☐	Rheumatoid Arthritis
	Joint Pain	Amputation - Right / Left / Bilateral - Above Knee - Below Knee - Great Toe - Other Toe(s)	715.0_	☐	Osteoarthritis/DJD (Generalized) Specify Sites:_____
	Redness of Joints		715.3_	☐	Osteoarthritis/DJD (Localized) Specify Sites: _____
	Swelling of Joints		724.00	☐	Spinal Stenosis Unspecified
			733.00	☐	Vertebral Wedge Fracture

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
	Back Pain Muscle Atrophy Fall(s) within last year Difficulty walking Use of assistive device(s) **Asymptomatic**	**WNL**	733.00	☐	Osteoporosis Unspecified
			733.01	☐	Osteoporosis, Senile
			V49.7_	☐	Amputation Status ☐ Above Knee ☐ Below Knee ☐ Great Toe ☐ Other Toe(s)
			V15.88	☐	History of Falling or At Risk for Falling
				☐	
Neurological	Hemiplegia Hemiparesis Vertigo Headaches Tremors Numbness/Tingling	Cranial Nerves +/- Motor Nerves +/- Coordination/Gait +/- Reflexes +/-	332.0	☐	Parkinson's Disease
			340	☐	Multiple Sclerosis
			346.90	☐	Migraines
			350.1	☐	Trigeminal Neuralgia
			356.9	☐	Ideopathic Peripheral Neuropathy
			438.11	☐	Aphasia – Late Effect of Stroke
			438.12	☐	Dysphasia – Late Effect of Stroke
			438.20	☐	Hemiparesis or Hemiplegia (Late Effects of Stroke)
			438.0	☐	☐ Cognitive Deficits - Late Effect of Stroke

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
	Seizures **Asymptomatic**	**WNL**	438.10	☐	☐ Late Effect of Stroke - Speech and Language Deficits
			V12.54	☐	History of CVA/Stroke
			780.39	☐	Seizure Disorder
			345.90	☐	Epilepsy
			344.00	☐	Quadriplegia
			344.1	☐	Paraplegia
			787.20	☐	Dysphagia
				☐	
Psychiatric	Depression Anxiety Nervousness Memory Loss Chronic Insomnia Stress **Asymptomatic**	Mood Flat Affect Hyperactive Manic Hallucinations Delusions **WNL**	296.20	☐	Major Depression
			311	☐	Depression
			300.4	☐	Depression with Anxiety
			300.02	☐	General Anxiety Disorder
			296.80	☐	Bipolar Disorder
			295.90	☐	Schizophrenia
			290.0	☐	Senile Dementia
			290.40	☐	Vascular Dementia
			294.10	☐	Dementia Alzheimer's Type
			294.8	☐	Dementia NOS
			331.0	☐	Alzheimer's Disease
			305.0_	☐	Alcohol Abuse: ☐Continuous ☐in Remission
			303.9_	☐	Alcohol Dependence: ☐Continuous ☐in Remission
			305.__	☐	Drug Abuse: ☐Continuous ☐in Remission

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
			304.__	☐	Drug Dependence: ☐Continuous ☐in Remission
			305.1	☐	Current Tobacco Use
			V15.82	☐	History of Tobacco Use
				☐	
Endocrine	Heat intolerance Cold intolerance Sweating Polyuria Polydipsia Polyphagia **Asymptomatic**	Last HgbA1C _____ (Annual) Last LDL _____ (Annual) Microalbumin ____ (Annual) Eye Exam ____ (Annual) Monofilament Impaired / WNL Enlarged thyroid Goiter **WNL**	250.0_	☐	Diabetes without mention of complications ☐ Type II ☐ Type I ☐ Controlled ☐ Uncontrolled
			250.4_	☐	Diabetes w/ renal manifestations
			585._	☐	☐ CKD Stage _____
			583.81	☐	☐ Nephropathy NOS
			250.5_	☐	Diabetes w/ ophthalmic manifestations
			362.01	☐	☐ Background retinopathy
			362.02	☐	☐ Proliferative retinopathy
			250.6_	☐	Diabetes w/ neurologic manifestations
			337.1	☐	☐ Peripheral autonomic neuropathy
			357.2	☐	☐ Polyneuropathy in diabetes
			250.7_	☐	Diabetes w/ peripheral circulatory manifestations
			443.9	☐	☐ Peripheral Vascular
			250.8_	☐	Diabetes with Other Complications
			707.__	☐	☐ Ulcer: Site: _____ Stage: _____

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
				☐	☐ Other Specify: _____
			242.90	☐	Hyperthyroidism
			244.9	☐	Hypothyroidism
Hematology/ Oncology	Bruising Bleeding Anemia Weight Gain Weight Loss History of Cancer: Where: When: **Asymptomatic**	Lumps Masses **WNL**	285.9	☐	Anemia Unspecified
			280.9	☐	Iron Deficiency Anemia NOS
			281.0	☐	Pernicious Anemia
			285.21	☐	Anemia due to CKD
			285.29	☐	Anemia of Chronic Disease
			288.00	☐	***Neutropenia***
			202.80	☐	Lymphoma
			204.1	☐	Chronic Lymphocytic Leukemia
			205.1	☐	Chronic Myelogenous Leukemia
			185	☐	CURRENT Prostate Cancer
			V10.47	☐	History of Prostate Cancer
			162.9	☐	CURRENT Lung Cancer
			V10.11	☐	History of Lung Cancer
			174.9	☐	CURRENT Breast Cancer
			V10.3	☐	History of Breast Cancer
			153.9	☐	CURRENT Colon Cancer
			V10.05	☐	History of Colon Cancer
				☐	CURRENT Cancer Other: _____
				☐	Hx of Cancer Other: _____

stem	Review of Systems	Physical Exam	Provider's Assessment and Diagnosis		
			225.0	☐	Benign neoplasm of Brain
				☐	

PHQ-9 Depression Screen

		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself, that you are a failure, or have let yourself/others down	0	1	2	3
7.	Trouble concentrating on things such as reading the paper or watching TV	0	1	2	3
8.	Moving or speaking so slowly that other people have noticed; or being excessively restless/fidgety	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
	ADD COLUMNS	☐	+ ☐	+ ☐	
				TOTAL	☐

10.	If you have reported any problems, how difficult have these problems made it for you to get things done or get along with other people?	Not difficult	Somewhat difficult	Very difficult	Extremely difficult

Mini-Mental Exam

Each question correctly answered by the patient scores one point. A score of 6 or less suggests delirium or dementia, although further and more formal tests are necessary to confirm the diagnosis.

Please administer mini-mental exam. If you do not have a standard exam, the following version may be used.

Question	Score
1. What is your age? (1 point)	
2. What is the time to the nearest hour? (1 point)	
3. Give the patient an address and ask him/her to repeat it at the end of the test. (1 point)	
4. What is the year? (1 point)	
5. What is the name of the hospital or number of the residence where the patient is situated? (1 point)	
6. Can the patient recognize two persons (the doctor, nurse, home help, etc.)? (1 point)	
7. What is your date of birth? (day/month sufficient) (1 point)	
8. In what year did World War 1 begin? (1 point) (other dates can be used, with a preference for dates some time in the past.)	
9. Name the current president of the United States? (1 point)	
10. Count backwards from 20 down to 1. (1 point)	

Health Maintenance Recommendations / Teaching	Done	**Needs F/U**
Medication Compliance and/or Side Effects		
Dietary/Nutrition Counseling		
Weight Loss		
Exercise / Activity		
Smoking Cessation		
Discuss Advance Directives		
Update Immunizations - Tetanus / Flu / Pneumo / Zostavax		
Eye Exam		
Colorectal Cancer Screening (Colonoscopy/ FOBT x 3, iFOBT x 1)		

Health Maintenance Recommendations / Teaching Continued	**Done**	**Needs F/U**
PAP		
Mammogram		
Calcium Supplement		
Other:		

Chronic Condition Recommendations / Teaching	**Done**	**Needs F/U**
Continue Current Treatment		
Medication Changes (Specify)		
Instruct Disease Process and Management		
Refer to Specialist (Specify)		
Labwork (Specify)		
Other:		
Other:		

☐ The following patient education literature provided at time of visit: Circle appropriate.

Hypertension	Incontinence	Falls Prevention	Osteoarthritis
Cholesterol	Flu Shot	Improving Balance	Osteoporosis
Glaucoma	Pneumonia Shot	Increasing Physical Activity	Preventive Health Guidelines
Depression			

€ Has CHF learning needs or care gaps that require case management

€ Has Diabetes learning needs or care gaps that require case management

€ Has Asthma or COPD learning needs or care gaps that require case management

€ Has Depression non-compliance with treatment; Request case management review

Notes:

Provider Signature _____ MD / DO / NP / CNS / PA

Please be certain to provide legible signature and credentials before submitting. Thank you!

Appendix G: Preventive Checklist for Patients – A Patient Tool

Write the dates in the boxes provided to help you remember when you had the test, procedure, or exam. Use the blanks at the bottom to fill in others you may need.

Test/ Procedure/ Exam ***Needed One Time Only***	**Date Received**					
Initial Medicare Wellness Visit *Within 12 months of becoming eligible for Medicare*						
Pneumonia Vaccination						
Test/ Procedure/ Exam ***Needed More Than One Time***	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Annual Wellness Visit						
Flu Vaccination every year						
Blood Pressure Check every year						
Height, Weight, BMI every year						
Cholesterol and Lipid Test						
Depression Screening						
Fall Risk Screening						
Tobacco and Alcohol Screening						
Glaucoma Test (if you are at risk)						
Cervical Cancer/PAP test for Women						
Mammogram for Women						
Osteoporosis Screening for Women						
Colorectal Cancer Screening – *can be one of these three:*						
- Fecal Blood Test every year						
- Sigmoidoscopy every 5 years						
- Colonoscopy every 10 years						

Appendix H- Prior Authorization Form

Print Form

CrestPointHealth

PRIOR AUTHORIZATION REQUEST

Please fax to (330) 996-1910

P. O. Box 3620 Akron, OH 44309-3620

***Please call (423) 952-2190 or (888) 261-0417 for urgent requests**

Date:

CONFIDENTIAL

Member Last Name:	
Member First Name:	
Member ID#:	
Member Group Number:	**Member Date of Birth:**
Requesting Physician First & Last Name:	
Practice/Group Name:	**Tax ID:**
Physician Phone Number:	**Physician Fax Number:**
Physician Contact Name:	
Procedure/Service:	
Date of Service:	**To be Scheduled:** ☐
Inpatient ☐	**Outpatient** ☐
Facility/Place of Service:	
Diagnosis:	

PLEASE FAX CLINICAL INFORMATION PERTINENT TO PROCEDURE/SERVICE

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and privileged information for the use of the designated recipients. If you are not the intended recipient, you are hereby notified that you have received this communication in error and any review, disclosure, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the address listed above via the United States Postal Service. If this was an email received in error, please notify the sender and delete it.

For Crestpoint Use Only

Authorization Number:	**Prior Authorization Not Required:** ☐
Crestpoint Contact:	

You will be notified by telephone if your request is not approved.

Appendix I: CrestPoint Health Medicare Advantage Formulary

Click on this link to go to a searchable formulary for CrestPoint Health's Medicare Advantage members: https://mp.medimpact.com/mp/secure/LaunchProductFrameset.jsp

Appendix J – CrestPoint Health MSHA Plans Formulary

The view and print version is located on the ISHN Website at: www.ISHNonline.com

Click on Clinical Resources in the left menu then scroll down to “CrestPoint Commercial”.

Click on “MSHA Plans Formulary”

Appendix K

Glossary of Healthcare Terms

ACCOUNTABLE CARE ORGANIZATION (ACO)

ACUTE CARE:
A level of care usual given in a hospital in response to an immediate or severe illness or accident

ADVANCED PRACTICE PRACTITIONERS:
Licensed practitioners, other than physicians, who are qualified by academic and clinical training, and by experience and competence to practice their specialty under the supervision of a physician (dependent or independent based on State and facility regulations. The most common mid-level categories are physician assistants, CRNA, Nurse Midwives and nurse practitioners.

ALLIED HEALTH PROFESSIONAL:
Referenced as an advanced practice or mid-level practitioner in this document and by use of acronym "AHP"

AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS):
An NCQA approved source for verification of board certification.

AMERICAN MEDICAL ASSOCIATION (AMA) PHYSICIAN MASTER FILE:
An NCQA approved source for verification of various MD credentials including but not limited to medical education and training.

AMERICAN OSTEOPATHIC ASSOCIATION (AOA) OFFICIAL OSTEOPATHIC PHYSICIAN PROFILE REPORT / PHYSICIAN MASTER FILE:
An NCQA approved source for verification of various Osteopathic DO Credentials, including, but not limited to medical education and training

AMBULATORY CARE:
Medical services delivered on an outpatient basis, i.e., at surgery centers, clinics, mobile service units.

ANCILLARY SERVICES:

Supplemental services such as laboratory, radiology and physical therapy that are provided in conjunction with medical care.

APPLICANT:
The individual who is applying for affiliation, association, contract, employment, participation or other relationship with the organization.

APPLICATION:
The form or documents designated for a specific purpose by ISHN/SVHN or completed by the applicant. The employment, contracting, enrollment and credentialing processes may be separate and distinct requiring a separate application for each.

COUNCIL FOR AFFORDABLE QUALITY HEALTH CARE (CAQH)
A nonprofit alliance of health plans and trade associations, is simplifying healthcare administration through industry initiatives that

- Promotes quality interactions between plans, providers and other stakeholders
- Reduces costs and frustrations associated with healthcare administration
- Facilitates administrative healthcare information exchange
- Encourages administrative and clinical data integration

CAQH provides a universal credentialing application accepted by ISHN.

CDS CERTIFICATION:
Controlled Dangerous Substance Certificate is required if the practitioner is prescribing dangerous substances.

CREDENTIALING:
The process by which the training, education, competency & trends of a practitioner are evaluated and compared to origin specific criteria. A practitioner is not considered to be credentialed until a complete application is received, verifications of credentials are completed, information is evaluated and the Chief Medical Officer and/or until the Credentials Committee makes a positive determination and/or recommendation which is approved by the Board.

Credentialing is an examination of a physician's or other healthcare provider's credentials to determine whether she/he should be entitled to clinical privileges in a hospital or to a contract with a managed care or preferred provider organization.

DEA CERTIFICATION:

Drug Enforcement Administration Certificate required if practitioner is prescribing controlled substances. Complete schedules indicate ability to order narcotics in designated categories of 2, 2N, 3, 3N, 4, and 5.

EDUCATIONAL COMMISSION FOR FOREIGN GRADUATES (ECFMG):
The organization that certifies practitioners who have graduated from a medical school in another country. ECFMG verifies each practitioner's diploma with the medical school prior to issuing certification. ECFMG is considered an acceptable source for verification for foreign medical graduates.

ENROLLMENT:
The process by which a practitioner application to participate with managed care companies is completed and filed with a specific manage care company for participation.

GOVERNING BOARD:
The Board of Trustees with ultimate authority and responsibility for the operations of the organization.

HEALTHCARE INTEGRITY AND PROTECTION DATABANK (HIPDB):
Established through the Health Insurance Portability and Accountability Act of 1996, the HIPDB is a national data collection program for the reporting and disclosure of certain final adverse actions taken against health care practitioners, providers, and suppliers. The HIPDB collects information regarding licensure and certification actions, exclusions from participation in Federal and State health care programs, criminal convictions, and civil judgments related to healthcare, and other adjudicated actions or decisions.

ISHN/SVHN NETWORK:
ISHN/SVHN Networks means the network of participating Providers with Integrated Solutions Health Network (ISHN/SVHN) Integrated Solutions Health Network (ISHN/SVHN)/Southwest Virginia Health Network (SVHN).

MANAGED CARE:
A type of healthcare delivery that emphasizes active coordination and arrangement of health services. Managed care usually involves three key components: Oversight of the medical care given, contractual relationships with an organization of the providers giving care, and covered benefits tied to managed care regulations.

CHIEF MEDICAL OFFICER:

The administrative physician appointed by the Governing Board to provide direction and leadership for clinical activities, clinical programs and the credentialing program.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA):
A private, not-for-profit organization dedicated to improving health care quality. NCQA has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what is important, how to measure it, and how to promote improvement. Some healthcare organizations may obtain accreditation and / or certification by NCQA for a variety of programs and activities.

NATIONAL PRACTITIONER DATA BANK (NPDB):
An information clearinghouse established by Title IV of Public Law 99-660 (the Health Care Quality Improvement Act of 1986), to collect and release certain information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. The U.S. Government established the Data Bank to enhance professional review efforts by making medical malpractice payments and adverse actions available to eligible entities and individuals.

NETWORK:
The group of providers and healthcare professionals that a health plan contracts with to provide healthcare services to its members. For purposes of the document, the term network references Integrated Solutions Health Network (ISHN)/Southwest Virginia Health Network (SVHN).

NURSE PRACTITIONER:
The Nurse Practitioner is a Registered Nurse, qualified by additional academic and clinical education to provide patient services. At ISHN/SVHN services are provided under the supervision of a network practitioner who, in turn, is responsible for the performance and clinical evaluation of the NP. A NP is considered an advanced practice (AHP) and may hold a DEA & perform services independently in some areas.

OFFICE OF INSPECTOR GENERAL (OIG):
In response to legislation preventing certain individuals and businesses from participating in federally funded health care programs (e.g. Medicare); the OIG developed a program to exclude these individuals and entities, and maintains a list of all currently excluded parties. Querying

the OIG identifies entities or personas excluded due to sanctions imposed by federally funded health care program and is a requirement of ISHN/SVHN credentialing.

OUTPATIENT CARE:
Healthcare services provided to a patient who is not admitted to a hospital or facility for an overnight stay. Outpatient care may be provided in a doctor's office, clinic, patient's home or hospital outpatient department.

PHYSICIAN ASSISTANT (PA):
The Practitioner Assistant is a skilled person, qualified by academic and clinical education to provide for patient services under the supervision of a network practitioner who, in turn, is responsible for the performance and clinical evaluation of this person. A PA is considered an Advanced Practice AHP and may hold a DEA and perform services independently in some areas.

PARTICIPATING PROVIDER:
Participating Provider means a provider who has entered into a Participating Provider Arrangement with ISHN/SVHN. This includes completion of the enrollment and credentialing processes.

A physician, hospital or other facility that participates through a contractual arrangement with a healthcare service contractor, HMO, PPO, IPA or other managed care organization to provide services for specified benefit plans. Also called a network provider.

PHYSICIAN:
A doctor, an individual who has been trained, educated and licensed to practice the art and science of medicine. Medical doctors (MDs), osteopathic doctors (DOs), dentists (DDSs and DMDs), and podiatrists (DPMs) are independent practitioners who are categorized as physicians.

PRACTITIONER:
An individual who is licensed and qualified as a health care professional. In this document, the term refers to a Physician, Doctoral level Psychologist (PhD, PsyD), Chiropractor (DC), a Physician Assistance (PA), Advanced Practice Nurse (APRN) and all AHP practitioners.

PRIMARY CARE PHYSICIANS:
Specialties identified as: Family Practice, General Practice, Internal Medicine, Pediatrics, and OB/GYN

PRIMARY SOURCE VERIFICATION (PSV):

Verification of a practitioner's qualifications and credentials with the source who issued the original credential. Refers to contacting the entity, agency, or institution that issued a practitioner's credential for verification of authenticity. For the purposes of this document, primary source verification (PSV) means contacting either the actual issuer or another recognized monitoring source approved for verification by the National Committee for Quality Assurance (NCQA).

RECREDENTIALING:
The process used to determine continued association or affiliation based on professional peer evaluation, changes in current licensure, DEA, MP insurance, sanctions and affiliations, NPDB and continued Board Certification.

REVIEW:
The review process includes review and evaluation of the data contained in the initial credentialing or recredentialing process at ISHN/SVHN Recredentialing review includes the provider has met requirements for continued participation or,
Did not satisfy the Re-credentialing Criteria of ISHN/SVHN/SVHN or did not comply with ISHN/SVHN policies, rules and regulations, either of which has resulted in (i) the termination of the Participating Provider; or (ii) the suspension of the Participation Provider or other disciplinary actions by ISHN/SVHN.

SPECIALISTS (SCP):
MD & DO practicing in all specialties other than those identified as Primary Care Physicians.

TORT LAW:
A body of rights, obligations, and remedies that is applied by courts in civil proceedings to provide relief for persons who have suffered harm from the wrongful acts of others.

VERIFICATION:
The process of determining the status, confirming credentials(s), and/or validation of information provided by the applicant.

120 DAY TIMEFRAME:
To ensure that the Credentials Committee does not consider an applicant whose credentials may have changed, verifications and attestations / release of information are to be less than 120 days old at the time of the credentialing decision. For written verifications, the 120 day time limit begins with the date on the written verification from the entity that verified that particular credential. This includes internet verifications.

Appendix L: Acronyms

AAAHC	Accreditation Association for Ambulatory Health Care
AANA	American Association of Nurse Anesthetists
AAPPO	American Association of Preferred Provider Organizations.
ABMS	American Board of Medical Specialties
ACCME	Accreditation Council for Continuing Medical Education
ACGME	American College of Graduate Medical Education
ACLS	Advanced Cardiac Life Support ACO Accountable Care Organization
ADA	Americans with Disabilities Act
AHA	The American Hospital Association
AHP	Allied Health Professional
AMA	American Medical Association
AOA	American Osteopathic Association
APIC	Association of Professionals in Infection Control and Epidemiology
ATLS	Advanced Trauma Life Support
BLS	Basic Life Support
CAMHS	Comprehensive Accreditation Manual for Healthcare services.
CAQH	Council for affordable Quality Healthcare
CDS	Controlled Drugs and Substances

CEO	Chief Executive Officer
CIN-BAD	Federation of Chiropractic Licensing Boards
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
COO	Chief Operating Officer
COP	Conditions of Participation
CRNA	Certified Registered Nurse Anesthetist
CVO	Credentials Verification Organization
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
BLS	Basic Life Support
DO	Doctor of Osteopathy
DOB	Date of Birth
DPM	Doctor of Podiatric Medicine
EAP	Employee Assistance Program. Services designed to assist employees, their families, and employers in finding solutions to workplace and personal problems.
ECFMG	Education Council for Foreign Medical Graduates
EMTALA	Emergency Medical Treatment and Active Labor Act
FACIS	Fraud and Abuse Control Information System

FCVS	Federal Credentials Verification Service
FDA	Food and Drug Administration
FMLA	Family and Medical Leave Act
FNP	Family Nurse Practitioner
FPPE	Focus Professional Practice Evaluation
FSMB	Federation of State Medical Boards
FTE	Full Time Equivalent
GME	Graduate Medical Education
GP	Group Health
GSA	General Services Administration
HCQIA	Health Care Quality Improvement Act
HEDIS	Healthcare Employers Data Information Set
HFAP	Healthcare Facilities Accreditation Program – the accrediting organization for AOA
HIPAA	Health Insurance Portability and Accountability Act
HIPDB	Healthcare Integrity & Protection Data Bank
HMO	Health Maintenance Organization
IPA	Independent Practice Association. A group of providers who have joined together formally or contractually, who contract with a PPO network as a group.
JCAHO (aka TJC)	Joint Commission on Accreditation of Healthcare Organizations. An

	independent, private, nonprofit organization that evaluates sets standards for and accredits hospitals, health plans and other healthcare organizations that provide home care, mental healthcare, ambulatory care and long term care services.
LIP	Licensed Independent Practitioner
LONG-TERM CARE (LTC)	Ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability.
MA	Medicare Advantage
MCO	Managed Care Organization
MD	Medical Doctor
MEC	Medical Executive Committee
MSSP	Medicare Shared Savings Plan
MSP	Medical Services Professional
NCQA	National Committee for Quality Assurance
NP	Nurse Practitioner (aka FNP – Family Nurse Practitioner or PNP Pediatric Nurse Practitioner)
NPI	National Practitioner Identifier
NPDB	National Practitioner Data Bank
NTIS	National Technical Information Services
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PA	Physician Assistant

PALS	Pediatric Advanced Life Support
PNP	Pediatric Nurse Practitioner
PPO	Preferred Provider Organization. An Organization that establishes contracts with providers of medical care.
PCP	Primary Care Physician. Providers in specialty of Internal Medicine, Family Practice, General Practice, Pediatrics or OB/GYN
QA	Quality Assurance. A formal set of activities to review and determine the quality of services provided. Quality Assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.
QI	Quality Improvement. A method of evaluation and improving processes of patient care that emphasizes a multidisciplinary approach to problem solving, and focuses not on individuals, but systems of patient care that might be the cause of variations.
QM	Quality Management. A broad term that encompasses both quality assurance and quality improvement, describing a program of evaluating the quality of care using a variety of methodologies and techniques.
RN	Registered Nurse
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SSN	Social Security Number
TAT	Turnaround time
TIN	Tax Identification Number

TPA	Third-Party Administrator. An independent corporate entity (third party) that administers group benefits, claims and administration for a self-insured company or group.
UPIN	Unique Physician Identification Number
URAC	Utilization Review Accreditation Commission
USMLE	United States Medical Licensing Exam
W-9	A required form prepared by the employer that reports annual wages and tax withheld for an employee.
X-WALK	Cross Walk. Usually identified as two like subjects that have similar descriptions. I.e., Revenue codes vs. CPT codes which are relevant to billing usually associated with ICD 9 codes.

Appendix M – Medicare Advantage **Member Rights and Responsibilities**

CrestPoint will honor your rights as a member of the plan

- You have the right to information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
- You have the right to be treated with fairness and respect at all times
- You have the right to get timely access to your covered services and drugs.
- You have the right to choose a provider for your care and to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.
- You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
- You have the right to privacy of your personal health information.
- You have the right to view information in your records at CrestPoint Health and to obtain a copy. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.
- You have the right to know how your information has been shared with others.
- You have the right to get information from us such as information about our plan. This includes as example:
    - Information about the plan's financial condition.
    - Information about the number of appeals made by members
    - The plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
    - **I**nformation about our network providers including our network pharmacies.
    - Information about your coverage and the rules you must follow when using your coverage.
    - Information about why something is not covered and what you can do about it.
- You have the right to request a coverage determination and have the right to ask us to change the decision, if denied. You can ask us to change the decision by making an appeal.
- You have the right to request information on how we pay providers in our network.
- You have the right to make decisions about your care and to know your treatment options and participate in decisions about your health care.
- You also have the right to know about the risks involved in your care.
- You must be told in advance if any proposed medical care or treatment is part of a research experiment.
- You always have the choice to refuse any experimental treatments.
- You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave.
- You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- You have the right to receive an explanation if you are denied coverage for care.
- You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. This means that, *if you want to*, you can fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself. You can give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.
- The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.
- You have the right to make complaints and to ask us to reconsider decisions we have made.
- You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past.
- You have the right to fair treatment without discrimination.

You have some responsibilities as a member of the plan.

- You have the responsibility to Get familiar with your covered services and the rules you must follow to get these covered services.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe.
- Tell us if you move. If you move outside of our plan service area, you cannot remain a member of our plan. If you move *within* our service area, we still need to know so we can keep your membership record up to date and know how to contact you.

Appendix N – MSHA Plan Member Rights and Responsibilities

The following Rights and Responsibilities apply to all covered members regardless of race, ethnicity, and cultural background, mental or physical abilities:

1. The right to receive information about the organization, the benefit plan, its services, practitioners, and member rights and responsibilities.
2. The right to be treated with dignity and respect.
3. The right to privacy and protection of covered health information.
4. The right to participate with providers in making decisions about health care, treatment, and goals.
5. A right to open and honest discussion of appropriate or medically necessary treatment options for conditions regardless of cost or benefit coverage.
6. A right to file a complaint or appeal regarding the health plan, the employer organization, provider or treatment team.
7. A right to request information on how we pay providers in our network.
8. A right to make recommendations to the sponsoring organization or plan regarding the rights and responsibilities policy.
9. A responsibility to provide the plan, provider and organization with information needed in order to provide care.
10. A responsibility to follow the plans and instructions for care to the best of your ability.
11. A responsibility, to the extent possible, to understand existing health problems and participate in shared decision making in setting treatment goals, plans, and monitoring or evaluation activities.