Physician Quality Summary

Primary Care Pay-for-Performance Program

2021 PQS Program Manual

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INTRODUCTION

As an organization committed to patient-centric quality care, Geisinger Health Plan strives to continuously enhance our provider network to provide the highest quality of care for the communities we serve. In doing so, we have worked to develop and implement an enhanced yet simplified structure to our performance programs. This will allow GHP to provide increased transparency while rewarding primary care providers for providing exceptional care to our members.

EXECUTIVE SUMMARY

The Physician Quality Summary (PQS) Primary Care Pay-for-Performance Program was designed to help Geisinger Health Plan monitor the performance of the primary care physicians (Family Practice, General Practice, Internal Medicine, Internal Medicine-Pediatrics, and Pediatrics) within the network.

Because PQS is a pay-for-performance initiative, physicians are rewarded for receiving superior scores in the quality and pharmaceutical metrics, when benched against the ***National 50th Percentile*****.** PQS is not intended to be a static measurement system and will continue to develop and change as the network, clinical practices and quality requirements evolve.

PQS performance reports will be posted to GHP's web site at a primary care site level so that members can judge the combined performance of all physicians at a given practice. Reporting will be updated every fall.

PRIMARY CARE PROGRAM DEFINITIONS

Continuous Enrollment (CE):	The amount of time a member must be enrolled for eligibility in a HEDIS® measure. The CE period can vary but typically it covers the entire measurement year. One gap in the enrollment period is allowed but cannot exceed 45 days.
HEDIS®:	Healthcare Effectiveness Data Set is a set of measures for which Geisinger Health Plan is held accountable by NCQA.
Measurement Year:	The HEDIS® definition of the main period of time for the event or diagnosis to occur to place a member into a measure eligible population. Typically, the measurement year is the calendar year previous to the year when the final HEDIS® results are produced.
Member Health Alerts (MHA):	HEDIS® metric care gaps are available via Geisinger's MHA tool. Participants are strongly encouraged to stay proactive in filling care gaps identified by this web-based tool.
NaviNet®:	Geisinger Health Plan's Pay-for-Performance Program manual and performance documentation are available to participants via the NaviNet® portal.
NCQA:	National Committee for Quality Assurance is the accrediting body for Managed Care Organizations, which sets the standards and measures that GHP must abide by and collect respectively.

PQS PROGRAM PARTICIPATION REQUIREMENTS

Primary Care Providers or Coverage PCPs in the following specialties with at least one member month as of June 30th of the measurement year are eligible for participation in PQS.

Eligible Primary Care Specialties:

- Family Practice
- Internal Medicine
- General Practice
- Pediatrics

PQS PROGRAM DATA COMPONENTS AND DESIGN

2021 PQS Data Timeline:

Membership[1]	Fiscal Year 2021 July 2020—June 2021
HEDIS	Calendar Year 2020 January 2020—December 2020
Provider Participation[2]	Fiscal Year 2021 July 2020—June 2021
PQS Star-Rating and Payment Distribution	September 2021

[1] *Membership for the 2021 PQS program will be measured on a fiscal year. This allows providers to be incentivized on their most current member population. Member Months for the Commercial population will include Exchange membership.*

[2] *To coincide with the membership timeline, providers must be active within the GHP network and eligible based on the eligibility standards noted on page 5 by the end of the program data period, on June 30th.*

2021 PQS Reporting:

PQS results will be posted to GHP's web site each fall.

Individual physician reports <u>will not be posted</u> for public review. These reports will be posted within a secure, password protected web page. The passwords will be provided to allow an individual physician to only view a report for physicians at their primary care site.

See Appendix I for physician specific PQS sample web report.

PQS reports posted on the GHP web page for public review will be at the primary care site-level. A primary care site roll-up methodology has been developed to aggregate all eligible primary care physicians into one inclusive site score. This methodology is detailed on page 7.

PQS PROGRAM SITE ROLL-UP METHODOLOGY

2021 PQS Site Roll-Up Methodology:

So as to maintain confidentiality, PQS reports posted for public review will be at a primary care site level. Each physician's overall level rating will be weighted according to the number of member months assigned to them. The overall primary care site member months weighted output is divided by the total member months for the site. The following is an example of that calculation:

Physician	Member Months	Star-Rating	Site Weight
A	1000	★	1000
B	500	★★★	1500
C	1000	★★	2000
D	250	★★★	750
E	750	★★	1500
Total:	3500		6750

PC Site Roll-up Calculation: 6750/3500 = 1.93 rounded to 2-star

PQS PROGRAM EVALUATION AND SCORING

2021 PQS Scoring Methodology:

Providers will be scored on their performance in the program HEDIS® and Pharmacy measures. Compliance rates for each metric will be benched independently against the National 50th Percentile for HEDIS® metrics. A pass/fail designation will be assigned for each program metric, indicating whether the PCP met/exceeded the designated threshold. Once computed, an overall program rate will be calculated based on a provider's overall program achievement. Performance will then be incentivized based on the pmpm methodology below.

Providers who do not have membership in a program metric will not be penalized, but will only be scored on metrics in which they have applicable data.

INCENTIVE CALCULATIONS

2021 PQS Payment Methodology:

Providers must achieve an overall two- or three-star rating to be eligible to receive a PQS incentive. Those providers who meet or exceed this threshold are eligible for payment based on the below pmpm rate and their program eligible, assigned FY membership.

Overall Star-Rating	Program Compliance Rate	FY 19 Membership	Incentive Payment
★	**< 50.00%**	**≥ 1 member month**	**$0.00 pmpm**
★★	**≥ 50.00% but < 75.00%**	**≥ 1 member month**	**$2.00 pmpm**
★★★	**≥ 75.00%**	**≤ 2999 member months** (less than 250 members) **Between 3000—6000 member months** (250-500 members) **≥ 6001 member months** (greater than 500 members)	**$8.00 pmpm** **$48,000 payment** **$8.00 pmpm**

Performance Calculation Example: *(Sample benchmarks are shown below for purpose of example only)*

PQS HEDIS Metric	Proposed Threshold for Success (compliance rate ≥)	Provider A		Provider B		Provider C	
		Compliance Rates	Success	Compliance Rates	Success	Compliance Rates	Success
Adolescent Immunizations (Combo 2)	68.92%	64.02%	--	--	--	89.97%	✓
Adolescent Well-Care	43.59%	71.46%	✓	--	--	75.25%	✓
Adult Annual Wellness Visits	60.00%	81.00%	✓	75.70%	✓	68.00%	✓
Breast Cancer Screening	74.10%	--	--	86.21%	✓	86.34%	✓
Comprehensive Diabetes Care: Eye Exams	67.74%	--	--	66.24%	--	92.51%	✓
Comprehensive Diabetes Care: HbA1c Poor Control	29.93%	--	--	29.00%	--	32.46%	✓
Cervical Cancer Screening	75.68%	--	--	62.55%	--	36.39%	--
Childhood Immunizations (Combo 10)	50.12%	49.16%	--	--	--	74.46%	✓
Chlamydia Screening	45.24%	--	--	30.33%	--	68.22%	✓
Colorectal Screening	64.36%	--	--	83.68%	✓	84.94%	✓
Medication Management for People with Asthma	45.49%	56.87%	✓	--	--	--	--
Well-Care Child Visits	76.42%	91.54%	✓	--	--	83.51%	✓

Compliance Rate Calculation Example:

Each provider's performance displayed on the previous page has been rolled up to calculate an overall program compliance rate, based on applicable metrics and their performance benched against the set thresholds.

	Total Applicable Measures (denominator)	Total Successful Measures (numerator)	Program Compliance Rate (numerator / denominator)
Provider A	7	5	71.43%
Provider B	11	5	45.45%
Provider C	12	10	83.33%

Incentive Payment Calculation Example:

Once a provider's program compliance rate is calculated, PCPs will be incentivized based on the designated star-rating thresholds.

	Program Compliance Rate	Star-Rating	FY Membership (member months)	Incentive
Provider A	71.43%	★★	351	$702.00
Provider B	45.45%	★	784	$0.00
Provider C	83.33%	★★★	597	$4,776.00

ADOLESCENT IMMUNIZATIONS

COMBO 2 (HPV, Tdap & Meningococcal)

Purpose: To monitor the administration of vaccines for adolescents

Description: The percentage of adolescents turning 13 years of age, as of December 31st of the measurement year, who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Continuous enrollment and benefit restrictions apply.

Compliant Member: An adolescent 13 years of age who had all of the following:

- one dose of meningococcal vaccine with a date of service on or between the member's 11th and 13th birthdays,
- one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between their 10th and 13th birthday
- at least two HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays. There must be at least 146 days between the first and second dose of HPV vaccine. OR at least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.

Exclusions: Adolescents that had a contraindication for a specific vaccine may be excluded from the denominator.
Tdap - Encephalopathy due to the vaccine
Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

ADOLESCENT WELL-CARE

Purpose: To monitor the number of well-care visits with either a primary care practitioner or OB/GYN practitioner that occurs each year for adolescents

Description: The percentage of adolescents, age 12 through 21 years old, as of December 31st of the measurement year, that had one well-care visit with a PCP or OB/GYN practitioner (visit is not required to occur with their "assigned" Health Plan physician).

Continuous enrollment and benefit restrictions apply.

Compliant Member: An adolescent 12 through 21 years old who had one comprehensive well-care visit, as signified by one of the applicable codes on a medical claim, during the measurement year.

Exclusions: Services specific to the assessment or treatment of an acute or chronic condition do not count towards the measure. Services rendered during an inpatient or ED Visits do not count toward the measure.

Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

ADULT ANNUAL WELLNESS VISITS

Purpose: To monitor the number of well visits with a primary care practitioner that occurs each year for older adults.

Description: The percentage of older adults, age 65 years and older, as of December 31st of the measurement year, that had one well visit with a PCP (visit is not required to occur with their "assigned" Health Plan physician).

Applicable Codes:

- G0438 - Annual wellness visit; includes a personalized prevention plan of service, initial visit
- G0439 - Annual wellness visit; includes a personalized prevention plan of service, subsequent visit
- G0468 - Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receive an ippe or awv

  Note: Contracted FQHC providers should use location code 50 when billing G0468.

Compliant Group: Any members age 65 and older who had one comprehensive well-care visit, as signified by one of the applicable codes on a medical claim, during the measurement year.

Eligibility Criteria: Services specific to the assessment or treatment of an acute or chronic condition do not count towards the measure. Services rendered during an inpatient or ED Visits do not count toward the measure.

This measure is only applicable to Medicare members who meet eligibility criteria.

Providers will receive credit for successfully completing this metric if at least 60% of eligible members are compliant in this measure.

BREAST CANCER SCREENING

Purpose: To monitor women who have had a mammogram to screen for breast cancer

Description: The percentage of women 52 to 74 years old, as of December 31st of the measurement year, that had a mammogram any time on or between October 1 two years prior to the measure year and December 31 of the measurement year.

Continuous enrollment and benefit restrictions apply.

Compliant Member: A woman who has had a mammogram, signified by one of the applicable codes on a medical claim any time on or between October 1st two years prior to the measurement year and December 31st of the measurement year. Diagnostic mammograms and tomosynthesis are included in the measure.

Exclusions: Women that have claims indicating a bilateral mastectomy, a unilateral mastectomy code with a bilateral modifier, or unilateral mastectomy on two separate occasions can be excluded from the eligible population.

Medicare members age 66 and older as of December 31 of the measurement year who meet any of the following during the measurement year as indicated by claims: enrolled in an Institutional SNP, living long-term in an institution, or indicated as having conditions of frailty and advanced illness.

Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

COMPREHENSIVE DIABETES CARE: MANAGEMENT OF EYE EXAMS

Purpose: To monitor eye exams for diabetic members

Description: The percentage of members 18 to 75 years as of December 31st of the measurement year who are identified as diabetic through either medical claims (i.e., two outpatient visits, observation visits, ED visits or nonacute inpatient encounters with a diagnosis of diabetes) or pharmacy claims (i.e., insulin, oral hypoglycemics or antihyperglycemic prescriptions) during the measurement year or the year prior that had an eye screening for diabetic retinal disease.

Continuous enrollment and benefit restrictions apply.

Compliant Member: A diabetic member that had a retinal or dilated eye exam in the measurement year; or a negative retinal or dilated eye exam in the measurement year or the year prior to the measurement year, or a bilateral eye enucleation.

Exclusions: Medicare members 66 years of age and older as of December 31st of the measurement year who meet any of the following during the measurement year as indicated by claims: enrolled in an Institutional SNP, living long-term in an institution, or indicated as having conditions of frailty and advanced illness.

Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

COMPREHENSIVE DIABETES CARE: HBA1C POOR CONTROL

Purpose: To monitor the HbA1c testing and control in members with Diabetes

Description: The percentage of members 18 to 75 years as of December 31st of the measurement year who are identified as diabetic through either medical claims (i.e., two outpatient visits, observation visits, ED visits or nonacute inpatient encounters with a diagnosis of diabetes) or pharmacy claims (i.e., insulin, oral hypoglycemics or antihyperglycemic prescriptions) during the measurement year or the year prior that had an HbA1c screening completed during the measurement year.

An unknown result from an HbA1c screening will be reported as >9.0.

Continuous enrollment and benefit restrictions apply.

Exchange membership is not included in this measure.

Compliant Member: A diabetic member whose last HbA1c level in the calendar year is less than 9.0%.

Exclusions: Medicare members 66 years of age and older as of December 31st of the measurement year who meet any of the following during the measurement year as indicated by claims: enrolled in an Institutional SNP, living long-term in an institution, or indicated as having conditions of frailty and advanced illness.

Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

CERVICAL CANCER SCREENING

Purpose: To monitor women who have had a pap smear every three or five years as applicable

Description: The percentage of women 21 to 64 years old, as of December 31st of the measurement year, who were screened for Cervical Cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed every 3 years
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Reflexive HPV testing doesn't meet criteria.

Continuous enrollment and benefit restrictions apply.

Compliant Member: A woman who has had a Pap smear or Pap and HPV co-testing, signified by one of the applicable codes on a medical claim, during the measurement year or up to four years previous to the measurement year, as applicable.

Exclusions: Women that have claims indicating a total hysterectomy can be excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

CHILDHOOD IMMUNIZATIONS

COMBO 10

Purpose: To monitor the administration of below recommended vaccines for children turning 2 years old during the measurement year

Description: The percentage of children 2 years of age as of December 31st of the measurement year, who had four diptheria, tetanus, acellular pertussis (DTaP); three polio (OPV/IPV); one measles, mumps, rubella (MMR), three haemophilus influenza type B (HiB); three hepatitis B (Hep B); one chicken pox vaccine (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV) and two influenza (Flu) vaccines by their second birthday. One VZV, one MMR, and one Hep A vaccine needs to be given between the child's 1st and 2nd birthday.

Continuous enrollment and benefit restrictions apply.

Compliant Member: A 2 year-old who has four DTaP, three IPV, one MMR, three HiB, three Hep B, one VZV, four PCV, one Hep A, two or three RV, and two Flu vaccines or evidence of the disease, as signified by one of the applicable codes on medical claims, by their 2nd birthday. One VZV, one MMR, and one Hep A vaccine need to be given between the child's 1st and 2nd birthday.

Exclusions: Children that had a contraindication for a specific vaccine may be excluded from the denominator only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety. HiB vaccine, IPV, DTaP, PCV, and RV vaccines do not count if administered prior to 42 days after birth. Influenza vaccine does not count when administered prior to 180 days after birth.

Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

CHLAMYDIA SCREENING

Purpose: To monitor members who are identified as sexually active and have been screened for chlamydia

Description: The percentage of members 16-24 years of age as of December 31st of the measurement year, that were identified as sexually active, either by pharmacy or claims data, which had at least one test for chlamydia during the measurement year.

Continuous enrollment and benefit restrictions apply.

Compliant Member: A woman is counted as having had a test if she had a claim/ encounter with a service date during the measurement year with one or more of the applicable codes.

Exclusions: Members who had a pregnancy test during the measurement year, followed within seven days (inclusive) by either a prescription for isotretinoin (Accutane) or an x-ray can be excluded from the eligible population.

Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

COLORECTAL CANCER SCREENING

Purpose: To monitor members who have had a colorectal cancer screening

Description: The percentage of adults 51 to 75 years old as of December 31st of the measurement year who have had one or more of the following screenings for colorectal cancer:

- a fecal occult blood test (FOBT) during the measurement year, assume the required number of samples were returned, regardless of FOBT type
- a flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- a colonoscopy during the measurement year or the nine years prior to the measurement year
- CT colonography during the measurement year or four years prior to the measurement year
- FIT-DNA test during the measurement year or the two years prior to the measurement year.

Continuous enrollment and benefit restrictions apply.

Compliant Member: An adult who has had one or more colorectal cancer screenings during the allotted time frames as listed above.

Exclusions: Adults with a diagnosis of colorectal cancer or total colectomy and members in hospice are excluded from the eligible population. DRE FOBT performed in an office setting does not count toward this measure.

Medicare members age 66 and older as of December 31st of the measurement year who meet any of the following during the measurement year as indicated by claims: enrolled in an Institutional SNP, living long-term in an institution, or indicated as having conditions of frailty and advanced illness.

Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA

Purpose: To ensure members with persistent asthma aged 5 to 64 years old are prescribed and adherent to their asthma controller medication

Description: The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Continuous enrollment and benefit restrictions apply.

Compliant Member: Members who achieved a Proportion of Days Covered (PDC) of at least 75% for their asthma controller medications during the measurement year.

Expected action:

- Integrate review of proper inhaler usage into ever encounter with an asthma patient
- Review medication list to ensure patient has prescription(s) for controller medication(s)
- Schedule proper follow-up with the patients to evaluate if medications are taken as prescribed
- Convert patient's controller medication to a 90-day supply at mail order or retail pharmacy to boost adherence

Exclusions: Members in hospice and members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:

- Emphysema Value Set
- Other Emphysema Value Set
- COPD Value Set
- Obstructive Chronic Bronchitis Value Set
- Chronic Respiratory Conditions Due to Fumes/Vapors Value Set
- Cystic Fibrosis Value Set
- Acute Respiratory Failure Value Set.

Members who had no asthma controller medications dispensed during the measurement year are also excluded from the population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

WELL CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE

Purpose: To monitor children, who are three to six years old, who received a well-child visit with a primary care practitioner during the measurement year

Description: The percentage of children, three, four, five or six years old as of December 31st of the measurement year, that had a well-child visit with a PCP during the measurement year. This visit does not need to have occurred with their "assigned" Health Plan physician.

Continuous enrollment and benefit restrictions apply.

Compliant Member: A child who has had a well-child visit, as signified by one of the applicable codes on a medical claim with a PCP during the measurement year (visits with physician assistants and nurse practitioners in primary care offices are acceptable).

Exclusions: Services specific to the assessment or treatment of an acute or chronic condition do not count towards the measure. Services rendered during an inpatient or ED visit do not count toward the measure. Members in hospice are excluded from the eligible population.

Reference: The 2021 HEDIS® Value Set Directory will not be available until Fall 2020. Please refer to the 2020 HEDIS® Value Set Directory.

APPENDIX A

Member Health Alerts

This report is available for physician viewing on NaviNet©

APPENDIX B

MedInsight PCP Attribution

MedInsight's standard attribution algorithm reviews 24 months of data, Each member is attributed to the PCP with the most visits and, in the case of a tie, to the PCP with the most recent visit. Note that urgent care services are excluded from consideration.

DESCRIPTION OF MSSP ATTRIBUTION METHODOLOGY

Medicare Shared Savings Program (MSSP) uses a two-step process to assign a member to an Accountable Care Organization (ACO). To be assigned to an ACO, the member must receive at least one primary care service from a physician within the ACO. If the member receives primacy care services from more than one ACO, the assigning process compares the proportion of primary care services (measured in terms of allowed charges) provided to a member by different ACOs and assigns the member to the ACO with the highest proportion.

1. In the first step, a member is assigned to an ACO when he/she receives a greater proportion of primary care services from PCPs within the ACO as compared to other ACOs.

2. PCPs are defined as those physicians with one of four specialty designations: internal medicine, general practice, family practice, and geriatric medicine, or those who provide services furnished in a federally qualified health center (FQHC) or rural health clinic (RHC).

3. If a member does not receive primary care services from any PCP, either inside or outside of the ACO, then the member is assigned to an ACO when he/she receives a greater proportion of primary care services from specialist physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO as compared to other ACOs.

The following table lists the E&M codes (Table A) used in our standard PCP attribution algorithm. For the E&M codes, we have highlighted the ones used in the MSSP method with an asterisk (*). The MSSP method uses E&M codes for services delivered in various inpatient facility settings. We used Milliman's Health Cost Guidelines (HCG) Grouper code sets, our review of other source documents, and clinical and actuarial judgment in order to develop the list of Evaluation and Management (E&M) codes down in Table A below.

APPENDIX B

MedInsight PCP Attribution

Table A—Evaluation and Management (E&M) visit codes for PCP Attribution (Updated 2015)

PROCEDURE CODE	DESCRIPTION	PROCEDURE CODE	DESCRIPTION
98966	Hc pro phone call 5-10 min	99391	Per pm reeval est pat infant
98967	Hc pro phone call 11-20 min	99392	Prev visit est age 1-4
98968	Hc pro phone call 21-30 min	99393	Prev visit est age 5-11
98969	Online service by hc pro	99394	Prev visit est age 12-17
99201*	Office/outpatient visit new	99395	Prev visit est age 18-39
99202*	Office/outpatient visit new	99396	Prev visit est age 40-64
99203*	Office/outpatient visit new	99397	Per pm reeval est pat 65+ yr
99204*	Office/outpatient visit new	99401	Preventive counseling indiv
99205*	Office/outpatient visit new	99402	Preventive counseling indiv
99211*	Office/outpatient visit est	99403	Preventive counseling indiv
99212*	Office/outpatient visit est	99404	Preventive counseling indiv
99213*	Office/outpatient visit est	99411	Preventive counseling group
99214*	Office/outpatient visit est	99412	Preventive counseling group
99215*	Office/outpatient visit est	99420	Health risk assessment test
99354	Prolonged service office	99429	Unlisted preventive service
99355	Prolonged service office	99441	Phone e/m phys/qhp 5-10 min
99358	Prolong service w/o contact	99442	Phone e/m phys/qhp 11-20 min
99359	Prolong serv w/o contact add	99443	Phone e/m phys/qhp 21-30 min
99381	Init pm e/m new pat infant	99444	Online e/m by phys/qhp
99382	Init pm e/m new pat 1-4 yrs	99499	Unlisted e&m service
99383	Prev visit new age 5-11	G0344	Initial preventive exam
99384	Prev visit new age 12-17	G0402*	Initial preventive exam
99385	Prev visit new age 18-39	S0610	Annual gynecological examination
99386	Prev visit new age 40-64	S0612	Annual gynecological examination
99387	Init pm e/m new pat 65+ yrs	S0613	Ann breast exam

APPENDIX C

Overview of National Percentiles

National Percentiles:

The NCQA calculates National Percentiles by metric annually . These percentiles indicate the value that the given percentage of physicians fall below and will serve as the benchmarks for the HEDIS® Quality Summary measures. The NCQA releases a percentile benchmark for Commercial and Medicare lines of business. When the percentile for a specific measure is different between Commercial and Medicare, GHP will use the higher percentile between the two.

For example: If Colorectal Screening's 50th percentile is 65% for Commercial and 67% for Medicare, the PQS benchmark will be set at 67%.

Providers in the 2021 PQS Program will be scored based on the National 50th Percentile benchmark for HEDIS YEAR 2019.

Rulename	National 50th Percentile
Adolescent Well-Care Visits	49.95%
Breast Cancer Screening	73.83%
Cervical Cancer Screening	75.72%
Childhood Immunization Status - Combo 10	57.23%
Chlamydia Screening in Women - Total	49.65%
Colorectal Cancer Screening	72.87%
Comprehensive Diabetes Care: Management of Eye Exams	75.28%
Comprehensive Diabetes Care: Medical Attention for Nephropathy	95.95%
Comprehensive Diabetes Care: HbA1C Poor Control	80.54%
Immunizations for Adolescents - Combo 2	27.15%
Medication Management for People with Asthma- Medication Compliance 75%	52.35%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	80.33%

The Benchmark for Adult Annual Wellness Visits will be 50.00%.