Professional Value-Based Reimbursement (Professional VBR) Program

Under the terms of the Asuris Northwest Health Participating Professional Services Agreement (the "Agreement"), providers agree to participate in this Professional Value-Based Reimbursement Program ("Professional VBR"). This document describes in greater detail the terms and conditions of the Professional VBR program.

1. Definitions

Terms:

- **Predominant Specialty** - a provider's practice specialty that accounts for over 50% of services on an allowed dollar basis, as determined by claims experience, for a single Tax Identification Number (TIN) within a state.
- **Base Reimbursement** – the commercial reimbursement schedule defined in the Agreement, excluding any impacts from the Professional VBR program.
- **VBR Reimbursement** – the Base Reimbursement as adjusted based on a provider's performance under the Professional VBR program.
- **VBR Level** – one of three resulting performance tiers to which providers are assigned based on the scoring methodology in this document, and on which VBR Reimbursement is based.
- **Metrics** – the individual measures used to assess performance under the Professional VBR program.
- **Metric Score** – a provider's performance outcome for a particular Metric, scaled from 0 to 100.
- **Composite Score** – the combined score for a provider across all their Metric Scores.
- **Metric Weight** – a value indicating the importance assigned to a Metric for the Professional VBR program. Metric Weights are used in combining Metric Scores into a Composite Score.
- **VBR Scorecard Report** – the report available to providers eligible for scoring in the program that contains a provider's Composite Score.
- **Measurement Period** – the period for which incurred claims data will determine Metric Scores.

2. Program participation and eligibility

Not all providers will be eligible for scoring into a VBR Level. Only certain Predominant Specialties will be scored under the Professional VBR Program (as described below). VBR scoring is based on the Metrics assigned to a provider's Predominant Specialty. See Sections 3 and 4 for details regarding reimbursement and scoring.

Not all Providers will be eligible to be assigned to a VBR Level. Providers not assigned a VBR Level will receive reimbursement in accordance with the Agreement and it will not be impacted or adjusted by this program. This may happen in the following cases:

- **Predominant Specialty not in program**. Either the assigned Predominant Specialty is not in the list below, or there is no Predominant Specialty (because no single specialty exceeds 50% of claims experience). No VBR Scorecard Report is provided for these providers.
- **Metric experience not credible**. Providers receive a VBR Level only if their Metric experience is deemed credible, as described in Section 4. VBR Scorecard Report will demonstrate any lack of credible experience.

Metrics are specific to a Predominant Specialty. The program currently measures quality and/or cost efficiency for the following Predominant Specialties:

- Dermatology
- Family Medicine and General Practice
- Internal Medicine
- Obstetrics & Gynecology
- Ophthalmology
- Psychiatry

Providers with a Predominant Specialty listed above are eligible for scoring and all services billed by professionals on the same TIN can contribute to the Metric Scores for the Predominant Specialty. Providers will receive access through Availity to the VBR Scorecard Report detailing their outcomes on each applicable Metric. Metric Scores and VBR Level will not be shared publicly.

Participation in the Professional VBR program does not preclude participation in other value-based care (VBC) programs, including the commercial Total Care Program.

There is no administrative action required by the provider to obtain a Metric Score; the program relies on adjudicated claims data.

3. Reimbursement

For providers receiving a VBR Level, the Professional VBR program adjusts Base Reimbursement according to reportable and measurable performance with respect to specified patient care quality measures, as reflected in the Composite Score and VBR Level. This document and provider-specific VBR Scorecard Reports describe the scoring process to determine a provider's VBR Level.

Providers measured in the program will be reimbursed at one of three VBR Levels according to their Composite Score. VBR Reimbursement is determined at each VBR Level by adjusting Base Reimbursement as follows:

VBR Level 1	VBR Level 2	VBR Level 3
99% (representing a downward adjustment of 1%)	100% (representing no adjustment)	101% (representing an upward adjustment of 1%)

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VBR Reimbursement is reset annually in accordance with Section 5 and is non-cumulative. In other words, VBR Reimbursement earned under the program applies for only one year and does not accumulate with VBR earned in any subsequent years, nor is it included in the basis for any adjustments to the standard reimbursement under the Agreement.

Providers will have access, no later than July 1 of each year, to a VBR Scorecard Report.

VBR Reimbursement applies to all professional services billed under the TIN, with the exceptions of services reimbursed as CLAB, DMEPOS, PEN and drugs. In other words, VBR Reimbursement is not limited to services rendered in the Predominant Specialty for which a provider is measured. For specific reimbursement methodology and rate details, see the commercial Professional Reimbursement Schedule.

4. Scoring process

The scoring process to determine the VBR Level consists of four main parts:

I. **Metrics** are specific to Predominant Specialty and define how performance will be measured.

II. **Metric Scores** are a provider's results in each Metric against peer averages.

III. **Composite Score** aggregates credible Metric Scores into comparable score.

IV. **VBR Level** is determined by ordering Composite Scores in a Predominant Specialty by tercile.

Each part is described below in more detail.

4.I. Metrics

Metrics generally measure two categories: cost efficiency and quality, though not all Predominant Specialties have Metrics that measure both categories.

- **Cost Efficiency Metrics** measure episodic cost of care. Provider average costs are compared to peer average costs for the same mix of episodes.
- **Quality Metrics** measure evidence-based compliance (or non-compliance) for specific care guidelines. Provider compliance rates are compared to the peer average rate.

The Professional VBR Program relies on third-party vendor software for the implementation of these Metrics, particularly for episode assignments and clinical quality rules. See Appendix A for details about the methodology underlying the Metrics. The specific Metrics that apply to each Predominant Specialty can be found in Appendix B.

Weights are assigned to each Metric to emphasize some Metrics over others. Metric Weights affect the Composite Score methodology described in Section 4.III. The weight assigned each Metric is in the VBR Scorecard Report.

4.II. Metric Scores

Metric Scores are a provider's performance outcome for each Metric. The score reflects a comparison of a provider's claims experience to peer averages. Metric Scores are on a scale from 0 to 100, where 50 is the peer average and higher scores indicate favorable performance. This program uses a statistical

process known as z-scoring to convert Metric results into Metric Scores, which is detailed in Appendix A.

Only Metrics for which a provider has credible experience are assigned a Metric Score. Credible experience for a Metric is defined as:

- Cost Efficiency Metrics: having 10 episodes in the measurement period.
- Quality – Evidence Based Medicine Metrics: having 5 events in the measurement period.
- Quality – Prescription Substitution Rates: having 30 events in the measurement period.

4.III. Composite Score

Composite Score are derived as the weighted average of each Metric Score, using the Metric Weights described in 4.I. Providers need Metric Scores on at least three Metrics in their Predominant Specialty to receive a Composite Score. The Composite Score is also on a 0 to 100 scale.

4.IV. VBR level

Provider Composite Scores are ordered within a Predominant Specialty and assigned to one of three VBR Levels, using percentiles. The thresholds that differentiate each VBR Level are the 33rd and 66th percentile Composite Scores:

- Providers with a Composite Score at or above the 66th percentile are assigned Level 3.
- Providers with a Composite Score at or above the 33rd percentile (and strictly below the 66th percentile) are assigned Level 2
- Providers with a Composite Score strictly below the 33rd percentile are assigned Level 1.

Using the above methodology, roughly one third of providers receiving a Composite Score in each Predominant Specialty will be assigned each VBR Level.

5. Program timing

The Measurement Period for Metric Scores will be on a calendar year basis. Adjustment for the Professional VBR program earned in a calendar year will take effect for a 12-month period beginning October 1 following the conclusion of the Measurement Period. VBR Levels are reestablished annually on October 1.

VBR Reimbursement will be effective to services rendered beginning on October 1 each year, beginning in 2024. For example, the VBR Levels effective on October 1, 2024 will be based on Metrics from claims incurred in calendar year 2023.

To allow proper notice, providers will have access to VBR Scorecard Reports by July 1 each year through Availity, which will detail the VBR Level effective for October 1.

6. General

In the event of any conflict between the terms of the Agreement and this program document, the terms of the Agreement control.

The terms of the Professional VBR program as described herein are subject to change in accordance with the terms of the Agreement.

In addition, if state or federal law or regulation, including regulator action, require a change to the program, including a pausing of the program, Asuris will use reasonable efforts to provide prior written notice of such changes.

APPENDIX A: Metric Information and Scoring Details

The Professional VBR Program relies on external vendors to group internal claims data into clinically appropriate episodes of care for measurement. This program does not alter the methodologies supplied by a vendor, except any decisions noted in this document.

This program relies on Impact Intelligence software supplied by Optum. We reserve the right to utilize other vendors to supply provider Metrics in the future. The scoring methodology documented in the main section of this document is intended to apply uniformly to any Metrics selected for the program. Metric specifics are detailed in the appendices.

A.1 Cost Efficiency Metrics

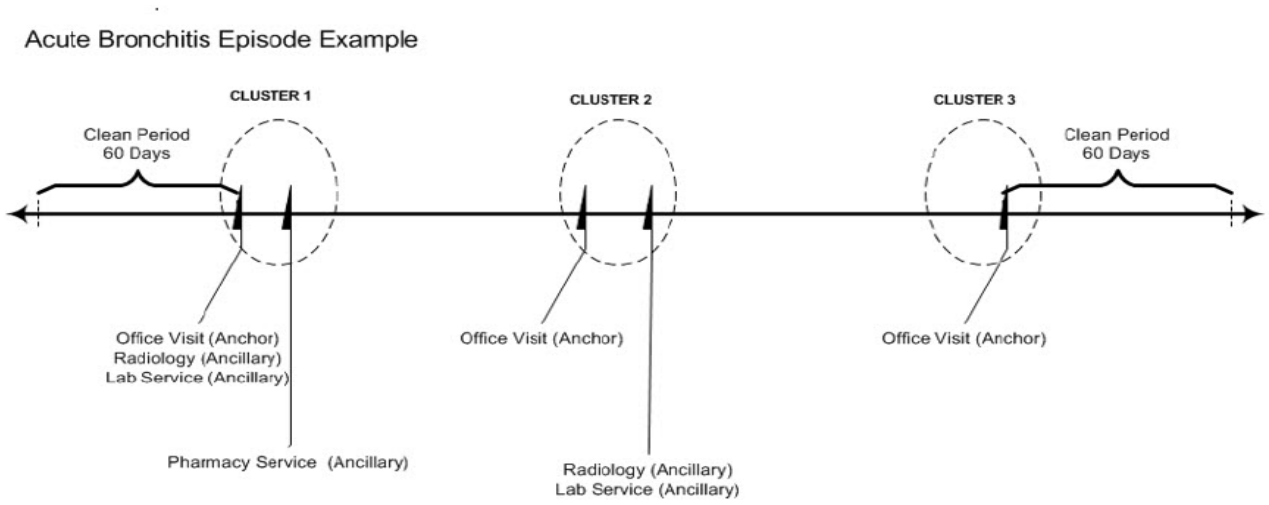
Providers are evaluated for cost efficiency by comparing actual to expected costs on an episodic basis. Depending on the specialty and availability of data, episodes are defined either by member condition or by procedure. In both cases, actual costs are averaged across all episodes where the provider was deemed the "responsible provider" by the vendor software, excluding episodes deemed inappropriate for comparison (see "Episode Exclusions" below). Note that episode costs are not limited to claims from a single provider and include applicable facilities fees; responsible provider methodology measures overall cost efficiency from a patient perspective.

Episode Treatment Groups (ETGs) are condition-based episodes specific to Optum's Impact Intelligence software. Details about ETG episodes are found below:

ETG determines the average cost of treating an episode of care for a variety of medical conditions. Using the ETG Grouper methodology, the Impact Intelligence system assigns the member's enrollment data, diagnostic and procedural information available on medical and pharmacy claims, and health care services to unique episodes of care. The methodology incorporates case-mix and severity adjustment.

Episodes are built by classifying claims into two categories: anchor or non-anchor record. Anchor records initiates an episode cluster and these records represent services provided by a clinician engaging in the direct evaluation, management, or treatment of a patient. Each ancillary record such as X-rays and labs is linked to the only one anchor record to form a cluster. These clusters are further grouped to form an episode based on a series of rules and the diagnoses and procedures found on medical claims, and the drug treatments included on pharmacy claims.

In the illustration below you can see an episode for acute bronchitis that contains three clusters of services. Each cluster begins with an anchor record for contact with a clinician.



Some clusters have one record, and some have several records. The episode begins and ends with a predefined clean period where no treatment activity related to the episode is present.

Procedure Episode Groups (PEGs) are procedure-based episodes determined by Optum's Impact Intelligence software. Details about PEG episodes are found below:

PEGs are a procedure classification methodology, similar in structure to Episode Treatment Groups. The PEG application provides a meaningful statistical unit of analysis to support assessment of surgical care. The PEG application uses ETG output files as data input and helps analyze the cost and quality of surgical providers, procedures, and related services.

PEG episodes are constructed like ETGs by identifying an anchor surgical procedure. Once a PEG anchor has been identified, claims are gathered within a "search window," and episodes are then built by identifying services related to the anchor procedure.

Additional information about the ETG and PEG methodologies is available at

- Measuring health care with meaningful episodes of care (**optum.com**)
- Symmetry Procedure Episode Groups (**optum.com**)

A.2 Quality of Care Metrics

Provider groups are evaluated for their quality of care using historical compliance rates based on services present in final claims data. These Metrics primarily consist of evidence-based medicine rules, and include generic substitution prescription rates, where appropriate.

Evidence Based Medicine (EBM) Metrics are available in Optum's EBM Connect tool. More details on EBM Connect are included below:

EBM Connect is a clinical support software application that uses medical claims, pharmacy claims, and laboratory result records to identify patients with selected clinical conditions and apply a series of rules-based criteria to identify:

- Gaps in patient care
- Patient adherence to clinical therapies

- Patient safety issues
- Unnecessary services
- Care patterns

Using outputs from this tool, this program can assess compliance with guidelines from evidence-based medicine and other national standards at a provider level. EBM Connect results are useful for computing rates of compliance or non-compliance across all members with a particular condition that were treated by a particular provider with a particular specialty.

For example, to determine if patients with diabetes managed by a provider (Dr. Jones) are adhering to clinical therapies, the EBM Connect application identifies members with diabetes and evaluates aspects of their care by applying a series of clinical rules (Rule Description). The clinical rules are derived from and supported by published professional societies, specialty organizations, or national clearinghouse guidelines, demonstrating a beneficial effect of treatment. The clinical rules define whether treatments for diabetes did or did not occur, and we can assess quality of care received by members from Dr. Jones.

Diabetic patients managed by a particular Internal Medicine physician

Managing provider: Dr. Jones
Specialty: Internal Medicine

Condition	Rule description	Eligible members	Number compliant	Compliance rate	Peer compliance rate
Diabetes	Patient(s) with DM and CAD that are currently taking a statin.	20	15	75%	78%
Diabetes	Patient(s) that had at least 2 tests in last 12 reported months.	80	65	81%	75%
Diabetes	Adult(s) with most recent LDL result <100mg/dL.	15	5	33%	50%

Additional information about EBM connect is available at:

- Optum Symmetry EBM Connect

Pharmacy Substitution Rates (RRX) are sourced from internal pharmacy claims data. These rates apply to prescriptions where generic and brand drugs are available. RRX is a measurement of how often brand drugs are prescribed when a generic is available. Generic prescription is preferred, and the proportion of preferred prescriptions to total prescriptions is known as the substitution rate.

A.3 Episode Exclusions

To provide meaningful provider results, this program filters out episodes that are either not comparable or are deemed outliers that could unfairly influence results. These exclusions include:

- Non-Primary Coverage: Episodes for patients with primary coverage under another insurer or Medicare.
- Non-Commercial Episodes: Episodes for members on Medicare or other specialty networks are removed.
- Outlier Episodes: For cost efficiency Metrics, both low and high outlier (by total cost) episodes are removed from scoring.

Outlier determination is done using internal claims experience, as follows:

1. Pull all episodes for the most recent two-year period (with 3 months runout), after making the above exclusions.
2. Only episodes flagged as “complete” are used in outlier determination.
3. Data is stratified by episode type and provider specialty into groups of comparable episodes.
    a. For ETGs, episodes are grouped by ETG and member severity, excluding complications. In other words, episodes “with complication” and “without complication” are considered together.
    b. For PEGs, episodes are grouped by PEG category and member severity.
4. Assess the distribution of costs across each comparable group of episodes, identifying the 25th (Q1), 50th (Median), and 75th (Q3) percentiles of episode cost.
5. Low Outlier threshold is identified as Q1 divided by 6.
    a. For example, if Q1 cost is $12,000, then any complete episodes with total cost below $2,000 would be deemed a low outlier and removed from scoring.
6. High Outlier threshold is identified as Median + (Q3 – Median) * 6
    a. For example, if Median cost is $15,000 and Q3 cost is $18,000, then episodes with total cost above $15,000 + ($3,000 x 6) = $33,000 are deemed a high outlier and removed from scoring.

A.4 Peer Benchmarking

For each Metric, this program uses the distribution of all available data to determine peer benchmarks. Each Metric will have a simple average and a standard deviation against which a z-scoring method is used to determine a provider's Metric Score against the benchmark. The z-score is defined as the distance from the average, divided by the standard deviation:

- Z-score = (Actual – Average) / Standard Deviation

Although the scores across providers are not expected to be normally distributed for every Metric, this approach allows different Metrics to be scored on the same scale.

Important z-scoring notes:

- For this program, a positive z-score always indicates a favorable result, which may vary in direction from measure to measure. As an example, both lower than average costs and higher than average compliance rates are favorable results and will result in a positive z-score.
- Z-scores are capped at -2.0 and +2.0.

For clarity in reporting, Metric Scores are expressed on a 0-100 scale by mapping the z-scores uniformly:

Z-score	Metric Score
-2.0	0
-1.0	25
0	50
1.0	75
2.0	100

A.5 Mechanics of Peer Benchmarking

For determining the expected distribution of Metric Scores, this program uses its large pool of data to derive the expected average and standard deviation:

- Two years (rolling 24 months) of all available episode data for cost efficiency; most recent available period for quality data, which can vary by Metric.
- Commercial fully insured and self-funded claims.
- Outlier cost episodes are removed, as described in a previous section.
- Providers must satisfy the minimum episode or event threshold to receive a score for a given Metric:
  - ETG and PEG must have at least 10 episodes
  - EBM must have at least 5 events
  - RRX must have at least 30 events

For ETG Metrics, peer benchmark costs for episodes are grouped by Episode Type and Member Severity Score, ignoring the classification for "with complication." This will case mix a provider's episodes for factors such as the presence of comorbid conditions, member risk factors, and the presence of a surgery.

For PEG Metrics, peer benchmark costs for episodes are grouped by Episode Type and Member Severity Score. This will case mix a provider's episodes for the presence of comorbid conditions and member risk factors.

EBM Metrics are not risk adjusted because the denominator explicitly defines the population that is at risk; thus, risk adjustment is

incorporated into the definition of the Metric. Only EBM episodes with YES or NO result types are included (e.g. omit questionable or N/A results). YES and NO result types have well-defined outcomes.

Incomplete and complete episodes are included in ETG and PEG scoring.

A.6 Mechanics of Provider Scoring

The most recent year of data with runout is used to create each Metric Score. This applies to EBM, RRX, ETG, and PEG episodes.

Providers must satisfy the minimum episode or event threshold to receive a score for a given Metric:

- ETG and PEG must have at least 10 episodes
- EBM must have at least 5 events
- RRX must have at least 30 events

The result of this process can be seen in a provider's VBR Scorecard Report. For each Metric in the Professional VBR program for a provider's Predominant Specialty, the provider can see the number of episodes they were responsible for in the most recent year. The VBR Scorecard Report shows the actual result of those episodes, as well as the expected average and standard deviation from the benchmark. For Metrics with a credible number of episodes, the final score (0 to 100) will be shown for each measure, derived by using z-scoring methodology as described previously.

A.7 Composite Score

Once every Metric is assigned a score (or deemed not credible), a Composite Score is created for ranking in the program.

The Composite Score is calculated as a weighted average of all Metric Scores. Just as each Metric Score is on a 0-100 scale, the Composite Score is also on a 0-100 scale.

Metrics are pre-assigned Metric Weights for each Predominant Specialty based on the relative importance this program places on each Metric.

To receive a Composite Score, a provider must have a Metric Score in at least three Metrics.

Providers are not penalized by Metrics for which they do not receive a Metric Score. The weighted average calculation only considers those Metrics that have a Metric Score.

Example:

Provider A receives Metric Scores in 4 of the 6 available Metrics

Metric	Weight	Metric Score
ETG1	1	70
ETG2	2	Not Credible
PEG1	3	55
EBM1	2	Not Credible
EBM2	1	40
RRX	2	60

Provider A's Composite Score would be:

- The sum of each Metric Score multiplied by its Weight, divided by:
- The sum of the Weights for those Metric Scores

This would be calculated as:

- (70 x 1) + (55 x 3) + (40 x 1) + (60 x 2) = 395, divided by
- 1 + 3 + 1 + 2 = 7
- 395 / 7 = 56.4 Composite Score

APPENDIX B: Metric List

This section contains the lists of Metrics that apply to each Predominant Specialty. More information about provider results and peer averages for Metrics in their specialty can be found in the VBR Scorecard Report.

Dermatology Metrics

Cost Efficiency, Condition-Based Episodes (ETG)

Metric: Provider Average Cost vs Peer Average Costs

Condition	Procedure, if specified	Weight
Malignant neoplasm of skin, major	Surgery, without active management	2
Malignant neoplasm of skin, major	Surgery, with active management	2
Malignant neoplasm of skin, minor	Surgery	2
Non-malignant neoplasm of skin	Major surgery	2
Non-malignant neoplasm of skin	Minor surgery	2
Non-malignant neoplasm of skin	No surgery	1
Acne		1
Viral skin infection		1
Psoriasis		1

Family Practice and General Medicine Metrics

Quality, Evidence-Based Medicine (EBM)

Metric: Provider Compliance Rate vs Peer Average Compliance

Diagnostic Category	Rule Name	Weight
Depression Med Mgmt	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 weeks (effective acute phase treatment)	2
LBP Imaging	Patient(s) with uncomplicated low back pain that did not have imaging studies	2
Prenatal & PP Care	Woman that received a prenatal visit in the appropriate time period	2
Statin Therapy for DM	Patient(s) 40-75 years with diabetes that received a statin medication	2
Bronchitis, Acute	Patient(s) with a diagnosis of acute bronchitis/bronchiolitis that did not have a prescription for an antibiotic on or within three days after the initiating visit	2
URI	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or within three days after the initiating visit	2
Asthma	Patient(s) that did not have an asthma related emergency department encounter in last 12 reported months	1
COPD - Part 1	Patient(s) that did not have a COPD related emergency department encounter in last 12 reported months	1
Heart Failure - Part 1	Patient(s) that did not have a heart failure related emergency department encounter in last 12 reported months	1
Breast CA - Part 1	Patient(s) that had an annual mammogram	1
Depression	Patient(s) with evidence of severe depression that had a mental health evaluation in last 3 months	1
Diabetes	Patient(s) that had at least one HbA1c test in the last 6 reported months	1
HTN	Patient(s) that had a serum creatinine in last 12 reported months	1

Quality, Generis Substitution Rate (RRX)

Metric: Provider Compliance Rate vs Peer Average Compliance

Rule name	Weight
Generic prescription substitution rate	1

Internal Medicine Metrics

Quality, Evidence-Based Medicine (EBM)

Metric: Provider Compliance Rate vs Peer Average Compliance

Diagnostic Category	Rule Name	Weight
Depression Med Mgmt	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 weeks (effective acute phase treatment)	2
LBP Imaging	Patient(s) with uncomplicated low back pain that did not have imaging studies	2
Statin Therapy for DM	Patient(s) 40-75 years with diabetes that received a statin medication	2
Bronchitis, Acute	Patient(s) with a diagnosis of acute bronchitis/bronchiolitis that did not have a prescription for an antibiotic on or within three days after the initiating visit	2
URI	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or within three days after the initiating visit	2
Asthma	Patient(s) that did not have an asthma related emergency department encounter in last 12 reported months	1
COPD - Part 1	Patient(s) that did not have a COPD related emergency department encounter in last 12 reported months	1
Heart Failure - Part 1	Patient(s) that did not have a heart failure related emergency department encounter in last 12 reported months	1
Depression	Patient(s) with evidence of severe depression that had a mental health evaluation in last 3 months	1
Diabetes	Patient(s) that had at least one HbA1c test in the last 6 reported months	1
HTN	Patient(s) that had a serum creatinine in last 12 reported months	1

Quality, Generis Substitution Rate (RRX)

Metric: Provider Compliance Rate vs Peer Average Compliance

Rule name	Weight
Generic prescription substitution rate	1

Ophthalmology Metrics

Cost Efficiency, Procedure-Based Episodes (PEG)

Metric: Provider Average Cost vs Peer Average Costs

Procedure	Weight
Cataract Removal	2
Intravitreal Injection Of A Pharmacologic Agent	2
Discission Of Secondary Membranous Cataract	2
Repair Of Retinal Detachment	2
Strabismus Revision	2
Destruction Of Retina	2
Vitrectomy	2
Trabeculoplasty By Laser Surgery	1
Prophylaxis Of Retinal Detachment	1
Closure Of The Lacrimal Punctum	1
Iridotomy/Iridectomy	1

Obstetrics & Gynecology Metrics

Cost Efficiency, Condition-Based Episodes (ETC)

Metric: Provider Average Cost vs Peer Average Costs

Condition	Procedure, if specified	Weight
Pregnancy, with delivery	With C-Section	3
Pregnancy, with delivery	Without C-Section	2
Spontaneous abortion		1

Cost Efficiency, Procedure-Based Episodes (PEG)

Metric: Provider Average Cost vs Peer Average Costs

Procedure	Weight
Hysterectomy	2
Hysteroscopy With Treatment	2
Removal Of Ovary/Ovarian Duct	2
Conization Of Cervix	2
Excision Of Ovary/Ovarian Duct	2

Quality, Evidence-Based Medicine (EBM)

Metric: Provider Compliance Rate vs Peer Average Compliance

Diagnostic Category	Rule Name	Weight
Prenatal & PP Care	Women that received a prenatal visit in the appropriate time period	3
Pregnancy Management	Pregnant women that had a syphilis screening	3
Pregnancy Management	Pregnant women that had HBsAg testing	1
Pregnancy Management	Pregnant women that had HIV testing	1
Pregnancy Management	Pregnant women that received Group B Streptococcus testing	1
Pregnancy Management	Pregnant women less than 25 years of age that had chlamydia screening	2
Pregnancy Management	Pregnant women less than 25 years of age that had gonorrhea screening	2
Cervical Dysplasia	Patient(s) with cervical dysplasia that had a PAP smear, hysterectomy, or other cervical procedure within 12-15 months of the initial diagnosis	2

Obstetrics & Gynecology Metrics (Cont.)

Quality, Generic Substitution Rate (RRX)

Metric: Provider Compliance Rate vs Peer Average Compliance

Rule name	Weight
Generic prescription substitution rate	1

Psychiatry Metrics

Quality, Evidence-Based Medicine (EBM)

Metric: Provider Compliance Rate vs Peer Average Compliance

Diagnostic Category	Rule Name	Weight
Depression Med Mgmt	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 weeks (effective acute phase treatment)	2
Mental Illness - FU After ER	Patient(s) six years of age or older with an ED visit for mental illness or intentional self-harm that had a follow-up visit within 7 days	2
Mental Illness - FU	Patient(s) hospitalized for mental illness or intentional self-harm that had a follow-up encounter with a mental health provider within 7 days after discharge.	2
Metabolic Mont Antipsychc	Patient(s) 1-17 years who had two or more antipsychotic medications and had blood glucose and cholesterol testing during the report period	2
Depression	Patient(s) with evidence of severe depression that had a mental health evaluation in last 3 months	1
Depression	Patient(s) 18 years of age or older taking a medication for depression treatment that had an annual provider visit	1
Depression	Patient(s) who are currently taking lithium or an antipsychotic-containing medication that had a psychiatric evaluation in last 6 reported months	1

Quality, Generis Substitution Rate (RRX)

Metric: Provider Compliance Rate vs Peer Average Compliance

Rule name	Weight
Generic prescription substitution rate	1