Michigan Primary Care Transformation Project


For Physician Organizations, Physician Hospital Organizations, Independent Practice Associations and Primary Care Practices
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Selection of the 2014 Performance Incentive Metrics

The 2014 Performance Incentive metric set, to be used for the 2014 midyear (30 month) and end of year (36 month) assessments, was selected and refined by the MiPCT Performance Incentive Subcommittee during a series of meetings in 2013. Performance Incentive Subcommittee members represented health plans, physician organizations and physician hospital organizations. Technical assistance was provided by consultants from the Michigan Data Collaborative and the MiPCT evaluation team at the Michigan Public Health Institute. The MiPCT Clinical Subcommittee and leadership from physician organizations and physician hospital organizations reviewed the proposed metrics and provided input. The MiPCT Steering Committee approved the 2014 performance incentive metrics on September 16, 2013.

MiPCT Performance Incentive Subcommittee

Members: Dr. Paul Ponstein (chair), Ruth Clark, Susan Dolby, Dr. Kimberly Coleman, Dr. Jim Forshee, Christina Hildreth, David Livingston, Ewa Matuszewski, Dr. Diane Sayers, Alicia Simmer and Betsy Wasilevich

Committee Consultants: Myron Hepner, Mallory Lawrenchuk and Clare Tanner

MiPCT Staff: Amanda First and Dana Watt

MDC Technical Manual Editors: Brian Allison and Christopher Reid
2014 MiPCT Performance Incentive Program

Objectives of the MiPCT Performance Incentive Program

The MiPCT Performance Incentive Program provides financial rewards to physician organizations/physician hospital organizations/independent practice associations (POs) and primary care practices for achievements on MiPCT Performance Incentive Metrics. The Performance Incentive Program is designed to transition over the three years of the demonstration from metrics that reward infrastructure and process development in 2012 toward those that reward improvement in quality and cost outcomes in 2014. The program is designed to

- Reward primary care practices for transformation efforts and for achieving desired outcomes.
- Reward/compensate POs for the services provided to assist MiPCT primary care practices to transform care processes and achieve desired outcomes.
- Reward improvement on population level indicators of patient health care status and decreased or stabilized cost of care.

2014 Incentive Periods and Payments

Performance Incentive periods are identified by the number of months since initiation of the MiPCT Demonstration Project. 2014 performance evaluations periods are 30 Month (midyear) and 36 Month (end of year). Payment will be made about 6 months following the close of the performance period.

2014 Performance Incentive Metrics Summary

Table 1 lists the 2014 metrics, data sources and the maximum points to be allotted to each measure for adult and child populations. The metrics will be used for both the 30 Month and 36 Month assessments.

- **Part I-III Outcome/Improvement Metrics**

  Utilization and clinical quality metrics will make up 85% of the possible points. The metrics will be assessed at the PO level for the total applicable population of adults (> 18 years) and/or children (< 18 years) in the PO and will not take practice type, e.g. pediatrics, into consideration. Total adult and child points for Parts I-III will be multiplied by the proportion of adults to children in the PO (see page 5).

- **Part IV Process Metrics**

  Process/Practice Capability metrics will make up 15% of the total possible points. Process measures will be assessed at the practice level and points will be allotted for the percent of practices in each PO with the process/capability in place.
Table 1: 2014 Performance Incentive Metrics, Data Sources and Maximum Points

<table>
<thead>
<tr>
<th>MiPCT Performance Incentive Measures</th>
<th>Data Source</th>
<th>2014 Points*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Adults in PO &gt; 18 years</td>
</tr>
<tr>
<td>I. Utilization (assessed at PO level)</td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>Score &gt; PO 50th percentile or &gt; 1% improvement over baseline**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Primary Care Sensitive ED Visits (NYU algorithm)</td>
<td>Claims</td>
<td>15</td>
</tr>
<tr>
<td>2. Asthma ED Visits for Previously Diagnosed Asthma***</td>
<td>Claims</td>
<td>10</td>
</tr>
<tr>
<td>3. Ambulatory Care Sensitive Hospitalizations</td>
<td>Claims</td>
<td>15</td>
</tr>
<tr>
<td>4. Hospital Readmissions</td>
<td>Claims</td>
<td>15</td>
</tr>
<tr>
<td>II. Clinical Quality Metrics (assessed at PO level)</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Score &gt; PO 50th percentile or &gt; 1% improvement over baseline**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Diabetes: Annual Retinal Eye Exams</td>
<td>Claims</td>
<td>5</td>
</tr>
<tr>
<td>2. Breast Cancer Screening</td>
<td>Claims</td>
<td>5</td>
</tr>
<tr>
<td>3. Cervical Cancer Screening</td>
<td>Claims</td>
<td>5</td>
</tr>
<tr>
<td>4. Well Child Visits - 15 months</td>
<td>Claims</td>
<td>5</td>
</tr>
<tr>
<td>5. Well Child Visits - 3-6 years</td>
<td>Claims</td>
<td>5</td>
</tr>
<tr>
<td>6. Adolescent Immunizations</td>
<td>MCIR</td>
<td>5</td>
</tr>
<tr>
<td>III. Clinical Quality Metrics (assessed at PO level)</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Score &gt; PO 50th percentile or &gt;1% improvement over 2013 score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Diabetes Control AIC &lt; 8</td>
<td>Registry</td>
<td>3</td>
</tr>
<tr>
<td>2. Diabetes: Blood Pressure &lt; 140/90</td>
<td>Registry</td>
<td>3</td>
</tr>
<tr>
<td>3. CVD: Blood Pressure &lt; 140/90</td>
<td>Registry</td>
<td>3</td>
</tr>
<tr>
<td>4. Hypertension: Blood Pressure &lt; 140/90</td>
<td>Registry</td>
<td>3</td>
</tr>
<tr>
<td>5. Tobacco Use Assessment</td>
<td>Registry</td>
<td>3</td>
</tr>
<tr>
<td>6. Weight Assessment for Children &amp; Adolescents</td>
<td>Registry</td>
<td>10</td>
</tr>
</tbody>
</table>

Part I, II & III Adult and Child Subtotals* | 85 | 85 |

PO Adult Points (Adult Subtotal x % adults in PO) |

PO Child Points (Child Subtotal x % Children in PO) |

PO Outcome Measures Subtotal (PO Adult Points + PO Child Points) | 85 |
Table 1: 2014 Performance Incentive Metrics, Data Sources and Maximum Points (continued)

<table>
<thead>
<tr>
<th>MiPCT Performance Incentive Measures</th>
<th>Data Source</th>
<th>2014 Points*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator</td>
<td>Denominator</td>
</tr>
<tr>
<td>IV. Process Measures (assessed at practice level)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Depression Screening for Patients with Chronic Health Conditions***</td>
<td>Registry</td>
<td>Claims</td>
</tr>
<tr>
<td>2. Notification of Hospital Admissions &amp; Discharges</td>
<td>MiPCT Quarterly Report</td>
<td>MiPCT Quarterly Report</td>
</tr>
<tr>
<td>3. Follow-Up Referrals to a Community-Based Program or Agency</td>
<td>MiPCT Quarterly Report</td>
<td>MiPCT Quarterly Report</td>
</tr>
<tr>
<td>4. Self-Management Support Offered for Chronic Condition of Focus</td>
<td>MiPCT Quarterly Report</td>
<td>MiPCT Quarterly Report</td>
</tr>
<tr>
<td>PO Process Measures Subtotal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PO Outcome Measures Subtotal (from page 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total PO Points</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Bold font numbers represent the maximum possible points available for the section and for each metric.
**Scores will be compared against a baseline average of the previous 2-3 year’s scores.
***New measure for 2014.

Changes from the 2013 MiPCT Performance Incentive Program

New Measures Added in 2014


Part IV: Depression Screening for Patients with Chronic Health Conditions. This process metric rewards POs that submit registry/EHR data that demonstrates individuals with chronic illness are being screened for depression.

2013 Measures Retired in 2014

Part II: Diabetes A1C tests completed.
Part IV: Tracking referrals of MiPCT eligible high-risk patients to community resources (PGIP 10.7).
Part IV: Self-Management Support Offered for Chronic Condition of Focus (PGIP 11.8).
Other Changes

Part III: Clinical quality metrics based on registry/EHR data were transitioned from process measures in 2013, where points were allotted for reporting clinical data, to outcome measures in 2014 where points are allotted for achievement.

Data Sources for 2014 Metrics

- **Claims:** Claims data will be used to calculate the numerators and denominators for Part I utilization and Part II clinical quality metrics. Claims data will be used to determine the denominators for the Part III clinical quality metrics and the Part IV depression screening metric. Data analysis will be delayed until after the 3 month run out period for claims submission is completed.
  - **30 Months:** The measurement year is 7/1/13 through 6/30/14. Some Part II clinical metrics have an additional one or two year claims look-back period. See metric specifications for details.
  - **36 Months:** The measurement year is 1/1/14 through 12/31/14. Some Clinical Quality metrics have an additional 1 or 2 year look-back period. See metric specifications for details.

- **Registry/EHR:** Numerators for Part III clinical metrics and the Part IV depression screening metric will be calculated from clinical registry/electronic health record data submitted by POs to the Michigan Data Collaborative.

- **Quarterly Report:** Part IV metrics 2, 3, and 4 will be assessed through PO attestation in the MiPCT Quarterly report.

- **Eligibility Data:** Some Part II and Part III metrics are applicable to the entire MiPCT subpopulation that meets age criteria. Denominators for these metrics will be identified from health plan eligibility and demographic data.

- **Michigan Childhood Immunization Registry (MCIR):** MCIR scores will be used for the adolescent immunization metric.

Submission of MiPCT Registry/EHR Data

Participating POs will submit specified registry/EHR data to the Michigan Data Collaborative for all participating MiPCT patients. Optionally, POs may submit data for all of the patients in the MiPCT practice and MDC will filter the data to identify the portion applicable to MiPCT patients. Submitted data will be loaded into the MiPCT multi-payer database, integrated with claims data, and used to calculate performance metrics for use in the project dashboard, reports and the incentive program.

Technical documentation for registry submissions is found in the Appendix (page 21) and on the MDC Support webpage at [https://www.michigandatacollaborative.org/MDC/#/support](https://www.michigandatacollaborative.org/MDC/#/support). (Navigate to MiPCT Registry Data Submission/Specifications/ Clinical data specs). For further information about submission of registry data, email the Michigan Data Collaborative at MichiganDataCollaborative@umich.edu.
Point Allotment Methodology

Utilization, Claims- and Registry-Based Clinical Quality Metrics: Points will be allotted for achievement and improvement. Points will be added and capped at the maximum point level. For the registry-based clinical quality metrics, POs must submit registry/EHR numerator data for 50% or more of the metric’s eligible population in order for the metric to be eligible for assessment and points.

- **Achievement.** Rates for each metric will be ranked lowest to highest rate for utilization and highest to lowest rate for clinical quality. Ranked rates will be divided into percentiles and points assigned as follows:
  - 90th percentile = full points
  - 80th percentile = 80% of points
  - 70th percentile = 60% of points
  - 60th percentile = 40% of points
  - 50th percentile = 20% of points
  - Less than 50th percentile = 0 points

- **Percent Improvement:** Improvement is defined as a positive percent change for clinical quality metrics and a negative percent change for utilization metrics. The percent change formula is (2013 rate – baseline rate / baseline rate x 100).
  - Significant improvement > 1% = full points
  - Non-significant improvement > 1% = 50% of points
  - Improvement <1% = 0 points

**Capability Metrics:** Points for these measures will be calculated by multiplying the total possible points for the measure by the percent of practices in the PO with attestation that the specified capability is in place.

Methodology for Calculation of Total PO Points

1. Assess applicable utilization and clinical quality metrics at the PO adult and/or child population levels (see Tables 1 and 2 on pages 4-6).
2. Sum points for utilization and process metrics and record Adult and Child Subtotals.
3. Multiply Adult Subtotal by the percent of adult beneficiaries in the PO to obtain PO Adult Points. Multiply the Child Subtotal Score by the percent of children in the PO to obtain PO Child Points.
4. Add PO Adult Points and PO Child Points to obtain the PO Outcome Measures Subtotal.
5. Assess Process Measures and calculate the PO Process Measure Subtotal.
6. Add PO Outcome Measures Subtotal (85 points possible) and Process Measures Subtotal (15 points possible) to obtain Total PO Points (100 points possible).
2014 Metric Specifications

Utilization Metrics

The Michigan Data Collaborative will use claims data to calculate the PO rates for the utilization metrics. Full points will be allotted to each metric for which the 2014 score exceeds the MiPCT benchmark rate. Variable points will be assigned to metrics for which the 2014 rate has improved in comparison to the baseline rate. Contact the Michigan Data Collaborative MichiganDataCollaborative@umich.edu for additional information.

1. Primary Care Sensitive ED Visits

**Metric Source:** MiPCT measure based on New York University Algorithm

**Definition:** *Portion of total ED Visits considered to be Primary Care Sensitive*

**Numerator:** The number of patients from the denominator who had an ED visit considered to be Primary Care Sensitive, defined as: Non-emergent, or Emergent but primary care treatable, or Emergent and ED care was needed but condition was preventable or avoidable according to the NYU algorithm.

**Denominator:** Total patients with outpatient ED Visits

**Methodology for determining numerator:** ED visits will be sorted into four categories using the NYU Algorithm for ED Visit classification. The first three categories are collectively referred to as preventable/avoidable or primary care sensitive (PCS) conditions/visits and reported as rate per 1000 visits.

- **Non-emergent.** Cases where immediate (within 12 hours) care is not required (e.g., sore throat, back pain, ingrown toenail, eczema, and attention to dressings).
- **Emergent, but primary care treatable.** Care is needed within 12 hours, but care could be provided in a typical primary care setting (e.g., infant with a 102° fever, nosebleed, abdominal pain, acute bronchitis, painful breathing).
- **Emergent, ED care needed but preventable/avoidable.** Immediate care in an ED setting is needed, but the condition potentially could have been prevented or avoided with timely and effective ambulatory care (e.g., asthma, cellulitis, emphysema, pelvic inflammatory disease, diabetic ketoacidosis, etc.).
- **Emergent, ED care needed, not preventable/avoidable.** Immediate care in an ED setting is needed and the condition could not have been prevented or avoided even with effective ambulatory care (e.g., heart attack, appendicitis, kidney stone, multiple trauma, and chest pain). This category includes visits with a principle diagnosis relating to injury, mental health, alcohol and drug related, and visits with an unclassified diagnosis that does not fall into one of the other categories.

This classification is then used to calculate rates of preventable/avoidable/PCS conditions per 1000 ED visits. Rates are known to vary by patient demographics, health plan source, and geography. © NYU Wagner
2. **Asthma Emergency Department (ED) Visits for Previously Diagnosed Asthma**

   **Metric Source:** Michigan Quality Improvement Consortium (MQIC)

   **Definition:** Individuals > 5 years of age previously diagnosed with asthma who have had a visit to an emergency department with a principle diagnosis of asthma. (The measure is reported per 1000 members with asthma).

   **Numerator:** The number of patients from the denominator who have had a visit to an Emergency Department with a principal diagnosis of asthma during the measurement period. The earliest asthma ED visit date is used.

   **Denominator:** Total number of patients > 5 years old with a qualifying asthma diagnosis between Jan 1, 2010 through the end of the measurement year.

   **Numerator Codes:** Asthma ICD-9 493.0, 493.1, 493.8, 493.9. Ed Visits CPT 99281-99285.

   **Methodology for Denominator Identification:** HEDIS criteria are used to identify members with persistent asthma. At least one of the following criteria must be met during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

   - At least 1 inpatient or ED visit with principal diagnosis of Asthma **Or**
   - At least 4 outpatient visits with any diagnosis of asthma **Or**
   - At least 4 prescriptions for an asthmatic drug (excluding leukotriene modifiers).

   **Exclusions:** Individuals with co-morbid diagnoses of COPD, emphysema and cystic fibrosis, or acute respiratory failure are excluded.

   **Exclusion Codes:** ICD-9-CM: 492, 518.1, 518.2, 491.2, 493.2, 496, 506.4, 277.0, 518.81.

3. **ACSC Hospitalization Rate (Adult and Child)**

   **Adult ACSC Hospitalization Rate**

   **Metric Source:** AHRQ Prevention Quality Indicators [http://www.qualityindicators.ahrq.gov](http://www.qualityindicators.ahrq.gov)

   **Description:** Percent of adult inpatient discharges that are classified by the AHRQ algorithm as potentially avoidable through early intervention and appropriate outpatient care.

   **Numerator:** The number of cases “flagged” with the outcome of interest.

   **Denominator:** The number of inpatient discharges for individuals over the age of 18.

   **Codes:** Available from the Michigan Data Collaborative

   **Exclusions:** Pregnancy, Childbirth and the Puerperium

   **Exclusion Codes:** Medical Diagnostic Code (MDC) 14

   **ACSC Methodology:** Definitions for ACSCs are based on ICD-9-CM diagnosis and procedure codes (often along with diagnosis related group (DRG), major diagnostic category (MDC), sex, age, procedure dates, admission type, admission source, discharge disposition).

   There are 9 chronic conditions: Chronic Diabetes Short Term Complications; Chronic Diabetes Long Term Complications; Chronic Diabetes Amputation; Chronic Diabetes Uncontrolled;
Chronic Hypertension; Chronic Angina no procedure; Chronic Congestive Heart Failure; Chronic COPD and Chronic Asthma in Young Adults (the only PQI with an upper limit Age at admission > 18 AND < 40.) There are 4 Acute Conditions: Acute Bacterial Pneumonia; Acute Dehydration; Acute UTI (urinary tract infection) and Acute Perforated Appendix.

**Children/Teen ACSC Hospitalization Rate**

**Metric Source:** AHRQ Prevention Quality Indicators

**Description:** Percent of potentially preventable inpatient admissions in children/teens < 18 years of age.

**Numerator:** The number of cases “flagged” with the outcome of interest.

**Denominator:** The number of inpatient discharges for children (see applicable age groups below).

**Methodology for Calculating Numerators:** PDIs included in the ACSC measure: Asthma Admission Rate (pediatric members 2 to 17 years), Diabetes Short-term Complications (pediatric members 6 to 17 years), Gastroenteritis Admission Rate (pediatric members 3 months to 17 years) Perforated Appendix Admission Rate (pediatric members 1 to 17 years) and Urinary Tract Infection Admission Rate (pediatric members 3 months to 17 years).

**Codes:** Available from Michigan Data Collaborative

**Exclusions:** Pregnancy, childbirth and the puerperium and Adult Diagnostic Related Groups.

**Exclusion Codes:** Medical Diagnostic Code (MDC) 14

4. **All-Cause Readmissions**

**Metric Source:** 2013 HEDIS

**Definition:** Percent of total acute inpatient stays for adults 18 years of age and older during the measurement year that was followed by an acute readmission for any diagnosis within 30 days.

**Numerator:** The number of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days for adults 18 years of age and older.

**Denominator:** Total number of acute inpatient stays during measurement period.

**Methodology:** NCQA provides tables to identify and calculate risk adjustment weights for each Index Hospital Stay (IHS) based on presence of surgery, discharge condition, comorbidity, age and gender.

**Exclusions:** Inpatient stays with discharges for death and inpatient discharge with a principle diagnosis for pregnancy or for any other condition originating in the perinatal period.

**Exclusion Codes:** CPT: 630-679, V22, V23, V28.

**Claims-Based Clinical Quality Metrics**
The Michigan Data Collaborative will use claims and eligibility data to calculate rates for the metrics in this group. The Michigan Data Collaborative does not currently have the capacity to receive and process supplemental data from POs to improve scores.

1. Diabetes: Eye Examination

**Metric Source:** 2012 HEDIS, NQF 0055, Meaningful Use 2014 Clinical Quality Measure CMS131v1, PQRI 117

**Definition:** Percent of patients 18-75 years of age with diabetes who had a dilated or retinal eye exam during the measurement year or a negative retinal eye exam during the prior year.

**Numerator:** The number of patients from the denominator with an eye exam in the measurement year or negative exam in the previous year.

**Denominator:** Total number of patients 18-75 years old with diabetes. Diabetes is identified by pharmacy or claims data identifying member as having diabetes during measurement year or prior to the measurement year.

- Claim/Encounter: Members who had one of the diagnosis of diabetes during the measurement year or the year prior to the measurement year;
  - Outpatient or non-acute inpatient: two face-to-face encounters on different dates of service with a diagnosis of diabetes,
  - Acute Inpatient or ED: One face-to-face encounter.
- Pharmacy data: Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics.


**Denominator Codes** (Diabetes) - ICD-9: 250, 250.0, 250.00, 250.01, 250.02, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0 - 362.07, 366.41, 648.0-648.04.

Contact MDC for the list of prescriptions and the outpatient, inpatient and ED visit codes.

2. Breast Cancer Screening

**Metric Source:** 2012 HEDIS, NQF 0031, Meaningful Use 2014 Clinical Quality Measure CMS125v1, PQRI 12

**Definition:** Percentage of women 40-69 years of age who received at least one mammogram to screen for breast cancer within the measurement year or one year prior.

**Numerator:** The number of patients from the denominator with 1 or more mammograms during the current or previous year.
Denominator: Total number of females 42-69 years old on the final day of the measurement year.

Numerator Codes: (Mammography): CPT: 77055, 77056, 77057; HCPCS: G0202, G0204, G0206; ICD-9: 87.36, 87.37; UB Revenue 0401, 0403.

Exclusions: Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies. Look for evidence of a bilateral mastectomy as far back as possible in the member’s history through December 31 of the measurement year.

Exclusion Codes: (Bilateral mastectomy): CPT: 19180, 19200, 19220, 19240, 19303-19307 with modifier 50 or modifier code 09950.
(Unilateral mastectomy -members must have 2 separate occurrences on 2 different dates of service): CPT: 19180, 19200, 19220, 19240, 19303-19307; ICD-9: 85.41, 85.43, 85.45, 85.47.

3. Cervical Cancer Screening

Metric Source: 2013 HEDIS, NQF 0032, Meaningful Use 2014 Clinical Quality Measure CMS124v1

Definition: Percent of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer within the measurement year or the prior 2 years.

Numerator: The number of patients from the denominator with 1 or more pap tests during the current or the last two years.

Denominator: Total number of female patients who were 24-64 years old on the last day of the measurement period. (There is a 3 year look-back period.)


Exclusions: Women who have had a hysterectomy on or before the end of the measurement period.

Exclusion Codes: (Hysterectomy): CPT: 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135; ICD-9 CM Procedure: 68.4-68.8l; ICD-9 CM Diagnosis Codes: 618.5, V67.01, V76.47, V88.01, V88.03.

4. Well-Child Visits in the First 15 Months of Life

Metric Source: 2013 HEDIS

Definition: Percent of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.

Numerator: Total number of patients who had six or more well-child visits with a PCP during their first 15 months of life.

Denominator: Total number of patients who turned 15 months old during the measurement year.

Numerator Codes: (Well-child visits): CPT: 99381, 99382, 99391, 99392, 9946; ICD 9 V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9; HCPCS: G0438, G0439.
5. **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life**

**Metric Source:** 2013 HEDIS

**Definition:** Percent of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.

**Numerator:** The number of patients from the denominator who received 1 or more well-child visits with a PCP during the measurement year.

**Denominator:** Total number of patients who turned 3-6 years old during the measurement year.

**Numerator Codes:** (Well child visits): CPT: 99382, 99383, 99392, and 99393; ICD-9: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9; HCPCS: G0438, G0439.

6. **Adolescent Immunizations**

**Metric Source:** 2013 HEDIS

**Definition:** Percent of youth who have received the following

a. Meningococcal vaccine on or between the members’ 11th to 13th birthdays.

b. 1 Tdap or 1 Td on or between the members’ 10th to 13th birthdays.

**Numerator:** The number of patients from the denominator who by their 13th birthday received one dose of meningococcal vaccine And one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) Or one tetanus, diphtheria toxoids vaccine (Td).

**Denominator:** Total number of patients who turned 13 years old during the measurement year.

**Numerator Codes:** (Meningococcal): 90733, 90734; (Tdap): 90715; (Td): 90714, 90718; (Tetanus): 90703; (Diphtheria): 90719; ICD-9-CM Procedure: (Diphtheria) 99.36, (Tetanus) 99.38, (Dtap) 99.39.

**Data Source:** Immunization data will be obtained from the Michigan Childhood Immunization Registry (MCIR).

**Registry/EHR-Based Clinical Quality Metrics**

For the metrics in this section, the Michigan Data Collaborative will calculate numerators from registry/EHR data submitted by the PO and will calculate denominators from claims and/or eligibility data. A data submission threshold of 50% applies to each of these metrics. POs must submit registry/EHR numerator data for 50% or more of the metric’s eligible population in order for the metric to be eligible for assessment and points.

1. **Diabetes: HbA1C Control (< 8%)**

**Metric Source:** HEDIS 2013, NQF 0575, Stage 1 Meaningful Use 2013 Menu Clinical Quality Measure

**Definition:** Percent of adults aged 18-75 years with a diagnosis of diabetes who had a screening AIC test in the measurement year with result of AIC < 8.

**Numerator:** The number of patients from the denominator with most recent HbA1c < 8.
Denominator: Total number of patients 18 - 75 years old with diabetes and one or more AIC tests during the measurement year. See denominator of Diabetes Eye Exam page 10 for diabetes diagnosis criteria.

Data for Numerator: Identifying data, date, AIC levels in standard format.

Denominator Codes (Diabetes): See denominator codes for Diabetes Eye Exams on page 10.

Exclusions: Polycystic ovary disease, steroid induced diabetes and gestational diabetes.

Exclusion codes: (Polycystic ovary disease): 256.4; (Steroid-induced diabetes): 249, 251.8, 962.0; (Gestational diabetes): 648.8 V22, V23, V28.

2. Diabetes: Blood Pressure Management

Metric Source: 2014 HEDIS, NQF 0061, Stage 1 Meaningful Use 2013 Menu Clinical Quality Measure, PQRI 3

Definition: Percent of adults aged 18-75 years with a diagnosis of diabetes with the most recent blood pressure during the measurement year recorded as less than 140/90.

Numerator: The number of patients from the denominator with most recent BP <140/90.

Denominator: Total number of patients 18-75 years old with diabetes and one or more primary care office visits during the measurement year. See denominator of Diabetes Eye Exam page 10 for diabetes diagnosis criteria.

Data for Numerator: Identifying data, date and blood pressure in standard format.

Codes for Denominator (Diabetes): See denominator codes for Diabetes Eye Exams on page 10.

Exclusions: Polycystic ovary disease, steroid induced diabetes and gestational diabetes.

Exclusion codes: (Polycystic ovary disease): 256.4; (Steroid-induced diabetes): 249, 251.8, 962.0; (Gestational diabetes): 648.8, V22, V23, V28; CPT 630–676 and 678–679.

3. Hypertension: Controlling High Blood Pressure

Metric Source: 2014 HEDIS, NQF 0018, Meaningful Use 2014 Clinical Quality Measure CMS165v1

Definition: The percent of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year.

Numerator: The number of patients from the denominator with most recent BP<140/90. The lowest systolic and lowest diastolic reading will be used if there are several blood pressures recorded on the same date.

Denominator: Total number of patients 18-85 years old with hypertension and one or more primary care office visits during the measurement year.

Data for Numerator: Identifying data, date and blood pressure in standard format.

Codes for denominator (Hypertension): ICD-9: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03,
404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93; CPT Office Visit Codes: 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397.

**Exclusions:** Evidence during the measurement year of end-stage renal disease (dialysis or renal transplant also meets the criteria), pregnancy, and/or an admission to a non-acute inpatient setting.


4. **Ischemic Vascular Disease (IVD): Blood Pressure Management**

**Metric Source:** NQF 0073, Stage 1 Meaningful Use 2013 Menu Clinical Quality Measure, PQRI 201

**Definition:** Percent of adults 18-75 years of age who were discharged alive for AMI, CABG or PCI from January 1 to November 1 of the year prior to the measurement year, or who had a diagnosis of IVD during the measurement year or who had a diagnosis of ischemic vascular disease during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control <140/90).

**Numerator:** The number of patients from the denominator with most recent BP<140/90. The lowest systolic and lowest diastolic reading will be used if there are several BP readings recorded on the same date.

**Denominator:** Total number of patients 18-75 years of age with at least one office visit who were discharged alive for AMI, CABG or PCI for an 11 month period in the year prior to the measurement year or who had a diagnosis of IVD January 1 to November 1 of the year prior to the measurement year, or who had a diagnosis of IVD during the measurement year.

**Data for Numerator:** Identifying data, date and blood pressure in standard format.


5. **Tobacco Use Assessment**

**Metric Source:** MiPCT measure adapted from part “a” of the 2014 Meaningful Use Clinical Quality Measure CMS138v1 and NQF 0028. Age range is extended from 18 years and older to 13 years and older and the measure period is decreased from two years to 1 year. The MiPCT metric does not assess part “b” that requires documentation that a smoking cessation intervention was provided.

**Definition:** Percent of individuals 13 years of age and older with an office visit during the measurement year for whom smoking status is recorded.

**Numerator:** The number of patients from the denominator for which smoking status is reported.
Denominator: Total number of unique MiPCT patients aged 13 years and older with a primary care office visit during the measurement year.

Data for Numerator: Identifying data, date and smoking status “yes” (smokes), “no” (doesn’t smoke) or “unknown” in standard format.
Note: Responses of “unknown” and blank smoking status fields do not count in the numerator.

Data for Denominator: Members in age range with an office visit identified by CPT: 99201-99205, 99211-99215, 99241-99245, 99384-99387, and 99394-99397.

6. Weight Assessment for Children and Adolescents

Metric Source: MiPCT metric based on the first bullet of 2013 HEDIS, 2014 Meaningful Use Clinical Quality Measure CMS155v1 (first bullet only) and NQF 0024a.

Definition: Percent of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) during the measure year and who body mass index (BMI) percentile documentation.

Numerator: The number of patients from the denominator with BMI percentile recorded.

Denominator: Total number of patients aged 3-17 years of age with an outpatient visit with a primary care physician during the measurement year.

Data for Numerator: Identifying data, date and BMI percentile in standard format.

Data for Denominator: Members in age range with CPT: 99201-99205, 99211-99215, 99241-99245, 99382-99384, and 99392-99394.

Exclusion: Diagnosis of pregnancy during the measurement period


Process Measures

Process measures are assessed at the practice level. To qualify for measure 1, depression screening data must be submitted to the Michigan Data Collaborative using a standard format. POs will attest to measures 2, 3, and 4 at the practice level in the MiPCT Quarterly Report. PO points will equal the percent of practices in the PO with the capability in place multiplied by the possible points for the metric.

1. Depression Screening for Patients with Chronic Health Conditions

Metric Source: MiPCT Measure adapted from the Meaningful Use 2014 Clinical Metric CMS 2v1 (NQF 0418) Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan. MiPCT modifications are limiting screening to individuals with one or more of the qualifying chronic illnesses in place of universal screening and not assessing documentation of a follow-up plan for positive screens.

Description: Percent of MiPCT practices in the PO that submit data for calculation of the following metric “Percent of individuals 12 years and older with diabetes, cardiovascular disease, chronic kidney disease, asthma, COPD, congestive heart failure and/or ADHD who were seen for an office
visit during the measurement year and have documentation that a depression screen was completed using a PHQ-2 or other age-appropriate standardized depression screening tool.”

**Note:** Care team support processes need to be in place during implementation of depression screening. Protocols are advised for processes such as using a diagnostic tool (e.g. PHQ-9) to follow up positive screens, initiating medication treatment for patients with diagnosed depression, referral of patients with depression for behavioral counseling and/or initiation of medications, self-management education and support (including care management services when indicated), and identification of referral sources/processes for patients identified with severe depression or those at risk for suicide.

**Numerator:** Number of Practices that report depression screening was done during an office visit for at least 30% of their MiPCT members 12 years of age and older with a qualifying chronic disease diagnosis.

**Denominator:** Number of practices in PO.

**Methodology:** Practices will submit depression screening data to MDC. MDC will use claims data from 2010 to 2014 and standard HEDIS methodology to identify the population of individuals with one or more of the specified chronic diseases.

**Numerator Data:** Identifying data, visit date and depression screen “yes”. Note: Blank screening fields and “no” responses are not added to the numerator.

**Denominator Codes:** (Diabetes): 250; (CHD - Acute Myocardial Infarction) 410-414; (Unspecified CVD): 429.2; (CHD – Angina): 413; (CHD – Stroke): 430-438; (Hypertension essential): 401; (HTN with heart failure): 402; (HTN with chronic kidney disease): 403, 404; (Chronic Kidney Disease): 585; (Asthma): 493; (COPD): 491, 492, 494, 496, 466.0; (Congestive Heart Failure): 428, 402.01, 402.11, 402.91, 518.4; (ADHD): 314.


**Exclusions:** An active diagnosis of Depression or Bipolar Disorder.

**Threshold:** The practice must submit data for at least 30% of the eligible MiPCT population to qualify for this measure.

2. **Notification of Hospital Admissions and/or Discharges**

**Metric Source:** MiPCT metric

**Metric Description:** A process is in place for the MiPCT practice to obtain daily notification of more than 50% of the hospital admissions and/or discharges and transfers for their patients.

**Numerator:** Number of practices with attestation in the MiPCT Quarterly Report that the notification process is in place.

**Denominator:** Number of Practices in PO

**Methodology for determining numerator:** POs will indicate for each practice in the MiPCT Quarterly Report the hospitals for which a notification process is in place. Credit will be awarded if the sum of the admissions to the identified hospitals represents > 50% of the total admissions for that practice.
3. Follow-Up Referrals to a Community-Based Program or Agency

**Metric Source:** BCBSM PGIP Capability 10.8 with words “MiPCT eligible” added.

**Definition:** A systematic approach is in place for conducting follow-up with MiPCT eligible high-risk patients regarding any indicated next steps as an outcome of their referral to a community-based program or agency.

**PCP and Specialist Guidelines:**

a. Patients may be held partially responsible for the tracking process. For example, Practice Units may use technology such as Interactive Voice Response (IVR) for patients to report initial contact and completion, develop a “passport” that patients can have stamped when they complete trainings or attend a support group, or use existing disease registries such as WellCentive to track community-based referral activities.

b. Process includes mechanism to track patients who decline care and obtain information about reasons care was not sought.

**Numerator:** Number of practices in PO with attestation in the MiPCT Quarterly Report that the follow up capability is in place.

**Denominator:** Number of Practices in PO.

4. Self-Management Support Offered for Chronic Condition of Focus

**Metric Source:** BCBSM PGIP Capability 11.2 with the words “MiPCT eligible patients” added.

**Definition:** Self-management support is offered to all MiPCT eligible patients with the chronic condition selected for initial focus (based on need, suitability, and patient interest).

**PCP and Specialist Guidelines:**

a. Self-management support is assisting patients in implementing their action plan through face-to-face interactions and phone outreach in between visits.

b. Self-management support services may be provided in the context of a planned visit.

c. An action plan is a patient-specific goal statement that incorporates treatment goals including aspects of treatment that involve self-management. It is not an action step; it is a goal statement.

d. Physicians may provide self-management support (but would not be eligible to bill T-codes for such services).

**Numerator:** Number of practices in PO with attestation in the MiPCT Quarterly Report that the self-management support capability is in place.

**Denominator:** Number of Practices in PO.
Performance Incentive Payment Process

1. Participating health plans contribute $3.00 per member per month to the incentive program pool. Nonparticipating health plans provide equivalent performance incentive funds through separate incentive programs.

2. Performance incentive metrics will be assessed every six months of the calendar year and all funds accumulated during that 6 month period will be awarded.

   a. The Michigan Data Collaborative will calculate a performance incentive score for each PO. Process/infrastructure metrics will be assessed at the practice level and rolled up to the PO level. Other metrics will be assessed at the PO level on all MiPCT beneficiaries in the PO.

   b. The Michigan Data Collaborative will calculate the payment due each PO based on the total performance incentive score received and the number of MiPCT beneficiaries. PO points will be ranked from high to low and then placed into 10 payment groups such that each payment group represents one tenth of MiPCT beneficiaries. Payment groups will be assigned a dollar value ranging from 82% to 118% of the mean payment. The number of payment groups may be adjusted to accommodate natural clusters of scores.

Calculation of MiPCT Performance Incentive Payments

The calculation of performance incentive payments is based on a decile ranking methodology. Payment amounts will range from 82% to 118% of the mean of $18.00 per member which is $3.00 per member per month times six months. An example of the payment calculation methodology is provided on the following page. The steps for calculating payments are shown below.

1. Attribute dollar amounts to the deciles.

<table>
<thead>
<tr>
<th>Decile</th>
<th>Formula</th>
<th>$ Per Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>118% x $18.00</td>
<td>$21.24</td>
</tr>
<tr>
<td>2</td>
<td>114% x $18.00</td>
<td>$20.52</td>
</tr>
<tr>
<td>3</td>
<td>110% x $18.00</td>
<td>$19.80</td>
</tr>
<tr>
<td>4</td>
<td>106% x $18.00</td>
<td>$19.08</td>
</tr>
<tr>
<td>5</td>
<td>102% x $18.00</td>
<td>$18.36</td>
</tr>
<tr>
<td>6</td>
<td>98% x $18.00</td>
<td>$17.64</td>
</tr>
<tr>
<td>7</td>
<td>94% x $18.00</td>
<td>$16.92</td>
</tr>
<tr>
<td>8</td>
<td>90% x $18.00</td>
<td>$16.20</td>
</tr>
<tr>
<td>9</td>
<td>86% x $18.00</td>
<td>$15.48</td>
</tr>
<tr>
<td>10</td>
<td>82% x $18.00</td>
<td>$14.76</td>
</tr>
</tbody>
</table>

2. Calculate the total performance incentive score for each PO and identify the number of MiPCT beneficiaries attributed to each PO.

3. Rank POs by score from high to low. If two or more POs receive the same score do a secondary ranking based on number of beneficiaries, listing the PO with the largest number first.
4. Divide the total number of MiPCT beneficiaries* by 10 to determine the number of beneficiaries to be attributed to each decile. Example: 450,000 Beneficiaries/10 = 45,000 beneficiaries per decile

5. Fill decile 1 with the number of beneficiaries from the top scoring PO. If this is fewer than the total beneficiaries allotted to decile 1 (one tenth), add the beneficiaries from the next highest ranking PO and repeat until decile 1 is complete. Any remaining beneficiaries from the last PO will then begin filling decile 2 and the process continues until all beneficiaries have been assigned.

6. The amount to be paid to each PO is the amount of beneficiaries attributed to the decile x the payment amount for the decile. If a PO’s beneficiaries are assigned to 2 or more deciles, the amount for each decile is calculated and the totals summed.

The fictitious example below shows how payment would be calculated for the 7 POs with the highest scores.

Example: Calculation of Performance Incentive Payments from Ranked Scores

<table>
<thead>
<tr>
<th>PO Rank</th>
<th>% Total Score</th>
<th># MiPCT members</th>
<th>Decile*</th>
<th>Decile breakdown</th>
<th>Payment 1</th>
<th>Payment 2</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>98%</td>
<td>11,031</td>
<td>1</td>
<td></td>
<td>$21.24 x 11,031</td>
<td></td>
<td>$ 234,298</td>
</tr>
<tr>
<td>2</td>
<td>96%</td>
<td>54,276</td>
<td>1</td>
<td>33,969 15,307</td>
<td>$21.24 x 33,969 $721,501</td>
<td>$20.52 x 15,307 $314,100</td>
<td>$ 1,035,601</td>
</tr>
<tr>
<td>3</td>
<td>95%</td>
<td>4,732</td>
<td>2</td>
<td></td>
<td>$20.52 x 4,732</td>
<td></td>
<td>$ 97,100</td>
</tr>
<tr>
<td>4</td>
<td>94%</td>
<td>30,718</td>
<td>2</td>
<td>24,962 5,757</td>
<td>$20.52 x 24,962 $512,220</td>
<td>$19.80 x 5,757 $113,988</td>
<td>$ 626,208</td>
</tr>
<tr>
<td>5</td>
<td>94%</td>
<td>3,361</td>
<td>3</td>
<td></td>
<td>$19.80 x 3,361</td>
<td></td>
<td>$ 66,548</td>
</tr>
<tr>
<td>6</td>
<td>92%</td>
<td>35,882</td>
<td>3</td>
<td></td>
<td>$19.80 x 35,882</td>
<td></td>
<td>$ 710,463</td>
</tr>
<tr>
<td>7</td>
<td>90%</td>
<td>15,161</td>
<td>4</td>
<td></td>
<td>$19.08 x 15,161</td>
<td></td>
<td>$ 289,272</td>
</tr>
</tbody>
</table>

*Each decile represents 45,000 beneficiaries

Continue the process for the remaining POs through Decile 10. POs in Decile 10 will receive $14.75 x the number of beneficiaries.
Distribution of Performance Incentive Payments

The Michigan Data Collaborative will determine the amount to be paid by participating health plans based on beneficiary enrollment numbers.

1. Payments will be made about 6 months after the close of each performance measurement period.

2. POs will retain the approved portion specified in the MiPCT implementation Plan (not to exceed 20%) to reward/compensate their contribution to primary care practice transformation efforts. The remaining funds are to be distributed to the participating primary care practices. Health systems are encouraged to implement processes to ensure incentive funds are passed on to the primary care practice unit level.

3. Funds retained by Physician Organizations are to be used to support primary care practice transformation activities through provision of one or more of the following:
   a. clinical leadership support
   b. implementation of tools and care processes that enable the primary care practices to achieve practice transformation, and
   c. analytic support with generation of reports to measure transformation progress.
Appendix: MiPCT Registry Data Submission Specifications

The following document describes the requirements for submission of registry data from MiPCT participating Physician Organizations (POs) registry systems. Data will be submitted from each MiPCT participating PO directly to the Michigan Data Collaborative (MDC). This data will be loaded into the MiPCT multi-payer database, integrated with claims data, and used in the project dashboard, reports and incentive payments.

For more information on the metrics which will use the registry data, refer to the Clinical Metrics document on the project website. This data should be submitted in the BCN Layout version that has been mutually agreed upon with MDC. If you have any doubt as to what that version is, please contact a member of MDC.

**File Format**

The data should be in an agreed upon version of the “BCN Layout”. This is the same format in which many POs currently submit data to BCN. This is a very flexible easy to use format. All valid versions of the data file layout and format are listed on the MiPCT website. There are also sample test data files available on the MDC website.

**Content**

The following are the types of data that will be required in the data submission with dates of service from 2010 to current:

- **Chronic Diseases**
  - Diabetes
    - HbA1c test results (value)
    - LDL-C test results (value)
    - Macroalbumin and microalbumin test results (value)
    - Retinal eye exam date
    - Blood Pressure results (value)
  - Cardiovascular Disease
    - Blood Pressure results (value)
    - LDL-C test results (value)
  - Hypertension
    - Blood Pressure results (value)
  - Asthma
    - Asthma self-management plan date

- **Everyone**
  - BMI – Adult and Pediatric (value, pediatric percentile accepted for children) date
  - Smoking status assessment (Y/N)

- **Preventive**
  - Mammogram test date
  - Pap smear test date
- Procedures performed – Date performed or age at time of procedure and year performed, as far back in history as possible
  - Hysterectomy
- Bilateral Mastectomy
- Chlamydia trachomatis test date
- Colorectal Cancer Screening (FOBT, Colonoscopy, Flexible Sigmoidoscopy) test date – Date and type of procedure performed or age at time of procedure and year performed, as far back in history as possible
- Lead screening test date
- Vaccine Preventable Diseases – Date of disease occurrence or age at time of occurrence
  - Measles
  - Mumps
  - Rubella
  - Hepatitis B
  - Chicken Pox/Shingles
  - Hepatitis A
- Vaccine Preventable Disease Serology Tests – Date and value
  - Measles
  - Mumps
  - Rubella
  - Hepatitis B
  - Varicella Zoster
  - Hepatitis A
- Immunizations/Vaccines – Date
  - Meningococcal
  - Tdap
  - Td
  - DTaP
  - IPV
  - MMR
  - HiB
  - Hepatitis B
  - Varicella Zoster
  - Pneumococcal Conjugate
  - Hepatitis A
  - Rotavirus (2 and 3 Dose)
  - Influenza
- Notations of the Following: Yes/No
  - Anaphylactic reaction to vaccine
  - Encephalopathy as a reaction to vaccine
  - Anaphylactic reaction to antibiotics (streptomycin, polymyxin B, neomycin)
  - Immunodeficiency or HIV disease
  - Cancer of lymphoreticular or histiocytic tissue
  - Cancer of multiple myeloma
  - Cancer of leukemia
- Well-Child or Adolescent Well-Care Visits through Age 21 – Date
Historical Data

By the end of 2013, a complete historical file will be submitted. This data submission should include as much historical data as possible going back to the beginning of 2010 as is available in your registry.

Production Data

Beginning in 2014, “incremental” data submissions will begin. Data submissions should occur every other month. Data submissions should be submitted no later than the last business day of the following month.

Examples:

- **January & February 2014** registry data should be submitted no later than the last business day of March, 2014.
- **March & April 2014** registry data should be submitted no later than the last business day of May, 2014.

Data Transmission to MDC

Mode of Transfer

Data will include all participating MiPCT patients and will be sent to MDC using the University of Michigan secure file transfer protocol (sftp) called MiShare. This is a secure, encrypted data transmission set up specifically for sensitive data transmissions. There is no cost to use this service.

Schedule of Transfers

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content of Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of November</td>
<td>Test transfer of one month’s worth of data</td>
</tr>
<tr>
<td>End of December</td>
<td>*Full transfer of historical data</td>
</tr>
<tr>
<td>Beginning in 2014</td>
<td>Monthly/bi-monthly transfer of live data</td>
</tr>
</tbody>
</table>

*The test transfer will be edit checked to ensure the content and format are acceptable. When it has been deemed acceptable, the full transfer of historical data will be requested. POs will wait for this notification before sending any data after the test transfer.

To contact MDC about submission of data from your registry, e-mail MichiganDataCollaborative@umich.edu to discuss your questions and needs.