AmeriHealth Caritas
Care is the heart of our work

AMERIHEALTH CARITAS USER GUIDE FOR THE 3M™ HEALTH INFORMATION SYSTEM BEHAVIORAL HEALTH DASHBOARD

AMERIHEALTH CARITAS FAMILY OF COMPANIES

AMERIHEALTH CARITAS USER GUIDE FOR THE 3M™ HEALTH INFORMATION SYSTEM BEHAVIORAL HEALTH DASHBOARD

AMERIHEALTH CARITAS FAMILY OF COMPANIES

The AmeriHealth Caritas Family of Companies includes the health plans listed below.

Medicaid Managed Care (MCO) Plans

- AmeriHealth Caritas Delaware
- AmeriHealth Caritas District of Columbia
- AmeriHealth Caritas Florida
- AmeriHealth Caritas Louisiana
- AmeriHealth Caritas New Hampshire
- AmeriHealth Caritas North Carolina
- AmeriHealth Caritas Ohio
- AmeriHealth Caritas Pennsylvania
- First Choice℠ by Select Health of South Carolina
- Keystone First

Medicare-Medicaid Plans

- AmeriHealth Caritas℠ VIP Care Plus®
- First Choice℠ VIP Care Plus

Medicare Dual Special Needs Plans (DSNPs)

- AmeriHealth Caritas℠ VIP Care®
- First Choice℠ VIP Care
- Keystone First VIP Choice

Health Insurance Marketplace Plans

- AmeriHealth Caritas Next℠ in Delaware
- AmeriHealth Caritas Next℠ in Florida
- AmeriHealth Caritas Next℠ in North Carolina
- First Choice Next℠ by Select Health of South Carolina

Community HealthChoices Plans

- AmeriHealth Caritas Pennsylvania Community HealthChoices
- Keystone First Community HealthChoices

CONTENTS

OVERVIEW

This guide provides an overview of the features and functionalities of the 3M ™ Health Information System (3M HIS) Behavioral Health Dashboard.

The Behavioral Health Dashboard provides users with access to critical key performance indicators relative to their patients with targeted behavioral health conditions, identified using the 3M Clinical Risk Group (CRG) software. The Dashboard is a visual tool that uses 3M's attribution process to auto-assign members with behavioral health conditions to the behavioral health provider that has primarily furnished services to the member. The Dashboard is refreshed by 3M once per month.

LEGAL DISCLAIMER

3M HIS system contains information disclosed from records protected by federal confidentiality rules and state law, including 42 CFR Part 2, which prohibit unauthorized use and disclosure of this information. User shall make no further disclosure of this information without the specific, written, and informed authorization of the individual to whom it pertains, or as otherwise permitted by applicable law. A general authorization for the disclosure of medical or other information is not sufficient for the release of this information. Unauthorized use or disclosure of this information is subject to legal sanctions under applicable federal and state law.

42 CFR Part 2 prohibits disclosure of information that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR § 2.31). Federal rules restrict any use of the information to investigate or prosecute any patient with a substance use disorder with regard to a crime, except as provided at 42 CFR §§ 2.12(c)(5) and 2.65.

Furthermore, laws in some states restrict the redisclosure of information on diagnoses or treatment for mental health conditions, developmental disabilities, AIDS, alcohol or substance abuse, sexually transmitted or other communicable diseases, and family planning services. Some state laws also restrict the redisclosure of HIV test results or genetic information. State law may require providers to obtain written consent from patients before redisclosing such information. Consult legal counsel for more information on confidentiality laws that apply to health care providers in your state.

DATA

3M receives medical, pharmacy, provider, primary care physician and patient information monthly from AmeriHealth Caritas, or "the plan." 3M's processing generates various clinical designations for the plan's members that are useful for managing patient care.

CORE 3M CLINICAL DESIGNATIONS

Some of these designations are not visible or accessible within the Behavioral Health Dashboard but are listed to help explain the various categorizations 3M uses to determine market and member scores.

Admission All Patient Refined Diagnosis Related Groups (APR-DRG): The 3M APR-DRG Classification System assigns a patient to a Major Diagnostic Group (MDC), based upon principal diagnosis, and then to a specific APR-DRG category based upon principal diagnosis (if medical) or operating room procedure (if surgical). APR-DRGs are used to determine the Expected cost of inpatient admissions.

- Examples of APR-DRGs: 196 Cardiac arrest and shock; 424 Other endocrine disorders; 811 Allergic reactions

Aggregated Clinical Risk Groups (ACRG): CRG Classification System provides three successively broader tiers of aggregation described as the Aggregated CRGs (ACRGs). This includes ACRG1, ACRG2 and ACRG3, with ACRG3 being the highest level of aggregation meaning it has the fewest number of categories (39). The ACRGs can be used to sort the population into higher level groupings to complement the analyses that are possible with the more detailed CRG groupings.

- ACRGs are available within the ***Population Data*** reports.
- Examples of ACRG 3's are as follows: 01 Non-User, 10 Healthy, 19 Significant Prescription Medicines, without Other Significant Illness, 20 Multiple or Recurring Significant Acute Illness, 60 Significant Chronic Disease in Multiple Organ Systems, 90 Catastrophic Conditions

Base Risk Group: A higher level grouping of Clinical Risk Groups.

- Base Risk Groups are available in the ***Member Lists*** found in the *Potentially Preventable Events* and *Utilization* sections.
- Example: Asthma.

Clinical Risk Groups (CRGs): A population classification system that uses inpatient and ambulatory diagnosis and procedure codes, pharmaceutical data, and functional health status to assign each individual to a single mutually exclusive, severity-adjusted group. It describes the health status and burden of illness of individuals and can help identify medically complex individuals by accounting for co-morbidities and health status of an individual over time. Each individual is assigned to a single mutually exclusive risk group that relates to the historical and demographic characteristics of the individual. CRGs group individuals who are similar, both clinically and in their use of healthcare resources.

- CRG's are available for chronically ill patients within the ***Care Management Patient List***

- Example: 57844 Chronic Alcohol Abuse/Dependence Level - 4 5 = Single Dominant or Moderate Chronic Disease. 784 = Chronic Alcohol Abuse/Dependence Level. 4 = Severity Level 4

CRG Weight or Risk Score: Represents the relative illness burden (average resource utilization) of an individual on a risk-adjusted bases. Average cost of care is estimated on a relative scale based on their specific health status, age, and gender. Weights are applied and depend on the spend and utilization associated with individuals in a particular CRG/age/gender combination.

- Member Risk Scores are available within the *Population Data* and *Care Management Patient List* reports.
- A physician's average Risk Weight for their member panel is available from within the multiple Total Cost of Care, Potentially Preventable Events, and Utilization Key Performance Measure drill downs in the dashboard.
- 0.0 (zero) is assigned to a non-user
- 1.0 (one) represents the average illness of the market. Members assigned a 1.0 have an illness burden comparable to the market's average illness burden.
- Between 0.0 and 1.0 represents individuals who are healthy or have an illness burden that is less than the market's average illness burden.
- Greater than 1.0 represent members with illness burdens more significant than the market's average illness burden. Significantly ill individuals will have very high risk scores.

Enhanced Ambulatory Patient Grouping Systems (EAPG): Used to explain the amount and type of resources used in ambulatory visits. These resources include pharmaceuticals, supplies, ancillary tests, equipment, type of room, treatment time, etc. Patients in each EAPG have similar clinical characteristics, resource use, and costs. The definition of the EAPG is not so specific that every patient included in the same EAPG is identical, but rather the level of variation in patient resource use is known and predictable.

Episode Diagnostic Category (EDC): Diagnosis codes are categorized into 516 episode diagnosis categories. An individual can be assigned to more than one EDC. An individual's most significant EDC is designated their Primary EDC. Each EDC is assigned to one of five types. Three of the EDC types refer to chronic diseases: Dominant Chronic EDC, Moderate Chronic EDC, or Minor Chronic EDC. A disease is classified as chronic if the duration of the disease is lifelong or of a prolonged duration. Two of the EDC types refer to acute diseases: Minor Acute EDC or Significant Acute EDC. A disease is classified as acute if the duration of the disease is short or the disease would naturally resolve. EDC's are only assigned to member with diseases.

- A member's Primary Episode Diagnostic Category is available within the *Population Data* reports.

- Examples of Episode Diagnostic Categories: 749 Depressive and Other Psychoses (DC = Dominant Chronic); 744 Eating Disorder (MC = Moderate Chronic); 757 Chronic Stress and Anxiety Diagnoses (C = Minor Chronic)

Expected Values, Variance from Expected: Normalized and risk-adjusted Expected Values are calculated for the Key Performance Indicators on the Behavioral Health Dashboard. Expected Values are determined differently depending on the Key Performance Indicator and can use the mix of patients as defined by CRGs, APR DRGs and Severity of Illness (SOI) levels, EAPGs and primary CPT4 procedure codes. The Variance from Expected indicates either utilization that is higher than expected rates (a positive numerical value) which may indicate opportunities to improve outcomes and increase overall healthcare efficiency or lower than expected rates (a negative numerical value).

Outpatient Enhanced Ambulatory Patient Grouping Systems (EAPG): Clinically meaningful sets of patient groups across all outpatient settings designed to explain the amount and type of resources used in an ambulatory visit. These resources include pharmaceuticals, supplies, ancillary tests, equipment, type of room, treatment time, etc.

- Examples of EAPGs: 840 Opioid Abuse and Dependence; 821 Major Depressive Diagnoses and Other or Unspecified Psychoses; 1021 Durable Medical Equipment – Oxygen and related equipment

Primary Chronic Disease (PCD): The Episode Diagnostic Category (EDC) that represents the most significant chronic disease for each organ system that has one or more chronic illness EDCs. An individual can have a single PCD selected, multiple PCDs selected, or no PCDs selected.

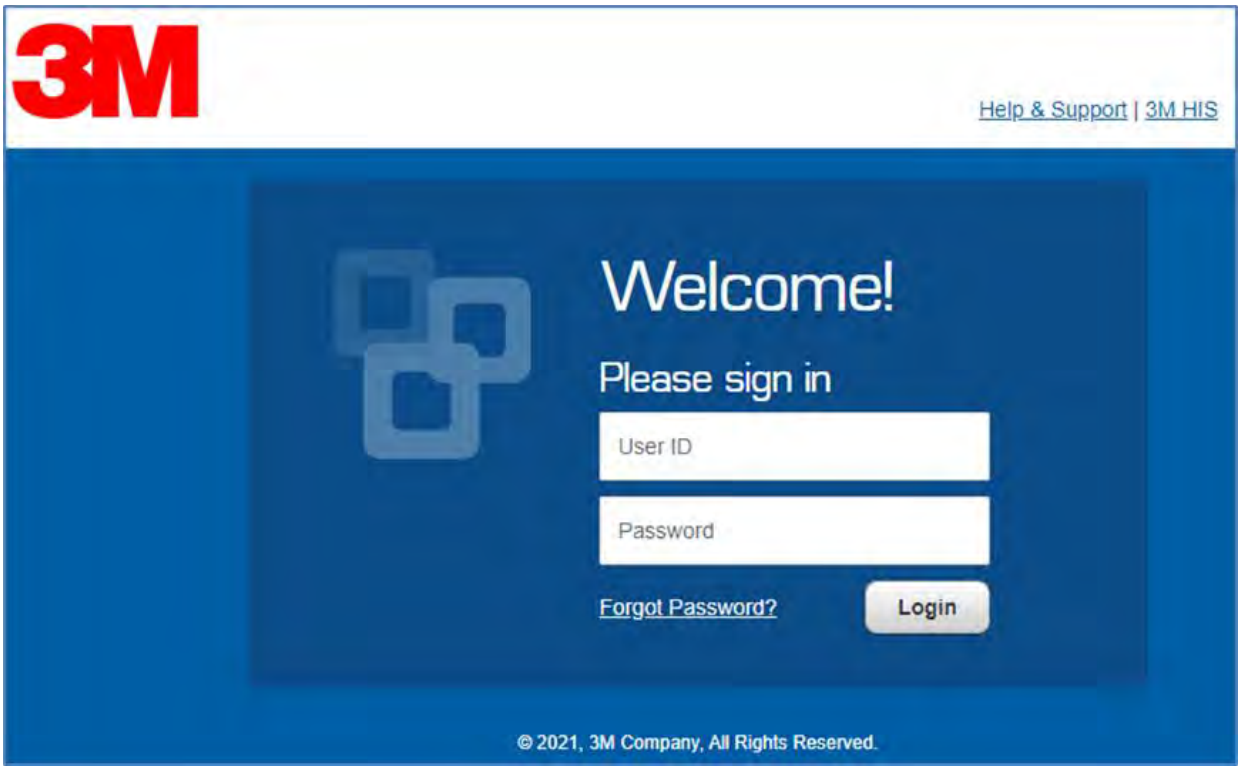
Severity of Illness (SOI): The 5th digit in the CRG assignment that indicates the severity of illness (SOI) level. A higher severity level number indicates a higher degree of treatment difficulty and a need for substantial medical care.

- 1 = Minor
- 2 = Moderate
- 3 = Major
- 4 = Extreme
- 5 to 6 = If the member has additional Primary Chronic Disease beyond those used to determine the base CRG

ACCESSING 3M HEALTH INFORMATION SYSTEM

Users requesting access to the Dashboards maintained by the plan must complete the 3M Health Information Systems Dashboards AmeriHealth Caritas User Access Request Form, distributed by the plan Provider Network team.

Once a user has been approved, access to the 3M™ Health Information System (HIS) is achieved through the online portal at https://pmportal.3mhis.com [pmportal.3mhis.com] using the email address as the User ID. If assistance is needed to troubleshoot accessing the portal, please contact the plan Provider Network representative assigned to the contracted group. To ensure compliance with privacy laws, only appropriately credentialed users have privileges to view the personally identifiable information contained in the dashboards (which may still be redacted in accordance with applicable regulations and/or stipulations regarding the patients' consent).



FORGOT PASSWORD INSTRUCTIONS

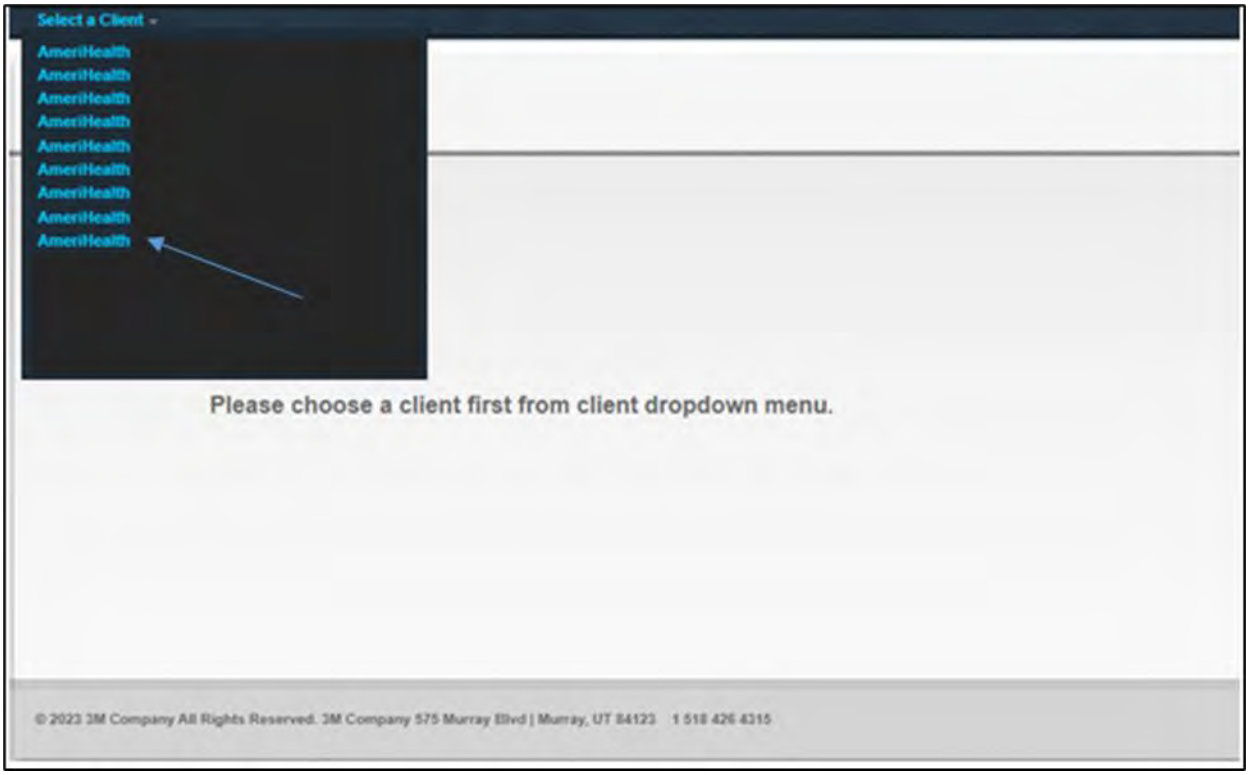
If a user has forgotten their password, click on the "Forgot Password" link to receive a password reset email. Emails regarding user account set up and password changes will originate from hisacctmgmt@solventum.com. If the 3M system does not allow a user to change their password, the user account is most likely locked. Please read the next section to resolve this issue.

LOCKED ACCOUNTS

To ensure only authorized users have access to the personally identifiable information contained within the dashboards, the 3M™ system may lock a user account. Accounts automatically lock after more than five incorrect login attempts. Accounts are automatically locked after 90 days of inactivity. Please contact 3M™ Help & Support at (800) 435-7776, Option 7 to unlock a user account after incorrect login attempts. Users may also contact the plan at VBPdashboards@amerihealthcaritas.com to reactivate accounts locked due to inactivity.

MARKET SELECTION

3M processes several AmeriHealth Caritas markets. If the provider group is contracted in multiple AmeriHealth Caritas markets, 3M user access may be set up to view more than one market. To switch between markets, select the drop down in the upper left corner that is just above the plan's logo.

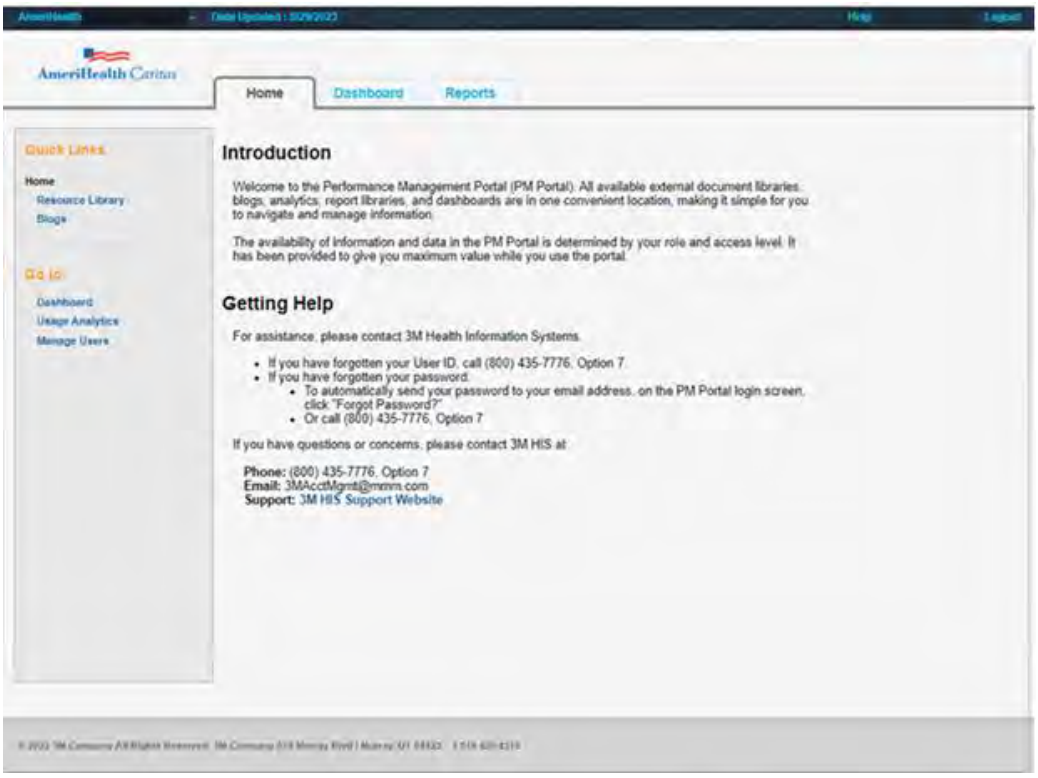


3M HIS WEBSITE TABS

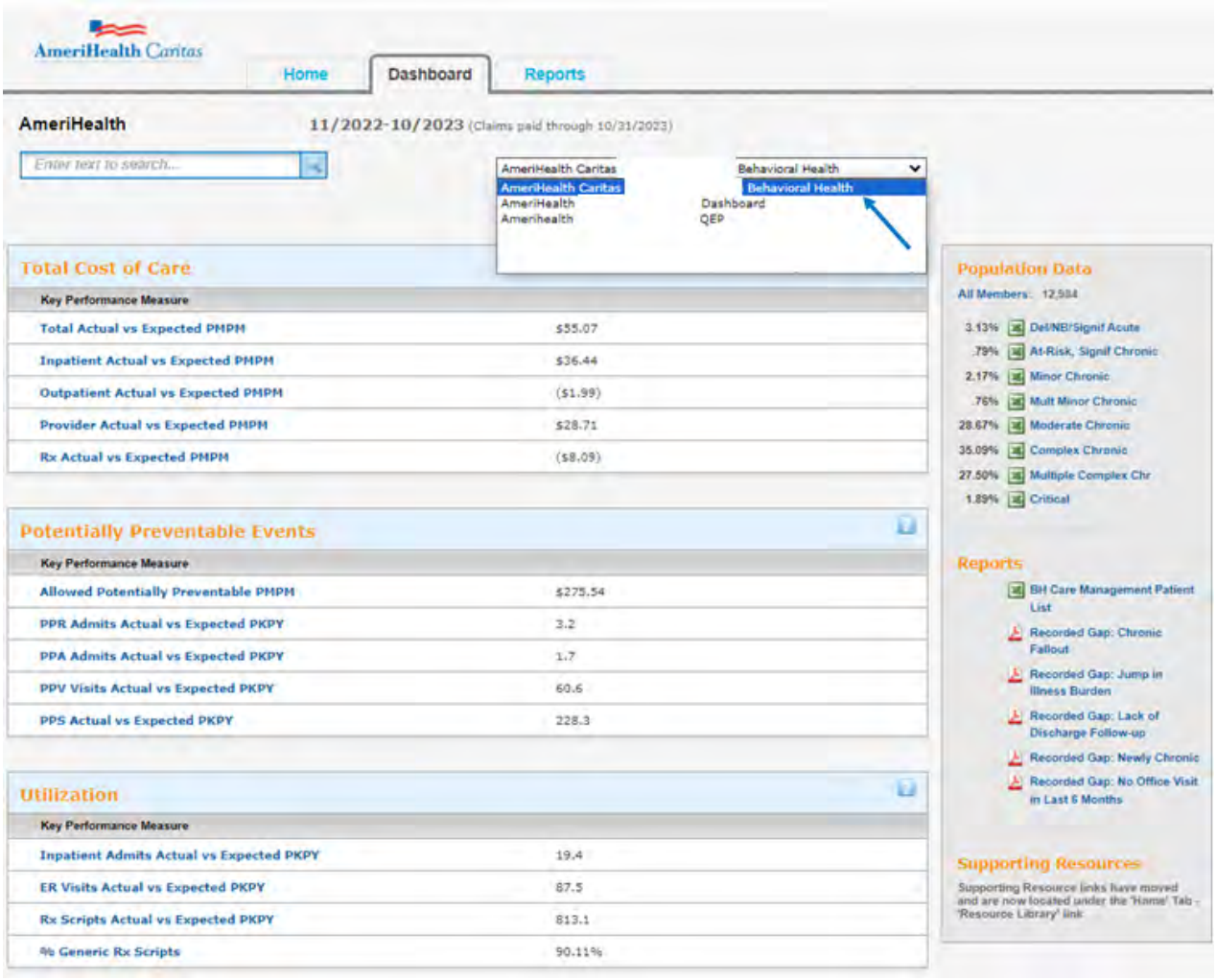
Upon accessing 3M HIS, a user arrives at the ***Home*** tab landing page. The ***Home*** tab contains a link to 3M's ***Resource Library***. The ***Resource Library*** contains documents detailing 3M's various assignments, calculations and methodologies.

The ***Dashboard*** tab contains any dashboards the user has access to. A drop-down box on the upper right side of the dashboard allows the user to select other available dashboards.

The ***Reports*** tab availability is dependent on the User permissions. This tab may not be available to view.



To access the Behavioral Health dashboard, navigate to the Dashboard tab and click on it. Select dashboard from the dropdown menu on the upper right side of the dashboard and select the Behavioral Health dashboard (screenshot shown below) Please note that the default dashboard view reflects user access and may vary from example provided.


AmeriHealth Caritas
Home
Dashboard
Reports
AmeriHealth
11/2022-10/2023 (Claims paid through 10/31/2023)
Enter text to search...
AmeriHealth Caritas
AmeriHealth Caritas
AmeriHealth
AmeriHealth
Behavioral Health
Behavioral Health
Dashboard
QEP
Total Cost of Care
Key Performance Measure
Total Actual vs Expected PMPM $55.07
Inpatient Actual vs Expected PMPM $36.44
Outpatient Actual vs Expected PMPM ($1.99)
Provider Actual vs Expected PMPM $28.71
Rx Actual vs Expected PMPM ($8.09)
Potentially Preventable Events
Key Performance Measure
Allowed Potentially Preventable PMPM $275.54
PPR Admits Actual vs Expected PKPY 3.2
PPA Admits Actual vs Expected PKPY 1.7
PPV Visits Actual vs Expected PKPY 60.6
PPS Actual vs Expected PKPY 228.3
Utilization
Key Performance Measure
Inpatient Admits Actual vs Expected PKPY 19.4
ER Visits Actual vs Expected PKPY 87.5
Rx Scripts Actual vs Expected PKPY 813.1
% Generic Rx Scripts 90.11%
Population Data
All Members: 12,584
3.13% Del/NB/Signif Acute
.79% At-Risk, Signif Chronic
2.17% Minor Chronic
.76% Mult Minor Chronic
28.67% Moderate Chronic
35.09% Complex Chronic
27.50% Multiple Complex Chr
1.89% Critical
Reports
BH Care Management Patient List
Recorded Gap: Chronic Fallout
Recorded Gap: Jump in Illness Burden
Recorded Gap: Lack of Discharge Follow-up
Recorded Gap: Newly Chronic
Recorded Gap: No Office Visit in Last 6 Months
Supporting Resources
Supporting Resource links have moved and are now located under the 'Home' Tab - 'Resource Library' link

BEHAVIORAL HEALTH DASHBOARD COMPONENTS

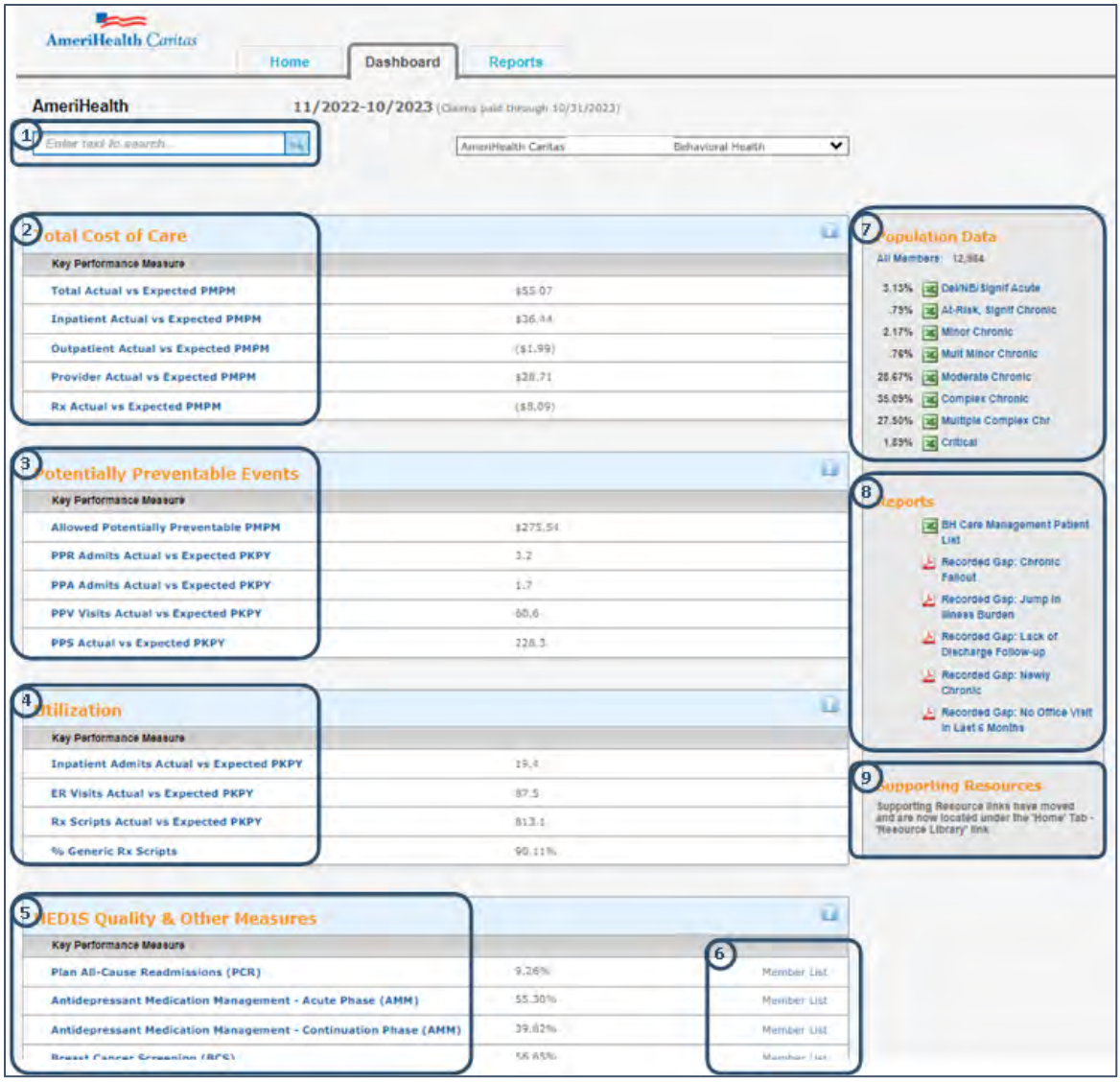
There are 9 main components to the Behavioral Health Dashboard:

1. **Provider Search**
2. **Total Cost of Care**
3. ***3.*** **Potentially Preventable Events**
4. **Utilization**
5. **HEDIS Quality & Other Measures**
6. **Member Lists**
7. **Population Data**
8. **Reports *(availability varies by market)***
9. **Supporting Resources**

Text displayed in blue represents a hyperlink that is capable of displaying detailed data. Placing the mouse over the measure, population data group, or report will allow the user to launch the corresponding report or a *Detail Dashboard*. Information in the header specifies the rolling 12-month period for which data is displayed as well as the claims run out period. Hover over the  icons on the dashboard to see more details about that measure or section.

If a Member List is not visible within the **Potentially Preventable Events** or **Utilization** sections, select a physician group or physician within the Provider Search Window (1) or select a physician from any of the **Key Performance Measure** *Detail Dashboard*. A new tab in your web browser will open with the Member Lists visible.

For each measure, the user has the option to drill down to a *Detail Dashboard* by clicking on that measure. Depending on the user's level of access, the Detail Dashboard provides an overview of performance on that measure for all the provider groups in the network, all providers within the practice, or population sets for each provider.

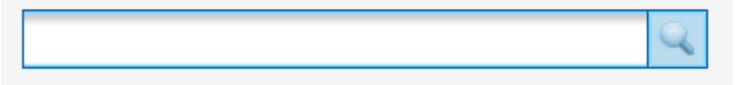


PROVIDER SEARCH (1)

Each dashboard aggregates data and allows drill downs starting from the Market Level down to the Individual Provider:

i. Accountable Care Organization (ACO) or Integrated Delivery System (IDS)
ii. Provider Group
iii. Individual Provider

Enter the name in the search box. Selecting a provider by using the **Provider Search** option opens a new web browser tab with a Medical Home dashboard specific to the user's selection.



KEY PERFORMANCE INDICATORS

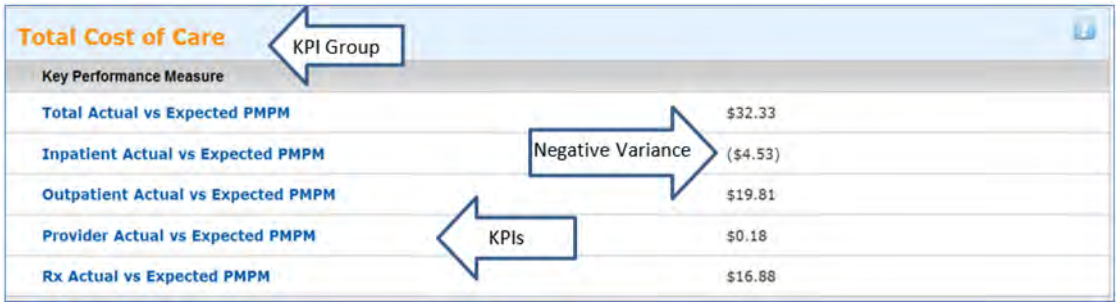
The Key Performance Indicators (KPIs) are designed to provide easy access to the critical measures to monitor performance. There are three groups of KPI measures: *Total Cost of Care*, *Potentially Preventable Events*, and *Utilization*. All the measures are calculated from values obtained from claims and pharmacy data and reflect all utilizations for the attributed members of the plan. A rolling 12-month period provides values for the most recent 12 months of data without run out.

Every KPI shows Actual vs Expected values and are presented as per-member, per-month dollars (PMPM) or per-thousand, per-year rates (PKPY). Generic prescription utilization is presented as a percentage of total scripts (% Rx). *Actual values* represent the costs or utilization of the attributed members. *Expected values* indicate risk adjusted and normalized re-distribution of actual costs or utilization based on the attributed member's Clinical Risk Group assignments. *Variance* indicates the difference between the actual value and the expected value.

Negative variances are shown in parentheses (#.##) and indicate that the observed value is lower than the expected rate. Positive or negative variances for an individual measure alone may not necessarily indicate quality of care or cost management and should be viewed in conjunction with the other measures. Higher than expected rates are shown as a positive variance and may indicate opportunities to improve outcomes and increase overall healthcare efficiency.

For each measure, the user has the option to drill down to a *Detail Dashboard* by clicking on that measure. Depending on the user's level of access, the *Detail Dashboard* provides an overview of performance on that measure for all the provider groups in the network, all providers within the practice, or population sets for each provider. This will be discussed in more detail later.

TOTAL COST OF CARE (2)



This section of Key Performance Indicators includes financial measures which have been developed from claims and pharmacy data. The measures have been risk-adjusted using Clinical Risk Groups (CRGs) of the attributed patients. Variance indicates the difference between the actual value and the expected value. Member lists are not available in this section. Each metric's hyperlink drills down into a Detail Dashboard table. The first row of data in the drill down table represents the overall value; subsequent rows show variation across the providers.

Total Actual vs Expected PMPM: Total includes inpatient, outpatient, provider, and pharmacy services. Total Actual or Allowed is the cost of services paid, which is compared against the Total

Expected to determine an overall variance, on a per Member per Month (PMPM) basis. Total Expected values indicate normalized and risk-adjusted costs using 3M's Clinical Risk Groups of the attributed patients. The variance is the difference between the allowed values (actual experience) and the expected values.

- Review the Inpatient, Outpatient, Provider, and Rx variances to determine what could be driving the overall Total Actual vs Expected PMPM variance.

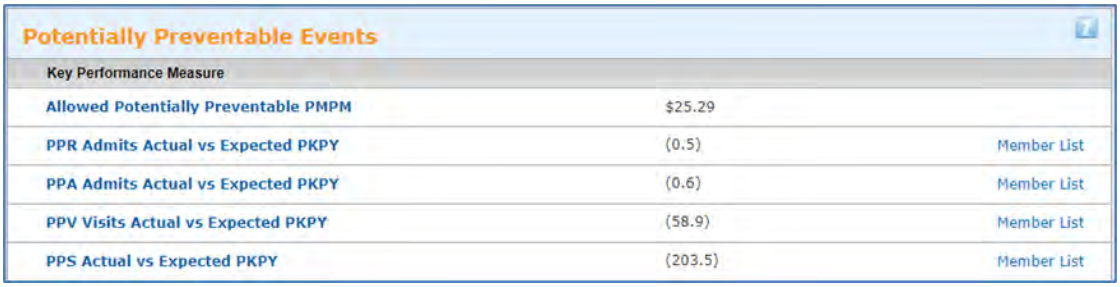
Inpatient Actual Vs Expected PMPM: Compare the overall inpatient allowed variance, on a per Member per Month (PMPM) basis. The variance is the difference between the allowed values (actual experience) and the expected values.

Outpatient Actual vs Expected PMPM: Compare the overall outpatient allowed variance, on a per Member per Month (PMPM) basis. Variance is the difference between the actual/observed and the expected values.

Provider Actual vs Expected PMPM: Compare the overall physician allowed variance, on a per Member per Month (PMPM) basis. Variance is the difference between the actual/observed and the expected values.

Rx Actual vs Expected PMPM: Compare the overall pharmacy prescriptions allowed variance, on a per Member per Month (PMPM) basis. Variance is the difference between the actual/observed and the expected values.

POTENTIALLY PREVENTABLE EVENTS (3)



This section of Key Performance Indicators includes measures of Potentially Preventable Events (PPEs), as defined by 3M HIS. The PPE values are developed from claims data and the measures have been risk-adjusted using Clinical Risk Groups (CRGs) of the attributed patients. Variance measures indicate the difference between the actual value and the expected value. Member lists are available in this section. Each metric's hyperlink drills down into a Detail Dashboard table. The first row of data in the drill-down table represents the overall value; subsequent rows show variation across the providers.

Allowed Potentially Preventable PMPM: Compares the Potentially Preventable Allowed dollars, on a per Member per Month (PMPM) basis. Potentially Preventable dollars are inclusive of

Potentially Preventable: Admissions (PPAs), Readmissions (PPRs), ER visits (PPVs), and Services (PPSs).

Potentially Preventable Admissions (PPA): PPAs are hospital admissions that could potentially have been dealt with in the outpatient setting. These hospital admissions may result from hospital and or ambulatory care inefficiency, lack of adequate access to outpatient care, or inadequate coordination of ambulatory care services.

- The *Member List* identifies members with at least one PPA during the 12-month reporting period.

Potentially Preventable Readmissions (PPR): PPRs are readmissions within a specified time interval that are clinically related to an initial hospital admission. A readmission is a return hospitalization to an acute care hospital that follows a prior admission from an acute care hospital. Intervening admissions to a non-acute care facility, for example, hospice, skilled nursing, home health, etc. would not be included. They are not considered readmissions and do not impact the designation of an admission as a readmission. Clinically related is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission.

- The *Member List* identifies members with at least one PPR during the 12-month reporting period.

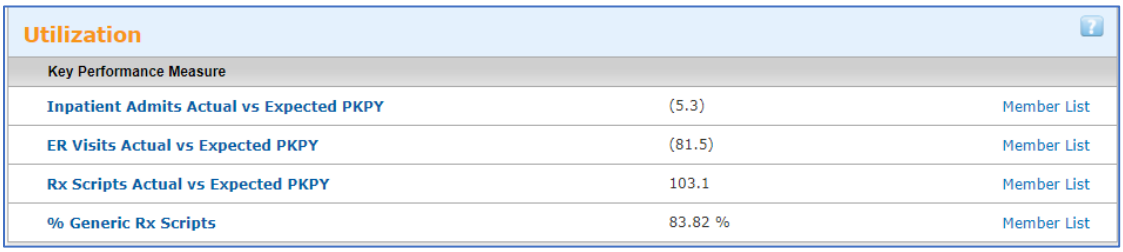
Potentially Preventable Emergency Department Visits (PPV): PPVs are emergency department visits for conditions that could otherwise be treated by a care provider in a non-emergency setting. PPVs may also result from a lack of adequate care or ambulatory care coordination, such as access to an urgent care facility, availability of primary care physicians, etc.

- The *Member List* identifies members with at least one PPV during the 12-month reporting period.

Potentially Preventable Services (PPS): PPSs are high-cost ancillary services that may not provide useful information for diagnosis or treatment, and therefore have no effect on clinical management. They include diagnostic tests, laboratory tests, therapy services, radiology services and pharmaceuticals that may be redundant or are not reasonably necessary for providing care or treatment. An example would be an MRI scan of the brain for a principal diagnosis of a headache.

- The *Member List* identifies members with at least one PPS during the 12-month reporting period.

UTILIZATION (4)



This section of Key Performance Indicators includes utilization measures which have been developed from claims and pharmacy data. The measures are risk-adjusted using Clinical Risk Groups (CRGs) of the attributed members. Variance measures indicate the difference between the actual value and the expected value. Member lists are available in this section. Each metric's hyperlink drills down into a Detail Dashboard table. The first row of data in the drill down table represents the overall value; subsequent rows show variation across the providers.

Inpatient Admits Actual vs Expected PKPY: Inpatient Admits are facility admissions. This indicator presents the variance of inpatient admissions, on a per thousand per year (PKPY) basis. Variance is the difference between the actual/observed rate and a risk-adjusted, expected rate.

- The *Member List* identifies members with at least one Inpatient Admission during the 12-month reporting period.

ER Visits Actual vs Expected PKPY: Emergency Room Visits. This indicator presents the variance of ER visits, on a per thousand per year (PKPY) basis. Variance is the difference between the actual/observed rate and a risk-adjusted, expected rate.

- The *Member List* identifies members with at least one Emergency Room Visit during the 12-month reporting period.

Rx Scripts Actual vs Expected PKPY: This indicator presents the variance of pharmacy prescriptions, on a per thousand per year (PKPY) basis. Variance is the difference between the actual/observed rate and a risk-adjusted, expected rate.

- The *Member List* identifies members with at least one Prescription during the 12-month reporting period.

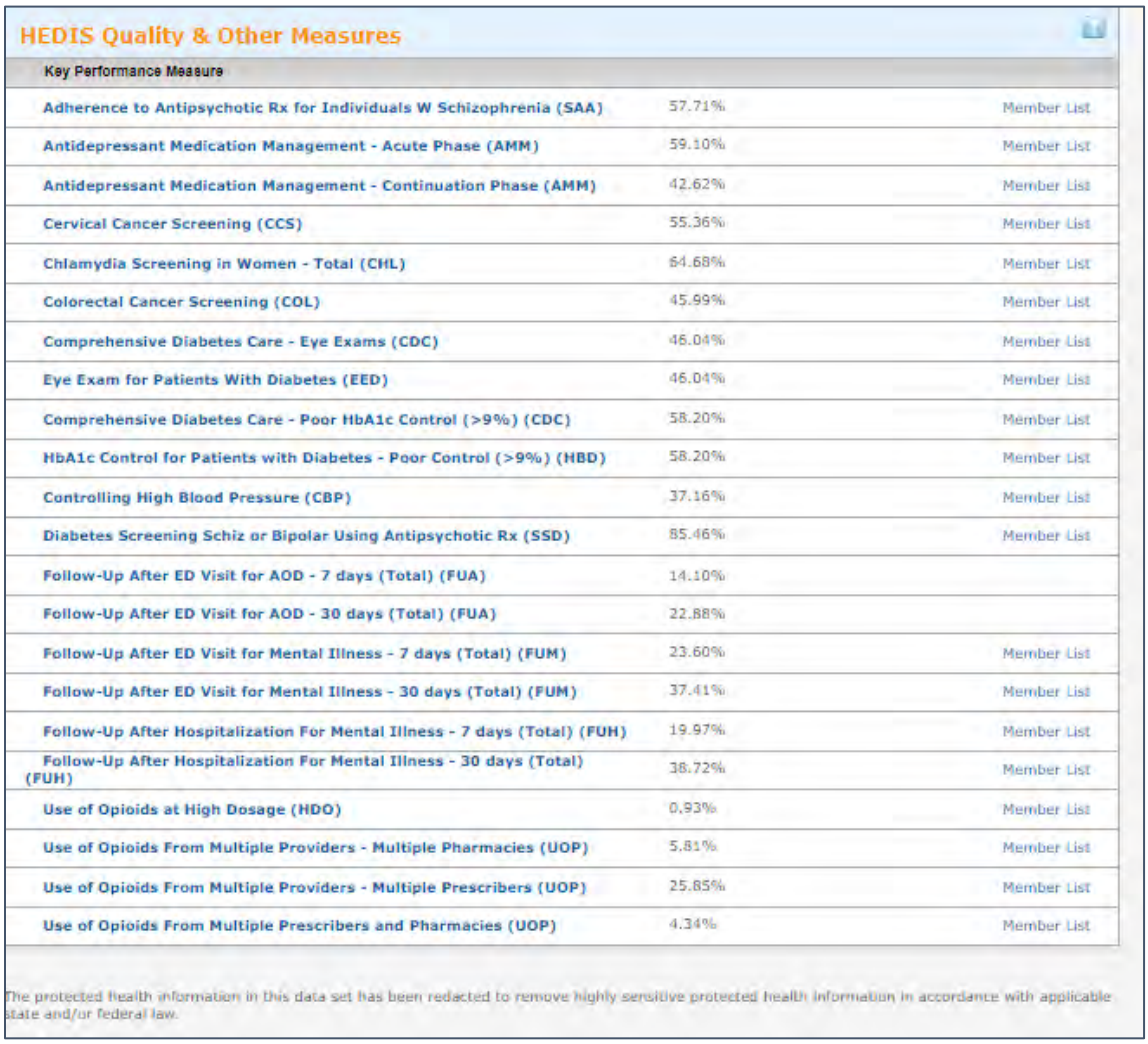
% Generic Rx Scripts: This indicator presents the percent of generic pharmacy prescriptions.

- The *Member List* identifies members with at least one Prescription and counts the number of Generic vs Brand prescriptions during the 12-month reporting period.

HEDIS QUALITY & OTHER MEASURES (5)

HEDIS® Measures: Healthcare Effectiveness Data and Information Set (HEDIS) measures are standardized performance measures designed to ensure consistent and reliable organization performance information. These measures are based upon services rendered during the reporting period and require accurate and complete encounter reporting. Results are calculated for each of

the Quality Performance Measures by individual practice and aggregated for a total score for all HEDIS measures. Overall practice scores are calculated as the ratio of members who received the services as evidenced by claim and/or encounter information (numerator) to those members in the practice's panel who were eligible to receive these services based upon the above definitions (denominator).



HEDIS Quality & Other Measures

Key Performance Measure		
Adherence to Antipsychotic Rx for Individuals W Schizophrenia (SAA)	57.71%	Member List
Antidepressant Medication Management - Acute Phase (AMM)	59.10%	Member List
Antidepressant Medication Management - Continuation Phase (AMM)	42.62%	Member List
Cervical Cancer Screening (CCS)	55.36%	Member List
Chlamydia Screening in Women - Total (CHL)	64.68%	Member List
Colorectal Cancer Screening (COL)	45.99%	Member List
Comprehensive Diabetes Care - Eye Exams (CDC)	46.04%	Member List
Eye Exam for Patients With Diabetes (EED)	46.04%	Member List
Comprehensive Diabetes Care - Poor HbA1c Control (>9%) (CDC)	58.20%	Member List
HbA1c Control for Patients with Diabetes - Poor Control (>9%) (HBD)	58.20%	Member List
Controlling High Blood Pressure (CBP)	37.16%	Member List
Diabetes Screening Schiz or Bipolar Using Antipsychotic Rx (SSD)	85.46%	Member List
Follow-Up After ED Visit for AOD - 7 days (Total) (FUA)	14.10%	
Follow-Up After ED Visit for AOD - 30 days (Total) (FUA)	22.88%	
Follow-Up After ED Visit for Mental Illness - 7 days (Total) (FUM)	23.60%	Member List
Follow-Up After ED Visit for Mental Illness - 30 days (Total) (FUM)	37.41%	Member List
Follow-Up After Hospitalization For Mental Illness - 7 days (Total) (FUH)	19.97%	Member List
Follow-Up After Hospitalization For Mental Illness - 30 days (Total) (FUH)	38.72%	Member List
Use of Opioids at High Dosage (HDO)	0.93%	Member List
Use of Opioids From Multiple Providers - Multiple Pharmacies (UOP)	5.81%	Member List
Use of Opioids From Multiple Providers - Multiple Prescribers (UOP)	25.85%	Member List
Use of Opioids From Multiple Prescribers and Pharmacies (UOP)	4.34%	Member List

The protected health information in this data set has been redacted to remove highly sensitive protected health information in accordance with applicable state and/or federal law.

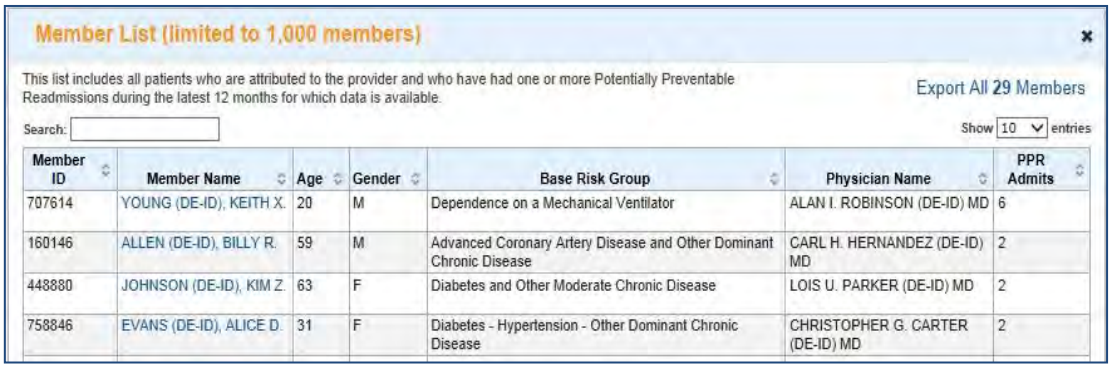
HEDIS MEMBER LISTS (6)

Member List drill downs may be available for certain Key Performance Measures. Clicking on the hyperlink correlated to the measure, which will open a new screen of members within that measure. The member list can then be exported into Excel.

MEMBER LISTS

The *Potentially Preventable Events* and *Utilization* key performance indicators offer lists of members who have at least one occurrence of the indicated metric. The member lists contain

some basic patient detail and the number of occurrences during the reporting period. The list can be exported to Excel by clicking the 'Export all ## Members' hyperlink at the top right of the display.



Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider and who have had one or more Potentially Preventable Readmissions during the latest 12 months for which data is available.

Export All 29 Members

Search:

Show 10 entries

Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	PPR Admits
707614	YOUNG (DE-ID), KEITH X.	20	M	Dependence on a Mechanical Ventilator	ALAN I. ROBINSON (DE-ID) MD	6
160146	ALLEN (DE-ID), BILLY R.	59	M	Advanced Coronary Artery Disease and Other Dominant Chronic Disease	CARL H. HERNANDEZ (DE-ID) MD	2
448880	JOHNSON (DE-ID), KIM Z.	63	F	Diabetes and Other Moderate Chronic Disease	LOIS U. PARKER (DE-ID) MD	2
758846	EVANS (DE-ID), ALICE D.	31	F	Diabetes - Hypertension - Other Dominant Chronic Disease	CHRISTOPHER G. CARTER (DE-ID) MD	2

KEY PERFORMANCE DRILL IN DETAIL (DETAIL DASHBOARD)

The *Detail Dashboard* will allow a drilldown into the ACO or Physician Group (based on user access) and will provide the rate of HEDIS measure closure, numerators and denominators for the medical group. As shown in the sample dashboard below, the *Detail Dashboard* may include information such as:

Rate: The percentage of qualifying members who have received the measured service. A score of 0% indicates that members qualified for the denominator but did not qualify for the numerator criteria. A score of N/A indicates that members did not qualify for the numerator or denominator criteria.

Numerators: The patient population identified through administrative data to have received the required service.

Denominators: The entire eligible population for the measure as determined through NCQA criteria, membership data and administrative data.

Variance: The difference between the actual allowed and expected value.

Allowed/Actual Value: This is the actual value, such as actual amount of dollars spent on the patient's medical services (Actual Allowed), or the actual number of admissions, pharmacy prescriptions, etc.

Expected Value: A value that reflects the expected, risk-adjusted value for a given measure.

Inpatient Expected: Calculated separately for each 3M APR-DRG and severity level and are based on all hospitals selected by the health plan for inclusion in the expected value pool.

Outpatient Expected: A weighted average based on calculating the population average for each primary CPT4 procedure found within an EAPG. The population average is multiplied by the actual number of occurrences of the primary CPT4 procedure. Values are then aggregated and divided by the total number of visits.

Professional Expected: CPT4 procedure, place of service type (facility/non-facility), and modifier group adjusted expected values.

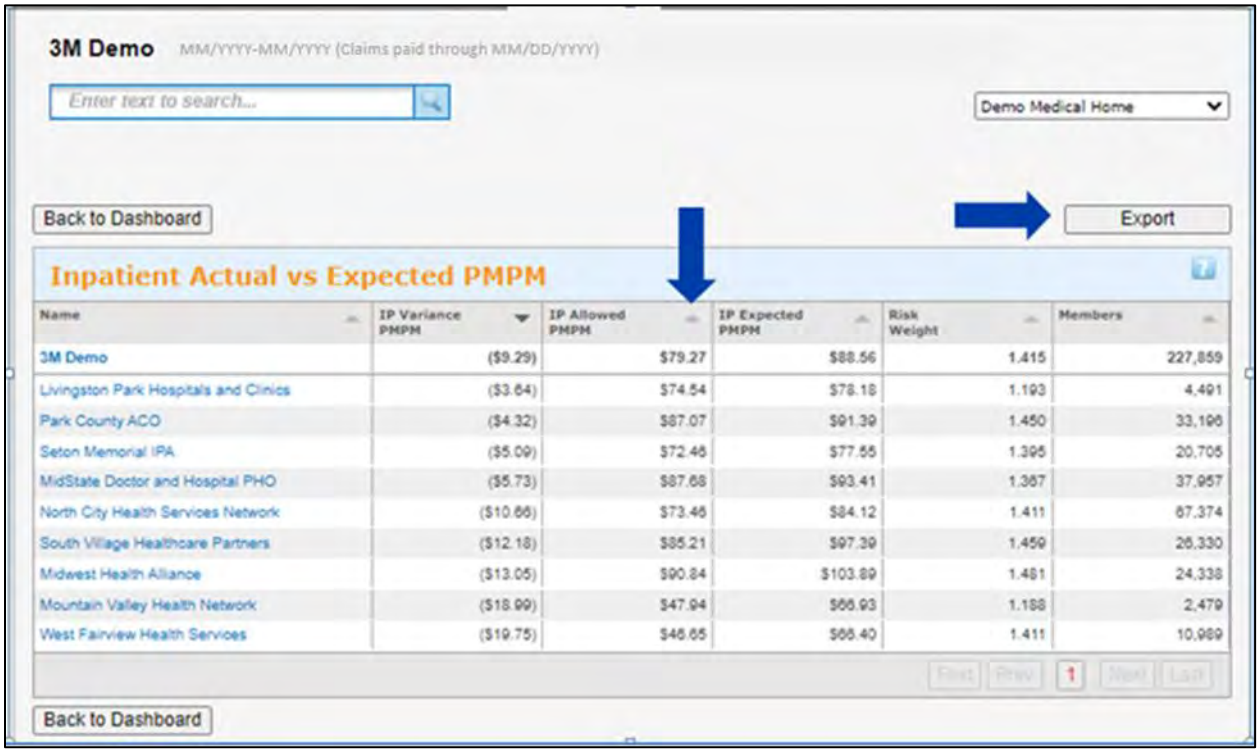
PMPM: Per Member Per Month

PKPY: Per Thousand Members Per Year

Risk Weight or CRG Weight: The relative illness burden of a patient population, risk-adjusted to a normative population for an "apples to apples" comparison. CRG weights above 1 indicate higher than network average illness burden, and CRG weights below 1 indicate lower than network average illness burden.

Members: The number of members assigned to the provider's membership panel.

Detail Dashboards can be exported to Excel by clicking the Export button and following the online prompt instructions.



Name	IP Variance PMPM	IP Allowed PMPM	IP Expected PMPM	Risk Weight	Members
3M Demo	($9.29)	$79.27	$88.56	1.415	227,859
Livingston Park Hospitals and Clinics	($3.64)	$74.54	$78.18	1.193	4,491
Park County ACO	($4.32)	$87.07	$91.39	1.460	33,196
Seton Memorial IPA	($5.09)	$72.46	$77.55	1.395	20,705
MidState Doctor and Hospital PHO	($5.73)	$87.68	$93.41	1.367	37,957
North City Health Services Network	($10.66)	$73.46	$84.12	1.411	67,374
South Village Healthcare Partners	($12.18)	$85.21	$97.39	1.459	26,330
Midwest Health Alliance	($13.05)	$90.84	$103.89	1.481	24,338
Mountain Valley Health Network	($18.99)	$47.94	$66.93	1.188	2,479
West Fairview Health Services	($19.75)	$46.65	$66.40	1.411	10,989

HOW TO FORMAT DETAIL DASHBOARDS

Sorting Data:
Users can sort data in the Detail Dashboard in ascending or descending order by clicking on the gray triangle buttons next to any column name. Clicking the gray triangle again re-sorts in the opposite direction. The triangles turn dark grey to indicate its use as an active sort. On the Medical Home Dashboard, providers or provider groups are sorted by default on the variance from expected values, i.e., the "Total Actual vs Expected" column, from ascending to descending. Positive values indicate spending or utilization greater than expected for the given population. Negative values in parenthesis indicate less than expected performance, i.e., spending or utilization is less than expected.

Adjust Column Width:
Users can adjust the column widths on the Detail Dashboard by placing the curser directly above a column borderline (in the white header area) until the cursor turns into a double line with arrows pointing opposite directions. Click and drag to adjust the column widths.

HOW TO EXPORT TO EXCEL

Click on the Export button and follow the prompts to send data in the Detail Dashboard to an Excel workbook.

DRILLDOWN CAPABILITIES WITH EXAMPLES

Depending on a user's role within an organization, various levels of data are available to provide an appropriate level of detail. Examples of the levels of views offered include:

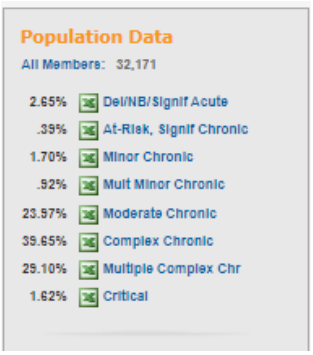
- Integrated Delivery System (IDS) or any other collective of provider groups
- Individual provider group
- Individual provider level

Users with access to an IDS can view all the data for physician groups in their organization, allowing for high-level comparisons. When access is granted at the provider group level the user is only able to view the data for providers within the group and drill into the associated physicians. Access granted at the individual provider level allows the user to view member information for those patients attributed to their panel.

While viewing any detail measure, click on the provider group or provider name to open a new dashboard within a new tab of the internet browser. The newly opened Medical Home Dashboard will focus all KPI's and reports on the selected provider's performance.

ACTIONABLE MEMBER LISTS - POPULATION DATA (7)

For providers in a quality and cost management program, being able to keep track of the patient population attributed to an organization is critical. Complementing the performance summaries on the *Detail Dashboards*, *Population Data* reports provide in-depth information on the patient population for the Accountable Care Organization, a specific provider group or a specific provider. These lists allow the user to get to know the members in the population, their health history, or disease burden.



Excel spreadsheets list all patients in the population organized by Population Health Categorizations, the core health status of the patient. The spreadsheet includes member identification, primary care physician information, member's assigned Population Health Segment, Aggregate CRG (ACRG), Primary Episode Diagnostic Category (EDC), CRG Weight, Total Cost of Care Allowed percentage difference from expected, and Potentially Preventable Event (PPE) counts for the 12-month reporting period. Sensitive conditions are redacted.

POPULATION DATA EXCEL REPORTS

Selecting a specific *Population Data* status group will launch an Excel file of the members assigned to the selected status group. Follow the instructions to download the Excel file.

All Members: Selecting the *All Members* hyperlink will launch an Excel file containing a record per attributed patients.

Non-User: Non-users have no healthcare system encounters during the analysis period. These members have an assigned CRG Weight = 0.000 and an ACRG3 Base of 1 Non-User. The Medical Home Dashboard is impacted by claims lag since it is as real-time as possible. At the time of Paid by Cycle in the dashboards, the plan has not received any service claims or pharmacy for a Non-User.

Healthy: Healthy status individuals have no significant acute Episode Diagnostic Categories (EDC) and no Primary Chronic Diseases (PCD) reported at any time during the analysis period. Associated with patients assigned to ACRG3 Base of 10 Healthy.

Del/NB/Signif Acute: Members who have delivered a baby, newborns, and individuals who have no PCD but had at least one significant acute EDC.

At Risk, Signif Chronic: Individuals with a history of a significant acute disease, have a significant prescription and may or may not have another significant illness.

Minor Chronic: Individual has a single minor chronic PCD that can usually be managed effectively with typically few complications; however, they can become serious in

advanced stages or be a precursor to a more serious disease. Typically associated with patients assigned to ACRG3 Base of 30 Single Minor Chronic Disease.

Multiple Minor Chronic: Individual has two or more Minor Chronic PCDs in multiple organ systems. Typically associated with patients assigned to ACRG3 Base of 40 Minor Chronic Disease in Multiple Organ Systems.

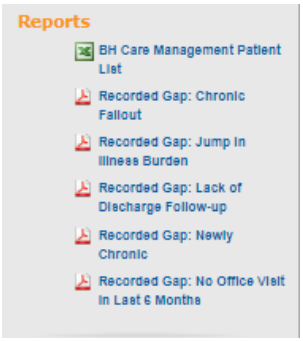
Moderate Chronic: Individuals with a single dominant or moderate chronic PCD that would be expected to require substantial amounts of medical care and resources. Typically associated with patients assigned to ACRG3 Base of 50 Single Dominant or Moderate Chronic Disease or 60 Significant Chronic Disease in Multiple Organ Systems.

Complex Chronic: Individuals with a single dominant and a moderate chronic PCD that would be expected to require substantial amounts of medical care and resources. Typically associated with patients assigned to ACRG3 Base of 50 Single Dominant or Moderate Chronic Disease or 60 Significant Chronic Disease in Multiple Organ Systems.

Multiple Complex Chronic: Individuals with two or more dominant chronic PCDs that would be expected to require substantial amounts of medical care and resources. Typically associated with patients assigned to ACRG3 Base of 60 Significant Chronic Disease in Multiple Organ Systems or 70 Dominant Chronic Disease in Three or More Organ Systems.

Critical: Individuals with malignancy under active treatment or a catastrophic condition. Associated with patients assigned to ACRG3 80 Malignance Under Active Treatment and 90 Catastrophic Conditions.

ACTIONABLE MEMBER LISTS - REPORTS (8)



An Excel spreadsheet provides a list of members who have a chronic illness or a condition that would benefit from care management. The report indicates members with identified gaps in services and is useful for identifying at-risk patients. Using this report, a clinician can quickly find a patient and easily identify all the reasons a member should be under care management.

CARE MANAGEMENT PATIENT LIST

This is an Excel spreadsheet list of patients classified with a chronic illness or patients who had an admission without a follow up in 7 or 30 days during the current 12-month reporting period or the previous 12-month reporting period processed. A clinician can quickly find a patient and easily identify changes in health status, or inadequate health maintenance. Patients will be included in the report if they are eligible during the reporting period and have at least one of the following:

- Newly Chronic
- Chronic Severity Jumper
- Chronic Status Jumper
- Chronic Fallout
- Lack of Office Visits
- Admissions without a follow up within 7/30days

Member Months: The number of months the patient was enrolled with the plan.

Fall Out Report / Chronic Fallout: The indicator of Y (Yes) identifies patients who were identified as having a chronic, catastrophic, or malignant condition in a prior 12-month period and are no longer flagged as such in the current 12-month period. This may indicate incomplete medical documentation or a gap in care for that individual since individuals with chronic conditions may experience a progression in disease – not a regression.

Jumpers Report / Jump in Illness Burden: The indicator of Y (Yes) identifies those patients whose CRG score has jumped significantly in status. A significant jump in status could entail moving from having one chronic condition to having multiple conditions or showing an increase in the severity of an existing condition.

Newly Chronic: The indicator of Y (Yes) identifies patients that are now considered chronic but were previously not chronic. These could be previously healthy patients, non-users, or newly attributed/enrolled patients. The data in this report is used to identify Providers with a disproportionate share of newly chronic patients and can also be used to generate lists for outreach initiatives.

No Office Visit in Last 6 months / Missing Office Visit: The indicator of Y (Yes) identifies chronically ill patients who have not had a provider visit in the last 6 months. The provider does not have to be associated with the PCP Physician group.

Inpatient Admissions without a 7 or 30 Day Follow Up Visit / Lack of Discharge Follow-up – 7 or 30 Day: The indicator presents all patients who had an admission to the hospital for any cause during the reporting period but who did not have a seven day and/or thirty-day follow-up visits to any provider in the community following discharge. The number indicator counts the number of admissions that did not have a corresponding 7 day follow-up, or 30 day follow-up.

Previous CRG and Previous CRG Description: For the previously processed 12-month period, a five-digit code representing the patient's core health status (the first digit), the base 3M CRG (the 2nd to 4th digit), and the severity of illness (the 5th digit). The severity of illness indicates the extent and progression of the disease selected as the PCD, and a higher level indicates a higher degree of treatment difficulty and a need for substantial medical care. Depending on the core health status, the severity of illness ranges from 1 to 6: minor (1), moderate (2), major (3), extreme (4), or the member has additional Primary Chronic Diseases beyond those used to determine the base CRG (5 or 6). The CRG Description details the assigned five-digit code. Redaction is in place for sensitive CRGs.

- Example: 57844 Chronic Alcohol Abuse/Dependence Level - 4 5 = Single Dominant or Moderate Chronic Disease. 784 = Chronic Alcohol Abuse/Dependence Level. 4 = Severity Level 4

Current CRG and Current CRG Description: For the current 12-month period, a five-digit code representing the patients core health status. Read the *Previous CRG and Previous CRG Description* above for further detail.

Case Management: The plan's Care Management Team attempts to engage members with significant illness or medical needs. If the plan's Care Management record indicates the member has agreed to be care managed and is "Fully Engaged" and actively enrolled, there will be a care management indicator. There will be timing differences comparing 3M's care management indicator and the live care management record.

A PDF of each recorded gap identifies the Physician Groups and a count of patients with gaps.

Sample "Recorded Gap: Lack of Discharge Follow-Up" report:

Recorded Gap: Chronic Fallout

IDS: Park County ACO

Source: 3M Demo 01/2015-12/2015

This report identifies members who were previously identified as having a chronic, catastrophic, or malignant condition, based on Clinical Resource Groups, in the 12-month period ending 11/30/2015 and are no longer flagged with this health status in the current reporting period ending 12/31/2015. This may indicate incomplete medical documentation or a gap in care for that individual since individuals with chronic conditions may experience a progression in disease-not a regression. *This data is useful for identifying at-risk patients and can be used to generate lists of patients for outreach/intervention.*

Physician Group	Members	CRG Weight	Members with Fall Outs
Payton Health System	11,172	1.6486	19
Park County ACO	**11,172**	**1.6486**	**19**
3M Demo	**84,332**	**1.6033**	**132**

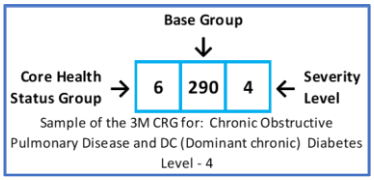
ACRG3	Members	CRG Weight	Members with Fall Outs
Healthy	3,672	0.2946	2
Single Dominant or Moderate Chronic	2,168	1.4156	0
Pairs - Multiple Dominant and/or Moderate Chronic	1,612	4.2527	0
Single Minor Chronic	1,518	0.8427	7
Multiple Minor Chronic	517	1.4636	7
Significant Acute	393	0.6047	0
Evidence of Significant Chronic or Acute Diagnosis without Other Significant Illness	362	1.4186	3
Healthy Non-User	310	0.0000	0
Evidence of Significant Chronic or Acute Diagnosis with History of Significant Acute Illness	147	1.8836	0
Delivery with Other Significant Illness	130	4.9404	0
Triples - Multiple Dominant Chronic	99	9.3647	0
Malignancies - Metastatic, Complicated or Dominant	90	17.7932	0
Delivery without Other Significant Illness	68	3.8865	0
Pregnancy without Delivery without Other Significant Illness	36	1.6732	0
Catastrophic	34	18.5815	0
Pregnancy without Delivery with History of Significant Acute Illness	16	1.7299	0
Park County ACO	**11,172**	**1.6486**	**19**
3M Demo	**84,332**	**1.6033**	**132**

SUPPORTING RESOURCES (9)

Supplemental documentation and resources may be included based on their relevance and are located in the Resource Library on the Home Tab.

CLINICAL RISK GROUPS NUMBERING SYSTEM

EXAMPLE AND SAMPLE CLINICAL RISK GROUP



37891	Cannabis and Other Minor Chronic Drug Abuse Level - 1
57842	Chronic Alcohol Abuse/Dependence Level - 2
70406	Dominant Chronic Mental Health - Dominant Chronic Substance Abuse - Other Dominant Chronic Disease Level - 6

SEVERITY LEVELS

1 = Minor
2 = Moderate
3 = Major
4 = Extreme
5 and 6

- For Core Health Status 6: If the member has additional Moderate Chronic Primary Chronic Diseases (PDCs) beyond those used to determine the base Clinical Risk Group (CRG), the severity level may be incremented by one up to a maximum of severity level 6.
- For Core Health Status 7: If the member has more than 3 Dominant Chronic or Moderate Chronic PCDs beyond those used to determine the base CRG, the severity level may be incremented by one up to a maximum of severity level 6.

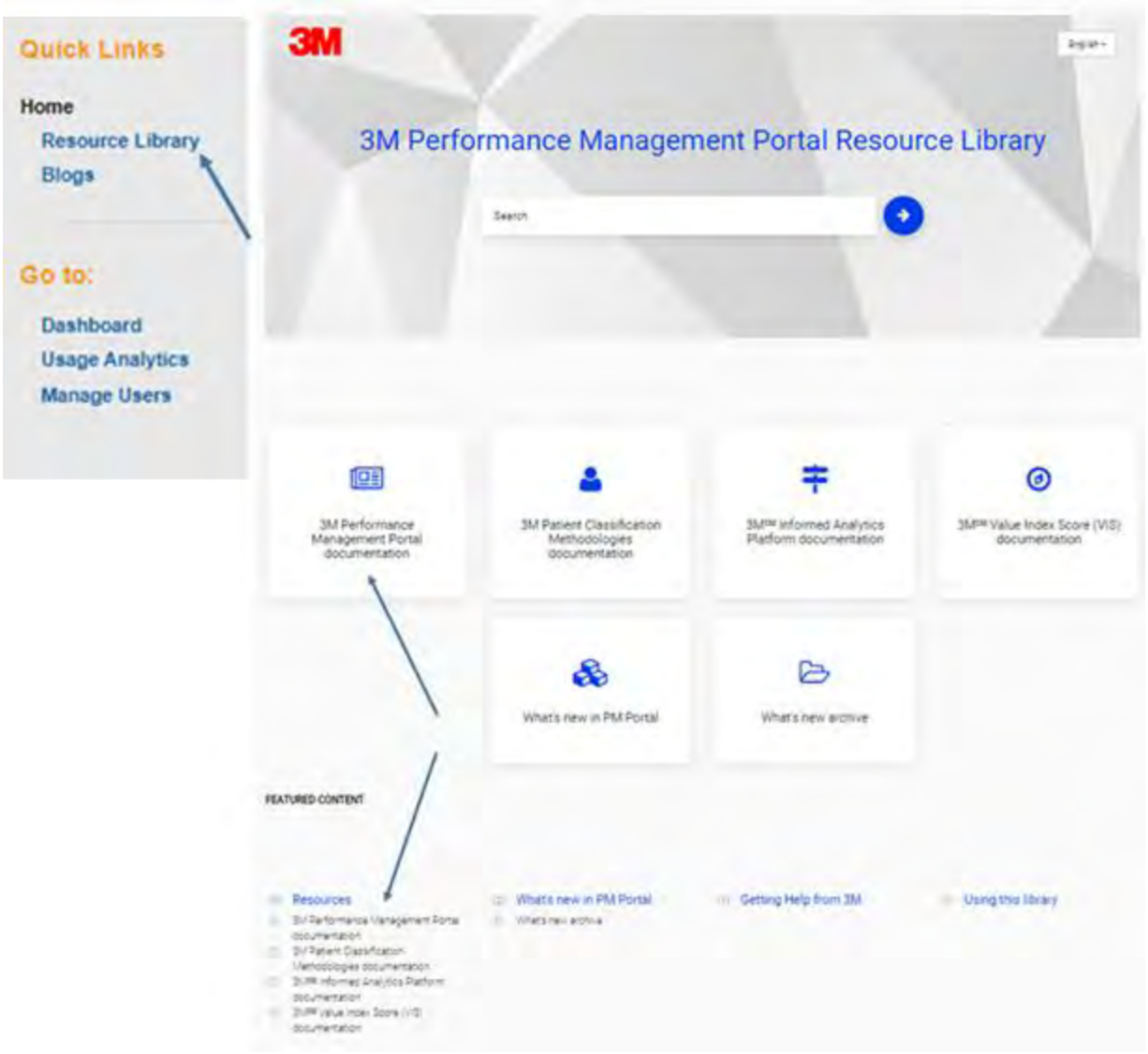
CORE HEALTH STATUS GROUPS

3M CRG Core health status groups (1-9) 1st digit in CRG	Description and Example	Maximum Severity Levels
9 – Catastrophic Conditions	Catastrophic conditions include long term dependency on a medical technology (e.g., dialysis, respirator, total parenteral nutrition) and life-defining chronic diseases or conditions that dominate the medical care required (e.g., acquired quadriplegia, severe cerebral palsy, cystic fibrosis, history of heart transplant).	4
8 – Malignancy, Under Active Treatment	A malignancy under active treatment.	4
7 – Dominant Chronic Disease in three or more organ systems	Three or more (usually) dominant Primary Chronic Disease (PCDs). In selected instances, criteria for one of the three PCDs may be met by selected moderate chronic PCDs. Example: Diabetes mellitus, congestive heart failure and chronic obstructive pulmonary disease.	6
6 – Significant Chronic Disease in Multiple Organ Systems	Two or more dominant or moderate chronic PCDs. Example: Diabetes mellitus and CHF.	6
5 – Single Dominant or Moderate Chronic Disease	A single dominant or moderate chronic PCD. Example: Diabetes mellitus.	4
4 – Minor Chronic Disease in Multiple Organ Systems	Two or more minor chronic PCD. Example: Migraine and benign prostatic hyperplasia.	4
3 – Single Minor Chronic Disease	A single minor chronic PCD. A disease is classified as chronic if it is either life-long or prolonged in duration. Some diseases are progressive, others can sometimes be cured or resolve in time, and others, while usually not curable, may often be controlled. Example: Migraine	2
2 – History of Significant	Individuals do not have Primary Chronic Diseases (PCD), but at least	None

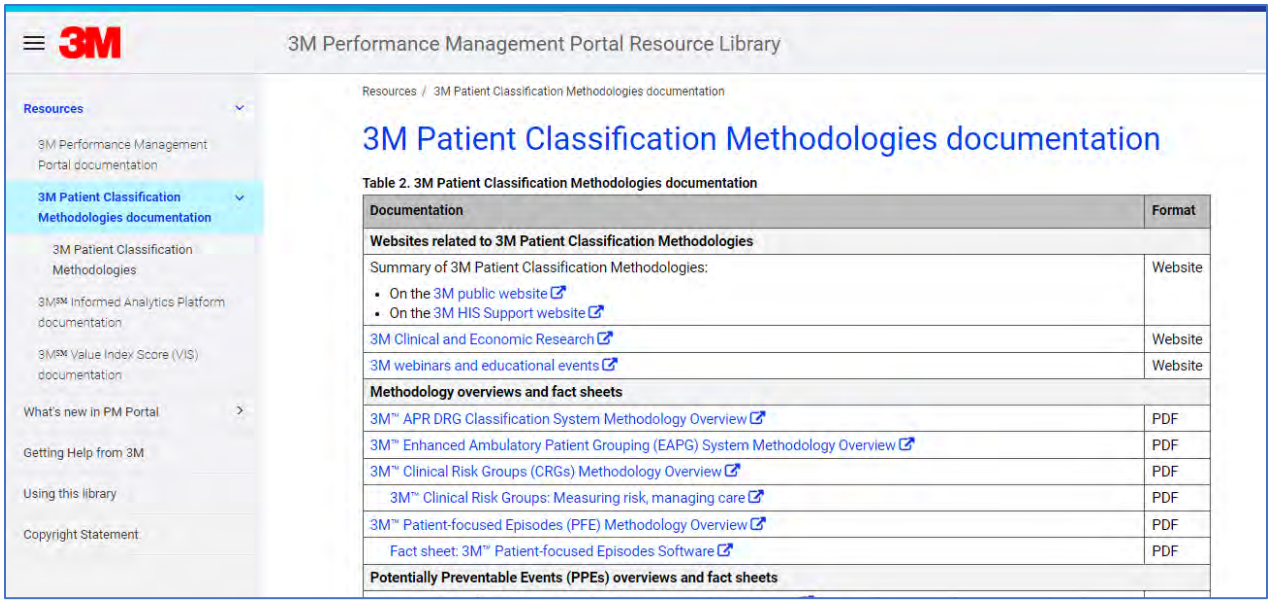
3M CRG Core health status groups (1-9) 1st digit in CRG	Description and Example	Maximum Severity Levels
Acute Disease	one significant acute Episode Diagnostic Category (EDC), Example: Chest pains.	
1 - Healthy	The absence of any significant acute Episode Diagnostic Category (EDCs) occurring within the last twelve months of the analysis period along with the absence of any validated PCDs reported at any time during the analysis period. CRG defines "Healthy" as individuals not qualifying for any of the eight other Health Statuses. Generally, this means there are no chronic conditions identified and no Significant Acute conditions noted within the most recent six months of the review period. These individuals may still have a significant health event such as pregnancy, obstetric delivery, or newborn birth and may be assigned to a CRG category to reflect this.	None
0 - Non User	The patient has not had any services.	

3M RESOURCE LIBRARY

3M™ HIS publishes manuals and supporting resources to the Resource Library site found on the Home tab. Selecting the *3M Patient Classification Methodologies documentation* link displays 3M's published papers on methodologies.



Clicking into the Resources icon or by selecting a link under the Resources section will open additional resource guides, as seen below. These guides can be helpful when understanding measure dashboard definitions and methodology (see screenshot below). Documentation and resources may be included in a market specific dashboard landing page based on the relevance to the market program.



To return to the main menu for the *3M Performance Management Portal Resource Library*, click on the 3M™ logo in the upper left-hand corner to navigate back to the home page.