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Inland Empire Health Plan (IEHP) is pleased to announce the second year of the Hospital Pay For Performance (Hospital P4P) Program for IEHP Medi-Cal contracted hospitals servicing Riverside and San Bernardino counties. The goal of the Hospital P4P Program is to provide financial rewards to hospitals that meet quality performance targets and demonstrate high-quality care to IEHP Members.

The 2019 Hospital P4P Program is structured as an incentive program with quarterly performance measurement and payment. Payments are scaled to the volume of IEHP Member admissions per hospital.

The 2019 program includes the six measures listed below. All measures are based on 2019 calendar year performance and are assessed on a quarterly schedule outlined in the “Payment Methodology” section.

- Manifest MedEx Active Data Sharing- Required Data Elements
- Manifest MedEx Active Data Sharing- Optional Data Elements
- Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate
- Physicians Order for Life-Sustaining Treatment (POLST) Registry Forms Submission
- Plan All-Cause Readmissions (PCR) Observed-to-Expected Ratio
- Post-Discharge Follow-Up Within Seven Days of Discharge for High-Risk Members

Participation Requirements

Hospitals with an active IEHP contract for the Medi-Cal population (located within Riverside and San Bernardino counties) at the beginning of the measurement year (2019) are eligible for Program participation. Other program requirements include:

- Hospitals with maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting and sign a CMQCC authorization release to share hospital-level results with IEHP by February 15, 2019, if an authorization of release was not completed in the 2018 program year.

- Hospitals with no maternity service line are not eligible to receive incentive dollars for the NTSV Cesarean Delivery Rate measure.
• Hospitals must provide Electronic Medical Record (EMR) access to IEHP to support concurrent review processes. Key information that should be available for viewing access by the IEHP concurrent review team includes:
  - History and Physical (H&P)
  - Labs
  - Medications
  - Updated clinical progress notes by all interdisciplinary teams
  - Orders
  - Ancillary notes (including SW, Psych, and PT/OT/ST notes)
  - Diagnostic procedures and results
  - Surgical procedures and outcomes
  - Case management notes
  - Discharge summary
  - Medication reconciliation upon discharge

Hospital EMR access to IEHP must be in place no later than April 30, 2019 and must be available through entire measurement year (2019).

Financial Overview

The annual budget for the 2019 Hospital P4P Program is $31 million in total possible payouts to qualifying hospitals that meet quality performance targets. The table below summarizes the Hospital P4P Program budget for the year and by dollars available per measure.

<table>
<thead>
<tr>
<th>MEASURE ALLOCATION</th>
<th>Payment Frequency</th>
<th>P4P Dollars Available per Measure</th>
<th>Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>MX Active Data Sharing- Required Data Elements</td>
<td>Quarterly</td>
<td>$1,000,000</td>
<td>$4,000,000</td>
</tr>
<tr>
<td>MX Active Data Sharing- Optional Data Elements</td>
<td>Semi Annually</td>
<td>$1,500,000</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>NTSV C-Section Rate</td>
<td>Quarterly</td>
<td>$1,500,000</td>
<td>$6,000,000</td>
</tr>
<tr>
<td>POLST Registry Form Submission</td>
<td>Quarterly</td>
<td>$1,500,000</td>
<td>$6,000,000</td>
</tr>
<tr>
<td>PCR Observed-to-Expected Ratio</td>
<td>Quarterly</td>
<td>$1,500,000</td>
<td>$6,000,000</td>
</tr>
<tr>
<td>Seven-Day Discharge Follow Up</td>
<td>Quarterly</td>
<td>$1,500,000</td>
<td>$6,000,000</td>
</tr>
</tbody>
</table>

**Annual Budget** $31,000,000
Eligible hospitals are evaluated quarterly on their performance in each of the P4P measures. Each measure is calculated following the guidelines listed in “Summary of Measures” section of this guide. Hospital performance is assessed based on the established performance goals. Below is a chart of the Hospital P4P Program measures and their performance goals. For measures that have two-tier performance goals, 50 percent of the available measure dollars are rewarded for reaching Tier 1 level performance and 100 percent of the available measure dollars are rewarded for reaching Tier 2 level performance. For measures that have only one performance goal, 100 percent of the available measure dollars are rewarded for meeting the goal rate.

### Payment Methodology

<table>
<thead>
<tr>
<th>MEASURE NAME</th>
<th>DATA SOURCE</th>
<th>2019 PERFORMANCE GOALS</th>
</tr>
</thead>
</table>
| MX Active Data Sharing- Required Data Elements | Manifest MedEx | All conditions must be met:  
1) Hospitals must have a current PA in place with MX  
2) Hospitals are actively sharing required data elements with MX per quarter  
3) Hospitals consistently submitting all required data elements for all hospital events throughout the entire measurement period |
| MX Active Data Sharing- Optional Data Elements | Manifest MedEx | Tier 1: Hospitals actively sharing optional data elements for all hospital events by 12/1/2019  
Tier 2: Hospitals actively sharing optional data elements for all hospital events by 6/30/2019 |
| NTSV C-Section Rate | CMQCC* | Less than or equal to 23.9% |
| POLST Registry Form Submission | POLST Registry | POLST forms submitted by hospital must be 10% of IEHP adult admissions per quarter |
| PCR Observed-to-Expected Ratio | IEHP Claims & Encounters | Hospital PCR O/E ratio <1.0 per quarter |
| Seven-Day Discharge Follow-Up | IEHP Claims & Encounters | Tier 1: 10% improvement over hospital-specific baseline performance**  
Tier 2: 47% or above (90th percentile performance for IEHP network) |

* California Maternal Quality Care Collaborative.  
** If minimum denominator requirements are not met, hospital is assigned a Tier 1 goal at the 50th percentile for the IEHP network.
Payment Schedule:
IEHP will adhere to the following payment schedule for all Hospital P4P measures:

<table>
<thead>
<tr>
<th>Measurement Payment Schedule</th>
<th>Payment Month</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2019</td>
<td>July 2019</td>
<td>$7,000,000</td>
</tr>
<tr>
<td>Q2 2019</td>
<td>October 2019</td>
<td>$7,000,000</td>
</tr>
<tr>
<td>Semi Annual- June</td>
<td>October 2019</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Q3 2019</td>
<td>January 2020</td>
<td>$7,000,000</td>
</tr>
<tr>
<td>Q4 2019</td>
<td>April 2020</td>
<td>$7,000,000</td>
</tr>
<tr>
<td>Semi Annual- December</td>
<td>April 2020</td>
<td>$1,500,000</td>
</tr>
</tbody>
</table>

Reported Timeline:

<table>
<thead>
<tr>
<th>MEASURE NAME</th>
<th>DATA SOURCE</th>
<th>MEASUREMENT PERIOD</th>
<th>DATA FREEZE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manifest MedEx Active Data Sharing- Required Data Elements</td>
<td>Manifest MedEx</td>
<td>Quarter 1: Jan - Mar</td>
<td>Quarter 1: June 15, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 2: Apr - June</td>
<td>Quarter 2: Sept 15, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 3: July- Sept</td>
<td>Quarter 3: Dec 15, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 4: Oct- Dec</td>
<td>Quarter 4: Mar 15, 2020</td>
</tr>
<tr>
<td>Manifest MedEx Active Data Sharing- Optional Data Elements</td>
<td>Manifest MedEx</td>
<td>June 2019</td>
<td>June: Sept 15, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec 2019</td>
<td>Dec: Mar 15, 2020</td>
</tr>
<tr>
<td>NTSV Cesarean Delivery Rate</td>
<td>CMQCC Maternal Data Center Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POLST Registry Forms Submission</td>
<td>POLST Registry &amp; IEHP</td>
<td>Quarter 1: Jan - Mar</td>
<td>Quarter 1: June 15, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 2: Apr - June</td>
<td>Quarter 2: Sept 15, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 3: July- Sept</td>
<td>Quarter 3: Dec 15, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 4: Oct- Dec</td>
<td>Quarter 4: Mar 15, 2020</td>
</tr>
<tr>
<td>PCR Observed-to- Expected Ratio</td>
<td>IEHP Claims &amp; Encounters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Discharge Follow-Up within Seven Days for High-Risk Members</td>
<td>IEHP Claims &amp; Encounters</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Payment Calculation:

Payments to hospitals are based on IEHP Member admissions, and are calculated by the following formula:

**Step 1: Determine the Percent of Total Admissions per Hospital**

\[
\text{Percent of Total Admissions} = \frac{\text{Total IEHP Admissions for Hospital in the Quarter}}{\text{Total IEHP Admissions for All Eligible Hospitals in the Quarter}}
\]

**Step 2: Determine the Amount of P4P Dollars Available per Hospital**

\[
\text{Total P4P Dollars Available per Hospital Per Quarter} = \text{Percent of Total Admissions} \times \text{Total Quarterly P4P Dollars Available}
\]

**EXAMPLE:** Hospital X

**Step 1: Determine the Percent of Total Admissions per Hospital**

IEHP Admissions for Hospital X for Quarter 1 2019 = 3,000

Total IEHP Admissions for All Hospitals for Quarter 1 2019 = 16,000

\[
\frac{3,000}{16,000} = 0.1875
\]

**Step 2: Determine the Amount of P4P Dollars Available per Hospital**

\[
0.1875 \times 7,000,000 = 1,312,500 \text{ Available for Hospital X for All Measures per Quarter}
\]
**Measure Name:** Manifest MedEx Active Data Sharing – Required Data Elements

**Background:**
Manifest MedEx (MX) supports Health Information Exchange (HIE) connectivity across the state of California and currently includes 30 hospitals, medical groups, IPAs and Physician practices in the Inland Empire. Manifest MX works closely with a local partner, Inland Empire Health Information Organization (IEHIO), which represents 11 hospitals and most of the Physicians in the area who participate in organized Physician groups and IPAs (2,400 unduplicated Physicians). The remaining Physicians are largely in solo practices. Manifest MX also includes many other healthcare organizations, such as Federally Qualified Health Centers (FQHCs) and multispecialty clinics.

**Performance Requirements:**
Hospitals must demonstrate active data sharing with Manifest MX by submitting all data types listed below throughout the entire measurement period (i.e., quarter). Completeness of hospital data will be assessed throughout the quarter to ensure data sharing was in place throughout the entire measurement period. It is expected that hospitals report all discharges and admissions (including emergency room, acute and subacute stays) to Manifest MX.

**REQUIRED MX DATA CONTRIBUTION FOR HOSPITALS:**

<table>
<thead>
<tr>
<th>Data Feed Type</th>
<th>Data Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>HL7 ADT data feed</td>
<td>Admissions Data, Discharge Data, Diagnosis Data</td>
</tr>
<tr>
<td>HL7 ORU data feed</td>
<td>Lab Results</td>
</tr>
<tr>
<td>HL7 RDE data feed</td>
<td>Prescribed Meds with Status &amp; SIG</td>
</tr>
</tbody>
</table>

Hospitals must have a **current participation agreement (PA)** in place with MX. The executed PA using MX’s post-merger PA structure must be in place at the beginning of each quarter in order to qualify for the quarterly payment.
Definitions:

Current Participation Agreement (PA)
Participant has executed a PA with MX using MX’s post-merger PA structure

Acronym Dictionary:
ADT: Admission, discharge, transfer message
HL7: Health level 7 standards development organization
ORU: Observation result message
PA: Participation agreement
RDE: Pharmacy/treatment encoded order message

Measure Name: Manifest MedEx Active Data Sharing – Optional Data Elements

Background:
Manifest MedEx (MX) supports Health Information Exchange (HIE) connectivity across the state of California and currently includes 30 hospitals, medical groups, IPAs and Physician practices in the Inland Empire. Manifest MX works closely with a local partner, Inland Empire Health Information Organization (IEHIO), which represents 11 hospitals and most of the Physicians in the area who participate in organized Physician groups and IPAs (2,400 unduplicated Physicians). The remaining Physicians are largely in solo practices. Manifest MX also includes many other healthcare organizations, such as Federally Qualified Health Centers (FQHCs) and multispecialty clinics.

Performance Requirements:
IEHP wants to encourage a more robust set of hospital data available within the HIE to support patient coordination of care. This measure is designed to reward hospitals who share a broader set of data with Manifest MX beyond the “Required” data element set.

Hospitals will have two opportunities to earn incentive dollars for this measure:

- Hospitals that have the following optional data-sharing elements in production with Manifest MX by June 30, 2019 will receive a one-time payment for early measure adoption.
- Hospitals that have the following optional data-sharing elements in production with Manifest MX no later than December 1, 2019 will be eligible for a one-time payment.
- For maximum incentive earnings, hospitals must have the following optional data-sharing elements in production with Manifest MX by June 30, 2019, and continue actively sharing through December 1, 2019.
In order to be compliant with this measure, it is expected that hospitals report all discharges and admissions (including emergency room, acute and subacute stays) to Manifest MX for all message types noted in the table below.

**MX DATA CONTRIBUTION FOR HOSPITALS:**

<table>
<thead>
<tr>
<th>HL7 ORU data feed that complies with MX data-sharing guidelines in production</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Documents</td>
</tr>
<tr>
<td>Pathology Documents</td>
</tr>
<tr>
<td>Radiology Documents</td>
</tr>
<tr>
<td>Chart Notes*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HL7 VXU data feed that complies with MX data-sharing guidelines in production</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization Data</td>
</tr>
</tbody>
</table>

*Chart notes include: discharge summary, consults, progress notes, surgical notes and procedure notes

Hospitals must have a **current participation agreement (PA) in place with MX**. The executed PA using MX’s post-merger PA structure must be in place at the beginning of each quarter in order to qualify for the quarterly payment.

**Definitions:**

**Current Participation Agreement (PA)**
Participant has executed a PA with MX using MX’s post-merger PA structure

**Acronym Dictionary:**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HL7</td>
<td>Health level 7 standards development organization</td>
</tr>
<tr>
<td>ORU</td>
<td>Observation result message</td>
</tr>
<tr>
<td>PA</td>
<td>Participation agreement</td>
</tr>
<tr>
<td>VXU</td>
<td>Immunization data</td>
</tr>
</tbody>
</table>

8
Measure Name: NTSV Cesarean Delivery Rate

Background:

California Maternal Quality Care Collaborative (CMQCC) calculates a standardized measure that assesses the rate of Cesarean births, focusing on the all-important first birth. This measure is known as the Nulliparous Term Singleton Vertex (NTSV) Cesarean Birth Rate. It identifies the proportion of live babies born at or beyond 37 weeks of gestation to women in their first pregnancy, which are singleton (no twins or beyond) and which are in the vertex presentation (no breech or transverse positions), via Cesarean birth. The United States Department of Health and Human Services, in its Healthy People 2020 project, simplified the name for non-obstetric audiences as “Low-Risk Cesarean Birth Among First-Time Pregnant Women.” This is somewhat imprecise, as there are some higher-risk patients who remain in the denominator but have very little impact.

The Joint Commission subsequently adopted this metric in 2010 and now requires all hospitals with more than 300 births to report their results as part of the Perinatal Core Measure Set. The metric has also been adopted by the Leapfrog Group and the Centers for Medicare and Medicaid Services. Several states also require hospital reporting as part of their Medicaid quality initiatives. The NTSV Cesarean Birth measure was re-endorsed as one of the National Quality Forum’s (NQF) Perinatal and Reproductive Health measures in 2016, and the Joint Commission is now the steward of the measure.

Methodology:

Hospitals with maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting and sign a CMQCC authorization release to share hospital-level results with IEHP by February 15, 2019 (if an authorization of release was not signed prior).

Hospitals with no maternity service lines are not eligible to receive incentive dollars for this measure.

All hospitals that participate in the IEHP Hospital P4P Program must report their rates according to the CMQCC reporting guidelines and timeframes, and must authorize CMQCC to give IEHP access to the reported rates. IEHP will receive hospital-specific rates from CMQCC according to the reporting timeline noted in the “Payment Methodology Section.”

A lower rate in this measure indicates better performance.
**Measure Name:** Physicians Order for Life-Sustaining Treatment (POLST) Registry Forms Submission

**Background:**

A Physicians Order for Life-Sustaining Treatment (POLST) Registry is a repository that hosts digital POLST forms and makes them accessible via various digital platforms. Physicians can access the digital POLST forms on demand throughout the continuum of care without any administrative delay. Integrating the POLST Registry into a hospital's electronic health record (EHR) facilitates usage of the POLST form. The registry is available to hospitals, skilled nursing facilities and the Inland Empire Health Information Exchange (IEHIE), as well as mobile and web technologies. Access, at any given time, will ensure that a patient’s end-of-life treatment wishes are honored.

IEHP has engaged the California POLST Registry to connect a digital POLST form network throughout the Inland Empire, linking hospitals, skilled nursing facilities, the HIE and independent Physicians. Each participating hospital must enter into an agreement with the California POLST Registry to integrate the POLST Registry into its EHR. Please contact:

- California POLST Registry
  - Email: support@capolstregistry.org
  - Phone: (888) 621-4383

This measure is based on the percentage of POLST Forms submitted by a hospital out of total IEHP admissions for adult Members per quarter.

**Numerator:**
Number of POLST forms submitted per hospital each quarter.

**Denominator:**
Total number of IEHP adult admissions for the quarter per hospital.

**Measure Goal:**
POLST forms submitted for at least 10 percent of the total adult IEHP hospital admissions per quarter.
Measure Name: Plan All-Cause Readmissions (PCR) Observed-to-Expected Ratio

For IEHP Members 18 years of age and older, the number of acute inpatient stays during the measurement period that are followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Description:
The Healthcare Effectiveness Data and Information Set (HEDIS ®) modified measure called “Plan All-Cause Readmissions” (PCR) is utilized to determine the 30-day readmission rate for IEHP Hospitals. Data are reported in the following categories:

1) Count of Index Hospital Stays (IHS) (Denominator)
2) Count of Observed 30-Day Readmissions (Numerator)
3) Count of Expected 30-Day Readmissions
4) Observed-to-Expected Ratio

The Observed-to-Expected Ratio (O/E Ratio) is the final measure used to determine hospital performance.

Count of Index Hospital Stays (IHS):
Count of all acute inpatient discharges on or between January 1 and December 31 of the measurement year (2019). The index stay must occur at the hospital being measured.

Count of Observed 30-Day Readmissions:
Count of all acute readmissions for any diagnosis within 30 days of the Index Discharge Date. The readmission can occur at any hospital, including a hospital separate from the hospital being measured.

Count of Expected 30-Day Readmissions:
The count of expected readmissions is determined in 2 steps:

1) Calculate the Estimated Readmission Risk for each IHS by summing the following risk adjustment weights:
   • Age/gender
   • Surgeries
   • Discharge clinical condition
   • Comorbidities

2) Sum the Estimated Readmission Risk for all IHS in the reporting period
**Observed 30-Day Readmissions Rate:**
The Count of Observed 30-Day Readmissions divided by the Count of Index Hospital Stays.

**Expected 30-Day Readmissions Rate:**
The Count of Expected 30-Day Readmissions divided by the Count of Index Hospital Stays.

**Observed-to-Expected Ratio:**
The Rate of Observed 30-Day Readmissions divided by the Rate of Expected 30-Day Readmissions.

**Exclusions:**
The following discharges are excluded from the measure:

- Principal diagnosis of pregnancy
- Principal diagnosis of a condition originating in the perinatal period
- Member died during the stay
- Nonacute inpatient stays
- Hospice care
- One-day stays
- Principal diagnosis of maintenance chemotherapy
- Principal diagnosis of rehabilitation
- Organ transplant
- Potentially planned procedures without a principal acute diagnosis

To be eligible for this measure, Members must be enrolled with IEHP 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date. No gap is allowed during the 30 days following the Index Discharge Date.

**Minimum Hospital Denominator Requirement:**
Count of Index Hospital Stays must be 20 or greater for this measure to be eligible for payment.
Measure Name: Post-Discharge Follow-Up Within Seven Days of Discharge for High-Risk Members

For High-Risk Medi-Cal Members, 18 years of age and older, the number of discharges during the measurement period that are followed by an outpatient visit within seven days.

To identify high-risk Members, IEHP employs the Johns Hopkins ACG System, which uses data from the prior 12 months to generate predictive risk scores for the next 12 months. The ACG System measures the morbidity burden of patient populations based on disease patterns, age and gender. A key strength of the ACG System is its ability to capture the interrelationships between co-occurring morbidities, which are the hallmark of the chronically ill populations that pose the greatest demands for health care resources. The clinical and statistical algorithms by which billions of potential disease combinations are distilled down to a fixed number of health status categories is the essence of the ACG System. IEHP uses the ACG System to harness the power of the ambulatory and inpatient diagnostic information as well as pharmaceutical information to risk-stratify the entire IEHP membership.

For the purpose of high-risk Member stratification, IEHP uses the ACG predictive marker called, “Probability of High Total Cost.” This marker predicts the probability of a Member being in the top 5 percent of the total high cost for IEHP in the next 12 months. Because of the robust algorithms used by the ACG System, individuals with short acute episodic utilization of the health care system are not part of the top 5 percent of the total high-cost population. The top 5 percent of the total high-cost population includes individuals with multiple chronic conditions and comorbidities who often require extensive utilization of the health care system. They demonstrate the need for timely post-discharge follow-up with a Primary Care Provider. 

For the purposes of this measure, IEHP considers high-risk Members to be those who have a probability score of ≥0.5 for being in the top 5 percent of the total cost.

Denominator:
All acute and nonacute inpatient discharges during the measurement period for high-risk Members.

IEHP utilizes the HEDIS® modified measure denominator specifications for Medication Reconciliation Post Discharge (MRP) to determine the initial denominator. Once these Members and discharges have been identified, the denominator is further refined to only include those Members who meet the high-risk criteria of a Probability of High Total Cost value of ≥ 0.5 on the date of discharge.

To be eligible for this measure, IEHP Members must be enrolled with IEHP on the date of discharge through 30 days after discharge (31 total days).
Note:
If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), only the last discharge is counted.

Minimum Denominator Requirement:
Denominator must be 10 or above for this measure.

Numerator:
High-risk Members who had a follow-up visit with a practitioner within seven days of discharge.

Exclusions:
The following are excluded from the measure:
- Hospice
- Skilled Nursing Facilities (SNF)
To view an IEHP Member’s current “Probability of High Total Cost” Risk Score, hospitals can log in to the IEHP Secure Provider Portal and follow these steps:

1. From the “Home Screen,” click on “Eligibility”

2. Enter the Member ID and Click “Search”

3. Click on the “Chart” icon

4. View Member Risk Score: “Probability of High Total Cost”