PAY FOR PERFORMANCE:

NAVIGATE THE RISKS, MAXIMIZE THE BENEFITS, PREPARE FOR THE FUTURE

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About Vista Community Clinic

OUR MISSION: To advance community health and hope by providing access to premier health services and education for those who need it most.

8 Site FQHC with locations in San Diego, Riverside, and Orange Counties

- 66,000 patients served
- 263,000 patient visits
- $60M annual budget
- 8 Managed MediCal Plans (5 in San Diego County, 1 in Orange (and 4 Networks), 1 in LA County, 2 in Riverside County)
- Participate in a Commercial IPA and Clinically Integrated Network in San Diego County

Managed Care Incentives – where are we?

- Where we were:
  - Traditional Plan Incentive Programs – primarily transactional
    - Submitting Encounters (capitated plans)
    - Well Child Visits
    - Tests and Services (ie. cervical cancer screening)
  - Plan incentivizes Provider in order to affect HEDIS scores
  - Little follow-up/tracking by Provider
  - 2015-2016 – Large MCE Incentives from some plans were passed down to providers
    - Resulted in strong bottom lines for many Health Centers

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Managed Care Incentives – where are we?

- Where we expected to be:
  - Payment Reform – Value instead of Volume
    - Value incentives – measurable impact on patient health
    - Incentives to help Providers improve population health – ie. Bonuses to add Care Coordination, PCMH Incentive, Patient Experience Bonuses, etc.
    - PCP is a Partner in order to bring down the total cost of care (and should benefit from shared savings)
    - Where US Healthcare is headed now!
- Where we are:
  - We are still in the old world – but being expected to achieve outcomes like we are in the new (plus traditional style of incentives are at risk)

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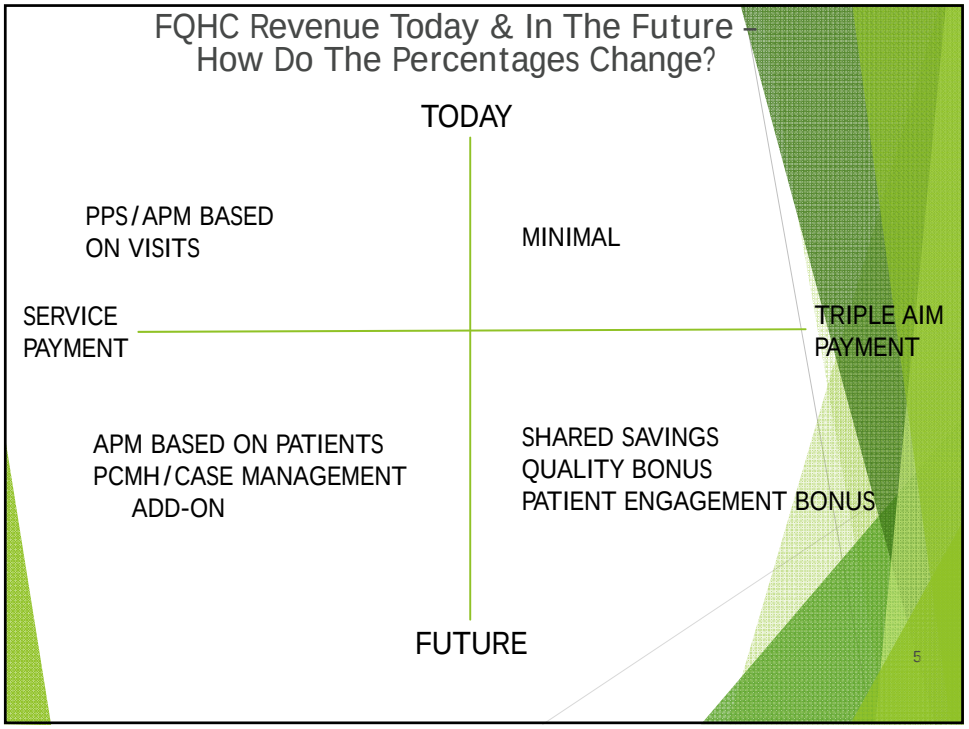
FQHC Revenue Today & In The Future – How Do The Percentages Change?



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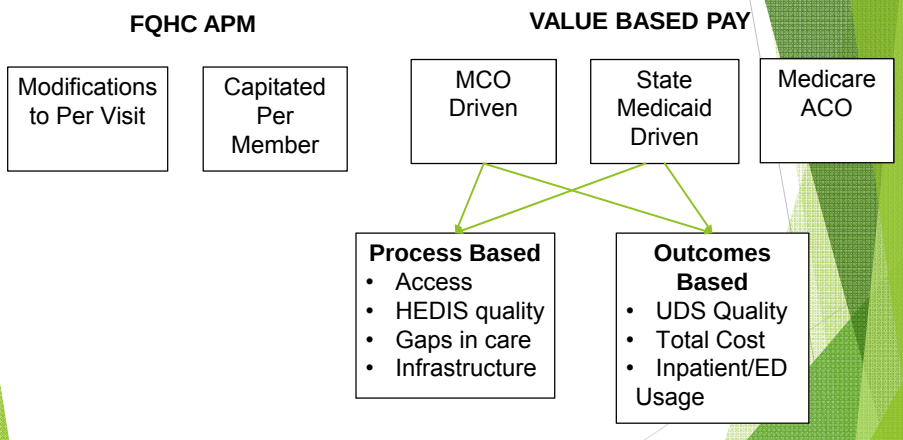
Types of Payment Reform



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Types of Pay-For-Performance

- Process Based – the provider is paid for certain specific actions, such as seeing patients within a certain time from assignment, or sending in data
- Outcomes Based
  - Typically based on Triple Aim (total cost of care, quality, and patient experience – access and customer service)
  - Total cost of care may be the primary driver. If not total cost of care, this measure if often broken into component parts such as:
    - Inpatient admissions
    - Readmission
    - ED utilization
    - Pharmaceutical cost
- Note that quality measures may be both process (did the health center provide appropriate care) and outcomes (diabetic hemoglobin)

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Requirements For Success In Pay For Performance

- Good performance – health center
- Good performance – health center members outside of health center
- Good data – health center
- Good data – plan
- Ability to locate/change behavior of all ASSIGNED health center members

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Cost vs. Non-Financial Benefits – a Current Dilemma

Staff groups added over the past few years that are key in a value based payment world, but are non-revenue producing (compensation includes fringe):

Staff Group		FTEs	Annual Comp
Nursing	additional	9.0	$ 800,000
Patient Engagement	new	4.0	$ 160,000
Care Coordination	new	13.0	$ 560,000
Clinical Informatics	new	3.5	$ 330,000
Population Health/QI	new	3.0	$ 250,000

Staffing additions total over $2 million in annual expense…

We have also added Scribes over the last year, but the primary goal there is Provider Retention and Satisfaction.

Total health center budget - $60 million

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Data in Pay For Performance

- Data in pay for performance is from the payor's system. Thus the data is not self-reported, even if health center reports (bills) are a source of some of the data
- In pay for performance, the data may be as important as the performance; i.e. bad data can misrepresent good performance

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HEDIS Medicaid Quality Measures

- Children immunization
- Adolescent immunization
- HPV for female adolescents
- Lead screening in children
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening
- Pharyngitis testing for children
- URI treatment for children
- Antibiotic avoidance adlt bronchitis
- Spirometry testing for COPD
- Pharmacotherapy mgmt of COPD
- Initiation & engagement for AOD
- Timeliness of prenatal & postpartum
- Frequency of adolescent care
- ED visiis
- Follow up on ADHC meds
- Use of asthma meds
- Asthma med mgt
- Asthma medication ratio
- Cholesterol mgmt for CV conditions
- Beta blocker after heart attack
- Comprehensive diabetes care
- DMARD therapy
- Imaging studies for low back pain
- Antidepressant med mgmt
- MH hospitalization f/u
- Monitoring for persistent meds
- Adult access to preventive/ambulatory
- Child access to PCP
- Frequency of prenatal care
- Frequency of well child visits
- Annual dental visits
- Developmental screening

Calculation Methodology

- Numerator – services from claims database. HEDIS criteria looks for specific CPT and ICD codes
- Denominator – "attributed" patients meeting criteria for each measure
- Measures are not 'use' rates, i.e. services per patient, but rather a measure of % of patients who received indicated service.
- Calculation is called administrative measure
- MCO may calculate hybrid measures, using chart reviews for certain measures. Hybrid measure performance is usually better than the administrative measure. However sampling methodology allows for limited chart review
- Different process for outcomes measures such as diabetic or hypertension control

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Potential Points of Data Failure

- Provider not recording the service
- Provider not recording the service with code (chart only)
- Provider not using code required by HEDIS or other analytics system
- Provider not recording code in PM/EHR
- FQHC not billing/recording code on claims (for example PAP immunizations)
- Reported code not making it into MCO's system

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Key Elements of Pay for Performance Attribution

- The key question, for pay-for-performance & population health is *Who Are Our Patients?*
- Current UDS definition (patients seen in a calendar year) is much different than the typical P4P definition
  - Patients who didn't need to be seen in a year
  - Patients who visited multiple PCPs
  - Assigned by payor but not seen by CHC (this figure is 60% at some CHC sites)
  - Regularly seen at CHC but assigned to someone else
- Many health centers experience large patient turnover (30% +) per year, that is 30% of their patients are new even when they don't grow

Patient Attribution – Who Are Our Patients?

- The payor's assignment list is used for all calculations – what were the costs of patients, who used the ED, what are the quality measures
- It takes substantial infrastructure to get it right, i.e. for the patient list to match the population that the health center feels they can manage:
  - Current financial impact is having to return capitation (little impact in fee-for-service)
  - Not included in UDS quality measures
  - Need to obtain correct demographic data for these patients. Work with MCO to determine if they are actually seen by another PCP.
  - If health center can get historical claims information, perhaps prioritize patients: 1. ED and inpatient follow-up, 2. patients who are not well and need to seen, 3. patients needing a health maintenance service, 4. healthy patients

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Impact of Assigned But Not Seen on Plan Quality Calculation

Well Child Exams in the First 15 Months of Life		
	HEDIS Score	
Overall Plan Performance	70%	
Required to Earn P4P Revenue	77%	
Health Center Performance		Patients
Plan Assigned Patients - Seen by CHC	80%	500
Plan Assigned Patients - Not Seen by CHC	70%	300
Total CHC Performance	76%	800

UDS vs. HEDIS – Sample

	Attributed Not Seen	Timely Entry Into Prenatal Care		Childhood Immunzation*	
		UDS	HEDIS	UDS	HEDIS
Health Center A	11%	74%	48%	68%	1%
Health Center B	11%	85%	66%	93%	0%
Health Center C	12%	86%	60%	84%	0%
Health Center D	9%	56%	53%	97%	1%
Statewide Administrative			59%		4.7%
Statewide Hybrid					64.7%

*Combination of Dtap, IPV, MMR, HiB, HepB, VZV, PCV

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What Drives Total Cost of Care?

Top (Costly Pts):	10%	20%	Everyone Else
# of Pts:	11,539	23,078	92,311
% of Total Costs:	59.3%	75.1%	24.9%

How many cases can a case manager manage to change behavior?

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A CHC Provider's Take on High Cost Patients

There were 101 high cost patients. Of these, 25 are "not currently attributed" to this CHC. Of the 76 attributed patients, 14 were children, 62 adults.

All of the 14 children were high need/intrinsically high cost - 2 with hemophilia (one with physical and sexual abuse), 5 complicated preemies, 2 cancers (malignancies), 2 severe autism/developmental delay, 1 cystic fibrosis with liver transplant, 1 severe ulcerative colitis with colectomy. The only one with asthma also has psychosis.

We can identify the 62 adults by the clusters of conditions which are the highest cost:

- HIV, Hep C, Substance Abuse
- Cancer
- Advanced Age with multiple conditions
- Severe mental illness plus or minus other health conditions
- Neurodegenerative disorders
- Dialysis, transplants

I find it hard to imagine how to impact their costs. There are about 2-3 adults who have problem lists and medication lists that are not huge, and for whom it is not totally evident why their costs are high. Each of these has home care services, which may be a major contributor to their cost.

Risk Adjustment in Infrastructure Programs – a Sample

- Three payment tiers in the P4P program:
  - Tier 1 - $1 PMPM – healthy, history of significant acute disease (chest pains), single minor chronic disease (migraine)
  - Tier 2 - $8 PMPM – minor chronic disease in multiple systems, significant chronic disease, significant chronic disease in multiple organ systems
  - Tier 3 – $22 PMPM - dominant chronic disease in 3 or more organ systems (diabetes mellitus, CHF, and COPD), dominant mestatic malignancy , catastrophic
  - Relies on coding
  - Relies on accurate managed care data capture

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Projecting P4P Revenue

- Consult the CMO and COO in making revenue projections!
- Dependent on data quality AND current performance
  - If currently meeting the measures, may be likely to keep meeting measures
  - If not meeting the measures, define what level of intervention/expense is necessary, the likelihood of changing performance, and the expected outcome (but unlikely to get direct cost benefit – if we hire 1 more case manager at $60,000, by how much will total cost of care decline?)
- Success stories from best practice health centers may not apply to you
- Be conservative! $0 is a good starting point

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Sample Payment Report

Incentive Category	MCO Standard	CHC Score	CHC Against Standard	P4P Earned
Discharges per 1,000*	70	74	(4)	$ -
ER Usage Per 1,000	597	427	170	$ 10,000
Encounter Reporting	81%	87%	6%	$ 10,000
HEDIS Measures				
- Breast cancer screening	21%	28%	7%	$ 4,000
- Well visits	80%	89%	9%	$ 4,000
- Cervical cancer screening	10%	14%	4%	$ 4,000
Total				$ 32,000
* Excludes maternity				

Financial/Operational/IT Concerns on Pay-For-Performance

- Today, P4P revenue is often insufficient to generate a positive return in a cost-benefit analysis
- P4P payment pool may be based on factors other than CHC performance (such as healthplan profitability), thus payment is not guaranteed
- P4P measures may not be tied to the primary driver of revenue (i.e. maximizing billable visits) and in fact may be at odds (longer preventive visits vs. easy visits)
- Often requires monitoring HEDIS in addition to UDS quality measure (without ability to vet accuracy of data in healthplan's claim system)

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Financial/Operational/IT Concerns on Pay-For-Performance

- It appears to be difficult to immediately change the outcomes that impact P4P measures
  - Much of the data is external with a managed care plan
  - That data is not received on timely basis that allows for actionable change
  - That data does not reside in the CHC's primary clinical data system (the EHR)
  - Patient assignment often includes patients who have never been to the health center
  - Staff (both the health center's and the healthplan's) don't understand the P4P program

Therefore, in preparation for P4P, and the first year of the program, the emphasis should be on getting the data right

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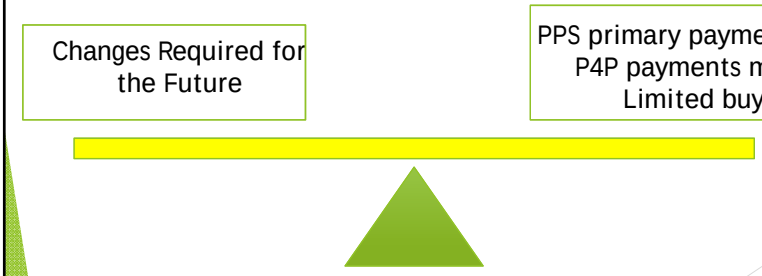
The Balancing Act
2017 - 2020



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Pay for Performance: Navigate the Risks, Maximize the Benefits and Prepare for the Future

COMMUNITY CLINIC ASSOCIATION

March 2, 2018

Lawrence Garcia and Steven Rousso

WIPFLI LLP CPAs and Consultants HEALTH CARE PRACTICE

HFS consultants

KRONICK MOSKOVITZ TIEDEMANN & GIRARD

OVERVIEW

- What are incentive payments and what your clinic should do to keep A&I from taking them!
- CMS, A&I Audits, San Mateo and P4P
- “It’s not their money”
- Follow the performance metrics and incentive payment definitions in your agreement with the health plans
- “They don’t have a list”
- Document Incentive Payments and Criteria
  - - Proactive versus Reactive

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CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

UNIQUE LEGAL RISKS FOR FQHCS

The receipt and failure to report *value-based* payments by FQHCs presents legal risks.

- **Wrap-Around Payments and Reconciliation Process**
  - FQHCs can be determined to have received "*overpayments*" if they do not properly report revenues and supplemental revenues in their Medi-Cal Reconciliation Process
  - Because of a "dearth" of regulatory guidance on whether value-based payments should be reported in the Reconciliation Process, ambiguity exists on whether value-based payments must be reported by FQHCs
- **FQHC Risks arising from this ambiguity are both Financial and Legal**
  - Potential need to payback payments to State in Reconciliation process if value-based payments are regarded as "*overpayments*"
  - Repayments can be significant and have an adverse impact upon the both the cash position and financial performance of FQHC
  - Because Reconciliation Process involves a formal "request for payment", the **60-Day Rule** can create a *False Claim* by the FQHC

LITTLE LEGAL GUIDANCE ON REPORTING DUTIES

- **Definition of Overpayment**. Overpayment must be identified and capable of quantification
  - Key issue is the date on which the overpayment begins to run
    - Duty to make a reasonable inquiry with *all deliberate speed* after learning of circumstances leading to the overpayment
    - Examples include: (i) incorrect coding error, (ii) patient death and billing continues, (iii) services provided by unlicensed or excluded provider, (iv) findings from internal audit reviews, (v) notice of government audit or investigation, (vi) learning the incentive payments must be reported in Reconciliation Process because they do not qualify for exclusion.
- **Implications**. 60-Day Rule can transform a "mere" overpayment into a False Claims Act violation if provider "knows", "should know" or "acts with willful blindness" to receiving an overpayment and does not refund it
  - Governmental audits can uncover overpayments not properly reported
  - Whistle blowers can recover a percentage of overpayments under a *Qui Tam* action
  - This legal exposure is NOT academic
- **Legal Risks**. False Claims Act Remedies are "Draconian"
  - 3X Overpayment
  - $11,000 Claim
  - Exclusion from Medicare/Medicaid Programs for both CHC and officers

2016 REGULATIONS IMPOSE THE 60-DAY RULE

- Regulations were issued on February 16, 2016
  - **Adoption**. After years of public comments, regulations were adopted specifically for Medicare and have application to Medi-Cal payments until a set of Medicaid regulations are adopted.
  - **Rule**. A provider that has received an "*overpayment*" **must** report and return the overpayment within 60 days of identification.
  - **Overpayment Identification**. Under the regulations, an "*overpayment*" has been "identified when "a person has, or through the exercise of reasonable diligence, determined that the person received an overpayment *and quantified the amount* of the overpayment."
  - **Deadline**. The deadline for reporting and refunding overpayments is the later of (i) 60 days after the date on which the overpayment was identified, or (ii) the date any corresponding cost report is due, if applicable.
  - **Reconciliation Payments**. The filing of Medi-Cal Reconciliation Reports represents a formal request for payment and can track the date on which an overpayment should have been identified before the request for payment, and certification, are made.
  - **Look-Back Period**. The regulations require a 6 year "*look back*" period from the date that the overpayment was received.

LESSONS FROM THE SAN MATEO CASE

On January 12, 2017 the Department of Health Care Services issued its opinion ("Opinion") on an appeal of a previous ALJ hearing which found in favor of the providers.

- The findings from the Opinion offer a few narrow and restrictive view of the types of incentive payments that an FQHC may exclude from its reporting obligations under the Reconciliation Process.
  - Payment for performance measures that pay for individual services are not to be excluded
  - Payment for performance measures that pay for improvements to clinical care or improving access to care are not to be excluded
  - Payment for performance measures that pay for the investment in care management infrastructure or improved clinical reporting are likely not eligible for exclusion unless a *direct link* can be made to lowering the cost of care
- The findings from the Opinion focus almost exclusively on utilization outcomes and reductions in patient costs.

A&I IS USING SAN MATEO CASE IN P4P INCENTIVE DENIALS

San Mateo Medical enter FQHCs ET Al. vs, DHCS appeal decision

- Audits reviewed the Final Decision from appeal case FQ14-0610-745B-LM, San Mateo Medical Center, which discussed the departments position on the inclusion of incentive payments with the total Pay-4-Permance managed care payments. The final decision of the Department states that an incentive payment must be linked to a reduction of unnecessary utilization of services or otherwise reduce patient costs. *"The P4P program encourages usage of services, promotes billing opportunities, increases patient costs, and is not tied to any utilization outcome"*
  - *Taken from a health center's PPS recon audit letter*

A&I QUOTES ON PPS RECON REVIEW

- *"These amounts paid to the provider do not qualify as "incentives" because they are not paid for the reduction of services or patient costs. Therefore audits will include them as part of the reconciliation review"*
  - ???? What?

    - *"Due to insufficient evidence that the incentive payments are not related to utilization efforts, audits will propose an adjustment"*

CMS IS ON YOUR SIDE

The September 27, 2000, CMS sent letters out to the State Medicaid Directors

- *"MCO's frequently use their **own funds** to include financial incentives in their contracts with subcontracting providers. Financial incentives provide the subcontractor with an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs"*
  - *Final decision in San Mateo case used this "absolute" definition*
- *"Incentives may be negative or positive" depending on desired outcome and performance*

INCENTIVE PAYMENT REGULATIONS

- *Therefore, 42 CFR 405.2469(a)(2) states: "Any financial incentives provided to Federally Qualified Health Centers under their Medicare Advantage Contracts, such as risk pool payments, bonuses, or withholds, are **prohibited** from being included in the calculation of supplemental payments due the Federally Qualified Health Center"*

CMS RULE ON INCENTIVE PAYMENTS - 2016

- In a recent final rule governing Medicaid managed care, CMS reiterated that ***FQHCs*** are to receive financial incentive payments from Medicaid managed care plans on top of the full PPS payment resulting from the supplemental payment: "FQHCs and RHCs are required by statute to be reimbursed according to methodologies approved under the State plan. **In the event a particular financial incentive arrangement related to meeting specified performance metrics for these providers is part of the provider agreement with the managed care plan, those financial incentives must be in addition to the required reimbursement levels specified in the State plan.**"
- *"Without regards to the effects of financial incentives that are linked to utilization outcomes or other reduction in patient costs"*
  - ***section 1902(a)(13)(C)(ii)***

EXCLUDING PAYMENTS FROM THE PPS RECON

- *If it is determined that the specified performance metrics and incentive payment exclusion list meet the criteria (as documented in the PSA), the incentive payments need **not be reported** and thus, **excluded** from the PPS reconciliation*
  - *Steven Rousso, circa 2018*

WILL A&I MAKE YOU INCLUDE THE INCENTIVE PAYMENTS ON THE PPS RECON?

- *If A&I makes you include the incentive payments on the PPS reconciliation, go immediately to informal appeal and show these regulations and agreement with the health plan*
- *A&I will not want this to go to formal appeal as this will set a precedent*
  - *A&I will negotiate a settlement*

KEY DATA TO REVIEW BEFORE MAKING INCENTIVE PAYMENT DETERMINATION

- *PSA (Professional Services Agreement)*
- *Description of the Incentive Payment Program describing the eligibility of the FQHC to receive payments*
- *The transmittal of any payment requests from the FQHC to the Plan along with any data and supporting information accompanying the request, and…*
- *The transmittal documents from the Plan to the FQHC making payments*

APPLICATION OF SAMPLE CRITERIA FOR INCENTIVE PAYMENT INCLUSION

- *Payments (**performance metrics**)are designed advance population health management objectives or other clinical goals of the plan*
- *Payments must not be for services to plan enrollees for which the FQHC has been paid by the health plan for the delivery of patient care services*
- *Payments are "at risk" for pre-established clinical performance objectives or only payable if established performance standards are met by the FQHC*
- *Payments are grants from the plan or otherwise are designed to meet an important public purpose*

SAMPLE - ED DIVERSION

- ***Description**: ABC Clinic contracted with primary care providers within their plan to offer an incentive grant to decrease the inappropriate utilization of ED care. Participating providers such as ABC clinic were given a detailed report of ER utilization by all eligible enrollees – benchmark period*
- ***Measurement/Objectives:** ABC clinic provided quarterly reports outlining enrollee ER usage to track utilization. At the end of the period, participating providers would receive 50% of the overall PMPM reduction - compared to benchmark period*
- ***Payments:** On December 29, 2014, ABC clinic received a one time payment for achieving objectives of $811,000.*
- ***Copy of check is enclosed.***

EXAMPLES OF OTHER INCENTIVE PAYMENTS

- *ED Diversion & Shared Savings Program*
- *Comprehensive Hepatitis C Program*
- *Safety Net Provider Incentive Program*
- *Provider Recruitment and Retention Grant*
- *Pay for Performance*****

- *Buckets of Incentives – keeps DHCS from making all inclusive incentive denial like the way did in the San Mateo case*
  - *Buckets within buckets!*

BOTTOM LINE

- *Document Clinic incentive payments and performance metrics*
- *Inform DHCS they are not included in PPS reconciliation*
- *Document Exclusion Criteria*
- *Document Incentive Program and Associated Payments*
- *Send in the CMS regulations*
- *And ask A&I, where is their list?*
- *And if all else fails, take them to informal appeal*

- *April 27th, 10:00 a.m., Sacramento – San Mateo Case will be heard*

WIPFLI CPAs and Consultants HEALTH CARE PRACTICE HFS COMMUNITY CLINIC ASSOCIATION OF SAN MATEO COUNTY KRONICK MOSKOVITZ TIEDEMANN & GIRARD

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QUESTIONS

WIPFLI CPAs and Consultants HEALTH CARE PRACTICE HFS COMMUNITY CLINIC ASSOCIATION OF SAN MATEO COUNTY KRONICK MOSKOVITZ TIEDEMANN & GIRARD

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California Primary Care Association

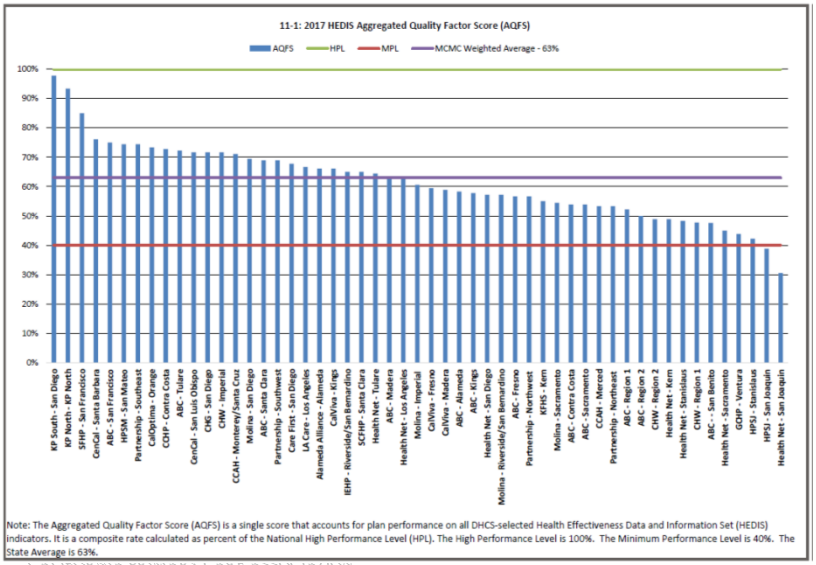
FQHC Incentive Payments: Aligning the Delivery System

Overview of P4P in Medi-Cal

- California's Department of Health Care Services (DHCS) monitors plans' quality of care, access to and timeliness of services.
  - External Accountability Set - Reporting on selected HEDIS measures.
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) Consumer satisfaction surveys

Plans have implemented pay for performance (P4P) programs for their providers to drive improvement in the quality of care and patient experience of their members

Overview of P4P in Medi-Cal



CALIFORNIA PRIMARY CARE ASSOCIATION

FQHCs & P4P Incentives

- Pressure points can be aligned – MCPs *want* to incentivize performance
- MCPs and IPAs can be partners
- Implementing best practices to minimize likelihood of DHCS "reconciling" P4P payments is in the best interest of MCPs/IPAs AND FQHCs

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CPCA Responds to San Mateo

- Outstanding Question: *What constitutes an "incentive" that can be excluded from reconciliation?*
- Workgroup of experts developed White Paper with best practices
- Statewide "Cleanup" to ensure that all FQHCs utilize best practices and NO ONE is in danger

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"Rules to live By"

1. Plan payments to FQs for primary care must be "no less" than plan pays other similar primary care providers
2. P4P payments should be completely separate from payments for services (cap or FFS)
3. Clear documentation of P4P programs and payments

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"Rules to live By"

4. Payments should be "at risk"
5. Incentives should be based on performance measured against a benchmark
6. P4P payments should be independent of providing any individual unit of service that generates a PPS payment
7. Rules apply whether P4P payments come directly from Medi-Cal managed care plan or from the IPA

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Alignment with IHA Core Measure Set

- IHA is leading an effort among Medi-Cal plans and provider organizations to create a standardized measure set for all Medi-Cal P4P programs.
- The voluntary effort aims to "strengthen the signal" from plans to providers regarding high-priority measures, and to reduce measurement burden among providers working with multiple plans.

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Alignment with IHA Core Measure Set

Domain	Measures	NQF #	Type	DHCS Acronym	Alignment*
Cardiovascular	Annual Monitoring for Patients on Persistent Medications: ACE or ARB indicators	0021	Process	MPM-ACE & MPM-DIU	EAS, QRS, CMS
	Annual Monitoring for Patients on Persistent Medications: Diuretics indicator	0021	Process	MPM-ACE & MPM-DIU	EAS, QRS, CMS
Diabetes Care	HbA1c Testing	0057	Process	CDC-HT	EAS, AA, QRS, CMS, NCQA
	HbA1c Control	0575	Outcome	CDC-H8	EAS & QRS
	Eye Exam	0055	Process	CDC-E	EAS, QRS, NCQA
Maternity	Timeliness of Prenatal Care	1517	Process	PPC-Pre	EAS, AA, QRS, CMS, NCQA
Prevention	Childhood Immunizations, Combo 3	0038	Process	CIS-3	EAS, AA, QRS, CMS, NCQA, UDS
	Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life	1516	Process	W-34	EAS, AA, QRS, CMS
	Cervical Cancer Screening	0032	Process	CCS	EAS, AA, QRS, CMS, NCQA, UDS
Respiratory	Asthma Medication Ratio	1800	Process	TBD	EAS, NCQA

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QUESTIONS?

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