PEOPLES HEALTH

Guide to Online Provider Resources

We work closely with our network providers to ensure that their Peoples Health patients receive the highest quality care. That is why we offer valuable resources online, including clinical resources and patient histories. Our goal is to help providers with more efficient chart preparation for more meaningful patient interactions, as well as to improve the health outcomes and bolster the risk scores of Peoples Health patients.

The Provider Portal is easy to use and offers quick access to information you may need from time to time to effectively treat your Peoples Health patients. Join the many providers who enjoy the convenience of using the portal.

We encourage you to explore the online resources described on the following pages. **For more information, contact your Peoples Health representative.**

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Provider Portal Features

The Provider Portal allows you to:

- Search and view claims status, amounts paid, paid dates and claims history
- Submit and view authorizations, as well as respond to clinical-documentation requests
- Verify patient eligibility and coverage information, such as effective dates, assigned primary care physician (PCP), benefit utilization, authorizations, and more
- View and download benefit details and documents, such as the *Evidence of Coverage* and the *Summary of Benefits*
- View a patient's annual maximum out-of-pocket amount
- Submit requests to adjust or review denied claims
- Upload medical records for claims processing or CMS star/quality purposes
- Access the Peoples Health Provider Reference Guide for information about policies and procedures
- View electronic remittance information by paid date
- View negative balance reports

If your office, facility or provider group does not already have an account or active Provider Portal local administrator, visit www.peopleshealth.com/providerportal to create an account or set up an administrator.

If you need access through an already-established portal account, reach out to the local administrator for the account within your office, facility or provider group. For further assistance, email us at phn.providerrelationswebe-@peopleshealth.com.
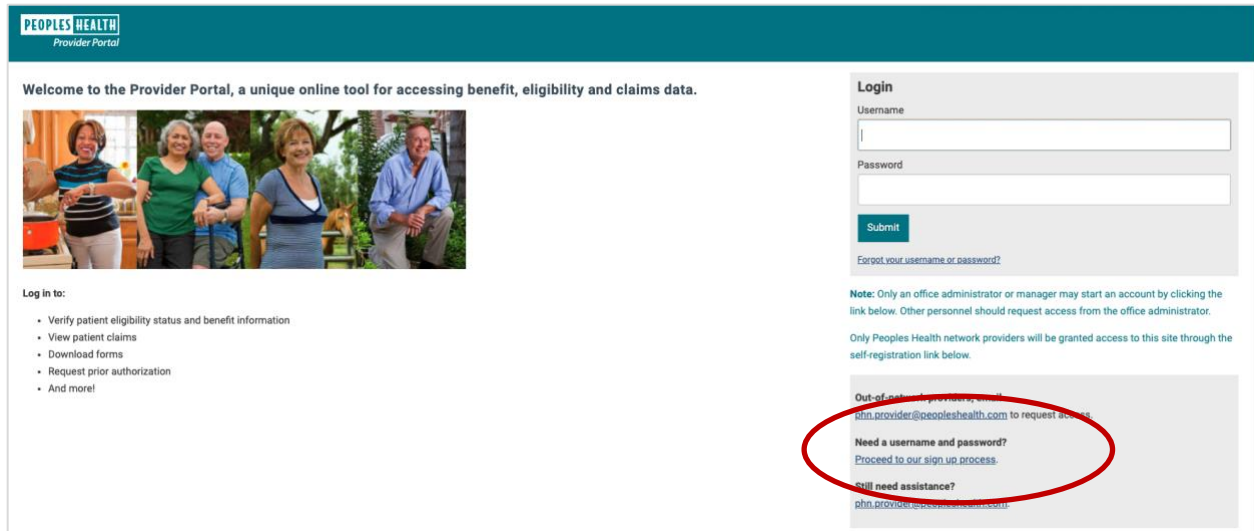
For the best experience, use Google Chrome, Microsoft Edge or Mozilla Firefox to access the portal (which doesn't work as efficiently with Internet Explorer). Be sure to bookmark www.peopleshealth.com/providerportal for easy access in the future.

Create an Account

You will need to create a local administrator account by accepting the website's License Agreement, creating a user login and password, and verifying certain information. A local administrator is a point person for managing the account. To validate your identity, you also need to enter the TIN for the account, as well as a paid claim number associated with the TIN. The claim must have been paid within the last 180 days.

To begin, click **Proceed to our sign up process** on the homepage.

Note: Out-of-network providers must email phn.provider@peopleshealth.com to request access.

Figure 1 - Provider Portal homepage

Step 1: License Agreement
Review and accept the License Agreement.

Figure 2 - License Agreement page

Step 2: Verify Provider Contact Information
Complete the fields to verify your provider details, and click **Add**.

Enter the TIN and a paid claim number associated with the TIN. As already noted, the claim must have been paid within the last 180 days. Click **Add** again. Repeat this for all TINs you want linked to the account. Once you've entered all TINs, click Next.

You can give the user profiles you'll create for authorized personnel in your practice or health care system access to the TINs linked to your account.

Figure 3 - Provider details page, setting up an account

Step 3: Create Login Information for the Local Provider Administrator

Input a username, email address and password for the account. Follow the guidelines on the page for creating a username and password.

Select three unique security questions and enter an answer for each.

You will also need to enable two-factor authentication, using an email address, a mobile phone number or an authenticator app such as Google Authenticator.

To continue, click Next.

PEOPLES HEALTH
Provider Portal

Create Login Information

You will use this information to log in to your user account.
Keep this information stored safely so your account information remains secure.

Username

Email Address

Confirm Email Address

Password

Confirm Password

Username: Must be a minimum of three characters and must start with a letter

Password: Must be at least eight characters; alpha-numeric and special characters "-_.!#$%&*@~^\?/+" are accepted
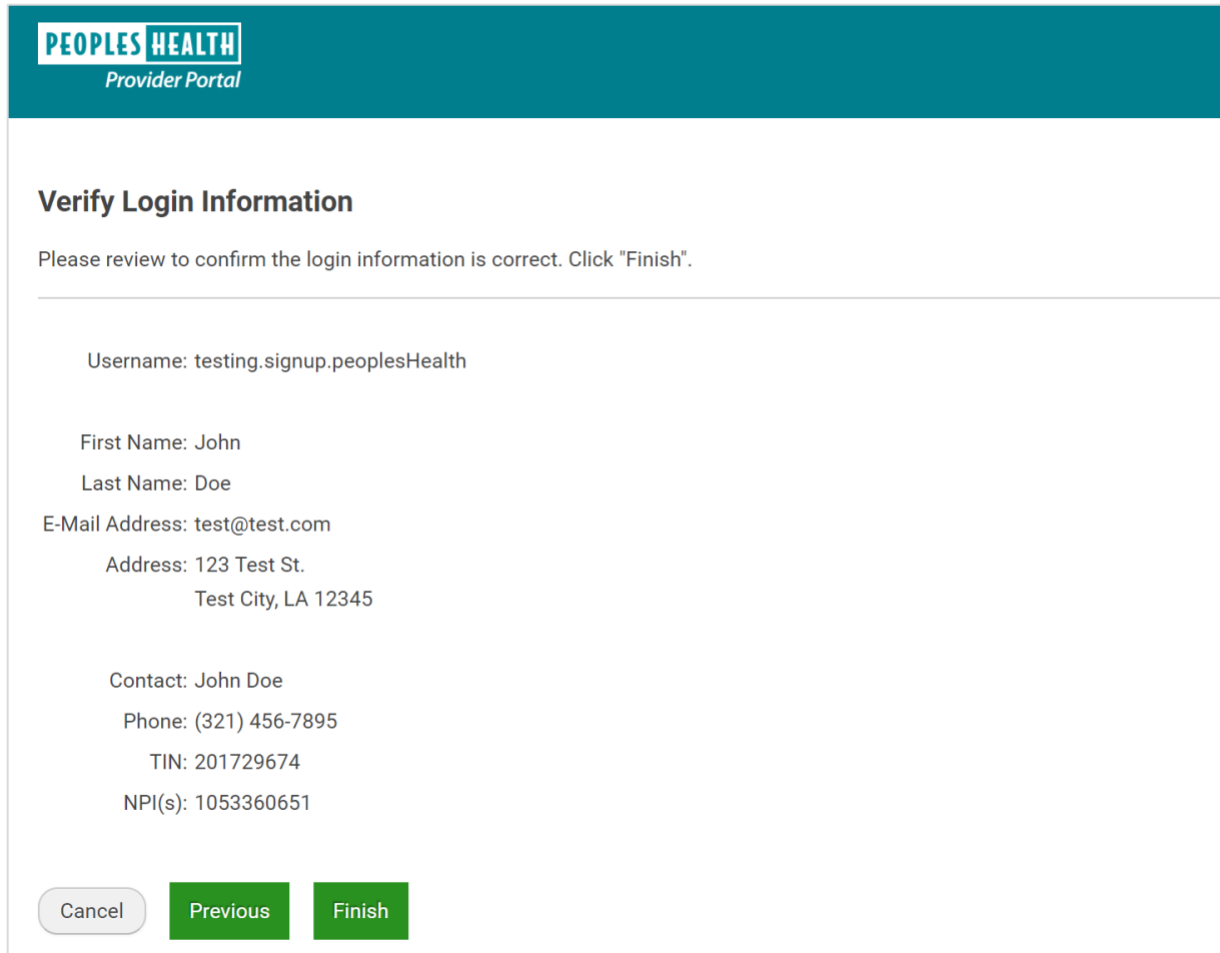
Don't have an email account?
Our Provider Portal requires a valid email address. If you do not have an email address, you may create a free email account with one of these popular providers:

- Gmail
- Yahoo!

Figure 4 - Login details page, setting up an account

Step 4: Registration Complete

On the final page, confirm your information, and click Finish. Peoples Health will reach out to you to sign a Data Access and Confidentiality Agreement. This agreement authorizes your account for access.

Figure 5 - Information verification page, setting up an account

Step 5: Adding Users

Once the account is authorized, the local administrator can create profiles for other users, such as other administrators or billing, back office or front office personnel. Additionally, it is the responsibility of the administrator to deactivate any user who no longer requires portal access or to change the level of access for current users.

To check for or add a user, click the **User Manager** tab. Complete the First Name and Last Name fields to conduct a user search. If the results yield the user, validate the user's email, telephone, level of access and the associated TIN. If no results are found, follow the steps below to create a user account.

Step 1: To add a user, click the Add User **button.**

Figure 6 - User Manager tab, adding users

Step 2: Create a profile for the user.

You must complete the fields with an asterisk, plus select a Keycode option. You will need the user's active email address. We also strongly suggest entering a telephone number and a fax number for the user.

Keycode options are Provider Back Office, Provider Front Office, Provider Billing and Provider Local Admin (local administrator).

The keycode determines the tabs available to the user:

User Type	User Keycode	Provider Portal Access
Provider	**Provider Back Office**	Home, Claims & Payment, Eligibility & Benefits, Authorizations, Resources, Member Viewer
Provider	**Provider Front Office**	Home, Eligibility & Benefits, Authorizations, Resources, Member Viewer
Provider	**Provider Billing**	Home, Claims & Payment, Eligibility & Benefits, Resources
Provider Admin	**Provider Local Admin**	Home, Claims & Payment, Eligibility & Benefits, Authorizations, Resources, User Manager, Member Viewer, Reports

- If choosing the **Provider Local Admin** keycode, you **must** select Provider Admin from the User Type drop-down menu.
- For all other keycodes, choose **Provider** from the drop-down menu.
- **Do not** select any other keycodes or the account will not function as expected.

Complete the profile by selecting the user type and keycode for the appropriate level of access. Do not check or uncheck any boxes under the Account Actions section. Leave the default selections as is. Upon first login, the user will be prompted to update their account password and one security (Hint) question. Click **Add User** when done, **but do not navigate away from the page**.

Figure 7 - User Manager tab, page to input user details and designate account access and actions; ONLY use keycodes pictured

There is a critical step to take before the account setup is complete.

You now need to link the associated provider TIN(s) to the user account.

If you do not complete this step, your account will not function properly, and you will not be able to add TINs after leaving the page.

Step 3: Adding TIN(s)
Click the **Provider Details** link at the top of the page. Then scroll to the bottom of the screen, and click **Add TIN** under the Associated TINs section.

Figure 8 - User Manager tab, Provider Details screen, Associated TINs section

Enter the TIN in the Edit Provider TIN pop-up box, then click **Add TIN** within the pop-up (if you don't click the button within the pop-up, the TIN will not be linked to the account). Complete this step for each TIN associated with your practice. Note that listing NPIs will limit user access in certain systems; only enter TINs on this screen. **Do not change or enter any other information except the TIN.**
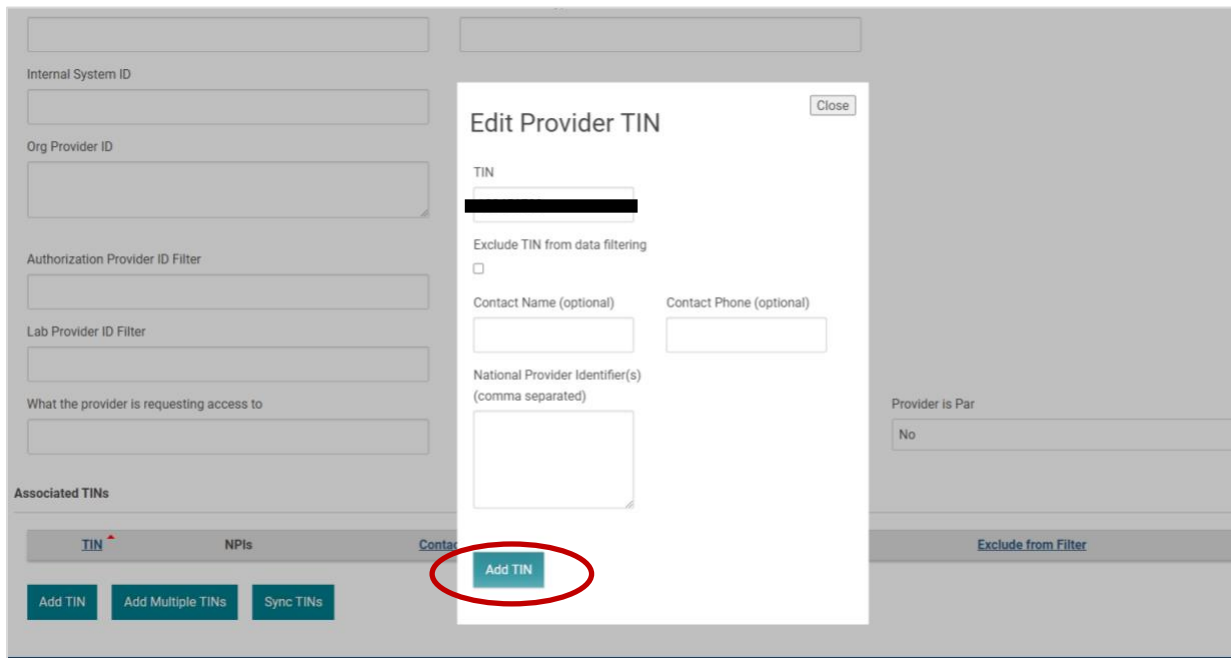
Figure 9 - TIN editing pop-up

Note:

- Provider Local Admins are restricted to adding only TINs they have access to.
- Select the **Imitate** link to test user account access.
- Provide users with their login credentials, along with the following instructions:
    - Log in at www.peopleshealth.com/providerportal using Google Chrome, Microsoft Edge or Mozilla Firefox. Avoid Internet Explorer, as the portal doesn't work as efficiently with it.
    - On first login, you'll be prompted to:
        1. Change your temporary password
        2. Complete the two-factor-authentication process
        3. Select and answer one security (Hint) question
- If users follow these steps, they should have no problems logging in to or navigating the portal. The Provider Portal administrator should be able to answer user questions.

Search Eligibility and Benefits

To retrieve a patient's plan information and eligibility details, select the **Eligibility & Benefits** tab, then enter the patient's member ID number (G number) or enter the patient's last name *and* date of birth. Click the patient's name in the results list.

Note for multi-provider clinics: Use the Filter by TIN drop-down menu to select a specific provider to only view the provider's panel.

Figure 10 - Eligibility & Benefits tab, input search criteria

Verify Eligibility and Benefits

Review the patient's coverage and service accumulators, such as maximum out-of-pocket costs for the year, or click the plan name link under the Coverages heading for current cost-sharing amounts.

Note: The patient's current plan (active coverage) will have an end date of 12/31/9999. If a plan is listed with an end date other than 12/31/9999, the patient is no longer active in that plan.

Also review care plans for members in dual-eligible special needs plans.

Current Patient:

Member

Member:		Plan Name:	CHOICES 65 NORTHSHORE
Member ID:		Status:	Active
Member DOB:		Member Gender:	Male
Member Address:		Member Phone:	
PCP:		PCP Phone:	
Member Responsibility:		COPAY APPLIES	

Coverages

Plan Copay Information: CHOICES 65 NORTHSHORE
Effective Date: 01/01/2023 End Date: 12/31/9999
Medicaid Status: QI

CHOICES 65 NORTHSHORE
Effective Date: 01/01/2022 End Date: 12/31/2022
Medicaid Status: QI

Accumulators

	Met	Amount
In Network Out of Pocket Max	$1,643.18	$4,500.00

	Count Met	Count Require
Annual Wellness Visit	0	1
Bone Density Testing	0	1
Myocardial Perfusion Imaging	0	1

Information for

Show/Hide Search

First Name:

Last Name:

Member ID(s):

Date of Birth:

Search

Care Plan Documents

Filename

Click to view Care Plan

Figure 11 - Sample Eligibility & Benefits page, patient results; new accumulators and additional personal demographic details may not be reflected in the above images

Review Claims and Payments

From the **Claims & Payment** tab, enter a paid date or enter a service date *and* a claim number, a check number or a patient's member ID number (G number) to view claims status and payments. Use the Filter by TIN drop-down menu to filter results. Click the **Download Results** link to export an Excel file of the claims report.

Figure 12 - Claims & Payment tab, sample search results page

In the **Claim Number** column, click the link for a specific claim to view payment or denial details. You can download a printable Explanation of Payment from the claim's details screen. If needed, you can submit a claim appeal by clicking the button at the top left. The appeal form will auto-populate with the details of the claim being viewed. Be sure to include supporting documentation with your claim adjustment request.

Figure 13 - Claims & Payment tab, sample Claim Number details page, claim adjustment request button

Submit Authorization Requests

Under the **Authorizations** tab, click the **icon for the type of services being requested** to access the portal's authorization homepage. For outpatient and inpatient services, follow the steps below, or view the Service Category Tip Sheets for additional instructions. For detailed instructions on how to enter Cancer Treatment requests through Optum's MBMNow, view the CGP Reference Guide.

Figure 14 - Authorizations tab, default page

Select the appropriate tab to submit documentation for a pended authorization, resume work on an incomplete request, review submitted authorizations or completed authorizations, or begin a new authorization. See the next section for how to begin a request.

Figure 15 - Authorizations tab, authorizations portal

Tab funtions:

Action Required - Review pended requests that require additional supporting information before processing. Click on a case, review the notes under the **Notes & Attachments** tab, then follow the instructions to complete the request. Use the blue **Add Notes and Attachments** button to upload requested clinical documentation.

Completed - Check case status, requested service details (including date of service), ordering and servicing providers, and more. Also select this button to request extensions to existing authorizations. Note that you can only request an extension if the authorization date has not expired.

Submitted - Verify requests submitted via the Provider Portal or by fax, and review request status.

Drafts - Resume completion of a draft authorization request that you or your staff previously initiated. Note that when inputting information for an authorization request, if you navigate away from the page or the page times out, the information is automatically saved in the Drafts section. Drafts must be completed and submitted for the request to be processed. The administrator or portal user is responsible for completing or deleting any draft requests.

New Request – Begin a new authorization request.

Export to Excel - Create an Excel report of authorizations submitted through the portal.

Filters - Search for authorization requests by member, service date or servicing provider. You may also search by case number or authorization number, as well as other options. To clear a filter, click the green X.
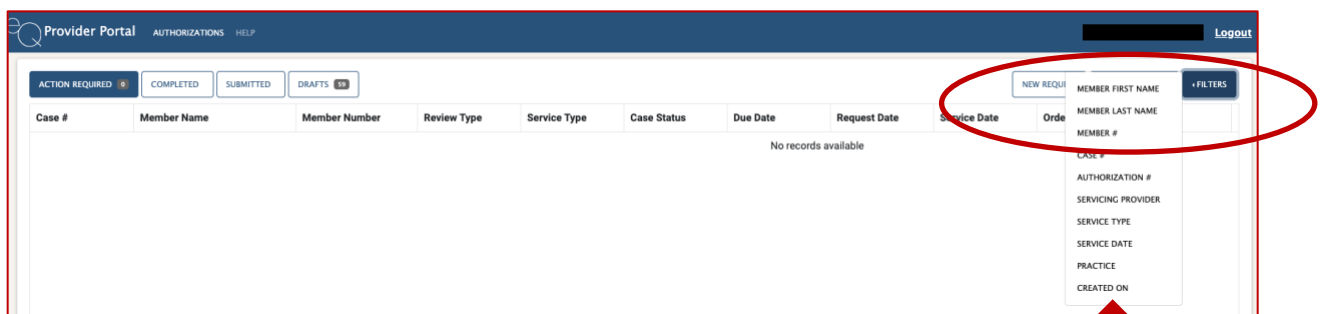
Figure 16 - Authorizations tab, authorizations portal, filters

Begin a New Authorization Request

Click **New Request** to begin an authorization request. Select the TIN if there are multiple providers in your office, facility or group, then click **Find patient…** Enter either the patient's member ID number or the patient's name and date of birth. Click the patient's name in the search results.

Figure 17 - Authorizations tab, authorizations portal, new request, TIN and find patient

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Figure 14 - Authorizations tab, authorizations portal, new request, patient search fields

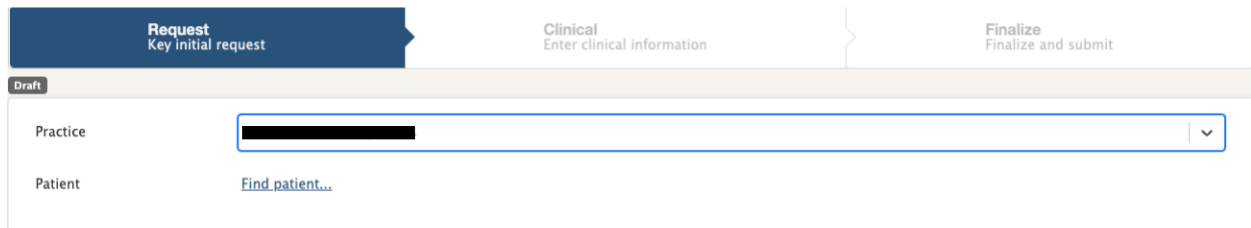Choose from the **Type of Service** options, and select a start date. The start date ensures the patient is eligible to receive services on the date of service or on the beginning date of the authorization span. Complete the remaining fields for the requested service.

Figure 15 - New authorization request, service details

When searching for and selecting a servicing provider, search by name or specialty. Be sure to select a servicing provider located near the patient. Narrow search results by entering a city or ZIP code. If a provider isn't found using the criteria, reduce or remove the criteria and search again. Names may be spelled differently in the system

and will not return an exact match. For example, inputting "Ochsner St Anne" would not find "Ochsner St. Anne Hospital" in the system.

When requesting DME, diabetes supplies or a consultation (such as for palliative care), enter "Peoples Health" in the Servicing Provider Name **field, and select the first result under Facility Name.** This will allow our staff to direct your request to the correct provider. For standard wheelchair requests, enter your preferred DME provider.

Figure 20 - New authorization request, service provider for DME, diabetes supplies or consultations

When requesting a level-of-care or facility change, select the appropriate option from the **Admission Source** drop-down menu. For services that are not a level-of-care or facility change, leave the field blank or select **Home** from the menu.
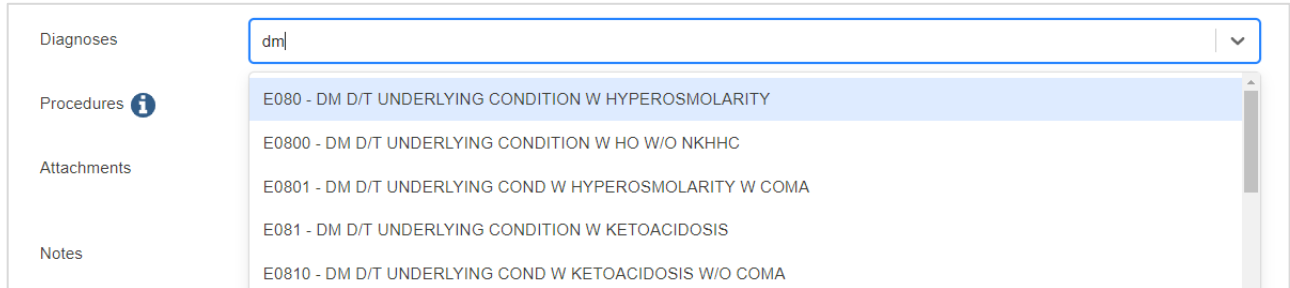
Figure 21 - New authorization request, admission source details

Complete all request fields and click Save & Continue.

Next, complete the clinical fields of the request form. Enter a diagnosis code or condition, and select from the options in the drop-down menu.
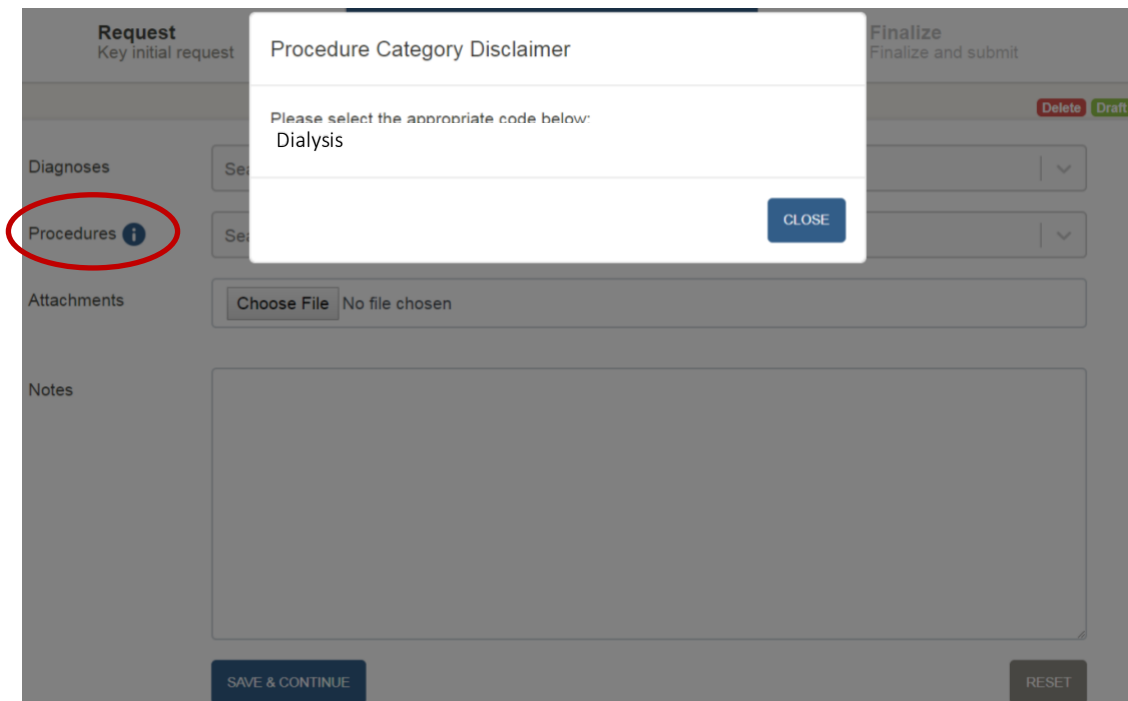
Figure 22 - New authorization request, diagnosis code selection

The system will prompt you to enter the appropriate procedure category for the service being requested. If a pop-up box to select a category does not automatically appear, click the information icon next to **Procedures** to find the correct category.

Figure 23 - New authorization request, procedure selection

Enter the procedure code and specify the total units needed, as well as the date span for the procedure frequency. Always select a unit and a total, as well as a date span from the calendar. Download Service Category Tip Sheets from the **Authorizations** tab if you need more guidance.

Figure 24 - New authorization request, service details

Some procedure categories, such as diabetes testing supplies, will automatically calculate the required units based on the testing frequency you provide. These counts may look different from what you entered. Do not change auto-populated counts.

Figure 25 - New authorization request, service details, sample categories with auto-populated units

You must attach a signed physician's order and provide detailed notes. Include your first and last name, telephone and fax number. For surgery requests, please include the appropriate CPT code. Click Save & Continue. To clear the information and enter different details, click the Reset button.

Review the requested procedures for accuracy, including frequency and timespan, then click Submit to finalize the request. Print the detailed summary page if desired. NOTE: Your request will remain under the Drafts tab until you click the Submit button.

Figure 26 - New authorization request, request details verification screen

Once a request has been submitted, you can create a fax cover sheet to send clinical information in support of the request, as well as request additional services for the same patient or return to the main screen.

Figure 27 - New authorization request, complete submission screen

Create a Fax Cover Sheet for Supporting Documentation

To fax clinical information to Peoples Health, create a cover sheet. From the **Actions** button, select **Create Fax Cover Sheet**. The cover sheet contains a code that links faxed documentation to the correct authorization request, speeding up the review process.

Figure 28 - New authorization request, fax cover creation

Follow the steps to complete the form, then click **Create**. Print the cover sheet and send it with your supporting documentation.

Figure 29 - New authorization request, sample fax cover

If the patient needs additional services in a different service category, close the fax window to return to the previous screen and click the Create New Auth for Current Patient link to initiate the new request.

Check Authorization Status

Note: This tab contains real-time authorization status for requests submitted through Provider Portal or by fax. Certain services, including home health, outpatient therapies and dialysis, may be automatically authorized once the request and supporting documentation are submitted.

Submitted requests are immediately assigned a case number.

Action Required Tab

Some cases may be pended for additional information and will appear under the **Action Required** tab, which is the default view when accessing this page. To review the action needed, click the case and review the information under the **Notes & Attachments** tab.

Figure 30 - Action Required tab

Respond by clicking the **Add Notes and Attachments** button and typing a response or uploading the requested documentation.

Figure 31 - Action Required tab, sample Notes & Attachments sub-tab to view and provide required actions

Click Save & Continue. Staff from our authorization division will be notified that you've responded to the request and will review the additional information.

Figure 32 - Add Notes and Attachments sample screen

Completed Tab
To review the status of an authorization request, click the **Completed** tab. Authorization requests that have been approved will have a case status of "Certified in Total," and an authorization number is added to the case. Denied authorizations show a status of "Not Certified" and will not have an authorization number.

Request an extension of an approved authorization by clicking the plus sign on the left side of the case number. Submit changes to a case by clicking on the case and typing your requested changes in the Notes and Attachments section. Include your first and last name, telephone number and fax number. For surgery requests, please include the CPT code and any supporting documentation. DO NOT start a new case when asking for an extension or requesting changes to an existing authorization.

Figure 33 - Completed Tab sample page

Submitted Tab

See a history of all authorization requests submitted for which you are the ordering or servicing provider. This includes authorizations submitted by fax.

Case #	Member Name	Member Number	Review Type	Service Type	Case Status	Request Date ↓	Service Date	Ordering Provider	Servicing Provider
8729342			Extension	Outpatient	In Progress	4/26/2023	12/13/2022		
9555135			Initial	Outpatient	In Progress	4/26/2023	4/26/2023		

Figure 34 - Submitted tab sample page

Drafts Tab

Review all authorization requests started by you or your staff but not yet submitted. You can either delete a case or click it to resume where you left off and submit the request. It is the responsibility of the provider office or facility to maintain any draft requests.

Delete	Member Name	Member Number	Review Type	Service Type	Request Date ↓	Service Date	Ordering Provider	Servicing Provider	Practice
🗑			Initial	Outpatient	4/26/2023	4/26/2023			
🗑			Extension	Outpatient	4/20/2023	4/19/2023			
🗑			Extension	Outpatient	4/19/2023	4/6/2023			

Figure 35 - Drafts tab sample page

Search Authorizations

From the **Authorizations** tab, click the link at the bottom of the page to view approved or denied authorizations up to a three-year date span. Search by authorization ID number or a patient's member ID number.

Note: Authorization information is not real-time and may be delayed for up to three business days. This tool is best for researching past authorizations.

Figure 36 - Authorizations page

Click a link in the **Auth Number** column to view details such as the authorizations status, requesting provider, servicing provider, date, count (number of approved visits), service description and more.

Figure 37 - Authorizations tab, sample results page, view approved and denied authorizations

Additional Resources

Under the **Resources** tab, find important forms, plan documents, coverage guidelines and more.
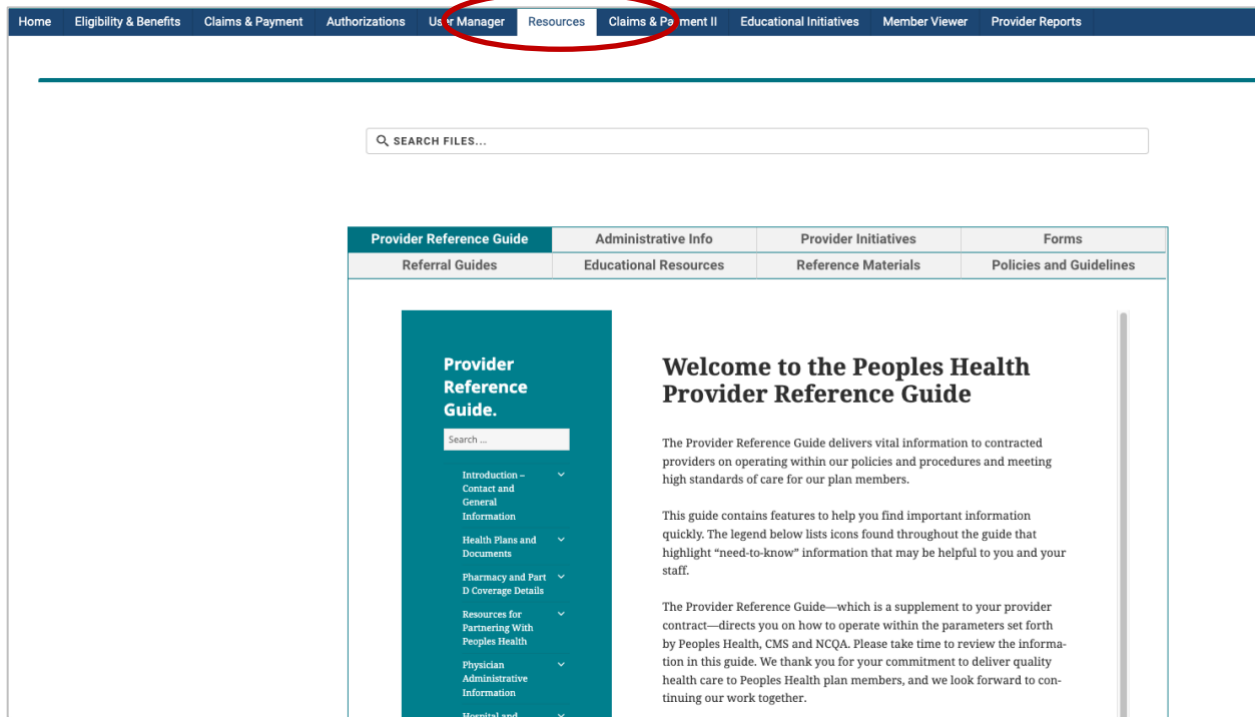
Figure 38 - Resources tab

Member Viewer

Select the **Member Viewer** tab to access additional clinical tools and information.

Note: The Provider Billing user type does not have access to patient clinical information in Member Viewer and cannot access this tab.
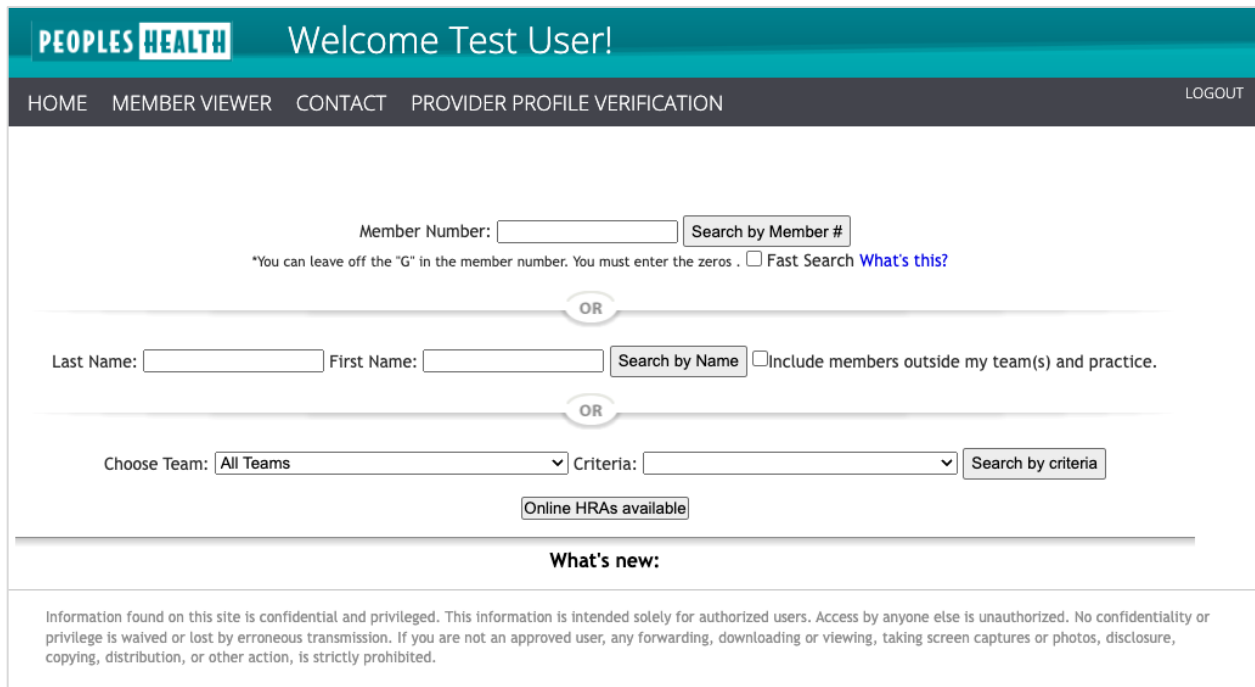
Figure 39 - Member Viewer homepage

Frequently Asked Questions

What are some of the features of the Provider Portal?

Through the Provider Portal, you and your authorized staff and billers can:

- Verify patient eligibility and coverage details, such as plan effective date and primary care physician, without having to call
- View and submit authorization requests
- View and download plan-specific benefit and cost-sharing information
- Search and view claims details and history, including status, amount paid and paid date
- View patient accumulators, including the annual out-of-pocket maximum for Part A and Part B services and benefit utilization counts
- Access provider tools, including important tips and training documents from the **Resources** tab, network provider search tools, and an authorization requirements search tool

How can I limit what an authorized user sees through the Provider Portal?

The portal administrator for the account must select a keycode (a role) for each authorized user. The keycode determines the tabs available to the user:

Keycode	User has access to these tabs:
Provider Back Office	Home, Claims & Payment, Eligibility & Benefits, Authorizations, Resources,
Provider Front Office	Home, Eligibility & Benefits, Authorizations, Resources, Member Viewer
Provider Billing	Home, Claims & Payment, Eligibility & Benefits, Resources
Local Admin	Home, Claims & Payment, Eligibility & Benefits, Authorizations, Resources, User Manager, Member Viewer, Reports

The portal administrator can further restrict user access based on the provider's NPI if in a setting with multiple providers. If staff should be limited to seeing their provider's patients only, follow these steps:

1) Log in to the Local Admin account
2) Click the **User Manager** tab
3) Search for the user by first and last name, username, or email address
4) Select the user's profile
5) Click the **Provider Details** link
6) Remove the TIN or NPI number as needed, and click Add TIN to save the changes

How do I delete a user account for someone who no longer works for my office?

User accounts cannot be deleted. However, the portal administrator can deactivate an account, which completely shuts off the user's access. To do this, the administrator can look up the user in User Manager; click the username link for the account to deactivate; on the Profile page under Account Status, click the **Inactive User** radio button; then click **Update User**. These steps will terminate the user's account access.

Figure 40 - User Manager, account status

What information will I see through my account?

The portal administrator must link a provider TIN(s) to user accounts so users are able to access information for the office's Peoples Health patients.

Additionally, each time a user is added under the Local Admin account, the TIN(s) for the account must be linked to the user. If the TIN is not added to the user account when the user account is set up, the user will not have full access to all the features in the Provider Portal, and the portal administrator will not be able to find the user in the system to update their profile. The portal administrator or the user should contact Peoples Health for help completing account setup for the user if this issue occurs.

Can I add a new TIN to my account after it's been created?

The portal administrator can add a new TIN. Under the **User Manager** tab, search for the account to update. Click the **Provider Details** link and at the bottom of the page, select **Add TIN**. Type the TIN to be linked to the account, and click **Add TIN**. You can only add TINs that are linked to your provider(s).

How do I verify patient eligibility?

From the **Eligibility & Benefits** tab, enter the patient's member ID number (G number) **or** the patient's last name and date of birth. Click the patient's name to review plan information, eligibility details and dual-eligible status, including whether the patient is responsible for copays. Click the plan name link to see detailed copay information by benefit category.

How do I request an authorization online?
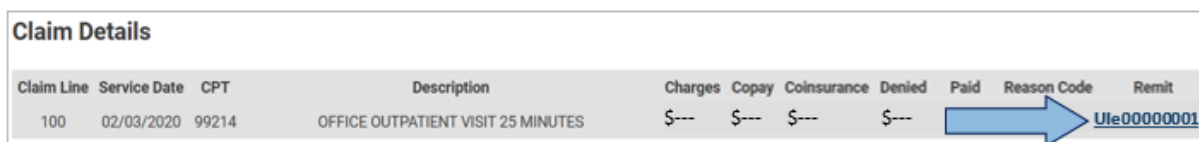
Click the **Authorizations** tab, then select the icon for the type of service needed (outpatient services, inpatient services, cancer treatment). Find a patient by entering either the patient's member ID number or the patient's name and date of birth. Complete the required information and attach supporting documentation or clinical notes, and submit the request. Certain services, including therapies, dialysis and home health, are authorized as soon as the request is submitted. Do not begin a new authorization when requesting an extension. For extensions, find the existing authorization on the **Completed** tab, then click the plus sign to the left to request an extension *if the authorization isn't already expired*.

Will I automatically be logged out of the system after a certain period of inactivity?

Yes. The session will timeout after 60 minutes of inactivity, and you will need to log in again to resume working in the portal.

How do I print an EOP (claims remittance advice)?

Click the **Claims & Payment** tab. To search, enter either a claim number, a check number, a paid date, a paid date range, or the member ID number (G number) *and* the service date range. Click **Search**. Click the claim number link to review the claim details screen, then click the link in the **Remit** column to view the EOP.

Figure 41 - Claims & Payment, claims details

I still have questions. Is there someone who can help me?

Email phn.provider@peopleshealth.com if you need further assistance, or reach out to your Peoples Health representative.

Member Viewer

With Member Viewer, you have secure access to your Peoples Health patients' medical profiles, including both current and historical clinical information, which can be used to review conditions that previously impacted a patient's risk adjustment and their compliance with measures included in the CMS Star Program.

Having these details readily available and accessible electronically can assist you in establishing a clearer picture of your patients' overall health and clinical histories.

Member Viewer Features

Clinical information in Member Viewer is updated regularly and available for users with Provider Local Admin, Provider Back Office and Provider Front Office access.

For your Peoples Health patients, you can access PCP member lists; hospital census and discharge reports; initiatives list; annual diagnoses history; diagnostic information, including lab results; pharmacy utilization information; and more.

Member Viewer Profile Summary

The orange Member Viewer Profile Summary button is a helpful tool that offers a printable overview of your patient's health. The summary can help improve patient visits by providing:

- Risk score
- Date of last flu shot (noted in **red** if vaccine is overdue)
- Date of last Medicare annual wellness visit
- Status of Peoples Health annual comprehensive wellness assessment
- Conditions requiring review for risk adjustment purposes (listed under the Disease Management and Clinical Indicators sections)
- Office visits and pharmacy utilization (last 90 days)
- Current and previous hospital admissions (last 12 months)
- Home health and DME utilization (lists open authorizations)
- Lab results (last 90 days)
- Medication adherence rates

Patient Medical History

Details about the following are available:

- Basic demographics, including full name, birth date, gender and contact information
- Plan-specific information, including current plan and member ID number, PCP history, Medicaid level and MOOP status
- Office visit details
- Behavioral health services
- Current and past hospital admissions
- ER visits (within past two years)
- Outpatient services
- Lab history and results
- Needed star and HEDIS measures, including compliance by measure year
- Prescribed medications and prescriptions filled
- Medicare Part B medications administered (medications covered under Medicare Part B—including immunosuppressant drugs, anti-cancer drugs, anti-emetic drugs and dialysis drugs—typically require the intervention of a physician to administer properly)

PCP Star Reports

Providers are encouraged to use the reports available in Member Viewer.

Use the Criteria drop-down search function on the main Member Viewer page to find a Daily Census of your patients in the hospital, along with other priority lists without any patient information needed. **To access:**

- Select **Provider Portal Quality Measure** from the Criteria drop-down box.
- Select the name of the physician whose panel you want to review from the **PCP** drop-down box, then select a navigation button.
    - Choose **Quality Measure Main** for a summary of star measure performance across the PCP's panel of patients. This feature allows you to pull up-to-date reports showing patients' compliance or deficiencies in certain star measures.
    - Choose the **PCP Panel** button for a list of patients on the PCP's panel. The results display basic demographic information (member ID number, name, date of birth and phone number), as well as the date of the patient's last PCP visit. Also displayed are columns for the various star measures. An **X** shows for non-compliant measures. The **total column** is a full count of the patients' non-compliant measures.
    - Choose the **Quality Measures** button for a list of the PCP's patients who fall within certain star measures. Select a measure and a compliance status from the drop-down menus, then click **Refresh**.
        - The results display basic information (member ID number and patient name), the star measures, compliance status, and note fields with pertinent information about the patient and the star measure.
        - Print or export the list as an Excel file to create a priority list for scheduling or to flag the records of patients in need of certain tests, screenings or prescription refills.
    - Choose the **Highlights** button for a summary of time-sensitive information. The results display up to four bullet points related to medication compliance and patients in need of a post-discharge medication reconciliation.