GEISINGER HEALTH PLAN FAMILY

Geisinger

Pay-for-Quality CY 2024 Program Manual

Introduction

The goal of the Pay-for-Quality payment is to encourage providers to exceed the quality-of-care standards for GHP Family members. The Pay-for-Quality program is available to physicians and advanced-level practitioners in primary care (i.e., Family Practice, Internal Medicine/Pediatrics, Internal Medicine, Pediatrics, Dentists and Obstetrics and Gynecology). Each specialty within primary care is considered separately. The Pay-for-Quality program was designed to help GHP Family monitor the accessibility and performance of the identified providers in the provider network. Physicians are rewarded for scoring well on the measures outlined in this program. The Pay-for-Quality program is not meant to be a static measurement system but flexible enough to meet changing clinical practices and quality requirements. Pay-for-Quality payments are based on administrative data including claims for services rendered, or a result electronically submitted to Geisinger Health Plan.

Measurement Periods

Quarter 1	January 1, 2024 – March 31, 2024
Quarter 2	April 1, 2024 – June 30, 2024
Quarter 3	July 1, 2024 – September 30, 2024
Quarter 4	October 1, 2024 – December 31, 2024

Utilization of Minimum Panel Size/MCO Enrollment

All primary care provider specialties, excluding OB/GYN clinicians, must average a panel size of 50 GHP Family members or more over the quarterly measurement period to be eligible for the Pay-For-Quality payout. To be eligible the providers must accept Medicaid products and have a Promise ID.

Provider Education

All providers are notified of the P4P program via orientation within 20 days of becoming a participating provider with GHP Family. GHP has developed a manual explaining each of the measures and their associated payout, which is updated and available at www.thehealthplan.com, by calling Customer Service and requesting it, or by requesting a visit from their Provider Relations representative, who will deliver a copy and review it with the provider/office. Updates are also highlighted in the quarterly provider newsletter for providers.

Evaluation of Provider P4P Effectiveness

Evaluating provider effectiveness is done multiple ways. Identifying areas for new and continuing education of current P4P program. Reviewing policies, procedures, and workflows that can help clinicians to improve care while improving incentive pay outs. Monitoring claims issues and resubmissions and providing education on claims best practices. Measure the usage of online submission tools and reeducating low utilizers. Review/evaluate processes used to verify and audit data accuracy and completeness from the time the claim/encounter is submitted until the provider payout is made. Measuring payments for continual growth and improvement. Measurement of HEDIS and PAPM rates to analyze the improvement of care gaps completed.

Health Equity Measures

The goal of the health equity measure incentives is to aid in removing health disparities and improving health equity for our African American population.

- Prenatal Care in the First Trimester
- Postpartum Care
- Well-Child Visits in the First 30 Months of Life
- Controlling High Blood Pressure
- Comprehensive Diabetes Care: Hemoglobin A1c Poor Control – (>9.0%)

Payment Schedule

At the end of each measurement period, a roll up of each participating provider's success with the measures will be completed with a total payout calculated.

**Quarterly payouts will be made to the provider to which the member is attributed as of the most recent period available at the time of payout. Payment amounts will be based upon the grid below.*

Quick Reference Guide

Refer to the HEDIS Guide for measure details

Measure	Description	Payment Amount
Child and Adolescent Well Care Visits	One payment per member per year for valid WCV visit based on claims submitted.	$30.00 paid quarterly.
Oral Evaluation, Dental Services	One payment per member per year (Under 21 years of age) for a valid OED visit based on claims submitted.	$25.00 paid quarterly for returning patients. $40.00 paid quarterly for new patients.
Well Child Visits in the First 30 Months of Life (6+ visits in the first 15 months and 2+ visits from 15 months to 30 months)	One payment per member per year for valid W15 6+ visits in the first 15 months and 2+ visits from 15 months to 30 months based on claims submitted.	$25.00 paid quarterly.
Prenatal Care in the 1st Trimester	One payment per member per pregnancy per year for valid PPC-PN visit based on claims submitted.	$25.00 paid quarterly.
Postpartum Care	One payment per member per pregnancy per year for valid PPC-PP visit based on claims submitted.	$25.00 paid quarterly.
Lead Screening for Children	One payment per member per year with one lead capillary or venous lead blood test on or before the child's second birthday.	$25.00 paid quarterly.

Measure	Description	Payment Amount
Asthma Medication Ratio	Members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications (reliever and controller) of 0.50 or greater at the completion of the measurement period.	$10.00 per compliant member paid annually.
Electronic Submission of ONAF via OPTUM web portal	One payment per quarter per pregnancy per trimester for forms submitted thru electronic OPTUM web portal.	$10.00 paid quarterly.
Glycemic Status Assessment for Patients with Diabetes (poor control) (> 9.0%) (electronic submission)	Up to 2 payments per member per year for electronic submission of glycemic status assessment has a result (HbA1c or GMI) of <9.0% on file by 1/15/25.	$25.00 paid quarterly.
Electronic Submission of Controlling High Blood Pressure	One payment per member per year based on last blood pressure reading of the year on file by 1/15/25.	$15.00 paid in 4th quarter only.
Developmental Screening in the First Three (3) Years of Life	One payment per member per year for children screened with CPT code 96110 on or by their first, second or third birthday	$25.00 paid quarterly
Plan all cause Readmissions	Payment for discharges without readmissions based on claims submitted. Readmissions/admissions is used to calculate rate.	Paid in 4th Qtr. Only. $20 per admission in denominator where a readmission did not occur if threshold is met.

Measure	Description	Payment Amount
Health Equity: Glycemic Status Assessment for Patients with Diabetes (poor control) (> 9.0%)	Up to 2 payments per African American member per year for a glycemic status assessment has a result (HbA1c or GMI) of <9.0% on file by 1/15/25.	$25.00 paid quarterly.
Health Equity: Controlling High Blood Pressure	One payment per African American member per year based on last blood pressure reading of the year on file by 1/15/25.	$15.00 paid in 4th quarter only.
Health Equity: Child and Adolescent Well Care Visits	One payment per African American member per year for valid WCV visit based on claims submitted.	$30.00 paid quarterly.
Health Equity: Prenatal Care in the 1st Trimester	One payment per African American member per pregnancy per year for valid PPC-PN visit based on claims submitted.	$25.00 paid quarterly.
Health Equity: Postpartum Care	One payment per African American member per pregnancy per year for valid PPC-PP visit based on claims submitted.	$25.00 paid quarterly.

Appendix A

MedInsight PCP attribution

MedInsight's standard attribution algorithm reviews 24 months of data. Each member is attributed to the PCP with themost visits and, in the case of a tie, to the PCP with the most recent visit. Note that urgent care services are excluded from consideration.

Description of MSSP attribution methodology

Medicare Shared Savings Program (MSSP) uses a two-step process to assign a member to an accountable care organization (ACO). To be assigned to an ACO, the member must receive at least one primary care service from a physician within the ACO. If the member receives primary care services from more than one ACO, the assigning processcompares the proportion of primary care services (measured in terms of allowed charges) provided to a member by different ACOs and assigns the member to the ACO with the highest proportion.

1. In the first step, a member is assigned to an ACO when they receive a greater proportion of primary care servicesfrom PCPs within the ACO as compared to other ACOs.
2. PCPs are defined as those physicians with one of four specialty designations — internal medicine, general practice, family practice or geriatric medicine — or those who provide services furnished in a federally qualified health center(FQHC) or rural health clinic (RHC).
3. If a member does not receive primary care services from any PCP, either inside or outside of the ACO, then the member is assigned to an ACO when they receive a greater proportion of primary care services from specialist physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO as compared to other ACOs.

The following table lists the Evaluation and Management (E&M) codes (Table A) used in our standard PCP attributionalgorithm. We have noted the E&M codes used in the MSSP method with an asterisk (*). The MSSP method uses E&Mcodes for services delivered in various inpatient facility settings. We used Milliman's Health Cost Guidelines (HCG) Grouper code sets, our review of other source documents, and clinical and actuarial judgment to develop the list of E&M codes in Table A.

Appendix B

MedInsight PCP attribution

Table A – Evaluation and Management (E&M) visit codes for PCP attribution (updated 2021)

Procedure code	Description	Procedure code	Description
99201*	Office/outpatient visit new	99354*	Prolonged e&m/psyctx serv o/p
99202*	Office/outpatient visit new	99355*	Prolonged e&m/psyctx serv o/p
99203*	Office/outpatient visit new	99358	Prolonged service w/o contact
99204*	Office/outpatient visit new	99359	Prolonged service w/o contact add
99205*	Office/outpatient visit new	99361	Med Conf by phy w/interd team
99211*	Office/outpatient avisit est	99381	Int pm e/m new pat infant
99212*	Office/outpatient visit est	99382	Int pm e/m new pat 1-4 yrs
99213*	Office/outpatient visit est	99383	Prev visit new age 5-11
99214*	Office/outpatient visit est	99384	Prev visit new age 12-17
99215*	Office/outpatient visit est	99385	Prev visit new age 18-39
99241	Office Consultation	99386	Prev visit new age 40-64
99242	Office Consultation	99387	Init pm e/m new pat 65+ yrs
99243	Office Consultation	99392	Prev visit est age 1-4
99244	Office Consultation	99393	Prev visit est age 5-11
99245	Office Consultation	99394	Prev visit est age 12-17
99271	Conf Cons for new or est pt	99395	Prev visit est age 18-39
99272	Conf Cons for new or est pt	99396	Prev visit est age 40-64
99273	Conf Cons for new or est pt	99397	Per pm reeval est pat 65+ yr
99274	Conf Cons for new or est pt	99401	Preventive counseling indiv
99275	Conf Cons for new or est pt	99402	Preventive counseling indiv
99341*	Home visit, new patient	99403	Preventive counseling indiv
99342*	Home visit, new patient	99404	Preventive counseling indiv
99343*	Home visit, new patient	99411	Preventive counseling group
99344*	Home visit, new patient	99412	Preventive counseling group
99345*	Home visit, new patient	99420	Health risk assessment test
99347*	Home visit, est patient	99429	Unlisted preventive service
99348*	Home visit, est patient	99499	Unlisted e&m service
99349*	Home visit, est patient		
99350*	Home visit, est patient		