Physician Quality Summary

Primary Care Pay-for-Performance Program
CY 2022 PQS program manual
2022

Geisinger

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Introduction

Your patients need quality care centered around them. That's why we at Geisinger Health Plan (GHP) continuously enhance our provider network — to give the communities we serve the best care possible. One way we do that is through an enhanced, simplified structuring of our Medicare, Commercial, CHIP and TPA incentive program. We can offer better transparency while rewarding primary care providers for the exceptional care you provide our members.

Primary Care Program definitions

1. **Continuous Enrollment (CE):** The amount of time a member must be enrolled for eligibility in a HEDIS® measure. The CE period can vary, but typically it covers the entire measurement year. One gap in the enrollment period is allowed, but it cannot exceed 45 days.
2. **HEDIS:** Healthcare Effectiveness Data and Information Set is a set of measures for which Geisinger Health Plan is held accountable by NCQA.
3. **Measurement Year:** The HEDIS definition of the main period of time for the event or diagnosis to occur to place a member into a measure eligible population. Typically, the measurement year is the calendar year before the year when the final HEDIS results are produced.
4. **NaviNet:** Geisinger Health Plan's Pay-for-Performance Program manual and performance documentation are available to participants via the NaviNet® portal.
5. **NCQA:** National Committee for Quality Assurance is the accrediting body for Managed Care Organizations, which sets the standards and measures that GHP must abide by and collect, respectively.

PQS Program participation requirements

Primary care providers or coverage PCPs in the following specialties with at least one member month as of the last day of the current measurement period are eligible for participation in PQS.

Eligible primary care specialties:

- Family practice
- Internal medicine
- General practice
- Pediatrics

Eligible lines of business:

- Commercial
- Medicare
- CHIP

Continuous enrollment and benefit restrictions apply.

Member must be made compliant to be eligible for payment.

Measurement periods

Quarter 1	Jan. 1 – March 31, 2022	**Quarter 3**	July 1 – Sept. 30, 2022
Quarter 2	April 1 – June 30, 2022	**Quarter 4**	Oct. 1 – Dec. 31, 2022

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.

For details on the attribution methodology, see Appendix A.

Well-Child Visit in the First 30 Months of Life (W30)

Description: Percentage of children who had the following number of well-child visits with a PCP during the first 30 months of life

- 5+ visits in the first 15 months
- 2+ visits between 15 months and 30 months

Documentation guidelines:

- Visits with a nurse practitioner or physician assistant count

Compliant member: Members who turn 30 months as of Dec. 31, who have had 8 Well Visits since DOB (must code the Well Visit appropriately)

Frequently utilized provider best practices:

- Submit proper codes for a well visit in person or e-visit.
- Complete and code for developmental screening.
- Complete and code for lead testing prior to 24 months.
- A sick visit and well-child visit can be performed on the same day by using modifier 25.
- Schedule child's next well visit before member leaves the office.

Child and Adolescent Well Care Visits (WCV)

Description: Percentage of members 3 to 21 years of age who had at least one comprehensive well visit with a PCP or an OB/GYN

Documentation guidelines:

- Visits with a nurse practitioner or physician assistant count

Compliant member: A member who has had one or more well-care visits, as signified by one of the applicable codes on a medical claim with a PCP during the measurement year (visits with physician assistants and nurse practitioners in primary care offices are acceptable).

Frequently utilized provider best practices:

- Submit proper codes for well care visits, in person or e-visits.
- Complete and code for developmental screening.
- Complete and code for hearing, vision, depression screenings, etc.
- A sick visit and well-child visit can be performed on the same day by using a 25 modifier.
- Schedule next well visit at the end of each appointment.

Childhood Immunization Status (CIS)

Description: The percentage of children 2 years of age as of Dec. 31 of the measurement year, who had four diphtheria, tetanus, acellular pertussis (DTaP); three polio (OPV/IPV); one measles, mumps, rubella (MMR), three haemophilus influenza type B (HiB); three hepatitis B (Hep B); one chickenpox vaccine (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV) and two influenza (Flu) vaccines by their second birthday. One VZV, one MMR, and one Hep A vaccine needs to be given between the child's 1st and 2nd birthday.

Compliant member: Meeting everything stated in description above. Immunization billed through GHP with correct coding will be captured for incentive

Frequently utilized provider best practices:

- Review a child's immunization record before every visit and administer needed vaccines.
- Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations.
- Have a system for member reminders.
- Document 2-dose or 3-dose vaccination for rotavirus.

Immunization for Adolescents (IMA)

Description: The percentage of adolescents 13 years of age who had

- 1 Tdap between 10th and 13th birthday
- 1 Meningococcal between 11th and 13th birthday
- 2 (146 days apart) or 3 HPV between 9th and 13th birthday

Compliant member: Meeting everything stated in description above. Immunization billed through GHP with correct coding will be captured for incentive

Frequently utilized provider best practices:

- Use state registries.
- Give Tdap, Meningococcal and first HPV at age 11 and second HPV before age 13.
- Address that HPV causes 6 types of cancer and the vaccine is used as cancer prevention.

Chlamydia Screening (CHL)

Description: The percentage of female members 16 to 24 years of age as of Dec. 31 of the measurement year, that were identified as sexually active, either by pharmacy or claims data, which had at least one test for chlamydia during the measurement year.

Compliant member: A woman is counted as having had a test if she had a claim/encounter with a service date during the measurement year with one or more of the applicable codes.

Frequently utilized provider best practices:

- Perform chlamydia screening every year on every female age 16 – 24 years (use any visit opportunity).
- Add chlamydia screening as a standard lab for women 16 – 24 years old. Use well-child exams and well women exams for this purpose.
- Remember that chlamydia screening can be performed through a urine test.

Cervical Cancer Screening (CCS)

Description: The percentage of women 24 to 64 years old, as of December 31st of the measurement year, who were screened for cervical cancer.

Compliant member:

- Women age 24 – 64 who had cervical cytology performed every 3 years
- Women age 30 – 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Frequently utilized provider best practices:

- Request to have results of Pap tests sent to you, if done at OB/GYN visits.

Eye Exam for Patients with Diabetes (EED)

Description: The percentage of members 18 to 75 years as of Dec. 31 of the measurement year who are identified as diabetic.

Compliant member: A diabetic member that had a retinal eye exam in the measurement year; or a negative retinal eye exam in the measurement year or the year prior to the measurement year.

Frequently utilized provider best practices:

- Make sure digital eye exam, remote imaging and fundus photography are read by an eye care professional (optometrist or ophthalmologist) so the results count.
- Use 3072F if member's eye exam was negative or showed low risk for retinopathy in the prior year.

Hemoglobin A1c Control for Patients with Diabetes (HBD)

Description: The percentage of members 18 to 75 years as of Dec. 31 of the measurement year who are identified as diabetic.

Compliant member:

Hemoglobin A1c result to GHP<9 via CPTII code

3051F - HbA1c level ≥ 7.0 and < 8.0
3052F - HbA1c level ≥ 8.0 and ≤ 9.0
3044F - HbA1c level < 7.0

Frequently utilized provider best practices:

- Bill for point-of-care testing if completed in office and ensure HbA1c result, and date are documented in the chart.
- Adjust therapy to improve HbA1c and BP levels; follow up with members to monitor changes.

Colorectal Cancer Screening (COL)

Description: The percentage of adults 51 to 75 years old as of Dec. 31 of the measurement year who have had one or more of the following screenings for colorectal cancer.

Compliant member:

- A fecal occult blood test (FOBT) during the measurement year, assume the required number of samples were returned, regardless of FOBT type
- A colonoscopy during the measurement year or the nine years prior to the measurement year
- FIT-DNA (Cologuard) test during the measurement year or the two years prior to the measurement year.

Frequently utilized provider best practices:

- Update member history annually regarding colorectal cancer screening (test done and date).
- Recommend FOBT/FIT-DNA as an alternative to colonoscopy.
- Provide ongoing outreach and education to non-compliant members.
- Use standing orders and empower office staff to distribute FOBT or FIT kits to members who need colorectal cancer screening or prepare referral for colonoscopy.

Breast Cancer Screening (BCS)

Description: The percentage of women 52 to 74 years old, as of Dec. 31 of the measurement year. Transgender population should be counted.

Compliant member:

A woman who has had a mammogram, signified by one of the applicable codes on a medical claim any time on or between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year. Diagnostic mammograms and tomosynthesis are included in the measure.

Frequently utilized provider best practices:

- Educate female members about the importance of early detection and encourage testing.
- Document a bilateral or unilateral mastectomy in the medical record.
- Do not miss the opportunity to schedule a mammogram for the member while at the office visit.
- Have a list of facilities available for members to choose where they would like to have the mammogram scheduled.
- Discuss possible fears the member may have about mammograms and explain current testing processes are less uncomfortable and require less radiation.

Plan All-Cause Readmissions (PCR)

Purpose: To assess inpatient acute care and observation stays with discharges that resulted in a subsequent readmission to an inpatient acute care within 30 days of the initial inpatient acute care discharge.

Description: For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Compliant site as measured annually: Discharges that did not result in an inpatient acute care readmission within 30 days of the initial inpatient acute care discharge.

Med Adherence Statin Therapy (SPC/SPD)

Description/compliant members:

SPC: The percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria.

- Statin adherence 85% – Members who remained on a high-intensity or moderate-intensity statin medication for at least 90% of the treatment period

SPD: The percentage of members 40 to 75 years of age during the measurement year with diabetes who do not have clinical ASCVD who met the following criteria

- Statin adherence 85% – Members who remained on a statin medication of any intensity for at least 90% of the treatment period

Frequently utilized provider best practices:

- Review member medication list to ensure current statin therapy and to determine statin use history.
- Schedule proper follow-up with the members to evaluate if medication is taken as prescribed.
- Convert member's statin medication to a 90-day supply at mail-order or retail pharmacy to boost adherence.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Educate members on the importance of staying on the medication.

There is a member threshold of ≥10 attributed members to be eligible for this measure.

Emergency Department Utilization (EDU)

Purpose: Improve Emergency Department utilization (EDU) in members (lower is better). Although using the ED cannot always be avoided, excessive ED utilization can reflect poor medical management.

Description: An Emergency Department visit per 1,000 members rate is calculated per primary care site. Urgent care visits and ED visits that turn into a hospital admission are excluded. Each site's ED visits/1,000 rate is compared to the 90th percentile. Payment determinations are based on the 90th percentile.

*Since a rate per primary care physician is not produced, all physicians at the same primary care site are awarded the same score.

Compliant site as measured annually, where lower is better:

- Primary care site's ED visit/1,000 rate above the 90th percentile = Payout
- Primary care site's ED visit/1,000 rate below the 90th percentile = No payout

Adult Annual Wellness Visits (AWV)

Description: The percentage of Medicare members who had one well visit with a PCP (visit is not required to occur with their "assigned" or "attributed" health plan physician) within the measurement year.

Applicable codes:

Annual Well Visit codes must be submitted to GHP

G0438

G0439

G0468

G0402

Note: Contracted FQHC providers should use location code 50 when billing G0468.

Appendix A

MedInsight PCP attribution

MedInsight's standard attribution algorithm reviews 24 months of data. Each member is attributed to the PCP with the most 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 process compares 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 services from 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 attribution algorithm. We have noted the E&M codes used in the MSSP method with an asterisk (*). The MSSP method uses E&M codes 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		

Quick reference chart

Measure	Description	Payment amount
Well-Child Visits in the First 30 Months of Life (W30)	One payment per member per year for valid W30 (5+ visits in the first 15 months and 2+ visits from 15 months to 30 months). Payments occur quarterly.	$25.00
Child and Adolescent Well Care Visits (WCV)	One payment per member per year for valid WCV visit based on claims submitted. Payments occur quarterly.	$30.00
Childhood Immunization Status (CIS)	One payment per member per year for children turning 2 as of Dec. 31 who completed Combo 10. Payments occur quarterly.	$50.00
Immunizations for Adolescents (IMA)	One payment per member per year for adolescents turning 13 years of age as of Dec. 31 who completed Combo 2. Payments occur quarterly.	$50.00
Chlamydia Screening in women (CHL)	One payment per member per year for members 16–24 as of Dec. 31 who are identified as sexually active and have been tested for chlamydia. Payments occur quarterly.	$50.00
Eye Exam for Patients with Diabetes (EED)	One payment per member per year for members 18–75 as of Dec. 31 who are diabetic must be screened for diabetic retinopathy. Payments occur quarterly.	$25.00
Hemoglobin A1c Control for Patients with Diabetes (HBD)	One payment per member per year for members 18–75 who are identified as diabetic, must have at least 1 A1c below 9 (last A1c of year with result). Paid in 4th quarter only.	$25.00
Cervical Cancer Screening (CCS)	One payment per member per year for women 24–64 as of Dec. 31 must be screened for for cervical cancer. Payments occur quarterly.	$30.00
Adult Annual Wellness Visit (AWV)	One payment per member per year for 1 completed Medicare Annual Wellness visit. Payments occur quarterly.	$25.00

Measure	Description	Payment amount
Colorectal Cancer Screening (COL)	One payment per member per year for members 51–75 as of Dec. 31, must have appropriate colorectal cancer screening completed. Payments occur quarterly.	**Differs by type of screening:**
Colonoscopy	Every 10 years per member	$125.00
Fitkit	Every year per member	$10.00
Cologuard	Every 3 years per member	$30.00
Breast Cancer Screening (BCS)	One payment per quarter per year for women 52–74 must have a mammogram between October, 2 years prior to the current year, through Dec. 31 of current year. Payments occur quarterly. *Transgender population is included.*	$25.00
Readmissions (PCR)	Payments for discharges without readmissions based on claims submitted. Paid in 4th quarter only. Readmissions/admissions is used to calculate rate.	$20.00
Prescribed Statin Therapy (SPC/SPD)	SPC – One payment per year for males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were prescribed statin therapy. Paid in 4th quarter only, meeting 85% or above.	$30.00
	SPD – One payment per year for members 40–75 years of age during the measurement year with diabetes who do not have clinical ASCVD and were prescribed statin therapy. Paid in 4th quarter only, meeting 90% or above.	$60.00
Emergency Department Visit (EDU)	Site paid based on 90th percentile and membership assigned as of last day of reporting period (above 90th percentile). Paid in 4th quarter only, paid at site level.	$5.00