Pay for Quality
2018
Program Manual

GHP Family Pay-for-Quality Program

Program Synopsis

The goal of the Pay-for-Quality payment is to encourage and promote a focus on exceeding all quality of care standards for our GHP Family members. The Pay-for-Quality program is available to physicians and mid-level practitioners in primary care (i.e., Family Practice, Internal Medicine/Pediatrics, Internal Medicine, and Pediatrics) 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 Health Plan's 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 must be flexible in order to meet changing clinical practices and quality requirements. Pay-for-Quality payments will be based on the simple receipt of a claim for a service associated with the measure, or for the electronic submission of a result of a measure.

All provider specialties, excluding OB/GYN and Dental providers, must average a panel size of 50 GHP Family member months or more over the measurement period to be eligible for the Pay-for-Quality payout.

Payout Schedule

Each quarter of the calendar year will be defined as a measurement period, with payout occurring within 120 days of the end of the measurement period. (example, the first quarter will be measured from 1/1/YY-3/31/YY and paid 120 days after the quarter ends, 7/31/YY)

For all metric payment methodology, please reference the table on page 9 which includes definitions and subsequent payout frequency.

In the event that the contract between GHP and the state expires, all GHP Family Pay-for-Quality incentives would cease effective the date of expiration. For computational and administrative ease, no retroactive adjustments will be made to incentive payments.

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Quality Measure Summary & Table of Contents

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The following are the measure definitions from the HEDIS® 2018 Technical Specifications, Vol. 2 publication. Continuous enrollment specifications will apply. See summary table on page 9 for the measurement incentive summary.

1. Comprehensive Diabetes Care: HbA1c Poor Control

Purpose: To monitor HbA1c levels in members with diabetes.

Description: HbA1c screening of members aged 18 to 75 with diabetes performed during the measurement year that was adequately controlled.

Compliant Member: Most recent HbA1c level is <9.0% during the measurement period.

Description	CPT Category II
Numerator compliant (HbA1c <9.0%)	3044F, 3045F
Not numerator compliant (HbA1c ≥9.0%)	3046F

* CPT Category II code 3045F indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, The Health Plan may use other sources (laboratory data, hybrid reporting method, etc.) to determine if the HbA1c result was <9%.

2. Controlling High Blood Pressure

Purpose: To monitor the blood pressure in members who have a diagnosis of hypertension.

Description: The number of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) is recorded and submitted during the measurement period will warrant payment. Additional payment is dependent upon adequate control (<140/90) in the last measurement period of the calendar year. BPs taken from an inpatient stay or ED visit or patient self-reported BPs are not acceptable.

Compliant Member: Both a representative systolic BP <140 mm Hg and a representative diastolic BP <90 mm Hg (BP in the normal or high-normal range). This indicator is measured by claim submission with a CPT code below, indicating degree of blood pressure control, or an alternative method of data submission as approved by the plan.

	CPT Category II	
Description	Systolic	Diastolic
Numerator compliant (BP <140/90 mm Hg)	3074F, 3075F	3078F, 3079F
Not numerator compliant (BP ≥ 140/90 mm Hg)	3077F	3080F

3. Medication Management for People with Asthma 75%

Purpose: To monitor the number of members with asthma who were dispensed appropriate medications.

Description: The number of members, age 5 – 85 years of age, as of December 31st of the measurement year identified as having persistent asthma and were dispensed appropriate asthma controller medication(s).

Compliant Member: Members who remained on an asthma controller medication for at least 75% of their treatment period.

4. Adolescent Well-Care

Purpose: To monitor the number of well-care visits with either a primary care practitioner or OB/GYN practitioner that occurs each year for adolescents.

Description: The number of adolescents, age 12 through 21 years old as of December 31st of the measurement year, that had a well-care visit with a PCP or OB/GYN practitioner.

Compliant Member: At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, as documented through either administrative data or claims submission. The PCP does not have to be assigned to the member.

5. Annual Dental Visits (paid to the Dental Provider)

Purpose: To monitor children aged 6 months to 20 years of age who receive their annual dental visit to encourage oral health.

Description: The percentage of members aged 6 months to 20 years of age who had at least one dental visit during the measurement year.

Compliant Member: One or more dental visits with a dental practitioner during the measurement year. New patients are those who have not received a preventive dental service in the previous calendar year but received a preventive dental service in the measurement calendar year. Returning patients are those who received a preventive dental service in the previous calendar year and received a preventive dental service in the current measurement calendar year. Data indicating compliance with this measure will be tracked through dental visit claims.

6. Well-Child Visits in the First 15 Months of Life, 6 or more

Purpose: To monitor the number of well-care visits with a primary care practitioner that occurs each year for newborns.

Description: The number of children, age 0 to 15 months, as of December 31st of the measurement year that had 6 well-care visits with a PCP.

Compliant Member: 6 comprehensive well-care visits with a PCP during the measurement year, as documented through either administrative data or claims submission. The PCP does not have to be assigned to the member.

7. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Purpose: To monitor the number of well-care visits with a primary care practitioner that occurs each year for preschool-aged children.

Description: The number of children, age 3 to 6 years old, as of December 31st of the measurement year that had a well-care visit with a PCP.

Compliant Member: At least one comprehensive well-care visit with a PCP during the measurement year, as documented through either administrative data or claims submission. The PCP does not have to be assigned to the member.

8. Reducing Potentially Preventable Readmissions

Purpose: To measure the percentage of inpatient acute care discharges with subsequent readmissions.

Description: The number of discharges for members below age 65, as of December 31st of the measurement year identified as having an inpatient acute care discharge between January 1st and December 1st of the measurement year. The denominator is based on the total number of discharges, not members.

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

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9. Emergency Room Utilization

Purpose: ED utilization improvement for Members. With primary care, the goal should be to keep members out of the emergency department. Although this cannot always be accomplished, excessive emergency department (ED) use is a sign of poor medical management.

Description: An emergency department visit per 1000 members rate is calculated per primary care site*. Urgent care visits and emergency department visits that turn into a hospital admission are excluded. Each site's ER visits/1000 rate is compared to other sites within the same specialty. Payment determinations are based on the percentiles illustrated below.

*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**:

- Primary Care site's ED visit/1000 rate above the 90th percentile = Payout Received
- Primary Care site's ED visit/1000 rate below the 90th percentile = No Payout

10. Prenatal Care – 1st Trimester

Purpose: To ensure appropriate and regular maternity care management.

Description: Number of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment into the organization.

Compliant Member: OBNA form submitted electronically to health plan within the first trimester or within 42 days of enrollment into the plan and/or claim submission with a date of service within the first trimester.

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11. Ongoing Prenatal Care: ≥ 81% of expected visits

Purpose: To ensure appropriate and regular maternity care management throughout the entire pregnancy.

Description: The number of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received ≥ 81% of expected visits. See Appendix B for details around required number of expected visits.

Compliant Member: OBNA form submitted electronically to health plan indicating dates of prenatal visits, and/or claim submission indicating prenatal visit encounters.

12. Postpartum Care

Purpose: To ensure appropriate follow-up care post-delivery.

Description: Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received a postpartum visit on or between 21 and 56 days after delivery.

Compliant Member: OBNA form submitted and/or claim submission to the Health Plan indicating the date of the postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery.

13. Electronic Submission of OBNA Form

Purpose: To ensure appropriate and regular maternity care management.

Description: Timeliness of the submission of OBNA Forms to The Health Plan electronically during the first trimester or within 42 days of enrollment into the organization, after the 28-32 week visit, and after the postpartum visit. The provider will utilize the online tool available thru Optum for this initiative at obcare.optum.com.

Compliant Member: Timely OBNA Form submitted electronically via the online tool for the first prenatal visit within the organization, the 28-32 week visit, and the postpartum visit.

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Payout Methodology

Appendix A

Measure	Description	Payment Amount
Comprehensive Diabetes care: HbA1c – Poorly Controlled (>9%)	Per Quarter per Diabetic patient with most recent HbA1c under control (Max 2 payments per patient per year)	$25.00
High Blood Pressure Control	Per Hypertension patient who had most recent High Blood Pressure under control (payment only in Q4)	$25.00
Adolescent Well-Care	Payment for each Adolescent Well-Care Visit (Max 1 payment per patient per year)	$30
Annual Dental Visit – Dentist	Payment for each Annual Dental Visit (Max 1 payment per patient per year)	$30.00 (new) $15.00 (returning)
Well-Child Visits in the first 15 months of life, 6 or more	Payment per Well-Child Visits (max 1 payment per patient per year)	$25.00
Well-Child Visits in the 3rd, 4th, 5th or 6th year of life	Payment per Well-Child Visits (max 1 payment per patient per year)	$25.00
Emergency Department Utilization	Payment Per Member Assigned to Practice for ER Utilization Performance (above 90th percentile)	$5.00
	Payment Per Member Assigned to Practice for ER Utilization Performance (below 90th Percentile)	$0.00
Prenatal Care - 1st Trimester	Payment for Each Prenatal visit (max 1 per pregnancy)	$25.00
Ongoing Prenatal Care: >81% expected visits	Payment for Ongoing Care (max 1 per pregnancy)	$50.00
Postpartum Care	Payment for Each Postpartum visit (max 1 per pregnancy)	$25.00
Electronic Submission of OBNA Form	Payment Per OBNA Form via the online tool per Quarter (max 3 per pregnancy)	$10.00
Medication Management of Asthma (75%)	Payment for members on appropriate medications (max 1 payment per patient per year)	$10.00
Potentially Avoidable Readmissions	Payment for discharges without readmissions (Paid Q4). Benchmark is set at 8.50%(Lower is better)	$20.00

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Appendix B

Expected Number of Prenatal Care Visits for a Given Gestational Age and Month Member Enrolled in the Organization									
Month of Pregnancy Member Enrolled in the Organization									
Gestational Age in Weeks	0 - 1st month	2nd Month	3rd Month	4th Month	5th Month	6th Month	7th Month	8th Month	9th Month
28	6	5	4	3	1	1	***	***	***
29	6	5	4	3	1	1	***	***	***
30	7	6	5	4	2	1	1	***	***
31	7	6	5	4	2	1	1	***	***
32	8	7	6	5	3	2	1	***	***
33	8	7	6	5	3	2	1	***	***
34	9	8	7	6	4	3	2	1	***
35	9	8	7	6	4	3	2	1	***
36	10	9	8	7	5	4	3	1	***
37	11	10	9	8	6	5	4	2	***
38	12	11	10	9	7	6	5	3	***
39	13	12	11	10	8	7	6	4	1
40	14	13	12	11	9	8	7	5	1
41	15	14	13	12	10	9	8	6	2
42	16	15	14	13	11	10	9	7	3
43	17	16	15	14	12	11	10	8	4
NOTE: * indicate that no visits are expected**									
Example: **If the member enrolls at 4 months and delivers at 38 weeks, follow table to determine the number of PN office visits. In this case, 9 visits are needed.**									