

Pay for Performance

**THE 2011 HMO
PRIMARY CARE PHYSICIAN
PAY FOR PERFORMANCE
PROGRAM**



HealthPlus
Health Plans

February 2011

Dear HealthPlus Primary Care Physician:

HealthPlus of Michigan is pleased to present the 2011 HMO Primary Care Physician Pay for Performance Program, known as the P4P Program. The Pay for Performance (P4P) Program has a history of recognizing and rewarding participating Primary Care Physicians for superior clinical quality, cost efficiency, and the implementation of healthcare informatics and technology.

The 2011 program measures are in alignment with those supported by the Michigan Primary Care Consortium (MPCC) and the National Committee for Quality Assurance (NCQA). The Program continues to be focused on two domains. The first domain measures implementation of components from the Patient Centered Medical Home model of care. Financial reward for this domain will be an annual payment. The second domain focuses on clinical quality of care measures. Financial reward for this domain will be based upon "pay-above measures" and will be distributed quarterly.

Program Enhancements include:

- Expansion of the program to include all managed lines of business: Commercial, Medicaid and Medicare Advantage
- Substantial increase in the overall program funding opportunity
- Reduction of Domain I member qualifier from 50 members in Commercial to 50 members across all managed lines of business: Commercial, Medicaid and Medicare Advantage.

HealthPlus believes that the combination of these two domains and the above enhancements will provide the greatest value to our Primary Care Physicians and members during the 2011 program year.

The 2011 P4P Program Manual includes standards and guidelines that are representative of the changes occurring in the marketplace. The manual also includes information regarding the Program, as well as support mechanisms and the efforts put in place to assist physicians, staff and administrators with participation, throughout the program cycle. For your convenience, the 2011 P4P Program Manual is available on our website at <http://www.healthplus.org/ProviderResources.aspx>. If you have issues accessing the manual please contact Sherry Lloyd at (810) 230-2172 for assistance.

If you have questions or concerns regarding the HealthPlus P4P Program, please feel free to contact your HealthPlus Provider Network Educator. Contact information is contained in the HealthPlus 2011 P4P Program Manual.

Professionally yours,



Richard S. Frank, M.D., MHSA
Vice President and Chief Medical Officer

RF/bs

Enclosure

cc: PHO/Medical Group Administrator
PHO Medical Director

HealthPlus of Michigan 2011 HMO Pay for Performance (P4P) Program

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1. Introduction

HealthPlus of Michigan is pleased to provide you with the specifications for the 2011 HMO Pay for Performance (P4P) Program. The 2011 HMO Pay for Performance booklet includes detailed information regarding the specific measurement attributes of the program, and also provides highlights regarding the support mechanisms and resources that HealthPlus has put in place to assist physicians, staff and administrators with their participation in the program.

The 2011 HMO Pay for Performance Program is for the Commercial, Medicaid and Medicare Advantage Products and continues to build upon the philosophy of rewarding and recognizing participating PCPs for high levels of performance in several key areas of primary care. The Program Domains, as outlined in Section 4, detail the program specifics and highlight the quality standards important to the HealthPlus members under your care.

The 2011 program measures are in alignment with those supported by the Michigan Primary Care Consortium (MPCC) and the National Committee for Quality Assurance (NCQA). Each year HealthPlus evaluates our performance measures and adjusts the categories based upon input from the industry and HealthPlus physician and Health System partners.

The 2011 HMO program is comprised of two Domains with the following component categories and measures:

Domain I - PCMH:

Health Information Technology (HIT) paid at a PMPM for all three Lines of Business
E-Prescribing
Patient Registries

Domain II – Clinical Quality:

Paid quarterly

Periodic Payout Commercial:

1. Appropriate Testing for Children with Pharyngitis (CWP)
2. Childhood Immunization Services (CIS)
3. Hemoglobin A1c Testing for Diabetics (A1c)
4. LDL Testing for Diabetes and Cardiac Patients (LDL)
5. Breast Cancer Screening (BCS)

Paid quarterly

Periodic Payout Medicaid:

1. Appropriate Testing for Children with Pharyngitis (CWP)
2. Lead Screening (LSC)
3. Childhood Access (CAP)
4. Hemoglobin A1c Testing for Diabetics (A1c)
5. LDL Testing for Diabetes and Cardiac Patients (LDL)
6. Breast Cancer Screening (BCS)

Paid quarterly

Periodic Payout Medicare Advantage:

1. Hemoglobin A1c Testing for Diabetics (A1c)
2. LDL Testing for Diabetes and Cardiac Patients (LDL)
3. Breast Cancer Screening (BCS)

The “Per Member Per Month” method will be utilized for Domain I-PCMH. This payment method is the same Per Member Per Month method utilized in previous Program years. This payment method entails:

- Metric performance measurement after the end of the Program year
- Payment for performance after the end of the Program year
- The Per Member Per Month method is based upon:
 - Performance measured from administrative claims data
 - Attainment of predetermined performance (Tier 1 and Tier 2) thresholds
 - PCP HealthPlus Commercial, Medicaid, and Medicare Advantage HMO membership
 - The specific Pay for Performance contractual agreement each Health System has with HealthPlus

The ‘Periodic Payout’ method will be utilized for Clinical Quality metrics. This payment method entails the following:

- Metric performance measurement every three (3) months (quarterly)
- Payment for performance quarterly after each 3 month measurement period
- This payment method is based upon payment for each clinical test ordered by the PCP and completed as indicated by administrative claims data. Please reference section 4 for specification
- A flat fee will be paid for each completed test

The measures within each Domain represent opportunities for Family Practice, Internal Medicine, and Pediatric PCPs to receive performance based incentives.

Thank you again for your participation in the 2011 Pay for Performance Program.

2. Highlighted P4P Program Enhancements/Changes

Highlighted Program Enhancements:

- Expansion of the program to include HMO: Commercial, Medicaid and Medicare Advantage
- Substantial increase in the overall program funding opportunity
- Reduction of Domain I member qualifier from 50 members in Commercial to 50 members across all managed lines of business: Commercial, Medicaid and Medicare Advantage.

Other Program Changes:

Dropped Metrics

- Member Experience – Overall Satisfaction with PCP
- PCP Treatable Non-Emergent ER Utilization
- Generic Usage Rate
- Access to Care for Members

HealthPlus of Michigan remains committed to supporting expanded access to Primary Care for all of its members. HealthPlus will not offer a financial incentive for PCPs to offer expanded Practice hours of access as part of the HMO 2011 Pay for Performances Program. However, HealthPlus has added CPT codes that may be billed as a payable to the HealthPlus fee schedule. These CPT codes may be billed in addition to the E/M codes for care administered by the PCP Practice relative to expanded access. These codes are:

99050 – Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service

99051 – Service(s) provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to basic service

99444 – Online E/M, by Physician to established patient parent/guardian, using internet

If you have any questions concerning the expanded access CPT codes, please contact your Provider Network Educator.

3. General P4P Program Participation Requirements

- For Domain I - PCMH metrics, PCPs must be affiliated with each line of business (LOBs) within the product for the entire calendar year of the measurement year, and have at least 50 members across all LOBs as of December 31 of the measurement year.
- The minimum membership requirements (of at least 50 members across all LOBs for the program year), will not be required for the Domain II – Clinical Quality Periodic Payout metrics.
- PCPs must also be affiliated with the HMO product for each LOB at the time of payment to be eligible for any Program payments.
- For Domain I – PCMH each PCP will be credited for services provided through December 31st of the program year to HMO members in their practice as of December 31st of the program year, regardless of whether the PCP was the member's PCP at the time services were provided.
- For Domain II – Clinical Quality Periodic Payout metrics, each PCP will be credited for services provided through the end of each quarter (measurement period) of the program year to HMO members for whom they provided services.
- The maximum payment to any PCP is determined by the specific P4P contractual agreement each Health System has with HealthPlus. Therefore, this document will not supply specific financial values of the program.
- HealthPlus retains the right to modify the program every incentive year as needed. Modifications may include, but are not limited to, inclusion or exclusion of measures or changes to the calculation methods.

4. Performance Measurement Specifications

Summary of HMO 2011 Program: Domains and Measures

Domain I PCMH Category	Measure	PMPM: Weight
Health Information Technology	E-Prescribing	50%
	Patient Registry	50%
Total: Domain I – PCMH		100%
Domain II Clinical Quality Category	Measure	Periodic Payout LOB
Clinical Quality	Diabetes HbA1C Test (A1c)	Commercial Medicaid Medicare Advantage
	LDL Testing for Diabetes and Cardiac Patients (LDL)	Commercial Medicaid Medicare Advantage
	Breast Cancer Screening (BSC)	Commercial Medicaid Medicare Advantage
	Pediatric Testing for Pharyngitis (CWP)	Commercial Medicaid
	Childhood Immunization Services (CIS)	Commercial
	Childhood Access (CAP)	Medicaid
	Lead Screening (LSC)	Medicaid
Specialty for both Domains		PCPs

*See page 2 for listing by Line of Business

RELATED NOTE FOR HEALTH INFORMATION TECHNOLOGY

As Health Systems and Physicians consider the many complex decisions related to the adoption or enhancement of Health Information Technology in their practices, HealthPlus of Michigan encourages physicians and practices to consider the use of CCHIT certified vendor products. The Certification Commission for HealthCare Information Technology (CCHIT) is a certification body for electronic health records and their networks and has been recognized by the U.S. Department of Health and Human Services. CCHIT is an independent body that certifies products (not companies) by name and version number tested.

The following link may be a valuable resource in considering your purchase and implementation decisions:

Information on CCHIT - <http://www.cchit.org>

E-PRESCRIBING

Measure Domain I - PCMH: Health Information Technology

Measure Summary: Demonstrated electronic prescribing use and capabilities in the PCP's office.

Each PCP's baseline e-prescribing rate will be determined from the prescriptions e-prescribed directly by that provider. The Primary Physician Group's e-prescribing rate will be determined from the aggregate of all e-prescriptions written by the Group's providers for their members. This will be measured by HealthPlus from electronic prescription claims billed by the pharmacy network with an NCPDP Prescription Origin Code of 3 at the beginning of the measurement year. Measurement includes new and refill prescriptions. Measurement is based on volume of e-prescriptions from total prescriptions prescribed, not an actual count of prescriptions.

DENOMINATOR CRITERIA

Identification Definition:

Tier 1: PCP meets QPP Program eligibility requirements. The denominator includes all prescriptions (written, telephone, electronic, facsimile) prescribed by the Primary Physician Group in the measurement year. Each prescription, new and/or refills, counts as one hit, regardless of the day supply prescribed. Count includes zero paid claims (prescription cost is less than the member's copay for example), all behavioral and non-behavioral health medications, non-adjusted (90 day supply equals 1 hit, not 3). All prescriptions for controlled substances (Schedule II through V) are excluded from the denominator for 2011. Recent changes in Michigan law allow e-prescribing of controlled substances, but these changes are not yet widely implemented in e-prescribing applications...

Tier 2: All prescriptions (written, telephone, electronic, facsimile) prescribed by the individual PCP in the measurement year with denominator as defined above.

Enrollment/Age Criteria: N/A

Exclusions: N/A

NUMERATOR CRITERIA

Qualifying Event Definition:

Tier 1:
HealthPlus will monitor and measure electronic prescription claims submitted to HealthPlus by the pharmacy, at the Primary Physician Group level. Based on National Council for Prescription Drug Programs, Inc. (NCPDP) claims processing standards and HealthPlus' submission requirements, prescription claims submitted to HealthPlus by the pharmacy will include an origin code (1=written, 2=telephone, 3=electronic, 4=facsimile); claims submitted with an origin code of 3 will count for this measure. The claims will also include an indicator for new and refilled prescriptions.

Tier 2: HealthPlus will monitor and measure electronic prescription claims submitted to HealthPlus by the pharmacy, at the individual physician level. Based on National Council for Prescription Drug Programs, Inc. (NCPDP) claims processing standards and

E-PRESCRIBING (cont)

HealthPlus' submission requirements, prescription claims submitted to HealthPlus by the pharmacy will include an origin code (1=written, 2=telephone, 3=electronic, 4=facsimile); claims submitted with an origin code of 3 will count for this measure. The claims will also include an indicator for new and refilled prescriptions.

MEASURE CALCULATION CRITERIA

Line of Business: Commercial, Medicaid, Medicare Advantage

Level of Measurement: Note: Payment may be made to Primary Physician Group or PCP

Eligible Physicians: All Program eligible Internal Medicine, Family Practice and Pediatric PCPs

Targets:

Tier 1: An e-prescribing rate will be measured at the Primary Physician Group level to determine a baseline rate and will continue to be measured throughout the measurement year.

If the Primary Physician Group demonstrates an increasing pattern of e-prescribing rates throughout the measurement year, then the entire Primary Physician Group shall be awarded the predetermined incentive.

Tier 2: An e-prescribing rate will be measured at the PCP level to determine a baseline rate and will continue to be measured throughout the measurement year.

If the individual PCP demonstrates an e-prescribing rate that is at or above the Primary Physician Group average, then the PCP shall be awarded the predetermined incentive.

Weight: Tier 1: 25/50 possible points
Tier 2: 50/50 possible points

Total Measure Value = 50 points of Domain I - PCMH

PATIENT REGISTRIES

Measure Domain I - PCMH: Health Information Technology

Measure Summary: Demonstrate patient registry for population management in the PCP's office

Identification Definition: PCP meets P4P Program eligibility requirements

Enrollment/Age Criteria: N/A

Exclusions: N/A

Qualifying Event Definition: The implementation and use of a patient registry system used as a population management tool with the following attributes:

- The functionality to manage populations by high-impact conditions such as diabetes, heart failure, COPD, asthma, low back pain, depression and others.
- Evidenced based medicine (EBM) guidelines continuously updated to current industry standards
- EBM guidelines forming gaps in care alerts

MEASURE CALCULATION CRITERIA

Line of Business: Commercial, Medicaid, Medicare Advantage

Level of Measurement: PCP Practice

Eligible Physicians: All Program eligible Internal Medicine, Family Practice and Pediatric PCPs

Targets: PCP/Practice is able to demonstrate the capability and use of patient registry system to HPM

Weight: Tier 1: 50/50 possible points

Total Measure Value = 50 points of Domain I - PCMH

CLINICAL QUALITY CRITERIA

APPROPRIATE TESTING for CHILDREN WITH PHARYNGITIS (CWP)

Measure Domain II: Clinical Quality

Measure Summary: Members 2 to 18 years of age as of end of the program year who were diagnosed with pharyngitis and received a group A streptococcus (strep) test within three days of the date of the pharyngitis diagnosis during the measurement period. The measurement period consists of three months (a quarter of the program year) and shall occur every 3 months (quarterly) throughout the program year.

Identification Definition: Members 2 – 18 years of age as of end of the program year

Enrollment/Age Criteria: Members must be enrolled at the time of service

Exclusions: N/A

Qualifying Event Definition: An outpatient visit or emergency department encounter with a diagnosis of pharyngitis and a group A streptococcus test within three days of the date of the pharyngitis diagnosis

Table CWP-A: Codes to Identify Pharyngitis

Description	ICD-9-CM Diagnosis
Acute pharyngitis	462
Acute tonsillitis	463
Streptococcal sore throat	034.0

Table CWP-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 0982, 0983
ED*	99281-99285	045x, 0981

*Do not include ED visits that result in an inpatient admission.

MEASURE PAYOUT CRITERIA

Line of Business: Commercial, Medicaid

Level of Measurement: Individual Physician

Eligible Physicians: All Program eligible Internal Medicine, Family Practice and Pediatric PCPs

Payout Methodology: The PCP will be eligible for payout for each group A streptococcus test completed for each eligible member during the measurement period (3 months). Payouts will be made quarterly throughout the program year.

Payout Type: Periodic Payout

Domain II

CHILDHOOD IMMUNIZATIONS (CIS)

Measure Domain II: Clinical Quality

Measure Summary: Children 12 months to 2 years of age during the program year who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. The measurement period consists of three months (a quarter of the program year) and shall occur every 3 months (quarterly) throughout the program year.

Identification Definition: Children who turn 12 months to 2 years of age during the program year.

Enrollment/Age Criteria: Members must be enrolled throughout the entire measurement period and are HealthPlus members on the last day of the measurement period.

Exclusions: N/A

Qualifying Event Definition: Completion of the entire combination of vaccines on or before the child's second birthday.

Vaccinations Included in the Complete Combination

Vaccine Type	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV
# of vaccines	4	3	1	3	3	1	4

Codes to Identify Childhood Immunizations

Immunization	CPT	HCPCS	ICD-9-CM Diagnosis*	ICD-9-CM Procedure
DTaP	90698, 90700, 90721, 90723			99.39
IPV	90698, 90713, 90723			99.41
MMR	90707, 90710			99.48
Measles and rubella	90708			
Measles	90705		055	99.45
Mumps	90704		072	99.46
Rubella	90706		056	99.47
HiB	90645-90648, 90698, 90721, 90748			
Hepatitis B**	90723, 90740, 90744, 90747, 90748	G0010	070.2, 070.3, V02.61	
VZV	90710, 90716		052, 053	
Pneumococcal conjugate	90669, 90670	G0009		

* ICD-9-CM Diagnosis codes indicate evidence of disease

MEASURE PAYOUT CRITERIA

Line of Business: Commercial

Level of Measurement: Individual Physician

Eligible Physicians: All Program eligible Internal Medicine, Family Practice and Pediatric PCPs

Payout Methodology: The PCP will be eligible for payout for one completed set of all vaccines for each eligible member during the program year. Payouts will be made quarterly throughout the program year.

Payout Type: Periodic Payout

Domain II

LEAD SCREENING IN CHILDREN (LSC)

Measure Domain II:	Clinical Quality
Measure Summary:	Children 2 years of age and under during the program year who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. The measurement period consists of three months (a quarter of the program year) and shall occur every 3 months (quarterly) throughout the program year.
Identification Definition:	Children who turn 2 years old or under during the program year
Enrollment/Age Criteria:	Members must be enrolled throughout the entire measurement period and are HealthPlus of Michigan members on the last day of the measurement period.
Exclusions:	N/A
Qualifying Event Definition:	At least one capillary or venous blood test on or before the child's second birthday and during the program year

Codes to Identify Lead Tests

CPT	LOINC
83655	5671-3, 5674-7, 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3

MEASURE PAYOUT CRITERIA

Line of Business:	Medicaid
Level of Measurement:	Individual Physician
Eligible Physicians:	All Program eligible Internal Medicine, Family Practice and Pediatric PCPs
Payout Methodology:	The PCP will be eligible for payout for one lead test completed for each eligible member during the program year. Payouts will be made quarterly throughout the program year.
Payout Type:	Periodic Payout
Domain II	

CHILD AND ADOLESCENT ACCESS TO CARE (CAP)

Measure Domain II: Clinical Quality

Measure Summary: Children 12 months to 19 years of age who had a visit with a PCP during the measurement period. The measurement period consists of three months (a quarter of the program year) and shall occur every 3 months (quarterly) throughout the program year.

Identification Definition: Members 12 months to 19 years of age or older as of the end of the program year.

Enrollment/Age Criteria: Members must be enrolled throughout the entire measurement period and are HealthPlus of Michigan members on the last day of the measurement period.

Exclusions: N/A

Qualifying Event Definition: One or more ambulatory or preventive care visits during the measurement year.

Codes to Identify Ambulatory or Preventive Care Visits

Description	CPT	ICD-9-CM Diagnosis
Office or other outpatient services	99201-99205, 99211-99215	
Home services	99341-99345, 99347-99350	
Preventive medicine	99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429, 99432, 99461	
General medical examination		V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

MEASURE PAYOUT CRITERIA

Line of Business: Medicaid

Level of Measurement: Individual Physician

Eligible Physicians: All Program eligible Internal Medicine, Family Practice and Pediatric PCPs

Payout Methodology: The PCP will be eligible for payout for one qualifying visit completed for each eligible member during the program year (1 year). Payouts will be made quarterly throughout the program year.

Payout Type: Periodic Payout

Domain II

HEMOGLOBIN A1C TEST FOR DIABETES (A1c)

Measure Domain II:	Clinical Quality
Measure Summary:	Members 18-75 years of age as of the end of the program year with diabetes (type 1 and 2) who had a hemoglobin A1c (HbA1c) test during the measurement period. The measurement period consists of three months (a quarter of the program year) and shall occur every 3 months (quarterly) throughout the program year.
Identification Definition:	<p>Diabetic members are those who had two face-to-face encounters with different dates of service in an outpatient setting or non-acute inpatient setting with a diagnosis of diabetes</p> <p>or</p> <p>had one face-to-face encounter in an acute inpatient or emergency room setting with a diagnosis of diabetes</p> <p>or</p> <p>were dispensed insulin or oral hypoglycemics/anti-hyperglycemics on an ambulatory basis during the program year or the year prior to the program year.</p> <p>Members 18 – 75 years of age as of the end of the program year.</p>
Enrollment/Age Criteria:	Members must be enrolled throughout the entire measurement period and are HealthPlus of Michigan members on the last day of the measurement period.
Exclusions:	<p>Members with a diagnosis of polycystic ovaries</p> <p>or</p> <p>Members with steroid induced diabetes</p> <p>or</p> <p>Members with gestational diabetes who did not have any face-to-face encounters with the diagnosis of diabetes, in any setting, during the program year or year prior to the program year.</p>
Qualifying Event Definition:	An HbA1c test performed during the measurement period as identified by a claim (administrative) with any of the following CPT codes or laboratory data.

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6, 59261-8

MEASURE CALCULATION CRITERIA

Line of Business:	Commercial, Medicaid, Medicare
Level of Measurement:	Individual Physician
Eligible Physicians:	All Program eligible Internal Medicine, Family Practice and Pediatric PCPs
Payout Methodology:	The PCP will be eligible for payout for one hemoglobin A1c (HbA1c) test completed for each eligible member during the program year. Payouts will be made quarterly throughout the program year.
Payout Type:	Periodic Payout
Domain II	

CHOLESTEROL (LDL-C) TEST FOR DIABETES AND CARDIAC PATIENTS (LDL)

Measure Domain II: Clinical Quality

Measure Summary: Members 18-75 years of age as of the end of the program year with diabetes (type 1 and 2) or a qualifying cardiac event who had a cholesterol (LDL-C) test during the measurement period. The measurement period consists of three months (a quarter of the program year) and shall occur every 3 months (quarterly) throughout the program year.

Identification Definition: Diabetic members are those who had **two** face-to-face encounters with different dates of service in an outpatient setting or non-acute inpatient setting with a diagnosis of diabetes
or
 had **one** face-to-face encounter in an acute inpatient or emergency room setting with a diagnosis of diabetes
or
 were dispensed insulin or oral hypoglycemics/anti-hyperglycemics on an ambulatory basis during the program year or the year prior to the program year.

Cardiac members are those who were discharged alive for AMI, CABG or PCI during the year prior to the measurement year
or
 met at least one of the following criteria during both the measurement year and year prior to the measurement year

- At least one outpatient visit with an IVD diagnosis , or
- At least one acute inpatient claim/encounter with an IVD diagnosis

Members 18 – 75 years of age as of the end of the program year.

Codes to Identify AMI, PCI and CABG

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
AMI (include only inpatient claims)			410.x1	
CABG (include only inpatient claims)	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209		36.1, 36.2
PCI	92980, 92982, 92995	G0290		00.66, 36.06, 36.07

Codes to Identify IVD

Description	ICD-9-CM Diagnosis
IVD	411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445

Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987

Enrollment/Age Criteria: Members must be enrolled throughout the entire measurement period and are HealthPlus of Michigan members on the last day of the measurement period.

Exclusions: Diabetic members with a diagnosis of polycystic ovaries
or
 Diabetic members with steroid induced diabetes
or
 Diabetic members with gestational diabetes who did not have any face-to-face encounters with the diagnosis of diabetes, in any setting, during the program year or year prior to the program year.

Qualifying Event Definition: A cholesterol LDL-C test performed during the measurement period as identified by a claim

(administrative) with any of the following CPT codes or laboratory data.

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2

MEASURE CALCULATION CRITERIA

Line of Business: Commercial, Medicaid, Medicare

Level of Measurement: Individual Physician

Eligible Physicians: All Program eligible Internal Medicine, Family Practice and Pediatric PCPs

Payout Methodology: The PCP will be eligible for payout for one cholesterol (LDL-C) test completed for each eligible member during the program year. Payouts will be made quarterly throughout the program year.

Payout Type: Periodic Payout

Domain II

BREAST CANCER SCREENING (BCS)

Measure Domain II: Clinical Quality

Measure Summary: Female members 40 - 69 years of age as of the end of the program year who had a mammogram to screen for breast cancer during the measurement period. The measurement period consists of three months (a quarter of the program year) and shall occur every 3 months (quarterly) throughout the program year.

Identification Definition: Female members 40 - 69 years of age as of the end of the program year.

Enrollment/Age Criteria: Members must be enrolled throughout the entire measurement period and are HealthPlus of Michigan members on the last day of the measurement period.

Exclusions: Women who have had a bilateral mastectomy or two unilateral mastectomies.

Qualifying Event Definition: At least one mammogram during the measurement period.

Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue
77055-77057	G0202, G0204, G0206	V76.11, V76.12	87.36, 87.37	0401, 0403

MEASURE PAYOUT CRITERIA

Line of Business: Commercial, Medicaid, Medicare

Level of Measurement: Individual Physician

Eligible Physicians: All Program eligible Internal Medicine, Family Practice and Pediatric PCPs

Payout Methodology: The PCP will be eligible for payout for one breast cancer screening completed for each eligible member during the program year. Payouts will be made quarterly throughout the program year.

Payout Type: Periodic Payout

Domain II

5. Payment Methodology

- The maximum payment to any PCP is determined by the specific Pay for Performance contractual agreement each Health System has with HealthPlus. Therefore, this document will not supply specific PMPM values.
- HealthPlus of Michigan will make every reasonable effort to remit Pay for Performance Program payments for Domain I (PCMH) Per Member Per Month metrics by Q3 of the reporting year, or approximately 9 months following the measurement year. This will allow for appropriate claims runoff, data validation, and report development and distribution.
- Program payout for Domain II (Clinical Quality) Periodic Payout metrics will be made on a quarterly basis throughout the program year.
- Payment will be determined by Health System/Physician Group (PPG) financial settlement process.
- Physician payment determination for Domain I (PCMH) Per Member Per Month metrics will be based upon the total of each Line of Business HMO member months reported for that PCP as of December 31 of the measurement year.
- If a physician does not meet the minimum membership requirements for Domain I (PCMH) and Per Member Per Month metrics in the program (an average membership of at least 50 members between the three LOBs for the program year), that physician will not be considered eligible for the Program.
- The minimum membership requirements (an average membership of at least 50 members between the three LOBs for the program year), will not be required for the Domain II (Clinical Quality) Periodic Payout metrics.

6. Program Performance Reporting and Timeframes

- Physicians and Physician Groups (PPG) will receive Pay for Performance Program performance reports from HealthPlus of Michigan:
 - Domain I (PCMH) Per Member Per Month metrics prior to the Q3 Program payout dates
 - Domain II (Clinical Quality) Periodic Payout metrics
- Finally, the accompanying **TABLE A** highlights additional reporting activity to PCPs by HPM throughout the calendar year report timeline, as well as additional supporting documentation that can be utilized by the PCP to assist in their understanding of year-to-date performance, and potentially improve rates if necessary. PCPs are encouraged to review the Clinical Quality materials that are supplied throughout the year and report any discrepancies to HPM for correction.

TABLE A

Report/Content	Report Period	Report Distribution Timeline	Department Responsible for Report Production/Development & Distribution
<u>Physician profile reports</u> (risk adjusted utilization). These reports support the efficiency metrics in the P4P program and provides member acuity information.	6 months	2nd and 4th quarter of the following year	Report Production: Business Intelligent Unit Distribution: PNM Educators (mail and office visits)
<u>Exception Lists of members</u> who have not received the required quality service to allow physicians to contact members to arrange for care. These support the Clinical Quality metrics of the P4P program.	Varies dependent on measure	At least annually; more often depending on measure	Report Production: Medical Services Distribution: Medical Services (mailed)
<u>HEDIS reports</u> which reflect physician quality scores for all measures. These support the Clinical Quality metrics of the P4P program.	Prior year	Annually	Report Production: Medical Services Distribution: Medical Services & PNM Educators (mail and office visits)
<u>Member outreach</u> targeted directly toward members to encourage them to obtain preventive services. Outreach includes reminder cards, letters, brochures, automated phone calls and newsletters.	Varies dependent on measure	Varies by topic	Report Production: Medical Services Distribution: Medical Services (mailed)
<u>Drug Summary</u> (formulary and generic compliance). These reports support the pharmacy measures in the P4P program.	Year to date	At least annually; more often depending on programs	Report Production: Pharmacy Distribution: Pharmacy and PNM Educators (mail and office visits)
<u>Top Fifty Drug Summary</u> (top drugs prescribed to patient panel). These reports support the pharmacy measures in the P4P program.	Year to date	At least annually; more often depending on programs	Report Production: Pharmacy Distribution: PNM Educators (mail and office visits)
<u>Pharmacy Opportunity Report</u> (current medications and cost-efficient alternatives). These reports support the pharmacy measures in the P4P program.	Preceding 6 months	At least annually; more often depending on programs	Report Production: Pharmacy Distribution: Pharmacy & PNM (Discussed at PPG meetings and one-on-one visits.)
<u>Physician-level member satisfaction reports</u> (C/G CAHPS® or ACES®) support the service quality measures of the P4P program	Prior Year	Annually	Report Production: Member Services and Satisfaction Distribution: PNM Educators (mail and office visits)

7. Physician Appeals – Reconsideration of Results

HealthPlus of Michigan will provide an opportunity for PCPs to address concerns with the data that was used to determine their performance. If a reconsideration of performance results is requested for an individual physician, the following processes will be followed:

Periodic Payout Clinical Quality HEDIS Metrics

- Reconsideration requests must be made in writing within 30 calendar days of the delivery of performance reports.
- Reconsideration requests should be sent to HPM by the individual PCP or through your PHO/PPG administrator. HPM will accept requests from the Health System/PPG on behalf of the PCP. However, in this case, HPM asks that all requests for reconsideration for the PCPs in question be sent to HPM as a single request. This will assist with an expedited response to the review.
- Reconsideration requests should be directed to the appropriate Provider Network Educator (see following list of contacts), either directly or through your PHO/PPG administrator.
- HealthPlus will require the following documentation from PCPs upon receipt of the reconsideration request:

HPM requires a copy of the appropriate section(s) of the medical record that indicates or describes compliance with the measure be submitted along with the reconsideration request. Measure specifications, including codes and timeframes, have been supplied in this document and highlight the requirements to satisfy the measure. If further clarification is required prior to sending in the request and associated documentation, please contact your HPM Provider Network Educator.

Periodic Payout Clinical Quality HEDIS Metrics

- If the reconsideration documentation that is sent to HPM supports recalculations and results in increased scores and payouts, the difference in payout will be added to the next measurement period (quarterly) payout and performance report for that PCP.

8. HealthPlus Staff Contacts

If you have questions or concerns regarding the HealthPlus of Michigan Pay For Performance Program, please direct them to your HPM Provider Network Educator.

Educator	Health System	E-mail	Phone Number
Layne Brown	<ul style="list-style-type: none"> • Covenant Medical Center • Hills & Dales General Hospital • Health Delivery, Inc. • Bay Health Network • St. Mary's of Michigan • Mid-Michigan Health Network - Midland 	lbrown@healthplus.org	989.797.4024
Jamie Betz	<ul style="list-style-type: none"> • Memorial Medical Associates – Owosso • Owosso Independents • Marlette Community Hospital • Mid-Michigan Health Network – Gratiot • St. Clair IPA • Physician HealthCare Network – Port Huron • Oakland Physician Network Services (OPNS) • United Physicians / Premier Physicians • Oakland Southfield Physicians • Greater Macomb PHO • Pontiac Osteopathic Hospital • Olympia Medical (Botsford) • Wayne State Univ. Physicians • Olympia Medical (Garden City) • St. John Health Partners • U of M • Beaumont Physician Organization 	jbetz@healthplus.org	810.230.2046
Diane Bradford	<ul style="list-style-type: none"> • Genesys PHO • Professional Med. Corp., PC (Hurley Adult & Pediatrics) • Hamilton 	dbradfor@healthplus.org	810.230.1083
Provider Network Management Department, Sherry Lloyd, Secretary	<ul style="list-style-type: none"> • Lapeer Independent Physicians • Lapeer Regional Medical Center Physicians • McLaren Regional Medical Center Physicians • McLaren Independent Physicians 	slloyd@healthplus.org	810.230.2172

9. Appendix

SAMPLE

2011 Commercial Health Information Technology (HIT) And Patient Access Assessment



INTERNAL USE ONLY

1. Provider Network Educator: _____

2. PPG Nbr: _____ 3. PCP Name: _____

4. HPM Provider Identifier: _____ 5. Date Visit _____

6. E-Prescribing Software Utilization:

6a. Is E-Prescribing Software Being Used? Yes No

6b. If Yes, Name of Software Utilized: _____

6c. Is an E-Prescribing Writer Being Used? Yes No

6d. Is the E-Prescribing Writer Linked to Patient Demographic/Clinical Information? Yes No

6e. Does E-Prescribing Writer Have Connectivity for E-Prescription Transmission to Pharmacy? Yes No

7. Is The PCP or the Health System the Sponsor:

7a. PCP / Practice

7b. Health System / PHO

7c. Other (Provide Description) _____

8. Patient Registry System/Software Utilization:

8a. Is Patient Registry Software Being Used? Yes No

8b. If Yes, Name of Software Utilized: _____

8c. Does Patient Registry Provide EBM (Evidenced Based Medicine) Guidelines? Yes No

8d. Does Patient Registry Provide Gaps In Care Information and Prompts? Yes No

8e. Does Patient Registry Have Compatibility/Connectivity With EMR? Yes No

9. Preference for Incentive Payout Frequency

9a. Quarterly Only

9b. BiAnnually Only

9c. Annually Only

9d. Quarterly and Annually