QualChoice® HEALTH INSURANCE

CPC+

CPC+ Participating Provider Training

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QualChoice, Your Partner for Success

As one of the major Comprehensive Primary Care Plus (CPC+) payers in Arkansas, QualChoice wants to ensure that you, as a participating primary care provider, have the information you need to succeed in this exciting five-year payment model. Rewarding practices who strengthen primary care is a goal we share with the Centers for Medicare and Medicaid Services (CMS).

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Why and How

CPC+ was developed to achieve three over-arching goals:

1. Improved patient care
2. Improve population health
3. Lower costs

CPC+ will help participating providers achieve these goals through:

1. Payment of population-based care management fees
2. Performance-based financial incentives

What is Being Tested with CPC+?

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Five "Comprehensive" primary care functions are being tested by the initiative:

1. Risk-stratified care management
2. Access and continuity
3. Planned care for chronic conditions and preventive care
4. Patient and family caregiver engagement
5. Coordination of care across medical neighborhood

Supporting the Five Functions

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To support the five primary care functions, CPC+ includes:

1. Multi-payer payment reform
2. Continuous use of data to guide improvement
3. Meaningful use of health information technology

Assumptions and Constraints

Meeting Targets

- PCP attribution will be based on claims data assignment or member designation according to QualChoice health plan requirements.

- Performance incentive payments paid to providers/practices will be based on quality and utilization metric reports.

Quality Reporting Requirements

Quality Report will be based on the following **Quality Measures:**

Inpatient Follow-up: Percentage of beneficiaries who had an acute inpatient hospital stay who were seen by a healthcare provider within 10 days of discharge.

Eye Exam*: Percentage of diabetic patients 18-75 years of age who had a retinal exam performed every two years.

Controlling Blood Pressure: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

HbA1c Poor control: Percentage of patients 18-75 years of age with diabetes (type1 or type2) whose most recent HbA1c level during the measurement period was greater than 9.0% or who were missing the most recent result if a HbA1c test was not done during the measurement period.

Tobacco Use: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling if identified as a tobacco user during the measurement period.

*See ***Alternate Measurement*** for patients tested before QualChoice enrollment.

Quality Reporting Requirements

Cervical CS*: Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 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

Colorectal CS*: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer during the measurement period.

BCS (Breast Cancer)*: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer during the measurement period.

Wellness Visit (Yearly): Percentage of beneficiaries who had a wellness visit during the measurement period (CPT Codes: 99381 – 99397); this includes:

- Age and gender-appropriate history and examination
- Counseling/anticipatory guidance/risk factor reduction interventions
- Ordering of laboratory/diagnostic procedures

*See ***Alternate Measurement*** for patients tested before QualChoice enrollment.

Alternate Measures

When performed prior to patient's enrollment in QualChoice Insurance, these four exams require alternate measures.

Code	Measure
3014F	Screening Mammography results, documented and reviewed
3015F	Cervical Cancer screening results, documented and reviewed
3017F	Colorectal Cancer screening results, documented and reviewed
2022F	Dilated Retinal Exam with interpretation by an ophthalmologist or optometrist, documented and reviewed

The majority of **Quality Measures** data will be claims-based only. However, three **Quality Measures** contain clinical information that must be collected as eCQMs from provider-submitted Category II CPT Codes. Those measures are:

Controlling Blood Pressure

HbA1c Poor Control

Tobacco Use

About Category II CPT Codes

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Category II CPT Codes, also known as F Codes, are non-billable codes used to report data about quality of care. This data will be collected from claims to analyze practice quality performance.

If a provider is unable to provide Category II CPT Codes, QualChoice will use Electronic Clinical Quality Measures (eCQMs) reported by CMS.

On the following pages, we share the metrics for each of these three quality measures: **Controlling Blood Pressure**, **HbA1c Poor Control**, and **Tobacco Use**. We also provide tips on how to meet your targets.

Quality Measure: Controlling High Blood Pressure

Controlling High Blood Pressure is defined as: % of patients with a Dx of HTN, whose most recent BP is <140/90 mmHg.

- **Success Numerator** = 3074F or 3075F (adequately controlled systolic BP) AND 3078F or 3079F (adequately controlled diastolic BP)
- **Failure** = 3077F (inadequately controlled systolic BP) or 3080F (inadequately controlled diastolic BP)
- **Denominator** = All patients in panel with Dx of HTN

Measure	Controlling High Blood Pressure
Description	Diagnosis of HTN and blood Pressure Controlled: ≤ 140/90
Denominator	Diagnosis of Hypertension in the measurement period or 12 months prior
	Systolic <140: Code 3074F OR 3075 Systolic >140: Code 3077F Diastolic <90: Code 3078F OR 3079F Diastolic >90: Code 3080F
Comments	If no code is submitted, the BP will be considered **UNCONTROLLED**

Quality Measure: HbA1c Poor Control

HbA1c Poor Control is defined as: % of patients with a Dx of T1DM or T2DM with HbA1c > 9.0% or HbA1c not tested.

- **Poor Control Numerator** = 3046F or no claim or code for HbA1c during measurement period
- **Good Control** = 3044F or 3045F during measurement period
- **Denominator** = All patients in panel with Dx of T1DM or T2DM

Measure	Diabetes: HbA1c Poor Control (>9)
Description	Diagnosis of Diabetes and have HbA1c >9% during the measurement period Calculation: 1 – the number of "controlled" A1c / Total Diabetics
Denominator	Diagnosis of Diabetes with a visit during the measurement period
	A1c Controlled: <7% OR 7-9%, Code 3044F OR 3045F A1c >9 Uncontrolled: Code 3046F
Comments	If A1c was **not taken** during the measurement period, the measure is **NOT MET** – do not submit a code

Quality Measure: Tobacco Use

Tobacco Use is defined as % of patients screened for tobacco use **and** offered cessation counseling/intervention.

Measure	Tobacco Screening and Cessation Intervention
Description	Percentage of adult patients who were screened for tobacco use one or more times within 24 months AND received intervention if a tobacco user
RATE 1 Denominator	All patients age 18 and older seen for at least 2 visits or at least one preventive visit during the measurement period
RATE 1 Success Numerator	Screening results (1034F [smoke] + 1035F [chew] + 1036F [non-user]) Screened and offered cessation counseling/intervention (4004F)
RATE 2 Denominator	Users based on screening (1034F [smoke] + 1035F [chew])
RATE 2 Success Numerator	4004F (screened and offered cessation counseling/intervention)

Utilization Measures

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The following utilization measures will be captured via reporting software:

1. Inpatient admissions per 1000 attributed beneficiaries
2. 30-day readmissions rate
3. Emergency Department (ED) visits billed per 1000 attributed beneficiaries
4. ED visits 6 or more times a year per 1000 attributed beneficiaries
5. Generic prescription dispensing rate
6. Prescriptions per attributed beneficiary per month
7. Imaging services per 1000 attributed beneficiaries per month

Utilization Measures

Measure	Metric	Calculation
Inpatient Admissions	Inpatient admissions per 1000 attributed beneficiaries	Hospitalization Rate per 1000, per month = (Number of admits/Total Member Months) * 1000
Thirty-Day Readmissions	Readmission to hospital within 30 days per 1000 attributed members	Thirty-Day Readmission Rate = Number of Readmits within 30 days/Total Admits
Emergency Department (ED) Visits	Billed Emergency department visits per 1000 attributed beneficiaries.	ED Rate per 1000 per month = (Number of ED Visits / Total Member Months)*1000
ED Visits, 6 or more	Beneficiary ED visits 6 or more times a year per 1000 attributed beneficiaries	More than 6 ED visits per 1000 per month = (Number of members with 6 or more ED visits/ Total Member Months)*1000
Generic Rate	Generic Prescription Dispensing Rate	Generic Dispensing Rate = Number Generic Rx Filled/ Total Rx Filled
Prescriptions	Prescriptions per Attributed Beneficiary per Month	Number of Rx per Member per Month = Number Rx Filled/ Total Member Months
Imaging Services	Imaging Services per 1000 Attributed Beneficiaries per Month	(Imaging Services per 1000 per month) = (Number of Imaging Services/ Total member months)* 1000

Utilization Report

A report is posted quarterly on the QualChoice.com *My Account* provider portal. This report includes:

1. A clinic rating against all other QualChoice CPC+ practices and general QualChoice membership for each utilization performance metric

2. An indication whether the clinic met the payment threshold for each metric at the end of the measurement year

3. The total average cost of care per member

Eligibility for Performance Incentives

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- Eligibility for incentives will be based on achieving **an above average performance (threshold) relative to other CPC+ practices on all combined quality metrics.**

- If the quality threshold of above average is not met, then there is no performance incentive payment of any kind. **The performance on utilization metrics will then be considered and will also be subject to above average methodology.**

- If the quality threshold is met, the incentive is based on the degree of above-average performance.

Payment Structure

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Payment consists of two elements:

Care Management Fee (CMF)

Performance-Based Incentive Payment

Care Management Fee (CMF):

Quarterly, providers receive non-visit based CMF paid Per Member Per Month (PMPM). Care Management Fees are based on the risk tiers. This means the amount is risk-adjusted for each practice to account for the intensity of services required for the practice's specific population. These risk adjustments are captured through an external tool.

Payment Structure

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Performance-Based Incentive Payment:

Annually, QualChoice will pay a retrospective, performance-based incentive, based on practice performance, clinical quality measures, and utilization measures that drive total cost of care. To qualify for performance incentive payment, practices must be in good standing with CMS.

Data Reporting:

QualChoice will publish member cost and utilization data at regular intervals for participating practices via the *My Account* portal at QualChoice.com.

Keeping You Informed

- As your partner in CPC+, we are ready to receive your comments, tips, and questions at **CPC+@QualChoice.com**.
- We will keep you informed on program developments via CPC+ QuickNews email updates.
- Visit QualChoice.com for CPC+ updates and other healthcare improvement topics.