FREQUENTLY ASKED QUESTIONS

As of July 2009

EPSDT SCREENING AND PARTICIPATION RATES

1. **Since the EPSDT Screening rate and EPSDT Participation rate are measured independently, how are the two calculated?**

   The EPSDT screening rate is calculated using the current CMS 416 logic available on the CMS web site. The actual number of initial and periodic screening services received is divided by the expected number of initial and periodic screening services. This rate indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by Passport Health Plan's (the Plan's) periodicity schedule, adjusted by the proportion of the year for which they are Medicaid eligible.

   The EPSDT participation rate is calculated using the current CMS 416 logic available on the CMS web site. The participation rate is the unduplicated count of members who received at least one documented initial or periodic screening service during the year divided by the number of members who should have received at least one initial or periodic screen, in accordance with the Plan's periodicity schedule and the average period of eligibility.

BREAST CANCER, CERVICAL CANCER, AND CHLAMYDIA SCREENINGS

2. **What clinical information or references are used as resources for the Provider Recognition Program to determine the age specifications and frequency of breast cancer, cervical cancer, and Chlamydia screenings?**

   While the **HEDIS®** tool is used for measuring data for the Provider Recognition Program, the Plan's Adult **Preventive Health Clinical Practice Guidelines (CPGs)** are the basis for obtaining clinical information.

3. **What is a "Measurement Period" as referred to in Provider Recognition Program information?**

   HEDIS® establishes a measurement period for each clinical measure. A measurement period is a defined length of time in which a service must occur in order to be calculated towards a PCP group's screening results. Some clinical measures are one calendar year in length, some are two calendar years, etc. as determined by HEDIS.®

4. **What is the frequency and age specification for breast cancer screenings?**

   Based on the Plan's CPGs, mammogram screenings (with or without a clinical breast exam) should be performed every one to two years at age 40 and older. In accordance with HEDIS® requirements, data is captured for women 40-69 years of age who had a mammogram to screen for breast cancer during the measurement period (the last two calendar years prior to the current year).

5. **What is the recommended age group for cervical cancer screenings?**

   Based on the Plan's CPGs, a Pap test to screen for cervical cancer is recommended annually; then, after three or more normal tests, the screening should be conducted at least once every one to three years. In accordance with HEDIS® requirements, data is captured for women 21-64 years of age who were screened for cervical cancer during the measurement period (the last three calendar years prior to the current year).

6. **What is the recommended age group for Chlamydia screenings?**

   Effective January 2009, and based on the Plan's CPGs, Chlamydia screenings are recommended for all sexually active and pregnant women **ages 24 and younger** annually, and for those **women at high risk** (i.e. have multiple partners, STD history, etc.). Prior to 2009, the upper age limit was 25.

   Rescreenings are recommended three to four months following treatment. In accordance with HEDIS® requirements, data is captured for women 16-24 years of age identified as sexually active who received at least one test for Chlamydia during the measurement period (the previous calendar year).

7. **Is the urine Chlamydia screening an acceptable screening for the Provider Recognition Program?**

   Yes. Urine Chlamydia screenings are included under CPT code 87110 (Chlamydia culture, any source) and allow provider reimbursement above capitation.

   Please refer to the Plan's *Provider Newsletter 2006 Volume 8 No. 2* for additional details regarding Chlamydia screenings reimbursed above capitation. This newsletter is available in the Provider Center of the Plan's web site, **www.passporthealthplan.com**.

8. **What methods are used to identify sexually active women for the Chlamydia screening?**

   There are two methods used to identify sexually active women: **(1) pharmacy data** and **(2) claims/encounter data**. Members can be identified as sexually active if they are dispensed prescription contraceptives (i.e. oral contraceptives, intrauterine devices (IUDs), diaphragms, or other prescribed contraceptives), or if they had at least one encounter of diagnosis or procedures such as pregnancy, prenatal testing, postpartum care, and/or test for other sexually transmitted diseases.

9. **If the member does not turn the recommended age for a screening until the end of the year, am I required to perform the screening during the same or following measurement period?**

   According to HEDIS® screenings must be performed **by December 31st** of the required measurement period.

ER UTILIZATION

10. How does Passport Health Plan proactively assist providers in decreasing inappropriate ER utilization?

Members identified as high utilizers of emergency rooms are encouraged to join one of our **health management or case management programs** in an effort to manage and coordinate their care with other providers.

The Plan's Health Management department distributes quarterly utilization reports to PCPs indicating panel members with eight (8) or more ER visits in a rolling 12 month period.

PCP groups also have an opportunity to receive **comprehensive service payments** for additional services provided. These services include, but are not limited to, extended office hours to treat patients outside of the non-traditional hours (morning, evening or weekend) each week. Morning hours are defined as before 8 a.m. Evening hours are defined as after 6 p.m.

In addition, the Plan offers **guidance to all PCPs** who must meet the Department for Medicaid Services (DMS) requirements regarding office standards, found in Section 4 of the Passport Health Plan Provider Manual.

PCP PROFILE INDEX

11. Will the PCP Profile remain a measure of the Provider Recognition Program?

Yes. The methodology used to calculate the PCP Profile remains unchanged and is now 20 percent of the financial distribution. In the previous PCP bonus, the PCP Profile accounted for approximately 60 percent of the financial distribution.

MEMBER SATISFACTION

12. How is the Member Satisfaction data gathered?

The Plan utilizes **member complaint data** to produce the Provider Recognition Program member satisfaction reports. Data is compiled twice annually, reflecting a six-month period.

13. If a member files a complaint for not receiving a prescription that is not on the Plan's formulary, does this complaint affect me?

No. This type of complaint is filed as a Denial or Reduction of Services **against Passport Health Plan**, not against the provider. However, if a provider refuses to write a prescription for drugs on the formulary, and does not follow the Plan's pharmacy guidelines (including prior authorization and/or step therapy treatment), a member complaint will be filed against the provider.

FINANCIAL DISTRIBUTION

14. Does the Provider Recognition Program affect my reimbursement, capitation and fee for service as a PCP?

No. Qualifying PCPs can acquire **additional** payments through the Provider Recognition Program by demonstrating improvement and/or excellence in performance in the categories of utilization, member satisfaction, access to care, and health outcomes.

15. If I qualify to receive rewards for any of the measures of the Provider Recognition Program, when will I receive payment?

If earned, payments for the Provider Recognition Program will occur during September, November, February, and May.

The mid-summer payments are distributed in September **in order to allow time for submission and review of the medical record documentation** during the annual Women's Health Outcome Reconsideration process.

16. I achieved over 100 percent for the EPSDT screening rate. Why did I not qualify for the Tier Two payment?

Providers who achieve a score within the top ten percent of all provider groups will earn Tier Two rewards. Due to the manner in which the screening rate is calculated, **receiving a score of 100 percent does not automatically mean you are in the top ten percent**.

The EPSDT screening rate indicates the actual number of initial and periodic screening services received divided by the expected number of initial and periodic screening services. This rate indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the Plan's periodicity schedule, adjusted by the proportion of the year for which they are Medicaid eligible.

For example:

- 10 members - all age four
- Each member was eligible six months (0.5 average period of eligibility)
- Provider is expected to perform five screenings (denominator)
- Provider performed 10 screenings – final rate = 200 percent

EDUCATION AND TRAINING

17. May I request onsite training for the rewards program?

Yes. Interested groups may contact their Provider Relations representative, the Provider Relations department at (502) 585-7943, or email provider.recognition@amerihealthmercy.org for additional assistance concerning the program.

WOMEN'S HEALTH OUTCOME REQUEST FOR RECONSIDERATION

18. A member identified in my women's health outcome screenings list as "No Screening" didn't receive the screening because it was not appropriate in accordance with the Plan's CPGs. How can I update my data?

After the women's health outcome data is distributed with member specific information, groups are given a four-week timeframe to review the data and provide a copy of the medical records indicating the screening is **not required based on the Plan's CPGs** (i.e. a copy of the medical record stating the patient either had a hysterectomy or bilateral mastectomy prior to December 31st of the previous year, or was not sexually active to require a Chlamydia screening during the previous calendar year).

19. **Members were identified in my women's health outcome screenings list as "No Screening" — but the screening was performed during the measurement period. How can I update my data?**

After the women's health outcome data is distributed with member-specific information, groups are given a four-week timeframe to review the results and provide a copy of the medical records **based on the Plan's CPGs** indicating the screening was **performed during measurement period**:

- Chlamydia screening during the previous calendar year.
- Breast cancer screening during the two years prior to the current calendar year.
- Cervical cancer screening during the three years prior to the current calendar year.

20. **Members were identified in my women's health outcome screenings list as "No Screening" — but the screening was performed during the current calendar year. Is this acceptable?**

No. Medical records reflecting services provided in the current calendar year do **not reflect the accurate measurement period**. This will not improve your current scores for any of the women's health outcome screenings.

However, the screening performed during the current calendar year will assist in next year's measure. **Screenings should be performed during the measurement period**:

- Chlamydia screening during the previous calendar year.
- Breast cancer screening during the two years prior to the current calendar year.
- Cervical cancer screening during the three years prior to the current calendar year.

21. **Members identified in my women's health outcome screenings list as "No Screening" did not attend their scheduled screening. Is it acceptable to submit notation indicating "member was a no show" or "no contact information?"**

No. Providers must submit medical record documentation that supports services performed and/or services not required based on the Plan's CPG's. Provider groups will not earn credit by submitting "No Show" notations for the Provider Recognition Program.

22. **Members identified in my women's health outcome screenings list as "No Screening were referred or self-referred (direct access) to a specialist (OB/GYN) to receive screenings. Do I receive credit for those screenings as well?**

Yes. The PCP has the responsibility for arranging and coordinating the delivery of medically-necessary health care services to members. Thus, any services that occur for the member are attributed to the PCP. Furthermore, specialists are to report the results of services to the member's PCP. The specialist should copy all test results in a written report to the PCP. The PCP is to maintain specialist reports in the member's central medical record and take steps to ensure that any required follow-up care is provided.

23. **Will I receive credit if I referred a member to a specialist to receive screening but they didn't follow through with the visit?**

No. Documentation of a referral does not earn credit in the Provider Recognition Program. The provider must submit medical records documenting the member received screenings in order to earn credit in the Provider Recognition Program.

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