Chapter 7

QualityBLUE℠ A Physician Pay-for-Performance Program

Unit 1: Overview - Fee-for-Service Payment

In this unit

7.1 Introduction to the QualityBLUE Fee-for-Service Program

Purpose

In July of 2005, Highmark Blue Shield began an additional Quality Incentive Payment System (QIPS) Program in a Fee-for-Service (FFS) environment to encourage physicians to continue to support Highmark's goal of providing accessible, high-quality health care as efficiently as possible. The name also changed from QIPS to QualityBLUE, A Physician Pay-for-Performance program.

In January 2007, the QualityBLUE capitation incentive program was eliminated based on the elimination of base capitation. The FFS incentive program remains active.

Definition

QualityBLUE is an incentive program that offers Primary Care Physicians (PCPs) (family practice, internal medicine, pediatric, and general practitioner specialties) an opportunity to earn an additional reimbursement for providing efficient, high-quality health care.

- The QualityBLUE FFS program is a reward program offered in addition to the fee schedule.
- The QualityBLUE FFS program will focus primarily on quality and efficiency measures.
- There are two components of the program: reports and payments.

Eligibility Requirements

PCPs can qualify for participation in the QualityBLUE FFS program once the provider meets the following eligibility and quality requirements:

- Our Network's Professional Agreement
- NaviNet enabled
- A 12-month practice volume of:
  - $40,000 of paid eligible Evaluation & Management (E&M) services.
  - 85% of claims submitted electronically.
- Achieved a minimum Total Quality Score – this applies only if above requirements are met.

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7.1 Introduction to the QualityBLUE Fee-for-Service Program, Continued

Prospective Only - Moving Forward Quality Incentive Pay For Performance	The calculation of the pay for performance quality incentive will be evaluated quarterly, and will pay prospectively. Once the notification of the signed agreement is received, and the eligibility and minimum quality requirements are met, the incentive payments may begin. No quality scoring or payment retroactivity will be calculated on evaluation and management services paid prior to the notification of the agreement. No claims adjustments will be calculated on evaluation and management services paid prior to the notification of the agreement.
Practitioner Agreement - Participation In The Western Region Network And/Or PremierBlue Network	Even though a physician practice may be credentialed in both the Western Region Network and PremierBlue networks, physician practices may only sign the Practitioner Agreement and participate in either the Western Region Network or PremierBlue QualityBLUE incentive. The review of the incentive eligibility and minimum quality requirements will only generate one performance detail report. If you have any questions, please contact your Provider Relations representative.
Practitioner Agreement - Listing of Practitioners	Each practitioner in a physician practice should be credentialed in the Western Region Network or PremierBlue network prior to participation in this quality incentive program. The Western Region Network and/or PremierBlue fee schedule and applicable incentives should be paid to participating physician practices only.

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7.1 Introduction to the QualityBLUE Fee-for-Service Program, Continued

What Products Are included?

The following products are included in the measurement of the QualityBLUE FFS program:

- PPOBlue
- EPOBlue
- DirectBlue POS
- DirectBlue PPO
- FreedomBlue Medicare Advantage PPO
- Western Region Medicare Advantage HMO
- Western Region Direct Access Medicare Advantage HMO
- Caring Program HMO
- adultBasic HMO
- adultBasic PPO
- BlueCHIP HMO
- Western Region Individual HMO
- Western Region POS

Measurement Period

The following table demonstrates the QualityBLUE measurement periods that relate to the Pay-for-Performance incentive payment quarters.

Incentive Payment received in this quarter	**Eligibility Requirements: $40 K (Annual 12 month) Paid Eligible Evaluation and Management Services and Electronic Claims Submissions**	**An additional month is given for remaining claims from prior months**	**Start date for data processing**
January – March	September 1 – August 31	September 30	December 1
April – June	December 1 – November 30	December 31	March 1
July – September	March 1 – February 28	March 31	June 1
October – December	June 1 – May 31	June 30	September 1

Ongoing Changes To The Program

This program continually evolves to meet the needs of Highmark and the Western Region Network practitioners. Accordingly, this program will be revised from time to time. Notice will be communicated by a separate letter mailed to your practice, and identified in the Special Bulletin or Clinical Views.

7.1 The QualityBLUE Fee-for-Service Detail Report – Quality

The Fee-for-Service Detail Report

The *QualityBLUE FFS Detail Report – Quality*, varies in length based on the type of specialty or detail used for each category and available data, and is generated quarterly based on:

- Clinical Quality Measures
- Generic/Brand Prescribing Patterns
- Member Access
- Best Practice Measure
- Electronic Health Records Implementation (EHR)
- Electronic Prescribing Implementation (eRX)

A sample report is included in this unit. The report is available online via NaviNet.

Performance Profile Graph Pages – Revised For Fee-For-Service Payments

The performance profile graph pages of the fee-for-service detail reports were modified for the pay-for-performance program, which includes the key drug utilization indicators section, quality trends, Rx trends and costs, and provides a visual snapshot of information in the report. Information displayed is practice-specific and based on the current quarter and available previous quarters or year.

The Incentive Trend Report – For Only Fee-For-Service Payments

As of January 2006, a quarterly Incentive Trend Report for only the fee-for-service payments is available online through the Provider Resource Center. The Incentive Trend Report/Fee-for-Service provides two separate reports:

- The first report is a Summary, listing the QualityBLUE incentive payment, level and number of select E&M services for a 12 month reporting period.
- The second report is a Claim Detail listing of claim number, procedure code, member ID, DOS, Paid Date, Incentive Level ($3, $6 or $9) based on the number of select E&M services, and the claim payment.

Note: This report will not be mailed. This report should be kept for your records, and be used to review the payment trends for your practice. If your practice is not NaviNet enabled, this report is not applicable.

7.1 The QualityBLUE Fee-for-Service Detail Report – Quality, Continued

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name - 000000000

Region: Western Specialty: Pediatrics

Practice Summary

Incentive Results

Total Quality Score:	103/115
Incentive Level:	High
Quality Incentive Amount:	$9 Per Select E & M Service

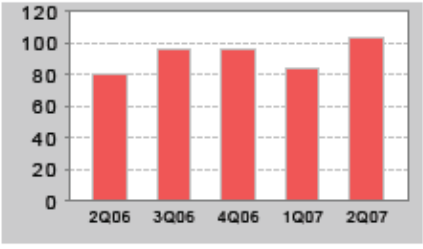
Quality Measure Scores

Quality Measure	Description	Possible Score	Practice Score
Clinical Quality	Expected Quality Guidelines *Uses a 1 - 4 year defined measurement period of claims data*	65	60
Generic / Brand RX	Generic/Brand Prescribing Patterns *Uses 3 months drug claims data in measurement period*	30	30
Member Access	Average Weekly Office Hours and Non-Traditional Hours *Uses current office hours*	5	5
Best Practice	Clinical Improvement Activity *Uses work plan progress documentation*	5	3
Electronic Health Record (EHR)	Electronic Health Record Implementation *Uses evidence of implementation progress*	5	0
Electronic Prescribing	Electronic Prescribing Implementation *Uses evidence of implementation progress*	5	5
Total Quality Score		**115**	**103**

Quality Incentive Level Scoring

Total Quality Score	Incentive Level	Incentive Amount
Over 100	High	$9 Per Select E & M Service
90 - 100	Medium	$6 Per Select E & M Service
65 - 89	Low	$3 Per Select E & M Service
0 - 64	None	$0 No Incentive

Quality Trends for the Practice



Eligibility Requirements

Incentive Bonus Eligibility and Minimum Quality Requirements - Measured and Moved Forward Quarterly

NaviNet Enabled

12-Month Volume of:

A minimum of $40,000 of paid Evaluation & Management (E&M) services

85% of claims submitted electronically

Achieved Minimum Total Quality Score - applies only if above two eligibility requirements are met

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7.1 QualityBLUE Fee-for-Service Payment

When Does Payment Occur?

When your practice submits claims with eligible Evaluation and Management (E&M) services, the QualityBLUE FFS incentive will be calculated at the time the claims are processed. (Incentive payments will be made based on incurred dates, not paid dates.)

How Does Payment Occur?

The incentive amounts will be added to your claims payments, which are included in your reimbursement check. The incentive amounts will be itemized separately on the Provider Explanation Of Benefit (EOB).

Quality Incentive Level Scoring

The quality incentive amount is based on the total quality score. Refer to the Quality Incentive Level Scoring Table below.

Total Quality Score Range	Incentive Level Description	Incentive Amount
Over 100	High	$9 Per E&M Service
90 - 100	Medium	$6 Per E&M Service
65 - 89	Low	$3 Per E&M Service
0 - 64	None	$0 No Incentive

Minimum Quality Standard

To be eligible for any QualityBLUE incentive, the practice must have a quality score of 65 and above.

7.1 Qualifying for QualityBLUE Fee-for-Service Payment

Reminder: Eligibility Requirements

PCPs can qualify for participation in the QualityBLUE FFS program once the provider meets the following eligibility and quality requirements:

- Western Region Network's Professional Agreement
- NaviNet enabled
- A 12-month practice volume of:
  - $40,000 of paid eligible Evaluation & Management (E&M) services.
  - 85% of claims submitted electronically.
- Achieved a minimum Total Quality Score – this applies only if above requirements are met.

Eligible E&M Codes

There are 12 Evaluation & Management (E&M) categories, and will total 106 individual codes. Please refer to the table below for more information. Please note: the review for eligible codes will be performed annually and as necessary.

E&M Category Description and Range	Number of Codes	Individual Codes
Office/Outpatient 99201 – 99215	10	99201-99205 99211-99215
Office/Preventative 99381 – 99412	20	99381-99387 99391-99397 99401-99404 99411-99412
Hospital Visit 99221 – 99239	11	99221-99223 99231-99236, 99238-99239
Outpatient Consults 99241 – 99245	5	99241-99245
Hospital Consults –Revised 1-1-06 99251 – 99255	5	99251-99255
Newborn 99431 – 99440	6	99431-99433, 99435-99436 99440
Observation 99217 – 99220	4	99217-99220
Nursing Home – Revised 1-1-2006 99304 – 99318	10	99304-99309, 99310, 99315-99316, 99318
Critical Care – Revised 1-1-2006 99289 – 99300	11	99289 99290-99296, 99298-99299 99300
ER 99281 – 99288	6	99281-99285, 99288
Rest Home – Revised 1-1-2006 99324 – 99337	9	99324-99328 99334-99337
Home Visit 99341 – 99350	9	99341-99345, 99347-99350

7.1 Qualifying for QualityBLUE Fee-for-Service Payment, Continued

Composite Quality Performance Measures

The QualityBLUE FFS payments are based on the QualityBLUE quality performance measures shown in the table below.

Measure	Based on…	Max score	Refer to Chapter, Unit, and Page
Clinical Quality	The clinical quality categories specific to each specialty with their corresponding expected quality guidelines	65	7.2 Page 2
Generic/Brand Prescribing Patterns	The percentage of prescriptions that are written for generic drugs	30	7.2 Page 29
Member Access	Average office hours and non-traditional office hours	5	7.2 Page 33
Best Practice	Clinical Improvement Activity	5	7.2 Page 37
EHR	Electronic Health Record Implementation	5	7.2 Page 43
eRX	Electronic Prescribing Implementation	5	7.2 Page 45
Maximum Total Quality Score		**115**	

Ineligibility

If any practitioner within a practice has been cited for network non-compliance or is in the sanctioning process, the practice is ineligible to participate in the QualityBLUE Program.

The three categories of non-compliance are:
- Quality of care concerns
- Unacceptable resource utilization
- Administrative non-compliance

The practice is ineligible to participate in QualityBLUE for at least one full quarter immediately following the citation or sanctioning date.

7.1 Qualifying for QualityBLUE Fee-for-Service PaymentQualityBLUE Reports Accessible via NaviNet

Online Resources For PCPs

Network PCPs can utilize the online Provider Resource Center, accessible via NaviNet or either of our public member sites, which includes helpful reference material related to QualityBLUE.

- The QualityBLUE program is detailed in the Highmark Blue Shield Office Manual, Chapter 7.
- Data submission forms for the Best Practice, Electronic Health Record (EHR), and Electronic Prescribing (eRx) quality measures are available for downloading under the **QualityBLUE Physician Pay-for-Performance Submission Forms**.
- In January 2006, two new reports were first made available on the NaviNet Plan Central page, under a new QualityBLUE section of the menu. They are the Clinical Quality Patient Names Report and the Incentive Trend Report/Fee-for-Service.
- The Clinical Quality Patient Names Report provides a convenient "check list," including patient name, ID number, date of birth and an indicator ("yes" or "no") on whether or not the expected quality guideline was met for each patient. This report can be viewed online or opened as an excel version. It can also be sorted to review and follow up on patients in need of specific care, per the quality guideline.
- The Incentive Trend Report/Fee-for-Service provides two separate reports. The first report is a Summary, listing the QualityBLUE incentive payment, level and number of select E&M services for a 12 month reporting period. The second report is a Claim Detail listing of claim number, procedure code, member ID, DOS, Paid Date, Incentive Level ($3, $6 or $9) based on the number of select E&M services, and the claim payment.
- As of April 2006, the Detail Report is also available for: Fee-for-Service – Quality and/or Capitation – Quality. Beginning January 2007, only a Fee-for-Service Quality report will be generated.
- The Detail Report provides several pages of practice specific information such as: the summary calculation for eligibility and incentive level, graph(s), clinical quality, member access, generic/brand prescribing patterns, best practice, electronic health record and electronic prescribing.