

**Frequently Asked Questions (FAQs)**  
**Pay for Performance Measurement Year 2011**  
**January 2012**

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<b>P4P</b>	<b>Meaningful Use of Health IT (MUHIT)</b>	<b>Reviewed:</b> 1/17/12
	<p><b>Question:</b> Page 115 of the manual was updated to state, "POs must have functional EHRs in place 90 days before the end of the measurement year (i.e., the PO's EHRs must be functional by October 1, 2011). Define "functionality." Our organization has been using an EHR system for a number of years (before October 1, 2011), but we have a backlog in becoming fully functional, as defined in each measure. Do we receive credit for all of the measures?</p> <p><b>Response:</b> No. For the MUHIT domain, "functionality" means a fully operational and implemented system that has been in use since October 1, 2011. An organization that has an EHR in place, but is not using it as defined in the measure intent statement, does not receive any points for that measure.</p>	
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<b>P4P</b>	<b>Meaningful Use of Health IT (MUHIT)</b>	<b>Reviewed:</b> 1/17/12
	<p><b>Question:</b> Define "intent" as used in the <i>Scoring</i> and <i>Required Submission</i> sections of each measure. How do we know we meet a measure's intent, with respect to Required Submission item 4 and Assigned Points item 5?</p> <p><b>Response:</b> For the MUHIT domain, "intent" refers to the measure's criteria, as specified in the <i>Intent</i> section. For Required Submission item 4, count the number of PCPs, or the number of patients assigned to PCPs who meet the criteria listed for each measure. Assign the number of points that correspond to the percentage of PCPs meeting the measure's intent.</p>	
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<b>P4P</b>	<b>Meaningful Use of Health IT (MUHIT)</b>	<b>Reviewed:</b> 1/17/12
	<p><b>Question:</b> For MY 2011, what is the definition of Primary Care Providers (PCPs)? Does this include Pediatricians?</p> <p><b>Response:</b> For MY 2011, POs should use their own designation of PCPs. This is in alignment with how P4P had defined PCPs for the IT-Enabled Systemness Domain.</p>	
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<b>P4P</b>	<b>Health Plan Clinical Measure File Layout</b>	<b>Reviewed:</b> 1/17/12
	<p><b>Question:</b> Why are there three "example" tabs in the MY 2011 Health Plan Data Submission file layout?</p> <p><b>Response:</b> In MY 2011, health plans may submit results for the Medicare product line and for the commercial product line. Because the Medicare product line is now reported by health plans, the Health Plan Clinical and Testing Measure file layouts have three tabs for the possible reporting scenarios (commercial HMO/POS and Medicare, commercial HMO/POS only, Medicare only).</p> <p>1. <b>Scenario 1: The health plan has both commercial HMO/POS and Medicare product lines</b></p> <p><b>Clinical Measure File Layout:</b> Plans that report for both the commercial HMO/POS and Medicare populations must have <u>66</u> clinical measure IDs per DMHC ID/Sub Unit, even if an individual PO has only commercial or Medicare enrollment.</p>	

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**Testing Measure File Layout:** Plans that report for both the commercial HMO/POS and Medicare populations must have 31 clinical measure IDs per DMHC ID/Sub Unit, even if an individual PO has only commercial or Medicare enrollment.

**Refer to Tab (5) Sample HP File—Both Commercial and Medicare**

**Examples 1–3:** The plan has commercial and Medicare product lines; POs 11111-00, 22222-03, 22222-05 and 33333-05 also have commercial and Medicare members: the plan submits commercial and Medicare data for these POs.

**Example 4:** The plan has commercial and Medicare product lines; PO 44444-01 has only Medicare members: the plan submits Medicare data for PO 44444-01 and populates commercial rows for PO 44444-01 with zero enrollment, zero denominator, zero numerator and rate “NB.”

2. **Scenario 2: The health plan has commercial HMO/POS product line only**

**Refer to Tab (6) Sample HP File—Commercial Only:** Plans that have the commercial product line only submit data for the commercial product. There are no rows for the Medicare product.

**Clinical Measure File Layout:** The plan reports 59 clinical measure IDs per DMHC ID/Sub Unit for the commercial product.

**Testing Measure File Layout:** The plan reports 10 testing measure IDs per DMHC ID/Sub Unit for the commercial product.

3. **Scenario 3: The health plan has Medicare product line only**

**Refer to Tab (7) Sample HP File—Medicare Only:** Plans that have the Medicare product line only submit data for the Medicare product. There are no rows for the commercial HMO/POS product.

**Clinical Measure File Layout:** The plan reports 7 clinical measure IDs per DMHC ID/Sub Unit for the Medicare product.

**Testing Measure File Layout:** The plan reports 21 clinical measure IDs per DMHC ID/Sub Unit for the Medicare product.

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<b>P4P</b>	<b>MY 2011 P4P Crosswalk to HEDIS 2012 NDC List</b>	<b>Reviewed:</b> 1/17/12
	<p><b>Question:</b> When looking for the NDC list for P4P tables CWP-C and URI-D, to which table in HEDIS should we crosswalk?</p> <p><b>Response:</b> For MY 2011 P4P tables CWP-C and URI-D, crosswalk to the HEDIS 2012 NDC list for table CWP-C.</p> <p><b>*Note:</b> The MY 2011 P4P crosswalk to HEDIS 2012 NDC List posted on December 8, 2011, has been corrected.</p>	
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<b>P4P</b>	<b>Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women</b>	<b>Reviewed:</b> 1/03/12
	<p><b>Question:</b> A new exclusion code (ICD 279) was added to the Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women measure, but no guidance was provided on time frame to allow the exclusion.</p> <p><b>Response:</b> For this exclusion, look back as far as possible in the member's history.</p>	
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<b>P4P</b>	<b>Meaningful Use of Heath IT (MUHIT)</b>	<b>Reviewed:</b> 1/03/12
	<p><b>Question:</b> Will PCPs who use certified modules and do some meaningful use measures get credit for the measures?</p> <p><b>Response:</b> Yes, although because MUHIT is scored at the measure level, PCPs might receive credit for some measures and not for others.</p>	
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<b>P4P</b>	<b>Proportion of Days Covered by Medications</b>	<b>Reviewed:</b> 1/03/12
	<p><b>Question:</b> How do you account for claim reversals?</p> <p><b>Response:</b> PDC measures are calculated through use of paid, nonreversed claims for target medications. If the drug claims dataset contains claim reversals (and paid claims that were reversed), analysts must ensure that the reversed claims are not used to calculate PDC. Claim reversals can be identified through multiple methods because there may be multiple fields in a drug claim that indicate whether it is a reversal. Many drug claims datasets have a "Count" field that contains a "1" for a paid claim and a "-1" for a claim reversal. The dataset may also have a field called "Reversal" that contains a "Y" if the claim is a reversal claim, or an "N" if it is not a reversal. Reversal claims typically have a negative quantity and a negative cost.</p> <p>The claim reversal ("-1" in the Count field or "Y" in the Reversal field) may have a "Claim Number" that is identical to the original claim being reversed. If the Claim Number for the reversal claim is not identical to the Claim Number for the original claim, analysts can create coding logic that will identify the reversed claim as immediately preceding the claim reversal. This latter approach is not usually necessary because most drug claims datasets allow a claim reversal to be linked to an original claim.</p>	

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<b>P4P</b>	<b>Proportion of Days Covered by Medications</b>	<b>Reviewed:</b> 1/03/12
	<p><b>Question:</b> The definition for “index prescription date” states that the index date should occur at least 91 days before the end of the measurement period. The “measurement period” is defined as the index date through the last day of the measurement year or until death or disenrollment. How should an organization handle a situation where a member’s first fill date is January 1, 2011, and the member disenrolls from the plan on March 15, 2011? How should an organization handle a situation where a member’s first fill date is November 1, 2011? Should the member be excluded from the measure?</p> <p><b>Response:</b> In the first scenario, the index date is 74 days prior to the end of the measurement period, so the member should be excluded. In the second scenario, the index date is 61 days prior to the end of the measurement period, so the member should be excluded.</p>	
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<b>P4P</b>	<b>Proportion of Days Covered by Medications</b>	<b>Reviewed:</b> 1/03/12
	<p><b>Question:</b> For all rates, step 2 of the numerator states that organizations should count the days when a member was covered by at least one drug in the class. However, each rate indicates that there are additional eligible population criteria for the member to have filled at least two prescriptions for the target drug. How can the numerator allow for just one drug in the class to be filled?</p> <p><b>Response:</b> “At least two prescriptions” means that the patient had at least two pharmacy claims for a drug in the target class (this can be refills for the same drug). In the numerator, for a day to be “covered,” a patient must have a supply on hand of at least one drug in the class.</p>	
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<b>P4P</b>	<b>Proportion of Days Covered by Medications</b>	<b>Reviewed:</b> 1/03/12
	<p><b>Question:</b> How should organizations count days when a member is covered by a drug in step 2 of the numerator for each rate? The specification states that if prescriptions for the same drug overlap, the prescription start date should be adjusted to be the day after the previous fill has ended. Does this mean that if a member fills a prescription for a 30-day supply of a drug on January 1, 2011, and fills another prescription for the same drug on January 15, 2011, also with a 30-day supply, the “days covered” is 45 days (30 days for the prescription filled on January 1; 15 days for the drug filled on January 15)?</p> <p><b>Response:</b> Sixty days are covered. The first prescription lasts 30 days, starting January 1. If you move the next prescription’s start date to the day after the previous fill has ended, it becomes January 31. The end date is March 1. In essence, the start date and the end date of the second prescription both move.</p>	

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<b>P4P</b>	<b>Proportion of Days Covered by Medications</b>	<b>Reviewed:</b>	1/03/12
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**Question:** Should “days covered” be capped at the number of days for the measurement period? For example, if a member’s measurement period is January 1–June 30, 2011 (180 days), and the member fills different prescriptions within the class (different GCNs) on January 1, April 1 and June 15, all with a 90-day supply (195 days within the measurement period), should the days covered be calculated as 180 days?

**Response:** In your example, the measurement period is 180 days (January 1–June 30). Step 2 of the numerator criteria reads, “within the measurement period, count the number of days the member was covered.” In this case, look for covered days from January 1–June 30; in essence, the numerator is being capped. The PDC is not calculated by summing the days supply for pharmacy claims. You may need to set up a time array for each claim, to identify the time frame covered by each fill, then count the number of days in the measurement period that are covered by the time arrays. Thus, the numerator may not exceed the denominator for the person-level PDC calculation. Refer to the attached example for SAS code for arrays.

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