

Frequently Asked Questions (FAQs)
Pay for Performance Measurement Year 2010
March 2011

MY 2010 P4P Measures	Date Posted
<p>Encounter Rate by Service Type</p> <p>Question: Table ENR-F, references the CMS website and indicates that CPT codes found in ASC_AddAA.CSV should be used. The zipped file on the CMS website references a text file, titled OCT10_ASC_AddAA.txt, should that be the one that is used?</p> <p>Response: Please use the document titled OCT10_ASC_AddAA.txt.</p>	03/2011
<p>Diabetes Care</p> <p>Question: HEDIS table CDC-L contains aliskiren-valsartan and amlodipine-hydrochlorothiazide-valsartan but the P4P table CDC-N does not. Should aliskiren-valsartan and amlodipine-hydrochlorothiazide-valsartan be in the P4P table CDC-N?</p> <p>Response: Please include aliskiren-valsartan and amlodipine-hydrochlorothiazide-valsartan in P4P table CDC-N.</p>	01/2011
<p>Asthma Medication Ratio</p> <p>Question: Based on the MY 2010 P4P Crosswalk to HEDIS 2011 NDC List document, P4P table AMR-C crosswalks to the HEDIS table ASM-C for the NDC list but long acting inhaled beta-2 agonists are no longer included in the P4P table AMR-C. Should long acting inhaled beta-2 agonists be used in the Asthma Medication Ratio measure for P4P?</p> <p>Response: Please do not include long acting inhaled beta-2 agonists when calculating the Asthma Medication Ratio measure.</p>	01/2011
<p>Emergency Department Visits</p> <p>Question: Please explain why POS is not included as a product line for reporting for the Emergency Department Visits measure but POS is included as a product line for reporting for the other Appropriate Resource Use measures.</p> <p>Response: Similar to the other Appropriate Resource Use measures, POS should be included as a product line for reporting in the Emergency Department Visits measure.</p>	01/2011
<p>Total Cost of Care</p> <p>Question: Are any members excluded from the Total Cost of Care measure based on per member costs?</p> <p>Response: All members in the eligible population are included, but per member per year costs above \$100,000 are excluded.</p>	01/2011
<p>Blood Pressure Control</p> <p>Question: Please provide clarity regarding capture of the lowest systolic and diastolic readings on different dates of service.</p> <p>Response: Similar to the other P4P measures, Blood Pressure Control for Diabetes is an electronic only measure. Organizations can rely on CPT II codes, registry data, or EHR's to collect blood pressure but paper chart review is not an option. The most recent BP reading during the measurement year must be used; therefore, documentation of systolic and diastolic on different dates of service is not permitted. If the most recent BP reading has multiple BP measurements on the same date, the lowest systolic and lowest diastolic BP reading may be used.</p>	12/2010

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<p>Audit Designations</p> <p>Question: Please clarify the new edit checks for Health Plans in the MY 2010 data submission file.</p> <p>Response: Additional instructions for data submission for Health Plans are:</p> <ul style="list-style-type: none"> • For the Encounter Rate by Service Type 1–6: Overall Rate (ENRSTOV) measure, the data submission file must be rounded to two decimal places. For example: <ol style="list-style-type: none"> 1. If the ENRSTOV is 4.004, round down to 4.00 2. If the ENRSTOV is 4.005, round up to 4.01 • If the rounded ENRSTOV is less than 4.00, then the result must be NA for all clinical measures for the PO. • If the rounded ENRSTOV is 4.00 or greater, the individual Encounter Rate by Service Type results (ENRST1 through ENRST6 rates) and all clinical measures must be truncated to five decimal places in the submission file. • If the rounded ENRSTOV is 4.00 or greater, and the denominator for any other measure is 0, then the designated rate for that measure should be 0 or NB (or NR for testing measures only). The rate of 0 includes instances when the health plan calculated the rate but found that no members met the criteria specified in the denominator. Small Denominator (SD) is not a valid result for health plans. 	<p>12/2010</p>
<p>Audit Designations</p> <p>Question: Please clarify the new edit checks for Self Reporting POs in the MY 2010 data submission file.</p> <p>Response: Additional instructions for data submission for Self Reporting POs are:</p> <ul style="list-style-type: none"> • If the denominator for any measure is 0, then the result should be 0, BR, NB, or NR. The rate of 0 indicates that the PO calculated the measure, but found that no members met the criteria specified for the denominator. 	<p>12/2010</p>
<p>Childhood Immunization Status (CIS)—24-Month Continuous Enrollment</p> <p>Question:</p> <p>In the September 2010 release of the P4P manuals, you revised the dosing requirement for the Childhood Immunization Status Hib antigen from two to three but the newly added Childhood Immunization Status Combination - All Antigens measure still lists Hib as having only two doses required.</p> <p>Response:</p> <p>The dosing requirement for the Hib antigen in the Childhood Immunization Status Combination - All Antigens is the same as the individual Hib antigen, with a dosing requirement of three. This change will be reflected in the November release of the P4P manuals.</p>	<p>9/2010</p>
<p>Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis and Annual Monitoring for Patients on Persistent Medications</p> <p>Question:</p> <p>In the September 2010 release of the P4P manual, Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis (AAB) is listed as having a Medicare product line. Given the eligible population criteria for this measure, this does not seem correct.</p> <p>Response:</p> <p>The wrong measure was flagged as a Medicare measure. For Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis (AAB), only the Commercial HMO/POS product line should be reported. Annual Monitoring for Patients on Persistent Medications (MPM) should have been flagged as a Medicare measure, and POs may report both the Commercial HMO/POS and Medicare product lines for this measure. The P4P manuals will be corrected in the November release.</p>	<p>9/2010</p>

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<p>General Guidelines</p> <p>Question:</p> <p>If our PO is not eligible or opted out of participating in our contracted health plan's P4P program, should we then exclude that health plan's data from our self reported results?</p> <p>Response:</p> <p>No, you should include all of your commercial HMO/POS members in your P4P clinical measure calculations, regardless of your eligibility for P4P payments from a health plan. Similarly, health plans should submit results for all clinical measures for all contracted POs with commercial HMO/POS contracts, regardless of a PO's eligibility for P4P payments from the health plan.</p>	<p>9/2010</p>
<p>General Guidelines</p> <p>Question:</p> <p>The data submission file indicates encounter rate by service type rates should be reported at the 5th decimal but the encounter rate by service type threshold is 4.00 rounded to the second decimal. Is the threshold rounded and how should I report these on the submission files?</p> <p>Response:</p> <p>The MY 2010 per member per year (PMPY) threshold will be 4.00 and is based on Encounter Rate by Service Type 1-6: Overall Rate, which is the sum of Rates 1, 2, 3, 4a, 5a and 6 (excluding Rates 4b and 5b). The Encounter Rate by Service Type 1-6: Overall Rate should be rounded to the second decimal. The individual Encounter Rate by Service Type rates should continue to be reported to the fifth decimal place.</p>	<p>9/2010</p>
<p>General Guidelines</p> <p>Question:</p> <p>Our PO (or health plan) calculated the rate but found that no members met the criteria specified in the denominator. How should I populate the rate in a case like this?</p> <p>Response:</p> <p>In your example, the rate would be zero since you calculated the rate but none of your members met the denominator criteria. The numerator, denominator, and rate would all be zero in this instance.</p> <p>If your organization does not calculate a particular measure, the numerator and denominator would also be zero, but the rate would be NR. For health plans, this would only apply for testing measures, since reporting is required for all clinical measures for payment and public reporting.</p>	<p>9/2010</p>