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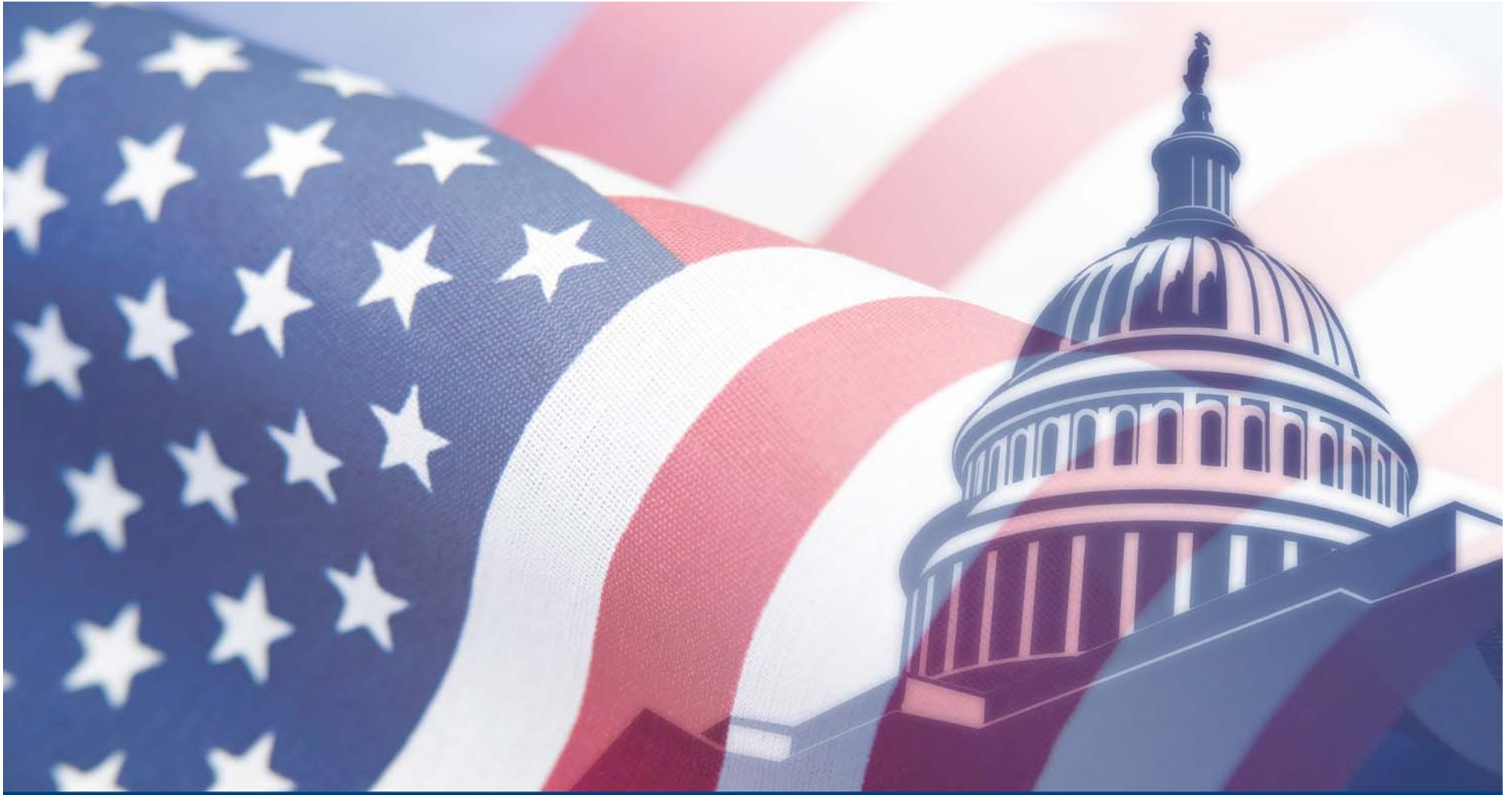
Welcome to the
Winter HMO
Administrative Forum



Welcome and Introduction to Program

*Presented by: Steve Hamman
VP, Provider Services, Illinois*





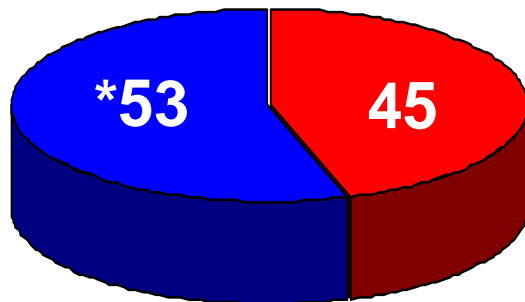
HMO Winter Administrative Forum
Political and Legislative Update
Jill Wolowitz, Government Relations

Post-Election Briefing: Agenda

- Election Outcome
- Political Environment
- Congressional Agenda
- Regulatory Update
- Key Issues Update

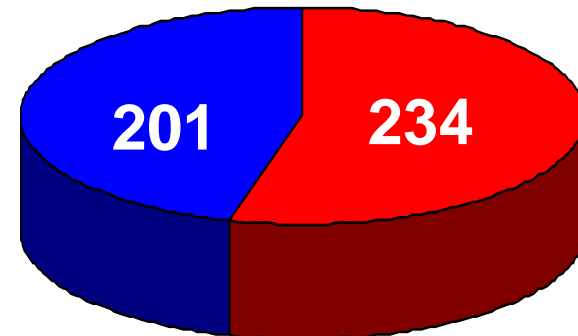
Election Outcome: Status Quo

Senate: 113th Congress



**Two independents will caucus with the Democrats*

House: 113th Congress



Political Environment

- Increased Polarization
- Leadership Dominance
- Deficit Politics
- Continued Opposition to ACA Elements
- Obama Legacy
- 2014 Senate Races – 20 Democrats/13 Republicans

Voter Turnout

- **Women: 11 points**
 - 55% Obama
 - 44% Romney
- **Youth (18-29): 23 points**
 - 60% Obama
 - 37% Romney
- **Hispanics: 44 points**
 - 71% Obama
 - 27% Romney

Legislative Update: Lame Duck Congress

- **Party Organization**
 - Leadership elections
 - Committee assignments
- **Legislative Agenda**
 - Fiscal Cliff
 - Bush tax cuts, alternative minimum tax (AMT), payroll tax, unemployment insurance, sequestration
 - Medicare Physician Payment Cut
- **Options**
 - No action
 - Short-term bridge
 - Grand bargain
- **Where 2012 Ends is Where 113th Congress Begins**

Regulatory Update

Key Issues	Regulatory Status
Health Insurance Exchanges	Released, but additional guidance expected
Federally Facilitated Exchange	Pending
Essential Health Benefits	Proposed Regulations Released late Nov.
2014 Insurance Market Reforms	Proposed Regulations Released late Nov.
Medicaid Expansion	Awaiting State Decisions

Key Issues Update

Key Issues	Status
Health Insurance Exchanges	<ul style="list-style-type: none"> • States that want to set up a partnership exchange have until Feb. 15th to submit plans • States that want to build their own exchange must notify HHS of their plans and submit blueprint by Dec. 14th
Insurance Market Reforms	<ul style="list-style-type: none"> • Proposed Regulations released 11/20/12
Insurer Tax	<ul style="list-style-type: none"> • Received over 218 co-sponsors in 112th Congress; new bill must be introduced in 2013
FEHBP "Modernization"	<ul style="list-style-type: none"> • Competitors lobbying for changes
Medicaid	<ul style="list-style-type: none"> • Support states' partial expansion of Medicaid eligibility
Medigap	<ul style="list-style-type: none"> • Proposed as offset in multiple deficit reduction proposals

HCSC Government Relations

- Issues Management
- Relationship Building
- Federal/State Coordination
- Grassroots/PAC
- Advocacy
 - Federal
 - State organizations with a National focus
- Enterprise-wide Public Policy

HCSC



1001 Pennsylvania Ave., NW, DC



medecision
Liberating.



TMG Health

Dearborn
national

HMO Network Management Update

*Presented by: Donna Levigne
DVP, Network Management*



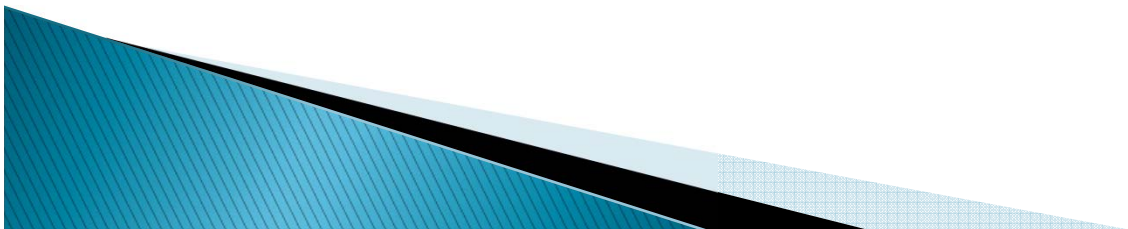
Agenda

- ▶ MSA Planning and Development
- ▶ 2013 MSA Highlights
- ▶ Government Program Update
- ▶ New Products
 - 2014 Exchange



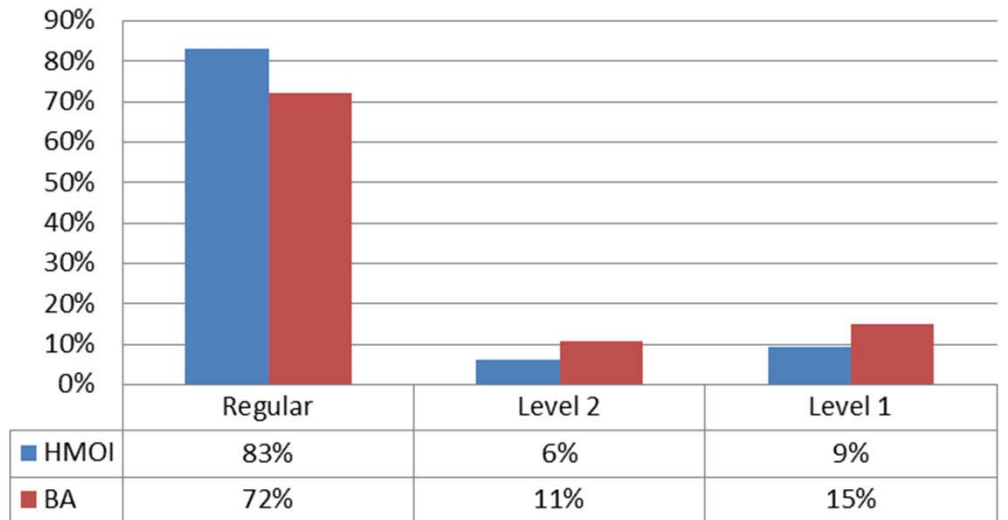
MSA Planning & Development

- ▶ Multi-disciplinary Leadership Team
- ▶ Triple Aim focused
 - Improving Member experience of care – Quality & Satisfaction
 - Improving health of our Members
 - Reducing per capita cost of health care
- ▶ Evaluation of Incentive programs
 - Hospitalist Program
 - PCER visits
- ▶ Program Alignment

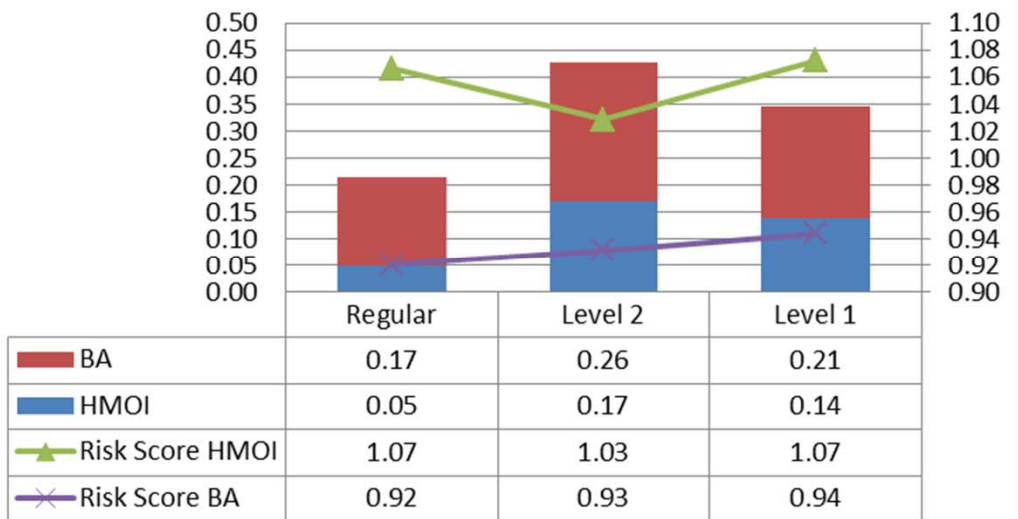


Hospitalist Program

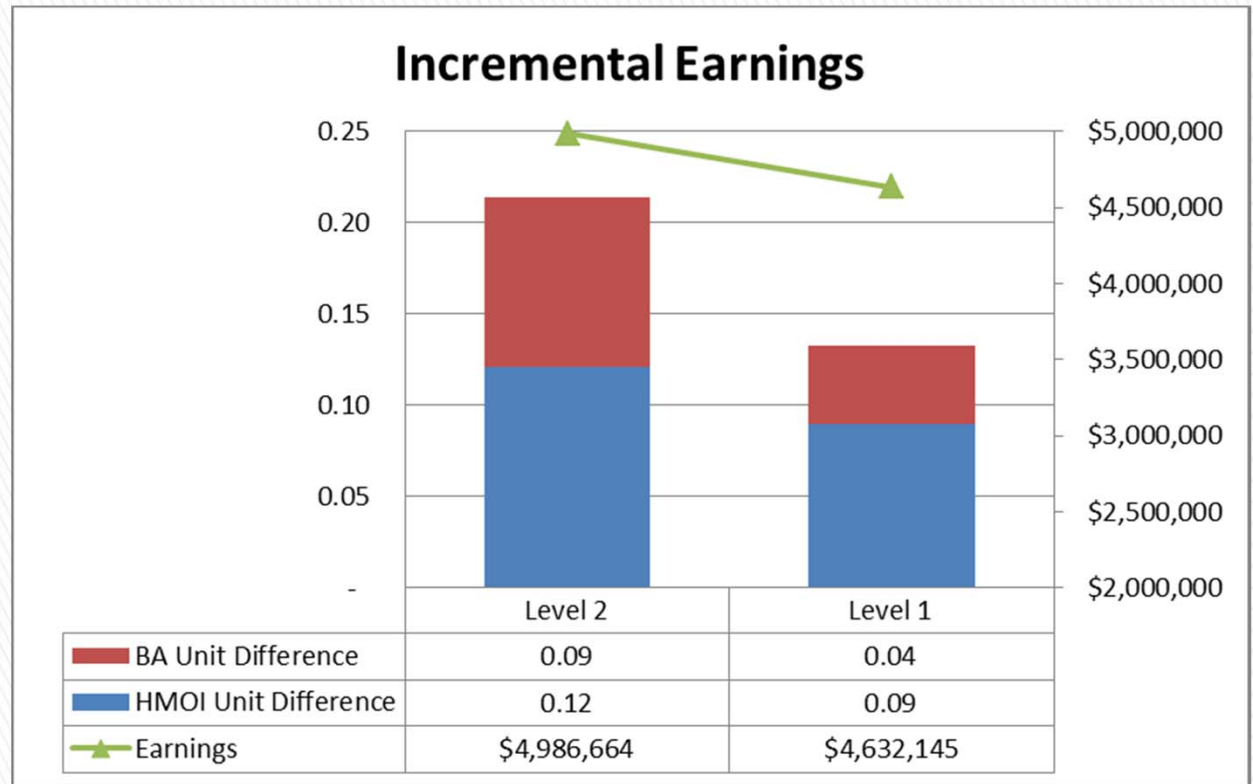
Hospitalist Program - Membership



Units Saved Per Member



Hospitalist Program



MG Average

- \$875K
- \$5.70 PMPM

2013 MSA Highlights

Program alignment

- ▶ Oversight and Reporting
 - Claims delegation oversight
 - Financial reporting
 - Income and Expense report including balance sheet
 - Audited or reviewed

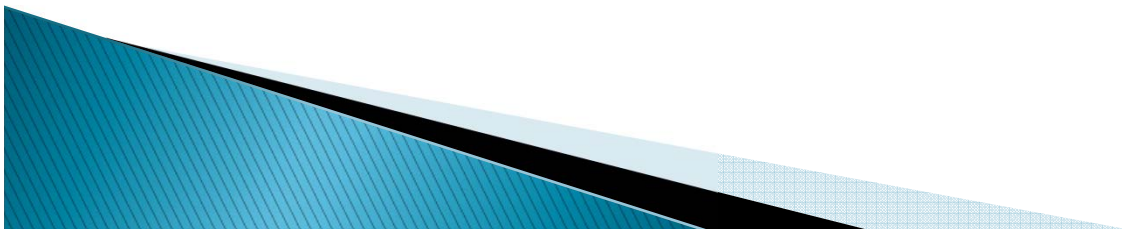


2013 MSA Highlights

- ▶ Risk Adjusted Funding
 - Increased funding based on risk score

Ranges of Model #26 Average Risk Score (ARS)	Utilization Management Fund Target Risk Adjustment Factor
if $1.25 \leq \text{ARS}$	then 1.035 -1.125
if $1.10 \leq \text{ARS} < 1.25$	then 1.025 -1.065
if $1.05 \leq \text{ARS} < 1.10$	then 1.020 -1.035
if $1.00 \leq \text{ARS} < 1.05$	then 1.015 -1.025
ARS < 1.00	then 1.000

- ▶ Case Management Program enhancements
 - Increased funding
 - Quarterly payments



2013 MSA Highlights

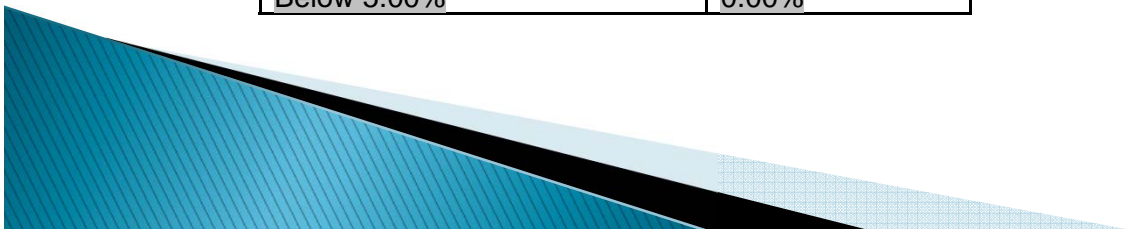
▶ Access to Care

- Assure that HMO Members enrolled with the IPA have extended access to PCP medical services

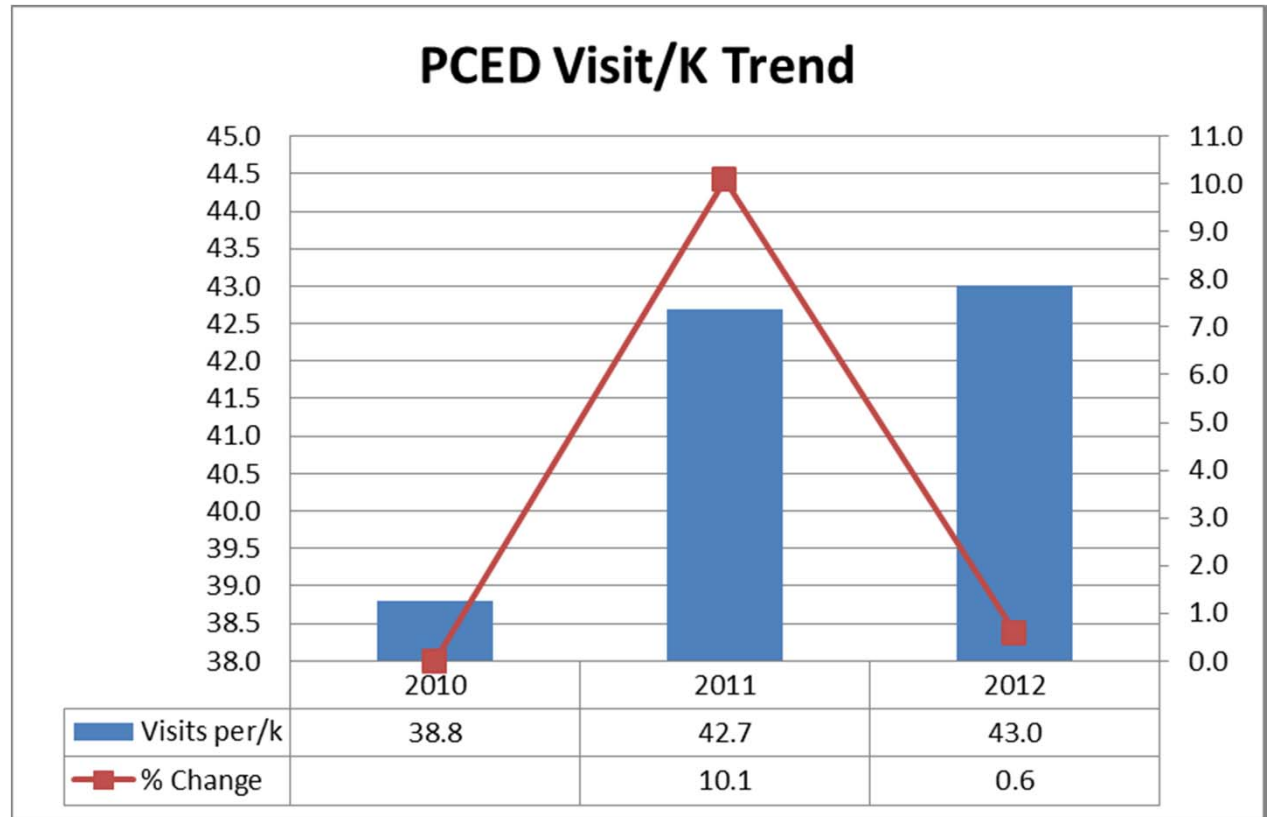
▶ Emergency Room Utilization Improvement Fund

- 2013 visit per 1000 rate for emergency room visits with a diagnosis code as defined in Appendix F will be compared to the 2011 visit per 1000 base rate for emergency room visits with a diagnosis code as defined in Appendix F.
- Increased incentives

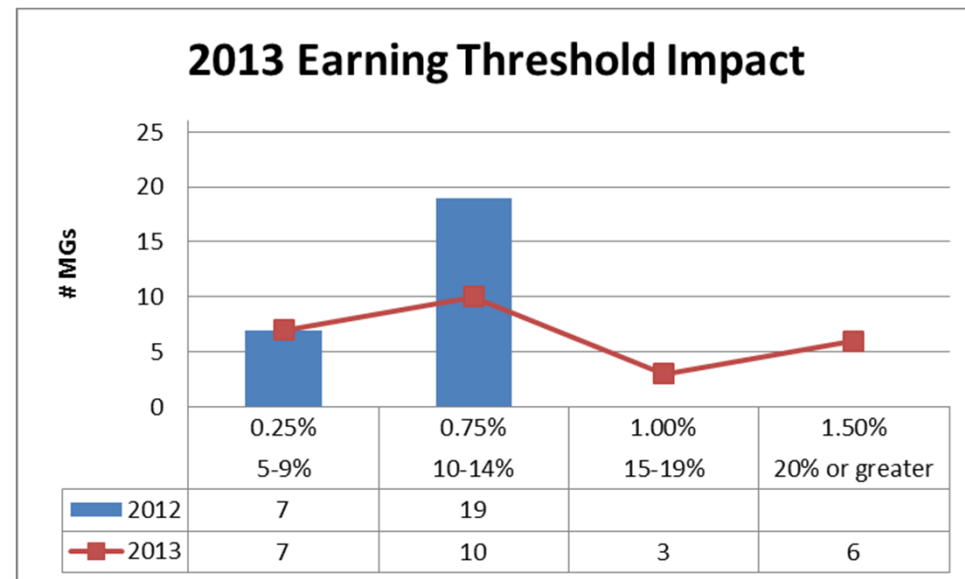
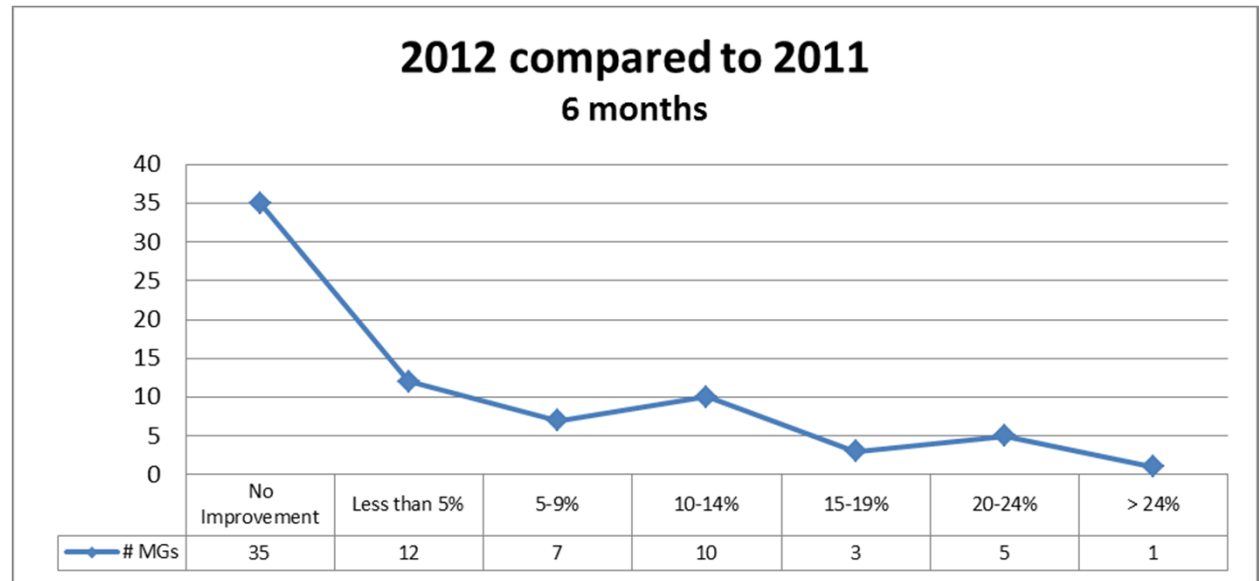
Percent of reduction in Appendix F ER visit/1000 rate	Percent of IPA base Capitation
20.00% or higher	1.50%
15.00% – 19.99%	1.00%
10.00% – 14.99%	0.75%
5.00% – 9.99%	0.25%
Below 5.00%	0.00%



PCER visits



PCER visits



2013 MSA Highlights

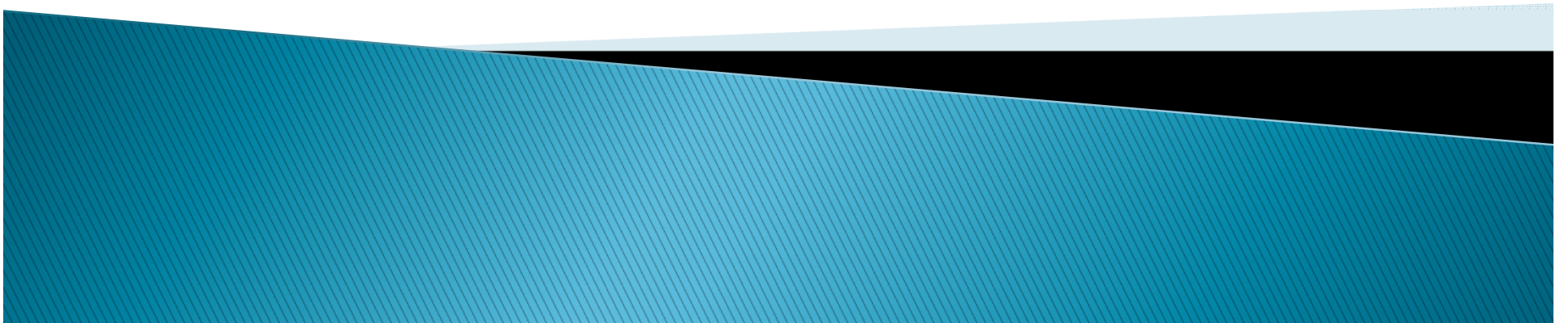
Quality Improvement

<p>Cultural Competence Physician Education Project Payment for the Cultural Competence Physician Education QI Fund Project is based upon the percentage of IPA PCP Physicians who complete the Quality Interactions for Physicians online cultural competence continuing medical education (CME) program offering up to 2.5 hours of CME credit on or before September 30, 2013. Payment will be made in accordance with the criteria sent with the project instructions.</p> <p>Payment Thresholds</p> <ul style="list-style-type: none">▪ IPA PCP completion rate $\geq 50\%$: 0.5% of the IPA base Capitation Fee▪ IPA PCP completion rate $\geq 35\%$ but $< 50\%$: the IPA base 0.25% of Capitation Fee	<p>i. Up to 0.50%</p>
--	---------------------------

i.



Planning for 2014



Government Programs Update

- ▶ Blue Medicare Advantage HMO
 - Narrow Network in 4 counties
 - Annual Election Period (AEP) enrollment
 - 2013 Marketing focus on Age-in population
 - 2014 expansion to Group business

- ▶ State of Illinois Dual Eligible Program
 - Network development in 6 counties
 - Care Model development
 - Long term support service (LTSS) network development



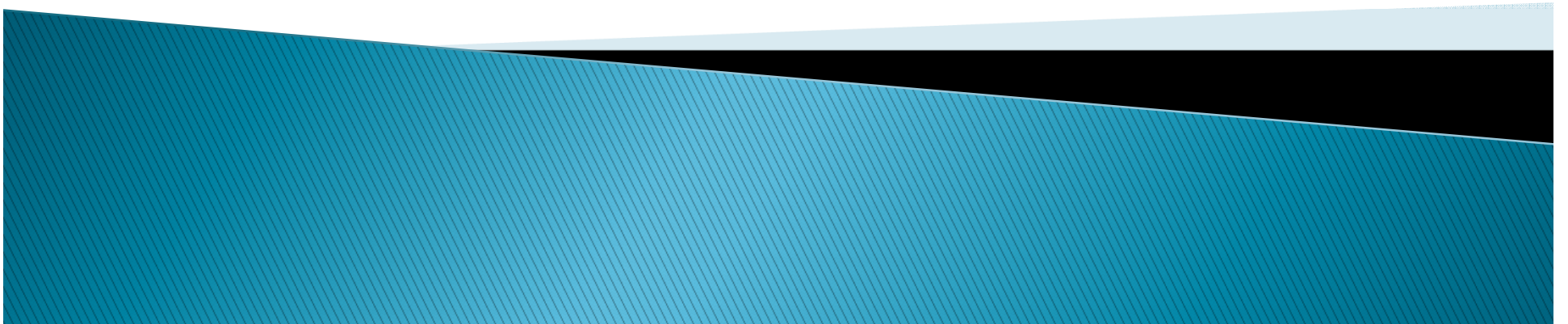
New Products

- ▶ 2014 Public Exchange participation
 - HMO offering
 - PPO offering including narrow network PPO

- ▶ Network Development focused on Triple Aim
 - High Member Satisfaction
 - High Quality of Care
 - Low Cost



Questions



BREAK



2013 HMO UM Plan

*Presented by: Sue Nowak-Small
Manager, Health Services Programs*





2013 HMO UM PLAN



Another UM Plan



- “Reality continues to ruin my life.”
— [Bill Watterson](#), [*The Complete Calvin and Hobbes*](#)





AGENDA



- 2013 HMO UM Plan Changes
- Hospitalist Program
- Denials
- Inter-rater Reliability
- Case Management



2013 HMO UM Plan



- Additions, Changes, Clarifications
 - IPA UM Plan due Friday, February 15, 2013
 - Approval completed Tuesday, April 30, 2013



Additions, Changes, Clarifications



- P 5 – HMO annual evaluation of CCM and ICM programs
- P 12 – Clarification of behavioral health practitioner credentials for implementation of the IPA UM Plan – doctoral level



Additions, Changes, Clarifications



- P 16 Inter-rater reliability - criteria
- P 18 Wording correction – 7th day after admission, not discharge
- P 19 Inter-rater reliability – timeframes
 - Changed to annual
 - 8 cases



Additions, Changes, Clarifications



p 19 – CM follow-up – correction to one year of data, not two

Pp 20-24 – case management

P 27 – moved from contract to UM Plan - Do not send denial letter if notified of past services - NGA



Additions, Changes, Clarifications



- P 32 – moved from contract to UM Plan
 - Annual review of PCP site visit results
- P 35 – TOB process
 - Electronic
 - Clinical notes, UM notes what occurred up to current date and current patient status



Hospitalist Program



- No Changes
- Level I Hospitalist on site
 - 100% PCP participation
- Level II Hospitalist on site
 - 50% PCP participation



Denials



- Small letter change – IL static the same
- Process change – in testing
 - Upload denial files with clinical to portal
 - Eliminates paper faxing and assists with appeals



Inter-rater Reliability -Criteria



- p 16 Changed to annual
- Must use NCQA methodology
 - 8 cases for each physician reviewer
 - If all physician decisions are not consistent, must test 22 more cases (30 total)
- Discussion in UM Meeting minutes
- See tools for suggestions



Case Management



- P 20 – 24 Program changes
- Definition – hybrid – risk and paid data
- Incentive – more money per case – both complex and intensive
- Documentation – same for both CCM ICM
- CCM Mandatory, before ICM



Case Management



- Definition:
- DxCG Risk Models – assignment of risk
 - Model 56
 - Paid claims data
- Hybrid combination – sorted highest to lowest
 - ½% CCM
 - Next ½% ICM



Case Management



- Two lists posted on portal – January, May
- 80% of CCM must have a clinical case review
- 100% of qualified – must be case managed – MANDATORY CCM



Case Management



- Clinical case review with attestation - \$100;
- Initial assessment - \$100;
- Monthly member contact - \$100;

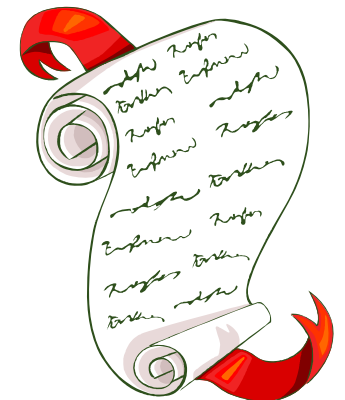
Possible \$1200 per member per calendar



Case Management



- Same documentation requirements for CCM and ICM
- ICM not mandatory
- 2012 CCM cases will be reimbursed under the 2012 payment until end for case
- 2012 CCM and ICM cases may be continued



Case Management



- Cases will be randomly audited
- Monthly log requirement – CCM and ICM
- IPA Case Management Portal updated for your use
- Trainings, webinars, tools
- Payment quarterly
- IPA added cases



Process - Step 1



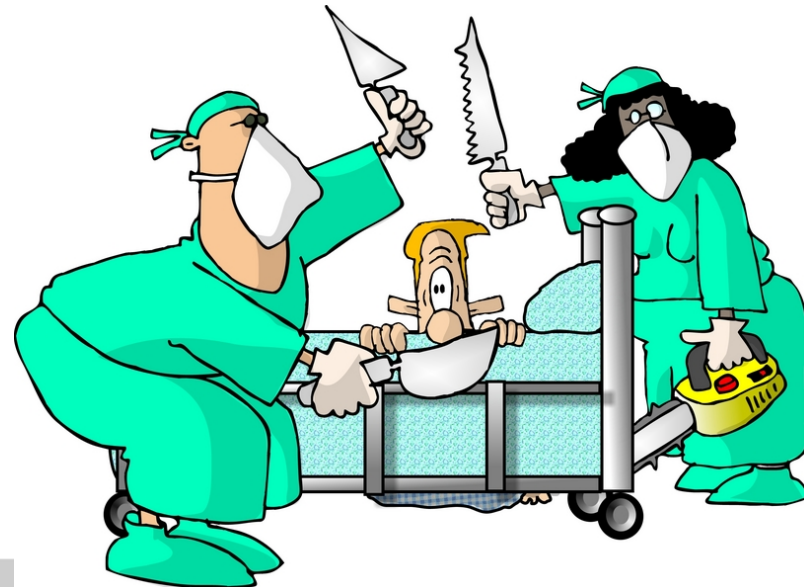
- List posted on portal
- Clinical case review begins – information regarding member from Verisk tool, EMR, PCP, specialist – no member contact
- 6 of the initial assessment fields
- Attestation



Process – Step 2



- Initial Assessment begins after Attestation
- Remaining fields for assessment
- Member contact with consent
- Dated and completed in 30 days



Process – Step 3



- Monthly member contacts
- Member and case manager
- Assess progress against goals
- CM sets contact schedule



Process – Step 4



- Case closure if goals met OR
- End goals and create new goals
- Member may OPT OUT at any time
- Assess need for member contact frequency



Continued CM



- 2012 CCM in 2013
 - Same monthly payment if in CCM or on 2013 list
- 2012 ICM
 - On 2013 list – same monthly payment
 - Not on 2013 list - \$20 per monthly contact
- An initial assessment cannot be more than 30 calendar days old – document contact attempts
- A member in case management for two years will require a re-assessment at the start of the third year

CM Auditing



- Random monthly audits
 - Clinical Case Reviews
 - Attestations
 - Initial Assessments
 - Monthly Member Contacts
- Non-payments if requirements not met
- Entire case audits for UM audit

Tools



- CCM ICM Identification Form
 - Assessment of patient acuity
 - Also use for IPA added cases (CCM)
- Attestation
 - Clinician – RN, MD, DO ,PA, etc
 - Attests to clinical and complex or intensive
 - Will be online
- Case Closure Tool
 - Recommended case closure guide
- Webinars



UM Adherence Audit 2013



- Semi-annual on site UM Audit
- Utilize ethnic, language info provided for minutes – review for CCM
- Inter-rater changed to annual
- Assessment of progress with CCM list
- CCM cases
- Education after visits



QI Fund 2013



- UM Audit and UM Plan
- Denial files submission and score
- CM Follow-up
- CM not a part of QI Fund



Submissions



- Monthly
 - CCM Log- include BH
 - ICM Log – include BH
 - Denial log and files
- Quarterly – UM Project
 - After 1st admission for primary diagnosis (asthma, diabetes, COPD, CHF, CVA, TBI, new paraplegia or quadriplegia, ALS, multiple trauma, subarachnoid hemorrhage), review for office visit within 7 days after discharge



Reminders



- Tools posted on IPA Portal under 2013
- Webinars – CCM ICM
 - Tuesday, 12/18 from 1-2;
 - Wednesday, 12/19 from 11-12
- CCM ICM Database – January/ Feb
- Webinars after Database is ready



Questions?



Thank you for your attention!



2013 QI Fund Project Updates

*Presented by: Carol Wilhoit, MD, MS
Quality Improvement Medical Director*



Disclaimer

- This presentation aims to describe and explain many of the major changes to the QI Fund for 2013.
- The presentation does not attempt to identify every change.
- QI Fund payments are based upon the actual MSA language and other supporting documents.
- While measurement timeframes and some payment thresholds have changed, these are not individually addressed in this presentation.



Asthma

- In 2013, payments will be based upon the:
 - Percentage of asthmatics who receive a written asthma action plan
 - Percentage of asthmatics who meet criteria for being Well Controlled
 - Percentage of asthmatics who are not Well Controlled who had a visit to determine whether changes in asthma treatment were needed
- There is no longer a payment based upon assessment of asthma control.



Diabetes Flowsheets

- For the Diabetes Flowsheet project, BCBSIL requires that services be documented on a flowsheet that “tracks, at a minimum, HbA1c, eye exam, LDL cholesterol, blood pressure and medical attention for nephropathy, and is organized to both trend results over time and remind the practitioner when a service is due.”
- The intent of this requirement is that the paper or electronic flowsheet is used by the clinician managing the care of the diabetic to improve control of HbA1c, LDL and blood pressure, and to be certain that the diabetic has received recommended services.
- However, it appears that some IPAs may have submitted flowsheets that are not being used by the clinician to improve care and/or are not a part of the member’s permanent medical record.



Diabetes Flowsheet

- In 2013, there will be additional focus on the flowsheet, **which must be incorporated into the Member's permanent medical record**. The Medical Director must attest that the submitted flowsheets are a part of the Member's permanent medical record.
- A registry is considered to meet the requirement of being part of the member's permanent medical record if it meets all of the following criteria:
 - The registry provides current data to the physician on an ongoing basis, with information available to the physician at the time of member visits.
 - The registry is designed to track services concurrently.
 - The registry trends levels of control (i.e., HbA1c values, LDL-C values, blood pressure values).
 - The registry can be used to identify gaps in care.



Diabetes Flowsheet Project Change

- Overall Diabetes Care is no longer included as a project indicator.



Childhood Immunization

- Annually, the Advisory Committee on Immunization Practices (ACIP) publishes Recommended Immunization Schedules. The recommendations for children have been approved by the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians.
- In 2012, ACIP recommends that children receive 24 – 28 doses of ten vaccines by their second birthday.
- For measurement purposes, HEDIS defines combinations of vaccines. A child needs to have received all vaccinations in the combination to be included in the numerator for the rate.
- For 2013, there are two QI Fund payment thresholds for Combination 3 and two payment thresholds for Combination 10.



HEDIS 2012 Vaccine Combination Rates

- Combination 3 includes:
 - 4 DTaP, 3 IPV, 1 MMR, 3 Hepatitis B, 3 Hib, 1 VZV and 4 PCV
- Combination 10 includes all Combination 3 vaccines plus:
 - ≥ 2 doses of influenza vaccine
 - Added to the ACIP schedule in January, 2005
 - Hepatitis A vaccine (2 doses)
 - Added to the ACIP schedule in January, 2006
 - 2-3 doses of rotavirus vaccine
 - Added to the ACIP schedule in January, 2007
- The additional vaccines in Combination 10 are not NEW!



Hepatitis A Vaccination

- From 2006-2011, ACIP recommended two doses of Hepatitis A vaccine between age 12 and 24 months, with the doses at least 6 months apart. However, depending upon the exact timing of well child visits, it was sometimes not feasible to give the second dose before the child's second birthday.
- In 2012, the ACIP recommendations for Hepatitis A vaccine were revised. The first dose should be given between 12 and 23 months of age, with the second dose to be given 6-18 months later.
- Therefore, HEDIS Childhood Immunization criteria were revised for reporting in 2013. Only one dose of Hepatitis A vaccine before the second birthday is needed for immunizations to be "complete."
- This change is also reflected in the 2013 Childhood Immunization QI Fund Project.



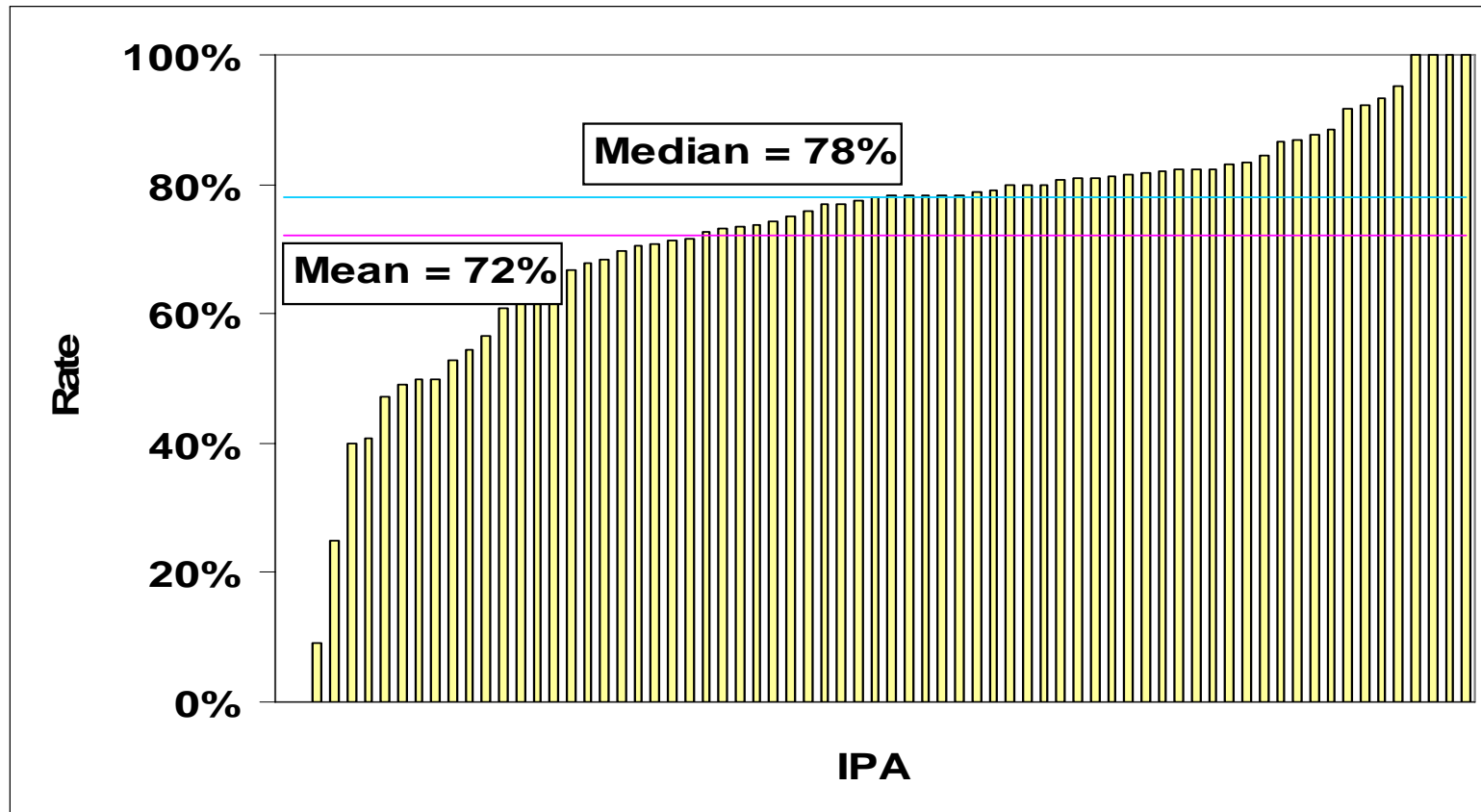
2012 Childhood Immunization QI Fund Project Results

- Combination 3 rate: 76%
- Combination 10 rate – with 2 doses of Hepatitis A: 23%
- Combination 10 rate – with ≥ 1 dose of Hepatitis A: 29%
- Influenza Vaccination Rate: 59%
- Hepatitis A Vaccination Rate (2 doses): 42% (1 dose): 55%
- Rotavirus Vaccination Rate: 72%

By contrast, BCBSIL HEDIS rates for the individual vaccines in Combination 3 range from 87% to 96%.



2012 Childhood Immunization Combination 3 Rate By IPA



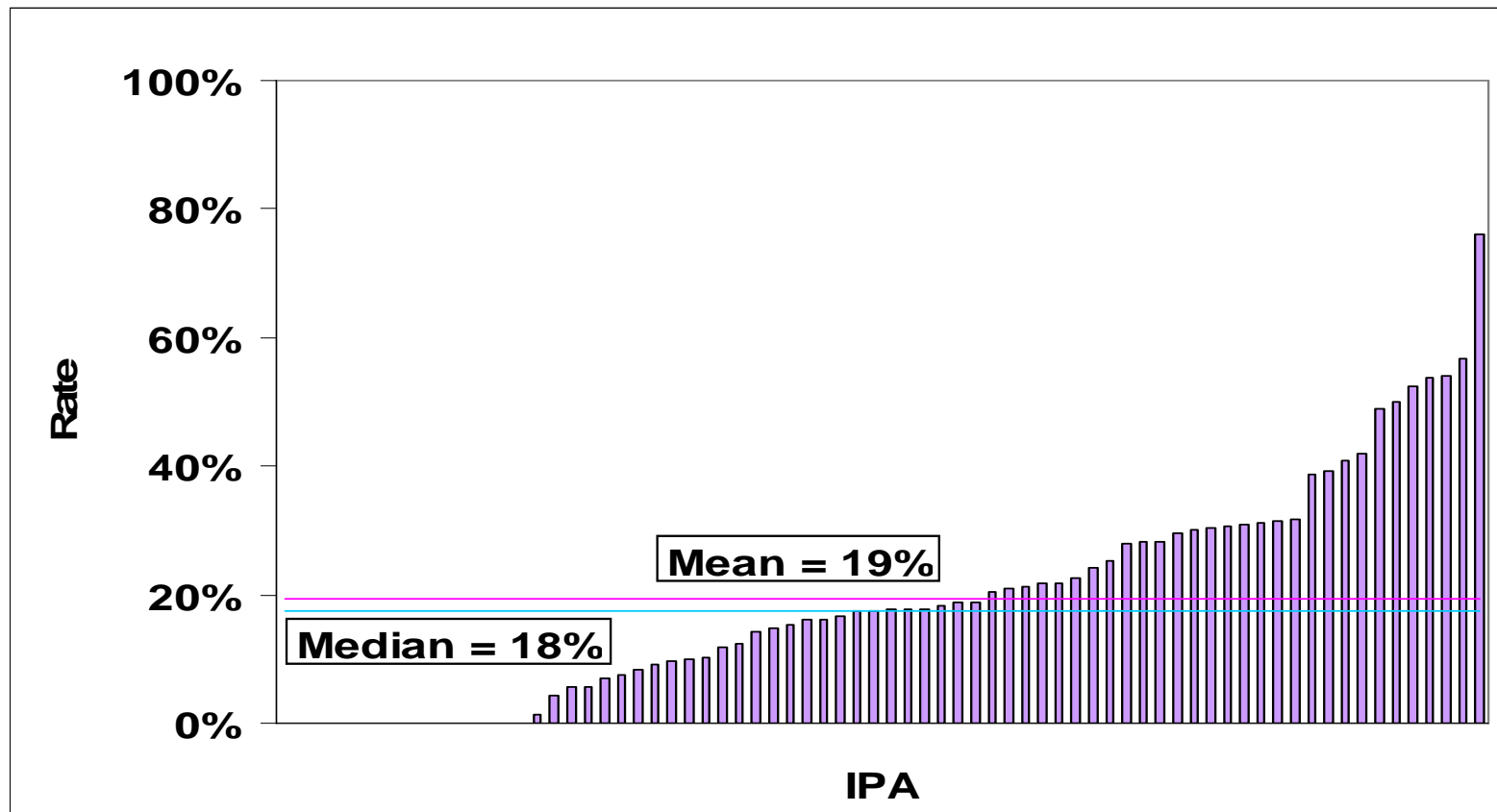
n = 72 Rates range from 0% to 100%

*There were no members identified for 3 IPAs.



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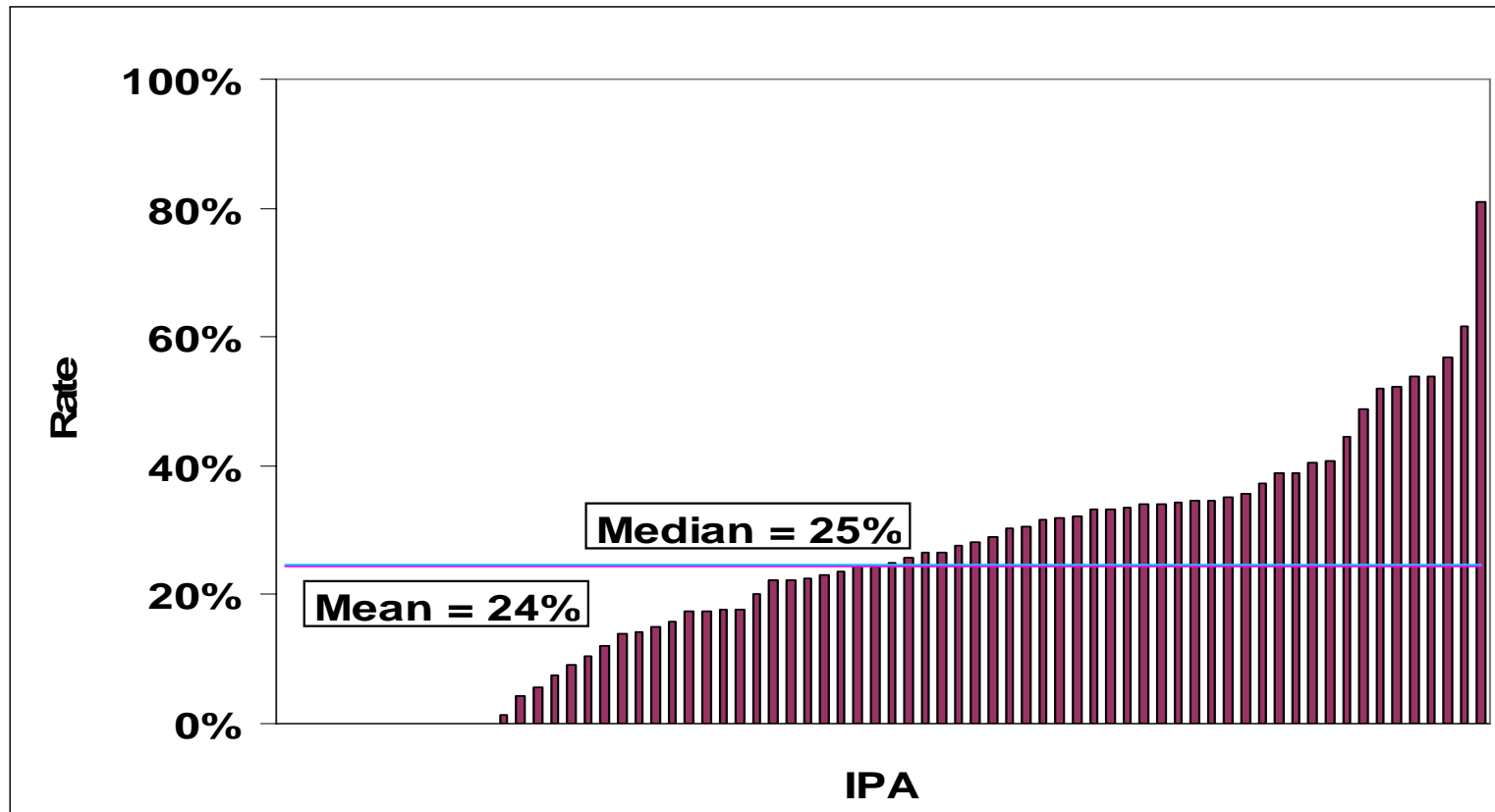
2012 Childhood Immunization Combination 10* Rate By IPA



* Includes 2 doses of Hepatitis A Vaccine
Combination 10 rate (n=72), Range: 0% to 76%, 15 IPAs with rate of 0%



2012 Childhood Immunization Modified Combination 10* Rate By IPA Analysis with one dose of Hepatitis A vaccine



* Criteria modified to require 1 dose of Hepatitis A Vaccine
n=72 Range: 0% to 81% 13 IPAs with rate of 0%



Improving the Combination 10 Rate

- Some IPAs have assumed that “the” problem with Combination 10 has been the timing of the second dose of Hepatitis A vaccine. However, this accounts for only part of the low Combination 10 rate. Suggestions for improvement:
 - Review your 2012 Childhood Immunization QI Fund Project member-specific report to identify the vaccine(s) that are issues for your IPA.
 - Analyze the IPA Childhood Immunization results by provider to see if there are specific pediatricians or family physicians with low immunization rates.
 - Discuss with IPA pediatricians and family physicians the procedures in place for administration of rotavirus, influenza and Hepatitis A vaccines. Why are the rates so different than the rates for other vaccines? Are physician offices stocking the vaccines?
- Note that capitation includes payment for all recommended childhood vaccinations.



Management of Members with Cardiovascular Conditions

- Management of Members with Cardiovascular Conditions includes members with claims confirming cardiovascular disease
 - Acute myocardial infarction, CABG, or percutaneous coronary intervention
- OR
 - Claims in each of two years for ischemic vascular disease
- The project assesses management of cardiovascular risk factors:
 - LDL-C control
 - Blood pressure control
 - Assessment of smoking status/advice to quit smoking
- New indicator for 2013: Aspirin Use (or Antiplatelet Medication)
 - Based on AHA guideline: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease



Cardiovascular Disease Prevention

- This is a separate project for 2013, addressing preventive measures in adults ages 45-64.
 - Members in the Diabetes or Management of Cardiovascular Conditions projects are excluded from the population.
- Payment in 2013 will be based upon the percentage of adult members who had all four of the following:
 - Aspirin in 2011-2012
 - The member was taking or received information about aspirin or another antiplatelet drug or anticoagulant.
 - Blood pressure documented in 2011-2012
 - LDL-C documented in 2011-2012 or <130 mg/dL in 2008-2010
 - Received advice to quit smoking in 2011-2012 or is a nonsmoker



Pediatric Wellness and Prevention

Adult Wellness and Prevention

- The Adult and Pediatric Wellness projects assess whether the BMI or BMI Percentile was documented in the medical record.
- Calculation of the BMI or BMI Percentile requires documentation of height and weight. The purpose of documenting the BMI or BMI Percentile is to alert the clinician of abnormal results so that they can be addressed during the visit.
- Differences between BMI / BMI Percentile documentation observed at the time of onsite medical record review and documentation submitted for the QI Project raises the question of whether some BMI / BMI Percentile results may have been calculated retrospectively.



New Focus for 2013:

Documentation Must Be in the Medical Record

- In 2013, for the Adult Wellness Project and the Pediatric Wellness Project, the IPA Medical Director must attest that each BMI value and BMI percentile submitted to BCBSIL had been documented **in the member's permanent medical record** on the date entered into the online tool.
- A registry is considered to meet the requirement of being part of the member's permanent medical record if it meets all of the following criteria:
 - The registry provides current data to the physician on an ongoing basis, with information available to the physician at the time of member visits.
 - The registry is designed to track services concurrently.
 - The registry trends values (i.e., BMI or BMI percentile).
 - The registry can be used to identify gaps in care.



Pediatric Wellness and Prevention

- For several years, the QI Fund has included separate payments for BMI Percentile, Counseling for Physical Activity and Counseling for Nutrition.
- In 2013, the payment will be based upon the percentage of children who received all three recommended services.



Select Administrative Quality Indicators Reported Using NCQA Certified Software

- IPA-specific results are reported for standardized clinical metrics based upon administrative data only.
- No additional data submission from IPAs is required for these quality indicators. Results are calculated using only BCBSIL claims and encounters submitted by IPAs in the form of QIRA data.
- Results for these indicators is based upon both:
 - Provision of recommended services / Avoidance of services recommended against
 - Timely submission of complete QIRA data
- Since 2011, IPAs that meet performance thresholds specified in the MSA have earned QI Fund payments.



Select Administrative Quality Indicators Reported Using NCQA Certified Software

The 2013 QI Fund again includes:

- Chlamydia Screening in Women
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Bronchitis
- Appropriate Testing for Children with Pharyngitis
- Annual Monitoring for Patients on Persistent Medications (Total)
- Well Child Visits in the First 15 Months of Life: ≥ 6 visits
- Antidepressant Medication Management: Effective Continuation Phase Treatment



Cervical Cancer Screening

Breast Cancer Screening

- In 2013, Breast Cancer Screening and Cervical Cancer Screening will become part of the *Select Administrative Quality Indicators Reported Using NCQA Certified Software*.
- There will no longer be a process for IPAs to submit supplemental administrative data for Breast Cancer Screening and Cervical Cancer Screening.



Cervical Cancer Screening

2012 Guideline Changes

- Early in 2012, the USPSTF and American Cancer Society guidelines for cervical cancer screening were updated.
- Previous guidelines recommended:
 - Beginning to screen for cervical cancer at age 21, or sooner if an adolescent was sexually active
 - Screening with a Pap smear at least every 3 years
- Key provisions of 2012 ACS and USPSTF guidelines:
 - Avoidance of screening prior to age 21
 - Screening women age 21-29 with a Pap smear every 3 years
 - Screening women age 30-65 with either:
 - Pap smear every 3 years, OR
 - Pap smear + HPV test every 5 years



Impact of Guideline Changes on Measurement

- NCQA has not yet updated the Cervical Cancer Screening HEDIS measure. In 2013, the HEDIS measure will assess:
 - women age 21-64 who had a Pap smear in 2010, 2011 or 2012.
- The HEDIS measure may under-report the 2012 Cervical Cancer Screening rate. Based upon the 2012 guidelines, the rate should include both:
 - women age 21-64 who had a Pap smear in 2010, 2011 or 2012
 - women age 30-64 who had a Pap smear + an HPV test in 2008 or 2009



Estimated Impact

- To estimate the adverse impact of the current HEDIS methodology, BCBSIL analyzed data for women included in the HEDIS Cervical Cancer Screening measure in 2012.
- Claims/QIRA data available for the analysis included 10 months of 2007 and all of 2008-2011.
- Conclusion: In 2013, the HEDIS Cervical Cancer Screening rate is likely to be adversely impacted by <1.5 percentage points.



Impact of Guideline Change on IPA Cervical Cancer Screening Rates

- While the overall adverse impact is likely to be <1.5 percentage points, this will probably vary by IPA. There will be little impact for some IPAs, and there could be more substantial impact for others.
- Therefore, for purposes of the QI Fund payment, BCBSIL will adjust the Cervical Cancer Screening rate by including in the numerator both:
 - Women who had a Pap smear in 2010, 2011 or 2012 (identified by HEDIS software)
 - Women age 30 and older who had a Pap smear + an HPV test in 2008 or 2009 (identified by additional BCBSIL analysis)
- BCBSIL is now archiving administrative data for HPV testing and Pap smears so that the data will be available in future years.



Cervical Cancer Screening Data and Analysis

HPV data are for the 148,937 women included the BCBSIL HMO HEDIS Cervical Cancer Screening measure for the 2011 measurement year who were ages 30-64.

Number with a Pap smear in 2009, 2010, 2011: 112,674 (76%)

Number with an HPV test in 2007-2011

(Counts are not unique: a woman may be counted in more than one year)

2007: 7,048

2008: 12,468

2009: 18,325

2010: 19,247

2011: 20,307

Number of unique women with an HPV test in 2007 or 2008: 17,214

Number of unique women with an HPV test in 2007 or 2008 who did not have a Pap smear in 2009, 2010 or 2011: 1,971

Percentage of women age 30-64 who had an HPV test in 2007-2008 who would not be counted using current HEDIS methodology: 1.3%

Percentage of women age 21-64 in the HEDIS Cervical Cancer Screening measure who would not be counted using current HEDIS methodology: 1.2%

Data Limitations: (1) For 2007, data are for ten months only (March-December). (2) Pap smear claims/encounters for 2007-2008 were not reviewed. Women with an HPV test in 2007-2008 may or may not have had a Pap smear during that timeframe.



QI Fund Projects without Substantive Changes

- Follow-Up After Hospitalization for Mental Illness
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Physician and Member Outreach



Cultural Competence Physician Education Project

- The 2013 QI Fund will include a new payment for a Cultural Competence education program for primary care physicians.
- The payment will be based upon the percentage of IPA PCPs who complete the Quality Interactions for Physicians continuing medical education program offering up to 2.5 hours of CME credit.
- The deadline for completion of the CME program is September 30, 2013.
- To receive credit, IPAs will need to submit copies of physicians' certificates documenting completion of the program.



Cultural Competence Physician Education Project

- BCBSIL plans to continue this program in 2014, so the IPA will receive credit in both 2013 and 2014 for physicians who complete the program by September 30, 2013.
- The percentage of physicians will be calculated using the IPA's credentialed physicians, as documented in BCBSIL credentialing records as of April 1, 2013.
- The IPA should begin to work now with Credentialing and the Network Consultant to be certain that credentialing records are current by April 1, 2013.



For All QI Fund Projects

- Information submitted for the QI Fund Projects is subject to audit.



Clinical QI Fund Summary Report

- Results for each of the QI Fund projects are provided to IPAs as they are finalized throughout the year.
- Results for all 2011 projects have been compiled in the 2012 Clinical QI Fund Summary Report, which was posted on the secure portal in September.
- IPA and Network results are trended for up to three years, with results in both graphical and tabular formats.
- The report also includes estimated financial impact to the IPA.
 - The estimate is based upon membership and does not precisely reflect the actual payment.
- The report is **ONLY** provided in the .pdf format that is posted. Results are not available in Excel format.



Special HEDIS Payments

- For HEDIS 2013, NCQA has strengthened the medical record review audit requirements. For all health plans, this change shortens the time available for medical record review.
- Vendor contracts beyond the control of BCBSIL have resulted in changes in the software BCBSIL uses for HEDIS reporting.
- As a result of these two changes, BCBSIL will “rotate” several HEDIS measures this year that have typically been reported annually. This means that there will be fewer members sampled for HEDIS medical record review in 2013.
- The final decision about whether the HEDIS data collection process will be online or will incorporate scannable data request forms has not yet been made.



CLOSING REMARKS



Thank You for Attending!

