Primary Care Provider Quality Enhancement Program for Value-Based Compensation

Improving quality care and health outcomes

AmeriHealth Caritas™
District of Columbia

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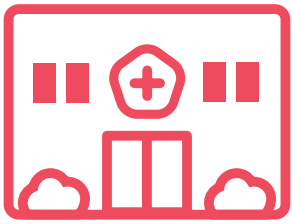
Introduction

AmeriHealth Caritas District of Columbia has created a value-based compensation program for participating primary care providers (PCPs) who furnish primary care services to AmeriHealth Caritas District of Columbia members. This program is called the Primary Care Provider Quality Enhancement Program (QEP). The program features a unique reimbursement model intended to reward providers for delivering high-quality and cost-effective care. Quality performance is the most important determinant of the additional compensation available to providers under this program.

Program Overview

The Primary Care Provider QEP provides performance-based financial incentives beyond a PCP practice's base compensation. Value-based incentive payments are based on the performance of each provider's group practice and not on individual performance (unless the participant is a solo provider).

The program provides for compensation based on both quality and cost efficiency measures that align with National Committee for Quality Assurance (NCQA) standards. Certain program components can only be measured effectively for PCP offices whose panels average 50 members for a defined 12-month period. Practices with fewer than 50 members are not eligible for participation in the Primary Care Provider QEP.



Practices with fewer than 50 members are not eligible for participation in the Primary Care Provider QEP.

Performance Components

Incentive compensation, in addition to a practice's base compensation, may be paid to those PCP groups that improve their performance in the defined components.

The five performance components are:

1. Quality metrics (HEDIS® measures)
2. Hospital utilization: low-acuity non-emergent emergency department (ED) visits
3. Hospital utilization: potentially preventable initial admissions
4. Hospital utilization: all-cause readmissions within 30 days
5. Improvement incentive

As additional meaningful measures are developed and improved, the quality indicators contained in the program will be refined. AmeriHealth Caritas District of Columbia reserves the right to make changes to this program at any time and shall provide written notification of any changes.

1. Quality Metrics (HEDIS Measures)

This component is based on Quality Performance Measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally recognized measures and predicated on AmeriHealth Caritas District of Columbia's preventive health guidelines and other established clinical guidelines. The practice's ranking is determined by performance on these measures relative to peer practices.

These measures are based upon services rendered during the reporting period and require accurate and complete encounter reporting.

Quality metrics	
Comprehensive diabetes care (CDC) — HbA1C testing	**Eligible members:** Members ages 18 – 75 years as of December 31 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year. **Measure description:** The percentage of members ages 18 – 75 years with diabetes (type 1 and type 2) who had hemoglobin A1C (HbA1C) testing.
Lead screening in children	**Eligible members:** Members age 2 years as of December 31 of the measurement year. **Continuous enrollment:** 12 months prior to the second birthday. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. **Measure description:** The percentage of members age 2 years who received at least one capillary or venous lead screening test on or before their second birthdays.
Adolescent well-care visit	**Eligible members:** Members ages 12 – 21 years as of December 31 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year. **Measure description:** The percentage of enrolled members ages 12 – 21 years who had at least one comprehensive well-care visit with a PCP or an OB/GYN provider during the measurement year.
Adult access to care	**Eligible members:** Members age 20 years and older as of December 31 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. **Measure description:** The percentage of members age 20 years and older who had at least one ambulatory or preventive care visit in the measurement year.

1. Quality Metrics (HEDIS Measures)

Quality metrics	
Breast cancer screening	**Eligible members:** Women ages 52 – 74 years during the measurement year. **Continuous enrollment:** October 1 two years prior to the measurement year through December 31 of the measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year). **Measure description:** The percentage of women ages 50 – 74 years who had a mammogram to screen for breast cancer during the measurement year or the year prior to the measurement year.
Cervical cancer screening	**Eligible members:** Women ages 24 – 64 years as of December 31 of the measurement year who have not had a complete hysterectomy with no residual cervix. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year. **Measure description:** The percentage of women ages 21 – 64 years who were screened for cervical cancer using either of the following criteria: • Ages 21 – 64 who had cervical cytology performed every three years • Ages 30 – 64 who had cervical cytology and human papillomavirus (HPV) co-testing performed every five years
Non-recommended cervical cancer screening	**Eligible members:** Adolescent females ages 16 – 20 years as of December 31 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year. **Measure description:** The percentage of adolescent females ages 16 – 20 years who were screened unnecessarily for cervical cancer.
Immunizations for adolescents	**Eligible members:** Members age 13 as of December 31 of the measurement year who have not had a previous anaphylactic reaction to the vaccine. **Continuous enrollment:** 12 months prior to the 13th birthday. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. **Measure description:** The percentage of adolescents age 13 years who had one dose of meningococcal conjugate vaccine; one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine; and three doses of the human papillomavirus (HPV) vaccine by their 13th birthdays.

1. Quality Metrics (HEDIS Measures)

Quality metrics	
Annual monitoring for patients on persistent medications	**Eligible members:** Members age 18 years and older as of December 31 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year. **Measure description:** The percentage of members age 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
Children and adolescents' access to PCPs (total)	**Eligible members:** Members ages 12 months – 19 years as of December 31 of the measurement year. **Continuous enrollment:** • For 12 months – 6 years: The measurement year. • For 7 – 19 years: The measurement year and the year prior to the measurement year. **Allowable gap:** • For 12 months – 6 years: No more than one gap in enrollment of up to 45 days during the measurement year. • For 7 – 19 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. **Measure description:** The percentage of members ages 12 months – 19 years who had a visit with a PCP during the measurement year.

Score Calculation

Results are calculated for the subset of the above quality metrics that meet minimum sample size for each practice. Practice measure scores will be calculated as the ratio of members who received the above services as evidenced by claim or encounter information (numerator) to those members in the practice's panel who were eligible to receive these services (denominator) subject to minimum sample size requirements. This score will then be compared to the score for all qualifying practices to determine the practice percentile ranking for each measure. The overall score will then be the average percentile ranking across included measures.

Submitting accurate and complete encounters is critical to ensuring the practice receives the correct calculation based on the services performed on AmeriHealth Caritas District of Columbia members.

If encounters reflecting the measures shown on pages 3 – 5 (where applicable) are not submitted, the provider's ranking rates will be adversely affected, thereby reducing the practice's value-based compensation.

Incentive Payment

The quality metrics value-based incentive payment is based on the practice's ranking relative to its peer network and panel status (open, current patients only, or closed). The program is settled semiannually based upon a 12-month performance period. The incentive payment is made semiannually on a per member per month (PMPM) basis, based on the number of AmeriHealth Caritas District of Columbia members on the practice's panel during the six-month payment period. There is no adjustment for the age or sex of each member. The following table is an example of potential earnings based on current projections.

The program is settled semiannually based upon a 12-month performance period.

Quality metrics (HEDIS measures)				
PCP office rank	Open office (PMPM)	Current patients only (PMPM)	Closed-reach panel max (PMPM)	Closed-provider request
95%	$1.65	$0.83	$1.65	$0.00
90%	$1.56	$0.78	$1.56	$0.00
85%	$1.46	$0.73	$1.46	$0.00
80%	$1.37	$0.69	$1.37	$0.00
75%	$1.28	$0.64	$1.28	$0.00
70%	$1.19	$0.60	$1.19	$0.00
65%	$1.10	$0.55	$1.10	$0.00
60%	$1.01	$0.51	$1.01	$0.00
55%	$0.92	$0.46	$0.92	$0.00
Below 55%	$0.00	$0.00	$0.00	$0.00

Note: The dollar amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

2. Hospital Utilization: Low-Acuity Non-Emergent ED Visits

AmeriHealth Caritas District of Columbia calculates a low-acuity non-emergent emergency department (LANE ED) rate for the members attributed to each practice. A LANE ED visit is defined as a visit to an ED with a primary discharge diagnosis that is included in the Mercer LANE diagnosis list provided by the Department of Health Care Finance.

The LANE ED visits rate is calculated by dividing the number of LANE ED visits as defined above by the total number of ED visits observed for members attributed to the practice.

The LANE ED visits incentive payment is based on practice performance compared to AmeriHealth Caritas District of Columbia's overall network average and the practice's current panel status (open, current patients only, or closed). A practice earns an incentive when it performs at a better level than the overall plan average.

For illustration purposes, 65.62 percent of the total ED visits is the plan's network-wide performance.

Low-acuity non-emergent (LANE) PMPM	
PCP office rank	**PMPM**
65.62 or higher	$0.00
64.8 – 65.61	$0.06
64.18 – 64.79	$0.39
63.72 – 64.17	$0.17
63.38 – 63.71	$0.23
0.00 – 63.37 (target rate)	$0.29

Note: The dollar amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

The hospital utilization: low-acuity non-emergent ED visits component of the Primary Care Provider QEP is not intended to provide an incentive to reduce or limit preventive and other medically necessary care to AmeriHealth Caritas District of Columbia members. This incentive rewards PCPs who effectively manage medical costs by ensuring members get access to low-acuity non-emergent care in a primary care setting.

3. Hospital Utilization: Potentially Preventable Initial Admissions

AmeriHealth Caritas District of Columbia calculates a potentially preventable initial admissions rate for the members attributed to each practice. A potentially preventable initial admission is defined as an admission to an acute care facility that meets the criteria defined by the Agency for Healthcare Research and Quality Prevention Quality Indicator (PQI)/Pediatric Quality Indicator (PDI) Indicated Inpatient (IP) Avoidable Admissions methodology.

The potentially preventable initial admissions rate is calculated by dividing the number of potentially preventable initial admissions as defined above by the total number of acute care admissions observed for members attributed to the practice.

The potentially preventable initial admissions incentive payment is based on practice performance compared to AmeriHealth Caritas District of Columbia's overall network average and the practice's current panel status (open, current patients only, or closed). A practice earns an incentive when it performs at a better level than the overall plan average.

For illustration purposes, 8.11 percent of the total admissions is the plan's network-wide performance.

Potentially preventable admission (PPA) PMPM	
PCP office rank	**PMPM**
8.11 or higher	$0.00
8.01 – 8.10	$0.06
7.93 – 8.00	$0.12
7.88 – 7.92	$0.17
7.83 – 7.87	$0.23
0.0 – 7.82 (Target Rate)	$0.29

Note: The dollar amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

The hospital utilization: potentially preventable initial admissions component of the Primary Care Provider QEP is not intended to provide an incentive to reduce or limit preventive and other medically necessary care to AmeriHealth Caritas District of Columbia members. This incentive rewards PCPs who effectively manage medical costs by ensuring members get access to care in an ambulatory setting to reduce the need for hospital admission.

4. Hospital Utilization: All-Cause Readmissions Within 30 Days

AmeriHealth Caritas District of Columbia calculates an all-cause readmissions within 30 days rate for the members attributed to each practice. All-cause readmission within 30 days is defined as an admission to an acute care facility within 30 days of discharge from an initial qualifying admission. To qualify as an initial admission for this measure, the admission must not indicate the patient was discharged or transferred to a hospital medical facility, federal facility, critical care access hospital, or other rehabilitation or that the patient expired.

The all-cause readmissions within 30 days rate is calculated by dividing the number of all-cause readmissions within 30 days as defined above by the total number of acute care admissions observed for members attributed to the practice.

The all-cause readmissions within 30 days rate incentive payment is based on practice performance compared to AmeriHealth Caritas District of Columbia's overall network average and the practice's current panel status (open, current patients only, or closed). A practice earns an incentive when it performs at a better level than the overall plan average.

For illustration purposes, 9.66 percent of the total admissions is the plan's network-wide performance.

Plan all-cause readmissions (PCR) PMPM	
PCP office rank	**PMPM**
9.66 or higher	$0.00
9.54 – 9.65	$0.06
9.45 – 9.53	$0.12
9.38 – 9.44	$0.17
9.33 – 9.37	$0.23
0.0 – 9.32 (target rate)	$0.29

Note: The dollar amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

The hospital utilization: all-cause readmissions within 30 days component of the Primary Care Provider QEP is not intended to provide an incentive to reduce or limit preventive and other medically necessary care to AmeriHealth Caritas District of Columbia members. This incentive rewards PCPs who effectively manage medical costs by ensuring members get follow-up care in an ambulatory setting to reduce readmissions.

5. Improvement Incentive

PCP practices eligible for the program that do not qualify for an incentive in a measure, but show at least a 10 percent ranking improvement compared to the prior measurement cycle, receive an improvement incentive.

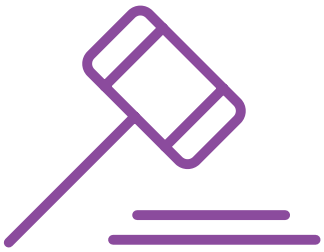
The improvement incentive is equal to 50 percent of the lowest qualifying percentile PMPM (adjusted for panel status).

Improvement incentive	
Incentive	**PMPM**
Quality metrics	$0.46
LANE ED visits	$0.03
Potentially preventable initial admissions	$0.03
All-cause readmissions within 30 days	$0.03

Note: The dollar amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

Provider Appeal of Ranking Determination

- If providers wish to appeal their rankings on any or all incentive components, they must submit appeals in writing
- The written appeal must be addressed to the AmeriHealth Caritas District of Columbia Director of Provider Network Management, and the basis for the appeal specified
- The appeal must be submitted within 60 days of receiving the results of the Primary Care Provider QEP from AmeriHealth Caritas District of Columbia
- The appeal will be forwarded to the AmeriHealth Caritas District of Columbia Primary Care Provider QEP Review Committee for review and determination
- If the AmeriHealth Caritas District of Columbia Primary Care Provider QEP Review Committee determines that a performance correction is warranted, an adjustment will be made following committee approval



If providers wish to appeal their rankings on any or all incentive components, they must submit appeals in writing.

Important Notes and Conditions

1. PMPM payments for quality metrics (HEDIS measures), LANE ED visits, potentially preventable initial admissions, and all-cause readmissions within 30 days will remain static for a six-month period, unless the practice panel status changes. Every six months, AmeriHealth Caritas District of Columbia will re-tabulate the rankings of all eligible practices (based on a rolling 12 months of encounter data). Incentive payments for the next six-month period will be based on the re-tabulated rankings. AmeriHealth Caritas District of Columbia will send all eligible practices notification of their rankings.
2. The AmeriHealth Caritas District of Columbia Primary Care Provider QEP, including, but not limited to, the quality performance measures included in the program, is subject to change at any time at AmeriHealth Caritas District of Columbia's discretion, upon written notice. AmeriHealth Caritas District of Columbia will continuously improve and enhance its quality management and quality assessment systems. As a result, new quality variables will periodically be added, criteria for existing quality variables will be modified, and modifications to the program will be made. AmeriHealth Caritas District of Columbia reserves the right to terminate the program at any time upon notice.
3. For computational and administrative ease, no retroactive adjustments will be made to incentive payments. All PMPM payments will be paid according to the membership known at the beginning of each month.

AmeriHealth Caritas District of Columbia will continuously improve and enhance its quality management and quality assessment systems.

Notes

ACDC-17231

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

AmeriHealth Caritas™
District of Columbia

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