The Primary Care Practitioner Quality Enhancement Program

Improving quality care and health outcomes

2020

AmeriHealth Caritas™
Pennsylvania

AmeriHealth Caritas™
Northeast

AmeriHealth Caritas Pennsylvania

AmeriHealth Caritas Northeast

8040 Carlson Road, Suite 500
Harrisburg, PA 17112

Dear Primary Care Practitioner:

AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast's Quality Enhancement Program (QEP) provides incentives for high-quality and cost-effective care, member service and convenience, and health data submission.

We are excited about our enhanced incentive program and will work with your primary care practice to maximize revenue while providing quality and cost-effective care to our members.

Thank you for your continued participation in our network and your commitment to our members. If you have any questions, please contact your provider Account Executive.

Sincerely,

Lily Higgins, M.D., M.B.A., M.S.
Market Chief Medical Officer

Stephen E. Orndorff
Director, Provider Network Management

AmeriHealth Caritas Pennsylvania Provider Services **1-800-521-6007**
www.amerihealthcaritaspa.com

AmeriHealth Caritas Northeast Provider Services **1-888-208-7370**
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Introduction

The Quality Enhancement Program (QEP) is a reimbursement system developed by AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast (the Plan) for participating primary care practitioners (PCPs).

The QEP is intended to be a fair and open system that provides incentives for high-quality and cost-effective care, member service and convenience, and submission of accurate and complete health data. Quality performance is the most important determinant of the additional compensation. As additional meaningful measures are developed and improved, the quality indicators contained in the QEP will be refined. We reserve the right to make changes to this program at any time and shall provide written notification of any changes.

Program overview

The QEP is intended to be a program that provides financial incentives over and above a PCP practice's base compensation. Incentive payments are not based on individual performance, but rather the performance of your practice, unless you are a solo practitioner.

Certain QEP components can only be measured effectively for offices whose panels averaged 50 or more members for a defined average enrollment period. For offices with fewer than 50 members, there is insufficient data to generate appropriate and consistent measures of performance. These practices are not eligible for participation in the QEP. Additionally, a Top Performer Incentive will accompany the final settlement paid to groups whose average peer comparison percentile ranking across all Quality measures is 65% or higher. PCP groups that did not meet network targets but did show an improvement of 10% or more for a given measure over the prior year will also be awarded an Improvement Incentive payment as well (see page 12).

Performance Incentive Payment (PIP)

A Performance Incentive Payment (PIP) may be paid in addition to a practice's base compensation. The incentive payment calculation is based on how well a PCP office scores on each measure relative to established targets. The two performance components are:

1. Quality Performance Measures.
2. CPT II Code Electronic Submission.

1. Quality Performance

This component is based on quality performance measures consistent with HEDIS® technical specifications and predicated on the AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast Preventive Health Guidelines and other established clinical guidelines.

These measures are based on services rendered during the reporting period and require accurate and complete encounter reporting. Please note that each measure requires participating PCP groups to have a minimum of five members who meet the HEDIS eligibility requirements detailed next to the HEDIS measure.

The Quality Performance measures are:

Measure	Eligible members	Continuous enrollment	Allowable gap	Measure description/ rate calculation
Adolescent Well-Care Visit (AWC)	Members ages 12–21 who had at least one comprehensive well-care visit during the measurement year.	The measurement year.	Members who had no more than one gap in enrollment of up to 45 days during the measurement year.	The percentage of enrolled members ages 12–21 who had at least one comprehensive well-care visit with a PCP during the measurement year.
Ambulatory Care (ED Visits) (AMB) **Child (21 and under)**	All active members within age range.	n/a	n/a	The provider score will equal the number of emergency department visits that do not result in an inpatient encounter once, regardless of the intensity or duration of the visit, per 1,000 member months. The requirements to receive the incentive are based on the peer ranking of the score, the published benchmarks, and the improvement compared to its prior score. Each PCP group will receive semiannual reports documenting their performance on each program measure, along with their incentive payments.
Ambulatory Care (ED Visits) (AMB) **Adult (22 and over)**				
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9%) (CDC >9%) HbA1c poor control (>9.0%)	Members with diabetes ages 18–75 as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the measurement year.	The percentage of members ages 18–75 with diabetes (Type 1 and Type 2) with hemoglobin A1c (HbA1c) testing HbA1c poor control (>9.0%).
Controlling High Blood Pressure (CBP)	Members with hypertension ages 18–85 as of December 31 of the measurement year.	The measurement year.	No more than one gap in continuous enrollment of up to 45 days during the measurement year.	The percentage of members ages 18–85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.

(continued on page 6)

Quality Performance measures (*continued from page 5*)

Measure	Eligible members	Continuous enrollment	Allowable gap	Measure description/ rate calculation
Developmental Screening in the First 3 Years	Children who turn 1, 2, or 3 years of age between January 1 and December 31 of measurement year	Children who are enrolled continuously for 12 months prior to the child's first, second, or third birthday.	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a one-month gap in coverage (i.e., a beneficiary whose coverage lapses for two months or 60 days is not considered continuously enrolled).	The percentage of children screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.
Lead Screening	Children who turn 2 years old during the measurement year	12 months prior to the child's second birthday	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday	The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday
Medication Management for People with Asthma (MMA)	Members with asthma ages 5–64 as of December 31 of the measurement year	The measurement year and the year prior to the measurement year.	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.	The percentage of members ages 5–64 during the measurement year with a documented history of asthma, who remained on an asthma controller medication for at least 75% of their treatment period.
Reducing Potentially Preventable Readmissions (RPR) - PA Specific Performance Measure (PAPM)	All ages categorized in the age bands shown	Member must be enrolled on the date of discharge from the first hospitalization event and on the date of admission of the second hospitalization event.	None	The members identified with a readmission hit under the following age bands: less than one year, one to 12 years, 13 to 20 years, 21 to 44 years, 45 to 64 years.

(*continued on page 7*)

Quality Performance measures (*continued from page 6*)

Measure	Eligible members	Continuous enrollment	Allowable gap	Measure description/ rate calculation
Well-Child Visits in the First 15 Months of Life, six or more (WC15)	Members 15 months old during the measurement year.	31 days to 15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.	The percentage of members who turned 15 months old during the measurement year.
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	Member ages 3–6 years as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.	The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

Overall practice score calculation

Results will be calculated for each of the aforementioned Quality Performance measures for each practice and then compared to the established targets in each payment cycle. Providers who meet the established targets will qualify for a per member, per month (PMPM) payment for that particular measure.

Quality Performance Incentive

This incentive is paid quarterly on a fixed PMPM basis, based on the number of AmeriHealth Caritas Pennsylvania and/or AmeriHealth Caritas Northeast members on your panel as of the first of each month during the quarter. PMPM amounts will be calculated based on meeting established target rates as illustrated below. (See quarterly targets table below.) There is no adjustment for the age or sex of the member.

Payment cycle	Enrollment	Claims paid through	Payment date
1	Q1	June 30, 2020	September 2020
2	Q2	September 30, 2020	December 2020
3	Q3	December 31, 2020	March 2021
4	Q4	March 31, 2021	June 2021

The following table is an example of potential earnings based on the program's past payment history. The dollar amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

Target cycles 1–4 example PMPMs

Quality measure targets achieved	Open office (PMPM)	Current patients only (PMPM)	Closed (PMPM)
11	$0.55	$0.28	$0.00
10	$0.50	$0.25	$0.00
9	$0.45	$0.22	$0.00
8	$0.40	$0.20	$0.00
7	$0.35	$0.18	$0.00
6	$0.30	$0.15	$0.00
5	$0.25	$0.12	$0.00
4	$0.20	$0.10	$0.00
3	$0.15	$0.08	$0.00
2	$0.10	$0.05	$0.00
1	$0.05	$0.02	$0.00
Open office 100%, current patients only 50%, closed 0%.			

Open office: Accepting all new patients (includes providers who have reached panel maximum).
Current patients only: Open only to current patients or their relatives.
Closed: Not accepting new patients.

Note: The submission of accurate and complete encounters is critical to ensure your practice receives the correct calculation, based on the services performed for AmeriHealth Caritas Pennsylvania and/or AmeriHealth Caritas Northeast members.

Note: If you do not submit encounters reflecting the measures shown on pages 5, 6, and 7 (where applicable), your ranking will be adversely affected, thereby reducing your incentive payment.

Target cycles 1–4 example PMPMs

Quality measures	Q1	Q2	Q3	Q4
Adolescent Well-Care Visits	20.54%	39.30%	51.08%	48.73%
Ambulatory Care — ED Visits (Adult)*	44.13	69.27	91.32	94.93
Ambulatory Care — ED Visits (Child)*	31.83	45.73	62.54	64.93
Comprehensive Diabetes Care — HBA1c Poorly Controlled (>9%)	80.09%	73.83%	71.88%	71.15%
Controlling High Blood Pressure	12.74%	14.96%	18.05%	20.55%
Developmental Screening in First Three Years	*****	*****	*****	52.26%
Lead Screening	*****	*****	*****	76.58%
Medication Management for People with Asthma (HEDIS) — Total 75% Covered	12.97%	39.54%	52.16%	55.42%
Reducing Potentially Preventable Readmissions	*****	*****	*****	11.30%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	35.72%	56.21%	69.45%	67.58%
Well-Child Visits in the First 15 Months of Life (six or more visits)	43.87%	58.74%	61.38%	57.19%

*Ambulatory Care is a per 1,000 rate measure.

2. CPT II Code Electronic Submission

A $10 reimbursement per occurrence for the electronic submission of a claim containing a valid combination of the following CPT II codes:

Reportable CPT II codes	Description
Reportable CPT II codes for Comprehensive Diabetes Care (CDC HbA1c test). Codes payable once every 90 days.	
3044F	Most recent HbA1c level less than 7.0%
3046F	Most recent HbA1c level greater than 9.0%
3051F	Most recent HbA1c level greater than or equal to 7.0% and less than 8.0%
3052F	Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%

Reportable CPT II codes for Comprehensive Diabetes Care (Medical Attention to Nephropathy). Any of these codes payable once per year.	
3060F	Positive microalbuminuria test results documented and reviewed (DM)
3061F	Negative microalbuminuria test results documented and reviewed (DM)
3062F	Positive microalbuminuria test results documented and reviewed (confirm positive with lab results)
3066F	Documentation of treatment for nephropathy (e.g., patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist) (DM)

Reportable CPT II codes for Controlling High Blood Pressure <140/90 mm Hg. Codes payable once every 90 days.	
3074F	Most recent systolic blood pressure <130 mm Hg
3075F	Most recent systolic blood pressure 130–139 mm Hg
3077F	Most recent systolic blood pressure >=140 mm Hg
3078F	Most recent diastolic blood pressure <80 mm Hg
3079F	Most recent diastolic blood pressure 80–89 mm Hg
3080F	Most recent diastolic blood pressure >=90 mm Hg
4010F	ACE inhibitor and ARB prescribed

(continued on page 11)

Reportable CPT II codes	Description
Reportable CPT II codes for low risk for retinopathy. Codes payable once per year.	
3072F	Low risk for retinopathy (no evidence of retinopathy in prior year)
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy

3. Top Performer Incentive/Improvement Component

A Top Performer Incentive will accompany the final payment for those groups whose average peer comparison percentile ranking across all Quality measures is 65% or higher. See table below for example PMPM rates.

PCP office rank	Open office (PMPM)	Current patients only (PMPM)	Closed (PMPM)
95th	$4.64	$2.32	$0.00
90th	$4.35	$2.17	$0.00
85th	$4.06	$2.03	$0.00
80th	$3.78	$1.89	$0.00
75th	$3.48	$1.74	$0.00
70th	$3.19	$1.59	$0.00
65th	$2.90	$1.45	$0.00

An Improvement Incentive will also be awarded to PCP groups that did not meet network targets but did show an improvement of 10% or more for a given measure over the prior year. This incentive will be calculated at the final payment of the program year. The payment will equal half of the incentive that would have been awarded if the group had met the target for that measure. See table below for example PMPM rates.

Quality measure targets achieved	Open office (PMPM)	Current patients only (PMPM)	Closed (PMPM)
11	$0.28	$0.14	$0.00
10	$0.25	$0.12	$0.00
9	$0.22	$0.11	$0.00
8	$0.20	$0.10	$0.00
7	$0.18	$0.09	$0.00
6	$0.15	$0.08	$0.00
5	$0.12	$0.06	$0.00
4	$0.10	$0.05	$0.00
3	$0.08	$0.04	$0.00
2	$0.05	$0.02	$0.00
1	$0.02	$0.01	$0.00

Provider appeal of ranking determination

- If a provider wishes to appeal their percentile ranking on any or all incentive components, this appeal must be made in writing.
- The written appeal must be addressed to the Market Chief Medical Officer of the Plan and specify the basis for the appeal.
- The appeal must be submitted within 60 days of receiving the overall ranking from the Plan.
- The appeal will be forwarded to the Plan's QEP Review Committee for review and determination.
- If the QEP Review Committee determines that a ranking correction is warranted, an adjustment will appear on the next payment cycle following committee approval.

Important notes and conditions

1. The sum of the incentive payments for the program will not exceed 33% of the total compensation for medical and administrative services. Only capitation and fee-for-service payments are considered part of the total compensation for medical and administrative services.
2. The Quality Performance measures are subject to change at any time upon written notification. The Plan will continuously improve and enhance its quality management and quality assessment systems. As a result, new quality variables will periodically be added, and criteria for existing quality variables will be modified.
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.

Our mission

We help people get care, stay well, and build healthy communities.

We have a special concern for those who are poor.

Our values

Advocacy

Care of the poor

Compassion

Competence

Dignity

Diversity

Hospitality

Stewardship

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