The Primary Care Provider Quality Enhancement Program

Improving Quality Care and Health Outcomes

October 2021

www.amerihealthcaritasla.com

AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana

P.O. Box 83580
Baton Rouge, LA 70884

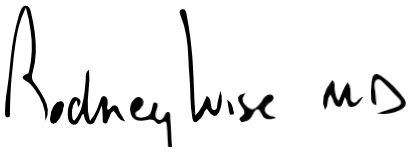
Dear Primary Care Provider:

AmeriHealth Caritas Louisiana is pleased to announce the continuation and expansion of our incentive program, the Quality Enhancement Program (QEP). The QEP provides incentives for high-quality and cost-effective care, member service and convenience, and health data submission.

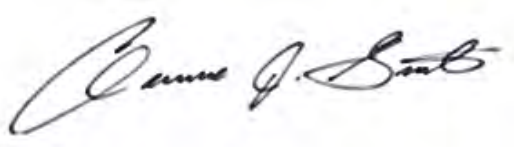
AmeriHealth Caritas Louisiana is excited about our enhanced incentive program. We will actively work with your primary care practice so you can maximize your revenue while providing quality and cost-effective care to our members. The enhanced program includes larger practices with panel sizes of 100 or more. 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 or Provider Services at **1-888-922-0007**.

Sincerely,



Rodney Wise, M.D., FACOG
Market Medical Executive



Clarence Grant
Director, Provider Network Management

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Introduction

The Quality Enhancement Program (QEP) is a unique reimbursement system developed by AmeriHealth Caritas Louisiana for participating primary care providers (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. AmeriHealth Caritas Louisiana reserves the right to make changes to this program upon prior written notice to PCP practices.

Program Overview

The QEP is intended to provide financial incentives beyond 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. Practices with panel sizes of 100 or more average enrollment are eligible for the full incentive payment under the QEP.

Hospital-owned and large PCP groups (including federally qualified health centers [FQHCs]) that have an alternate incentive arrangement or risk-sharing arrangement with AmeriHealth Caritas Louisiana will be considered for participation on a case-by-case basis. PCP practices that are part of a large system but are not owned by that system, in which the system has an alternative incentive arrangement or risk-sharing arrangement with AmeriHealth Caritas Louisiana, are eligible for participation in the QEP.

Program Specifications

The QEP is designed to reward higher performance by practices that meet financial and quality benchmarks by reducing unnecessary costs and delivering quality health care for our members. The quality measures represent a comprehensive patient quality model covering availability of care, use of services, and preventive screenings. The quality score is calculated according to the number of measures for which the provider meets or exceeds the established target, multiplied by the points available per measure. The composite average score across all quality measures will be used to determine the overall quality performance score upon which incentive payments are based.

The incentive payment is based on a total cost of care risk-adjusted shared savings pool. This shared savings pool is available to practices whose attributed population demonstrates efficient use of services. Efficient use of services is defined as having an actual medical and pharmacy spend that is less than the expected medical and pharmacy spend in the measurement year as determined using the 3M^{TM} Clinical Risk Groups (CRG) methodology described below.

The risk-adjusted trend calculation leverages the 3M CRG platform to determine the total expected medical and pharmacy cost for all the members attributed to the practice. The expected medical and pharmacy cost for each individual member is the average of the cost observed for all members within each clinical risk group. These calculations are adjusted to remove outlier patients with excessive medical or pharmacy costs from consideration.

Each member is assigned to a clinical risk group (CRG) based on the presence of disease and their corresponding severity level(s), as well as additional information that informs their clinical risk. CRGs can provide the basis for a comparative understanding of severity, treatment, best practice patterns, and disease management strategies, which are necessary management tools for payers who want to control costs, maintain quality, and improve outcomes.

By comparing the actual cost to the expected cost, AmeriHealth Caritas Louisiana calculates the actual versus expected cost ratio. The actual versus expected cost ratio is the ratio of the actual medical and pharmacy cost to the expected cost. A practice's panel whose actual medical cost is exactly equal to the expected medical cost would have an actual versus expected cost ratio of 1, or 100%, indicating that the panel cost is exactly as expected for the health mix of the attributed population. An actual versus expected cost ratio of less than 100% indicates a lower than expected spend and therefore a savings. The savings percentage is then calculated using the difference between 100% and the practice's actual versus expected cost ratio. This savings percent is capped at 10%. Should the result of this calculation be greater than 10%, 10% will be used. The shared savings pool will be equal to the savings percent times the practice's quarterly paid claims for primary care services. The pool will be distributed across five components as shown below.

Quality performance, severity of illness, and utilization management components each have three target rates or tiers. Practices that achieve the minimum performance target in a component will be assigned the core tier and earn the percentage of the shared savings pool for the core tier of that component. Similarly, practices who achieve the target performance rate for the premium or elite tiers will earn the higher percentages of the pool for those tier assignments. This program is not intended as an inducement or incentive to reduce or limit medically necessary services furnished to members.

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.

Performance Incentive Payment (PIP)

A PIP may be paid in addition to a practice's base compensation. The payment amount is calculated based upon how well a PCP office scores on each bonus component relative to the NCQA Quality Compass Medicaid National 50th percentile target and/or peer percentile performance.

The five components are listed below:

1. Quality performance.

2. Severity of illness.

3. Utilization management.

4. Patient-centered medical homes (PCMHs).

5. Clinical data file access and exchange of HEDIS measure data.

6. Member Experience Pulse Survey.

Quality Metrics (HEDIS® Measures)

The metrics used to evaluate quality performance measures are consistent with Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally recognized measures and predicated on AmeriHealth Caritas Louisiana's Preventive Health Guidelines and other established clinical guidelines. Your practice rate is determined by your performance on these measures relative to NCQA Quality Compass Medicaid National 50th percentile targets.

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

Quality performance measures (These measures are subject to change.)

2021 quality metrics (HEDIS measures)	
Childhood Immunization Status (CIS) Combination 10	**Measurement description:** The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three *Haemophilus influenzae* type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. **Eligible members:** Children who turn 2 years of age during the measurement year. **Continuous enrollment:** 12 months prior to the child's 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.
Immunizations for Adolescents (IMA) Combination 2	**Measurement description:** The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their thirteenth birthday. **Eligible members:** Adolescents who turn 13 years of age during the measurement year **Continuous enrollment:** 12 months prior to the member's 13th birthday.
Chlamydia Screening in Women (CHL)	**Measurement description**: The percentage of women ages 16 – 24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement year. **Eligible members**: Women ages 16 – 24 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.
Colorectal Cancer Screening (COL)	**Measurement description:** The percentage of members 50– 75 years of age who had appropriate screening for colorectal cancer. **Eligible members:** Members 51 – 75 years as of December 31 of the measurement year. **Continuous enrollment:** The measurement year and the year prior to the measurement year. **Allowable gap:** No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.

Controlling Blood Pressure (CBP)	**Measurement description:** The percentage of members 18 – 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. **Eligible members:** 18 – 85 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 each year of continuous enrollment. • Captured through CPT Category II codes submitted for the appropriate systolic and diastolic range.
Comprehensive Diabetes Care (CDC) HbA1c poor control >9%	**Measurement description**: The percentage of members ages 18 – 75 years with diabetes (Type 1 and Type 2) who had a HbA1c with poor control (>9%) during the measurement year. **Eligible members**: Members ages 18 – 75 years during the applicable 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.

Cervical Cancer Screening (CCS)	**Measurement description:** The percentage of women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria: Women 21 – 64 years of age who had cervical cytology performed within the last 3 years. Women 30 – 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. Women 30 – 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years. **Eligible members:** Women 24 – 64 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 each year of continuous enrollment.
Follow-up After Emergency Department Visit for Mental Illness (FUM)	**Measurement description:** The percentage of emergency department (ED) visits for members 6 years of age and older with a diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 30 days of the ED visits (31 total days). **Eligible members:** 6 years and older as of the date of the ED visit. Report three age stratifications and total rate: • 6-17 years. • 18-64 years. • 65 years and older. • Total. **Continuous enrollment:** Date of the ED visit through 30 days after the ED visit (31 days total). **Allowable gap:** No gaps in enrollment.

Follow-up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence (FUA)	**Measurement description:** The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for AOD within 30 days of the ED visits (total 31 days). **Eligible members:** 13 years and older as of the ED visit. Report two age stratifications and a total rate: • 13–17 years. • 18 and older. • Total. **Continuous enrollment:** Date of the ED visit through 30 days after the ED visit (31 total days) **Allowable gap:** No gaps in enrollment.
Developmental Screening in the First Three Years of Life (DEV CH) (Informational Only Reporting Measure)	**Measurement description**: The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first, second or third birthday. 1) Percentage of children who turned 1, 2, or 3 during the performance period who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report within 12 months preceding or on their birthday **Eligible members**: Children who are continuously enrolled for 12 months prior to the child's 1st, 2nd, or 3rd birthday. No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's 1st, 2nd, or 3rd birthday. **Continuous enrollment**: To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled). **Allowable gap**: No more than one gap in enrollment of up to 1-month gap in coverage during the measurement year.
Hepatitis C Virus Screening (HCV) (Informational Only Reporting Measure)	**Measurement description**: The percentage of eligible members ages 18 – 79 screened for the Hepatitis C Virus during the measurement year. **Eligible members**: Members ages 18 – 79 years during the applicable 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.

Overall practice score calculation

Results are calculated for each of the above quality performance measures per practice. Practices are awarded from 0 to 3 points for each metric that meets minimum sample size requirements.

PCP practices eligible for the programs that do not meet or exceed the target in a measure, but show at least a 5% or higher rate improvement compared to the prior measurement cycle are given an improvement point (a half point).

The average number of points awarded for all metrics which meet the minimum sample size is the overall practice score.

Note: The submission of accurate and complete encounters is critical to ensure your practice receives a correct score and practice ranking, based on the appropriate delivery of services for AmeriHealth Caritas Louisiana members.

1. Quality performance incentive

Sixty percent of the incentive program pool will be allocated to the quality performance incentive payment. This program pool is calculated quarterly based on the number of AmeriHealth Caritas Louisiana members on your panel. There is no adjustment for the age or sex of the member.

Practices that achieve a practice score of 1 or below will earn up to 20% percent of the shared savings pool for quality. Similarly, practices that achieve a practice score of greater than 1 but less than 2 will earn between 20% and 40% of the shared savings pool. Finally, practices that achieve a practice score of greater than 2 will earn between 40% and 60% of the shared savings pool.

Note: If you do not submit encounters reflecting the appropriate delivery of services in these measures, your ranking will be adversely affected, thereby reducing your incentive payment.

2. Severity of illness

Ten percent of the incentive program pool will be allocated to the severity of illness component. The intent of this measure is to compensate practices that are treating higher-risk panels than their peers.

Overall practice ranking

The risk-adjusted practice score is ranked against the scores for all practices.

Severity of illness incentive

The severity of illness incentive payment is based on your ranking. This incentive is paid quarterly based on the number of AmeriHealth Caritas Louisiana members on your panel. There is no adjustment for the age and sex of the member.

Practices that achieve the minimum performance target in this component will be assigned the core tier and earn 3.33% of the shared savings pool for the core tier of this component. Similarly, practices who achieve the target performance rate for the premium or elite tiers will earn the 6.67% or 10% respectively of the shared savings pool for this component.

Note: If you do not submit claims or encounters that contain all confirmed diagnoses, your ranking will be adversely affected, thereby reducing your incentive payment.

3. Utilization management

Thirty percent of the incentive program pool will be allocated to the utilization management measures. The following potentially preventable measures will be the components upon which utilization management will be based:

Potentially preventable readmissions

These are hospital readmissions that are clinically related to the initial hospital admission of a member.

Potentially preventable admissions

These are hospitalizations that could have been prevented with consistent, coordinated care and patience adherence to treatment and self-care protocols.

Potentially preventable emergency room visits

These are any emergency room visits caused by a lack of adequate access to care or ambulatory care coordination.

Utilization management practice score calculation

Actual and expected population-focused preventable components will be calculated using 3M's methodology and will be risk-adjusted at the member level based on member disease conditions and severity using 3M's CRGs.

Practices that achieve the minimum performance target in each metric of this component will be assigned the core tier for that metric and earn 3.33% percent of the shared savings pool for that metric. Similarly, practices who achieve the target performance rate for the premium or elite tiers will earn the 6.67% or 10% percent, respectively, of the shared savings pool for that metric.

PCP practices eligible for the programs that do not qualify for an incentive in a measure, but have at least a 5% or higher rate improvement compared to the prior measurement cycle are given an improvement incentive. The improvement incentive is equal to the 3.3% of the shared savings pool.

Note: The cost-efficiency management component of the Quality Enhancement Program is not intended to provide an incentive to reduce or limit preventive and other medically necessary care to AmeriHealth Caritas Louisiana members. To the contrary, this incentive rewards PCPs who effectively manage medical costs while ensuring members get the care they need.

4. Patient-centered medical homes (PCMHs)

An additional 5% incentive may be earned for being a patient-centered medical home (PCMH). PCMHs are a way of organizing primary care practices to emphasize care coordination and communication. The National Committee for Quality Assurance (NCQA) offers a recognition program for practices that function as PCMHs. AmeriHealth Caritas Louisiana values PCMHs because research indicates that PCMHs offer higher quality care at lower cost and improve both patient and provider experiences.

In appreciation for the efforts of practices that have achieved NCQA recognition as a PCMH, these recognized practices are eligible for an enhanced payment when they qualify for payment under one or more of the non-PCMH QEP measures. Qualified PCMH practices receive an enhanced payment of 5% of the total per member per month (PMPM) payment earned for the non-PCMH QEP measures.

5. Remote EHR Access and Supplemental Data Exchange

An additional 5% incentive may be earned for collaborating with the health plan by allowing remote access to Electronic Health Records (EHRs), or by participating in a supplemental data exchange as described below.

Use of EHRs results in improved care coordination, practice efficiencies and cost savings, and overall improved patient care and outcomes. Practices that allow AmeriHealth Caritas Louisiana remote access to their EHRs for AmeriHealth Caritas Louisiana member information, will be eligible for an additional 5% of the total PMPM earned incentive. This remote access by dedicated AmeriHealth Caritas Louisiana staff will be utilized for operations, quality and HEDIS scores, and care management. Access to practice-remote EHRs will be verified by AmeriHealth Caritas Louisiana staff who require specific member information.

Practices that participate in a supplemental data exchange with AmeriHealth Caritas Louisiana will be eligible for an additional 5% of the total PMPM earned incentive. The supplemental data exchange allows providers to submit supplemental transactional or claims specific data through a secure automated and systematic mechanism. Submission is completed through the secure Sterling File Gateway (SFG). This information is used to support activities such as HEDIS and quality performance reporting, and can or should include events data for actively enrolled members. Data can provide detail into a patient's history or current and persistent clinical conditions, including but not limited to evidence of immunizations, procedures, lab results as well as social and demographic information relevant to a members health. The data exchange process allows providers to demonstrate their commitment to delivering quality care.

6. Member Experience Pulse Survey

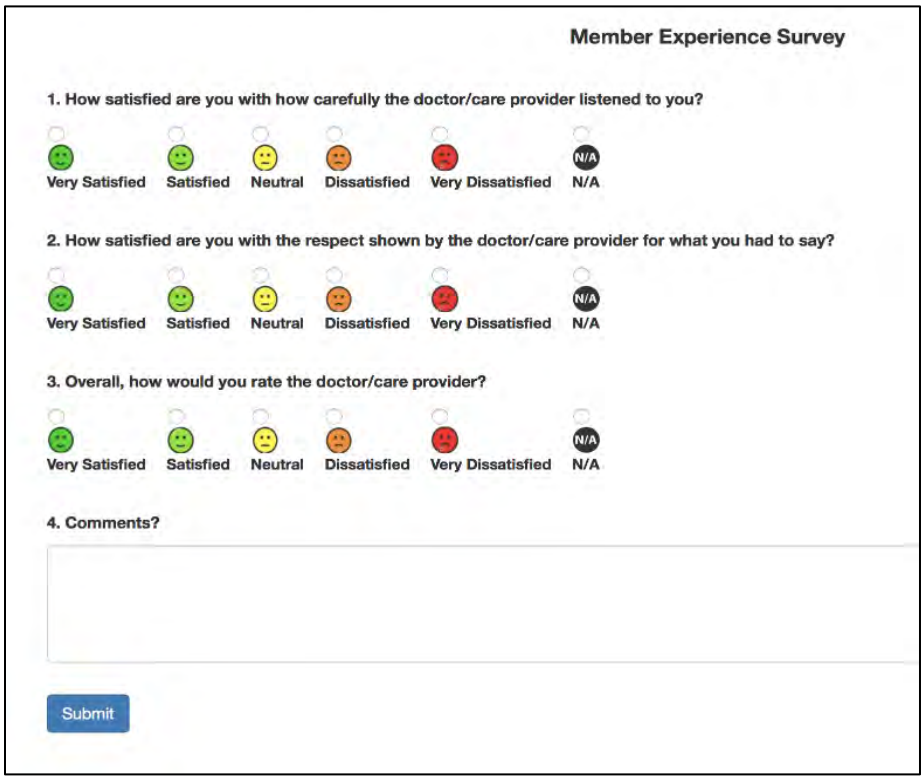
The purpose of the Member Experience Pulse Survey is to assess the member's experience following a provider visit. To make the process easier for members, emoji's were incorporated to simplify the responses. For each survey question answered, a provider is assigned a score. Primary Care Practices eligible to participate in the QEP and whose rate is ranked in the top 50th percentile will be eligible for an incentive under this metric after the initial six month monitoring period ends. A fixed funding pool will be distributed across these eligible providers on a sliding scale whereby the highest performing providers receive a larger share of the available pool.

The Numerator is calculated for each survey question answered, a provider is assigned a score as follows:

- Very Dissatisfied: 0 points
- Dissatisfied: 0.25 points
- Neutral: 0.5 points
- Satisfied: .75 points
- Very Satisfied: 1 point

The Denominator is developed from each survey question answered by a member and is counted as 1 in the Denominator.

Practice Rate = Numerator/Denominator



Reconsideration of Ranking Determination

- Providers desiring a reconsideration of their percentile rankings must submit a written request.
- The written reconsideration request must be addressed to AmeriHealth Caritas Louisiana's Medical Director and specify the basis for the reconsideration.
- The reconsideration request must be submitted within 60 days of receiving an overall ranking from AmeriHealth Caritas Louisiana.
- The reconsideration request will be forwarded to AmeriHealth Caritas Louisiana'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 may not exceed 33% of the total compensation for medical and administrative services. This includes the improvement incentive. Only capitation and fee-for-service payments are considered part of the total compensation for medical and administrative services.

2. The QEP may be further revised, enhanced, or discontinued. AmeriHealth Caritas Louisiana reserves the right to modify the program at any time and shall provide written notification of any changes.

3. The quality metrics are subject to change at any time upon written notification. AmeriHealth Caritas Louisiana continuously improves and enhances its Quality Management and Quality Assessment systems. As a result, new quality variables may periodically be added, and criteria for existing quality variables may be modified.

4. For computational and administrative ease, no retroactive adjustments are made to incentive payments.

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