The Primary Care Provider Quality Enhancement Program

Improving quality care and health outcomes

2022

AmeriHealth Caritas Delaware

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AmeriHealth Caritas Delaware

Dear Primary Care Provider:

We are pleased to present AmeriHealth Caritas Delaware's Quality Enhancement Program (QEP) which was introduced **January 1, 2020**. The QEP is specifically designed for PCPs, and pays incentives for delivering high-quality, cost-effective care; providing member services and conveniences; and submitting timely key health data.

AmeriHealth Caritas Delaware is excited about our enhanced incentive program, and will work with your practice to assist in maximizing your revenue while providing quality, 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 regarding our new QEP, please contact your Provider Network Account Executive.

Sincerely,

Deborah Allen-Brown, MD
Market Chief Medical Officer

Stephanie Miller
Director Provider Network Management

Program overview

The Quality Enhancement Program (QEP) is a reimbursement opportunity developed by AmeriHealth Caritas Delaware 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 new meaningful measures are developed and introduced, the quality indicators contained in the QEP will be refined. AmeriHealth Caritas Delaware reserves the right to make changes to this program at any time and will provide written notification of any changes.

QEP participation

The QEP is intended to be a program that provides financial incentives beyond a PCP practice's base reimbursement. QEP performance and associated incentive payments are calculated at the group or solo practice level — not per individual provider.

Eligible providers include:

- PCP groups or solo practices with average panel sizes of 50 or more assigned AmeriHealth Caritas Delaware members during the measurement period*

* Members who reside in skilled nursing facilities or who are dual-eligible members are not included in the quantified results for the QEP program.

Ineligible providers include:

- PCP practices with average panel sizes of less than 50 AmeriHealth Caritas Delaware members during the measurement period.
- PCP providers with voluntarily closed panels are not eligible to participate in the QEP program.
- PCP providers participating in an AmeriHealth Caritas Delaware value-based purchasing agreement or Accountable Care Organization (ACO) agreement are not eligible to participate in the QEP program.

QEP Performance Incentive Payment (PIP)

A Performance Incentive Payment (PIP) associated with the quality performance aspect of the QEP will be paid on a quarterly basis. Incentive payments associated with the Potentially Preventable Events (PPE) and the Member Experience Pulse Survey portions of the program will be paid on an annual basis. All PIP payments are in addition to the group or solo practice's base reimbursement. The payment amount will be calculated based on the PCP group or solo practice performance compared to their peers on each identified measure.

The total PIP payment is apportioned as follows:

1. Quality performance (75%).
2. Member Experience Pulse Survey (5%)
3. Potentially preventable events (20%).

Seventy-five percent (75%) of the PIP is based on quality performance results; beginning January 1, 2022, five percent (5%) is based on Member Experience Pulse Survey scores; and, the remaining 20 percent (20%) is based on Potentially Preventable Events (PPE) results. Payment schedules are outlined in subsequent sections of this document.

1. Quality performance measures

This component is based on quality performance measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS®) specifications; in addition, this component is predicated on the AmeriHealth Caritas Delaware Preventive Health Guidelines* and other established clinical guidelines.

PCP quality performance is measured on services rendered during the reporting period and require accurate and complete encounter reporting. **Please note:** For each quality performance (HEDIS) measure, participating PCP groups or solo practitioners must have a minimum of five AmeriHealth Caritas Delaware members who meet the HEDIS measurement definition requirements.

Helpful hints to improve your HEDIS performance:

- Use your member roster to identify and contact patients who are due for an examination or are newly assigned to your practice.
- Take advantage of this QEP guide, applicable coding information, and online resources to assist your practice with understanding each HEDIS measure in order to maximize compliance with HEDIS requirements.
- Use your Gaps in Care member list to reach out to patients in need of services or procedures.
- Schedule the member's next well visit at the end of the current appointment.
- Assign a staff member with HEDIS knowledge or experience to complete ongoing internal reviews and serve as the point person for AmeriHealth Caritas Delaware's Quality Management staff.
- Institute HEDIS alerts and flags in your electronic health records (EHRs) to notify office personnel of patients in need of HEDIS services.

* Please note that each HEDIS measure requires participating PCP groups to have a minimum of five members who meet the HEDIS eligibility requirements.

Quality performance measures	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	**Measurement definition:** The percentage of members ages 20 and older who had an ambulatory or preventive care visit with any provider type on an outpatient basis during the measurement year.
Antidepressant Medication Management (AMM) Effective Continuation Phase Treatment	**Measurement definition:** The percentage of members ages 18 years and older who had a diagnosis of major depression and who were treated with antidepressant medication and remained on an antidepressant medication for at least 180 days (i.e., six months).
Asthma Medication Ratio (AMR)	**Measurement definition:** The percentage of members ages 5 to 11 and 12 to 18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year.

Quality performance measures	
Breast Cancer Screening (BCS)	**Measurement definition:** This measure captures the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer from October 1 two years prior to the measurement period through the end of the measurement period.. ***Measure exclusion criteria:*** *a woman who had a bilateral mastectomy, unilateral mastectomy with bilateral modifier, two unilateral mastectomies, or unilateral mastectomy with right/left side modifier any time during the member's history through the end of the measurement period.*
Cervical Cancer Screening (CCS)	**Measurement definition:** The percentage of women ages 24 to 64 years as of December 31 of the measurement year who were screened for cervical cancer using either of the following criteria: • Women ages 21 to 64 who had cervical cytology performed within the last three years. • Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years. • Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years. ***Measure exclusion criteria:*** *a woman who had a hysterectomy with no residual cervix any time during the member's history through the end of the measurement period.*
Child and Adolescent Well- Care Visits (WCV)	**Measurement definition:** The percentage of members three to 21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.
Hemoglobin A1c Control for Patients with Diabetes (HBD)	**Measurement definition:** The percentage of members 18 – 75 years of age with diabetes (Types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: HbA1c control (<8.0%).
Controlling High Blood Pressure (CBP)	**Measurement definition:** Members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
30-Day Hospital Readmission Rate (DMMA Measure)	**Measurement definition:** The readmission event must occur 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 facility, or that the patient expired.

Note

The submission of accurate and complete claims data is critical to ensure your practice receives the correct calculation, based on the services performed for AmeriHealth Caritas Delaware members.

If you do not submit claims reflecting the measures shown on pages 6 through 7 (where applicable), your performance ranking will be adversely affected, thereby reducing your incentive payment.

Quality performance measures incentive calculation

Measures are calculated for each practice participating in the QEP. This rate is calculated by dividing the number of members who received the service (numerator) by the number of members eligible to receive the service (denominator). This rate is compared to the rates calculated for all other eligible practices to determine the peer percentile rank. The practice's score for the quality component is the average of the peer percentile ranks of all measures for which the practice's panel met minimum denominator criteria. The practice score (e.g., average peer percentile rank) determines the per member per month (PMPM) earning for the quality component. Payment for the quality component is paid at the PMPM rate for members during each month of the settlement quarter. PMPM payments are not adjusted for the age or sex of the member. See the chart below.

Payment cycle	Enrollment	Claims paid through	Payment date
1	Q1	June 30, 2022	September 2022
2	Q2	September 30, 2022	December 2022
3	Q3	December 31, 2022	March 2023
4	Q4	March 31, 2023	June 2023

2. 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, emojis are incorporated to simplify the responses. For each survey question, a provider is assigned a score. Primary care practices are eligible to participate in the QEP and are ranked in the top 50 percent after the initial six month monitoring period ends.

The numerator is calculated for each survey question and a provider is assigned the following score:

- Very dissatisfied: 0 points
- Dissatisfied: 0.25 points
- Neutral: 0.5 points
- Satisfied: 0.75 points
- Very Satisfied: 1 point

The denominator is developed from each member answer and is counted as one in the denominator.

How the Member Experience Pulse Survey incentive is calculated

Survey results for each practice are calculated and subject to a minimum sample size requirement. This rate is compared to all qualifying practices to determine the peer percentile ranking. To qualify for an incentive payment, practices must rank within the top 50 percent in satisfaction results when compared to their peers.

Member Experience Survey

1. How satisfied are you with how carefully the doctor/care provider listened to you?

2. How satisfied are you with the respect shown by the doctor/care provider for what you had to say?

3. Overall, how woud you rate the doctor/care provider?

4. Comments?

3. Potentially Preventable Event (PPE) measures

The population-focused preventable (PFP) components and industry- standard definitions are used to measure performance:

Potentially preventable admissions (PPAs) — A hospitalization that could have been prevented with consistent, coordinated care and patient adherence to treatment and self-care protocols. PPAs are ambulatory sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. The occurrence of high rates of PPAs represents a failure of the ambulatory care provided to the patient.

Potentially Preventable Emergency Room Visits (PPVs) — An emergency room visit that results from a lack of adequate access to ambulatory care coordination. PPVs are ambulatory sensitive conditions (e.g., asthma), for which adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate the need for ER services. In general, the occurrence of high rates of PPVs represents a failure of the ambulatory care provided to the patient.

Potentially preventable events (PPEs) incentive calculation — The PPE component evaluates PPAs and PPVs of panel members in the QEP. Results for each PPE are calculated annually for each group and/or provider. The overall practice score is calculated by dividing the observed number of PPEs by the expected number of admissions. This score is compared to all eligible practices to determine the percentile ranking for each PPE. This annual incentive is based on the practice's overall ranking and the number of members on the practice's panel during the Q4 measurement period. There is no adjustment for age or sex of the member.

Available resources

Your Provider Network Management Account Executive can familiarize you with the QEP and provide additional training to you and your staff.

- **NaviNet® —** Participating primary care providers can access this secure provider portal and resolve HEDIS® Care Gaps for AmeriHealth Caritas Delaware members. Learn more about resolving care gaps in NaviNet by visiting **www.amerihealthcaritasde.com > Providers > Resources > NaviNet > Identify and improve HEDIS gaps.**
- **Delaware Health Care Claims Database —** The Delaware Health Care Claims Database (HCCD) is a database powered by the Delaware Health Information Network (DHIN) that collects healthcare claims, enrollment, and provider data from Medicare, Medicaid, and commercial health insurers in the State of Delaware. To learn more about DHIN visit **https://dhin.org/healthcare-claims-database/.**

Provider appeal of incentive calculations or ranking determination

- If a provider wishes to appeal their percentile ranking on any or all incentive components, the appeal must be in writing.
- The written appeal must be addressed to the AmeriHealth Caritas Delaware Chief Medical Officer and include a detailed description of the appeal.
- The appeal must be submitted within 60 days of receiving the information/results from AmeriHealth Caritas Delaware.
- The appeal and all supporting documentation will be reviewed by the AmeriHealth Caritas Delaware QEP Review Committee.
- If the QEP Review Committee rules in favor of the provider and an adjustment or correction is required, it will be included in the next scheduled payment cycle following Committee approval.

Important notes and conditions

1. The total annual sum of incentive payments awarded to a specific group or solo practice for the QEP will not exceed 33% of the total AmeriHealth Caritas Delaware annual reimbursement paid for medical and administrative services. Only capitation and fee-for- service payments are considered part of total reimbursement for medical and administrative services.
2. The quality performance measures are subject to change at any time upon written notification. AmeriHealth Caritas Delaware will continuously evaluate and enhance its quality management and quality assessment systems. As a result, new quality variables may be added periodically, and criteria for existing quality variables may be modified.
3. For computational and administrative ease, no retroactive adjustments with the exception of those associated with QEP appeals, will be made to incentive payments. All per member per month (PMPM) payments will be paid according to the known membership at the beginning of each month.

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