Behavioral Health Provider Quality Enhancement Program

Improving quality care and health outcomes

April 2019

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Introduction

AmeriHealth Caritas District of Columbia (DC) has created a value-based compensation program for behavioral health (BH) providers who furnish behavioral health services to AmeriHealth Caritas DC members. This program is called the Behavioral Health 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 Behavioral Health Provider QEP provides performance-based financial incentives beyond a BH 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).

Certain QEP components can only be measured effectively for BH offices who panels averaged 20 or more members. The average of 20 is based on a defined average enrollment period for the particular measurement year. For offices with fewer than 20 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 for groups whose average peer comparison percentile ranking across all quality measures is 50 percent or higher. BH groups that were not eligible in quarter four of the program year are not eligible for the Top Performer Incentive.

Practices with fewer than 20 members are not eligible for participation in the Behavioral Health Provider QEP.

Performance Components

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

The five performance components are:

1. Quality metrics (Healthcare Effectiveness Data and Information Set [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. Top Performer Incentive

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

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

1. Quality Metrics (HEDIS Measures)

This component is based on quality performance measures consistent with HEDIS or other nationally recognized measures and predicated on AmeriHealth Caritas DC'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	
Antidepressant medication management (AMM) — acute	**Measurement description:** The percentage of members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment for at least 84 days (12 weeks) **Eligible members:** Members age 18 and older as of April 30 of the measurement year **Continuous enrollment:** 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD **Allowable gap:** One gap in enrollment of up to 45 days
Antidepressant medication management (AMM) — continuation	**Measurement description:** The percentage of members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment for at least 180 days (6 months) **Eligible members:** Members age 18 and older as of April 30 of the measurement year **Continuous enrollment:** 105 days prior to the IPSD through 231 days after the IPSD **Allowable gap:** One gap in enrollment of up to 45 days
Follow-up after ED visit for mental illness (FUM) — seven days	**Measurement description:** The percentage of ED visits for members age 6 and older with a principal diagnosis of mental illness who had a follow-up visit for mental illness within seven days of the ED visit (8 total days) **Eligible members:** Members age 6 and older as of the date of the ED visit **Continuous enrollment:** Date of the ED visit through 30 days after the ED visit (31 total days) **Allowable gap:** No gaps in enrollment
Follow-up after ED visit for mental illness (FUM) — 30 days	**Measurement description:** The percentage of ED visits for members age 6 and older with a principal diagnosis of mental illness who had a follow-up visit for mental illness within 30 days of the ED visit (31 total days) **Eligible members:** Members age 6 and older as of the date of the ED visit **Continuous enrollment:** Date of the ED visit through 30 days after the ED visit (31 total days) **Allowable gap:** No gaps in enrollment

1. Quality Metrics (HEDIS Measures)

Quality metrics	
Follow-up after hospitalization for mental illness (FUH) — seven days	**Measurement description:** The percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within seven days after discharge **Eligible members:** Members age 6 and older as of the date of discharge **Continuous enrollment:** Date of discharge through 30 days after discharge **Allowable gap:** No gaps in enrollment
Follow-up after hospitalization for mental illness (FUH) — 30 days	**Measurement description:** The percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge **Eligible members:** Members age 6 and older as of the date of discharge **Continuous enrollment:** Date of discharge through 30 days after discharge **Allowable gap:** No gaps in enrollment

Physical health quality metrics	
Breast cancer screening — (BCS)	**Measurement description:** The percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer during the measurement year or the year prior to the measurement year **Eligible members:** Women ages 52 to 74 during the applicable measurement year **Continuous enrollment:** The measurement year and two years prior to the measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during each year of continuous enrollment
Annual monitoring for patients on persistent medications (MPM) — total	**Measurement description:** The percentage of members age 18 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 **Eligible members:** Members age 18 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

1. Quality Metrics (HEDIS Measures)

Physical health quality metrics	
Comprehensive diabetes care (CDC) — eye exams	**Measurement description:** The percentage of members ages 18 – 75 with diabetes (type 1 and type 2) who received a retinal eye exam **Eligible members:** Members ages 18 – 75 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
Comprehensive diabetes care (CDC) — HbA1C testing	**Measurement description:** The percentage of members ages 18 – 75 with diabetes (type 1 and type 2) who had hemoglobin A1C (HbA1C) testing **Eligible members:** Members ages 18 – 75 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
Comprehensive diabetes care (CDC) — nephropathy	**Measurement description:** The percentage of members ages 18 – 75 with diabetes (type 1 and type 2) who received medical attention for nephropathy **Eligible members:** Members ages 18 – 75 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

2. Hospital Utilization:

Low-acuity non-emergent ED visits

AmeriHealth Caritas DC 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 the target, and, if the target is met, the per-measure amount is paid.

Top 10 LANE Diagnoses:

Diagnosis	Diagnosis Code	LANE Utilization Rank
Acute upper respiratory infection, unspecified	J069	1
Acute nasopharyngitis [common cold]	J00	2
Headache	R51	3
Unspecified asthma with (acute) exacerbation	J45901	4
Acute pharyngitis, unspecified	J029	5
Urinary tract infection, site not specified	N390	6
Low back pain	M545	7
Unspecified abdominal pain	R109	8
Streptococcal pharyngitis	J020	9
Noninfective gastroenteritis and colitis, unspecified	K529	10

3. Hospital Utilization:

Potentially preventable initial admissions

AmeriHealth Caritas DC 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 (AHRQ) Prevention Quality Indicator (PQI)/Pediatric Quality Indicator (PDI) Indicated Inpatient (IP) Avoidable Admissions methodology. Examples of potentially preventable initial admissions include some cases of diabetes, congestive heart failure, and asthma.

For more information, visit **https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure3.html**.

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 the target, and, if the target is met, a per-measure amount is paid.

4. Hospital Utilization:

All-cause readmissions within 30 days

AmeriHealth Caritas DC calculates a rate of all-cause readmissions within 30 days 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 facility, or that the patient expired.

The rate of all-cause readmissions within 30 days 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 rate of all-cause readmissions within 30 days incentive payment is based on practice performance compared to the target, and, if the target is met, the per-measure amount is paid.

5. Electronic Medical Records (EMR)

Purpose and intended use of data sharing — A participation requirement for the Shared Risk Agreement is the sharing of clinical and transactional data. The consistent exchanging of a comprehensive, pre-defined set of data provides for higher-quality care, enhanced services coordination, and more favorable health outcomes for our members. Providing accurate, up-to-date, and complete information about patients at the point of care also enables more efficient access to patient records leading to more effective, coordinated care.

Additionally, the exchange of data will allow for transparency in the Shared Risk Agreement, as the providers or health systems will have access to the clinical and transactional information being used to assess performance against the agreement's objectives/goals.

Period of agreement — The data sharing requirement shall remain in place for the duration of the Shared Risk Agreement.

Description of data — The attached file formats provide a more precise description of the data to be shared.

File template	Elements of file layouts
EMR	Captures CPT, HCPCS, CPT II, and ICD-10 codes
Immunization	Captures all vaccine-related data
Lab	Collects laboratory values (such as LONIC and/or CPT codes)
Medication electronic health record (EHR)	Collects NDC codes and other medication-related data This file format captures data needed for HEDIS reporting and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) compliance — note that a revised version of this format is being developed and may not be available until Q4 2019.

6. Chesapeake Regional Information System for our Patients (CRISP)

CRISP is one of our local health information exchanges and an essential tool for your practice in coordinating patient care between various levels of care and improving on quality scores related to follow-up care after ED visits and hospitalizations.

For your organization to be fully active with CRISP, you must submit a Participation Agreement, Substance Use Disorder Treatment Attestation Form, updated Notice of Privacy Practices, and a recent patient census. Additionally, you must be live on the Encounter Notification System (PROMPT and/or DIRECT) and the Unified Landing Page (Patient Care Snapshot, Query Portal, and/or HealthRecords). For more information on how to be fully active with CRISP, contact Ronald Emeni at **ronald.emeni@crisphealth.org**.

Overall Practice Score and Incentive Calculation

Results will be calculated quarterly for each of the previously mentioned quality performance and hospital utilization measures for each practice (see Table A), and then compared to the established targets in each payment cycle (see Table B). Providers who meet the established targets will qualify for a per-measure payment for that particular measure. The practice must also have an average monthly panel of 20 to qualify for the program.

Table A

Schedule	Membership period	Payment date
Quarter 1	1/1/19 – 3/31/19	September 2019
Quarter 2	4/1/19 – 6/30/19	December 2019
Quarter 3	7/1/19 – 9/30/19	March 2020
Quarter 4	10/1/19 – 12/31/19	June 2020
Bonus	10/1/19 – 12/31/19	June 2020

Table B

Measures	Q1	Q2	Q3	Q4
Antidepression medication management — acute	63.32%	62.86%	53.00%	52.29%
Antidepression medication management — continuation	44.79%	48.93%	40.07%	38.73%
Follow-up after ED visit for mental illness (FUM) — seven days	38.89%	33.65%	36.94%	36.36%
Follow-up after ED visit for mental illness (FUM) — 30 days	54.17%	49.04%	56.05%	55.61%
Follow-up after hospitalization for mental illness (FUH) — seven days	41.07%	39.52%	41.88%	40.75%
Follow-up after hospitalization for mental illness (FUH) — 30 days	57.59%	58.62%	62.04%	61.12%
Breast cancer screening (BCS)	57.53%	63.35%	65.79%	63.48%
Annual monitoring for patients on persistent medications (MPM) — total	67.67%	80.80%	88.17%	88.56%
Comprehensive diabetes care (CDC) — eye exams	26.69%	45.81%	53.23%	53.35%
Comprehensive diabetes care (CDC) — HbA1C testing	60.67%	74.87%	80.88%	80.53%
Comprehensive diabetes care (CDC) — nephropathy	74.72%	84.03%	87.33%	86.00%
All-cause inpatient readmissions within 30 days	17.14%	15.23%	14.97%	14.55%
Avoidable inpatient admission rate	3.13%	3.51%	4.30%	4.72%
Low acuity non-emergent ED visits	49.31%	49.26%	50.51%	51.22%

Overall Practice Score and Incentive Calculation

The total potential payment is established by multiplying the practice's member months for the quarter with $2.50 per member per month (PMPM), and that amount is divided into five categories (see Table C). The total potential payment for each category (BH, physical health [PH], and hospital utilization [HU]) is then divided by the number of measures that the practice qualifies for* to arrive at a funding level per measure within each category. The funding level per measure is then multiplied by the number of measures met (in each category) to arrive at the total incentive earned (see Calc. A example below). The EMR and CRISP payment is comprised of 20 percent of the total potential payment (10 percent for each component). To earn the EMR and CRISP incentive, the provider must share the electronic data based on the descriptions in sections 5 and 6 of this manual.

Table C

Behavioral health (BH) — quality measures	**30%**
Physical health (PH) — quality measures	**20%**
Hospital utilization (HU)	**30%**
EMR	**10%**
CRISP	**10%**

*Minimum denominator greater than five

Calc. A

Total potential calculation example			PMPM	$2.50				
Provider	**Panel count**	**Q4 MM**	**BH — 30%**	**PH — 20%**	**Hospital — 30%**	**EMR — 10%**	**CRISP — 10%**	**Total**
A	500	1500	$1,125.00	$750.00	$1,125.00	$1,125.00	$1,125.00	$5,250.00

Payment calculation example	BH	PH	Hospital	EMR	CRISP	Total
Count of qualifying measures*	6	5	3	Y	N	
Funding per measure	$187.50	$150.00	$375.00	$1,125.00	$0.00	$1,837.50
Count of measures that met target	4	2	2	Y	N	
Total earned	$750.00	$300.00	$750.00	$1,125.00	$0.00	$2,925.00

*Measure must have denominator greater than 5 to qualify

Bonus calculation example	BH	PH	Hospital	Total
Average peer percentile rank* (using 4Q rates)	60%	75%	30%	
Calculated PMPM	$0.30	$0.75	$0.00	
Bonus awarded	$450.00	$1,125.00	$0.00	$1,575.00

*Must be above 50th Percentile to qualify for bonus

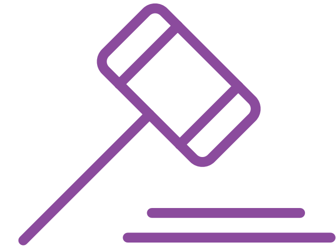
7. Top Performer Incentive

A Top Performer Incentive will be calculated and paid after the fourth quarter's calculation and accompany the fourth quarter's payment for those groups whose average peer comparison percentile ranking across all quality measures is 50 percent or higher (see bonus calculation example above).

An Improvement Incentive will be added in the second year of this program.

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 DC Director of Provider Network Management, and the basis for the appeal must be specified
- The appeal must be submitted within 60 days of receiving the results of the Behavioral Health Provider QEP from AmeriHealth Caritas DC
- The appeal will be forwarded to the AmeriHealth Caritas DC Behavioral Health Provider QEP Review Committee for review and determination
- If the AmeriHealth Caritas DC Behavioral Health Provider QEP Review Committee determines that a performance correction is warranted, an adjustment will be made following committee approval



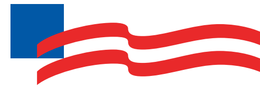
If providers wish to appeal their rankings on any or all incentive components, they must submit appeals in writing.

Important Notes and Conditions

- The AmeriHealth Caritas DC Behavioral Health 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 DC's discretion, upon written notice. AmeriHealth Caritas DC 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 DC reserves the right to terminate the program at any time upon notice.
- For computational and administrative ease, no retroactive adjustments will be made to incentive payments

AmeriHealth Caritas DC will continuously improve and enhance its quality management and quality assessment systems.

Notes



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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR