PerformPlus™ True Care Behavioral Health Program

Improving quality care and health outcomes

AmeriHealth Caritas™
District of Columbia

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Introduction

AmeriHealth Caritas District of Columbia (DC) is updating its value-based compensation program that it launched in 2019 for behavioral health (BH) providers who furnish behavioral health services to AmeriHealth Caritas DC enrollees. This program is called the PerformPlus™ True Care Behavioral Health Program (formerly 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 program provides the opportunity to earn performance-based financial incentives beyond a BH provider'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 provider is a solo provider).

The sum of the incentive payments may not exceed 25% 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.

Certain components can only be measured effectively for BH providers with panels averaging 50 or more enrollees. The average of 50 is based on a defined average enrollment period for the particular measurement year. For practices that furnish BH services to fewer than 50 enrollees semi-annually, there is insufficient data to generate appropriate and consistent measures of performance. These practices are not eligible for participation in the program.

Providers with fewer than 50 enrollees are not eligible for participation in the BH Provider Program.

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

Performance components

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

The performance components are:

1. Quality metrics (Healthcare Effectiveness Data and Information Set [HEDIS®] measures)
2. Potentially preventable events (PPE)
3. Social determinants of health (SDOH)
4. Pulse survey

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 will provide written notification of any changes.

1. Quality metrics (HEDIS measures)

This component is based on quality performance measures consistent with HEDIS and predicated on AmeriHealth Caritas DC's preventive health guidelines and other established clinical guidelines.

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

Behavioral health HEDIS quality metrics	
Antidepressant medication management (AMM) — acute	**Measurement description:** The percentage of enrollees 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 enrollees:** Enrollees age 18 and older as of the index prescription start date (IPSD) who met enrollment and event/diagnosis criteria **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
Antidepressant medication management (AMM) — continuation	**Measurement description:** The percentage of enrollees 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 (six months) **Eligible enrollees:** Enrollees age 18 and older as of the index prescription start date (IPSD) who met enrollment and event/diagnosis criteria **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 enrollees age 6 and older with a principal diagnosis of mental illness or intentional self-harm for which the enrollee received follow-up within seven days of the ED visit (eight total days) **Eligible enrollees:** Enrollees age 6 and older as of the date of the ED visit who met enrollment and event/diagnosis criteria **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 enrollees age 6 and older with a principal diagnosis of mental illness or intentional self-harm for which the enrollee received follow-up within 30 days of the ED visit (31 total days) **Eligible enrollees:** Enrollees age 6 and older as of the date of the ED visit who met enrollment and event/diagnosis criteria **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)

Behavioral health HEDIS quality metrics	
Follow-up after hospitalization for mental illness (FUH) - 7 days	**Measurement description:** The percentage of discharges for enrollees 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 enrollees:** Enrollees age 6 and older as of the date of discharge who met enrollment and event/diagnosis criteria **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 enrollees 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 enrollees:** Enrollees age 6 and older as of the date of discharge who met enrollment and event/diagnosis criteria **Continuous enrollment:** Date of discharge through 30 days after discharge **Allowable gap:** No gaps in enrollment

Physical health HEDIS quality metrics	
Breast Cancer Screening (BCS-E)	**Measurement description:** . The percentage of enrollees 50-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer **Eligible enrollees:** Enrollees 52-74 years of age by the end of the measurement period who were recommended for routine breast cancer screening and who also met enrollment criteria **Continuous enrollment:** October 1 two years prior to the measurement period through the end of the measurement period **Allowable gap:** No more than one gap in enrollment of up to 45 days for each full calendar year. No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period
Eye exam for patients with diabetes (EED)	**Measurement description:** The percentage of enrollees ages 18 – 75 with diabetes (Type 1 and Type 2) who received a retinal eye exam **Eligible enrollees:** Enrollees ages 18 – 75 as of December 31 of the measurement year who met enrollment and event/diagnosis criteria. **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year
Glycemic Status Assessment for Patients with Diabetes (GSD) <8%	**Measurement description:** The percentage of enrollees ages 18 – 75 with diabetes (Type 1 and Type 2) whose most recent glycemic status (HbA1c or GMI) was less than 8% during the measurement year **Eligible enrollees:** Enrollees ages 18 – 75 as of December 31 of the measurement year who met enrollment and event/diagnosis criteria **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year

Kidney health evaluation for patients with diabetes (KED)	**Measurement description:** The percentage of enrollees ages 18 – 85 with diabetes (Type 1 and Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year **Eligible enrollees:** Enrollees ages 18 – 85 as of December 31 of the measurement year who met enrollment and event/diagnosis criteria **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)

For tracking and informational purposes only	
Depression **Screening and follow-up for adolescents and adults (DSF-E)* - Follow-up**	**Measurement description:** The percentage of enrollees 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days **Eligible enrollees:** Enrollees 12 years of age and older at the start of the measurement period who also met enrollment and event/diagnosis criteria **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year
Depression **Screening and follow-up for adolescents and adults (DSF-E)*- Screening**	**Measurement description:** The percentage of enrollees 12 years of age and older who were screened for clinical depression using a standardized instrument **Eligible enrollees:** Enrollees 12 years of age and older at the start of the measurement period who also met enrollment and event/diagnosis criteria **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year
Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults (DMS-E)*	**Measurement description:** The percentage of enrollees 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. **Eligible enrollees:** Enrollees 12 years and older at the start of the measurement period who also met enrollment and event/diagnosis criteria **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year
Depression remission or response for adolescents and adults (DRR-E)* - Response	**Measurement description:** The percentage of enrollees 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score who showed response within 4-8 months after the initial elevated PHQ-9 score **Eligible enrollees:** Enrollees 12 years of age and older at the start of the intake period who also met enrollment and event/diagnosis criteria **Continuous enrollment:** May 1 of the year prior to the measurement year through December 31 of the measurement year **Allowable gap:** A gap in enrollment is allowed only in the measurement period. No gaps in enrollment are allowed from May 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period
Depression remission or response for adolescents and adults (DRR-E)* - Remission	**Measurement description:** The percentage of enrollees 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who achieved remission within 4-8 months after the initial elevated PHQ-9 score **Eligible enrollees:** Enrollees 12 years of age and older at the start of the intake period who also met enrollment and event/diagnosis criteria **Continuous enrollment:** May 1 of the year prior to the measurement year through December 31 of the measurement year **Allowable gap:** A gap in enrollment is allowed only in the measurement period. No gaps in enrollment are allowed from May 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period

Depression remission or response for adolescents and adults (DRR-E)*- Follow-Up	**Measurement description:** The percentage of enrollees 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of a follow up PHQ-9 score documented within 4-8 months after the initial elevated PHQ-9 score **Eligible enrollees:** Enrollees 12 years of age and older at the start of the intake period who also met enrollment and event/diagnosis criteria **Continuous enrollment:** May 1 of the year prior to the measurement year through December 31 of the measurement year **Allowable gap:** A gap in enrollment is allowed only in the measurement period. No gaps in enrollment are allowed from May 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period

2. Potentially preventable events (PPE)

By comparing the actual medical and pharmacy cost to the 3M expected cost, AmeriHealth Caritas DC calculates the actual versus expected cost ratio. 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.

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 readmission (PPRs) — A return admission to an acute care hospital that is identified as potentially preventable. Preventability is determined by:

- Identifying that the return admission is clinically related to the initial admission —defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission.

- Determining that the readmission rate could be decreased by either providing excellent care during the initial admission and/or putting into place the best possible coordination plans with the outpatient setting—including both the outpatient health professional team and the patient/family/caregiver.

3. Social determinants of health (SDOH)

AmeriHealth Caritas DC will assess, identify, and address health care and social determinants of health needs in the populations we serve. We help enable enrollees to live healthier lives and achieve maximum independence. As a Behavioral Health provider, you deliver health care services to our enrollees. When you submit claims, please add the appropriate ICD-10 codes that identify social determinants of health. With your help, we will have actionable data and be able to respond to our enrollees' unmet needs. On the next page are the IDC-10 codes and descriptions that we are collecting. A $5.00 incentive will be paid for each AmeriHealth Caritas DC enrollee that you bill SDOH codes (Z codes) for on a claim within the measurement period. Codes related to SDOH are in the table below.

Social Determinants of Health Z Code Categories	
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z59	Problems related to housing and economic factors
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

4. Pulse enrollee satisfaction survey and incentive

To compensate practices that receive positive enrollee satisfaction survey responses, AmeriHealth Caritas DC will use the Pulse survey to engage enrollees regarding their experience during a recent BH visit. Enrollees will be asked the following questions about the visit.

- How carefully did the doctor or care provider listen to you?
- How much respect did the doctor or care provider show for what you had to say?
- Overall, how would you rate the doctor or care provider?

The enrollee can respond by choosing one of the following for each question:
very dissatisfied, dissatisfied, neutral, satisfied, or very satisfied.

Survey result rates for each practice will be calculated and subject to minimum sample size requirements. This rate will then be compared to the rate for all qualifying practices to determine the practice's peer-percentile ranking. To qualify for an incentive payment, practices must rank within the top 50th percentile in satisfaction results when compared to their peers.

The enrollee satisfaction survey rate incentive payment is based on each practice's ranking relative to its peer network. This program component is settled semi-annually based on the prior 6-month performance period. The practice's peer percentile rank shall be used to determine the per member per month (PMPM) rate earned for the enrollee satisfaction rate component. PMPMs will be established starting at the 50th percentile using 5% increments. PMPM payments are not adjusted for the age or sex of the enrollee.

Overall practice score and incentive calculation

Overall results will be calculated and paid semi-annually (see Table A) for each of the previously mentioned quality performance and potentially preventable measures for each practice and then compared to the established targets in each payment cycle (see Table B). Providers who meet the established targets will qualify for a payment. The practice must also have an average monthly panel of 50 to qualify for the program.

Table A

Claims paid	Payment date
January 1, 2024 – June 30, 2024	December 2024
June 30, 2024 – December 31, 2024	June 2025

Table B

Component	Measures	2024 target
BH	Antidepression medication management — acute	58.93%
BH	Antidepression medication management — continuation	43.10%
PH	Breast cancer screening (BCS)	64.06%
PH	Eye exam for patients with diabetes (EED)	64.48%
PH	Hemoglobin A1c control for patients with diabetes (HBD)	51.34%
PH	Kidney health evaluation for patients with diabetes (KED)	40.60%
PPE	Potentially preventable admissions (PPA)	100%
PPE	Potentially preventable ER visits (PPV)	100%
PPE	Potentially preventable readmissions (PPR)	100%

Practice score rates are calculated by diving the number of members who received the described services (numerator) by the number of members eligible to receive the services (denominator). Each quality performance measure is subject to a minimum denominator value. The result of this calculation is then compared to the targets for each measure (see Table B). The aggregate number of measures within each component that meet or exceed the measure specific goal will be divided by the number of measures in that component that met the minimum denominator. This rate will be used to determine a PMPM for that component.

Funding for the quality performance (BH and PH) and potentially preventable events (PPE) is listed in Table C below.

Table C - Components

Behavioral health (BH) — quality measures	**35%**
Physical health (PH) — quality measures	**25%**
Potentially preventable events (PPE)	**35%**
Pulse survey	**5%**
Per-occurrence payments	
SDOH per enrollee billed	**$5**
Completion of follow-up after ED visit for mental illness (FUM) — within 7 days	**$50**
Completion of follow-up after ED visit for mental illness (FUM) — between 8 – 30 days	**$25**
Completion of follow-up after hospitalization for mental illness (FUH) — within 7 days	**$50**
Completion of follow-up after hospitalization for mental illness (FUH) — between 8 – 30 days	**$25**

Follow-up after ED visit for mental illness (FUM) — 7 days

A $50 incentive will be paid for completion of a follow-up visit for mental illness with a qualified mental health provider within seven days of an ED visit for enrollees age 6 and older with a principal diagnosis of mental illness.

Follow-up after ED visit for mental illness (FUM) — 30 days*

A $25 incentive will be paid for completion of a follow-up visit for mental illness with a qualified mental health provider provided between eight and 30 days of an ED visit for enrollees age 6 and older with a principal diagnosis of mental illness.

Follow-up after hospitalization for mental illness (FUH) — 7 days

A $50 incentive will be paid for each completion of a follow-up visit for mental illness with a qualified mental health provider within seven days after discharge for enrollees age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.

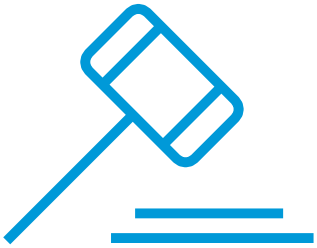
Follow-up after hospitalization for mental illness (FUH) — 30 days*

A $25 incentive will be paid for each completion of a follow-up visit for mental illness with a qualified mental health provider between eight and 30 days after discharge for enrollees age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.

*Please note for the 30-day incentives that the qualifying follow-up visit must be provided between eight and 30 days of the ED/hospital discharge. Those who complete a visit within seven days are not eligible for both the seven- and 30-day incentive.

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 Program from AmeriHealth Caritas DC.
- The appeal will be forwarded to the Behavioral Health Provider Program Review Committee for review and determination.
- If the Behavioral Health Provider Program 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 Behavioral Health Provider Program, 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.

AmeriHealth *Caritas*™

District of Columbia

www.amerihealthcaritasdc.com

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR