PerformPlus™ Total Cost of Care

Improving quality care and health outcomes

AmeriHealth Caritas™
District of Columbia

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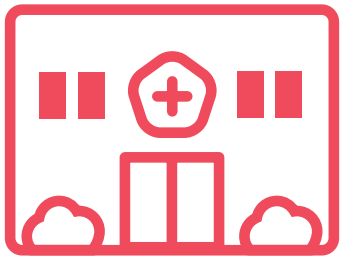
Introduction

AmeriHealth Caritas District of Columbia has created a value-based compensation program for participating primary care providers (PCPs) who furnish primary care services to AmeriHealth Caritas District of Columbia enrollees. This program is called the PerformPlus™ Total Cost of Care Primary Care Provider Value-Based Program (PCP VBP). 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 PCP VBP provides performance-based financial incentives beyond a PCP 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).

The program provides for compensation based on both quality and cost efficiency measures that align with National Committee for Quality Assurance (NCQA) standards. Certain program components can only be measured effectively for PCP offices with panels averaging 200 enrollees per month for a defined 12-month period. Practices with fewer than 200 enrollees are not eligible for participation in the PCP VBP.



Practices with fewer than 200 enrollees are not eligible for participation in the PCP VBP.

Program specifications

The incentive payment is based on a total cost of care shared savings pool. This shared savings pool is available to practices with attributed populations demonstrating efficient use of services relative to the overall population. Efficient use of services is defined as having actual medical and pharmacy spend less than the expected medical and pharmacy spend, while continuing to deliver high quality care, in the measurement year.

The risk-adjusted calculation leverages the 3M Clinical Risk Grouper platform to determine the expected medical and pharmacy cost of the enrollees attributed to the practice. The expected medical and pharmacy cost for each enrollee is the average cost observed for all enrollees within each clinical risk group. These calculations are adjusted to remove from consideration outlier patients with excessive medical and pharmacy costs.

Each enrollee is assigned to a clinical risk group (CRG) based on the presence of disease and their corresponding severity level, 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.

Program specifications (continued)

A practice with a panel having an efficient use of services will create a savings pool. 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 annual paid claims for primary care services. The pool will be distributed across four components as shown in the first four performance component descriptions below.

Each of these components has three target rates. Practices that achieve the minimum performance target in a component earn the percentage of the shared savings pool.

Practices that do not meet the minimum performance target but demonstrate stated improvement in the practice rate for that component, would receive the percentage of the pool shown in the improvement rate.

Performance components

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.

The five performance components are:

1. Quality metrics (HEDIS measures)
2. Potentially preventable admissions (PPA): Hospital admissions that could potentially have been dealt with in the outpatient setting and avoided with adequate monitoring and follow-up. May result from hospital and or ambulatory care inefficiency, lack of adequate access to outpatient care, or inadequate coordination of ambulatory care services.
3. Potentially preventable emergency room visits (PPV): Visits that could have been treated by a care provider in a non-emergency setting and could have been prevented by adequate patient monitoring and treatment.
4. Potentially preventable readmissions (PPR): Return hospitalizations within a 30-day readmission time interval that is clinically-related to a previous hospital admission and may result from incomplete treatment of the underlying problem, or the development of complications that become evident after discharge.
5. Improvement incentive

As additional meaningful measures are developed and improved, the quality indicators contained in the program will be refined. AmeriHealth Caritas District of Columbia 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 PCP groups that improve their performance in the defined components.

1. Quality metrics (HEDIS® measures)

This component is based on quality performance measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally recognized measures and predicated on AmeriHealth Caritas District of Columbia'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	
Lead screening in children	**Eligible enrollees:** Enrollees age 2 as of December 31 of the measurement year. **Continuous enrollment:** 12 months prior to the 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. **Measure description:** The percentage of enrollees age 2 who received at least one capillary or venous lead screening test on or before their second birthdays.
Adult access to care	**Eligible enrollees:** Enrollees age 20 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 each year of continuous enrollment. **Measure description:** The percentage of enrollees age 20 and older who had at least one ambulatory or preventive care visit in the measurement year.
Breast cancer screening	**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. **Measure 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.
Cervical cancer screening	**Eligible enrollees:** Women ages 24 – 64 as of December 31 of the measurement year who have not had a complete hysterectomy with no residual cervix. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year. **Measure description:** The percentage of women ages 21 – 64 who were screened for cervical cancer using either of the following criteria: • Women ages 21 – 64 who had cervical cytology performed every three years • Women ages 30 – 64 who had cervical cytology and human papillomavirus (HPV) cotesting performed every five years

1. Quality metrics (HEDIS measures)

Quality metrics	
Immunizations for adolescents	**Eligible enrollees:** Enrollees age 13 as of December 31 of the measurement year who have not had a previous anaphylactic reaction to the vaccine. **Continuous enrollment:** 12 months prior to the 13th birthday. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. **Measure description:** The percentage of enrollees age 13 who had one dose of meningococcal conjugate vaccine; one tetanus, diphtheria toxoids, and acellular pertussis (DTaP) vaccine; and three doses of the human papillomavirus (HPV) vaccine by their 13th birthdays.
Child and adolescent well-care visits (WCV)	**Eligible enrollees:** Enrollees ages 3 – 21 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 12 months. **Measure description:** The percentage of children and adolescents who had one or more comprehensive well-care visits with a PCP or an OB/GYN practitioner during the measurement year.
Glycemic status assessment for patients With diabetes (GSD) <8%	**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. **Measure 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.
Kidney health evaluation for patients with diabetes (KED)	**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. **Measure 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.

1. Quality metrics (HEDIS measures)

For tracking and informational purposes only	
Depression screening and follow-up for adolescents and adults (DSF-E)*- Follow-up	**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. **Measure 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.
Depression screening and follow-up for adolescents and adults (DSF-E)*- Screening	**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. **Measure description:** The percentage of enrollees 12 years of age and older who were screened for clinical depression using a standardized instrument.
Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults (DMS-E)*	**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. **Measure 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.
Depression remission or response for adolescents and adults (DRR-E)*- Response	**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. **Measure 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.
Depression remission or response for adolescents and adults (DRR-E)*- Remission	**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. **Measure 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.
Depression remission or response for adolescents and adults (DRR-E)*- Follow-Up	**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. **Measure 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.

Score calculation

Results are calculated for the subset of the above quality metrics that meet minimum sample size for each practice. Practice measure scores will be calculated as the ratio of enrollees who received the above services as evidenced by claim or encounter information (numerator) to those enrollees in the practice's panel who were eligible to receive these services (denominator), subject to minimum sample size requirements. This score will then be compared to the score for all qualifying practices to determine the practice percentile ranking for each measure. The overall score will then be the average percentile ranking across included measures.

Practices with average percentile ranks above 50% will be eligible to earn a percentage of the quality metrics pool.

Submitting accurate and complete encounter records is critical to ensuring the practice receives the correct calculation based on the services performed on AmeriHealth Caritas District of Columbia enrollees.

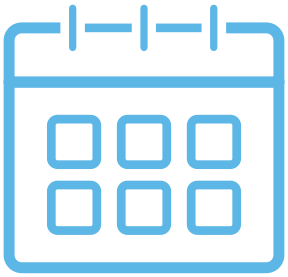
If encounter records reflecting the measures shown on pages 4 – 5 (where applicable) are not submitted, the provider's ranking rates will be adversely affected, thereby reducing the practice's value-based compensation.

Incentive payment

The quality metrics value-based incentive payment is based on the practice's ranking relative to its peer network. The incentive payment is made annually following the settlement calculation. The following table is an example of the incentive breakdown. Quality metrics component weight is 40% of the shared savings pool.

Practice rank	Percent of quality pool
5.0% improvement	25.0% improvement
50.0%	25.0%
60.0%	50.0%
75.0%	100.0%

Note: The amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.



The program is settled annually based upon a 12-month performance period.

2. Potentially preventable readmissions

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

3. Potentially preventable admissions

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

4. 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

60% of the incentive savings pool will be allocated to the utilization management measures. Actual and expected population-focused preventable components will be calculated using 3M's methodology and will be risk-adjusted at the enrollee level based on enrollee disease conditions and severity using 3M's CRGs. Practices that achieve the minimum performance target in each metric of this component will be eligible to earn a percentage of the shared savings pool for that metric savings pool.

The hospital utilization component of the PCP VBP is not intended to provide an incentive to reduce or limit preventive and other medically necessary care to AmeriHealth Caritas District of Columbia enrollees. This incentive rewards PCPs who effectively manage medical costs by ensuring enrollees get access to care in an ambulatory setting to reduce the need for preventable hospital admission, preventable emergency room visits and preventable readmissions to the hospital.

Utilization management pool payout percent	
Performance target	**Percent of utilization pool**
5.0% improvement	25.0% improvement
95.0%	25.0%
85.0%	50.0%
80.0%	100.0%

Note: The amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

5. Improvement incentive

PCP practices eligible for the program that do not qualify for an incentive in a measure, but show at least a 5% improvement compared to the prior measurement cycle, receive an improvement incentive equal to the percentage for that component, as outlined in each of the tables above.

Social determinants of health (SDOH)

AmeriHealth Caritas District of Columbia will assess, identify, and address health care and social determinants of health needs in the populations we serve, helping enable them to live healthier lives and achieve maximum independence. 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. Codes related to SDOH are shown in the table below. The practice's peer-percentile rank shall be used to determine the per enrollee per month (PEPM) rate earned for the SDOH component.

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

Recognizing individual social equity (RISE)

AmeriHealth Caritas District of Columbia developed an incentive for practices who are tasked with caring for our enrollees facing socioeconomic disparities. Utilizing race, ethnicity and language (REL) and social determinants of health (SDOH) data, this component of the program recognizes providers who are caring for these enrollees.

For this component, enrollees are grouped into social risk groups (SRG). Each enrollee is then assigned a risk weight based upon utilization of services determined for their SRG. For example: A risk score of 3 indicates those enrollees utilize services at 3 times the network average.

A weighted average social risk score will then be calculated for each of the practices using their attributed enrollees' enrollment and risk weight. Practices with a higher weighted average social risk score, will receive a higher incentive for their panel of enrollees.

Pulse enrollee satisfaction survey and incentive

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

- How satisfied were you with how carefully the doctor or care provider listened to you?
- How satisfied were you with the level of respect the doctor or care provider showed for what you had to say?
- Overall, how would you rate your satisfaction with the doctor or care provider?

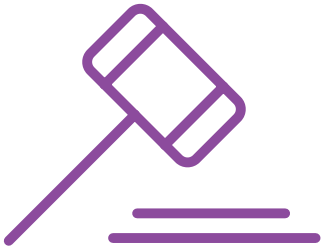
The enrollee can respond by choosing one of the following for each question: Very dissatisfied, Dissatisfied, Neutral, Satisfied, or Very satisfied.

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 annually based on the prior 12-month performance period. The practice's peer-percentile rank shall be used to determine the per enrollee per month (PEPM) rate earned for the enrollee satisfaction rate component.

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 District of Columbia Director of Provider Network Management, and the basis for the appeal specified.
- The appeal must be submitted within 60 days of receiving the results of the PCP VBP from AmeriHealth Caritas District of Columbia.
- The appeal will be forwarded to the AmeriHealth Caritas District of Columbia PCP VBP Review Committee for review and determination.
- If the AmeriHealth Caritas District of Columbia PCP VBP 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 District of Columbia PCP VBP, including, but not limited to, the quality performance measures included in the program, is subject to change at any time at AmeriHealth Caritas District of Columbia's discretion, upon written notice. AmeriHealth Caritas District of Columbia 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 District of Columbia 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.
- The sum of the incentive payments for the program 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.

AmeriHealth Caritas District of Columbia will continuously improve and enhance its quality management and quality assessment systems.

AmeriHealth Caritas™

District of Columbia

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MURIEL BOWSER, MAYOR