The Patient-Centered Medical Home Program
Improving quality care and health outcomes
2019

AmeriHealth Caritas
Pennsylvania

AmeriHealth Caritas
Northeast
The Patient-Centered Medical Home (PCMH) Program

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Introduction

AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast, referred to hereafter collectively as “the Plan,” consider the Patient-Centered Medical Home (PCMH) model of care to be the foundation for effective value-based purchasing strategies. The PCMH program is a reimbursement system for high-volume providers in our network who meet the state-specified requirements of a PCMH. In addition to rewarding PCMHs with monthly enhanced payments, PCMHs can earn additional funding in the Plan’s Quality Enhancement Program (QEP). The measurement year for this program will be calendar year 2019. The overall goal of this PCMH model is to support infrastructure for health care delivery transformation efforts and compensate for traditionally nonreimbursed services.

Program overview

PCMHs provide a way of organizing primary care practices to emphasize care coordination and communication. The Plan recognizes the importance of alternative payment methodologies (APMs) that include additional payments in support of delivery system reform. Practices will use this enhanced, non-visit-based compensation to augment staffing and training in support of whole-person care that integrates behavioral and physical health, increases access to care, improves quality of care, and uses a team-based approach to population health management with a focus on high-risk members. The program will be supported by use of electronic health records and the timely exchange of clinical and claims data to ensure effective use of health information technology to track and improve care.

The Plan will offer resources to help providers achieve, maintain, and enhance their PCMH model of care. We are committed to collaborating with providers to share best practices, learning opportunities, and tools to assist in transformation and performance improvement. Support will focus on those attributes/functions prioritized by the Pennsylvania Department of Human Services (DHS) program: (1) access and continuity; (2) care management; (3) community-based care management teams; (4) patient and caregiver engagement; (5) effective use of electronic health records and participation in a health information exchange; and (6) managing transitions in care, i.e., follow-up visits with a primary care practitioner (PCP) within seven days of hospital discharge.
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**PCMH provider requirements**

The Plan will ensure the PCMH provider meets the following requirements, as mandated by the Commonwealth of Pennsylvania. PCMHs that meet the criteria as described below will be considered for participation in the program and thus eligible for PCMH funding. The Plan will meet with each contracted PCMH provider frequently throughout the calendar year to monitor progress toward PCMH program compliance. Those PCMHs that are unable to meet all requirements by the end of the calendar year may be subject to an action plan wherein future participation in the program could be in jeopardy. The Plan's PCMH network will include high-volume adult and pediatric providers that serve the percentage of total membership and percentage of members that fall within the top 5th percentile of medical costs. For the 2019 program, membership used to establish payment is defined by the period ranging from October 1, 2017, through September 30, 2018. Throughout the 2019 program year, these PCMHs will serve at least 20 percent of their total membership and at least 33 percent of members who fall within the top 5th percentile of costs. The Plan re-established the membership period in December 2018 for the 2019 program.

1. Be a high-volume Medicaid practice already participating in the Plan's pay-for-performance program or a defined set of practices willing to share care management resources.
2. Accept all new patients or be open to face-to-face visits at least 45 hours per week.
3. Have already received a payment in the Medicaid or Medicare electronic health record meaningful use (MU) program, as per the Medicaid MU payment file from DHS or the Medicare MU file: [www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/dataandreports.html](http://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/dataandreports.html).
4. Join a health information exchange organization in order to share health-related data, as listed on the DHS website: [http://dhs.pa.gov/provider/healthinformationexchange/choosetheyrhoI/](http://dhs.pa.gov/provider/healthinformationexchange/choosetheyrhoI/).
5. Deploy a community-based care management team as described in the next section (Community-based care management).
6. Collect and report annual quality data and outcomes pertinent to their patient population as defined by the current AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast provider pay-for-performance program for 2019. We reserve the right to collect additional measures related to the Integrated Care Program, and additional population-specific measures defined by DHS, that would be mutually agreed upon by both AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast and the provider at that time.
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7. Upon the effective date of the program, will conduct internal clinical quality data reviews on a quarterly basis, report results, and discuss improvement strategies with AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast based on the data elements within the Plan’s provider pay-for-performance program. The Plan reserves the right to request report results and improvement strategies from additional measures which would be mutually agreed upon by both the managed care organization (MCO) and the provider.

8. Measure patient satisfaction among a random and statistically significant sample size, using a validated low-literacy appropriate tool to assess individual and family/caregiver experience as approved by the Plan.

9. Include, as part of the health care team, patient advocates or family members to support the patient’s health goals and advise practices.

10. See 75 percent of patients within seven days of discharge from the hospital with an ambulatory-sensitive condition as defined by the preventable quality indicator list established by the Agency for Healthcare Research and Quality (AHRQ), available here: www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_250992.pdf.

11. Participate in a PCMH learning network by attending at least two learning network events.

12. Complete a Social Determinants of Health assessment using a nationally recognized tool and submit ICD-10 diagnostic codes for all patients.

13. Educate and disclose to patients through low-literacy appropriate material that the practice is a PCMH with a community-based care management team available to help patients manage complex care needs.

Community-based care management

The PCMH must deploy a community-based care management (CBCM) team that consists of licensed professionals such as nurses, pharmacists, or social workers and unlicensed professionals such as peer recovery specialists, peer specialists, community health workers, or medical assistants. The CBCM team’s activities can replicate but not duplicate already existing and CBCM-reimbursed care management services. The care management team will work within their local community to accept individuals with complex care needs from local emergency departments, physical and behavioral health hospitals, specialty providers, and MCOs. Through actively engaging patients and taking into account their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited to, physical health, substance use disorder, and mental health treatments. The CBCM team will also connect individuals as needed to community resources and social support services through “warm hand-off” referrals for assistance with problems such as food insecurity and housing instability.
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Payments to providers

Monthly per member per month (PMPM) payments will be made to the PCMHs based off their attributed membership in the top 5 percent of medical costs compared to the network of PCMHs’ attributed membership in the top 5 percent of medical costs. AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast reserve the right to incorporate additional members identified through acuity and/or clinical complexity.

For example, Provider X has 100 members in the top 5 percent of medical costs and 2,500 members on their panel (5,500 top 5 percent members in the network of PCMH providers). The total estimated funding (funding levels are subject to change) for the 2019 program is $5,110,000. Therefore, Provider X would receive approximately 1.82 percent (100/5,500) of the overall funding for 2019, or about $93,002. The $93,002 will be represented as a PMPM payment based on their overall attributed panel size (2,500; $3.10). This payment represented in a monthly flat payment would be $7,750.17.

Quality Enhancement Program (QEP)

In addition to monthly enhanced payments to PCMHs, additional compensation can be earned through the QEP, in which all PCMHs will automatically be enrolled. The QEP is a reimbursement system developed by AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast for participating PCPs, PCMHs, OB/GYN providers, and dental providers. 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 additional compensation. For additional information about the QEP, please visit our websites:

AmeriHealth Caritas Pennsylvania
www.amerihealthcaritaspa.com/provider/resources/qep/index.aspx

AmeriHealth Caritas Northeast
www.amerihealthcaritasnortheast.com/provider/resources/qep.aspx

The CBCM team will also connect individuals as needed to community resources and social support services through “warm hand-off” referrals for assistance with problems such as food insecurity and housing instability.

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Measures for the 2019 QEP are listed below:

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Adolescent well-care visits</strong></td>
<td>To qualify for this measure, the participating PCP group must have a minimum of five members who meet the HEDIS® eligibility requirements (denominator). The provider group’s score will equal the percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit during the measurement year.</td>
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<tr>
<td><strong>Ambulatory care – (ED visits) (AMB) – Child (age 21 and under)</strong></td>
<td>To qualify for this measure, the participating PCP’s score will equal the number of emergency department (ED) visits that do not result in an inpatient encounter once, regardless of the intensity or duration of the visit, per 1,000 member months.</td>
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<tr>
<td><strong>Ambulatory care – (ED visits) (AMB) – Adult (age 22 and over)</strong></td>
<td>To qualify for this measure, the participating PCP’s score will equal the number of ED visits that do not result in an inpatient encounter once, regardless of the intensity or duration of the visit, per 1,000 member months.</td>
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<tr>
<td><strong>Annual dental visit (ages 2 – 20 years) – PCPs</strong></td>
<td>To qualify for this measure, the participating PCP group must have a minimum of five members who meet the HEDIS eligibility requirements (denominator). In an effort to encourage PCPs to refer members for routine dental care, the provider score will equal the percentage of members 2 – 20 years of age who had at least one dental visit during the measurement year.</td>
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<td><strong>Comprehensive diabetes care – HbA1c poorly controlled (&gt;9 percent)</strong></td>
<td>To qualify for this measure, the participating PCP group must have a minimum of five members who meet the HEDIS eligibility requirements (denominator). The provider score will equal the percentage of members 18 – 75 years of age with diabetes (type 1 and type 2) who had HbA1c tests performed during the measurement year and the most recent HbA1c level is &gt;9 percent.</td>
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<td><strong>Controlling high blood pressure</strong></td>
<td>To qualify for this measure, the participating PCP group must have a minimum of five members who meet the HEDIS eligibility requirements (denominator). The provider score will equal the percentage of members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (&lt;140/90) during the measurement year.</td>
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<tr>
<td><strong>Electronic submission of any mandatory measure, optional measure, or any clinical quality measure (CQM) approved by the current Centers for Medicare &amp; Medicaid Services (CMS) meaningful use electronic health record program rules</strong></td>
<td>CPT II code submission paid at $10 per qualifying occurrence.</td>
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### Medication management for people with asthma (75 percent)
To qualify for this measure, the participating PCP group must have a minimum of five members who meet the HEDIS eligibility requirements (denominator). The provider score will equal the percentage of members 5 – 64 years of age with a documented history of asthma and that remained on an asthma controller medication for at least 75 percent of their treatment period.

### Plan All-Cause Readmission
For Medicare, age 18 and older as of the Index Discharge Date. For Medicaid, ages 18 to 64 as of the Index Discharge Date. Continuous enrollment: 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.

The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and predicted probability of an acute readmission.

### Well-child visits in the first 15 months of life, six visits or more
To qualify for this measure, the participating PCP group must have a minimum of five members who meet the HEDIS eligibility requirements (denominator). The provider score will equal the percentage of members who turned 15 months old during the measurement year and who had at least six well-child visits with a PCP during their first 15 months of life.

### Well-child visits in the third, fourth, fifth, and sixth years of life
To qualify for this measure, the participating PCP group must have a minimum of five members who meet the HEDIS eligibility requirements (denominator). The provider score will equal the percentage of members 3 – 6 years of age during the measurement year who had at least one comprehensive well-child visit with a PCP.

### Important notes and conditions
The sum of the incentive payments for the program may not exceed 33 percent 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.
Our mission

We help people get care, stay well, and build healthy communities.

We have a special concern for those who are poor.

Our values

Advocacy  Dignity
Care of the poor  Diversity
Compassion  Hospitality
Competence  Stewardship