2021 NexUS Value-Based Incentive Program Provider Manual

ProviDRs Care
WPPA, INC.
NexUS

Table of Contents

NexUS **4**
Primary Care Selection & Assignment 4
Panel Capacity & Notification 4
CNP Program Participation 5
CNP Program Compliance 5
Provider Referral Program 5
Care Coordination with the PCP 6
Care Coordination with Other Providers 6
Member-Centered Plan of Care 6
Coordinating Care through Transitions and Discharge Planning 6
Data Sharing & Quality Reporting 7
Clinical Data Reporting 7
Data Sharing 7
Incentive Payment and Structure 7
Access 8
Utilization 9
Quality 10
Referrals 15
NexUS Connect **15**
Primary Care Selection & Assignment 15
Panel Capacity & Notification 16
Participation Performance 16
Data Sharing & Quality Reporting 17
Clinical Data Reporting 17
Data Sharing 17
Referrals 17
Primary Care Physician Performance-Based Incentive Payment and Structure 19
Access 20
Utilization 20
Quality 21
Referrals 23
Behavioral Health **25**
Overview of the Behavioral Value-Based Program 25
Population Criteria 25

Member Invitations & Opt-in....25
Provider Refusal of Member Assignment....26
Member Enrollment and Disenrollment....26
Health Action Plan....27
Claims Submission and Billing....28
Data Sharing & Quality Reporting....28
Clinical Data Reporting....28
Performance-Based Incentive Payment and Structure....28
Utilization....29
Quality....29
Appendix A....32
Appendix B....33

NexUS

Primary Care Selection & Assignment

Members enrolled in NexUS are required to select a Primary Care Provider (PCP). If a PCP is not selected by a member, the network will:

- Inform members of their right to choose a PCP.
- Assist members in selecting a PCP.
- Inform members that each eligible family member has the right to choose their own PCP.
- Automatically assign a PCP to members who do not proactively choose a PCP prior to enrollment with the plan.
- Advise members who their PCPs are and provide contact information. ProviDRs Care considers

  the following when assigning a PCP:

  - The member's previous PCP (if known and if the provider's capacity and location allows).
  - The closest PCP to the member's ZIP code location.
  - Children/adolescents within the same family are assigned together.

Members who were automatically assigned to a PCP and will be notified of the opportunity and procedures to change PCPs.

Members may request to change their PCP with approved changes effective the first of the following month.

Panel Capacity & Notification

When members choose a provider as their PCP, they are assigned to the provider's panel of members.

The panel remains open unless the following occurs:

- The PCP is under sanction;
- The PCP has voluntarily closed his/her panel; or,
- The panel is closed by ProviDRs Care due to member access issues.

PCPs must have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards including CMS guidance on this issue. In evaluating the capacity of PCPs, ProviDRS Care shall take into consideration both a PCP's existing ProviDRs Care member load, overall member load (across all programs), as well as its total patient load and will assess the overall patient load against community standards for any specialty involved. ProviDRs Care will also consider whether the provider is in compliance with the Access Standards set forth in this ProviDRS Care Provider Manual. Should ProviDRS Care identify access concerns, the PCP will be notified within 30 days of such findings. The PCP will have 30 days to respond, in writing, to ProviDRs Care regarding the access concerns with a documented process to correct access concerns. ProviDRs Care will not assign additional members to a single PCP if the network believes that PCP has reached the capacity to provide high quality services to Network members if corrective action has not been taken by the PCP.

Care Navigator Program (CNP)

This program serves members identified as needing comprehensive and disease-specific assessments, and re-assessments, along with the development of short- and long-term goals and a member-centered plan of care, developed in collaboration with the member, the member's caregiver(s) and the member's physician(s).

Members in the CNP are screened for the following as part of standard protocol:

- All members receive a comprehensive initial assessment.
- Subsequent detailed reassessments are performed for any item that screens positive in the initial assessment.

CNP Program Participation

Participation in the CNP program is offered to members identified as high risk, rising risk, and those referred by their PCP.

Members are initially identified for specific CNP needs upon joining the Plan. Members are encouraged to let ProviDRs Care know if they have a chronic condition, special health need or if they are receiving ongoing care. ProviDRs Care will use clinical and claims data to identify members for participation in the CNP on a go forward basis. Members will be asked to sign a consent form to participate in the CNP.

CNP Program Compliance

Members are encouraged to comply with CNP program to improve healthcare outcomes and improve the quality of life for members requiring care coordination and disease management. CNP activities and program compliance are designed to effectively manage a member's health.

Members are encouraged and may be financially incentivized to ensure the following goals are achieved:

- All care gaps closed within 3 months of participation and care plan established
- PCP office visit for any admission, readmission or ER visit within 1-2 weeks of discharge and development of care plan
- Completion of initial assessment within first 30 days of enrollment in the CNP
- Action plan is developed within the first 60 days of enrollment to meet the member's health goals
- 80% of action plan goals achieved within the first 4 months of participation
- Participate in bi-monthly health education lessons with the Care Navigator via face to face meeting or virtual meeting

Provider Referral Program

Providers are encouraged to refer members to the CNP program as needs arise or are identified through our Provider Referral Program. If you recognize a member with a special, chronic or complex condition

who may need the support of the CNP, please contact our team at 1-800-801-9772, option 5. Providers can also complete a Care Navigator Referral form and fax to our staff fax line for members that have missed appointments, need transportation services, or further education or management on their treatment plan or chronic condition. This form can be downloaded from our website at www.providrscare.net.

Care Coordination with the PCP

ProviDRs Care recognizes the PCP is the cornerstone of the member's care coordination and delivery system. Our Care Navigator staff contacts each PCP during a member's initial enrollment into the CNP, as part of the comprehensive assessment and member-centered plan of care development process. Care Navigators will create the member's action plan of care using the PCP's plan as a foundation. Through this approach, program staff complements the PCP's recommendations in the development of an enhanced and holistic action plan specific to the member's health needs. . The Care Navigator remains in close communication with the PCP during the implementation of the plan of care, should issues or new concerns arise.

Care Coordination with Other Providers

ProviDRs Care staff also contacts the member's key and/or current providers of care, as well as the member's behavioral health care providers, to determine the best process to support the member. This process eliminates redundancies and supports efficiencies for both programs. Care Navigators also engage key providers to be part of the development of the member-centered action plan . As the member is reassessed, a copy of the action plan goals is supplied to both the provider and member.

Member-Centered Plan of Care

Through the CNP, Care Navigators work with practitioners, members, and outside agencies to develop member-centered action plan. The member's action specifies mutually agreed-upon goals, medically-necessary services, behavioral health and as well as any support services necessary to carry out or maintain the plan of care, and planned care coordination activities. The member's action plan also take into account the cultural values and any special communication needs of the member.

Member-centric plans of care for members with special healthcare needs are to be reviewed and updated every 12 months, or as needed by the CNP.

Coordinating Care through Transitions and Discharge Planning

One of the most important functions of the Care Navigator is to assist in coordination of care during transitions. This includes, but is not limited to:

- Changes in care setting from hospital to home.
- Changes in health status due to presentation of a new chronic, sometimes life-threatening condition;
- Temporary or permanent changes in the fulcrum of care when a patient must change from a

primary care physician to a specialist due to a surgical need or exacerbation of a chronic condition;
- Changes in a living situation to obtain more independence or because of a need for greater support.

During transitions, members are supported through a Care Navigator. In order for this to occur, providers who are involved in such transitions are required to cooperate. Care Navigators will participate and cooperate in the care planning process.

Data Sharing & Quality Reporting

Clinical Data Reporting

Participating PCPs are encouraged to submit clinical data through the Kansas Health Information Network (KHIN) for clinical data reporting purposes.

PCPs that choose not to report clinical data through KHIN may submit their relevant clinical data for quality measures that may require information directly from the member's medical records. Should PCPs choose to submit this data outside of KHIN to ProviDRs Care, the appropriate clinical information should be indicated in accordance with Appendix A and sent in a secure format to NexUS@ProviDRsCare.net.

Clinical data should be submitted monthly and must be received by ProviDRs Care prior to the end of each month to receive credit during monthly performance reviews.

Data Sharing

ProviDRs Care will provide PCPs with a roster of attributed members and dashboard monthly. The dashboard provides each PCP with their current performance, community average, benchmarks and available and earned incentives within each domain as further described under Incentive Payment and Structure.

Incentive Payment and Structure

Participating PCPs will receive a management fee based upon their performance in accordance with the table below.

Performance of each participating PCP is evaluated monthly based on a rolling 12 months of data and the management fee payment is adjusted accordingly. The total available incentive may be adjusted annually.

Participating PCPs will have the option to receive their management fee via check or electronically and if the group chooses to send payment to each individual participating PCP or at the group level. Providers can complete the online form available at www.ProviDRsCare.net to indicate how they prefer to receive payment.

Pediatric PCPs

Domain	Measure	Weight
Access	• Adults' access to preventive/ambulatory health services • Children's and adolescents' accessto primary care providers	10%
Hospital Utilization	• Inpatient hospital PMPM • Emergency department PMPM	40%
Quality	• HEDIS	30%
Referrals	• Specialist referral PMPM	20%

All Other PCPs

Domain	Measure	Weight
Access	• Adults' access to preventive/ambulatory health services • Children's and adolescents' accessto primary care providers	10%
Hospital Utilization	• Inpatient hospital PMPM • Emergency department PMPM	40%
Quality	• HEDIS	10%
Referrals	• Specialist referral PMPM	40%

Access

Patient access to primary care providers (PCPs) who serve as a usual source of care is important in developing meaningful and sustained relationships. Seeing a PCP on a regular basis generally results in greater trust in the provider, improved patient-provider communication and the likelihood patients will receive the appropriate care. Access is measured using clinical indicators.

1. ***Measure****:* Adults' Access to Preventive/ Ambulatory Health Services (AAP)

   Measure Description: The percentage of members 20 years and older who had an ambulatory or preventive care visit during the member's plan year or the two years prior to the member's plan year.

   Timeframe*:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   Numerator*:* One or more ambulatory or preventive care visits during the member's plan year or the two years prior to the member's plan year.

   Denominator*:* Members 20 years and older.
   Exclusions*:* None

   Data Source: Claims

2. ***Measure:*** Children's and Adolescents' Access to Primary Care Practitioners (CAP)

   Measure Description: Children ages 12 months to 19 years of age who had a visit with a PCP during the member's plan year.

   Timeframe: Data is evaluated monthly based on the previous 12 months of incurred claims.

   Numerator: One or more ambulatory or preventive care visits during the member's plan year or the two years prior to the member's plan year.

   Denominator: Members 12 months to 19 years of age.

   Exclusions: None

   Data Source: Claims

Utilization

Utilization is measured on a rolling 12 months for admissions and emergency department pmpm spend. PCPs are encouraged to provide holistic care to prevent unnecessary hospital utilization.

1. ***Measure:*** Inpatient pmpm

   Description: Inpatient pmpm spend months during the measurement period.

   Timeframe: Data is evaluated monthly based on the previous 12 months of incurred claims.

   Numerator: Total inpatient claims spend.

   Denominator: Total member months.

   Exclusions: None

   Data Source: Claims

2. ***Measure:*** Emergency Room pmpm

   Description: Emergency room pmpm spend during the measurement period.

   Timeframe: Data is evaluated monthly based on the previous 12 months of incurred claims.

   Numerator: Total emergency department claims spend.

   Denominator: Total member months.

***Exclusions**:* None

***Data Source**:* Claims

Quality

Providers will be notified in advance of the measures used for evaluating performance within the quality domain.

1. ***Measure**:* Controlling High Blood Pressure (CBP)

   ***Description**:* The percentage of patients 18 to 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.

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   ***Numerator**:* Patient who's the most recent BP reading taken during a qualifying visit as <140/90 mmHg during the measurement year.

   ***Denominator**:* Patients 18–85 years who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement. (Only one of the two visits may be a telephone visit, an online assessment or a telehealth visit.)
   ***Exclusions**:* Exclude patients who meet any of the following criteria:

   - Medicare patients 66 years of age and older as of December 31 of the measurement year who meet either of the following:
     - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
     - Living long-term in an institution any time during the measurement year.
   - Patients 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty documented during the measurement year.
   - Patients 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Advanced illness includes any of the following during the measurement year or the year prior:
     - At least two qualifying visits on different dates of service, with an advanced illness diagnosis.
     - At least one acute inpatient encounter with an advanced illness diagnosis.
     - A dispensed dementia medication.

   ***Data Source**:* Claims or EHR

2. ***Measure**: Comprehensive Diabetes Care*

   Description: The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:
   - Hemoglobin A1c (HbA1c) testing.

- HbA1c control (<9.0%).
- Eye exam (retinal) performed.

Timeframe: Data is evaluated monthly based on the previous 12 months of incurred claims.

Numerators:

- HbA1c Testing: An HbA1c test performed during the measurement year.
- HbA1c Control <9%: The most recent HbA1c test during the measurement year is <9.0
- Eye Exam: Screening or monitoring for diabetic retinal disease. This includes diabetics who had one of the following:
    - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
    - A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
    - Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year.

Denominator: Patients 18 to 75 years identified as having diabetes during the measurement year or the year prior to the measurement year.

Exclusions All CDC Measures: Exclude patients who meet any of the following criteria:

- Medicare patients 66 years of age and older as of December 31 of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Advanced illness includes any of the following during the measurement year or the year prior:
    - At least two qualifying visits on different dates of service, with an advanced illness diagnosis.
    - At least one acute inpatient encounter with an advanced illness diagnosis.
    - A dispensed dementia medication.

3. ***Measure****:* Childhood Immunization Status (CIS)

Description: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Timeframe*:* Data is evaluated monthly based on the previous 12 months of incurred claims.

***Numerators**:*

- For MMR, hepatitis B, VZV and hepatitis A, count any of the following:
    - Evidence of the antigen or combination vaccine, or
    - Documented history of the illness
- DTaP: At least four DTaP vaccinations, with different dates of service or before the child's second birthday.
- IPV: At least three IPV vaccinations with different dates of service on or before the child's second birthday.
- MMR Any of the following on or between the child's first and second birthday:
    - At least one MMR.
    - At least one measles and rubella vaccination and at least one mumps vaccination or history of the illness.
    - At least one measles vaccination or history of the illness and at least one mumps vaccination or history of the illness and at least one rubella vaccination or history of the illness.
- HiB: At least three HiB vaccinations with different dates of service on or before the child's second birthday.
- Hepatitis B: Any of the following on or before the child's second birthday:
    - At least three hepatitis B vaccinations with different dates of service.
    - History of hepatitis illness.
- VZV: Either of the following on or between the child's first and second birthdays:
    - At least one VZV vaccination with a date of service on or before the child's second birthday.
    - History of varicella zoster (e.g., chicken pox) illness.
- Pneumococcal conjugate: At least four pneumococcal conjugate with different dates of service on or before the child's second birthday
- Hepatitis A: Either of the following on or between the child's first and second birthdays:
    - At least one hepatitis A vaccination with a date of service on or before the child's second birthday.
    - History of hepatitis A illness.
- Rotavirus: Any of the following on or before the child's second birthdays:
    - At least two doses of the two-dose rotavirus vaccine on different dates of service.
    - At least three doses of the three-dose rotavirus vaccine on different dates of service.
    - At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine all on different dates of service.
- Influenza: At least two influenza vaccinations with different dates of service on or before the child's second birthday.
- Combination Rates
  Two combination rates are also reported:
    - DTaP, IPV, MMR, HiB, HepB, VZV, PCV
    - DTaP, IPV, MMR, HiB, HepB, VZV, PCV, Hep A, RV, Influenza

***Denominator**:* Children who turn 2 years of age during the measurement year.

***Exclusions**:* Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.

4. ***Measure:*** Immunizations for Adolescents (IMA)

   Measure Description: The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

   Timeframe:

   ***Numerators**:*

   - Meningococcal: At least one meningococcal serogroups A, C, W, Y vaccine with a date of service on or between the patient's 11th and 13th birthdays.
   - Tdap: At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between the patient's 10th and 13th birthdays.
   - HPV: Must meet one of the following:
     - At least two HPV vaccines with different dates of service on or between the patient's 9th and 13th birthdays with at least 146 days between the first and second doses. OR
     - At least three HPV vaccines with different dates of service on or between the patient's 9th and 13th birthdays.
   - Combination Rate
     - Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

   ***Exclusions**:* None

5. ***Measure***: Breast Cancer Screening (BCS)

   ***Description**:* The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   ***Numerator**:* One or more mammograms any time two years prior to the measurement year.

   ***Denominator**:* Women 52–74 years during the measurement year.

   ***Exclusions**:* Patients who meet any of the following criteria:

   - Bilateral mastectomy any time during the patient's history through December 31 of the measurement year.

- Medicare patients 66 years of age and older who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Advanced illness includes any of the following during the measurement year or the year prior:
    - At least two qualifying visits on different dates of service, with an advanced illness diagnosis.
    - At least one acute inpatient encounter with an advanced illness diagnosis.
    - A dispensed dementia medication.

***Data Source**:* Claims

6. ***Measure**:* Colorectal Cancer Screening (COL)

Description: The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

***Numerator**:* One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA test during the measurement year or the two years prior to the measurement year.

***Denominator**:* Patients 51–75 years during the measurement year.

***Exclusions**:* Any of the following any time during the patient's history through December 31 of the measurement year:

- Colorectal cancer.
- Total colectomy.
- Medicare patients 66 years of age and older who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Advanced illness includes any of the following during the measurement year or the year prior:
    - At least two qualifying visits on different dates of service, with an advanced illness diagnosis.
    - At least one acute inpatient encounter with an advanced illness diagnosis.
    - A dispensed dementia medication.

Referrals

***Description**:* Referral pmpm spend months during the measurement period.

***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

***Numerator**:* Total referral claims spend.

***Denominator**:* Total member months.

***Exclusions**:* None

***Data Source**:* Claims

NexUS Connect

Primary Care Selection & Assignment

Members enrolled in NexUS Connect are required to select a Primary Care Provider (PCP). If a PCP is not selected by a member, the network will:

- Inform members of their right to choose a PCP.
- Assist members in selecting a PCP.
- Inform members that each eligible family member has the right to choose their own PCP.
- Automatically assign a PCP to members who do not proactively choose a PCP prior to enrollment with the plan.
- Advise members who their PCPs are and provide contact information. ProviDRs Care considers the following when assigning a PCP:

- The member's previous PCP (if known and if the provider's capacity and location allows).
- The closest PCP to the member's ZIP code location.
- Children/adolescents within the same family are assigned together.

Members are not auto assigned to PCPs enrolled in NexUS Connect. Members that select a Tier 1 PCP may change their designated PCP no more than twice each plan year. Members must notify ProviDRs Care of their change no later than the 15th of the month prior to the effective date of the newly selected PCP.

Panel Capacity & Notification

When members choose a provider as their PCP, they are assigned to the provider's panel of members.

The panel remains open unless the following occurs:

- The PCP is under sanction;
- The PCP has voluntarily closed his/her panel; or,
- The panel is closed by ProviDRs Care due to member access issues.

PCPs must have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards including CMS guidance on this issue. In evaluating the capacity of PCPs, ProviDRs Care shall take into consideration both a PCP's existing ProviDRs Care member load, overall member load (across all programs), as well as its total patient load and will assess the overall patient load against community standards for any specialty involved. ProviDRs Care will also consider whether the provider is in compliance with the Access Standards set forth in this ProviDRs Care Provider Manual. Should ProviDRs Care identify access concerns, the PCP will be notified within 30 days of such findings. The PCP will have 30 days to respond, in writing, to ProviDRs Care regarding the access concerns with a documented process to correct access concerns. ProviDRs Care will not assign additional members to a single PCP if the network believes that PCP has reached the capacity to provide high quality services to Network members if corrective action has not been taken by the PCP.

Participation Performance

In addition to contractual obligations, providers must maintain a rolling 12 month per member per month (pmpm) medical spend of no more than $300 to remain on active status participation in NexUS PCP or as otherwise determined by ProviDRs Care.

Providers that do not meet the minimum threshold will be notified of their performance and will be placed on probation status. While on probation status, PCP's are not eligible for additional incentives. Providers will have the opportunity to improve their performance following the notification. The pmpm spend for the PCP's panel of members must fall below $300 pmpm or continue to show improvement, to be placed back to active status. Performance will be evaluated on a quarterly basis and weighted accordingly:

Q1: 12.5%
Q2: 12.5%
Q3: 25%
Q4: 50%

Providers that fail to meet the threshold are subject to termination at the discretion of the network.

Terminated providers may reapply to participate in NPCP no earlier than 6 months from the date of their termination. Providers must provide supporting data and/or documentation of changes implemented that will reduce the cost of care.

Exclusions

- Providers with less than 240 member months (this equates to 20 members for 12 months)
- Cap aggregate allowed amount at $25,000 for member for rolling 12 months

Data Sharing & Quality Reporting

Clinical Data Reporting

Participating PCPs are encouraged to submit clinical data through the Kansas Health Information Network (KHIN) for clinical data reporting purposes.

PCPs that choose not to report clinical data through KHIN may submit their relevant clinical data for quality measures that may require information directly from the member's medical records. Should PCPs choose to submit this data outside of KHIN to ProviDRs Care, the appropriate clinical information should be indicated in accordance with Appendix A and sent in a secure format to NexUS@ProviDRsCare.net.

Clinical data should be submitted monthly and must be received by ProviDRs Care prior to the end of each month to receive credit during monthly performance reviews.

Data Sharing

ProviDRs Care and Participating Provider will work in good faith to share data to help will provide PCPs with a roster of attributed members and dashboard monthly. The dashboard provides each PCP with their current performance, community average, benchmarks and available and earned incentives within each domain as further described under Incentive Payment and Structure.

Referrals

The Primary Care Physician (PCP) serves as the initial contact and coordinator of health care services in the outpatient services. Member are required to get PCP referral authorization for most out-patient services to receive the highest level of coverage from the health plan.

Referral Authorizations can only be obtained from the Members assigned PCP (or covering physician) and must be completed prior to the delivery of the services. A valid referral must include the following information:

- Patient Name
- Patient Plan ID#
- Performing Provider
- Date of Service of Date range
- Services Authorized
- If applicable, Number of services or visits.

Referral Authorizations should be specific to the patient and services to be provided. Claims submitted for payment that include codes that are incident to or considered part of the authorized services will be paid at the referred level benefit.

The PCP's office is responsible for communication of the referral authorization to ProviDRs Care and notification to the receiving referral provider. Referrals Authorizations are created through ProviDRs Care provider portal. Retro-active Referrals are Referral Authorizations created and received and/or performed without the PCP's knowledge are not allowed and will processed at self-referral benefit level. Retro-active referrals will not be processed unless formally appealed by the PCP.

Services requiring Prior Authorization must have referral authorization to receive Referred benefit level.

Excluded:

- Behavioral Health
- Chiropractor
- Inpatient services (POS 21, 25, 51)
- Professional claims (POS 21, 25, 51)
- All capitated services performed under PCP's Tax ID

Primary Care Physician Performance-Based Incentive Payment and Structure

1. PCP may receive additional reimbursement based upon their performance in accordance with the table below.

2. Performance of each participating PCP is evaluated monthly based on a rolling 12 months of data for attributed members with the performance-based reimbursement adjusted in accordance with established measures.

3. 100% of performance-based incentive availability is subject to referral gate benchmarks as updated from time-to-time**.**

4. Primary Care Physician's that have a total pmpm medical spend below $100 will bypass 4 of the 5 domains within the performance-based incentive criteria and will receive 90% of available incentive. The remaining 10% of the eligible incentive will be subject to the quality domain.

5. Available incentive is 25% of the then current total available pmpm.

   Example:

   Primary Care Services Compensation: $75 pmpm
   Available Performance-Based Incentive: $25 pmpm
   Total Available: $100 pmpm

Domain	Measure	Weight
Access	• Adults' access to preventive/ambulatory health services • Children's and adolescents' access to primary care providers	10%
Utilization	• Inpatient hospital pmpm spend • Emergency department pmpm spend	40%
Quality	• HEDIS	10%
Referrals	• Referral management	40%

Access

1. ***Measure**:* Adults' Access to Preventive/ Ambulatory Health Services (AAP)

   Measure Description: The percentage of members 20 years and older who had an ambulatory or preventive care visit during the member's plan year or the two years prior to the member's plan year.

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   ***Numerator**:* One or more ambulatory or preventive care visits during the member's plan year or the two years prior to the member's plan year.

   ***Denominator**:* Members 20 years and older.

   ***Exclusions**:* None

   Data Source: Claims

2. ***Measure**:* Children's and Adolescents' Access to Primary Care Practitioners (CAP)

   ***Measure Description**:* Children ages 12 months to 19 years of age who had a visit with a PCP during the member's plan year.

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   ***Numerator**:* One or more ambulatory or preventive care visits during the member's plan year or the two years prior to the member's plan year.
   ***Denominator**:* Members 12 months to 19 years of age.

   ***Exclusions**:* None

   ***Data Source**:* Claims

Utilization

3. ***Measure**:* Inpatient PMPM Spend

   ***Description**:* Inpatient PMPM spend for attributed members.

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   ***Data Source**:* Claims

4. ***Measure**:* Emergency Room Visits

   ***Description**:* Emergency room PMPM spend for attributed members.

Timeframe: Data is evaluated monthly based on the previous 12 months of incurred claims.
Exclusions: None

Data Source: Claims

Quality

1. ***Measure:*** Controlling High Blood Pressure (CBP)

   Description: The percentage of patients 18 to 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.

   Timeframe: Data is evaluated monthly based on the previous 12 months of incurred claims.

   Numerator: Patient who's the most recent BP reading taken during a qualifying visit as <140/90 mmHg during the measurement year.

   Denominator: Patients 18–85 years who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement. (Only one of the two visits may be a telephone visit, an online assessment or a telehealth visit.)

   Exclusions: Exclude patients who meet any of the following criteria:

   - Medicare patients 66 years of age and older as of December 31 of the measurement year who meet either of the following:
     - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
     - Living long-term in an institution any time during the measurement year.
   - Patients 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty documented during the measurement year.
   - Patients 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Advanced illness includes any of the following during the measurement year or the year prior:
     - At least two qualifying visits on different dates of service, with an advanced illness diagnosis.
     - At least one acute inpatient encounter with an advanced illness diagnosis.
     - A dispensed dementia medication.

   Data Source: Claims or EHR

2. ***Measure****: Comprehensive Diabetes Care*

   Description: The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:
   - Hemoglobin A1c (HbA1c) testing
   - HbA1c control (<9.0%)
   - Eye exam (retinal) performed

Timeframe: Data is evaluated monthly based on the previous 12 months of incurred claims.

Numerators:

- HbA1c Testing: An HbA1c test performed during the measurement year.
- HbA1c Control <9%: The most recent HbA1c test during the measurement year is <9.0
- Eye Exam: Screening or monitoring for diabetic retinal disease. This includes diabetics who had one of the following:
    - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
    - A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
    - Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year.

Denominator: Patients 18 to 75 years identified as having diabetes during the measurement year or the year prior to the measurement year.

Exclusions All CDC Measures: Exclude patients who meet any of the following criteria:

- Medicare patients 66 years of age and older as of December 31 of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year.
- Patients 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Advanced illness includes any of the following during the measurement year or the year prior:
    - At least two qualifying visits on different dates of service, with an advanced illness diagnosis.
    - At least one acute inpatient encounter with an advanced illness diagnosis.
    - A dispensed dementia medication.

3. ***Measure****:* Cervical Cancer Screening (CCS)

   Description: Percentage of women 21 to 64 years of age who were screened for cervical cancer.

   Timeframe*:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   Numerator*:* Women who were screened for cervical cancer using either of the following criteria:

   - Women 21–64 years of age who had cervical cytology performed every 3 years.
   - Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

   Denominator*:* Women 21–64 years of age.

   Exclusions*:* Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time prior

to December 31 of the measurement year.

4. ***Measure**:* Colorectal Cancer Screening (COL)
   Description: The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   ***Numerator**:* One or more screenings for colorectal cancer. Any of the following meet criteria:

   - Fecal occult blood test during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
   - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
   - Colonoscopy during the measurement year or the nine years prior to the measurement year.
   - CT colonography during the measurement year or the four years prior to the measurement year.
   - FIT-DNA test during the measurement year or the two years prior to the measurement year.

   ***Denominator**:* Patients 51–75 years during the measurement year.

   ***Exclusions**:* Any of the following any time during the patient's history through December 31 of the measurement year:

   - Colorectal cancer.
   - Total colectomy.
   - Medicare patients 66 years of age and older who meet either of the following:
     - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
     - Living long-term in an institution any time during the measurement year.
   - Patients 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Advanced illness includes any of the following during the measurement year or the year prior:
     - At least two qualifying visits on different dates of service, with an advanced illness diagnosis.
     - At least one acute inpatient encounter with an advanced illness diagnosis.
     - A dispensed dementia medication.

Referrals

***Description**:* PMPM spend for services authorized for attributed members in the following categories:

- Participating specialists - for office visit and treatments
- Free-standing - (not hospital-based) imaging centers and labs
- Ambulatory Surgery Centers - except for excluded procedures that need prior authorization
- Orthotics/Prosthetics
- Physical, Occupational or Speech Therapy
- DME

***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

***Exclusions**:* None

***Data Source**:* Claims

Behavioral Health

Overview of the Behavioral Value-Based Program

This program is intended to provide members with a behavioral health diagnosis comprehensive behavioral health services with little to no financial barrier in accessing these services. The coordination of a member's care is performed by the contracting entity who oversees and coordinates access to all of the behavioral health services a member requires in order to optimize member health.

It is anticipated that the provision of appropriate access and care coordination will reduce avoidable emergency department visits and inpatient stays and improve health outcomes. With the member's consent, health records will be shared among providers to ensure that the member receives needed unduplicated services.

Population Criteria

These services are provided to a subset of ProviDRs Care value-based products with complex behavioral health needs whose care is often fragmented, uncoordinated and duplicative.

Members who receive a behavioral health diagnosis within the past 12 months are eligible for these services. A list of the eligible ICD 10 codes are updated from time-to-time and can be reviewed upon request.

Note: This program is intended to provide members with a behavioral health diagnosis comprehensive behavioral health services with little to no financial barrier in accessing these services. The coordination of a member's care is performed by the contracting entity who oversees and coordinates access to all of the behavioral health services a member requires in order to optimize member health.

It is anticipated that the provision of appropriate access and care coordination will reduce avoidable emergency department visits and inpatient stays and improve health outcomes. With the member's consent, health records will be shared among providers to ensure that the member receives needed unduplicated services.

Member Invitations & Opt-in

ProviDRs Care members who are determined eligible are notified of their eligibility for the program by their Primary Care Physician, ProviDRs Care, or the behavioral health entity based on information from claims and other data, or as a result of a referral by a provider in the community. Members will have a choice of which behavioral health entity they would like to participate with, but this choice may be limited by the member's geographic area and or behavioral health entity's participating in the program.

When a member is identified, ProviDRs Care will send an invitation letter explaining:

- the program and its benefits
- Why the member is eligible
- How to opt in to the program

Opting in to the program will be accomplished through completing and mailing in the opt-in form included with the assignment letter. If the letter is not returned, ProviDRs Care will assume the member has declined to participate in the program. Members will be able to opt out at any time after the initial opt-in form is received.

Members who choose not to opt in to the program will be reassessed annually and another invitation letter will be sent at that time. If a member does not opt in, but later wants to join or one of their providers submits a referral form, ProviDRs Care will send another invitation letter whether or not a year has passed since the member originally was invited.

Any referrals from providers that result in identification of additional members will result in invitation letters being sent the following month.

Provider Refusal of Member Assignment

A provider may not refuse to accept an assigned member, except for some limited reasons. These reasons include:

- The member has not participated for two consecutive quarters.
- The member resides outside the geographic range served by the provider, e.g. a Community Mental Health Center
- The member is outside the age range parameters established by the provider, e.g. a pediatrician is not required to serve adults
- The provider has reached its capacity
- The member poses a danger to himself or herself, or to provider staff – the member will be assigned to a new provider

In cases where the Refusal Form is used for any of the above reasons, the Refusal Form shall be sent to ProviDRs Care. However, if the provider chooses to refuse a member for any other reason, not listed above, the refusal will be reviewed. The provider must submit the reason for refusal on the Member Assignment Refusal Form to ProviDRs Care. The form can be found here: https://providrscare.net/providers/

Member Enrollment and Disenrollment

ProviDRs Care will inform the provider of assigned members. This will be the signal to initiate contact with the member and begin the Health Action Plan process.

ProviDRs Care will be responsible for handling any requests for a change of provider assignment at any time during the member's eligibility the program. A member must choose from available providers in the program which serve the area where the member lives.

There will be reasons some members are discharged from the program. This includes:

- The member having a catastrophic illness or event, like end stage renal disease that makes it unlikely the member will continue to benefit from the program – the member will be ineligible for services
- The member loses eligibility in their health plan or is no longer participating under ProviDRs Care

- A claim has not been submitted for 90 consecutive days since the last claims submission

To officially request a discharge or disenrollment for a member from the program, the provider must submit a completed Discharge Form to ProviDRs Care. The form can be found here: https://providrscare.net/providers/

Health Action Plan

The Health Action Plan is a tool developed by the member, provider, and others who will be involved, to document goals the member will pursue within the program, and the progress toward meeting those goals. Each member is required to have a HAP. The HAP is developed by the member with the assistance of the Care Coordinator, with input from others who are involved in the member's care, including those people the member chooses to include in the process.

The HAP is developed in a face-to-face or telehealth meeting with the member, care coordinator and any others who are involved in the member's care. The initial HAP meeting must be face-to- face. The HAP must be completed and sent to ProviDRs Care within 90 days from the first day the member is eligible to receive services. If a member is treated in an institution during this initial 90 days, such as an acute hospitalization (medical or psychiatric) or receive treatment in a Psychiatric Residential Treatment Facility (PRTF), the 90-day clock for the HAP will restart. The HAP may be updated as often as necessary; however the HAP must be submitted to ProviDRs Care at a minimum of every 90 days after the previous HAP submission.

These services have been promoted as an intensive care coordination effort which will result in improved health and quality of life, as well as reduced health care costs. A face-to-face meeting between the member and care coordinator are warranted for the following reasons:

- Care coordination involves a relationship that engages members in their self-care and encourages and supports adherence to a treatment plan. This type of relationship typically occur in a traditional care coordination model.

- If the traditional care coordination model was effective, it is likely that fewer people who receive case management would need these services. Given that claims and payment data indicate that a number of them would benefit from these services, the need to try a more "hands on" care coordination approach is warranted.

- Problems with physical or behavioral health, in the member's environment, may be more apparent during a face-to-face encounter, versus over the telephone.

The Health Action Plan is not intended to replace any specific treatment plans or person centered support plans already required. It is designed to capture some minimal critical information that can be shared with all providers involved with the member. Additionally, it is necessary to assign specific responsibilities to providers and the member related to health goals.

The Health Action Plan includes:

- Demographic information
- Contact information
- Physical and behavioral health information

- Whether there is a Home and Community Based Services waiver plan in place, and the type of waiver plan
- Whether the member has an Advanced Directive, and where it is located
- Goals, steps to achieve each goal, strengths and needs, measurable outcomes, start date, progress
- Signatures

The Health Action Plan can be submitted to CareNavigator@ProviDRsCare.net. The Health Action Plan manual form and instructions may found here: https://providrscare.net/providers/.

Claims Submission and Billing

This program is considered a bundled service, so individual core services provided within any month will not be reimbursed under fee-for-service. However, the provider must continue to submit fee-for-service claims for all services rendered. Payment is a per member per month (PMPM) payment made each month. In order for the provider to receive the PMPM payment, the provider must provide the member with at least one service within 90 days of the previous date of service. Should the provider not submit a claim for 90 consecutive days, the member will move back to fee-for-service and will be notified of the change.

Data Sharing & Quality Reporting

Clinical Data Reporting

Participating providers are encouraged to submit clinical data through the Kansas Health Information Network (KHIN) for clinical data reporting purposes.

Providers that choose not to report clinical data through KHIN may submit their relevant clinical data for quality measures that may require information directly from the member's medical records. Should providers choose to submit this data outside of KHIN to ProviDRs Care, the appropriate clinical information should be indicated in accordance with Appendix A and sent in a secure format to NexUS@ProviDRsCare.net.

Clinical data should be submitted monthly and must be received by ProviDRs Care prior to the end of each month to receive credit during monthly performance reviews.

Performance-Based Incentive Payment and Structure

1. Providers may receive additional reimbursement based upon their performance in accordance with the table below. ProviDRs Care will make reasonable effort to notify providers at least 120 days in advance of the measures, their associated benchmarks and targets.

2. Performance of each participating provider is evaluated monthly based on a rolling 12 months of data for attributed members with the performance-based reimbursement adjusted in accordance with established measures.

Example:

Behavioral Health Services Compensation: $100 pmpm
Available Performance-Based Incentive: $25 pmpm
Total Available: $125 pmpm

Domain	Measure	Weight
Hospital Utilization	• PMPM spend for hospital admissions • PMPM spend for emergency room visits	70%
Quality	• Follow-up after hospitalization for mental illness • Depression remission after 6 months • Depression remission after 12 months	30%

Utilization

1. ***Measure**:* Inpatient PMPM Spend

   ***Description**:* Inpatient PMPM spend for participating members.

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   ***Data Source**:* Claims

2. ***Measure**:* Emergency Room Visits

   ***Description**:* Emergency room PMPM spend for participating members.

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

   ***Exclusions**:* None

   ***Data Source**:* Claims

Quality

1. ***Measure**:* Follow-up after hospitalization for mental illness

   ***Description**:* The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

   - The percentage of discharges for which the patient received follow-up within 30 days of discharge
   - The percentage of discharges for which the patient received follow-up within 7 days of discharge

   ***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

***Numerator**:*

30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.
***Denominator**:*

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.

Exclusions:

Exclude from the denominator for both rates, patients who receive hospice services during the measurement year.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health.

These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

***Data Source**:* Claims

2. ***Measure**:* Depression Remission after 6 Months and 12 months

***Description**:* The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 6 and 12 months (+/- 60 days) after an index event date.

***Timeframe**:* Data is evaluated monthly based on the previous 12 months of incurred claims.

***Numerator**:*

Adolescent patients 12 to 17 years of age and adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at six and twelve months as demonstrated by a six month and twelve month (+/- 30 days) PHQ-9 score of less than five.

***Denominator**:*

Adolescent patients 12 to 17 years of age and adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.

Exclusions:

Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.

Data Source*:* Claims

Appendix A

The data elements listed below are required upon submission for the PCP to receive credit for their quality scores.

Member Policy Number (reference member panel roster)	xxxxxx
Member DOB	1/1/2006
Member First Name	Jon
Member Last Name	Smith
Measure Code **(see Appendix B)**	CIS - HepB
Measure Met	Y
Date Measure Completed	10/25/2017
Systolic Blood Pressure (required for CBP and CDC - BP149)	135
Diastolic Blood Pressure (required for CBP and CDC - BP149)	86
Lab Value (require for CDC - HbA1c)	8.6
Rendering Provider First Name	Luke
Rendering Provider Last Name	Picard
Rendering Provider NPI	123456789

Appendix B

Measure Name	Measure Code	Measure Description
Adults Access to Preventive/Ambulatory Health Services	AAP	Adults Access to Preventive/Ambulatory Health Services
Adult BMI Assessment	ABA	Adult BMI Assessment
Breast Cancer Screening	BCS	Breast Cancer Screening
Children and Adolescents Access to Primary Care Practitioners	CAP - 1 to 19 Y	Children and Adolescents Access to Primary Care Practitioners - 1 to 19 Year
Controlling High Blood Pressure	CBP	Controlling High Blood Pressure
Cervical Cancer Screening	CCS	Cervical Cancer Screening
Comprehensive Diabetes Care	CDC - BP149	Comprehensive Diabetes Care - BP Control <140/90 mm Hg
	CDC - Eye	Comprehensive Diabetes Care - Eye Exam
	CDC - HbA1c	Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) testing
	CDC - MAN	Comprehensive Diabetes Care - Medical Attention for Nephropathy
Childhood Immunization Status - Combination 3	CIS - DTaP	Childhood Immunization Status - Diphtheria, Tetanus and acellular Pertussis
	CIS - HepB	Childhood Immunization Status - Hepatitis B
	CIS - HiB	Childhood Immunization Status - H influenza type B
	CIS - IPV	Childhood Immunization Status - Polio
	CIS - MMR	Childhood Immunization Status - Measles, Mumps and Rubella
	CIS - PCV	Childhood Immunization Status - Pneumococcal Conjugate
	CIS - VZV	Childhood Immunization Status - Chicken Pox
Colorectal Cancer Screening	COL	Colorectal Cancer Screening
Immunizations for Adolescents – Combination 2	IMA - HPV	Immunizations for Adolescents - Human Papillomavirus Vaccine for Adolescents
	IMA - Mng	Immunizations for Adolescents - Meningococcal
	IMA - Tdap	Immunizations for Adolescents - Tetanus, Diphtheria toxoids and acellular Pertussis