buckeye health plan

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2022 P4P/P4Q Program Booklet

Pay for Performance and Partnership for Quality Programs

Medicaid (Buckeye Health Plan)
866.296.8731

Medicare (Wellcare By Allwell)
855.766.1851

Marketplace (Ambetter)
877.687.1189

buckeyehealthplan.com/providers

Table of **contents**

To Our Valued **Provider Network Partners,**

We are happy to deliver our 2022 Quality Incentive Program to our Primary Care Physicians. This program supports closing HEDIS-based care gaps for our members. Closing these care gaps can improve the overall health and wellness of our members, your patients, and we appreciate your active participation in the program.

The Quality program has been designed for each individual Line of Business (LOB). There are separate Medicaid, Marketplace and Medicare programs, which will allow the programs to be based on the LOB's own population. Separating out the programs allows you to focus on measures that matter most for each LOB.

All Primary Care Physicians, who have at least one Buckeye member that qualifies for a measure, are eligible. Please see detailed information in the 2022 Quality Performance Measures document for each LOB.

We appreciate the care you provide our members and look forward to strengthening our partnership with you to close care gaps and further improve health outcomes for your Buckeye Health Plan patients.

If you have questions, please reach out to your Provider Relations representative or call Provider Services.

Thank you for being our partner in care.

Natalie Lukaszewicz
Vice President, Network Development & Contracting,
Buckeye Health Plan

Medicaid Program

Overview

Eligible Members:
Buckeye Health Plan members who have formally been assigned to a Contracted BHP Provider

Performance Incentive:
Each measure has its own incentive amount paid after achieving the minimum target score

Requirements for Payout:
- Payout 75% of measure incentive amount for reaching Target 1
- Payout 100% of measure incentive amount for reaching Target 2

Measurement Period
- Measurement period is Jan. 1 - Dec. 31, 2022
- All claims and encounters must be received by June 30, 2023

Date of Service:
Retroactive to January 1st to allow for full credit of all gaps closed during the measurement time period

Reports and Payment:
- Three payouts per year (Q1-2/Q3/Q4-Final Reconciliation)
- Monthly reporting gaps in care
- Performance scorecard Payment Level: Paid at the TIN levels

How does the P4P work?

- The P4P measures are based on Buckeye Medicaid State P4P measures and are consistent with NCQA and HEDIS quality performance standards
- Each measure is assigned an incentive dollar amount and target percentage
- 2 tier targets based on HEDIS 25th and 50th percentiles
  - Target 1: 75% of incentive dollar amount
  - Target 2: 100% of incentive dollar amount
- Each measure is evaluated independently and can qualify and receive an incentive payment for one, multiple or all of the measures
- Measures are intended to be closed with claims data, although supplemental data is accepted
- Payments are made via paper checks, based on TAX ID

Medicaid 2022 Measure and Incentive Summary

Healthcare Effectiveness Data and Information Set (HEDIS) measures included in the 2022 Medicaid P4P (P4P) program are represented in the following table. National benchmark targets are based on those established by the National Committee for Quality Assurance (NCQA). The financial incentives are paid by Buckeye according to the target met for each measure.

HEDIS MEASURES	Target 1 (Payout 75%)	Target 2 (Payout 100%)	Incentive Amount
Adults' Access to Preventative/Ambulatory Health Services: Total	75.02%	79.03%	$5.00
Antidepressant Medication Management: Effective Acute Phase Treatment	55.63%	62.56%	$5.00
Antidepressant Medication Management: Continuation Phase Treatment	39.74%	45.24%	$5.00
Appropriate Testing for Pharyngitis: Total	67.76%	75.56%	$20.00
Asthma Medication Ratio: Total	58.42%	61.97%	$40.00
Breast Cancer Screening: Total	52.05%	54.51%	$10.00
Cervical Cancer Screening	54.99%	59.98%	$10.00
Child and Adolescent Well-Care Visits 3-11 years	45.12%	49.23%	$20.00
Child and Adolescent Well-Care Visits 12-17 years	37.63%	42.31%	$5.00
Child and Adolescent Well-Care Visits 18-21years	21.28%	23.26%	$5.00
Childhood Immunization Status - Combo 10	31.39%	34.06%	$20.00
Chlamydia Screening: Total	51.73%	56.09%	$10.00
Comprehensive Diabetes Care: HbA1c Testing	82.00%	84.17%	$20.00
Comprehensive Diabetes Care: HbA1c>9 Poor Control*	48.18%	56.45%	$20.00
Comprehensive Diabetes Care: Blood Pressure <140/90	50.85%	62.41%	$15.00
Comprehensive Diabetes Care: Eye Exam	46.23%	50.85%	$20.00
Controlling High Blood Pressure	50.36%	57.79%	$10.00
Follow-Up After Hospitalization for Mental Illness: Total Follow-Up Within 7 Days	29.33%	41.16%	$50.00
Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroids	70.55%	75.03%	$50.00
Statin Therapy for Patients with Cardiovascular Disease - Total	80.56%	82.12%	$50.00
Statin Therapy for Patients with Diabetes	64.81%	67.45%	$20.00
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total	62.57%	65.83%	$50.00
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Total (BMI Percentile Documentation)	66.18%	73.72%	$10.00
Well-Child Visits in the First 30 Months of Life - 0 - 15 Months (6 or More Visits)	64.91%	67.53%	$20.00
Well-Child Visits in the First 30 Months of Life - 15 - 30 Months (2 or More Visits)	51.22%	55.4%	$20.00

**Inverted Measure Rate*

Frequently Asked Questions and Resources

How does the program work?

Buckeye Health Plan is focusing on measures that have the greatest potential to positively impact the health and wellness of your Buckeye Health Plan patients, and potentially avoid future health issues, preventable hospitalizations and emergency room visits. The most important step you can take to improve the health of your patients is to engage with them and encourage they visit you for regular care.

Each quality measure is evaluated independently, and providers can qualify to receive an incentive payment for achieving one, multiple, or all of the measures. In addition, only one (1) qualified member is needed per measure to be eligible for the incentive payment.

Who is eligible to participate in the program?

The program is available to all Buckeye Health Plan network primary care provider (PCP) partners.

Who is considered a qualifying member?

A qualifying member is someone who meets the criteria to be included in the denominator for the measure as defined by HEDIS technical specifications. This may be a combination of age, gender or diagnosis identified on a claim.

Who is considered a compliant member?

A patient who is a Buckeye Health Plan member and receives a prescribed service based on the HEDIS technical specifications for that measure is considered a compliant member. This is determined based on claims paid by Buckeye Health Plan.

When will these measures go into effect?

Providers are given credit for any and all applicable services that their assigned Buckeye Health Plan members receive, beginning Jan. 1, 2022. This aligns with the HEDIS measurement year. Incentive calculations begin Jan. 1, 2022.

What is the best source of care gap information for my patients?

The Provider Analytics Dashboard provides performance insights, with member-level drill-down and export available. Provider Analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts in order to optimize P4P payouts. The dashboards are refreshed monthly. Access this tool on the Buckeye Health Plan Provider Portal.

How is my performance tracked?

Your performance on these measures is based on claims data you submit. Please make sure to include all applicable codes and documentation. You can track your pay-for-performance earnings in the Provider Analytics Dashboard on our Secure Provider Portal at Buckeye Health Plan/providers.

Wellcare By Allwell /Medicare Program

Wellcare By Allwell understands that the provider-member relationship is a key component in ensuring superior health care and the satisfaction of our members. Because we recognize these important partnerships, we are pleased to offer the 2022 Partnership for Quality (P4Q) Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

The P4Q program aligns payment with quality. Providers can earn incentives at multiple levels based upon Medicare STAR Rating achievement for each measure.

Each measure will be calculated and rewarded individually. STAR Rating is determined by comparing a P4Q Quality provider's compliance percentage for a given program measure to established benchmarks.

Medicare Partnership for Quality (P4Q) Program Overview

Measurement Period

- Measurement period is Jan. 1 - Dec. 31, 2022
- All claims and encounters must be received by Jan. 31, 2023

Members assigned to the physician based on the following:

- If the anchor date is prior to the payment date, it is the provider assigned as of the anchor date
- If the anchor date is after the payment date, the current provider is assigned

Description

- Bonuses vary by measure based on measure weight and STAR score achievement

Program Requirements

- Program is open to all PCPs
- Claims based program – members need to be seen and claims must be submitted

Reporting and Payouts

- Three quarterly payments and a final true-up payment
- Performance evaluation is based on H contract* and Provider Tax ID

**H contract – CMS contract number for our agreement to provide Medicare services*

Program Measures

The program consists of 18 measures. Each measure has a Base amount and three targets - 3, 4 and 5 STAR performance

- Base payments are the minimum amount that a provider will receive for closing program measures
- STAR performance incentives include the Base amount
- STAR target benchmarks are used to determine if STAR performance incentives will be paid out in the true-up payment
- Measures are calculated and rewarded individually

MEASURE NAME	Base	3-STAR	4-STAR	5-STAR
Bone Mineral Density Testing	$10	$25	$35	$45
Care of Older Adult: Medication List and Review	$5	$15	$25	$35
Care of Older Adult: Pain Screening	$5	$15	$25	$35
Colorectal Cancer Screen	$10	$25	$35	$45
Diabetes - Dilated Eye Exam	$10	$25	$35	$45
Diabetes HbA1c ≤ 9	$10	$30	$45	$60
FMC - F/U ED Multiple High Risk Chronic	$10	$15	$25	$35
Hypertension	$10	$30	$45	$60
Mammogram	$10	$25	$35	$45
Med Adherence - Diabetic	$10	$30	$45	$60
Med Adherence - RAS	$10	$30	$45	$60
Med Adherence - Statins	$10	$30	$45	$60
SPC - Statin Therapy for Patients with CVD	$10	$25	$35	$45
Statin Use in Persons With Diabetes	$10	$25	$35	$45
TRC - Engagement After Discharge	$10	$15	$25	$35
TRC - Medication Reconciliation Post-Discharge	$10	$15	$25	$35

How is my performance tracked?

Your performance on these measures is based on claims data you submit. Please make sure to include all applicable codes and documentation. You can track your pay-for-performance earnings in the Provider Analytics Dashboard on our Secure Provider Portal at Buckeye Health Plan/providers.

STAR Score Target Table

STAR performance is determined by comparing a provider's compliance percentage for a measure to the Centene established benchmarks in the STAR target table

- Benchmarks are based on expected industry performance in Calendar Year 2022 (full year)

MEASURES	3-STAR	4-STAR	5-STAR
Bone Mineral Density Testing	46%	57%	75%
Care of Older Adult: Med List and Review*	79%	92%	98%
Care of Older Adult: Pain Screening*	84%	95%	98%
Colorectal Cancer Screen	69%	79%	88%
Diabetes – Dilated Eye Exam	69%	79%	87%
Diabetes HbA1c ≤ 9**	67%	80%	89%
F/U ED Multiple High-Risk Chronic Conditions	64%	67%	69%
Hypertension**	71%	79%	90%
Mammogram	68%	76%	84%
Med Adherence – Blood Pressure**	86%	91%	95%
Med Adherence – Diabetes**	89%	91%	96%
Med Adherence – Statins**	87%	91%	96%
Statin Therapy for Patients with CVD	89%	92%	97%
Statin Use in Patients With Diabetes	84%	88%	92%
TRC - Engagement After Discharge	90%	94%	98%
TRC - Med Reconciliation Post-discharge	63%	76%	90%

**Dual Eligible Special Needs Plan (D-SNP) members only*
***Control measures are only paid in the final true-up payment*

Payment Structure

Payments #1, #2 & #3

First three payments will pay a measure closure at Base level

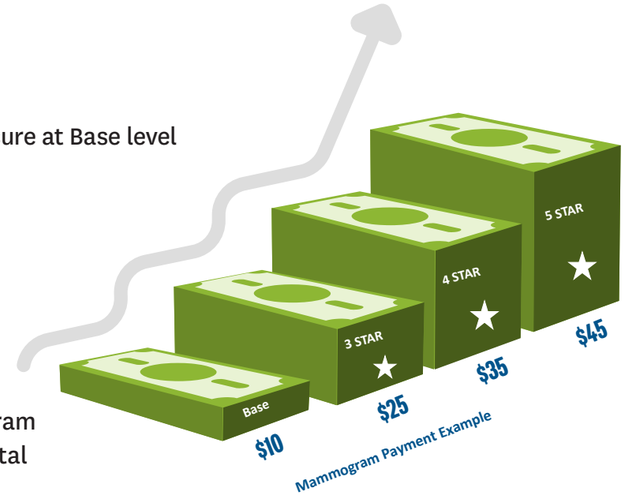
Payment #4 – True-up

True-up payment will make the provider whole based on final STAR rating for the program measure. Control measures are also paid at this time.

Payment Example:

A physician achieves a 5 STAR for Mammogram at the end of the program and receives a total of $45 per compliant member.

- $10 for the Base payment
- $35 additional for 5 STAR achievement



Payment Structure Example

Provider A and B both have 50 members that qualify for a mammogram for 2022. At the end of July, both of completed 30 of them. Both providers would receive $300.

- A 30 x $10 (Base) = $300 payout
- B 30 x $10 (Base) = $300 payout

At the end of September, Provider A has completed 5 more mammograms and Provider B has completed 10 more mammograms.

- A 35 x $10 (Base) = $350 $350 - $300 = $50 payout
- B 40 x $10 (Base) = $400 $400 - $300 = $100 payout

At the end of the year, Provider A has completed 40 total mammograms and Provider B has completed 45 total mammograms.

- A 40/50 = 80% (4 STAR), 40 X $35 = $1400, $1400 - $350 (previous payouts) = $1050 true-up
- B 45/50 = 90% (5 STAR), 45 X $45 = $2025, $2025 - $400 (previous payouts) = $1625 true-up

MEASURES	Base	3-STAR	4-STAR	5-STAR
Mammogram	$10	$25	$35	$45
Mammogram		66%	76%	83%

Additional Conditions

- All P4Q Providers must: (a) be in a participation agreement with Wellcare By Allwell either directly or indirectly through a vendor, from the effective date and continually through the dates the bonus payments are made, and (b) be in compliance with their participation agreement including the timely completion of required training or education as requested or required by the Plan.
- Bonuses are paid to the eligible member's Provider of record at the end of the applicable measurement periods as defined by the P4Q program.
- Any bonus payments earned through this P4Q program will be in addition to the compensation arrangement set forth in your participation agreement, as well as any other Wellcare By Allwell incentive program in which you may participate. At Wellcare By Allwell discretion, P4Q Providers who have a contractual or other quality incentive arrangement with Wellcare By Allwell either directly or through an IPA/vendor may be excluded from participation in this P4Q program.
- The terms and conditions of the participation agreement, except for appeal and dispute rights and processes, are incorporated into this program, including without limitation, all audit rights of Wellcare By Allwell and the P4Q Provider agrees that Wellcare By Allwell or any state or federal agency may audit their/its records and information.
- The Program is discretionary and subject to modification due to changes in government healthcare program requirements, or otherwise. Wellcare By Allwell will determine if the requirements are satisfied and payments will be made solely at Wellcare By Allwell discretion. There is no right to appeal any decision made in connection with the program. If the program is revised, the Plan will send a notice to the P4Q Provider by email or other means of notice permitted under the participation agreement.
- Wellcare By Allwell reserves the right to withhold the payment of any bonus that may have otherwise been paid to a P4Q Provider to the extent that such P4Q Provider has received or retained an overpayment (any money to which the P4Q Provider is not entitled, including, but not limited to, Fraud, Waste or Abuse) from the Plan, or Plan's Eligible Member. If Wellcare By Allwell determines a P4Q Provider has been overpaid, Wellcare By Allwell may offset any bonus payment that may have otherwise been paid to the P4Q Provider against overpayment.
- Only one bonus payment will be made for a specific HEDIS and medication adherence member-measure combination.
- The Plan shall make no specific payment, directly or indirectly under a provider incentive program, to a P4Q Provider as an inducement to reduce or limit medically necessary services to an enrollee, and this P4Q program does not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care. All services should be rendered in accordance with professional medical standards.
- If you have questions about the P4Q program, please contact your Provider Relations representative, Quality Practice advisor, or call Provider Services.

Quality Bonus Instructions

1. Measurement period is Jan. 1 - Dec. 31, 2022. Wellcare By Allwell must receive claims/encounters by Jan. 31, 2023.
2. Schedule and conduct an exam with the eligible member using HEDIS reports as guides to close care gaps and update diagnoses. Note: Additional STAR measures may become applicable to eligible members as claims and data are received throughout 2022.
3. Provide appropriate medications to your members and encourage them to fill their prescriptions; consider 90-day supplies for members stable on therapy.
4. Upon completion of the examination, document care and diagnosis in the patient's medical record and submit claim/encounter containing all relevant ICD-10, CPT and/or CPT II codes by Jan. 31, 2023.

Definitions

Eligible Member is a member who meets the age, sex, and/or disease-specific criteria, and the enrollment and other technical criteria, set forth in the HEDIS Technical Specifications or the most recent CMS Medicare Part C&D STAR Rating Technical Notes document for the Program Measures.

P4Q Provider means a primary care physician (PCP), vendor or independent practice association (IPA) who has a contract with Wellcare By Allwell and receives this Program Information Guide.

HEDIS means Healthcare Effectiveness Data and Information Set. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS Technical Specifications means the HEDIS 2022, Technical Specifications as published by the National Committee for Quality Assurance (NCQA) or any applicable successor specifications.

Medication Adherence Measures are the three Medication Adherence Measures published in the most recent CMS Medicare Part C&D STAR Rating Technical Notes document:

- Medication Adherence – Diabetes Medications
- Medication Adherence – Blood Pressure Medications
- Medication Adherence – Statins

Program Measures are the HEDIS and Medication Adherence Measures that are included in the bonus amounts table. Program Measures are defined according to the HEDIS Technical Specifications or the most recent CMS Medicare Part C&D STAR Rating Technical Notes document.

Ambetter Program

Overview

Eligible Members:
Buckeye Health Plan members who have formally been assigned to a Contracted BHP Provider

Performance Incentive:
Each measure has its own incentive amount paid after achieving the minimum target score

Requirements for Payout:
- Payout 75% of measure incentive amount for reaching Target 1
- Payout 100% of measure incentive amount for reaching Target 2

Measurement Period
- Measurement period is Jan. 1 - Dec. 31, 2022
- All claims and encounters must be received by June 30, 2023

Date of Service:
Retroactive to January 1st to allow for full credit of all gaps closed during the measurement time period

Reports and Payment:
- Three payouts per year (Q1-Q2/Q3/Q4-Reconciliation)
- Monthly reporting gaps in care
- Performance scorecard Payment Level: Paid at the TIN levels

How is the P4P program structured?

- Each measure is assigned an incentive dollar amount and target percentage.
- Incentives paid on each compliant member once target has been met for that particular measure.
- There are 10 measures in the program, each has two targets. If the provider reaches the first target, the bonus is paid at 75% of the incentive amount for that measure; if the provider reaches the second target, the bonus is then paid at 100% of the incentive amount.
- Each measure is evaluated if there is at least one (1) qualified event in the denominator, providers can qualify and receive an incentive payment for one, multiple or all of the measures.
- Target 1 is set at the QRS 4-STAR target and Target 2 is set at the QRS 5-STAR target.
- HEDIS measures are evaluated using NCQA HEDIS established guidelines, ***except*** minimum qualified members per event is not thirty (30), it is one (1).
- Three payouts made (Expected after Q2/ Q3 /Q4 with Final Reconciliation mid 2023) each report.

- Gap closure rates/scores are accumulated based upon member assigned PCP. The assigned PCP receives credit for gaps closed.
- Monthly performance reports and care gaps will be put on the providers portal via Provider Analytics.
- There is no claw back provision for this program so if a provider terms mid year or no longer has assigned membership we will not recoup funds.

How the Math Works

(Incentive Amount x Number Compliant) X 75% for reaching Target 1, **or** 100% for reaching Target 2

Program Definitions

- **Qualified** – members who are eligible for the service.
- **Compliant** – members who actually received the service.
- **Quality Score** – per measure, the percentage of compliant members to qualified members (sum of compliant divided by qualified).
- **Target** – set by plan, the percentile target that the Provider is striving to reach per measure.
- **Maximum Bonus** – amount the provider is eligible to receive based on their quality if all the eligibility requirements are met.
- **Bonus earned** – payment the provider will actually receive this period.

2022 Ambetter P4P Program - FAQs

How were the measures identified?
The measures are consistent with NCQA and HEDIS quality performance standards.

How often would measures change?
We continue to monitor all quality metrics and relative performance across the network. We refine our focus on an annual basis. We will provide a minimum notice of 30 days in case we plan to change any of the measured services.

What will the monthly report contain?
The monthly reports will include a scorecard on the measured service including projected incentive amounts. It will also include detailed provider level score cards and member level quality gaps-in-care reports.

Given the contract is established mid-year, how will it be measured?
For the quality program the providers will be given credit for any and all services that they have performed for members in this calendar year. Providers will also have an opportunity to improve their scores through the remainder of the year to maximize their bonus.

How is my performance tracked?

Your performance on these measures is based on claims data you submit. Please make sure to include all applicable codes and documentation. You can track your pay-for-performance earnings in the Provider Analytics Dashboard on our Secure Provider Portal at Buckeye Health Plan/providers

Ambetter - 2022 Measure and Incentive Summary

Quality Rating System (QRS) Healthcare Effectiveness Data and Information Set (HEDIS) measures are included in the 2022 Ambetter P4P (P4P) program on the table below. National benchmark targets are based on those established by the National Committee for Quality Assurance (NCQA™). The financial incentives are paid by Buckeye according to the target met for each measure.

HEDIS MEASURES	Target 1 (Payout 75%)	Target 2 (Payout 100%)	Incentive Amount
Antidepressant Medication Management - Effective Acute Phase Treatment	72.74%	76.05%	$25.00
Antidepressant Medication Management - Continuation Phase Treatment	72.74%	76.05%	$25.00
Appropriate Testing for Pharyngitis - Total	76.83%	80.95%	$25.00
Asthma Medication Ratio - Total	75.00%	90.00%	$25.00
Cervical Cancer Screening	64.97%	71.47%	$25.00
Chlamydia Screening - Total Ages 16-20	52.96%	58.95%	$25.00
Chlamydia Screening - Total Ages 21-24	52.96%	58.95%	$25.00
Comprehensive Diabetes Care - Eye Exam	52.8%	59.45%	$25.00
Monitoring for individuals on Warfarin - INR	75.00%	90.00%	$25.00
Proportion of Days Covered - Diabetes All Classes	80.23%	83.13%	$25.00

2022 Provider Resources

Get the tools you need to manage your administrative needs and keep your focus on the health of your patients in the Provider Portal at **buckeyehealthplan.com/providers.html** Coding tip sheets are available to assist with clinical documentation of HEDIS measures.