2022 Aetna Better Health Provider Pay-for-Performance (P4P) Proposal Template

Instructions:

The Provider Pay-for-Performance (P4P) proposal template should be completed as follows:

Part A: Provide a detailed description of the overall Provider P4P program.

Part B: Provide a detailed description of each measure's targeted provider(s), scoring and payment methodology, and payment amount.

Part C: Provide a detailed description of use of panel size and payment schedule.

Part D: Provide a detailed description of how the MCO intends to measure Provider(s) success or compliance within Program.

Part E: Provide a concise description of the roll-out strategy to notify and educate providers about the Provider P4P program

Part F: Provide a detailed description of how the MCO will evaluate the effectiveness of its Provider P4P Program.

Part G: Provide PH-MCO's Single Point of Contact (SPOC) name, email, and phone number for individual responsible for submission of the Provider P4P Program and the Provider P4P Change Form.

A. Description of your Provider P4P Program:

The overarching goal of the Aetna Better Health (ABH) 2022 Pay-for-Performance/Pay-for-Quality Program is to improve member outcomes and reward providers who partner with us to close gaps in care for their patients, our members. Our 2022 P4P is a vital component of our overall Value Based Services (VBS) strategy which aims to move providers into shared savings agreements with the plan. As in previous years, the 2022 program will require providers to achieve specific targeted goals for most measures and improve the capture of care by submitting information on their patients in an electronic format that can be imported into our systems and used to enhance claims data. The overall goal of the program is to improve our overall HEDIS rates and achieve the 75th percentile or higher in key performance measures identified within this document and as defined by the NCQA 2022 Technical Specifications.

Our monthly gaps in care reports have been optimized to provide information on health equity and outlining the provider's performance in this area as well as comparison to peers. and continue provide a comprehensive view of members in need of services by individual provider and group. These profiles also continue to include member specific information on the P4P measure and provide an avenue for the provider to have information on the need to perform member outreach to meet the goals outlined in this document.

The measures selected include services performed by Primary Care Providers (PCPs), OBGYN, Pediatric, and Dental providers with specific requirements outlined for each measure. Our robust Quality Practice Liaison (QPL) are assigned and dedicated to providers throughout the state to perform onsite education on the program, medical record reviews to determine missed opportunities, areas for improvement and who will serve as the provider's primary point of contact for this program. QPLs aid the provider in the form of member outreach that can occur through our Community Health Worker (CHW) program and referrals to Case Management when appropriate. The QPLs partner with our Provider Experience Representatives which allows for the provider to obtain additional information which may be out of scope of the QPL.

Providers who are eligible for this program will receive payment for services rendered during each biannual (six month) period or annually, as described under each measure. Aetna will distribute any remaining balance of P4P funds post-distribution for the complete calendar year 2022, divided equally to providers meeting performance targets for both the Child and Adolescent Well-Care Visits (Total) and Lead Screening measures, resulting in an increased payment to the provider groups who qualified by reaching the benchmark for those measures.

B. <u>Mandatory Measures:</u>

Child and Adolescent Well-Care Visits (WCV Total)

Targeted providers: All PCP or Pediatric providers with a panel size of at least 50 members attributed at the Tax ID Number (TIN) level who reach benchmark performance and perform the attributed services as defined per the 2022 HEDIS Technical Specifications for administrative collection for Child and

Adolescent Well-Care Visits (WCV) (Total) measure.

Payout amount to providers: Practices who reach the benchmark percentage 58% are eligible for payment. Those eligible will receive $40 per qualifying service rendered as per HEDIS 2022 Technical Specifications. Payment will be made once per member in the WCV denominator for the first qualifying visit captured. Payments for this measure will be made biannually. Pending the availability of additional funding, practices eligible for payment for this measure (WCV - Total) will share in any remaining balance of P4P funds.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must perform a qualifying well-care visit for members who are between the ages of 3 – 21 years old in accordance with HEDIS 2022 Technical Specifications (including continuous enrollment criteria). The provider must have submitted a qualifying well-care visit code between January 1, 2022 and December 31, 2022 as per the HEDIS 2022 Specifications. Payment is attributed to the practice (by TIN). Benchmark thresholds apply as noted in the Payment Amount to Providers section above. Any remaining balance of P4P funds post distribution for the complete calendar year of 2022 will be applied to the adolescent well care measure resulting in an increased payment to these providers.

Annual Dental Visit (Ages 2 – 20 years)

Targeted providers: Dental Practitioners: DDS, DMD, and certified and licensed dental hygienists

Payout amount to providers: Dental practitioners who perform the attributable service will receive $50 per qualifying service once per year per member for members 6 months – 5 years; and $25 per qualifying service once per year per member for members 6 – 20 years old. A biannual payment by TIN will be made once per member that receives a preventive dental visit in calendar year 2022. Only one visit per member per year (the first visit captured) is eligible for incentive payment.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Dental practitioners must perform a qualifying preventive dental visit for members who are between the ages of 6 months – 20 years and have been enrolled continuously with the plan for at least the calendar year 2022 (with one allowable gap of enrollment of no more than 45 days) Payment is attributed to the practice (by TIN).

The provider must have submitted the qualifying preventive dental visit codes between January 1, 2022 and December 31, 2022 as stated below.

Two codes per visit submission are required to qualify:
Include one of the following codes:
D0120 periodic oral evaluation – established patient
D0145 oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150 comprehensive oral evaluation – new or established patient
AND
Include one of the following procedure types:
D1000 – D1999

Controlling High Blood Pressure

Targeted providers: All PCP providers with panel size of at least 50 members attributed at the Tax ID Number (TIN) level who reach benchmark performance and perform the attributed services as defined per the 2022 HEDIS Technical Specifications for administrative collection for the Controlling High Blood Pressure (CBP) measure.

Payout amount to providers: Practices who reach the benchmark percentage 68% are eligible for payment. Those eligible will receive $50 per member who meets the HEDIS 2022 Technical Specifications measure requirements. Payment will be made by TIN once per member in the CBP denominator that demonstrates controlled blood pressure (BP) in 2022 of <140/90 mmHg. Only the representative BP (last in the calendar year) will be used to determine incentive payment. Payment will occur after completion of calendar year 2022.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must demonstrate good blood pressure control for members who are between the ages of 18 and 85 years who have at least two diagnoses of hypertension from 1/1/2021 through 6/30/2022 and whose BP was adequately controlled during the measurement year in accordance with HEDIS 2022 Technical Specifications (including continuous enrollment criteria). The provider must have submitted qualifying systolic and diastolic blood pressure codes for the last blood pressure recorded in calendar year 2022 as per the HEDIS 2022 Specifications. Payment is attributed to the practice (by TIN). Benchmark thresholds apply as noted in the Payment Amount to Providers section above.

Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)

Targeted providers: All PCP providers with a panel size of at least 50 members attributed at the Tax ID Number (TIN) level who reach benchmark performance and

perform the attributed services as defined per the 2022 HEDIS Technical Specifications for administrative collection for the HbA1c Poor control measure.

Payout amount to providers: Providers who reach the benchmark percentage of 35% or below are eligible for payment. Those eligible will receive $50 by TIN per member who meets the HEDIS 2022 Technical Specifications measure requirements. Payment will be made once per member by TIN in the CDC denominator that demonstrates controlled HbA1c value in 2022 of less than 9%. Only the last HbA1c value in the calendar year is to be used to determine incentive payment. Payment will occur after completion of calendar year 2022 by TIN.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must demonstrate HbA1c control for members who are between the ages of 18–75 with diabetes (Type 1 and Type 2) as measured by the last HbA1c result of the measurement year being less than 9%, in accordance with the HEDIS 2022 technical specifications (including continuous enrollment criteria). The provider must have submitted a qualifying A1c value code as per the HEDIS 2022 Specifications. Payment is attributed to the practice (by TIN). Benchmark thresholds apply as noted in the Payment Amount to Providers section above.

Prenatal Care in the First Trimester

Targeted providers: All OB/GYN or PCP providers who perform the attributable prenatal services as defined per the 2022 HEDIS Technical Specifications. There is no panel requirement for this measure.

Payout amount to providers: Eligible providers will receive $75 by TIN per member who delivers between October 8, 2021 and October 7, 2022, is in the Prenatal and Postpartum Care measure denominator and who receives a qualifying prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization in accordance with 2022 HEDIS Technical Specifications (excluding members that do not meet continuous enrollment requirements). Payment will be made once per member by TIN and attributed to the provider who renders the qualifying prenatal visit. Payments for this measure will be made biannually.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must perform a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization on members who deliver between October 8, 2021 and October 7, 2022 and are in the HEDIS 2022 Prenatal and Postpartum Care measure denominator (excluding members not

meeting continuous enrollment requirements). The provider must have submitted a qualifying prenatal visit code as per the HEDIS 2022 Specifications. Only one visit (the first visit captured) is eligible for incentive payment. Payment is attributed to the practice (by TIN) and to the practice rendering the qualifying visit.

Postpartum Care

Targeted providers: All OB/GYN or PCP providers who perform the attributed postpartum services as defined per the 2022 HEDIS Technical Specifications. There is no panel requirement for this measure.

Payout amount to providers: Eligible Providers will receive $75 by TIN per member who delivers between October 8, 2021, and October 7, 2022, is in the Prenatal and Postpartum care (PPC) measure denominator and who receives a postpartum visit 7-84 days after delivery in accordance with 2022 HEDIS Technical Specifications (excluding members not meeting continuous enrollment requirements). Payment will be made once per member in the PPC denominator with the qualifying postpartum visit. Payments will be made biannually, attributed to the practice (by TIN) and to the practice rendering the qualifying visit.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must perform a postpartum visit 7-84 days after delivery on members who deliver between October 8, 2021 and October 7, 2022 and are in the HEDIS 2022 Postpartum Care denominator at the time of a payment calculation. The provider must have submitted a qualifying postpartum visit code as per the HEDIS 2022 Specifications. Only one visit (the first visit captured) is eligible for incentive payment. Payment is attributed to the practice (by TIN) and to the practice rendering the qualifying visit.

Well-Child Visits in the First 30 Months of Life (W30 – 15-month age bracket)

Targeted providers: All PCP or Pediatric providers with panel size of at least 50 members attributed at the Tax ID Number (TIN) level who reach benchmark performance and who perform the attributed services as defined per the 2022 HEDIS Technical Specifications for administrative collection of the Well-Child Visits in the First 30 Months of Life (W30) measure – 15-month age bracket.

Payout amount to providers: Practices that reach the benchmark percentage of 65% are eligible for payment. Those eligible will receive $75 by TIN per member turning 15 months that have at least six qualifying services rendered as per HEDIS 2022 Technical Specifications. Payment will be made once per member in the W30 – 15 months age bracket denominator that receives six visits from birth through 15 months of age. Payments for this measure will be made biannually, will be attributed to the practice (by TIN) and to the practice attributed to the member at the time of payment calculation.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must perform at least six qualifying well care visits for members who are turning 15 months of age or two qualifying well care visits for members turning 30 months of age in calendar year 2022 in accordance with HEDIS 2022 Technical Specifications (excluding members not meeting continuous enrollment requirements). The provider must have submitted the appropriate number of well-care visit codes for visits for members turning 15 months of age as per the HEDIS 2022 Specifications. Payment is attributed to the practice (by TIN). Benchmark thresholds apply as noted in the Payout amount to providers section above.

Asthma Medication Ratio

Targeted providers: All PCP providers with panel size of at least 50 members attributed at the Tax ID Number (TIN) level who reach benchmark performance and who perform the attributable services as defined per the 2022 HEDIS Technical Specifications for administrative collection

Payout amount to providers: Providers who reach the benchmark percentage of 72% are eligible for payment. Those eligible will receive $100 by TIN per qualifying member as per HEDIS 2022 Technical Specifications. Payment will be made once per member in the Asthma Medication Ratio (AMR) denominator that had a ratio of controller medications to total asthma medications of 0.50 or greater during calendar year 2022. Payment will occur after completion of calendar year 2022.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must demonstrate medication adherence for members between the ages of 5–64 during 2022 who were identified as having persistent asthma had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement period in accordance with the 2022 HEDIS Technical Specifications (excluding members not meeting continuous enrollment requirements). Adherence is determined by pharmacy data (members in the denominator filling prescriptions). Payment is attributed to the practice (by TIN). Benchmark thresholds apply as noted in the Payment Amount to Providers section above.

Lead Screening for Children (LSC)

Targeted providers: All PCP or Pediatric providers with panel size of at least 50 members attributed at the Tax ID Number (TIN) level who reach benchmark performance and who perform the attributed services as defined per the 2022

HEDIS Technical Specifications for administrative collection for the Lead Screening Measure (LSC).

Payout amount to providers: Practices who reach the benchmark percentage 81% are eligible for payment. Those eligible will receive $50 by TIN per qualifying service rendered as per HEDIS 2022 Technical Specifications. Payment will be made once per member in the LSC denominator that receives venous or capillary blood draw for lead levels in calendar year 2022. Only one lab (the first qualifying service of the year that is captured) is eligible for incentive payment. Payments for this measure will be made biannually. Pending the availability of additional funding, practices eligible for payment for this measure (LSC) will share in any remaining balance of P4P funds.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must perform a venous or capillary blood draw for lead levels for members turning two years of age during 2022 who receive one or more capillary or venous lead blood test for lead poisoning in accordance with HEDIS 2022 Technical Specifications (excluding members not meeting continuous enrollment requirements). The provider must have submitted a qualifying lead screening code between January 1, 2022 and December 31, 2022 as per the HEDIS 2022 Specifications. Payment is attributed to the practice (by TIN). Benchmark thresholds apply as noted in the Payout amount to providers section above.

Plan All Cause Readmissions (PCR)

Targeted providers: All PCP groups whose total assigned members have a combined minimum of 25 eligible inpatient admissions in the calendar year and who service attributable members as per the 2022 HEDIS Plan All-Cause Readmission (PCR) measure, without risk stratification.

Payout amount to providers: Providers who achieve a 30-day hospital readmission rate at the benchmark percentage of 8.75% or less are eligible for payment for the Plan All Cause Readmissions (PCR) measure (without risk stratification). Those eligible will receive $2500 by TIN annually for reaching the required readmission benchmark of 8.75% or less. Payment will occur after completion of calendar year 2022.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must demonstrate a 30-day hospital readmission rate of 8.75% or less for members who have acute inpatient or observation stays in 2022. Payment is attributed to the practice (by TIN).

Developmental Screening in the First Three (3) Years of Life (FTY)

Targeted providers: All PCP or Pediatric providers with panel size of at least 50 members attributed at the Tax ID Number (TIN) level who reach benchmark performance and who perform the attributed services as defined per the 2022 Pennsylvania Performance Measure – Developmental Screening in the first three years of life (FTY) specifications.

Payout amount to providers: Providers who reach the benchmark percentage of 57% are eligible for payment. Those eligible will receive $50 by TIN per qualifying service of a comprehensive developmental screening. Payment will be made once per member in the FTY denominator that receives a comprehensive developmental screening in 2022. Only one screening (the first captured) is eligible for incentive payment. Payments for this measure will be made biannually

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Providers must perform a qualifying developmental screening for members who are between the ages of 1-3 years old. The provider must have submitted a qualifying developmental screening code between January 1, 2022 and December 31, 2022. Payment is attributed to the practice (by TIN). Benchmark thresholds apply as noted in the Payout amount to providers section above.

Electronic Quality Measure
Payment for establishment of regular and ongoing data feeds containing blood pressure and Hemoglobin A1c values or electronic submission of the Obstetrical Needs Assessment Form (ONAF),

Direct Data Feeds

Targeted providers: PCPs that have a minimum member panel size of 50 or are under Value Based Solutions (VBS) contracts. Fulfillment of the program requirements is attributed to the practice (by TIN).

Payout amount to providers: $1500 per practice (per TIN) per year for ongoing monthly electronic submission of blood pressure and A1c values by September 30th, 2022, to the plan which closes gaps in care administratively; payment rendered annually.

Description of the specific requirements the providers must complete to receive the incentive (i.e., attribution to individual provider versus practice, use of established NCQA benchmark thresholds to initiate payments, and methodology for determining payments made via relative scaling):

Participating PCPs will be eligible for a one-time payment by TIN

for completing ongoing monthly electronic transfer of blood pressure and A1c values from EHRs (electronic health and care information which closes gaps in care administratively) with Aetna Better Health of Pennsylvania through a secure FTP - $1500.

ONAF Forms Submitted through the Optum OB Care Portal

In addition to a gap in care closure for Prenatal Care in the First Trimester, OB/Gyn providers are eligible to receive $25 per TIN per adherent member if the provider submits the member's initial ONAF form before 14 calendar days after their first pre-natal visit through the Optum OB Care portal.

In addition to a gap in care closure for Postpartum Care, OB/Gyn providers are eligible to receive $25 per TIN per adherent member if the provider submits the member's completed and final ONAF form before 14 calendar days after the qualifying post-partum visit through the Optum OB Care portal.

Health Equity Measures

In addition, qualifying provider groups will be eligible for a Health Equity Bonus Payment for the following measures:

- Prenatal Care in the First Trimester
- Postpartum Care
- Well-Child Visits in the First 15 Months of Life
- Controlling High Blood Pressure
- Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)

To be eligible for the bonus payment, the provider group at the TIN level must have reached the corresponding NCQA benchmark rates for each measure where indicated. The group will then achieve a bonus payment of an additional $10 per adherent member who is of the lowest rate by race/ethnicity according to the following list:

- Prenatal Care in the First Trimester – Alaskan/American Indian or African American
- Postpartum Care - Alaskan/American Indian or Hispanic
- Well-Child Visits in the First 15 Months of Life - Alaskan/American Indian or African American
- Controlling High Blood Pressure – African American or Hispanic
- Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) - African American or Hispanic

C. Utilization of Minimum Panel Size/MCO Enrollment:

There is a 50-member minimal panel requirement attributed at the Tax ID Number (TIN) level for participation for the Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits, Controlling High Blood Pressure, HbA1c Poor Control, Lead Screening in Children, Asthma Medication Ratio, and

Development Screening measures. The Emergency Room (ER) Utilization measure requires a minimum panel size of 250 members and Plan All Cause Readmissions requires a minimum of 25 admissions during calendar year 2022. There are no panel requirements for the Annual Dental Visit, Prenatal Care in the First Trimester, or Postpartum Care measures. To be included in the qualifying benchmark for HEDIS measures (W30, WCV, CBP, CDC poor control, LSC, MMA) the members must meet measure and enrollment requirements in accordance with the 2022 HEDIS Technical Specifications.

Payment Schedule: *Please describe the payment frequency in detail below.*
Biannual payment will occur for the annual dental visit, well care, lead screening timeliness of prenatal care, postpartum visit, and electronic ONAF submissions during 2022. Payment for the Controlling High Blood pressure, HbA1c Poor Control, Asthma Medication Ratio, ED utilization, readmission metrics and electronic health record data transfer will be issued annually – by June 30, 2022. Any remaining balance of P4P funds post- distribution for the complete calendar year of 2022 will be divided equally to the adolescent well care and lead screening measures resulting in an increased payment to the practices who qualified by reaching the benchmark for both those measures.

D: **Measurement of Provider(s) Success/Compliance**

Administrative receipt of claim or supplemental data feed during 2022 that captures applicable services rendered in 2022 for measures in the P4P Program in accordance with HEDIS or PA Performance Measure Technical Specifications. There are no medical record reviews accepted for this program.

E: **Provider Education:**

As part of the Value Based Services strategy for Aetna Better Health, education to Provider Relations, Network Management and Quality staff will occur in order to ensure that all staff that interface with providers are well-versed in the 2022 P4P/P4Q program. Providers will receive information via the mail for the Aetna Better Health 2022 P4P Program that includes a description of the program and measures, payment methodology, attributable events, and codes and how to obtain access to profiles with member gaps in care information. This information will also be posted to the plan's provider website.

The plan's Quality Provider Liaison and Provider Relations staff will target visits to PCP offices who have a minimum of 50 members on their panel and OBGYNs to educate on the P4P program. Onsite or telephonic education will be provided upon request by any provider or their staff.

The plan's Quality staff will also provide WebEx educational opportunities for providers to address the P4P Program, including providers who are not visited. Invitations will be sent to provider groups with at least 50 members on their panels.

A reminder postcard will be sent to providers in May, and September 2022. P4P profiles will be produced and available via the plan's provider portal. Also, upon request the plan will supply a hard copy of the P4P profile and they will be distributed during onsite visits by the plan's QPL staff members.

Year-to-date Provider rates are calculated monthly. All providers are notified of the availability of the profiles on the web portal and key providers will be contacted by Quality Provider Liaisons at least quarterly. Providers will also receive information by fax throughout the year as profiles are reviewed, gaps identified, and educational needs addressed. Quality Practice Liaisons will distribute profiles and program information to the providers participating in the P4P program that they visit throughout the year.

F: **Evaluation of Provider P4P Effectiveness:**

Aetna Better Health will outline the 2022 Program outcomes in accordance with the DHS template requirements. At a minimum our analysis will include: 1. Analysis as to whether the Plan attained/surpassed the 75th percentile overall for the P4P selected HEDIS measures. Achievement of additional percentiles will also be determined. 2. Comparison of previous years P4P measures results to P4P 2021 results by measure, where applicable. 3. Provider performance by zone 4. Assessment of provider satisfaction with the P4P program via survey.

G: **SPOC Name, Email, Phone**

Alice Jefferson, Director Quality Management jeffersona@aetna.com 610-731-3947

Attestation:

I,  , CEO, attest that Aetna Better Health will perform the above
(signature of CEO)

Provider Pay for Performance Program(s).