Blue Cross complete of Michigan

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AmeriHealth Caritas℠

COMPASS

# PROGRAM GUIDE FOR BLUE CROSS COMPLETE PROVIDERS

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## Introduction

**Beginning May 1, 2022,** Blue Cross Complete will implement AmeriHealth Caritas COMPASS℠ (herein after known as "the program"), a referral optimization initiative that will give referring primary care providers information about specialists' performance as measured by established and objective quality and efficiency performance measures. AmeriHealth Caritas℠ is a separate company that provides provider performance ratings for referral optimization. Initially, the program will assess the performance of specialist providers, but ancillary service providers will be included in a later phase.

## Program overview

Our mission is to help people get care, stay well, and build healthy communities. To help achieve that mission, we are committed to providing members access to effective, efficient, and quality services. The program is designed to support that objective.

This program, which is voluntary for primary care providers and specialists, strives to increase member access to high-performing specialists by:

1. Twice per year, calculating the quality and efficiency of specialists' performance based upon established and objective quality and efficiency performance measures
2. Using that information to rank specialists in our provider network by a defined set of episode categories
3. Assigning a score to in-network specialist providers who meet the minimum number of episodes to participate in the program based on their ranked performance against their peers
4. Sharing the scores of providers who are participating in the program with primary care providers (and specialists) in the form of a *Referral Guide* for each episode category, broken down by provider specialty and hospital referral region.

## *Referral Guide*

The *Referral Guide* will be a resource for primary care providers who would like to access additional information to make informed referrals for their patients. The *Referral Guide* will be updated twice annually and will be available to both primary care providers and specialists via our secure provider portal, NaviNet®. The *Referral Guide* will be organized by episode category, provider specialty, and hospital referral region. Providers with performance above the network average, as compared to peers, and who are participating in the program will be indicated by a score of two and a half or more in the *Referral Guide*. Program-participating specialty providers with scores lower than 2.5 will be listed in the *Referral Guide* in alphabetical order but won't have a score indicated. Specialist providers who don't meet the minimum number of attributed episodes for the episode category associated with their specialty, or who are part of an entity that has opted-out of the program won't be listed in the *Referral Guide*.

Although primary care providers will have access to the *Referral Guide* to aid in making referrals, they aren't required to utilize the *Referral Guide* in their referral process.

Referrals made on the basis of the information presented in the *Referral Guide* shouldn't affect a member's ability to choose who they see for in-network specialty care. Members have the right to decide the specialist from whom they ultimately receive care.

## Episode categories

The episode categories used in the program have condition-specific definitions that group the entire range of care used to treat a clinical condition for a specific time period across the continuum of care. The episode categories are defined by PROMETHEUS Analytics and are used across the health care sector.

An episode is a measurement of a single occurrence that meets the criteria of an episode category (e.g., an asthma episode includes services occurring 30 days prior to the date of the trigger service and lasts until the end of the study period, or until the patient's date of death). Episodes include all components of the total episode costs within the measurement, or study period (e.g. the costs associated with typical or routine care, complications, and potentially avoidable complications).

Episode categories are described as chronic, procedural or other. Procedural episode types are episodes attributed to specific clinical procedures (e.g. colonoscopy). Procedural episode types have shorter episode durations than chronic episodes. Chronic episodes are episodes related to chronic conditions with a twelve-month episode durations (e.g. asthma and diabetes). Other episode types are related to pregnancy and newborn care.

The initiative is being implemented for the following episode categories:

- Allergic rhinitis-chronic sinusitis (chronic)
- Asthma (chronic)
- Depression and anxiety (chronic)
- Diabetes (chronic)
- Gastro-esophageal reflux disease (chronic)
- Hypertension (chronic)
- Low back pain (chronic)
- Newborn (other)
- Osteoarthritis (chronic)
- Pregnancy (other)

The publication of provider scores is limited to the program participating specialists providing care that meets the criteria within the aforementioned set of episode categories for each of the bi-annual reporting periods.

For a complete list of episode category definition parameters, please contact Blue Cross Complete Provider Inquiry at 1-800-312-5713 or your Blue Cross Complete provider account executive.

### Allergic rhinitis-chronic sinusitis

Allergic rhinitis-chronic sinusitis (RHNTS) is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period, or until the patient's date of death. The trigger service can be an inpatient service with a rhinitis/sinusitis-specific principal diagnosis code or an outpatient or professional E&M service with a rhinitis/sinusitis-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional rhinitis/sinusitis-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to either allergic rhinitis or chronic sinusitis such as postnasal drip or headache have been defined as typical care for RHNTS, and conditions such as fluid and electrolyte disturbances have been labeled as complications.

In addition, other concurrent episodes of upper respiratory infection are linked back at the patient level to allergic rhinitis-chronic sinusitis episodes as complications.

*Source: Prometheus Analytics, Allergic Rhinitis/Chronic Sinusitis Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=RHNTS. Contact your account executive for access.*

## Asthma

Asthma is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period, or until the patient's date of death. The trigger service can be an inpatient service with an asthma-specific principal diagnosis code or an outpatient or professional E&M service with an asthma-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional asthma-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to asthma such as wheezing or shortness of breath, and for other associated conditions such as exercise-induced bronchospasm or allergic broncho-pulmonary disease, have been defined by physician consultants as typical care for asthma, but admission for similar conditions or for acute exacerbation of asthma have been labeled as complications.

In addition, other concurrent episodes of pneumonia and upper respiratory infection are linked back at the patient level to asthma episodes as complications.

*Source: Prometheus Analytics, Asthma Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=ASTHMA. Contact your account executive for access.*

## Depression and anxiety

Depression and anxiety (DEPANX) is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period, or until the patient's date of death. The trigger service can be an inpatient service with a depression and anxiety-specific principal diagnosis code or an outpatient or professional E&M service with a depression and anxiety-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional depression and anxiety-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to depression and anxiety such as sleep disturbances have been defined by physician consultants as typical care for depression and anxiety, and conditions such as severe malnutrition or adverse effects of drugs have been labeled as complications.

*Source: Prometheus Analytics, Depression & Anxiety Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=DEPANX. Contact your account executive for access.*

## Diabetes

Diabetes is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period, or until the patient's date of death. The trigger service can be an inpatient service with a diabetes-specific principal diagnosis code or an outpatient or professional E&M service with a diabetes-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional diabetes-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to diabetes such as polyuria, polyphagia, polydipsia or impaired glucose tolerance, and for other associated conditions such as diabetic neuropathy or peripheral vascular disease, have been defined by physician consultants as typical care for diabetes, but admission for similar conditions or for uncontrolled diabetes have been labeled as complications.

In addition, other concurrent episodes of AMI, pneumonia and stroke are linked back at the patient level to diabetes episodes as complications.

*Source: Prometheus Analytics, Diabetes Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=DIAB. Contact your account executive for access.*

## Gastro-esophageal reflux disease

Gastro-esophageal reflux disease is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period, or until the patient's date of death. The trigger service can be an inpatient service with a GERD-specific principal diagnosis code or an outpatient or professional E&M service with a GERD-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional diabetes-related E&M service at least seven days later. Services with diagnosis codes for signs and symptoms related to GERD such as dyspepsia or heartburn have been defined as typical care for GERD, and conditions such as admission for aspiration pneumonia and fluid and electrolyte disturbances have been labeled as complications.

In addition, patients who undergo an Upper GI endoscopy are included in a separate procedural episode but are linked back to the GERD episode to understand the frequency and consequently the appropriateness of these procedures in GERD patients. Furthermore, other concurrent episodes of pneumonia are linked back at the patient level to GERD episodes as complications.

*Source: Prometheus Analytics, Gastro-Esophageal Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=GERD. Contact your account executive for access.*

## Hypertension

Hypertension is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period, or until the patient's date of death. The trigger service can be an inpatient service with a hypertension-specific principal diagnosis code or an outpatient or professional E&M service with a hypertension-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional hypertension-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to hypertension have been defined as typical care, and conditions such as fluid and electrolyte disturbances have been labeled as complications.

*Source: Prometheus Analytics, Hypertension Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=HTN. Contact your account executive for access.*

## Low back pain

Low back pain is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period, or until the patient's date of death. The trigger service can be an inpatient service with a low back pain-specific principal diagnosis code or an outpatient or professional E&M service with a low back pain-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional low back pain-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to low back pain such as lumbago or sciatica have been defined as typical care for low back pain, and conditions such as electrolyte disturbances or GI bleed due to use of pain medicines without proper protection have been labeled as complications.

Patients who undergo a lumbar laminectomy (LBRLAM) are included in a separate procedural episode but are linked back to the low back pain episode to understand the frequency and consequently the appropriateness of these procedures in low back pain patients. In addition, the low back pain episode is related back to the underlying osteoarthritis episode

(if one exists) as typical care at the patient level, and is compared to similar low back pain episodes as part of the risk adjustment methodology.

*Source: Prometheus Analytics, Low Back Pain Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=LBP. Contact your account executive for access.*

### Newborn

Newborn (NBORN) is an episode that is triggered by the presence of a definitive newborn diagnosis. The Newborn episode is open from the date of the episode's trigger until 30 days after the date of trigger. Services with diagnosis codes for signs and symptoms related to Newborn such as screening for development have been defined as typical care for Newborn, and conditions such as fetal distress have been labeled as complications.

*Source: Prometheus Analytics, Newborn Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=NBORN. Contact your account executive for access.*

### Osteoarthritis

Osteoarthritis (OSTEOA) is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period, or until the patient's date of death. The trigger service can be an inpatient service with an osteoarthritis-specific principal diagnosis code or an outpatient or professional E&M service with an osteoarthritis-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional osteoarthritis-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to osteoarthritis such as joint derangement have been defined by physician consultants as typical care for osteoarthritis, and conditions such as deep vein thrombosis or muscle weakness have been labeled as complications.

*Source: Prometheus Analytics, Osteoarthritis Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=OSTEOA. Contact your account executive for access.*

### Pregnancy

Pregnancy (PREGN) is a condition that is triggered retroactively by the presence of a vaginal delivery or cesarean section episode. Since pregnancy is triggered by a delivery episode, it has a 300-day look back and no look forward period. Services with diagnosis codes for signs and symptoms related to pregnancy such as absence of menstruation have been defined as typical care for pregnancy, and conditions such as electrolyte disturbances have been labeled as complications.

Vaginal delivery (VAGDEL) or cesarean section (CSECT) episodes are linked back to the pregnancy episode to understand the frequency and consequently the appropriateness of C-sections in pregnancy. In addition, other concurrent episodes of AMI, pneumonia and stroke are linked back at the patient level to pregnancy episodes as complications.

*Source: Prometheus Analytics, Pregnancy Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=PREGN. Contact your account executive for access.*

## Provider performance

Performance scores included in the *Referral Guide* correlate to specialty provider performance based upon established and objective quality and cost efficiency measures. Provider performance is determined using PROMETHEUS episode category definitions, case rates, and risk adjustment features). Scores are calculated at the individual provider level for each episode category, provider specialty and hospital referral region.

## Quality performance

Quality performance is calculated using PROMETHEUS potentially avoidable complications specifications for each episode category. PROMETHEUS PACs are used as a measure of quality designed to determine variation in care that could be reasonably attributed to complications under the control of providers.

These measure PACs are based on services rendered during the reporting period. Please note that evaluation for each PAC requires individual program-participating specialists to have a minimum of five attributed episodes during the reporting period. The program uses a one-year reporting period for chronic and other episode categories and a two-year reporting period for procedural episode categories.

## Efficiency performance

Efficiency performance is measured using PROMETHEUS episode-specific risk-adjusted case rates. The efficiency performance component of the provider score is calculated based on a comparison of the total episode cost to the risk-adjusted episode cost. A higher total cost to risk-adjusted cost ratio indicates lower efficiency performance. As such, individual network-participating specialty providers are ranked inversely among other network-participating providers of the same specialty and geographic area, who meet the minimum number of attributed episodes criteria for each episode category.

Episode case rates are risk-adjusted to account for individual risk in relation to episode costs. Risk adjustment is applied using PROMETHEUS' analytic models.

## Risk adjustment

PROMETHEUS' risk adjustment models predict individualized episode costs using demographic information, individuals' comorbidities, and episode severity. The estimates are the result of a series of regression models that combine to produce expected episode costs. These costs are delineated between costs for typical care and PACs. Each aspect of the modeling procedure is described below.[i]

The costs of each component serve as the dependent variables in the models. Separate risk adjustment models are created for each cost component and for every episode category. Risk factors used in the models include:

- Patient demographics and plan enrollment status during the reporting period
- Condition-specific risk factors
- Episode category subtypes
- End-of-life probability

For additional detail on PROMETHEUS' risk adjustment models, please refer to An Overview of the Risk Adjustment Methodology for Prometheus Analytics.

# Provider scoring

The program uses the objective quality and efficiency measures detailed above to rank individual network-participating specialty providers with the minimum number of attributed episodes for each episode category by specialty and hospital referral region. The providers are then given a score, on a scale of 1 to 4, based on their ranked performance, with 4 indicating highest overall performance. The *Referral Guide* identifies program-participating providers and includes an indicator for those performing providers with performance above the network average. After implementation, program-participating provider scores will be updated bi-annually on or about April 1 and October 1. Providers will be updated if

the report publication date changes.

Provider scores are calculated through the following steps:

1. Attribute episodes to individual specialist providers based on episode category criteria. To qualify for program participation, individual specialist providers must be attributed to five or more episodes within a one-year reporting period for chronic episode categories and a two-year reporting period for procedural episode categories.
2. Calculate episode case rates
3. Apply episode-specific risk adjustment
4. Evaluate quality performance and efficiency performance
5. Rank provider performance against like peers within the specialist's hospital referral region
6. Calculate provider score
7. Publish scores for providers who are participating in the program

As additional measures are developed and improved, performance indicators contained in the program will be added. Blue Cross Complete reserves the right to make changes to this program at any time and shall provide written notification of any changes.

## Accessing the *Referral Guide*

The *Referral Guide* will be a resource to primary care providers who would like to access additional information to make informed referrals for their patients. The *Referral Guide* will be updated twice annually and deployed to providers (primary care providers and specialists) via our secure provider portal, NaviNet.

Primary care providers and specialists can access and download PDF copies of available *Referral Guide* via NaviNet by following the steps outlined below.

1. Log into NaviNet.
2. Click the "***AmeriHealth Caritas COMPASS Referral Guide*"** link on the landing page.
3. From the list of reports provided, select the *Referral Guide* you wish to access.
4. The *Referral Guide* will open as a PDF. It can be saved or printed for in-office use.

## Provider appeal of score determination

- If a provider wishes to appeal their score, this appeal must be made in writing.
- The written appeal must be addressed to the Blue Cross Complete provider account executive and specify the basis for the appeal. If you don't know who your provider account executive is, call Blue Cross Complete Provider Inquiry at 1-888-312-5713 or visit mibluecrosscomplete.com, and go to the *Providers* tab and click on *Resources*. Scroll down to *County-based contacts for providers* and select your county.
- The appeal must be submitted within 30 days of receiving the score.
- The appeal will be forwarded to the program review committee for review and determination.
- If the review committee determines that a score correction is warranted, the correction will be made as follows:
    - Updated guides will be redistributed within 60 days of the initial *Referral Guide* deployment.
    - Appeals requests received after the 30-day period following the initial *Referral Guide* deployment will be addressed (as deemed necessary) during the next published *Referral Guide*.

## Specialist provider opt-out procedure

**Participation in the AmeriHealth Caritas COMPASS program is voluntary.** Entities can opt-out of the program at the tax ID level; individual specialists can't opt-out individually. If the entity (tax ID) in which a specialist is affiliated wishes to opt-out, a request must be submitted in writing. Requests submitted will affect all specialists with the same tax ID.

To opt-out of the program:

1. An entity representative must submit a written request to their Blue Cross Complete provider account executive via mail or email.
2. The request must include the entity's tax name, tax ID, and acknowledgement that once the opt-out request is submitted, no individual specialists affiliated with the entity's tax ID will be listed in the *Referral Guide*.
3. For initial program implementation, opt-out requests must be received by April 22, 2022, which is at least seven days prior to the scheduled *Referral Guide* deployment on May 1, 2022.
4. Entities wanting to opt-out post-implementation must submit a request at least 30 days prior to the next scheduled *Referral Guide* update, which occurs bi-annually on or about April 1 and October 1. Providers will be updated if the report publication date changes.
5. In the event that an opt-out request is received after the deadline, the entity will be notified via email that the request will be addressed during the next bi-annual *Referral Guide* refresh.

Once an entity has opted-out, the specialist providers affiliated with the entity's tax ID won't be included in *Referral Guides* unless a formal request is made by the entity to participate.

**Failure to opt-out of the program is equivalent to agreeing to participate.** By agreeing to participate in the program, the entity permits Blue Cross Complete to publish the performance score of each specialist affiliated with the entity's tax ID as described above.

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[i] Andrew Wilson, MPH, MA, "An Overview of the Risk Adjustment Methodology for PROMETHEUS Analytics," *Prometheus Analytics*, *http://www.prometheusanalytics.net/sites/default/files/attachments/Risk-Adjustment-Methodology.pdf*

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