

Provider Manual

Section 5.0

Provider Reimbursement

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5.0 Provider Reimbursement

5.1 Primary Care Practitioner (PCP) Reimbursement

PCPs are reimbursed via capitation and fee-for-service, as outlined in the PCP Contract. PCPs receive a monthly capitation payment based on the age, the gender, and the category of aid of each Passport Health Plan member assigned to their panel. After monitoring monthly enrollment and disenrollment from each provider's member panel, Passport Health Plan issues a capitation check and a report on the amount of payment per member to the provider on or about the 15th of each month. An encounter bonus is also available for the submission of encounters which reflect capitation-only services. This bonus program, along with others, is explained further in upcoming sections.

5.1.2 Additional Capitation Payments

5.1.2.1 Capitated Radiology Services

Providers are eligible to receive additional capitation payments for radiology services. A provider must provide all the services (and their successor CPT codes) included in the Provider Contract in order to be eligible for the additional radiology capitation payment. The PCP capitation payment for these services will be based on category of aid: "AFDC/TANF/SOBRA/ Foster Care" or "SSI Without Medicare." There is no additional capitation payments made for members in the "SSI With Medicare" category.

5.1.3 Procedures Reimbursed Above Capitation

Please refer to your PCP Contract for specific services reimbursed above capitation.

5.2 PCP Bonuses and Provider Recognition Program

5.2.1 Comprehensive Services Bonus

In order to qualify for the Comprehensive Services Bonus, the PCP/practice must meet all of the following criteria for a consecutive two month period:

- A panel size equal to or greater than 75 members.
- Meet office hour criteria: An office must be open at least 44 hours per week and open to treat patients a minimum of three nontraditional, evening or weekend hours, each week. Evening hours are defined as after 6 p.m.
- Have a system to remind patients of appointments and to follow up with patients who do not keep appointments.

Providers who meet these requirements will receive a predetermined per member per month (PMPM) payment as defined in the contract between the provider and Passport Health Plan. Providers must request in writing the Comprehensive Services Bonus payment and sign an

amendment to the PHP PCP Contract. As appropriate, the rate for the Comprehensive Services Bonus will be added to the base capitation rate outlined in the PCP contract.

5.2.2 PCP Encounter Bonus

Passport Health Plan is required to submit encounter data to the Kentucky Department for Medicaid Services. To encourage the submission of capitated encounter reporting, the Plan offers a monthly encounter bonus payment for each submitted member encounter claim that does not contain any services reimbursed on a fee-for-service basis. Encounter claims that contain both capitated and fee-for-service codes are not eligible for the bonus. A list of codes reimbursed on a fee-for-service basis can be found in Appendix C of the PCP Contract. To be eligible for the bonus, the PCP must submit all encounters on appropriate claim forms within 180 days of the dates those services are rendered.

5.2.3 Provider Recognition Program

The Provider Recognition Program is designed to further the Plan's mission of improving the health and quality of life of our members. Through the Passport Health Plan Provider Recognition Program, qualifying PCPs can acquire additional payments by demonstrating improvement and/or excellence in performance in the categories of cost containment, access to care, health outcomes, and member satisfaction. Passport Health Plan believes that in order for a managed care system to foster quality health services, emphasize preventive medicine, and contain costs, PCPs must be instrumental in directing patients' care. The Plan's Provider Recognition Program aims to provide PCPs with the necessary tools to assess their efficiency in carrying out Passport Health Plan's philosophy of managed care.

The program design is composed of clinically sound measures relevant to the Plan's population. The program is evaluated annually and subsequently adjusted in accordance with the Plan's needs and opportunities for improvement.

The selected clinical and service indicators of the Provider Recognition Program are outlined below in Sections 5.2.3.1 through 5.2.3.4. A portion of the overall PCP Provider Recognition Program funds has been allocated for each individual outcome as follows:

5.2.3.1 PCP Profile Index

Passport Health Plan's PCP Profile Index was established in December of 1999 to assess and reward PCP groups' efforts in providing quality, cost-effective health care to members.

The PCP Profile Index is a measure of the utilization of the entire health care resources by the PCP's panel of patients (actual expenses in dollars Per Member Per Month or "PMPM"). It is compared to the average utilization of the health care resources by all other members in the health plan (expected expenses in dollars PMPM), controlled for age, sex, and principle diagnoses of the PCP's specific panel of patients. Catastrophic cases, which are defined as any members who have greater than \$20,000 in medical expenses during the one-year review period, are excluded from the calculation. The expected cost is totaled for all members on the primary care group's panel to

establish a total expected cost for the group. The total expected cost is then compared to the total actual cost to derive the group's index.

The index is then used as a comparative measure to evaluate a PCP group's performance. Passport Health Plan currently separates the practitioner network into two peer groups representing urban/suburban PCPs and rural PCPs. An index greater than 1.00 indicates the utilization of more resources than the average of the colleagues for patients with similar age, gender, and diagnostic categories. An index below 1.00 represents less utilization than the average. An index of 1.00 denotes overall utilization equal to the average of all colleagues in the Passport Health Plan network peer group.

The total allocated dollars for the PCP Profile Index are distributed as follows:

Tier One: Provider groups falling at or below 1.00 but not below one standard deviation (for the peer group, identified as Urban or Rural) below 1.00. Payment is made at a rate of one share per member month (obtained from the profiling data for the last quarter of the period reviewed) of the total pool of money allocated to the PCP profile index portion.

Tier Two: Provider groups falling at or below one standard deviation below 1.00. This tier's payment is equal to a rate of 1.5 shares per member month (obtained from the profiling data for the last quarter of the period reviewed) of the total pool of money allocated to the PCP profile index portion.

The PCP Profile component of the Provider Recognition Program is earned quarterly, and paid quarterly at a rate per member per month included in the PCP Profile Report being reported each particular quarter. All PCP groups with 450 or more member months in the quarter qualify to participate in the PCP Profile Index measure.

5.2.3.2 Access to Care/ER Utilization

In accordance with the current year's Healthcare Effectiveness Data and Information Set (HEDIS®) data, emergency room (ER) utilization is based on the total number of emergency room visits within the reporting period divided by the total member months. Total Plan data is reported in a per 1000 member month rate. The methodology for the Provider Recognition Program stratifies the total Plan data by PCP group by assigning member months to the PCP group receiving capitation payment for individual months. To illustrate, if a member had three PCPs during the reporting period, and was with each PCP for four months, each PCP would be accountable for his/her individual four member months within the Provider Recognition Program. ER visits are likewise assigned to the PCP group that received capitation payment for the member during the month in which the ER date of service occurred.

The formula divides the total number of ER visits within the reporting period, by the total member months, multiplying the quotient times 1000. Providers who demonstrate improvement in accordance with NCQA's methodology for achieving statistically significant improvement will earn shares from the Tier One improvement level (see chart below). Providers who achieve a score within the top ten percent of all provider groups will earn shares from the Tier Two excellence level. Shares of the reward are 1.5 for Tier Two and 1.0 for Tier One.

<u>Baseline Rate</u>	<u>Minimum Reduction</u>
41/1000 or greater	2/1000
26 to < 41/1000	1.67/1000
16 to <26/1000	1.33/1000
>10 to <16/1000	1/1000
1 to 10/1000	Maintain 1 – 10/1000

The ER Utilization component of the Provider Recognition Program is earned annually and paid quarterly at a rate per member per month, based upon the number of member months accounted for in the annual measurement. All PCP groups qualify to participate in the ER Utilization measure.

5.2.3.3 Health Outcomes

In each of the current health outcomes (EPSDT screening and participation rates, breast cancer, cervical cancer, and Chlamydia screenings), qualifying PCP groups will have improved from the previous year's rate utilizing the following methodology. This methodology has been adapted from NCQA's table of Needed Improvement to demonstrate significant statistical improvement. The following chart is used in accordance with sections 5.2.3.3.1 and 5.2.3.3.2.

<u>Baseline Rate</u>	<u>Minimum Improvement</u>
<60%	2 Percentage Points
60% to < 75%	1.67 Percentage Points
75% to < 80%	1.33 Percentage Points
80% to <90%	1 Percentage Point
≥ 90%	Maintain 90% or greater

5.2.3.3.1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Rate and Participation Rate

Passport Health Plan continues to include EPSDT as a component of our Provider Recognition Program. The Plan identified EPSDT as a quality indicator because 71% of our members are eligible for EPSDT services and the Plan promotes preventive care.

The EPSDT screening rate is calculated using the current CMS 416 logic. The screening rate is the actual number of initial and periodic screening services received divided by the expected number of initial and periodic screening services. This rate indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the Plan's periodicity schedule adjusted by the proportion of the year for which they are Medicaid eligible. Providers who demonstrate improvement in accordance with NCQA's methodology for achieving statistically significant improvement will earn shares from the Tier One improvement level. Providers who achieve a score within the top ten percent of all provider groups will earn shares from the Tier Two excellence level. Shares of the reward are 1.5 for Tier Two and 1.0 for Tier One.

The EPSDT screening rate is earned annually and paid quarterly at a rate per screen based upon the number of screenings performed in an annual measurement.

The EPSDT participation rate is also calculated using the current CMS 416 logic. The participation rate is the unduplicated count of members who received at least one documented initial or periodic screening service during the year divided by the number of members who should have received at least one initial or periodic screen, in accordance with the Plan's periodicity schedule and the average period of eligibility. Providers who demonstrate improvement in accordance with NCQA's methodology for achieving statistically significant improvement will earn shares from the Tier One improvement level. Providers who achieve a score within the top ten percent of all provider groups will earn shares from the Tier Two excellence level. Shares of the reward are 1.5 for Tier Two and 1.0 for Tier One.

The EPSDT participation rate is earned annually and paid quarterly at a rate per member based upon the number of members receiving at least one screening in an annual measurement.

5.2.3.3.2 Breast Cancer, Cervical Cancer, and Chlamydia Screenings

In developing the Provider Recognition Program, clinical quality outcomes were selected due to the relevancy to the Plan's population. In accordance with the current year's HEDIS® methodology, total Plan data for breast cancer, cervical cancer, and Chlamydia screenings includes a denominator of all members who qualify for the screening and the numerator reflects members from the denominator who have received the screening. The methodology for the Provider Recognition Program stratifies the total Plan data by PCP group. The Plan's methodology allocates members to the PCP group that has received seven (7) or more months capitation for the member during the reporting period. Once the members have been stratified within the denominator, numerator events are allocated to the PCP group accordingly. Providers who demonstrate improvement in accordance with NCQA's methodology for achieving statistically significant improvement will earn shares from the Tier One improvement level. Providers who achieve a score within the top ten percent of all provider groups will earn shares from the Tier Two excellence level. Shares of the reward are 1.5 for Tier Two and 1.0 for Tier One.

The breast cancer, cervical cancer, and chlamydia screening rates are earned annually and paid quarterly at a rate per screen based upon the number of screenings performed in an annual measurement.

5.2.3.4 Member Satisfaction

Passport Health Plan utilizes member complaint data approved by the Plan's Credentialing Committee. This data is used to produce the Provider Recognition Program PCP member satisfaction reports. Data is compiled twice annually, reflecting a six-month period.

PCP groups are stratified by panel size for statistically appropriate peer group comparisons. Peer group one includes panel sizes of 260 members or greater, peer group two includes panel sizes of 110-259 members, and peer group three includes panel sizes of less than 110 members. The rate is calculated by dividing the total number of member complaints against the PCP group by the total number of PCP panel member months during the reporting period, multiplying the quotient times 1000. Results of each PCP group are then compared to colleagues in like peer groups. Providers who qualify at or below the mean but are greater than one standard deviation below the mean earn shares from the Tier One improvement level. Providers who qualify at or below the one standard

deviation below the mean earn shares from the Tier Two excellence level. Shares of the reward are 1.5 for Tier Two and 1.0 for Tier One.

Subsequently, PCP groups that receive complaints based on the following raw calculations are added as a qualifier and earn shares at the Tier One level.

- Groups with two complaints or less in peer group three of less than 110 members.
- Groups with three complaints or less in peer group two of 110-259 members.
- Groups with four complaints or less in peer group one of 260+ members.

The member satisfaction rate is earned twice annually and paid quarterly at a rate per member month based upon the number of member months included in the capitation reports for the quarter.

5.3 Specialist Provider Reimbursement

Specialist providers are reimbursed on a fee-for-service basis in accordance with their Provider Contract. Payment is based on member eligibility at the time of service. PCP referrals are required for most specialty care prior to the rendering of services. Members may self-refer for specific services, as outlined in Section 7.1 “Member Self Referral (Direct Access).” Passport Health Plan also requires prior authorization for select services as set forth in Section 6.3. Specialist providers must obtain prior authorization for these services and comply with referral requirements.

5.4 Financial Awards & Incentives

The Board of Directors of University Health Care, Inc. as a means to incentivize the efficient delivery of healthcare services, reserves the right to pay similar type providers financial awards and/or incentives, based upon approved criteria, including but not limited to, quality and/or medical outcomes. Such payment methodologies will not, either directly or indirectly, have the effect of reducing or limiting services provided to members.

5.5 Coordination of Benefits

Passport Health Plan follows its Coordination of Benefits Policy when members have other medical insurance including Medicare. Because Passport Health Plan is a Medicaid program, it is considered the “payer of last resort” on all claims. All insurance including any automobile (personal protection) coverage or other medical coverage, including Medicare, pays the member’s claims before Passport Health Plan. These types of coverage are considered “primary” coverage.

Passport Health Plan coordinates benefits up to the Plan’s allowed amount for fee-for-service reimbursements for covered Passport Health Plan benefits. This means the Plan will **pay the lesser of**:

- Passport Health Plan’s allowed amount minus the primary insurer’s payment, or
- The deductible, copay, and coinsurance totals from the primary insurer up to Passport Health Plan’s allowed amounts.

Second party deductible, copayment, and coinsurance is considered a component of the PCP capitation for primary care services, and the Plan will not reimburse additional amounts for those

charges. Services covered by a primary insurer but not by Passport Health Plan will not be coordinated.

Members seeking care, except Medicare dual eligibles and TriCare members, are required to follow authorization and referral procedures as set forth in Sections 6 and 7. These members are also required to select participating providers or obtain appropriate prior authorization for providers outside the Passport Health Plan network. If nonparticipating providers are used for medical services and appropriate authorizations are not obtained, payment will be denied. If members obtain care outside Passport Health Plan's network without appropriate authorization or for nonemergency care, they will be financially responsible.

Authorizations are only required for Medicare dual eligible or TriCare members when Passport Health Plan has assumed the primary coverage responsibility for the requested services.

Claims submitted with Passport Health Plan as the secondary insurer are subject to routine referral and utilization management prior-authorization policies. To receive payment for services, the billing provider must:

- Follow all procedures for notification and authorization.
- Submit a copy of the primary carrier's explanation of benefits (EOB) along with the claims.
- Submit claims to Passport Health Plan within 180 days from the date of service (DOS) or 60 days from the date of the primary carrier's EOB.

Members may not be billed by participating providers for deductibles, copays, and coinsurance except those allowed by DMS. If the above criteria are met, appropriate payment will be made. If the above criteria are not met, resulting in a denied claim, the provider may NOT seek financial resolve from the member.

The PCP Contract describes specific services covered under capitation.

The following physical examinations and completion of related forms are not covered by Passport Health Plan:

- Federal Aviation Administration (pilot's license).
- Return to work following work-related injury (workers compensation).
- Immigration examination.