The Perinatal Quality Enhancement Program (PQEP)

Improving quality care and health outcomes

January 2023

www.amerihealthcaritasnc.com

AmeriHealth Caritas™
North Carolina

Dear Obstetrics Provider:

AmeriHealth Caritas North Carolina (ACNC) is pleased to offer the Perinatal Quality Enhancement Program (PQEP). The PQEP is a reimbursement system developed for participating obstetric and midwife practitioners to deliver quality, cost-effective and timely care to our pregnant members.

The PQEP program provides an opportunity for obstetric practitioners to enhance revenue while providing quality and cost-effective care in the following components:

1. Prenatal care:

    a. Timelines of prenatal care

2. Postpartum care

3. Severity of illness

4. Cesarean section rate

5. Social determinants of health (SDOH) Z-codes

ACNC is excited to work with your practice to advocate for and encourage the delivery of healthy babies.

Thank you for your continued participation in our network and your commitment to our members. Together, we can improve maternal outcomes in North Carolina.

If you have any questions, contact your Provider Network Management Account Executive (AE) or ACNC Provider Inquiry at **1-888-738-0004**.

Sincerely,

George R. Cheely Jr., M.D., M.B.A.
Market Chief Medical Officer,
Administration
AmeriHealth Caritas North Carolina

Kristen Kanach
Director, Provider Network Management
AmeriHealth Caritas North Carolina

Introduction

The Perinatal Quality Enhancement Program, or PQEP, is a reimbursement system developed by AmeriHealth Caritas North Carolina for participating obstetric and midwife practitioners who provide obstetric care.

The PQEP is intended to be a fair and open system that provides incentives for high-quality and cost-effective care and submission of accurate and complete health data.

The PQEP provides financial incentives over and above a provider group's base compensation for the provision of services to attributed members. Incentive payments aren't based on individual provider performance, but rather the performance of your practice in providing prenatal, intrapartum, and postpartum care services in accordance with the quality metrics outlined in the PQEP.

Program overview

To be eligible for participation in the PQEP program, a provider must have a minimum of 30 live-birth deliveries in the first delivery window and 40 live-birth deliveries in the second delivery window. (For reference, see payment schedule on page 8.) The incentive payments are distributed semi-annually based on deliveries occurring during the delivery window, with a focus on treating each delivery as an episode of care.

Quality performance determines any incentive payment received through the PQEP program, and quality performance is based on the completion of specific quality measures. Measures are fulfilled by rendering clinically appropriate services during the reporting period and by submitting accurate and complete encounter and clinical data via claims. Practices that have alternate incentive arrangements or risk-sharing arrangements with AmeriHealth Caritas North Carolina may not be eligible for participation in the PQEP.

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Quality performance

The quality performance measures were selected based on national and state areas of focus, and predicated on AmeriHealth Caritas North Carolina's (ACNC) Preventive Health Guidelines and other established clinical guidelines.

These measures are based on services rendered to eligible members during the reporting period and require accurate and complete encounter reporting.

1. Timeliness of prenatal care

Measurement description: The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization

Eligible members: None specified

Continuous enrollment: 43 days prior to delivery through 60 days after delivery

Allowable gap: No allowable gap during the continuous enrollment period

Anchor date: Date of delivery

2. Postpartum care

Measure description: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Eligible members: No specific age

Continuous enrollment: 43 days prior to delivery through 56 days after delivery

Allowable gap: No allowable gap during the continuous enrollment period.

Anchor date: Date of delivery

3. Severity of illness

The intent of this measure is to compensate practices that are treating higher-risk panels than their peers. ACNC evaluates all the claims and encounters submitted by a practice and risk adjusts this information using 3M's Risk Adjusted Methodology.

The severity of illness rate, based on claims, will be compared for all obstetrical practices.

4. Cesarean section rate for nulliparous, term, singleton, vertex pregnancies

Cesarean deliveries can be life-saving procedures when medically necessary, but they carry a higher risk of negative outcomes for mothers and babies. Complication rates for women also increase with each C-section delivery. Current trends in maternity care show that many pregnant women undergo procedures such as non-medically indicated Cesarean delivery and labor inductions that increase the overall cesarean rate. The rise in cesarean rates has resulted in significant health (e.g., placenta accreta and previa, uterine rupture, hemorrhage and adhesions), social and economic costs for American women.

The C-section rate among low-risk, first-time mothers (also called Nulliparous, Term, Singleton, Vertex [NTSV] Cesarean Birth Rate) is the proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions), via C-section birth.

The C-section rate, based on claims, will be compared for all obstetrical practices.

5. Social determinants of health (SDOH)

ACNC will assess, identify, and address health care and social determinants of health needs in the populations we serve. We help enable enrollees to live healthier lives and achieve maximum independence. As an OB/GYN, you deliver health care services to our enrollees. When you submit claims, please add the appropriate ICD-10 codes that identify social determinants of health. With your help, we will have actionable data and be able to respond to our enrollees' unmet needs. Listed below are the ICD-10 codes and descriptions that we are collecting. Codes related to SDOH are in the table below.

Social Determinants of Health Z Code Categories

Z55 Problems related to education and literacy

Z56 Problems related to employment and unemployment

Z57 Occupational exposure to risk factors

Z59 Problems related to housing and economic factors

Z60 Problems related to social environment

Z62 Problems related to upbringing

Z63 Other problems related to primary support group, including family circumstances

Z64 Problems related to certain psychosocial circumstances

Z65 Problems related to other psychosocial circumstances

Practice score calculation

The quality performance incentive payment is based on your peer percentile ranking of the live deliveries meeting the selected quality measures and severity of illness during the delivery window.

Results will be calculated for each of the quality performance measures and for each practice and then aggregated for a total score. Overall practice scores will be calculated as the ratio of attributed members who received the described services, as evidenced by claim or encounter information (numerator), to those members receiving obstetrical care who were eligible to receive these services (denominator). Relative scaling at 5% intervals begins with the 50th percentile up to the 95th percentile; the aggregate score for the measures is compared to peers.

The quality performance incentive payment is based on your peer percentile ranking of the attributed live deliveries meeting the selected quality measures during the delivery window.

Reconsideration of ranking determination

- If a provider wishes to appeal their percentile ranking on any or all incentive components, the appeal must be submitted in writing.
- The written appeal request must be addressed to the ACNC Market Chief Medical Officer and specify the basis for the appeal.
- The appeal request must be submitted within 60 days of receiving a performance report card from ACNC.
- The appeal request will be forwarded to ACNC's PQEP Review Committee for review and determination.
- If the PQEP Review Committee determines that a correction is warranted, providers will be notified of the adjustment amount and findings of the committee. If approved, an adjustment will appear on the next payment cycle following committee approval.

Payment schedule

The incentive payments are distributed semi-annually based on deliveries occurring during the delivery window, with a focus on treating the delivery as an episode of care.

Payment cycle	Deliveries	Delivery window	Claims paid through	Payment date
1	30	10/8/22 – 9/30/23	Sept. 30, 2023	December 2023
2	40	10/8/22 – 10/7/23	March 31, 2024	June 2024

Important notes and conditions

1. Eligibility for quality enhancement program payments is forfeited if the practitioner/practitioner group is placed on a corrective action or performance improvement plan at any time during the measurement year.

2. The PQEP may be further revised, enhanced or discontinued. ACNC reserves the right to modify the program at any time and shall provide written notification of any changes.

3. The Quality Performance Measures are subject to change at any time, upon written notification. ACNC will continuously improve and enhance its Quality Management and Quality Assessment Systems. As a result, new quality variables will periodically be added, and criteria for existing quality variables will be modified.

4. Semi-annually, ACNC will calculate the rankings of all eligible practices.

5. The sum of the incentive payments for the quality performance components of the program will not exceed 25% of the total compensation for medical and administrative services. Only capitation and fee-for-service payments are considered part of the total compensation for medical and administrative services.

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