Keystone First

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AmeriHealth Caritas℠

COMPASS

PROGRAM GUIDE FOR KEYSTONE FIRST PROVIDERS

Keystone First marketing piece for the AmeriHealth Caritas COMPASS℠ program

Contents

AmeriHealth Caritas℠ is a separate company that provides provider performance ratings for referral optimization.
NaviNet® is an independent web-based solution linking providers to Keystone First.
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Introduction

Beginning April 1, 2022 Keystone First, in collaboration with AmeriHealth Caritas℠, will implement the AmeriHealth Caritas COMPASS℠ Program (herein after known as "the program"), a referral optimization initiative that will give referring Primary Care Providers (PCPs) 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 PCPs 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 and,
4. Sharing the scores of providers who are participating in the program with PCPs (and specialists) in the form of a Referral Guide for each episode category, broken down by provider specialty and hospital referral region (HRR).

Referral Guide

The Referral Guide will be a resource for PCPs 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 PCPs and specialists via our secure provider portal, NaviNet®.

The Referral Guide will be organized by episode category, provider specialty, and HRR. 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 two and a half will be listed in the Referral Guide in alphabetical order but will not have a score indicated. Specialist providers who do not 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 will not be listed in the Referral Guide.

Although PCPs will have access to the Referral Guide to aid in making referrals, they are not required to utilize the Referral Guide in their referral process.

Referrals made on the basis of the information presented in the Referral Guide should not 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)
- Bariatric Surgery (Procedural)
- Colonoscopy (Procedural)
- Depression & Anxiety (Chronic)
- Diabetes (Chronic)
- Hepatitis C (Chronic)
- Hypertension (Chronic)
- Low Back Pain (Chronic)
- Newborn (Other)
- Osteoarthritis (Chronic)
- Pregnancy (Other)
- Substance Use Disorder (Chronic)
- Upper GI Endoscopy (Procedural)

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 Provider Services at 1-800-521-6007 or email your Provider Network Management 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 (URI) 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.

Bariatric Surgery

Services and costs associated with a procedure of Bariatric Surgery (BARI) are grouped together to include the index stay during which the procedure was performed, a 30-day look back period to capture pre-operative diagnostic workup leading to the surgery and a 90-day post-discharge period to capture post-operative care. Patients are identified as those with a primary procedure code of Bariatric Surgery on an inpatient stay service or a Bariatric Surgery procedure code in any position on an outpatient facility/professional service, along with a qualifying diagnosis code.

As part of the BARI episode, we evaluate services that are 1) typical or routine and considered part of expected care for BARI; and 2) those that are related to complications associated with BARI.

Source: Prometheus Analytics, Bariatric Surgery Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=BARI. Contact your Account Executive for access.

Colonoscopy

Most colonoscopies are currently done in an outpatient setting, either in a doctor's office or in an ambulatory surgery

center, so these are the ones intended to be captured in the COLOS episode. The COLOS episode focuses on screening, surveillance and diagnostic colonoscopies.

Services and costs associated with a procedure of colonoscopy (COLOS) are grouped together to include the index event during which the procedure was performed, a 3-day look back period to capture pre-operative diagnostic workup leading to the colonoscopy and a 14-day post-discharge period. Patients are identified as those with a procedure code of colonoscopy in any position on an outpatient facility/professional service, along with a qualifying diagnosis code.

As part of the Colonoscopy episode, we evaluate services that are 1) typical or routine and considered part of expected care for colonoscopy; and 2) those that are related to complications associated with colonoscopy.

Colonoscopy is associated to other colonoscopy episodes that occur within 90 days of each other. Colonoscopy is also associated to Colon Resection as typical when it occurs up to 30 days prior to the Colon Resection episode or anytime during a Colon Resection episode, and to Diverticulitis as typical when it occurs up to 14 days prior to the inpatient admission for diverticulitis or anytime during a Diverticulitis episode. Otherwise, the colonoscopy episode is related back to the underlying Colon Cancer or Rectal Cancer episode (if one exists) as part of typical care of colon or rectal cancer at the patient level, and is compared to similar Colonoscopy episodes as part of the risk adjustment methodology. Colonoscopy is also associated to the Preventive Care episode (if one exists).

Source: Prometheus Analytics, Colonoscopy Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=COLOS. Contact your Account Executive for access.

Depression & Anxiety

Depression & 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 & anxiety-specific principal diagnosis code or an outpatient or professional E&M service with a depression & anxiety-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional depression & anxiety-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to Depression & Anxiety such as sleep disturbances have been defined by physician consultants as typical care for Depression & 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.

Hepatitis C

Hepatitis C (HCV) is a condition that is triggered by a definitive service with a qualifying diagnosis code of Hepatitis C. The Hepatitis C episode is open from 90 days prior to the date of trigger service until 180 days after the date of trigger. Services with diagnosis codes for signs and symptoms related to Hepatitis C have been defined as typical care for Hepatitis C, and conditions such as sepsis have been labeled as complications.

Source: Prometheus Analytics, Hepatitis C Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=HCV. Contact your Account Executive for access.

Hypertension

Hypertension (HTN) 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 HTN 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.

Substance Use Disorder

Substance Use Disorder (SUDS) 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 substance use disorder-specific principal diagnosis code or an outpatient or professional E&M service with a substance use disorder-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional substance use disorder-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to substance use disorder such as sleep disturbances have been defined by physician consultants as typical care for substance use disorder, and conditions such as severe malnutrition or adverse effects of drugs have been labeled as complications.

Source: Prometheus Analytics, Substance Use Disorder Definition Version 5.5, Change Healthcare, 2021,

http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=SUDS. Contact your Account Executive for access.

Upper GI Endoscopy

Most upper GI endoscopies are currently done in an outpatient setting, either in a doctor's office or in an ambulatory surgery center, so these are the ones intended to be captured in the EGD episode.
Services and costs associated with a procedure of Esophagogastroduodenoscopy Upper GI (EGD) are grouped together to include the index event during which the procedure was performed, a 3-day look back period to capture pre-operative diagnostic workup leading to the endoscopy and a 14-day post-discharge period. Patients are identified as those with a procedure code of endoscopy in any position on an outpatient facility/professional service, along with a qualifying diagnosis code.

As part of the Upper GI Endoscopy episode, we evaluate services that are 1) typical or routine and considered part of expected care for upper GI endoscopy; and 2) those that are related to complications associated with endoscopy.

Upper GI Endoscopy is associated to Bariatric Surgery and Gall Bladder Surgery as typical when it occurs up to 30 days prior to the procedural episodes. Otherwise, the EGD episode is related back to the underlying GERD episode (if one exists) as part of typical care of GERD at the patient level, and is compared to similar EGD episodes as part of the risk adjustment methodology.

Source: Prometheus Analytics, Upper GI Endoscopy Definition Version 5.5, Change Healthcare, 2021, http://prometheusanalytics.net/deeper-dive/episodes-definitions/ecr-descriptions?version=5.5.000&name=EGD. 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 HRR.

Quality Performance

Quality performance is calculated using PROMETHEUS Potentially Avoidable Complications (PAC) 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 measures 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 (5) five attributed episodes during the reporting period. The program uses a 1-year reporting period for chronic and other episode categories and a 2-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 HRR. 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 1st and October 1st. 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 1-year reporting period for chronic episode categories and a 2-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 HRR.
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. Keystone First 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 PCPs 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 (PCPs and specialists) via our secure provider portal, NaviNet.

PCPs 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 may 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 Provider Network Management Account Executive and specify the basis for the appeal.
- 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 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 Keystone First 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 March 25, 2022, which is at least seven days prior to the scheduled Referral Guide deployment on April 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 Keystone First 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*