Healthy happens together

2021 Value-Based Programs

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Aetna Better Health® of Michigan

Contents

A Letter from our CEO

Dear Aetna Better Health of Michigan Provider,

At Aetna Better Health of Michigan, we value the role you play in providing the highest quality care to your patients – our members. We also understand that improving the health outcomes of our members necessitates a level of collaboration between us – you as the professional who provides the care, and ourselves, as the health plan that covers the care. To show you how deeply we are committed to working with you, we are proud to introduce our 2021 Value-Based Programs to you.

Amongst the best in the Michigan market, our 2021 Value-Based Programs not only pay higher incentives for many measures, but also makes it easier to qualify for incentives.

It does not end there. Along with top-paying comprehensive programs come the expertise and support of our Quality Management and Network Management staff. We will work with you and your staff to regularly track your progress and suggest opportunities to increase member engagement, which should translate into higher incentive potential for your practice.

This manual contains everything you need to know about how our Value-Based Programs work. Additionally, it presents the Aetna Better Health of Michigan team members who are available to support you and help you maximize the programs' incentive opportunities. I invite you to share your thoughts with me about our programs by writing to me at: **BAAllen@aetna.com**.

Thank you again for your continued participation in our provider network and helping us improve the quality of care our members receive.

Beverly Allen
Chief Executive Officer
Office: **313-465-1517**

About Us

Nationally recognized – locally focused

For more than 160 years, our success has been built on serving our members at the local, community-based level with a fully integrated care model that includes physical health, behavioral health and attention to the social determinants of health. Our history and experience demonstrate our total commitment to achieving a healthier population in the communities we serve.

Your partner in providing quality health care

We take great pride in our network of physicians and related professionals. We want to assist those who serve our members with the highest level of quality care and service. We are committed to making sure our providers receive the best possible information, and the latest technology and tools available. This helps ensure their success in providing for our members. Our focus is on operational excellence. We strive to eliminate redundancy and streamline processes for the benefit and value of all our partners.

Who we serve

We are a state-contracted Medicaid managed care health plan that offers MI Medicaid, Healthy MI, MI Child, and Children's Special Health Care Services in regions 8, 9, and 10. Aetna Better Health℠ Premier Plan is our MI Health Link managed care plan, where we help to coordinate physical, behavioral, and long-term care services for dually eligible Medicaid and Medicare beneficiaries age 21 and over in regions 4, 7, and 9 (Southwest Michigan, Wayne County, Macomb County).

Our 2021 goals:

- Receive NCQA Commendable Accreditation, demonstrating our ongoing commitment to providing quality care
- Continued focus on quality improvement
- Continued network improvement and expansion
- Alignment to our Primary Care Strategy to provide value based solutions to our providers
- Optimized and supportive partnerships with our network physicians to ensure our members are receiving high-quality health care
- Getting every member to a primary care visit yearly, or more often as necessary
- Improving ER and inpatient utilization

Always Here to Help – Contact Us

We want to assist those who serve our members with the highest level of quality and service. That's why we are always here to help support you. Our dedicated team is fully committed to supporting our network of providers in achieving a high level of quality. Our staff works directly with you to:

- Host face-to-face informational sessions and provider feedback forums
- Provide onsite training and support
- Conduct face-to-face quarterly report and progress reviews
- Assist with plan-based interventions to help you increase your scores, such as:
  - Member outreach: telephone calls, mail campaigns, newsletters and website updates
  - Onsite or webinar meetings for you and your staff to refresh your knowledge of HEDIS measures and how to maximize results
  - Specific measure-based focused activities and member incentive initiatives
  - Enhanced data and analytics
  - Access to a population health specialist

If you have questions or concerns, contact a member of our dedicated team:

Name	Title	Phone	Email
Tim Burns, MHSA	Medicaid Regional Lead, Value-Based Solutions	734-351-6873	BurnsT5@aetna.com
Dante' Gray	Director, Quality Management	313-465-1513	DAGray@aetna.com
Kate Zavala, LPC, CCM	Population Health Specialist	269-491-9456	ZavalaK@aetna.com
Sue Burns	Contract Negotiator, Network	313-465-1503	BurnsS@aetna.com
Joyce Poole	Director, Provider Experience	313-465-1563	PooleJ2@aetna.com
Cathleen Claire	Contract Negotiator, Network Management	313-465-1506	ClaireC@aetna.com
Jacqueline Simmons, MD, MPH, MS, CPE, PCMH CCE	Chief Medical Officer	313-465-1562	SimmonsJ3@aetna.com
Dangtoy Fitzgerald-Lewis, MSW, LCSW	Manager, Clinical Health Services, Medicaid	248-452-1587	Fitzgerald-LewisD@aetna.com

2021 Value-Based Programs

Purpose

At Aetna Better Health of Michigan, we understand that a key component of achieving superior health care and satisfaction for members is the doctor-patient relationship. Members who have a positive relationship with their healthcare provider are more likely to seek appropriate care. Our primary care programs seek to enhance this relationship and support our members in achieving the highest quality healthcare, as measured by national benchmarks.

Our Value-Based Programs are quality focused. These programs reward providers for meeting or exceeding specific quality goals. As a result of delivering the highest-quality health care to our members, providers are eligible to earn incentive payments.

Our Value-Based Programs support your patients and our quality care initiatives by promoting:

- Care that improves quality and outcomes, thus resulting in a healthier population
- Healthcare delivery consistency and adherence to evidence-based standards of care
- Continuous quality improvement orientation
- Care coordination between providers and the health plan, and alignment of goals for our members' health

We have Value-Based Programs for every primary care setting. Some programs apply to smaller practices and others to larger practices. We also offer incentive opportunities specific to providers serving only adult or pediatric populations.

Quality performance outcomes included in Aetna Better Health's Value-Based Programs are determined using HEDIS quality measures administrative data only.

What is HEDIS?

HEDIS is a registered trademark of the National Quality Committee for Quality Assurance (NCQA).

Healthcare Effectiveness Data and Information Set (HEDIS)

NCQA defines HEDIS as *"a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans."*

- HEDIS is a registered trademark of the National Committee for Quality Assurance
- HEDIS is a performance measurement tool that is coordinated and administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations
- Results from HEDIS data collection serve as measurements for quality improvement processes, educational initiatives, and preventive care programs
- All managed care companies who are NCQA accredited perform HEDIS reviews the same time each year
- HEDIS 2020 consists of 92 measures across six domains of care that address important health issues
- HEDIS is a retrospective review of services and performance of care from the prior calendar year

There are two types of HEDIS data collected:

- Administrative data – comes from submitted claims and encounters (claim-like records of services)
- Hybrid data – comes from chart collection/review

About Our Programs

The program measurement year is the calendar year, covering dates of service January 1 to December 31, 2021.

Specific to the population of Aetna members you serve, a program is available for you to earn incentives while providing quality care for your patients, our members. There are three standard Value-Based Programs, along with two pilot programs, we introducing in 2021. The 2020 VBS programs are:

1. Pay for Quality (P4Q) Program

Our P4Q program is available to all Aetna Better Health Medicaid participating primary care providers, regardless of participation in our other Value-Based Solutions (VBS) Programs. The P4Q program has annual and quarterly components.

Annual

The annual component of the P4Q program rewards PCPs for achieving a level of performance, as compared to defined targets, on selected HEDIS measures applicable to the practice's Aetna Better Health membership panel.

All primary care providers who meet the 150-member threshold are automatically enrolled.

The annual portion of our P4Q program offers an incentive opportunity using the following methodology:

- Five HEDIS measures with the largest denominator, equal to or greater than 10, will be eligible for an annual P4Q incentive of $1.00 PMPM per measure (maximum payout $5.00 PMPM).
- HEDIS performance for each eligible measure will be calculated using claims data submitted within 90 days following the end of the performance year (2021). One cumulative score for each measure will be determined for all providers in a practice.
- Two targets are set based on the 2020 National Medicaid HEDIS 50th, 75th, or 90th percentile or plan-defined targets when NCQA HEDIS national benchmarks were not available. A PCP practice is either rewarded $0.50 PMPM for their entire assigned Aetna Better Health Medicaid membership panel for each eligible measure for which they meet or exceed target 1 (T1) or a $1.00 PMPM incentive for each eligible measure that meets or exceeds target 2 (T2).
- Annual financial incentive payments are expected to be paid in June of 2022.
- Provider performance is evaluated, and incentives are paid, at the TIN-level.

Annual P4Q Program Model	
Standardized, market-based programs where performance can be accurately tracked on a monthly basis.	
Provider Eligibility	No less than 150+ Aetna members per practice (average over the performance period). Must have "open" panel
Performance Measurement	Selected measures – up to 5 of 16 HEDIS measures; bonus will be based upon the 5 measures most relevant to provider's member panel determined by denominator size Applicable measure must have at least 10 members in the denominator to be eligible for payment Two targets are set based on the 2020 National Medicaid HEDIS 50th and 75th percentiles or plan custom targets where 2020 National Medicaid HEDIS benchmarks were not available
Payment Model	Annual payment if quality targets achieved $5 PMPM is the maximum payout. Each selected measure has a maximum payout $1 PMPM. A PCP practice is rewarded either $.50 PMPM for their entire assigned Aetna Better Health Medicaid membership panel for each eligible measure for which they meet or exceed target 1 (T1) or a $1 PMPM incentive for each eligible measure that meets or exceeds target 2 (T2)
Data & Reporting	Standardized, centralized, actionable monthly group reports available to providers through Aetna Medicaid web portal Reports include gaps in care The first performance report will be available in April, 2021
Management Process	Quarterly review of performance with providers Annual determination of provider readiness to move to more advanced AP

Annual P4Q Quality Measures			
Measure	Description	T1	T2
Adults Access to Preventive/ Ambulatory Health Services (AAP): Members Age 20-44	The percentage of members 20-44 years of age who had an ambulatory or preventive care visit.	78.61	82.46
Adults Access to Preventive/ Ambulatory Health Services (AAP): Members Age 45-64	The percentage of members 45-64 years of age who had an ambulatory or preventive care visit.	86.48	88.94
Asthma Medication Ratio (AMR): Total	The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the year.	62.43	68.13
Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age in the measurement year who had a mammogram to screen for breast cancer from October 1 two years prior to the measurement year through December 31 of the measurement year.	58.82	64.06
Cervical Cancer Screening (CCS)	The percentage of women 21-64 years of age who were screened for cervical cancer.	61.31	67.40
Child & Adolescent Well-Care Visits (WCV)	The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	82.39	86.96
Childhood Immunization Status (CIS): Combo 3	The percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP), 3 polio (IPV), 1 measles, mumps and rubella (MRR), 3 haemophilus influenza type B (HiB), 3 hepatitis B (Hep B), 1 chicken pox (VZV), 4 pneumococcal conjugate (PCV) by their second birthday.	71.05	75.18
Chlamydia Screening in Women (CHL): Total	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in the measurement year.	58.44	66.26
Comprehensive Diabetes Care (CDC): Eye Exam	Members 18 to 75 years of age with diabetes (type 1 and type 2) who had a dilated retinal eye exam in the measurement year or a dilated retinal eye exam that was negative for retinopathy in the year prior to the measurement year. Bilateral eye enucleation any time during the member's history also meets compliance.	58.64	64.48
Comprehensive Diabetes Care (CDC): HbA1c Adequate Control (<8)	Members 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c test in the measurement year and the HbA1c< 8%.	51.73	55.96
Comprehensive Diabetes Care (CDC): HBA1C Testing	Members 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c test in the measurement year.	88.79	91
Immunizations for Adolescents (IMA): Combination 2	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	36.86	43.06
Lead Screening in Children (LSC)	The percentage of children turning 2 years of age in the measurement year who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	73.11	81.02
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.	66.79	76.28
Well Child Visit 0-30 months (W30): 0-15 months, 6+ visits	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-child visits in the first 15 months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	71.29	75.63
Well Child Visit 0-30 months (W30)	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-child visits for age 15 months–30 months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	71.29	75.63

Annual pay-for-quality incentive payments will be paid based upon administrative data with 90 days run-out to ensure data completion. Expected payout is June 2022.

Quarterly P4Q Quality Measures

In addition to the reimbursement described above, provider shall be eligible for additional incentive reimbursement for the services as described in the chart directly below ("eligible services") that meet the corresponding measure for a member. Payment will be made on a quarterly basis for eligible services rendered.

Service	Measure	Incentive Basis	Rate
Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age in the measurement year who had a mammogram to screen for breast cancer from October 1 two years prior to the measurement year through December 31 of the measurement year.	Provider will be paid for each HEDIS-eligible member who has received at least one mammogram during the measurement year. Payment is limited to one per year.	$50
Cervical Cancer Screening (CCS)	Women ages 21-64 who received one or more pap tests to screen for cervical cancer during the measurement year.	Provider will be paid for each HEDIS-eligible member who receives one cervical cancer screening per measurement year. Payment is limited to one per year.	$25
Childhood Immunization Status (CIS): Combo 3	The percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP), 3 polio (IPV), 1 measles, mumps and rubella (MRR), 3 haemophilus influenza type B (HiB), 3 hepatitis B (Hep B), 1 chicken pox (VZV), 4 pneumococcal conjugate (PCV) by their second birthday.	Provider will be paid for each HEDIS-eligible member who completes a series or receives all combo 3 immunizations by their second birthday.	$25 per completion of each series in combo 3 plus $100 bonus for completion of combo 3
Chlamydia Screening in Women (CHL): Total	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in the measurement year.	Provider will be paid for each HEDIS-eligible member who has received at least one test for chlamydia during the measurement year. Payment is limited to one per year.	$25
Comprehensive Diabetes Care (CDC): Eye Exam	Members 18 to 75 years of age with diabetes (type 1 and type 2) who had a dilated retinal eye exam in the measurement year or a dilated retinal eye exam that was negative in the year prior to the measurement year.	Provider will be paid for each HEDIS-eligible diabetic member who has received a dilated eye exam during the measurement year. Payment is limited to one per year.	$25
Comprehensive Diabetes Care (CDC): HBA1C Testing	Members 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c test in the measurement year.	Provider will be paid for each HEDIS-eligible diabetic member who receives HbA1c test per measurement year. Payment is limited to one per year.	$25
Immunizations for Adolescents (IMA): Combination 2	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	Provider will be paid for each HEDIS-eligible member who receives both combo 2 immunizations between their 11th and 13th birthdays.	$50
Lead Screening in Children (LSC)	The percentage of children turning 2 years of age in the measurement year who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	Provider will be paid for each HEDIS-eligible member who receives one blood lead screening prior to their second birthday.	$25
Prenatal and Postpartum Care (PPC): Postpartum Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 to 56 days after delivery.	OB/GYNs, midwives and family practitioners can earn an incentive for antepartum care examinations performed in accordance with HEDIS guidelines.	$100

Quarterly P4Q Quality Measures			
Service	Measure	Incentive Basis	Rate
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.	OB/GYNs, midwives and family practitioners can earn an incentive for antepartum care examinations performed in accordance with HEDIS guidelines.	$100
Care Management/ Care Coordination Services	**Code** **Description** G9001 Comprehensive Assessment G9002 In-person CM/CC Encounters G9007 Care Team Conferences G9008 Provider Oversight 98966 Telephone CM/CC Services 98967 Telephone CM/CC Services 98968 Telephone CM/CC Services 98961 Education/Training for Patient Self Management 98962 Education/Training for Patient Self Management 99495 Care Transitions 99496 Care Transitions S0257 End of Life Counseling	Provider will be paid for each eligible care management/care coordination service appropriately rendered and billed during the measurement period, in accordance with state guidelines.	$25

Michigan 4 x 4 Plan health screening – Provider shall be eligible for additional incentive reimbursement for the eligible services, described in the chart directly below, that comply with the Michigan 4 x 4 Plan. Payment will be made on a quarterly basis for eligible services rendered.

Health Screen/ Required Billing Codes	Payable Codes	Incentive Basis
Body Mass Index (BMI) diagnosis codes	ICD-10 CM code Z68*	Provider will be paid $5 one time per eligible member per year
Blood Pressure Screening	CPT code 93770	Provider will be paid $5 one time per eligible member per year
Cholesterol Level (LDL-C)	CPT codes 80061, 83700, 83701, 83704, 83721	Provider will be paid $5 one time per eligible member per year
Blood Glucose Level	CPT codes 82947-82962	Provider will be paid $5 one time per eligible member per year

All P4Q quarterly and Michigan 4 x 4 Plan health screening incentives earned for eligible services will be calculated and paid quarterly. Incentives will be paid in accordance with the following schedule:

Claim Service Date	Incentive Payment Date	Claim Service Date	Incentive Payment Date
January 1 to March 31, 2021	July, 2021	July 1 to September 30, 2021	January, 2022
April 1 to June 30, 2021	October, 2021	October 1 to December 31, 2021	June, 2022

After Hours – Providers shall be eligible for additional incentive reimbursement for the eligible services described in the chart directly below. Services will be paid at the rate indicated based on billed claims.

Service	Measure	Incentive Basis	Rate
After Hours (Codes 99050 & 99051)	Services provided in the office at times other than regularly scheduled office hours must be billed with appropriate E & M code to be paid.	Provider will be paid for services provided in the office Monday through Friday after 5:00 PM and on weekends.	$25

2. Patient-Centered Medical Home (PCMH)

A voluntary program for selected providers with at least 150 Aetna Better Health members, our PCMH program helps address the complex health needs of our members through a coordinated system of care, including comprehensive primary care, referral to specialty care, acute care, behavioral health integration, and referral to community resources. A contract addendum is required for participation in the Aetna PCMH program. Requirements may be individualized for each participating practice.

- **PCMH Lite**
  - — An introductory program which supports providers' growth and advancement along the value-based continuum. Provider participation may help support practice transformation activities allowing PCMH recognition and progression into more advanced VBS programs.
  - — Eligibility criteria:
    i. Maintain an open PCP panel for the assignment of prospective eligible members, subject to company monitoring and audit
    ii. Remain in good standing and compliant with company's credentialing standards and requirements
    iii. Submit a monthly roster by containing an accurate list of providers participating in the program
- **PCMH+**
  - — In alignment with the Michigan Department of Health and Human Services (MDHHS) State-Preferred PCMH model, the Aetna Better Health of Michigan PCMH+ program builds upon the PCMH Lite model, with more stringent eligibility requirements and the potential for higher reimbursement compared to PCMH Lite program.
  - — In addition to the PCMH Lite criteria, the following criteria applies:
    i. **PCMH Designation:** Possess and maintain current designation from one of the following organizations/programs:
       a. National Committee for Quality Assurance (NCQA)
       b. Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP)
       c. Utilization Review Accreditation Commission (URAC)
       d. Accreditation Association for Ambulatory Health Care (AAAHC) Medical Home
       e. The Joint Commission (TJC) Primary Care Medical Home
       f. Commission on Accreditation of Rehabilitation Facilities-Health Home (CARF)
       g. other PCMH standards approved by MDHHS

— **24/7 Access:** Ensure patients have 24/7 access to a care team practitioner (defined as: physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals) who has real-time access to the EHR.
— **Alternative to Traditional Visits:** Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.
— **Same-Day Appointments:** Ensure a portion of available appointments are reserved for same day for attributed/assigned patients.
— **Care Management Embedment:** Care Management and Coordination staff members functioning as integral, fully involved members of every participating care team.
— **Longitudinal Care Management:** Provide targeted, proactive, relationship-based (longitudinal) care management and coordination using a plan of care centered on patient actions and support needs to all patients identified as at increased risk and who are likely to benefit from care management.
— **Episodic Care Management:** Provide short-term (episodic) care management and coordination along with medication reconciliation to patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management/coordination.
— **Electronic Health Record:** Possess and utilize a fully implemented Office of the National Coordinator for Health Information Technology (ONC) certified Electronic Health Record (EHR) system.
— **Location:** Practice must be located within Michigan.

Both PCMH programs are intended to prepare providers to progress to more advanced payment models along the value-based continuum.

Our PCMH program uses the following payment mode

- Fee-for-service payments for services provided with a per-member-per-month (PMPM) care coordination payment and additional incentives based on clinical outcomes measures.
- Providers participating in the PCMH+ program may be eligible for an increased care coordination payment rate on a PMPM basis compared to the PCMH Lite rate.
- PCMH agreements are collaborative and outline the expectations of both stakeholders so that all share accountability for outcomes.

The PCMH arrangements are generally made up of five HEDIS quality measures, negotiated with provider, based on assigned membership and other factors. **PCMH+ arrangements may also include annual measures related to adoption and continued use of MDHHS state-preferred care management/care coordination billing codes.**

3. Shared Savings/Shared Risk

A voluntary program for selected providers with generally 1,000 or more Aetna Better Health members, however interested practice with fewer assigned members are still invited to reach out for more information.

Our Shared Savings arrangements are built on a fee-for-service architecture and include an opportunity for providers to earn incentives based on the cost of the services they provide compared to a benchmark.

Providers must qualify to earn Shared Savings incentives by achieving clinical quality outcomes. These arrangements are for those practices serving a larger portion of our members and who possess the skills and infrastructure necessary to manage the population and financial risk.

The Shared Savings/Shared Risk arrangements are generally made up of two utilization measures and three additional HEDIS quality measures. The provider will have the option to choose from a preselected group of measures specific to the provider's practice type (pediatrician, family practice or internal medicine). Descriptions for both the utilization measures and HEDIS quality measures can be found in the next section of this booklet.

All providers participating in the Shared Savings arrangement require a signed contract addendum. Any practice with interest in a Shared Savings/Shared Risk agreement can contact Joyce Poole, Director, Provider Experience, or Tim Burns, Regional Lead, Value-Based Solutions.

4. Pilot Programs

In 2021, we are also launching two innovative pilot programs in order to expand our suite of Aetna Better Health of Michigan VBS Program offerings.

Primary Care Capitation Program

- In alignment with the MDHHS and industry movement towards greater provider adoption of Advanced Alternative Payment Models, we are piloting a Primary Care Capitation (PCP Cap) program in 2021. The PCP Cap program is intended to encourage providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice.

Integrated Physical & Behavioral Health Program

- In alignment with the MDHHS desire to more fully integrate physical and behavioral health services, we are piloting an Integrated Physical and Behavioral Health program in 2021. The Integrated Physical and Behavioral Health program is designed to provide an incentive for selected integrated physical and behavioral health practices for managing patient interactions in a more comprehensive manner, and ensuring both physical and behavioral health services are provided, when appropriate, to members while onsite.

Both pilot programs will be actively monitored and assessed for continuation after the pilot program year, as well as for expansion to a broader pool of provider partners. If your organization has interest in participating in either pilot program, please contact Tim Burns, Medicaid Regional Lead, Value-Based Solutions at **734-351-6873** or **BurnsT5@aetna.com**.

Targets and Terms for PCMH and Shared Savings Programs

Targets

2021 Measures	HEDIS 2018 National Medicaid 50th Percentile Target
Utilization Measures	
PCR – Plan All Cause Readmissions	12 readmissions/1000 member months
AMB – Emergency Department Utilization	52 ER visits/1000 member months

Measure Definitions

Member months = the sum of the number of individuals participating in an insurance plan each month. For example, a member enrolled for a full year has 12 member months.

PCR – Plan All-Cause Readmissions – For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of index hospital stays (IHS) (denominator)
- Count of 30-day readmissions (numerator)
- Expected readmissions rate

AMB – Emergency Department Utilization – This measure summarizes utilization of ambulatory care in ED visits.

Providers in a PCMH or Shared Savings Program will be required to select at least three additional measures from the pediatric, adult or family practice measures listed on pages 25-39, depending upon their practice population.

For additional details and coding tips, please refer to: Gaps in Care Technical Specifications and PCP Billing Guide 2021

All HEDIS measures used in our Value-Based Programs are described in this guide, and are listed by alphabetical order, starting on page 25.

How to calculate my annual P4Q payment?

The table and data below are for illustrative purposes only.

	Provider Annual Performance Rate			Annual Performance Targets		Incentive Earned
Measure	Numerator	Denominator	Rate	Target 1	Target 2	Dollars
AAP (20-44 yrs)	100	125	80%	77.97%	82.40%	$5,364
AAP (45-64 yrs)	14	75	18.67%	86.49%	89.07%	$0
AWC	40	75	53.33%	54.57%	61.99%	$0
BCS	22	22	100%	58.04%	64.12%	$0
CCS	27	42	64.29%	60.10%	66.01%	$5,364
CAP (Rate 1)	4	9	44.44%	95.66%	97.03%	$0
CAP (Rate 2)	8	8	100%	87.47%	90.47%	$0
CAP (Rate 3)	7	8	87.50%	90.69%	93.04%	$0
CDC HBA1C Test	20	40	50%	51.34%	55.47%	$0
CDC HBA1C <8	30	40	75%	87.83%	90.45%	$0
W15 (6+)	35	45	77.78%	66.23%	71.29%	$10,728
Average Panel Size: 894				Total Dollars Earned		$21,456

Annual P4Q financial award calculation process

1. Calculate provider annual performance rates
   - Identify assigned members who met the inclusion criteria established for each quality measure included in the program (measure denominator).
   - Identify assigned members who met the inclusion criteria established for each quality measure AND who also received the qualifying services (measure numerator).
   - Determine provider annual performance rate for each quality measure (numerator/denominator)
2. Determine payout measures
   - Identify top five measures where provider has the greatest denominator (highlighted in gray in example table).
3. Determine measure success for payout measures
   - Compare provider annual performance rate against designated performance targets for each payout measure.
   - For each payout measure where provider annual performance rate is greater than or equal to target 1, but less than target 2, provider receives $0.50 per member per month, based on total panel size. For each payout measure where provider annual performance rate meets or exceeds target 2, provider receives $1.00 per member per month.

4. Calculate total dollars earned
    - Multiply average panel size times 12 months times per member per month incentive earned.
      Example, if Target 1 met: 894 x 12 x $0.50 = $5,364.00
    - Sum incentives earned for each payout measure
      Example: $5,364.00 + $0 + $0 + $5,364.00 + $10,728.00 = $21,456.00

NOTE: The performance of all individual practitioners is aggregated at the provider Tax Identification Number (TIN) level for the purpose of performance analysis and payment. Incentive payments will be distributed to providers in the summer following the end of the performance period.

Annual Award Determination Process

Award opportunity

- Providers will receive credit for any metric-related service for those members identified as part of their panel as of December 31, 2021 (even when care was rendered by another Aetna Better Health of Michigan practitioner).
- ***For example:*** Mary Jane's PCP is Dr. Smith. Member obtains an AWC visit from Dr. Jones in March, but switches to Dr. Smith as PCP in October. Dr. Smith will be given the credit for fulfillment of the AWC visit for that member since he is the PCP of record as of 12/31. Conversely, Jane Miller is a patient of Dr. Smith until November 2018 and never had her AWC visit. In November, Jane becomes the patient of Dr. Jones. Dr. Jones is held accountable for Jane's care for all of 2021.
- Performance for each metric is compared against the target; incentive dollars are awarded based on a practice's performance against the targets and the total number of measures achieved.

Reconciliation

- The reconciliation process will begin once the end of year reports are available (Q2 2020).
- Aetna Better Health of Michigan will conduct an initial program reconciliation based on the services rendered to each provider's members relevant to the metrics.
- Reconciliation is completed at the TIN-level or contract-level, depending on program.
- 90 days is allowed for a claims lag period.
- After the 90-day claims lag period, performance will be calculated.

When will I be paid?

- If an incentive is due, a check will be mailed to your office address on file; in some cases, the check will be personally delivered by a member of the Aetna Better Health of Michigan management team.
- Incentive payments for the 2021 Value-Based Program will be distributed to providers in June 2022.

Provider incentive payments

- Incentive payments for the 2021 P4Q program are determined at the TIN-level, while PCMH, Shared Savings, and other contractual VBS programs are determined at the contract-level, and may aggregate performance across multiple participating TINs.
- Detailed reports will be provided as supplemental information to the incentive checks.

VBS Reports and Performance Monitoring

As a participant in a Value-Based Program, you can obtain access to reporting to support your efforts. P4Q program performance is measured at the Tax Identification Number (TIN) level. All participants in PCMH or Shared Savings programs have access to Aetna Better Health of Michigan's Provider Portal in order to see Gaps in Care at the contract-level. Participants in Pay for Quality may request access to the Provider Portal (see below).

P4Q Program: Participants can obtain access to the Quality Report, which provides individual and provider group performance against program quality measures and targets. The report highlights gaps in care (services that members should have received) and the actions required to successfully achieve program targets. An itemized list of all members for whom the quality measures apply is also included to assist with outreach efforts. Program participants can get access to view performance for all providers associated with their TIN.

The VBS Quality Reports are available on the Aetna Medicaid Provider Web Portal, with the first reporting of the year posted in June of each year and monthly for the rest of the year to help providers track progress of members toward meeting HEDIS measure goals. Providers can get access to the Web Portal by contacting Provider Services for the enrollment form and instructions. We encourage providers to log on frequently to review their data and identify opportunities for achieving quality care initiatives for their patients.

PCMH and Shared Savings Programs: Program participants will receive VBS Key Performance Indicators and Financial Reports, which are delivered via secure email.

Key Performance Indicators Report includes both individual and provider group performance compared to quality and utilization benchmarks. This report contains 12 months of rolling clinical and quality data to drive clinical decision making and determine necessary interventions.

In addition to the VBS Key Performance Indicators reports, providers in these programs have access to **Gaps in Care** reports, which show by individual measure, which members on your panel have not completed the measure; this data is available starting in June of 2020 and is refreshed monthly thereafter. These reports do not provide aggregate results – data is reported by member at the measure level.

Financial Report includes performance against program financial goals. Among the details are delineation of specific members included in the numerator and denominator for each measure and cumulative information by service location and provider. Data are refreshed periodically (at least quarterly).

A Cumulative Year-End Report calculates financial rewards distributed at the conclusion of the 2020 performance year for participating practices in all Value-Based Shared Savings programs. The report highlights performance within the entire program. The report allows for a 90-day claims run-out (service dates January 1, 2021 through December 31, 2021, paid through March 2022). The year-end report will highlight performance for the entire program and will be used to calculate financial rewards.

Accessing reports

Please contact your Aetna Better Health of Michigan Provider Relations Liaison to request Web Portal access. If you need to identify your liaison, please call Provider Services at **1-866-314-3784**.

Gaps in Care Technical Specifications and PCP Billing Guide 2021

Disclaimer

This material serves as a tool to assist providers, their clinical team, and billing staff with information to improve HEDIS performance.

HEDIS 2020 Volume 2 Technical Specifications for Health Plans was used to generate this Provider Billing Guide. The Technical Specifications were current at the time of publication (December 2020).

HEDIS indicators have been designed by NCQA to standardize performance measurement and do not necessarily represent the ideal standard of care.

Information contained in this report is based on claims data only.

Tips and Best Practices

General tips and information that can be applied to most HEDIS measures:

1. Use your member roster to contact patients who are due for an exam or are new to your practice.
2. Take advantage of this guide, coding information, and the on-line resources that can assist the practice with HEDIS measure understanding, compliance, and requirements.
3. Use your Gaps in Care member list to outreach to patients in need of services/procedures.
4. You can provide evidence of completed HEDIS services and attach the supporting chart documentation by contacting the Quality Management department.
5. Schedule the members' next well-visit at the end of the current appointment.
6. Assign a staff member at the office knowledgeable about HEDIS to perform internal reviews and serve as a point of contact with plans and their respective Quality Management staff.
7. Set up your Electronic Health Records (EHRs) so that the HEDIS alerts and flags alert office personnel of patients in need of HEDIS services.

HIPAA

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted, and the release of this information requires no special patient consent or authorization. Please be assured our members' personal health information is maintained in accordance with all federal and state laws. HEDIS results are reported collectively

without individual identifiers or outcomes. All of the health plans' contracted providers' records are protected by these laws.

- HEDIS data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities
- The records you provide us during this process help us to validate the quality of care our members received

Importance of Documentation

Adherence to principles governing the medical record and proper documentation:

1. Enables physician and other healthcare professionals to evaluate a patient's healthcare needs and assess the efficacy of the treatment plan.
2. Serves as the legal document to verify the care rendered and date of service.
3. Ensures date care was rendered is present and all documents are legible.
4. Serves as a communication tool among providers and other healthcare professionals involved in the patient's care, for improved continuity of care.
5. Facilitates timely claim adjudication and payment.
6. When done appropriately, will reduce many of the "hassles" associated with claims processing and HEDIS chart requests.
7. ICD-10 and CPT codes reported on billing statements should be supported by the documentation in the medical record.

Common reasons members who have seen their PCP visits will not receive "credit" for recommended services/procedures:

1. Missing or lack of all required documentation components.
2. Service provided without claim/encounter data being submitted.
3. Lack of referral note in chart directing member to obtain the recommended service (e.g. diabetic member eye exam to check for retinopathy).
4. Service provided but outside of the required timeframe or anchor date (i.e. lead screening performed after age 2).
5. Incomplete services (e.g. no documentation of anticipatory guidance during a well visit for the adolescent well-child measure).
6. Failure to document or code exclusion criteria for a measure.

Look for the 'Common chart deficiencies and tips' sections for guidance with some of the more challenging HEDIS measures

AAP Adults' Access to Preventive/ Ambulatory Health Services

Measure definition:

Members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.

Common chart deficiencies and tips:

1. Each adult Medicaid or Medicare member should have a routine outpatient visit annually
2. Utilize your Gaps in Care report to identify members who have not had a visit

Billing Reference – AAP		
Description	**CPT**	
Ambulatory Visits	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429	
	HCPCS	**UBREV**
	G0402, G0438, G0439, G0463, T1015	051X, 052X, 0982, 0983
	ICD 10	
	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9, Z76.1, Z76.2	
Other Ambulatory Visits	**CPT**	UBREV
	92002, 92004, 92012, 92014, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0524, 0525
Any of the above ambulatory visits with or without a telehealth modifier		
	Telehealth CPT Modifier	95, GT
Online Assessments	CPT	98969, 99444
Telephone Visits	CPT	98966-98968, 99441-99443

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BCS Breast Cancer Screening

Measure definition:

The percentage of women who are 52–74 years of age in 2019 and had a mammogram to screen for breast cancer from October 2018 through December 31, 2020.

Billing Reference – BCS				
Description	**CPT**		**HCPCS**	**UB Revenue**
Breast Cancer Screening	77055-77057, 77061-77067		G0202, G0204, G0206	0401, 0403
Measure Exclusion Criteria				
A female who had the following: Bilateral mastectomy or any combination of unilateral mastectomy codes that indicate a mastectomy on both the left and right side before December 31, 2020.				
Exclusion Description	**ICD-10 CM**		**ICD-10 PCS**	
Bilateral Mastectomy			0HTV0ZZ	
Hx. Bilateral Mastectomy	Z90.13			
Unilateral Mastectomy with Bilateral Modifier				
Exclusion Description	**CPT**			
Unilateral Mastectomy	19180, 19200, 19220, 19240, 19303-19307			
With LT (left) or RT (right) modifier				
Exclusion Description	**ICD-10 CM**			
Unilateral Mastectomy	Left	0HTU0ZZ	Right	0HTT0ZZ
Absence of Breast	Left	Z90.12	Right	Z90.11
Additional Exclusion Criteria				
Exclude from Medicare reporting members age 66 and older as of December 31st of the measurement year who were enrolled in an Institutional SNP (I-SNP) any time during the measurement year or living long-term in an institution any time during the measurement year. Exclude members age 66 and older as of 12/31 of the measurement year with both advanced illness and frailty: A claim for an advanced illness condition from the measurement year or the year prior and a claim for frailty during the measurement year are required.				

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CCS Cervical Cancer Screening

Measure definition:

The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed within the last three years.
- Women age 30-64 who had cervical high-risk human papillomavirus (hrHPV) co-testing performed within the last five years.
- Women age 30-64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed within the last five years.

Common chart deficiencies and tips:

1. Documentation of hysterectomy must include words such as 'complete', 'total', or 'radical'
2. Documentation of hysterectomy alone does not meet guidelines because it does not indicate the cervix was removed
3. Reflex testing (performing HPV test after determining cytology result) does NOT count
4. Cervical cytoloy and human papillomavirus test must be completed four or fewer days apart in order to qualify for testing every five years

Billing Reference – CCS		
Description	**CPT**	**HCPCS**
Cervical Cytology Test	88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	
High-Risk HPV Lab Test	87620-87622, 87624-87625	G0476

Measure Exclusion Criteria:

A female who had a hysterectomy with no residual cervix.

Exclusion Description	CPT	ICD-10 PCS	ICD-10 CM
Hysterectomy with no residual cervix	57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 58956, 59135	0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ	Absence of cervix
			Q51.5, Z90.710, Z90.712

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CDC Comprehensive Diabetes Care – HbA1c Testing

Measure definition:

Members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year.

Common chart deficiencies and tips:

1. Educate member on importance of completing the HbA1c test
2. Lab results not documented in chart
3. Lab values show poor control (>9)

Billing Reference – CDC		
Description	**ICD-10 CM**	
Diabetes	E10.10-E13.9, O24.011-O24.13, O24O311-24.33, O24.811-O24.83	
Description	**CPT**	
HbA1c Screening	83036, 83037	
Description	**Lab Result**	**CPT II**
HbA1c Result	<7%	3044F
	7.0%-9.0%	3045F
	>9.0%	3046F
Measure Exclusion Criteria:		
Identify members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior and who meet either of the following criteria: A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior, with no encounters in any setting with a diagnosis of diabetes.		
Exclusion Description	**ICD-10 CM**	
Diabetes Exclusions	E08.00-E09.9, O24.410-O24.439, O24.911-O24.93	
Additional Exclusion Criteria		
Exclude from Medicare reporting members age 66 and older as of December 31st of the measurement year who were enrolled in an Institutional SNP (I-SNP) any time during the measurement year or living long-term in an institution any time during the measurement year. Exclude members age 66 and older as of 12/31 of the measurement year with both advanced illness and frailty: A claim for an advanced illness condition from the measurement year or the year prior and a claim for frailty during the measurement year are required.		

CHL Chlamydia Screening in Women

Measure definition:

The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Billing Reference – CHL	
Description	**CPT**
Chlamydia Test	87110, 87270, 87320, 87490-87492, 87810
Measure Exclusion Criteria:	
Exclusion: Female members who qualified for the denominator based on a pregnancy test alone and who meet either of the following: • A pregnancy test in the measurement followed within seven days (inclusive) by a prescription for isotretinoin. • A pregnancy test in the measurement year followed within seven days (inclusive) by an x-ray.	
Exclusion Description	**CPT**
Pregnancy Test Exclusion	81025, 84702, 84703
WITH	
Exclusion Description	**CPT**
Diagnostic Radiology	70010-76499
OR	
Retinoid	Isotretinoin Prescription

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CIS Childhood Immunization Status

Measure definition:

The percentage of children turning 2 years of age during the measurement year who received recommended vaccinations prior to their second birthday. Recommended vaccinations and number in series to meet compliance are listed below.

The measure calculates a rate for each vaccine and nine separate combination rates.

Common chart deficiencies and tips:

1. Vaccinations for DTaP, IPV, HiB, or PCV given before 42 days after birth date do not count toward vaccine compliance
2. Participate in state Immunization registries, where available
3. Devote time during each visit to review immunization record and look for opportunities to catch up on missing immunizations
4. Document date of first hepatitis B vaccination if given at hospital and note the hospital
5. Document history of illness in chart if child has had varicella zoster or measles

Billing Reference – CIS				
Immunization Description	**# in Series**	**CPT**	CVX	
DTaP	4	90698, 90700, 90721, 90723	20, 50, 106, 107, 110, 120	
IPV	3	90698, 90713, 90723	10, 89, 110, 120	
MMR	1	90707, 90710	03, 94	
Any combination of the following to satisfy recommendation of one MMR				
Measles Only	1	90705	05	
Mumps Only	1	90704	07	
Rubella Only	1	90706	06	
Measles and Rubella	1	90708	04	
Immunization Description	**# in Series**	**CPT**	HCPCS	CVX
Hib	3	90644-90648, 90698, 90721, 90748		17, 46-51, 120, 148
Hepatitis B	3	90723, 90740, 90744, 90747, 90748	G0010	08, 44, 45, 51, 110
VZV	1	90710, 90716		21, 94
Pneumococcal Conjugate	4	90669, 90670	G0009	100, 133, 152
Hepatitis A	1	90633		31, 83, 85

Billing Reference – CIS continued				
Immunization Description	**# in Series**	**CPT**	HCPCS	CVX
Rotavirus 2-dose or 3-dose vaccinations satisfy Rotavirus recommendations				
Rotavirus 2-dose	2	90681		119
Rotavirus 3-dose	3	90680		116, 122
Influenza	2	90655, 90657, 90661, 90662, 90673, 90685-90688	G0008	88, 135, 140, 141, 150, 153, 155, 158, 161
ICD-10 CM Codes for Illnesses				
Hepatitis A	B15.0, B15.9			
Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51			
Measles	B05.0-B05.4, B05.81, B05.89, B05.9			
Mumps	B26.0-B26.3, B26.81-B26.85, B26.89-B26.9			
Rubella	B06.00-B06.02, B06.09, B06.81-B06.82, B06.89, B06.9			
Varicella Zoster	B01.0, B01.11-B01.2, B01.81-B01.9, B02.0, B02.1, B02.21-B02.29, B02.30-B02.39, B02.7-B02.9			
CIS Measure Exclusion Criteria				
Exclusion: Exclude children who had a contraindication for a specific vaccine.				
Exclusion Description	**ICD-10 CM**			
Any particular vaccine – Anaphylactic reaction	T80.52XA, T80.52XD, T80.52XS			
DTaP – Encephalopathy with adverse effect	G04.32 **with** T50.A15A, T50.A15D, T50.A15S			
MRR, VZV and Influenza – Immunodeficiency, lymphoreticular cancer, multiple myeloma or leukemia or HIV	D80.0-D81.2, D81.4, D81.6-D82.4, D82.8-D83.2, D83.8-D84.1, D84.8-D84.9, D89.3, D89.810-D89.13, D89.82, D89.89, D89.9, B20, Z21, B97.35, C81.00-C86.6, C88.2-C88.9, C90-C96.Z			
Rotavirus – Severe combined immunodeficiency or a history of intussusception	D81.0-D81.2, D81.9, K56.1			
Exclusion Description	**General Exclusion Criteria**			
MRR, VZV and Influenza	Anaphylactic reaction to neomycin			
IPV	Anaphylactic reaction to streptomycin, polymyxin B, or neomycin			
Hepatitis B	Anaphylactic reaction to common baker's yeast			

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IMA Immunizations for Adolescents

Measure definition:

The percentage of adolescents turning 13 years of age in the measurement year who received one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) and completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates:

- Tdap and meningococcal conjugate
- Tdap, meningococcal conjugate and HPV
- The measure calculates a rate for each vaccine and nine separate combination rates.

Common chart deficiencies and tips:

1. Participate in state Immunization registries, where available
2. Devote time during each visit to review immunization record and look for opportunities to catch-up on missing immunizations
3. Meningococcal recombinant serogroup B does NOT count
4. Educate teens and parents/guardians about the importance of these immunizations

Meningococcal vaccine – at least one meningococcal serogroups A, C, W, Y vaccine administered between the 11th and 13th birthday

Tdap vaccine – administered between the 10th and 13th birthday

HPV – two HPV vaccines between the 9th and 13th birthday with at least 146 days between the doses OR three doses with different dates of service between the 9th and 13th birthday.

Billing Reference – IMA		
Description	**CPT**	CVX
Tdap	90715	115
Meningococcal	90734	108, 114, 136, 147, 167
Human Papillomavirus	90649, 90650, 90651	62, 118, 137, 165
Measure Exclusion Criteria		
Exclude children who had a contraindication for a specific vaccine.		
Exclusion Description	ICD-10 CM	
Anaphylactic Reaction	T80.52XA, T80.52XD, T80.52XS	
DTaP – Encephalopathy with Adverse-Effect	G04.32 **WITH** T50.A15A, T50.A15D, T50.A15S	

LSC Lead Screening in Children

Measure definition:

The percentage of children turning 2 years of age in the measurement year who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Common chart deficiencies and tips:

1. Lead screening is considered late if performed after the child turns 2 years of age
2. A lead risk assessment does not satisfy the blood lead test requirement for Medicaid members regardless of the risk score
3. Options exist for in-office lead testing, including blood lead analyzer and MedTox filter paper testing

Billing Reference – LSC	
Description	CPT
Lead Tests	83655

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PPC Prenatal and Postpartum Care

Measure definition:

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment start date or within 42 days of enrollment in the organization.

Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Common chart deficiencies and tips:

1. Stress importance of keeping post-partum check-up appointment when member is discharged from the hospital
2. Refer to and use ACOG sheets or computerized template

Billing Reference – PPC			
Timeliness of prenatal care / codes to identify prenatal care visit – method 1			
Description	**CPT/CPT II**		**HCPCS**
Prenatal Bundled Services	59400, 59425, 59426, 59510, 59610, 59618		H1005
Stand-Alone Prenatal Visits	99500, 0500F, 0501F, 0502F		H1000-H1004
Timeliness of prenatal care / codes to identify prenatal care visits – method 2			
Description	CPT/CPT II		HCPCS
Prenatal Visits	99201-99205, 99211-99215, 99241-99245, 99483		T1015, G0463
With one of the following pregnancy diagnoses:			
Description	CPT	ICD-10 PCS	
Pregnancy Diagnosis	ICD10CM	O09.0-O9A3, O10.011-O9A.519, Z03.71-Z36.9	
Postpartum visit – any of the following meet criteria			
Description	CPT/CPT II	ICD-10 CM	HCPCS
Postpartum Visit	57170, 58300, 59430, 99501, 0503F	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	G0101
Description	CPT	HCPCS	
Cervical Cytology	88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	
Description	CPT		
Postpartum Bundled	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622		

WCC Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure definition:

The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.

Common chart deficiencies and tips:

1. BMI percentile or BMI percentile plotted on growth chart for members 3-17 years of age required to meet measure (BMI value alone does NOT meet compliance)
2. Must include documentation indicating counseling for nutrition and physical activity

Billing Reference – WCC			
Description	**CPT**	**HCPCS**	**ICD-10 CM**
BMI Percentile			Z68.51-Z68.54
Nutrition Counseling	97802-97804	G0270, G0271, G0447, S9449, S9452, S9470	Z71.3
Physical Activity Counseling		**G0447** (face-to-face behavioral counseling for obesity – 15 minutes) **S9451** (exercise classes – non-physician provider)	**Z02.5** (sports physical) **Z71.82** (exercise counseling)
Measure Exclusion Criteria			
Any diagnosis of pregnancy during the measurement year counts as an exclusion for this measure			

WCV Child and Adolescent Well Care

Measure definition:

Members 3-21 years of age with at least one comprehensive well-care visit with a primary care practitioner **or** an OB/GYN practitioner annually.

The comprehensive well care visit includes:

- **A health history** – assessment of member's history of disease or illness and family health history.
- **A physical development history** – assessment of specific age-appropriate physical development milestones.
- **A mental development history** – assessment of specific age-appropriate mental development milestones.
- **A physical exam**
- **Health education/anticipatory guidance** – guidance given in anticipation of emerging issues that a child/family may face.

Common chart deficiencies and tips:

1. Missing or undocumented anticipatory guidance
2. Sick visit in calendar year without well-child visit – turn a sick visit into a well-child visit
3. Schedule next visit at end of each appointment
4. Educate parent/guardian on importance of annual well visit

Documentation that DOES NOT meet criteria:

- **For health history:** notation of allergies or medications or immunization status alone. If all three are documented, it meets health history.
- **For physical development history:** notation of appropriate for age without specific mention of development; notation of well-developed/nourished; tanner stage (except for adolescents – then it meets compliance).
- **For mental development history**: notation of appropriately responsive for age; neurological exam; notation of well-developed.
- **For physical exam:** vital signs alone; for adolescent visits to an ob/gyn they do not meet compliance if the visit is limited to OB/GYN topics.
- **For health education/anticipatory guidance:** information regarding medications or immunizations or their side effects. Handouts given during a visit without evidence of discussion.

Billing Reference – **WCV**				
Description	**CPT**	**HCPCS**	**ICD-10 CM**	**Telehealth Modifiers**
Office Visit	99381-99385, 99391-99395, 99461	G0438, G0439, S0302	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2	95, GT

WCV Well-Child Visits in the First 30 Months of Life

Measure definition:

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months.

Two rates reported:

- Six or more well visits by age 15 months
- Two or more well visits between 15 and 30 months

The comprehensive well care visit includes:

- **A health history** – assessment of member's history of disease or illness and family health history.
- **A physical development history** – assessment of specific age-appropriate physical development milestones.
- **A mental development history** – assessment of specific age-appropriate mental development milestones.
- **A physical exam**
- **Health education/anticipatory guidance** – guidance given in anticipation of emerging issues that a child/family may face.

Common chart deficiencies and tips:

1. Missing or undocumented anticipatory guidance
2. Sick visit in calendar year without well-child visit – turn a sick visit into a well-child visit
3. Schedule next visit at end of each appointment
4. Call parent/guardian to reschedule when a visit is missed
5. Educate parent/guardian regarding the need for so many visits in the first 30 months

Documentation that DOES NOT meet criteria:

- **For health history:** notation of allergies or medications or immunization status alone. If all three are documented, it meets health history.
- **For physical development history:** notation of appropriate for age without specific mention of development; notation of well-developed/nourished; tanner stage (except for adolescents – then it meets compliance).
- **For mental development history**: notation of appropriately responsive for age; neurological exam; notation of well-developed.
- **For physical exam:** vital signs alone; for adolescent visits to an ob/gyn they do not meet compliance if the visit is limited to OB/GYN topics.
- **For health education/anticipatory guidance:** information regarding medications or immunizations or their side effects. Handouts given during a visit without evidence of discussion.

Billing Reference – **WCV**				
Description	**CPT**	**HCPCS**	**ICD-10 CM**	**Telehealth Modifiers**
Office Visit	99381-99385, 99391-99395, 99461	G0438, G0439, S0302	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2	95, GT

G9001 – Comprehensive Assessment

- **Definition:** Coordinated care fee, initial rate
- Assessment, supervision, and education of patients with chronic illness requiring complex or multidisciplinary care modalities involving regular monitoring and revision of the plan of care. Includes initial and ongoing assessments, data collection, communication with patient, caregivers, and other providers, integration of new information into the plan of care and/or modification of interventions
- **Limitations:** Must include at least one face-to-face encounter; cannot be billed/paid in the same month as G9002.
- **Duration of service:** Once per year, unless a different diagnosis
- **Who can support the service:** Primary care provider or other qualified health care professional
- **Additional documentation guidelines:** Comprehensive assessment results and detailed, individualized care plan need to be documented in the patient chart.

G9002 – In-Person Encounter

- **Definition:** Coordinated care fee, maintenance rate
- **Limitations:** Once per month; cannot be billed/paid in the same month as G9001
- **Duration of service:** At least 30-minutes; cumulative
- **Who can support the service:** May be provided by clinical staff under direct supervision of primary care provider or other qualified health care professional

  Codes that CAN be billed more often are those that are less time/resource intensive – i.e. telephonic outreach F/U unrelated to post-op can be billed

G9007 – Team Conference

- **Definition:** Coordinated care fee, scheduled team conference
- Conference by a physician with interdisciplinary team of health professionals or representatives of community agencies or care management entity to coordinate activities of patient care (patient not be present)
- **Limitations:** Face-to-face team conference
- **Duration of service:** Approximately 30 to 60 minutes.
- **Who can support the service:** Billable by primary care provider only; other team members should be present.
- **Additional documentation guidelines:** Update(s) and/or additions made to individualized care plan

G9008 – Physician Coordinated Care Oversight

- **Definition:** Coordinated care fee, physician coordinated care oversight services
- Includes: physician supervision, development and revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies and data, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy
- **Limitations:** Once per month
- This code should not be used unless the beneficiary requires recurrent supervision of therapy. The work involved in providing very low intensity or infrequent supervision services is included in the pre- and post-encounter work of other typically covered physician visits and services.
- **Duration of service:** 30-60 minutes (patient not present)
- **Who can support the service:** Primary care provider

98966, 98967, 98968 – Telephone Services

- **Definition:** Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent, or guardian.
  These codes are not reported if:
  - The telephone service is related to a service provided within the previous 7 days or within the postoperative period of a previously completed procedure, or
  - The telephone service results in a decision to see the patient within 24 hours or soonest available appointment.
- This applies to both unsolicited patient follow-up or that requested by the health care professional.
- **Limitations:** One per day unless one of the above scenarios apply
- **Duration of service:** 98966 – 5-10 minutes, 98967 – 11-20 minutes, 98968 – 21-31 minutes
- **Who can support the service:** A qualified nonphysician health care professional

99495 – Care Transition

- **Definition:** Transitional care management services for your patients transitioning out of an inpatient hospital, SNF, outpatient observation or partial hospitalization, includes the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision-making of at least moderate complexity during the service period
  - Face-to-face visit, within 14 calendar days of discharge
- **Limitations:** Only one individual may report these services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within the 30 days.
- **Duration of service:** 30 days; TCM commences upon the date of discharge and continues for the next 29 days
- **Who can support the service:** Physician or other qualified health care professional; non-face-to-face services may be provided by clinical staff under the direction of the physician or other qualified health care professional
- **Additional consideration:**
  - This is a covered service – all Medicaid health plans must reimburse for the provision of this service
  - When using TCM codes 99495 and 99496; the practice cannot bill TCM and G/CPT code (G9002 or 98966, 98967, 98968) at the same time if the work is related to Transition of Care.

99496 – Care Transition

- **Definition:** Transitional care management services for your patients transitioning out of an inpatient hospital, SNF, outpatient observation or partial hospitalization, includes the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision-making of high complexity during the service period
  - Face-to-face visit, within 7 calendar days of discharge
- **Limitations:** Only one individual may report these services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within the 30 days.
- **Duration of service:** 30 days; TCM commences upon the date of discharge and continues for the next 29 days.
- **Who can support the service:** Physician or other qualified health care professional; non-face-to-face services may be provided by clinical staff under the direction of the physician or other qualified health care professional
- **Additional consideration:**
  - This is a covered service – all Medicaid health plans must reimburse for the provision of this service
  - When using the TCM codes 99495 and 99496; the practice cannot bill TCM and G/CPT code (G9002 or 98966, 98967, 98968) at the same time if the work is related to Transition of Care.

98961 and 98962 – Group Education and Training

- **Definition:** Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients, use 98961; 5-8 patients, use 98962.
- **Limitations:** Must be prescribed by a physician or other qualified healthcare professional. More than one patient must be present. Caregiver/family could be included but do not count toward total patients.
- **Duration of service:** Reported in 30-minute increments
- **Who can support the service:** A qualified non-physician health care professional
- **Additional guidelines:**
  - Services should be separately billed for each individual patient
  - Code selection depends upon total number of patient participants in the session
  - Quantity depends upon length of session (reported in thirty-minute increments)

S0257 – End-of-life Counseling

- **Definition:** Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate. Service is required to be provided face-to-face.
- **Limitations:** No limits on number of services per patient per year
- **Duration of service:** N/A
- **Who can support the service:** May be provided by clinical staff under direct supervision of primary care provider or other qualified health care professional

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