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Quality Improvement for Providers 2021

Quality Incentive Programs

Content Covered Today

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

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HEDIS

Domains of Care, Data Collection, Importance to providers, Your Role in HEDIS, and How to improve overall HEDIS scores

What is HEDIS?

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Healthcare Effectiveness Data and Information Set

- A set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) for the managed care industry
- A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service
- Consists of 92 measures across 6 domains of care
- Designed to allow consumers to compare health plan performance to other plans on an “apples-to-apples” basis
- HEDIS results are audited by an independent NCQA-certified auditor prior to being reported.
- Results are reported as part of Medicare Stars, NCQA Health Plan Ratings, and State and Marketplace Report Cards.

What is HEDIS?

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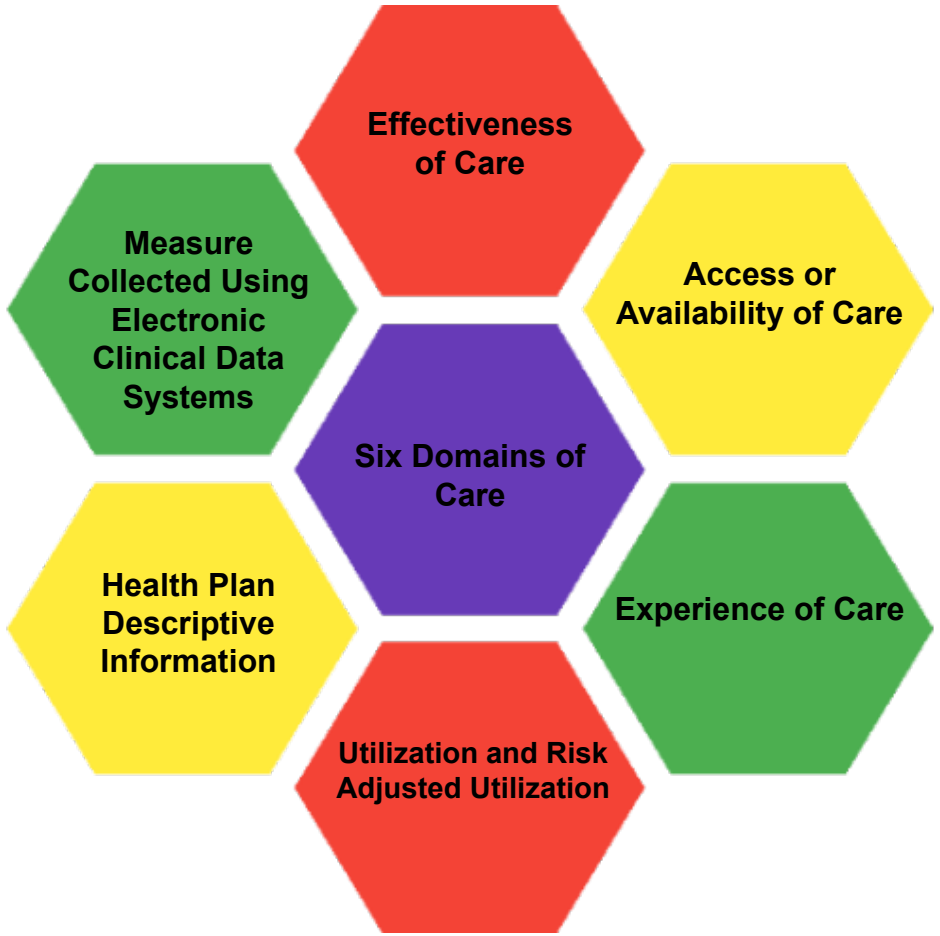
HEDIS Results:

- Serve as measurements for quality improvement processes and preventive care programs
- Evaluate the health plan's ability to demonstrate improvement in its preventive care and quality measurements
- Provide a picture of the overall health and wellness of the plan's membership
- Identify gaps in care and develop programs/interventions to help increase compliance and improve health outcomes
- Demonstrate the provider's commitment to quality care and improved patient outcomes

HEDIS Domains of Care



These domains of care measure important dimensions of care and service.

Each of these domains *help to identify gaps in care*, particularly preventative care, in a variety of chronic populations.

How is Data Collected for HEDIS?

- Three sources:
  - **Administrative**
    - Administrative measures use claims/encounters for hospitalizations, medical office visits, labs, and procedures as well as pharmacy data
  - **Hybrid**
    - Hybrid measures combine data obtained from the member's medical record with administrative data
  - **Survey of Member Experience**
    - Survey measures compile data collected directly from members via the CAHPS, HOS, and ECHO surveys

Why is HEDIS Important to for you?

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- HEDIS is a tool for providers to ensure timely and appropriate care for their patients.
- HEDIS assists providers in identifying and eliminating gaps in care for the patients assigned to their panel.
- As HEDIS rates increase, there is potential for the provider to earn maximum or additional revenue through the Pay for Quality, Value Based Services, and other pay-for-performance models.
- Measure rates can be used as a tool to monitor compliance with incentive programs.
- Improved rates impact potential benefits offered to members year over year as outcomes improve.

What is your role in HEDIS?

- You play a central role in promoting the health of our members.
- You and your office staff help facilitate the HEDIS process improvement by:
  - Reaching out to new and currently assigned members for your practice and scheduling annual well exams.
  - Providing the appropriate care within designated time frames.
  - Documenting clearly and accurately in the medical record ALL of the care you provide to our members.
  - Knowing your HEDIS measures documentation requirements and specific parameters.
  - Accurately coding all claims. Providing accurate information on a claim may reduce the number of records requested. (Tip sheets are available on the provider website for guidance).
    - The ultimate goal is for providers to submit claims/encounters with coding that administratively captures all required HEDIS data via claims.
      - This decreases or removes the need for medical record review

How Can You Improve Your Overall HEDIS Scores?

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- Schedule and conduct Well Visits in the first quarter of the year. Plans run on calendar year and not 365 days.
- Conduct and bill a well visit with a sick visit for a member who has not had his/her annual exam.
- Expand a basic sports physical, especially for adolescents, to include education and anticipatory guidance. Including these components will increase the Adolescent Well Visit and Well Child rates.
- Contact members that are delinquent in needed care and schedule services.
- Be sure that follow-up instructions are clear and documented in the medical record (ex: for future appointments and what to do).
- Schedule the next appointment before the patient leaves the office.
- Collaborate with the health plan on programs and interventions including disease management, social work, and case management to assist members with action plans.
- Utilize mail order and 90 day fill on medications to assist with compliance.
- Schedule hospital follow-ups within 7 days of discharge.
- Address open care gaps at each visit.

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CAHPS & HOS Surveys

A Component of HEDIS and Best Practices

CAHPS Survey – A Component of HEDIS

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- Member Satisfaction Survey - A Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey is also a part of HEDIS
  There is an adult and a child version of this survey and the questions are similar in both
- CMS selects 800+ members annually to be sampled between March and June using two survey mailings and telephone follow-up of non-respondents.
- The CAHPS survey includes questions about access to care and care delivery over the last 6 months. Patients' experience with their provider is a main focus in this survey. Here are a few examples of the survey questions:
  - When you needed care right away, how often did you get care as soon as you needed?
  - How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
  - When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
  - On a scale of 0 -10 where 0 is worst and 10 is best, what number would you use to rate your personal doctor?
  - How often did your personal doctor listen to you and show you respect?
- Measures Collected Through the CAHPS Survey
  - Flu Vaccinations for Adults Ages 18-64 (FVA)
  - Flu Vaccination for Adults Ages 65 and Older (FVO)
  - Medical Assistance With Smoking and Tobacco Use Cessation (MSC)
  - Pneumococcal Vaccination Status for Older Adults (PNU)

HOS Survey – A Component of HEDIS

- Member Quality of Life Survey - A Health Outcomes Survey (HOS) is also a part of HEDIS
- CMS selects a group of 1200 members to be sampled between March and July each year. Two years later, these same respondents are surveyed again.
- HOS is intended to gather self-reported quality of life data over time. MA Health plans can use data to assess program performance, monitor the health of its population and venerable subgroups, and evaluate treatment outcomes and procedures.
- Survey collects information about the members health status- Improving or Maintaining Physical and Mental Health. Here are a few examples of the survey questions:
  - In general, how would you rate your health? Excellent, Good, Fair or Poor
  - Does your health limit your daily activity?
  - During the past 4 weeks how much pain interferes with your normal activity?
  - Do you have any emotional problems that interfere with daily work activities?
  - How much time during the last 4 weeks did you feel blue or down?
- Measures Collected Through the HOS Survey
  - Medicare Health Outcomes Survey (HOS)
  - Fall Risk Management (FRM)
  - Management of Urinary Incontinence in Older Adults (MUI)
  - Physical Activity in Older Adults (PAO)

CAHPS & HOS Survey – Best Practices

Tips and Discussion Points for Providers:

- **Was Seen Within 15 Minutes of Appointment**
  - Provide frequent updates to your patients waiting to see their provider. This will assist with helping your patients feel their time is appreciated.
  - During waiting times, the medical assistant could measure vitals, address falls, urinary incontinence, mental health, physical activity, etc.
- **Had Flu Shot:**
  - Provide your patients with educational materials on the benefits, provide vaccine within the office, or provide your patients with a list of locations in the area where they can receive the vaccine.
- **Rating of Healthcare:**
  - Encourage your patients to make their routine appointments for checkups or follow up visits as soon as they can – weeks or even months in advance.
  - Ensure all comorbidities are addressed during a visit, ensure your patient walks away satisfied their issues/needs were addressed, and follow up timely on all test results and/or questions.
  - Maintain an effective triage system to ensure that your frail and/or very sick patients are seen right away or provided alternate care via phone and urgent care.
- **Routine Care as Soon as Needed:**
  - Try to have open slots available daily for urgent visits.
  - When needing labs, x-rays, specialists, or external testing for your patients ensure staff schedule these prior to the member leaving the office after their visit.
  - Ensure the specialists referring to are in-network for ease of care.
  - Ensure that your patient knows how to receive care when your office is closed.
  - Remind your patients about important prevention measures, such as regular flu shots.
  - Follow up on referrals and discuss your patient's current specialist care.
  - Contacting your patients to remind them when it's time for preventive care services such as annual wellness exams, recommended cancer screenings, and follow-up care for ongoing conditions such as hypertension and diabetes.
- **Easy to get Tests, Care, Treatment:**
  - When needing labs, x-rays, specialists, or external testing for your patients ensure staff schedule these prior to the member leaving the office after their visit.
  - Ensure the specialists or facility for testing referring to are in-network for ease of care.
  - Ensuring all information for specialists, tests, and procedure authorizations is provided and following up as necessary.
  - Following up your patients after referral to specialists to ensure care is coordinated.

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CPT Category II Coding

Best Practices for HEDIS

CPT® Category II Codes

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- **What are they?**
  - CPT Category II codes are reporting codes that relay important information to the health plan. This information can close quality care gaps related to specific health outcome measures.
- **Why are they Important?**
  - CPT Category II codes should be submitted in conjunction with CPT or other codes used for billing and will decrease the need for record abstraction and chart reviews, minimizing your administrative burden.
- **How to bill CPT Category II codes:**
  - CPT Category II codes are billed in the procedure code field, just as CPT Category I codes are billed. CPT Category II codes describe clinical components usually included in evaluation and management or clinical services and are not associated with any relative value. Therefore, CPT Category II codes are billed with a $0.00 or $0.01 billable charge amount.
- **How can CPT Category II codes be used to close quality gaps in care on specific HEDIS measures?**
  - CPT Category II codes can relay important information related to health outcome measures such as*:
    - ACE/ARB Therapy Controlling blood pressure
    - Comprehensive diabetes care
    - Care of Older Adults
    - Medication Reconciliation
    - Prenatal and Postpartum Care

*Examples list is not all-inclusive

CPT® Category II Codes

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Quality Measure	Indicator or Description	CPT Category II codes
Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy	ACE/ARB Therapy	4010F
Controlling High Blood Pressure	Blood Pressure Readings	3074F, 3075F, 3077F, 3078F, 3079F, 3080F
Comprehensive Diabetes Care	A1C Results	3044F, 3046F, 3051F, 3052F
	Eye Exam	2022F, 2023F, 2024F, 2025F, 2026F, 2033F, 3072F
	Nephropathy Screening	3060F, 3061F, 3062F, 3066F, 4010F
Care of Older Adults	Advanced Care Planning	1123F, 1124F, 1157F, 1158F
	Functional Status Assessment	1170F
	Medication Review	1111F, 1159F, 1160F
	Pain Screening	1125F, 1126F
Medication Reconciliation after Discharge	Medication Reconciliation	1111F
Prenatal and Postpartum Care	Prenatal Visit	0500F, 0501F, 0502F
	Postpartum Visit	0503F

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Incentive Programs and Opportunities for Providers

Diabetic Eye Exam & Pay for Performance (P4P)

Diabetic Retinal Eye Exams

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Arkansas Health and Wellness & Arkansas Total Care are committed to improving the health of our community by helping people with diabetes lead healthier lives. Because of your vital role in patient health, we are asking for your assistance by facilitating preventive care through annual diabetic eye exams and reporting of exam findings.

Routine retinal evaluation is recommended to reduce the risk of diabetes-related blindness. While exams do not require prior authorization, please be sure to adhere to Arkansas Health and Wellness clinical policies regarding medical necessity.

Please reference plan specifics and applicable billing guidelines when selecting the most appropriate CPT code for services rendered.

Using these codes may help reduce the need for medical record reviews.

CPT:
65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114, 67028, 67030, 67031, 67036,
67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245

***CPT Category II:**
2022F-2026F, 2033F, 3072F

HCPCS:
S0620, S0621, S3000

Diagnosis Code: (diabetes without complications)
E10.9, E11.9, E13.9

***Note:** When submitting CPT II codes, you may be entitled to a $10 bonus payment per member per year.
Providers must bill $10 in the claim filing to receive reimbursement.

Pay for Performance Programs (P4P)

- Arkansas Health & Wellness invites you to participate in our pay-for-performance (P4P) programs. These programs are designed to enhance quality of care through a focus on preventative and screening services while promoting engagement with our members. Based on program performance, you are eligible to earn compensation in addition to that which you are paid through your Participating Provider Agreement. The P4P program is “upside only” and involves no risk to you. Further, contract document is not required to participate in this program.

- The P4P program provides financial incentives for engaging your members and closing care gaps based on NCQA and HEDIS quality performance standards. Each care gap has its own incentive amount and is paid for each compliant member event once the target has been achieved for that specific measure.

- Incentives are paid based on member primary care assignment. In other words, a closed care gap results in an incentive to the tax identification numbers for the primary care provider of record for that member. Incentives are paid three times per year and providers will receive credit for all care gaps closed during the calendar year.

Ambetter P4P

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2 Types of Incentive Payments

1. Annual Wellness Visit (AWV) "Quick Strike" Payments

- $100 bonus paid for every Wellness Visit
  - ❑ Paid to the Assigned PCP
  - ❑ No minimums
- E&M list matches MyHealthPays

- Paid Monthly
- Health Plan generates reports and payment

2. Ambetter Pay per Measure Quality Program

- 12 HEDIS Measures available for payments
- Incentives are paid on each compliant member once the target has been met for that measure
  - ❑ $30 - $100 potential per measure
  - ❑ Two targets with increasing payouts

- Paid 3x per year
- Centene Corporate generates reports and payment

Ambetter Annual Physical Exam (APE)

Annual Physical Exams include an appropriate history/exam with risk counseling and/or quality intervention.

Extent of exam depends on the age and gender of the patient. This service is covered once per calendar year.

A successful annual wellness visit will:

- Identify patients who need disease management or intervention.
- Improve meaningful data exchanges between health plan and providers.
- Improve quality of care provided and patient health outcomes.

The medical record *must* support all diagnoses and all services billed on the claim.

- Address all conditions that require or affect patient care, treatment or management.
- Thoroughly document the specific diagnoses and care plan.
- Code to the highest specificity using ICD-10 guidelines.
- Consider including CPT® II codes to provide additional details.
- Submit claim/encounter data for each service rendered.
- Ensure all claim/encounter data is accurate and submitted in a timely manner.

Focused on modifiable risk factors and disease prevention

- No chief complaint/not due to present illness
- Complete Systems Review
- Past medical, social and family history
- Pertinent risk factors
- Risk factor and age appropriate counseling, screening, labs, tests and vaccines

Documentation should include:

- Status of chronic conditions that are not significant enough to require additional work-up
- Description and care plan for minor problems that do not require additional work-up
- Orders and/or referrals

Note: Follow ICD-10-CM/CPT/HCPS Guidelines for Coding and Reporting at https://www.cms.gov. HEDIS measures can be found at https://www.ncqa.org.

Ambetter Annual Physical Exam (APE), cont.

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Exam Type	Initial CPT	Subsequent CPT
Age 0	99381	99391
Age 1-4	99382	99392
Age 5-11	99383	99393
Age 12-17	99384	99394
Age 18-39	99385	99395
Age 40-64	99386	99396
Age 60+	99387	99397

Separate Evaluation and Management[1]

- Provider may perform separately identifiable services 99202-99215, 99381-99387, 99391-99397 on the same day.
- The components of both the AWV and the Routine Physical Exam must be met and documented.
- Report E/M and routine physical with modifier -25 when performed on the same date.
- If the provider's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.
- A separately identifiable E/M service may be reported if prompted by symptoms or chronic conditions assessed during the annual physical. Select the appropriate level of E/M services based on the following:
  1. The level of the medical decision making as defined for each service;
     or
  2. The total time for E/M services performed on the date of the encounter.

Ambetter Annual Physical Exam (APE), cont.

ICD-10: Encounter for general medical exam
Report the documented reason for the encounter as the primary diagnosis code and assign additional diagnosis codes if applicable. Follow the current year's Official ICD-10-CM Guidelines for Coding and Reporting.
… infant exam 7 days and younger, Z00.110 Use when identifying health supervision for newborn under 8 days old.
…infant exam 8 to 28 days, Z00.111 Use when identifying health supervision for newborn 8 to 28 days old.
…child exam with normal findings, Z00.129 Use when conditions are stable or improving. Report additional codes for chronic conditions.
…child exam with abnormal findings, Z00.121 Use when any abnormality is found during the visit. Report additional codes for all existing conditions.
…adult exam with normal findings Z00.00 Use when conditions are stable or improving. Report additional codes for chronic conditions.
…adult exam with abnormal findings, Z00.01 Use when any abnormality is found during the visit. Report additional codes for all existing conditions.

HEDIS® Measures			
Prevention / Visits	Schedule Screenings	Diabetes	Medication Management
Blood Pressure Control	Colorectal Cancer	HbA1c Testing & Control	Asthma
Immunizations	Breast Cancer	Kidney Health Evaluation	Antidepressants
Well-Child Visit	Cervical Cancer	Nephropathy Screening	ACE/ARB
Weight Assessment and Counseling for Children & Adolescents	Diabetic Eye Exam		Statins
	Annual Dentist Visit		Diabetes Medications

Ambetter P4P cont.

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Objective	• Enhance quality of care through a PCP driven pay for performance program with a focus on preventative and screening services
Member Attribution	• Ambetter Members who have been formally assigned to Provider Tax ID Number (TIN)
Targeted Services	• Selected measures are focused on PCP Engagement and Practitioner-influenced health care services identified in the current HEDIS technical Specifications published by NCQA. 1. Antidepressant Medication Management 2. Breast Cancer Screening 3. Cervical Cancer Screening 4. Colorectal Cancer Screening 5. Controlling High Blood Pressure 6. Medication Management Asthma 7. Proportion of Days Covered by Medication (ACE/ARB) 8. Proportion of Days Covered by Medication (Diabetes) 9. Proportion of Days Covered by Medication (Statins) 10. Comprehensive Diabetes Care – Eye Exam 11. Comprehensive Diabetes Care – HbA1c Control <8 12. Comprehensive Diabetes Care - Nephropathy
Performance Incentive	• Payout is based upon meeting designated target(s) for selected measures. • Each measure has a designated incentive amount. • Higher incentive amounts are available for achieving Target 2.
Requirements for Payout	• Each selected measure is assigned a pay per measure amount. • Payment is made for each compliant event once the target is met.
Payout	• Three payouts per year (Q2/Q3/Q4 Final Reconciliation) • Monthly reporting for gaps in care

Ambetter P4P cont.

How does the Ambetter P4P Program work?

- Each measure is assigned an incentive dollar amount and a target based on QRS 4-Star and 5-Star benchmarks.
- Measures are evaluated using NCQA HEDIS established guidelines.
- Increasing incentives are paid on each compliant member event once the target has been met for the measure.
- Rates are accumulated based upon member assigned PCP, assigned PCP receives credit for gaps closed.
- If the provider reaches the first target (4-Star Benchmark) the bonus is paid at 75% of the incentive amount. If the provider reaches the second target (5-Star Benchmark) the bonus is paid at 100% of the incentive amount.
- Additional $75 bonus is paid for Wellness Visits incurred during the year.
- Each measure is evaluated independently and can qualify and receive an incentive payment for one, multiple or all of the measures.
- Three payouts made (Q2 July/ Q3 Nov/ Q4 Final Reconciliation after 180 days of claim runout)

Ambetter P4P cont.

Ambetter P4P Measures, Targets, and Incentives

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HEDIS MEASURES	Target 1 Pays 75% of Incentive Amount	Target 2 Pays 100% of Incentive Amount	Incentive Amount
ANTIDEPRESS MEDS - ACUTE PHASE	73.8%	77.2%	$ 100
ANTIDEPRESS MEDS - CONTINUATION PHASE	57.4%	62.2%	$ 100
BREAST CANCER - NON-MCR TOTAL	73.2%	78.8%	$ 75
CERVICAL CANCER - CERVICAL CANCER	65.2%	72.5%	$ 30
COLORECTAL CANCER - TOTAL	63.0%	69.1%	$ 50
COMP DIAB NON MCR - NON-MCR A1C<8	63.8%	67.5%	$ 75
COMP DIAB NON MCR - NON-MCR EYE EXAM	56.1%	66.4%	$ 75
COMP DIAB NON MCR - NON-MCR NEPH ATTN	92.7%	94.5%	$ 75
CONT BP NON-MCR - CONT BP NON-MCR	69.8%	75.4%	$ 50
MED MGMT ASTHMA - TOTAL 5 TO 64 75% COVERED	62.0%	67.7%	$ 100
QRS PDC - PDC ACE/ARB	81.7%	85.1%	$ 50
QRS PDC - PDC ORAL DIABETES RX	77.5%	81.6%	$ 65
QRS PDC - PDC STATINS	78.6%	81.8%	$ 50

Allwell P4P

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2 Types of Incentive Payments

1. Annual Wellness Visit (AWV) or Annual Physical Exam (APE) "Quick Strike" Payments

- $100 bonus paid for every Wellness Visit
  - ❑ Paid to the Assigned PCP
  - ❑ No minimums
- E&M list matches MyHealthPays

- Paid Monthly
- Health Plan generates reports and payment

2. Allwell Pay per Measure Quality Program

- 12 HEDIS Measures available for payments
- Incentives are paid on each compliant member once the target has been met for that measure
  - ❑ $25 - $75 potential per measure
  - ❑ Three targets with increasing payouts

- Paid 3x per year
- Centene Corporate generates reports and payment

Allwell Annual Wellness Visit (AWV) *and/or* Annual Physical Exam (APE)

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A successful annual wellness visit will:

- Identify patients who need disease management or intervention.
- Improve meaningful data exchanges between health plan and providers.
- Improve quality of care provided and patient health outcomes.

The medical record *must* support all diagnoses and all services billed on the claim.

- Address all conditions that require or affect patient care, treatment or management.
- Thoroughly document the specific diagnoses and care plan.
- Code to the highest specificity using ICD-10 guidelines.
- Consider including CPT® II codes to provide additional details.
- Submit claim/encounter data for each service rendered.
- Ensure all claim/encounter data is accurate and submitted in a timely manner.

Annual Wellness Visits			
Welcome to Medicare Exam G0402 (Once in a lifetime benefit)	**Initial Annual Wellness Visit G0438** (Once in a lifetime benefit)	**Subsequent Annual Wellness Visit** G0439 (All subsequent Visits)	The Annual Wellness Visit (AWV) includes Personalized Prevention Plan Services (PPPS) that focus on disability and disease prevention. This service is covered once per calendar year. (Refer to Medicare Claims Processing Manual for other services covered at the time of an IPPE or AWV.)

Note: Follow ICD-10-CM/CPT/HCPS Guidelines for Coding and Reporting at https://www.cms.gov. HEDIS measures can be found at https://www.ncqa.org.

Allwell Annual Wellness Visit (AWV) *and/or* Annual Physical Exam (APE), cont.

Annual Physical Exams			
Exam Type	**Initial**	**Subsequent**	Annual Physical Exams include an appropriate history/exam with risk counseling and/or quality intervention. The extent and focus of exam depends on the age and gender of the patient. This service is covered once per calendar year. (Refer to CPT Code book for further guidance and to view other services covered at the time of a preventative medicine exam.)
Age 18-39	99385	99395	
Age 40-64	99386	99396	
Age 60+	99387	99397	

ICD-10: Encounter for general adult medical exam
Report the documented reason for the encounter as the primary diagnosis code and assign additional diagnosis codes if applicable. Follow the current year's Official ICD-10-CM Guidelines for Coding and Reporting.
…with normal findings, Z00.00 Use when conditions are stable or improving. Report additional codes for chronic conditions.
…with abnormal findings, Z00.01 Use when any abnormality is found during the visit. Report additional codes for all existing conditions.

Note: Follow ICD-10-CM/CPT/HCPS Guidelines for Coding and Reporting at https://www.cms.gov. HEDIS measures can be found at https://www.ncqa.org.

Allwell Annual Wellness Visit (AWV) *and/or* Annual Physical Exam (APE), cont.

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HEDIS® Measures			
Prevention / Visits	**Schedule Screenings**	**Diabetes**	**Medication Management**
Blood Pressure Control Medication Reconciliation Cognitive Function Depression	Colorectal Cancer Breast Cancer Osteoporosis Diabetic Eye Exam	HbA1c Testing & Control Nephropathy Screening Kidney Health Evaluation	ACE/ARB Statins Diabetes Medications

Separate Evaluation and Management[1]

- Provider may perform separately identifiable services 99202-99215, 99385-99387, 99395-99397, G0402, G0438-G-439 on the same day.
- The components of both the AWV and the Routine Physical Exam must be met and documented.
- Report E/M and routine physical with modifier -25 when performed on the same date.
- If the provider's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.
- A separately identifiable E/M service may be reported if prompted by symptoms or chronic conditions assessed during the AWV/Physical. Select the appropriate level of E/M services based on the following:
  1. The level of the medical decision making as defined for each service;
     or
  2. The total time for E/M services performed on the date of the encounter.

Allwell P4P cont.

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Objective	• Enhance quality of care through a PCP driven pay for performance program with a focus on preventative and screening services
Member Attribution	• Ambetter Members who have been formally assigned to Provider Tax ID Number (TIN)
Targeted Services	• Selected measures are focused on PCP Engagement and Practitioner-influenced health care services identified in the current HEDIS technical Specifications published by NCQA. 1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Controlling High Blood Pressure 4. Comprehensive Diabetes Care – HbA1c Control <9 5. Comprehensive Diabetes Care – Eye Exam 6. Comprehensive Diabetes Care - Nephropathy 7. Proportion of Days Covered by Medication (ACE/ARB) 8. Proportion of Days Covered by Medication (Diabetes) 9. Proportion of Days Covered by Medication (Statins) 10. Medication Reconciliation Post-Discharge 11. Statin Therapy for Patients with Cardiovascular Disease 12. Statin Use in Persons with Diabetes
Performance Incentive	• Payout is based upon meeting designated target(s) for selected measures • Each measure has a designated Incentive amount • Higher Incentive amounts are available for achieving Target 2 and 3
Requirements for Payout	• Each selected measure is assigned a pay per measure amount • Payment is made for each compliant event once the target is met
Payout	• Three payouts per year (Q2/Q3/Q4 Final Reconciliation) • Monthly reporting for gaps in care

Allwell P4P cont.

How does the Allwell P4P Program work?

- Each measure is assigned an incentive dollar amount and a target based on CMS 3-Star, 4-Star, and 5-Star benchmarks.
- Measures are evaluated using NCQA HEDIS established guidelines.
- Increasing incentives are paid on each compliant member event once the target has been met for the measure.
- Rates are accumulated based upon member assigned PCP, assigned PCP receives credit for gaps closed.
- If the provider reaches the first target (3-Star Benchmark) the bonus is paid at 50% of the incentive amount. If the provider reaches the second target (4-Star Benchmark) the bonus is paid at 75% of the incentive, and if the provider reached the third target (5-Star benchmark) the bonus is paid at 100% of the incentive amount.
- Additional $100 bonus is paid for Annual Wellness Visits (AWV) and/or Annual Physical Exam (APE) incurred during the year.
- Each measure is evaluated independently and can qualify and receive an incentive payment for one, multiple or all of the measures.
- Three payouts made (Q2 July/ Q3 Nov/ Q4 Final Reconciliation after 180 days of claim runout).

Allwell P4P cont.

Allwell P4P Measures, Targets, and Incentives

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HEDIS MEASURES	3 Star Benchmark Pays 50%	4 Star Benchmark Pays 75%	5 Star Benchmark Pays 100%	Incentive Amount
BREAST CANCER - MCR TOTAL	66.0%	76.0%	83.0%	$ 25
COLORECTAL CANCER - MCR TOTAL	62.0%	73.0%	80.0%	$ 25
COMP DIAB MCR - MCR A1C<=9	61.0%	72.0%	85.0%	$ 50
COMP DIAB MCR - MCR EYE EXAM	69.0%	73.0%	78.0%	$ 25
COMP DIAB MCR - MCR NEPH ATTN	80.0%	95.0%	97.0%	$ 25
CONT BP MCR - CONT BP MCR	62.0%	75.0%	82.0%	$ 40
MED REC POST DIS - TOTAL	62.0%	71.0%	84.0%	$ 75
QRS PDC - PDC ACE/ARB	83.0%	86.0%	88.0%	$ 50
QRS PDC - PDC ORAL DIABETES RX	78.0%	82.0%	85.0%	$ 50
QRS PDC - PDC STATINS	80.0%	84.0%	87.0%	$ 50
STATIN CARDIO - MCR STATIN THERAPY TOTAL	79.0%	83.0%	87.0%	$ 75
STATIN THERA DIAB - MCR STATIN THERAPY	78.0%	81.0%	83.0%	$ 75

P4P Program Definitions

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- Qualified – members who are eligible for the service
- Compliant – members who actually received the service
- Quality Score – per measure, the percentage of compliant members to qualified members (sum of compliant divided by qualified)
- Target – set by plan, the percentile target that the provider is striving to reach per measure
- Maximum Bonus – amount the provider is eligible to receive based on their quality if all the eligibility requirements are met
- Bonus earned – payment the provider will actually receive this period

P4P Program FAQs

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1. **How were the measures identified?**
   The measures are consistent with NCQA and HEDIS quality performance standards.

2. **How often would measures change?**
   We continue to monitor all quality metrics and relative performance across the network. We refine our focus on an annual basis. We will provide a minimum of 30-days notice in case we plan to change any of the measured services

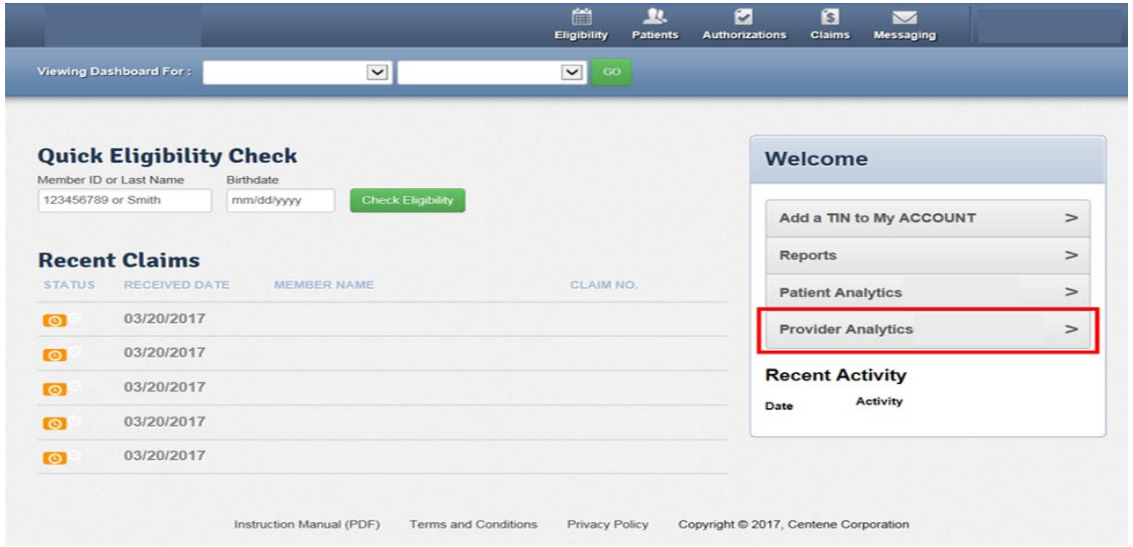
3. **Can I get any interim payment on the quality program?**
   YES, we do support interim payments on our quality programs. The final payout will be reconciled with any previous payments and will allow for sufficient time to look at chart reviews and medical records to supplement the quality scorecard. This process provides us a more accurate view of a provider's performance on a quality metric.

4. **What will the monthly report contain?**
   The monthly reports will include a scorecard on the measured service including projected incentive amounts. It will also include detailed provider level score cards and member level quality gaps-in-care reports.

5. **Given the contract is established mid-year, how will it be measured?**
   For the quality program the providers will be given credit for any and all services that they have performed for members in this calendar year. Providers will also have an opportunity to improve their scores through the remainder of the year to maximize their bonus.

P4P Resources for Providers

- Get the tools you need to manage your administrative needs and keep your focus on the health of your patients.



- Coding tip sheets are available to assist with clinical documentation of HEDIS measures.

Incentive Programs and Opportunities for Members

My Health Pays

Allwell MyHealthPays

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Welcome to the myhealthpays® Rewards Program!

Getting started is as easy as 1-2-3.

1. **You're already enrolled.**
   As an Allwell member you are automatically enrolled in the My Health Pays® Rewards Program.
2. **Earn money.**
   Complete each preventive screening or healthy task shown on the right.
3. **Get paid.**
   You'll receive a My Health Pays Visa® Prepaid Card with the money you've earned after completing your first eligible activity.

Here's your to-do list. Get started today!

The more healthy activities you complete, the more money you'll earn:

$25	Flu Vaccine
$25	Breast Cancer Screening
$25	Ongoing Diabetes Care
$100	Annual Wellness Visit
$25	Follow-up Visit after Inpatient Hospitalization
$25	Bone Density Test
$25	Colon Cancer Screening
$25	Health Risk Assessment
$25	BONUS Reward for Completing All Eligible Activities

Spend the money you've earned on a variety of products and services* like:

Purchases at Walmart / sam's club

Transportation
like the bus, train, taxi or ride-share

Utilities
like your gas, electric and water bills

Telecommunications
like internet, cell and home phone bills

Education
like expenses for K-12, college and trade schools

To learn more about how the program works, visit:
allwell.arhealthwellness.com/rewards
or call us at 1-855-565-9518 (TTY: 711).

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*This card is limited to qualifying products and services as listed above. Eligible items up to the amount of your balance will be covered. Any remaining balance will remain on your card. You can use it for future purchases. The card may not be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

Ambetter MyHealthPays

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myhealthpays® Rewards Program

- Our MyHealthPays program helps members focus on their total health. When healthy activities (i.e. eating well, moving more, saving smart and living well) are completed, members can earn reward points. All members have to do is log in to their online member account to get started.
- Members can earn 500 points in MyHealthPays rewards after their first checkup.
- For more information and helpful resources, visit ambetter.arhealthwellness.com.

Provider Resources

Tip Sheets, Provider Tools and Contact Information

Tip Sheets Available on the Provider Website

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CPT CATEGORY II CODES

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What are they? CPT Category II Codes are reporting codes that relay important information to the health plan. This information can close quality care gaps related to specific health outcome measures.

Why are they Important? CPT Category II codes should be submitted in conjunction with CPT or other codes used for billing and will decrease the need for record abstraction and chart reviews, minimizing your administrative burden.

How to bill CPT Category II Codes: CPT Category II codes are billed in the procedure code field, just as CPT category I codes are billed. CPT Category II codes describe clinical components usually included in evaluation and management or clinical services and are not associated with any relative value. Therefore, CPT Category II codes are billed with a $0.00 or $0.01 billable charge amount.

How can CPT Category II codes be used to close quality gaps in care on specific HEDIS measures?
CPT Category II codes can relay important information related to health outcome measures such as:

- ACE/ARB Therapy
- Controlling blood pressure
- Comprehensive diabetes care
- Care of Older Adults
- Medication Reconciliation
- Prenatal and Postpartum Care

The following table lists the HEDIS quality measure, indicator description, and the CPT Category II codes recognized in the HEDIS specifications for the current 2020 Provider Quality Reports.

Quality Measure	Indicator Description	CPT Category II codes
Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy	ACE/ARB Therapy	4010F

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Measure	Requirement	Coding Assistance
A1C **Hemoglobin A1C Testing and Control**	**Test Needed:** HbA1C required at least one time in the measurement year and most recent test results must be < 9.0%. **Excludes:** Members with a diagnosis of gestational diabetes or steroid-induced diabetes.	**CPT® Code(s):** 83036, 83037 **CPT® II Code(s):** 3044F, 3045F, 3046F *When coding a Hemoglobin A1C Test, it is required to include the CPT®II Code with*

Cervical Cancer Screening Tips

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Cervical Cancer Screening HEDIS Measure: Women ages 21 to 64 should be screened for cervical cancer using either of the following criteria[1]:

- Women ages 21 to 64 should have cervical cytology performed every 3 years.
- Women ages 30 to 64 should have cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Not Recommended for: Women with evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix. Documentation of complete, total or radical abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. Please ensure proper documentation.

Coding	CPT Codes	HCPCS	ICD-10	Lab Extracts
Cervical Cytology codes (ages 21-64)	88141-88143, 88147, 88148, 88150,	G0123, G0124, G0141, G0143-G0145,	**Abdominal hysterectomy:** 0UT90ZZ, 0UT94ZL, 0UT94ZZ,	Cervical cytology: 10524-7, 18500-9, 19762-4, 19764-0,

Provider Tools Available

- Provider Portal and Availity
  - Member attribution
  - Care Gaps
  - P4P and Incentives
- HEDIS team
  - Resources
  - In-depth gap closure strategy
  - Specialized reporting needs
  - Medical record review and abstraction year-round
- Case Management
- Health plan outreach programs
  - Member engagement
  - Appointment scheduling assistance
  - Specialized screening kits for some conditions such as colorectal cancer
  - Health fairs

Provider Relations

- For further training on any of the provider tools, website, portal, or Availity please contact your provider representative.

- Contact information can be found at:
  - https://www.arhealthwellness.com/providers/provider_relations.html
  - https://www.arkansastotalcare.com/providers/provider_relations.html

- You may also email:
  - providers@arhealthwellness.com
  - providers@arkansastotalcare.com

Quality Improvement HEDIS Team

- Tip Sheets can be found on the provider websites:
  - https://www.arhealthwellness.com/providers/resources/CODING_TIP_SHEETS_AND_FORMS.html
  - https://www.arkansastotalcare.com/providers/resources/CODING_TIP_SHEETS_AND_FORMS.html
- For further information on HEDIS gap closure, resources, special reporting, or any other HEDIS needs please reach out to the HEDIS team.
- Secure Email: QI_AR_HEDIS@CENTENE.COM
- Secure Fax: 800-716-2380

Quality Improvement HEDIS Team

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