Healthy happens together

2021 Value-Based Programs

AetnaBetterHealth.com/NJ

Aetna Better Health® of New Jersey

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Welcome

Dear Aetna Better Health of New Jersey Provider,

At Aetna Better Health of New Jersey, 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.

Among the best in the New Jersey 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, support and access to tools and resources at Aetna to help you in achieving success. 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 New Jersey team members who are available to support you and help you maximize the Programs' incentive opportunities.

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

Sincerely,

Aetna Better Health of New Jersey

About Us

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 Medicaid services, Children's Health Insurance Programs (CHIP) and Managed Long Term Care Services and Support (MLTSS) to NJ FamilyCare members in all 21 counties.

Our 2021 goals:

- Achieving NCQA Accreditation in 2021, demonstrating our ongoing commitment to providing quality care
- Continued focus on improvement in quality
- Continued network improvement
- Alignment with our Primary Care Strategy to provide value-based solutions to our providers
- Optimize supportive partnerships with our network physicians to ensure our members are receiving high-quality health care
- Get every member into a primary care visit at least yearly
- Improve ER and inpatient utilization
- Improve pre-term birth weight rate, neonatal outcomes and postpartum wellness and recovery
- Support providers in improving access to telehealth services

Always Here to Help – Contact Us

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

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

If you have questions or concerns, contact one of our dedicated staff:

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2021 Value-Based Programs

Purpose

At Aetna Better Health of New Jersey, 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 health provider are more likely to seek appropriate care. Our programs seek to enhance this relationship and support our members toward the highest quality healthcare as measured by national benchmarks.

All of our Value-Based Programs are based on quality parameters we collect in our data processes. There are multiple programs that reward providers for meeting or exceeding quality goals. By meeting or exceeding the quality goals, providers are eligible to earn incentive payments, while delivering the highest-quality health care to our members.

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

- Promoting care that results in a healthier population by improving quality and outcomes
- Enriching care delivery consistency and adherence to evidence-based standards of care
- Promoting a continuous quality improvement orientation
- Promoting care coordination between providers and the health plan, resulting in greater alignment of goals for our members' health

We have Value-Based Programs for every kind of primary care setting. Some programs apply to small practices and others to large practices and now feature the ability for providers limited to adults or pediatrics to have access to a full range of incentives. Our 2021 program now rewards OB/GYNs for timeliness of prenatal and postpartum visits.

Aetna Better Health's Value-Based Programs are based only on HEDIS administrative data.

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 2021 consists of over 90 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

HEDIS rates can be calculated in two ways: administrative data or hybrid data

- Administrative data consists of claim or encounter data submitted to the health plan
- Hybrid data consists of both administrative data and a sample of medical record data

About Our Programs

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

Based upon your population of Aetna members, a program is available for you to earn incentives while providing quality care for your patients, our members. **All four of our Programs are all "up-side", which means there is no financial incentive penalty for not achieving your quality metrics ("down-side") as part of the Program. Credit is given for any claim showing provision of a service related to a metric, provided any time in 2021; all credits may be included in the financial payout calculations.**

1. Quality Incentive Program

For all providers with a population of 50 or more Aetna Better Health members

The Quality Incentive Program is an annual program based on quality metrics for providers who do not immediately qualify for our other Value-Based Solutions (VBS) and Programs; the program rewards providers for achieving better performance on a broad spectrum of HEDIS and utilization metrics for the practice's Aetna Better Health member panel.

The program does not require a contract addendum and all providers who meet the 50-member threshold are automatically enrolled.

Certain HEDIS measures have been specifically selected for this program. Performance targets for all measures are based upon the 2020 National Medicaid HEDIS 50th and 75th percentile. As your quality improves, so will your gap closure payments.

- Each metric is calculated and rewarded individually, based on claims data, which has a 90-day lag after submission of a claim. At the end of the performance year (2021), the cumulative annual performance is calculated for each measure and for each eligible provider in a practice.
- Providers are rewarded for each metric-related service for which they meet or exceed the established target. Financial incentive payments are expected to be paid during summer 2022.
- High performers in this program will receive $50 or $100 per gap closure if the reach the 50th percentile or 75th percentile respectively.

Summary

- All providers with at least 50 members are automatically enrolled
- Percentiles are determined based on your based on your year-end performance.
- Providers who fail to meet the 50th or 75th percentile will receive $10 dollars per gap closure.
- Payments will be based on a pay per gap closure
- High performers (50th and 75th percentile) will receive larger gap closure payments
- Providers who fail to meet the minimum threshold will still receive a $10 per gap closure payment
- As your practice's quality improves, so will the size of the payment per gap closure
- Claims data is reviewed for HEDIS measures automatically
- Providers meeting the above criteria will automatically receive their quality payment

2. Patient-Centered Medical Home (PCMH)

A voluntary program for selected providers with 100-999 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.

Providers do not need to be NCQA-certified as a PCMH. A contract addendum is required for participation in the Aetna PCMH program. Requirements may be individualized for each participating practice.

Our PCMH program uses the following payment model:

- Fee-for-service payments for services provided with a per-member-per-month (pmpm) care coordination payment and quality incentives based on clinical outcomes measures.
- Providers are rewarded for each metric-related service for which they meet or exceed the established target. Financial incentive payments are expected to be paid during summer 2022.
- Quality payments are calculated based on a PMPM basis. Payments have been structured to incentive high quality providers.
- Providers who meet the 50th percentile threshold will receive a $0.50 PMPM and providers who achieve the 75th percentile will receive a $0.75 PMPM.
- PCMH agreements are collaborative and outline the expectations of both stakeholders so that all share accountability for outcomes.

The PCMH arrangements are made up of two utilization measures and 3 additional HEDIS quality measures. The provider will have the option to choose from a preselected group of measures specific to the providers practice type (pediatrician, family practice or internal medicine). Descriptions for both the utilization measures and HEDIS quality measures can be found on page 25.

3. Shared Savings/Shared Risk

A voluntary program for selected providers with 1,000 or more Aetna Better Health members.

Our Shared Savings arrangements are built on a fee-for-service architecture and include an opportunity for providers (with 1,000 or more members) to earn incentives based on the costs 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 Medicaid members and who possess the skills and infrastructure necessary to manage the population and financial risk.

The Shared Savings/Shared Risk arrangements are 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 on page 25.

All providers participating in the Shared Savings agreement require a signed contract addendum. Any practice with interest in a Shared Savings/Shared Risk agreement can contact Ashley Bolduc, Director of Market Strategy.

4. OB/GYN Quality Incentive Program (QIP)

Our OB/GYN Quality Incentive Program allows you to earn up to a $1,100 bonus for timeliness of prenatal and postpartum visits.

Measure Name	Measure Description	QIP Provider Payment
Prenatal care visit (first trimester)	Women who delivered a live baby and had prenatal care during first trimester or within 42 days of enrollment.	$200
Prenatal care visits 6+	Women who delivered a live baby and had six or more prenatal care visits before delivery. First trimester visit will count if it occurred.	$600
Postpartum	Postpartum care visit between 7 and 84 days after delivery.	$300
Total		**$1,100**

2021 VBS Program HEDIS Measures

Quality Measures for VBS Programs will include three HEDIS measures plus two Utilization Measures (ED visits/1000 and Inpatient readmissions).

Internal medicine (adults) measures

AAP – Adult Access to Primary Care – The percentage of members 20 years and older who had an ambulatory or preventive care visit.

BCS – Breast Cancer Screening – Percentage of women ages 50-74 years of age screened for breast cancer.

CDC – Comprehensive Diabetes Care HbA1c Control and Retinal Eye Exam – The percentage of members 18-75 years of age with diabetes type 1 and type 2 who had both of the following: HbA1c control and retinal eye exam.

CDC Comprehensive Diabetes Care – HbA1c Control – The percentage of members 18–75 years of age with diabetes (type 1 and type 2) that had evidence of an HbA1c adequate result (<8).

Family medicine measures

AAP – Adult Access to Primary Care – The percentage of members 20 years and older who had an ambulatory or preventive care visit.

CDC – Comprehensive Diabetic Screening – The percentage of members 18–75 years of age with diabetes (type 1 and type 2) that had evidence of an HbA1c adequate result (<8).

IMA – Immunizations in Adolescents – Members who turned 13 years of age in the measurement year and received by age 13: Tdap vaccine, meningococcal conjugate vaccine and HPV.

LSC – Lead Screening for Children – The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

WCV – Child and Adolescent Well-Care Visits – 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. **Minimum of one required annually.**

Pediatric measures

IMA – Immunizations in Adolescents – Members who turned 13 years of age in the measurement year and received by age 13: Tdap vaccine, meningococcal conjugate vaccine and HPV.

CIS – Childhood Immunization Status – The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

LSC – Lead Screening for Children – The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

WCV – Child and Adolescent Well-Care Visits – 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. **Minimum of one required annually.**

WCC BMI – Weight Assessment BMI – The percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a BMI percentile documentation during the measurement year.

Utilization Measures, Targets and Terms for PCMH and Shared Savings Programs

Targets

2020 Measures	HEDIS 2020 National Medicaid 50th Percentile Target
Utilization Measures	
PCR – Plan All Cause Readmissions	12% readmissions/1000 member months
AMB – Emergency Department Utilization	58.14 visits/1000 member months
W30 – Well-Child 30 (Rate 1)	Rate 1: 6 comprehensive well-child visits by 15 months Rate 2: 2 or more comprehensive well-child visits by 30 months

Measure Definitions

Member months = 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.

W30 – Well-Child 30 – Rate 1: Members 0-15 months of age with six comprehensive well-child visits. Rate 2: Members 15-30 months of age with two or more comprehensive well-child visits. Comprehensive visits must include:

- Health history
- Physical development
- Mental development
- Physical exam
- Health education/anticipatory guidance

Providers in a PCMH or Shared Savings Program will be required to select at least three additional HEDIS measures from the pediatric, adult or family practice measures listed on pages 25-34, depending upon their practice population.

For additional details and coding tips, please refer to:
Gaps in Care Technical Specifications and PCP Billing Guide 2020

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

Overview of all VBS Programs

Program and Measures Summary Table

Program Type	Pediatrics	Adults	Family Practice
HEDIS Measures			
Adults' Access to Preventive/Ambulatory Health Services (AAP)		X	X
Breast Cancer Screening (BCS)		X	
CDC – Comprehensive Diabetes Care HbA1c Control and Retinal Eye Exam		X	
Comprehensive Diabetes Care – HbA1c Control (< 8 %) (CDC<8%)		X	X
Child and Adolescent Well-Care Visits (WCV)	X		X
Weight Assessment and Counseling for Nutrition and Physical Activity (BMI only) (WCC-BMI)	X		X
Childhood Immunizations: CIS Combo 10 (CIS)	X		
Lead Screening for Children (LCS)	X		X
Immunizations for Adolescents – Combo 2 (IMA)	X		
Utilization Measures			
Readmissions All Cause (30 d) (PCR)		X	X
ED Utilization Rate (AMB)	X	X	X
Well-Child Visit 30[1] (W30) Rate 1	X		

[1] Utilization metric for pediatric agreements only.

All PCMH and Shared Savings Programs include measures of utilization in their quality metrics. Additional quality metrics eligible for program incentives (or disincentives) are selected from the measures above and agreed upon in the contract addendum for each participating practice.

How to calculate my payment?

The tables and data in this section are for illustrative purposes only.

Quality Incentive Program

- Full participants: 50 or more members

Bonus payouts for full participants will be based on the number of gaps closed in the predetermined measures. Additional dollar incentives will be paid out depending on the measure's year end percentile. For each quality measure where the provider successfully met or exceeded the performance target, the provider will receive either $10 (<50th percentile), $50 (50th percentile) or $100 (75th percentile) per gap closed.

Financial award calculation process

Number of gaps closed in each percentile **x** percentile bonus **=** total performance bonus

Measure	<50th Percentile	50th Percentile	75th Percentile
Number of Gap Closures	5	55	50
Performance Bonus Per Gap Closure	$10	$50	$100
Amount Earned Subtotal	*$50*	*$2,750*	*$5,000*
Total Performance Bonus		$7,800	

NOTE: If two-tiered program, provider receives additional point for successfully achieving second target. Some quality measures are inverse measures, where success is measured by provider performance rate being below performance target. The performance of all individual practitioners is aggregated at the provider tax ID (TIN) level for the purpose of performance analysis and payment. Incentive payment amounts are calculated by the VBS team and will be reviewed with the health plans for approval. Health plans complete a check request to ABH Treasury department. Provider Relations staff will distribute incentive payment checks to providers in the Summer following the end of the performance period.

PCMH model

Calculating the annual payout of a PCMH agreement includes two steps.

1. Calculate annual care coordination fee
2. Calculate quality incentive payout. *For each quality measure where provider successfully met or exceeded the performance target, provider receives an additional .50 or .75 cents PMPM (for total panel not members who fall into the measurement category).*

Sample calculation is based on a panel size of 350 Aetna members with a $5 monthly care coordination fee

1. **Care coordination fee calculation**
   350 members **x** 12 months **=** 4,200 member months (MM) → 4,200 MM **x** $5PMPM =
   $21,000 annual care coordination payout

2. **Quality incentive bonus calculation**
   Calculation based on 350 members or 4,200 MM

Measure	50th Percentile		75th Percentile	
	Performance Met	Potential Payout $0.50 PMPM	Performance Met	Potential Payout $0.75 PMPM
Metric 1	X	$2,100		
Metric 2			X	$3,150
Metric 3				
Metric 4	X	$2,100		
Metric 5				
Subtotal		$4,200		$3,150
Total			**$7,350**	

Example: Provider met measure at the 50th percentile, so payout would be:
350 members **x** 12 months **=** 4,200 member months (MM) → 4,200 MM **x** .50 **=**
$2,100 in additional quality incentive payments

Total annual payout = $28,350
(annual care coordination fee + quality incentive bonus [$21,000 + $7,350])

NOTE: If two-tiered program, provider receives additional point for successfully achieving second target. Some quality measures are inverse measures, where success is measured by provider performance rate being below performance target. The performance of all individual practitioners is aggregated at the provider tax ID (TIN) level for the purpose of performance analysis and payment. Incentive payment amounts are calculated by the VBS team and will be reviewed with the health plans for approval. Health plans complete a check request to ABH Treasury department. Provider Relations staff will distribute incentive payment checks to providers in the summer following the end of the performance period.

Shared Savings model

Calculating the annual payout in a Shared Saving model assumes the following:

- 1,000+ Aetna members
- Target MBR = at or below 85%
- 50 plan/50 provider payout
  - Yields approximately $100,000 payout per 1,000 members assuming all 5 metrics are met at the 75th percentile NCQA benchmark. Each metric earns 20% of payout or $20,000 at the 75th percentile
- Metric payout structured to incentivize improved provider performance – opportunity to earn up 125% of payout
  - Metric payout is weighted in four tiers. Payout range is 5 to 25% of provider's value pool depending on percentile met. See Exhibit I – Tiered Payout Structure on page 18
- Includes a monthly care coordination fee

Calculating the annual payout of a Shared Savings agreement includes two steps.

Sample calculation is based on a panel size of 1,000 Aetna members (12,000 member months) with a $5 monthly care coordination fee and a 50/50 payout.

1. **Calculate care coordination "pmpm" fee**
   1,000 members **x** 12 months **=** 12,000 member months (MM) → 12,000 MM **x** $5PMPM **=** **$60,000 annual care coordination payout** (paid monthly to the provider via EFT)**.**
   As provider panel grows, care coordination fee increases.

2. **Calculate quality incentive payout**
   For each quality measure where provider successfully met the NCQA percentile target, the provider receives a percent of their total value pool. See Exhibit I-Tiered Payout Structure.

Exhibit I – Tiered Payout Structure

	Tier 1	Tier 2	Tier 3	Tier 4
NCQA Percentile Target	**25th%**	**50th%**	**75th%**	**90th%**
Payout Weight = % of Provider Share	**5%**	**15%**	**20%**	**25%**

Sample Results			
	Current		Current
Rev PMPM	$360.00	Total Premium	$4,320,000
Member Months	12,000	Provider Value Pool	$108,000
Adjust MBR	**80.0%**	**Total Provider Value Pool**	**$108,000**

Payout Tier	Tier 1 (5%)	Tier 2 (15%)	Tier 3 (20%)	Tier 4 (25%)	Target Met	% Earned	$ Earned
NCQA Benchmark	25th%	50th%	75th%	90th%			
HEDIS Measure 1			√		Y	20%	$21,600
HEDIS Measure 2		√			Y	15%	$16,200
HEDIS Measure 3				√	Y	25%	$27,000
Utilization Measure 1			√		Y	20%	$21,600
Utilization Measure 2			√		Y	20%	$21,600
					Total	**100%**	**$108,000**

NOTE: Some quality measures are inverse measures, where success is measured by provider performance rate being below performance target. The performance of all individual practitioners is aggregated at the provider tax ID (TIN) level for the purpose of performance analysis and payment. Incentive payment amounts are calculated by the VBS team and will be reviewed with the health plans for approval. Health plans complete a check request to ABH Treasury department. Provider Relations staff will distribute incentive payment checks to providers in the summer following the end of the performance period.

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 New Jersey practitioner).
- For example: Mary Jane's PCP is Dr. Smith. Member obtains an WCV 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 WCV 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 2019 and never had her WCV visit. In November, Jane becomes the patient of Dr. Jones. Dr. Jones is held accountable for Jane's care for all of 2021.
- Any eligible provider who meets the performance target for at least one metric will be eligible for the quality payment commensurate with the percentile achieved.
- Performance for each metric is compared against the target; incentive dollars are awarded based on a provider'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 2022).
- Aetna Better Health of New Jersey will conduct an initial program reconciliation based on the services rendered to each provider's members relevant to the metrics for Aetna Better Health of New Jersey and reviewed with our finance team.
- Reconciliation is completed at the TIN level.
- Upon approval from the Aetna Better Health of New Jersey Finance team, the Aetna VBS team will complete the process to request checks for providers eligible for incentives.

When will I be paid?

- At the end of the calendar year, 90 days is allowed for a claims lag period.
- After the 90-day claims lag period, each measure will be calculated individually.
- If an amount of reward is due, a check will be mailed to your office address on file; in some cases the check will be personally delivered by an Aetna Better Health of New Jersey Manager or above.

Provider incentive payments

- Incentive payments for the 2021 Value-Based Program are generated at the TIN level and distributed to providers in summer 2022.
- Detailed reports will be provided to Aetna Better of Health of New Jersey as supplemental information to the incentive checks.
- Final reconciliation will be completed by summer 2022.

VBS Reports and Performance Monitoring

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

Quality Incentive model: 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 (once available) 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 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 July 2021 and is refreshed monthly thereafter. These reports do not provide aggregate results – data is reported at the measure level, by member.

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 2021 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 (January 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 New Jersey Provider Relations Liaison to request Web Portal access. If you need to identify your Liaison, please call Provider Services at 1-855-232-3596.

Once access is obtained:

Step 1: Log on to the Aetna Medicaid Web Portal **https://medicaid.aetna.com/MWP/selectPlan/showPlans**

Step 2: Enter your Plan Code (provided once access is obtained) and Group Provider ID (The health plan is pre-selected upon login)

Step 3: Select your group by name to display performance data

Additional details on accessing reports and reviewing program data will be provided during our HEDIS seminars for providers to be held in Q1 2021. Additional information will be provided on seminars and dates in January 2021 and posted on our website at **AetnaBetterHealth.com/NJ**.

Gaps in Care Technical Specifications and PCP Billing Guide 2020

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.

The HEDIS 2021 billing guide will be available in early 2021 and Aetna Better Health of New Jersey will communicate any updates or changes to the information in this guide to our providers.

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**	
	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429	
	HCPCS	**UBREV**
Ambulatory Visits	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	
	CPT	**UBREV**
Other Ambulatory Visits	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 2020 and had a mammogram to screen for breast cancer from October 2018 through December 31, 2021.

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, 2021.				
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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CDC Comprehensive Diabetes Care – HbA1c Control

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 – HbA1c Testing		
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.		

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CDC Comprehensive Diabetes Care – HbA1c Control and Retinal Eye Exam

Measure definition:

The percentage of members 18-75 years of age with diabetes type 1 and type 2 who had each of the following:

- **HbA1c control:** The member will fall into one of the following categories, based upon their results:
  HbA1c control <9.0
  HbA1c control <8.
  HbA1c control <7.0
  These categories are dependent upon actual results being received from the lab, or complete coding of results via CPT-II codes by provider.
- **Retinal eye exam:** An eye screening for diabetic retinal disease.
  A retinal or dilated eye exam by an eye care professional in the measurement year (regardless of results) or a retinal or dilated eye exam by an eye care professional in the year prior to the measurement year that was negative for retinopathy.

Order screenings annually or more often as needed and educate member on importance of compliance with testing and medications.

Refer member to optometrist or ophthalmologist for dilated retinal eye exam annually.

Explain to patients why this is important and that it is different than an eye exam for glasses or contacts.

Two event/diagnosis visits with a diabetes diagnosis may be telehealth.

BP readings that are member-reported and/or taken with remote digital monitoring devices are now acceptable.

Billing Reference – CDC – HbA1c Control and Retinal Eye Exam	
HbA1c	CPT Codes: 83036, 83037
CPT II HbA1c Result Codes	HbA1c level less than 7.0: 3044F
	HbA1c level greater than 9.0: 3046F
	HbA1c level greater > or = 7 & < 8: 3051F
	HbA1c level greater > or = 8 & < 9: 3052F
Blood Pressure CPT Codes	Systolic BP: < 130 3074F, 130-139 3075F;
	>/= to 140 3077F
Diastolic BP Codes	80-89 3079F; < 80 3078F; >/= 90 3080F

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

Table continued on next page

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 in Adolescents

Measure definition:

Members who turned 13 years of age in the measurement year and received by age 13:

- Tdap vaccine – one dose between the 10th and 13th birthday
- Meningococcal conjugate vaccine – one dose of meningococcal serogroups A, C, W, Y vaccine between the 11th and 13th birthday
- HPV – either two doses of HPV vaccine between the 9th and 13th birthday with at least 146 days between doses **OR** three doses with different dates of service between the 9th and 13th birthday.

Educate staff to schedule **prior** to 13th birthday. Give call reminders for series vaccines

Meningococcal recombinant (serogroup B) vaccines **do not count**.

Be sure your immunization claims and records are clear about which meningococcal vaccine was given!

Document and submit claims timely with correct code. HPV rates are now reported for both females and males.

Educate families on the importance of these immunizations.

Billing Reference – IMA	
Tdap	CPT Code: 90715
	CVX Code: 115
Meningococcal	CPT Codes: 90734
	CVX Codes: 108, 114, 136, 147, 167
HPV	CPT Codes: 90649, 90650, 90651
	CVX Codes: 62, 118, 137, 165

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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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			

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WCV – Child and Adolescent Well-Care Visits

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. **Minimum of one required annually.**

Never miss an opportunity! Exam requirements can be performed during a sick visit or a well-child exam.

Documentation MUST include ALL of the following:

- 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

Documentation that Does NOT count as compliant::

- **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

See Billing Reference on next page

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

W30 Well-Child Visits in the First 30 Months of Life (Rate 1)

Measure definition:

The percentage of members who turned 30 months old in the measurement year and had the following number of well-child visits with a PCP during their first 15 months of life:

- No well-child visits
- One well-child visit
- Two well-child visits
- Three well-child visits
- Four well-child visits
- Five well-child visits
- Six well-child visits (goal)

The comprehensive well-care visit includes:

- Health history – assessment of history of disease or illness and family health history
- Physical developmental history – assessment of specific age-appropriate physical development milestones
- Mental development history – assessment of specific age-appropriate mental development milestones
- 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 15 months

Billing Reference – W30 (Rate 1)			
Description	**CPT**	**HCPCS**	**ICD-10 CM**
Office Visit	99381-99382, 99391-99392, 99461	G0438, G0439	Z00.11-Z00.129, Z00.5, Z00.8, Z02.0-Z02.9

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