Anthem

Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

2020 Provider Quality Incentive Program — Essentials

All provider meeting

Agenda

- 2020 health plan updates
- 2020 Provider Quality Incentive Program- Essentials (PQIP-E)
- Provider Care Management Solutions (PCMS) overview and demonstration

Telehealth changes in response to COVID-19

The following slides reference IHCP *BT202034*:

- **Telemedicine** — The use of technology which allows a healthcare provider to render an exam or other service to a patient at another location.
- **Telehealth** — The scheduled remote monitoring of clinical data through technologic equipment in the member's home. The IHCP covers telehealth services provided by home health agencies to members who are approved for other home health services.

Telehealth changes in response to COVID-19 (bulletin: 202022, 202034)

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202034 APRIL 2, 2020

IHCP COVID-19 Response: IHCP responds to telemedicine FAQs as of April 1, 2020

The Indiana Health Coverage Programs (IHCP) is providing this frequently asked question (FAQ) bulletin to providers due to the change in telemedicine and telehealth during the current coronavirus disease 2019 (COVID-19) public health emergency. The following definitions have been revised to accommodate this current situation:

- **Telemedicine** – The use of technology which allows a healthcare provider to render an exam or other service to a patient at another location.
- **Telehealth** – The scheduled remote monitoring of clinical data through technologic equipment in the member's home. The IHCP covers telehealth services provided by home health agencies to members who are approved for other home health services.

1. ***Are there any changes regarding prior authorization (PA) requests or timely filing?***
   Some changes related to PA and specific services have been made; see *IHCP Bulletins* BT202030 and BT202031 for additional details. Please continue to check IHCP publications for updated information regarding COVID-19-related policy changes.
2. ***Can telemedicine be provided via audio-only communication?***
   Any IHCP-covered service – aside from the exclusions listed in BT202022 and speech, occupational, and physical therapies – can be provided through audio-only, given that the service can reasonably be provided through audio-only communication. Some services may be better provided through video; however, the IHCP acknowledges some patients may not have access to video communication. Executive Order 2020-13 excludes speech, occupational, and physical therapies from audio-only telemedicine.
3. ***What services cannot be provided via telemedicine?***
   According to BT202022, surgical procedures, radiological services, laboratory services, anesthesia services, audiological services, chiropractor services, care coordination without the member present (unless this service is covered under the member's benefit plan or package), durable medical equipment (DME)/home medical equipment (HME) providers, and provider-to-provider consultation cannot be provided via telemedicine. Procedure codes that include physical interaction in the service definition, for example chiropractic services, which cannot be replicated via video or audio, are not reimbursable via telemedicine. IHCP expects providers to use their professional discretion when determining if a service can be provided via telemedicine.
4. ***Is the GT modifier required for codes not listed on the telemedicine code set?***
   The GT modifier is strongly encouraged, but is not required. If the GT modifier is not used on the claim, the provider must maintain and be prepared to provide documentation that notes that the service was provided via telemedicine. For information about billing for services listed on *Telemedicine Services Codes* (accessible from the Codes Sets page at in.gov/medicaid/providers), refer to the *Telemedicine and Telehealth Services* provider reference module.

Page 1 of 4

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202022 MARCH 19, 2020

IHCP issues telemedicine billing guidance for providers during COVID-19 outbreak

Effective March 1, 2020, and through the duration of the Governor's Declaration of Public Health Emergency for Coronavirus Disease 2019 Outbreak, Indiana Health Coverage Programs (IHCP)-enrolled providers may use the following billing guidance for providing services through telemedicine. This policy applies to both in-state and out-of-state providers and all IHCP-covered services, with some exceptions for services that require physical interaction. This policy includes both Traditional Medicaid (fee-for-service) as well as all managed care benefit programs. All services rendered must be within the provider's applicable licensure and scope of practice.

All services delivered through telemedicine are subject to the same limitations and restrictions as they would be if delivered in-person. Appropriate consent from the member must be obtained by the provider prior to delivering services. Documentation must be maintained by the provider to substantiate the services provided and that consent was obtained. Documentation must indicate that the services were rendered via telemedicine, clearly identify the location of the provider and patient, and be available for postpayment review. The provider and/or patient may be located in their home(s) during the time of these services.

Telemedicine services may be provided using any technology that allows for real-time, interactive consultation between the provider and the patient. This includes, but is not limited to, the use of computers, phones, or television monitors. This policy includes voice-only communication, but does not include the use of non-voice communication such as emails or text messages. This expansion of allowable forms of telecommunication for telemedicine services is due to the federal waiver of certain *Health Insurance Portability and Accountability Act* (HIPAA) requirements in response to the current national emergency and is subject to change based on federal policy and guidance.

During this period, coverage of telemedicine services will not be limited to the codes on the *Telemedicine Services Codes* (accessible from the Codes Sets page at in.gov/medicaid/providers). In addition, the following provider types and services ***may not be reimbursed for telemedicine:*** surgical procedures, radiological services, laboratory services, anesthesia services, audiological services, chiropractor services, care coordination without the member present, durable medical equipment (DME)/home medical equipment (HME) providers, and provider-to-provider consultation.

When billing telemedicine for services *not* listed on *Telemedicine Services Codes*, providers must include both of the following on the claim:

- Valid procedure code(s) for the IHCP covered service
- Modifier GT – *Via interactive audio and video telecommunication systems* (This modifier will be used to indicate that services were furnished through telemedicine communication.)

Page 1 of 2

Services that cannot be provided via telemedicine

Services that cannot be provided via telemedicine (reference IHCP *BT202022*)		
Surgical procedures	Radiological service	Laboratory services
Anesthesia services	Audiological services	Chiropractor services
Care Coordination without the member present (unless this benefit is covered under the member's benefit plan or package)	DME (home medical equipment)	Provider to provider consultation

PQIP-E overview

PQIP-E rewards primary care providers for the quality care they provide to our Medicaid members.

Program objectives

- Support a patient-centered system by investing in primary care and focusing on improving patient health.
- Redesign the current payment model to move from volume-based to value-based payment.
- Improve patients experience by facilitating better PMP access, encourage patient participation in their own health and focus providers' attention on opportunities to lower cost of care while improving quality outcomes.

Program objectives (cont.)

PQIP-E supports these principles by providing:

- Meaningful and actionable information about your patients.
- Population health management and performance management data to assist in improving internal processes and patient outcomes.

Eligibility requirements

All of the following requirements must be met in order for PMPs to be eligible for the program and to potentially earn an incentive payment:

- Execute a PQIP-E letter of agreement prior to the start of the measurement period.
- Have between 250-999 attributed members.
- Be a participating provider for the entire measurement period.
- Remain in good standing at all times during the measurement period.
- Register and use Provider Care Management Solutions (PCMS) during the measurement period.
- Provide a contact name and email address of the practice individual responsible for PCMS registration.
- Maintain an open panel status for at least one practitioner during the program year.

Quality gate

- The quality gate metric for the 2020 measurement period is the provider's average performance for all scored quality measures must exceed the national NCQA 33rd percentile across all quality measures.
- The 2020 quality gate is the average of the NCQA 33rd percentile across all of the quality measures.
- For program year 2020, the Quality Gate rate is 51.48%.

PQIP-E performance indicators

7 Clinical Quality Measures

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Adolescent Well-Care Visits (AWC)
- Lead Screening in Children (LSC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Medication Management for People With Asthma (MMA)

3 Access Measures

- Newly Assigned Member PMP visit
- Annual PMP visit
- Annual Dental Visit

2 Utilization Measures

- Potentially Avoidable ER Visits/1,000
- Inpatient Admissions/1,000

Clinical Quality Measures

Quality measure name	Definition
Adult prevention	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Percentage of eligible Members ages 20 and older who had an ambulatory or preventive care visit during the current MP as documented through administrative data.
Pediatric prevention	
Adolescent Well-Care Visits (AWC)	Percentage of eligible Members ages 12 to 21 who received at least one well-care office visit with a PMP or OB-GYN during the current MP as documented through administrative data.
Lead Screening in Children (LSC)	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.

Access measures

Access measures	
Measure name	**Definition**
Newly Assigned Member PMP Visit	**Percentage of Members newly assigned to the PMP from January 1, 2020 to October 31, 2020 of the Measurement Period who were attributed for at least 60 days of the Measurement Period and who have a PMP visit within 60 days of assignment.** **Minimum Threshold: 20 Members Partial Credit: 50% Compliance Rate Full Credit: 75% Compliance Rate**
Annual PMP Visit	**Percentage of eligible Members with at least one PMP visit within the Measurement Period; eligible Members are those that are attributed to the PMP at the end of the Measurement Period and have been attributed to the PMP for at least six months of the Measurement Period.** **Minimum threshold: N/A Partial Credit: N/A Full Credit: 80% Compliance Rate**
Annual Dental Visit	**Percentage of eligible Members age 2 to 21 with at least one dental visit per year; Eligible Members are those that are attributed to the PMP at the end of the Measurement Period and have been attributed to the PMP for at least six months of the Measurement Period.** **Minimum threshold: 30 Members Partial Credit: N/A Full Credit: 50% Compliance Rate**

Utilization measures (cont.)

Utilization measures	
Measure name	**Definition**
Inpatient Admission/1,000	**Utilization rate per 1,000 Members per year of all general hospital/acute care inpatient admissions, excluding maternity admissions; data is risk adjusted for a Provider's entire panel based on the illness of their population.** **Minimum threshold: N/A**
PAER Visits/1,000	**Utilization rate, per 1,000 members per year, of PAER Visits within the measurement year.** **Minimum threshold: N/A**

Total earned incentive payment

- Within 180 days from the end of the relevant measurement period, Anthem Blue Cross and Blue Shield will determine performance on all program scorecard measures for the measurement period.
- This time frame allows for a claims run out period prior to calculating performance of the scorecard measures.

Quality measures performance scoring

Quality measures	75th low target		90th high target	
AWC	62.77	$0 .08	68.14	$0.15
AAP	84.97	$0.08	87.24	$0.15
W15	69.83	$0.07	73.24	$0.14
W34	78.46	$0.07	83.85	$0.14
LSC	81.02	$0.07	85.90	$0.14
MMA	35.90	$0.07	42.84	$0.14
FUA	16.93	$0.07	22.99	$0.14
Maximum total			$1.00	

Access measures performance scoring

Access Measures	Partial Credit		Full Credit	
Newly Assigned PCP Visit	50% Compliance	$0.25	75% Compliance	$0.50
Annual PCP Visit			80% Compliance	$0.50
Annual Dental			50% Compliance	$0.25
Maximum Total			$1.25	

Utilization measures performance scoring

Utilization measures	Partial credit		Full credit (90th percentile)	
Inpatient admissions	(Highest max) 80.06	$0.13	(Ideal) 64.27	$0.25
PAER visits	(Highest max) 407.00	$0.25	(Ideal) 305.18	$0.50
Maximum total			$0.75	

Scorecard example

Quality Scorecard Measures	Numerator	Denominator	Compliance Rate	Low Target 75th Percentile	High Target 90th Percentile	Partial PMPM	Full PMPM	Earned PMPM
Adults' Access to Preventive/Ambulatory Health Services (AAP)	80	97	82.40%	84.98%	87.24%	$0.08	$0.15	$0.00
Adolescent Well-Care Visits (AWC)	69	101	68.10%	62.77%	68.14%	$0.08	$0.15	$0.08
Lead Screening in Children (LSC)	15	18	83.30%	81.02%	85.90%	$0.07	$0.14	$0.07
Well-Child Visits in the First 15 Months of Life (W15)	38	43	87.30%	69.83%	73.24%	$0.07	$0.14	$0.14
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	85	105	80.95%	78.46%	83.85%	$0.07	$0.14	$0.07
Medication Management for People With Asthma (MMA) 5-11 75%	94	123	76.42%	35.90%	42.84%	$0.07	$0.14	$0.14
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) –7-day	54	126	42.80%	16.93%	22.99%	$0.07	$0.14	$0.14
Total Earned PMPM for Quality Composite								**$0.64**
The actual Low and High Targets will be expressed as a percent based on NCQA percentiles and will be provided prior to the start of the Measurement Period.								

Scorecard example (continued)

Measure	Compliance Rate	Low Target 75th Percentile	High Target 90th Percentile	Partial PMPM	Full PMPM	Earned PMPM
Quality Measures					$1.00	**$0.64**
Potentially Avoidable ER/1,000	407.50	407.00	305.18	$0.25	$0.50	$0.25
Inpatient Admissions/1,000	64.50	80.06	64.27	$0.13	$0.25	$0.25
Annual PMP Visit	83%	----	80%	----	$0.50	$0.50
Newly Assigned Member PMP Visit	77%	50%	75%	$0.25	$0.50	$0.50
Annual Dental Visit	72%	----	50%	----	$0.25	$0.25
Incentive Payment Calculation				Total Earned PMPM		**$2.39**

Provider Member Months	**11,848**
Total Earned PMPM	**$2.39**
Incentive Payment to Provider	**$28,316.72**

PCMS demonstration

Questions?

Quality Management contacts

Manager
Lisa Lant
Lisa.lant@anthem.com
812-746-0140

West Central
Sheila Bell
Sheila.bell@anthem.com
317-690-0790

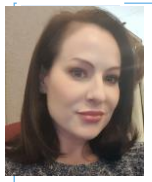
Central
Katie Johnson-Sivado
Katie.johnson@anthem.com
317-519-5677

Northwest
LaMisa Marshall
Lamisa.marshall@anthem.com
219-743-2303

East-East Central
Michele Gwin
Michele.gwin@anthem.com
317-504-0672

Southwest
Angi Darnell
Angela.darnell@anthem.com
317-452-2914

Southeast
JoNell Ohololrogg
Jonell.ohololrogg@anthem.com
317-601-9239



North-Northeast
Diana Hammar
Diana.hammar@anthem.com
317-504-0237]

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

www.anthem.com/inmedicaiddoc

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative

AINPEC-2570-20 April 2020