AETNA BETTER HEALTH® OF PENNSYLVANIA

2018 Provider Pay for Quality (P4Q) Tip Sheet

Aetna Better Health’s P4Q program offers incentives for complete coding, excellent care, and quality metrics!

Collaboration for improved scores and healthier member outcomes!

Provider and health plan partnerships will close care gaps, enrich care delivery, improve data capture, and engage membership. This results in improved quality scores and healthier member outcomes. Please review this sheet on the P4Q program, how you are eligible to participate, and what the potential incentive payment is you could receive.

Program Timeline

✓ The program measurement year is the 2018 calendar year for dates of service January 1 - December 31, 2018.
✓ Maternity measures include care of members with deliveries from November 6, 2017 – November 5, 2018.

Provider Eligibility

✓ Panel requirements vary by measure; please refer to Pay for Performance Measures section of this document for a listing of measures in the program and panel requirements

Incentive Payments

✓ Care must be captured administratively through claims
  o Medical record submission will not count towards P4Q payments.
    ▪ Recommended code classes are CPT or ICD-10
  o Please review coding tips provided in this handout or contact Aetna Better Health’s Quality Management Department for additional approved NCQA Coding Tips at AetnaBetterHealthPAQM@aetna.com
  o Providers may resubmit claims for care in applicable measurement periods not captured administratively. Claims must be resubmitted as a correct claim type.
✓ Incentive payments are attributed to eligible practice TINs in one of two ways:
  o Achieving the required NCQA benchmarks or thresholds for a specific HEDIS® (Healthcare Effectiveness Data and Information Set) measure OR
  o Based on each member that receives the required service for measures where there is no minimum benchmark or threshold
    ▪ Please refer to Pay for Performance Measures section of this document for a listing of measures in the program and specific incentive payment information
✓ There is a large list of approved NCQA codes used to identify the services or conditions included in the measures in the P4Q program. Just a few of the approved codes are included in this document. For a full list please go to the National Committee for Quality Assurance’s website- www.NCQA.org.
2018 Pay for Performance Measures

Measures with Annual Incentive Payment

Incentive payment to occur June 2019 following completion of calendar year 2018

Comprehensive Diabetes Care: HbA1c Poor Control >/=9% (CDC >9%) - Primary Care Providers

Minimum panel requirement- 50 members

- Population: Members age 18-75 years with type 1 or type 2 diabetes whose most recent HbA1c in 2018 is <9% as shown through claims data or by services that Quest Labs and LabCorp obtain (Aetna Better Health’s lab vendors).
- The Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>/=9%) measure is an inverse HEDIS measure, therefore you would want your reports to reflect members not adherent for this measure.
- Incentive: $50.00 once per member whose last HbA1c in calendar year 2018 is <9%

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<thead>
<tr>
<th>Measure</th>
<th>Code Description</th>
<th>Codes</th>
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<tbody>
<tr>
<td>CDC &gt;9%</td>
<td>HbA1c Test</td>
<td>83036, 83037</td>
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<tr>
<td>CDC &gt;9%</td>
<td>HbA1c Levels</td>
<td>3044F, 3045F, 3046F</td>
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Controlling High Blood Pressure (CBP) - Primary Care Providers

- Minimum panel requirement- 50 members
- Population: Members from age 18 and older who have a diagnosis of hypertension
- Members age 18-59 must have a last recorded (representative) BP of <140/90 in 2018
- Members age 60 and older without a diagnosis of diabetes must have a last recorded (representative) BP of <150/90 in 2018
- Members age 60 and older with a diagnosis of diabetes must have a last recorded (representative) BP of <140/90 in 2018
- Diagnosis of hypertension must be documented on or prior to 6/30/18
- Representative BP - taken on a separate visit after a diagnosis of hypertension is documented
- If multiple BP’s are taken on the same visit- we will use the lowest systolic and lowest diastolic reading
- No BP measured in 2018 - member is considered not controlled
- Data Capture- CPT II codes indicating controlled representative BP reading. Associated diagnosis of hypertension must also be captured. (2 visits)
- Incentive: $25.00 once per member whose last recorded BP reading of 2018 is:
  - <140/90 for members ages 18-59 years
  - <150/90 for members ages 60 years and older without a diagnosis of diabetes
  - <140/90 for members ages 60 years and older with a diagnosis of diabetes

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<tr>
<td>CBP</td>
<td>Essential (primary) Hypertension</td>
<td>I10</td>
</tr>
<tr>
<td>CBP</td>
<td>Systolic Reading</td>
<td>3074F, 3075F, 3077F</td>
</tr>
<tr>
<td>CBP</td>
<td>Diastolic Reading</td>
<td>3078F, 3079F, 3080F</td>
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Medication Management for People with Asthma 75% (MMA) - Primary Care Providers

- Minimum panel requirement- 50 members
- Population: Members ages 5–85 years of age who were identified as having persistent asthma
- These members were dispensed appropriate medications that they remained on during 75% of the treatment period as shown through pharmacy claims
- Incentive: $20.00 once per member diagnosed with persistent asthma who remains on appropriate medications during 75% of the treatment period
Emergency Room Utilization (EDU) - Primary Care Providers
- Minimum panel requirement - 200 members
- Population: All members who utilize the Emergency Room for ambulatory care services that did not result in an inpatient admission
- Thresholds for payment: 62.67 visits/1000 member months to realize payment; additional payment will be awarded to providers who achieve a threshold of 52.27 visits/1000 member months
  - Measure is inverse – lower number of ED visits is desirable
- Incentive: $1500 per TIN for reaching 62.67 visits/1000 member months; $2500 per TIN for reaching or exceeding 52.27 visits/1000 member months

Reducing Potentially Preventable Readmissions (RPR) - Primary Care Providers
- Providers must have a minimum of 25 admissions
- Thresholds for payment: minimum 30 day readmission rate of 8.0%; additional payment will be rewarded to providers with a 30 day readmission rate of 7.0% or less
  - Measure is inverse – lower number of readmissions are desirable
- Providers will receive $1500 per TIN for a 30 day all cause readmission rate of 8.0%; $2500 per TIN for a 30 day all cause readmission rate of 7.0% or better

Measures with Quarterly Incentive Payment in 2018

Adolescent Well Care Visits (AWC) - Primary Care Providers
- Minimum panel requirement - 50 members
- Population: Members age 12-21 who receive one well-visit between 1/1/18-12/31/18
- Incentive: $25.00 once per member ages 12-21 years that receives at least one well visit during calendar year 2018

Well Child in the First 15 Months of Life, 6 or More Visits (W15) - Primary Care Providers
- Minimum panel requirement - 50 members
- Population: members who turn 15 months old during 2018 who have had 6 or more well visits with a PCP during their first 15 months of life
- Incentive: $50.00 once for each member who has at least six well visits with their PCP during their first 15 months of life

Well Child in 3, 4, 5, 6 Years of Life (W34) - Primary Care Providers
- Minimum panel requirement - 50 members
- Population: Members 3, 4, 5 or 6 years of age during 2018 and who have had one or more well-child visits with a PCP during 2018
- Incentive: $25.00 once for each member ages 3, 4, 5 or 6 years who has at least one well visit during calendar year 2018

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<tr>
<td>AWC, W34, W15</td>
<td>Well Care Visit</td>
<td>99381-99385,99391-99395, 99461</td>
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Annual Dental Visit (ADV) - Primary Care Providers
- No minimum panel requirement
- Population: member ages 0 – 5 years who receive one appropriate application of fluoride varnish between 1/1/18-12/31/18
- Incentive: $10.00 once per member ages 0 – 5 years for an appropriate application of fluoride varnish during calendar year 2018.
  - Care is captured in claims via CPT code 99188 and ICD-10 diagnosis code Z41.8 and for referral of member to a dentist evidenced by YD modifier submitted with code for fluoride application.
Maternity Measures- Family Practice PCP or OB/Gyn

- 3 HEDIS Measures: Frequency of ongoing prenatal care (FPC); prenatal care in the first trimester (PPC-Timeliness); postpartum care (PPC-Post-partum Care)
- No minimum panel requirement
- Population: Members who deliver between 11/6/17 -11/5/18
  - HEDIS Measure Incentive: $100.00 per measure ONCE for each member that meets the following requirements:
    * Completes 81% of the recommended prenatal visits
    * Completes a prenatal visit during the first trimester or within 42 days of enrollment into the plan
  - HEDIS Measure Incentive: $150.00 per member who has one postpartum visit 21-56 days post delivery
  - Total potential incentive payment- $350.00 per member

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<tr>
<td>FPC</td>
<td>Standalone Prenatal Visit</td>
<td>99500, 0500F, 0501F, 0502F</td>
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<tr>
<td>PPC - Timeliness</td>
<td>Standalone Prenatal Visit</td>
<td>99500, 0500F, 0501F, 0502F</td>
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<tr>
<td>PPC- Post-Partum Care</td>
<td>Post-Partum Visit</td>
<td>Z01.411, Z01.419, Z01.42, Z30.430, Z39.1- Z39.2</td>
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Incentive to occur 30 days following data submission

Electronic Submission of Data- PCPs in the Philadelphia, southeastern region of Pennsylvania

- No minimum panel requirement
- Providers must actively participate in the exchange of member specific data with HealthShare Exchange of Southeastern Pennsylvania (HSX)
- Payment for participation comes out of a shared pool of $30,000 once upon confirmation that connection has been achieved and data exchange has occurred.
- Eligible submissions: mandatory measures, optional measures, the Obstetrical Needs Assessment Form (ONAF), or any Clinical Quality Measure (CQM) approved by the current CMS meaningful use electronic health record program rules.