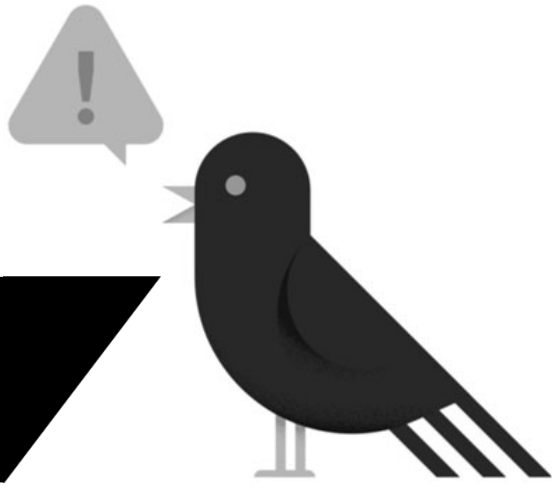
United Healthcare Community Plan



Fax Alert
2023 Pay for Performance

2023 Pay for Performance
Primary Care Provider Incentive Program

We've updated our 2023 Primary Care Provider Incentive Program effective January 1, 2023. The program was designed with the goal of helping your patients, who are UnitedHealthcare Community Plan members, become more engaged with their preventive health care.

What's new for 2023?
For 2023, monthly PCMH practice payments will be made to providers who have current Patient Centered Medical Home status. As with the 2022 program, there is no annual maximum limit for these PCMH practice payments. However, for 2023, **we have increased the per member per month payment to $3.00 from $1.25 and have reduced the assigned member threshold from 50 to 25 members**.

For 2023, we have also **added new measures to the quality incentive program and have significantly increased incentive payments for existing measures**. In addition, we have **changed the timing of quality incentive payments from an annual to a quarterly basis** with the first payments for 2023 qualifying services to be made in April 2023.

For 2023, we have also **expanded the list of incentive eligible care management and care coordination codes**. As a reminder, $50 incentives are paid for these codes based on submission of required CPT codes on claims.

Primary Care Provider Incentive Program: What You Need to Know

We're excited to offer you the opportunity to participate in our Primary Care Provider Incentive Program. The program provides you with:

- An opportunity to earn monthly PCMH practice payments
- Multiple incentive opportunities for addressing care opportunities tied to HEDIS® and state quality measures
- Incremental payment for the provision of care management and care coordination services
- Fee-for-service payments for all covered services

Earning Your Incentive – PCMH Practice Payments

Monthly payments of $3 per member per month are available to primary care providers with current Patient Centered Medical Home accreditation/certification status who meet the following criteria:

	Tier 1	Tier 2
Panel Status	Open	Closed
Membership Threshold	25+ members	500+ members
PCMH	Yes	Yes
Monthly PMPM	$3.00 pmpm	$3.00 pmpm

The following PCMH designations will be accepted:

- National Committee for Quality Assurance (NCQA®)
- Blue Cross Blue Shield of Michigan Primary Group Incentive Program (PGIP)
- Utilization Review Accreditation Commission (URAC®)
- Accreditation Association for Ambulatory Health Care (AAAHC) Medical Home
- The Joint Commission® Primary Medical Home
- Commission on Accreditation of Rehabilitation Facilities – Health Home (CARF)
- Other MDHHS approved certifications

*Please Note: A copy of the practice's PCMH certification from the accrediting body must be submitted to UnitedHealthcare Community Plan fax **844-304-2840** to receive PCMH practice payments. PCMH status for PCMH practice payments is updated in January and July each year. Payments exclude CSHCS and Medicaid Secondary members.*

Earning Your Incentive – Quality Bonus

For this part of your incentive, you can earn a bonus for addressing each of the care opportunities tied to the quality measures in the following table. The table shows the measure name, the applicable age range, the required codes for claims and the amount you will receive for successful completion.

2023 Quality Incentives

United Healthcare Community Plan

Individual Immunization Series Completion Before 2nd Birthday:

DTaP	**$40**	***CPT Codes:*** *90697-90698; 90700; 90723*
IPV	**$30**	***CPT Codes:*** *90697-90698; 90713, 90723*
MMR	**$10**	***CPT Codes:*** *90707; 90710*
HiB	**$30**	***CPT Codes:*** *90644; 90647-90648; 90697-90698; 90748*
Hepatitis B	**$30**	***CPT Codes:*** *90697; 90723, 90740; 90744; 90747-90748*
VZV	**$10**	***CPT Codes:*** *90710; 90716*
PCV	**$40**	***CPT Code:*** *90670*
Hepatitis A	**$10**	***CPT Code:*** *90633*
Rotavirus	**$30**	***CPT Codes:*** *90680-90681*
Influenza	**$20**	***CPT Codes:*** *90655; 90657; 90661; 90673; 90685-90689*

Criteria: *Series of immunizations include: 4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hepatitis B, 1 VZV, 4 PCV, 1 Hepatitis A, 2 or 3 RV (2 or 3 dose schedule), 2 Influenza*

Lead Screening:

Lead Screening: **$40** ***CPT Code:*** *83655*

Criteria: *Member must have at least one capillary or venous lead screening on or before 2nd birthday.*

Appropriate Testing for Pharyngitis: $10

Diagnosis Codes: *J02.0; J02.8; J02.9; J03.00-01; J03.80-81; J03.90-91*

Group A Strep Tests CPT Codes: *87070-87071; 87081; 87430; 87650-87652; 87880*

Antibiotics: Amoxicillin; Amoxicillin-clavulanate; Ampicillin; Azithromycin; Cefaclor; Cefadroxil; Cefazolin; Cefdinir; Cefditoren; Cefixime; Cefpodoxime; Cefprozil; Ceftibuten; Ceftriaxone; Cefuroxime; Cephalexin; Ciprofloxacin; Clarithromycin; Clindamycin; Dicloxacillin; Doxycycline; Erythromycin; Erythromycin ethylsuccinate; Erythromycin lactobionate; Erythromycin stearate; Levofloxacin; Minocycline; Moxifloxacin; Ofloxacin; Penicillin G benzathine; Penicillin G potassium; Penicillin G sodium; Penicillin V potassium; Sulfamethoxazole-trimethoprim; Tetracycline; Trimethoprim

Criteria: *Members between the ages of 3-65+ who are diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.*

Antipsychotic Medication Adherence for Individuals with Schizophrenia:

Antipsychotic Medication Adherence: **$15**

Criteria: *Members 18 years and older who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.*

Asthma Medication Ratio:

Asthma Medication Ratio: **$25**

Criteria: *Members between the ages of 5-64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications.*

Women's Measures:

Cervical Cancer Screening: $40 ***CPT Codes:*** *88141-88143; 88147-88148; 88150; 88152-88153; 88164-88167; 88174-88175; 87624-87625; G0123-G0124; G0141; G0143-G0145; G0147-G0148; G0476; P3000; P3001; Q0091*

Criteria: *Women between the ages of 21-64 who are screened for cervical cancer.*

Breast Cancer Screening: $40 ***CPT Codes:*** *77061-77063; 77065-77067*

Criteria: *Women between the ages of 50-74 who had a mammogram to screen for breast cancer.*

Chlamydia Screening: $40 ***CPT Codes:*** *87110; 87270; 87320; 87490-87492; 87810*

Criteria: *Women between the ages of 16-24 who had a chlamydia screening (urine or culture).*

Prenatal Care*: $100 ***CPT Codes:*** Multiple qualifying CPT codes as defined by HEDIS specs

Postpartum Care*: $75 ***CPT Codes:*** Multiple qualifying CPT codes as defined by HEDIS specs

**The prenatal and postpartum care measure is the one exception to the one payment per quality measurement period per plan member requirement.*

Diabetic Measures: *Members must have at least 2 face-to-face (i.e. E&M) claims in a 2 year period with a diagnosis of Diabetes*

HbA1c Control (<8.0%): $30 ***CPT Category II:*** *3044F; 3051F*

Criteria: *Members between the ages of 18-75 whose most recent HbA1c level is <8.0%*

Completion of Diabetic Eye Exam: $50 ***CPT Category II:*** *2022F-2026F; 2033F*

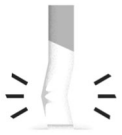
Services Include: *A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year* ***or*** *a retinal or dilated eye exam which is negative for retinopathy by an eye care professional within the past 2 years; Bilateral eye enucleation any time during the member's history through December 31.*

Criteria: *Members between the ages of 18-75 who have been screened or being monitored for diabetic retinal disease.*

Kidney Evaluation for Diabetes: $50 ***CPT Codes:*** *80047; 80048; 80050; 80053; 80069; 82565; 82570; 82043-82044; 84156*

Criteria: *Members between the ages of 18-85 who must have both the serum eGFR (estimated glomerular filtration rate) and a urine ACR (albumin creatinine ratio) lab tests.*

Tobacco Cessation Counseling:



Tobacco Cessation Counseling: $15 ***CPT Codes:*** *99406; 99407*

Criteria: *Members age 14 and over in which had a smoking and tobacco use cessation visit.*

Healthy Michigan Health Risk Assessment:

Completion of Healthy Michigan Health Risk Assessment:

$25 received via **FAX** $50 entered into **CHAMPS**

Criteria: *One per member per measurement year.* ***Members must maintain or select a healthy behavior.***

Well Child Visits:

Well-Child Visits in the First 30 Months of Life: $75 ***CPT Codes:*** *99381-99382; 99391-99392*

Diagnosis Codes: *Z00.110; Z00.111; Z00.121; Z00.129*

Criteria: *Children who turned 15 months old must have six or more well-child visits. Children who turned 30 months old must have two or more well-child visits.*

Child and Adolescent Well-Care visits (3 to 11 years): $50 ***CPT Codes:*** 99382-99383; 99392-99393

Diagnosis Codes: *Z00.121; Z00.129*

Criteria: *Members between the ages of 3-11 who had at least one comprehensive well-care visit with their PCP*

Child and Adolescent Well-Care visits (12 to 17 years): $50 ***CPT Codes:*** *99384; 99394*

Diagnosis Codes: *Z00.121; Z00.129*

Criteria: *Criteria: Members between the ages of 12-17 who had at least one comprehensive well-care visit with their PCP*

Child and Adolescent Well-Care visits (18 to 21 years): $75 ***CPT Codes:*** *99385; 99395*
Diagnosis Codes: *Z00.121; Z00.129*

Criteria: *Criteria: Members between the ages of 18-21 who had at least one comprehensive well-care visit with their PCP*

UHC will pay for a well visit two times per year for members over two years old along with one extra for female members when billed by an OB/GYN. UHC will pay up to nine well visits for children until age 24 months. Well visits and sick visits can be billed on the same claim.

Adult Well Visits:

Adult Access to Preventative/Ambulatory Services (20 to 44 years): $50

CPT Codes: *99385-99386; 99395-99396*

Care Management Incentives:

$50 for each of these CM/CC codes that does not have a state assigned Medicaid rate.

G9001 Comprehensive Assessment

G9002 In-Person Care Management/Care Coordination Encounter

G9007 Care Team Conferences

G9008 Provider Oversight

98966 Telephone Care Management/Care Coordination Services

98967 Telephone Care Management/Care Coordination Services

98968 Telephone Care Management/Care Coordination Services

98961 Education/Training for Patient Self-Management

98962 Education/Training for Patient Self-Management

99495 Transitional Care Management Services

99496 Transitional Care Management Services

99497 Advance Care Planning

99498 Advance Care Planning

G0511 Chronic Care Management for FQHCs

G0512 Psychiatric Collaborative Care for FQHCs

S0257 End of Life Counseling

All incentives are paid once per HEDIS quality measure period unless indicated above. To qualify for a Quality Incentive payment, the service must be delivered in strict accordance to HEDIS® guidelines. Timeframes and enrollment criteria for each measure must be met. / All Quality Incentive earning potential is dependent on the timely receipt of claims billed with the appropriate codes.

To qualify for a Quality Incentive payment, the service must be delivered in strict accordance to HEDIS® guidelines. Timeframes and enrollment criteria for each measure must be met. All Quality Incentive earning potential is dependent on the timely receipt of claims billed with the appropriate codes.

- UnitedHealthcare Community Plan will pay for a well visit in conjunction with a sick visit one time per year for members ages 2 and older when billed on the same claim. For children ages 24 months and younger, UnitedHealthcare Community Plan will pay up to nine sick and well visits when billed on the same claim.
- Immunizations should be administered based on Centers for Disease Control and Prevention (CDC) guidelines.
- Only covered services as defined by this agreement are eligible for reimbursement at 100% of prevailing Michigan Medicaid rates, regardless of the codes submitted.
- Procedure codes are derived from MDHHS Practitioner database: OPPS codes may not be listed.

Earning Your Incentive – Incremental Care Coordination and Care Management Payments

As a reminder, we still require practices to submit care management and care coordination codes on claims to document provision of these services. Codes on the Michigan Medicaid fee schedule will be reimbursed the fee schedule rate as part of normal claims processing. For codes not on the Michigan Medicaid fee schedule, we will reimburse you $50 for each code submitted with payment made on a quarterly basis at the same time as quality incentives.

The care management and care coordination codes required for submission are:

- G9001 Comprehensive Assessment (one paid per year)
- G9002 In-Person Care Management/Care Coordination Encounter
- G9007 Care Team Conferences
- G9008 Provider Oversight
- 98966 Telephone Care Management/Care Coordination Services
- 98967 Telephone Care Management/Care Coordination Services
- 98968 Telephone Care Management/Care Coordination Services
- 98961 Education/Training for Patient Self-Management
- 98962 Education/Training for Patient Self-Management
- 99495 Transitional Care Management Services
- 99496 Transitional Care Management Services
- 99497 Advance Care Planning
- 99498 Advance Care Planning
- G0511 Chronic Care Management for FQHCs
- G0512 Psychiatric Collaborative Care for FQHCs
- S0257 End of Life Counseling

We're Here to Help

If you have any questions, please contact your Provider Advocate or Provider Services at **800-903-5253.**

Thank you!