AmeriHealth Caritas
District of Columbia

PROVIDER ADVISORY REPORT

FEBRUARY 16, 2023
5:30PM - 7:00PM
VIRTUAL - ZOOM

www.amerihealthcaritasdc.com

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EXECUTIVE SUMMARY

AmeriHealth Caritas DC designed and developed the Provider Advisory Committee (PAC) to support local providers and increase access to care for those they serve. The PAC is an opportunity for DC area providers to collaborate and engage with AmeriHealth Caritas DC leadership. Through this collaboration we want our providers to work together to find new and better ways for enrollees to be healthier, and improve and reduce the cost of care.

The mission of the AmeriHealth Caritas DC (AmeriHealth) Provider Advisory Committee is to create a partnership with provider organizations and community-based organizations who share the same goals and values. Our main focus is helping DC residents obtain access to care, staying well, and building healthy communities. The committee provides critical input on innovative and collaborative strategies focusing on effective integration of care coordination and care management programs, and other programs to achieve desired outcomes. We find it vital to our mission to work with our providers and community-based organizations to proactively improve the health status of those we serve. Increased emphasis on medical outcomes, preventive care, and other social determinants of health will reward all stakeholders.

The February 16, 2023, PAC session focused on **current initiatives and program updates**. The session served as an informative platform and was effective in providing the participants with information and tools that will, if applied, be beneficial in serving our enrollees. During the meeting participants were given the opportunity to ask questions and receive direct responses from leadership.

Summary of Presentations:

- **LabCorp Overview:** At Home Test Kits, LabCorp Insight Analytics, ICD-10 Coding Analytics, and LabCorp Diagnostic Assistant.
- **PCP Condition Optimization Program (COP):** Incentive programs - Retrospective Outreach Program and Prospective Outreach Program.
- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):** EPSDT Trends, Outreach Efforts, and Medical Record Retrieval.
- **Enrollee Wellness and Opportunity Center**: News of Re-opening Center.
- **Maternal Health Initiative:** Incentive Program, Dental Utilization Rate, and Training Opportunities.

OVERVIEW

AmeriHealth Caritas DC held its Provider Advisory Committee meeting on **Thursday, February 16, 2023**, to a virtual audience of **43** Providers and administrative staff. This event took place from **5:30 pm to 7:00 pm Eastern Standard Time (EST) virtually on Zoom**. This meeting was recorded, and all participants were notified before the start of the discussion. The Provider Advisory Committee meeting was facilitated by Tamu Tucker of MMI Consulting Group, LLC. After the meeting concluded the participants were provided the meeting minutes, slides, resource fliers, and a post-event survey with nine (9) fillable and multiple-choice questions centered on understanding their experience and ways to enhance future engagements.

SPEAKERS

- **Bobbie Monagan** - Director, Provider Network Management, AmeriHealth Caritas DC
- **Lisa Hughes** - Payor Solutions Executive - DC/VA, LabCorp
- **Marshay Price** - Regional Manager of Business Development, LabCorp
- **Emily Quick** - Risk Adjustment Data Analyst III, Corporate Risk Adjustment Programs, AmeriHealth
- **Amena Hamilton** - EPSDT Program Manager, AmeriHealth Caritas DC
- **Darla Bishop** - Manager of Marketing, Communications and Health Programs, AmeriHealth Caritas DC
- **Nathan Fletcher, D.D.S** - Dental Director, AmeriHealth Caritas DC

AGENDA

- Welcome and Agenda by Tamu Tucker
- Opening Remarks by Bobbie Monagan
- LabCorp Overview by Lisa Hughes and Marshay Price
- PCP Condition Optimization Program (COP) Enrollee Initiatives by Emily Quick
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) by Amena Hamilton
- Enrollee Wellness and Opportunity by Darla Bishop
- Maternal Health Initiative by Dr. Nathan Fletcher
- Open Discussion and Survey by Bobbie Monagan and Tamu Tucker

OVERVIEW *...continued*

HIGHLIGHTS

- Tamu Tucker opened the meeting with instructions and a review of the agenda. Opening remarks were made by Bobbie Monagan (Director of Provider Network Management).
- Lisa Hughes and Marshay Price went over their services, available home testing kits, and the availability of analytics to Providers.
- Emily Quick reviewed two (2) incentive programs and did a walk-through of NaviNet regarding those incentives.
- Amena Hamilton showed EPSDT trends, discussed current outreach efforts to enrollees, and the push regarding medical record retrieval.
- Darla Bishop discussed the re-opening of the Enrollee Wellness and Opportunity Center and its offerings to the community.
- Dr. Nathan Fletcher explained the need for pregnant women to receive optimal dental care before, during, and after their pregnancy.
- During the Open Discussion and Survey section participants were informed by Bobbie Monagan of the Provider Action Committee Meeting and its purpose. Participants were then given three (3) survey questions to answer.
- Questions and Answers were handled throughout the meeting. These can be found within the meeting minutes in the addendum.
- Bobbie Monagan closed out the session with closing remarks and thanks to those that attended.

SURVEY SUMMARY

A live survey was conducted during the Open Discussion so that leadership at AmeriHealth Caritas DC could in real time obtain usable data to ensure the PAC meetings are held at the most advantageous time of day, seek out topics that Providers deem as valuable to their practice, and to extend an invitation to participate as a panel member for the Provider Action Committee.

Based on the impromptu survey results, AmeriHealth Caritas DC has agreed to hold the PAC meetings from **5:30 PM to 7:00 PM**. A variety of topics were also provided for future discussions, and **three (3) participants** volunteered to be active committee members, with **six (6)** wanting more information. Specific details of this survey can be found in the addendum.

PARTICIPANTS

AmeriHealth Caritas DC attracted a diverse participant group from across the District of Columbia Metropolitan Area. The attendees were made up of one (1) dentist, one (1) general practice, one (1) addiction treatment care center, one (1) acute care center, eight (8) counseling/psychiatric centers, three (3) oncology centers, two (2) general hospitals, one (1) medical supplier, one (1) technical training entity, and three (3) public assistance centers.

Attendee	Organization
Tatyana Abramov	US Oncology
Kyle Black	US Oncology
Dr. Patrick Canavan	Prestige Healthcare Resources
Michelle Cook	Prestige Healthcare Resources
Yndia Cooper	SOME - So Others Might Eat
Lily Cowan	Unknown
Theressa Davis	Howard University Hospital
Sheandinita Dyson	McClendon Center
Dr. Kashif Firozvi	Maryland Oncology Hematology
Jason Ginevan	SOME - So Others Might Eat
Bernie Hughes	Unknown
Keyan Javadi	Integrated Care DC
Karen Jefferson	Unknown
Eunice Joseph	Unknown
Pamela Khumbah	Doors of Hope
Ebony Lea	A Fresh Start Therapy
Britt Mobley	Prestige Healthcare Resources
Beverly Morgan	Bridgepoint Healthcare
Gail Nunlee-Bland	Howard University Hospital
Dr. Lavdena Orr	Total Medical Care
Karen Ostlie	Anchor Mental Health Association
Andre Pelegrini	Pathways to Housing DC
Michael Pickering	RAP Residential SUD - Gaudenzia
Angel Thompson	An Angels Touch
Nkereuwem Udo	Holistic Medical Supplies
Tanya Wilson	Captial Dental of VA

CONCLUSIONS

The February 2023 Provider Advisory Committee meeting outlined many initiatives and programs that are in place to help ensure enrollees are receiving optimal care. Speakers delivered detailed information on resources that are available. For more information, please see the presentation slides and meeting minutes within the addendum.

- Free of charge, Providers have access to LabCorp laboratory data where they can run reports to help support their quality metrics.
- The Retrospective Outreach Program is an incentive Providers receive by reviewing their patient's record. Whether a Provider agrees or disagrees with the diagnosis being reviewed is not relevant, the incentive is simply paid once the task is complete.
- The Prospect Outreach Program is an incentive to reach out and complete a PCP visit with patients that have a documented chronic and or complex medical need.
- Maternal Health Initiative is an incentive program to educate and ensure pregnant women receive the dental care they need.
- This year AmeriHealth Caritas DC is working on updating enrollee medical records to ensure the records match Provider records in terms of visits completed, visits needed, who may have third party insurance, etc.
- Enrollee Wellness and Opportunity Center has its grand opening April 1, 2023, from 1:00pm to 4:00pm.

Reminder!

Providers are encouraged to reach out to their Account Executives to discuss the incentives they could be owed.

More Questions? Contact us!

Speaker Contact Information

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ADDENDUM

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AmeriHealth Caritas
District of Columbia

PROVIDER ADVISORY PRESENTATION SLIDES

AmeriHealth Caritas

CARE IS THE HEART OF OUR WORK℠

Provider Advisory Committee Meeting

February 16, 2023

Our Agenda

Opening Remarks

*

LabCorp Overview

*

PCP Condition Optimization Program

*

Early and Periodic Screening, Diagnostic, and Treatment

*

Communications and Health Program Information

*

Maternal Dental Program

*

Open Discussion

Provider Advisory Committee | Opening Remarks

Bobbie J. Monagan
Director of Provider Network Management

Responsibilities include:

- Value Based Contracting
- Create new and support existing company initiatives
- Collaborate with internal and external stakeholders to ensure enrollees have access to the best quality of care via a robust provider network!

Contact Information
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LabCorp Overview

Lisa Hughes
Payor Solutions Executive - DC/VA, LabCorp

AmeriHealth Caritas DC Provider Advisory Committee Meeting

February 16, 2023

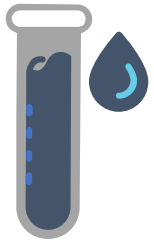
Lisa Hughes- Payer Solutions Executive
Marshay Price- Regional Manager Business Development

labcorp

Agenda

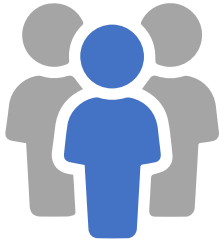
- Labcorp overview
- Enhancing the Patient Experience
- At-Home Test Collection
- Data and Analytics

Labcorp: Science, Technology, Innovation



~3 million

Patient specimens processed per week



400,000+

Practicing physicians using Labcorp for patient testing

700+

Ph.D. and M.D.

~5,000

Tests - including esoteric

36

Branch labs

~1,600

Contracts with health plans and payers

11

Scientific centers of excellence

~2,000

Patient service centers

~6,000

In-office phlebotomists

Labcorp- A Broad Network of Labs

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Specialty Medicine and Testing

Labcorp, through scientific innovation and strategic acquisitions, has built an industry-leading network of laboratories to meet the demands of physicians, patients and health plans.

- Oncology
- Genetics
- Pharmacogenomics
- Pathology expertise
- Women's health
- Paternity and family DNA
- Esoteric coagulation
- Cardiovascular disease
- Kidney disease
- Endocrine disorders
- Liver disease
- Specialty toxicology
- Medical drug monitoring
- Pediatric rare disease
- Infectious disease
- Donor testing

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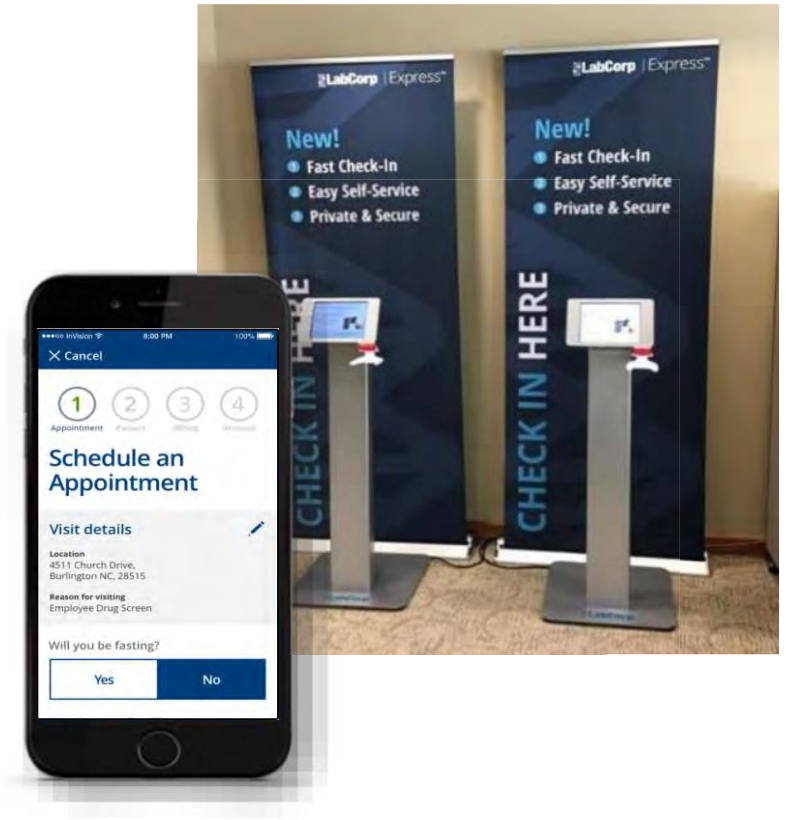
Enhancing the Patient Experience

- **Labcorp has 8 conveniently located Patient Service Centers (PSC's) throughout the District.**

- **Mobile Check-In** feature for patients to leverage when they arrive at Patient Service Center (PSC).
  - PSC self check in kiosks
  - Smart phone enabled remote check in
  - Increased efficiency, decreased wait times

- **Labcorp Patient Portal**- Easy access to lab results. A mobile app is also available.
  - Official report available for download
  - Online PSC locater
  - PSC appointment scheduling
  - Lab test educational material and content

- **Patient Satisfaction Survey**
  - Emailed to patient after checking in at a PSC
  - Feed back used for PSC enhancements



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Improving Quality Measures Through At-Home Test Collection

Convenient access combined with proven national reference lab quality

- Home test collection kits focus on quality measures for critical diseases such as diabetes, colorectal cancer and chronic kidney disease.
- Leverages Labcorp diagnostic testing portfolio and quality standards.

Quality Measures	At-Home Test Collection Kit Target
Colorectal Cancer Screening (COL)	• iFOBT
Hemoglobin A1c Control for Patients With Diabetes (HBD)	• A1c+eAG, Dried Blood
Kidney Health Evaluation for Patients With Diabetes (KED)	• Urine Albumin Creatinine Ratio (uACR) • Creatinine eGFR, Dried Blood (eGFR) • eGFR + uACR • A1c+eAG & eGFR + uACR

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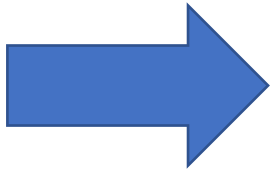
Laboratory Data is a Powerful Tool

Laboratory data is a critical tool in managing population health, providing result values, demographics, payer coding, and frequent touch-points with patients

Leveraging Laboratory Analytics

- ✓ Access results daily from any provider
- ✓ Identify and monitor high-risk patients
- ✓ Target lab-based care gaps
- ✓ Support coding accuracy
- ✓ Optimize use of laboratory testing
- ✓ Benchmark population against community-wide disease trends



Support Quality Metrics

Prioritize Care Management

Decrease Hospital-ER Visits

Improve Performance on Quality Measures

Reduce Total Cost of Care

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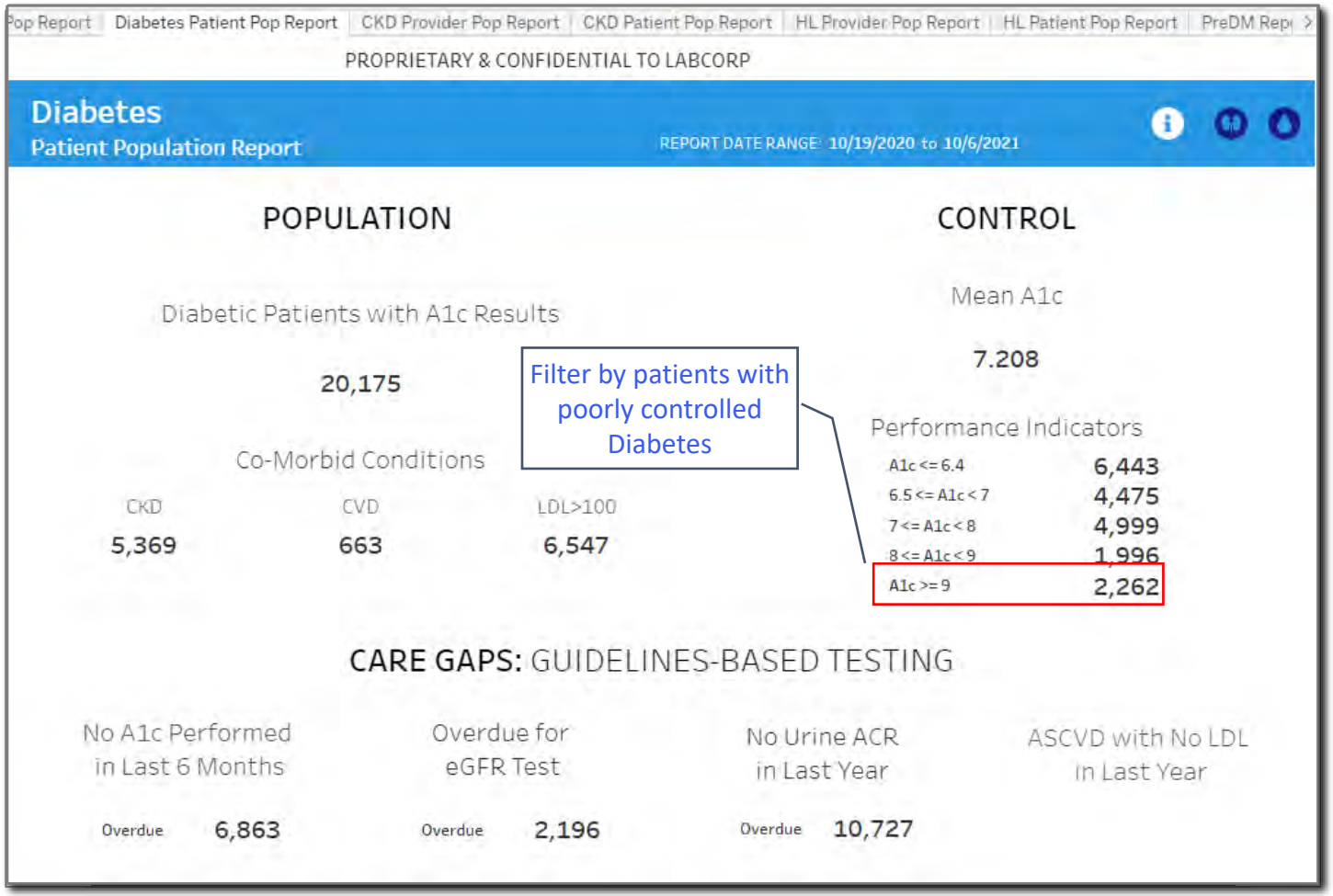
Labcorp can provide prebuilt, lab-based population health analytics as a tool to define targeted opportunities

Interactive population analytics dashboards

- Utilizes Labcorp patient and results data
- Includes built-in filters
- Reveal details when hovering over visuals
- Provide ability to drill down to the provider or patient level
- Available on demand via Labcorp Link portal
- Report options available:
  - Chronic Conditions
  - Lab Stewardship
  - Population Analysis
  - Community Health

Example of Labcorp Insight Analytics™ – *Chronic Conditions*

- Review patient population & target gaps-in-care



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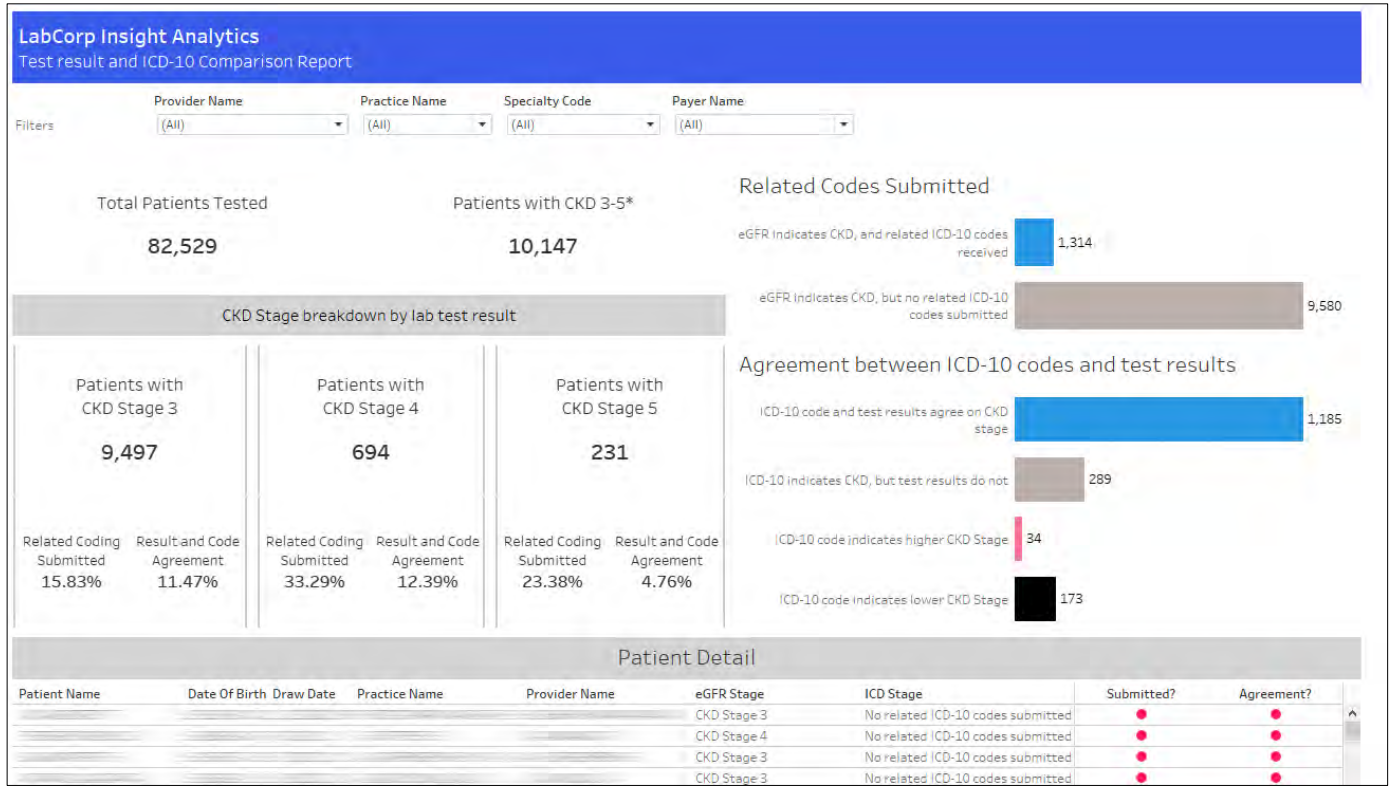
Analytics to support accurate ICD-10 coding

Diabetic care gaps & CKD are associated with inaccurate ICD-10 coding[1,2,3]

Using lab-data powered dashboards can highlight & monitor:

- Patients that have CKD and/or Diabetes according to biochemical testing
- Comparisons between ICD-10 codes & test results
- Patients that should be assessed for newly detected CKD and/or Diabetes
- Patients where CKD and/or Diabetes may be progressing rapidly



1. Horsky, J., Drucker, E. A., & Ramelson, H. Z. (2017). Accuracy and completeness of clinical coding using ICD-10 for ambulatory visits. In AMIA annual symposium proceedings (Vol. 2017, p. 912). American Medical Informatics Association
2. Lois G Kim, Faye Cleary, David C Wheeler, Ben Caplin, Dorothea Nitsch, Sally A Hull, the UK National Chronic Kidney Disease Audit, How do primary care doctors in England and Wales code and manage people with chronic kidney disease? Results from the National Chronic Kidney Disease Audit, Nephrology Dialysis Transplantation, Volume 33, Issue 8, August 2018, Pages 1373–1379, https://doi.org/10.1093/ndt/gfx280
3. Norton JM, Grunwald L, Banaag A, et al. CKD Prevalence in the Military Health System: Coded Versus Uncoded CKD. Kidney Med. 2021;3(4):586-595.e1. Published 2021 Jun 2. doi:10.1016/j.xkme.2021.03.015

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LABCORP DIAGNOSTIC ASSISTANT

Delivering Labcorp Data and Insights – At the Point of Care

Labcorp Diagnostic Assistant delivers patient-centric Labcorp data and insights where it matters most – right at the point of care. Embedded within the electronic health record (EHR), Labcorp Diagnostic Assistant provides the most complete view of a patient's lab result history while delivering actionable evidence-based guidelines and lab-based clinical insights to facilitate informed clinical decision-making and improved patient care.

Using Labcorp Diagnostic Assistant

1. As a clinician opens a patient medical record in the EHR, Labcorp Diagnostic Assistant collects information from that patient's record.
2. Labcorp Diagnostic Assistant then identifies if the patient had any lab tests performed at Labcorp, but ordered outside of the clinician's organization.
3. Those additional Labcorp test results are then combined with the information from the EHR to create a single patient record.
4. That single patient record is delivered as a view back into the EHR in real-time at the point of care. Without Labcorp Diagnostic Assistant, the EHR's lab data could be incomplete for many patients, potentially altering treatment plan decisions.

Through Labcorp Diagnostic Assistant, a patient's EHR data is combined with Labcorp test results that were ordered from outside of the clinician's organization, giving clinicians real-time patient level access to **Labcorp's unified data platform that includes lab results for approximately 50% of the United States population.**

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PCP Condition Optimization Program (COP)

Emily Quick
Risk Adj Data Analyst III, Corporate Risk Adjustment Programs

PCP Condition Optimization Program (COP)

Provider Training

Disclaimer: The information in this presentation describes a health plan program. Neither the information herein or the execution of this voluntary health plan program should interfere with clinical practice. All practitioners remain responsible for exercising independent clinical judgment in the care of their patients.

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Delivering the Next Generation of Health Care

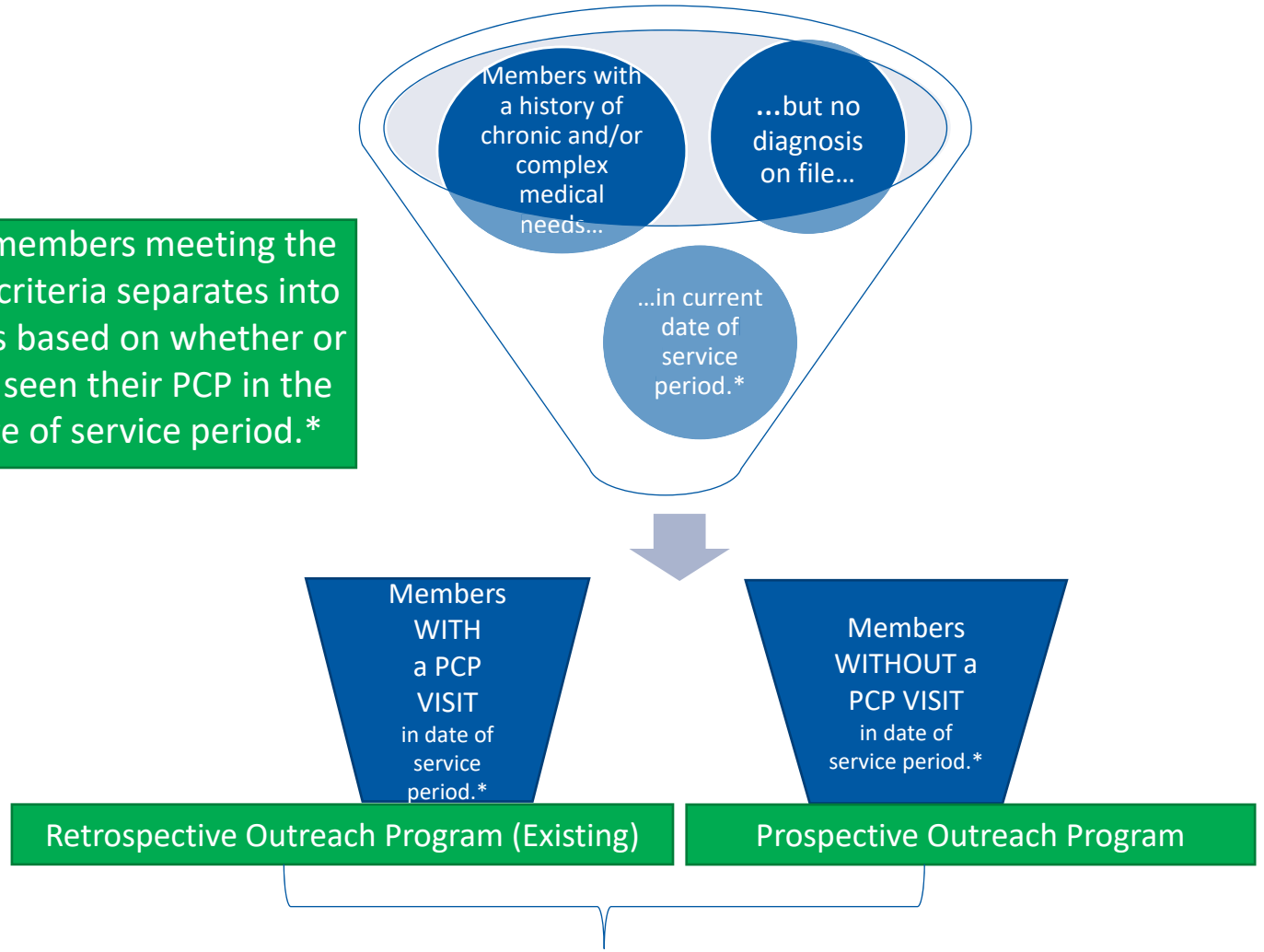
Goals of the Condition Optimization Program

- Allow the health plan to gather info about members with chronic and/or complex medical needs.
- Help Primary Care Providers (PCPs) identify assigned members with chronic and/or complex medical needs.
- Promote routine access to primary care for members with chronic and/or complex medical needs
- Increase member appointment compliance through outreach.
- *Healthy People 2020* reports:
  - People with a usual source of care have better health outcomes, fewer disparities, and lower costs.
  - Having a primary care provider (PCP) who serves as the usual source of care is associated with greater patient trust in the provider, better patient-provider communication, increased likelihood that patients will receive appropriate care, and lower mortality from all causes.

  Source: Office of Disease Prevention and Health Promotion. (n.d.). *Access to Health Services*. Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services. Accessed July 2021.

Identifying Members for COP

ONE set of members meeting the established criteria separates into TWO subsets based on whether or not they've seen their PCP in the current date of service period.*



Condition Optimization Program begins April 1, 2022

**There are two dates of service periods per year; exact period dates vary and are determined by the Medicaid agency in each state.*

Retrospective Outreach Program

Health plan:

- Identifies target members with the most chronic and/or complex medical needs and with a visit to their assigned PCP in the date of service period.*
- Medical record(s) will be requested from provider.
- Diagnosis codes will be abstracted from the medical record and any diagnosis missing on the originally billed claim will be shared in NaviNet.

Provider opting to participate in ROP:

- *Provider Self Review* - Open patient medical record and determine if diagnosis suspected can be confirmed. Check off confirm or can't confirm and go to next step.
- *Plan Medical Record* Review - Review the results of the medical record abstraction in NaviNet and if in agreement with diagnosis/condition(s) identified, confirm the diagnosis code(s).
- Submit the transaction to complete the claim adjustment that adds procedure code 99499 to the originally submitted claim (to make administrative payment) and corrects the diagnosis code(s) by adding any confirmed codes to the previously submitted claim.
- Administrative payment will be issued on next remittance advice.

*There are two date of service periods per year; exact period dates vary and are determined by the Medicaid agency in each state.

Retrospective Outreach Provider Incentive

- Incentive payment is issued through Facets on a per claim basis.
- Payment will be on normal claim remittance advice.
- Claims adjusted are subject to random audit to confirm completeness and accuracy of diagnosis codes reported on the claim.

For NaviNet Navigation, general instructions for accessing NaviNet are on slides 9 - 11. Please click here to access the slides that include instructions for completing Retrospective Action Items: Step One: Access the Worksheet - Retrospective

Prospective Outreach Program

Health plan:

- Identifies up to 150 target members with the most chronic and/or complex medical needs and with no visit to their assigned PCP in the date of service period.*

Provider opting to participate in POP:

Pre-Appointment

- You are notified of target members via NaviNet.
- Your office outreaches to member and schedules a visit or marks member as unavailable/unscheduled in NaviNet if no contact and/or no member interest in scheduling appointment.

During Appointment

- For the purpose of the program, review suspected chronic and/or complex medical needs listed for the member during the visit.
- Document diagnosed chronic and/or complex medical needs in the member's medical record.

Post Appointment

- **Submit a Scheduled Appointment Worksheet for the target member** in NaviNet – confirmed or unconfirmed chronic and/or complex condition (represented by diagnosis codes.)
- **Submit a Claim** with confirmed and/or newly identified diagnosis along with the appropriate E&M codes.
- Diagnosis codes must be reported via the Scheduled Appointment Worksheet, Claim, and Medical Record.
- All three components are audited to confirm accuracy and completeness; errors identified in coding of claim must be corrected before claim will be approved for incentive payment.

*There are two dates of service periods per year; exact period dates vary and are determined by the Medicaid agency in each state.

Prospective Outreach Provider Incentive

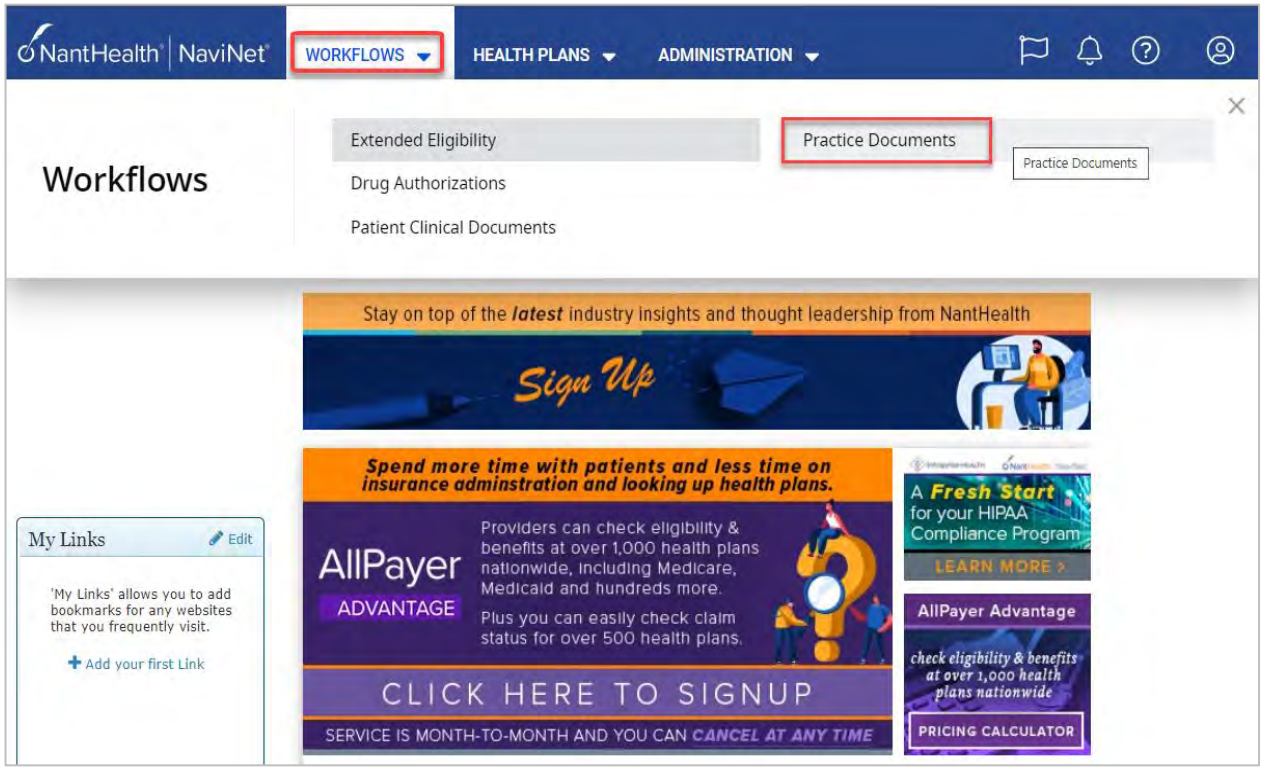
- Program begins: April 1, 2022
- Participants receive incentive payments in January and July of each year.
- Payment is sent in one check with explanation code **POPP – Prospective Outreach Prgm Pymt.**
- Incentive is limited to one completed visit per target member, per risk period.
  - Target member list is in NaviNet and incentive may only be earned for the identified members.
  - Identified members may be removed from list if diagnosis gap is closed or member loses eligibility (The identified member list is updated on the 1st of each month; consult NaviNet for updates.)
- Each qualifying visit will be audited to confirm completeness and accuracy of diagnosis codes reported on claim.

NaviNet Navigation

Start Here - Practice Documents Workflow

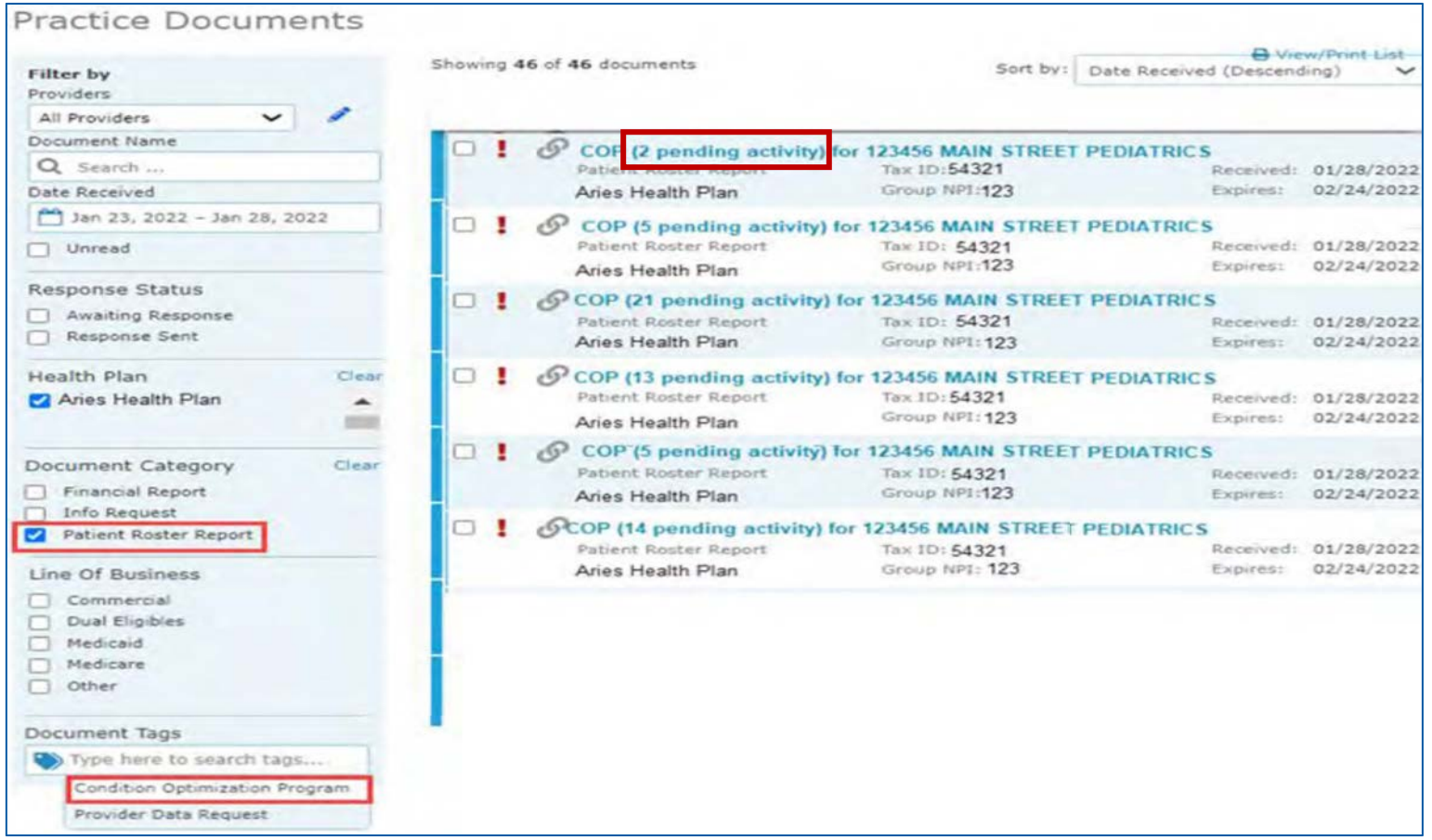
Log in to NaviNet and select:

- Workflows
- Practice Documents



Practice Documents

1. To view COP-related documents, filter for **Patient Roster Report** under **"Document Category"** or type **Condition Optimization Program** into the "Document Tags" field.
2. Check for **Pending Activity** by looking for the indicator at the end of a document title.



Select the Member List

1. Click on a record to view. For example, “COP for 123456 MAIN STREET PEDIATRICS.”

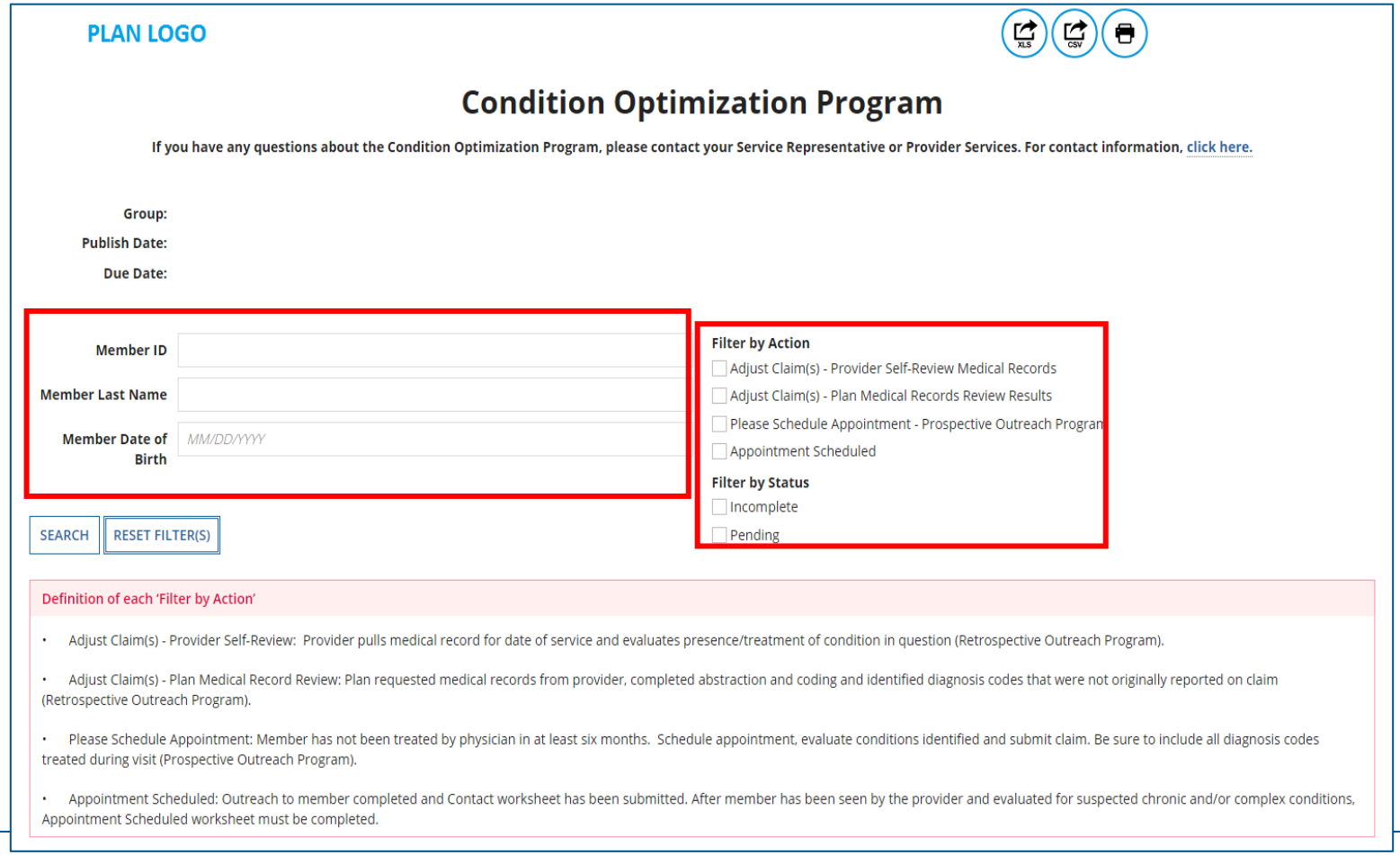
2. The screen below will display. Click on **Member Selection** at the bottom of this screen to access COP activities.

Preparing for Outreach

The Condition Optimization Program screen appears.

Here users can choose to:

Search for a specific member using **Member ID**, **Member Last Name**, or **Member Last Name + Member Date of Birth** or **Filter by Action** type or by **Filter by Status**.



Search Options

- Search for a specific member using **Member ID**, **Member Last Name**, or **Member Last Name + Member Date of Birth. OR**
- Filter by Action:
  - **Prospective Outreach Program**
    - **Please Schedule Appointment –** will filter for members who may need to be seen by their PCP for overdue routine care. For these members, a **Contact Worksheet** will need to be submitted.
    - **Appointment Scheduled** – will filter for members previously updated on the **Please Schedule Appointment** action as scheduled for evaluation of suspected historical diagnoses. For these members, a **Scheduled Appointment Worksheet** will need to be submitted.

Search Options (cont.)

- Filter by Action:

  - **Retrospective Outreach**:
    - **Adjust Claims – Plan Medical Record Review –** will filter for members where medical records have been received, abstraction has been completed, and diagnosis codes were identified that were not originally reported on the claim (Retrospective Outreach Program). These diagnosis codes will require review to update the claim.
    - **Adjust Claims - Provider Self-review –** will filter for members who have claim(s) that have been adjusted, or may need adjustment in order to reflect complete and accurate diagnosis data.

Member Listing

After the filters are applied, the **Member Listing** which contains all COP members associated with the practice will be displayed.

Member ID	Last Name	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT - PROSPECTIVE OUTREACH PROGRAM	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT - PROSPECTIVE OUTREACH PROGRAM	INCOMPLETE	
				ADJUST CLAIM(S) - PROVIDER SELF-REVIEW MEDICAL RECORDS	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				ADJUST CLAIM(S) - PROVIDER SELF-REVIEW MEDICAL RECORDS	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	

ACTION column will indicate:

- **Retrospective Outreach**: Adjust Claims – *Plan Medical Record Review* or *Provider Self-review.*
- **Prospective Outreach**: *Please Schedule Appointment*.

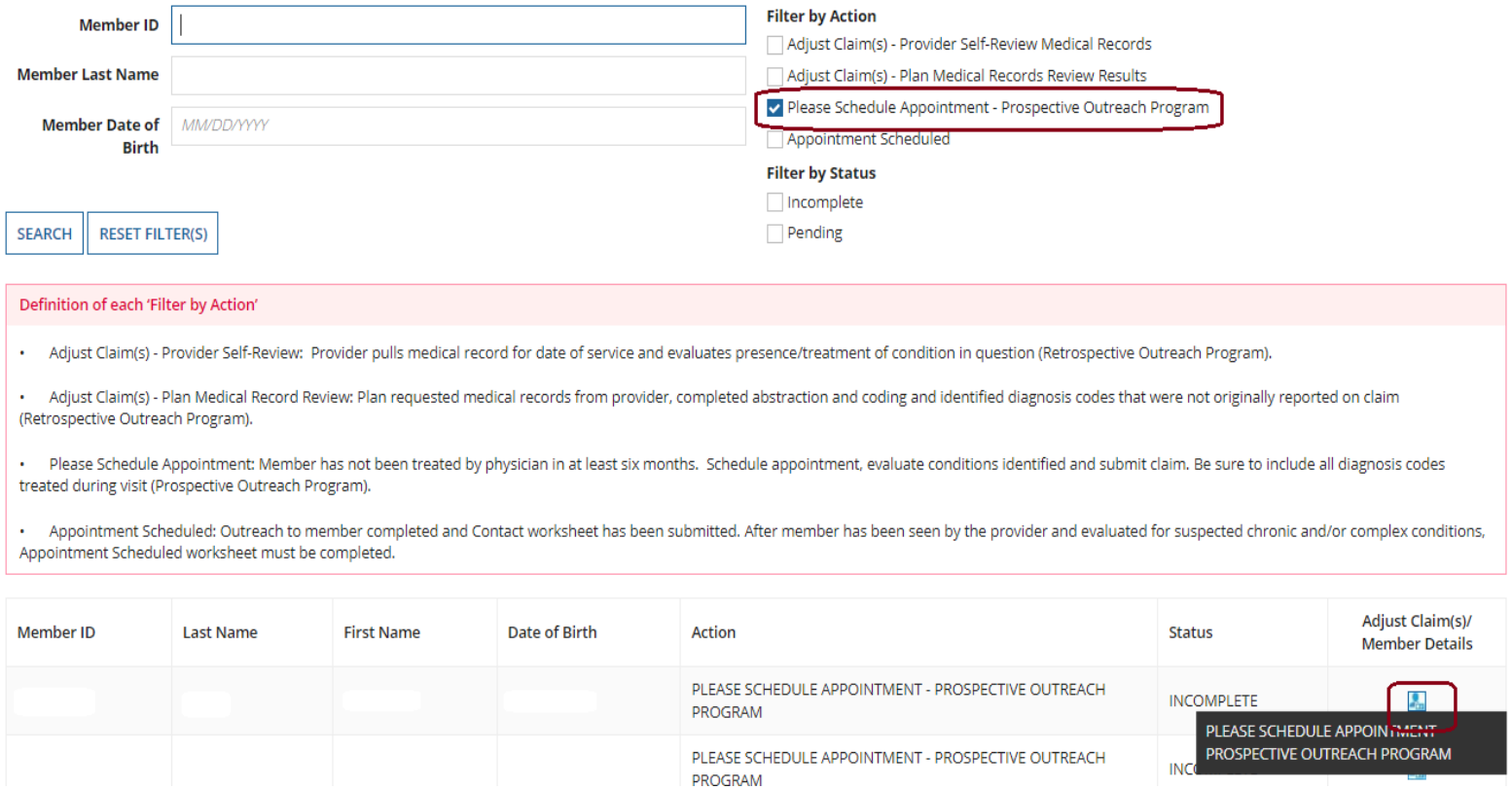
Member Listing Status

STATUS column will indicate three possible statuses in the **Member Listing** screen:

- **INCOMPLETE** - This status will be populated when at least one claim for a member has an “Incomplete” status and needs to be reviewed.
- **PENDING** - This status will be populated when at least one claim for a member has a “Submitted; Waiting batch process” status and no other claim is in “Incomplete” status.
- **COMPLETED** - This status will be populated when all claims are in “Claim Adjusted status.

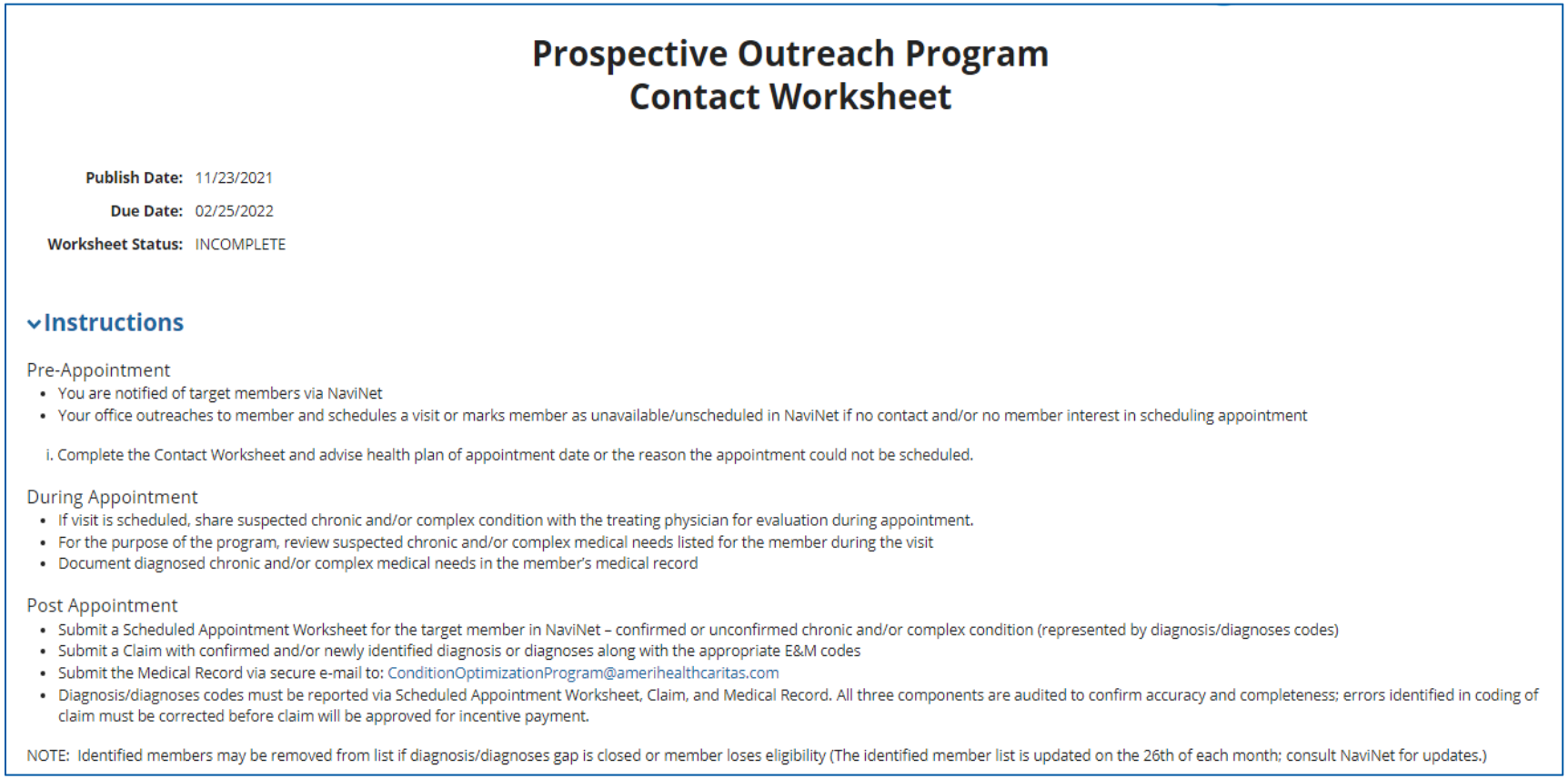
Step One: Access the Worksheet - Prospective

Under **Filter by Action**, select "**Please Schedule Appointment – Prospective Outreach Program**" to display all records of this type. Then, under "**Adjust Claim(s)/Member Details,"** click on the **Please Schedule Appointment – Prospective Outreach Program** icon to view the complete list of adjustable claims associated with that member.



Contact Worksheet

The ***Contact Worksheet*** will display with instructions for the provider.



Prospective Outreach Program
Contact Worksheet

Publish Date: 11/23/2021

Due Date: 02/25/2022

Worksheet Status: INCOMPLETE

Instructions

Pre-Appointment

- You are notified of target members via NaviNet
- Your office outreaches to member and schedules a visit or marks member as unavailable/unscheduled in NaviNet if no contact and/or no member interest in scheduling appointment

i. Complete the Contact Worksheet and advise health plan of appointment date or the reason the appointment could not be scheduled.

During Appointment

- If visit is scheduled, share suspected chronic and/or complex condition with the treating physician for evaluation during appointment.
- For the purpose of the program, review suspected chronic and/or complex medical needs listed for the member during the visit
- Document diagnosed chronic and/or complex medical needs in the member's medical record

Post Appointment

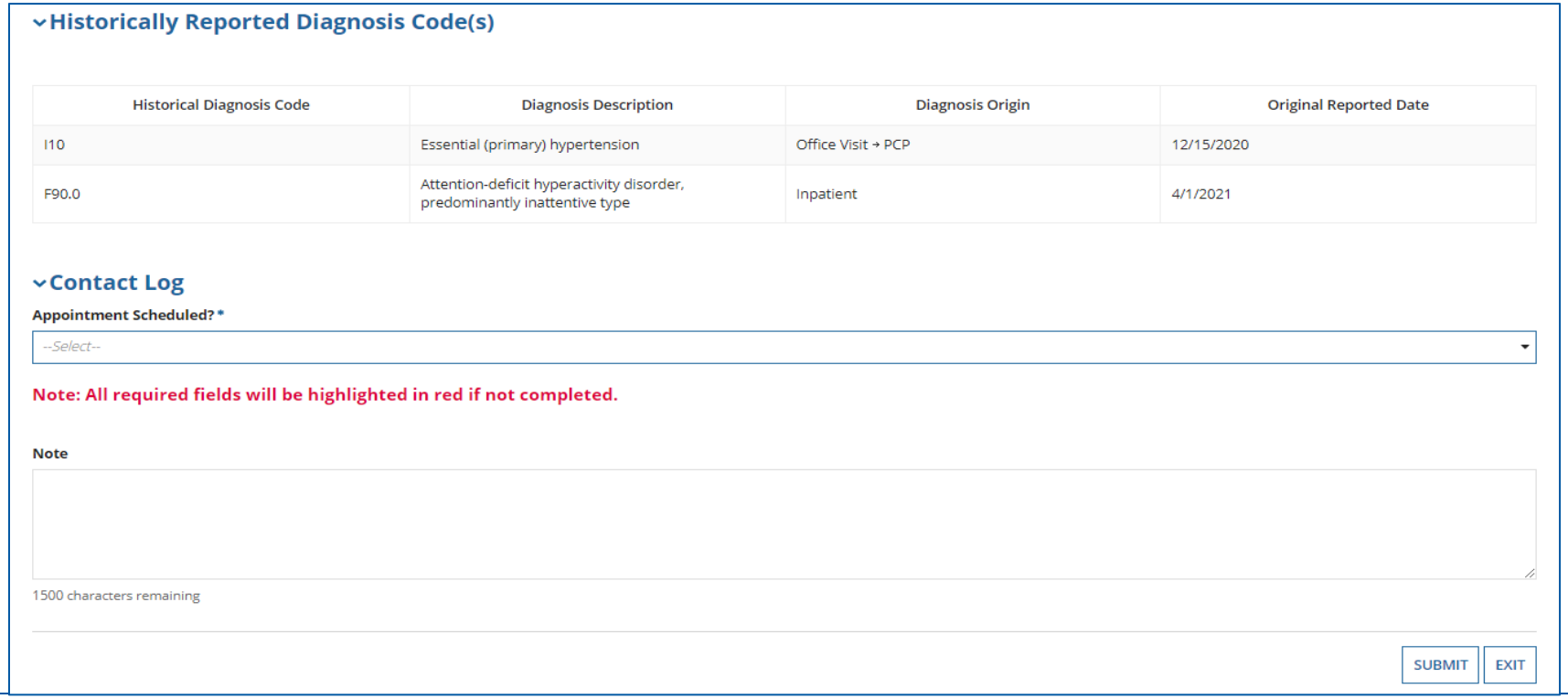
- Submit a Scheduled Appointment Worksheet for the target member in NaviNet – confirmed or unconfirmed chronic and/or complex condition (represented by diagnosis/diagnoses codes)
- Submit a Claim with confirmed and/or newly identified diagnosis or diagnoses along with the appropriate E&M codes
- Submit the Medical Record via secure e-mail to: ConditionOptimizationProgram@amerihealthcaritas.com
- Diagnosis/diagnoses codes must be reported via Scheduled Appointment Worksheet, Claim, and Medical Record. All three components are audited to confirm accuracy and completeness; errors identified in coding of claim must be corrected before claim will be approved for incentive payment.

NOTE: Identified members may be removed from list if diagnosis/diagnoses gap is closed or member loses eligibility (The identified member list is updated on the 26th of each month; consult NaviNet for updates.)

Contact Worksheet (cont.)

IMPORTANT NOTE: Select Health has no record of these members being treated by their PCP in the last 6 months. Additionally, these members may have **never** been seen at your office or haven't been seen for more than a year (but you are listed as their PCP.) Providers should:

- Attempt to schedule a *new* visit for members who are on their patient roster.
- Complete the Contact Worksheet to inform Select Health if they were able to schedule an appointment.



Historically Reported Diagnosis Code(s)

Historical Diagnosis Code	Diagnosis Description	Diagnosis Origin	Original Reported Date
I10	Essential (primary) hypertension	Office Visit → PCP	12/15/2020
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type	Inpatient	4/1/2021

Contact Log

Appointment Scheduled? *

--Select--

Note: All required fields will be highlighted in red if not completed.

Note

1500 characters remaining

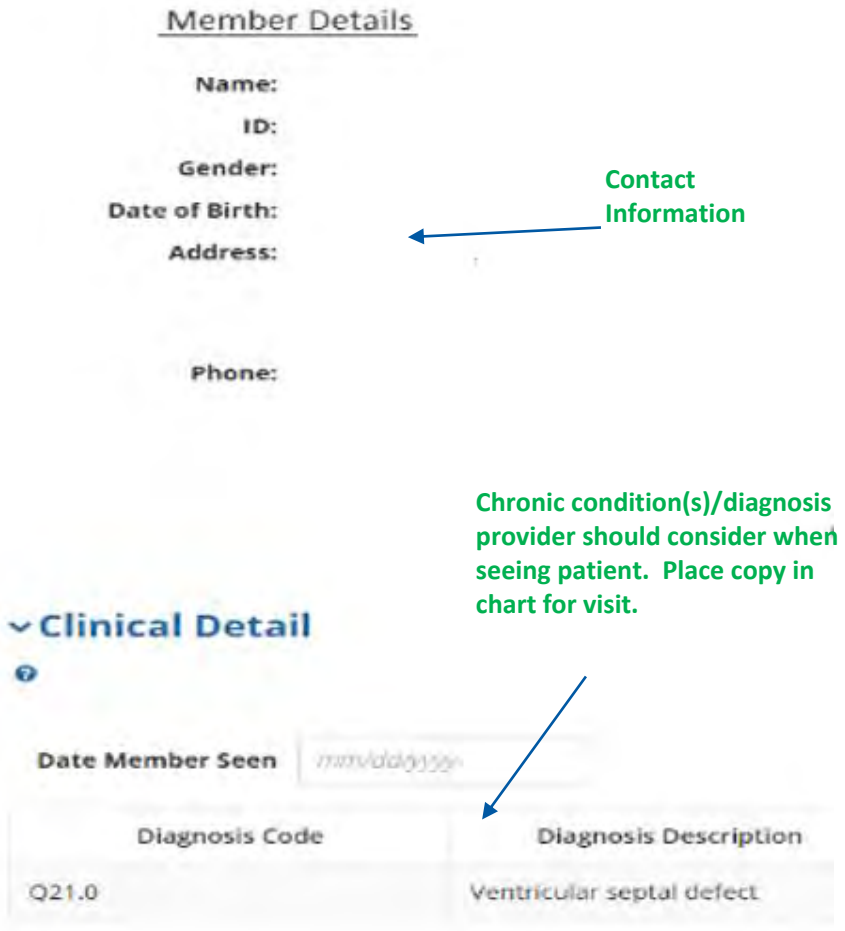
SUBMIT EXIT

Step Two: Outreach - Schedule an Office Visit

The **Contact Worksheet** provides contact information for the member and information related to the suspected chronic and/or complex medical needs (represented by diagnosis or diagnoses codes).

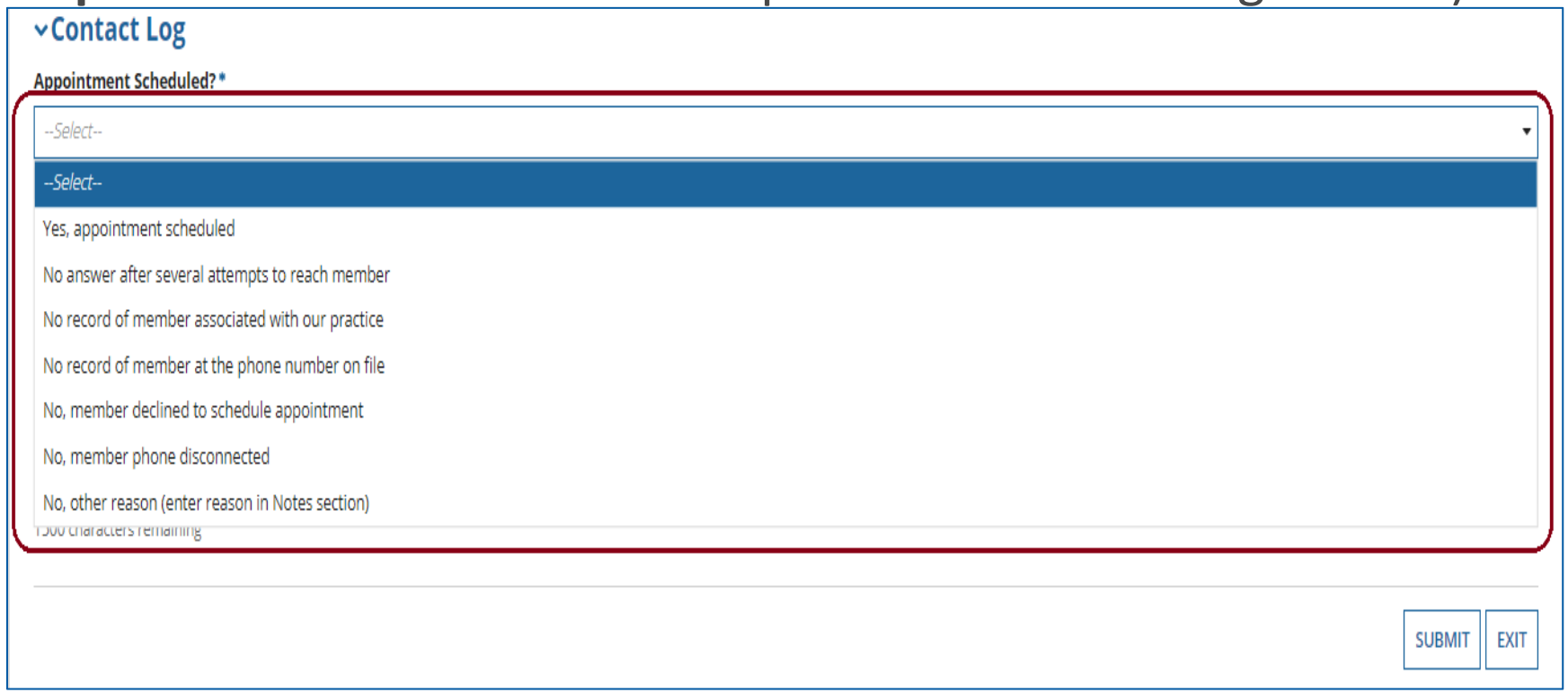
Office staff should reach out to the member to schedule an appointment and complete the Contact Worksheet.

Once the appointment is scheduled, it is suggested that a print out of the worksheet be included in the member's chart for the provider to reference during the visit with patient.

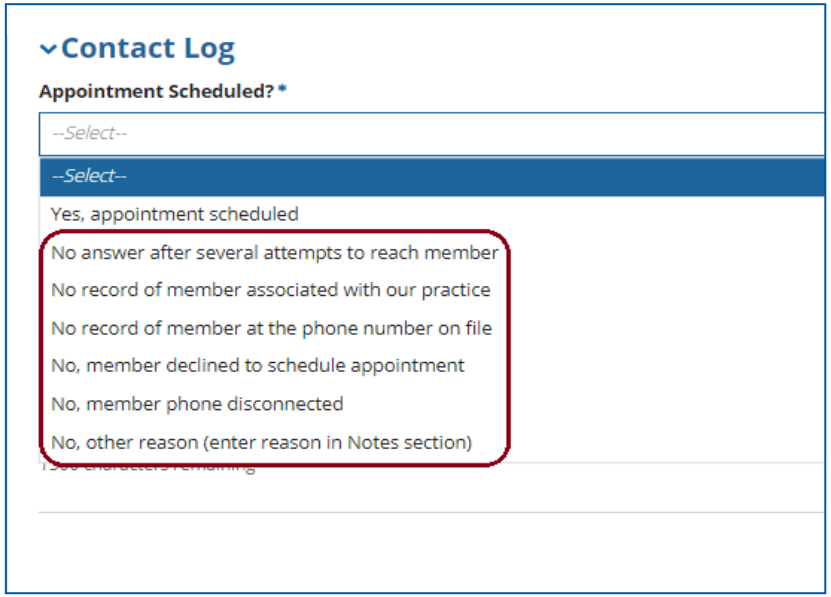


Completing the Contact Worksheet

On the **Contact Worksheet**, in the **Contact Log** section, click on the drop-down box under **Appointment Scheduled** (this is a **required** field that must be completed before clicking **Submit**).



What If No Appointment Is Scheduled?



The program does not reimburse for unscheduled or uncompleted visits.

It is important to inform the health plan that the member could not be scheduled for an appointment.

Complete the **Contact Log** when:

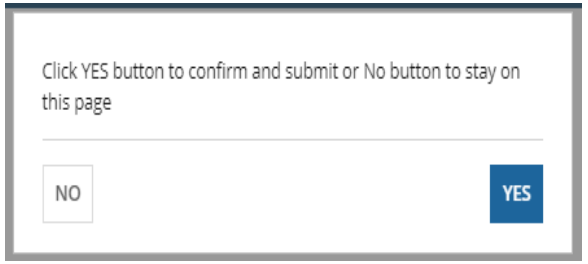
- ✓ Attempts to schedule have been exhausted.
- ✓ A member is transferred or discharged from the practice.
- ✓ Member could not be reached with the contact information available.
- ✓ Member did not show for a scheduled visit.
- ✓ If selecting the option “No, other reason (enter reason in Notes section)”, detailed information about that attempt should be provided in the Notes section.

Complete the Contact Log section and Submit the Contact Worksheet.

Submission of the Contact Worksheet

After completing the required information in the Contact Log section:

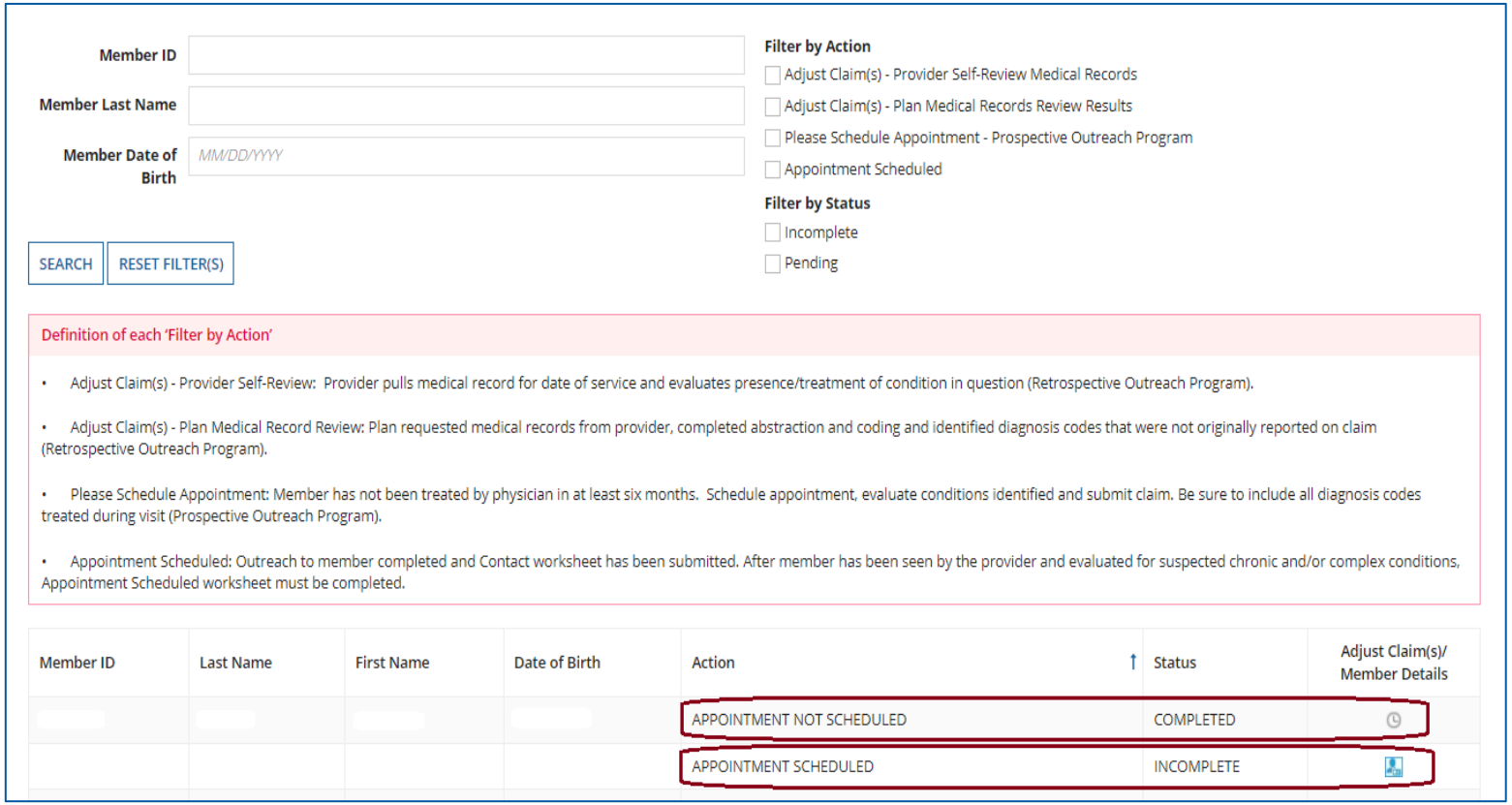
A warning message will display:



- Double check the selections made.
- Changes are not permitted after the worksheet has been submitted.
- Once information is confirmed, click the **Submit** button in the lower right section of the page.

Submission of the Contact Worksheet (cont.)

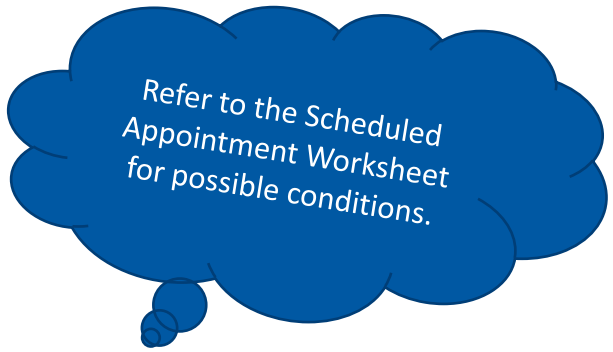
Once successfully submitted, depending on whether an appointment was/was not scheduled, the record will change from the Action type “Please Schedule Appointment” to **“Appointment Scheduled”** or “**Appointment Not Scheduled**”.



Completion of Appointment Action Types

- **Appointment Not Scheduled** - No further action is required.
- **Appointment Scheduled:**
  - After the member has come in for the visit, provider's office will need to complete the **Scheduled Appointment Worksheet**.
  - Information reported in the *Scheduled Appointment Worksheet*, helps the Plan:
    - Determine if the chronic condition(s)/diagnoses are still present, never present, or resolved.
    - There is also an option to update the diagnosis with a more accurate diagnosis.

Step Three: During the Appointment



When the patient presents for the appointment, the practitioner performs an examination and determines whether or not the chronic and/or complex medical needs (represented by diagnosis codes):

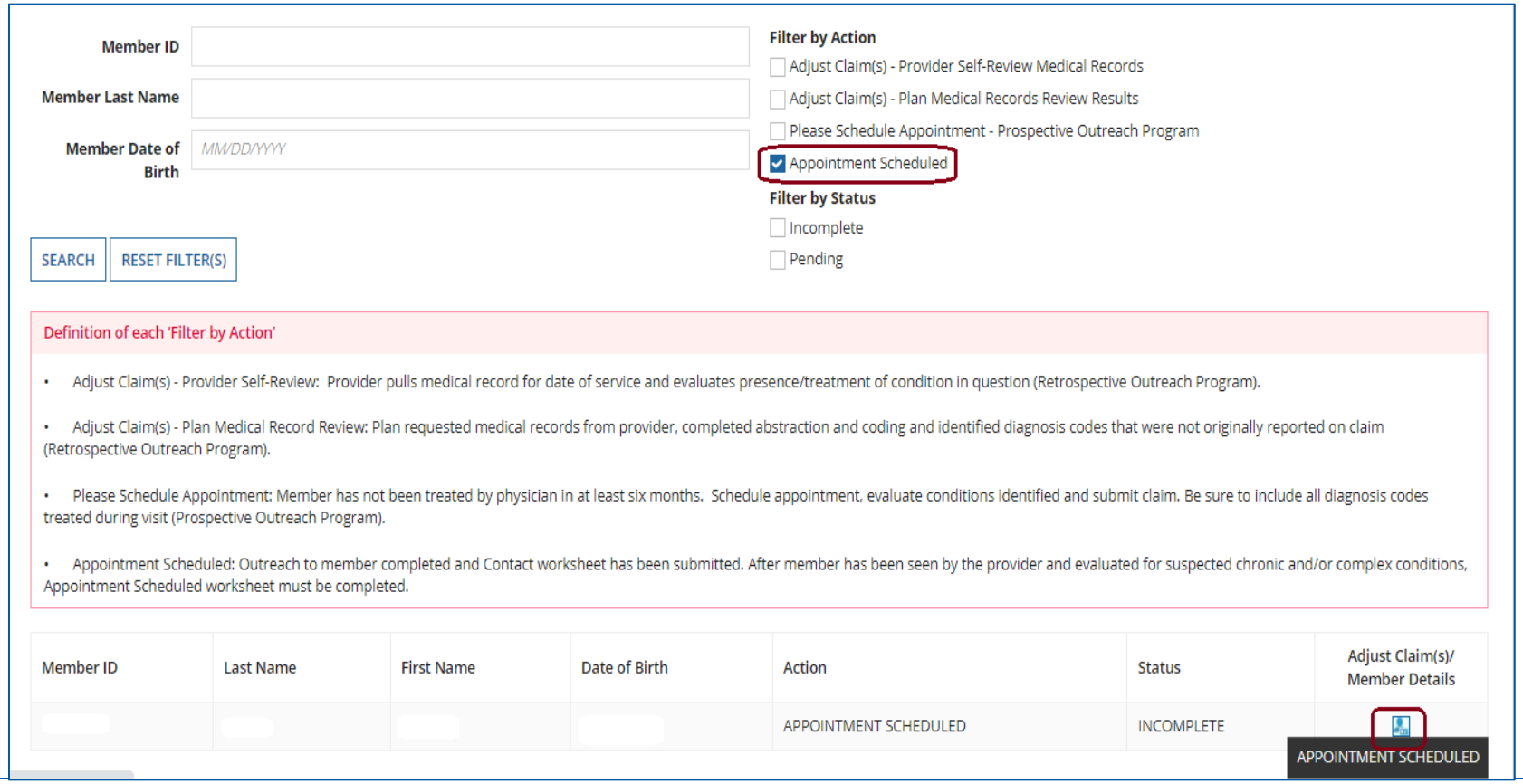
- Was/Were Ever Present
- Is/Are Resolved
- Is/Are Present /Confirmed

The practitioner adds any newly-identified diagnosis or diagnoses codes that should be documented for the patient.

The medical record must properly document any and all condition(s) the member is currently being treated for by the practitioner.

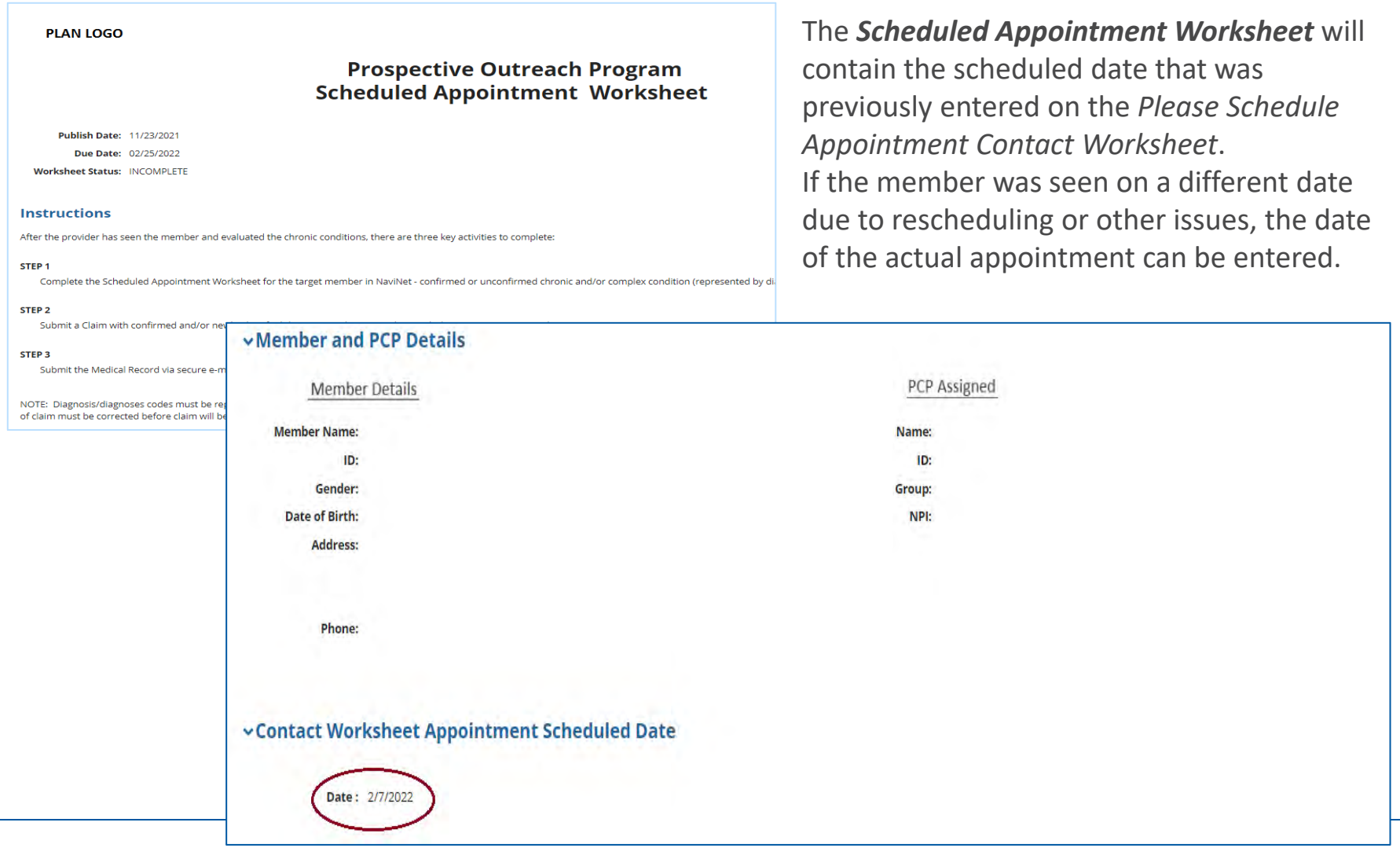
Step Four: After Appointment (part A)

Under **Filter by Action**, select "**Appointment Scheduled**" to display all records of this type. Then, under **"Adjust Claim(s)/Member Details,"** click on the **Appointment**



Step Four: After Appointment (part A – cont.)

The **Scheduled Appointment Worksheet** will display.



PLAN LOGO

Prospective Outreach Program
Scheduled Appointment Worksheet

Publish Date: 11/23/2021
Due Date: 02/25/2022
Worksheet Status: INCOMPLETE

Instructions

After the provider has seen the member and evaluated the chronic conditions, there are three key activities to complete:

STEP 1
Complete the Scheduled Appointment Worksheet for the target member in NaviNet - confirmed or unconfirmed chronic and/or complex condition (represented by di

STEP 2
Submit a Claim with confirmed and/or ne

STEP 3
Submit the Medical Record via secure e-m

NOTE: Diagnosis/diagnoses codes must be re
of claim must be corrected before claim will be

Member and PCP Details

Member Details		PCP Assigned	
Member Name:		Name:	
ID:		ID:	
Gender:		Group:	
Date of Birth:		NPI:	
Address:			
Phone:			

Contact Worksheet Appointment Scheduled Date

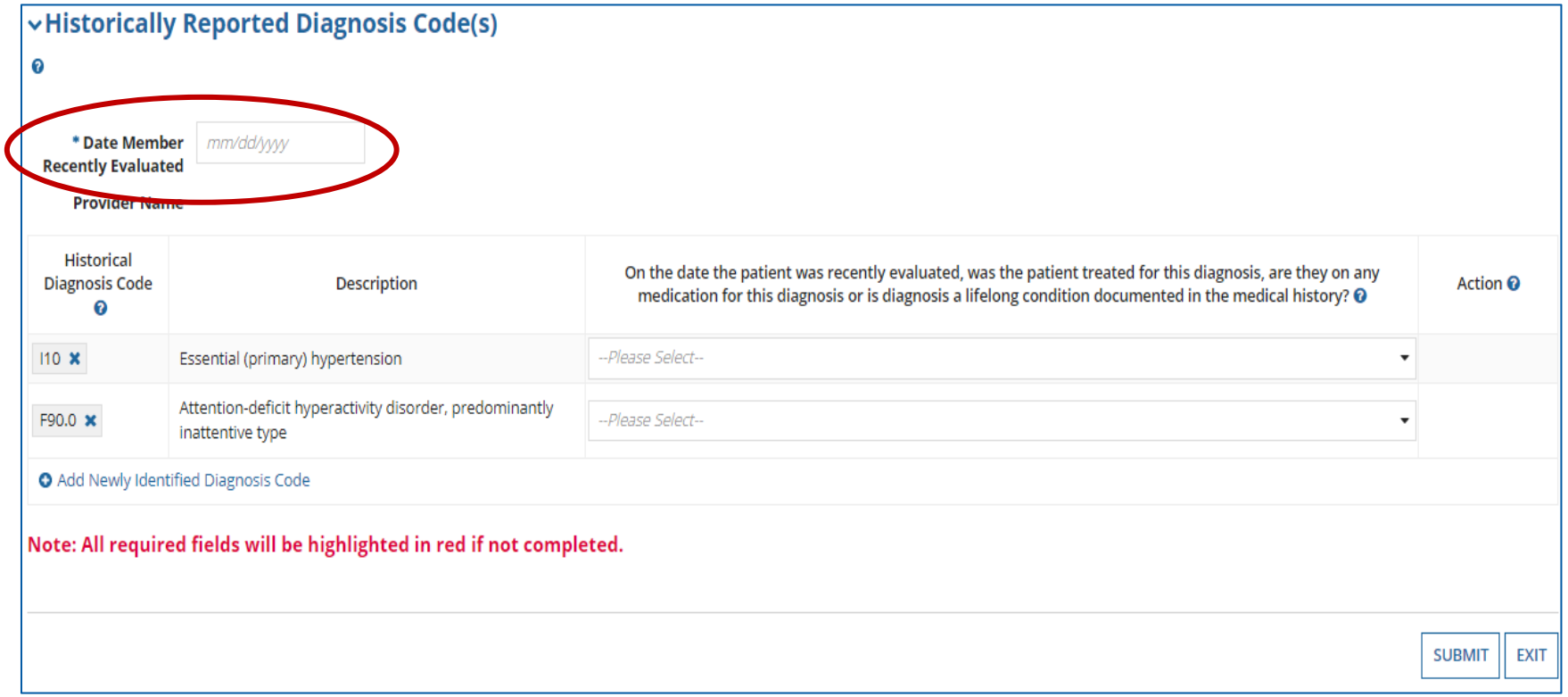
Date : 2/7/2022

The ***Scheduled Appointment Worksheet*** will contain the scheduled date that was previously entered on the *Please Schedule Appointment Contact Worksheet*.
If the member was seen on a different date due to rescheduling or other issues, the date of the actual appointment can be entered.

Step Four: After Appointment (part A – cont.)

In the **Historically Reported Diagnosis Code(s)** section, enter the date that the member was recently seen and evaluated in the box labeled **Date Member Recently Evaluated** (**this is a required field**).

NOTE: Only the current date or a date within the last 6 months can be entered.



Step Four: After Appointment (part A – cont.)

Based on the evaluation, select the appropriate status for each diagnosis code under **"Historically Reported Diagnosis Code(s)":**

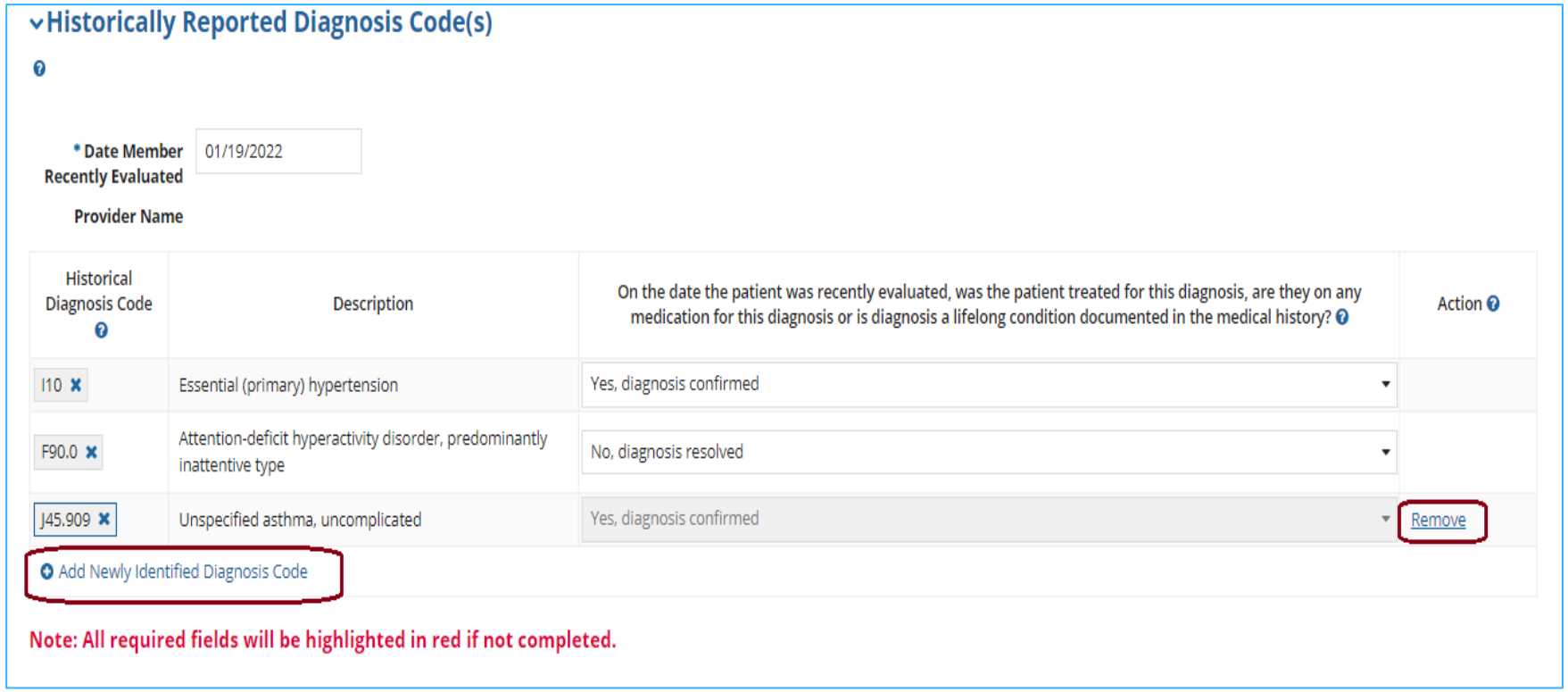
- **Yes, diagnosis confirmed** – Attests/confirms the diagnosis is still present.
- **Yes, but diagnosis updated** – If the diagnosis code listed is not correct for the member's condition, update the form with the correct diagnosis by clicking the "x" and entering at least the first three characters of the updated diagnosis.

NOTE: If the "x" is clicked in error, select **Undo Changes** under "**Action**" to revert to the original code.

- **No, cannot confirm** – Attests that provider has no record of diagnosis; never present.
- **No, diagnosis resolved** – Attests that the diagnosis has been treated and is no longer present.

Step Four: After Appointment (part A – cont.)

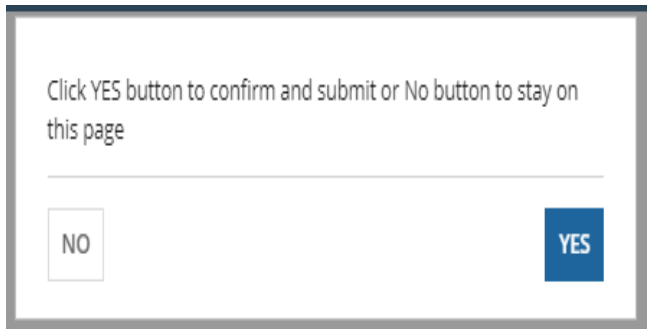
Users also have the option to add newly identified diagnosis codes if a new diagnosis is identified or was previously unlisted on the claim. To enter a new diagnosis, type at least **the first three characters** to populate the ***Add Newly Identified Diagnosis Code*** field.



Step Four: After Appointment (part A – cont.)

After completing the required information in the **Historically Reported Diagnosis Code(s)** section:

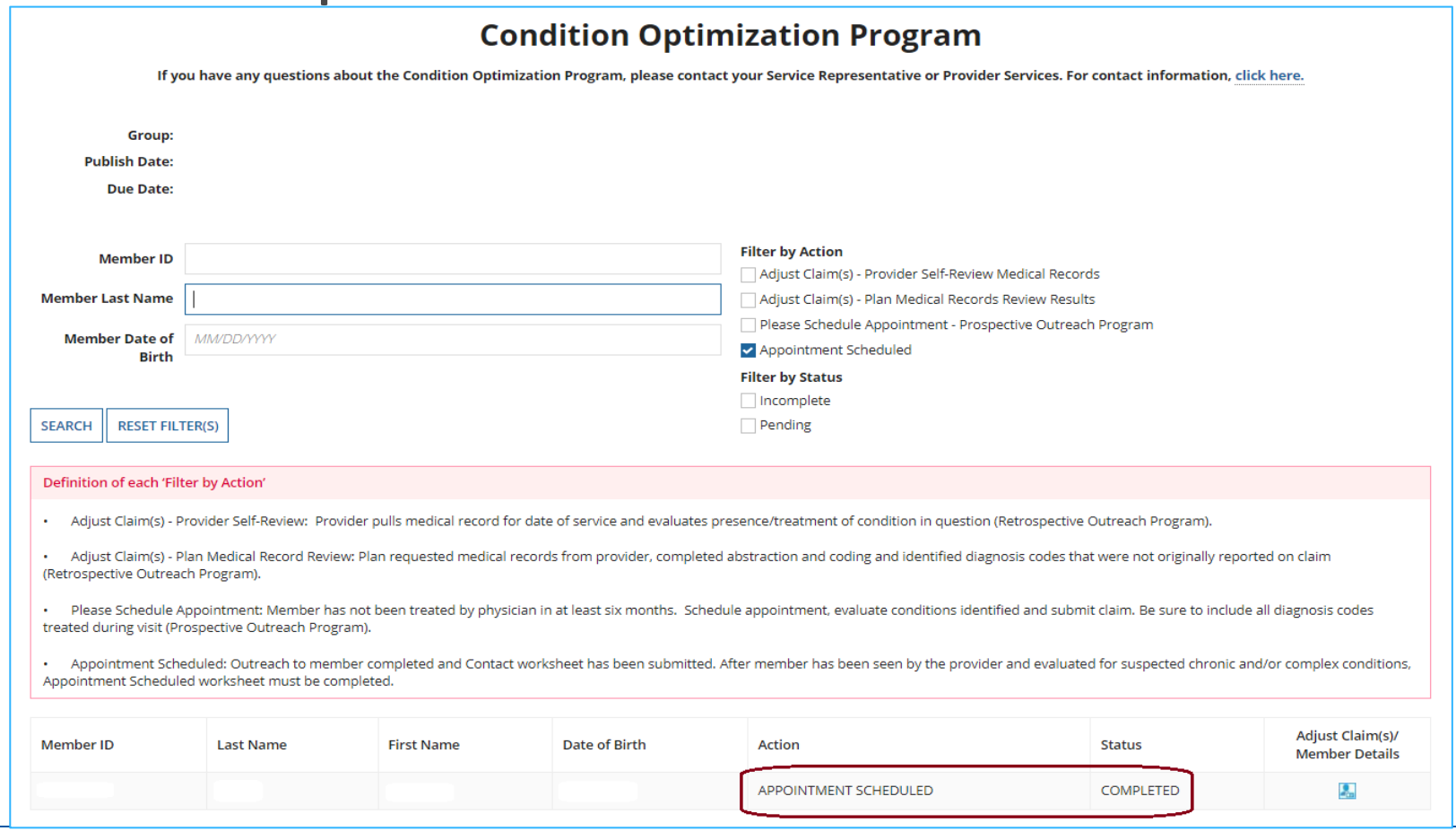
- Double check the selections made.
- This message will appear.



- Click **NO,** if changes need to be made. Click **YES** If no changes need to be made. Changes will not be permitted after submission.
- Once selections are confirmed, click on the **Submit** button in the lower right at the bottom of the page.

Step Four: After Appointment (part A) - **Completed**

After competing all steps, the user is returned to the main Condition Optimization Program page. The ***Appointment Scheduled*** record will now show with the status of **Completed**.



Condition Optimization Program

If you have any questions about the Condition Optimization Program, please contact your Service Representative or Provider Services. For contact information, click here.

Group:
Publish Date:
Due Date:

Member ID
Member Last Name
Member Date of Birth MM/DD/YYYY

SEARCH | RESET FILTER(S)

Filter by Action
- [ ] Adjust Claim(s) - Provider Self-Review Medical Records
- [ ] Adjust Claim(s) - Plan Medical Records Review Results
- [ ] Please Schedule Appointment - Prospective Outreach Program
- [x] Appointment Scheduled

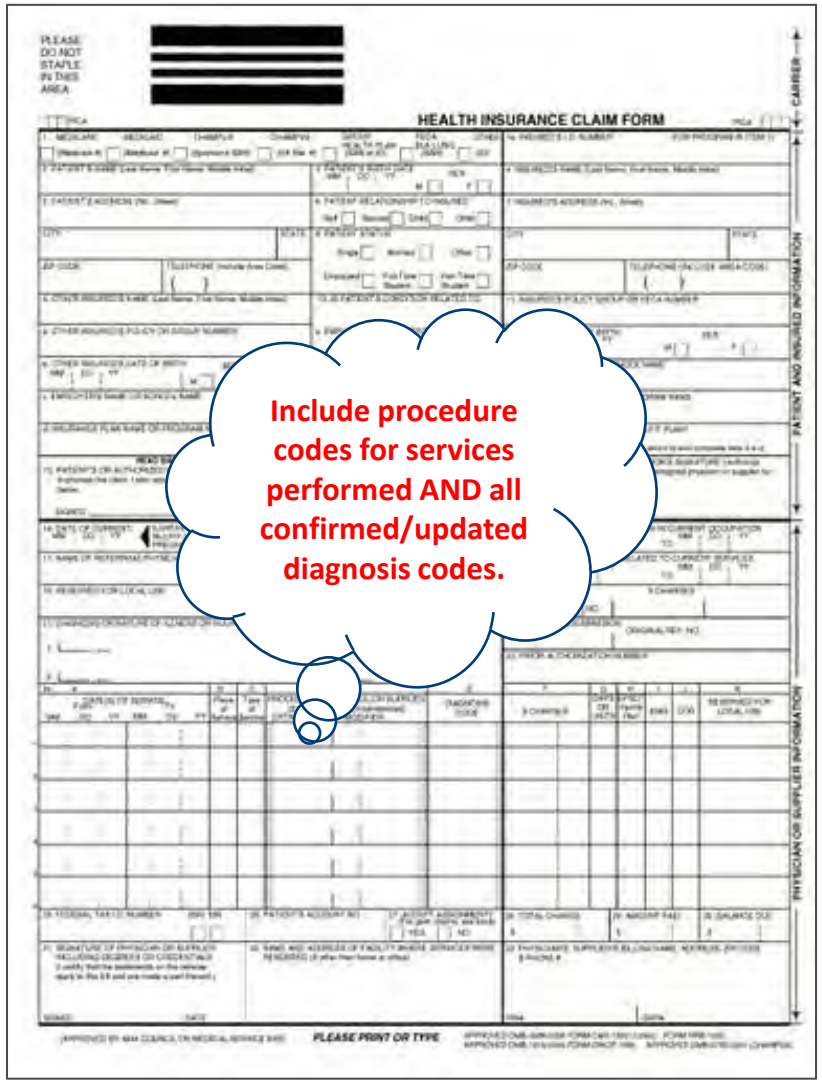
Filter by Status
- [ ] Incomplete
- [ ] Pending

Definition of each 'Filter by Action'

- Adjust Claim(s) - Provider Self-Review: Provider pulls medical record for date of service and evaluates presence/treatment of condition in question (Retrospective Outreach Program).
- Adjust Claim(s) - Plan Medical Record Review: Plan requested medical records from provider, completed abstraction and coding and identified diagnosis codes that were not originally reported on claim (Retrospective Outreach Program).
- Please Schedule Appointment: Member has not been treated by physician in at least six months. Schedule appointment, evaluate conditions identified and submit claim. Be sure to include all diagnosis codes treated during visit (Prospective Outreach Program).
- Appointment Scheduled: Outreach to member completed and Contact worksheet has been submitted. After member has been seen by the provider and evaluated for suspected chronic and/or complex conditions, Appointment Scheduled worksheet must be completed.

Member ID	Last Name	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
				APPOINTMENT SCHEDULED	COMPLETED	

Step Four: After Appointment (part B) – **Claim**



A claim must be submitted following the normal submission process and must include:

- ❑ Procedure codes for any services performed (e.g., E/M code, vaccines, EKG, etc.).
- ❑ **All diagnosis codes** identified during the office visit and any codes confirmed or updated on the *Appointment Scheduled Worksheet*.

Claim will process with zero payment **and explanation code "ZN7"** ***Prospective Outreach Program- Payment issued in January and July.***

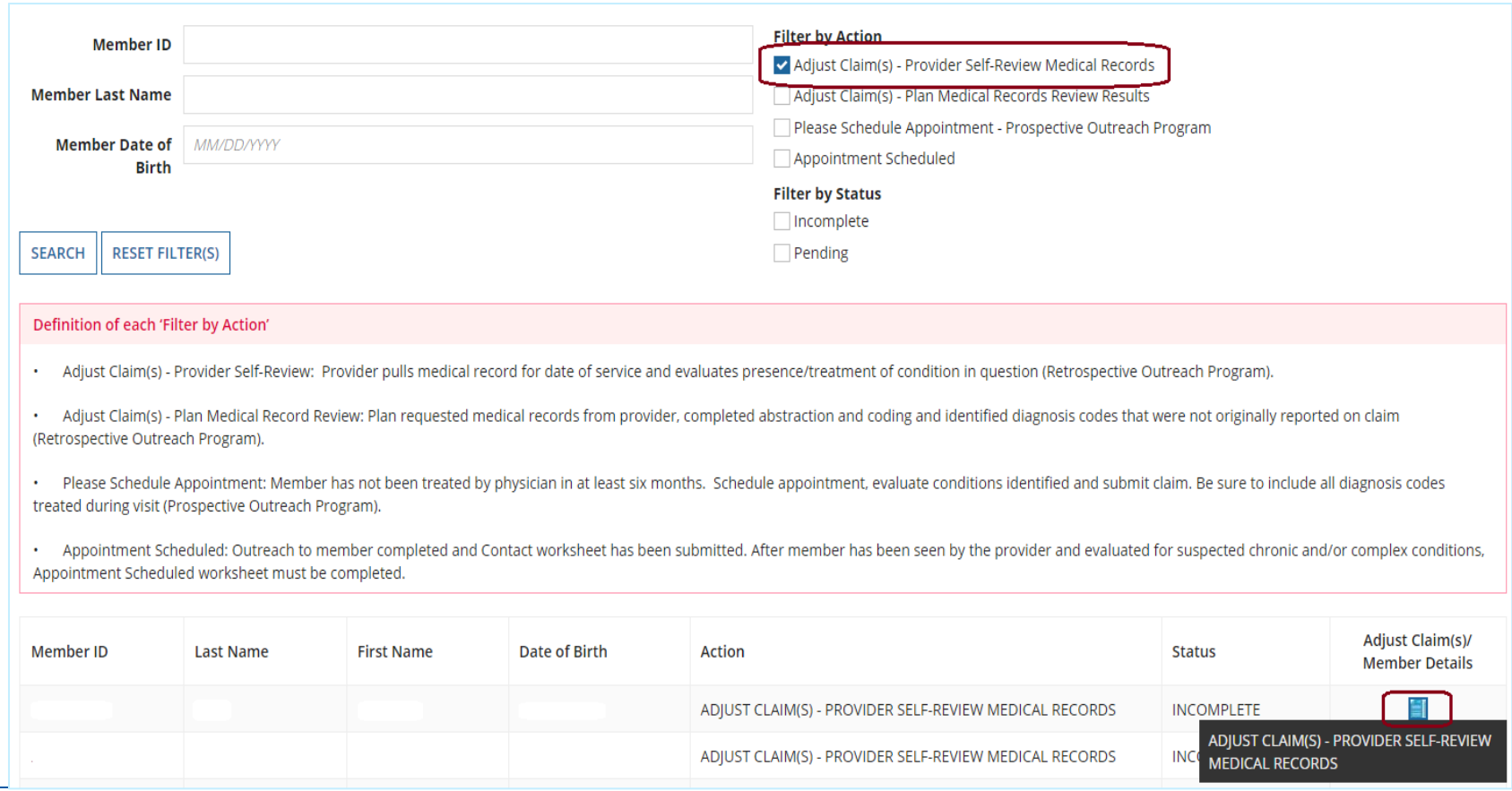
Step Four: After Appointment (part C) - **Validation Process**

- For each scheduled appointment worksheet submitted, we will search for a corresponding medical claim.
- Diagnosis code(s) confirmed on the worksheet are compared to the medical claim submission.
  - If no discrepancies are noted, the member is scheduled for payment in January or July.
  - If a discrepancy is noted, the provider is notified via audit report, and a correction to the claim is requested.
    - When correction is received and validated, payment will be issued in next payment cycle.

NOTE: A random audit is performed each risk period (January and July) and medical records may be requested to validate the worksheet and medical claim.

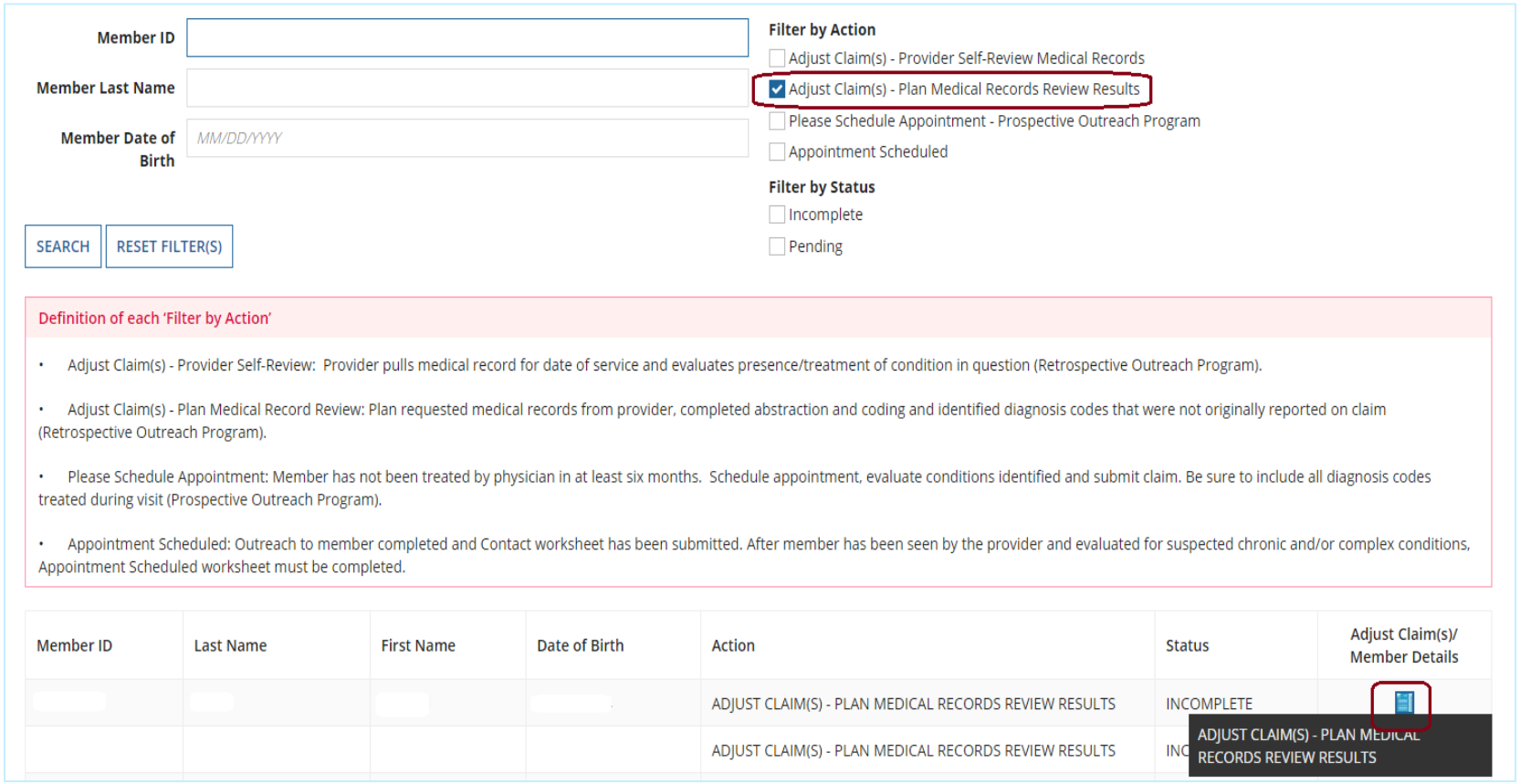
Step One: Access the Worksheet - Retrospective

Under **Filter by Action**, select "**Adjust Claim(s) – Provider Self-Review Medical Records**" if the provider pulls the medical record for dates of service and evaluates presence or treatment of conditions in question.



Step One: Access the Worksheet - Retrospective

OR select "**Adjust Claim(s) – Plan Medical Records Review Results**" if Plan requested medical records, completed abstraction and coding and identified diagnosis codes not originally reported on claims.



Then, under **"Adjust Claim(s)/Member Details,"** click on the applicable icon to view the complete list of adjustable claims associated with the member.

Access Claims to be Adjusted

To view claims details and to make claim adjustments, select the **Adjust Claim(s) Icon** on the right once again.

Claim Listing Status

There are three possible statuses in the Claim Listing screen are:

- **INCOMPLETE** - You can adjust claims which are in an INCOMPLETE status.
- **SUBMITTED; WAITING BATCH PROCESS** - Status will be seen when you already submitted an adjustment, but you can re-adjust a claim in this status.
- **CLAIM ADJUSTED ON MM/DD/YYYY** - Status is populated when user submitted adjustment and batch process is completed.

Claim Adjustment Screen

The **Claim Adjustment Screen** will display.

Retrospective Outreach Program
Claim Adjustment(s) - Provider Self-Review Medical Records

Instructions

1) Pull medical record for the claim date of service.
2) Note the Suspected Diagnosis Code(s) listed under the Diagnosis Code Adjustment section.
3) Review the visit record to determine if the suspected conditions was treated, a prescription was ordered or the diagnosis is a lifelong condition documented in the medical history for this condition or a related condition.
   a. If a suspected condition(s)... is supported within the medical record, confirm the documented condition and agree to add the diagnosis to the claim adjustment.
      i. If condition identified requires a more appropriate diagnosis code, click the "x" next to the provided code to remove it and enter the updated diagnosis code in the field.
   b. If a suspected condition is **not** supported within the medical record, deny the presence of the condition and move to the next diagnosis.
4) Review the diagnosis codes submitted on the original claim and determine if there are any additional conditions not reported.
   a. Click the add diagnosis field and enter the omitted code.
5) When all conditions are considered, submit the transaction. All diagnosis codes confirmed, added or updated will appear on the adjusted claim record.

Patient and Provider Details

Patient Details		Provider Details	
Name:		**Billing Provider Name:**	
ID:		**Billing Provider ID:**	
Gender:		**Servicing Provider Name:**	
		Servicing Provider ID:	

Claim Details

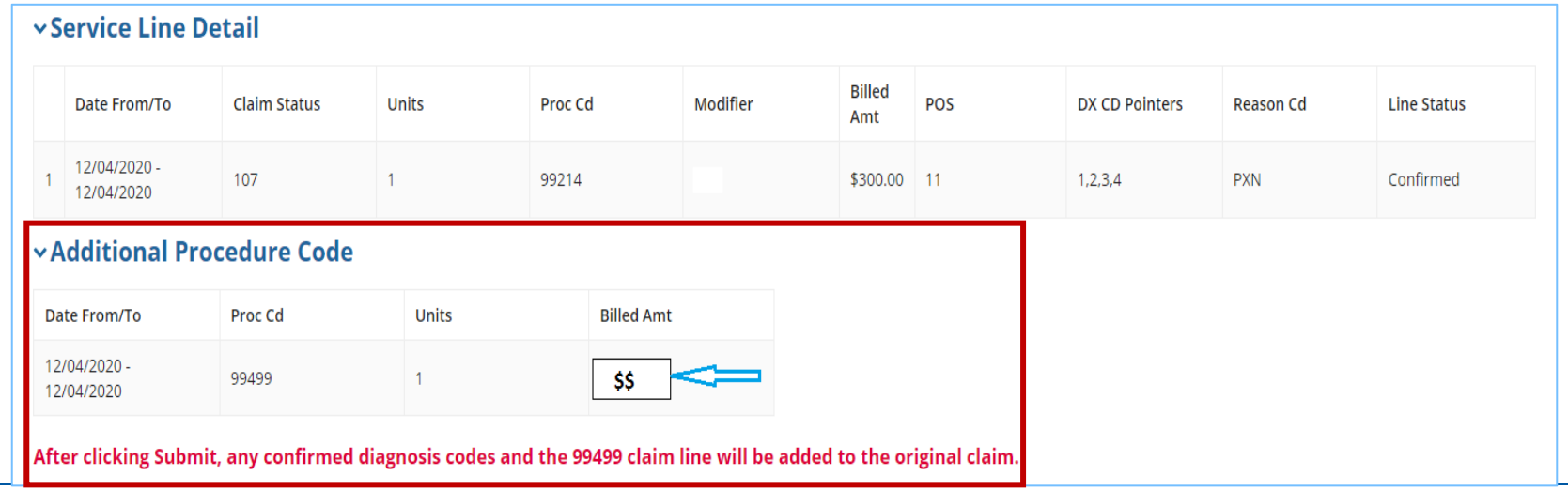
Claim Number:		**Status Date:**	1/1/2021
Service Date Range:		**Status Code:**	107
Total Amount Billed:		**Category Code:**	F1
Total Amount Paid:		**Remark Code:**	
Paid Date:	01/01/2021	**Check Number:**	

Diagnosis Codes:
1. C61 - Malignant neoplasm of prostate
2. C79.51 - Secondary malignant neoplasm of bone
3. G89.3 - Neoplasm related pain (acute) (chronic)
4. Z79.899 - Other long term (current) drug therapy

Claim Adjustment Screen (cont.)

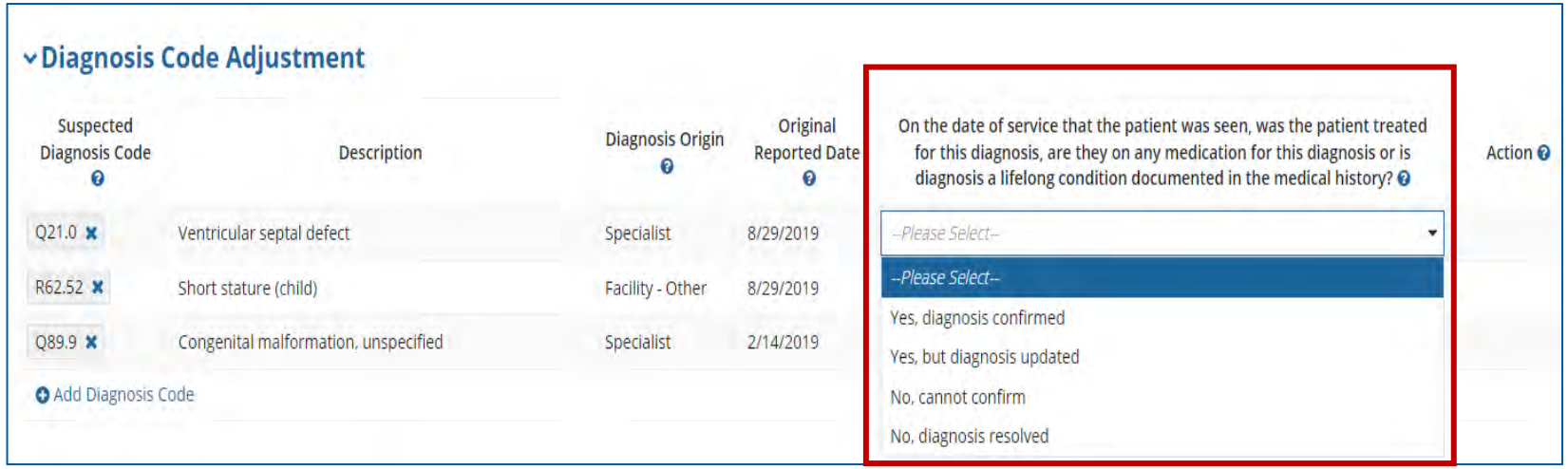
Claim Adjustment screen shows:

- **Patient and Provider details**
- **Claim Details** – for the original claim, including DX codes previously submitted.
- **Service line** (procedure codes) submitted on the original claim.
- **Additional procedure code** – CPT code 99499 is added to the adjusted claim in order to pay the incentive for reviewing the claim.



Diagnosis Code Adjustment

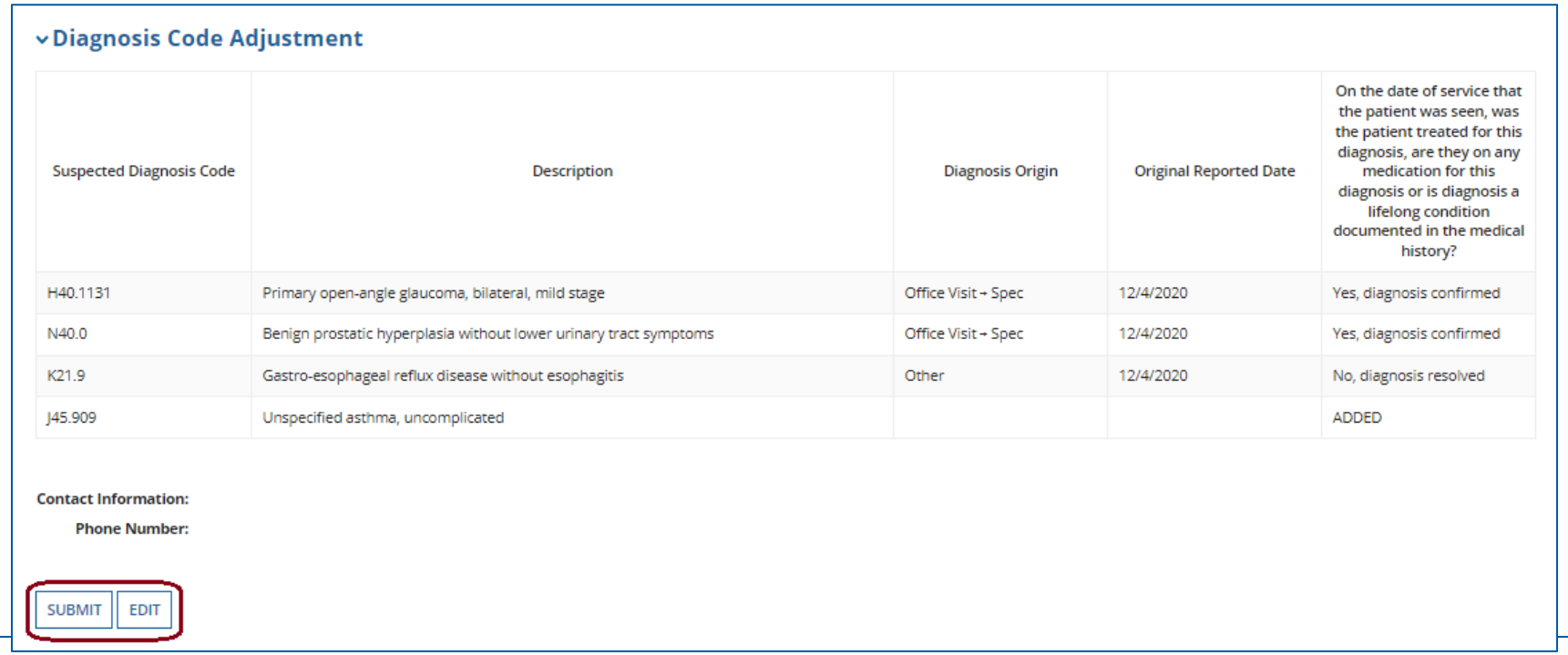
- **Diagnosis Code Adjustment** – shows the suspected DX codes that were not submitted on the original claim.
  - Providers must review these codes and indicate status:
    - ***Yes, diagnosis confirmed*** - Attesting the diagnosis is still present.
    - ***Yes, but diagnosis updated*** - If another diagnosis code better describes the member condition, update with the correct diagnosis by clicking the "x" and entering at least the first three characters of the updated diagnosis.
    - ***No, cannot confirm*** - Attesting to no record of this diagnosis; never present.
    - ***No, diagnosis resolved*** - Attesting the diagnosis has been treated and is no longer present.



Completion of Adjustment

Select **Preview** at the bottom of the screen for an opportunity to review the "Verification" page.

- Click **Edit** to return to the Claim Adjustment screen if additional changes are needed, OR
- Click **Submit** to complete the claim adjustment activity. After submission, the Claim Listing status for adjusted claims will change to: "**Submitted; Waiting batch process.**"



Diagnosis Code Adjustment

Suspected Diagnosis Code	Description	Diagnosis Origin	Original Reported Date	On the date of service that the patient was seen, was the patient treated for this diagnosis, are they on any medication for this diagnosis or is diagnosis a lifelong condition documented in the medical history?
H40.1131	Primary open-angle glaucoma, bilateral, mild stage	Office Visit→Spec	12/4/2020	Yes, diagnosis confirmed
N40.0	Benign prostatic hyperplasia without lower urinary tract symptoms	Office Visit→Spec	12/4/2020	Yes, diagnosis confirmed
K21.9	Gastro-esophageal reflux disease without esophagitis	Other	12/4/2020	No, diagnosis resolved
J45.909	Unspecified asthma, uncomplicated			ADDED

Contact Information:

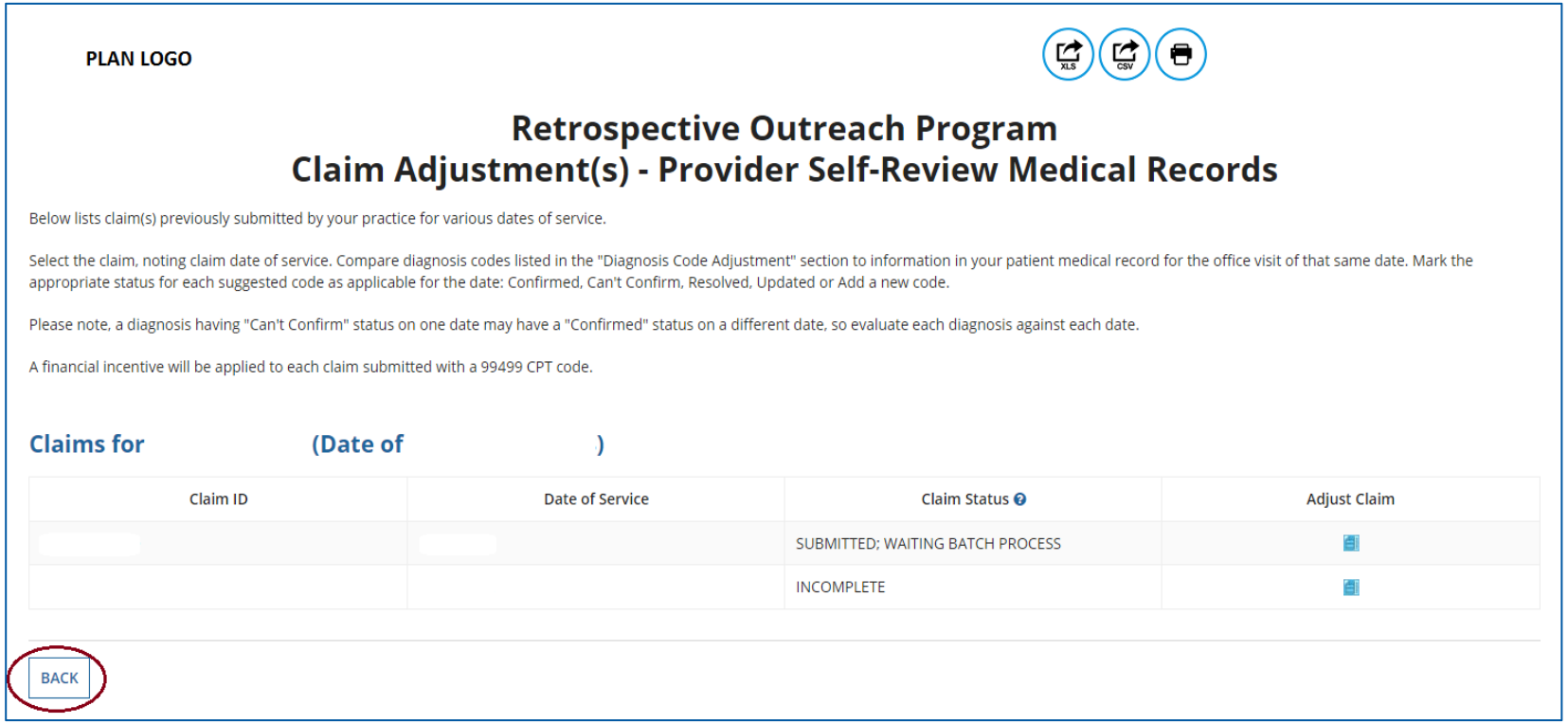
Phone Number:

SUBMIT EDIT

Completion of Adjustment (cont.)

After submitting the adjustment, the user is returned to the *Claim Listing* screen.

If there are additional claims to adjust, proceed to the next claim OR click the *Back* button to return to the Member Listing screen.


PLAN LOGO

XLS CSV

Retrospective Outreach Program
Claim Adjustment(s) - Provider Self-Review Medical Records

Below lists claim(s) previously submitted by your practice for various dates of service.

Select the claim, noting claim date of service. Compare diagnosis codes listed in the "Diagnosis Code Adjustment" section to information in your patient medical record for the office visit of that same date. Mark the appropriate status for each suggested code as applicable for the date: Confirmed, Can't Confirm, Resolved, Updated or Add a new code.

Please note, a diagnosis having "Can't Confirm" status on one date may have a "Confirmed" status on a different date, so evaluate each diagnosis against each date.

A financial incentive will be applied to each claim submitted with a 99499 CPT code.

Claims for (Date of)

Claim ID	Date of Service	Claim Status	Adjust Claim
		SUBMITTED; WAITING BATCH PROCESS	
		INCOMPLETE	

BACK

Adjust Claim(s) – Plan Medical Records Review Results

For the ***Adjust Claims – Plan Medical Records Review*** option:

The basic steps for accessing the member listing are the same.

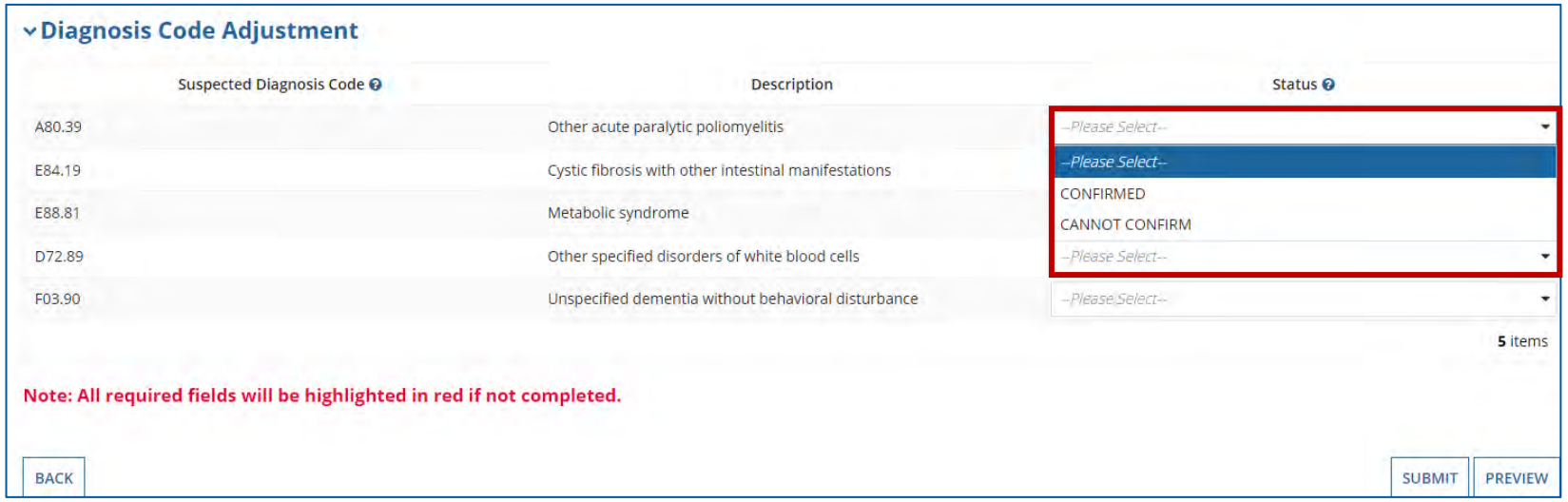
Differences under this option are:

- There are three possible statuses in the Claim Listing screen are:
  - **INCOMPLETE** - You can adjust claims which are in an INCOMPLETE status.
  - **SUBMITTED; WAITING BATCH PROCESS** - Status will be seen when you already submitted an adjustment, but you can re-adjust a claim in this status.
  - **Claim Adjusted on MM/DD/YYYY** - Status is populated when user submitted adjustment and batch process is completed.

Adjust Claim(s) – Plan Medical Records Review Results – Diagnosis Code Adjustment

Remember this option is for DX codes abstracted based on the medical record review by the Plan.

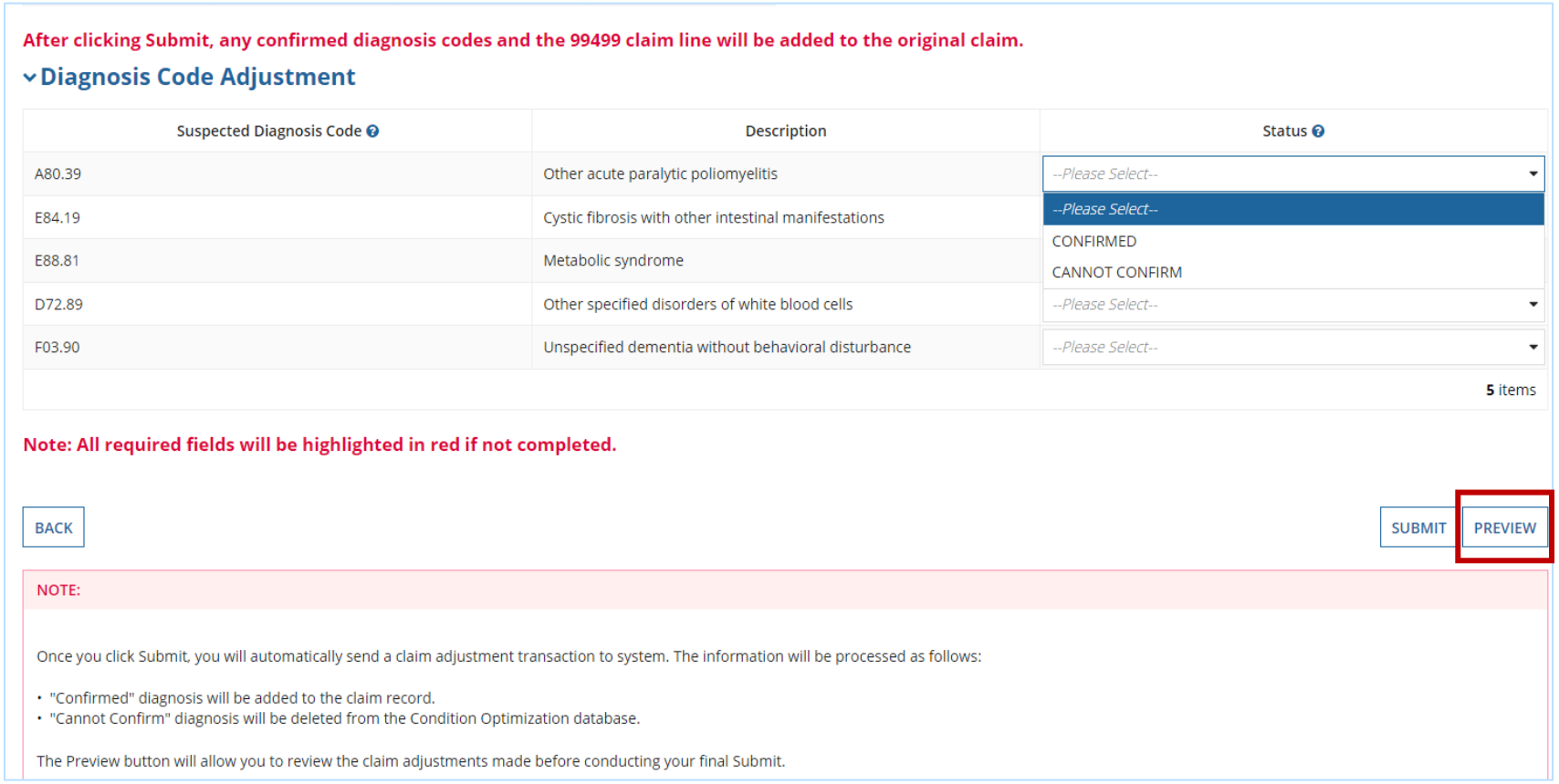
- In the **Diagnosis Code Adjustment** section, we are requesting review of the diagnosis codes listed against the medical record for the member. There are only two options available:
  - **Confirmed** – If user agrees that the diagnosis code should have been included on the original claim.
  - **Cannot Confirm** – If user disagrees that the diagnosis was present.



Completion of Diagnosis Code Adjustment

To complete the adjustment the user should:

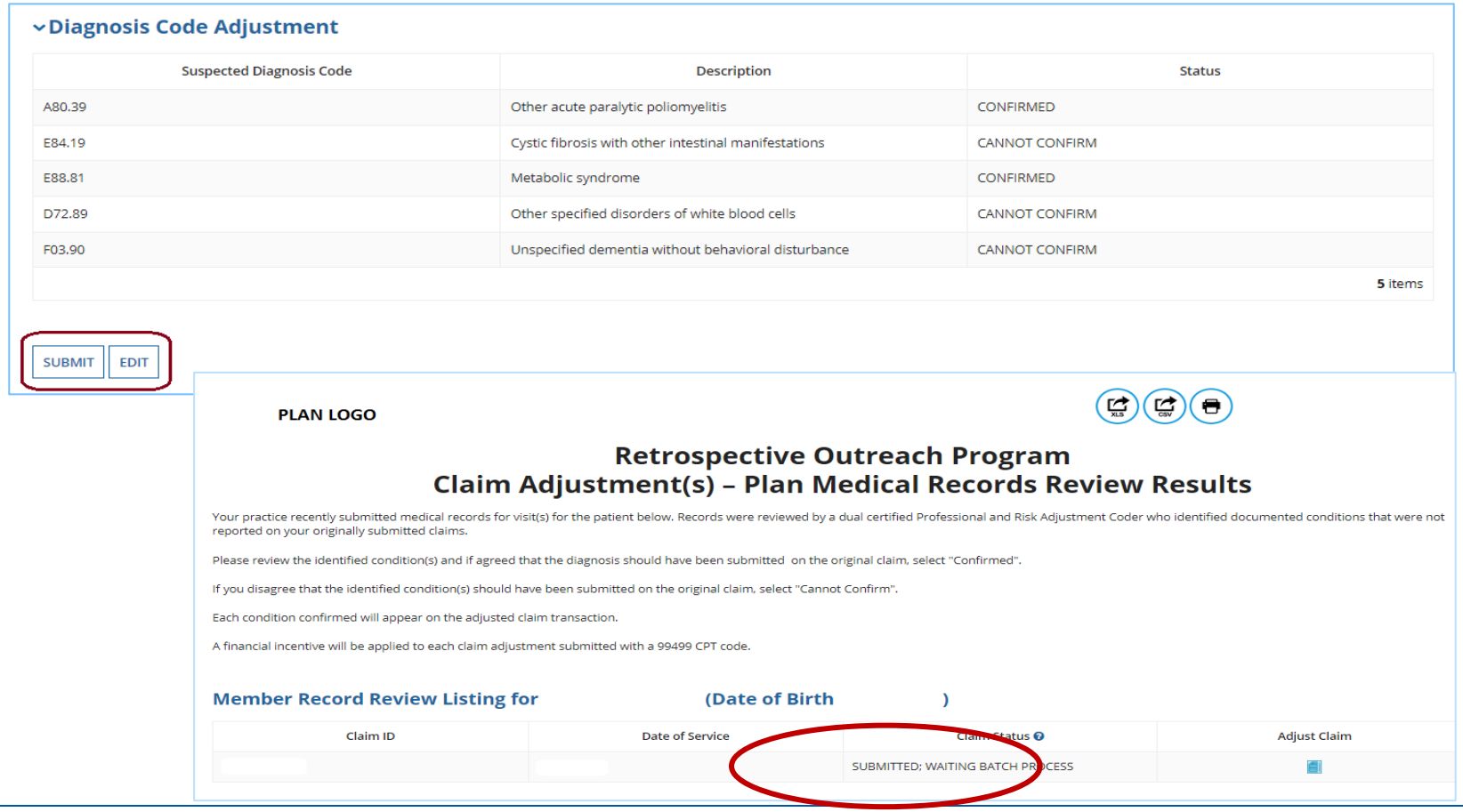
- Select **Preview** at the bottom of the screen for an opportunity to review the "Verification" page.



Completion of Diagnosis Code Adjustment

Click **Edit** to return to the Claim Adjustment screen if changes need to be made.

OR Click **Submit** to complete the claim adjustment activity. The Claim Listing screen status for adjusted claims will display: "**Submitted; Waiting batch process.**"



Diagnosis Code Adjustment

Suspected Diagnosis Code	Description	Status
A80.39	Other acute paralytic poliomyelitis	CONFIRMED
E84.19	Cystic fibrosis with other intestinal manifestations	CANNOT CONFIRM
E88.81	Metabolic syndrome	CONFIRMED
D72.89	Other specified disorders of white blood cells	CANNOT CONFIRM
F03.90	Unspecified dementia without behavioral disturbance	CANNOT CONFIRM

5 items

SUBMIT EDIT

PLAN LOGO

Retrospective Outreach Program
Claim Adjustment(s) – Plan Medical Records Review Results

Your practice recently submitted medical records for visit(s) for the patient below. Records were reviewed by a dual certified Professional and Risk Adjustment Coder who identified documented conditions that were not reported on your originally submitted claims.

Please review the identified condition(s) and if agreed that the diagnosis should have been submitted on the original claim, select "Confirmed".

If you disagree that the identified condition(s) should have been submitted on the original claim, select "Cannot Confirm".

Each condition confirmed will appear on the adjusted claim transaction.

A financial incentive will be applied to each claim adjustment submitted with a 99499 CPT code.

Member Record Review Listing for (Date of Birth)

Claim ID	Date of Service	Claim Status	Adjust Claim
		SUBMITTED; WAITING BATCH PROCESS	

How are incentive payments issued?

- **Prospective Outreach Program** claims process with a zero payment and explanation code of **ZN7 - *Prospective Outreach Program- Payment issued in January and July.***
- Claims are validated in conjunction with the submission of the *Scheduled Appointment* worksheet to ensure confirmed diagnosis are reported on the medical claim.
- In January and July a lump sum payment will be issued with a remittance file listing paid members.
- There are two date of service periods per year; exact period dates vary and are determined by the Medicaid agency in each state.
- **Retrospective Outreach Program** claims are paid via the normal claims process once the adjusted claim is submitted.
- Providers are paid the incentive amount for each adjusted claim.

NOTE: A random audit is performed each risk period (January and July) and medical records may be requested to validate the worksheet and medical claim.

REMEMBER: Program goal is to capture complete and accurate diagnosis codes.

FAQs

Q: Why do you need the medical record if I submitted a worksheet and claim for a completed visit?

A: One goal of the Condition Optimization Program is to help ensure that a member's record contains complete and accurate diagnosis information. A percentage of submitted Scheduled Appointment Worksheets are audited and the medical record is used to validate that all diagnosis codes submitted on the worksheet and claim are also captured in the member's medical record.

Q: Is there someone I can contact if I have questions?

A: E-mail questions to: ConditionOptimizationProgram@amerihealthcaritas.com.

Kelley Royer-Marek
Director of Risk Adjusted Programs
kroyer-marek@amerihealthcaritas.com

Emily Quick
Risk Adjusted Data Analyst III, Corporate Risk Adjustment Programs
equick@amerihealthcaritas.com

AmeriHealth Caritas
District of Columbia

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Amena Hamliton
EPSDT Program Manager

AmeriHealth Caritas
District of Columbia

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Amena Hamilton – EPSDT Program Manager

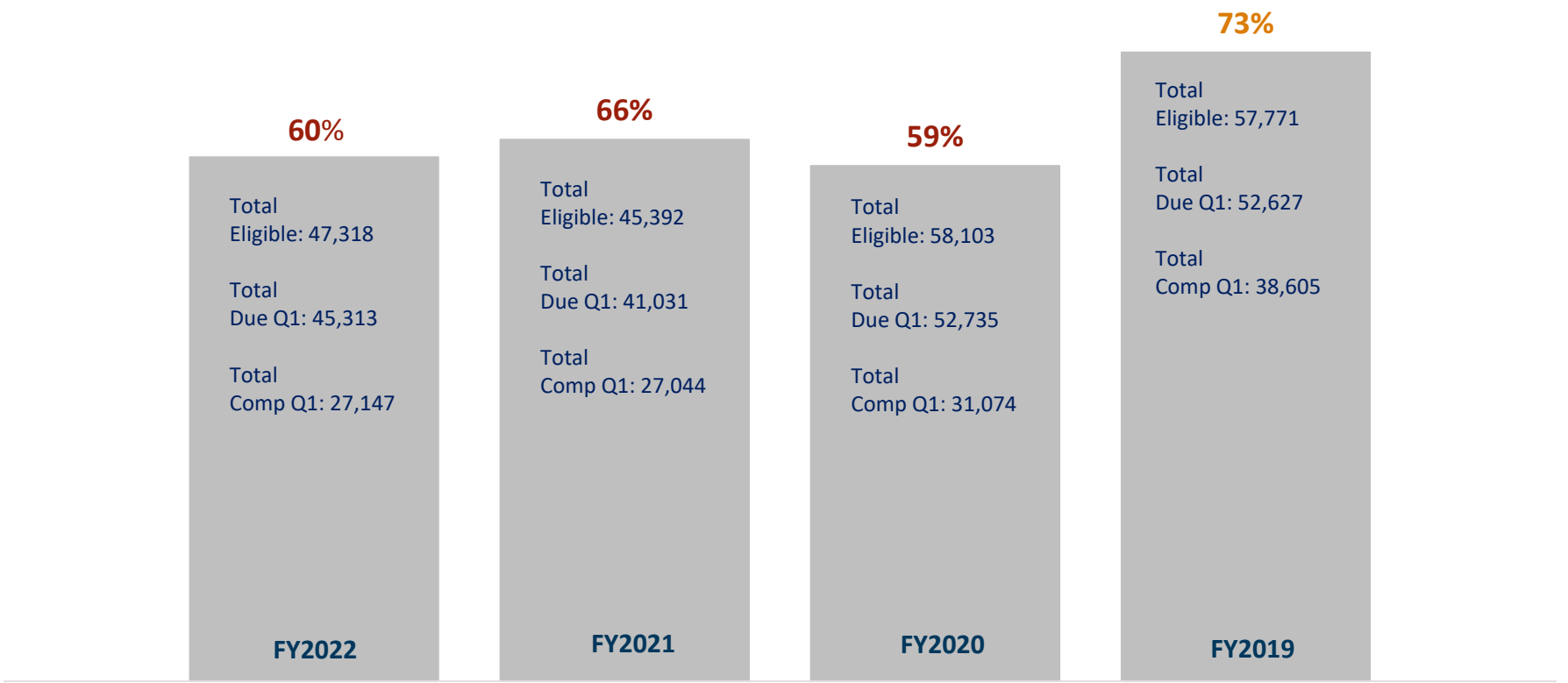
February 16, 2023

AmeriHealth Caritas
District of Columbia

Delivering the Next Generation of Health Care

ESPDT Participation Ratio Trend (as of February 2023)

Annual Results



EPSDT Participation Ratio – FY2022 (As of February 2023)

	2022	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	Total:	45,313	1,438	4,911	7,102	9,436	11,556	7,704	3,166
9. Total Eligibles Receiving at least One Initial or Periodic Screen	Total:	27,147	1,332	3,975	4,509	5,388	6,738	4,176	1,029
10. PARTICIPANT RATIO	Total:	**60%**	**93%**	**81%**	**63%**	**57%**	**58%**	**54%**	**33%**
# Additional needed for 75%		6,838			818	1,689	1,929	1,602	1,346
# Additional needed for 80%		**9,103**			**1,173**	**2,161**	**2,507**	**1,987**	**1,504**

EPSDT Telephonic Outreach

Telephonic Outreach

- **Birthday Calls (Monthly)**
  - Discussions around due or overdue for WCV and Immunizations
  - Lead screening reminder calls (as appropriate).
  - Covid-19 vaccination discussion is also integrated into all of our outbound and inbound calls for review of gaps in care, care management and customer service
- **Well-child Exam Auto-dialer Campaigns with Live Connect Option (Monthly)**
  - New enrollees to the plan
  - Families with children due and overdue for well-child exams
  - Dental gaps in care continue to be discussed as part of all outbound EPSDT calls (as appropriate).
- **Manual Call Outreach**
  - New Member Outreach to those we were not able to contact via the Auto Dialer
  - Non-Compliant Enrollees with Large FQHCs as their PCP
  - Proactive outreach to those with care gaps who have upcoming birthdays

Mailings and Home Visit Outreach

Home Visit Outreach

- ACDC has restarted our face-to-face outreach to enrollees who we are unable to connect with telephonically after multiple attempts.
- Our focus is currently on Large Families (5+ enrollees under one family link) to help facilitate appointment schedules.

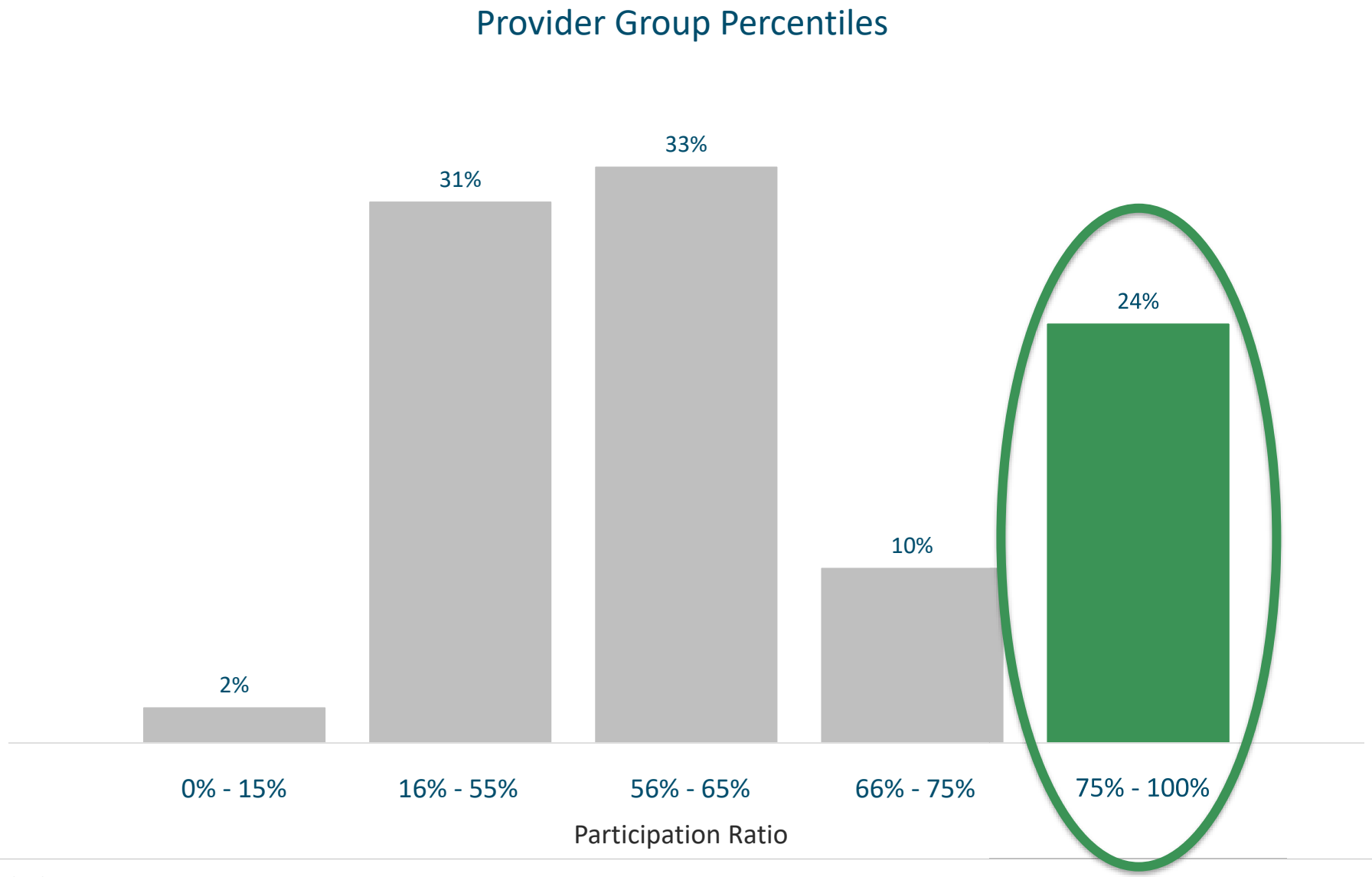
Text Message (SMS) Outreach

- Monthly text messaging reminders are sent to the guardians of all due and overdue enrollees to let them connect with an outreach representative who will assist with scheduling their EPSDT Health-check appointments.

Mailings

- Send unable to reach letters to those enrollees we cannot contact after a live call attempt
- Postcard mailings to enrollees with invalid, disconnected, wrong and no numbers (monthly).

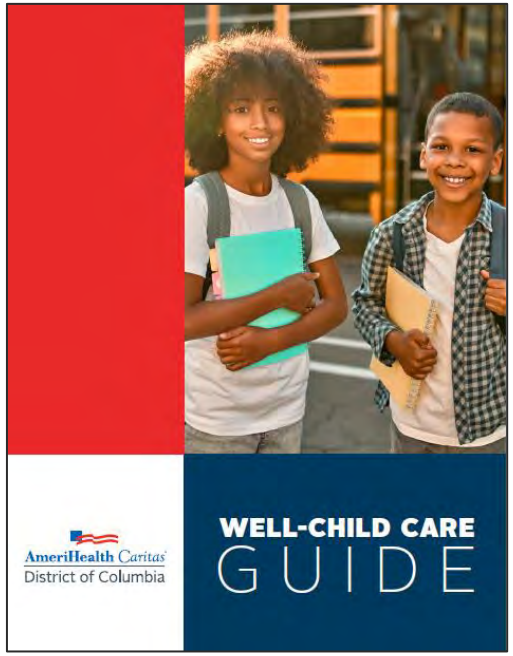
Provider Discussions - FY2022 (Oct 2021 – Sept 2022)

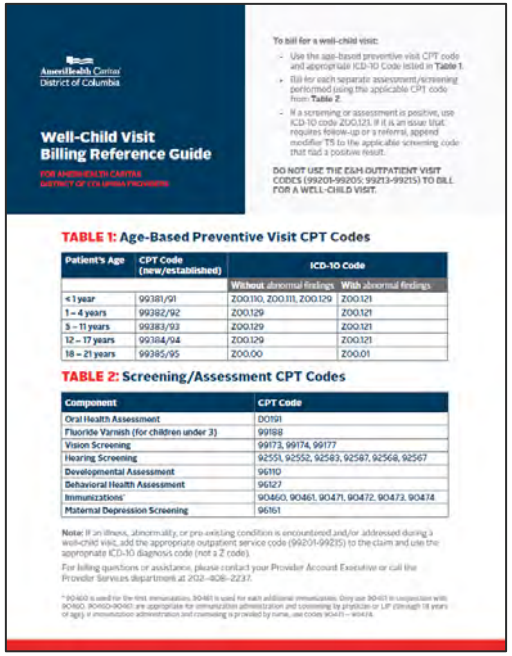


PROVIDER DISCUSSIONS

- **Provider Outreach and Coordination Meetings (Bi-Monthly)**
  - Sharing of provider-specific EPSDT CMS 416 participant ratio performance
  - Exchanging data to optimize outreach efforts
  - Reestablish Community Health Workers being embedded at provider sites
- **Family Wellness Days and Block-Scheduling Opportunities**
  - Focused on those providers with larger enrollee panels or capacity for special scheduling
  - Wellness Clinic Days established at HUFPP, Elaine Ellis and District Urgent Care
- **Medical Record Retrieval**
  - Based discussion has been around challenges with access to records.
  - Record access has been established at Unity, Mary Center and Children's National Ped & Assoc.
  - For FY2022, no records have been retrieved due to claims in system.
- **Provide Training, Resources and Job-Aid to Providers**
  - Focus individualized training sessions, as appropriate, for provider practices
  - Utilizing Provider Advisory Committee Meeting as a platform to introduce training

Resources and Job-Aids





[EPSDT/ HealthCheck Guidelines]
(https://www.amerihealthcaritasdc.com/provider/resources/epsdt.aspx)

Amena Hamilton

EPSDT Program Manager

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Communication and Health Program Information

Darla Bishop
Manager – Marketing, Communications and Health Programs

AmeriHealth Caritas
District of Columbia

Enrollee Wellness and Opportunity Center

Health Promotion

- Fitness Classes
- Cooking
- Wellness Circles
- Smoking Cessation
- Stress Management
- BH Support

Community Resources

- Enrollee Orientation
- SNAP Ed/WIC
- ESA
- Tzadek
- DHS Childcare

Economic Empowerment

- Financial Literacy
- Internship
- Job Training
  - CL Russell Group
  - Kitchen Savage
  - DC Central Kitchen
- Home Ownership

Darla Bishop

Manager – Marketing, Communications and Health Programs

dbishop1@amerihealthcaritasdc.com

AmeriHealth Caritas

District of Columbia

Maternal Health Initiative

Dr. Nathan Fletcher
Dental Director, ACDC

AmeriHealth Caritas
District of Columbia

Oral Care Connect
Maternal Health Initiative

Dr. Nathan Fletcher

Dental Director, ACDC

Purpose and Program Overview

Purpose:
The goal of the incentive-based program aims to raise awareness for OB/GNY's, Family providers and Primary Dental Provider's (PDP) of urgent maternal oral health warning signs and help our members attain optimal overall health before, during and after pregnancy.

Furthermore, we aspire for the physicians and their staff to have oral-health-focused conversations relating to maternal health and refer pregnant members to dentists within the network of participating providers.

Vice versa, we hope to have dentists who may have a patient that indicates they are pregnant on their health history to inquire about their perinatal status and OB engagement with appropriate referrals when necessary.

Program Overview:
For pregnant members, an incentive payment will be made to the providers when a dental claim is noted and paired with an OB/GYN or PCP claim within 60 days prior to the date of the initial dental appointment. Once an eligible member receives an initial exam that corresponds with a specific dental (D) code, a 60-day look-back will be initiated. If an OB/GYN or PCP claim is identified within this 60-day time frame, an incentive payment of $50 per qualifying member will be paid out to the OB/GYN or Family Care provider.

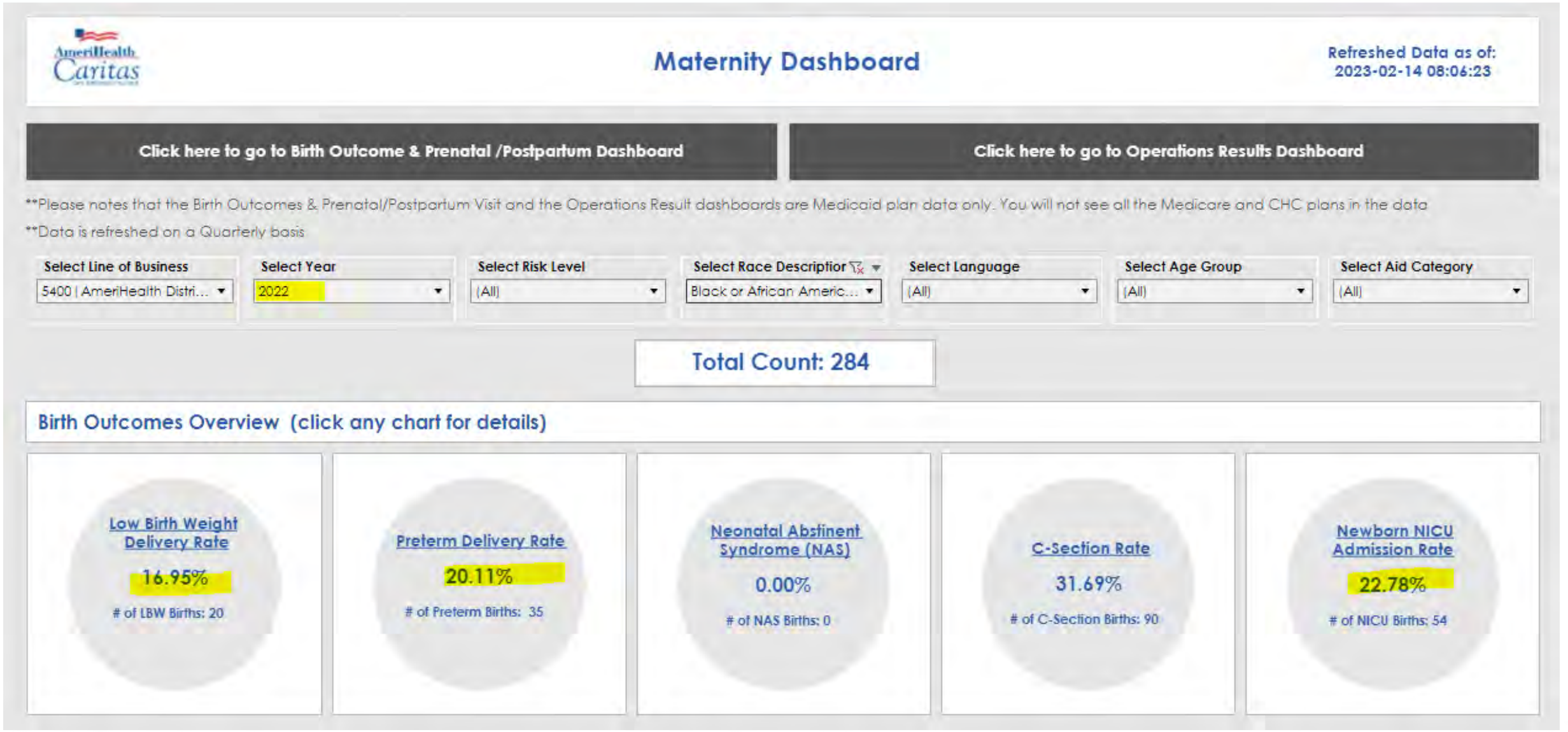
Program Objectives

- Conducting a broad-based education and awareness campaign
- Executing a focused outreach plan to members and providers
- Incentivizing OB/GYN's and Family Care providers for referring pregnant enrollees to dentists.

Program Outcomes

- To Increase the percentage of women receiving dental care before, during, and after pregnancy.

Maternity Dashboard with Low Birth Rate and Preterm Birth



Program Evaluation Maternal Health

Intended Outcome	Metric	Baseline	Target	YTD Results					Comments
				Q1	Q2	Q3	Q4	Trend	
Increase # of Qualifying members	Dental Utilization Rate	3.7%	10%					↑	Primary Focus
Decrease of Medical Cost Drivers Associated with Maternal Care	ACDC Preterm Delivery	12.0%	10.0%					↓	Incidental
	ACDC NICU Admits	18.8%	16.0%					↔	Incidental
	US Avg Medicaid Payment for Maternal Care	$12,235 vaginal $17,004 cesarean						↓ ↓	Incidental
Increase # of prenatal oral health screenings	Bright Start Assessments	22	50					↑	Focused Training

Next Steps

- **We want to begin to coordinate training opportunities with OB offices and FQHCs to maximize the reach for training.**

- **We would like to know the contact person for each entity to set up training.**

- **There may be an opportunity to provide CME for the training.**

- **The AmeriHealth Caritas DC point of contact is Donna Fisher at**

Email: DFisher@amerihealthcaritas.com
Telephone: (302) 362-1655

Dr. Nathan Fletcher

Dental Director, ACDC

nlfletcher@amerihealthcaritasdc.com

Survey & Open Discussion

<u>Survey:</u>

- You will see a poll pop up that will ask you three questions. Please answer the best you can.
- These questions plus a few more will also be available in our post survey.

Thank You!

*We are so very excited to have you as a provider partner and wanted to thank you from the bottom of our hearts for all you do to service our enrollees. Our strategy for 2023 is to c*reate a network on the cutting edge of provider transformation by embracing the health plan's role in access to care and delivering value through data.

More than

35 YEARS

of making

care the **heart**

of our **work.**

AmeriHealth Caritas
District of Columbia

MEETING MINUTES

AmeriHealth Caritas District of Columbia
1250 Maryland Avenue SW, Suite 500
Washington, DC 20024

AmeriHealth Caritas District of Columbia

PROVIDER ADVISORY COMMITTEE

MEETING MINUTES

Thursday, February 16, 2023

5:30pm – 7:00pm

FACILITATOR:

- Tamu Tucker, Facilitator, Provider Advisory Committee

SPEAKERS:

- Bobbie Monagan, Director, Provider Network Management, AmeriHealth Caritas DC
- Lisa Hughes, Payor Solutions Executive - DC/VA, LabCorp
- Marshay Price, Regional Manager of Business Development, Labcorp
- Emily Quick, Risk Adj Data Analyst III, Corporate Risk Adjustment Programs AmeriHealth
- Amena Hamilton, EPSDT Program Manager, AmeriHealth Caritas DC
- Darla Bishop, Manager of Marketing, Communications and Health Programs, AmeriHealth Caritas DC
- Nathan Fletcher, D.D.S., Dental Director, AmeriHealth Caritas DC

AGENDA:

- Welcome and Agenda
- Opening Remarks
- LabCorp Overview
- PCP Condition Optimization Program (COP) Enrollee Initiatives
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Enrollee Wellness and Opportunity Center
- Maternal Health Initiative
- Open Discussion and Survey

DISCUSSION:

- <u>Welcome and Agenda</u>
    - Tamu Tucker started with meeting instructions and a review of the agenda.

- <u>Opening Remarks Bobbie Monagan:</u>
    - We are excited to kick off our Provider Advisory Committee Meetings for the 2023 calendar year and the opportunity we will be presenting this evening. We appreciate your time this evening.

DHCF This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.
GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

- LabCorp Overview – Lisa Hughes & Marshay Price
    - LabCorp is the main umbrella company, and we specialize in many testing areas, such as pathology, kidney stone analysis, and drug testing.
    - Providers have access to many different services and all the companies under the LabCorp umbrella.
    - LabCorp has eight (8) patient services centers throughout the District of Columbia.
        - We now offer a mobile check-in feature so patients can check-in remotely from their phone.
        - We also have kiosks on site where they can check-in by scanning their ID.
        - The mobile or kiosk check-in helps increase efficiency and decrease wait times at our service centers. We also have a patient portal and mobile app that lets patients schedule appointments, look at their results, and look at educational material on any tests they will be receiving.
        - A patient survey is automatically emailed after the patient checks in for their appointment.
        - LabCorp reviews and analyzes this data regularly to help enhance their services and make any enhancements to the patient service centers.
    - At home test kits are available; in addition to the COVID-19 tests we also have Colorectal Cancer Screening tests, Hemoglobin A1C tests, as well as Kidney Health Evaluation test kits.
        - These kits can be ordered in bulk by the health plan or by individual physicians to be sent directly to the patient's home.
    - Laboratory data is useful for providing patient results, payer coding, demographics, coding accuracy, monitoring risk patients and more.
        - Having access to this data and using it will help support with quality metrics, prioritizing care management, decreasing hospital emergency room visits, and reduce total cost of care.
    - LabCorp Insight Analytics is a reporting tool that provides Providers with the opportunity to get very detailed, at a patient level, data.
        - There are preset filters that let Providers run reports on chronic conditions, population analysis, etc.
    - ICD-10 coding analytics is something LabCorp is working on. This report will identify gaps in ICD-10 coding and help provide coding support.
        - There are few ways to view this report because it can be drilled down by Provider, payer name, specialty code, or practice name.
    - LabCorp Diagnostic Assistant can deliver focused patient data starting from the beginning of patient care, at no cost to Providers.
        - It provides a complete view of a patient's lab result history.

- This data gives evidence-based guidelines to help facilitate decision-making as well as improve patient care by collecting patient data, and identifying what tests were performed at LabCorp; note that this would also include testing that was ordered outside of the Providers organization if they are a LabCorp patient.
- The patient's record is delivered to the Providers DHR in real time at the point of care.

- <u>Primary Care Physician (PCP) Condition Optimization Program – Emily Quick</u>
  - The Condition Optimization Program's goal is to have the most up to date information about our members' complete chronic or complex medical condition and diagnostic codes in our system.
    - This way we can help Primary Care Physicians (PCP) identify said patients as well as promote routine access to primary care to those patients.
  - To accomplish our goal, we run a data analysis process that identifies members by reviewing their claims history.
    - We first look at who has chronic and or complex medical needs on file and then, we see if those chronic and or complex medical conditions have been treated in the current data service period.
    - When they have not been treated within the current data service period they are considered a suspect number and are identified as having missing information.
    - We take that information and place it in two buckets, one for members that have a PCP visit within the date of service period and one for those that do not.
  - Retrospective Outreach Program: Patient records are requested from the Provider that have chronic and or complex medical needs that have visited a PCP within the date of service period.
    - Per the Provider Self Review, we ask the Provider to determine if the diagnosis can be confirmed or not.
    - Per the Plan Medical Review, the patients' medical record abstraction will be reviewed in NaviNet by a coder to confirm or not confirm the diagnosis.
    - For each adjustment that is reviewed there is an incentive payment of $25, with each additional visit asked to be reviewed for the same member there is an additional $7. This incentive is not based on whether you agree with the diagnosis or not, just that you completed the task.
  - Prospect Outreach Program: This is for patients with chronic and or complex medical needs that have not had a PCP visit within the date of service period.
    - We encourage Providers to outreach to the patients to try and schedule a visit.
    - There is an incentive to complete these as well; once all the requirements are met, a completed prospective action item is worth a $150 incentive payment.
  - Walked through NaviNet slides with examples and screen shots of how to search for information, complete adjustments, and receive incentives.
  - Prospective Outreach Program incentives are paid out twice a year.

- Retrospective Outreach Program incentives are paid through the normal claims process.
- Providers can reach out to the PCP Condition Optimization Program to see how much they would receive in incentives if or when they complete all of their adjustments.

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Amena Hamilton

  - EPSDT Participation Ratio trend shows that in 2022 we reached 60%, our goal is to reach 80%.
  - Over the years since 2019 we have put a lot of effort into getting our families to visit their PCP so their children can receive their well child visits. The pandemic did have an impact on this trend.
    - We are looking for ways to re-engage the community to get them to come in and understand the importance of their child's development and why it is important they come in for their well child visits.
    - As the children grow up and immunizations are not the priority, we see a drop in the number of them coming in for their annual physicals.
    - AmeriHealth offers an incentive of $50 for the 12yrs-20yrs old age group if they come in for their well child visit within the timeframe they are due.
  - EPSDT outreach includes telephonic efforts.
    - Monthly birthday calls are made in an effort to have them come in for their annual well child visit; discussions of overdue immunizations, lead screenings if appropriate, as well as COVID-19 vaccinations and other gaps of care are also held when needed.
    - We have an IBR that does a monthly campaign to those that are new to the plan and those that are due, overdue or have a gap in dental care.
    - We do a manual outreach call, here we are trying to connect them to their PCP and get them an appointment in the necessary time frame.
  - Home visits are also attempted where we have made multiple attempts to contact them with no success.
  - For those families that have five or more members we want to work on helping facilitate getting them appointments because we hear it is harder for larger families to get appointments for everyone at once.
  - We are trying to help the children where they are; so, if they are enrolled in a school that has a school-based health center we are looking to see how they can get the care or their well child visit done there.
  - We also do text messages and mailings for outreach.
    - We do our best to keep the phone calls and text messages at the same cadence.
  - Our Provider participating ratio in 2022 shows that 24% of Providers are participating within the 75-100% ratio.

- We see our highest Provider group (33%) participates at the 56-65% ratio.
    - Please note that in the previous year the 56-65% participation ratio group was at 23%, so we have made a rise in how Provider groups are able to get their patients in and be seen.
- It is important that we partner together so we can get our numbers to increase and ensure that our children are seen.
- Amena Hamilton hosts bi-monthly calls with Provider groups to discuss their specific CMS 416 participant ratio performance.
    - Discussions include how to best optimize outreach efforts and the opportunity to have community health workers established in their facilities.
    - This way the community health worker can assist with no show ratios and be a resource for enrollees that come in as your patients; if they need changes to their PCP or even new cards there is someone there to help.
- We are trying to re-establish Family Wellness Days and block scheduling opportunities, especially for our larger families that find it harder to get everyone scheduled together.
- Medical record retrieval will be a big push this year to make sure that the information we have as far as those that are due or overdue align with what Providers have in their system.
    - This includes to ensure we are clear on who has been seen, who has third party insurance and that we are capturing the data accurately and not reaching out to people unnecessarily.
- Ms. Hamilton can give insight and train your team from a billing aspect upon request.

- <u>Enrollee Wellness and Opportunity Center - Darla Bishop</u>
    - AmeriHealth Caritas DC is re-opening our Enrollee Wellness and Opportunity Center slowly to enrollees throughout the month of March with a grand opening on April 1, 2023, from 1-4pm.
    - This center focuses on three main pillars:
        - Health Promotion – to connect enrollees to healthy activities to help them feel good. These include fitness classes, cooking classes, wellness circles, stress management, etc.
        - Community Resources – to connect enrollees to the many resources available, like enrollee orientation, SNAP, childcare, etc. People who do not have their basic social needs met cannot be focused on their health.
        - Economic Empowerment – to offer financial literacy courses, internships, job trainings, and home ownership resources.
    - If anyone is aware of any resources, please let Darla Bishop know, it would be extremely helpful.

- Question by Bobbie Monagan, AmeriHealth: What are activities around redetermination and helping our enrollees qualify. What is AmeriHealth Caritas an organization doing in that space?
    - Response by Darla Bishop: We have been messaging enrollees in English and Spanish to make sure they have their contact information up to date with us.
        - We have also directed people to use District Direct, which is the District of Columbia's portal for all government benefits, to make sure their address, phone number, and email are all correct.
        - This is to ensure that when the notices to renew are sent out, the enrollee receives them and can take positive action.
        - There are a few things we have learned, and that is that it is important for people to sign up through District Direct and then connect it to the healthcare plan they are enrolled in.
        - Department of Health Care Finance (DHCF) has found that if there is a different spelling of their name, even if it is just a different capitalization, the system may not recognize them so enrollees need to connect District Direct to their Healthcare Plan with their social security number (SSN) or Medicaid Identification Number.
- Question by Stephanie Hafiz, AmeriHealth: In the previous Enrollee Wellness and Opportunity Center there was pharmacy support. Will we have the opportunity in the future?
    - Response by Darla Bishop: "Ask the Pharmacist" is not being brought back as of yet. We have a slightly different physical layout, so we have reserved those spaces for care management to ensure the Care Managers are there each day along with two to three Outreach Staff members.
        - Once we have a stable schedule with our care management team and outreach team we are hoping to bring back "Talk with the Pharmacist Day," we will also be doing some behavioral health activities soon.
- Question by Beverly Morgan, Bridgepoint Healthcare: Does AmeriHealth offer food subscriptions where the members can go and get healthy food options?
    - Response by Darla Bishop: We partner with DC Greens, and their program is called Produce Prescription. Enrollees can get fresh fruit and vegetables as long as they are with certain Federally Qualified Heath Center's (FQHC) in the District of Columbia and have a diagnosis of diabetes, pre-diabetes or hypertension. We also have meal deliveries that are condition appropriate and medically tailored for people really wanting to change the direction of their condition.

- Maternal Health Initiative – Dr. Nathan Fletcher
    - The purpose of the program is to incentivize OBGYN's and raise awareness with Family Providers and Primary Dental Providers (PDP) of maternal oral health warning signs and

help members obtain optimal overall care before, during, and after pregnancy thru oral health care.

- The incentive payment will be made when a dental claim is noted and paired with an OB/GYN or PCP claim within 60 days of the initial dental appointment. The incentive is a payment of $50 per qualifying member.

- Our objective is to conduct a broad-based education awareness campaign. We have already developed brochures for members and Providers.

- We have published within the Provider newsletter with information on the importance of oral health of pregnant moms.

- The goal is to increase the percentage of women receiving dental care before, during and after their pregnancy.

- Inflammation is a potential problem related to preterm births.

  - Periodontitis/gum disease is the number one inflammatory issue in adults in the world.
  - By having a pregnant woman go to the dentist to address their dental needs we hope to reduce this factor from contributing to pre-term births.

- Currently the Dental Utilization Rate is at 3.7%, our target is 10%; reaching our target is our primary focus.

- There are other aspects that we also hope to reduce; preterm delivery and NICU admissions, which will help drive down medical costs.

- We also want to try and address increases in the assessments by using Bright Start and care management.

- We want to coordinate training opportunities with OB offices and FQHC's to maximize the reach for training.

  - We need to know the point of contact of each office to set this up.
  - We have done this in the past as a lunch and learn where we provide the lunch, and we can possibly provide a Continuing Medical Education (CME) credit for the training.
  - We will only take 30-45 minutes to bring OB's up to speed and answer their questions.

- Question by Bobbie Monagan, AmeriHealth: Does an enrollee need to have a referral from a medical doctor in order to receive dental services?

  - Response by Dr. Nathan Fletcher – No, they would not need to present a referral. What we will try to do is assist them in setting up an appointment. We

can and hope to provide a list based on geographical access to a particular OB office that is within proximity of the enrollee. They can set up the appointment themselves or go through member services or through outreach phone calls. Every enrollee is assigned a PDP, it is written on their membership card along with their PCP.

- Survey & Open Discussion – Bobbie Monagan and Tamu Tucker
    - We have a poll to ask a few questions. One of the questions is about the Quarterly Provider Action Committee. This will serve as a more interactive forum where Providers can provide their feedback.
        - Poll Questions:
            - What is the best time for you to attend our Provider Advisory Committee Meeting? (Choose your top two)
            - If none of the previously suggested times work. Please state what time does work for you.
            - What issues, services, and or initiatives do you want to see presented and discussed?
            - Would you like to participate as part of a panel for our Provider Action Committee?
    - We want to partner with the Providers and have these focus groups be interactive.
    - We will talk about best practices and maybe use the recommendations to adjust how we do business so that we can make it easier for you, as Providers, to interact with us.
    - There are Continuing Education Units (CEU) associated with the "March of Dimes – Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare" learning event.
    - If there are any clinicians that are interested in applying for CEU's or are interested in what we are doing to partner with March of Dimes in reference to Maternal Health, please take the flyer and pass it along so they can take the course.
- Questions and Answers:
    - Question in the Chat from Lavdena Orr MD CMO - Are Continuing Medical Education credits (CME) available for physicians? Can we check with March of Dimes to see if they offer CMEs?
        - Response by Dr. Nathan Fletcher: We may be able to arrange for CMEs related to the Maternal Oral Health training.
        - Response by Bobbie Monagan: Yes, we can check with the March of Dimes to see if they offer CMEs as well.

- Question in the Chat from Ebony Lea, A Fresh Start Therapy - I usually get communications about changes and updates via fax. Is that the standard way to receive information or is there another medium?
    - Response by Bobbie Monagan: Yes, this is still the standard, and we realize that some offices now prefer fax, text, or emails. We would like to discuss this within our focus group meetings (Provider Action Committee).

- Closing Remarks – Bobbie Monagan:
    - We had a great turn out; I appreciate all of you and the time you gave us this evening. Please take a moment to sign up for our Provider Action Committee. We want to partner with you and ensure you have access to the same resources we do; we are also open to your feedback. We are working on making the Provider Action Committee an in-person meeting, so in the post survey you will be asked what times and day work best for you in this regard; we are flexible in this regard. This is meeting is meant to be an open dialogue driven by Providers.

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ACTION ITEMS:

- Please take a moment to fill out the post survey.
- Reach out to your Account Executive to discuss the incentives you could be owed.

AmeriHealth Caritas
District of Columbia

Live Survey Results

What is the best time for you to attend our Provider Advisory Committee Meeting? (choose your top two)

12:00pm - 1:30pm: 15%
4:30pm - 6:00pm: 38%
5:30pm - 7:00pm: 42%
6:30pm - 8:00pm: 3%

What issues, services, and or initiatives do you want to see presented and discussed?

- 3M
- Substance Use Disorder (SUD) and Mental Health
- Client referrals to Providers
- Open dialogue and incorporating oral health in the discussion
- Claims processing changes and claims payment processing
- EPSDT initiatives and increasing preventive screenings for children
- How oncology practitioners can deliver care to the unique population of AmeriHealth Caritas
- Gaps in care

Would you like to participate as a part of a panel for our Provider Action Committee?

Yes: 3 votes
Maybe: 6 votes
No: 3 votes

AmeriHealth Caritas
District of Columbia

RESOURCES

HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

AWARENESS TO ACTION: DISMANTLING BIAS IN MATERNAL AND INFANT HEALTHCARE™

Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare™ provides authentic, compelling content for health care providers caring for women before, during and after pregnancy. We offer implicit bias training to increase awareness and stimulate action to address implicit bias in maternity care settings.

Training alone won't lead to immediate improvements in racial and ethnic disparities, but it can provide health care providers with important insights to recognize and remedy implicit bias. These actions can result in improved patient-provider communication, overall patient experience and quality of care and a culture shift across committed organizations towards the broader goal of achieving equity for all moms and babies.

LEARNING OBJECTIVES

(1) Understand and be able to identify implicit bias, the cognitive basis that informs bias, and its impact on maternity care settings.

(2) Explain how structural racism has played a key role in shaping care settings within the U.S. and contributes to implicit biases in patient/provider encounters.

(3) Recognize one's potential for implicit bias and apply strategies, such as the CARES Framework™ and practice cultural humility, to effectively mitigate their own implicit biases.

(4) Recognize and establish a culture of equity as an organizational commitment through action planning to elevate the quality of maternity care.

How to Access eLearning Module

Follow these instructions to access/create your March of Dimes account and begin training.

1. Visit: https://modprofessionaled.learnuponus.com/. If you have previously created a March of Dimes LearnUpon account, login and you will proceed to your course dashboard and follow the link to add your new Course ID and access your training. (If you don't remember your password, you can click the "Forgot Password" to receive a link and reset.)
2. To Create a new account click the **"Sign Up Now"** link below the login box and follow the directions below:
3. Enter your email address and create a password for your account.
4. Check your email and click the confirmation link that we send to you.
5. Complete all fields on your account profile in order to access the training. ENTER YOUR COURSE ID: (Located in red box to the right)
6. Click SAVE to complete your signup. This course may be accessed until **April 1, 2023**.

YOUR COURSE ID

ACT64

AmeriHealth Caritas District of Columbia

Accreditation Statement:

In support of improving patient care, this activity has been planned and implemented by Amedco LLC and March of Dimes. Amedco LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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Nurses:

Amedco LLC designates this activity for a maximum of 1.50 ANCC contact hours.

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AmeriHealth Caritas
District of Columbia

WELLNESS AND OPPORTUNITY CENTER

GRAND OPENING

NEW LOCATION, MORE OPPORTUNITIES

For AmeriHealth Caritas District of Columbia Enrollees!

DON'T MISS IT!

STOP BY AND ENJOY

- Exercise demonstrations
- Face painting
- Refreshments
- And much more

We'll also be there to answer any health care questions you might have.

Saturday
April 1, 2023
1 – 4 p.m.

1209 Good Hope Road, SE
Washington, DC 20020

RSVPS to 202-216-2318

TO LEARN MORE, CALL:

Medicaid Enrollee Services
202-408-4720
(Toll Free: 1-800-408-7511)

Alliance Enrollee Services
202-842-2810
(Toll Free: 1-866-842-2810

Swipe & Save with OTC Network®

Your AmeriHealth Caritas District of Columbia CARE Card can save you money as well as earn you rewards. The OTC Network® can help you get instant savings on select wellness and everyday items.

Just swipe your CARE Card at participating retailers when buying eligible products to save up to $100 each month. You just need one card to enjoy all the benefits!

Get the OTC Network® mobile app

The OTC Network mobile app can help you save money and keep track of your CARE Card. With the app, you can:

- Check card balance
- Choose a participating retailer
- Discover item eligibility by scanning the bar code

Visit www.myotccard.com

English: If you do not speak and/or read English, please call **1-800-408-7511 (TTY 1-800-570-1190)**, available 24 hours a day, seven days a week. A representative will assist you.

Español: Si no habla y/o lee inglés, llame al **1-800-408-7511 (TTY 1-800-570-1190),** línea disponible las 24 horas del día, los siete días de la semana. Un representante le ayudará.

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Tiếng Việt: Nếu quý vị không nói và/hoặc đọc Tiếng Anh, vui lòng gọi **1-800-408-7511 (TTY 1-800-570-1190),** 24 giờ một ngày, bảy ngày một tuần. Sẽ có người đại diện hỗ trợ quý vị.

繁體中文：如果您不會講或讀英文，請致電 **1-800-408-7511 (TTY 1-800-570-1190)**，此電話每天 24 小時，每週 7 天開通。您將得到一位服務代表的協助。

한국어: 영어를 말하거나 읽지 못하는 경우, 365일 24시간 이용 가능한 **1-800-408-7511 (TTY 1-800-570-1190)번**으로 전화하십시오. 직원이 도와드릴 것입니다.

Français: Si vous ne parlez, ni ne lisez anglais, veuillez appeler au numéro **1-800-408-7511 (TTY 1-800-570-1190)**, disponible 24 heures sur 24, 7 jours sur 7. Un représentant pourra vous aider.

www.amerihealthcaritasdc.com

AmeriHealth Caritas District of Columbia

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance. DHCF

GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

AmeriHealth Caritas District of Columbia

CARE CARD PROGRAM

AmeriHealth Caritas District of Columbia

Don't miss your chance to earn rewards for good health!

As an **AmeriHealth Caritas DC enrollee**, you may be eligible to get rewards for doing things that help you stay healthy.

How it works

Complete one of the recommended health screenings or tests below to get started. Once your provider notifies us that you have completed a healthy activity, we will add rewards to your card. **It's that easy!**

CATEGORY	DETAILS	REWARD AMOUNT
Child wellness visit *For enrollees ages 12–20*	—Have your annual wellness visit with your primary care provider (PCP)	**$50**
Prenatal visit	—Visit your OB/GYN or midwife in your first trimester (before you are 13 weeks pregnant)	**$25**
Postpartum visit	—Visit your OB/GYN or midwife within one to 12 weeks (7-84 days) after delivery	**$25**
Diabetic screening *For enrollees ages 18–75 who have been diagnosed with diabetes*	—Visit your eye doctor and get a retinal eye exam —Receive hemoglobin A1C (HbA1C) and nephropathy tests from your primary care provider (PCP)	**$25**

Places you can use your CARE Card

Walgreens

CVS pharmacy

RITE AID PHARMACY

Walmart

Your rewards may not be converted to cash. Once your doctor notifies us that you have completed a healthy activity, we will add rewards to your card. Eligible CARE Card program rewards are subject to change. AmeriHealth Caritas District of Columbia will notify you before the change happens. Rewards expire if you lose AmeriHealth Caritas DC eligibility or are disenrolled from the plan.

Products you can buy with your CARE Card include:*

Health Foods
Fruit and vegetables
Bottled water
Meats
Milk, cream

Baby Care
Diapers
Baby wipes
Nursing items
Bottles
Formula
Baby foods
Baby clothes

Eye Care
Contact solution
Contact lens cases
Eye drops
Glasses

Family planning
Pregnancy tests
Condoms
Contraceptives

Women's care
Feminine pads and tampons
Panty liners
Anti-fungal creams

Diabetic supplies
Glucose monitors
Test strips
Compression socks
Foot bath supplies

Pain relief
Aspirin
Acetaminophen
Ibuprofen
Joint pain medicines

Digestion medicines
Antacids
Laxatives
Stomach medicines
Hemorrhoid creams

Wellness items
Vitamins
Nutrition bars
Sports drinks
Weight loss foods and shakes

*For a list of additional items you can buy with your CARE Card, please visit **www.amerihealthcaritasdc.com/carecard** or call Enrollee Services at **1-800-408-7511 (TTY 1-800-570-1190)**, 24 hours a day, seven days a week.

AmeriHealth Caritas
District of Columbia

WELL-CHILD CARE GUIDE

Please make sure to bring a copy of the Universal Health Certificate to all well-child visits, lead screenings, and COVID-19 vaccinations.

The Universal Health Certificate is available online at **www.dchealth.dc.gov/node/113622**.

WELL-CHILD VISITS

Well-child visits, sometimes called HealthCheck visits, are routine checkups your child has with their doctor or another medical professional. Your child should have a well-child visit every year around the time of their birthday. These appointments help your child's provider diagnose and treat any potential health issues as early as possible. You will not be charged for a well-child visit.

WHAT TO EXPECT DURING A WELL-CHILD VISIT

- Physical exam
- Growth and development check
- Hearing and vision screening
- Appropriate shots/vaccines
- Lab testing (Including blood lead levels)
- Mental health and risk behavior check
- Health education for parent and child

WELL-CHILD VISIT SCHEDULE

It is important that your child visits their provider at the following ages:

2-5 days old

1 month old

2 months old

4 months old

6 months old

9 months old

12 months old

Every year until age 21

After your child turns one year old, they should have an appointment with their pediatrician once per year.

VISION

Your child's provider will perform vision screenings and can refer your child to an optometrist if they need vision care.

HOW TO FIND A PROVIDER

You can find a provider by visiting **www.amerihealthcaritasdc.com** or by calling **Enrollee Services** at **1–800–408–7511**.

IMMUNIZATIONS

As your child reaches certain ages, they will need shots that help protect them from diseases. These shots are called immunizations. Your child's provider will know which immunizations your child is due for, including the seasonal influenza (flu) vaccine and the COVID-19 vaccines.

Age	Immunization or Test	
Birth	- HepB #1 - Newborn metabolic/ hemoglobin screening	
2 months	- HepB #2 - DTaP #1 - RV #1	- Hib #1 - PCV #1 - IPV #1
4 months	- DTaP #2 - RV #2 - Hib #2	- PCV #2 - IPV #2
6 months	- HepB #3 - Hib #3 - DTaP #3	- RV #3 - PCV #3 - IPV #3
12 months	- Hib #4 - MMR #1 - Varicella #1 - PCV #4 - HepA #1 - DTaP #4	- Lead screening - Hemoglobin/ hematocrit - Tuberculosis test if at risk

KEY

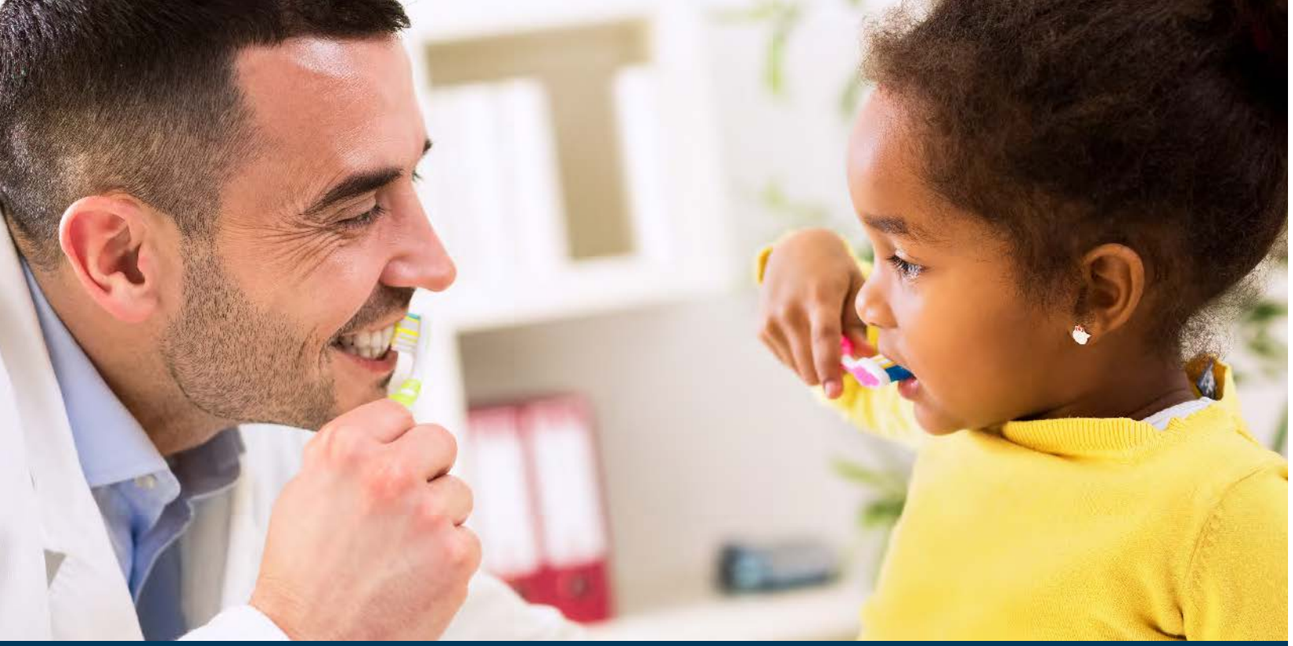
DTaP	Diphtheria, tetanus toxoid, and acellular pertussis vaccine
Hep	Hepatitis vaccine
Hib	Haemophilus influenzae type b vaccine
HPV	Human papillomavirus vaccine
IPV	Inactivated polio vaccine
MCV4	Meningococcal conjugate vaccine
MMR	Measles, mumps, and rubella vaccine
PCV	Pneumococcal conjugate vaccine
RV	Rotavirus vaccine
Varicella	Chickenpox vaccine

Age	Immunization or Test
18 months	HepA #2
24 months	Lead screening
Every year	Beginning at 6 months, seasonal influenza (flu) vaccine as recommended each year
3 – 6 years	- Blood lead test - Varicella #2
4 – 6 years	- DTaP #5 - MMR #2 - IPV #4
11 – 12 years	- HPV #1 (girls only) - MCV4
13 – 16 years	HPV #2
18 years or younger	MCV4

The above vaccination schedule was retrieved from the Centers for Disease Control website at https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html.

SCREENINGS

Screenings are tests that detect the presence of certain health risks or conditions. For example, lead exposure is a very dangerous health risk for children. Therefore lead screenings are recommended for children at 12 months old, 24 months old, and sometime between the ages of 3 and 6 years.



DENTAL

Teeth cleanings and other dental services help keep your child's teeth healthy and prevent common conditions, like tooth decay. Make sure you follow the recommended dental checkup schedule below.

If your child does not have a dentist, call Enrollee Services at 1–800–408–7511.

Birth – 1 year old
Your child receives dental services from their pediatrician

1 – 3 years old
Your child receives dental services from their pediatrician during checkups OR your child goes to the dentist once per year

3 – 20 years old
Your child goes to the dentist every six months (two times per year)

Please bring the Oral Health Assessment form to your child's dental visits.

The Oral Health Assessment form is available at **www.dchealth.dc.gov/node/113622**.

WE ARE HERE TO HELP

Call **Transportation Services** at **1–800–315–3485** to schedule a ride to and from appointments at no cost.

If you have questions or need assistance scheduling an appointment, call:

Community Outreach Solutions
Monday through Friday
8 a.m. to 6 p.m.
202–216–2318

EARN $50 IN REWARDS

CARE Card
REWARDS PROGRAM

TAKING CARE OF YOUR HEALTH HAS ITS REWARDS!

If you are between the ages of 12 and 20 and have an annual well-child visit, you will receive $50 on your CARE Card.*

For details, visit https://amerihealthcaritlsdc.com/member/eng/care-card.aspx.

***Certain limitations and restrictions may apply.**

AmeriHealth Caritas
District of Columbia

Well-Child Visit Billing Reference Guide

FOR AMERIHEALTH CARITAS DISTRICT OF COLUMBIA PROVIDERS

To bill for a well-child visit:

- Use the age-based preventive visit CPT code and appropriate ICD-10 Code listed in **Table 1**.
- Bill for each separate assessment/screening performed using the applicable CPT code from **Table 2**.
- If a screening or assessment is positive, use ICD-10 code Z00.121. If it is an issue that requires follow-up or a referral, append modifier TS to the applicable screening code that had a positive result.

DO NOT USE THE E&M OUTPATIENT VISIT CODES (99201-99205; 99213-99215) TO BILL FOR A WELL-CHILD VISIT.

TABLE 1: Age-Based Preventive Visit CPT Codes

Patient's Age	CPT Code (new/established)	ICD-10 Code	
		Without abnormal findings	**With** abnormal findings
< 1 year	99381/91	Z00.110, Z00.111, Z00.129	Z00.121
1 – 4 years	99382/92	Z00.129	Z00.121
5 – 11 years	99383/93	Z00.129	Z00.121
12 – 17 years	99384/94	Z00.129	Z00.121
18 – 21 years	99385/95	Z00.00	Z00.01

TABLE 2: Screening/Assessment CPT Codes

Component	CPT Code
Oral Health Assessment	D0191
Fluoride Varnish (for children under 3)	99188
Vision Screening	99173, 99174, 99177
Hearing Screening	92551, 92552, 92583, 92587, 92568, 92567
Developmental Assessment	96110
Behavioral Health Assessment	96127
Immunizations*	90460, 90461, 90471, 90472, 90473, 90474
Maternal Depression Screening	96161

Note: If an illness, abnormality, or pre-existing condition is encountered and/or addressed during a well-child visit, add the appropriate outpatient service code (99201-99215) to the claim and use the appropriate ICD-10 diagnosis code (not a Z code).

For billing questions or assistance, please contact your Provider Account Executive or call the Provider Services department at 202–408–2237.

* 90460 is used for the first immunization, 90461 is used for each additional immunization. Only use 90461 in conjunction with 90460. 90460-90461 are appropriate for immunization administration and counseling by physician or LIP (through 18 years of age). If immunization administration and counseling is provided by nurse, use codes 90471 – 90474.

AmeriHealth Caritas
District of Columbia

Examples of Different Billing Scenarios

- **2-year-old established patient**

  During the 2-year-old visit for an established patient, all required components of the visit are completed: a physical, an oral health assessment, fluoride varnish application, developmental assessment using a standardized tool, behavioral health assessment using a standardized tool, any needed immunizations, and a blood lead screen. The behavioral health assessment has a positive result and requires a referral to another provider.

  The visit should be billed for as follows:

Screening	CPT Code	Modifier	ICD-10
Preventive Medicine Visit	99382		Z00.121
Oral Health Assessment	D0191		
Fluoride Varnish Application	99188		
Developmental Assessment	96110		
Behavioral Health Assessment	96127	TS	
Immunization Administration	90460		
*Immunization Admin (each additional if warranted)	90461*		
Blood Lead Screen (from lab)	83655		

- **8-year-old new patient**

  During the 8-year-old visit for a new patient, all required components of the visit are completed: a physical, vision screening, hearing screening, behavioral health assessment, and any needed immunizations. The screens/assessments did not produce any abnormal results.

  The visit should be billed for as follows:

Screening	CPT Code	Modifier	ICD-10
Preventive Medicine Visit	99383		Z00.129
Vision Screen	99173		
Hearing Screen	92551		
Behavioral Health Assessment	96127		
Immunization Administration	90460		
Immunization Admin* (each additional if warranted)	90461*		

* 90460 is used for the first immunization, 90461 is used for each additional immunization. Only use 90461 in conjunction with 90460. 90460-90461 are appropriate for immunization administration and counseling by physician or LIP (through 18 years of age). If immunization administration and counseling is provided by nurse, use codes 90471 – 90474.