arkansas health & wellness™

Second Quarter Provider Updates

June 21, 2018

Disclaimer

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- The presentation is a general summary that explains certain aspects of the program, but is not legal document.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice.
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Acronyms

Acronym	Definition
ACA	Affordable Care Act
AWV	Annual Wellness Visit
CPC+	Comprehensive Primary Care Plus
DHS	Department of Human Services
HEDIS	Healthcare Effectiveness Data and Information Set
HMO	Health Maintenance Organization
ID	Identification
MAPD	Medicare Advantage Prescription Drug
NPI	National Provider Identifier
P4P	Pay for Performance
PCMH	Patient Centered Medical Homes
PCP	Primary Care Physician
TIN	Tax Identification Number

AGENDA

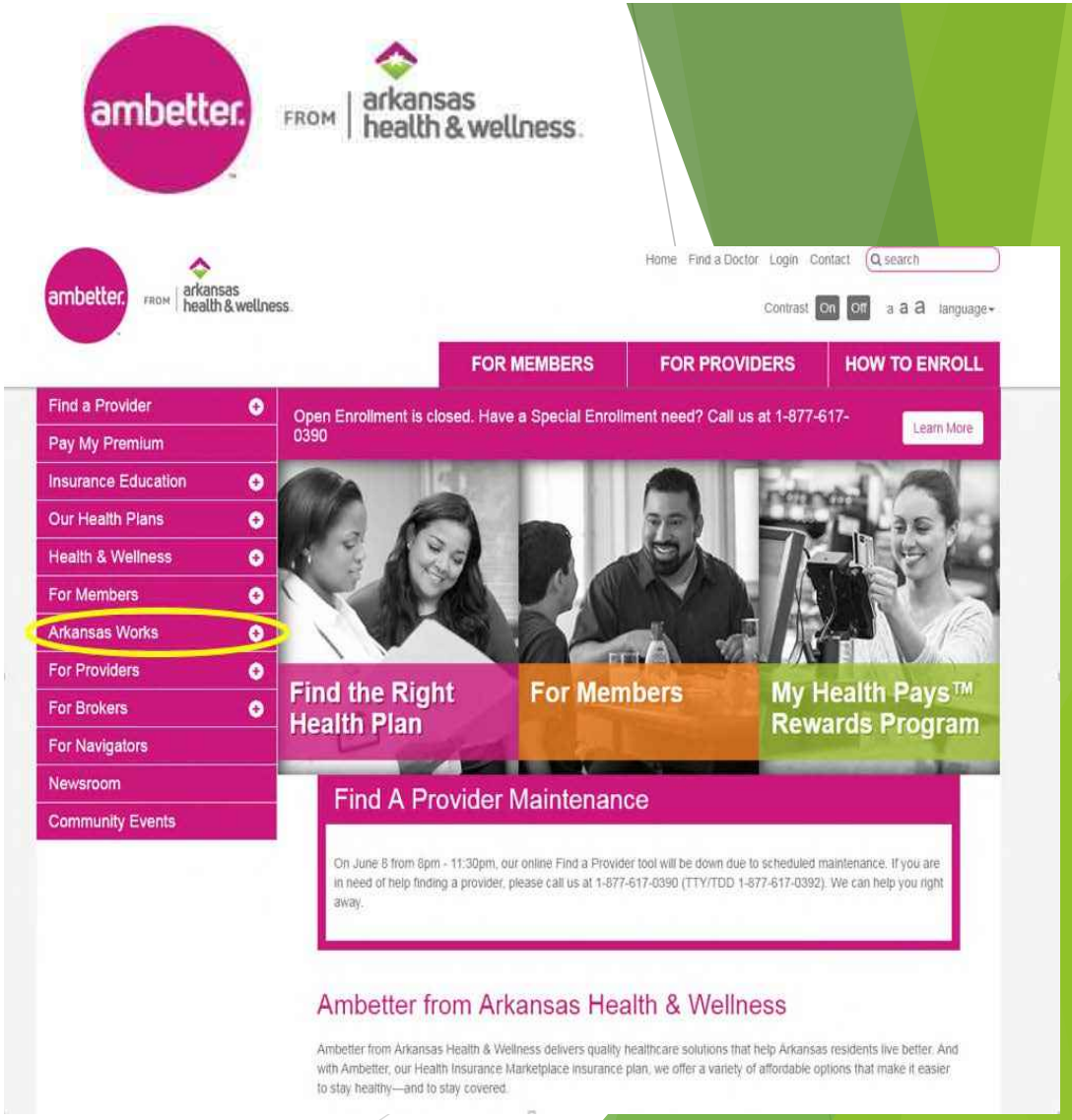
- Overview and Updates
  - Ambetter
    - Arkansas Works Updates
  - Arkansas Total Care
  - Allwell Overview
- Provider & Member Incentives
- Quality Improvement
- Provider Analytics
- Risk Adjustments
- Important Reminders

Overview and Updates

Arkansas Works 2.0

- Arkansas Works – formally known as Private Option or Healthcare Independence Program:
  - Medicaid Expansion Eligible
  - Enroll through local DHS office or https://access.arkansas.gov

- New 2018 Work Requirements:
  - Notifications were sent to recipients in March 2018
  - Work proof or exemptions became effective as of June 1, 2018
  - 2018 Work Requirement will apply to enrollees age 30-49 that do not meet an exemption



Member Work and Exemption Requirements

- Arkansas Health and Wellness members are able to report an exemption or work requirement through the portal at www.access.arkansas.gov


Report Work Online


Report Work by Phone

- If members need someone to assist them with reporting work activities or exemptions, they can contact us at 1-877-617-0390 (TTY/TDD 1-877-617-0392) and speak with one of our Work Requirement Specialists
- Members can also authorize a family member, friend or someone else to report work for them

NEW

Arkansas Total Care

Introducing Arkansas Total Care (ARTC)- your partner for success

- Arkansas Medicaid created a new model of organized care called a Provider-led Arkansas Shared Savings Entity (PASSE):
  - This model forms a more organized system that will improve the health of Arkansas who need more intensive levels of specialized care
- PASSE will serve Medicaid beneficiaries who have behavioral health (BH) and/or intellectual and developmental disabilities (IDD) service needs
- ARTC has been certified by the Arkansas Insurance Department and will provide care coordination and management for individuals who have complex medical and social needs
- For more information contact us at 1-800-294-3557 (TDD/TTY:711)
- Visit the website at www.ArkansasTotalCare.com

PASSE Model Implementation

- There are two phases for Arkansas Medicaid's implementation of this new model

	Phase I - 2018		Phase II - 2019
	Arkansas Total Care	AR Medicaid	Arkansas Total Care
Care Coordination Services	X		X
Benefits & Eligibility		X	X
Claims Processing		X	X
Prior Authorization		X	X
Utilization Management		X	X
Case Management		X	X
Network Contracting	X		X
Provider Network		X	X

PASSE Member Benefits

- PASSE members will receive person-centered care coordination services that include:
  - Finding a PCP
  - Scheduling an appointment with your PCP
  - Health education and coaching
  - Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services
  - Assistance with social determinants of health, such as access to healthy food and exercise
  - Coordination of community-based management of medication therapy
  - Get interpretation services
  - Finding a doctor or specialist

PASSE Participation

- ARTC encourages all providers to participate with all PASSE organizations in the state
  - ARTC providers will provide services for all healthcare needs including preventative, chronic and acute care services
  - If you are already credentialed through Arkansas Health & Wellness for the Ambetter or Allwell products, there is no additional credentialing required
  - Remembers, all providers must be Medicaid providers

NEW

Medicare Advantage Plan 2018

- This year Arkansas Health & Wellness is offering Allwell as a new Medicare Advantage health plan
- Allwell MAPD plans are currently available for Medicare-eligible Arkansans in the following counties:
  - Benton
  - Crawford
  - Sebastian
  - Garland
  - Pulaski
  - Saline
  - Washington

Allwell Identification Cards

Allwell offers plans that utilize two distinct networks of providers, Allwell Medicare HMO and Allwell Medicare HMO ***Select***. When searching for a participating provider on the Find A Provider tool, please make sure you select the network that corresponds to the network listed on the members identification card.

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Members Benefits and Programs

Prescription Coverage
Our Medicare Advantage plans include prescription drug coverage to help your patients treat or manage their conditions.

Care Management
Care Managers will work closely with you and your Allwell patients to make sure their health needs are always met.

24/7 Nurse Advice Line
Members will receive 24-hour, toll-free phone access to registered nurses for answers to their medical questions.

Over-the-Counter Allowance
Every quarter, members will receive $60 to spend on certain OTC items that are delivered via mail order.

Vision and Dental Benefits
In addition to medical benefits, members will be able to keep dental and eye health a priority with routine checkups and care.

MemberConnections Program
Plan representatives will provide members with in-person support to access their health benefits and community resources to ensure the members' health and safety.

Senior Health Resources
We will partner with our members to keep them engaged in their healthcare – including sending preventive health reminders, providing general health information, or offering support so that they can maintain their best health.

Secure Provider Portal

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Website: Allwell.ARHealthWellness.com

- Patient care forms
- Pre-Auth Needed tool
- Provider newsletters
- Provider Manual
- Preferred Drug List
- Member resources

Secure Provider Portal: Allwell.ARHealthWellness.com

- Verify member eligibility
- Access patient health records
- View patient gaps
- Manage prior authorizations
- Submit and manage claims
- And more!

Member Eligibility

Check member eligibility via:

- Secure Web Portal
- Provider Services: 1-855-565-9518
- TTY/TDD: 711

Patient Care Gaps

Find recommended services that a member has not completed.

1. Visit the Secure Provider Portal.
2. Review patient information for any gaps in care.
3. Plan to address care gaps during future appointment.

Pre-Visit Planning Checklist

- ✓ Verify member eligibility.
- ✓ Check for patient care gaps and address them during upcoming office visit.
- ✓ Use Pre-Auth Needed tool to determine if prior authorization is needed before appointment.

Prior Authorization and Claims

Prior Authorization

Use the Pre-Auth Needed tool on our website to determine if prior authorization is required.

Submit prior authorizations via:

- Secure Provider Portal
- Fax: 1-833-562-7172
- Phone: 1-855-565-9518

Claims

Timely Filing guidelines: 180 days from date of service.

Claims can be submitted via:

- Secure Portal
- Clearinghouses: EDI Payor ID 68069
- Mail paper claims to:
  Allwell from Arkansas Health & Wellness
  ATTN: Claims
  P.O. Box 3060
  Farmington, MO 63640-3822

Other Partners

To contact our other health services partners:

- Dental: 1-855-565-9518
- Vision: 1-855-565-9518
- Behavioral Health: 1-855-565-9518

Allwell.ARHealthWellness.com

Provider and Member Services: 1-855-565-9518

Reminders

- Allwell does not require a referral for specialist visits
- PCP visits do not require a co-pay
- Out of Network benefits are not available for Allwell members

Risk Adjustment 101

Importance of Effective Risk Adjustment Program to Health Plans and Providers

Risk Adjustment Overview

- Risk Adjustment is the method developed and used by the Department of Health & Human Services (HHS) to predict health costs of members
- The purpose of risk adjustment is to deter plans from developing products that only attract the healthiest members – protect against adverse selection
- Center for Medicare and Medicaid Services (CMS) uses the Hierarchical Condition Category (HCC) grouping logic as basis of risk adjustment model

Hierarchical Condition Categories

- HCC's assign values to criteria used to calculate risk factor score:
  - Chronic health conditions
  - Demographic Information:
    - Age
    - Gender
    - If member is community based or institution based
  - Interaction between disease categories within the hierarchy
- HCC's are based on encounter or claims data collected from providers
- Not all diagnosis map to an HCC

Risk Adjustment Importance

- CMS & HHS **REQUIRE** health plans to report complete **and** accurate diagnostic information on enrollees:
  - Diagnoses confirmed through medical record review
- Conditions must be reported and documented in each member's chart **ANNUALLY:**
  - Conditions not documented annually do not exist
- Opportunity for providers to provide comprehensive care with every face-to face encounter:
  - Address chronic conditions, co-existing conditions, active status conditions, and pertinent past conditions

Risk Adjustment & Providers

- Capture patient's entire risk profile in the medical record **AND** report correct codes on claims and encounter data
- Address all suspected chronic conditions listed on health form provided by health plan
- Document confirmed conditions, assessments, and treatment plans appropriately in the member's medical record
- Take holistic approach of care for every visit with patient

Risk Adjustment & Providers

- Providers should use M.E.A.T guidelines to establish the presence of a condition during an encounter:
  - Monitoring signs, symptoms, disease progression or regression
  - **E**-Evaluating test results, medication effectiveness, response to treatment
  - **A**-Assessing/addressing ordering tests, discussion, review records, counseling
  - **T**-Treatment medications, therapies, other modes

Coding & Documentation

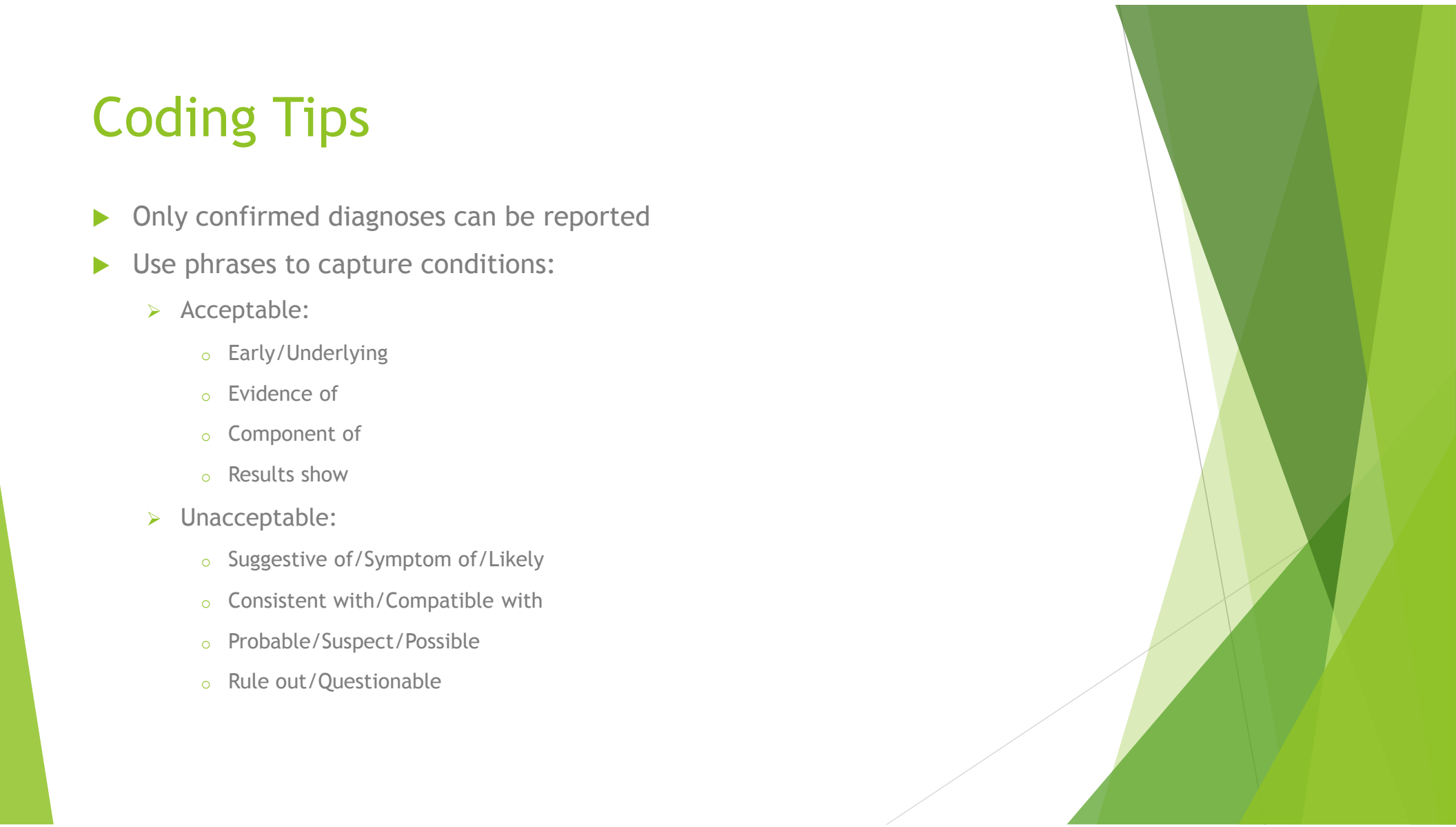
- Ensure diagnosis are coded to the highest specificity using applicable ICD-10 code
- Correlate underlying conditions and manifestations to chronic conditions in documentation and medical record
- Codes submitted MUST be supported by documentation in the medical record including brief assessment and plan of treatment
- Specify if condition is acute or chronic
- Document chronic conditions annually

Coding & Documentation Cont'd

- Document and code only those conditions evaluated during the face-to-face encounter
- Understand proper use of "history of":
  - Typically means condition is no longer present and/or no longer being treated
  - Do not use as narrative of current condition or reason for encounter
  - Condition MUST be actively managed and treated in order to be coded except:
    - Amputation status
    - Transplant status
    - HIV status
- Notes must be dated and signed
- Electronic health record must be electronically signed

Coding Tips

- Only confirmed diagnoses can be reported
- Use phrases to capture conditions:
  - Acceptable:
    - Early/Underlying
    - Evidence of
    - Component of
    - Results show
  - Unacceptable:
    - Suggestive of/Symptom of/Likely
    - Consistent with/Compatible with
    - Probable/Suspect/Possible
    - Rule out/Questionable



Coding Tips Examples

- Establish and document the cause and effect relationship of concurrent chronic conditions when applicable:
  - Ensures correct ICD-10 code assignment:
    - Ex: Diabetes Mellitus, unspecified (E11.9) ***and*** Polyneuropathy (G62.9)

      vs

    - Polyneuropathy ***associated with*** Type I Diabetes Mellitus (E10.42)
  - Impacts HCC risk value:
    - Ex: Diabetes without complications (HCC19 - lower risk), Polyneuropathy (no HCC)

      vs

    - Diabetes with chronic complications (HCC18 – higher risk)

Additional Coding Tips

- Common chronic conditions with co-existing/related conditions:
  - Diabetes Mellitus
  - Chronic Kidney Disease
  - Hypertension
  - Cardiovascular Disease
  - Neoplasms

Annual Wellness Visit

- Review health plan patient profile identifying potential risk gaps prior to the visit
- Rule out or address suspected conditions
- Document “annual wellness exam” as the reason for the visit
- Submit appropriate CPT code (99381-99397) on the claim
- Code encounter for general health examination first followed by supplemental or chronic condition codes:
  - Z00.00 (adult) Z00.129 (child) “with normal findings” for conditions that are stable or improving at time of visit
  - Z00.01 (adult) Z00.121 (child) “with abnormal findings” for *any* abnormality present at time of visit
- If an abnormality is encountered or preexisting condition is addressed *and* additional work-up satisfies the key components of a problem-oriented E/M (separately from the components of the wellness visit) *then* the appropriate office visit code (99201-99215) may be reported with modifier 25 in addition to the wellness visit

Medical Record Reviews

- Health plans are required to validate member diagnosis annually through Risk Adjustment Data Validation (RADV) audit.
- Health Plans also engage in chart review projects to ensure member diagnosis are being reported accurately
- Health Plans are required to:
  - Obtain charts from providers
  - Review and abstract data from the medical record
  - Ensure medical record follows HHS guidelines or obtain attestation from provider
  - Submit medical record and attestation to HHS

Medical Record Requirements

- Two patient identifiers on EACH page of every document:
  - Patient's name, date of birth, medical record number
- Dates of Service:
  - Complete Month/Day/Year
- Face-to-face encounter with acceptable type provider & setting
- Acceptable provider signature with credentials
- Documentation, signature, credentials, must be legible

Benefits of Effective RA Program

- Effectively managing member's risk is beneficial for health plan, provider, and member
- Benefits Include:
  - Improving quality of care for member
  - Better coordination of care between payer, health plan, and member
  - Allows health plan to offer more comprehensive and affordable benefit packages to member
  - Improved care leads to improved member health outcomes

Provider Partnerships

- **Telephonic Outreach Program:**
  - Member Outreach to assist with scheduling AWV
  - Utilize Patient Profile to address/document/close gaps
- **Chart Review Projects (RADV/RetroChart):**
  - Timely response for member medical record
  - Vendor cannot speak directly to copy center
  - Clinic responsibility to ensure copy center responds to request
- **EMR Access:**
  - Work with provider partners to obtain EMR access remote/onsite
- **Patient Profile Program:**
  - Deliver Patient Profile Package for all members assigned to providers
  - Utilize Patient Profile to address/document/close gaps

Q & A

Risk Adjustment Contact

Sherrill Montgomery, RA Supervisor 501.954.6100 x 8152

Sherrill.S.Montgomery@Centene.com

Haley Hicks, CPC, RA Coding Analyst 501.725.7691

Haley.M.Hicks@Centene.com

Provider and Member Incentives

Provider Incentives

- Annual Wellness Visit (AWV)Incentive Program Details
  - What - A flat-rate incentive payment of $100 for every member seen and coded as a well visit:
    - All eligible codes can be found on our website at: ambetter.arhealthwellness.com or for Allwell members: Allwell.arhealthwellness.com
  - What – Deadline to complete AWVs:
    - Allwell members AWVs must be completed by June 30, 2018
    - Ambetter members have until December 31, 2018 to complete their AWVs
    - Ambetter providers must be PCMH or CPC+
  - Payments - Earned incentive payments are paid monthly (limited to one AWV per member per calendar year):
    - No additional documentation is needed – payments will be based on paid claim activity
  - Member Incentive – Ambetter members will receive a My Health Pay incentive of $75 per year for one visit that is coded as a well visit & Allwell members will earn $100 for one well visit per year.
  - The wellness outreach program is designed to complement the Marketplace P4P model so please be sure to utilize the secure provider portal to assist in your outreach efforts to your members

Ambetter Member Rewards Program

- Ambetter from Arkansas Health and Wellness also offers members rewards dollars for completing healthy behaviors through the My Health Pays Program
- This is in addition to provider incentives for closing care gaps, performing wellness visits, or being identified as PCMH or CPC+
- Members have the ability to earn up to $200 on their My Health Pays reward card for activities such as:
  - Completing an Ambetter Wellbeing survey during the first 90 days of their membership
  - Getting an annual wellness exam with their PCP provider
  - Receiving their annual flu shot

Allwell Member Rewards Program

- Allwell from Arkansas Health and Wellness also offers members rewards dollars for completing healthy behaviors
- Here is how members can earn rewards:
  - Earn $100 by visiting your PCP for a wellness exam, one per calendar year
  - Earn $25 by getting a colorectal cancer screening, one per calendar year
  - Earn $25 by getting a mammogram, one per calendar year
  - Earn $25 by getting a flu vaccine, one per flu season
  - Earn $25 for completing an HbA1c test if the member has diabetes, one per calendar year
  - Earn $25 for completing diabetes retinal screening, one per calendar year
  - Earn $25 for completing a kidney screening (urine protein test) if you have diabetes, one per calendar year

Allwell Performance-Based Incentive Program

- Plan will provide Performance-Based Incentive payments to primary care physicians based on the closure of HEDIS gaps according to the table

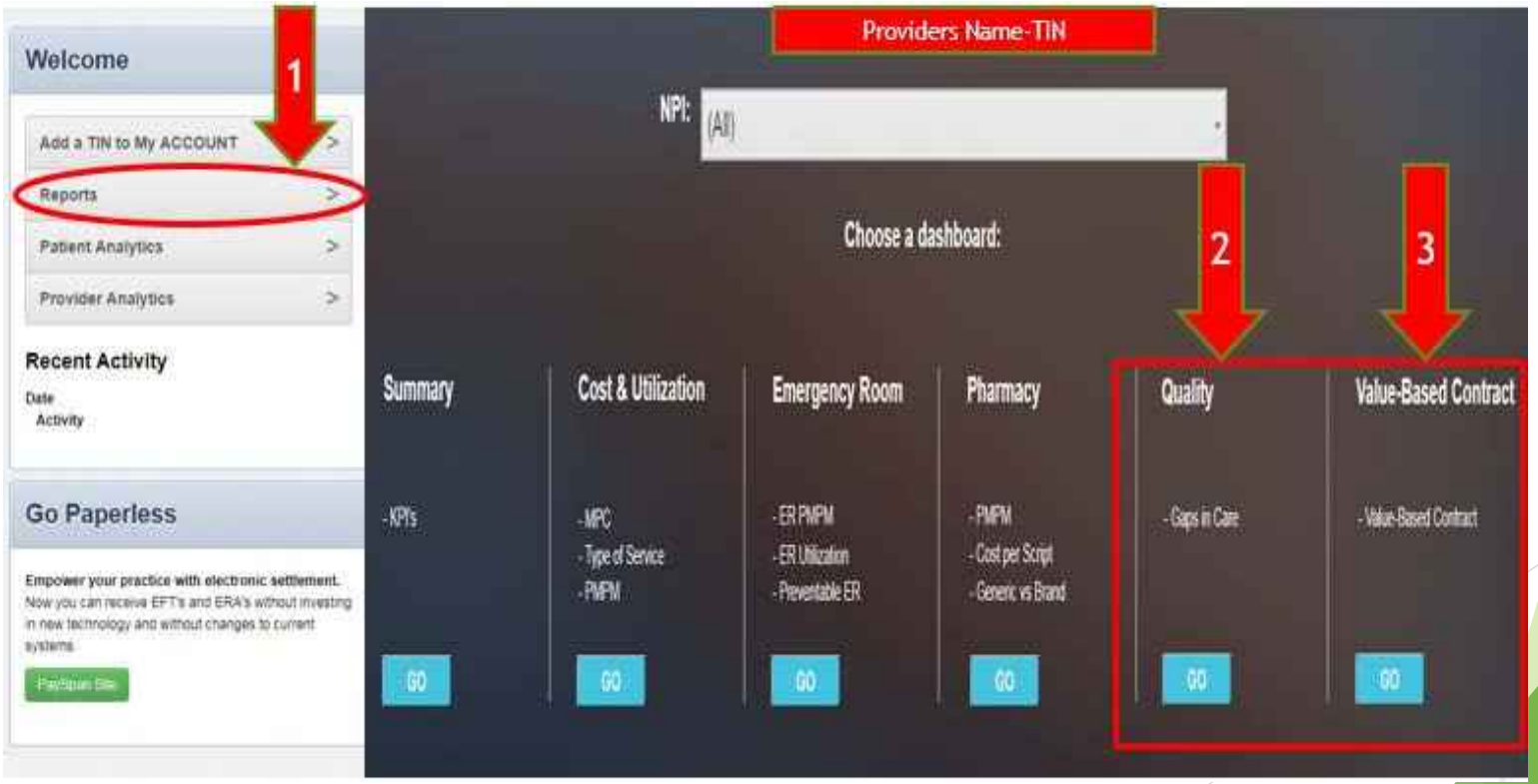
Non-CPC+ PCP Providers	PPM Amount	Target 1 Paid @ 75%	Target 2 Paid @ 100%
Breast Cancer Screening	$ 15	63%	69%
Colorectal Cancer Screening	$ 5	62%	71%
Osteoporosis Management in Women who had a fracture	$ 100	34%	51%
Diabetes Care - Eye Exam	$ 15	61%	73%
Diabetes Care - Blood Sugar Controlled	$ 50	62%	76%
Diabetes Care - Nephrology	$ 15	56%	64%
Controlling Blood Pressure	$ 20	56%	64%
Rheumatoid Arthritis Management	$ 125	72%	76%
All-Cause Re-admissions (Lower score is better)	$ 50	12%	10%
Medication Reconciliation Post Discharge	$ 75	25%	42%
Annual Wellness Visit	$ 100	Annual Wellness Visits in 6 months	

Provider Analytics

Provider Analytics Tool

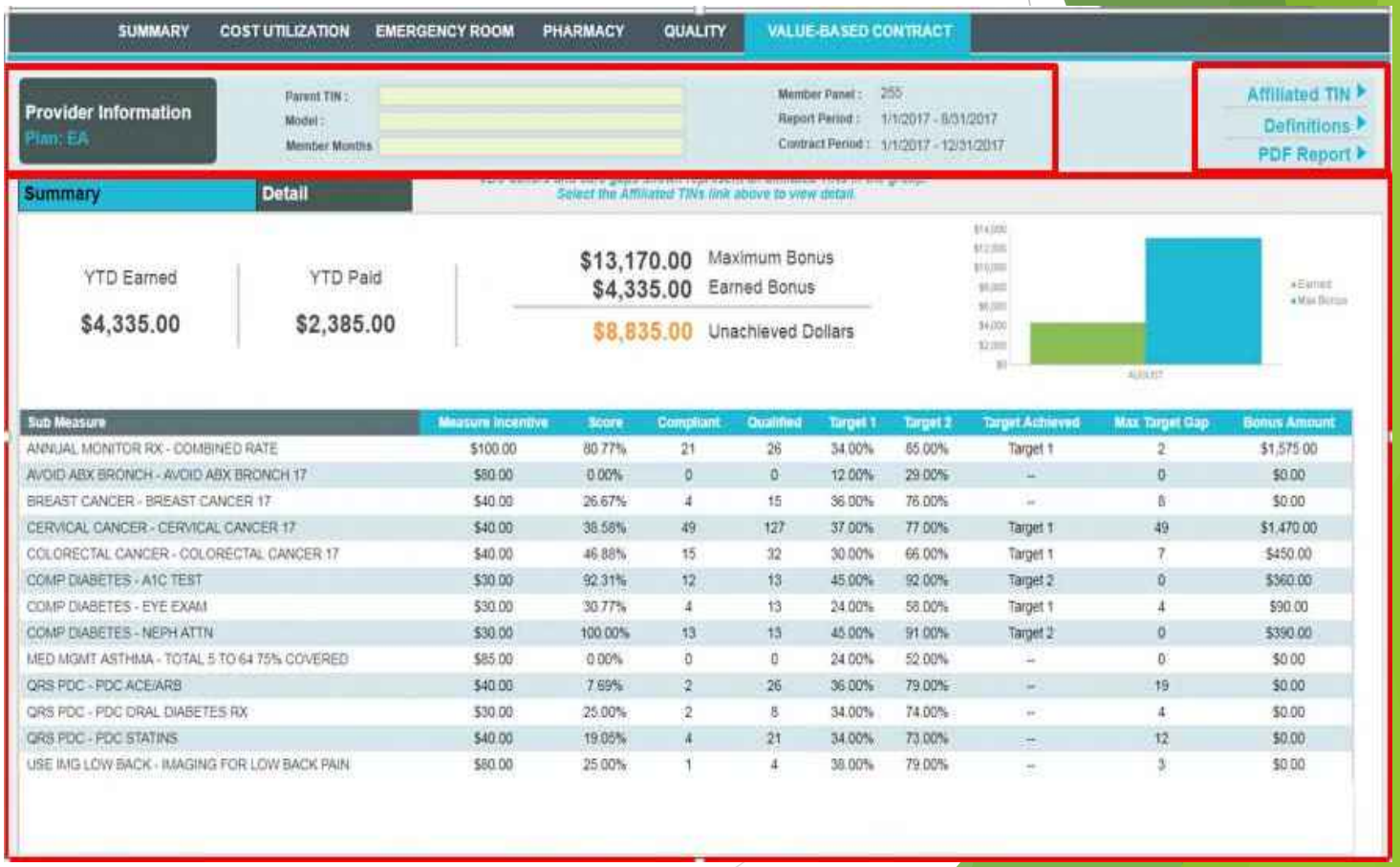
To access Provider Analytics:

1. From the portal, click on the Provider Analytics link to be directed to the launch page.
2. Click on Quality to be directed to the HEDIS Care Gap Dashboard and Member Gap in Care Reports.
3. Click on Value-Based Contract to be directed to the Pay for Performance dashboard and report.



Provider Analytics – P4P

- Provider Information:
  - Parent TIN
  - Model
  - Member months
  - Member panel
  - Report period
  - Contract period
- User has the option to view an affiliated TIN, product list, or definitions found in the report
- Summary shows:
  - Earned and paid amount year to date
  - Outlines the maximum, earned, and unearned bonus amounts in figures and graphical form
  - Measures list that displays the score, compliant and qualified counts, targets, maximum target gap, and bonus amount



Sub Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target Achieved	Max Target Gap	Bonus Amount
ANNUAL MONITOR RX - COMBINED RATE	$100.00	80.77%	21	26	34.00%	65.00%	Target 1	2	$1,575.00
AVOID ABX BRONCH - AVOID ABX BRONCH 17	$80.00	0.00%	0	0	12.00%	29.00%	--	0	$0.00
BREAST CANCER - BREAST CANCER 17	$40.00	26.67%	4	15	36.00%	76.00%	--	8	$0.00
CERVICAL CANCER - CERVICAL CANCER 17	$40.00	38.58%	49	127	37.00%	77.00%	Target 1	49	$1,470.00
COLORECTAL CANCER - COLORECTAL CANCER 17	$40.00	46.88%	15	32	30.00%	66.00%	Target 1	7	$450.00
COMP DIABETES - A1C TEST	$30.00	92.31%	12	13	45.00%	92.00%	Target 2	0	$360.00
COMP DIABETES - EYE EXAM	$30.00	30.77%	4	13	24.00%	56.00%	Target 1	4	$90.00
COMP DIABETES - NEPH ATTN	$30.00	100.00%	13	13	45.00%	91.00%	Target 2	0	$390.00
MED MGMT ASTHMA - TOTAL 5 TO 64 75% COVERED	$85.00	0.00%	0	0	24.00%	52.00%	--	0	$0.00
QRS PDC - PDC ACE/ARB	$40.00	7.69%	2	26	36.00%	79.00%	--	19	$0.00
QRS PDC - PDC ORAL DIABETES RX	$30.00	25.00%	2	8	34.00%	74.00%	--	4	$0.00
QRS PDC - PDC STATINS	$40.00	19.05%	4	21	34.00%	73.00%	--	12	$0.00
USE IMG LOW BACK - IMAGING FOR LOW BACK PAIN	$80.00	25.00%	1	4	38.00%	79.00%	--	3	$0.00

Quality Improvement

Healthcare Effectiveness Data and Information Set (HEDIS)

- HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows a comparison of quality across health plans
  - NCQA holds Arkansas Health & Wellness accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership
- HEDIS scores are physician-specific scores that used to measure your practice's preventive care efforts
- Your practice's HEDIS score determines your rates for physician incentive programs that pay you an increase premium:
  - P4P
  - Quality Bonus Funds

HEDIS Measures

- HEDIS measure fall into three categories:
  - Adult health
  - Women's health
  - Pediatric health
- Detailed HEDIS guidelines are available on our website under the Quality Improvement section under the "For Provider" tab
- You and your staff can help facilitate the HEDIS process improvement by:
  - Providing appropriate care within the designated timeframes
  - Documenting all care in the patient's medical record
  - Submit claim/encounter data for each and every service rendered, regardless of contract status
  - Ensure that claim/encounter data is submitted in an accurate and timely manner
  - Code to the highest specificity
  - Consider including CPT II codes to provide additional data and reduce medical record requests
  - Responding to our requests for medical records within the requested timeframe

HEDIS Gaps

- You and your staff can improve your HEDIS scores by:
  - Submit claim/encounter data for each and every service rendered
  - Make sure that chart documentation reflects all services billed
  - Bill (or report by encounter submission) for all delivered services, regardless of contract status
  - Ensure that all claim/encounter data is submitted in an accurate and timely manner
  - Consider including CPT II codes to provider additional details and reduce medical record requests

Provider Data Accuracy

Arkansas Health & Wellness has partnered with **LexisNexis** to validate the demographic data we have on file quarterly to ensure accuracy. Providers should have recently received information with instructions on how to log in to the AMA portal and validate your data. Validating through the AMA portal this will allow your edits to be implemented across all Medicare and Marketplace payers who also use the AMA portal.

We validate provider demographic data quarterly for numerous reasons including:

- to help provide our members with accurate information through our Find a Provider tool on the website.
- to allow our members to locate and access the care and services that they are needing from in-network providers.
- to help other providers make referrals and accurately direct their patients' care to in-network practitioners and providers.
- to ensure that payment and other correspondence are received timely, and reduces the potential for delayed or denied payments resulting from inconsistent demographic information
- to ensure that we meet the regulatory standards set by the Centers for Medicare & Medicaid Services.

Important Reminders

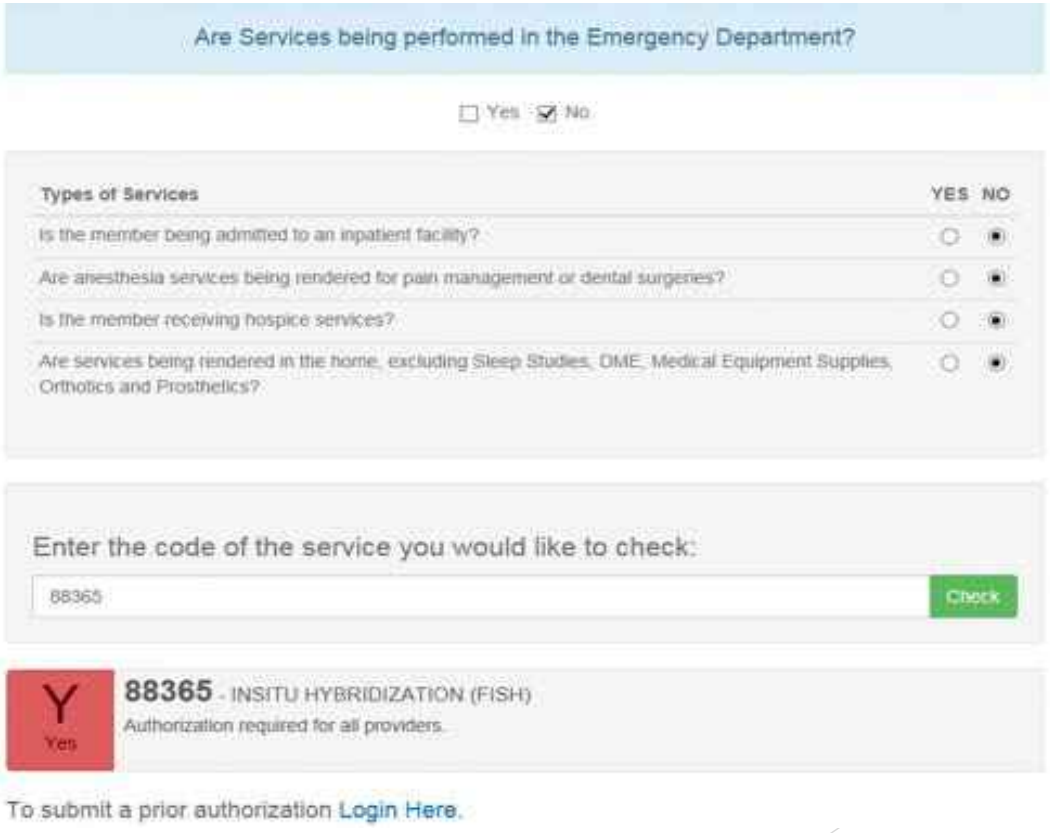
Secure Provider Portal

Information contained on our Secure Provider Portal:

- Member Eligibility
- Patient Listings
- Health Records & Care Gaps
- Authorizations
- Case Management Referrals
- Claims Submissions & Status
- Corrected Claims & Adjustments
- Payments History
- PCP Reports

Prior Authorization Reminders

All authorizations are done at the procedure code level. The Pre-Auth Needed tool is found on the public website and does not require a login to use.



Contact Information

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TTY/TDD: 711
allwell.arhealthwellness.com

Arkansas Health and Wellness Credentialing
Phone: 1-844-263-2437
Fax: 1-844-357-7890
Email: arkcredentialing@centene.com

Provider Relations
Providers@ARHealthwellness.com

Thank you!