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Continuity of Care Provider Program

(formerly Partnership for Quality/P4Q)

3/5/2021

Disclaimer

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- The presentation is a general summary that explains certain aspects of the program, but is not a 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 program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice.
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What is the Continuity of Care Program?

- Continuity of Care is **a Provider Engagement** program incentivizing providers incrementally for their work on addressing chronic conditions.
- AHW pays **INCENTIVES** for completed and verified Provider Appointment Agendas and/or submission of Comprehensive Exam medical record.
- Providers earn bonus payments for proactively assessing members' current conditions in an effort to improve health and provide clinical quality care.
- Providers can enter relevant documentation in the Arkansas Health & Wellness Secure Provider Portal under the "Provider Analytics" section.
- Measurement Period is from January 1, 2021 - December 31, 2021

2021Continuity of Care Program Goals

- Ensure members receive care and treatment for all active health conditions, not just for acute health issues.
- Assess and document any and all active conditions that are required to be reported annually.
- Recognize and reward Providers who collaborate with Arkansas Health & Wellness to deliver quality care and improve documentation of care for members.
- Promote preventive services and quality of care for members.

NOTE: Participation in the Continuity of Care program may result in a request for medical records. The request may be part of an internal health plan, state, and/or federal audit or any NCQA program such as HEDIS™

About Continuity of Care Program

- Targeted Lines of Business (LOB)
  - WellCare Medicare Business (does not replace or duplicate existing program)
  - Ambetter from Arkansas Health & Wellness Marketplace Business
  - Allwell from Arkansas Health & Wellness Medicare Business

- Who is included in the program?
  - Members included are those with disease conditions that are required to be assessed, addressed, and reported annually.
  - Member Selections are identified at the beginning of the program and are subject to change in future programs.
  - Members are listed under their assigned provider's Continuity of Care dashboard located in the Secure Provider Portal.
    - MKP members – members choose or are auto assigned
    - MCR members – members choose their PCP

Provider Bonus for Continuity of Care Program

- Bonus = $100 for every Assessed Member
- Can increase up to $200 and $300 based on meeting thresholds outlined below.

% of Appointment Agenda Completed/Paid	Bonus Amount Per Paid Appointment Agenda
<50%	$100
>50 to <80%	$200
>80%	$300

- Assessed member defined as:
  - **100%** of diagnosis coding gaps are assessed
    - Diagnosis gaps assessed by submitting diagnosis code(s) on a medical claim OR
    - Gaps assessed by checking “Assessed and Documented”, or the “Resolved/Not Present” box OR by submitting a Comprehensive Physical Exam Medical Record along with a completed an Appointment Agenda with boxes checked as above.
    - Provider must submit an acceptable claim with all “Assessed and Documented” diagnosis codes included demonstrating that an assessment was completed this year.

Provider Responsibilities

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- Log into Dashboard under the Provider Analytic section of the Secure Provider Account
  - Confirm or Deny whether conditions identified are Valid/Present or Resolved/Not Present by checking the appropriate box.
  - Submit a Claim showing member has been assessed this calendar year.
- Schedule and conduct an exam with targeted members and use the Appointment Agenda as a guide assessing the validity of each condition identified.
- Submit the claim using the correct ICD-10, CPT ®, CPTII ® or NDC Codes.
  - You may also print the Appointment Agenda, sign and date the form, and submit the Competed Appointment Agenda and/or a Comprehensive Exam Medical Record by fax at 1-813-464-8879 or send via secure email to agenda@wellcare.com.

Comprehensive Exam (CPE) Requirements

- The documentation of each encounter should include:
  - Date and Time
  - Patient's name and date of birth
  - Medical History
    - Chief Complaint
    - History of Present Illness
    - Review of Systems (ROS)
    - Past medical, family, social history
  - Physical Examination
  - Assessment, clinical impression, or diagnosis
  - Treatment
  - Provider Name, Signature, Credentials and date signed

2021 Early Submitter Bonus (ESB)

A subset of the Continuity of Care Program

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We are offering an additional $50 bonus for completing a valid office/telehealth visit by May 31, 2021 AND submitting a completed Appointment Agenda by June 30, 2021. Submitted Appointment Agenda diagnoses must be verified on the claim.

Continuity of Care Appointment Agenda

Components of the Appointment Agenda:

1. Health Condition History

Providers should check one box for each Disease Category listed on the agenda.

- 'Active Diagnosis & Documented' – Patient is currently presenting with this condition. Providers must submit a claim with a diagnosis code that maps to the Disease Category listed on the agenda.
- 'Resolved/Not Present' – Patient is not presenting with this condition. Provider must submit a claim with a 2020 face to face visit and should submit appropriate codes for conditions the Patient is currently presenting.

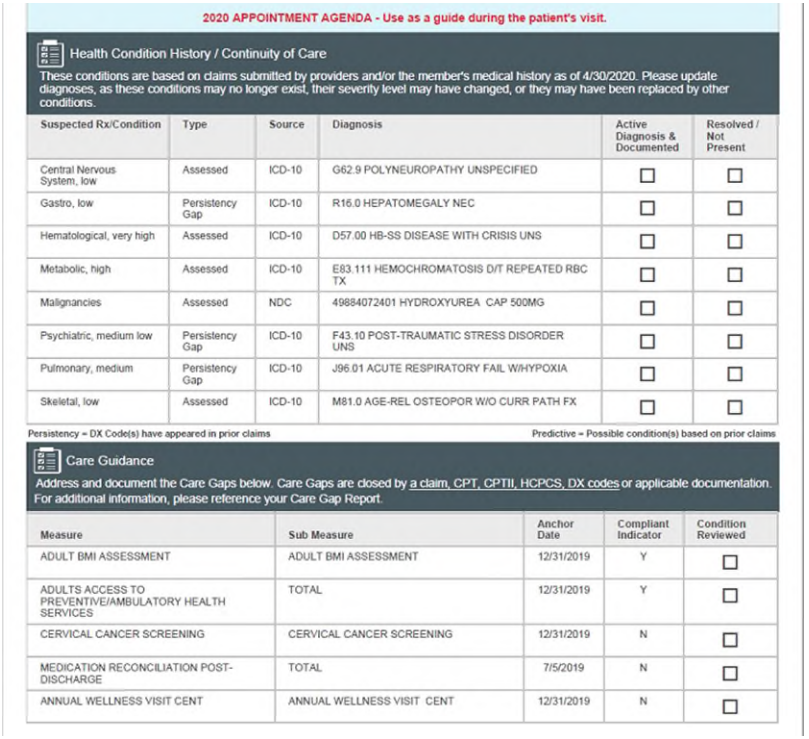
The Health Condition History/CoC component is all or nothing, ALL Disease Categories must have a box checked and verified with a claim to be eligible for the Bonus.

2. Care Guidance

Address and document the Care Gaps below. Care Gaps are closed by a claim, CPT, CPTII, HCPCS, DX codes or applicable documentation. For additional information, please reference your care gap report.

Providers should submit the Agenda once the Health Condition History/CoC component is completed in its entirety. They do **NOT** need to complete the Care Guidance components prior to submitting.

The signature component can be completed by a credentialed provider or the facilitator of the program.



2020 APPOINTMENT AGENDA - Use as a guide during the patient's visit.

Health Condition History / Continuity of Care

These conditions are based on claims submitted by providers and/or the member's medical history as of 4/30/2020. Please update diagnoses, as these conditions may no longer exist, their severity level may have changed, or they may have been replaced by other conditions.

Suspected Rx/Condition	Type	Source	Diagnosis	Active Diagnosis & Documented	Resolved / Not Present
Central Nervous System, low	Assessed	ICD-10	G62.9 POLYNEUROPATHY UNSPECIFIED	☐	☐
Gastro, low	Persistency Gap	ICD-10	R16.0 HEPATOMEGALY NEC	☐	☐
Hematological, very high	Assessed	ICD-10	D57.00 HB-SS DISEASE WITH CRISIS UNS	☐	☐
Metabolic, high	Assessed	ICD-10	E83.111 HEMOCHROMATOSIS D/T REPEATED RBC TX	☐	☐
Malignancies	Assessed	NDC	49884072401 HYDROXYUREA CAP 500MG	☐	☐
Psychiatric, medium low	Persistency Gap	ICD-10	F43.10 POST-TRAUMATIC STRESS DISORDER UNS	☐	☐
Pulmonary, medium	Persistency Gap	ICD-10	J96.01 ACUTE RESPIRATORY FAIL W/HYPOXIA	☐	☐
Skeletal, low	Assessed	ICD-10	M81.0 AGE-REL OSTEOPOR W/O CURR PATH FX	☐	☐

Persistency = DX Code(s) have appeared in prior claims

Predictive = Possible condition(s) based on prior claims

Care Guidance

Address and document the Care Gaps below. Care Gaps are closed by a claim, CPT, CPTII, HCPCS, DX codes or applicable documentation. For additional information, please reference your Care Gap Report.

Measure	Sub Measure	Anchor Date	Compliant Indicator	Condition Reviewed
ADULT BMI ASSESSMENT	ADULT BMI ASSESSMENT	12/31/2019	Y	☐
ADULTS ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES	TOTAL	12/31/2019	Y	☐
CERVICAL CANCER SCREENING	CERVICAL CANCER SCREENING	12/31/2019	N	☐
MEDICATION RECONCILIATION POST-DISCHARGE	TOTAL	7/5/2019	N	☐
ANNUAL WELLNESS VISIT CENT	ANNUAL WELLNESS VISIT CENT	12/31/2019	N	☐

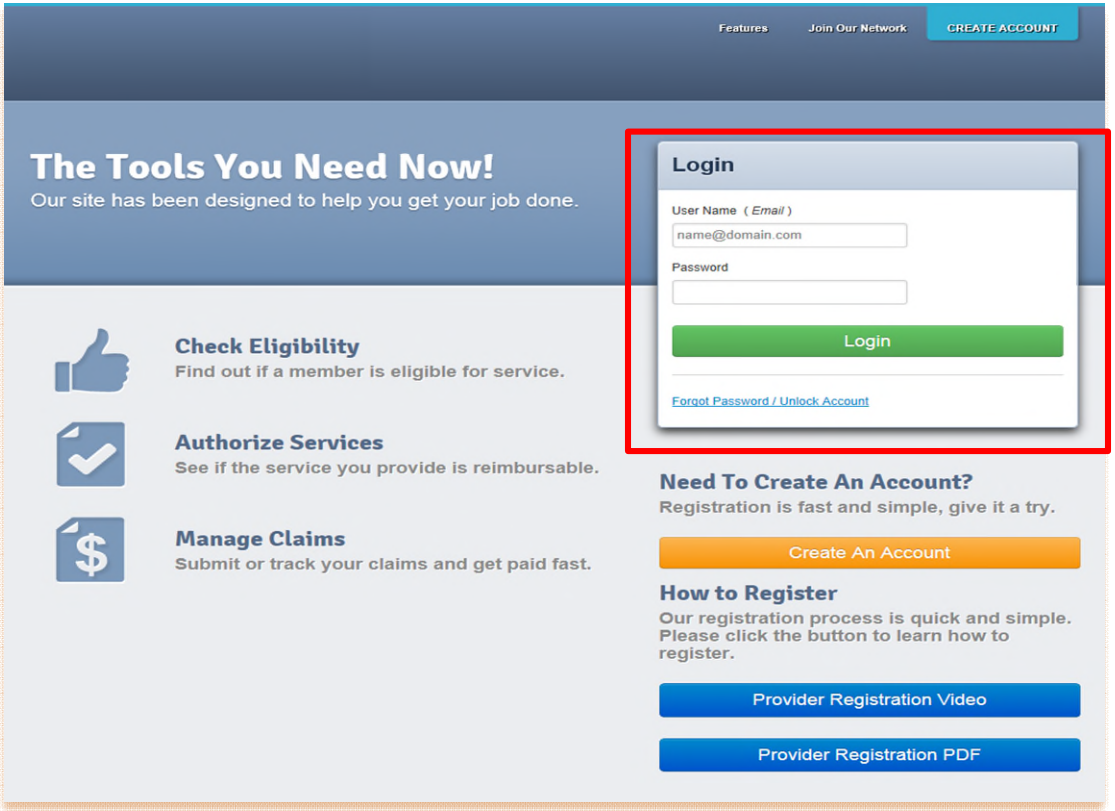
Telehealth Guidance

- Telehealth services that are furnished using interactive, audio/video, real-time communication technology are acceptable for the Continuity of Care program.
- Annual Wellness Visits can still be performed.
- The E/M level selection furnished via telehealth can be based on Medical Decision Making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter.
- Medicare does not offer clear guidance and relies on health care providers to serve their patients in good faith when utilizing technology through audio and video communication to deliver care.
- Marketplace members can be seen using audio only telehealth visits.

Note: Providers should reference CMS Telehealth Services document for further requirements when performing telehealth services.

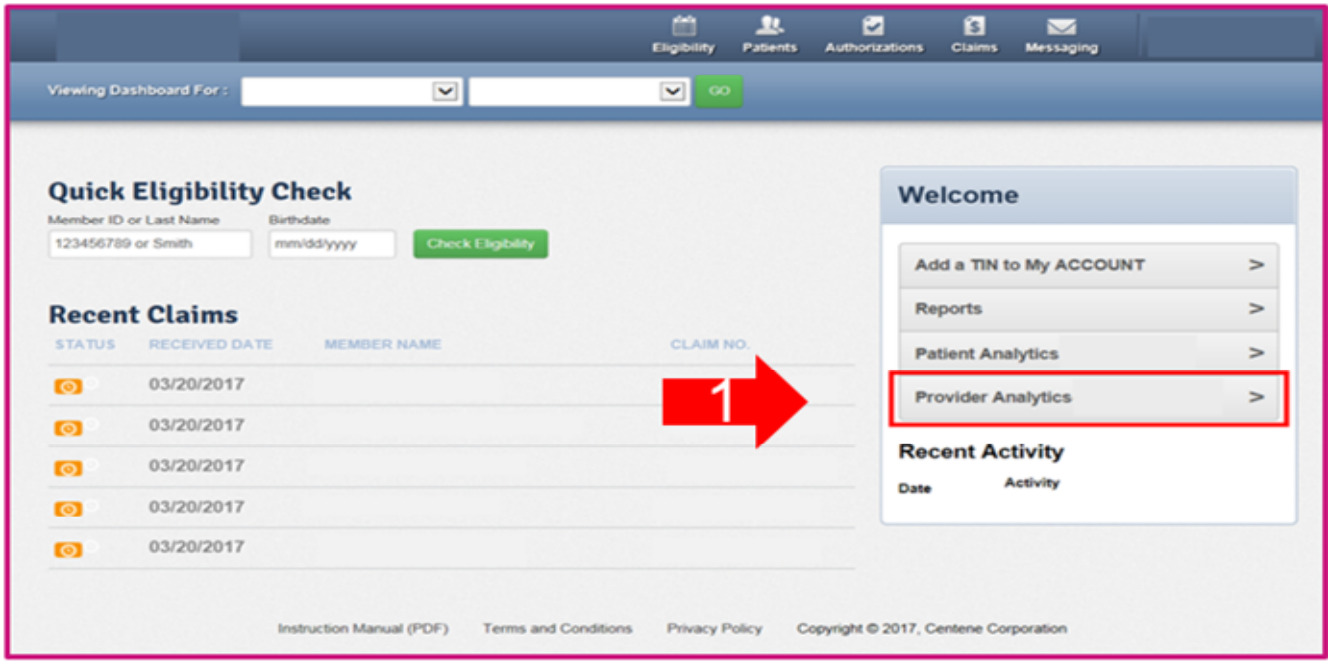
Accessing the Secure Provider Portal

Ready to Login



Navigating to Provider Analytics

From the Provider Portal click on the ***Provider Analytics*** link to be directed to the landing page.

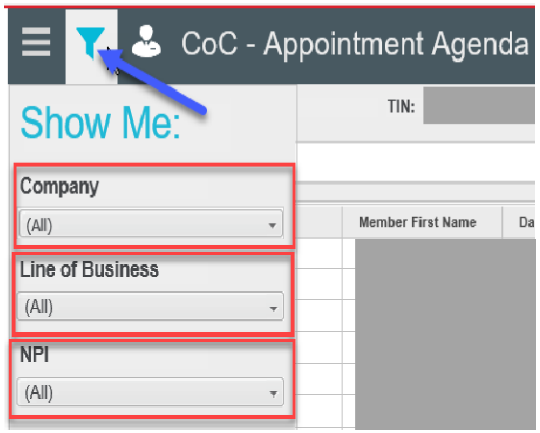


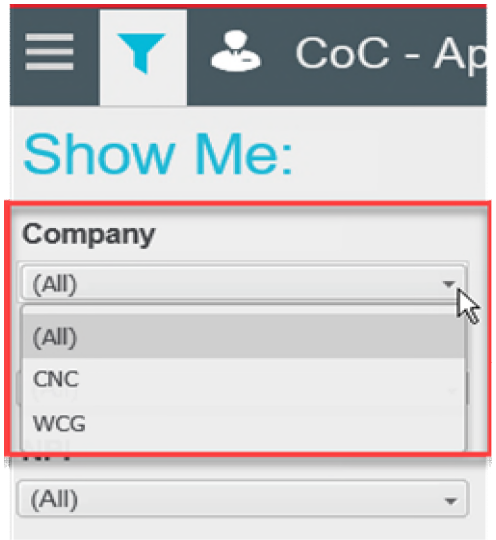
Portal Navigation

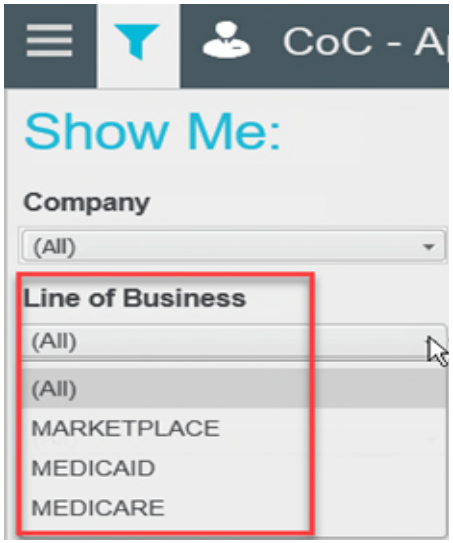
Select **CoC - Appointment Agenda**

Continuity of Care Portal Navigation

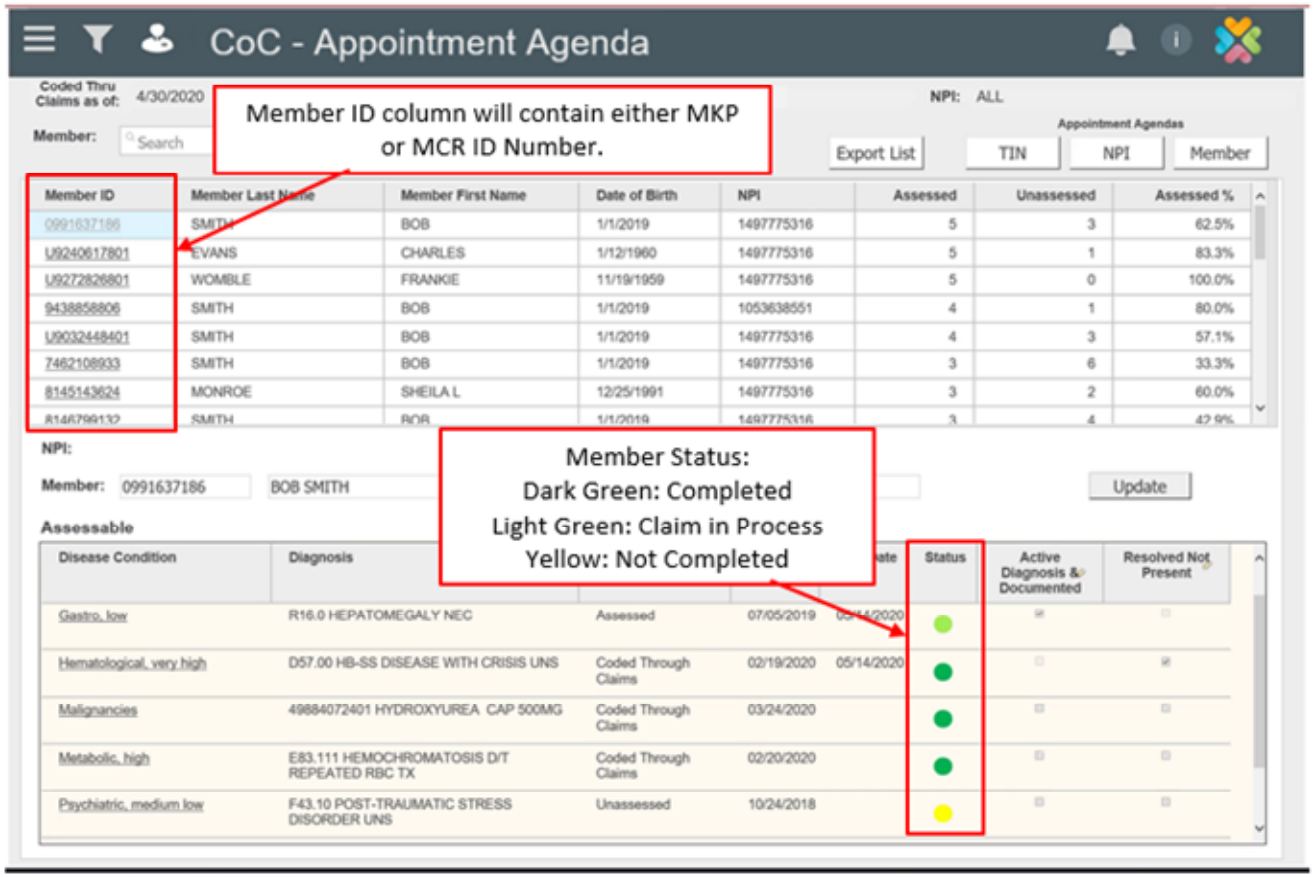
Utilize the Filter Feature to narrow your search options







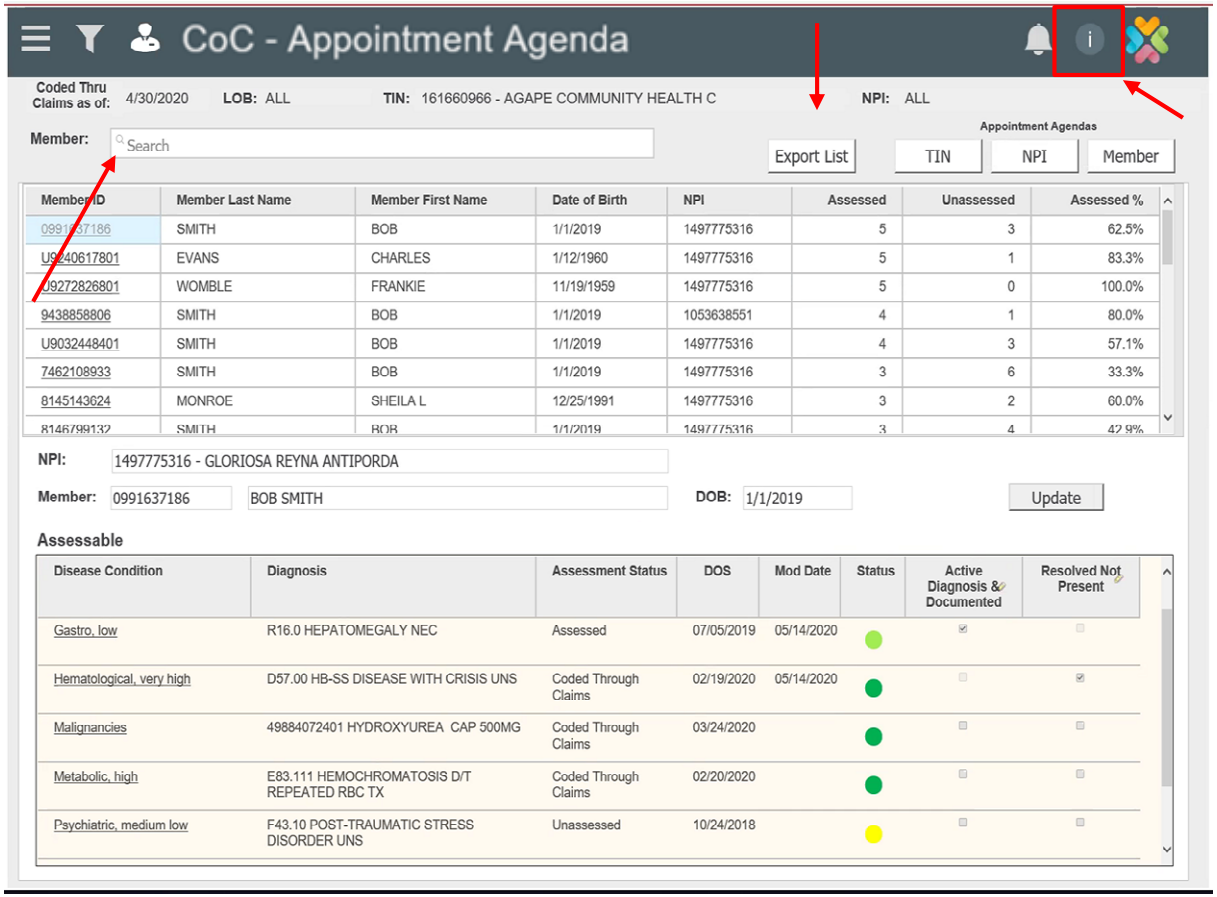
Continuity of Care Portal Navigation



All data shown here is for illustrative purposes only. No actual PHI data is presented.

Continuity of Care Portal Navigation

Users can export their list to excel.



Providers can search for a specific patient by typing in either the name or ID of the patient.

The info button is a drop-down menu containing links to FAQ on program rules and potentially detailed lists of diagnosis codes under each disease condition

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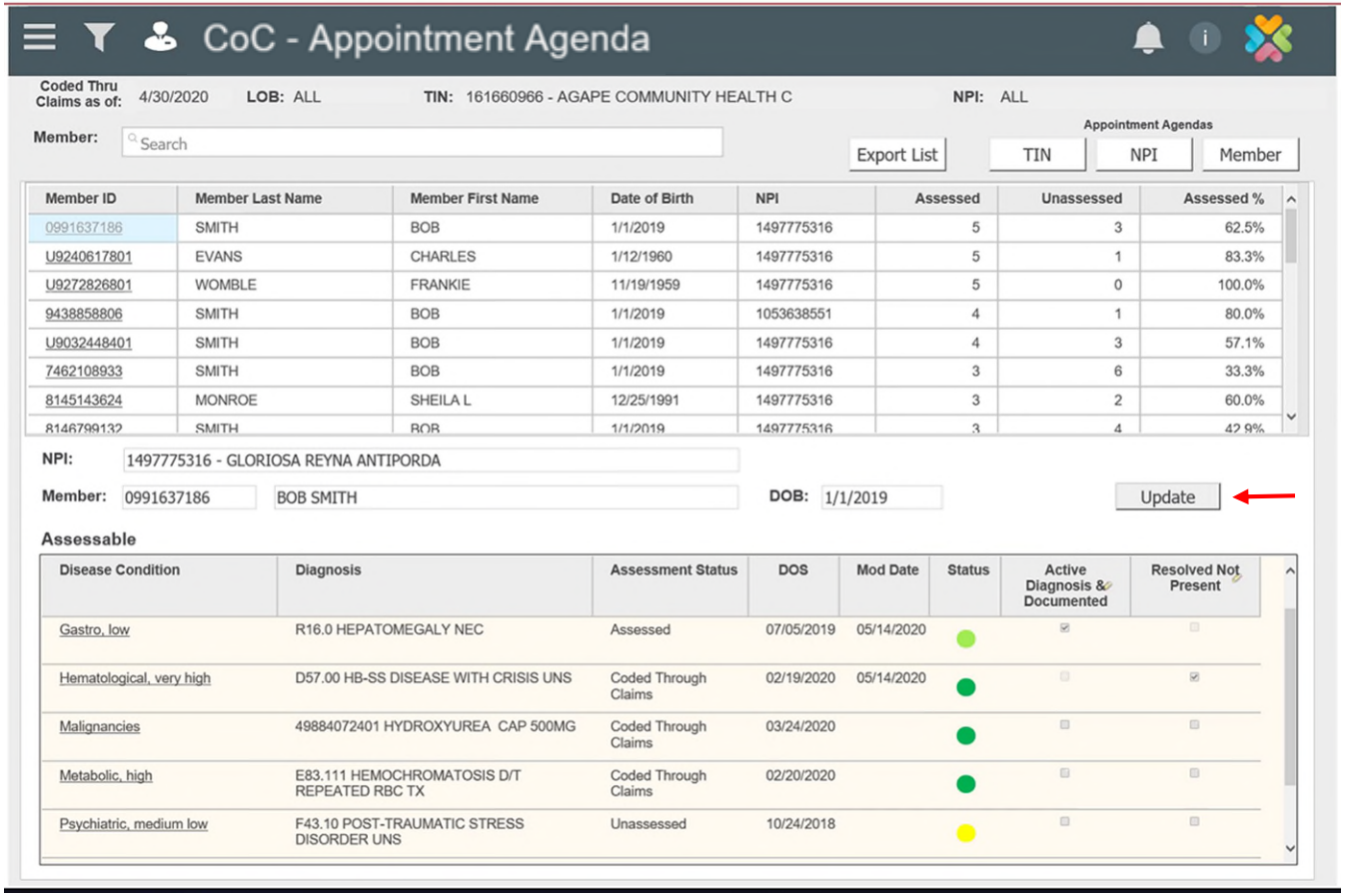
Continuity of Care Portal Navigation



Once a box is checked or unchecked, the provider or authorized personnel needs to click “update” to save the updates

Note: If users export to Excel, they still need to go back into the P4Q dashboard to enter any exclusions.

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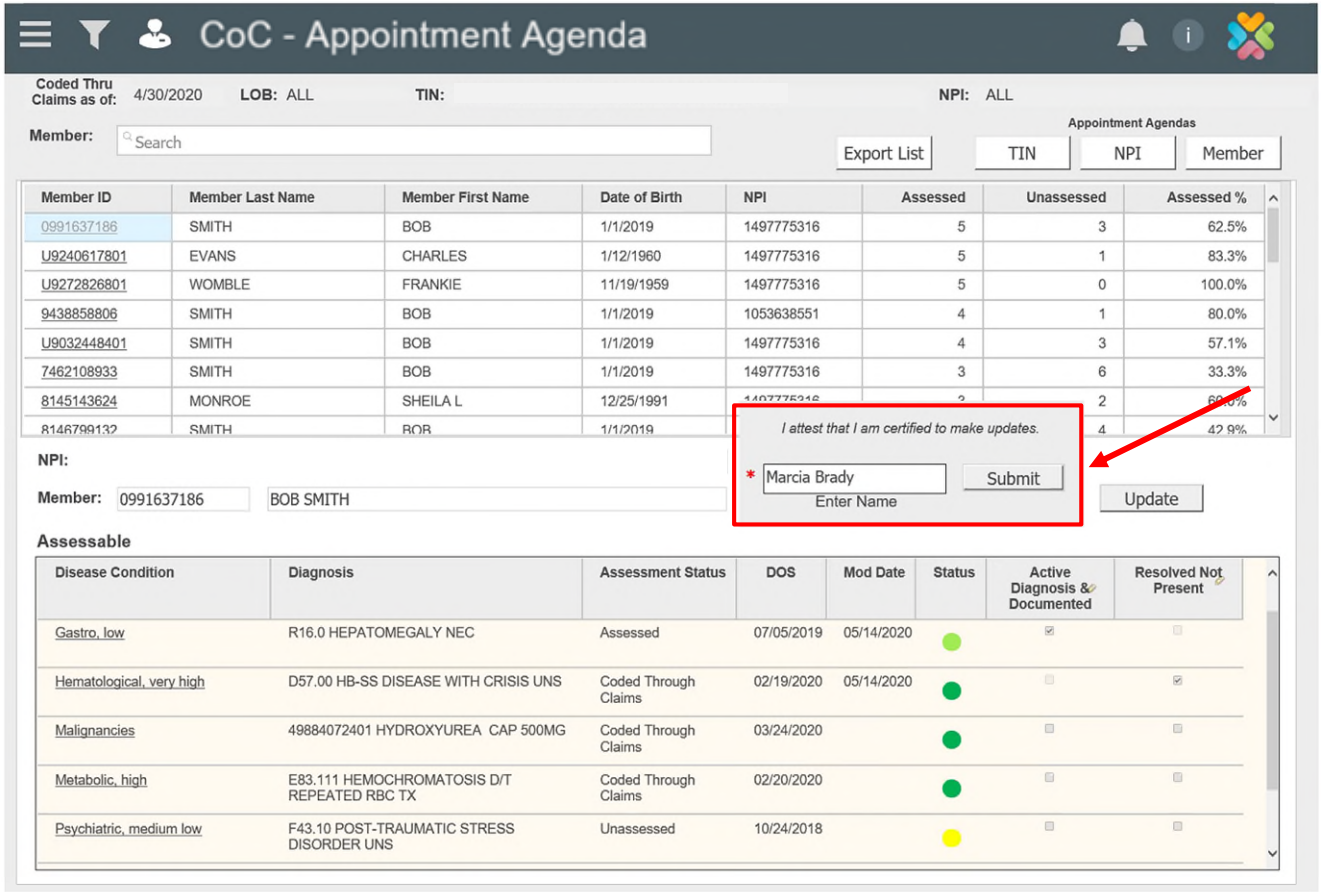
Continuity of Care Portal Navigation



Authorized personnel needs to enter their name to attest to the changes.

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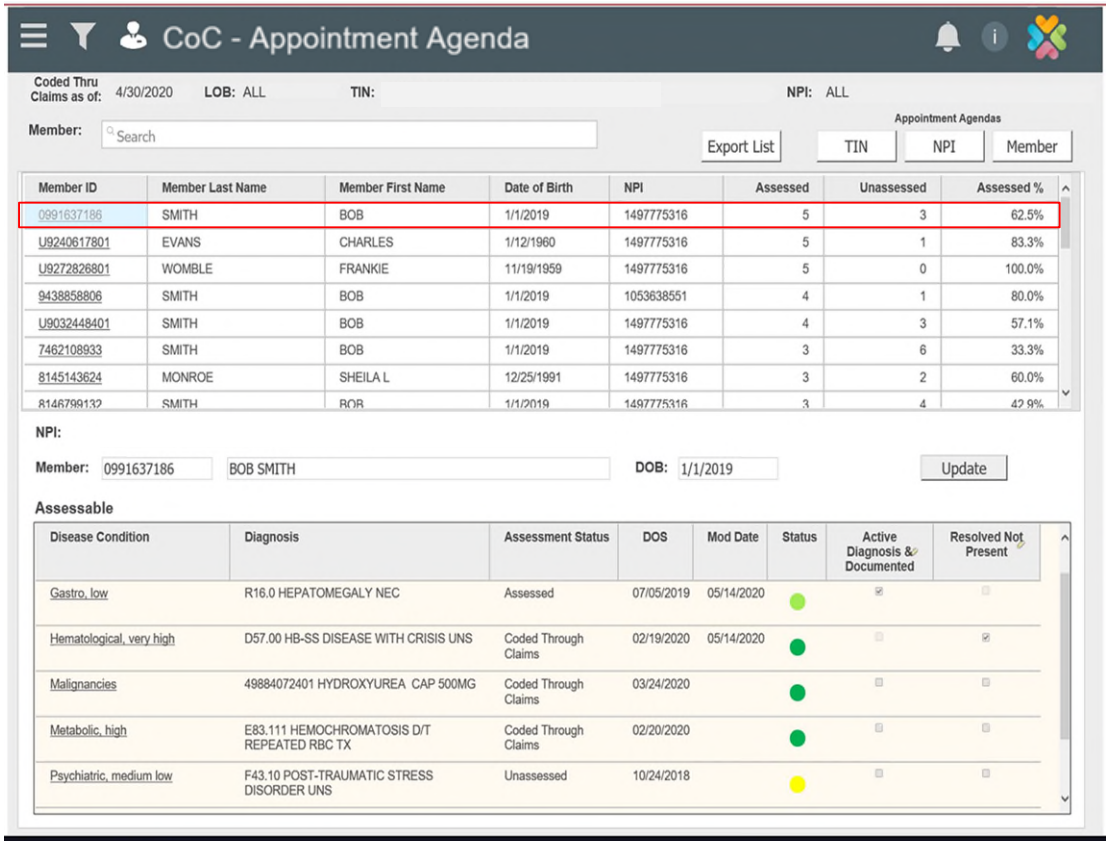
Continuity of Care Portal Navigation



The member's record will now reflect the updated data.

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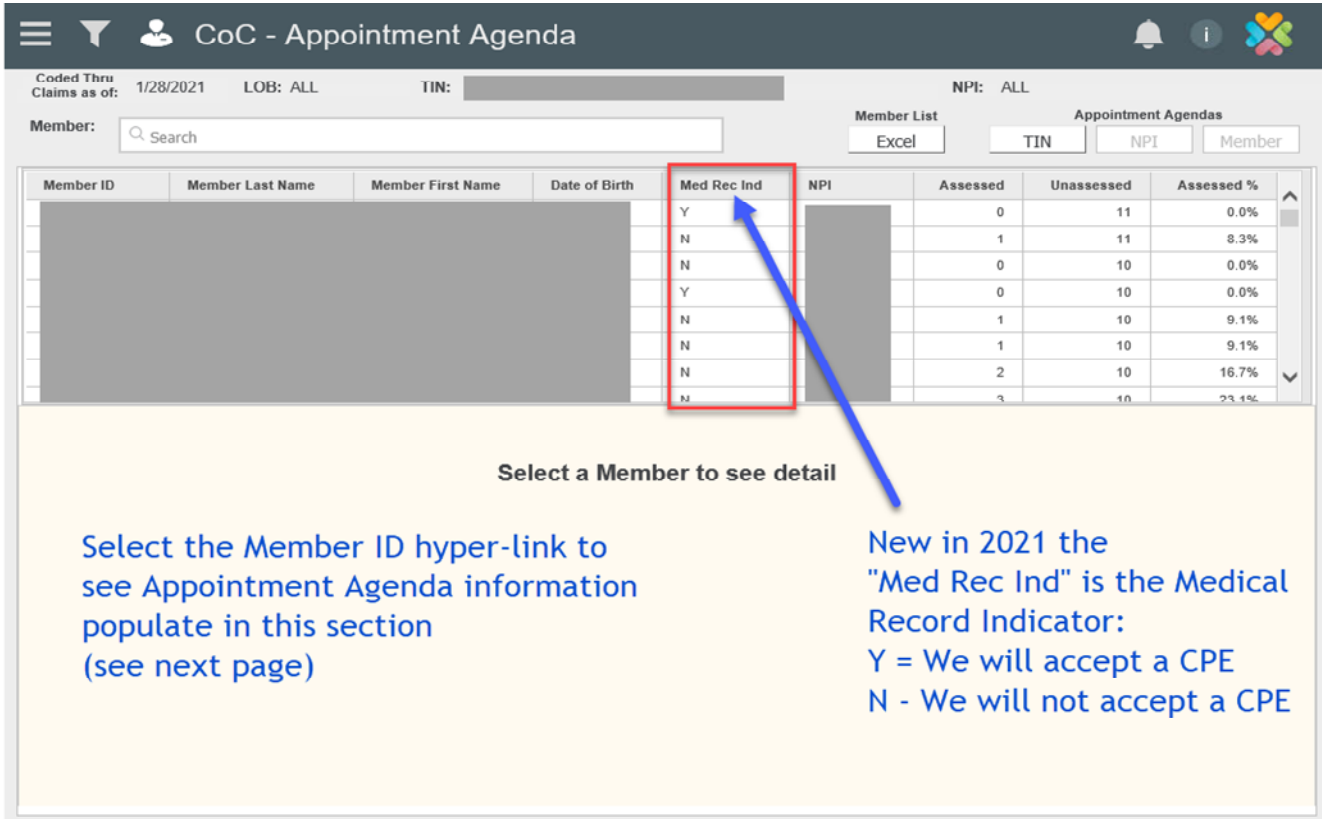
Continuity of Care Portal Navigation



Education Requests

Would you like training for you and your staff?

You can submit your requests to

providers@arhealthwellness.com

or

contact your Provider Relations Specialist directly

Coding and Documentation

Medical records may be requested to support data received via claims, on the Appointment Agendas and/or entered into the Provider Analytic tool.

Verifying Conditions for the CoC Program

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✓Suspected conditions were derived from a variety of sources.

- Claims data – a condition may have derived from the hospital, but the provider office now needs to confirm if the condition continues with any side effects or sequela (late effects or problems occur as a result of the event).

  Example: Acute Deep Vein Thrombosis (DVT)

  The member was discharged from the hospital with Acute DVT and is now being managed prophylactically with compression stockings and medication.

  Provider Action: Document whether condition is chronic or recurrent or if it has resolved (history of). Make sure to support this with documentation that states if patient is following a medication regimen and/or seeing a specialist.

Coding & Documentation Tips

- Document & Code all conditions present at time of encounter
- Utilize M.E.A.T guidelines to validate active conditions.
  - Monitor
  - Evaluate
  - Assess and Address
  - Treat
- Code to the highest specificity for all conditions and support with proper medical record documentation.
  - Diabetes vs. Diabetes with Complications
- Active chronic conditions coded and documented as active & conditions that no longer exist no code on claim.

***Note**: Additional Coding Tip Sheets can be found on the Arkansas Health & Wellness Provider Resource Page.*

Coding & Documentation Tips

- Active conditions are not coded or documented as “History of” and past conditions are not coded or documented as active.

“History of” Documentation = Resolved	Active Condition Documentation
H/O CHF = CHF Resolved	Compensated CHF, Stable on Lasix
H/O Angina = Angina Resolved	Angina is stable on Active Treatment
Cancers Post Chemotherapy/Radiation	Cancer in active treatment or patient refused treatment

Note: Additional Coding Tip Sheets can be found on the Arkansas Health & Wellness Provider Resource Page.

Continuity of Care Best Practices

- Engage with your assigned RA Coordinator.
- Utilize the Secure Provider Tool to access your data and to submit agendas electronically.
  - Assign resource(s) to oversee program and coordinate with health plan.
- Start now and earn the Early Submitter Bonus.
  - Promptly return the completed Agenda and/or CPE after member has been assessed (DOS 1/1/21-5/31/21; Agenda returned by 6/30/21).
- Schedule member for AWV if they have not had this year to earn an additional $100.
- Incorporate the diagnosis information from the agenda in your workflow to ensure provider has during encounter.
- Include all active ICD-10 diagnosis on the claim and document in medical record.
- Promptly file your claims.

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