Continuity of Care Provider Program

(formerly Partnership for Quality/P4Q)

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Risk Adjustment 101

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What is Risk Adjustment?

CMC-HCC Risk Adjustment is the process by which the Centers for Medicare and Medicaid Services (CMS) adjusts payments to health plans based on the perceived healthcare needs (i.e., anticipated healthcare costs) of their members. These needs are determined using member demographics (age, gender) and diagnosis that are reported for members.

What are Hierarchical Conditions Categories (HCC's)?

HCC's are hierarchy condition categories for Medicare and Marketplace that link to corresponding diagnosis categories. CMS determines the qualifying codes and assign risk adjustment factors to HCC's and can change annually.

Why is Risk Adjustment Important?

The main role of diagnosis codes in the model is to increase diagnosis coding accuracy. This helps the health plan improve health outcomes for members.

What is Continuity of Care Program (CoC)?

- Continuity of Care is a Provider Engagement program incentivizing providers incrementally for their work on addressing chronic conditions to improve the health of your members and provide appropriate clinical quality care.
- AHW pays INCENTIVES for completed and verified Provider Appointment Agendas and/or submission of Comprehensive Exam medical record.
- Appointment Agendas serve as a valuable tool that provides offices with insight into historical diagnosis data and clinical services as an aid to assist providers in assessing their members' chronic conditions that are required to be reported annually by CMS
- Providers can enter relevant documentation in the Arkansas Health & Wellness Secure Provider Portal under the "Provider Analytics" section.
- Measurement Period is from January 1, 2023 - December 31, 2023

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
- Wellcare by 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 throughout the program year.
- Incremental additions due to new members enrolling into health plan and member attribution changes may contribute to add, deletes, and changes to appointment agendas during the program year.
- Members are listed under their assigned provider's Continuity of Care dashboard located in the Secure Provider Portal.

Provider Bonus for CoC Program

- Bonus = $100 for every Assessed Member with a completed Appointment Agenda and verified/documented diagnosis.
- Can increase up to $200 and $300 based on meeting thresholds outlined below.
- Bonus Eligibility requires a qualified visit & a paid risk adjustable claim with a 2023 date of service.

% 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.

2023 Medicare Bonus Increase

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Medicare Bonus Increase

We are offering an additional $100 for completing valid office or telehealth visit on Medicare members with a 2023 date of service, and an Appointment Agenda with active diagnosis verified on the claim.

2023 Continuity of Care Program Goals

- Ensure members receive care and treatment for all active health conditions, not just for acute health issues.
- Assess and document 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 HEDISTM

Roles & Responsibilities

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Health Plan

Introduce the program and guide to targeted providers and serve as resource throughout program year for engagement and education.

Provider

- Schedule and conduct an exam with targeted members and use the Appointment Agenda as a guide assessing the validity of each condition identified PROACTIVELY.
- Document care and diagnosis in the medical record following coding and documentation guidelines
- Submit the claim using the correct ICD-10, CPT ®, CPTII ® or NDC Codes within timely filing period.
- Utilize the Secure Provider Portal to electronically submit completed appointment or print and fax completed agenda to 1-813-464-8879 or securely email to agenda@centene.com or agenda@wellcare.com OR submit Comprehensive Exam medial record in lieu of agenda.

Continuity of Care Appointment Agenda

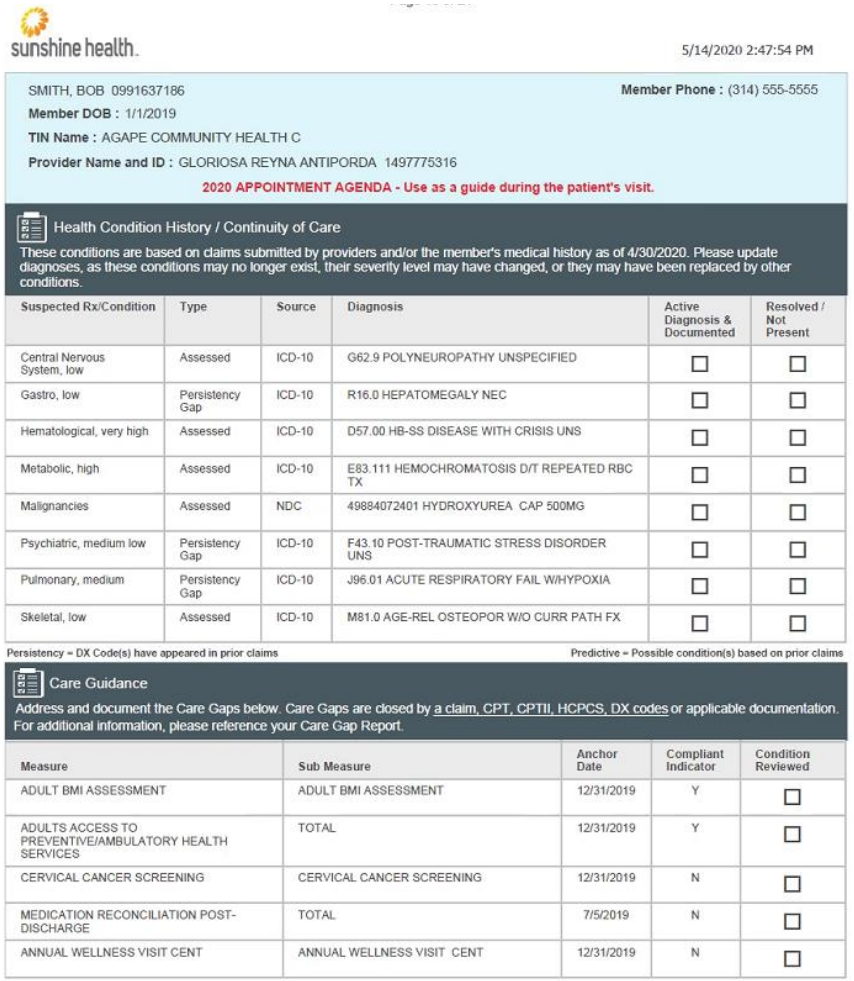
Components of the Appointment Agenda:

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.



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SMITH, BOB 0991637186 **Member Phone :** (314) 555-5555

Member DOB : 1/1/2019

TIN Name : AGAPE COMMUNITY HEALTH C

Provider Name and ID : GLORIOSA REYNA ANTIPORDA 1497775316

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	☐

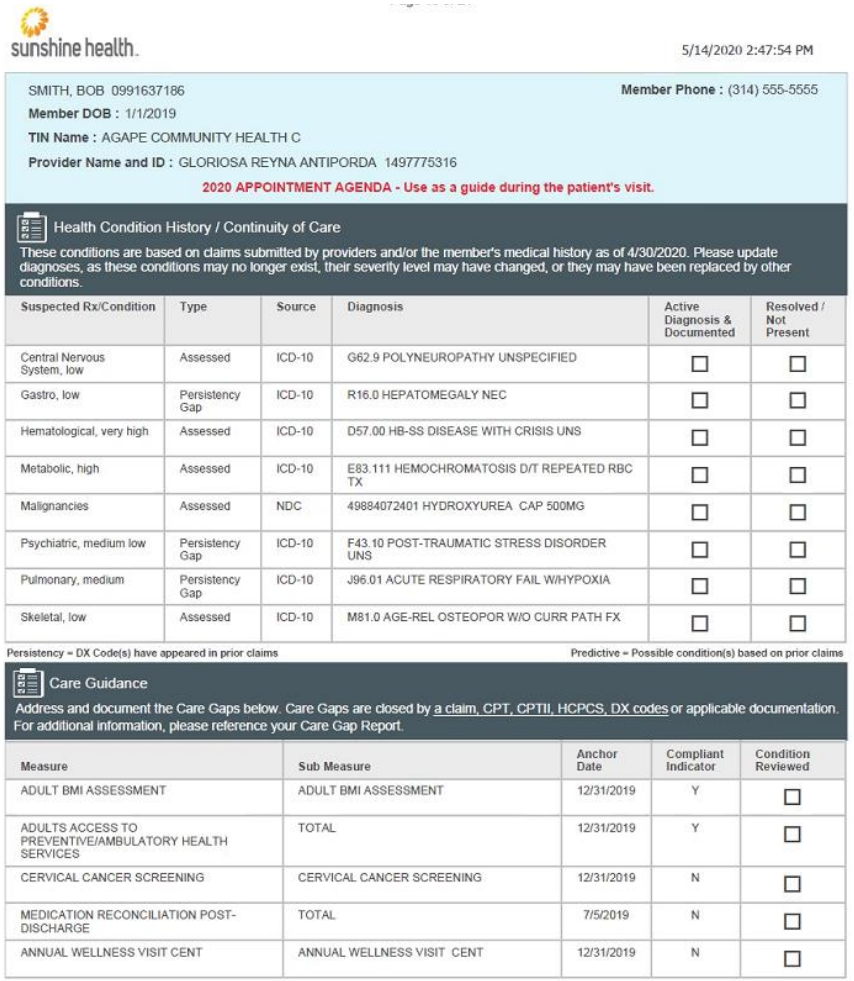
Continuity of Care Appointment Agenda

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 when submitting paper agenda.



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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	☐

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

Note: Any CPE submitted not meeting all requirements will not be accepted or eligible for incentive.

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. Guidelines subject to change per CMS.

2023 Continuity of Care Submission Methods

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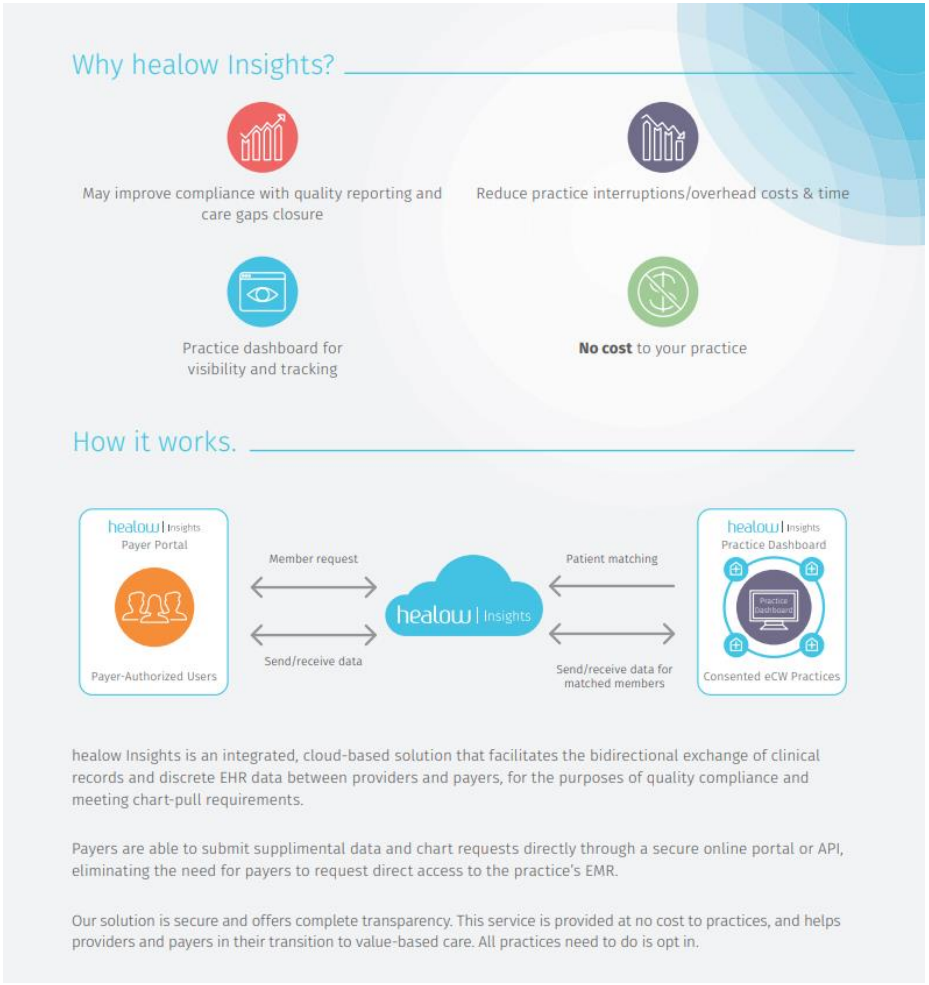
- Continuity of Care Dashboard on the Secure Provider Portal
- Fax completed Agenda or Comprehensive Exam Medical Record to 1-813-464-8879. Retain a copy of all faxed agendas.
- Securely email completed Agenda or Comprehensive Exam medical record to Agenda@wellcare.com or Agenda@centene.com Retain a copy of all faxed agendas.
- Secure Active Diagnosis File to RAPSActiveDX@Wellcare.com Completed Appointment Agenda required. (Risk Adjustment Only)
- EMR Flat File (Completed Appointed Agenda Required) Risk Adjustment and Quality
- Bi-Directional Feed using third party vendor
- RX Effect (Medicare Line of Business Only)
- Contact your Assigned Risk Adjustment Specialist for alternate options

BiDirectional Feed - Healow



Integrated cloud- based solution for exchange of clinical records and discreet EHR data.

BiDirectional Feed - Moxe

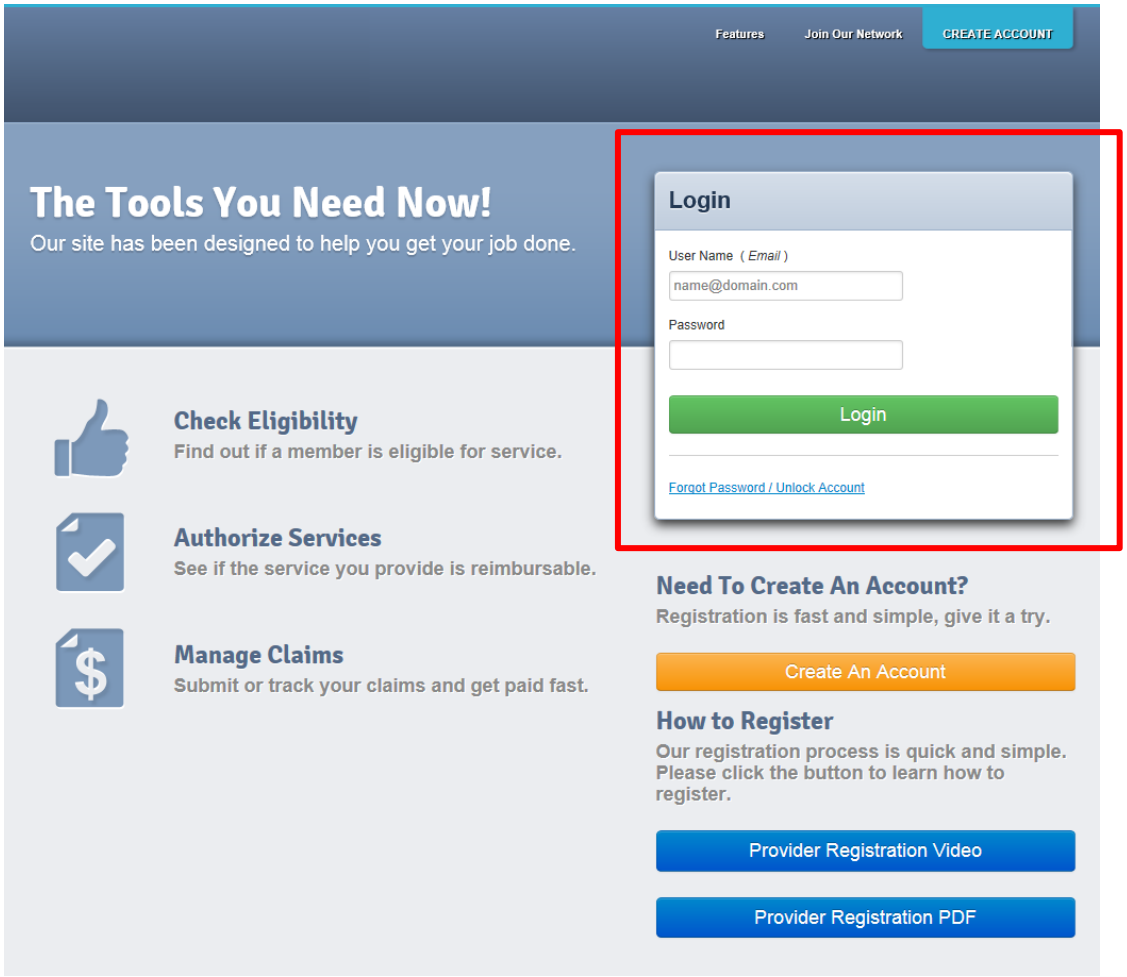
Actionable insights at the point of care to streamline clinical data exchange.

EMR Capability:

- Epic
- Meditech
- Allscripts
- Cerner

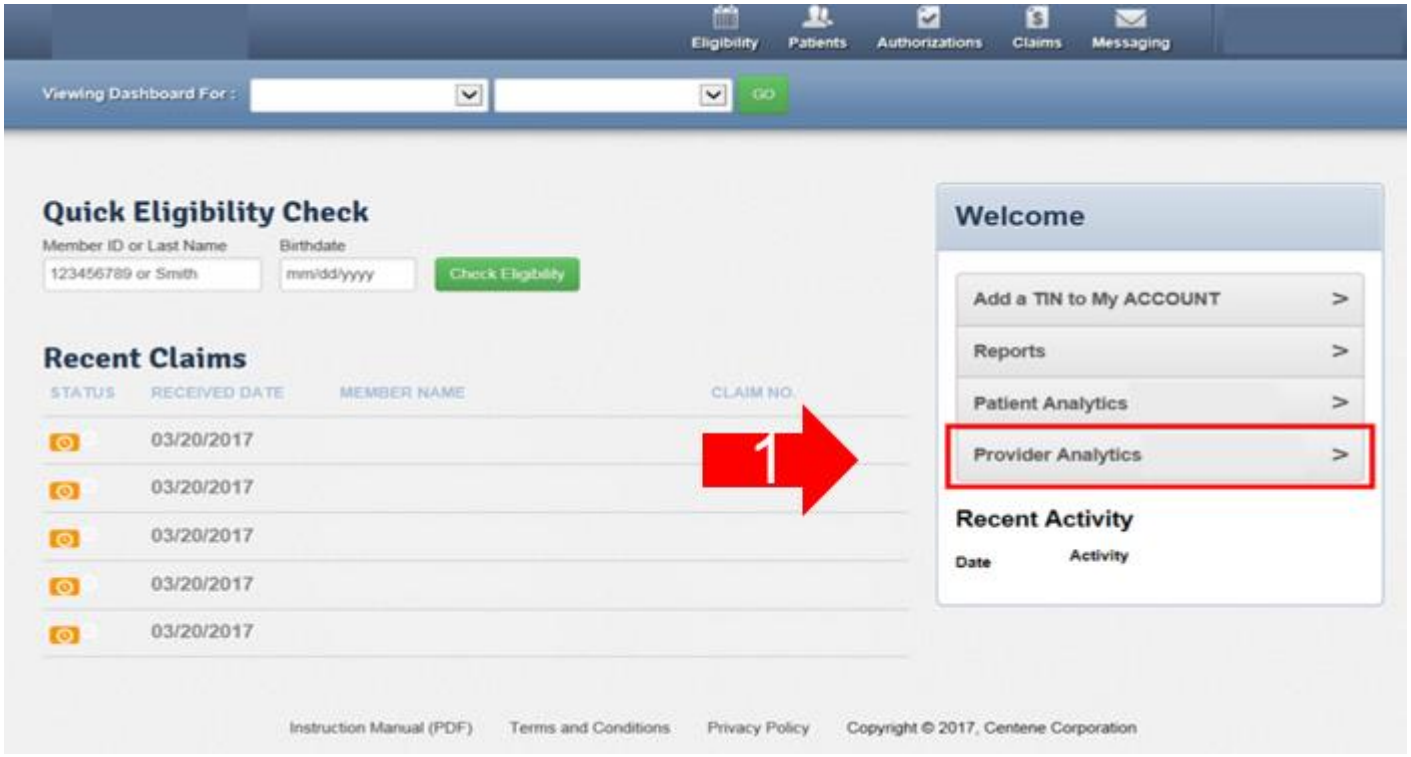
Accessing the Secure Provider Portal

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

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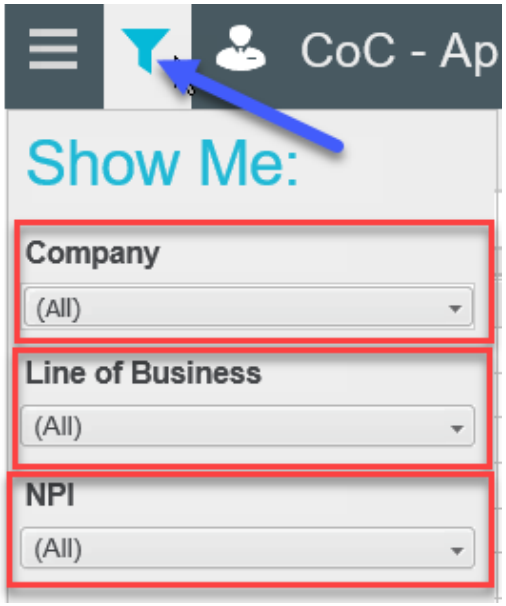
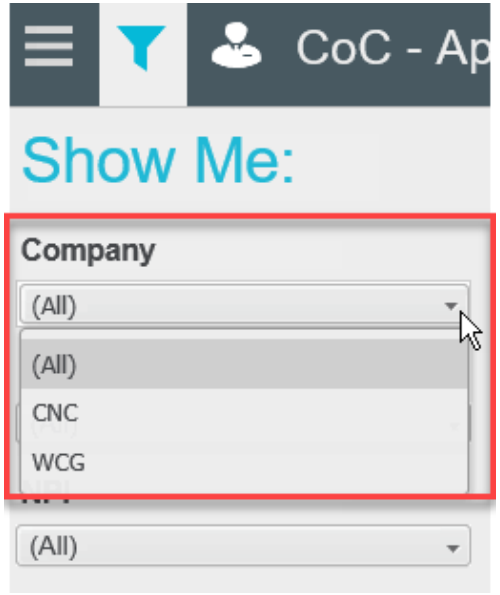
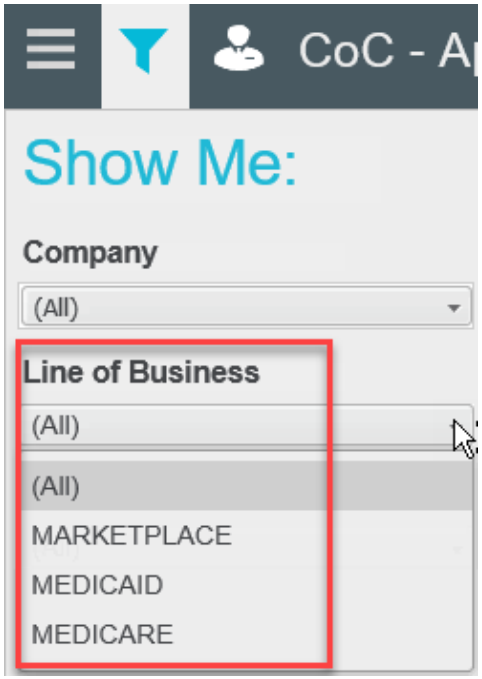
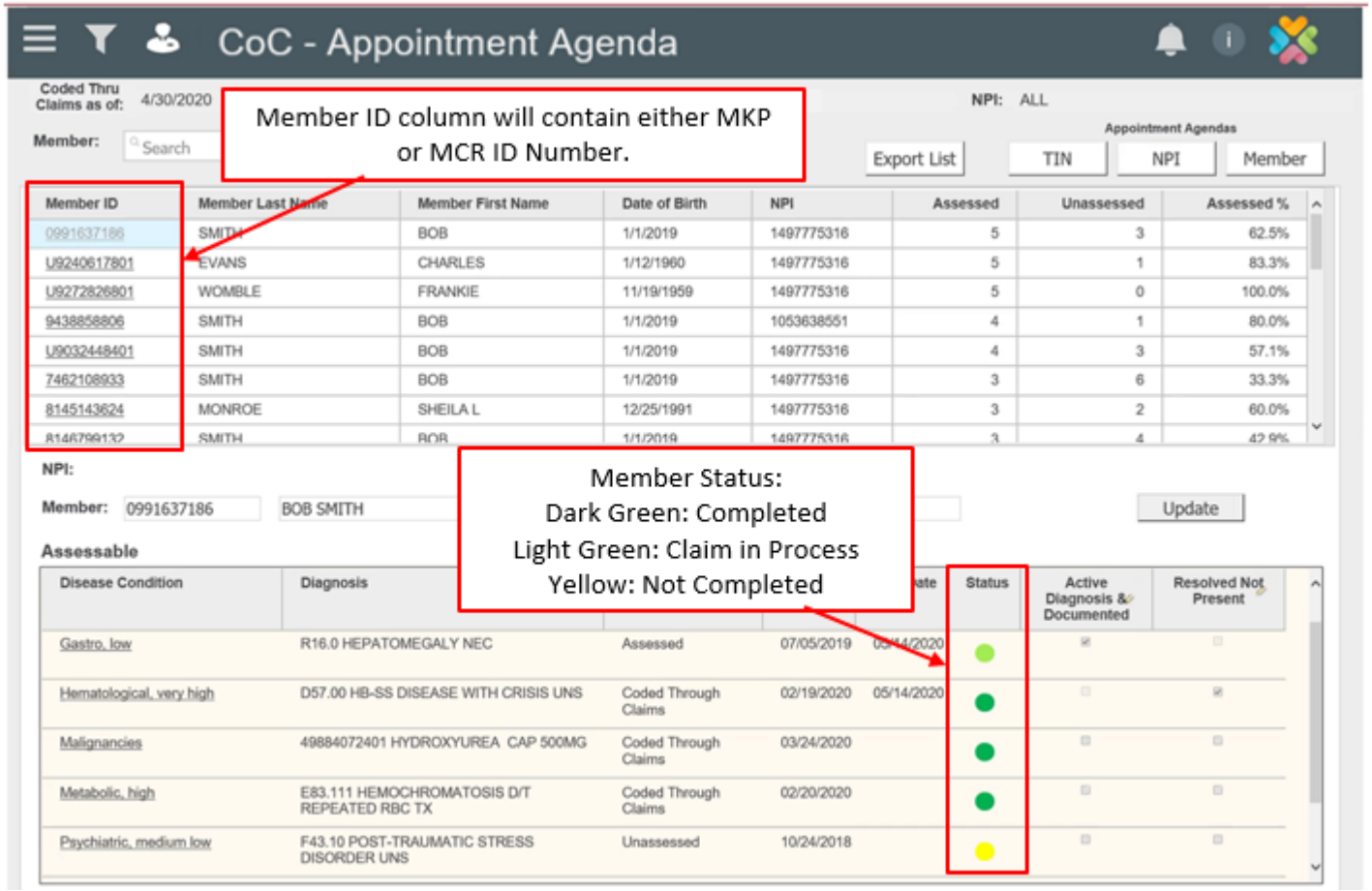
Utilize the Filter Feature to narrow your search options







Continuity of Care Portal Navigation



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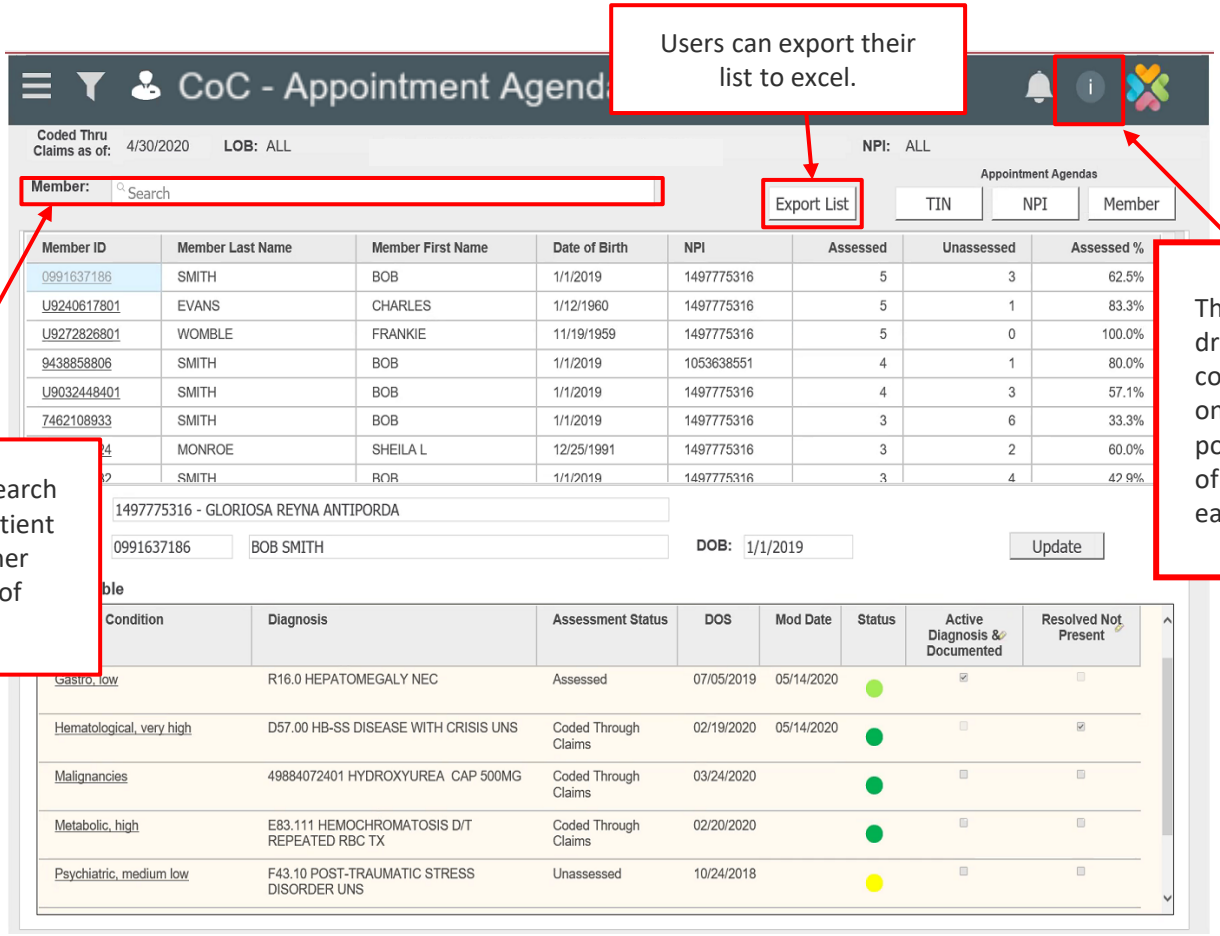
Continuity of Care Portal Navigation



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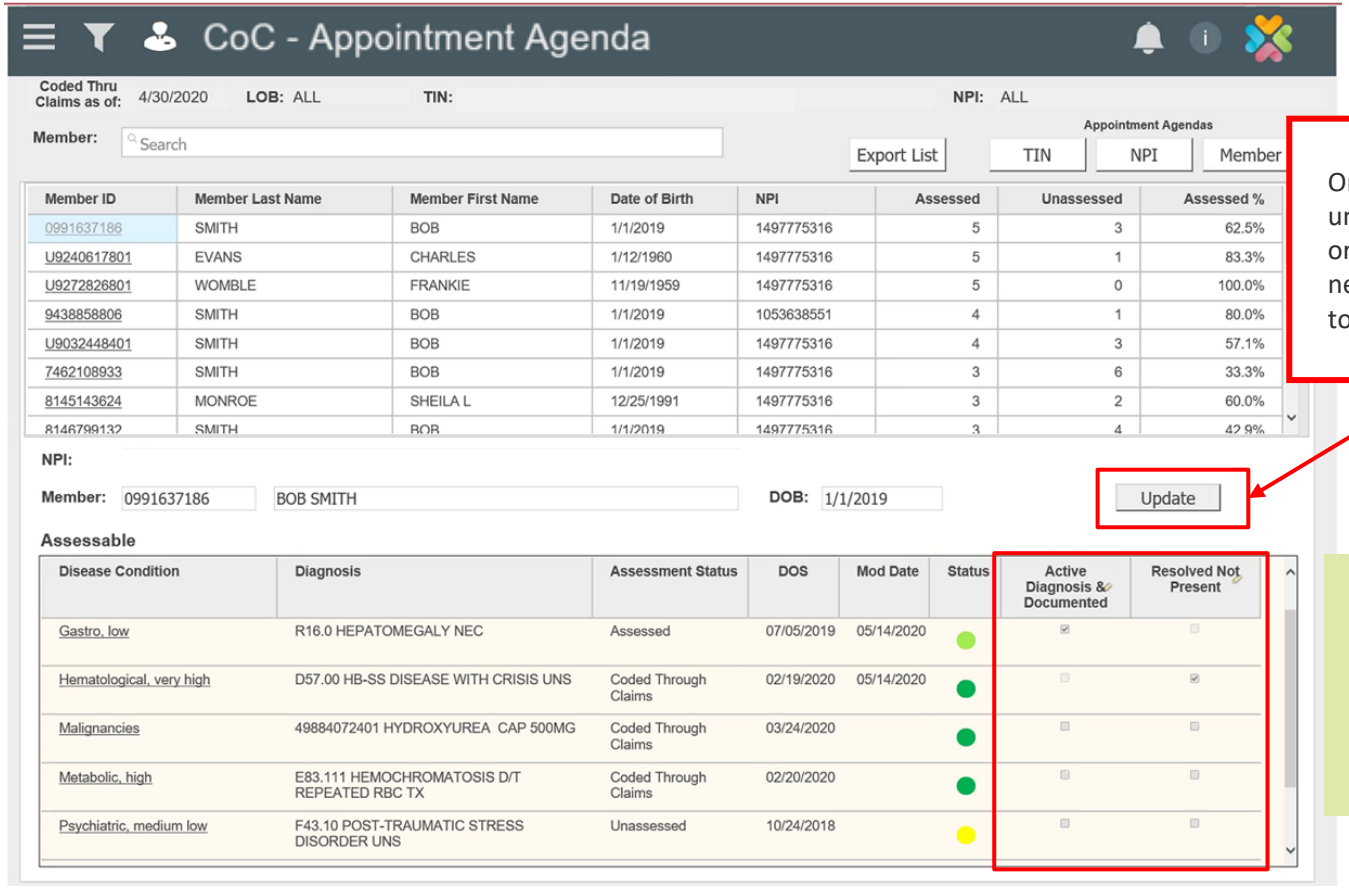

Once a box is checked or unchecked, the provider or authorized personnel needs to click "update" to save the updates.

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

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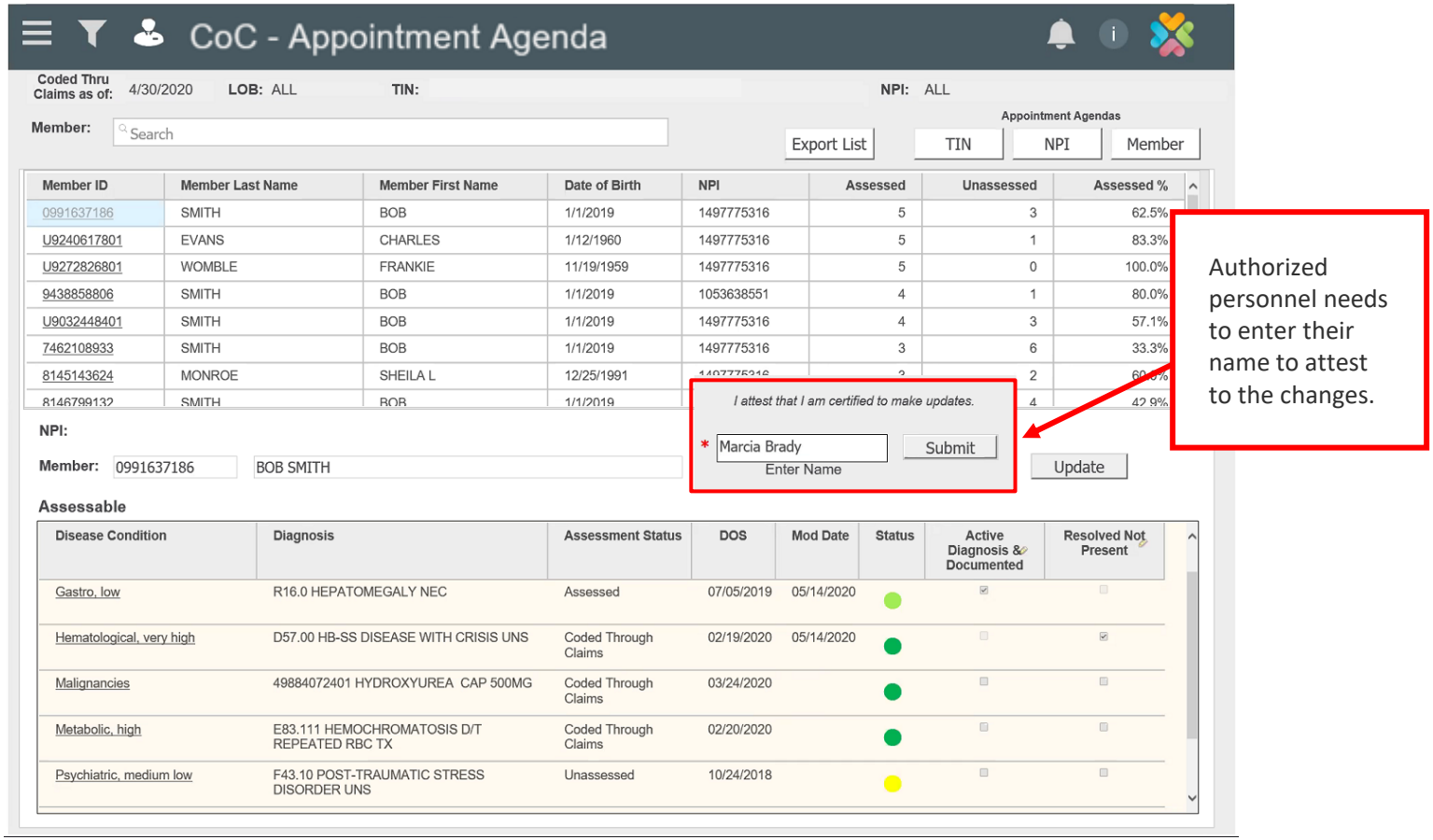
Continuity of Care Portal Navigation



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

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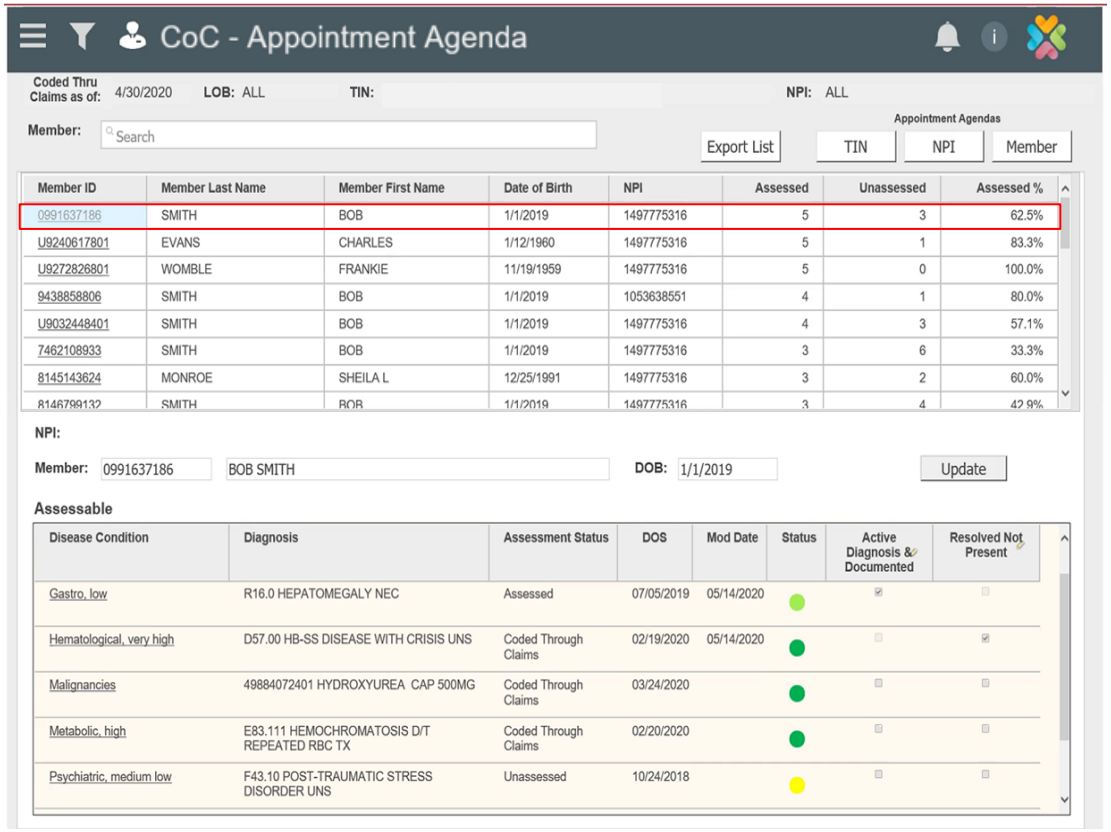
Continuity of Care Portal Navigation



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

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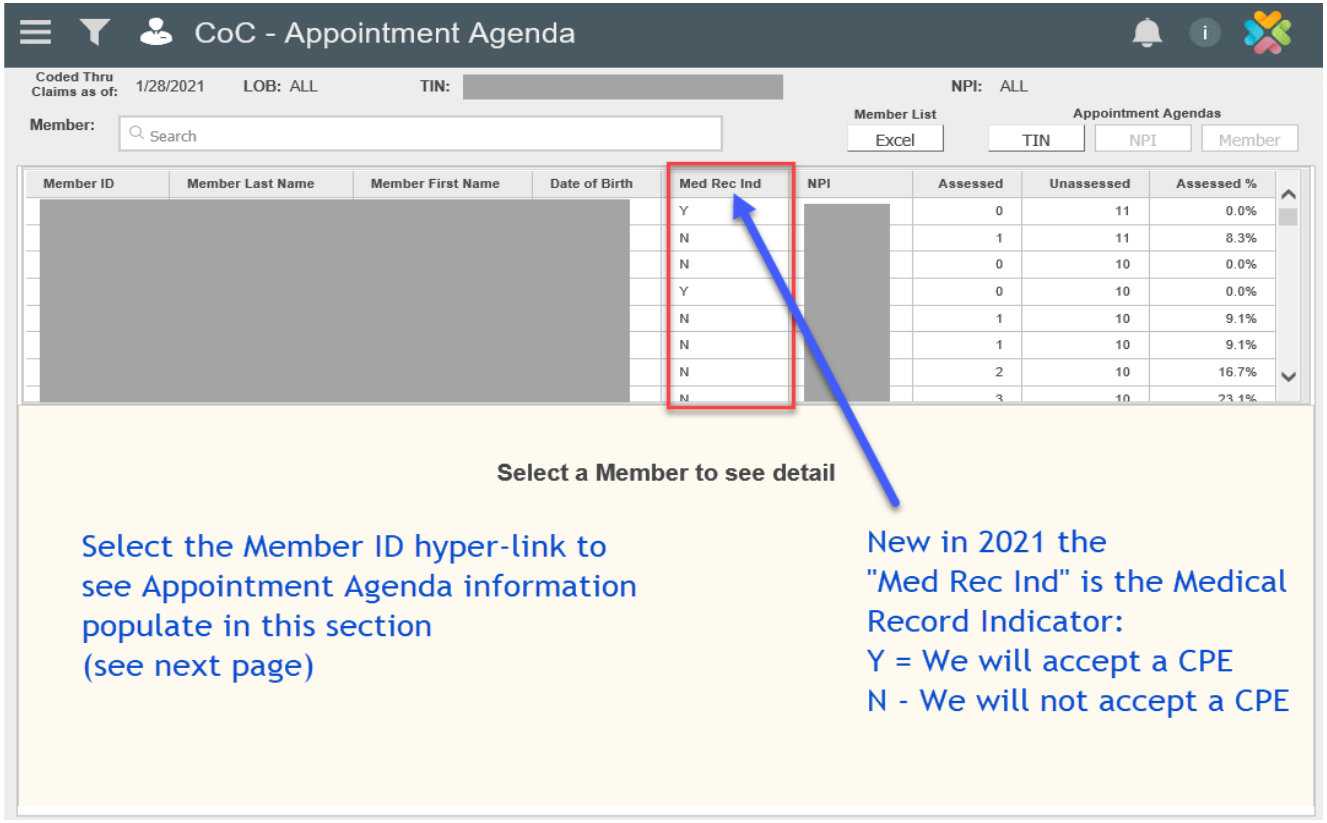
Continuity of Care Portal Navigation



Education Requests

Would you like training for you and your staff on this program?

Submit your requests to:

RiskAdjustment@arhealthwellness.com

or Contact your assigned Risk Adjustment Specialist

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.

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 should be coded and documented as active & conditions that no longer exist should not have a code on claim.

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 Specialist.
- 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.
- 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.

Questions

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