First Quarter Provider Webinar

Housekeeping

- Please mute your phone.
- Please do not place this call on hold as all attendees will hear your hold music.
- Please hold all questions until the end of the presentation.
- This presentation will be posted to the Arkansas Health & Wellness website soon.

Disclaimer

- Arkansas Health & Wellness has produced this material as an informational reference for providers furnishing services in our contract network. Arkansas Health & Wellness employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material.

- 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 ensure the accuracy of this information at the time of publication, the program is constantly changing, and it is the responsibility of each provider to remain abreast of program requirements. Any regulations, policies, and/or guidelines cited in this publication are subject to change without further notice.

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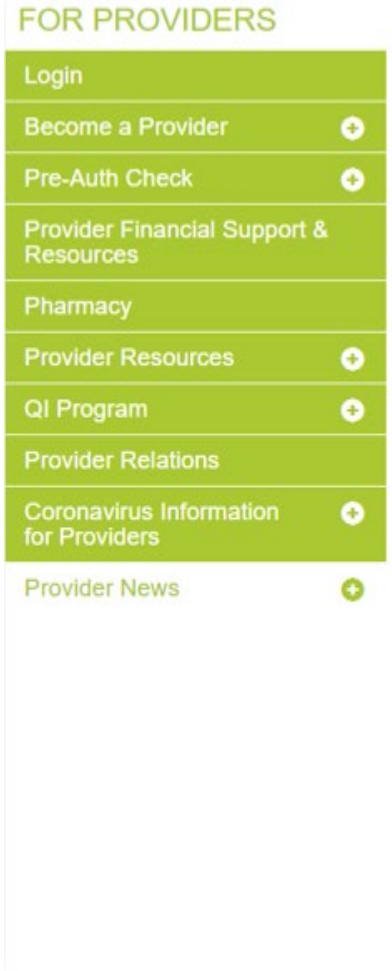
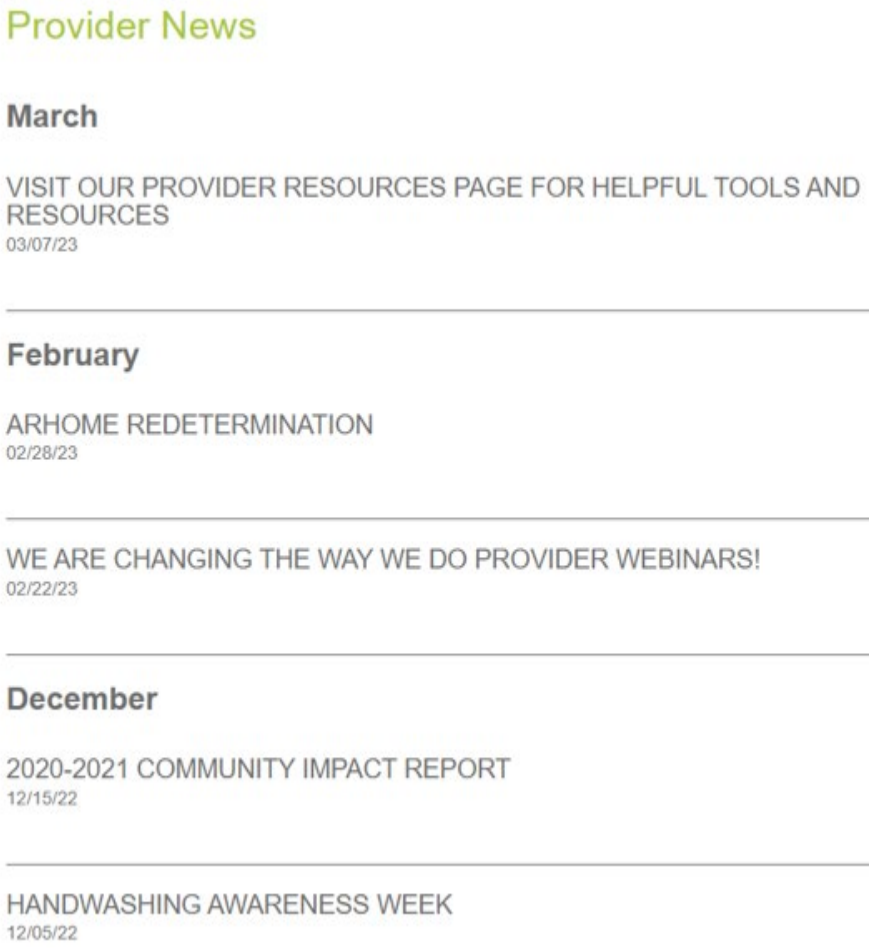
Agenda

- Provider Relations Territories
- Provider News Blog
- How to Join Our Email List
- Clinical and Payment Policy Updates
- Eligibility and Redeterminations
- Prior Authorizations
  - National Imaging Associates (NIA)
  - TurningPoint
- Wellcare by Allwell
  - Prior Authorization Changes
- Secure Provider Portal
- Risk Adjustment
- Quality Improvement
- Contact Information

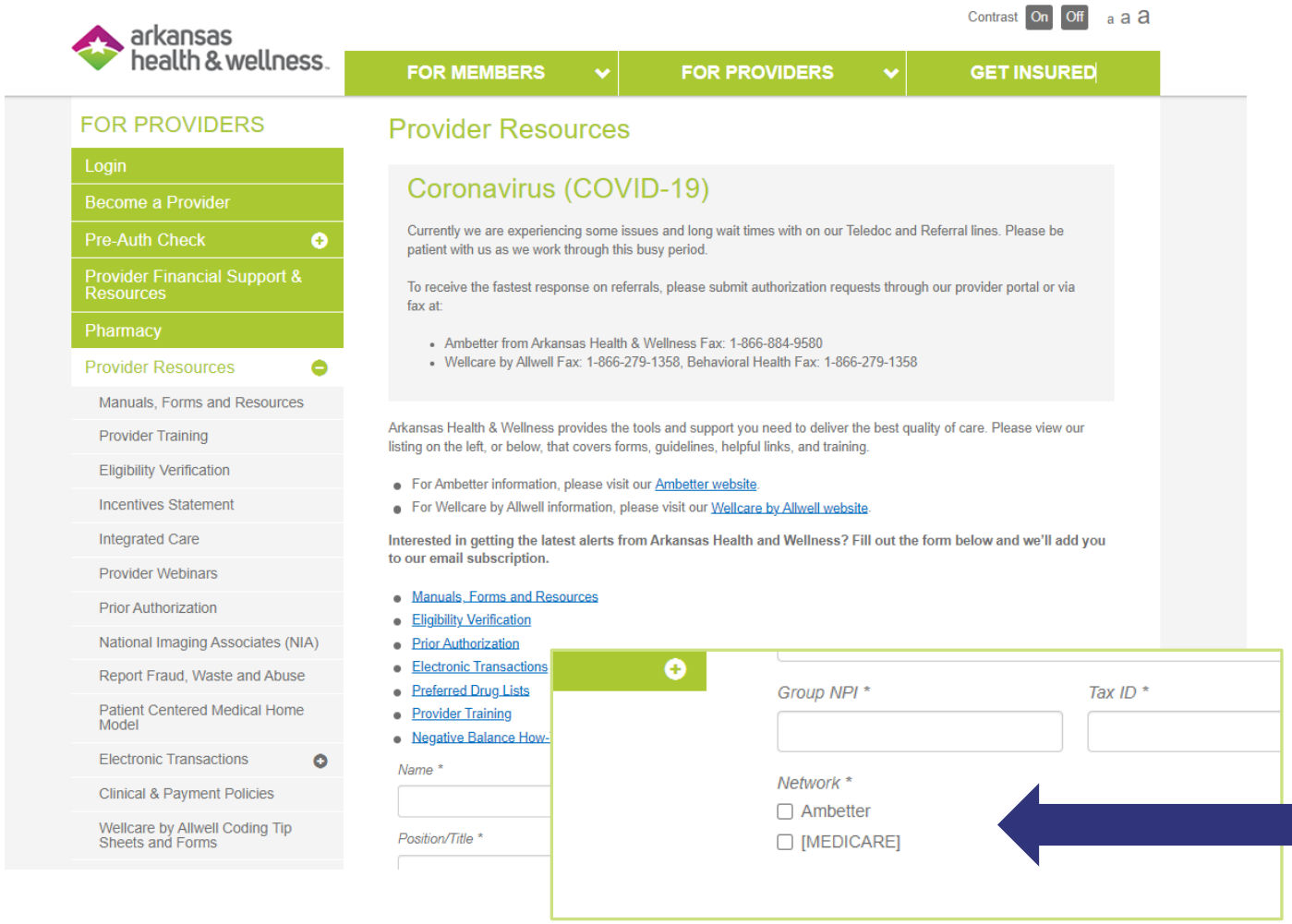
New Blog!

Arkansas Health & Wellness has a new blog on the public website for providers! Check out the Provider News section on the ARHealthWellness.com website. This is a faster way for us to get information posted for you to see. We will continue sending newsletters in addition to updating the Provider News Blog.





Join Our Email List Today



Receive current updates at

https://www.ARHealthWellness.com/providers/resources.html

- Choose the network you wish to receive information on: Ambetter or Wellcare by Allwell

Clinical & Payment Policy Updates

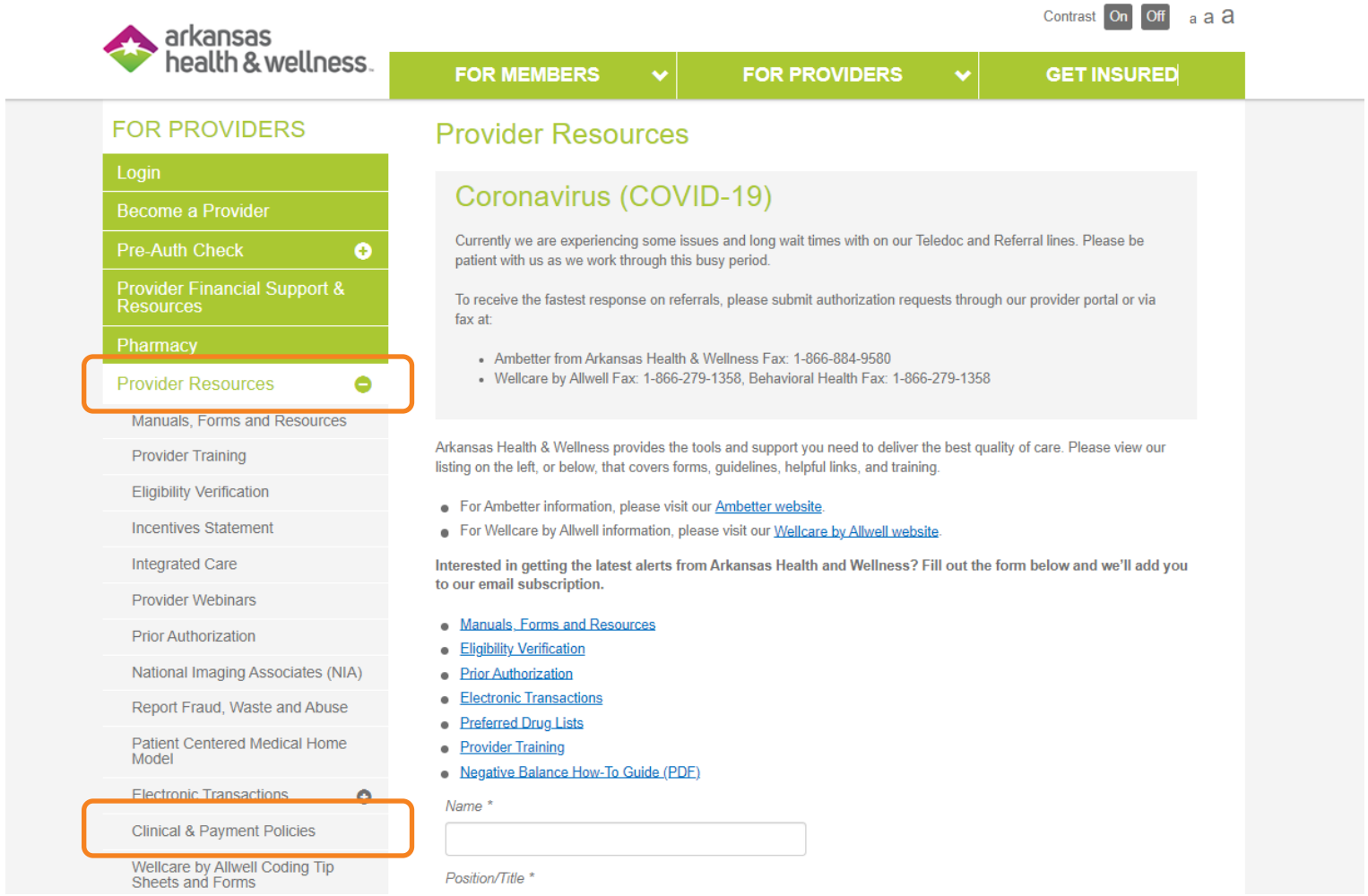
Clinical & Payment Policy Updates

Arkansas Health & Wellness is amending or implementing new policies that can be found on the public website.

- Clinical, payment, and pharmacy policies are available at ARHealthWellness.com.
  - Select the For Providers tab at the top of the screen.
  - Under Provider Resources, select Clinical & Payment Policies.
  - Choose between Ambetter and Wellcare by Allwell clinical, payment, or pharmacy policies.
- Use the Ctrl+F (Command+F on Mac) function on your keyboard to search by keyword, policy number, or effective date.

If you have questions, please call 1-877-617-0390 (TTY: 1-877-617-0392) or email Providers@ARHealthWellness.com

Clinical & Payment Policy



Important Policy Updates

Effective June 1, 2023

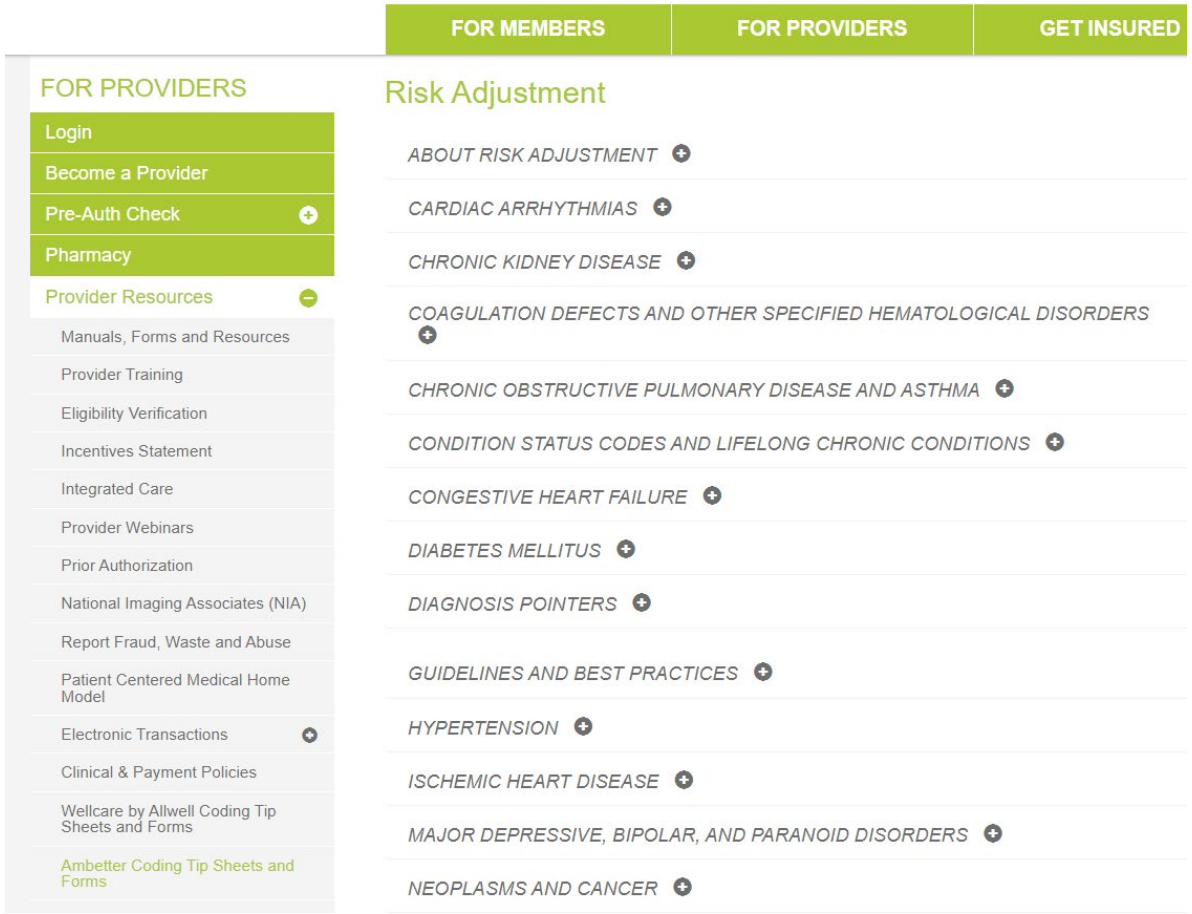
Inappropriate Primary Diagnosis

Effective June 1, 2023, the below changes have been made to align with current guidance from the Centers for Medicare & Medicaid Services (CMS). These are not health plan policy updates.

Inappropriate Primary Diagnosis

- Description: Denies or limits diagnosis codes based on coding guidelines supported by CMS and ICD-10. Claims will be denied when billed with unacceptable primary/principal diagnosis, manifestation diagnosis, and sequela diagnosis in outpatient or inpatient facilities.
- This impacts: Ambetter from Arkansas Health & Wellness (Marketplace); Wellcare by Allwell (Medicare)

Coding Tip Sheets and Forms



Wellcare by Allwell
Payment Policy Updates

Interim Claims

Effective June 1, 2023, Wellcare by Allwell will be update the payment and utilization policy on Interim Claims to ensure compliance with industry standards while delivering the best patient experience to our members.

- Bill types ending in XX2 or XX3 will be denied when discharge status **30** is not present on the claim.
- This change impacts Wellcare by Allwell only.

Eligibility and Redeterminations

The Centers for Medicare & Medicaid Services (CMS) require beneficiary eligibility when a Public Health Emergency (PHE) ends.

Medicaid Eligibility and Redeterminations

Overview

- A Public Health Emergency (PHE) in response to the COVID-19 pandemic was declared in March 2020.
- The Families First Coronavirus Response Act (FFCRA) prohibited states from disenrolling Medicaid recipients in order to provide continuous coverage during the emergency.
- When the PHE ends, the continuous coverage policy will be discontinued.
  - Unwinding PHE policies and resuming regular operations will require providers to help educate patients so they do not lose coverage, as patients' eligibility will no longer be tied to the PHE.
  - States will have up to 12 months to return to normal eligibility and enrollment operations.

What Redetermination Means for Your Patients

Impacts

- Nearly all of the 80 million people currently enrolled in Medicaid will have their eligibility redetermined, triggering a high risk of coverage losses.
  - This risk can be mitigated through careful planning by CMS, states, health plans, providers, consumers, and advocates.
  - Patients can lose eligibility due to changes in age, household income, and other state-specific criteria.
  - Loss of coverage could make it harder for patients to get medical care and result in expensive medical bills.
- Patients who have moved, have limited English proficiency (LEP), and/or have disabilities may be at greater risk for losing Medicaid coverage.

Talk to Your Patients about Annual Medicaid Eligibility Renewal.

If they no longer are eligible for Medicaid, let them know they have options.

Help your patients avoid gaps in coverage and let them know:

- They are required to verify eligibility every year, or risk losing their Medicaid coverage, by visiting HumanServices.Arkansas.gov.
  - They should receive a letter a few months before their Medicaid anniversary date with instructions for verifying eligibility.
- They must follow through on eligibility renewal instructions or risk having their coverage canceled.
- If they are no longer eligible for Medicaid coverage, they can explore other options, such as Marketplace or Medicare health plans.

Resources

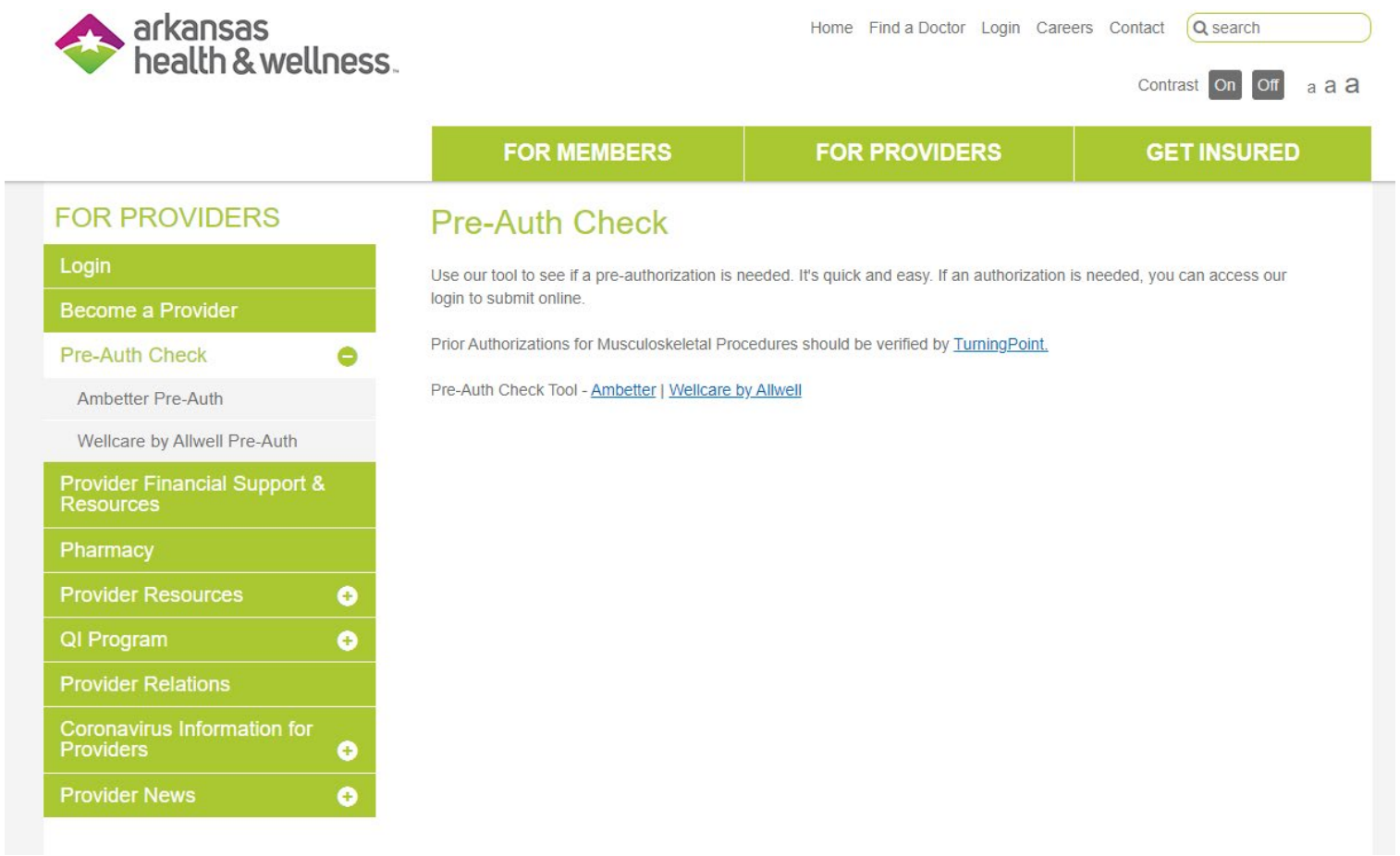
CMS: Unwinding Guidance & Resources
https://www.cms.gov/aian-unwinding

Medicaid.gov (Unwinding FAQs)
https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf

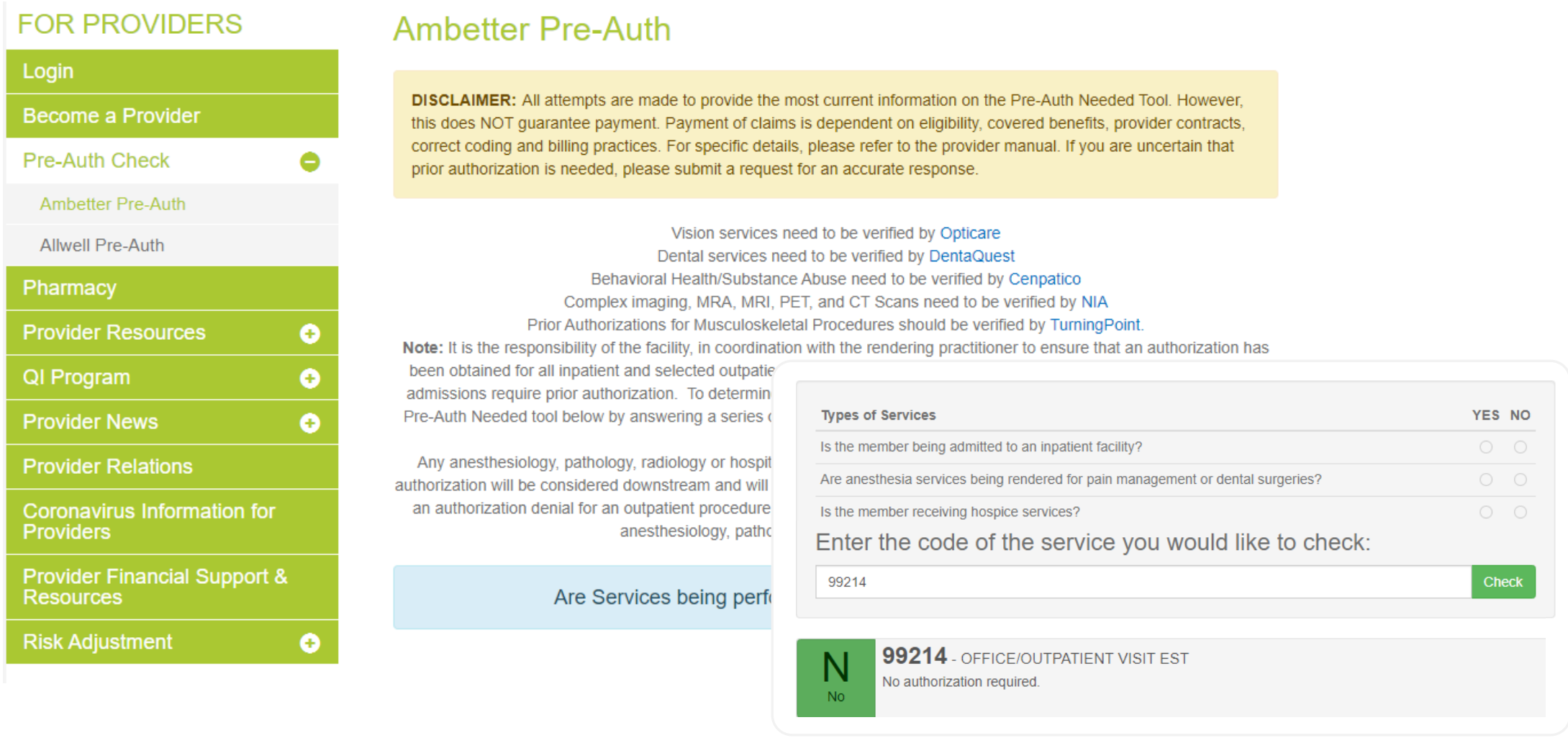
CMS: Unwinding and Returning to Regular Operations after COVID-19
https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html

Prior Authorization

Pre-Auth Check Tool



Pre-Auth Check Tool



How to Secure Prior Authorization

Prior Authorizations can be requested in the following ways:

Secure Web Portal

This is the preferred and fastest method.

- Both portals for Ambetter and Wellcare by Allwell can be found at Provider.ARHealthWellness.com

Phone

- Ambetter: 1-877-617-0390
- Wellcare by Allwell: 1-855-565-9518

Fax

IP and OP paper forms are available on the website, under Provider Resources.

- Ambetter: 1-866-884-9580
- Wellcare by Allwell: 1-833-562-7172

After normal business hours and on holidays, calls are directed to the plan's 24/7 Nurse Advice Line. Notification of authorization will be returned via phone, fax, or web.

Wellcare by Allwell
Prior Authorization Changes

Medicare Prior Authorization Change Summary

Effective January 1, 2023:

Wellcare by Allwell is committed to delivering cost-effective, quality care to our members. This means ensuring that our members receive only treatment that is deemed medically necessary for them. We rely on prior authorization (PA) requests from our providers to verify the medical necessity of a treatment in advance, using independent and objective medical criteria as well as in-network utilization where applicable.

Wellcare by Allwell requires PA as a condition of payment for many services. It is the ordering/prescribing provider's responsibility to determine which specific codes require prior authorization.

Medicare Prior Auth List

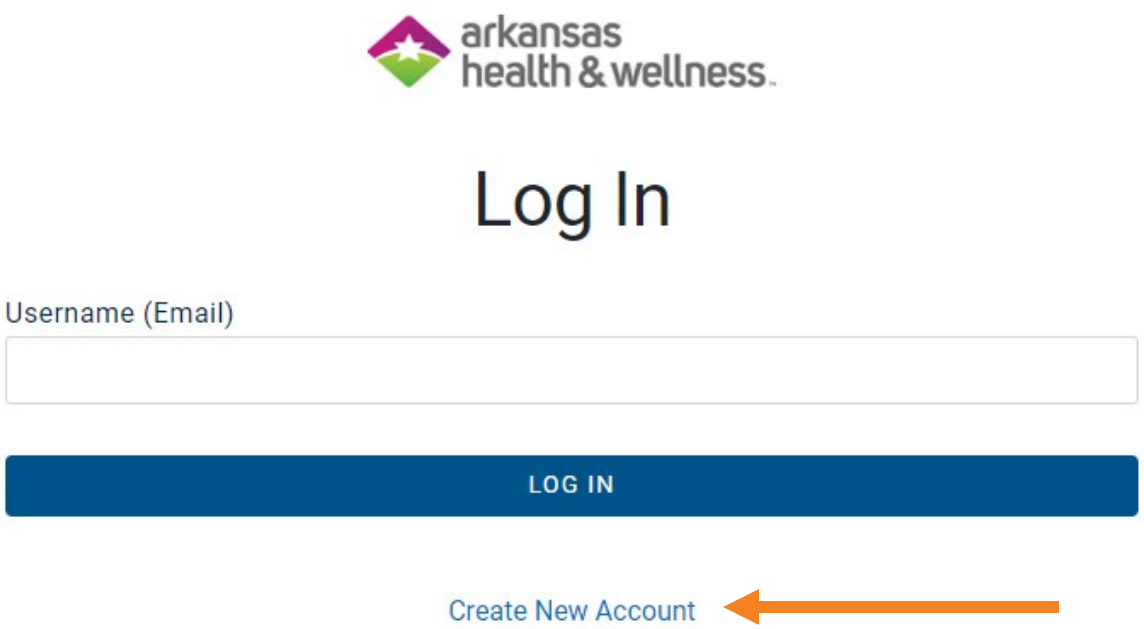
Effective January 1, 2023 Note: This is not an all-inclusive list.

Service Category	PA Rule	Services	Procedure Codes
Audiology	**PA Required**	Hearing Aid	V5256, V5258, V5261
	No PA Required	Speech Audiometry threshold	0210T
Behavioral Health	**PA Required**	Behavior assessments	97151,97152
		Adaptive behavior treatment	97153,97154, 97155, 97156
	No PA Required	Psychotherapy, training and education	90832, 90834, 90837, 90846, 90847, 90853, G0177
		Hypnotherapy	90880
		Brief behavior assessment	96127
Neurostimulators	**PA Required**	Insertion/replacement neurostimulator	0425T, 0426T
	No PA Required	Electronic analysis of neurostimulator	95970, 95971, 95972, 95980, 95981, 95982
		Removal of neurostimulators system	0428T
Pain Management	**PA Required**	Injection, anesthetic agent or steroid	64400, 64408, 64415, 64416, 64417, 64418, 64420, 64421, 64430, 64445, 64446, 64447, 64448, 64449, 64454, 64480, 64484, 64491, 64492, 64494, 64495
		Implant of hypoglossal neurostimulator	64582
		Destruction by neurolytic agent	64634, 64636, 64640
	No PA Required	Injection, anesthetic agent	64505, 64517, 64530
		Destruction by neurolytic agent	64620, 64630, 64632, 64680, 64681

Secure Provider Portal

Secure Provider Portal — Create an Account

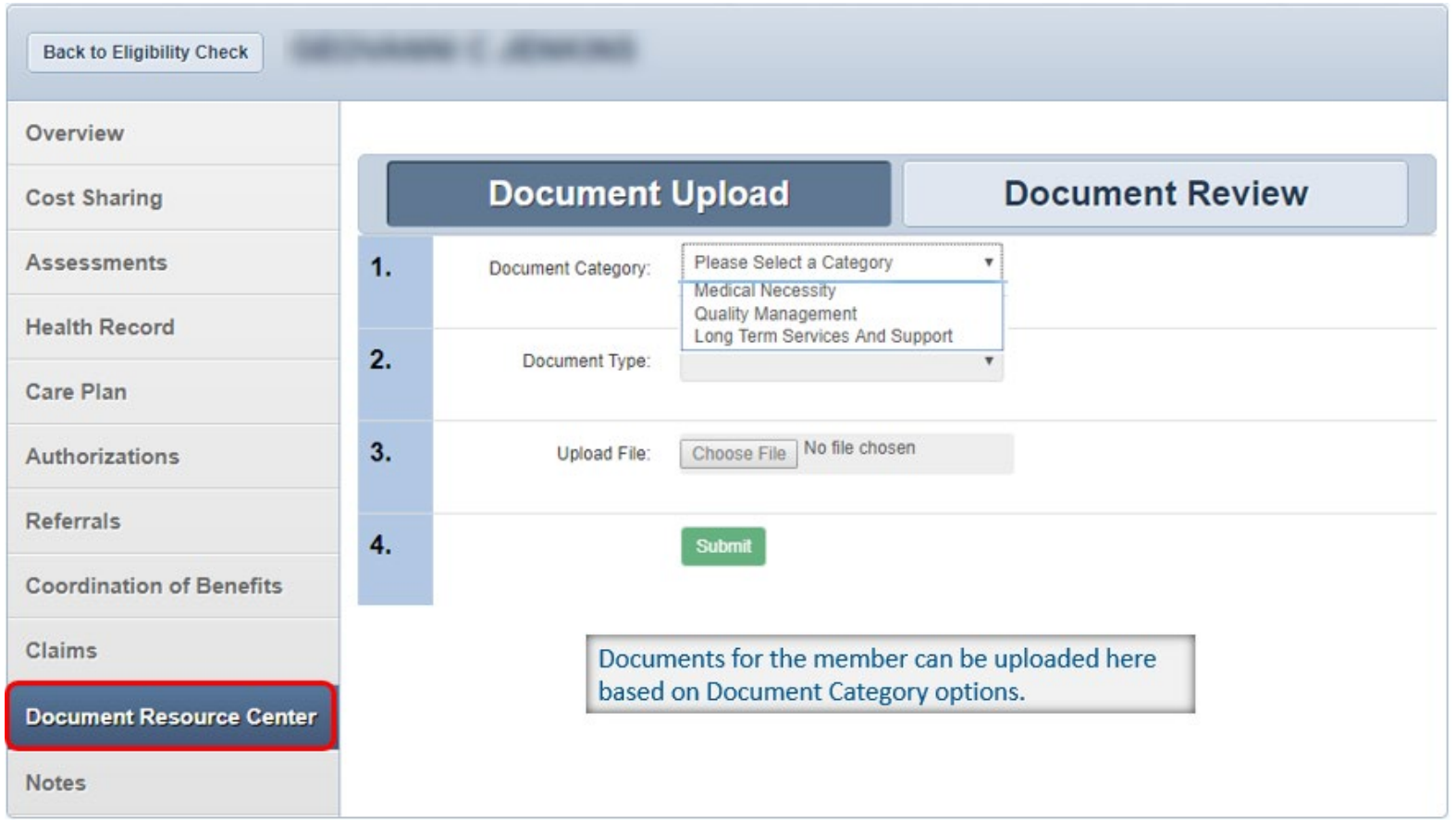
Registration is free and easy at Provider.ARHealthWellness.com



Secure Portal Features

- A member eligibility overview page that reflects all critical data in a single view
- Ability to submit and track the status of claim reconsiderations online
- Expanded free text fields for reconsideration comments and explanations
- Ability to attach required documentation when filing a reconsideration
- Ability to upload records for care gap information
- Push notifications regarding reconsideration status changes
- Void/recoup option on claims already adjudicated by the health plan
  - The manual inside the Secure Provider Portal has instructions for this new feature on page 92.

Patient Overview Document Resource Center



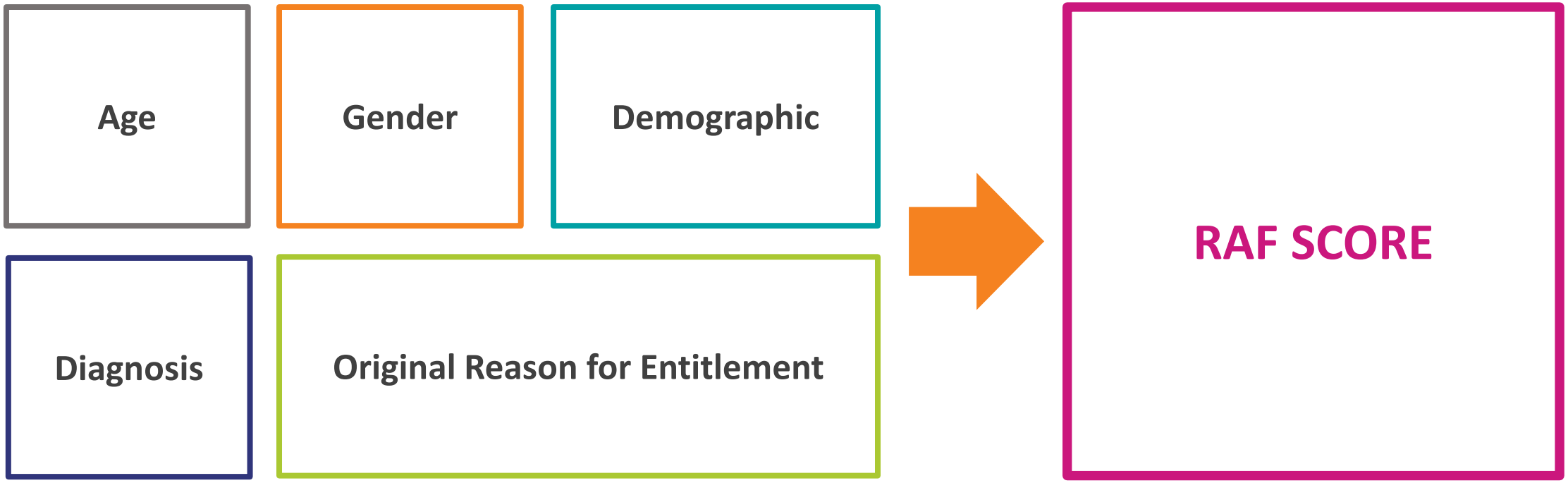
Risk Adjustment

Coding & Documentation 101

Agenda

- Risk Adjustment Overview
- Coding & Documentation Best Practices
- The Role of the Providers
- Program Initiatives

What is Risk Adjustment?



Risk Adjustment uses a predictive algorithm that incorporates information on individuals' demographics and health conditions to predict variation in future medical expenditures.

Hierarchical Condition Categories (HCCs)

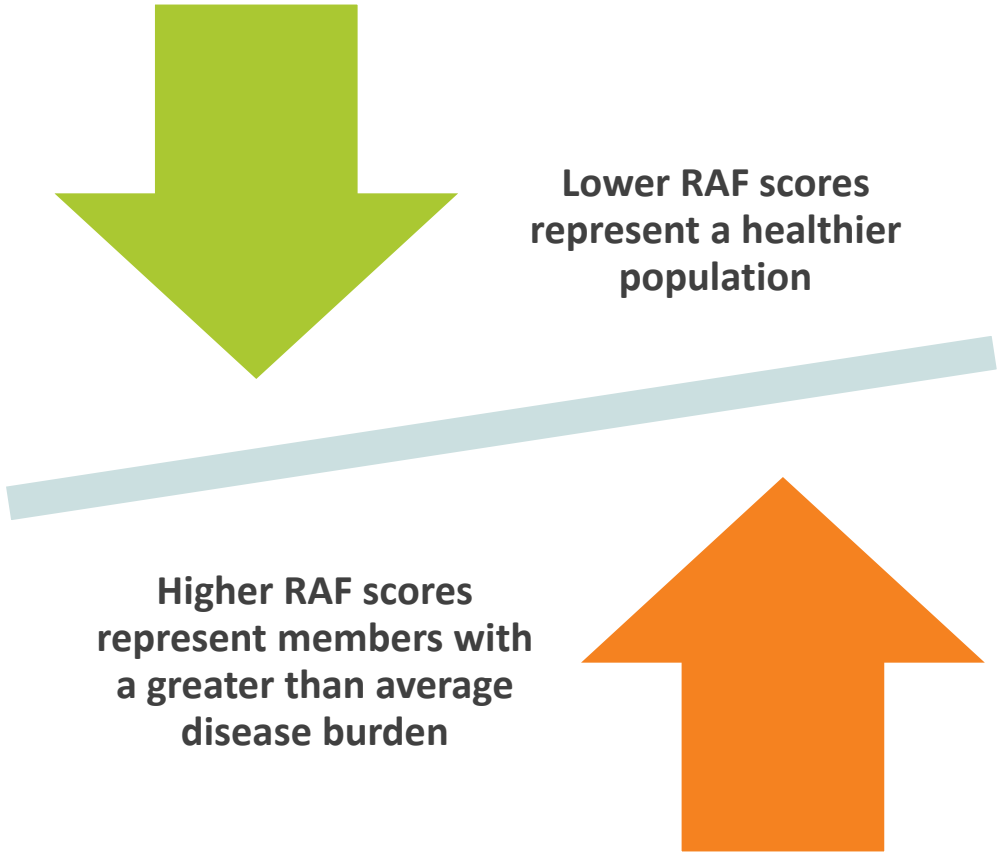
HCCs reflect hierarchies among related disease categories.

- Only the most severe HCC within the hierarchy is calculated in RAF.
- HCCs captured from unrelated diagnosis are cumulative.

CMS determines the qualifying ICD-10 diagnosis codes for each category and assigns the risk factor value.

- Not all diagnoses map to an HCC.
- Some diagnosis map to multiple HCCs.

Hierarchical Condition Categories



Causes of inaccurate RAF scores:

- Inadequate documentation
- Lack of specificity in ICD-10 code assignment
- Patient not seen

What Can You Do?

- Coding is the official language between payers and providers.
- Diagnosis codes will tell the story of each patient encounter, which enables CMS to determine the burden of disease.
- Accurate coding reflects the disease burden of a member; if not accurate, the coding will affect the member's health status, making them look healthier or sicker than they really are.
- If it's not coded and reported, the patient doesn't have it.
- CMS MIRACLE — On January 1 of each year, the patient's diagnosis information is reset in preparation for a new year of diagnosis encounter data. All conditions must be documented and reported every calendar year.

"I just want to take care of my patients."

"Coding is busy work."

"I'm a doctor, not a coder."

"I only care about CPT codes."

"I only need one diagnosis to submit a claim."

What Can You Do?

See the patient at least once a year to assess health status

- Evaluate and document ALL active conditions
- Simply listing every diagnosis in the medical record is not acceptable and does not support reporting an HCC

Be as specific as possible in the documentation

- This will allow for the most accurate ICD-10 code to be reported
- Documentation should include additional manifestations and complications related to a chronic disease

Maximize reporting opportunities

- Verify the condition is properly documented in the medical record
- Assign the appropriate ICD-10 diagnosis code to the highest specificity
- Submit the ICD-10 diagnosis code on the claim correctly

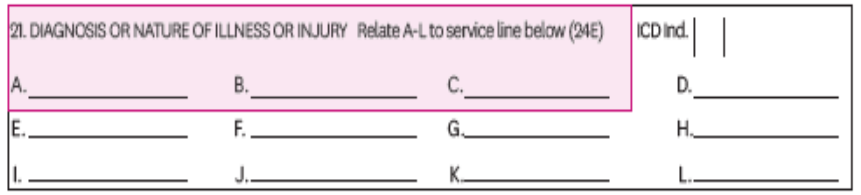
Diagnosis Pointers

Diagnosis pointers connect the diagnosis made by the provider to each CPT code billed on the claim. Only four diagnosis pointers can be listed per CPT code.

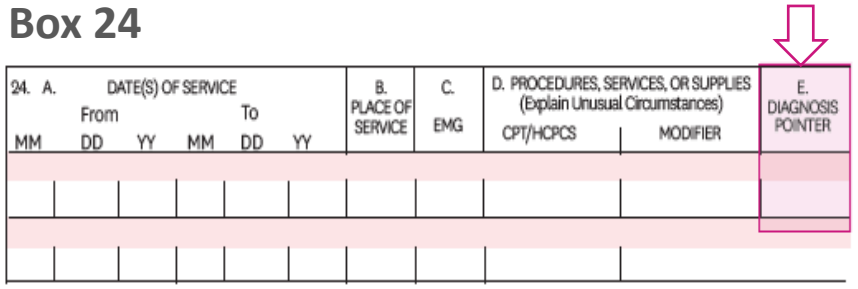
- Identify the four most important or serious diagnoses that the procedure is intended to treat.
- Enter the diagnosis pointers in order of severity.

The Diagnosis Pointer is the line letter (A–L) from Box 21 that relates to the service provided for the specific line in Box 24.

Box 21



Box 24



What can you do?

Coding & Documentation Improvement Plan

- Routine review for proper medical record documentation is vital for clinical documentation improvement.
  - Keep in mind, what might be “good enough” to establish medical necessity may not be specific enough for accurate risk score calculation.

- Follow Risk Adjustment coding guidelines for diagnoses to ensure specificity in coding and documentation.
  - Coding tip sheets can be found under the Provider Resources tab of the Arkansas Health & Wellness For Providers page.

How Can We Help You?

The Purpose

- Help providers understand and apply Risk Adjustment concepts
- Help in the application of Risk Adjustment best practices to workflows
- Protect the integrity and accuracy of risk adjusted diagnoses and improve outcomes

The Goal

- Engage staff and entire team in learning
- Enhanced communication support between coding staff, administrative staff, and providers
- Increase awareness of implications related to inaccurate coding and increase HCC proficiency

Risk Adjustment Programs

Annual programs include (but are not limited to):

Continuity of Care (CoC) Provider Incentive Program

- Program Dates: January 1, 2023 – December 31, 2023
- Provider has until January 31, 2024, to return completed agendas to earn incentives.
- Medicare and Marketplace members targeted

In-Office Assessment (IOA) Provider Incentive Program

- Program Dates: January 1, 2023 – December 31, 2023
- Provider has until January 1, 2024, to return completed agendas to earn incentives.
- Medicare and Marketplace members targeted

Medical Record Review Program

- Medicare and Marketplace programs concurrently running
- Vendors: Change Healthcare and Ciox
- Program Dates October 2022 – May 2023 (dates subject to change)

Provider Education Program

- Disease-specific coding reference material
- Tailored education based on chart review
- Complimentary services available year-round

Contact:

Secure Communications
Email: RiskAdjustment@ARHealthWellness.com
Fax: 844-822-6220

Marketplace P4P Program

2023

Pay for Performance (P4P) Program Overview

Objective	Enhance quality of care through a PCP-driven pay-for-performance program with a focus on preventive and screening services
Member Attribution	Members who have been formally assigned to a provider's Tax ID Number (TIN)
Targeted Services	Selected measures are focused on PCP engagement, screening services, and medication adherence, which align with QRS HEDIS® tech specs 1. Asthma Medication Ratio (AMR) 2. Cervical Cancer Screening (CCS) 3. Child and Adolescent Well-Care Visits (WCV) 4. Chlamydia Screening in Women (CHL): Total (16-24) 5. Proportion of Days Covered (PDC) - Diabetes All Classes 6. Controlling High Blood Pressure (CBP) 7. Eye Exam for Patients with Diabetes (EED) 8. Monitoring for Warfarin (INR) 9. PPC — Postpartum (PPC) 10. Use of Imaging for Low Back Pain (LBP)
Performance Incentive	Each measure has its own incentive amount paid after achieving its own target score
Requirements for Payout	• Payout 75% of measure incentive amount for reaching Target 1 • Payout 100% of measure incentive amount for reaching Target 2
Payout	• Three payouts per year (Q2/Q3/Q4 Final Reconciliation) • Monthly reporting gaps in care • Monthly performance scorecards

Pay-for-Performance (P4P) Program Overview

How is the P4P program structured?

- Each measure is assigned an incentive dollar amount and target percentage.
- Incentives are paid on each compliant member once the target has been met for that measure.
- There are 10 measures in the program. Each has two targets. If the provider reaches the first target, the bonus is paid at 75% of the incentive amount for that measure. If the provider reaches the second target, the bonus is paid at 100% of the incentive amount.
- Each measure is evaluated if there is at least one qualified event in the denominator. Providers can qualify and receive an incentive payment for one, multiple, or all measures.
- Target 1 is set at the Quality Rating System 3-Star target and Target 2 is set at the Quality Rating System 4-Star target.

Pay-for-Performance (P4P) — Measures

2023 Measure List	Measure Incentive	Target 1 Pays 75% of Incentive	Target 2 Pays 100% of Incentive
Asthma Medication Ratio (AMR)	$25	80.40%	86.00%
Cervical Cancer Screening (CCS)	$25	57.30%	66.20%
Child and Adolescent Well-Care Visits (WCV)	$25	49.90%	59.70%
Chlamydia Screening in Women (CHL): Total (16-24)	$25	43.00%	53.60%
Controlling High Blood Pressure (CBP)	$25	61.10%	68.60%
Eye Exam for Patients with Diabetes (EED)	$25	43.80%	53.30%
Monitoring for Warfarin (INR)	$25	56.50%	66.00%
PPC — Postpartum (PPC)	$25	81.90%	88.80%
Proportion of Days Covered (PDC) - Diabetes All Classes	$25	76.20%	80.10%
Use of Imaging for Low Back Pain (LBP)	$25	76.80%	81.60%

How the Math Works

(Incentive Amount) x (Number Compliant) x (75% for reaching Target 1 or 100% for reaching Target 2).

No bonus is earned if minimum target is not achieved.

Measure	Incentive Amount	Qualified	Compliant	Score	Target 1	Target 2	Bonus Earned	Target Achieved
Asthma Medication Ratio	$25	87	81	93.10%	80.40%	86.00%	$2,025.00	Target 2
Cervical Cancer Screening	$25	645	415	64.34%	57.30%	66.20%	$7,781.25	Target 1
Monitoring for Warfarin	$25	110	50	45.45%	56.50%	66.00%	$0.00	None

P4P Program — FAQs

- **How were the measures identified?**
  The measures are consistent with NCQA and HEDIS quality performance standards.

- **How often would measures change?**
  We continue to monitor all quality metrics and relative performance across the network. We refine our focus on an annual basis. We will provide a minimum 30-day notice in case we plan to change any of the measured services.

- **What will the monthly report contain?**
  The monthly reports will include a scorecard on the measured service including projected incentive amounts. They will also include detailed provider-level score cards and member-level quality gaps-in-care reports.

- **Can I get any interim payment on the quality program?**
  Yes, we do support interim payments on our quality programs. The final payout will be reconciled with any previous payments and will allow for sufficient time to look at chart reviews and medical records to supplement the quality scorecard. This process provides us a more accurate view of a provider's performance on a quality metric.

- **Given the contract is established mid-year, how will it be measured?**
  Providers will be given credit for any and all services that they have performed for members in this calendar year. Providers will also have an opportunity to improve their scores through the remainder of the year to maximize their bonus.

Provider Website

- Visit our website at ARHealthWellness.com to view coding tip sheets and forms for Ambetter and Wellcare by Allwell.
- From the homepage, select **For Providers**, then select the applicable **Coding Tip Sheets and Forms** option from the **Provider Resources** menu.

Quality Improvement

Partnership for Quality Program

Partnership for Quality

We are pleased to introduce the 2023 Medicare Partnership for Quality (P4Q) program.

New in 2023

- Increased base payments by $20 to $40 a measure
- Removed the STAR targets for 3-, 4-, and 5-STAR performance
- Added a 50% bonus increase if the provider achieves an average STAR rating of 4.0 or higher across HEDIS and pharmacy measures

Why did we make these changes?

- Easy to communicate the new bonus structure to providers
- Bigger checks to motivate providers
- Ability to update CMS cut-points in provider reports

Medicare P4Q Program Design

The program consists of 16 measures

- Base payments are the amount that a provider will receive for closing program measures.
- Providers can earn a 50% bonus increase by achieving an aggregate STAR rating of 4.0 or higher across HEDIS and pharmacy measures.
- Bonus for achieving a 4.0 or higher STAR score will be paid out in the final true-up payment.

2023 P4Q Program

MEASURE NAME	BASE
BCS — Breast Cancer Screening	$50
CBP — Controlling High BP	$50
Diabetes — Dilated Eye Exam	$40
Diabetes HbA1c ≤ 9	$50
COA — Pain Screening	$25
COA — Med List and Review	$25
COL — Colorectal Cancer Screen	$50
FMC — F/U ED Multiple High Risk	$40

MEASURE NAME	BASE
Med Adherence — Diabetes Meds	$50
Med Adherence — BP Meds	$50
Med Adherence — Statins	$50
OMW — Osteoporosis Management	$50
SPC — Statin Therapy for Patients with CVD	$50
SUPD — Statin Use in Persons with Diabetes	$50
TRC — Medication Reconciliation	$25
TRC — Engagement After Discharge	$25

Payment Structure

Payments 1, 2, & 3
First three payments will pay a measure closure at base level

Payment 4 — True-up
True-up payment will include:

- Control measures payments
- A 50% bonus increase if the provider achieves an average STAR rating of 4.0 or higher across HEDIS and pharmacy measures

Payment Example:
A physician achieves a STAR rating of 4 across HEDIS and pharmacy measures at the end of the program and received a total of $1,000 in base payments

- $1,000 for the base payment
- $500 additional for the 4-STAR achievement

Provider Website

- Visit our website at ARHealthWellness.com to view coding tip sheets and forms for Wellcare by Allwell and Ambetter.
- From the homepage, select **For Providers**, then select the applicable **Coding Tip Sheets** and Forms option from the **Provider Resources** menu.

Contact Information

Provider Services Call Center

arkansas health & wellness

First line of communication

- Ambetter Provider Services
  1-877-617-0390 (TTY: 1-877-617-0392)
- Wellcare by Allwell Provider Services
  1-855-565-9518 (TTY: 711)

Representatives are available Monday through Friday from 8 a.m. to 5 p.m. CT

Provider Service Representatives can assist with questions regarding:

- Eligibility
- Authorizations
- Claims
- Payment inquiries
- Appeal status
- Negative balance reports

Contacting the Provider Services Center

The Provider Services Call Center can assist with the following provider inquiries:

- Member eligibility
- Claim inquiries
- Prior authorization requests
- Network verification
- Appeal status
- Payment inquiries
- Check stop pay or check reissues
- Negative balance report requests
- Provider demographic change requests
- Secure Provider Portal password resets

Contracting Department

Phone Number: 1-844-631-6830

Hours of Operation: 8 a.m. – 4:30 p.m.

Press 1	If you know your party's extension	**Press 2**	Ambetter	**Press 3**	Wellcare by Allwell	**Press 4**	Arkansas Total Care	**Press 5**	To repeat

Provider Contracting Email Address: ArkansasContracting@centene.com

Regular contracting inquiries and contract requests

Education Requests

Would you like training for you and your staff?

Submit your requests to:

Providers@ARHealthWellness.com