Maximizing Your Quality Performance

mhs™

ACCREDITED NCQA HEALTH PLAN

ambetter.™

Hoosier Healthwise

HIP HEALTHY INDIANA PLAN

Hoosier CARE CONNECT

allwell.™

0521.PR.P.PP.3 12/21

Agenda

- Tools for Achieving a Better P4P Payout
- Pay for Performance (P4P) Measures
  - Medicaid
  - Ambetter
  - Allwell
- CoC
- HEDIS® Measures and Codes
- Provider Relations Team
- Questions and Answers

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Tools for Achieving a Better P4P Payout

- Secure Provider Portal
- Provider Analytics
- My Health Direct

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Home Find a Provider Portal Login Events Careers Contact Us search

Contrast On Off a a a language

Select Your Plan Below *Which plan do I have?*

FOR MEMBERS | FOR PROVIDERS | GET INSURED

- Allwell From MHS
- Ambetter From MHS
- Healthy Indiana Plan
- Hoosier Care Connect
- Hoosier Healthwise

Find a Provider

Finding a doctor is quick and easy. Search for Primary Medical Providers, hospitals, pharmacies and more.

Opioid Resource Center

Opioid use disorder is a disease. Recovery is possible – find support and resources here.

Complete Your HNS

Take the Health Needs Screening (HNS) and start earning CentAccount rewards today!

Allwell from MHS | Ambetter from MHS | Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect

FOR PROVIDERS

Login

Enrollment and Updates

Prior Authorization

Dental Providers

Pharmacy

Opioid Resources

Behavioral Health

Provider Resources

QI Program

Provider News

Email Sign Up

Portal Login

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login/register button. A new window will open. You can login or register for a new account.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

PORTAL TRAINING GUIDES

Secure Provider Portal

Login/Register

Provider Email Sign Up

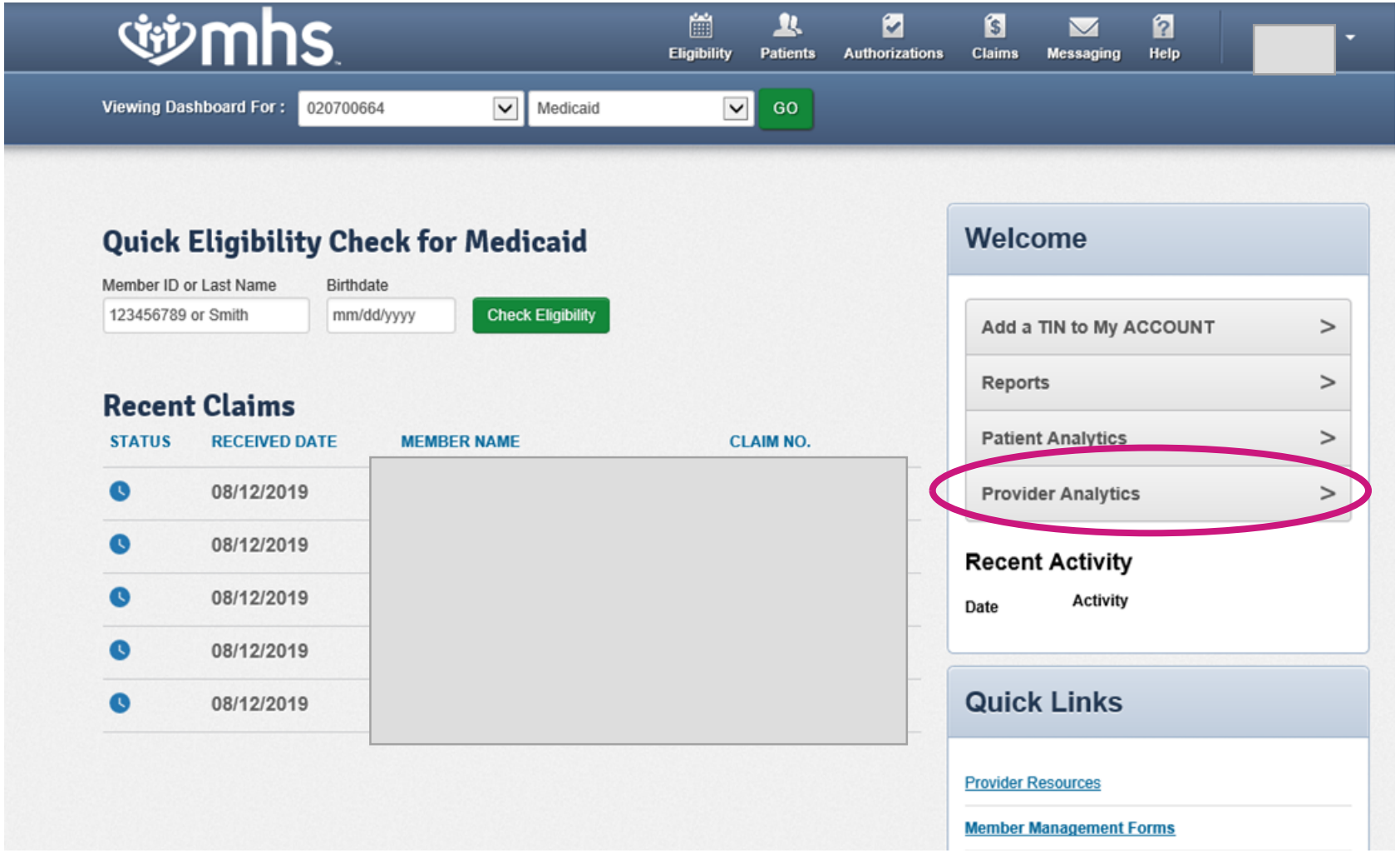
Sign Up

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

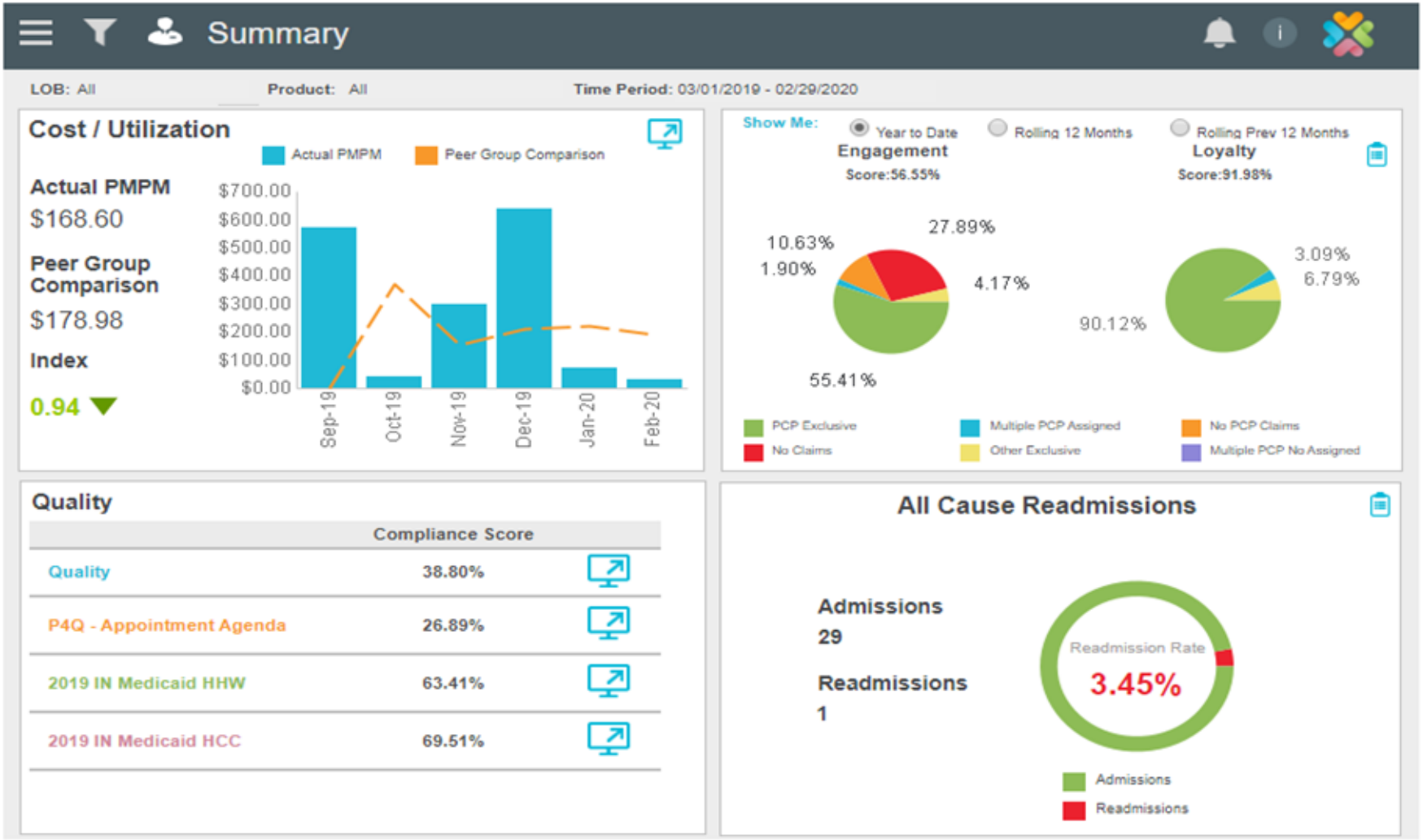
Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our Become a Provider page to get started. For further assistance, you can call Provider Services at 1-877-647-4848 or see our Account Registration Guide (PDF).

MHS Secure Portal



Provider Analytics Landing Page



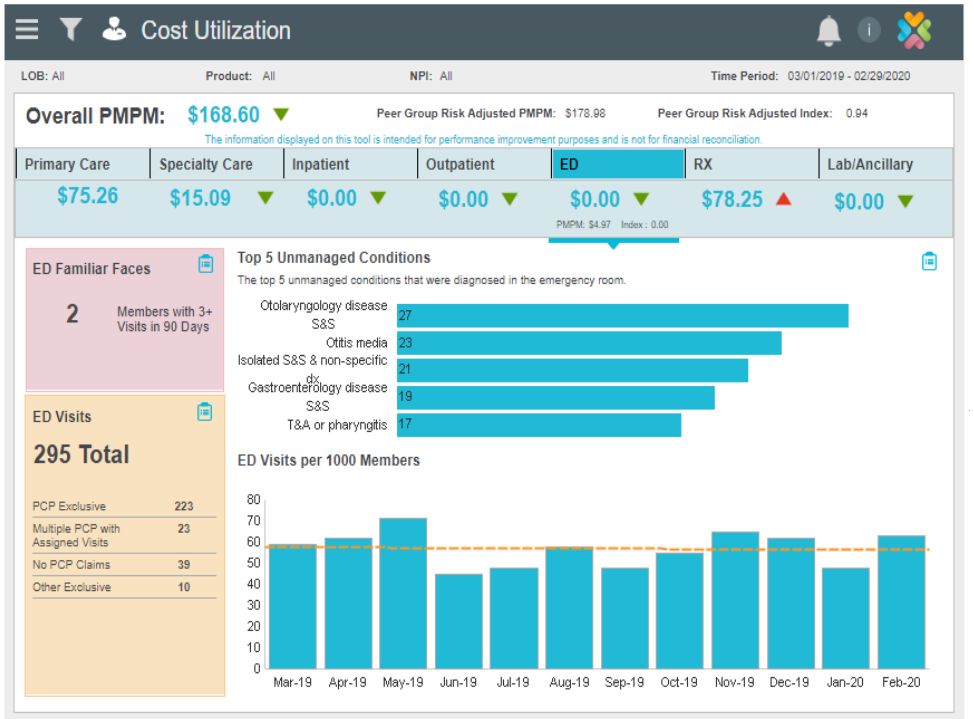
Provider Engagement and Loyalty

Patient Segment	Segment Traits
PCP Exclusive	These patients have been assigned to you and have been seen by you or one of your partners
Multiple PCP Assigned	These patients are assigned to you, but have been seen by your practice ***AND*** other PCP groups
No PCP Claims	These are patients who seek all of their care from specialists, ER, and Urgent Care.
Other Exclusive	These patients are assigned to you, but have been seeing another PCP group exclusively
No Claims	These patients are assigned to you but have no claim data to indicate they have received any medical care from a PCP, emergency department or urgent care center
Multiple PCP No Assigned	These patients are assigned to you, but have only been seen other PCP groups.

*In order to improve quality and cost, it's important to engage members who are not actively being managed; therefore, provider engagement provides the most inclusive view of member activity.

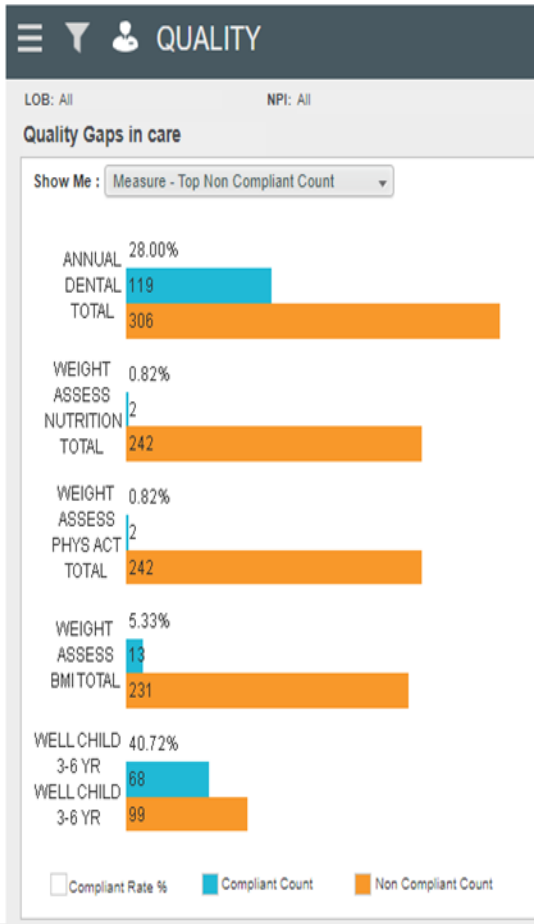
Cost & Utilization: Emergency Department

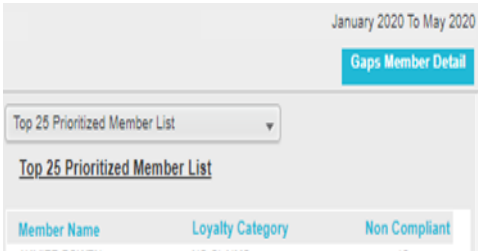
- Shows Per Member Per Month (PMPM) for Emergency Department (ED) visits compared to peers' risk-adjusted PMPM.
- Four sections:
  - Bar graph shows top five unmanaged conditions.
  - Bottom of the page shows average ED visits for provider's patients compared to plan.
  - Box on top left side shows number of patients with 3+ visits in the last 90 days.
  - Box on bottom left side shows number of total ED visits by engagement category.
- Click on the charts for patient-level detail.



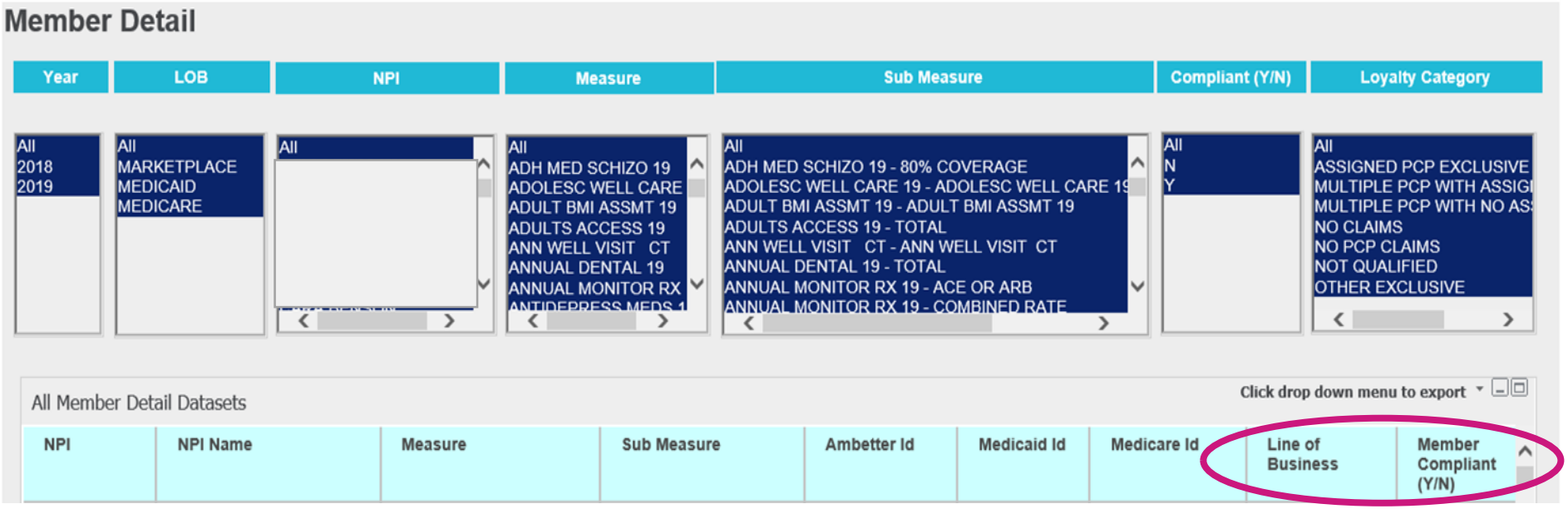
Quality HEDIS View: Gaps in Care

- Left defaults to top five measures by non-compliant count.
- Drop-down arrow changes view to see:
  - Measures – Non-compliant count, compliant count, compliant rate % or all.
  - NPI – Non-compliant count, compliant count, compliant rate % or all.
- Right side displays top 25 members with the most open care gaps.





Quality HEDIS View: Member Detail



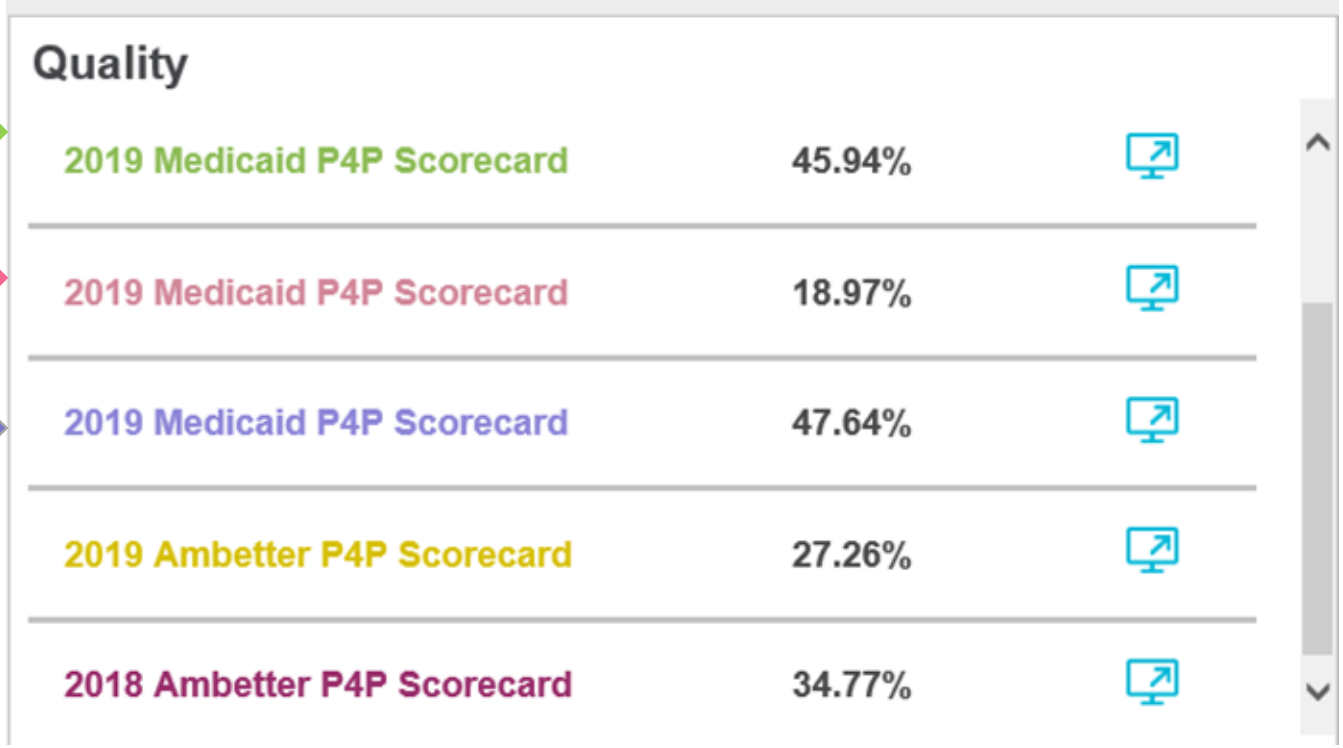
- Selections can be made to narrow search to a specific year, Line of Business, NPI name, HEDIS measure, Compliant status, or Loyalty Category.
- Providers can customize lists by grouping HEDIS measures into “well-child”, “women’s health”, or just the individual measure.
- Practice resources can be aligned once workload is identified creating efficiencies.
- Data exports to Excel or PDF available.

Monthly Scorecards

HIP

HHW

HCC



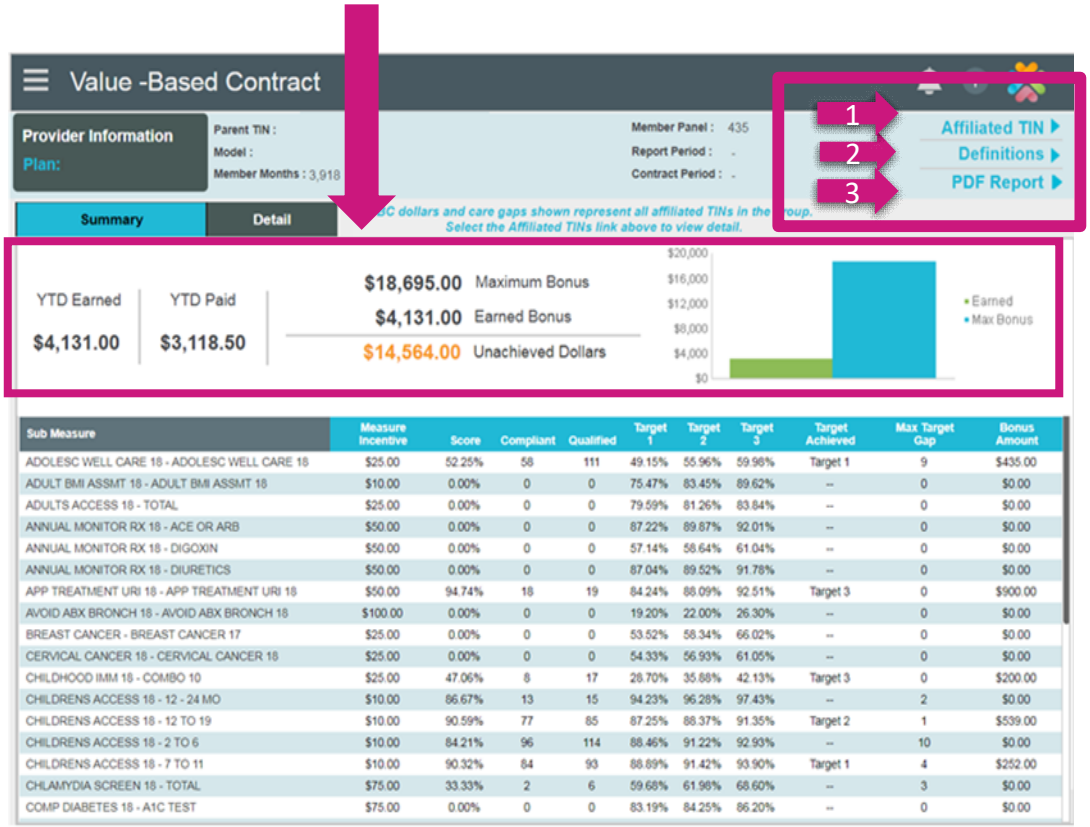
- Claims data
  - Pharmacy
  - Medical Encounter
- CHIRP
  - Immunizations
  - Lab results
- Medical record documentation

**** Send email to P4P@mhsindiana.com to sign up to receive email alerts when documents are posted!***

Quality HEDIS View: Scorecards

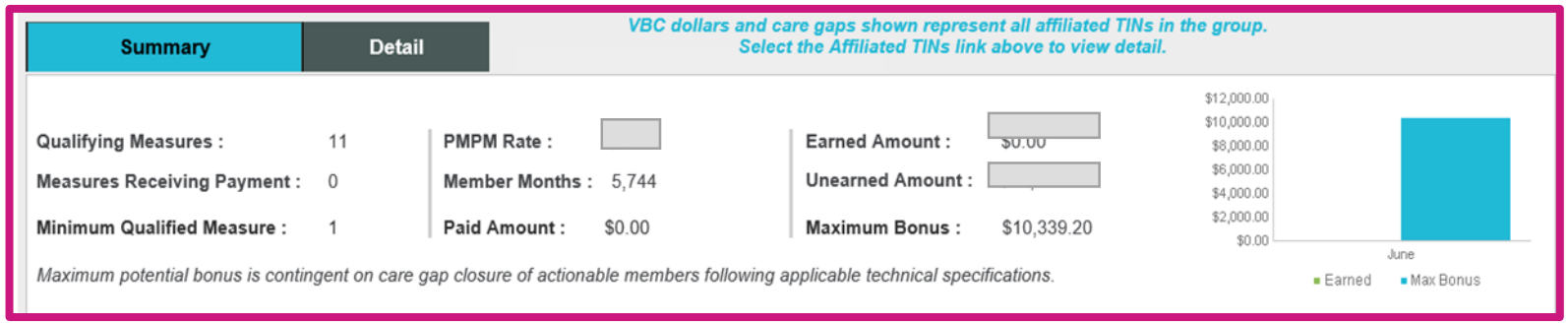
- For providers in P4P arrangement.
- Shows measure incentive, amount earned, and unachieved dollars.

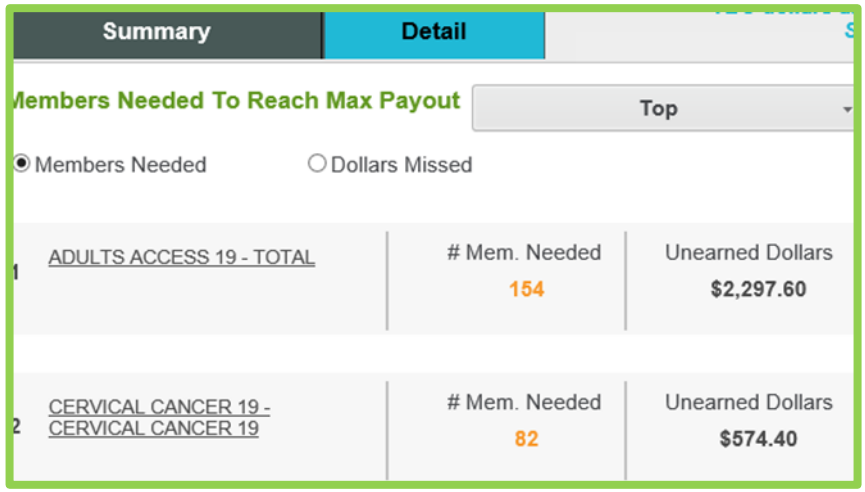
- In right hand corner:
  1. All TINs associated with P4P program.
  2. List of definitions and meanings.
  3. Scorecard summarizing provider's performance in Quality.

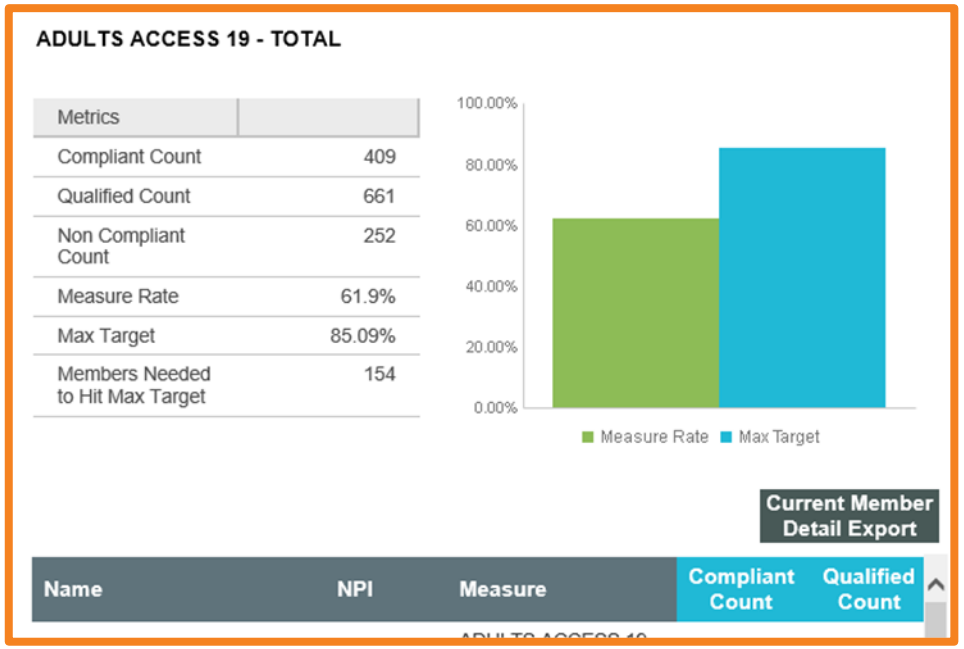


Sub Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target 3	Target Achieved	Max Target Gap	Bonus Amount
ADOLESC WELL CARE 18 - ADOLESC WELL CARE 18	$25.00	52.25%	58	111	49.15%	55.96%	59.96%	Target 1	9	$435.00
ADULT BMI ASSMT 18 - ADULT BMI ASSMT 18	$10.00	0.00%	0	0	75.47%	83.45%	89.62%	--	0	$0.00
ADULTS ACCESS 18 - TOTAL	$25.00	0.00%	0	0	79.59%	81.26%	83.84%	--	0	$0.00
ANNUAL MONITOR RX 18 - ACE OR ARB	$50.00	0.00%	0	0	87.22%	89.87%	92.01%	--	0	$0.00
ANNUAL MONITOR RX 18 - DIGOXIN	$50.00	0.00%	0	0	57.14%	58.64%	61.04%	--	0	$0.00
ANNUAL MONITOR RX 18 - DIURETICS	$50.00	0.00%	0	0	87.04%	89.52%	91.78%	--	0	$0.00
APP TREATMENT URI 18 - APP TREATMENT URI 18	$50.00	94.74%	18	19	84.24%	88.09%	92.51%	Target 3	0	$900.00
AVOID ABX BRONCH 18 - AVOID ABX BRONCH 18	$100.00	0.00%	0	0	19.20%	22.00%	26.30%	--	0	$0.00
BREAST CANCER - BREAST CANCER 17	$25.00	0.00%	0	0	53.52%	58.34%	66.02%	--	0	$0.00
CERVICAL CANCER 18 - CERVICAL CANCER 18	$25.00	0.00%	0	0	54.33%	56.93%	61.05%	--	0	$0.00
CHILDHOOD IMM 18 - COMBO 10	$25.00	47.06%	8	17	28.70%	35.68%	42.13%	Target 3	0	$200.00
CHILDRENS ACCESS 18 - 12 - 24 MO	$10.00	86.67%	13	15	94.23%	96.28%	97.43%	--	2	$0.00
CHILDRENS ACCESS 18 - 12 TO 19	$10.00	90.59%	77	85	87.25%	88.37%	91.35%	Target 2	1	$539.00
CHILDRENS ACCESS 18 - 2 TO 6	$10.00	84.21%	96	114	88.46%	91.22%	92.93%	--	10	$0.00
CHILDRENS ACCESS 18 - 7 TO 11	$10.00	90.32%	84	93	88.89%	91.42%	93.90%	Target 1	4	$252.00
CHLAMYDIA SCREEN 18 - TOTAL	$75.00	33.33%	2	6	59.68%	61.96%	68.60%	--	3	$0.00
COMP DIABETES 18 - A1C TEST	$75.00	0.00%	0	0	83.19%	84.25%	86.20%	--	0	$0.00

MHS Scorecard Detail







* Example of an actual scorecard.

Pay for Performance
P4P - Medicaid

P4P Administrative Measures

A Provider is determined to be in "Good Standing" if they comply and complete the following:

1. *Host, or participate in, a Preventive Health Outreach program or activity,*
2. *Do not have a closed Provider Panel, and are able to accept new members,*
3. *Attendance in one MHS training/orientation session during the calendar year.*

OR

1. Enrolls in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the calendar year.

MyHealthDirect: Overview

myhealth direct

MyHealthDirect is a service sponsored by MHS to schedule healthcare appointments for MHS members.

How is MyHealthDirect different from other services?

- MHS makes scheduling appointments for your members easy. We reach out to schedule appointments with your patients on your behalf.
- Together we close gaps in care.

How does MyHealthDirect work?

1. MHS contacts and schedules with your patient
2. Both you and the patient get a confirmation email
3. You enter the appointment into your PM system
4. Automatic reminder(s) are sent to patient
5. Patient attends their appointment

MyHealthDirect is FREE to you and your patients. You still keep full control over your calendar and appointments. We do the rest.

Want to learn more? Contact your Provider Representative or MyHealthDirect today!

Liz McDonell
Account Specialist II, MyHealthDirect
liz.mcdonell@experian.com | 615.830.0546

myhealth direct

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2021 P4P Program Overview

Objective	Enhance quality of care through a PMP driven pay for performance program with a focus on preventive and screening services.
Member Attribution	Healthy Indiana Plan (HIP), Hoosier Healthwise (HHW), and Hoosier Care Connect (HCC) members who have been formally assigned to a Provider group.
Performance Incentive	• MHS has funded an incentive pool of $2.00 PMPM for each program (HIP, HHW, HCC). • Each program has its own set of measures, targets and incentive amounts.
Measurement Time Period	• HEDIS calendar year January 1 – December 31. • Contract effective date is January 1st, allowing for full credit of all gaps closed during the measurement period.
Requirements for Payout	• Minimum number of covered persons must be achieved for the applicable measure. • Payouts are earned for each compliant member after reaching the minimum Target score applicable for each measure.
Reports and Payouts	• Member level care gap reporting and scorecards are available monthly on Provider portal. • Final reconciliation and payout will be processed no later than 180 days following the measurement period.

Annual P4P Payout

- P4P Payout calculations are based on final HEDIS Administrative rates and paid at group level.

- Factors include:
  - Panel Size—150 minimum
  - Required number of members qualified per measure
  - Funds from measures without enough members get rolled into other qualifying measures

** Send email to P4P@mhsindiana.com to sign up to receive email alerts when documents are posted!*

Pay For Performance (P4P) - Measures

2021 Measure List (HIP)	Weight of Measure
Chlamydia Screening in Women (CHL)	5 Points
Cervical Cancer Screening (CCS)	5 Points
Breast Cancer Screening (BCS)	5 Points
Diabetes Care – Eye Exam (retinal) Performed	6 Points
Antidepressant Medication Management (AMM) – Acute Phase	6 Points
Prenatal and Postpartum Care (PPC) - Postpartum	15 Points
Timeliness of Ongoing Prenatal Care (PPC)	15 Points
Adult Preventative Care	20 Points
Ambulatory Care (AMB) – ER Utilization	13 Points
Provider Outreach (Administrative) Credit	**10 Points**

Pay For Performance (P4P) - Measures

2021 Measure List (HCC)	Weight of Measure
Childhood Immunization Status (CIS) COMBO 10	5 Points
Well-Child Visits in the First 30 Months of Life (W30): Well Child Visits in the First 15 months	10 Points
Well-Child Visits in the First 30 Months of Life (W30): Well Child Visits for Age 15 months-30 months	10 Points
Child and Adolescent Well-Care Visits (WCV)	15 Points
Pharmacotherapy Management of COPD Exacerbation (PCE) - systemic corticosteroid	5 Points
Diabetes Care - Eye exam (retinal) performed	7 Points
Antidepressant Medication Management (AMM) – Acute Phase	6 Points
Adult Preventive Care	20 Points
Ambulatory Care (AMB) – ER utilization	12 Points
Provider Outreach (Administrative) Credit	**10 Points**

Pay For Performance (P4P) - Measures

2021 Measure List (HHW)	Weight of Measure
Childhood Immunization Status (CIS) COMBO 10	5 Points
Lead Screening in Children	10 Points
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	5 Points
Follow-Up Care for Children Prescribed ADHD Medication – continuation phase	5 Points
Well-Child Visits in the First 30 Months of Life (W30): Well Child Visits in the First 15 months	10 Points
Well-Child Visits in the First 30 Months of Life (W30): Well Child Visits for Age 15 months-30 months	10 Points
Child and Adolescent Well-Care Visits (WCV)	20 Points
Prenatal and Postpartum Care (PPC) - Postpartum	6 Points
Timeliness of Ongoing Prenatal Care (PPC)	9 Points
Ambulatory Care (AMB) – ER utilization	10 Points
Provider Outreach (Administrative) Credit	**10 Points**

Marketplace 2021 – P4P Program (Ambetter)

Pay for Performance (P4P) Program Overview

Objective

- Enhance quality of care through a PCP driven pay for performance program with a focus on preventative and screening services

Member Attribution

- Members who have been formally assigned to a Provider 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. Antidepressant Medication Management- Acute Phase
2. Antidepressant Medication - Continuation Phase
3. Appropriate Treatment for Children with Pharyngitis
4. Asthma Medication Ratio
5. Cervical Cancer Screening
6. Chlamydia Screening in Women- Ages 16-20
7. Chlamydia Screening in Women- Ages 21-24
8. Comprehensive Diabetes Care – Eye Exam
9. Monitoring for Warfarin
10. Proportion of Days Covered- Diabetes All Classes

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 particular 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 then paid at 100% of the incentive amount.
- Each measure is evaluated if there is at least one (1) qualified event in the denominator, providers can qualify and receive an incentive payment for one, multiple or all of the measures.
- Target 1 is set at the QRS 4-Star target and Target 2 is set at the QRS 5-Star target.
- Member Engagement ratio represents the percentage of members that have been seen by their assigned PCP during the year.

Pay for Performance (P4P) Program Overview

- HEDIS Measures are evaluated using NCQA HEDIS established guidelines, *except* minimum qualified members per event is not thirty (30), it is one (1).
- Three payouts made (Expected after Q2/ Q3 /Q4 with Final Reconciliation mid 2022) each report netting any prior payouts against total earned.
- Gap closure rates/scores are accumulated based upon member assigned PCP. The assigned PCP receives credit for gaps closed.
- Monthly performance reports and care gaps will be placed on the providers portal via Provider Analytics.
- The checks can be mailed to the providers or the health plan may prefer to hand deliver all/some of the provider incentive checks.
- There is no claw back provision for this program so if a provider terms mid year or no longer has assigned membership we will not recoup funds.

Pay for Performance (P4P) – Measures

Ambetter - $6.00 PMPM

2021 Measure List	Measure Incentive	Target 1 Pays 75% of Incentive	Target 2 Pays 100% of Incentive
Antidepressant Medication Management (AMM): Effective Acute Phase Treatment	$25	73.8%	77.2%
Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment	$25	57.4%	62.2%
Appropriate Treatment for Children with Pharyngitis (CWP)	$25	92.3%	95.2%
Asthma Medication Ratio (AMR)	$25	75.0%	90.0%
Cervical Cancer Screening (CCS)	$25	65.2%	72.5%
Chlamydia Screening in Women (CHL): Ages 16-20	$25	47.3%	55.4%
Chlamydia Screening in Women (CHL): Ages 21-24	$25	47.3%	55.4%
Comprehensive Diabetes Care- Eye Exam (CDC-DRE)	$25	56.1%	66.4%
Monitoring for Warfarin (INR)	$25	75.0%	90.0%
Proportion of Days Covered (PDC)- Diabetes All Classes	$25	77.5%	81.6%

**Represents the ratio of members that have been seen by their assigned PCP.*

2021 Medicare Continuity of Care (CoC) Quality Program

Medicare Continuity of Care (CoC) Program Methodology

- Centene is pleased to introduce the 2021 Medicare Continuity of Care (CoC) program. This new program, formally known as Partnership for Quality (P4Q) at WellCare and Allwell Pay for Performance (P4P) at Centene, combines the best of both incentives and puts the provider at the center of delivering excellent care to our members.

- The 2021 Medicare CoC program utilizes a blended approach, leveraging the **industry best practice** identified by McKinsey of combining pay per gap and pay for performance.

Note: Some contracts are excluded from the program with market CEO approval. Please confirm contract inclusion prior to communication with providers.

Medicare Continuity of Care (CoC) Program Overview

Measurement Period

- Jan. 1 to Dec. 31, 2021
- All claims and encounters must be received by Jan. 31, 2022

Member Attribution

Members assigned to the physician based on the following:

1) If the anchor date is prior to the payment date, it is the provider assigned as of the anchor date.
2) If the anchor date is after the payment date, the current provider is assigned

Description

- Consistent program for all Medicare providers.
- Combines pay per gap and pay for performance
- Bonuses vary by measure based on measure weight and STAR score achievement

.

Program Requirements

- Program is open to all PCPs. Markets can exclude some PCPs (ex: Full Risk contracts)
- Claims based program – members need to be seen and claims must be submitted

Reporting and Payouts

- Care gap reports available in late Q2
- Three quarterly payments and a final true-up payment
- Performance evaluation is based on H contract* and Provider Tax ID

*H contract – CMS contract number for our agreement to provide Medicare services

Program Measures

- The program consists of 15 measures. Each measure has a Base amount and three targets - 3, 4 and 5 STAR performance
  - Base payments are the minimum amount that a provider will receive for closing program measures
  - STAR performance incentives include the Base amount
  - STAR target benchmarks are used to determine if STAR performance incentives will be paid out in the true-up payment
  - Measures are calculated and rewarded individually

Program Measures	Base	3-STAR	4-STAR	5-STAR
Bone Mineral Density Testing	$10	$20	$30	$40
Care of Older Adult - Medication List and Review*	$5	$10	$20	$30
Care of Older Adult - Pain Screening*	$5	$10	$20	$30
Colorectal Cancer Screen	$10	$20	$30	$40
Diabetes - Dilated Eye Exam	$10	$20	$30	$40
Diabetes HbA1c ≤ 9	$10	$25	$40	$55
Diabetes Monitor Nephropathy	$5	$10	$20	$30
Hypertension	$5	$10	$20	$30
Mammogram	$10	$20	$30	$40
Medication Adherence – Blood Pressure Medications	$10	$25	$40	$55
Medication Adherence – Diabetes Medications	$10	$25	$40	$55
Medication Adherence – Statins	$10	$25	$40	$55
Medication Reconciliation Post-discharge	$10	$20	$30	$40
Statin Therapy for Patients with Cardiovascular Disease	$10	$20	$30	$40
Statin Use in Persons With Diabetes	$10	$20	$30	$40

**Dual Eligible Special Needs Plan (DSNP) members only*

STAR Score Target Table

STAR performance is determined by comparing a provider's compliance percentage for a measure to the Centene established benchmarks in the STAR target table

- Benchmarks are based on expected industry performance in Calendar Year 2021 (full year)

**Dual Eligible Special Needs Plan (D-SNP) members only*
***Control measures are only paid in the final true-up payment*

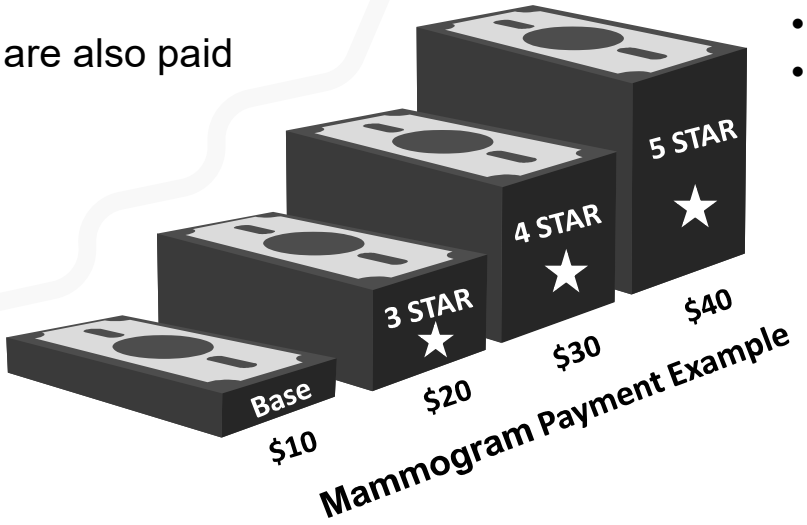
Measure	3 STAR	4 STAR	5 STAR
Bone Mineral Density Testing	43%	53%	69%
COA – Med List and Review*	78%	88%	96%
COA – Pain Screening*	82%	87%	95%
Colorectal Cancer Screen	63%	74%	81%
Diabetes – Dilated Eye Exam	70%	74%	79%
Diabetes HbA1c ≤ 9**	63%	73%	86%
Diabetes Monitor Nephropathy	83%	96%	98%
Hypertension**	70%	76%	90%
Mammogram	66%	76%	83%
Med Adherence – Blood Pressure**	86%	89%	91%
Med Adherence – Diabetes**	82%	85%	89%
Med Adherence – Statins**	82%	87%	91%
Med Reconciliation Post-discharge	64%	73%	85%
Statin Therapy for Patients with CVD	80%	84%	88%
Statin Use in Patients With Diabetes	81%	85%	91%

Payment Structure

Payment #4 – True-up
True-up payment will make the provider whole based on final STAR rating for the program measure

- Control measures are also paid at this time

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



Payment Example:
A physician achieves a 5 STAR for Mammogram at the end of the program and receives a total of $40 per compliant member

- $10 for the Base payment
- $30 additional for 5 STAR achievement

FAQs

- **Q: Where can I find 2021 Medicare Continuity of Care reports and the Provider Scorecard?**
- Reporting and the Scorecard are in development. Trainings will be scheduled prior to market roll-out
- **Q: How can a Market exclude a provider/group?**
- Markets may exclude providers/groups based on contracts (Ex: Full Risk or other Quality agreements) and market preferences (Ex: Provider(s) will be terminated in the future).
- To permanently exclude a provider/group from the program, please email Quality_CoC@wellcare.com. Submit approval from the CEO with your request.
- **Q: What if a provider does not submit data by the date required (January 31, 2022)?**
- Claims, encounters and standard supplemental data – Centene's discretion (Corporate) to pay incentives for submissions after January 31, 2022
- Non-standard supplemental data - no exceptions will be made for data submission after January 31, 2022
- **Q: Will a provider get credit if a gynecologist orders a mammogram or an endocrinologist does an A1c?**
- Yes, the PCP will still receive payment for the service
- **Q: Is there any additional information regarding care gap payments?**
- The program pays for care gaps closed in the measurement period
- Only one bonus payment will be made for a specific HEDIS and Medication Adherence member-measure combination
- Medication Reconciliation Post-discharge is paid once per discharge

Continuity of Care Program (Former P4Q Program)

What is the Continuity of Care (CoC) Program?

CoC is a Risk Adjustment bonus program for you, our Provider Partner, aimed at increasing visibility into members' existing, as well as suspected conditions, which leads to enhanced quality of care for chronic condition management and prevention.

What is in it for members?

Members with existing or newly suspected chronic conditions will receive regular and proactive assessments to prevent chronic conditions from going undiagnosed or untreated.

What is in it for providers?

Providers will receive incentive payments by continuously improving and maintaining performance in assessing members for conditions. Providers receive *incremental* bonuses for their *incremental* work.

Who is Included in the CoC Program?

Eligible Providers and Members

- Providers and Members are loaded into the CoC Dashboard (CoC Appointment Agenda)
  - Members with disease conditions that need to be assessed annually

Targeted Lines of Business (LOB)

- Ambetter
- Allwell
- Medicaid

Provider Incentives

% of Appointment Agendas Completed/Paid	Bonus per Paid Appointment Agenda
≤ 50 %	$100
>50 to ≤80 %	$200
>80 %	$300

- 100% of the Risk Adjustment gaps are assessed in the CoC Dashboard
  - Check Active Diagnosis and Documented box or Resolved / Not Present box then authenticate and submit the agenda in the Dashboard **or**
  - **Fax or email** the printed and completed paper Appointment Agent **or**
  - Fax or email a medical record (Medicare or Marketplace only)
  - Submit all appropriate diagnoses on a claim
  - Providers will be paid quarterly

Provider Partnership

- Schedule an appointment and conduct a visit with the patient prior to December 31, 2021 (ESB must be prior to May 31, 2021)
- Use the appointment agenda as a guide, assessing the validity of each condition
- Document the care in the medical record following coding and documentation guidelines
- Update diagnoses and close gaps in the CoC Portal
- Submit electronically through the CoC Portal or
- Submit signed paper appointment agenda and/or medical records to fax 1-813-464-8879 or by secure email at agenda@wellcare.com
- Submit the claim/encounter containing all relevant diagnosis codes and CPT codes

Provider Incentives

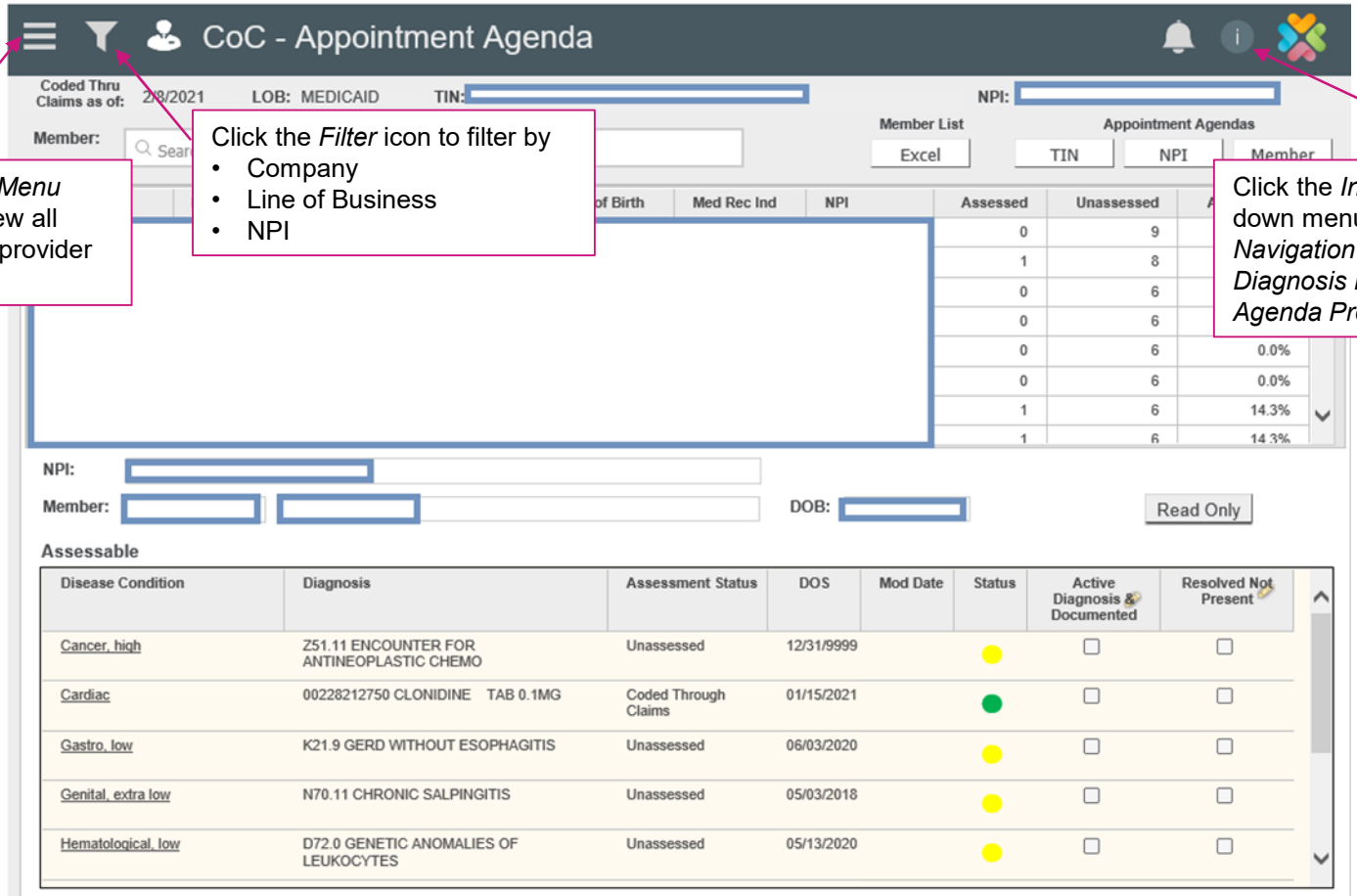
CoC Early Submitter Bonus (ESB)

- Medicare and Marketplace
- MHS is offering an additional $50.00 to providers
- Complete a valid office/telehealth visit by May 31, 2021 DOS
- Submit the Appointment Agenda (AA) by June 30, 2021
- Submitted AA diagnoses must be verified on the claim

Provider Guide for CoC

- Log into the Provider Portal
- Click on CoC - Appointment Agenda
- Filter by LOB and/or NPI
- Search by Member Name, or
- Click on a Member ID
- Begin Assessment

CoC Portal Navigation



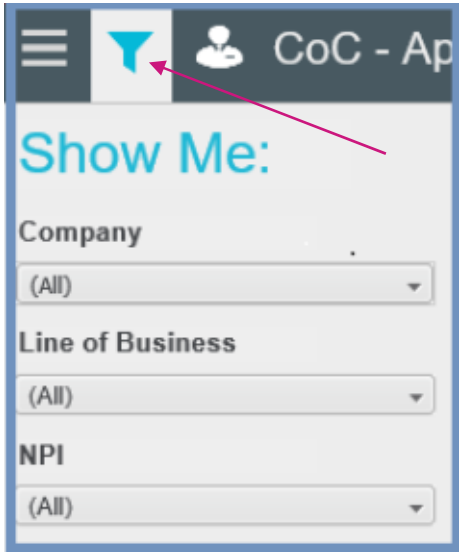
Click the *Menu* icon to view all available provider portals

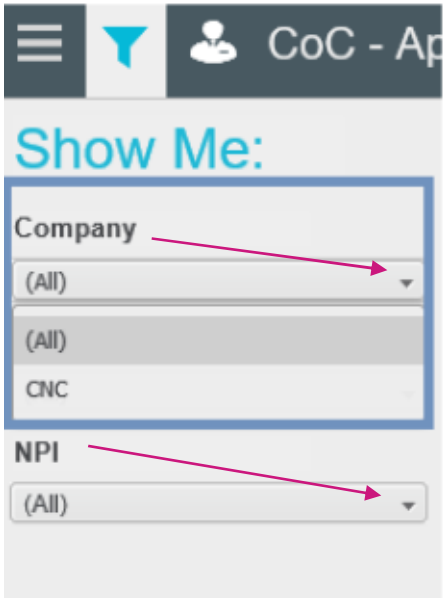
Click the *Filter* icon to filter by
- Company
- Line of Business
- NPI

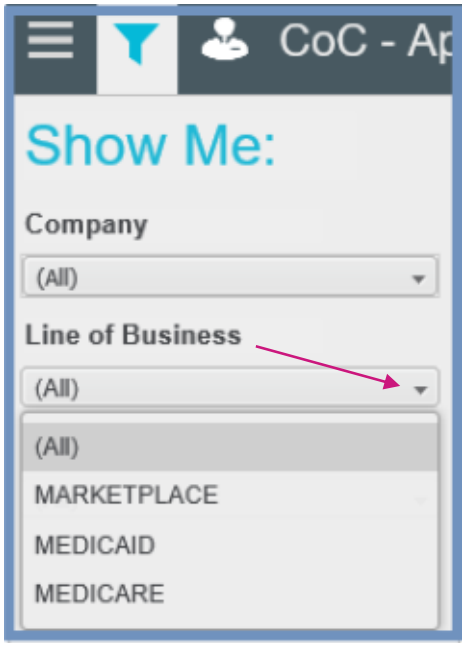
Click the *Info* button to view a drop-down menu containing links to the *Navigation Tool, Case Study, FAQs, Diagnosis List, and CoC Appointment Agenda Program Rules* documents

CoC Portal Navigation

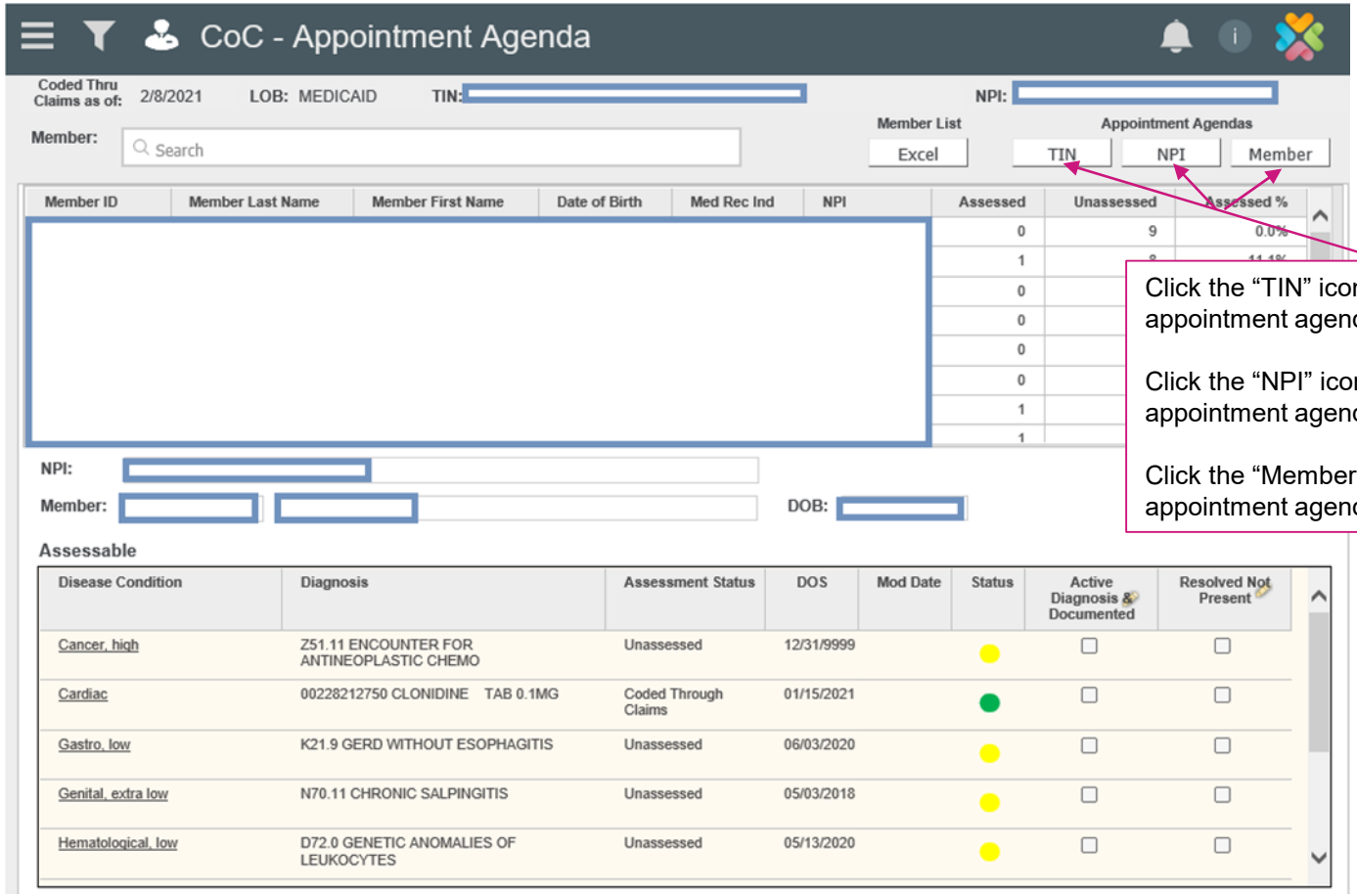
Filter Icon







CoC Portal Navigation



Click the “TIN” icon to view all printable appointment agendas under a specific TIN

Click the “NPI” icon to view all printable appointment agendas under a specific provider

Click the “Member” icon to view a printable appointment agenda for an individual member

CoC Portal Navigation
Printable Appointment Agenda

2/12/2021 9:27:03 AM

Member DOB :

Member Phone :

TIN Name :

Provider Name and ID :

2021 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 2/8/2021. 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
Cardiovascular, medium	Persistency Gap	ICD-10	I11.0 HTN HEART DISEASE W/HEART FAIL	☐	☐
Diabetes, type 2 low	Persistency Gap	ICD-10	E13.622 OTHER SPEC DM W/OTHER SKIN ULCER	☐	☐
Infectious, high	Predictive Gap	ICD-10	A48.0 GAS GANGRENE	☐	☐
Metabolic, very low	Persistency Gap	ICD-10	E87.6 HYPOKALEMIA	☐	☐
Cardiac	Assessed	NDC	68180051801 LISINOP/HCTZ TAB 10-12.5	☐	☐
Diabetes	Assessed	NDC	00002821501 HUMULIN R INJ U-100	☐	☐
Skeletal, medium	Predictive Gap	ICD-10	M86.172 OTH ACUTE OSTEOMYEL LT ANKLE FOOT	☐	☐
Skin, low	Persistency Gap	ICD-10	L97.524 N-PRS ULCR OTH PRT LT FT NEC BONE	☐	☐

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

Predictive = Possible condition(s) based on prior claims

Care Guidance

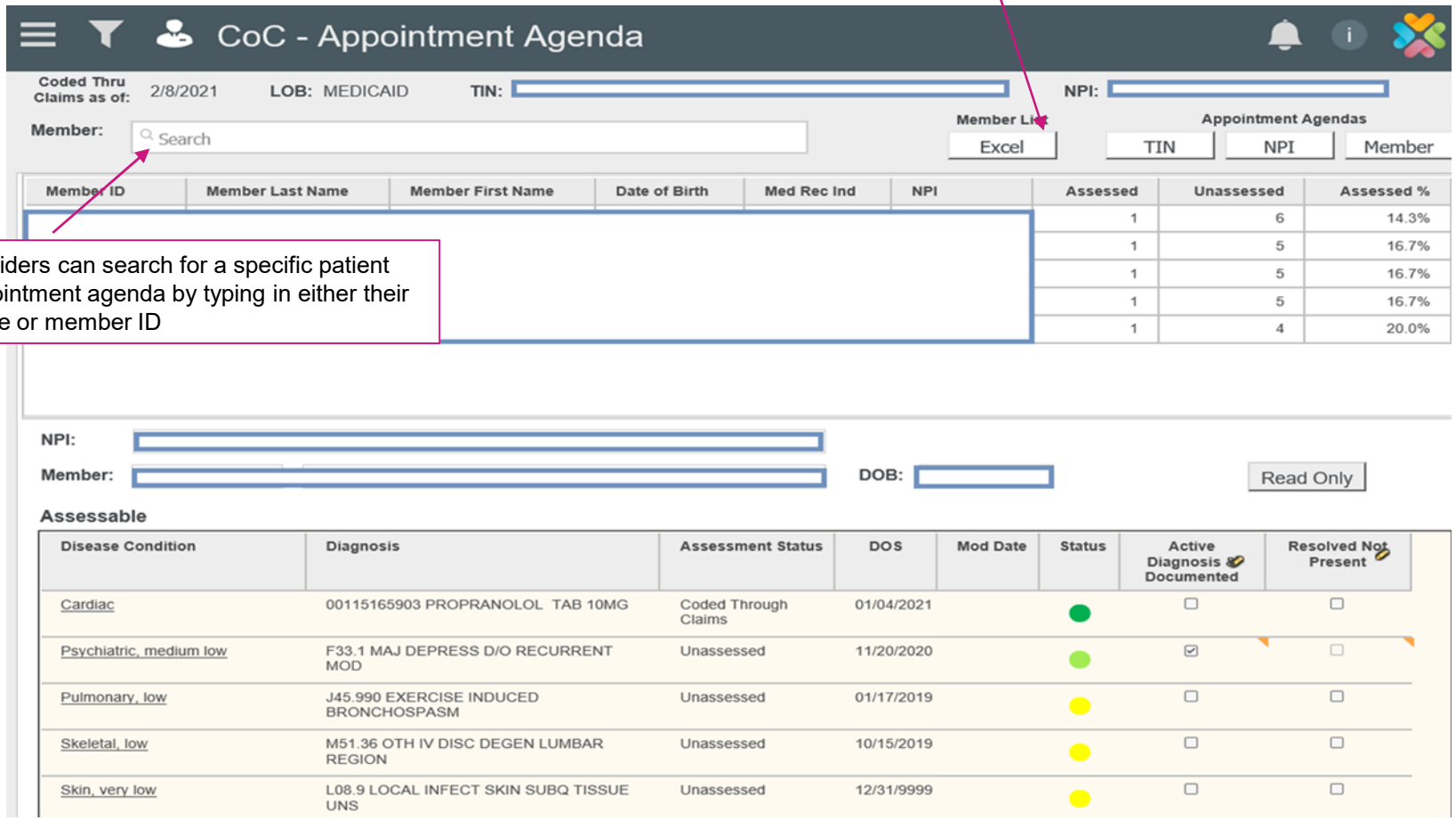
Address and document the Care Gaps below. Care Gaps are closed by a claim, CPT, CPTII, HCPCS, DX codes or applicable documentation. For additional information, please reference your Care Gap Report.

Type:
Predictive Gap
and
Persistency Gap

CoC Portal Navigation

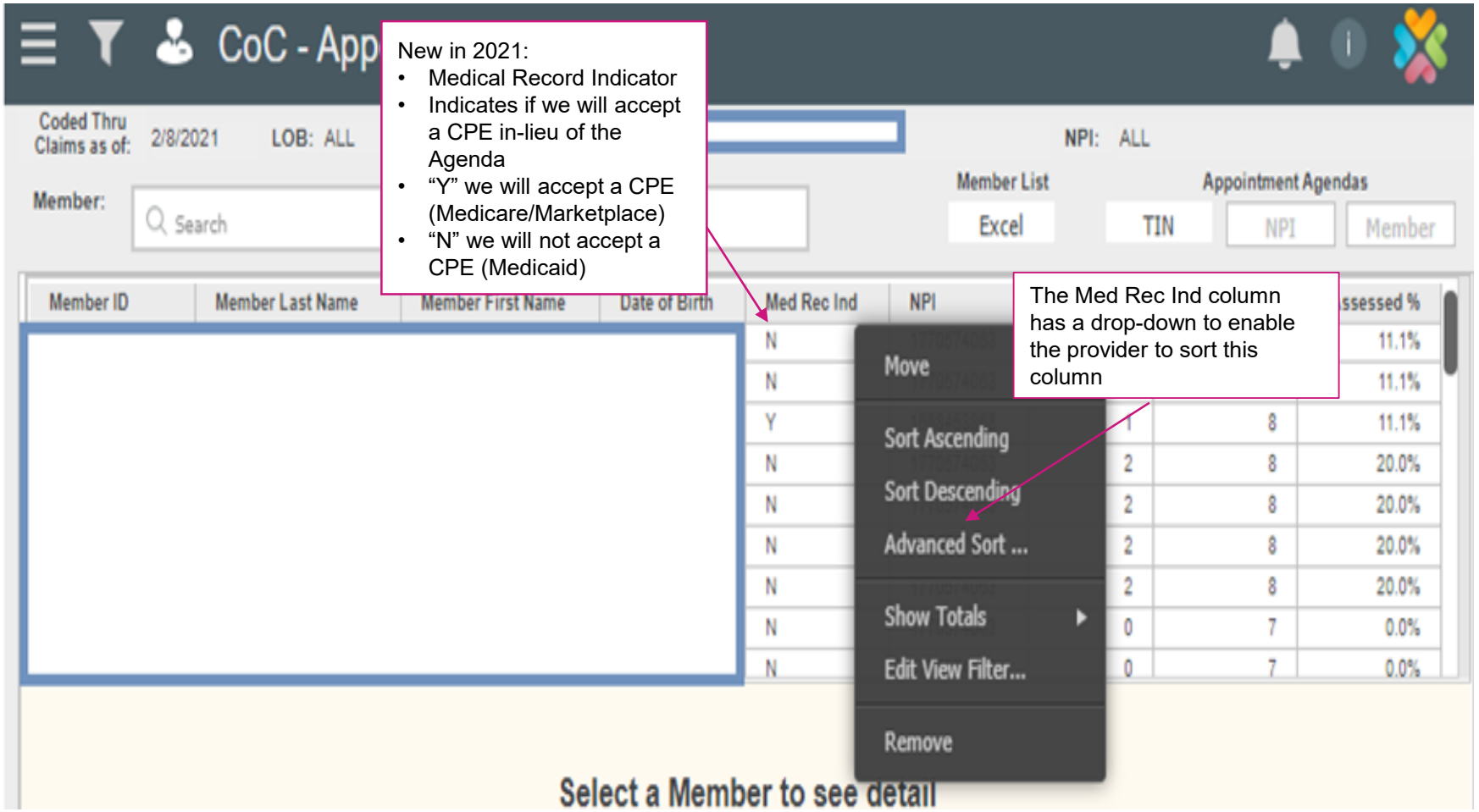
Users can export a list of all Member Appointment Agendas to Excel

Note: If users export to Excel they still need to go back into the portal dashboard to check boxes, update, sign and submit

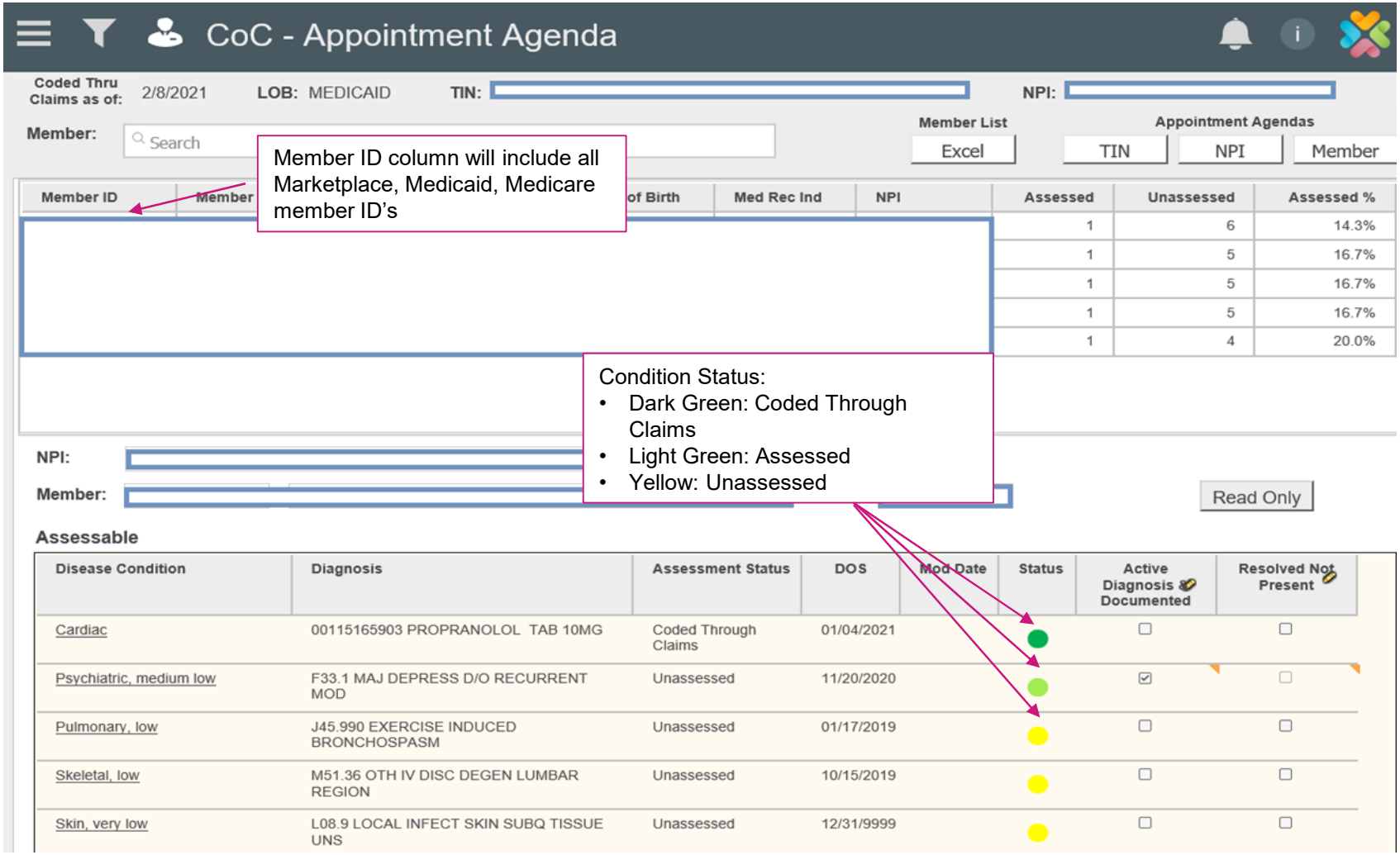


Providers can search for a specific patient appointment agenda by typing in either their name or member ID

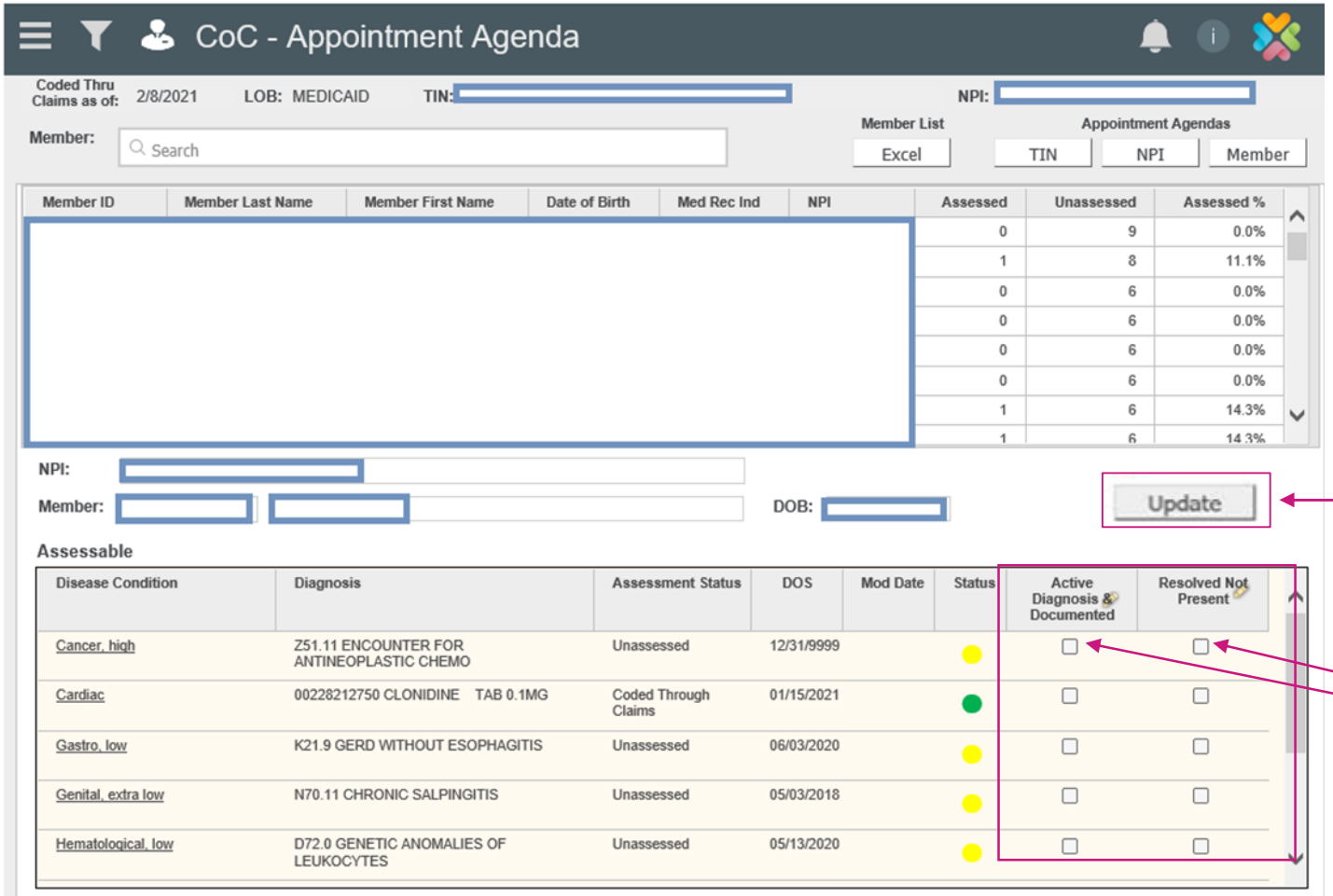
CoC Portal Navigation



CoC Portal Navigation



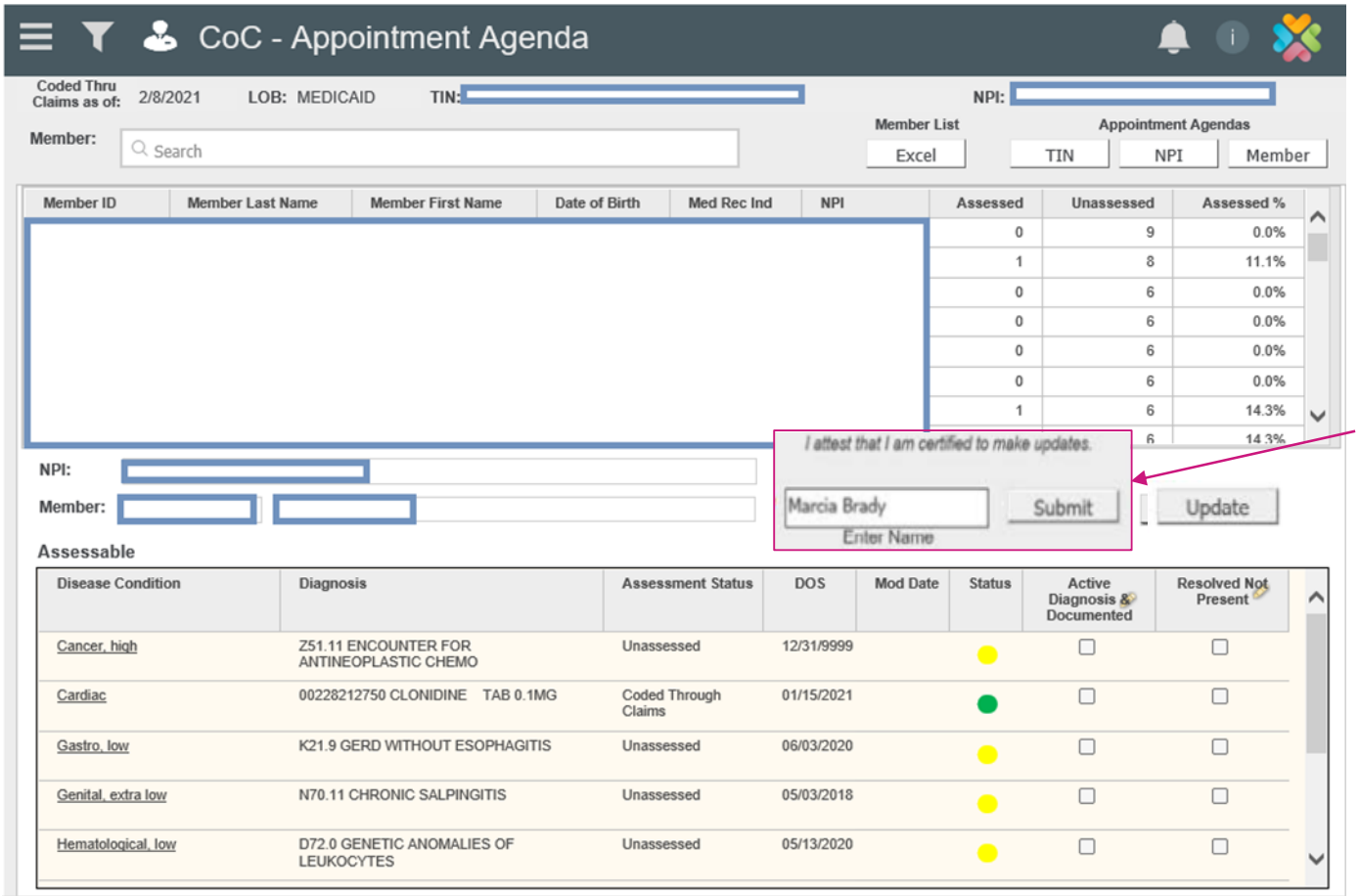
CoC Portal Navigation



Once a box is checked or unchecked the provider or provider representative will need to click *Update* to save the changes

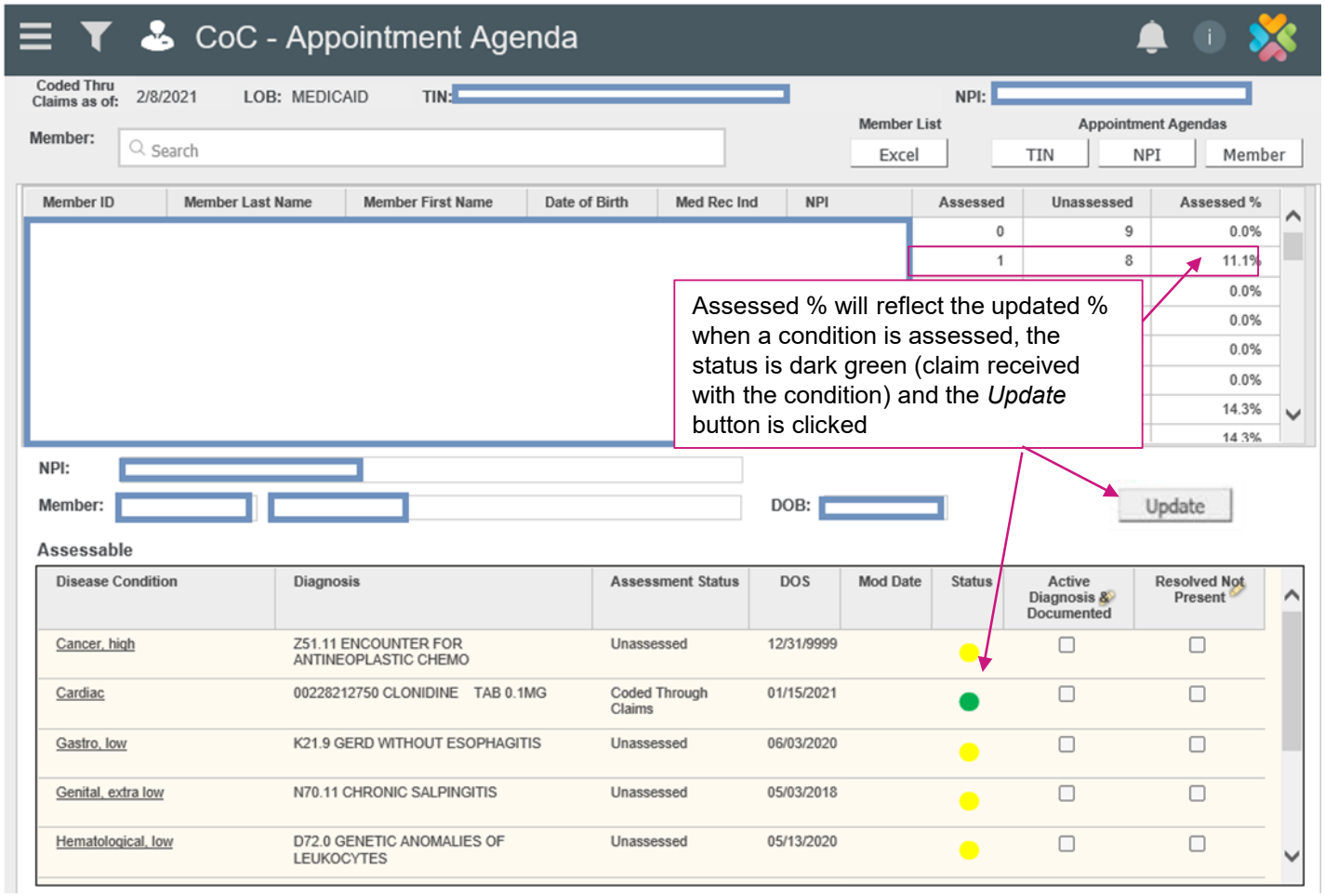
Note: If users export to Excel they still need to go back into the portal dashboard to check boxes, update, sign and submit

CoC Portal Navigation



Authorized personnel will need to enter their name to attest to the changes, then hit submit to send the appointment agenda updates to MHS

CoC Portal Navigation



HEDIS Measures and Coding

Adults' Access to Preventive/ Ambulatory Health Services (AAP)

HIP
HCC

- **Applicable members:** 20 years and older as of December 31 of the measurement year, calculated separately by line of business.

- **Requirements:**
  - One or more ambulatory or preventive care visits during the measurement year.
  - Members must be continuously enrolled for the measurement year with no more than one 45-day gap in enrollment.
  - ICD-10 and CPT codes found on page 6 of the MHS HEDIS Quick Reference Guide.

Care for Children Prescribed ADHD Medication (ADD)

HHW

Initiation Phase – members with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-days after IPSD.

Continuation Phase – members with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had **at least two follow-up visits** with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Applicable members: Members who turn 6 years as of March 1 of the year prior to the measurement year to 12 years as of **February 28 of the measurement year.**

Index Prescription Start Date (IPSD) - The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.

Members must be continuously enrolled 120 days (4 months) prior to the IPSD through 30 days after the IPSD with no gap in enrollment.

*CPT codes may be found on page 34 of the MHS HEDIS Quick Reference Guide.

Antidepressant Medication Management (AMM)

HIP
HCC

Acute Phase:

- **Applicable members:** 18 years and older as of April 30 of the measurement year.
- **Requirement:**
  - Members remained on an antidepressant medication for at least 84 days (12 weeks).
  - Member must be continuously enrolled May 1 of the year prior to the measurement year through April 30 of the measurement year with MHS with no more than a 45 day gap in enrollment.

Breast Cancer Screening (BCS)

HIP

- **Applicable members:** Women 50-74 years of age as of December 31st of the measurement year.
- **Requirement:** Women who have had at least one mammogram any time on or between October 1 two years prior to the measurement year and December 31st of the measurement year.
- ICD-10 and CPT Codes may be found on page 11 of the MHS HEDIS Quick Reference Guide.

**** Women who have had a bilateral mastectomy or two unilateral mastectomies can be excluded from this measure. Medical records will be required in order to exclude the member.***

Cervical Cancer Screening (CCS)

HIP

- **Applicable members:** Women 21-64 years of age as of December 31st of the measurement year.
- **Requirement:** Women 24-64 receive 1 Pap test during the measurement year or within 3 years prior OR women 30-64 receive cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years (must occur within 4 days of each other).
- Women who have had either a complete, total or radical hysterectomy (vaginal or abdominal) with evidence that the cervix has been removed can be excluded from the measure based on medical record documentation.
- ICD-10 and CPT Codes may be found on page 14 of the MHS HEDIS Quick Reference Guide.

Comprehensive Diabetes Care

HIP
HCC

Diabetes Care – Eye Exam

Applicable members: Members ages 18-75 as of December 31st of the measurement year with diabetes (types 1 & 2).

Requirements:

- Members identified with diabetes (types 1 & 2) who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) completed every year OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior.
- Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.

Diabetes Care –Nephropathy

Applicable members: Members ages 18-75 as of December 31st of the measurement year with diabetes (types 1 & 2).

Requirements:

- Members identified with diabetes (types 1 & 2) who had a nephropathy screening performed at least once per year.
- A member who is on ACE/ARBs or has nephropathy is compliant for this measure.
- Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.

* ICD-10 and CPT Codes for CDC-Eye and CDC-Nephropathy may be found on pages 23 & 24 of the MHS HEDIS Quick Reference Guide.

Chlamydia Screening in Women

HIP

- **Applicable Members:** Women 16-24 years of age as of December 31st during the measurement year.

- **Requirement:**
  - Women who were identified as sexually active and had at least 1 test for Chlamydia during the measurement year.
  - Sexually active women are identified through evidence of a pregnancy test or prescription for a contraceptive.
  - Members cannot be excluded for receiving prescription contraceptives for off label use.
  - CPT Codes may be found on page 21 of the MHS HEDIS Quick Reference Guide.

Child & Immunization Status (CIS) COMBO 10

HHW
HCC

- **Applicable age group:** Children who turn two years of age in the measurement year.

- **Requirements:** 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu.
  - Vaccinations given prior to 42 days after birth or following the members 2nd birthday will not be counted.
  - Members must be continuously enrolled with the health plan for 12 months prior to their 2nd birthday with no more than a 45 day gap in enrollment.
  - ICD-10 Codes available in the MHS HEDIS Quick Reference Guide.

Lead Screening in Children (LSC)

HHW

- **Applicable age group:** Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning before their second birthday.

- **CPT:** 83655 from page 43 of the MHS HEDIS Quick Reference Guide.

** Children age out every day. Proactive review of open care gaps list is beneficial.*

Pharmacotherapy Management of COPD Exacerbation (PCE)

HCC

- **Applicable members:** Members 40 years of age & older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1- November 30 of the measurement year and who were dispensed appropriate medications.

  - Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.

Prenatal & Postpartum Care (PPC)

HHW
HIP

Timeliness of Prenatal Care:

- **Applicable members:** Women who delivered between October 8 of the year prior to the measurement year and October 7 of the measurement year..

- **Requirement:** Prenatal visit must occur within the first trimester or within 42 days of enrollment.

Postpartum Care:

- **Applicable members:** Women who delivered between November 6 of the year prior to the measure year and November 5 of the measure year.

- **Requirement:** At least 1 postpartum visit on or between 7 and 84 days after delivery

* ICD-10 and CPT codes may be found on pages 54 -55 in the MHS HEDIS Quick Reference Guide.

Well-Child Visits First 30 Months of Life (W30)

HHW
HCC

- **Applicable members:** Children who turn 15 months old during the measurement year.

- **Requirement:** Six or more well-child visits before 15 months of age.

  - Medical record documentation must include health history, physical exam, mental developmental history, physical developmental history, and anticipatory guidance/health education.
  - Member must have been continuously enrolled with MHS from 31 days to15 months of life with no more than a 45 day gap in enrollment.
  - ICD-10 and CPT Codes may be found on page 66 of the MHS HEDIS Quick Reference Guide.

Well-Child Visits First 30 Months of Life (W30)

HHW
HCC

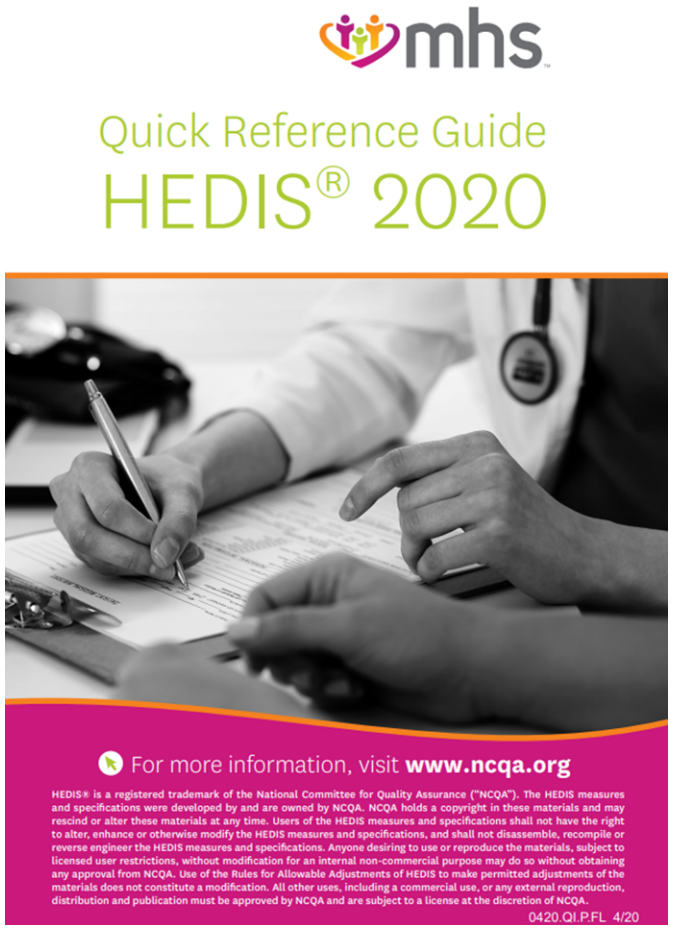
- **Applicable members:** Members who turn 30 months during the measurement year.

- **Requirement:** At least two or more well-child visit between 15 to 30 months of age during the measurement year.

  - Medical record documentation must include health history, physical exam, mental developmental history, physical developmental history, and anticipatory guidance/health education.
  - Member must be continuously enrolled with MHS for 12 months with no more than a 45 day gap in enrollment.
  - ICD-10 and CPT Codes may be found on page 66 of the MHS HEDIS Quick Reference Guide.

Measure Requirements and Coding

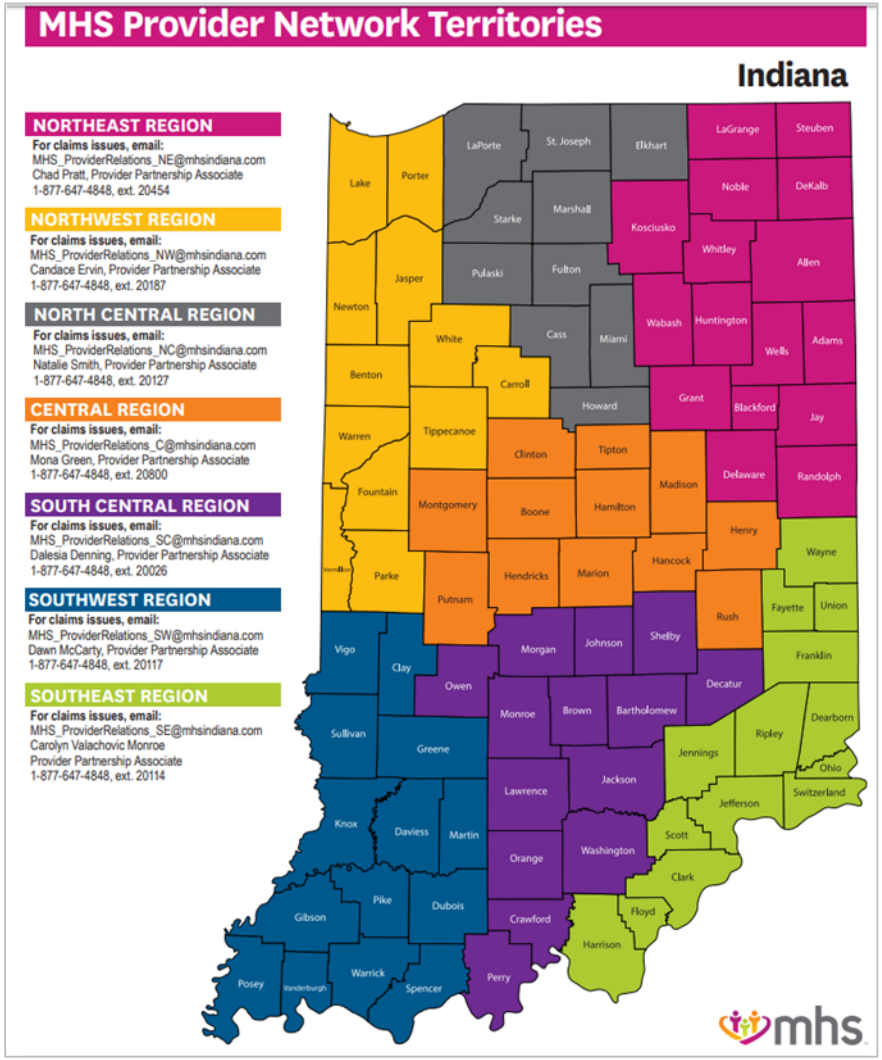
- Find additional information on the measurement requirements and some tips for coding on our website located under HEDIS.
- The HEDIS Quick Reference Guide (shown here) is available online or from your Provider Partnership Associate.



Why Participate in P4P and CoC?

- Enhances quality of care through a focus on preventative and screening services while promoting engagement with our members.
- Based on program performance, you are eligible to earn compensation in addition to that which you are paid through your Participating Provider Agreement.
- Is “upside only” and involves no risk to you.
- Providers will receive incentive payment by continuously improving or maintaining performance in assessing members for conditions and closing care gaps.

Provider Relations Team



Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf

NORTHEAST REGION
For claims issues, email:
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Chad Pratt, Provider Partnership Associate
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Franciscan Alliance
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Parkview Health System
South Bend Clinic

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PROVIDER GROUPS
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Community Physicians of Indiana
HealthNet
Health & Hospital Corporation of Marion County
Indiana University Health
St. Vincent Medical Group

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Back of Map

Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf

Questions?

Thank you for being our partner in care.