Maximizing Healthcare Excellence

MHS Quality and Incentive Programs for Primary Medical Providers

MHS offers several quality and incentive programs to partner with providers to enhance the health of our patients for 2024.

- Pay-for-Performance (P4P) program
- Continuity of Care (COC) program
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Front Office Visit Incentive
- Smoking Cessation
- Z-Code

Pay-for-Performance (P4P) Medicaid

2024 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	• Enhance quality of care through a PMP driven pay for performance program with a focus on preventive and screening services.
Performance Incentive	• MHS has funded an incentive pool for each program (HIP, HHW, HCC). • Each program has its own set of measures, targets and incentive amounts.
Measurement Time Period	• Healthcare Effectiveness Data and Information Set (HEDIS®) calendar year January 1 – December 31. • Contract effective date is January 1, 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.

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

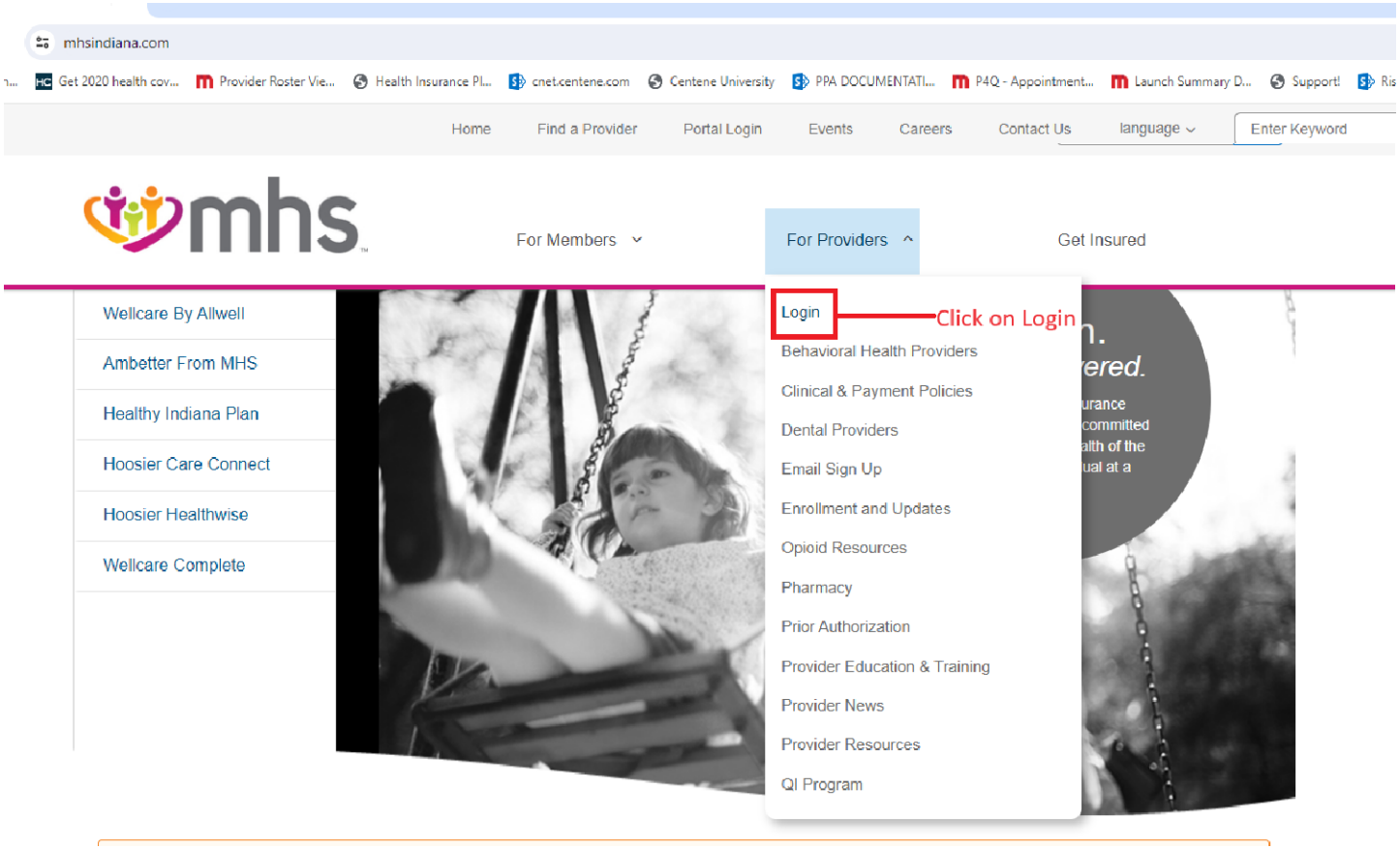
- Provide direct access to medical records or identify a specific contact for medical records requests.

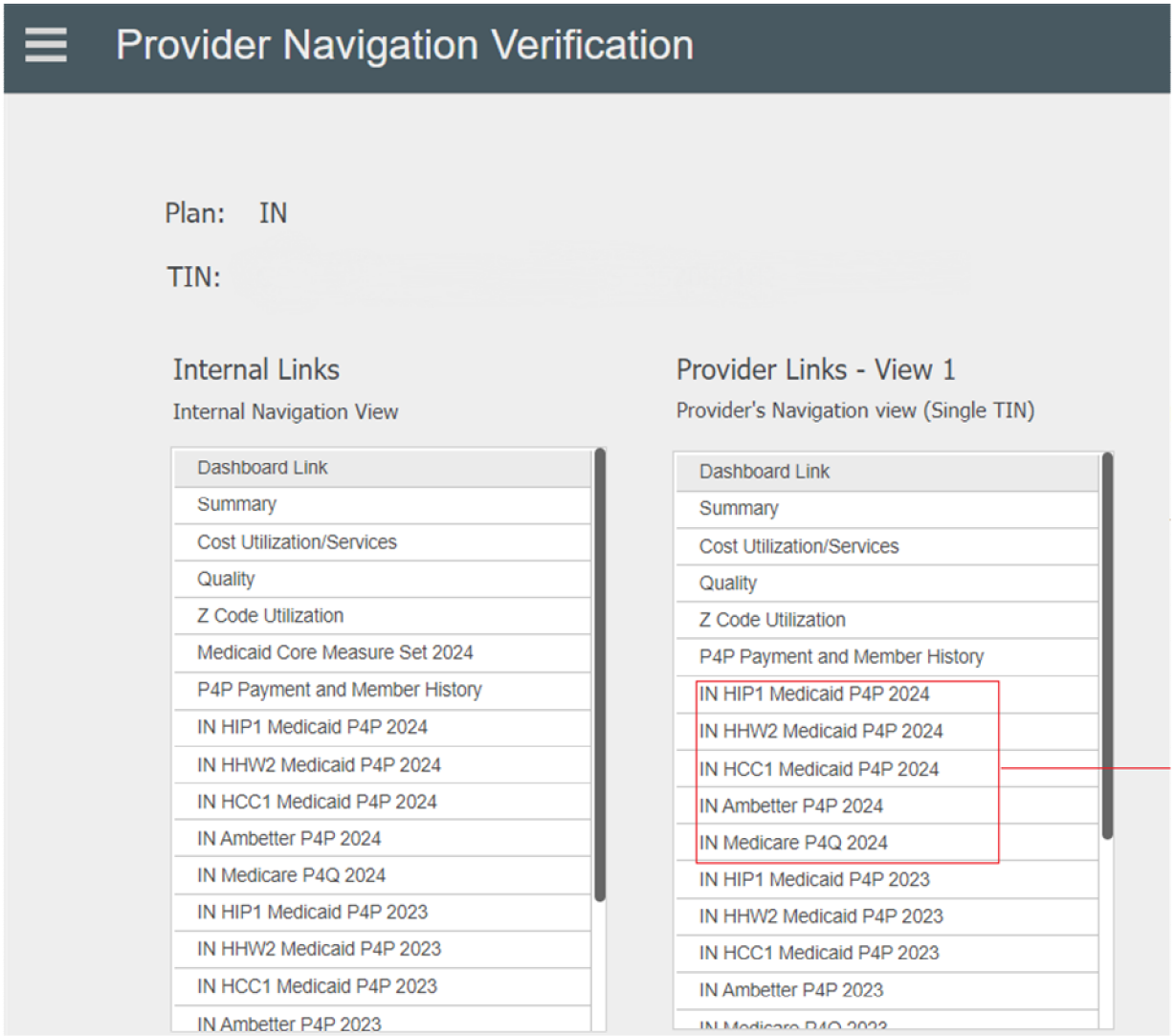
Annual P4P Payout

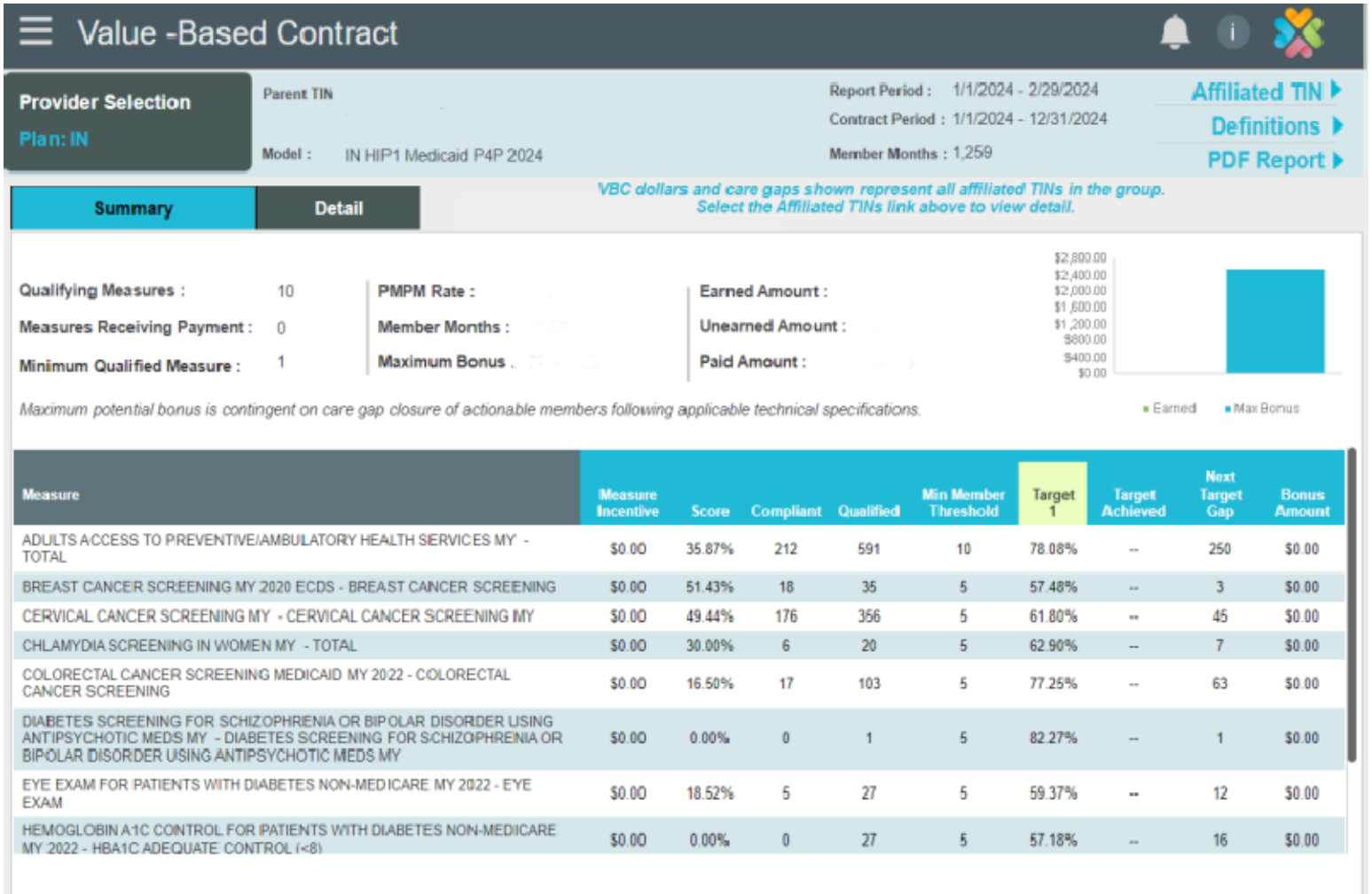
- P4P Payout calculations are based on final HEDIS Administrative rates and paid at group level.
- Factors include:
  - Panel Size—150 minimum
  - Required number of members qualified per measure
  - Funds from measures without enough members get rolled into other qualifying measures

Navigation

Log in to the MHS Provider Portal




Provider Navigation Verification
Plan: IN
TIN:
Internal Links
Internal Navigation View
Dashboard Link
Summary
Cost Utilization/Services
Quality
Z Code Utilization
Medicaid Core Measure Set 2024
P4P Payment and Member History
IN HIP1 Medicaid P4P 2024
IN HHW2 Medicaid P4P 2024
IN HCC1 Medicaid P4P 2024
IN Ambetter P4P 2024
IN Medicare P4Q 2024
IN HIP1 Medicaid P4P 2023
IN HHW2 Medicaid P4P 2023
IN HCC1 Medicaid P4P 2023
IN Ambetter P4P 2023
Provider Links - View 1
Provider's Navigation view (Single TIN)
Dashboard Link
Summary
Cost Utilization/Services
Quality
Z Code Utilization
P4P Payment and Member History
IN HIP1 Medicaid P4P 2024
IN HHW2 Medicaid P4P 2024
IN HCC1 Medicaid P4P 2024
IN Ambetter P4P 2024
IN Medicare P4Q 2024
IN HIP1 Medicaid P4P 2023
IN HHW2 Medicaid P4P 2023
IN HCC1 Medicaid P4P 2023
IN Ambetter P4P 2023
P4P Program data



Measure	Measure Incentive	Score	Compliant	Qualified	Min Member Threshold	Target 1	Target Achieved	Next Target Gap	Bonus Amount
ADULTS ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES MY - TOTAL	$0.00	35.87%	212	591	10	78.08%	--	250	$0.00
BREAST CANCER SCREENING MY 2020 ECDS - BREAST CANCER SCREENING	$0.00	51.43%	18	35	5	57.48%	--	3	$0.00
CERVICAL CANCER SCREENING MY - CERVICAL CANCER SCREENING MY	$0.00	49.44%	176	356	5	61.80%	--	45	$0.00
CHLAMYDIA SCREENING IN WOMEN MY - TOTAL	$0.00	30.00%	6	20	5	62.90%	--	7	$0.00
COLORECTAL CANCER SCREENING MEDICAID MY 2022 - COLORECTAL CANCER SCREENING	$0.00	16.50%	17	103	5	77.25%	--	63	$0.00
DIABETES SCREENING FOR SCHIZOPHRENIA OR BIPOLAR DISORDER USING ANTIPSYCHOTIC MEDS MY - DIABETES SCREENING FOR SCHIZOPHRENIA OR BIPOLAR DISORDER USING ANTIPSYCHOTIC MEDS MY	$0.00	0.00%	0	1	5	82.27%	--	1	$0.00
EYE EXAM FOR PATIENTS WITH DIABETES NON-MEDICARE MY 2022 - EYE EXAM	$0.00	18.52%	5	27	5	59.37%	--	12	$0.00
HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES NON-MEDICARE MY 2022 - HBA1C ADEQUATE CONTROL (<8)	$0.00	0.00%	0	27	5	57.18%	--	16	$0.00

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 from MHS
  - Wellcare By Allwell
  - Medicaid

CoC Program Overview

- Continuity of Care (CoC) - Risk Adjustment bonus program for our Providers
- Risk Adjustment pays bonuses for completed and verified Provider Appointment Agendas and/or submission of Comprehensive Exam medical records. (Wellcare By Allwell only)
- This is a claims-based program; members need to be assessed during the program year by their PCP along with a claim submitted to support the provider's assessment.
- Providers earn bonus payments for proactively coordinating preventive medicine and thoroughly assessing all their patient's current conditions in an effort to improve health and provide appropriate clinical quality of care.
- The intent of the CoC Program is to promote proactive management of chronic conditions and preventative services.
- Appointment Agendas serve as a valuable tool that provides offices with both insight into historical diagnosis data (submitted on their patients), as well as clinical services for providers to use to assist in assessing their members to ensure all member conditions are assessed at least once per year.

Provider Partnerships

- Schedule an appointment and conduct a visit with the patient prior to December 31, 2024. Telehealth services that are furnished using interactive, audio/video, real-time communication technology are acceptable for the Continuity of Care (CoC) program.
- 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.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Goal of the EPSDT Program

- To facilitate access to the important EPSDT services of well-child visits in the first 30 months of life, lead screening and childhood immunizations for MHS members beyond the focus of HEDIS measure compliance
- Traditional provider incentive program reward providers for closing the HEDIS care gap
- This program rewards providers for providing this care to MHS members during a 90-day grace period after the HEDIS deadline

Program Details: Measures

- Measures in Incentive Program
  - W30: Well-Child Visits in the first 30 months of life
  - LSC: Lead Screening in Children
  - CIS-10: Childhood Immunization Status-Combination 10

- How is it different from HEDIS Measure Compliance?
  - This program allows a provider an additional 90-day grace period after the HEDIS deadline, to provide the missing care and receive an incentive.

Program Details: Criteria

- Criteria to Receive Incentive Payment
  - Medicaid members with a care gaps for W30, LSC and/ or CIS-10 measures
  - Provider receives $25 for every gap closed in the 90-day grace period at the measure level
  - Provider can receive up to $75 per member if all three care gaps are closed in the 90-day grace period
- Measure Level Criteria to Receive Incentive Payment
  - The grace period is 90 days beyond the HEDIS deadline.
  - At the end of the 90-day grace period, these services should be completed to receive the incentive:
    - W30: At least eight (8) well-child visits
    - LSC: At least 1 (one) lead screening
    - CIS-Combination 10: All immunization specified by this HEDIS measure completed

Incentive Assessment & Distribution

HEDIS Care Gap deadline in	90-day grace period ends in	90-day claims lag ends in	Incentive Assessment completed & paid by
Q1	Q2	Q3	Q4
Q2	Q3	Q4	Q1 next year
Q3	Q4	Q1 next year	Q2 next year
Q4	Q1 next year	Q2 next year	Q3 next year

- MHS will allow for a 90-day claims lag run-out to identify all care gaps closed in the 90-day grace period to calculate the incentive payment.
- Members with care gaps for these three measures can be identified in the Provider Analytics Tool.
- Your MHS Quality Provider Associate and/ or Provider Network Associate can also show you how to identify members who have failed the HEDIS measure(s) but are eligible for this incentive.
- The MHS Provider Network team will distribute the incentive payments to the providers.

Incentive Assessment & Distribution

HEDIS Care Gap deadline in	90-day grace period ends in	90-day claims lag ends in	Incentive Assessment completed & paid by
Q1	Q2	Q3	Q4
Q2	Q3	Q4	Q1 next year
Q3	Q4	Q1 next year	Q2 next year
Q4	Q1 next year	Q2 next year	Q3 next year

- MHS will implement this program in Q4 2023. Any member with a W30, CIS-10 or LSC care gap that has a HEDIS deadline in Q4 2023, is eligible for this incentive.
- The provider has 90 additional days from the deadline of the HEDIS measure to provide this care. The grace period will end by Q1 2024.
- MHS will allow for an additional 90 days of claims run-out to identify any care gap that failed the HEDIS measure in Q4 2023, but received the care within the 90-day grace period in Q1 2024.
- Incentive payments will be made in Q3 2024 and will continue quarterly using the timeline above.

Front Office Staff Incentive

Front Office Staff Incentive

- NEW! Front office staff incentive program that rewards your office for scheduling preventive care for MHS members
  - This incentive payment is payable to the Tax ID Number (TIN) or the IRS number only.
  - The TIN will need to opt-into this incentive program by contacting your MHS Provider Engagement Administrator.
  - At least 15-30 days before the start of an eligible quarter, your MHS Provider Engagement Administrator will give you a list of all members in your TIN that have a care gap for one or more of the preventive care measures.
  - If the TIN closed at least 50% of all care gaps prorated for the quarter, you will receive a gift card of $250 for that quarter to reward your front office staff.

Performance Period for Incentive: <Quarter> <Year>
Provider TIN: <TIN>
Total Care Gaps: < Count >
Prorated Care Gaps: <Count>
Performance Target (50% of Prorated Care Gaps): <Count>

Measure Type	**Measure**	**Total Care Gaps to Close**
Well-Child Visits in the first 30 months of life (W30)	HEDIS	<count>
Child and Adolescent Well-Care Visits (WCV)	HEDIS	<count>
Annual Well-Visits for Adults (ages 21 and over) (AWV)	MHS developed internal measure	<count>
Total Care Gaps to Close		**<Sum of counts above>**

Please remember these incentives are for Medicaid patients only.

Smoking Cessation

Smoking Cessation

- All counseling can be billed to MHS using CPT code
  - 99406 – Intermediate counseling greater than 3 minutes, up to10 minutes
  - 99407- Intensive counseling greater than 10 minutes
- Counseling is billable as individual or group; if billing group session, the use of HQ modifier is required.
- $50 “pay above” incentive for initial counseling visit for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Members
- The Indiana Tobacco Quitline
  - 1-800-QUIT-NOW (1-800-784-8669)
  - Free, phone-based counseling service that helps Indiana smokers quit
  - One-on-one coaching for tobacco users trying to quit
  - Resources available for both providers and patients

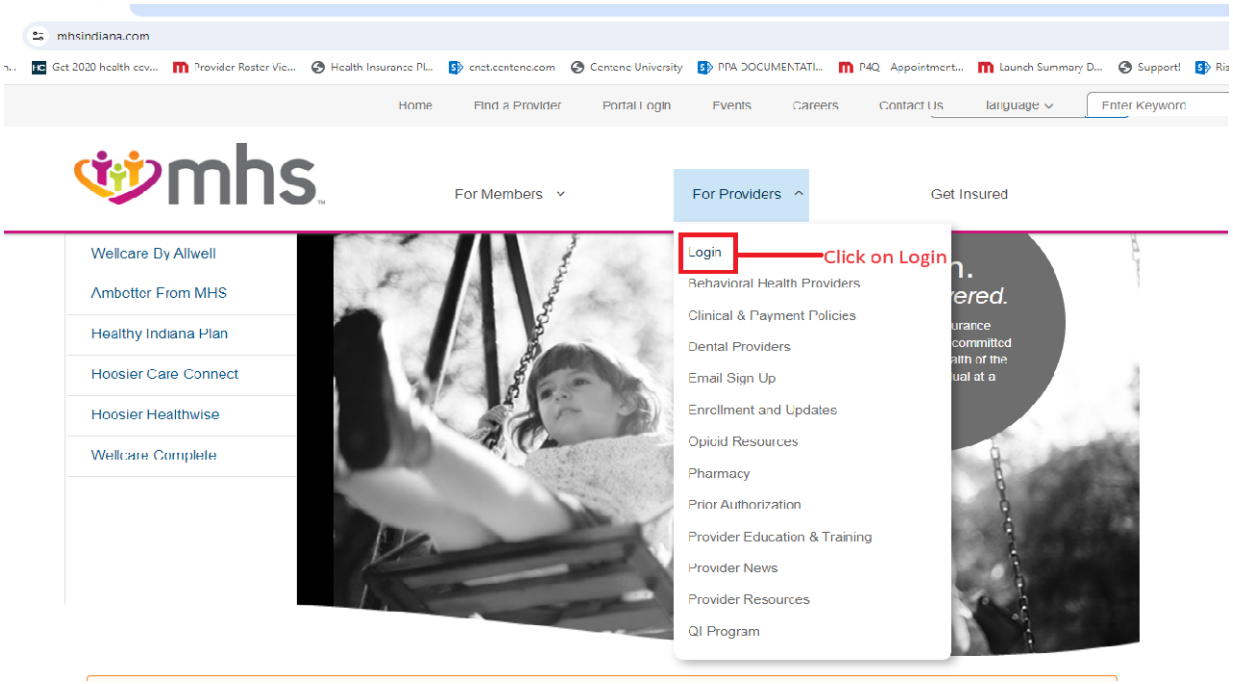
Z-Code Incentive Program

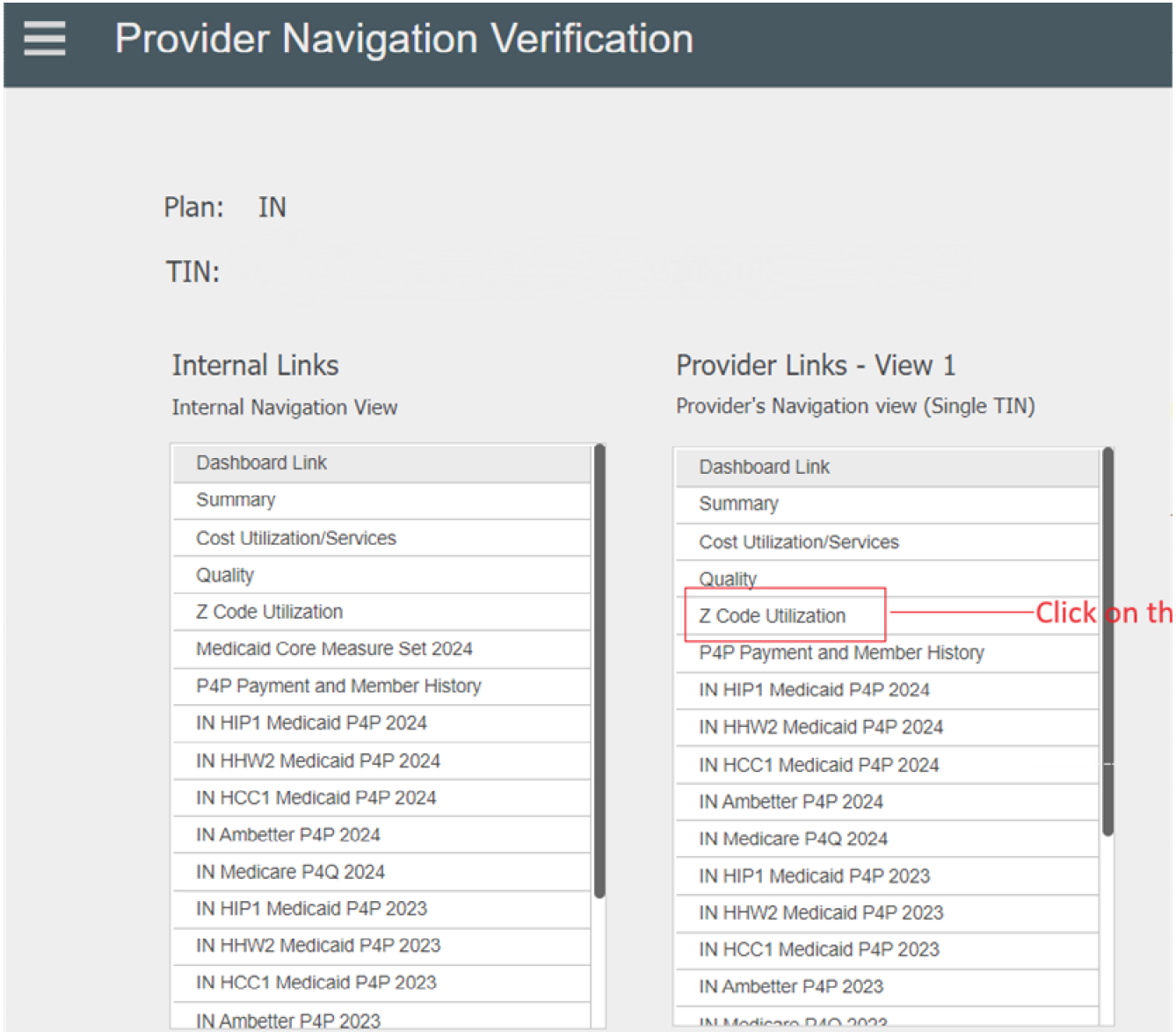
- Social Determinants of Health (SDOH) impact patient outcomes. By including SDOH diagnoses on claims, MHS is providing information that allows us to identify members for additional outreach an assistance. This allows MHS to enhance programs and community connections to address the SDOH diagnosis codes.

Diagnosis Code	Description
Z55	• Problems related to education and literacy; Example billable code • Illiteracy and low-level literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances

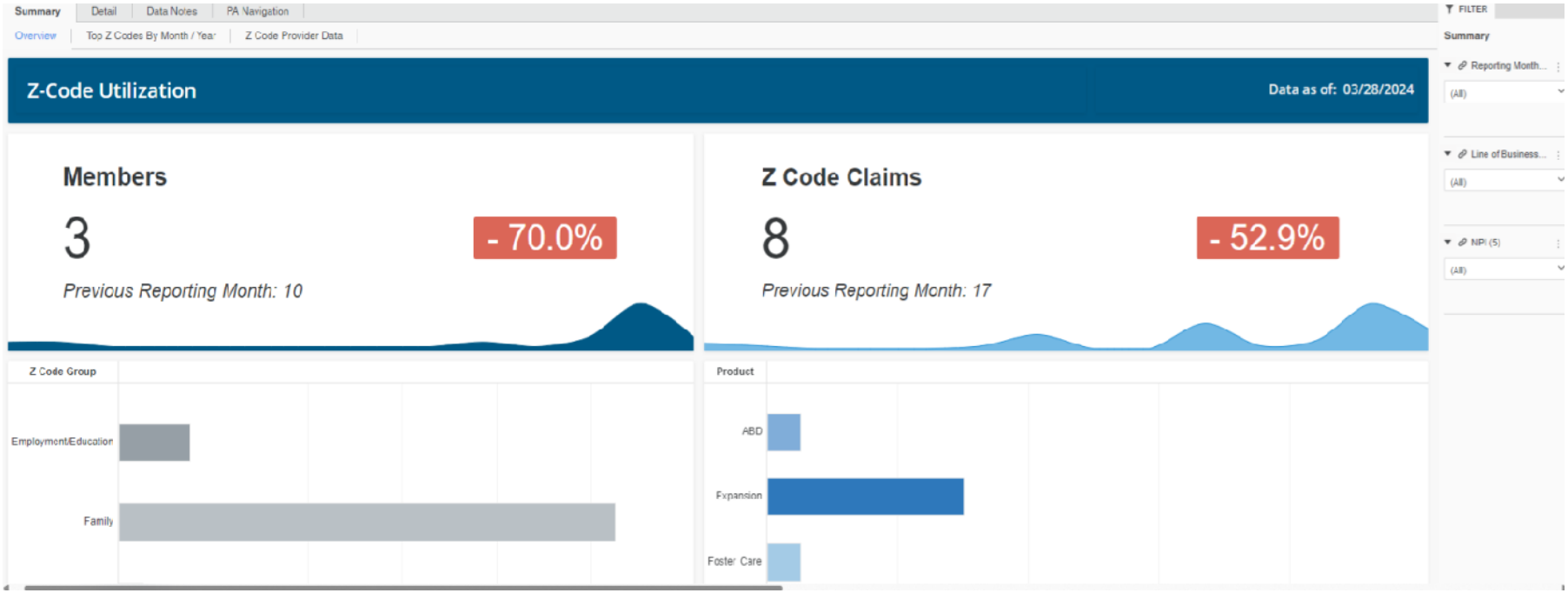
- To improve submission of applicable SDOH diagnosis codes on claims, MHS invites providers to participate in the Z-Code Incentive Program. Beginning with claims processed on December 1, 2023, payments will automatically pay an SDOH incentive on a quarterly basis, for paid claims processed during the most recent quarter.
  - First targeted SDOH diagnosis on a claim: $10
  - Subsequent SDOH diagnosis codes on a claim: $5
  - (Maximum of three total Z-Codes per member)

Log in to the MHS Provider Portal




Provider Navigation Verification
Plan: IN
TIN:
Internal Links
Internal Navigation View
Dashboard Link
Summary
Cost Utilization/Services
Quality
Z Code Utilization
Medicaid Core Measure Set 2024
P4P Payment and Member History
IN HIP1 Medicaid P4P 2024
IN HHW2 Medicaid P4P 2024
IN HCC1 Medicaid P4P 2024
IN Ambetter P4P 2024
IN Medicare P4Q 2024
IN HIP1 Medicaid P4P 2023
IN HHW2 Medicaid P4P 2023
IN HCC1 Medicaid P4P 2023
IN Ambetter P4P 2023
Provider Links - View 1
Provider's Navigation view (Single TIN)
Dashboard Link
Summary
Cost Utilization/Services
Quality
Z Code Utilization
Click on the Zcode
P4P Payment and Member History
IN HIP1 Medicaid P4P 2024
IN HHW2 Medicaid P4P 2024
IN HCC1 Medicaid P4P 2024
IN Ambetter P4P 2024
IN Medicare P4Q 2024
IN HIP1 Medicaid P4P 2023
IN HHW2 Medicaid P4P 2023
IN HCC1 Medicaid P4P 2023
IN Ambetter P4P 2023

Once you click on Z-Code utilization, you will access your TIN's information for members/claims.



Questions?