VALUE-BASED CARE AND RHC-FQHC 2023

CHARLES JAMES: NORTH AMERICAN HMS/ RURAL ADVANTAGE ACO

May 21, 2023

VALUE BASED PAYMENTS (VBP)

- ✓ Quality Payment Programs
- ✓ Spectrum of Risk
- ✓ Medicare Shared Savings/Accountable Care Organizations
- ✓ HEDIS - CAHPS
- ✓ Medicare Advantage
- ✓ Care Gaps: Value Based Dollars Now!!

WHAT ARE VALUE-BASED PAYMENT PROGRAMS?

According to the Centers for Medicare and Medicaid Services (CMS):

“Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of our larger quality strategy to reform how health care is delivered and paid for”

“What are Value Based Payment Programs”. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs. Centers for Medicare and Medicaid Services. Page Last Modified: 03/31/2022. Accessed 5.23.2023.

CMS QUALITY PAYMENT PROGRAM

1. Support care improvement by focusing on better outcomes for patients, decreased provider burden, and preservation of independent clinical practice;
2. Promote adoption of Alternative Payment Models that align incentives across healthcare stakeholders; and
3. Advance existing efforts of Delivery System Reform, including ensuring a smooth transition to a new system that promotes high-quality, efficient care through unification of CMS legacy programs.

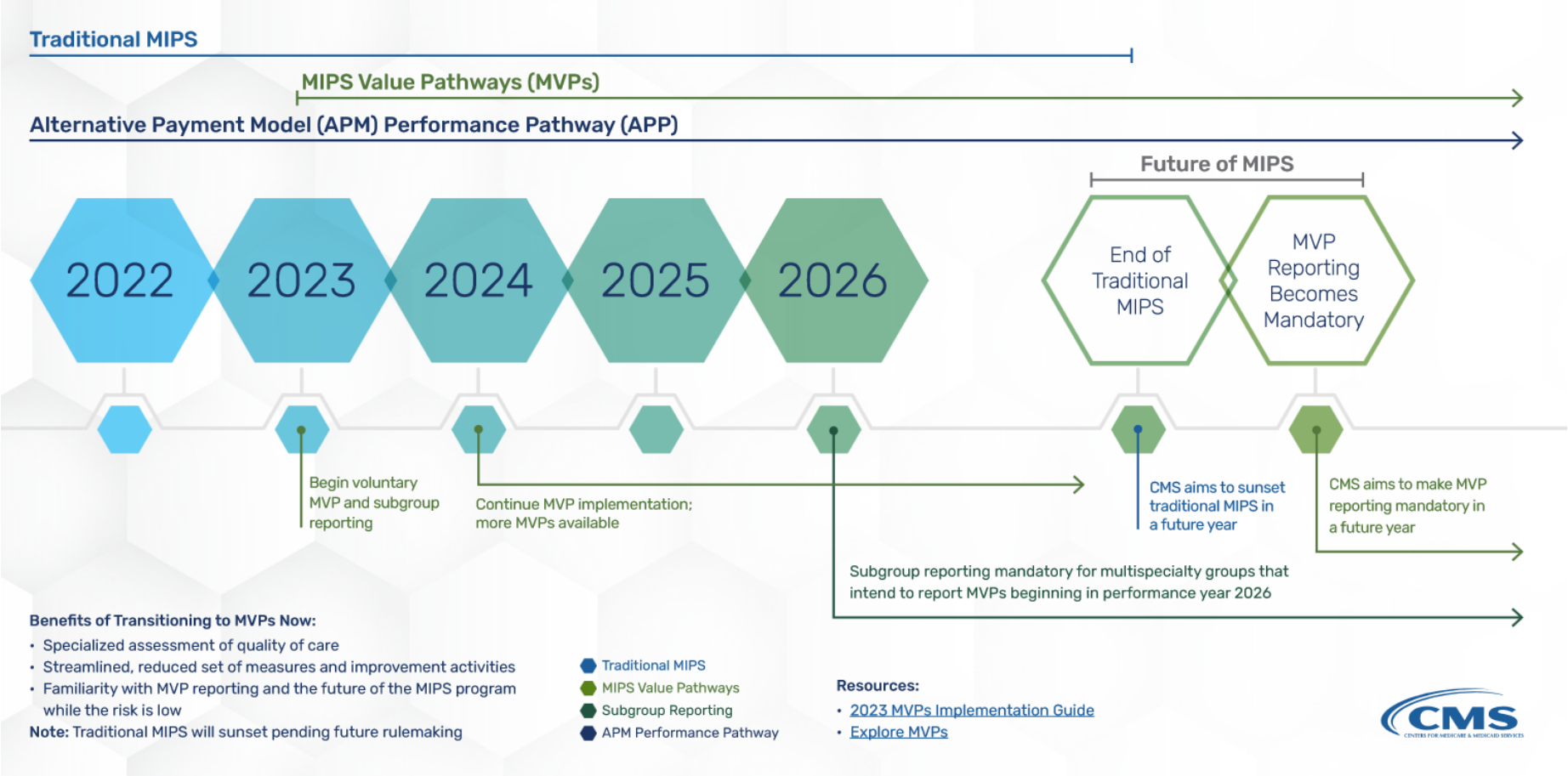
(CMS MIPS Final Rule)

MEDICARE QUALITY PAYMENTS

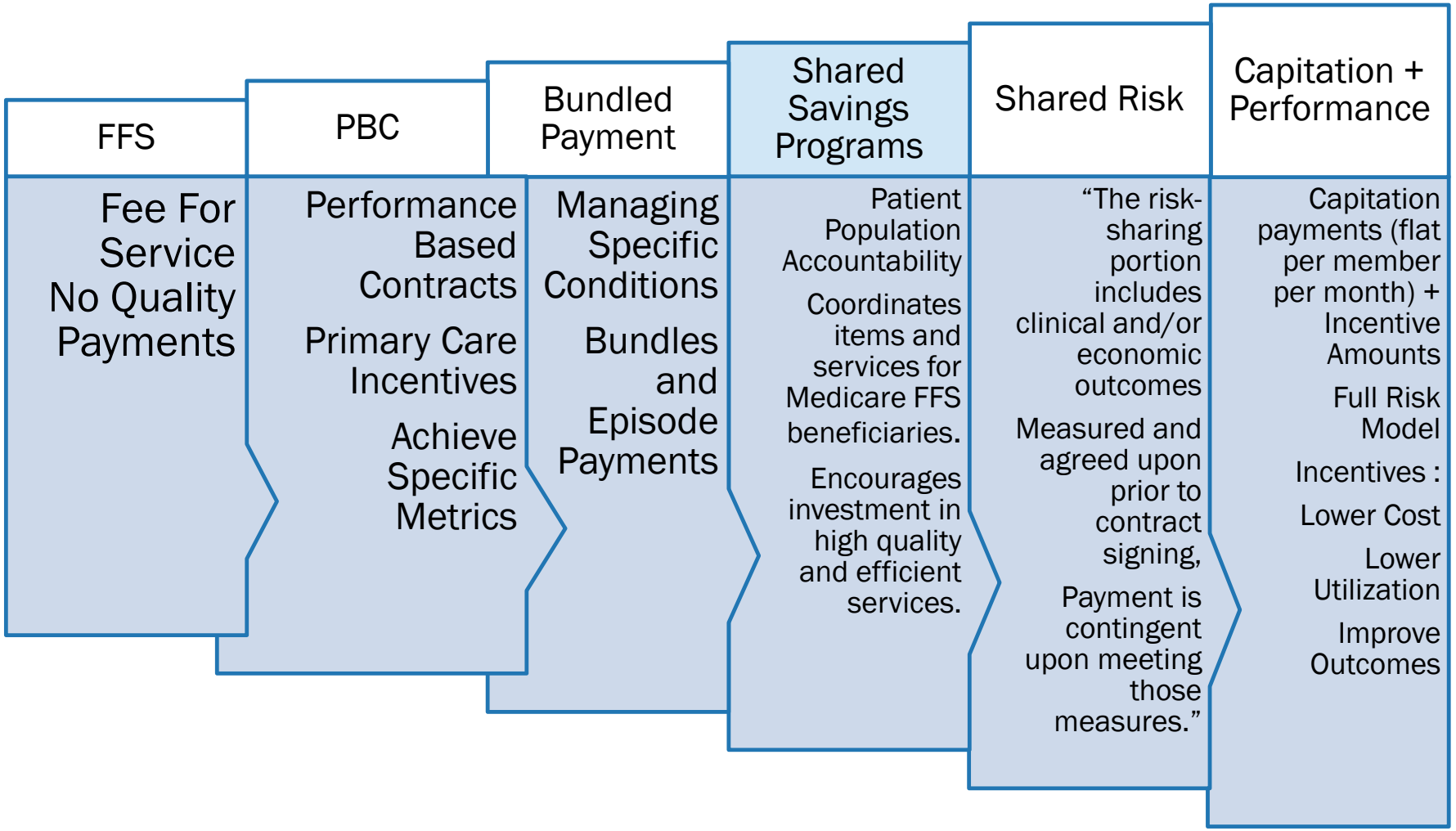
What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks:

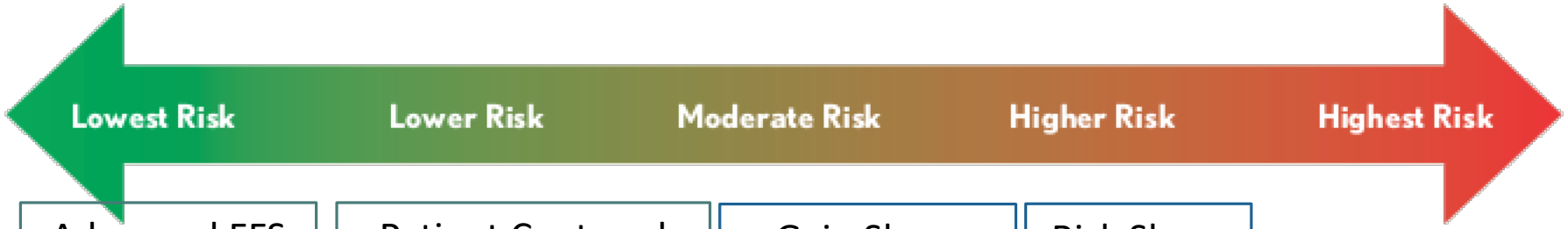
TRANSITION FROM MIPS TO [VALUE PAYMENTS]



THE SPECTRUM OF QUALITY PAYMENT PROGRAMS



SPECTRUM OF RISK IN VALUE-BASED ARRANGEMENTS



Lowest Risk	Lower Risk	Moderate Risk	Higher Risk	Highest Risk
Advanced FFS (DRGS, APCS)	Patient Centered Medical Home (PCMH)	Gain Share	Risk Share	Global Payment Capitation
Shared Savings (Upside Only)	Pay For Performance	Episode & Other Specialist Programs (Bundled Payments, etc.)		

- Incentives/penalties applied to provider payments to promote improved outcomes
- Provider payments for investments in care delivery, care coordination and health IT (infrastructure)
- Financial incentives for quality reporting
- Reward only payments for high-quality performance

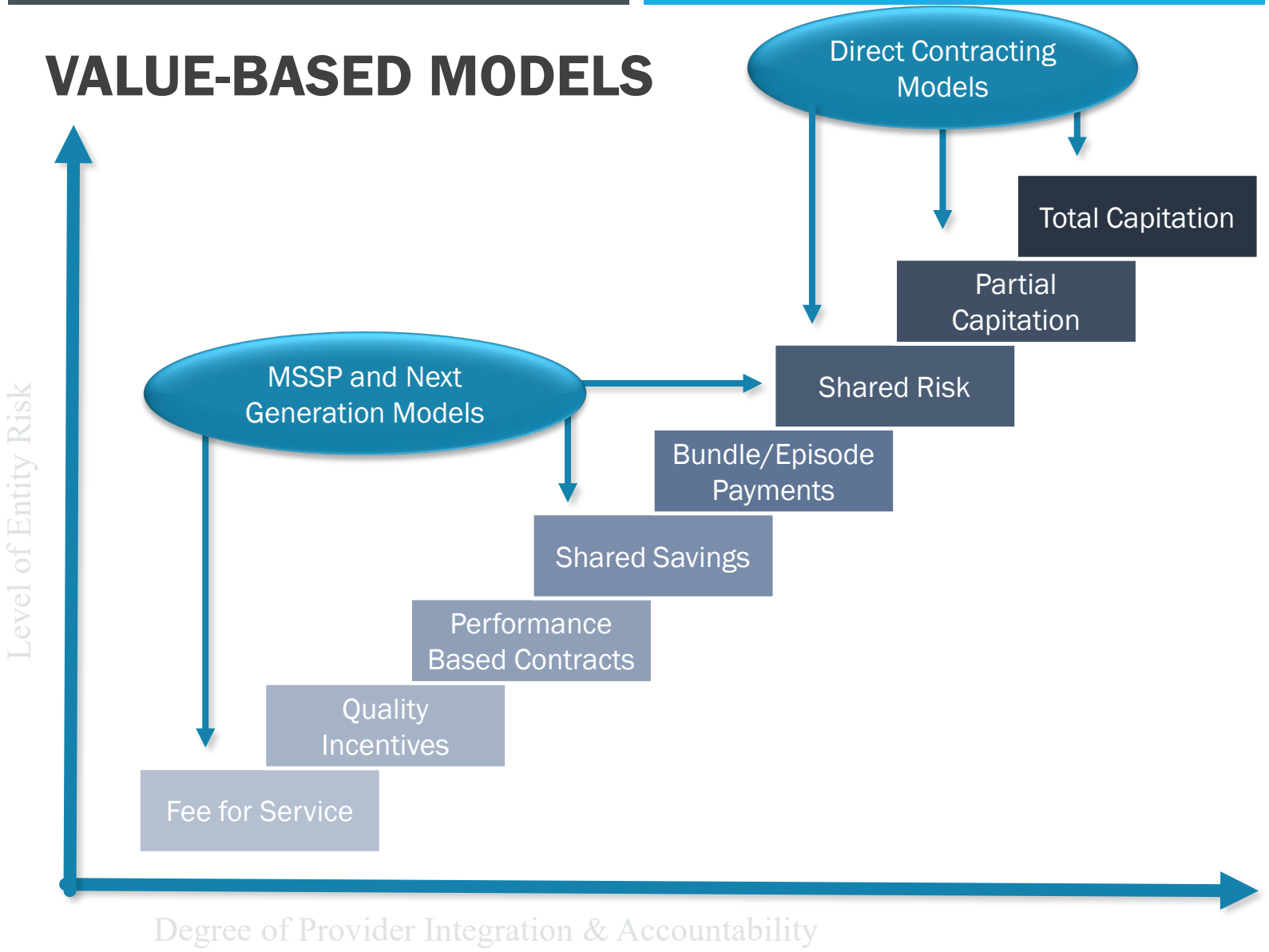
- Savings from care improvement shared between payer and provider
- Emerging care models with rewards or incentives
- Episode-based payment for clinical conditions

- Provider paid a single payment for a defined group of individuals
- Population-based payment for specific conditions
- Capitated payment based on care for a covered population
- Integrated payment and delivery systems (i.e., provider-based insurance plans)

5 STRATEGIC OBJECTIVES FOR ADVANCING SYSTEM TRANSFORMATION

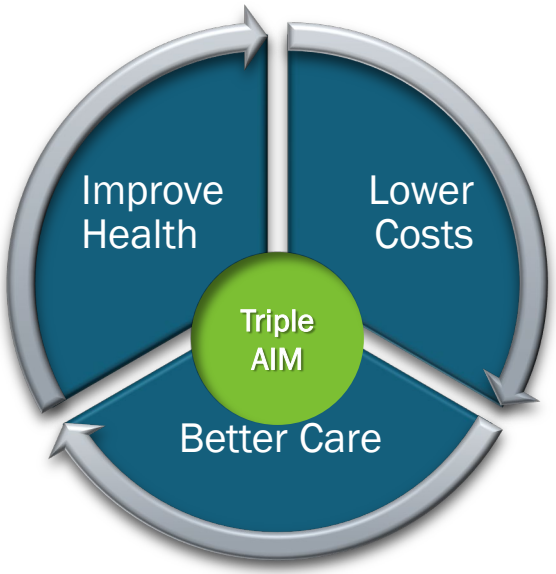
CMS Innovation Center is launching a bold new strategy with the goal achieving equitable outcomes through high-quality, affordable, person-centered care. The strategic objectives above will guide the Innovation Center's second decade.

VALUE-BASED MODELS



Value-Based Program =
Care delivery reform
+
Quality component
+
Payment reform

Value-based care doesn't describe a single model, but a spectrum of models



MEDICARE SHARED SAVINGS

ACCOUNTABLE CARE ORGANIZATIONS

BASIC TRACK (5 YEARS) – MIN. 5,000 BENEFICIARIES

An ACO in the Basic Track will automatically progress to the next level of risk annually

Basic Track (A & B)

163 ACOs

- Upside Only: Similar to Track 1 from previous rules
- Savings Rate: 40%
- Shared Loss Rate: 0%
- No Advanced APM Qualification
- Attribution: Prospective or Retrospective

Basic Track (C & D)

31 ACOs

- Two-Sided Risk
- Savings Rate: 50%
- Shared Loss Rate: 30%; capped at 2-4% of ACO revenue
- No Advanced APM Qualification
- Attribution: Prospective or Retrospective

Basic Track (E)

69 ACOs

- Two-Sided Risk
- Savings Rate: 50%
- Shared Loss Rate: 30%; capped at 8% of ACO revenue,
- Advanced APM Qualification
- Attribution: Prospective or Retrospective

ENHANCED TRACK (5 YEARS) – MIN. 5,000 BENEFICIARIES

Enhanced Track – *76 ACOs*

- Two-Sided Risk
- Savings Rate: 75%
- Shared Loss Rate: 40-70%; capped at 15% of benchmark
- Advanced APM Qualification
- Attribution: Prospective or Retrospective

Comparison to Other Programs

	Medicare Shared Savings Program	Direct Contracting (REACH) [Professional/Global]	Direct Contracting (Geographic)	Medicare Advantage
Risk Covered	Total cost of care	Primary care services / Total cost of care	Total cost of care / Partial Cost of care	Total cost of care
Programmatic Incentives	• Reduce total costs • High quality care	• Increase primary care services • Bring care in network • High quality care	• Bring care in network • High quality care • Manage many beneficiaries in a region	• Reduce total costs • Bring care in network • High quality care
Payment Structures	*FFS + reconciliation for shared savings/losses*	PBP + performance reconciliation	PBP + performance reconciliation	Capitation
Comparison Cohort	• Own historic experience • Regional/national assignable population	• Own historic experience • Regional USPCC	• Regional USPCC	• County level USPCC
Flexibility in Waivers/Beneficiary Incentives	• Few waivers • Optional benefit for E&M services	• Beneficiary incentives • Many waivers	• Beneficiary incentives • Many waivers	• Benefit flexibility options • Uniformity flexible benefits
Additional Infrastructure Requirements	N/A	• Capitation distribution to participating providers	• Capitation distribution • Payment of non-network FFS claims	• Provider reimbursement • Risk sharing arrangement
Alignment/Assignment	Prospective/Retrospective	Prospective	Regional	Voluntary alignment
Risk Adjustment	3% upside, unlimited downside; across entire 5-year agreement period	Medicare Advantage Risk Adjustment with Normalization and Coding Intensity Factor Adjustments	Zero-Sum Risk Coding	Medicare Advantage risk adjustment process

RHC PARTICIPATION IN MSSP 2023

ACO PARTICIPANT LIST COMPOSITION	
Participant TINs	15,539
Physicians and non-Physicians	573,126
Hospitals	1,450
Federally Qualified Health Centers (FQHCs)	4,409
Rural Health Clinics (RHCs)	2,240
Critical Access Hospitals	467
Shared Savings Program Fast Facts – As of January 1, 2023	

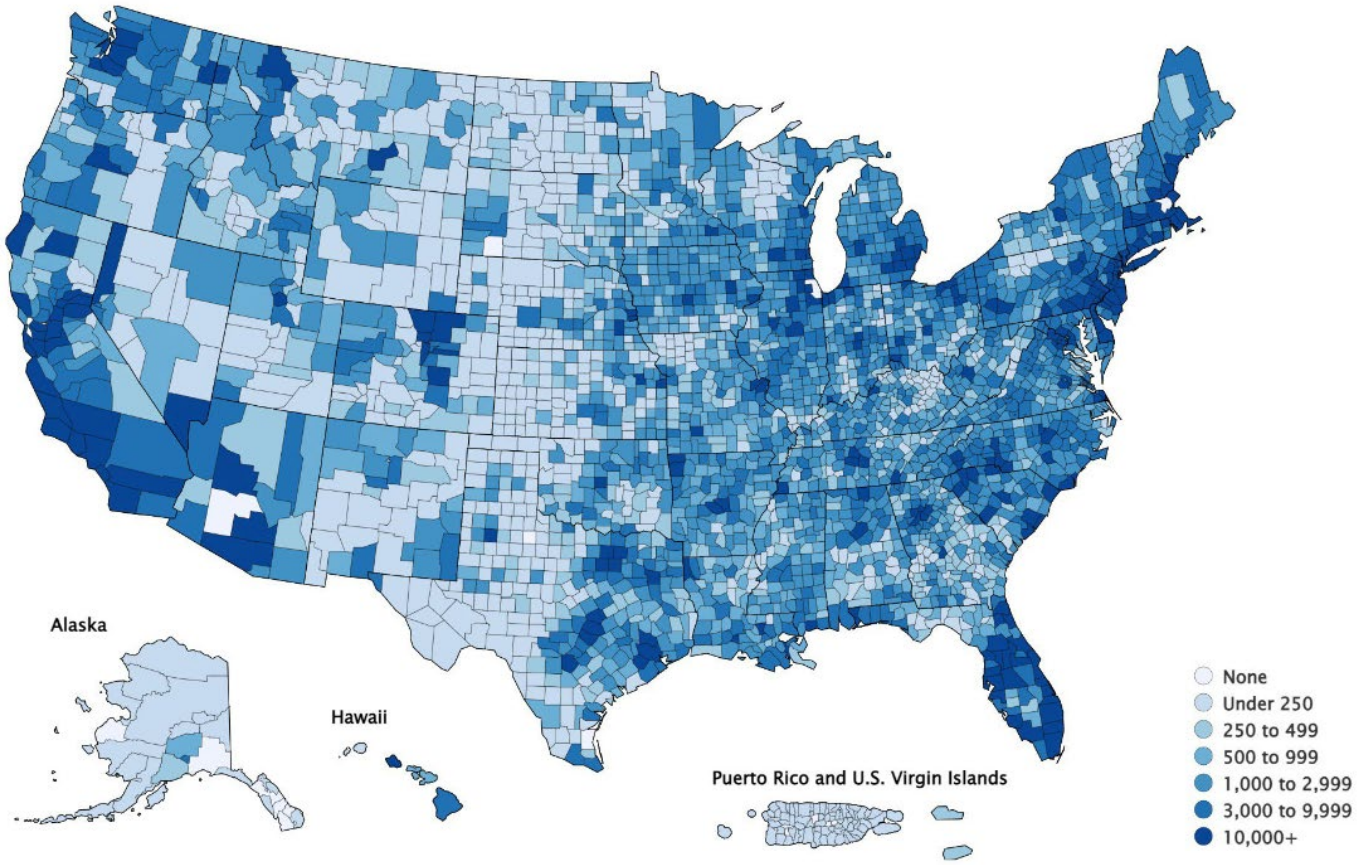
MEDICARE SHARED SAVINGS PROGRAM

Assigned Beneficiary Population by County

Shared Savings Program Fast Facts – As of January 1, 2023

MEDICARE SHARED SAVINGS PROGRAM

Medicare Shared Savings Program ACO Assigned Beneficiary Population by County



TYPICAL ACO MEASURES

- Care Management Services
- Annual Wellness Visits
- Transitional Care Management
- Preventive Screenings
- ER Visits and Re-Admissions
- ICD-10 Coding (HCC)

TYPICAL* ACO ANALYTICS

- Patient Attribution
- Annual Wellness Visit History
- Documented Disease Burden
- Patient Outreach
- Hospitalizations/ER Visits

TYPICAL* REVENUE SPLIT

GENERIC MEDICARE-SHARED SAVINGS PLAN TRACK A

50 - 60% of Revenue => Providers

40-50% of Revenue => ACO

Does not [usually] include downside risk.

MEDICARE ADVANTAGE / COMMERCIAL PAYERS

Medicare Advantage and Commercial health plans contracts with CMS are based upon pay for performance.

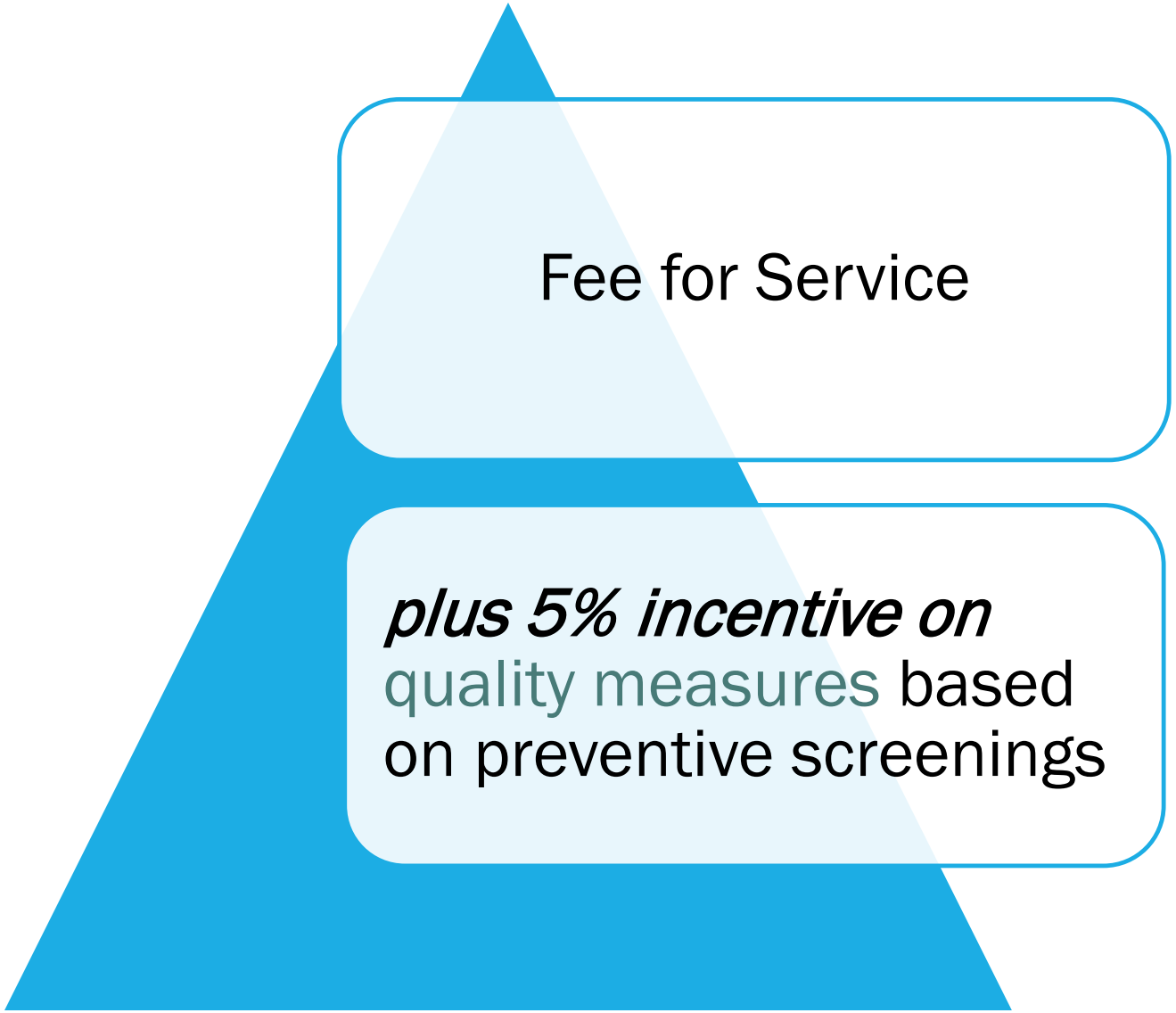
Provider contracts align with payer incentives.

STARS 5 components include:

- ✓ quality/HEDIS measures data,
- ✓ member CAHPS surveys,
- ✓ member HOS surveys,
- ✓ Pharmacy/Part D measures data,
- ✓ health plan operations data.

Commercial Payers are increasingly paying for performance!

COMMERCIAL PAYMENT EXAMPLE



PATIENT CENTERED MEDICAL HOME

- ✓ High-risk patients benefit from PCMH pro-active coordination and follow-up communication by their Care Team. Having their ongoing needs addressed, prevents trips to the hospital and saves them (and their families) both time and money and reduces unscheduled health emergencies.

- ✓ Providers report deep satisfaction by keeping their most vulnerable patients out of the hospital and maintaining their highest level of independence.

- ✓ Care Teams work smarter, not harder by developing customized patient-centered health improvement plans for high-risk patients, using electronic health technology effectively and by communicating patient updates through huddles/communication boards. Everyone functions at the top of their licenses.

- ✓ PCMH meets MIPS guidelines for CMS reimbursement and can result in increased payments from CMS ***and other payors.***

COMMON PERFORMANCE MEASURES

- ✓ CAHPS: Consumer Assessment of Healthcare Providers and Systems (Patient Survey)
- ✓ HEDIS: Healthcare Effectiveness Data and Information Set
- ✓ HOS: Medicare Health Outcome Survey
- ✓ Pharma Part D Measures
- ✓ Health Operations – Cost
- ✓ Patient Centered Medical Home Status

REPORTING QUALITY DATA

Use a Certified EHR Technology. You must capture your patients' clinical data using a certified EHR technology. Not only can this make you eligible for MIPS bonus points, but most certified EHR technologies automatically capture quality measure data for you as you enter information into each patient's record.

Electronically Calculate Clinical Quality Measures. If you have a certified EHR technology, it may already include a number of electronic clinical quality measures that can be calculated. You may also use the assistance of a third party, like a specialty society registry or qualified clinical data registry (QCDR), to calculate the electronic clinical quality measure data captured within your certified EHR technology.

Submit Quality Measure Reports Electronically. You must submit an electronic file of your electronic clinical quality measure data to CMS. You may use a certified EHR technology with the ability to create an electronic submission file or use the assistance of a third party, like a specialty society registry or QCDR, to submit an electronic file on your behalf.

WHERE DO RHC/FQHCS FIT IN?

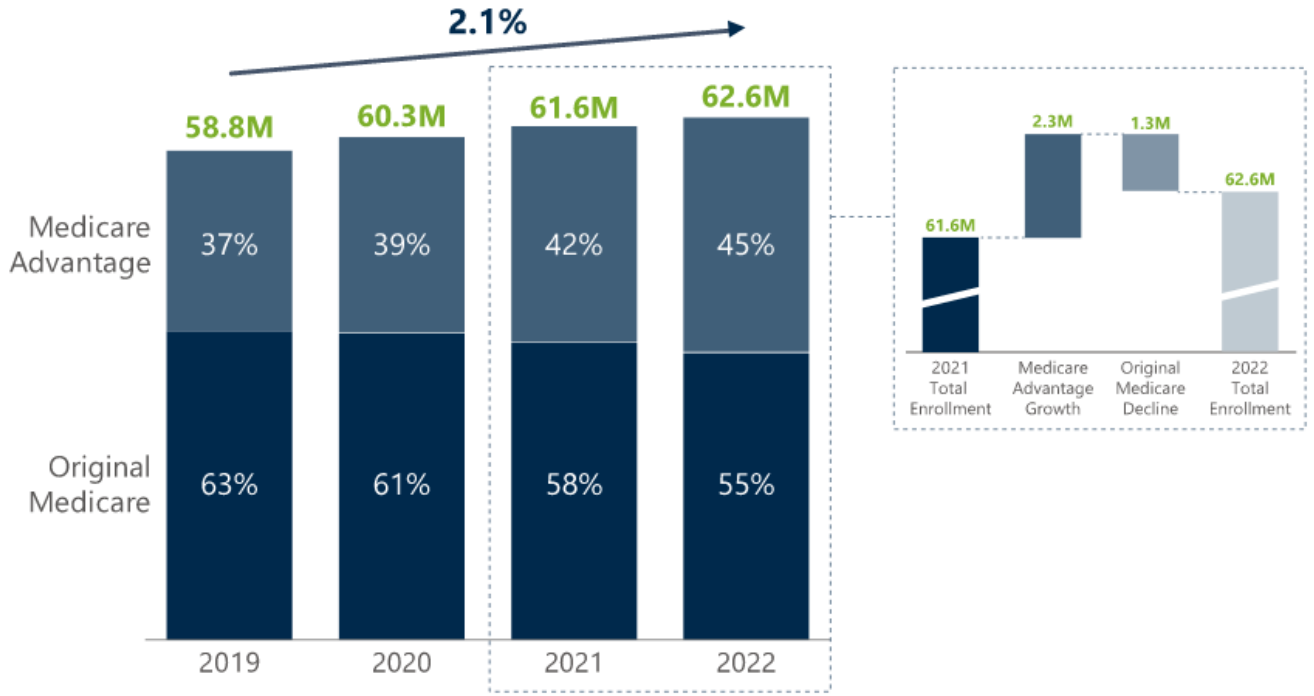
- ✓ Many of us are participating with ACOs as part of provider-based organizations or larger Medical Group (which exempts us from MIPS).
- ✓ Medicare Advantage plans are paying quality incentives, right now. You are leaving money on the table during this presentation.
- ✓ Medicaid MCO and Commercial plans are paying quality incentives, right now. This is more money you are leaving on the table during this presentation.

MEDICARE ADVANTAGE AND VALUE BASED CARE: CLOSING CARE GAPS

TAKE ADVANTAGE OF VALUE-BASED DOLLARS NOW!!

TRENDS: MEDICARE ADVANTAGE PENETRATION

Medicare Enrollment and Penetration Change by Year



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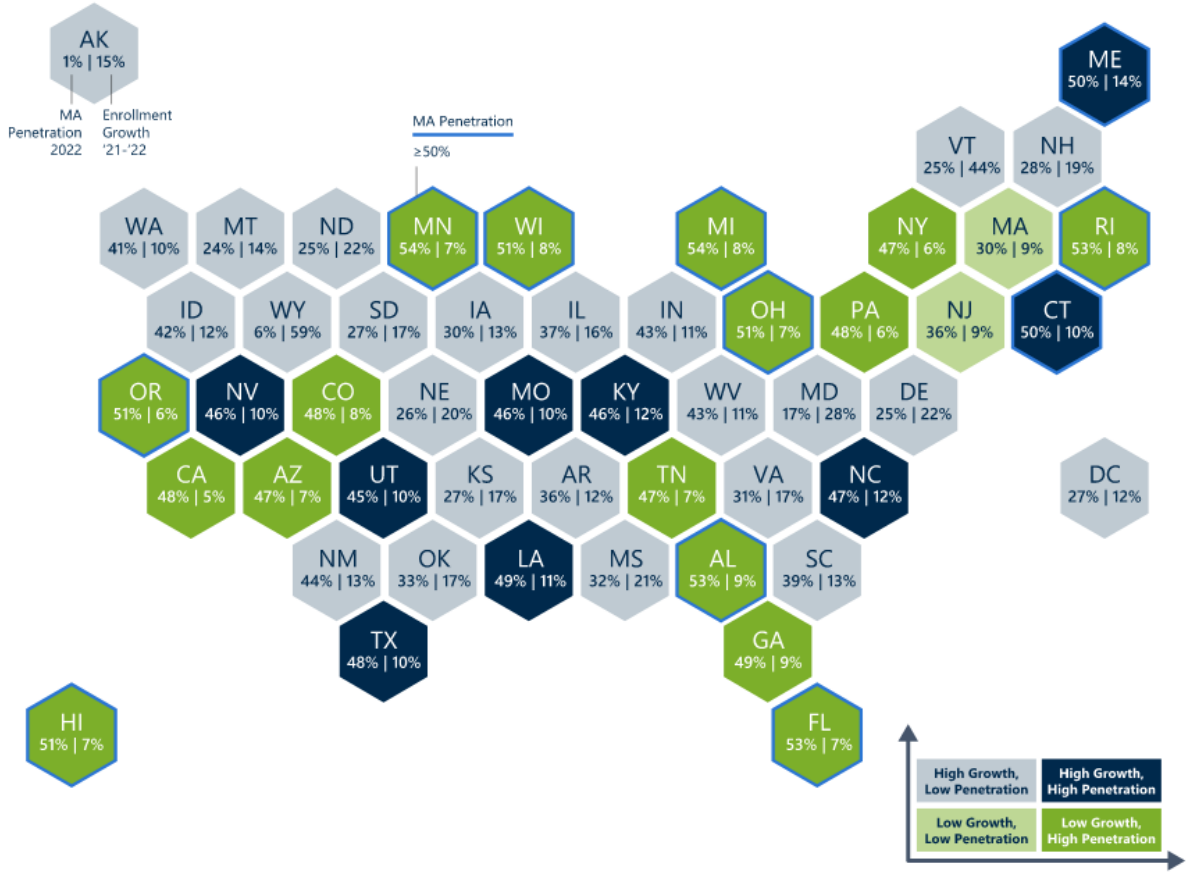


MEDICARE ADVANTAGE GAPS

All Medicare Advantage plans are scored by CMS in almost exactly the same manner as ACO participants are in “value-based” care arrangements.

HEDIS AND CAHPS

“Learn it. Know it. Live it.”

- Brad Hamilton

CAHPS

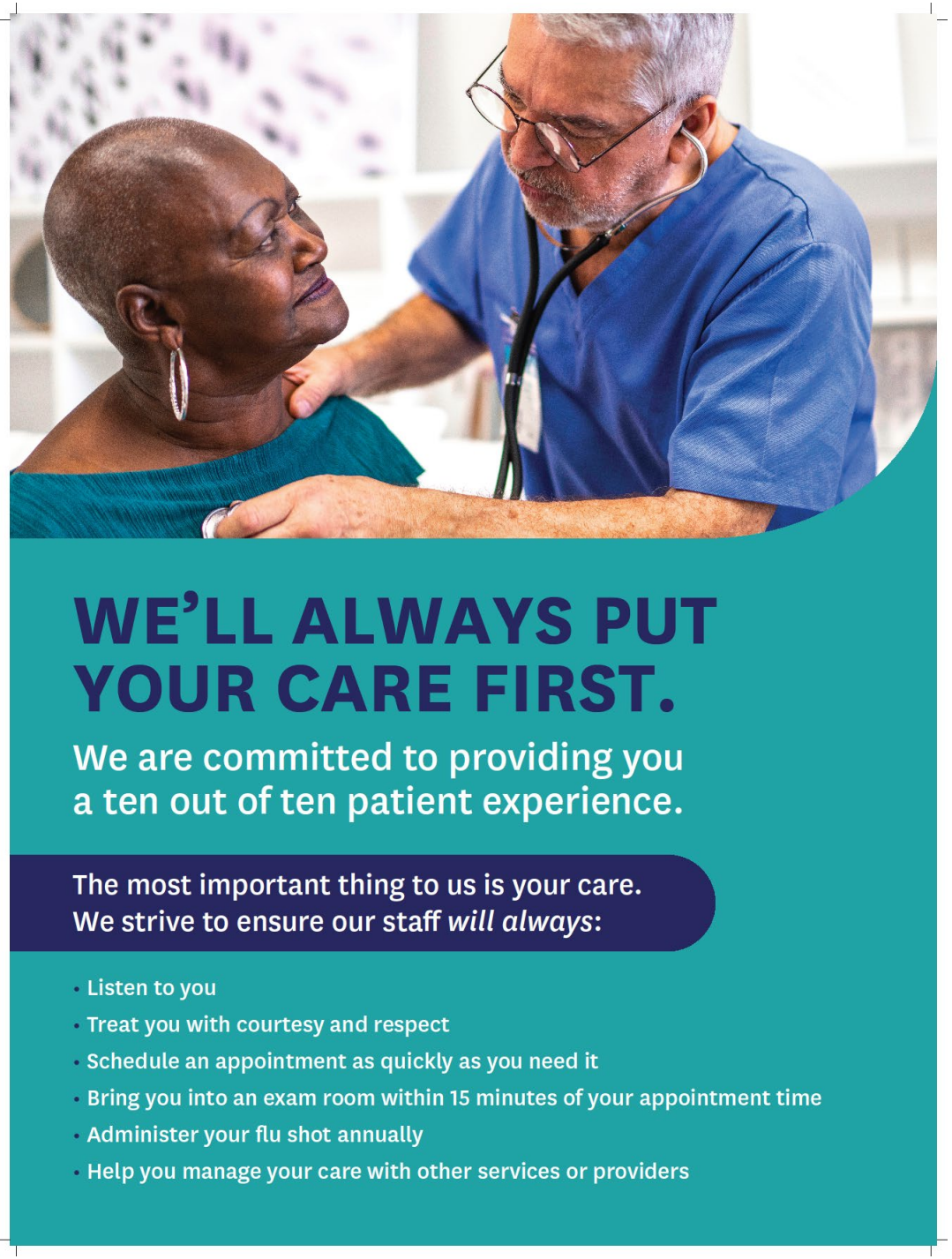
Consumer Assessment of Healthcare Providers and Systems

Surveys are developed by Agency for Healthcare Research & Quality (AHRQ)

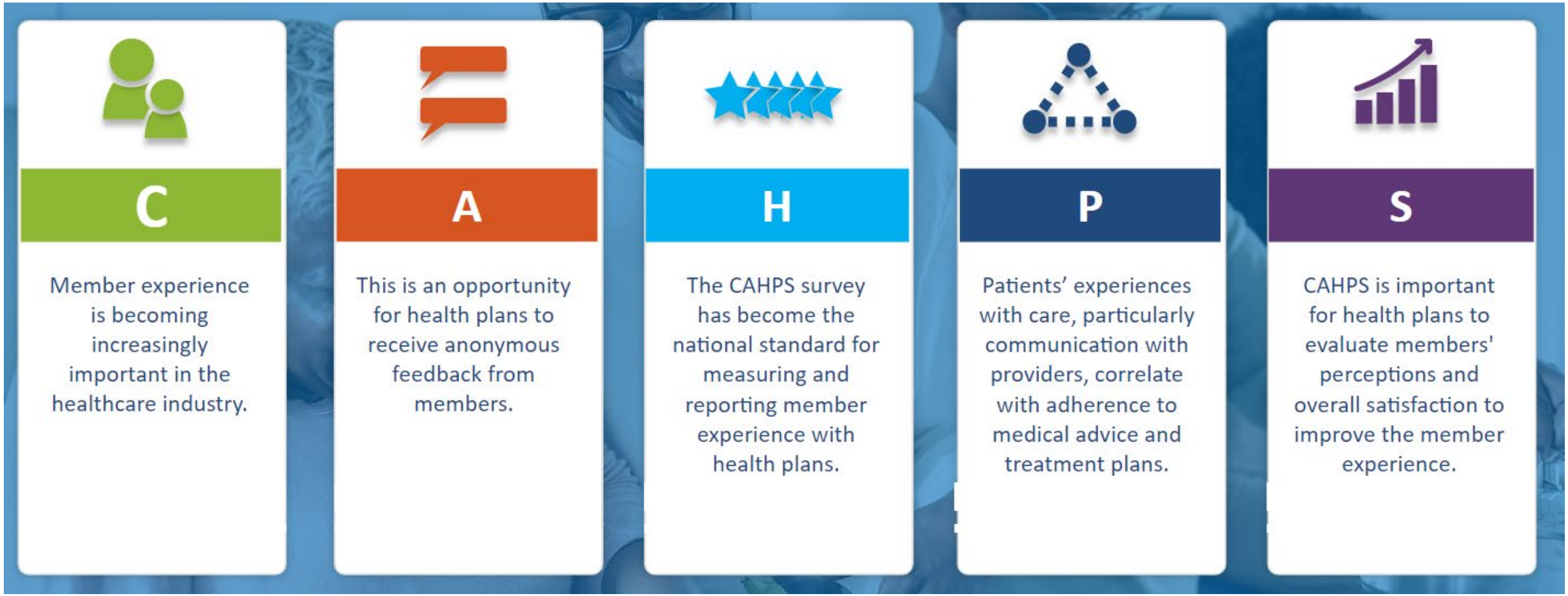
It is a standardized tool used among health plans & prescription drug plans regarding member experience

CAHPS is used for:

- ✓ Accreditation/Star Rating
- ✓ Health Plan Ratings (HPR)
- ✓ Report Card



Why Is CAHPS Important?



C

Member experience is becoming increasingly important in the healthcare industry.

A

This is an opportunity for health plans to receive anonymous feedback from members.

H

The CAHPS survey has become the national standard for measuring and reporting member experience with health plans.

P

Patients' experiences with care, particularly communication with providers, correlate with adherence to medical advice and treatment plans.

S

CAHPS is important for health plans to evaluate members' perceptions and overall satisfaction to improve the member experience.

CAHPS FOCUS

Domain	CAHPS Questions	
Getting Needed Care and Getting Care Quickly	In the last 6 months, how often was it easy to get the care, tests or treatment you needed?	**Best Practices** – Ensuring patients have an appointment as needed based on assessment of their need to obtain care – Following up with patients to ensure they are able to schedule an appointment with specialist – Ensuring they have appointments available for patients that need urgent care – Offering patients a possible appt due to a cancellation – Offering patients a telehealth appt if office has capability – Ensuring access and availability standards are met – Monitoring time spent in waiting and exam rooms – Notifying patients if there is a delay in seeing their provider
	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	
	In the last 6 months, when you needed care right away, how often did you get care as soon as needed?	
	In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?	
	Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	

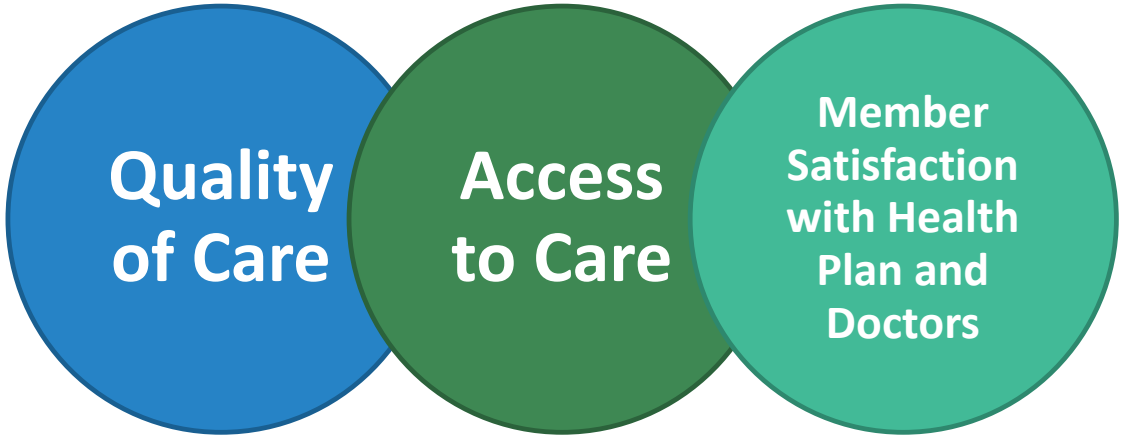
CAHPS FOCUS

Domain	CAHPS Questions	
How well Doctors Communicate	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	**Best Practices:** - Ensure patients understand the information provided to them and their next steps – Follow-up with patients for any questions or concerns they may have – Following up with patients to ensure they have the appointments, results needed – Offering patients a telehealth appt if office has capability – Ensuring appointments are scheduled to provide enough time for patients questions – Monitoring time spent in waiting and exam rooms – Notifying patients if there is a delay in seeing their provider
	In the last 6 months, how often did your personal doctor listen carefully to you?	
	In the last 6 months, how often did your personal doctor show respect for what you had to say?	
	In the last 6 months, how often did your personal doctor spend enough time with you?	

What is HEDIS®?

HEDIS = **H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et

- There are over 90 HEDIS® measures that compare performance in these areas:



Widely used set of performance measures to assess the quality of healthcare, based on clinical practice guidelines

- Plans that report HEDIS results enroll 191 million members
- HEDIS data is used to calculate national benchmarks

Key Medicare HEDIS® Measures

MEDICARE HEDIS MEASURES

(OMW) Bone Mineral Density Testing	(COL) Colorectal Cancer Screen	(EED) Eye Exam for Member with Diabetes	(HBD) Hemoglobin A1c test result ≤9	(FMC) Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions
(CBP) Controlling Blood Pressure <140/90 - Hypertension	(BCS) Breast Cancer Screen - Mammogram test	Medication Adherence • Blood Pressure • Diabetes • Statins	Statin Therapy for Patients with Cardiovascular Disease	Statin Use in Persons with Diabetes
	(TRC) Transitions of Care • (MRP) Medications Reconciliations Post Discharge • Patient Engagement after Inpatient Discharge	**Care of Older Adult – Medication List and Review (Special Needs Plan members only)**	Care of Older Adult – Pain Screening (Special Needs Plan members only)	

Breast Cancer Screening (BCS)

Population: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Criteria: One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year

Tips: Make sure to offer breast cancer screenings when scheduling other services

CONTROLLING BLOOD PRESSURE (CBP)

Population: Patients 18 to 85 years old who had a diagnosis of hypertension.

Criteria: Most recent controlled BP (<140/90) during the measurement year

Tips:

- A blood pressure reading can be collected via telehealth visits, and it does not require a remote monitoring device to be the source
- You are encouraged to re-take BP readings if the reading is >140/90 mm Hg

HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES (HBD)

Population: Patients 18 to 75 years old diagnosed with diabetes (type 1 and 2)

Criteria: Patients whose most recent HbA1c was at the following levels during the measurement year:

- HbA1c control (<8.0%)
- HbA1c poor control (>9.0%)

MEDICATION ADHERENCE

Medication Adherence consists of three measures:

- Diabetes
- RAS (hypertension)
- Statins (cholesterol)

Population: Patients who filled the same type of medication two or more times during the measurement year

Criteria: Patients must be adherent with their medications. Medication Adherence is defined as 80% proportion of days (PDC) covered in the calendar year:

Tips:

- Write 90-day prescriptions
- Encourage patients to use mail-order pharmacy
- Perform medication reviews at every visit
- Correct medication dosage and frequency

Wellcare Medicare 2023 P4Q

Wellcare Medicare Provider Portal
866-592-5832 M-F 7a-5p CST
https://provider.wellcare.com

Wellcare Medicare P4Q New in 2023

- Increased base payments by $20 to $40 a measure
- Removed 3-, 4- & 5-STAR target performance
- Added a 50% bonus increase by achieving an aggregate STAR rating of 4.0 or higher across HEDIS and pharmacy measures
- Provider obtains a base rate for every member who completes a measure
- First three payments will reflect base level. Final true-up payment the following year (2nd or 3rd quarter) will reflect any earned bonus amounts on HEDIS & pharmacy measures
- All claims, encounters, and data submissions must be received by 1/31/24 to be eligible for incentives

See attached booklet for more information

2023 Partnership for Quality

wellcare

Wellcare understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because Wellcare recognizes these important partnerships, we are pleased to offer the 2023 Partnership for Quality (P4Q) Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

The P4Q Program includes a bonus enhancement to better align payment with quality. **Providers can now potentially earn a 50% bonus increase by achieving an aggregate STAR Rating of 4.0 or higher across HEDIS® and Pharmacy measures.**

Program Measures	Amount Per
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$50
Diabetes – Dilated Eye Exam	$40
Diabetes HbA1c <= 9	$50
COA – Care for Older Adults – Pain Assessment*	$25
COA – Care for Older Adults – Review*	$25
COL – Colorectal Cancer Screen	$50
FMC – F/U ED Multiple High Risk Chronic Conditions	$40
Medication Adherence – Blood Pressure Medications	$50
Medication Adherence – Diabetes Medications	$50
Medication Adherence – Statins	$50
OMW – Osteoporosis Management in Women Who Had Fracture	$50
SPC – Statin Therapy for Patients with CVD	$50
SUPD – Statin Use in Persons With Diabetes	$50
TRC – Medication Reconciliation Post Discharge	$25
TRC – Patient Engagement after Inpatient Discharge	$25

Special Needs Plan (SNP) members only

APPOINTMENT AGENDAS FOR WELLCARE, MERIDIAN & AMBETTER

The CoC program is designed to support outreach **Appointment Agendas for Wellcare, Meridian & Ambetter** to members for annual visits and condition management, which helps to identify members eligible for case management.

- ✓ Providers earn bonus payments for proactively coordinating preventative medicine and for thoroughly addressing patients' current conditions to improve health and clinical quality of care.
- ✓ ***This is a claims-based program.*** Members need to be assessed during the year by their PCP, along with a claim submitted to support the provider's assessment.
- ✓ Bonuses are paid per NPI for each completed agenda (disease condition/continuity of care portion only) with verified/documented diagnoses.
- ✓ Refer to each line of business program manual for specific terms and conditions

APPOINTMENT AGENDAS CONTINUED

Eligible providers and members are loaded into the CoC dashboard on the Secure Provider Portal.

Members included in the program are those with disease conditions that need to be assessed year over year.

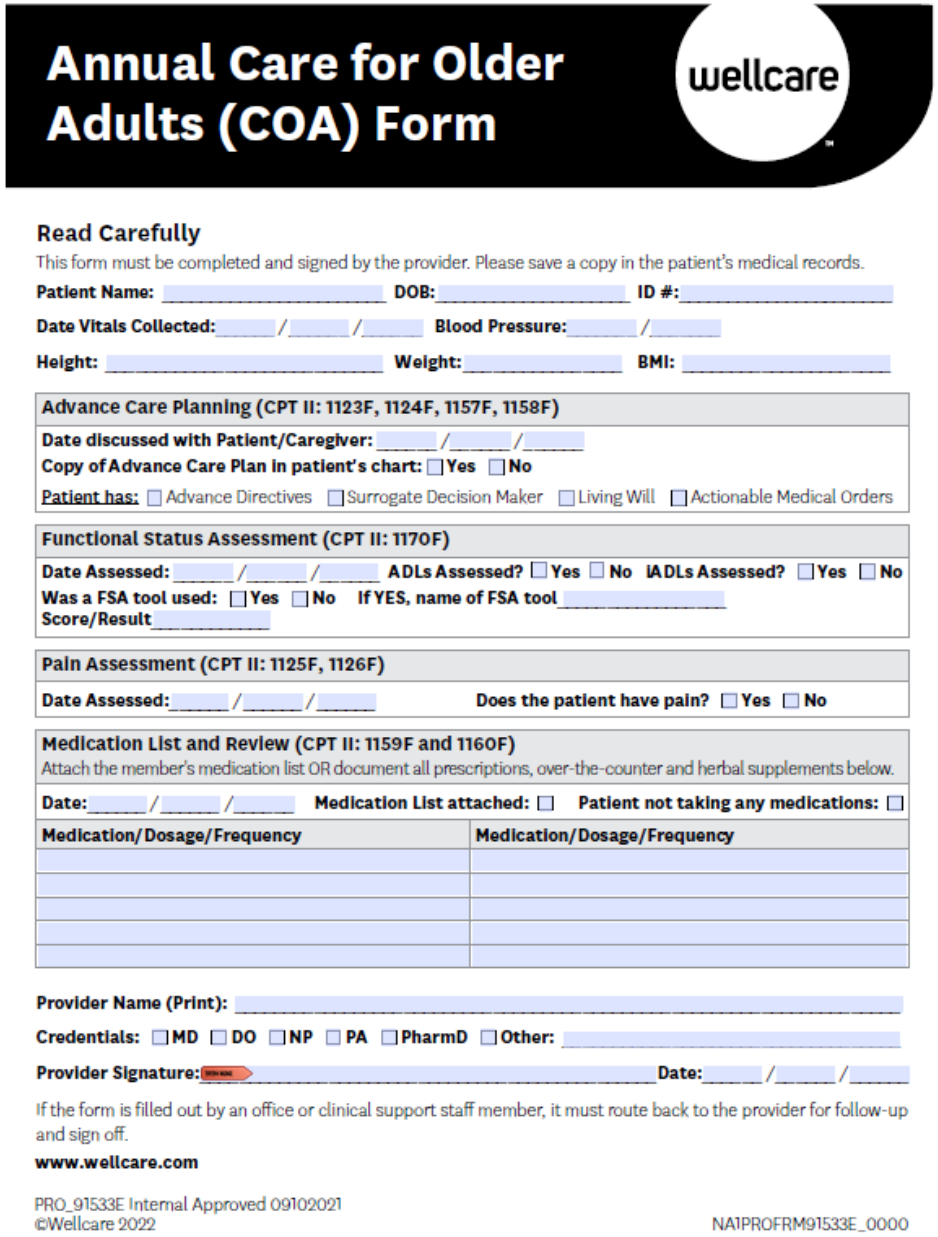
Member’s selection are identified at the beginning of the program and are subject to change in future programs.

Incremental additions due to new members into the health plan and member moves may contribute to the adds, deletes, and changes to the agendas during the program year.

Assessed member is defined as 100% of the gaps are addressed (through a medical claim or checking the exclusion box on the dashboard).

OLDER ADULT ASSESSMENT FORM

- ✓ Patient Demographics
- ✓ Advanced Care Planning
- ✓ Functional Assessment
- ✓ Pain Assessment
- ✓ Medication List and Review
- ✓ Provider Signature (can be electronic)



Annual Care for Older Adults (COA) Form

wellcare

Read Carefully

This form must be completed and signed by the provider. Please save a copy in the patient's medical records.

Patient Name: _____ **DOB:** _____ **ID #:** _____

Date Vitals Collected: ____/____/____ **Blood Pressure:** ____/____

Height: _____ **Weight:** _____ **BMI:** _____

Advance Care Planning (CPT II: 1123F, 1124F, 1157F, 1158F)

Date discussed with Patient/Caregiver: ____/____/____

Copy of Advance Care Plan in patient's chart: ☐ **Yes** ☐ **No**

Patient has: ☐ Advance Directives ☐ Surrogate Decision Maker ☐ Living Will ☐ Actionable Medical Orders

Functional Status Assessment (CPT II: 1170F)

Date Assessed: ____/____/____ **ADLs Assessed?** ☐ **Yes** ☐ **No** **IADLs Assessed?** ☐ **Yes** ☐ **No**

Was a FSA tool used: ☐ **Yes** ☐ **No** **If YES, name of FSA tool** _____

Score/Result _____

Pain Assessment (CPT II: 1125F, 1126F)

Date Assessed: ____/____/____ **Does the patient have pain?** ☐ **Yes** ☐ **No**

Medication List and Review (CPT II: 1159F and 1160F)

Attach the member's medication list OR document all prescriptions, over-the-counter and herbal supplements below.

Date: ____/____/____ **Medication List attached:** ☐ **Patient not taking any medications:** ☐

Medication/Dosage/Frequency	Medication/Dosage/Frequency

Provider Name (Print): _____

Credentials: ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** ☐ **PharmD** ☐ **Other:** _____

Provider Signature: _____ **Date:** ____/____/____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.

www.wellcare.com

PRO_91533E Internal Approved 09102021
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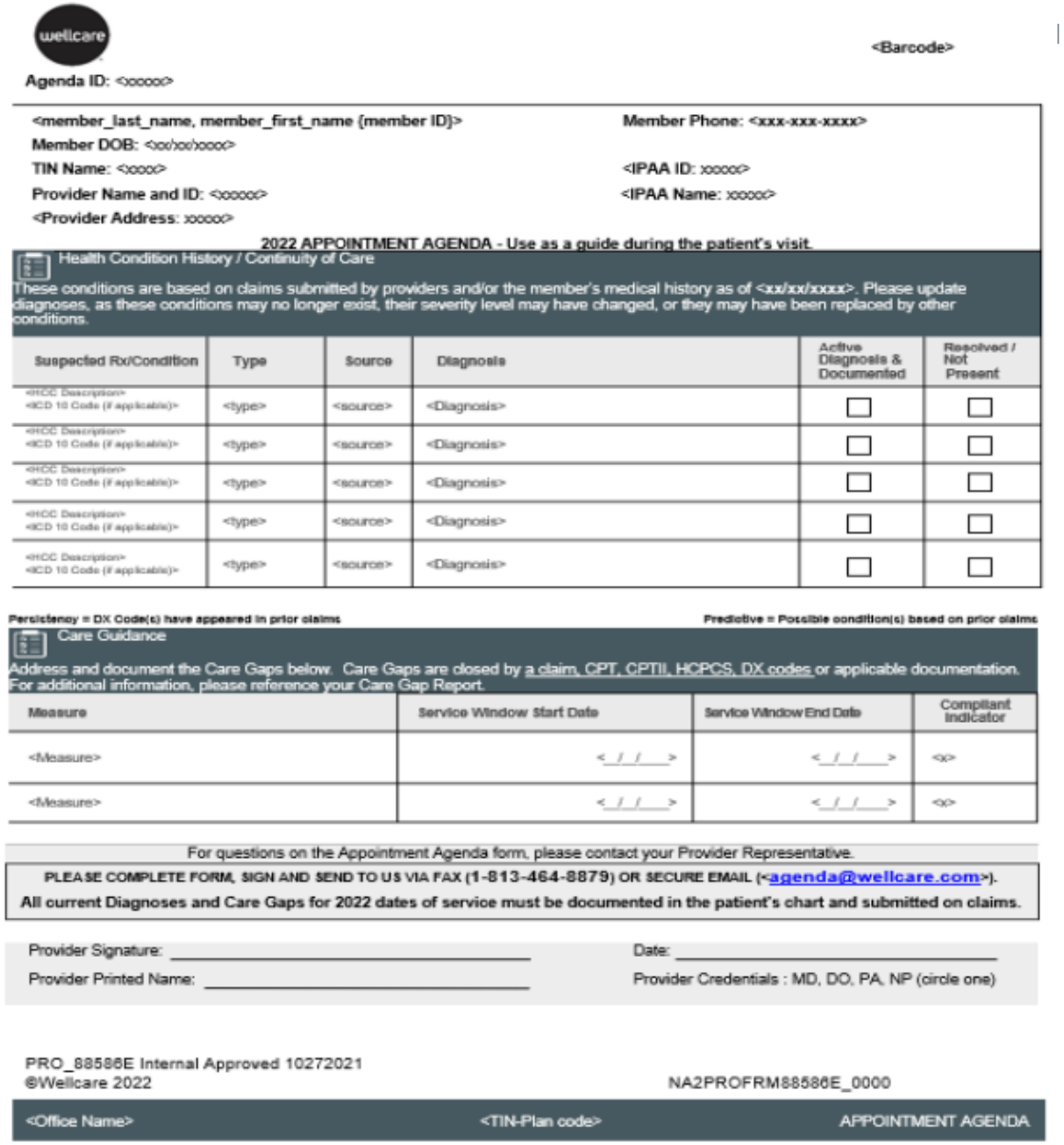
Example of PDF agenda submission

These agendas can be faxed to: 1-813-464-8879 or securely emailed to: agenda@centene.com

Schedule and conduct a comprehensive exam with the patient using the Appointment Agenda as a guide, assessing the validity of each condition on the agenda.



wellcare

<Barcode>

Agenda ID: <xxxxx>

<member_last_name, member_first_name (member ID)>
Member DOB: <xx/xx/xxxx>
TIN Name: <xxxx>
Provider Name and ID: <xxxxx>
<Provider Address: xxxxx>

Member Phone: <xxx-xxx-xxxx>
<IPAA ID: xxxxx>
<IPAA Name: xxxxx>

2022 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 <xx/xx/xxxx>. 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
<HCC Description><ICD 10 Code (if applicable)>	<type>	<source>	<Diagnosis>	☐	☐
<HCC Description><ICD 10 Code (if applicable)>	<type>	<source>	<Diagnosis>	☐	☐
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<HCC Description><ICD 10 Code (if applicable)>	<type>	<source>	<Diagnosis>	☐	☐
<HCC Description><ICD 10 Code (if applicable)>	<type>	<source>	<Diagnosis>	☐	☐

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	Service Window Start Date	Service Window End Date	Compliant Indicator
<Measure>	<__/__/____>	<__/__/____>	<y>
<Measure>	<__/__/____>	<__/__/____>	<y>

For questions on the Appointment Agenda form, please contact your Provider Representative.

PLEASE COMPLETE FORM, SIGN AND SEND TO US VIA FAX (1-813-464-8879) OR SECURE EMAIL (<agenda@wellcare.com>).

All current Diagnoses and Care Gaps for 2022 dates of service must be documented in the patient's chart and submitted on claims.

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider Credentials : MD, DO, PA, NP (circle one)

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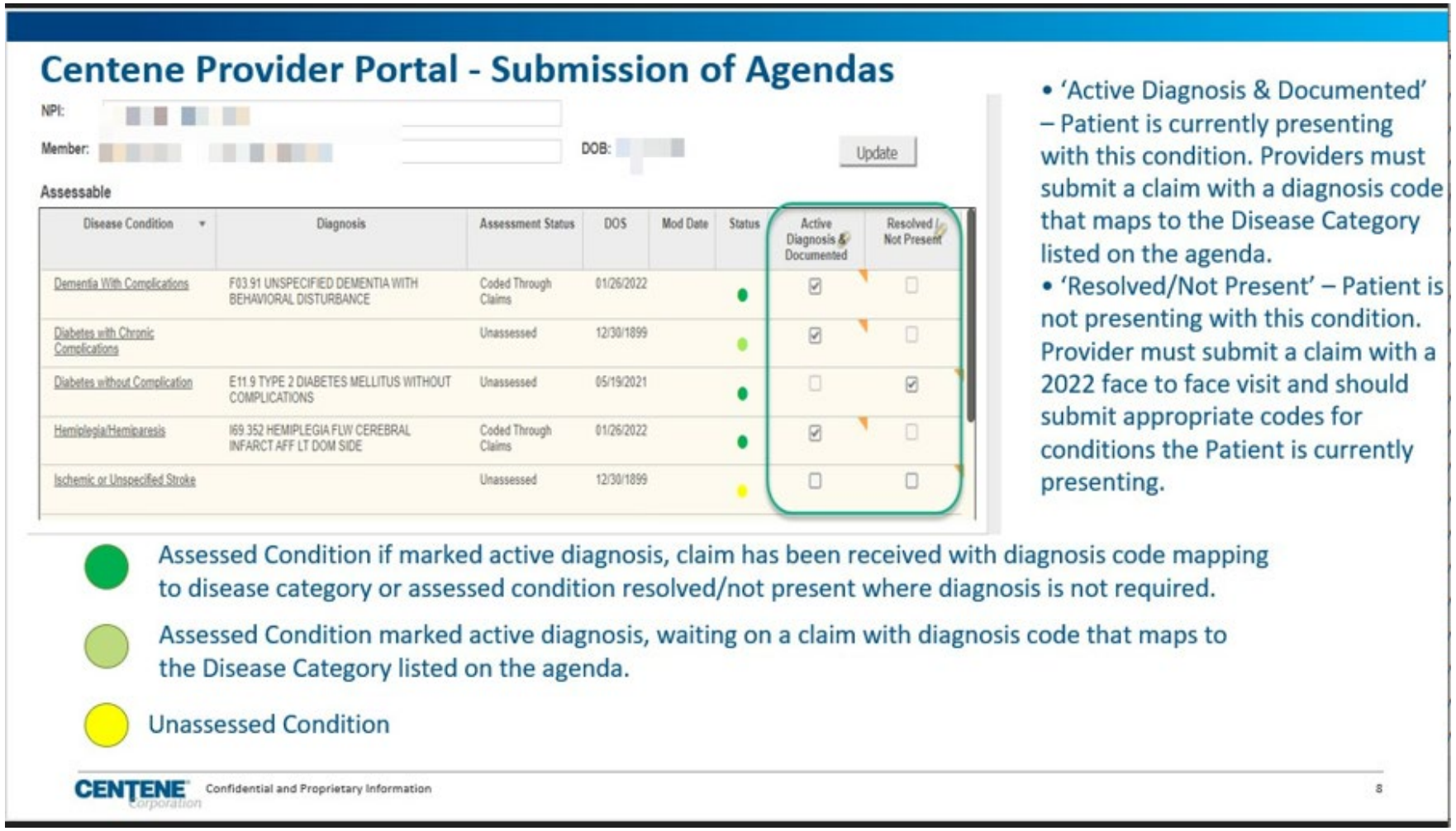
<Office Name> <TIN-Plan code> APPOINTMENT AGENDA

EXAMPLE OF CENTENE PORTAL AGENDA SUBMISSION



Threshold % of AAs completed per NPI	Medicare bonus p/agenda-includes $100 additional bonus	Medicaid bonus p/agenda
< 50%	$200	$100
≥ 50% to < 80%	$300	$200
≥ 80%	$400	$300

COMMERCIAL AND MEDICAID MCOS

Check with ALL of your payers to ensure enrollment in the quality program they offer.

There is often NO enrollment, just registration on Quality Website.

Provider representatives are usually eager to help.

FORECAST BEYOND 2023

Value-Based Program Revenue will become and increasingly urgent source of revenue, and ultimately a matter of survival.

WELLCARE QUALITY RESOURCES

For additional information on specific HEDIS® measures, see Quick Reference Guide (QRG):

IL Meridian Health Plan https://ilmeridian.com/providers/resources/quality-improvement.html

Wellcare wellcare.com/Illinois/Providers/Medicare/Quality

YouthCare ilyouthcare.com/content/dam/centene/meridian/il/pdf/YouthCare2022-HEDIS-QRG-R4_Final.pdf

Email ILHEDISOps@mhplan.com

RESOURCES

"What are Value Based Payment Programs". www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html. Centers for Medicare and Medicaid Services. 07/16/2019. Accessed 5.23.2023.

Quality Measures Reporting. www.healthit.gov/topic/federal-incentive-programs/MACRA/MIPS/quality-measures-reporting. 2.12.2019. Accessed 5.23.2023

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