Quality & Incentives

Thank you for joining us today.
We'll start momentarily.

If you haven't already, please call into the webinar to hear us speak. Your phone will automatically be set to mute.

Conference Number: **(855) 351-5537**
Conference Code: **7413903784**

You can ask us questions via the 'Chat' feature, but please hold your questions until the end of the presentation. If we run out of time before we get to your question, please email us at **Contact_Us_Provider_AR@centene.com**

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Quality & Incentives

Quarterly Provider Webinar
June 15, 2017

AGENDA

1. Quality Improvement
    1. HEDIS
    2. Quality Improvement Programs
2. Member & Provider Incentives
3. Primary Care Physician Auto Assignment
4. Primary Care Physician Reports
5. Provider Data Accuracy
6. Physician Assistants
7. Important Reminders
    1. Same Day Wellness and Sick Visit
    2. Pre-Auth Needed Tool
    3. Clinical and Payment Policies
8. Contact Information
9. Questions

Quality Improvement

HEDIS

What is **HEDIS**?

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows a comparison of quality across health plans. This gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

Through HEDIS, NCQA holds Arkansas Health & Wellness accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership. Arkansas Health & Wellness also reviews HEDIS rates regularly as part of its quality improvement efforts.

What are **HEDIS** scores used for?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS rates to evaluate health insurance companies' efforts to improve preventive health outreach for members.

Physician-specific scores are also used to measure your practice's preventive care efforts. Your practice's HEDIS score determines your rates for physician incentive programs that pay you an increased premium — for example Pay For Performance or Quality Bonus Funds.

HEDIS Measures

What are the **HEDIS** measures?

HEDIS measures fall in to three categories:

1. Adult Health
2. Women's Health
3. Pediatric Health

You can find detailed HEDIS Guidelines on our website under the Quality Improvement section of the For Provider tab. The guidelines include detailed code information related to each measure.

Sample measure

DIABETES CARE *(Comprehensive)*

Measure demonstrates the percentage of members ages 18-75 with diabetes (types 1 & 2) who were compliant in the following submeasures:

HbA1c Test: is completed at least once per year (includes rapid A1c).

CPT	CPT II	HCPCS
83036, 83037	—	—

Eye Exam: a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) is completed every year OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior. CPT II code 3072F reflects a dilated retinal exam negative for retinopathy.

67028, 67030, 67031, 67036, 67039-67043, 67101, 67105,67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F, 2024F, 2026F, 3072F	S0620, S0621, S0625, S3000

Nephropathy Screening Test: is performed at least once per year. A member who is on ACE/ARBs or has nephropathy is compliant for this submeasure.

82042, 82043, 82044, 84156, 81000, 81001, 81002, 81003, 81005	3060F, 3061F, 3062F	—

HEDIS

What can the provider do to improve **HEDIS** scores?

Providers play a central role in promoting the health of our members. You and your staff can help facilitate the HEDIS process improvement by:

- Providing appropriate care within the designated timeframes
- Documenting all care in the patient's medical record
- Submit claim/encounter data for each and every service rendered, regardless of contract status
- Ensure that claim/encounter data is submitted in an accurate and timely manner
- Code to the highest specificity
- Consider including CPT II codes to provide additional data and reduce medical record requests
- Responding to our requests for medical records within the requested timeframe

Quality Improvement Programs

What programs do we offer to improve quality?

- Member Connections Representatives
- Disease Management
- Start Smart OB Case Management
- Pharmacy Program
  - Pharmacy Lock-In Program
- Medication Adherence Program
- Reduce Emergency Room visits

Member & Provider Incentives

Member Incentives

In addition to provider incentives for closing care gaps, performing wellness visits, or being identified as PCMH or CPC+, Ambetter from Arkansas Health and Wellness also offers members rewards dollars for completing healthy behaviors through the My Health Pays Program.

Members have the ability to earn up to $200 on their My Health Pays reward card for activities such as:

- Completing an Ambetter Wellbeing survey during the first 90 days of their membership
- Getting an annual wellness exam with their PCP provider
- Receiving their annual flu shot

Members can use reward dollars to help pay for:

- Utilities (gas, water, electric)
- Telecommunications (phone bill)
- Health-related costs such as monthly premium payments, medical copays, deductibles and coinsurance

Pay for Performance (P4P) Incentive Program

Ambetter offers a Pay for Performance (P4P) Incentive Program. This program rewards the provider for ensuring that their Ambetter patients receive preventive services according to clinically recommended schedules and for helping with the management of their chronic conditions. This is an opportunity for additional reimbursement with no downside to you.

Program Details:

- This program is only being offered to participating Primary Care Providers.
- As a participating Ambetter PCP, you are automatically enrolled in this program.
- The incentive amount is in addition to the contractual reimbursement you receive for providing services to your Ambetter members.

A recent mailing has gone out to all in network primary care physicians with detailed information on the P4P program. Please contract Provider Services if you did not receive a copy.

Primary Care Physician (PCP) Auto Assignment

Ambetter members are directed to select a participating primary care provider at the time of enrollment. In the event an Ambetter member does not make a PCP choice, Ambetter will select a PCP based on:

1. A previous relationship with a PCP based on claims history. If a member has not designated a PCP within the first 30 days of being enrolled in Ambetter, we will review claims history to determine if a PCP visit has occurred and assign the member to that PCP.
2. Geographic proximity of PCP to member residence. The auto-assignment logic is designed to select a PCP for whom the members will not travel more than the required access standards.
3. Appropriate PCP type. The algorithm will use age, and other criteria to identify an appropriate match, such as children assigned to pediatricians.

Members may change their PCP at any time with the change becoming effective as early as the next business day.

PCP Reports

PCP Reports

- PCP reports, including Patient Lists are available on Ambetter's secure provider web portal and are generated on a monthly basis. The reports can be exported into a PDF or Excel format.

PCP Patient List Includes:

- Patient List that include Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- Members who are flagged for Disease and Case Management

Provider Data Accuracy

Ambetter has partnered with LexisNexis to validate the demographic data we have on file quarterly to ensure accuracy. Providers should have recently received information with instructions on how to log in to the AMA portal and validate your data. Validating through the AMA portal this will allow your edits to be implemented across all Medicare and Marketplace payers who also use the AMA portal.

We validate provider demographic data quarterly for numerous reasons including:

- to help provide our members with accurate information through our Find a Provider tool on the website.
- to allow our members to locate and access the care and services that they are needing from in-network providers.
- to help other providers make referrals and accurately direct their patients' care to in-network practitioners and providers.
- to ensure that payment and other correspondence are received timely, and reduces the potential for delayed or denied payments resulting from inconsistent demographic information
- to ensure that we meet the regulatory standards set by the Centers for Medicare & Medicaid Services.

Physician Assistants

Ambetter from Arkansas Health and Wellness is now recognizing and credentialing Physician Assistants.

If you are currently contracted through a delegated entity, we have reached out to that organization for a complete roster of Physician Assistants that are currently credentialed.

If you are directly contracted with NovaSys Health for the Ambetter product, in order to be a participating practitioner, you will need to complete an Allied Credentialing application.

If you would like to request a copy of the Allied Credentialing application, please contact us at the phone, fax or email listed below.

Credentialing Department
Phone: 1-844-263-2437
Fax: 1-844-357-7890
Email: arkcredentialing@centene.com

Important Reminders

Same Day Well & Sick Visit Guidelines

Multiple E/M codes may be billed on the same claim for visits that occur on the same day.

Example:
A scheduled wellness visit that turns into a (consecutive) sick visit can both be billed on the same claim

To bill for a wellness/preventative care visit, use one of the following procedure/diagnosis codes:

Check the Ambetter Provider Manual for more information regarding use of E/M Modifier 25

Procedure Codes:

99381,99382,99383,99384,99385,99386, 99387,99391,99392,99393,99394,99395, 99396, 99397,99461

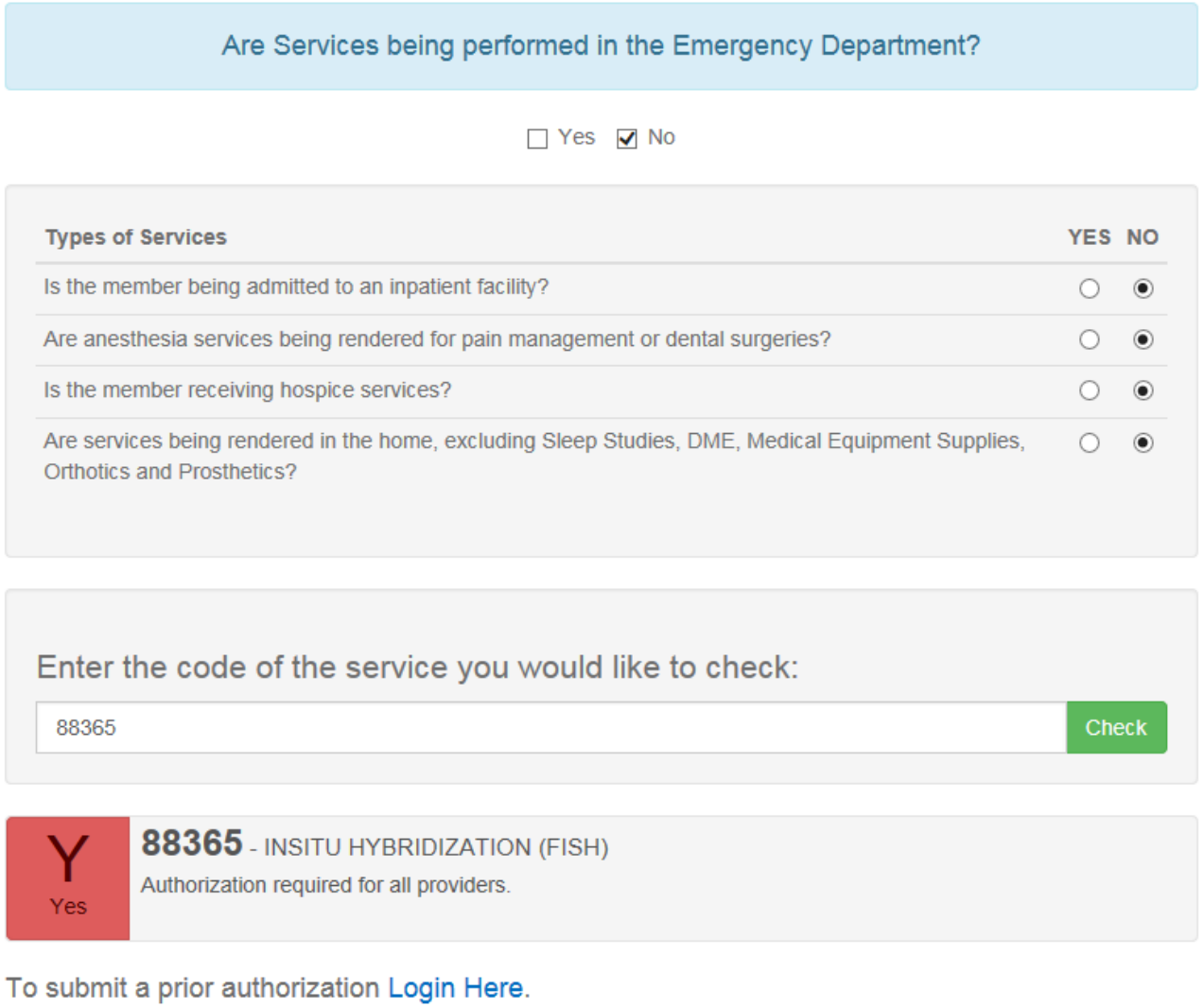
Diagnosis Codes:

V202, V203, V2031, V2032, V700, V703, V705,V706,V708,V709,Z0283,Z0283, Z0271,Z0282,Z0281,Z024,Z025,Z022, Z005,Z023,Z029,Z00111,Z008,Z026, Z00110,Z00121,Z020,Z021,Z00129, Z0001,Z0000,Z0279,Z0289

Important Reminders

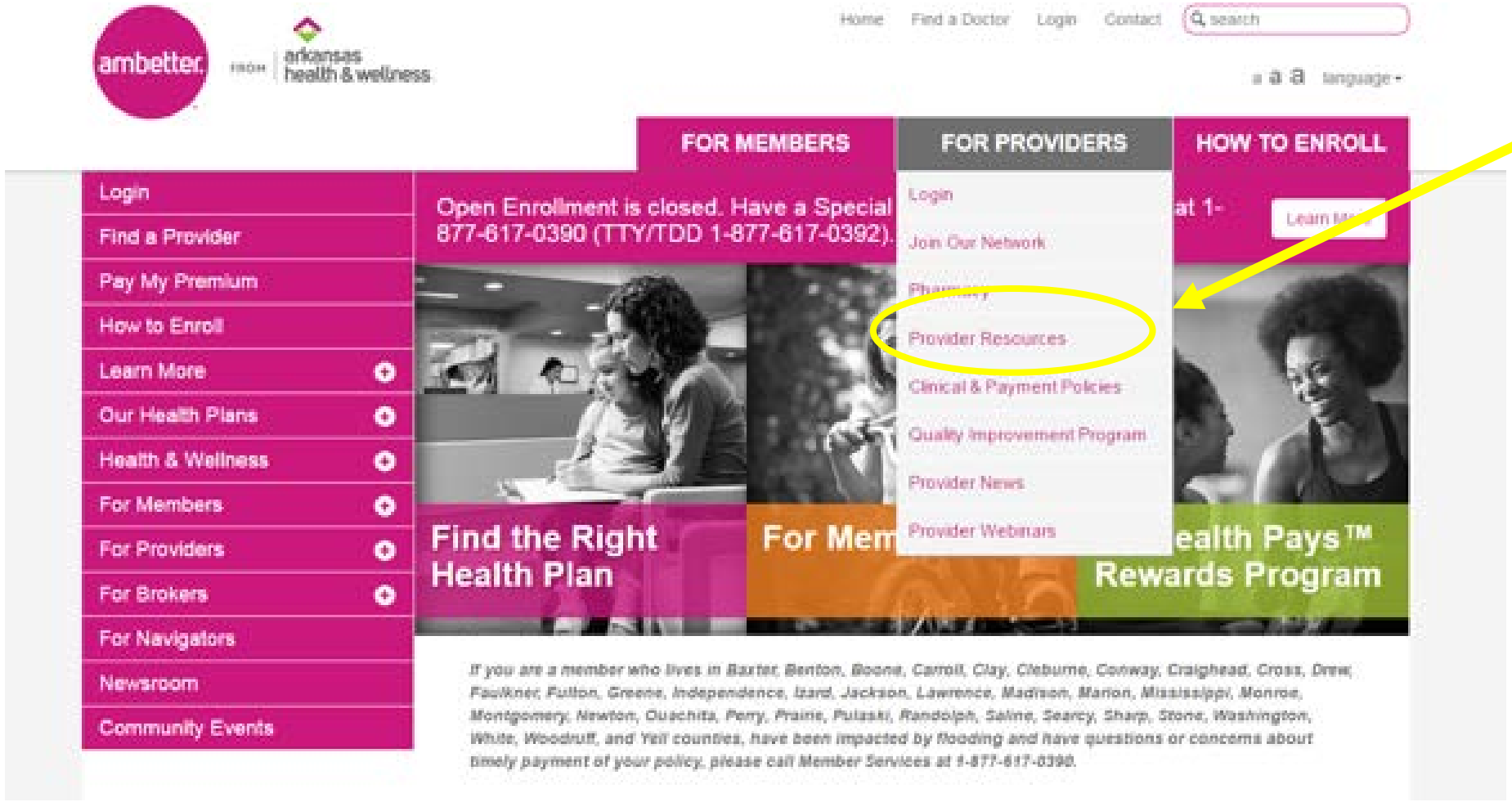
Pre-Auth Needed Tool

- All authorizations are done at the procedure code level. The Pre-Auth Needed tool is found on the public website and does not require a login to use.



Important Reminders

Clinical and Payment Policies



- Clinical and Payment policies are also located on the public website.

Contact Information

Ambetter from Arkansas Health and Wellness

Provider Services
Phone: 1-877-617-0390
TTY/TDD: 1-877-617-0392

Credentialing
Phone: 1-844-263-2437
Fax: 1-844-357-7890
Email: arkcredentialing@centene.com

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Questions?

Please submit any additional questions using ‘Provider Webinar” in the subject line to Contact_Us_Provider_AR@centene.com
Thank you.