Continuity of Care (CoC) and CoC+ Provider Programs

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- The presentation is a general summary that explains certain aspects of the program but is not a legal document.
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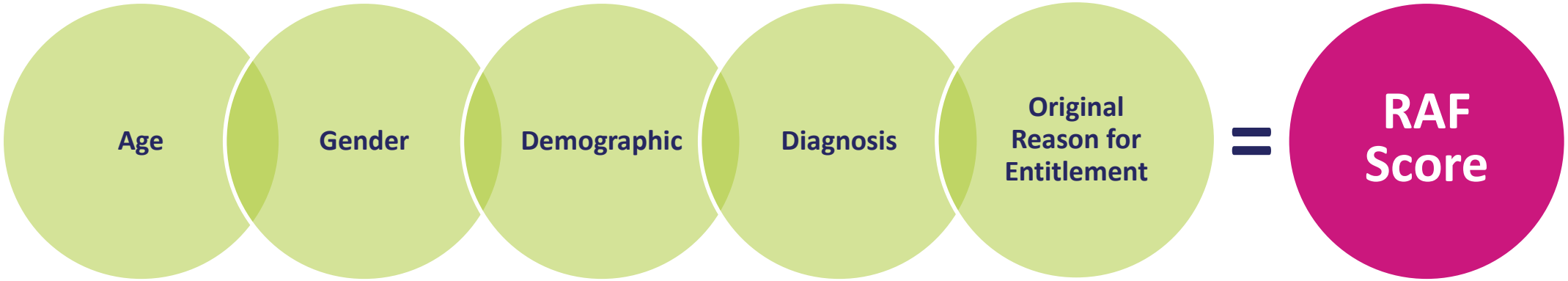
Introduction to Risk Adjustment

Risk Adjustment Overview

Risk adjustment is a tool used to predict the likely use and cost of healthcare based on an individual's risk factors, including:

- Age
- Gender
- Community status
- Severity of health conditions



Importance of Risk Adjustment

Identify actual disease burden of member and patient population

Improved quality of care through disease management programs

Ensure coverage of health expenditures and appropriate risk premiums

Hierarchical Condition Categories (HCCs)

- HCCs reflect hierarchies among related disease categories.
- Only the most severe HCC within a hierarchy is calculated in RAF.
- HCCs captured from unrelated diagnoses are cumulative.

- CMS determines the qualifying ICD-10 diagnosis codes for each category and assigns the risk factor value.
- Not all diagnoses map to an HCC.
- Some diagnoses map to multiple HCCs.

ICD-10-CM Coding

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Documentation should describe the condition details and include specific diagnoses.

Code all documented conditions that coexist at the time of the visit that require treatment or affect care.

Code to the highest level of specificity supported by the medical record documentation.

Include the appropriate ICD-10 diagnosis code(s) on the claim for the date of service.

MEAT Documentation

M Monitor	Document signs, symptoms, disease progression, and ongoing surveillance of the chronic condition.
E Evaluate	Document current state of chronic condition, physical exam findings, test results, medication effectiveness, and response to treatment.
A Assess	Document discussion of chronic condition, review of records, counseling, how chronic conditions will be managed, and the need for further tests.
T Treat	Document care being offered for chronic condition(s), prescribing or continuing of medications, referring to specialists, ordering diagnostic studies, therapeutic services (therapies), other modalities, and planning for management of chronic condition(s).

Risk Adjustment Documentation Requirements

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- Face-to-face encounter*
- Correct entry for date of service
- Two patient identifiers on every page
- Acceptable provider type
- Proper signature with credentials
- Acceptable service type
- Use of standard abbreviations
- Clear and legible handwriting

*Telemedicine satisfies the face-to-face component. An audio/video visit must be performed and specifically documented for MA plans.

2025 CoC & CoC+ Programs

Risk Adjustment Goals

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1. Assist providers with engaging patients and actively address chronic conditions.
2. Ensure risk-adjusted conditions are coded accurately and documented annually.
3. Develop relationships with provider partners to serve as a resource and assist with strategy to target patients.
4. Increase recapture and assessment rates.
5. Decrease members without visit (MWOV) rates.

2025 Continuity of Care (CoC)

CoC is a claims-based provider engagement program specific to Medicare and Marketplace risk adjustment efforts. The CoC program provides increased visibility of members' health conditions for better quality of care through chronic condition management and prevention.

PCPs can earn $400–$450 per member* for proactively coordinating preventive medicine and thoroughly assessing patients' health conditions.

The 2025 CoC program launches February 12 and runs through December 31.

Incentive Eligibility Requirements

Providers within the assigned TIN must:

- Complete a qualified visit with the member during the program year (January–December)
- Address patient conditions at the point of care, utilizing the appointment agenda
- Include ICD-10 code(s) for all active conditions (supported in the medical record) on the claim for DOS
- Submit completed agenda with 100% of conditions assessed

2025 CoC Provider Incentives

CoC Program Incentive Earning Potential | For completed Medicare & Marketplace agenda submissions for 2025 dates of service January–December

THRESHOLD PERCENTAGE OF APPOINTMENT AGENDAS COMPLETED	BONUS PAID PER PAPER APPOINTMENT AGENDA SUBMISSION	BONUS PAID PER ELECTRONIC APPOINTMENT AGENDA SUBMISSION
<50%	$50	$100
≥50–80%	$100	$200
≥80%	$150	$300

Thresholds are calculated at the company, line of business, and provider levels. Agendas must be completed at 100% and be submitted via portal, fax, or secure email. Comprehensive medical record submissions are not eligible for CoC compensation.

2025 Continuity of Care Plus (CoC+)

- The CoC+ program is a separate incentive program that provides insights specific to Quality reporting.
- Complete additional portions of the appointment agenda to be eligible for additional compensation!

All CoC+ insights must be received by July 1, to be eligible for incentives.

Additional incentive opportunity:

- $150 per Medicare Agenda
- $100 per Marketplace Agenda

- All boxes related to the high risk, care guidance, clinical, and/or drivers of health portions must be checked and verified where applicable.

CoC Insight: Risk Gaps

Risk gaps include **predictive** and/or **persistent** member disease conditions that need to be addressed and documented annually, as clinically appropriate.

Recognize and manage conditions proactively to:

- Help prevent complications
- Reduce likelihood of hospitalizations

CoC+ Insights:

- **High Risk** provides insight to member emergency room (ER) visits and highlights key details such as the visit date, the facility visited, and the diagnosis (DX) from that facility to help to identify and reduce preventable ER visits.
- **Care Guidance** provides insight to Quality/HEDIS® gaps.
- **Clinical** will identify if the member has had a hospital outpatient visit, been prescribed medication, or received specialist services without a PCP visit.
- **Drivers of Health** (or Social Determinates of Health (SDoH)) identify non-medical factors, such as access to transportation, affordable housing, and other social factors, that influence health outcomes.

Appointment Agenda Components

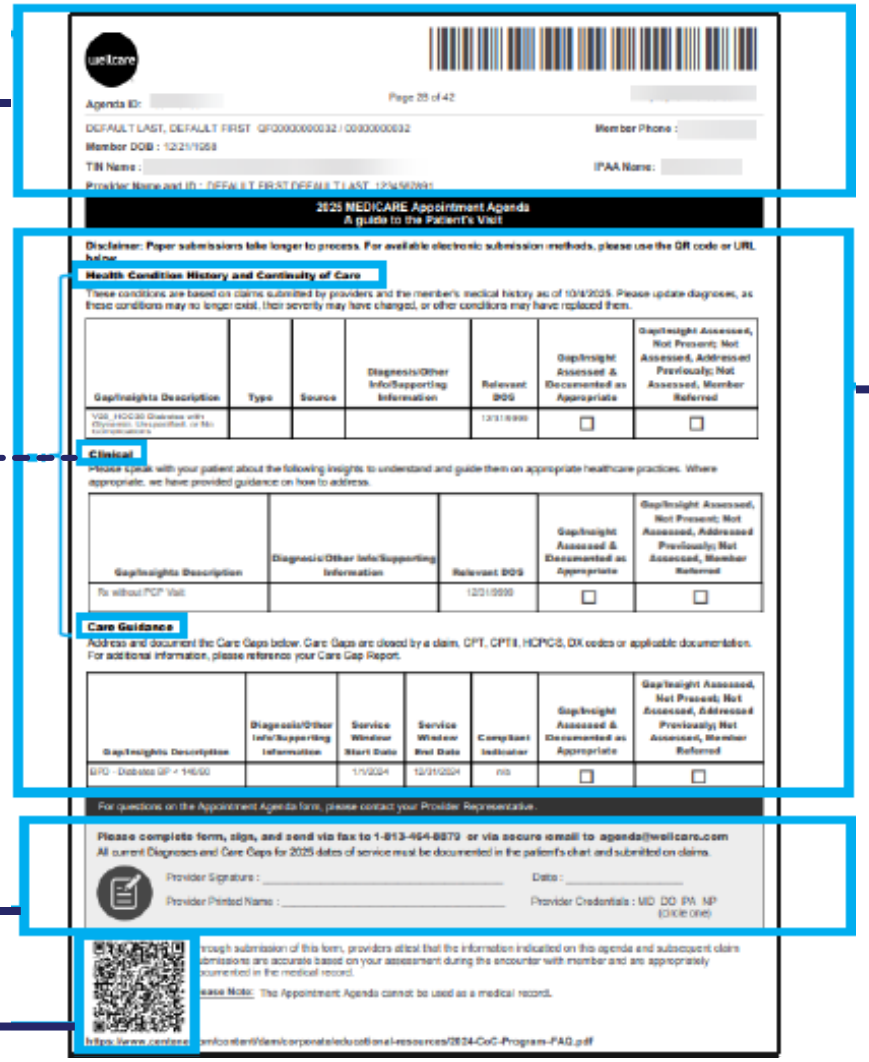
Agenda, member, and provider details

Barcode or No Bonus Eligible
Agendas that have “No Bonus Eligible” where the barcode typically resides in the upper right-hand corner are not eligible for CoC incentives.

Additional headers for member gap and insights

Signature
The signature component may be completed by a credentialed provider or the facilitator of the program.

QR Code
Providers may use the QR code or URL to access additional resources FAQs.



Member Gap and Insight
Insights will vary by line of business. Providers should check one box for each gap/insight category listed on the agenda:

- Gap Assessed and Documented as Appropriate
- Assessed, Not Present
- Not Assessed, Addressed Previously
- Not Assessed, Member Referred

Health Condition History and Continuity of Care
ALL disease categories must have a box checked, verified with a risk-adjustable visit and paid claim, to be eligible for the incentive.

Additional insights are all or nothing as part of the CoC+ program.

	Risk Adjustment	DOH	High Risk	Quality	Clinical (CNC Only)
Medicare	X		X	X	X
Marketplace	X		X	X	X

Program Roles and Responsibilities

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Health Plan Responsibilities

- Introduce the program and guide provider on submission methods.
- Support provider practices through education and engagement to achieve appropriate quality outcomes.

Provider Responsibilities

- Schedule and conduct an exam with the member(s).
- Use the Appointment Agenda as a guide and review all member gaps and insights.
- Submit the completed Appointment Agenda via fax, email, or spreadsheet.
- Submit qualified claim(s) ensuring the corresponding diagnoses supported in medical record.

Agenda Submission via Fax or Email

Fax

Fax completed Appointment Agendas to:
1-813-464-8879.

Please retain copies of all faxed Agendas in case they need to be referenced.

Email

Securely email completed appointment Agenda to:

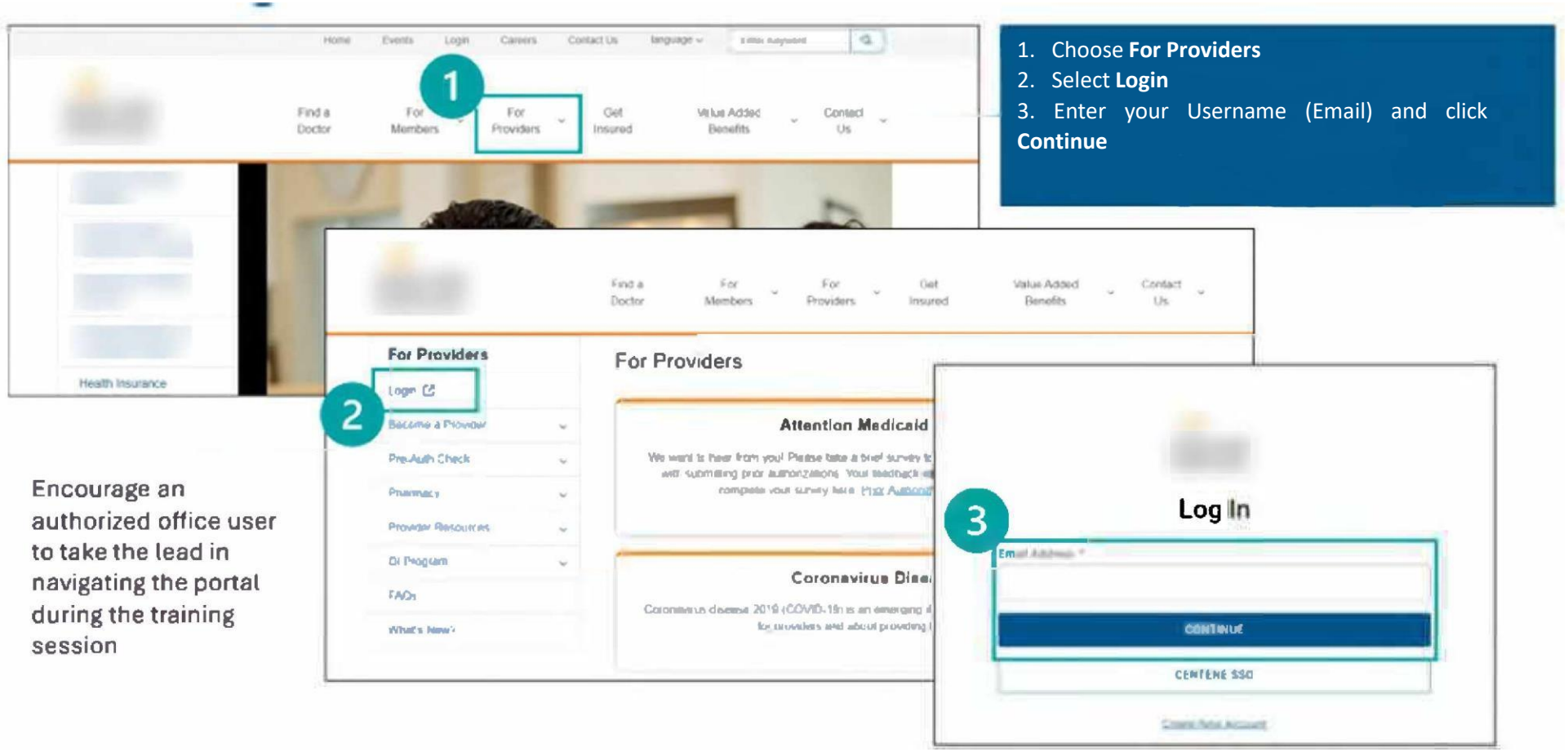
Agenda@wellcare.com

or

Agenda@centene.com

Using the Centene Portal to Complete & Submit Appointment Agendas

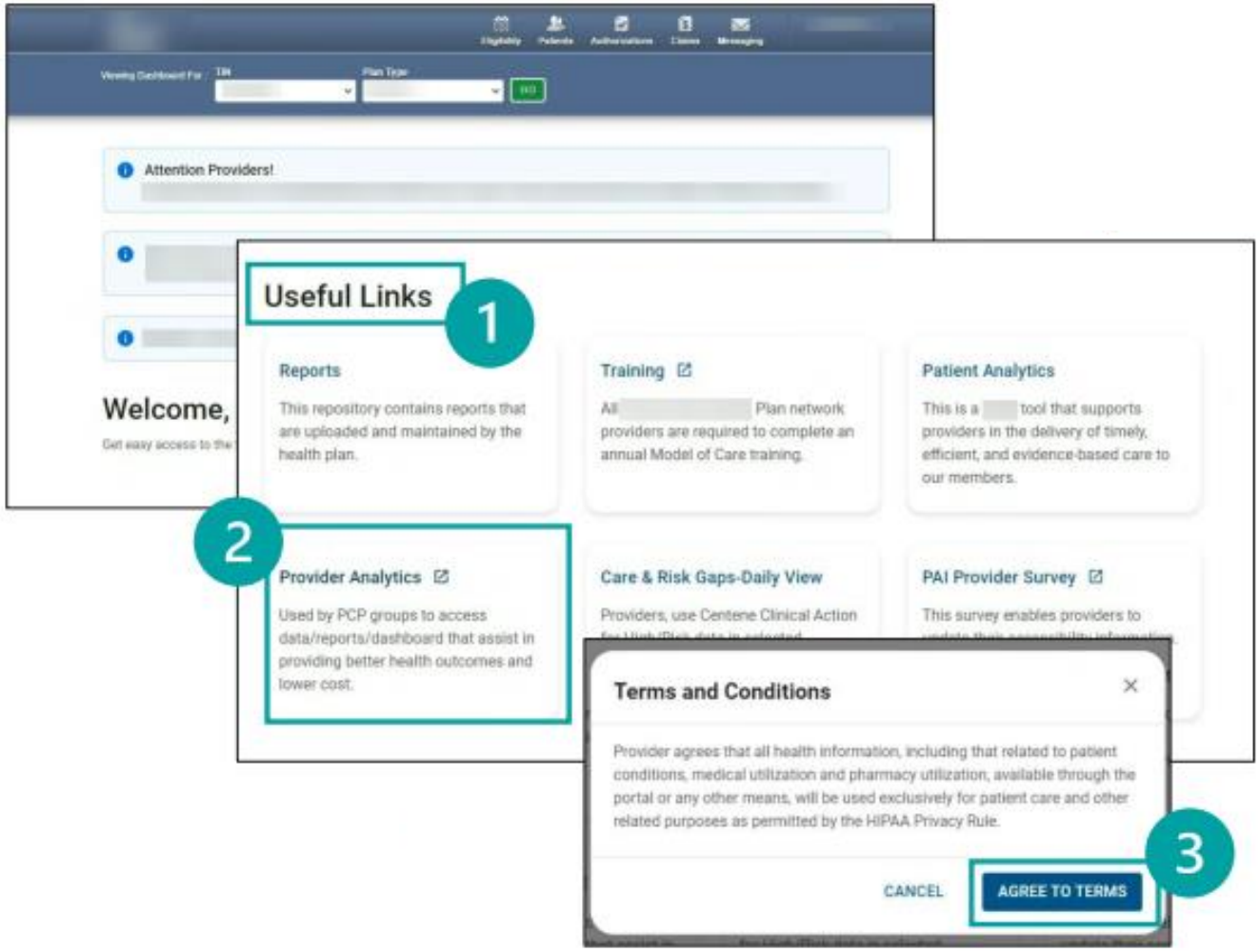
Centene Portal Log In



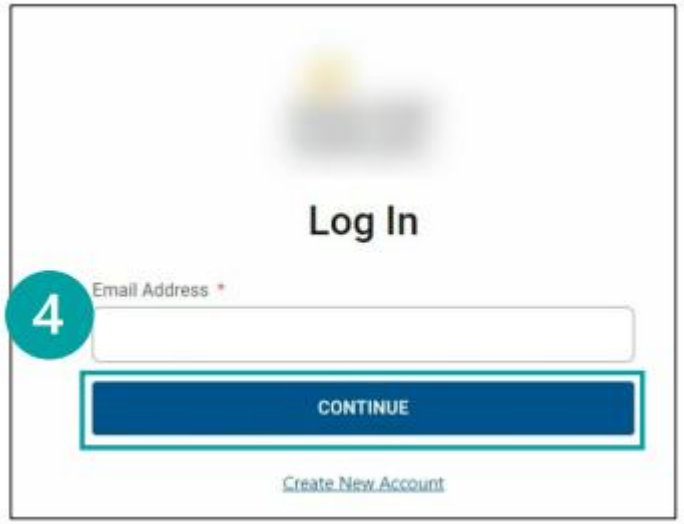
1. Choose **For Providers**
2. Select **Login**
3. Enter your Username (Email) and click **Continue**

Encourage an authorized office user to take the lead in navigating the portal during the training session

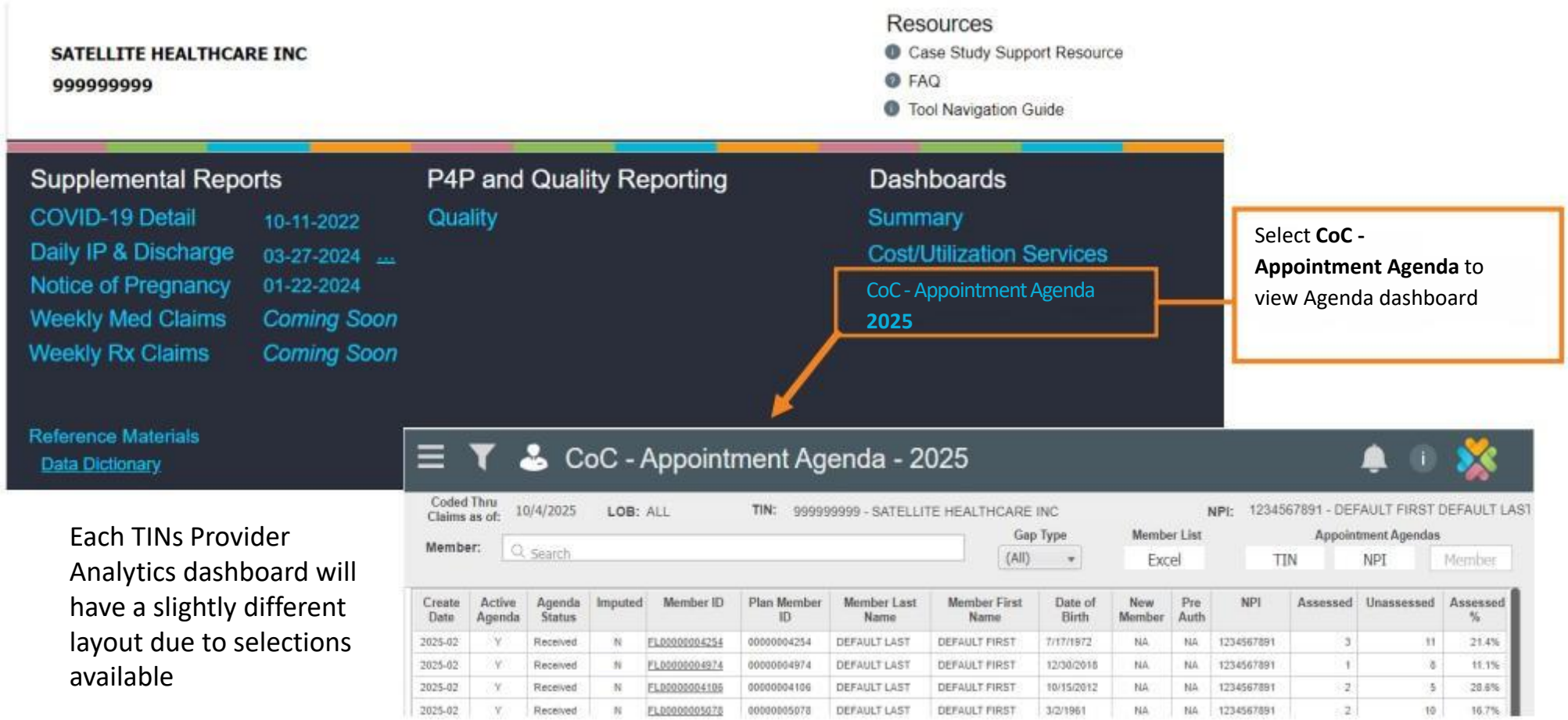
Provider Home Page



1. From the Home page, scroll down to **useful links**
2. Once at useful links, select **Provider Analytics**
3. Terms and conditions box will pop up, **Agree to Terms**
4. Enter your **Username (Email), click** Continue



Dashboards

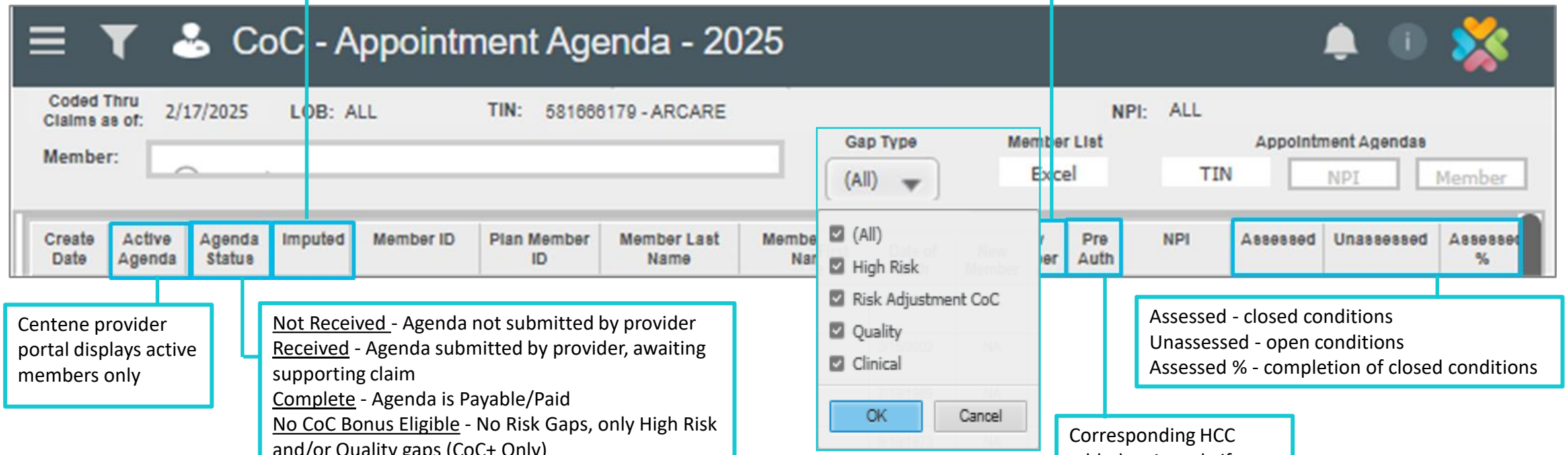


Each TINs Provider Analytics dashboard will have a slightly different layout due to selections available

Appointment Agenda

Imputed Appointment Agendas are created for patients that are seeing a provider outside of their assigned PCP Tax ID

Patients new to Medicare effective January 1st , will have the 11 most prevalent Risk conditions listed on their Agenda, along with any Care Gaps and/or High-Risk gaps



Centene provider portal displays active members only

Not Received - Agenda not submitted by provider
Received - Agenda submitted by provider, awaiting supporting claim
Complete - Agenda is Payable/Paid
No CoC Bonus Eligible - No Risk Gaps, only High Risk and/or Quality gaps (CoC+ Only)
Not CoC Bonus Eligible - Full Risk contract providers

Assessed - closed conditions
Unassessed - open conditions
Assessed % - completion of closed conditions

Corresponding HCC added to Agenda if member has pre-auth for high-cost medication

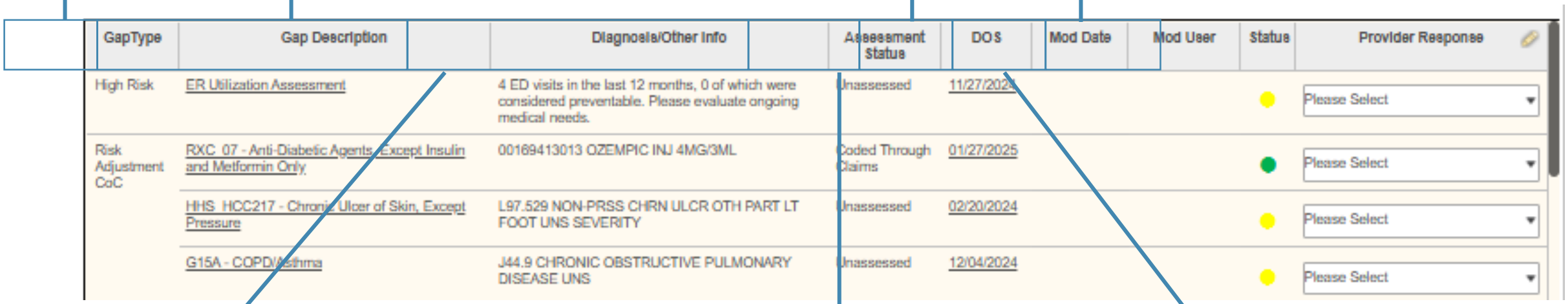
Appointment Agenda

Member Insight Category

Description of Gap Type

Date gap was last billed, if applicable. Dates showing 12/31/9999 are predictive (suspected) conditions. By left clicking on the DOS under the high-risk gap type, providers can view Member details pertaining to the visit.

Provider Portal User who submitted and attested to Appointment Agenda (this could be a name or email address)



GapType	Gap Description	Diagnosis/Other Info	Assessment Status	DOS	Mod Date	Mod User	Status	Provider Response
High Risk	ER Utilization Assessment	4 ED visits in the last 12 months, 0 of which were considered preventable. Please evaluate ongoing medical needs.	Unassessed	11/27/2024				Please Select
Risk Adjustment CoC	RXC_07 - Anti-Diabetic Agents, Except Insulin and Metformin Only	00169413013 OZEMPIC INJ 4MG/3ML	Coded Through Claims	01/27/2025				Please Select
	HHS_HCC217 - Chronic Ulcer of Skin, Except Pressure	L97.529 NON-PRSS CHRN ULCR OTH PART LT FOOT UNS SEVERITY	Unassessed	02/20/2024				Please Select
	G15A - COPD/Asthma	J44.9 CHRONIC OBSTRUCTIVE PULMONARY DISEASE UNS	Unassessed	12/04/2024				Please Select

Last diagnosis code mapping to disease category, if applicable

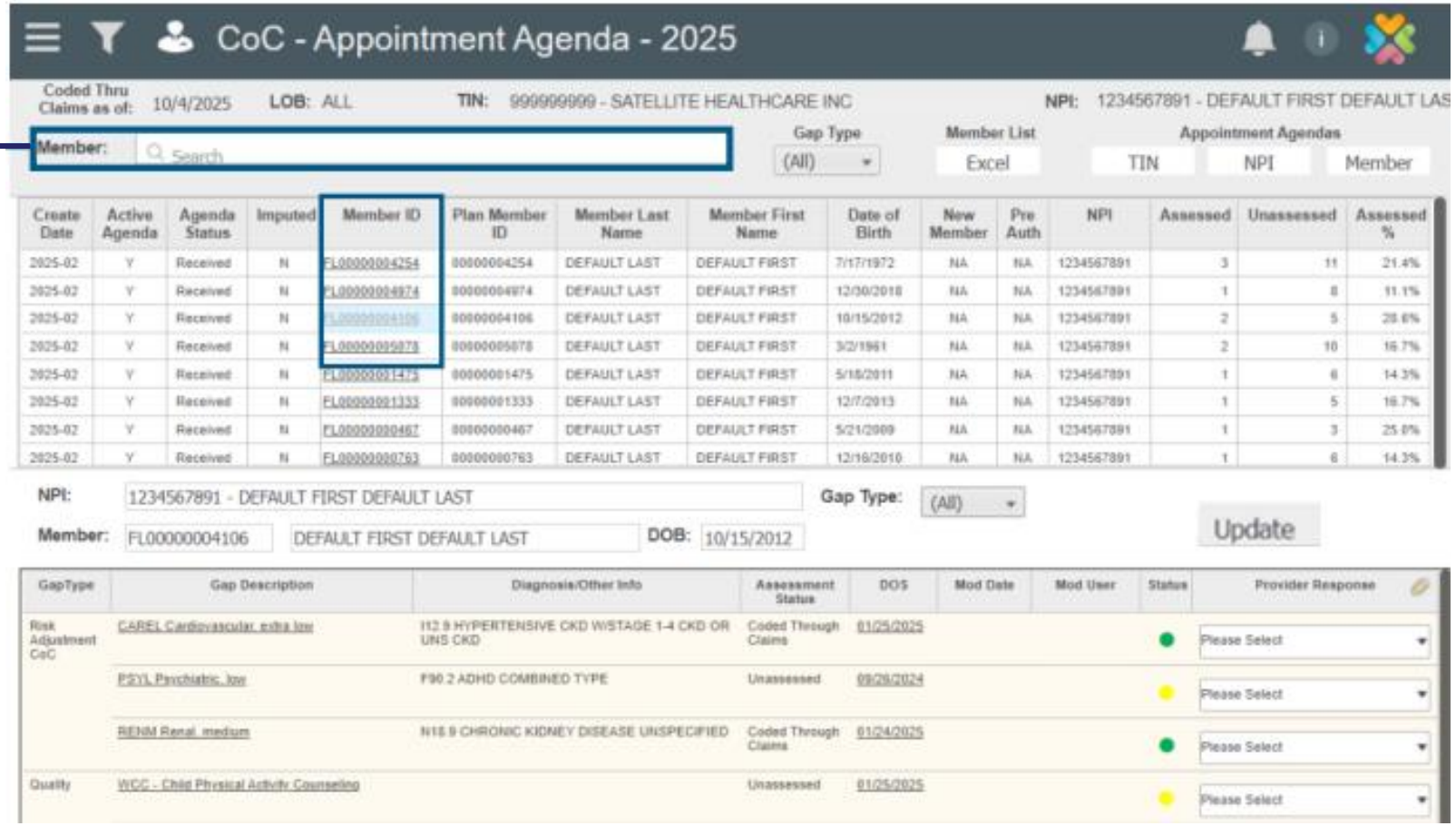
Assessed - Claim has been received with diagnosis code mapping to disease category and condition has been assessed by provider
Unassessed - No mapping diagnosis code to disease condition has been received on claim
Coded Through Claims - Claim has been received with diagnosis code mapping to disease category, condition has not been addressed on Appointment Agenda

Date when boxes were checked

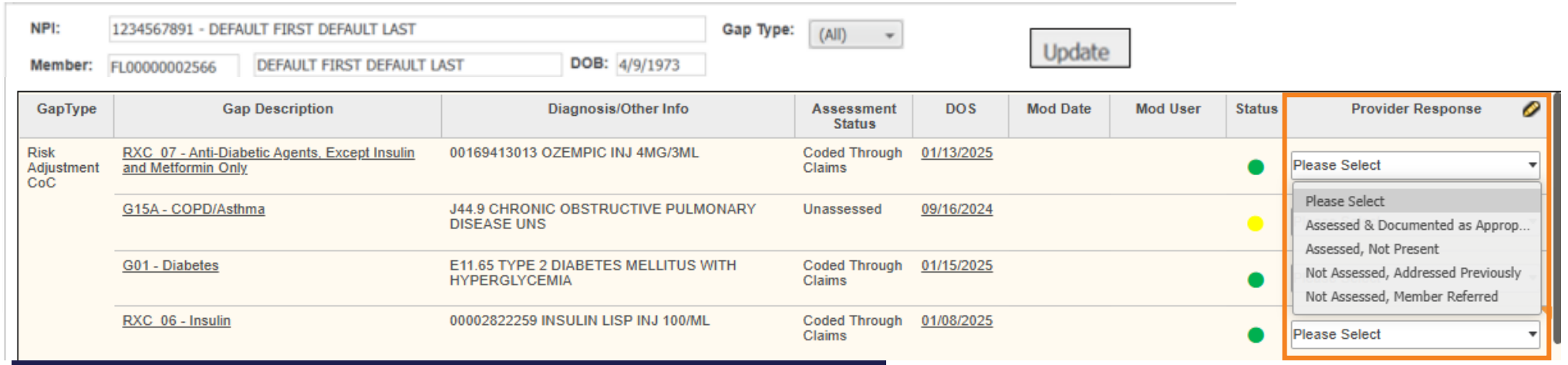
Submission of Agendas

Member can be searched by typing name or Member ID in the Member search box

Clicking on the Member ID hyperlink, under the Member ID column header, will display the Members Risk, Quality, and/or High-Risk gaps



Gap Assessment Status



Member Gap and Insight

Insights will vary by Line of Business. Providers should check one box for each Gap/Insight Category listed on the Agenda.

- Assessed & Documented as Appropriate.
- Assessed, Not Present.
- Not Assessed, Addressed Previously.
- Not Assessed, Member Referred

Condition History/ Continuity of Care component is all or nothing, ALL Disease Categories must have a box checked, verified with a qualified visit and paid claim to be eligible for the incentive. Additional insights are all or nothing as part of the "CoC +" Program.

'Please Select" Unassessed condition Provider has not responded to the gap/insight and must select appropriate response

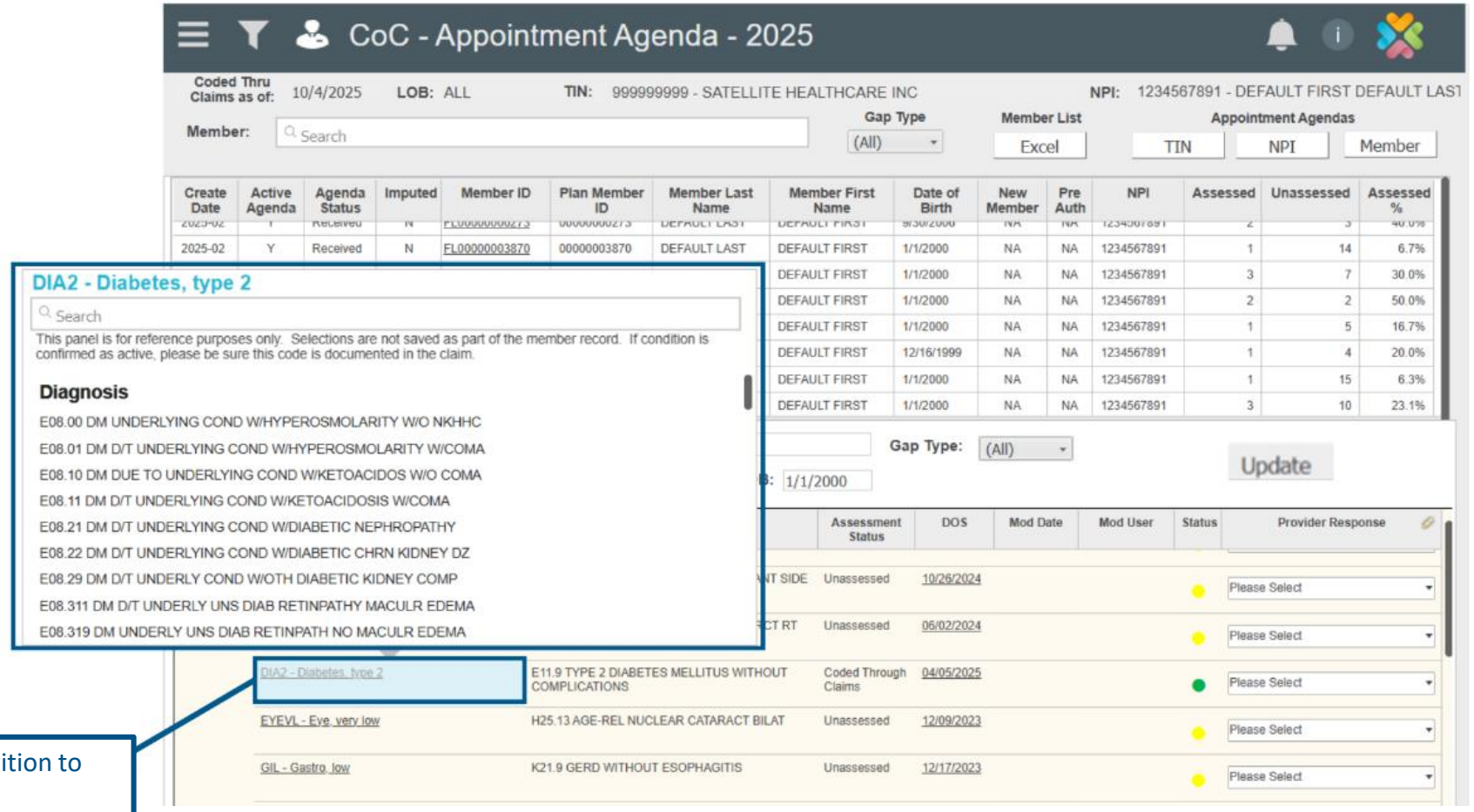
'Gap Assessed and Documented as Appropriate' Marked active diagnosis, waiting on a claim with diagnosis code that maps to the Disease Category listed on the Agenda

'Gap Assessed and Documented as Appropriate' Claim has been received with diagnosis code mapping to disease category or assessed condition/insight marked 'Assessed, Not Present/ Not Assessed, Addressed Previously/ Not Assessed, Member Referred' where diagnosis is not required

Built in Crosswalk

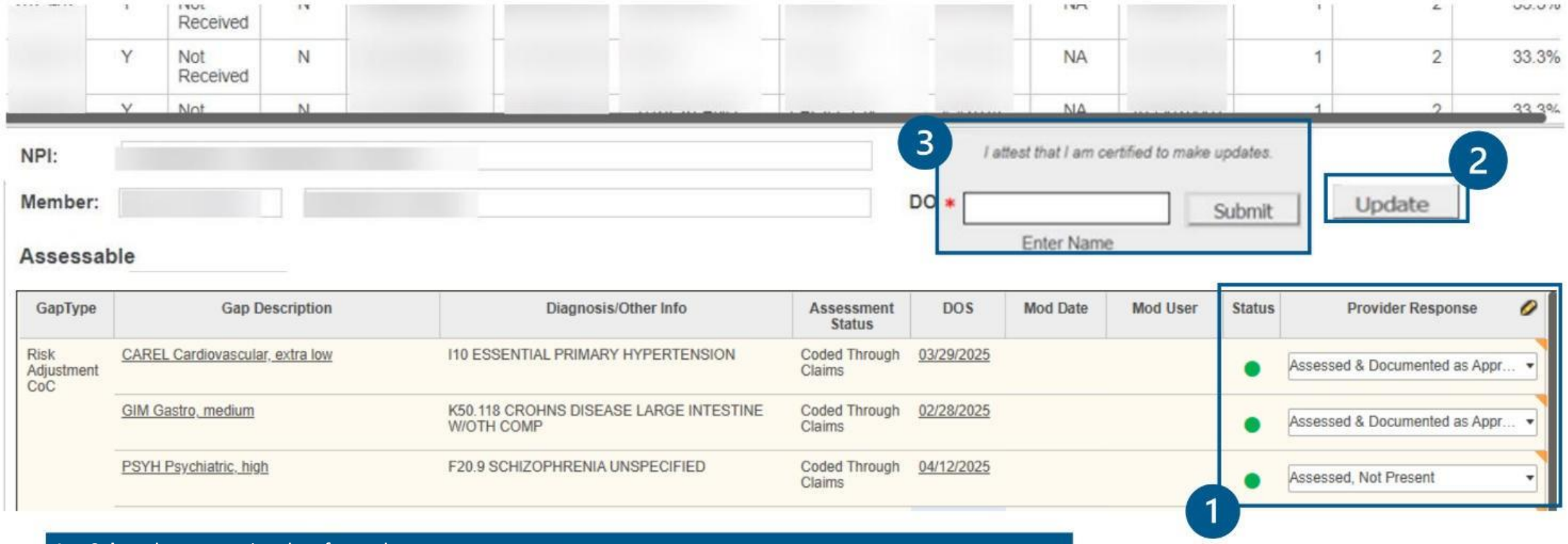
A claim must be submitted with a current program year date of service.

When checking the condition as ‘Gap Assessed and Documented as Appropriate’, we must receive a corresponding ICD10 on the claim



Click on the hyperlink under Disease Condition to populate the risk gap crosswalk

Attesting & Submitting the Agenda



1. **Select** the appropriate box for each gap
2. The provider, or authorized personnel, must click **Update** to save the changes
3. Provider, or authorized personnel enters their name, clicking **Submit**

Use Case – Risk Adjustment Gap Provider Response (CoC)

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Assessed & Documented as Appropriate

Gap Description does present based on assessment

Visit Overview: A Member presents for a routine visit. The provider reviews the Member's open condition for V28_HCC127 Dementia, Mild or Unspecified.

Assessment： During the visit, the provider assesses the Member. After evaluating the Member's symptoms and medical history, the provider diagnoses the Member with G30.0, Alzheimer's disease, early onset.

Documentation : The provider enters the diagnosis G30.0 into the Member’s medical record, ensuring it aligns with the clinical findings. The provider also notes the cognitive assessment, including any findings, treatments, or recommended follow-up plans.

Billing: The diagnosis G30.0 is then billed appropriately on the claim for the visit.

Agenda Provider Response： Given that the Member's condition was reviewed, diagnosis was made, the provider selects 'Assessed & Documented as Appropriate* on the Agenda, signifying that the open condition for V28_HCC127 Dementia, Mild or Unspecified presents.

Assessed, Not Present

Gap Description does not present based on assessment

Visit Overview: A Member presents for a routine visit. The provider reviews the open condition for V28_HCC127 Dementia, Mild or Unspecified as part of the Member's ongoing care.

Assessment: During the visit, the provider evaluates the Member. After conducting a thorough assessment, the provider diagnoses the Member with F01B11 (Vascular Dementia, Alzheimer's Disease Type).

Documentation: The provider documents the new diagnosis F01A11 in the Member's medical record, noting the updated findings, clinical reasoning, and any relevant treatment or care plan changes.

Billing: The provider ensures that the diagnosis F01B11 is accurately billed on the claim for the visit.

Agenda Provider Response: The Member's condition has changed and the new diagnosis F01B11 does not relate back to gap description shown on the Agenda as V28_HCC127 Dementia, Mild or Unspecified. This Indicates that the previously identified dementia condition (HCC 127) is no longer relevant to the Member's current diagnosis, and the condition is not present in the updated assessment.

Not Assessed, Member Referred

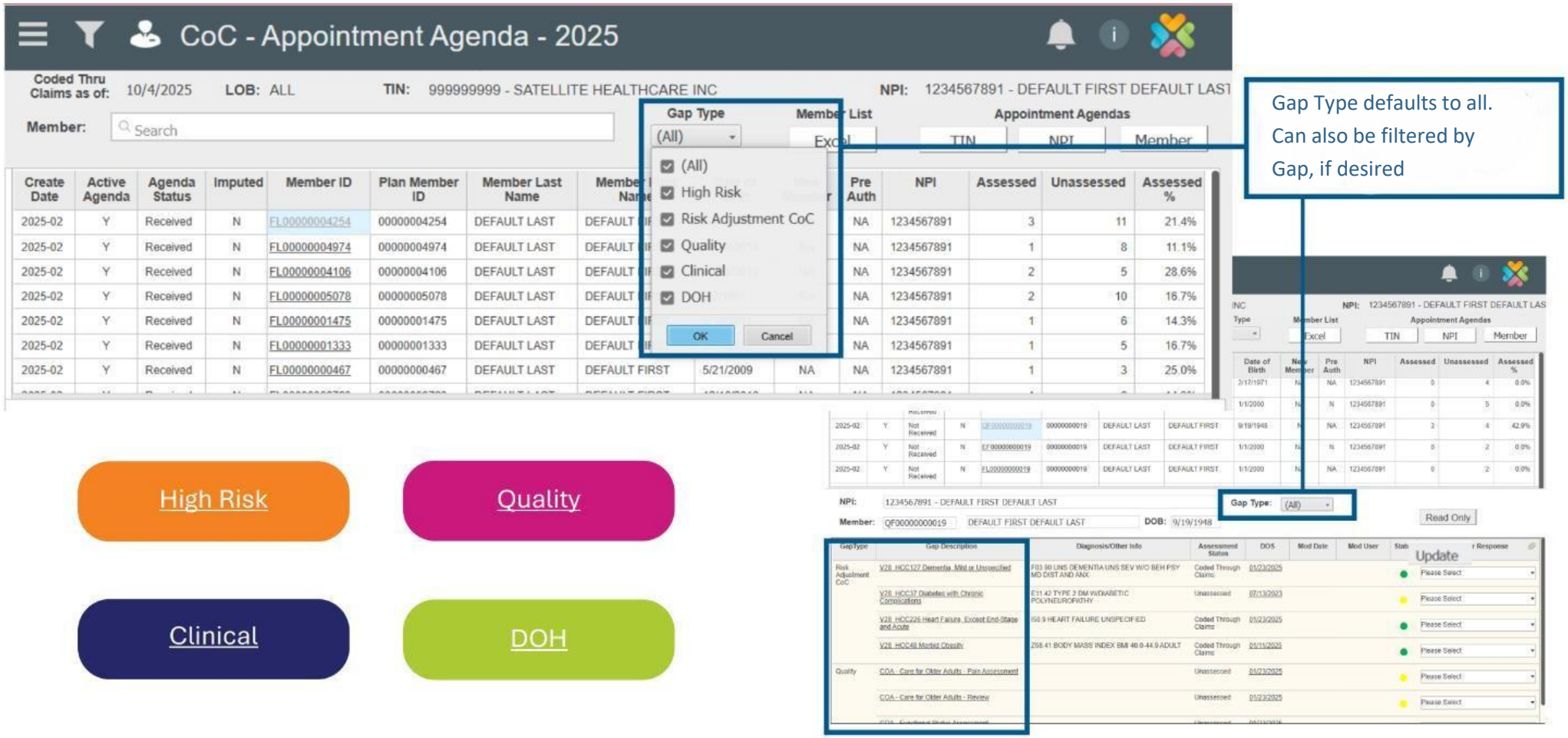
Gap Description was not assessed by provider during visit, Member was referred for further evaluation

Visit Overview: A Member presents for a routine visit. The provider reviews the open condition for V28_HCC136 Chronic Kidney Disease, Moderate as part of the Member's open conditions shown on the Agenda.

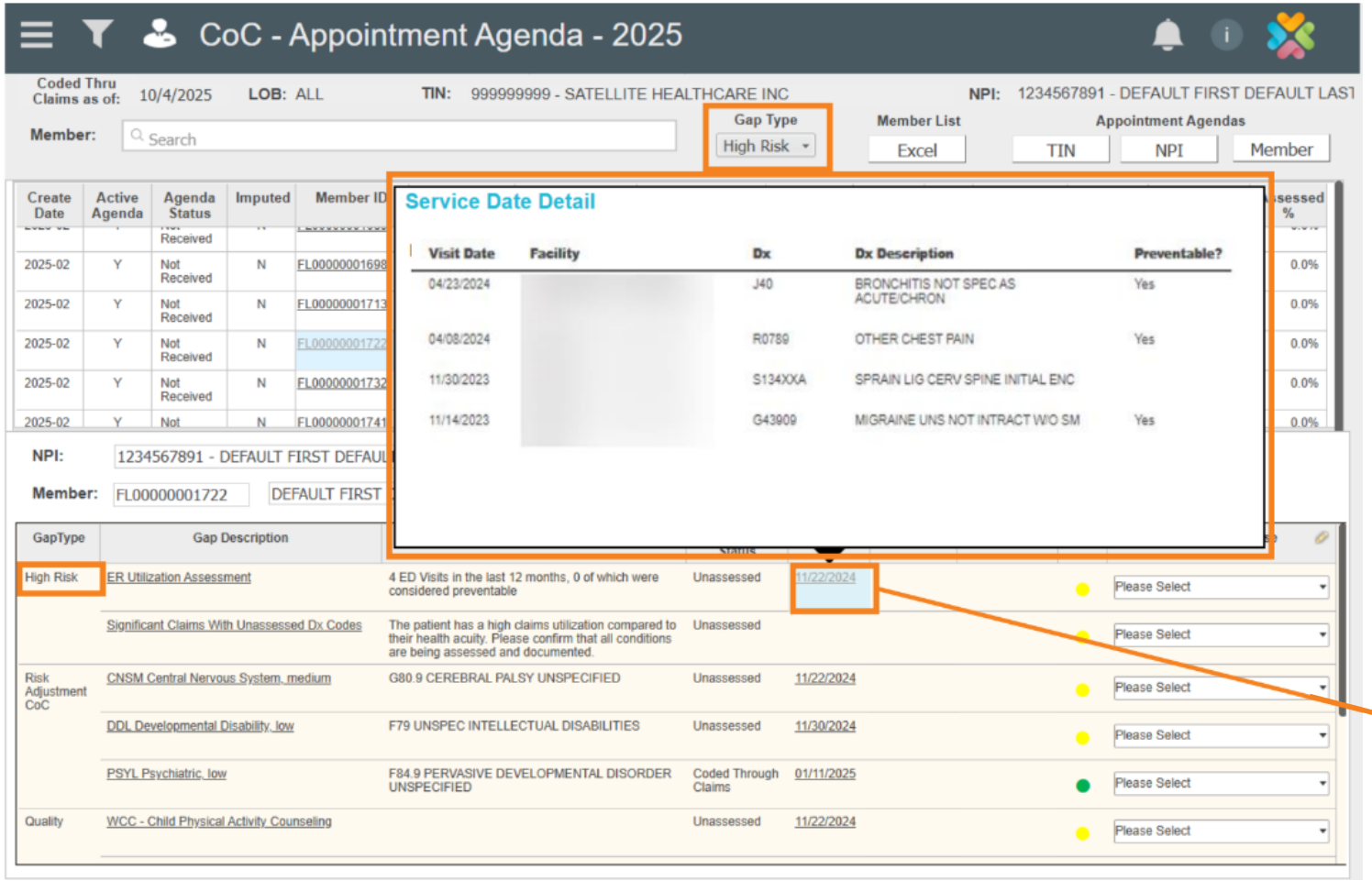
Assessment: During the visit, the provider evaluates the Member and refers the Member to their Nephrologist for diagnosis.

Agenda Provider Response: Provider is not assessing the Gap Description shown on the Agenda. Provider selects Not Assessed, Member Referred indicating the condition was not directly assessed by the provider in this visit, but referral was made for further diagnosis.

Filter Gap Type



Filtering High Risk Insights (CoC+)



High Risk provides insight to Member emergency room visits:

- Visit date
- Facility
- Diagnosis (DX)
- DX Description
- Preventable visit, based on diagnosis

This analysis can help to identify preventable ER visits, and/or high utilization compared to documented acuity offering an opportunity for providers to engage with the patient and discuss potential improvements in care to reduce ER utilization

When reviewing ER Utilization Assessment, recent ER utilization, will populate when clicking on the date

***No data populates when clicking on the Risk, Quality or Clinical dates. This feature is only for High Risk ER Utilization Assessment Only and does not include significant claims with unassessed DX codes.**

Use Case – High Risk Gap Provider Response (CoC+)

High Risk Insight

ER Utilization Assessment. <#> ED visits in the last 12 months, <#> of which were considered preventable.

Assessed & Documented, as Appropriate

Visit Overview:

A Member with an open gap for high-risk utilization presents for a routine visit. The provider reviews the Member's health status and addresses Members ER utilization during the visit.

Agenda Provider Response:

Assessed & Documented as Appropriate

- Provider reviewed ER utilization with Member during visit
- Provided education providing resources that are available. to Plan Members to access the right level of care at the right time

Not Assessed, Addressed Previously

Visit Overview:

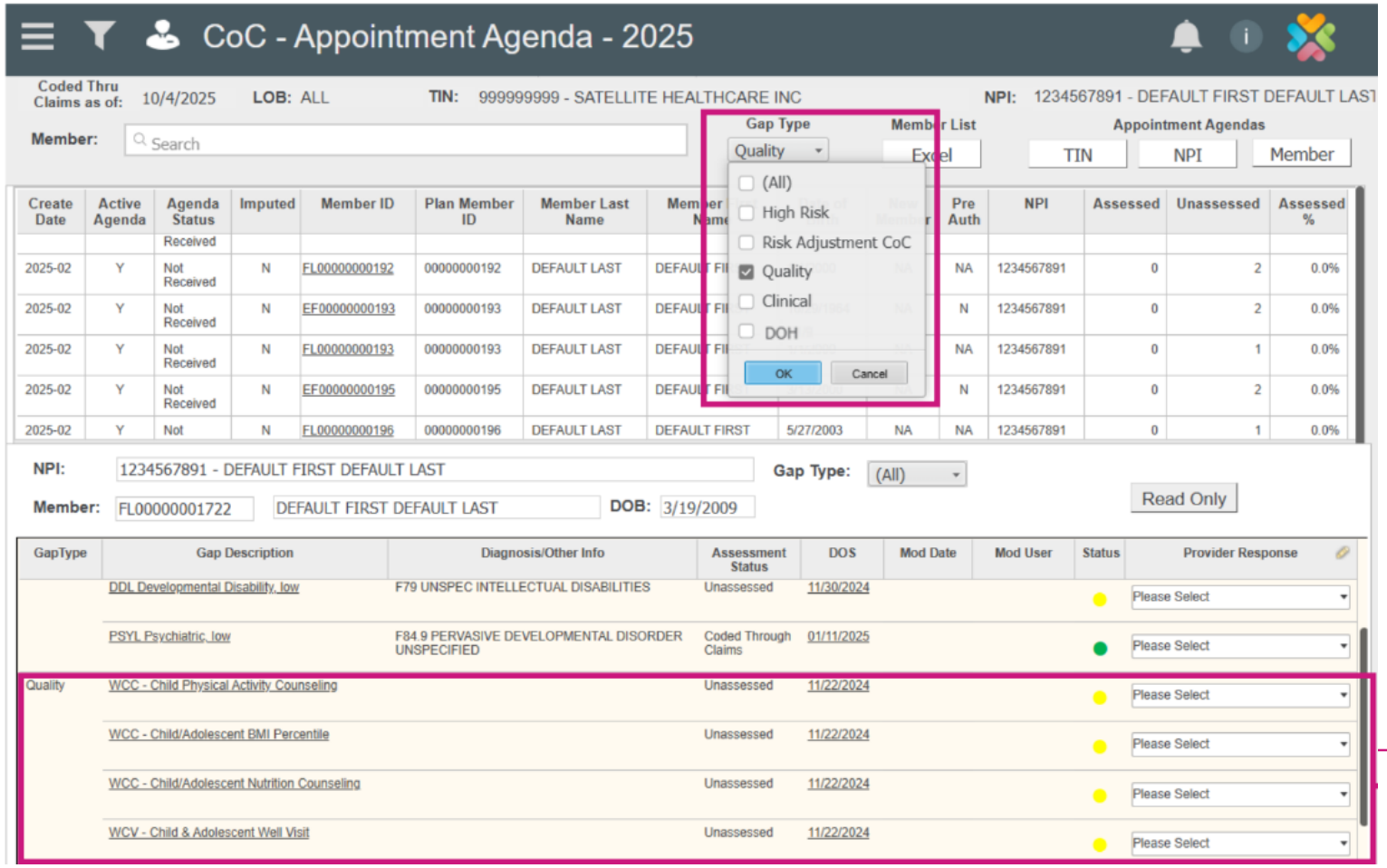
A Member with an open gap for high-risk utilization presents for a routine visit. The provider reviews the Member's health status but does not specifically address ER utilization during the visit.

Agenda Provider Response:

Not Assessed, Addressed Previously

- Provider did not review ER utilization with Member during visit
- Previously reviewed within the calendar year

Filtering Quality Insights



Quality Gaps, also known as HEDIS gaps, are tracked in collaboration with Centene's Quality department to improve overall care quality. HEDIS insights are critical for provider offices as they help ensure that we are meeting established care standards for our Members. By addressing these gaps, we can identify areas for improvement and ensure that our Members are receiving the best possible care.

All Care Gaps require a checkbox, in the Care Guidance section, address and document the Care Gaps. Care Gaps are closed bya claim, CPT,CPTII, HCPCS, DX codes or applicable documentation. For additional information, please reference your care gap report

Note: No data populates when clicking on the gap description

Use Case – Quality Provider Response (CoC+)

Assessed & Documented, as Appropriate

Sap Description does present based on assessment

Visit Overview: A Member presents for a routine visit with an open quality gap for BPD- Diabetes BP <140/90. The provider is tasked with addressing this gap by assessing and managing the Member's blood pressure as part of the HEDIS measure for diabetes care.

Assessment: During the visit, the provider performs a blood pressure check on the Member. The blood pressure reading is recorded as 138/87, which is below the threshold of 140/90 set for the quality gap. This indicates that the Member's blood pressure is controlled, meeting the HEDIS measure for diabetes management.

Billing/Documentation: The provider bills for the routine visit, and the BPD CPTII codes 3075F and 3079F are included on the claim to reflect the completed blood pressure measurement and the compliant result, documenting the Member's adherence to the BPD-Diabetes BP <140/90 quality measure. The provider documents the blood pressure reading of 138/87 in the Member's medical record.

Agenda Provider Response: Given that the blood pressure was assessed, and the result was compliant with the quality measure, the provider selects 'Assessed & Documented, as Appropriate'on the Agenda. This indicates that the quality gap for BPD- Diabetes BP <140/90 was reviewed and addressed, with the results properly documented in the Member's record.

Assessed, Not Present

Gap Description does not present based on assessment

Visit Overview: A Member presents for a routine visit with an open quality gap for BPD- Diabetes BP <140/90. During this visit, the provider is expected to address the Member's blood pressure to close the gap for the HEDIS measure.

Assessment: During the visit, the provider checks the Member's blood pressure, which is recorded as 145/90, indicating that the Member's blood pressure is above the target of 140/90 for diabetes management. Given this reading, the quality gap for the HEDIS measure BPD- Diabetes BP <140/90 cannot be closed during this visit.

Documentation: The provider documents the blood pressure reading of 145/90 in the Member's medical record. This is noted as a non-compliant result for the BPD- Diabetes BP <140/90 quality measure. The provider also documents the education provided to the Member, explaining the importance of blood pressure control in managing diabetes, the potential risks of uncontrolled hypertension, and a follow-up appointment is scheduled.

Billing: The provider bills for the routine visit, but as the BPD-Diabetes BP <140/90 quality gap remains open due to the uncontrolled blood pressure.

Agenda Provider Response: Since the Member's blood pressure was not controlled during the visit and the quality gap could not be closed, the provider selects 'Assessed & Not Present' on the Agenda. This response reflects that while the blood pressure was assessed, it was not in compliance.

Not Assessed, Member Referred

Gap Description was not assessed by provider during visit, Member was referred for further evaluation

Visit Overview: A Member presents for an Annual Wellness Visit (AWV) with an open quality gap for EED- Diabetes-Dilated Eye Exam. The provider is responsible for addressing the gap but recognizes that the dilated eye exam is not within the scope of care provided by the primary care provider (PCP). The provider determines that the Member needs to be referred to an ophthalmologist for the exam.

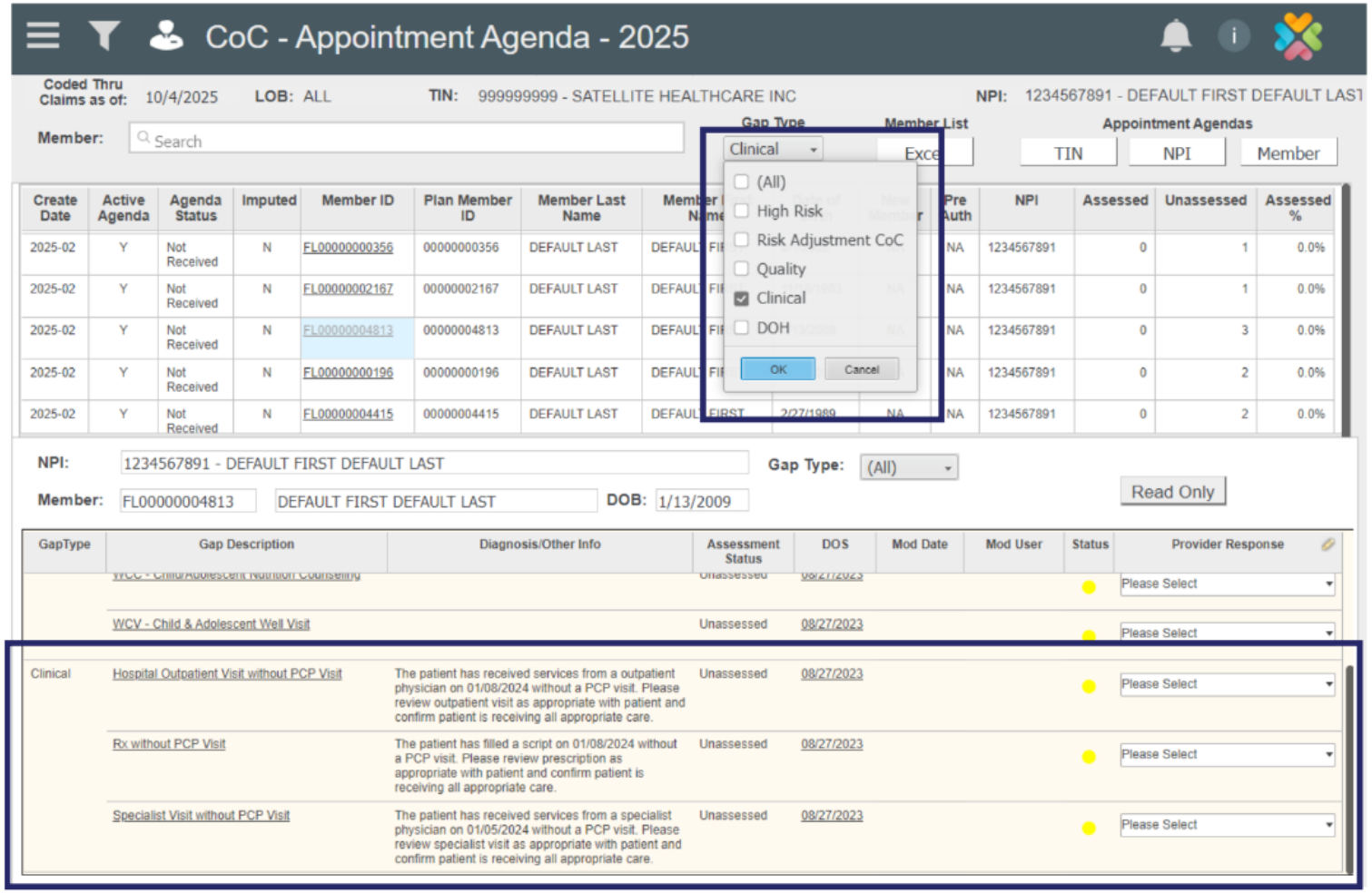
Assessment: The provider explains to the Member that a dilated eye exam is an essential part of diabetes care for detecting diabetic retinopathy and other potential eye complications. The provider also discusses the importance of having this exam completed by an ophthalmologist.

Documentation: The provider documents the referral for the Dilated Eye Exam in the Member's medical record.

Billing: The provider bills for the routine visit as usual, and no specific CPTII codes related to the EED quality measure are billed since the dilated eye exam is being referred to a specialist for completion.

Agenda Provider Response: Since the EED- Diabetes - Dilated Eye Exam is not assessed during this visit and a referral is made to the ophthalmologist, the provider selects 'Not Assessed, Member Referred on the Agenda'. This response on the Agenda reflects that the quality gap could not be closed by the PCP during this visit, but the referral to a specialist has been made for the appropriate assessment and care.

Filtering Clinical Insights



Clinical Gaps highlight Members who have not had a visit with an assigned Primary Care Provider (PCP). Insights may show if a Member has had a hospital outpatient visit without an assigned PCP visit, been prescribed medication without an assigned PCP visit, or received specialist services without an assigned PCP visit. Addressing these clinical gaps can ensure better coordinated and comprehensive care for the Member.

Use Case – Clinical Provider Response (CoC+)

Clinical Insight

The Member has filled a script without a PCP visit. Please review prescription as appropriate with Member and confirm Member is receiving all appropriate care.

The Member has received services from a specialist physician without a PCP visit. Please review specialist visit as appropriate with Member and confirm Member is receiving all appropriate care.

The Member has received services from an outpatient physician without a PCP visit. Please review outpatient visit as appropriate with Member and confirm Member is receiving all appropriate care.

Assessed & Documented as Appropriate

Visit Overview: The provider is reviewing open conditions on the Agenda and notices the following clinical gaps in care:

- **The Member has filled a prescription without a PCP visit**
- **The Member has received services from a specialist physician without a PCP visit**
- **The Member has received services from an outpatient physician without a PCP visit**

Given these gaps, the provider schedules an Annual Wellness Visit (AWV) with the Member to review the situation and ensure comprehensive care coordination.

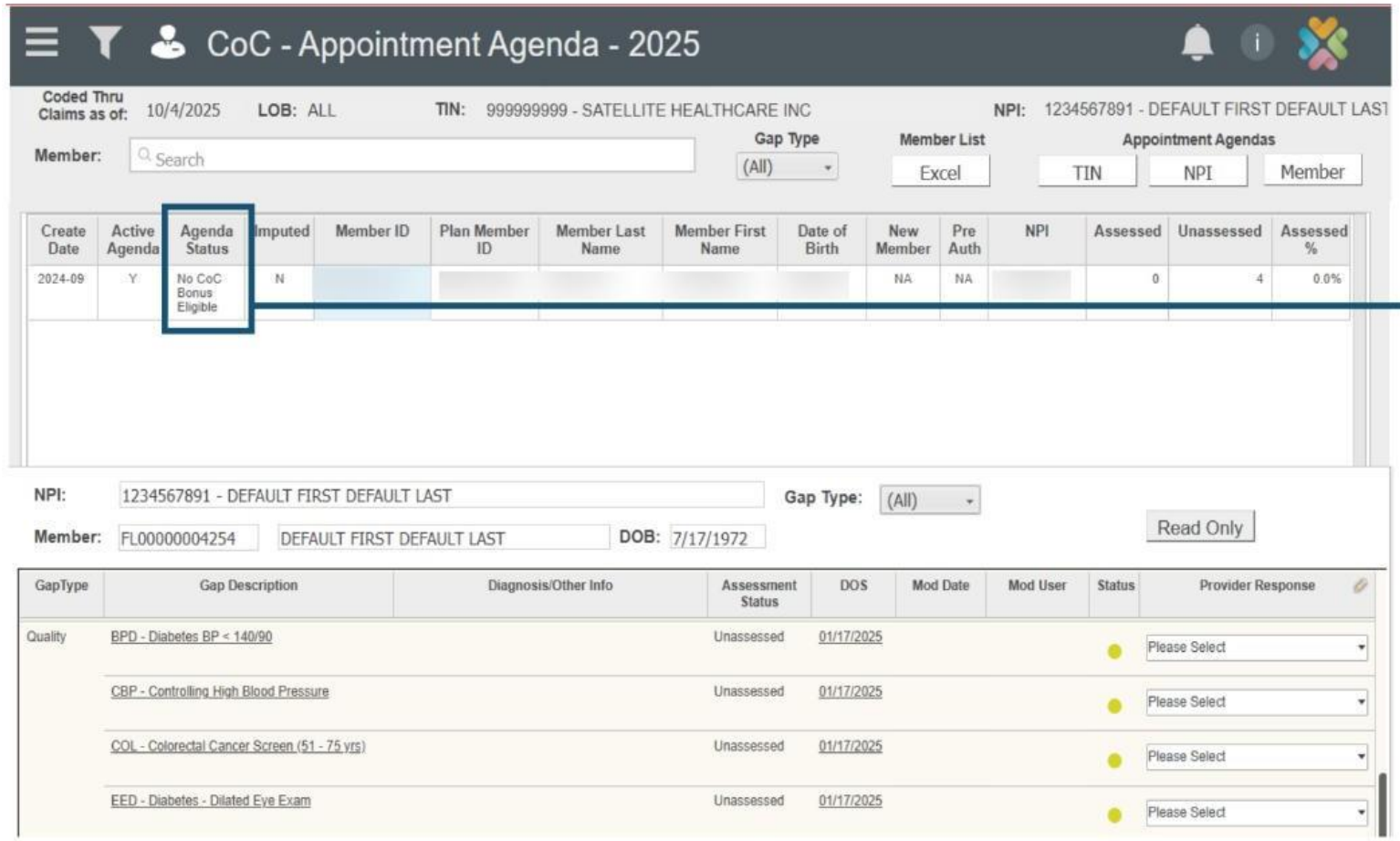
Assessment: During the AWV, the provider assesses the Member's overall health status, reviews recent healthcare utilization. The provider uses this AWV as an opportunity to reinforce the importance of care coordination through the PCP

Documentation: The provider Notes the details of the prescription, documents any specialist visit and records the details of the outpatient services. The Provider determines the need for future follow ups with the Member.

Billing： The provider bills for the AWV)using the appropriate CPT codes. The AWV is billed for the comprehensive evaluation and care coordination provided, including reviewing the above open conditions and discussing follow-up plans.

Agenda Provider Response: Clinical Insights on the Agenda showed a need for the Member to have a visit with their PCP. The AWV closes the gap and 'Assessed & Documented as Appropriate' would be the appropriate response on the Agenda. This response indicates that the provider has reviewed all relevant open conditions and addressed them during the AWV, ensuring proper follow-up care and coordination of the Member's healthcare services.

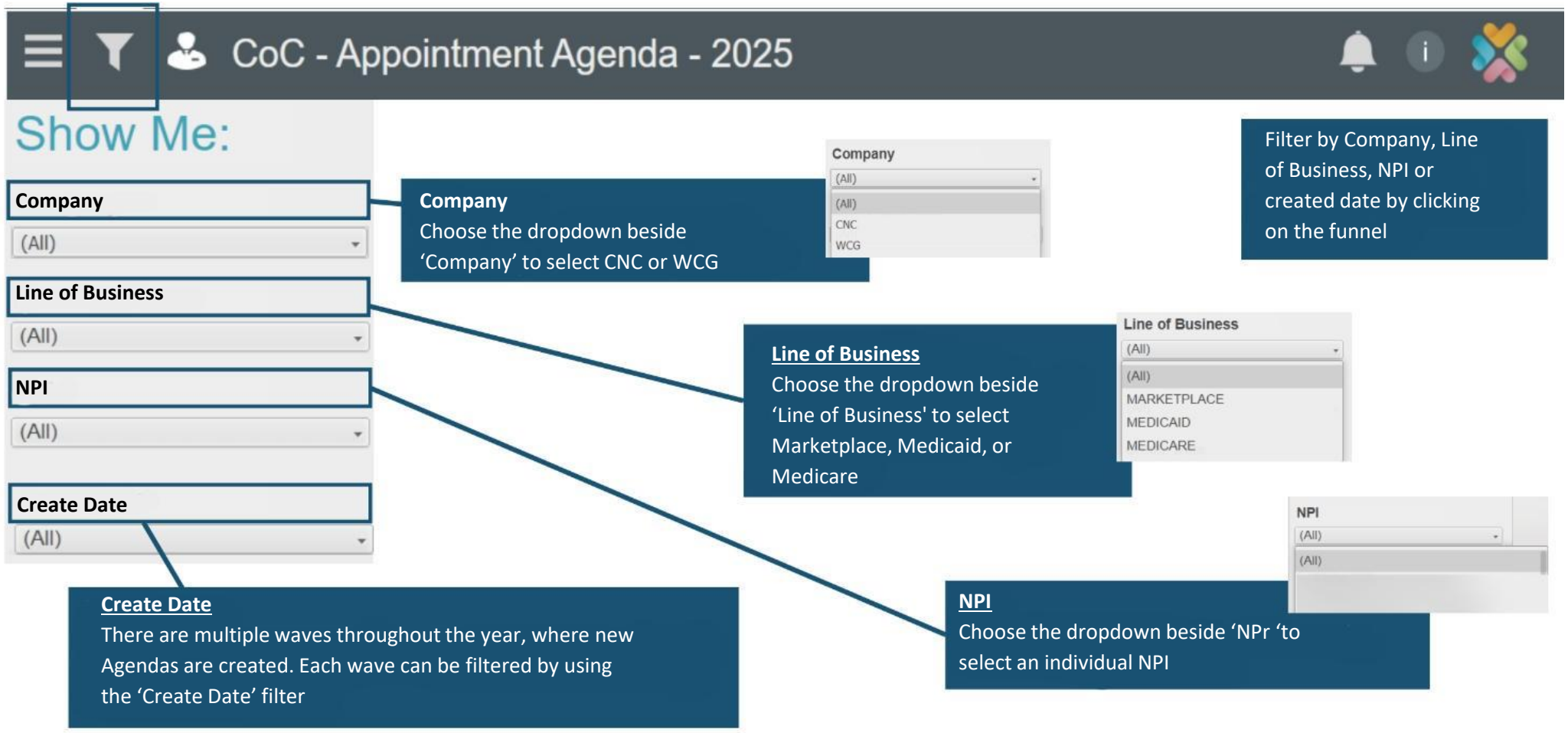
No Risk Gaps / Open Additional Insights



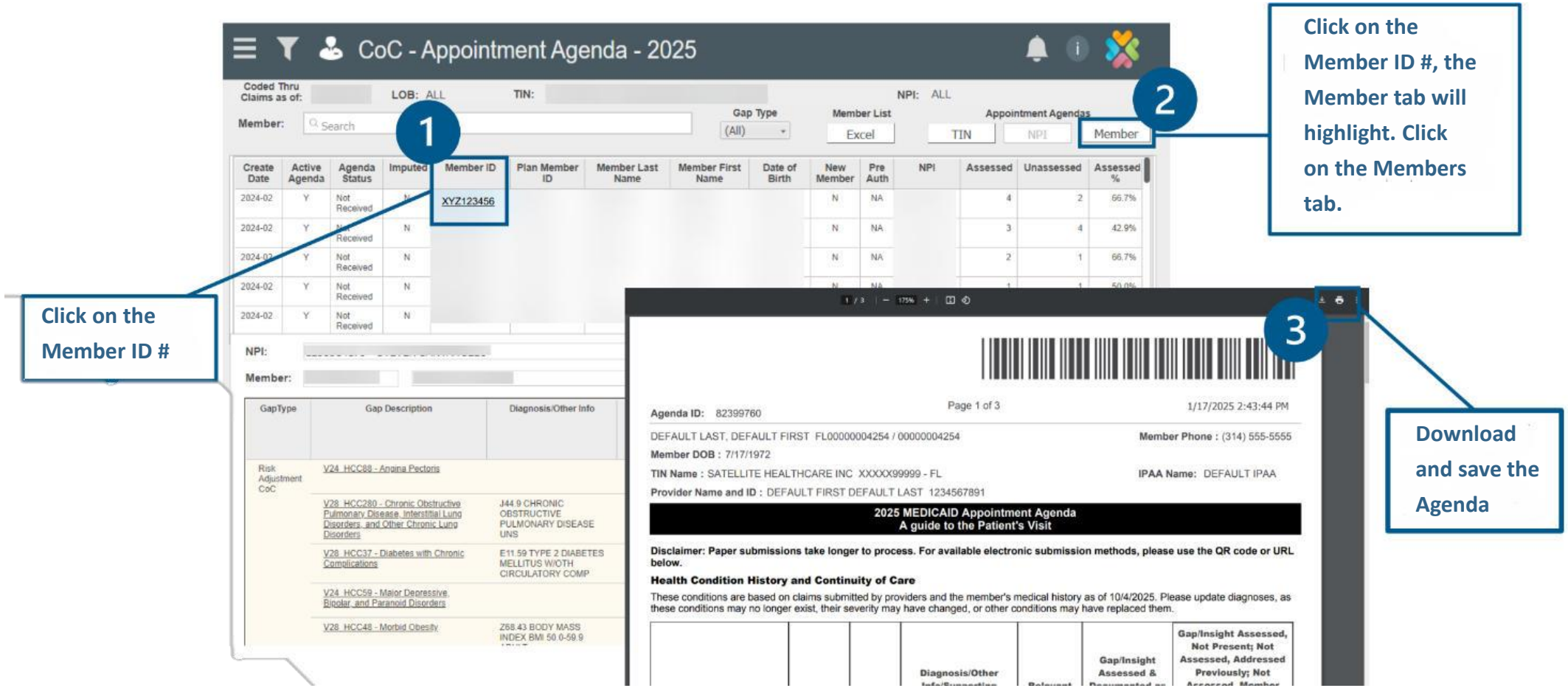
If the Member does not have CoC Risk Adjustment gaps for the calendar year or the TIN is not eligible for participation in the CoC Program, the Agenda status will show 'No CoC Bonus Eligible'. Providers are still eligible for the CoC+ incentive

Agendas are created for Members with no Risk Gaps. These Members will show No CoC Bonus Eligible, as the Members have additional insights. Ensure you review the Agendas showing No CoC Bonus Eligible

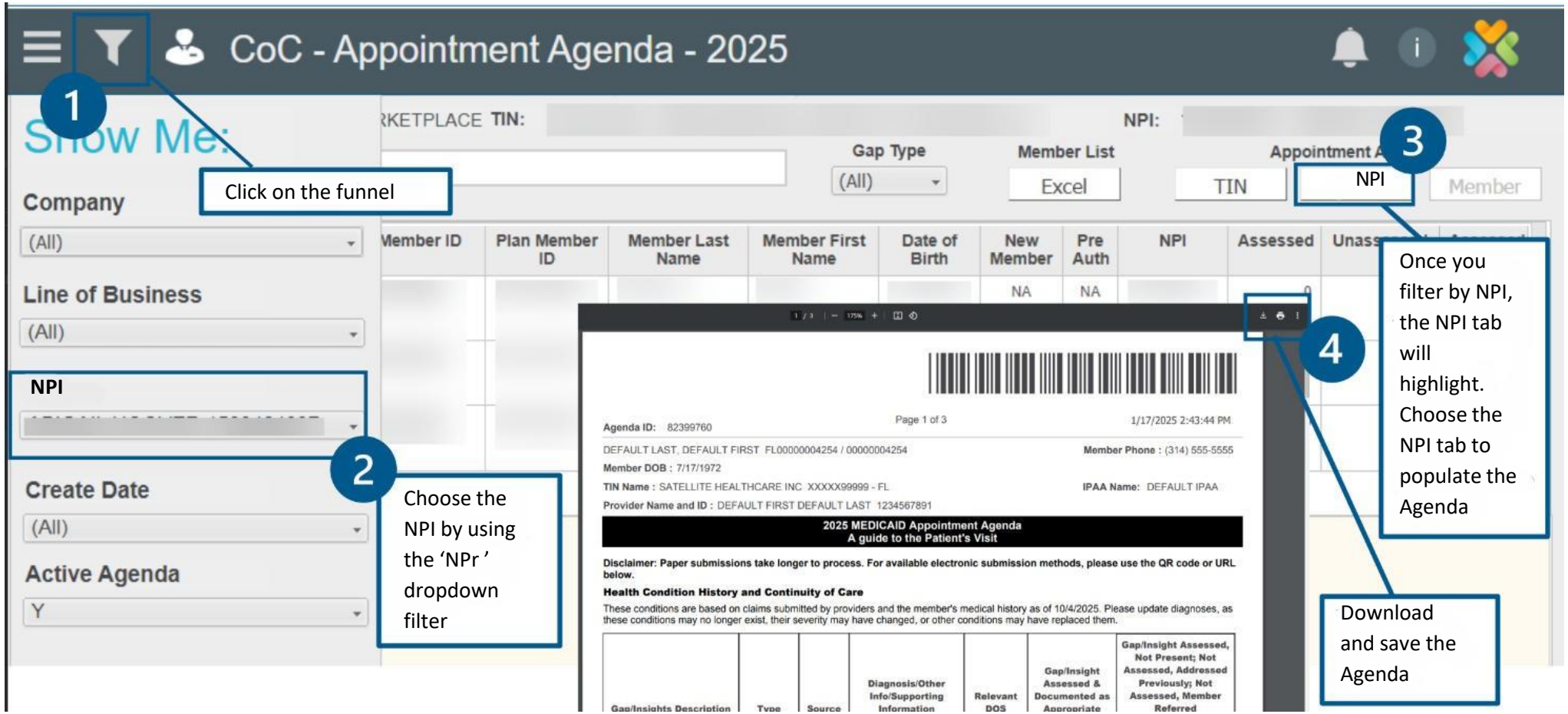
Agenda Filters



Single Agenda Export to PDF



NPI Export to PDF



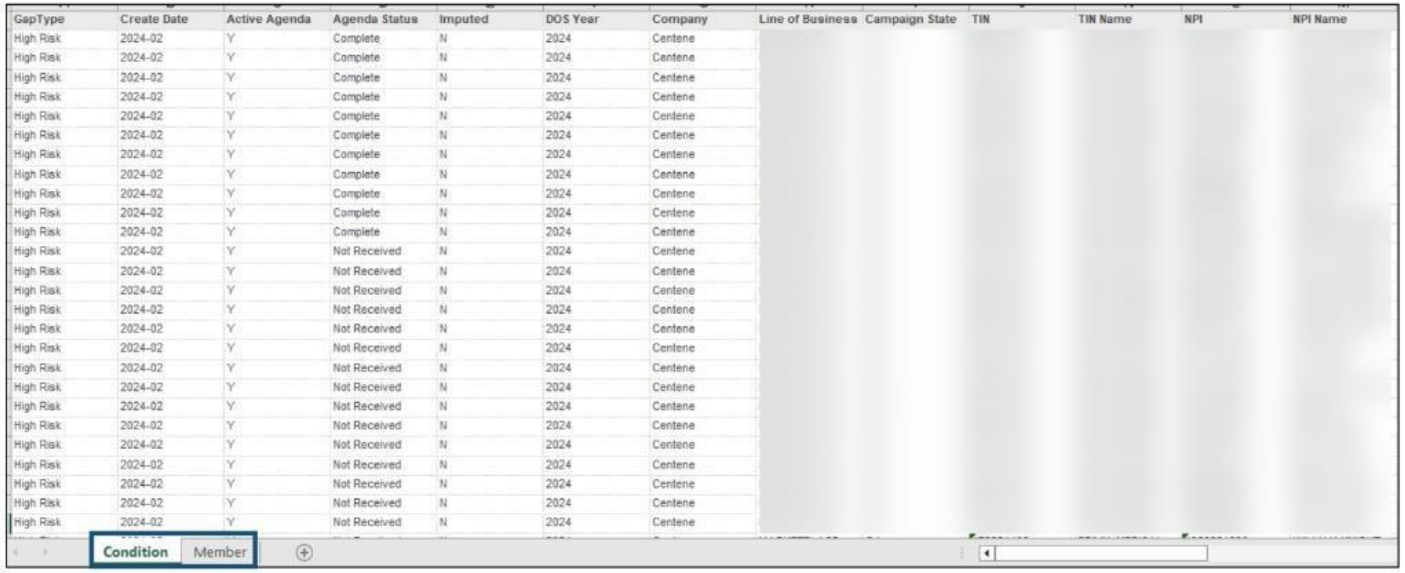
Download Excel Report

A Member list can be exported by choosing the 'Excel' tab

Excel Report

- **Condition** tab shows all disease conditions, per Member
- **Member** tab shows one line, per Member

Note: Both tabs include Member demographic information



Prospective Solutions

Bi-directional feed

Benefits of automated data exchange between payor and provider:

- Increased data accuracy
- Improved workflow
- Decreased administrative burden
- Enhanced patient care
- Better health outcomes

Active EMR Point of Care Alerts:

Epic Payor Platform

Healow

Moxe

Athena

Future Connections:
Veradigm (Practice Fusion, All Script, NexGen), VIM, and Oracle

Summary of Best Practices