



3rd Quarter Provider Webinar 2026

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Agenda

- ▶ Join Our Email List Today
- ▶ Clinical and Payment Policy Updates
- ▶ Ambetter Other Insurance Coverage Changes for ARHOME
- ▶ Appointment Availability & Wait Times
- ▶ Prior Authorizations
- ▶ Pre-Auth Check Tool
- ▶ Secure Provider Portal
- ▶ Availability Essentials
- ▶ Sober Sidekick Program
- ▶ Transitional Care Management (TCM)
- ▶ Provider Self-Led Trainings
- ▶ Risk Adjustment
- ▶ Quality Improvement
- ▶ Contact Information

Join Our Email List Today

For Members ▾For Providers ▾Get Insured

For Providers

Login

Become a Provider ▾

Pre-Auth Check ▾

Provider Financial Support & Resources

Pharmacy

Provider Resources ^

Ambetter Clinical Coverage/Medical Policy Updates

Ambetter Coding Tip Sheets and Forms

Clinical & Payment Policies

Electronic Transactions ▾

Eligibility Verification

Incentives Statement

Integrated Care

Manuals, Forms and Resources

National Imaging Associates (NIA)

Patient Centered Medical Home Model

Prior Authorization

Provider Attestation

Provider Training ▾

Provider Resources

Arkansas Health & Wellness provides the tools and support you need to deliver the best quality of care. Please view our listing on the left, or below, that covers forms, guidelines, helpful links, and training.

- For Ambetter information, please visit our [Ambetter website](#).
- For Wellcare by Allwell information, please visit our [Wellcare by Allwell website](#).

Interested in getting the latest alerts from Arkansas Health and Wellness? Fill out the form below and we'll add you to our email subscription.

- [Manuals, Forms and Resources](#)
- [Eligibility Verification](#)
- [Prior Authorization](#)
- [Electronic Transactions](#)
- [Preferred Drug Lists](#)
- [Provider Training](#)
- [Negative Balance How-To Guide \(PDF\)](#)

Name *

Position/Title *

Email *

Phone Number *

Group Name *

Group NPI *

Tax ID *

Network *

☐ Ambetter

☐ Wellcare by Allwell

Submit

Receive current updates:

- ▶ <https://www.arhealthwellness.com/providers/resources.html>
- ▶ Choose the network you wish to receive information from: Ambetter or Wellcare by Allwell

Clinical and Payment Policy Updates

Clinical and Payment Policy Updates



Arkansas Health & Wellness is amending or implementing new policies that can be found on the public website.

Clinical Policies for Ambetter

- ▶ Ambetter ABA Therapy AMB26-AR-H-093 Effective August 1, 2026

Clinical and Payment Policy Updates



Arkansas Health & Wellness routinely amends and/or implements new policies. These policies are available on our website at ARHealthWellness.com.



For Members ▾ For Providers ▾ Get Insured

For Providers

Login

Become a Provider ▾

Pre-Auth Check ▾

Provider Financial Support & Resources

Pharmacy

Provider Resources ^

Ambetter Clinical Coverage/Medical Policy Updates

Ambetter Coding Tip Sheets and Forms

Clinical & Payment Policies

Electronic Transactions ▾

Eligibility Verification

Incentives Statement

Clinical & Payment Policies

To easily search for a policy, use the Ctrl+F (Command+F on Mac) function on your keyboard to search by keyword, policy number or effective date.

What are Clinical Policies?

Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include, but are not limited to, policies relating to evolving medical technologies and procedures, as well as pharmacy policies. Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical practice including peer-reviewed medical literature, government agency/program approval status, evidence-based guidelines, positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas affected by the policy, and other available clinical information.

All policies found in the Arkansas Health & Wellness Clinical Policy Manual apply to Arkansas Health & Wellness members. Policies in the Arkansas Health & Wellness Clinical Policy Manual may have either an Arkansas Health & Wellness or a "Centene" heading. Arkansas Health & Wellness utilizes InterQual® criteria for those medical technologies, procedures, or pharmaceutical treatments for which a Arkansas Health & Wellness clinical policy does not exist. InterQual is a nationally recognized evidence-based decision support tool. You may access the InterQual® SmartSheet(s)™ for Adult and Pediatric procedures, durable medical equipment, and imaging procedures by logging into the [secure provider portal](#) or by calling Arkansas Health & Wellness at [1-877-617-0390](tel:1-877-617-0390).

In addition, Arkansas Health & Wellness may, from time to time, delegate utilization management of specific services; in such circumstances, the delegated vendor's guidelines may also be used to support medical necessity and other coverage determinations. Other non-clinical policies (e.g., payment policies) or contract terms may further determine whether a technology, procedure, or treatment that is not addressed in the Clinical Policy Manuals or InterQual® criteria is payable by Arkansas Health & Wellness.

If you have any questions regarding these policies, please contact Member Services and ask to be directed to the Medical Management department.

What are Payment Policies?

2026 Ambetter Other Insurance Coverage Changes for ARHOME

Coverage Changes for ARHOME



Provider Notification

Provider Notifications

Effective January 1, 2026, Ambetter's ARHOME coverage is the payer of last resort for coordination of benefits purposes. This means that if members have any other insurance, it must pay first, and Ambetter will pay claims as secondary.

There are three main ways you can check to see if a member has an ARHOME plan.

Ambetter Other Insurance Coverage Changes for ARHOME

1. Secure Provider Portal

Log in to your Ambetter Provider Portal at Provider.ARHealthWellness.com and use the Quick Actions tool to search for the appropriate member. If they have an ARHOME plan, the plan product name will start with a “PO Bal” identifier.



Ambetter Other Insurance Coverage Changes for ARHOME



2. Member ID Card

Check the member’s Ambetter ID card. If it has a blue ARHOME logo on the front, beside the Ambetter logo, that member is part of an ARHOME plan.

FROM  **arkansas health & wellness.**

HEALTH & WELLNESS FOR AR

REFERRAL NOT REQUIRED

PREMIER

MEMBER: [Jane Doe]
Subscriber: [John Doe]
Subscriber ID: [xxxxxxxxxx] **Member ID:** [xxxxxxxxxxxxxxxxxx]
Plan: [Plan name]
[Network Name] Network Coverage
RXBIN: 003858 **RXPCN:** A4 **RXGROUP:** 2CRA **Effective Date:** [00/00/00]

COPAYS
PCP: [\$10 copay after ded.]
Specialist: [\$25 coin. after ded.]
Urgent Care: [20% coin. after ded.]
ER: [\$250 copay after ded.]

COST SHARES
INN DED Ind/Fam: [\$7,065/\$18,000]
OON DED Ind/Fam: [\$22,500/\$45,000]
QUARTERLY INN MOOP Ind/Fam: [\$11,500/n/a]
OON MOOP Ind/Fam: [\$25,000/\$45,000]

For detailed benefit information, please visit AmbetterHealth.com/copays

AmbetterHealth.com/AR
Member/Provider Services: 1-877-6T7-0390
(TTY 1-877-6T7-0392)
24/7 Nurse Line: 1-877-6T7-0390

Numbers below for providers:
Pharmacist Only: 1-833-750-1105
EDI Payor ID: 68069
[Centene Vision Services: 1-877-268-7755]
[Centene Dental Services supported by
United Concordia: 1-855-609-5155]

Medical Claims Address:
Ambetter from Arkansas
Health & Wellness
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

**NovaSys**
HEALTH
Marketplace Network

Ambetter from Arkansas Health & Wellness is insured by Celtic Insurance Company (dba Arkansas Health and Wellness Insurance Company), QCA Health Plan, Inc., and QualChoice Life & Health Insurance Company, Inc. These companies are Qualified Health Plan issuers in the Arkansas Health Insurance Marketplace. ©2005 Celtic Insurance Company (dba Arkansas Health and Wellness Insurance Company), QCA Health Plan, Inc., and QualChoice Life & Health Insurance Company, Inc. All rights reserved.

AMBES-AR-C-00060

Ambetter Other Insurance Coverage Changes for ARHOME

3. Call Center

Our call center is available to assist you in reviewing a member's plan division to determine whether they are an ARHOME member. Give us a call at 1-877-617-0390 (TTY: 1-877-617-0392).

What do I need to do?

For Ambetter members with ARHOME coverage, file claims with the primary insurance carrier first. You should file with Ambetter only after the claim has been filed with the primary carrier.

Appointment Availability & Wait Times

Appointment Availability & Wait Times

Arkansas Health & Wellness follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. We monitor participating provider compliance with these standards at least annually and use the results to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table on the right depicts appointment availability for members.

Appointment Access Calendar

Appointment Type	Access Standard
PCPs – Routine Visits	15 business days
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	48 hours
Behavioral Health – Non-Threatening Emergency	6 hours
Specialist Routine Visit	Within 30 business days
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	48 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician.
Emergency Providers	24 hours a day, 7 days a week

Appointment Availability & Wait Times

Type of Care	Accessibility Standard*
Primary Care	
Emergency	Same day or within 24 hours of member's call
Urgent care	Within 2 days of request
Routine	Within 21 days of request
Specialty Referral	
Emergency	Within 24 hours of referral
Urgent care	Within 3 days of referral
Routine	Within 45 days of referral

The in-office wait time is less than 45 minutes, except when the provider is unavailable due to an emergency.

Type of Care	Accessibility Standard*
Maternity	
1st trimester	Within 14 days of request
2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancies	Within 3 days of identification or immediately if an emergency exists
Dental	
Emergency	Within 24 hours of request
Urgent care	Within 3 days of request
Routine	Within 45 days of request

Prior Authorizations

How to Secure Prior Authorization

Prior Authorizations can be requested in the following ways



► **Secure Web Portal:** This is the preferred and fastest method

- Ambetter and Wellcare by Allwell: Provider.ARHealthWellness.com



► **Phone**

- Ambetter: 1-877-617-0390
- Wellcare by Allwell: 1-855-565-9518

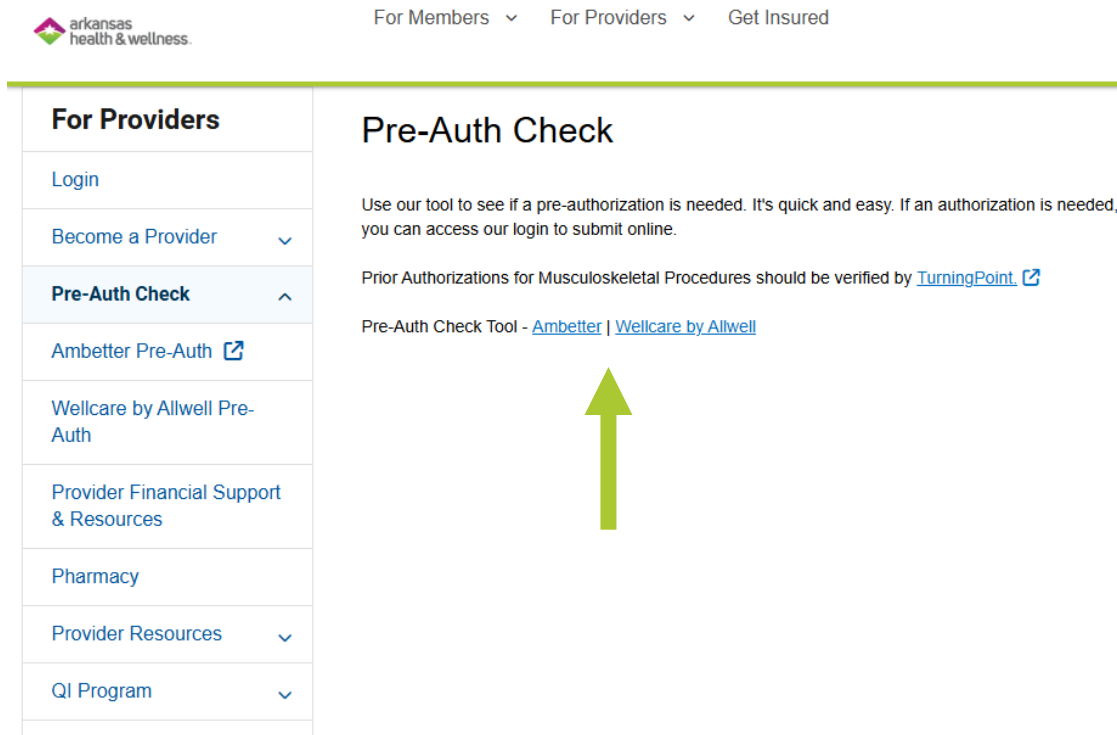


► **Fax:** IP and OP forms are available on the [Provider Resources](#) page

- Ambetter: 1-866-884-9580
- Wellcare by Allwell: 1-833-562-7172

After normal business hours and on holidays, calls are directed to the plan's 24-hour Nurse Advice Line. Notification of authorization will be returned via phone, fax, or web.

Pre-Auth Check Tool

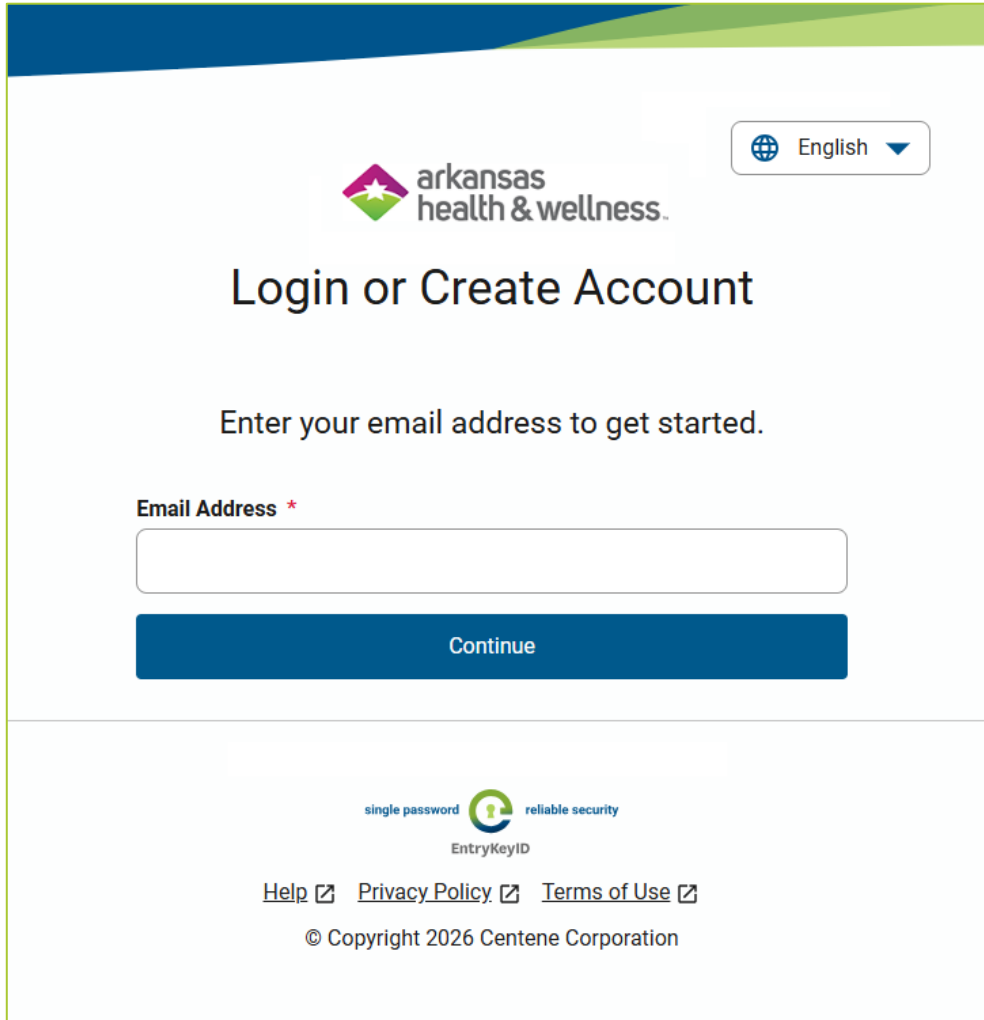


Use the [Pre-Auth Check Tool](#) on the Arkansas Health & Wellness public website to determine whether a service requires prior authorization. No login is required.

- ▶ Go to Provider Resources and select the Pre-Auth Check Tool.
- ▶ Answer the required questions using the radio buttons.
- ▶ Enter the applicable service code when the code field appears.
- ▶ Review the result: green “N” means no authorization is required, red “Y” means authorization is required, and blue “C” means the requirement is conditional.
- ▶ Providers are responsible for confirming prior authorization requirements before rendering services.

Secure Provider Portal

Secure Provider Portal – Create An Account



The screenshot shows the 'Login or Create Account' page of the Arkansas Health & Wellness Secure Provider Portal. At the top, there is a language selector set to 'English'. The main heading is 'Login or Create Account', followed by the instruction 'Enter your email address to get started.' Below this is a text input field labeled 'Email Address *'. A blue 'Continue' button is positioned below the input field. At the bottom of the page, there is a logo for 'EntryKeyID' with the tagline 'single password reliable security'. Below the logo are links for 'Help', 'Privacy Policy', and 'Terms of Use', each followed by an external link icon. The footer text reads '© Copyright 2026 Centene Corporation'.

English

arkansas
health & wellness.

Login or Create Account

Enter your email address to get started.

Email Address *

Continue

single password reliable security
EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#)

© Copyright 2026 Centene Corporation

Registration is free and easy

Provider.ARHealthWellness.com

Secure Portal Features

- ▶ View member eligibility and critical data in a single overview.
- ▶ Submit and track claim reconsiderations online.
- ▶ Add comments and explanations using expanded free-text fields.
- ▶ Attach required documentation to a reconsideration.
- ▶ Upload records related to care gaps.
- ▶ Receive push notifications when reconsideration status changes.
- ▶ Void or recoup claims already adjudicated by the health plan. See page 92 of the portal manual for instructions.

Patient Overview – Document Resource Center



[Back to Eligibility Check](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Document Upload

Document Review

1.

Document Category:

Please Select a Category

Medical Necessity

Quality Management

Long Term Services And Support

2.

Document Type:

3.

Upload File:

Choose File

No file chosen

4.

Submit

Documents for the member can be uploaded here based on Document Category options.

The Document Resource Center lets providers upload and review member documents by category. Select the document category and type, choose the file to upload, and select Submit.

Availity Essentials

Availity Essentials

- ▶ Since November of 2024, providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access Arkansas Health & Wellness payer resources through Availity Essentials.
- ▶ If you are already working in Essentials, you can log in to your existing Essentials account to enjoy these benefits.
- ▶ Use Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.
- ▶ Look for additional functionality in Arkansas Health & Wellness' payer space on Essentials and use the heart icon to add apps to My Favorites in the top navigation bar. Our current Secure Provider Portal will still be available for other functions you may use now.
- ▶ Access Manage My Organization — save provider information in Essentials and auto-populate it to save time and prevent errors.
- ▶ If you are new to Availity Essentials, getting your Essentials account is the first step toward working with Arkansas Health & Wellness on Availity.

Availity Designation

Getting Started: Designate an Availity Administrator for Your Provider Organization.

Your provider organization's designated Availity administrator is the person responsible for registering your organization in Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization.



Availity Contact Information



Availity Client Services
1-800-282-4548

Sober Sidekick Program

Sober Sidekick Program

Sober Sidekick is a virtual platform designed to empower addiction by connecting individuals with tools and resources in their communities. This includes creating opportunities for connection, encouragement, and shared experiences through its peer-driven community.

By gathering and analyzing behavioral insights, the partnership will enable a deeper understanding of challenges and opportunities, allowing for more proactive and supportive care for those in recovery.

- ▶ **Bridging Gaps in Care**
- ▶ **Reducing Relapse Rates**
- ▶ **Scalable Recovery Support**
- ▶ **Available to all Arkansans**

This resource is available to all Arkansas residents in partnership with Ambetter from Arkansas Health & Wellness.

Transitional Care Management (TCM)

Transitional Care Management (TCM)

- ▶ Arkansas Health & Wellness is introducing a new way to work in partnership with the Transitional Care Management. The TCM program is a new initiative by Arkansas Health & Wellness aimed at improving the care coordination and outcomes for high-risk behavioral health members with high-risk substance use disorders receiving inpatient treatment. By providing targeted support before discharge, we aim to reduce readmission rates and enhance the overall quality of care.
- ▶ The TCM team is here to assist members in coordinating medical, behavioral, and social needs prior to discharging and upon entry into the community. The team's goal is to ensure the members are equipped with appropriate resources and support to facilitate an easy transition from your facility

How TCM Program Works

1. Identification:

Care managers will identify high-risk behavioral health members who are receiving inpatient treatment.

2. Assessment:

A thorough assessment will be conducted to understand the members needs and develop a care plan.

3. Coordination:

The care manager will work closely with the member, facility, staff, and other providers to coordinate care and ensure a smooth transition.

4. Follow-Up:

After discharge, the care manager will continue to follow up with the member to monitor progress and address any issues that arise.

The TCM team will contact the treating provider to coordinate a meeting with the member while the member is still receiving inpatient care. This interaction is intended to support both the provider and the member. Some of the support provided can include assistance with discharge planning, coordinating resources, addressing social determinants of health (SDoH), and care gaps. The goal is to ensure all discharge needs are addressed prior to returning to their community setting

Key Benefits of TCM Initiative

► **Improved Member Outcomes:**

Coordinating care before discharge, members receive more comprehensive support, leading to better health outcomes.

► **Reduced Readmission Rates:**

Aims to reduce the likelihood of members being readmitted to the hospital by ensuring they have the necessary resources and follow-up care.

► **Enhanced Care Coordination:**

Facilitates better communication between care providers, ensuring that all aspects of the members care are addressed.

► **Member Empowerment:**

Empowers members to take an active role in their care by providing them with the resources and support they need.

► **Provider Collaboration:**

By engaging providers in a coordinated care approach, the program ensures that all stakeholders are informed and aligned on the members care plan.



Transitional Care Management Contact
Care Manager for questions at 1-800-
575-2763 or email Provider Relations at
Providers@ARHealthWellness.com

Provider Self-Led Trainings

Provider Self-Led Trainings



For Providers
Login
Become a Provider ▼
Pre-Auth Check ▼
Provider Financial Support & Resources
Pharmacy
Provider Resources ^
Ambetter Clinical Coverage/Medical Policy Updates
Ambetter Coding Tip Sheets and Forms
Clinical & Payment Policies
Electronic Transactions ▼

- ▶ Provider self-led trainings are available 24/7 on the Arkansas Health & Wellness website.
- ▶ Go to ARHealthWellness.com and select For Providers.
- ▶ Open Provider Resources, then select Provider Training.
- ▶ Choose the applicable training or guide.
- ▶ After completing a required training, complete the associated Attestation Form.

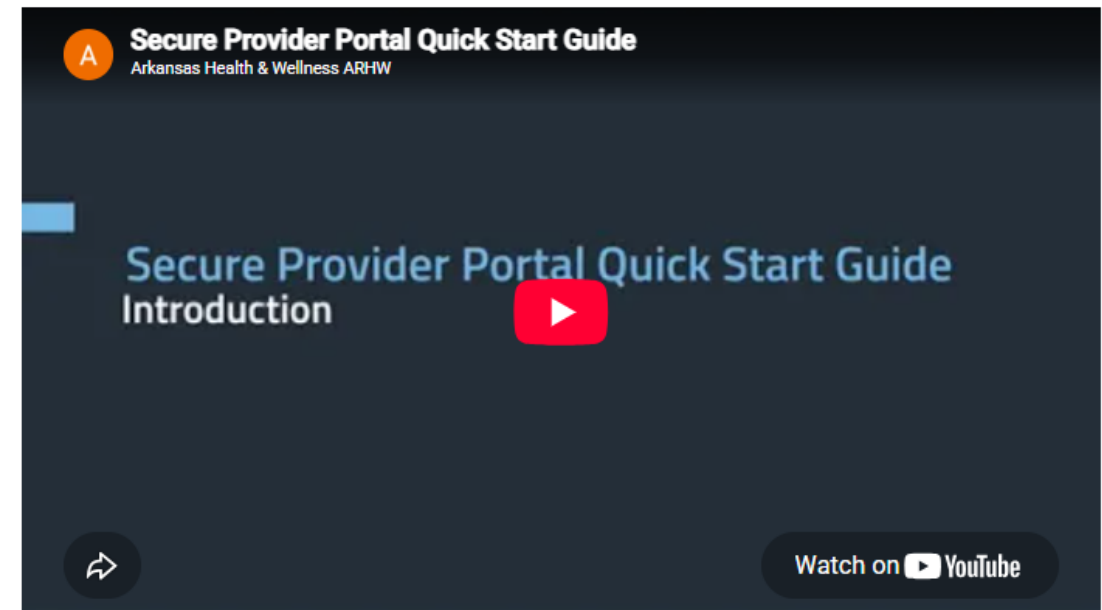
Self-Led Trainings

Secure Provider Portal Quick Start Guide

Arkansas Health & Wellness provides a Secure Provider Portal Quick Start Guide with an overview of registration and account setup, member eligibility and patient listings, health records and care gaps, prior authorizations, claim submission and status, and corrected claims and adjustments.

The training is available 24/7 on the Provider Training page. After completing the training, complete the Attestation Form.

ARHealthWellness.com/Providers/Resources/Provider-Training/Secure_Provider_Portal_Quick_Start_Guide.html



Risk Adjustment

Risk Adjustment Overview



Risk Adjustment is used to estimate healthcare expenditures for a given year based on an individual’s overall health status and perceived healthcare needs which are determined by demographic risk factors and the number and severity of health conditions.

RAF Score						
Age	+	Gender	+	Disease Conditions	+	Reason for Entitlement

Hierarchical Condition Categories (HCCs)

- ▶ ICD-10 diagnosis codes for certain chronic and acute medical conditions that require ongoing or long-term treatment map to a corresponding Hierarchical Condition Category (HCC).
- ▶ Each HCC code reflects a group of related health conditions that represent similar levels of severity and resource utilization. CMS determines the qualifying ICD-10 codes for each category and assigns the risk factor value.
- ▶ All current or active HCC diagnoses must be captured between January 1 and December 31, annually.

Medical Record Requirements

Face-to-face
encounter

Acceptable
provider type

Acceptable
service type

Correct entry for
date of service

Two patient
identifiers

Use of standard
abbreviations

Complete and
legible

Proper signature
w/ credentials

Provider's Role in Risk Adjustment

- ▶ Provider coding and documentation directly drives the capture of chronic and complex conditions that are reported for risk adjustment purposes.
- ▶ Effective risk adjustment practices require comprehensive assessment of all conditions, with ICD-10-CM codes included on claims for active diagnoses, coded to the highest specificity supported by medical record documentation.

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 Program Initiatives

Continuity of Care (CoC)

Provider incentive program — increases visibility into members' existing medical conditions for chronic condition management (PCP only).

In-Office Assessment (IOA)

Provider incentive program — supports early detection and ongoing annual assessment of chronic conditions for patients to help improve health outcomes.

Clinical Documentation Improvement (CDI)

Complimentary review of provider coding and documentation trends with education tailored to review findings.

Annual Chart Review Projects

Vendor works with providers and health plan to retrieve medical records and accurately report members health status in compliance with Risk Adjustment guidelines.

2026 Continuity of Care Plus (CoC+)

1 Risk Adjustment Insight

Eligibility Requirements

Participating PCPs can earn up to \$300 per member.
Provider within assigned TIN must:

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

2 Comprehensive Insights

Additional incentive opportunity:

\$150

per Medicare Agenda

\$100

per Marketplace Agenda

All boxes related to the high complexity, Quality, clinical, and/or drivers of health Insights must be checked and verified, where applicable.

2026 CoC+ Program runs through December 31st

Risk Adjustment Medical Records Requests

Medical Record Requests are a regulatory and operational necessity designed to ensure fairness, accuracy, and compliance in healthcare reimbursement. These requests serve several critical purposes:

Regulatory Compliance

Risk adjustment is mandated by CMS under the Affordable Care Act to prevent adverse selection of only healthy members and to stabilize premiums.

Health Equity

Risk adjustment ensures that higher-risk populations receive appropriate resources which allows equitable care for more vulnerable members.

Care Quality

Risk adjustment diagnostic data is used to forecast costs, fund essential programs, and maintain continuity of care, supporting better clinical decision making.

Data Integrity

Risk adjustment chart requests serve in diagnosis code validation which ensures member health status is accurately reported.

Risk Adjustment Data Validation (RADV)

Centers for Medicare and Medicaid Services (CMS) implemented policy changes for RADV:

- ▶ Annual audits for all Marketplace and Medicare Advantage plans
- ▶ Expanded record samples
- ▶ Accelerated audit timelines

Due to CMS aggressive workplan, providers may experience:

- ▶ Higher volume of record requests
- ▶ Tighter turnaround windows

**Benefits of automated data exchange
between payor and provider:**

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

**Bi-directional feed and point of care
alerts can be integrated into EMR:**

Athena	Epic	eClinical Works
Allscripts	Practice Fusion	Cerner
Office Ally	NextGen*	Meditech*

*Future Connections

Clinical Documentation Improvement Webinars

Risk Adjustment Coding and Documentation Education

Join Centene Corporation's CDI Webinar Series designed to enhance your understanding of:

- ▶ Risk adjustment methodologies
- ▶ Accurate and compliant documentation practices
- ▶ Coding strategies aligned with regulatory standards

Who Should Attend?

Providers, non-physician practitioners, coders, billers, and administrative staff involved in clinical documentation and coding.

Advanced registration is required. Utilize the corresponding registration link provided for each topic (links are unique to each webinar). If you have questions or need assistance with registration, email CDIWebinars@centene.com.

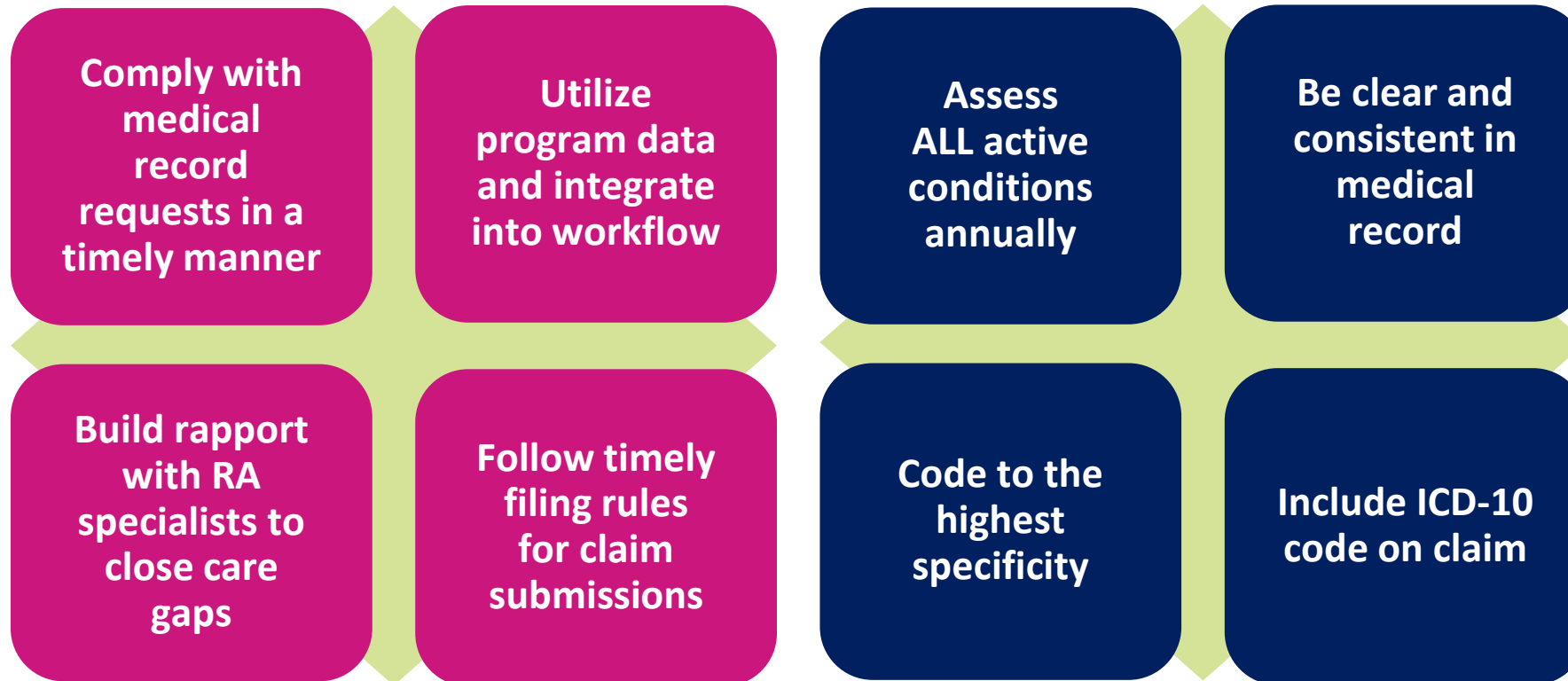
2026 Webinar Series

Registration Link: January–November



[Register here!](#)

Summary of Best Practices



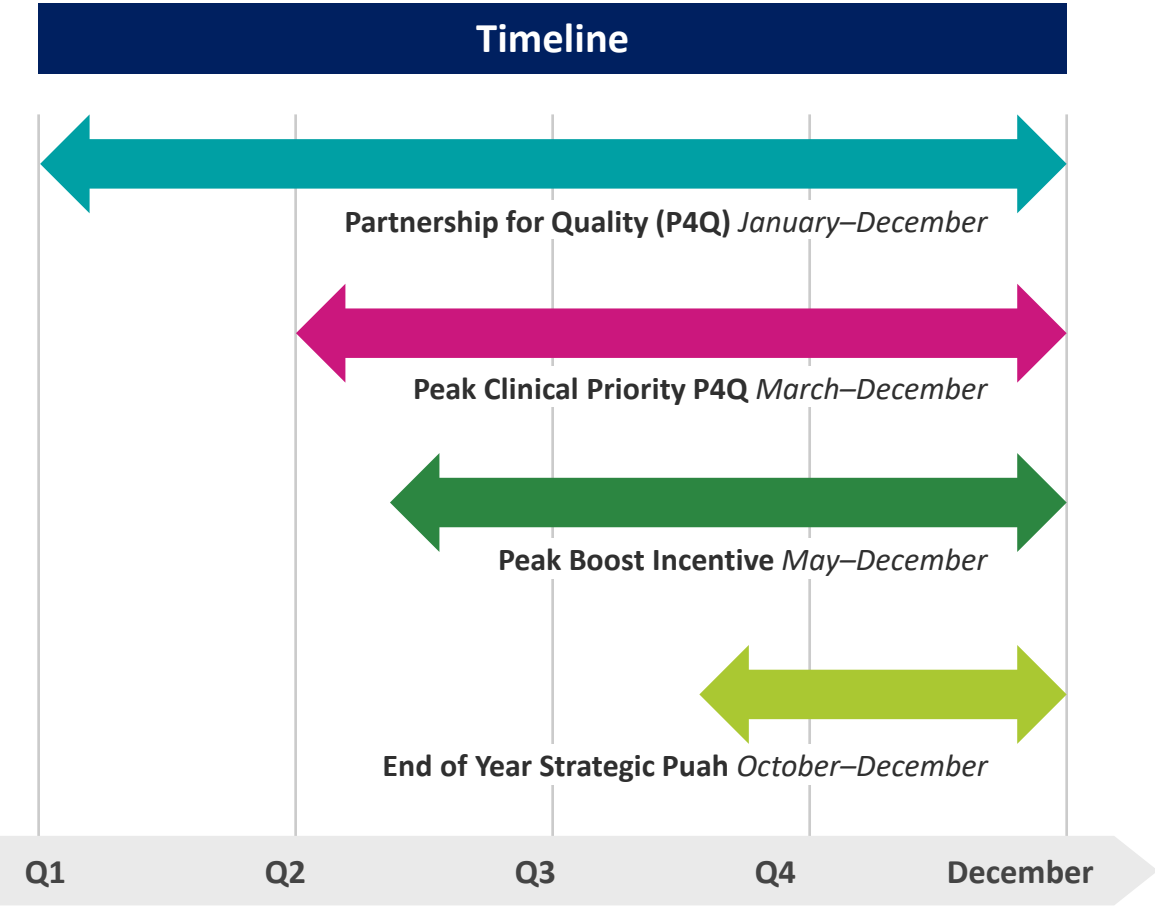
Quality Improvement

2026 Partnership for Quality (P4Q)

2026 P4Q Program Highlights

- ▶ PCPs can earn incentives by addressing preventive care activities and closing care gaps for members.
- ▶ Clinical Priority members may have additional incentive opportunities.
- ▶ Contact patients, schedule needed visits, complete appropriate preventive services, and close care gaps by December 31, 2026.
- ▶ Document care, treatment, and diagnoses in the medical record and submit applicable diagnosis information through approved channels by January 31, 2027.
- ▶ Review and counsel patients on test and screening results.
- ▶ The 2026 P4Q program has four payment cycles; balances under \$100 roll to the next payment cycle, subject to program terms.

2026 Quality Provider Incentive Programs



P4Q runs January–December. Peak Clinical Priority P4Q runs March–December, Peak Boost Incentive runs May–December, and the End of Year Strategic Push runs October–December.

Partnership for Quality (P4Q)

PCPs earn incentives by addressing preventive care and closing care gaps

Peak Clinical Priority P4Q

PCPs can earn additional incentives for Clinical Priority* members

Peak Boost Incentive

PCPs can earn incentives for Year-over-Year Quality Score improvement

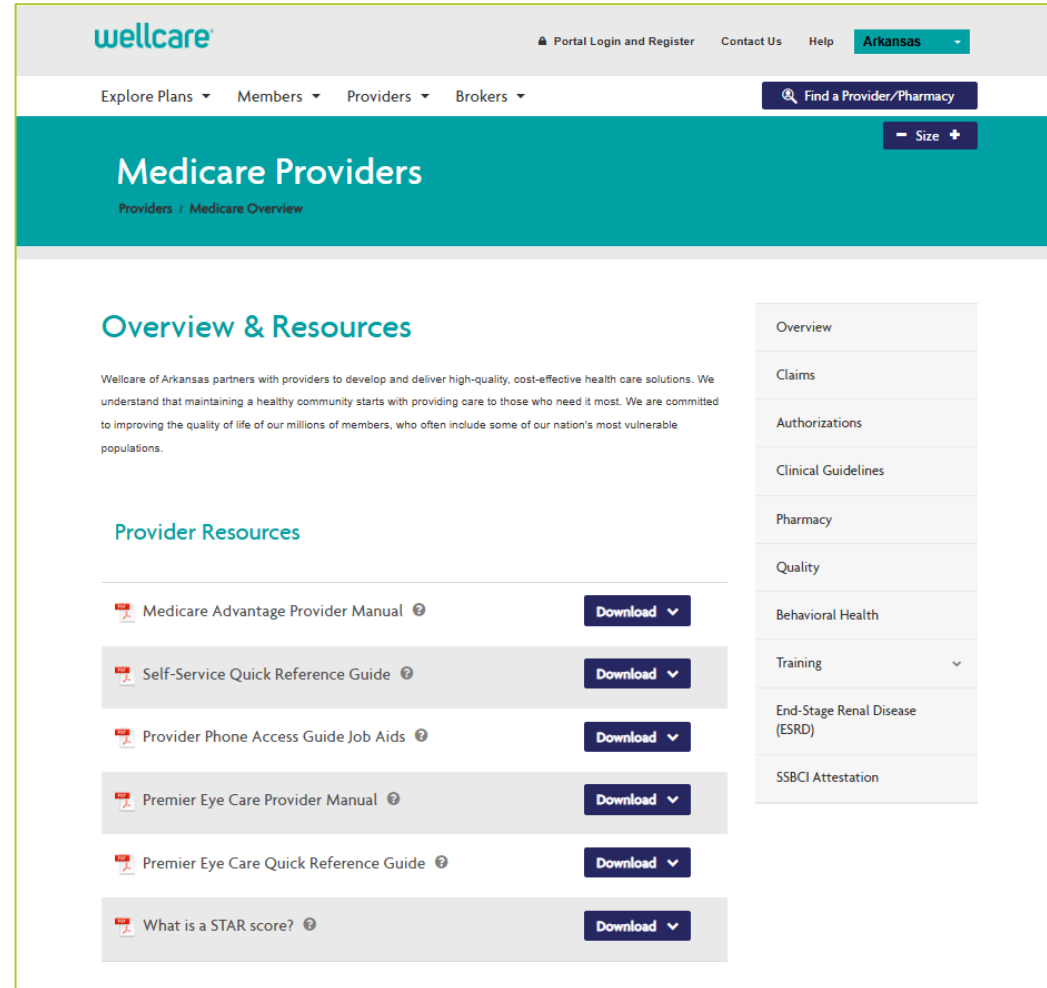
End of Year Strategic Push

to be contract/measure focused

*Clinical Priority patients may require a greater level of medical attention due to chronic illnesses, disabilities, age, or other factors that necessitate the need for more frequent provider visits, specialized treatments, and chronic care support. Note: additional provider incentive programs are available (Rx Effect, MFIP, local health plan programs, etc.). This is not a comprehensive list of all incentive programs.

Quick Reference Guides

Access Medicare provider materials, including the Arkansas Medicare Quick Reference Guide, at [Wellcare.com/Arkansas/Providers/Medicare](https://www.wellcare.com/Arkansas/Providers/Medicare).



The screenshot shows the Wellcare website interface for Medicare Providers. The header includes the Wellcare logo, navigation links for Portal Login and Register, Contact Us, Help, and a dropdown for Arkansas. Below the header is a search bar with the text "Find a Provider/Pharmacy" and a "Size" button. The main content area is titled "Medicare Providers" with a breadcrumb "Providers / Medicare Overview". Under the "Overview & Resources" section, there is a paragraph about Wellcare of Arkansas's commitment to high-quality, cost-effective health care solutions. Below this is a "Provider Resources" section with a list of downloadable documents: Medicare Advantage Provider Manual, Self-Service Quick Reference Guide, Provider Phone Access Guide Job Aids, Premier Eye Care Provider Manual, Premier Eye Care Quick Reference Guide, and What is a STAR score?. Each document has a "Download" button. On the right side, there is a sidebar with a list of topics: Overview, Claims, Authorizations, Clinical Guidelines, Pharmacy, Quality, Behavioral Health, Training, End-Stage Renal Disease (ESRD), and SSBCI Attestation.

2026 Ambetter P4P

Pay-for-Performance (P4P) Measures

The 2026 Ambetter P4P program provides measure-specific incentives for closing eligible care gaps. Measures include breast and cervical cancer screening, child and adolescent well-care visits, chlamydia screening, colorectal cancer screening, blood pressure control, diabetic eye exams, glycemic status assessment, kidney health evaluation, and depression screening and follow-up.

Each measure has defined performance targets. Target 1 pays 75% of the applicable measure incentive, and Target 2 pays 100%.

Pay-for-Performance (P4P) Program Overview

- ▶ Objective: Improve quality through a PCP-driven program focused on preventive and screening services.
- ▶ Member attribution: Members are formally assigned to a provider's Tax ID Number (TIN).
- ▶ Targeted services: Selected PCP engagement, screening, and medication adherence measures aligned with applicable quality specifications.
- ▶ Performance incentive: Each measure has its own incentive amount tied to its performance target.
- ▶ Requirements for payout: Target 1 pays 75% of the measure incentive; Target 2 pays 100%.
- ▶ Payout: Three payouts per year (Q2, Q3, and Q4 final reconciliation), with monthly gap-in-care reporting and performance scorecards.

CPT II Coding

Submitting CPT II and HCPCS codes improve efficiencies in closing patient care gaps and in data collection for performance measurement. Wellcare has taken steps to help ensure submissions for the following select codes to the Medicare fee schedule at a price of \$0.01.

Medicare Annual Preventive Visit (APV)

Schedule an Annual Preventive Visit with eligible members.

- ▶ The Annual Preventive Visit is a Medicare visit used to discuss the member's health and create a personalized prevention plan.
- ▶ Eligible Wellcare members may receive one Annual Preventive Visit per calendar year.
- ▶ A routine physical exam is a separate Medicare Advantage supplemental benefit that provides a comprehensive physical examination to screen for disease and promote preventive care.
- ▶ Refer to current billing guidance for applicable coding and billing requirements.

Topics to address during an Annual Preventive Visit may include:

- ▶ Update the medical record, including demographics, other treating providers, and family history.
- ▶ Conduct a social determinants of health assessment and discuss advance care planning.
- ▶ Screen for cognitive impairment, depression, mental wellness, and emotional health.
- ▶ Reconcile medications and assess opportunities for extended-day fills when appropriate.
- ▶ Complete pain, functional, fall-risk, and health-risk assessments.
- ▶ Assess bladder leakage and care options.
- ▶ Create a preventive screening schedule and make appropriate referrals.
- ▶ Check routine measurements and review opioid prescriptions and potential substance use disorders.
- ▶ For routine physical visits, also review health history, vital signs, and the appropriate physical examination.

AWV Quick Reference & Tips

- ▶ For people with diabetes: diabetic retinal eye exam, medication adherence review, blood pressure monitoring, HbA1c testing/control, kidney function testing, and attention to nephropathy.
- ▶ Important cancer screenings: colorectal, breast, prostate, and lung cancer screening, as appropriate.
- ▶ Care for older adults: medication review/reconciliation, functional status assessment, pain assessment, advance care planning, and depression screening.
- ▶ Adult vaccinations: review recommended COVID-19, influenza, pneumococcal, meningococcal, Td/Tdap, shingles, hepatitis A, and hepatitis B vaccinations as appropriate.
- ▶ Share test and screening results with members, submit applicable diagnoses, and use appropriate quality coding to support outcomes and reduce chart collection.

Medication Adherence Tips

Best practices to promote medication adherence:

- ▶ Prescribe a 90-day supply for chronic medications when appropriate.
- ▶ Review all medications with the patient during each visit; remove medications that are no longer needed and reduce dosages when appropriate.
- ▶ Check for understanding by explaining why the medication is prescribed, what it does, and how to manage potential side effects.

RxEffect LIS Indicator: If the LIS flag reflects 'Yes,' your patient (our member) is eligible to fill a 90-day prescription for the same cost as a 30-day prescription.

Contact Information

Provider Services Call Center



First line of communication

- ▶ Ambetter Provider Services
1-877-617-0390 (TTY: 1-877-617-0392)
- ▶ Wellcare by Allwell Provider Services
1-855-565-9518 (TTY: 711)

**Representatives are available
Monday through Friday from
8 a.m. to 5 p.m. CT**

Provider Service Representatives can assist with questions regarding:

- ▶ Member Eligibility
- ▶ Claim Inquiry
- ▶ Prior Authorization
- ▶ Network Verification
- ▶ Appeal Status
- ▶ Payment Inquiries
- ▶ Check Stop Pay or Check Reissues
- ▶ Negative Balance Report
- ▶ Provider Demographic Change Request
- ▶ Secure Portal Password Reset

Provider Inquiries

- ▶ After speaking with a Provider Services Representative, you will receive a reference number, which will be used to track the status of your inquiry.
- ▶ If you need to contact your assigned Provider Relations Representative, you must have the following when submitting an email inquiry:
 - Reference number assigned by the Provider Services Center
 - Provider's Name
 - Tax ID
 - National Provider Identifier (NPI)
 - Summary of the issue
 - Claim numbers (if applicable)



Providers@ARHealthWellness.com

Contracting and Credentialing

Contracting Department

- ▶ Hours of Operation: 8 a.m.– 4:30 p.m.
- ▶ Provider Contracting Email Address:
ArkansasContracting@centene.com
Regular contracting inquiries and contract requests

Arkansas Health & Wellness Credentialing Department

- ▶ Provider Credentialing Email:
ArkCredentialing@centene.com

Education Requests

Would you like training for you and your staff?



You can submit your requests to:
Providers@ARHealthWellness.com

