VALUE-BASED CARE AND RHC-FQHC 2023

CHARLES JAMES: NORTH AMERICAN HMS/ RURAL ADVANTAGE ACO

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CHARLES A. JAMES - NORTH AMERICAN HMS

Executive Director – Rural Advantage ACO

Charles@ruraladvantage.net

www.ruraladvantage.net

President and CEO - North American HMS

cjamesjr@northamericanhms.com

www.northamericanhms.com

314.560.0098

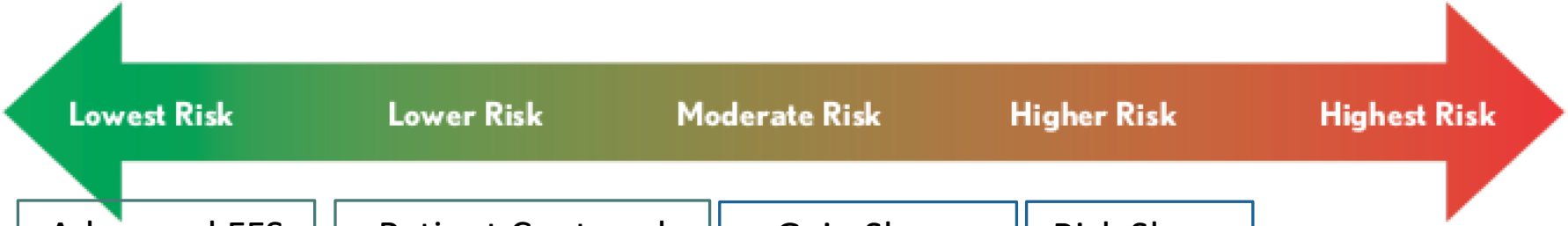
314.968.6883 (Fax)

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)

SPECTRUM OF RISK IN VALUE-BASED ARRANGEMENTS



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)

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

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

Medicare Shared Savings 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

MSSP PARTICIPANT ACTIVITIES

- Care Management Services
- Annual Wellness Visits
- Transitional Care Management
- Preventive Screenings
- ICD-10 Coding (HCC)
- CPT II/Claims-Based Reporting

ACO DATA AND ANALYTICS

- Patient Attribution
- Annual Wellness Visits
- Documented Disease Burden
- SNF/ESRD Utilization
- Re-Admissions/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.

PROVIDER CONSIDERATIONS

We ARE talking about practice transformation.

- Annual Wellness Visit completion
- Coding Education => Accurately reflect patient illness
- Care Management
- Patient attribution

RHC CONSIDERATIONS

- Annual Wellness Visits and Preventive Screenings are Stand-Alone encounters
- We CANNOT submit CPT II codes on UB04 claims
- Medicare attribution is per clinic - not provider.

SHARED SAVINGS PAYMENTS

GENERIC MEDICARE-SHARED SAVINGS PLAN TRACK A

MSSP are calculated for each Performance Year.

Data is based on claims for attributed patients.

Payments are *ANNUAL*.

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	

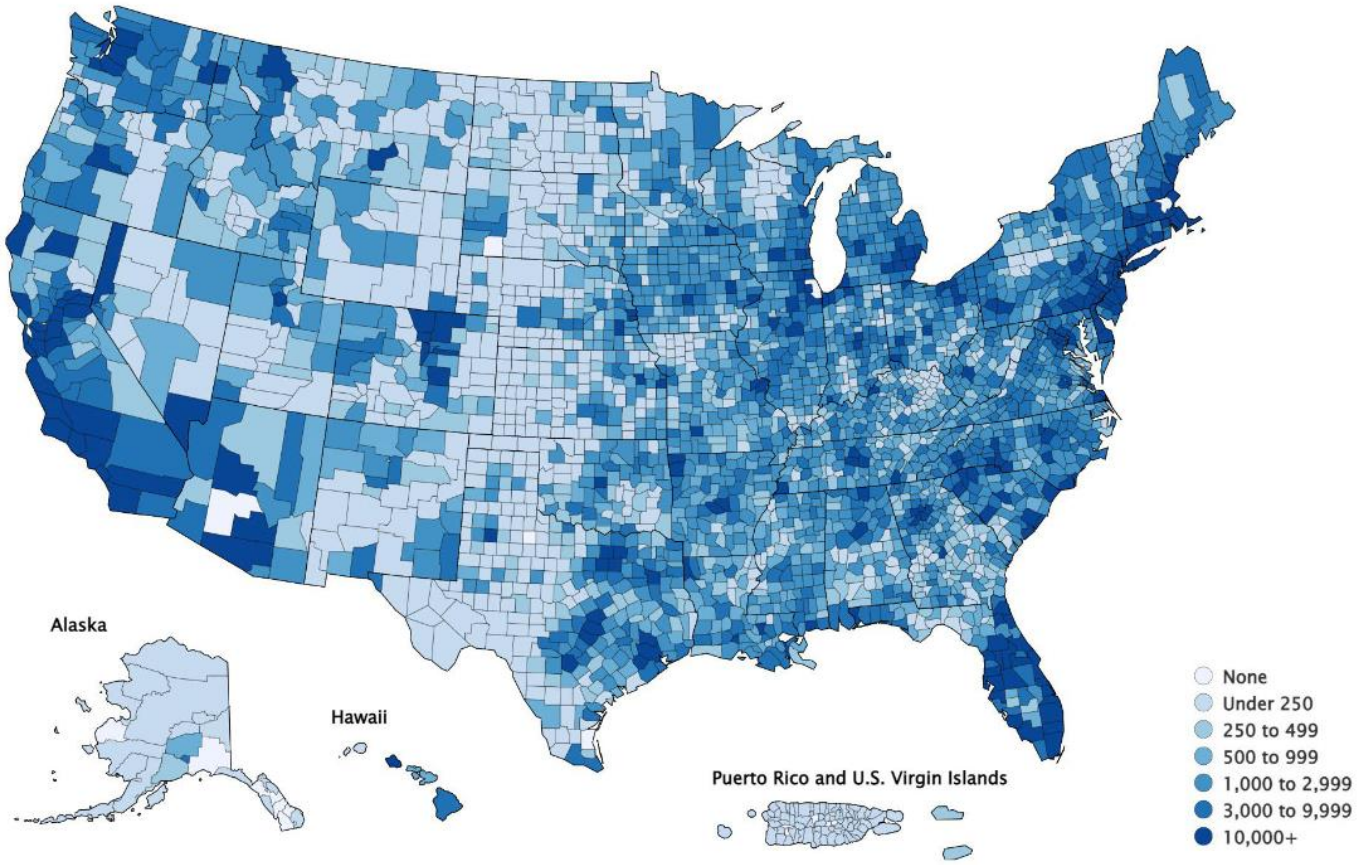
MEDICARE SHARED SAVINGS PROGRAM

Assigned Beneficiary Population by County

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

CMS | MEDICARE SHARED SAVINGS PROGRAM

Medicare Shared Savings Program ACO Assigned Beneficiary Population by County

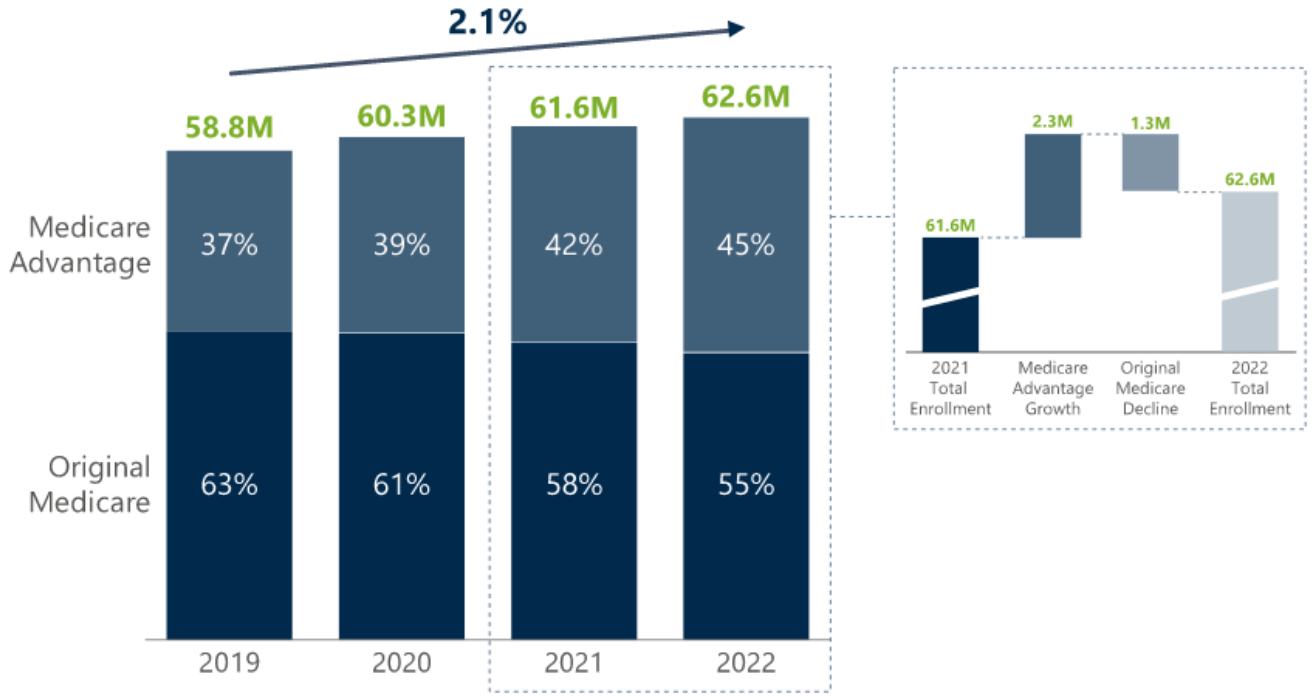


MEDICARE ADVANTAGE AND VALUE BASED CARE: CLOSING CARE GAPS

TAKE ADVANTAGE OF VALUE-BASED DOLLARS NOW!!

TRENDS: MEDICARE ADVANTAGE PENETRATION

Medicare Enrollment and Penetration Change by Year



MEDICARE ADVANTAGE / COMMERCIAL PAYERS

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!

CAHPS

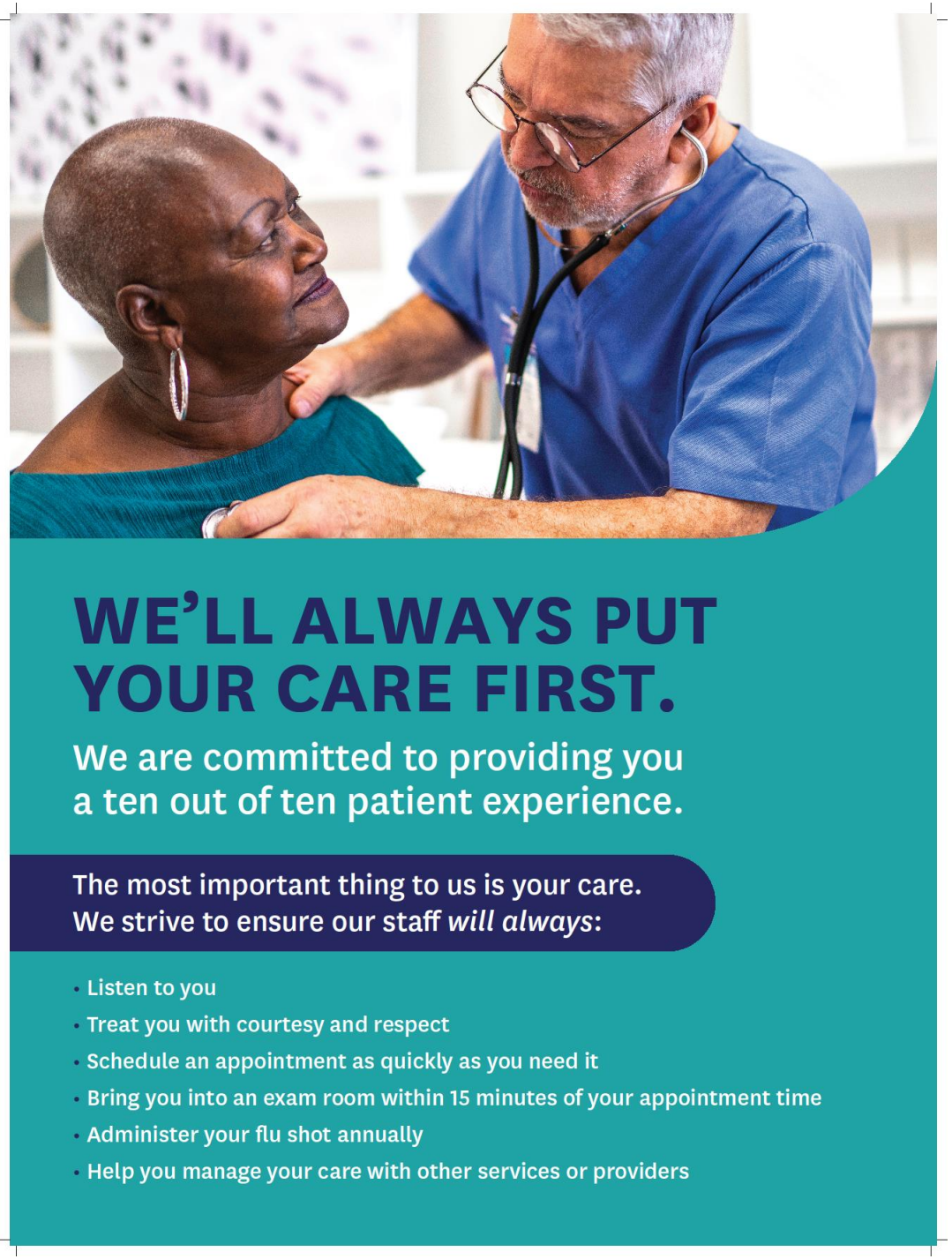
Consumer Assessment of Healthcare Providers and Systems

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



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?	

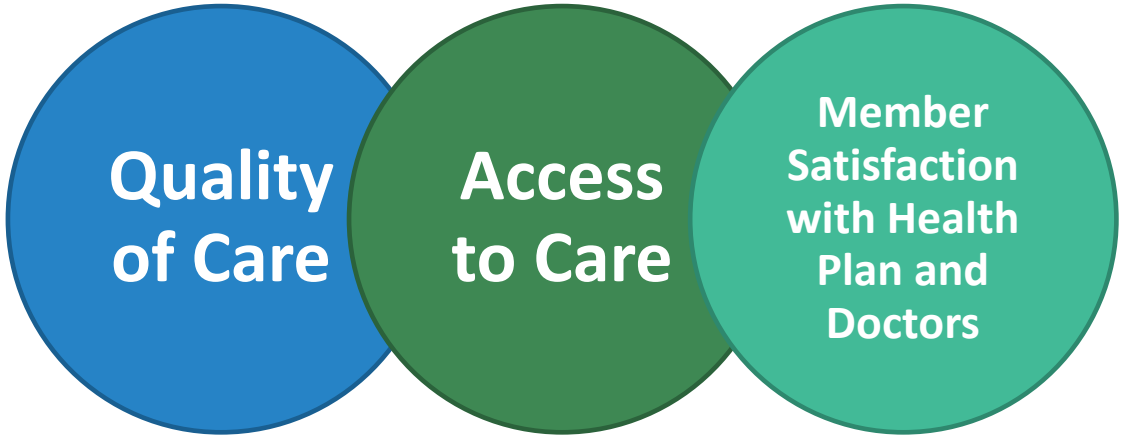
CAHPS FOCUS

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

HEDIS AND CAHPS

“Learn it. Know it. Live it.”

- Brad Hamilton

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)	

INCENTIVE DOLLARS NOW!

MEDICARE ADVANTAGE – COMMERCIAL – MEDICAID MCO

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

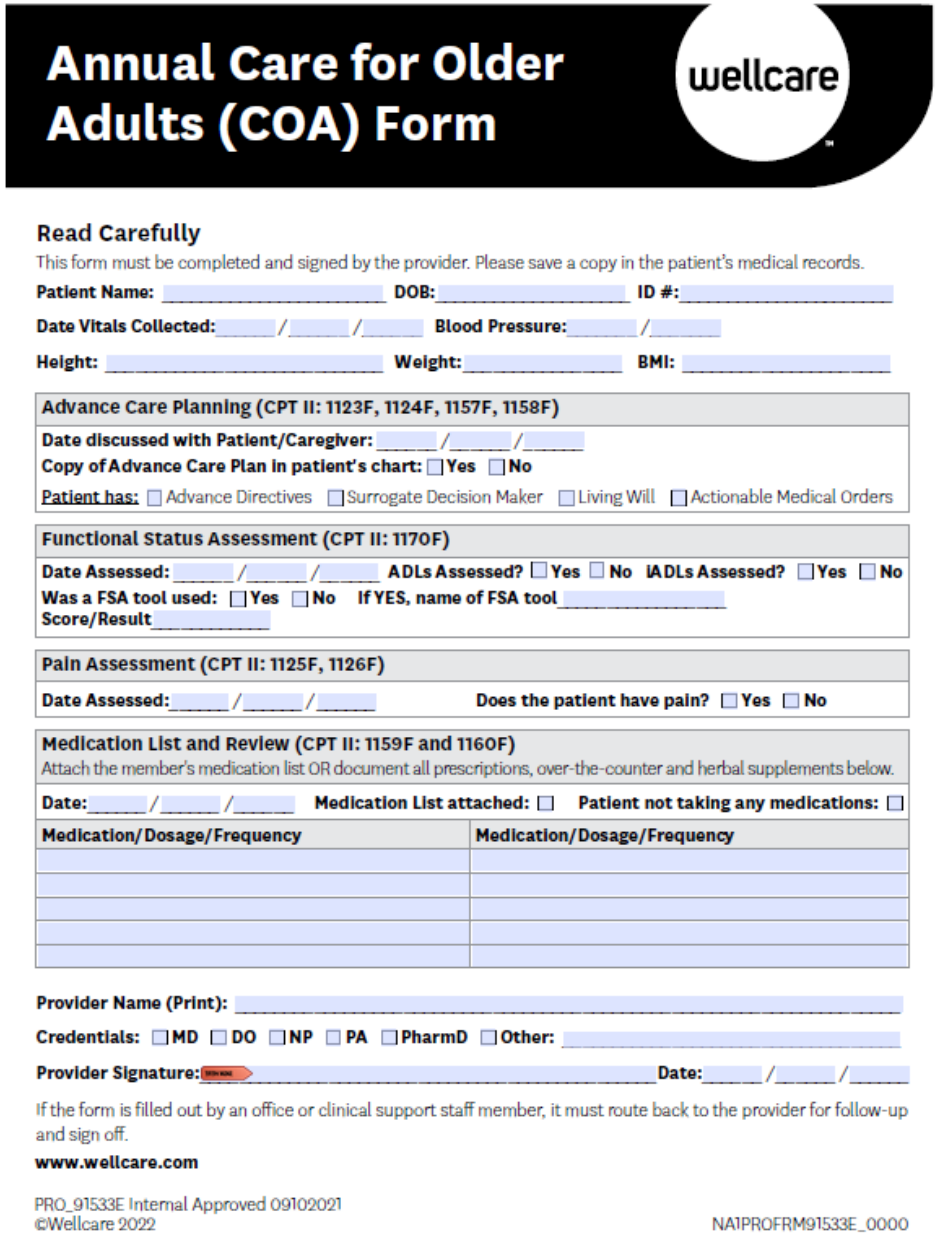
APPOINTMENT AGENDAS FOR WELLCARE, MERIDIAN & AMBETTER

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

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

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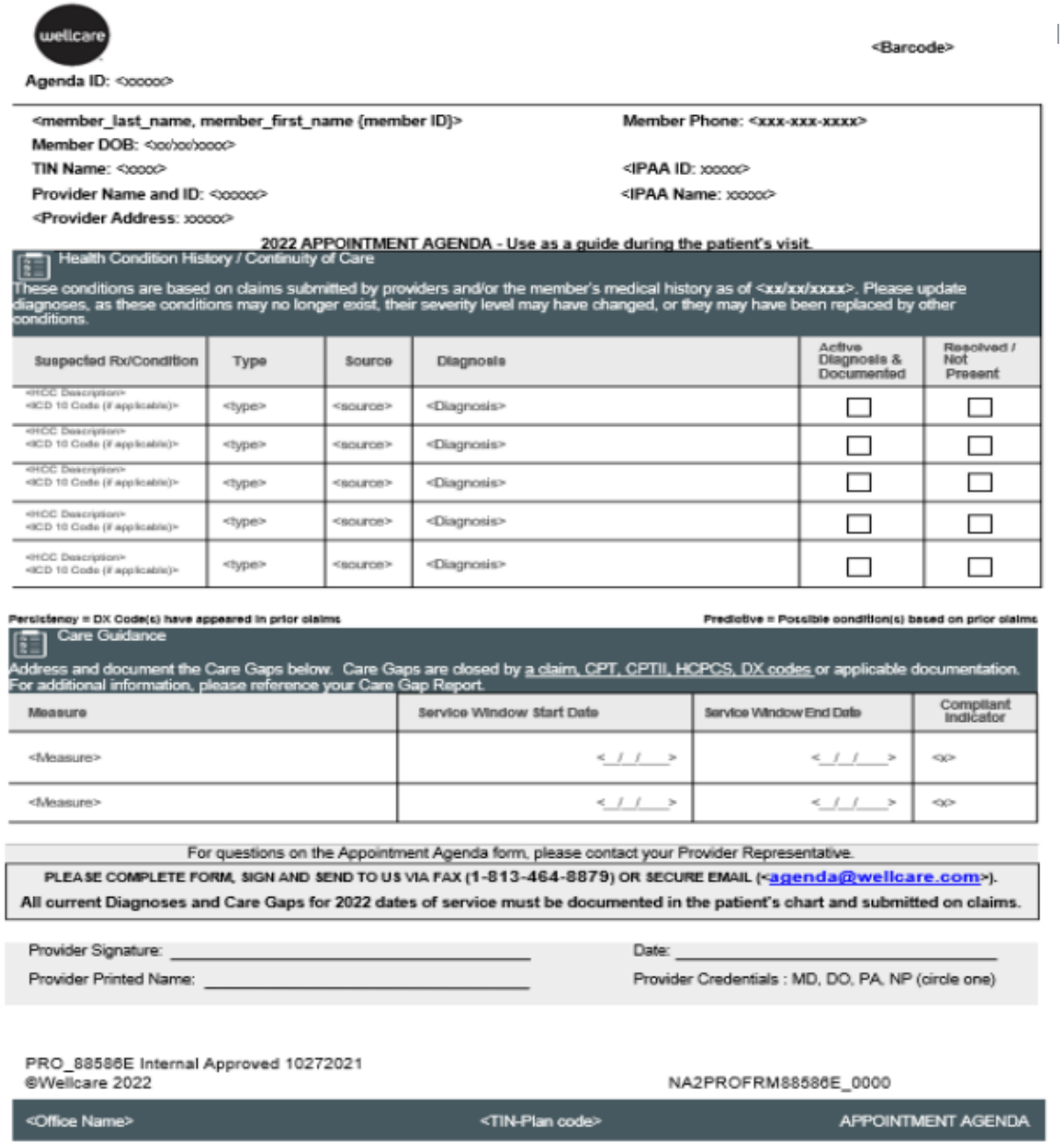
Example of PDF agenda submission

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>	☐	☐
<HCC Description> <ICD 10 Code (if applicable)>	<type>	<source>	<Diagnosis>	☐	☐
<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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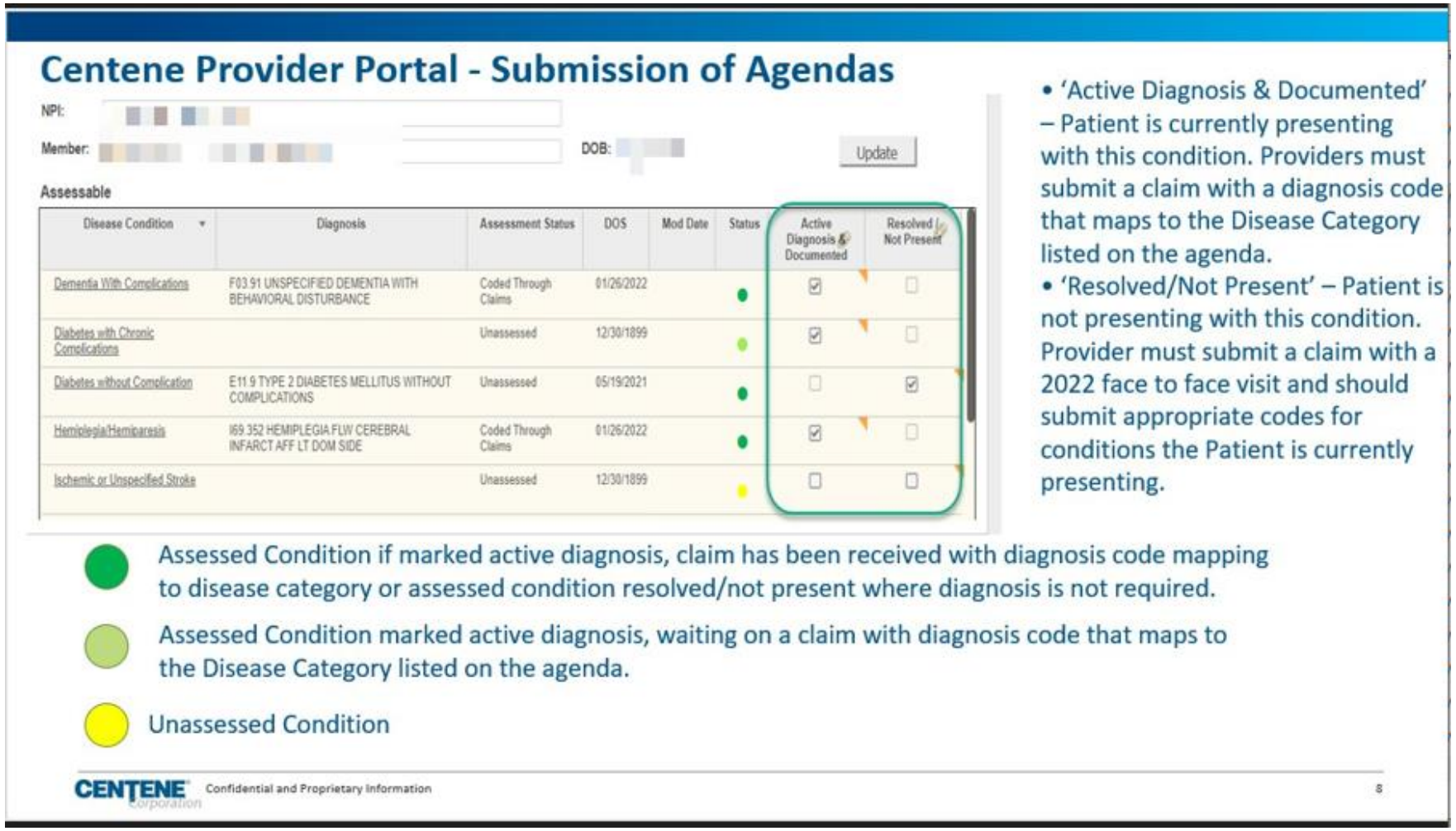
<Office Name> <TIN-Plan code> APPOINTMENT AGENDA

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.

CARE GAPS ARE CLAIMS BASED! CPT II REPORTING

Report CPT II Codes on ALL claims to ALL payers.

- ✓ MEDICARE UB04! Not yet!!
- ✓ United
- ✓ Wellcare/BC
- ✓ ALL Medicare Advantage plans
- ✓ Medicaid MCO plans
- ✓ Reach out to provider representatives about their quality plans and how to receive incentives!
- ✓ Test claims first!

TRADITIONAL MEDICARE UB04 CPT II REPORTING

We cannot yet file CPT II Codes on UB04 to Traditional Medicare.

-Report/record CPT Code in EHR/PM system.

-Suppress CPTII Code from CLAIMS only.

-This will ensure that the data is identifiable for future retrieval.

CHANGE YOUR THINKING:

REPORT EVERY SERVICE THAT IS DUE, PERFORMED, AND DOCUMENTED.

- ⇒ Including, and especially, CPT Level II codes
- ⇒ For ALL Payers!

FORECAST BEYOND 2023

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

The Rural Advantage Mission:

"Provider and Patient Well-Being."

RURAL ADVANTAGE

Our main organizational objective is to return value to our providers.

Charles A. James, Jr.
President and CEO
North American HMS
RHC-FQHC Experts since 1992

The Rural Advantage was created by North American HMS to provide a mechanism for value-based participation for Rural Providers, Rural Hospitals, RHCs and FQHCs.

Dr. Tom Davis, MD

Value-Based Payment Expert

Dr. Tom Davis, MD is an expert in value-based healthcare and full-risk insurance contracting.

Dr. Tom Davis, MD is THE national expert in value-based healthcare delivery and full-risk insurance contracting. A family physician for over 25 years, angel investor, founder of 6 companies, co-founder of 8, he has successfully managed thousands of patients under Medicare Advantage and other value-based care programs. He is a sought-after consultant, speaker, and trusted advisor.

Kelly Conroy

Director
Pinnacle Healthcare Consulting

Kelly brings more than 30 years of healthcare finance, management and leadership experience to Pinnacle with significant experience in Value Based Care. As a leader in the field, she'd contributed through multiple start up healthcare companies with a leading-edge focus on advancements in care delivery and alignment.

Kelly started the first Medicare ACO in the country, which delivered nearly $40M in savings in its first year and has gone on to manage some of the most profitable ACOs in the country.

How to increase revenue?

We all know that you can’t keep doing what you’ve been doing – much less MORE of it.

The Rural Advantage:

Provider payments are OVER-AND-ABOVE Claims Revenue.

Rural Advantage Proposed Measures PY2023

Rural Advantage
Participant Scorecard 2023

Participant	Provider 1	Provider 2	Provider 3	Provider 4
Attribution				
PMPY				
Shared Savings				

Quality Measure	Weight	Weight	Weight	Weight
Attendance at Rural Advantage Educational Sessions	15%	15%	15%	15%
Attendance at Rural Advantage Monthly/Quarterly Meetings	15%	15%	15%	15%
Panel Size/Patient Retention (Maintain or increase attributed patients)	10%	10%	10%	10%
Annual Wellness Visits (>70% of patients eligible for AWV receive one)	40%	40%	40%	40%
Transitional Care Management	20%	20%	20%	20%
Subtotal				

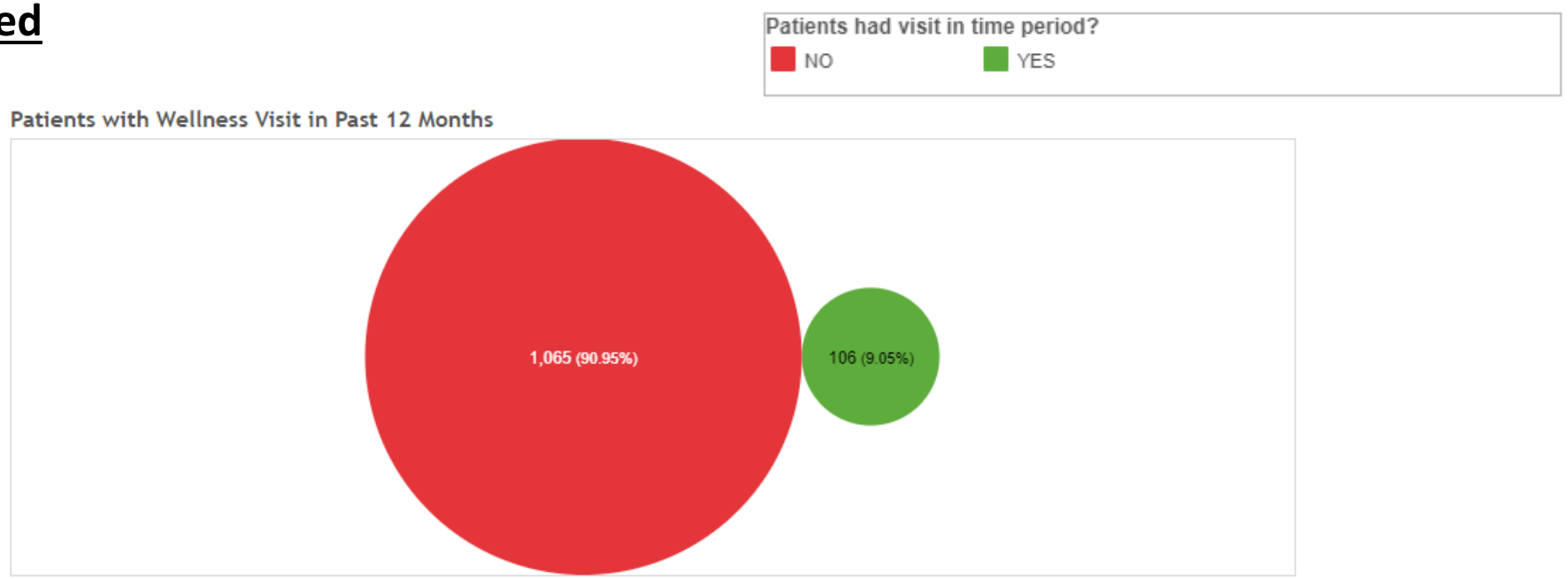
RURAL ADVANTAGE

agenda

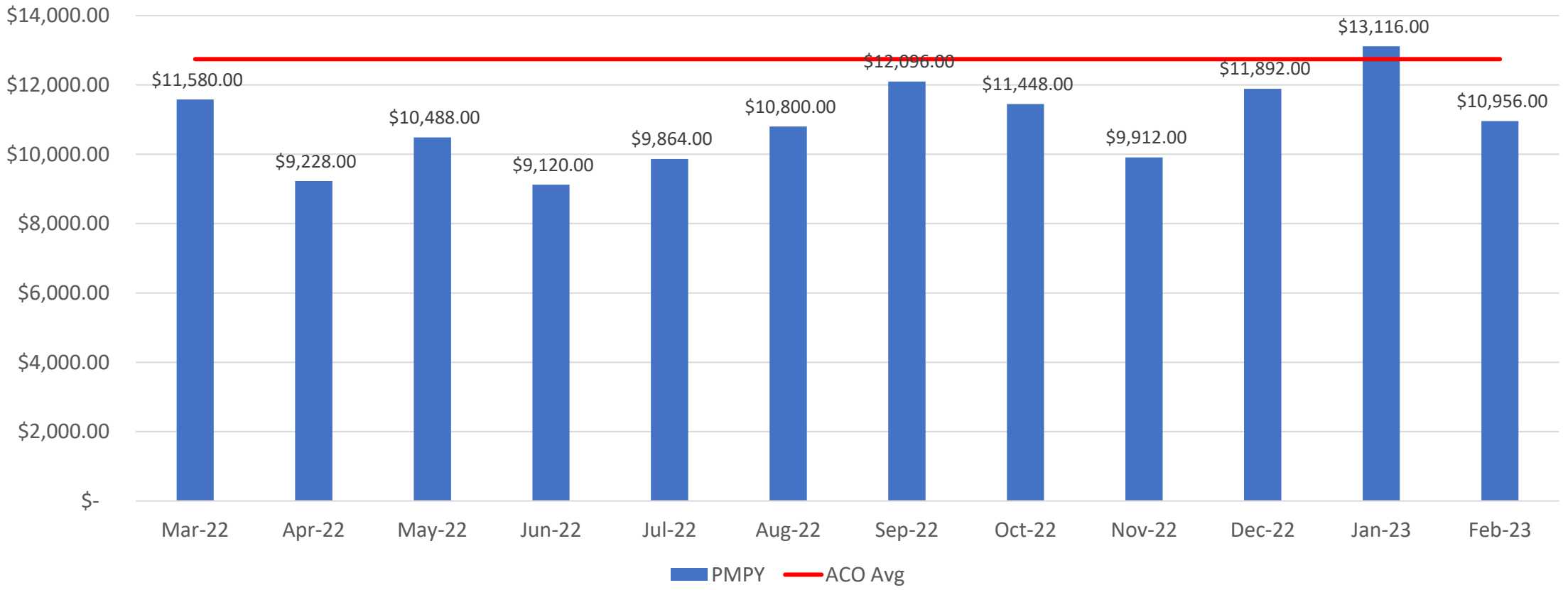
- Practice Stats
- Monthly cost & utilization metrics (rolling 12 months)
  - PMPY
  - ER per 1,000
  - IP per 1,000
  - IP readmissions
  - SNF PMPY

Practice Stats

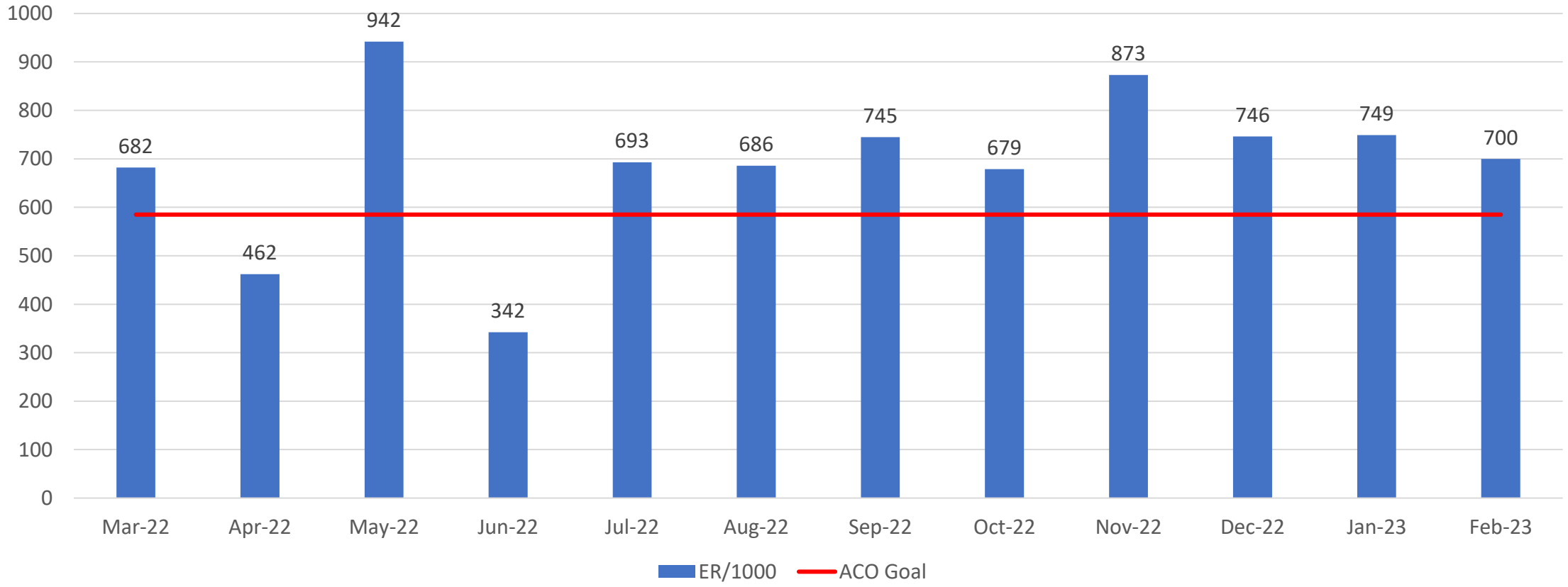
- Attributed patients: 1,171
- HCC Risk Score: 0.960
- **AWV Completed**



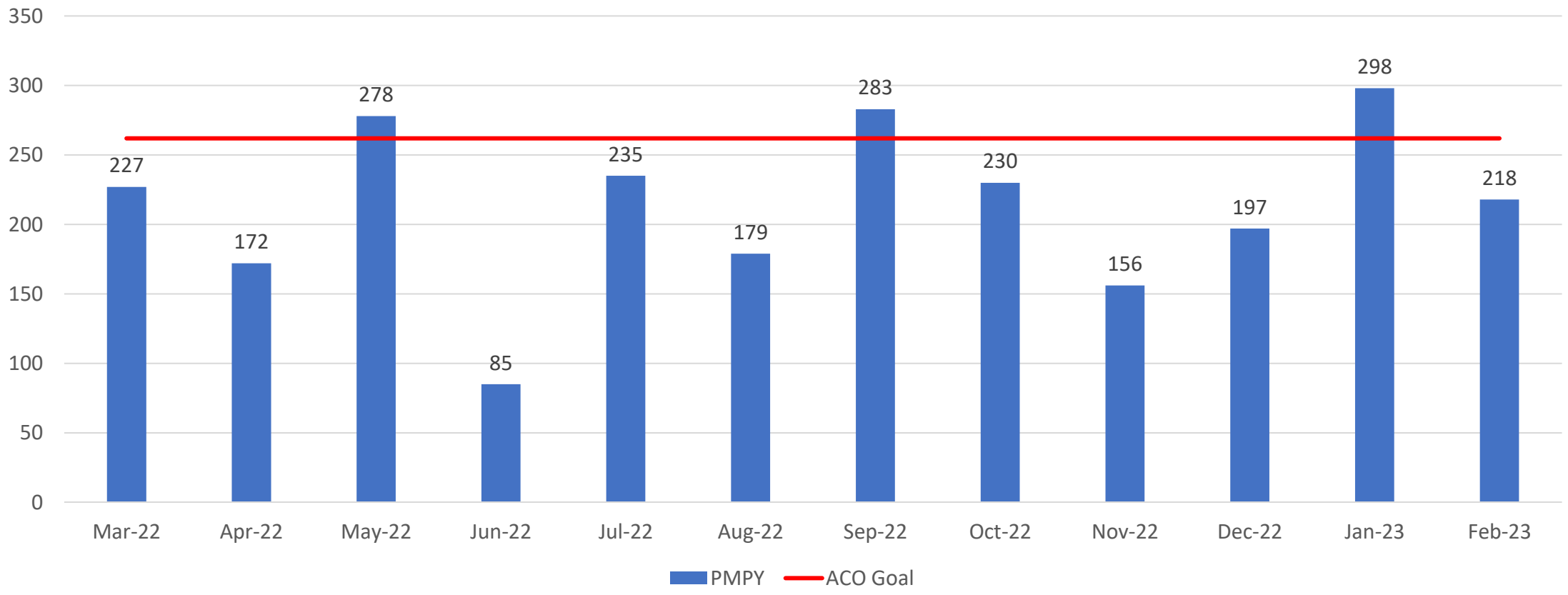
Per member per year cost



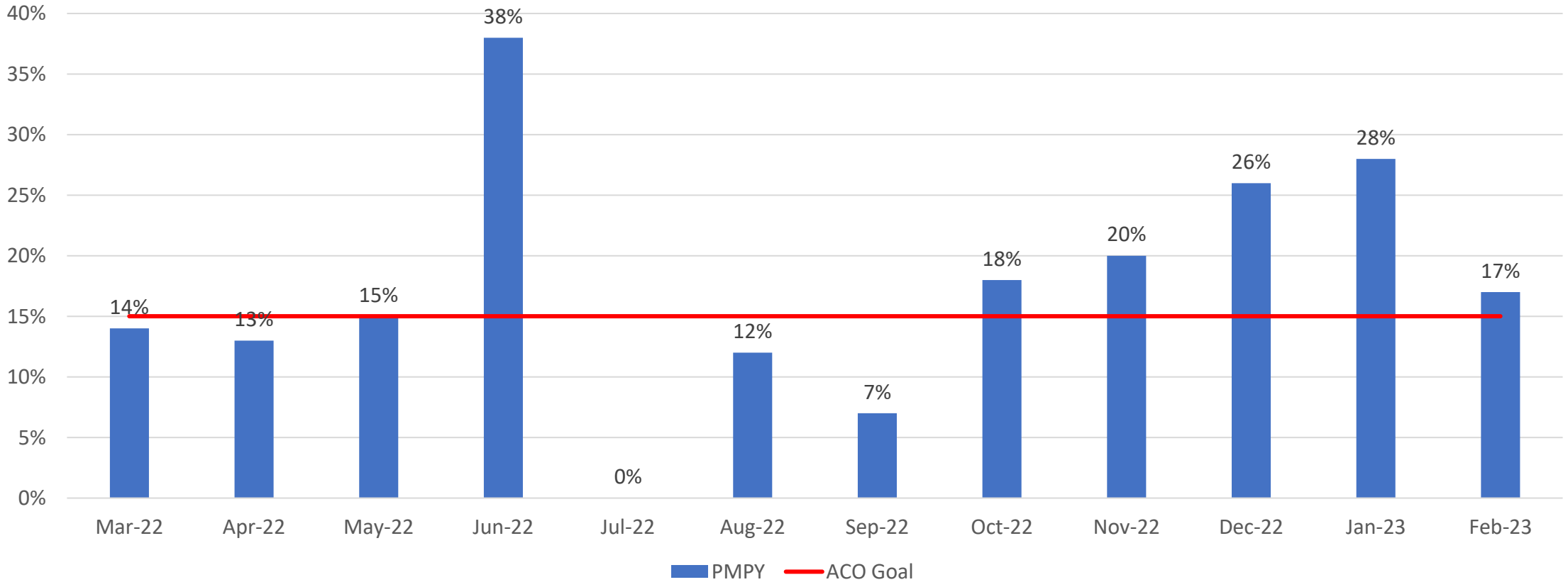
ER Visits per 1,000



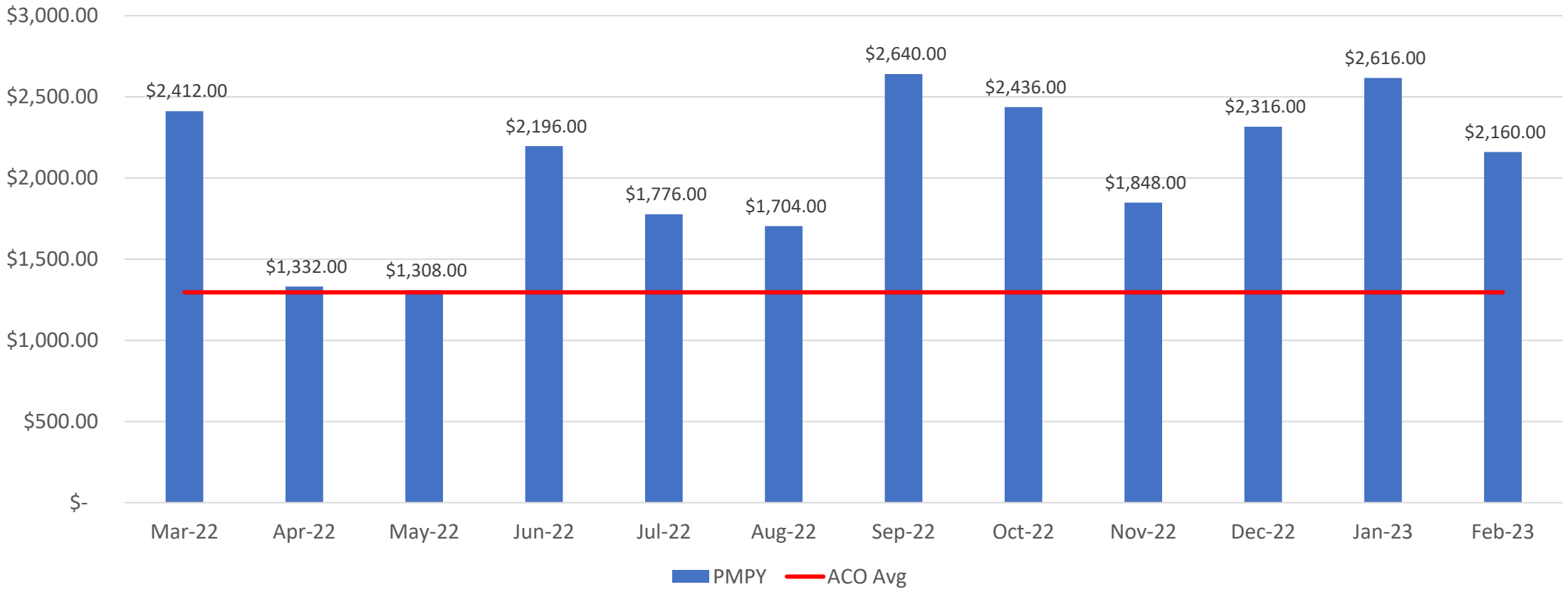
IP Admissions per 1,000



IP readmissions



SNF PMPY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$2,412.00
$1,332.00
$1,308.00
$2,196.00
$1,776.00
$1,704.00
$2,640.00
$2,436.00
$1,848.00
$2,316.00
$2,616.00
$2,160.00
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
PMPY
ACO Avg

Straightforward Scorecard

- Patient Attribution
- Annual Wellness Visits
- Education/Learning
- Provider Engagement
- Utilization

RURAL ADVANTAGE

The Rural Advantage does not, nor will we ever, interfere in the provider/patient relationship.

WHAT IS OUR PROPOSITION?

RURAL ADVANTAGE REVENUE SPLIT:

75% of Revenue => Providers

25% of Revenue => ACO

WE ARE ENROLLING PARTICIPANTS.

We are actively signing participants.

The performance year is 2024.

A Participation Agreement gets us started.

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

CHARLES A. JAMES - NORTH AMERICAN HMS

Executive Director – Rural Advantage ACO

Charles@ruraladvantage.net

www.ruraladvantage.net

President and CEO - North American HMS

cjamesjr@northamericanhms.com

www.northamericanhms.com

314.560.0098

314.968.6883 (Fax)