

Continuity of Care Program | Appointment Agendas

How to Get Started Guide

The Continuity of Care (CoC) Program provides an opportunity to earn added compensation by using the appointment agenda as a tool to guide your patient encounters with your plan members. The Appointment Agenda combines the health condition history, HEDIS measures, pharmacy, high risk, clinical and drivers of health (aka social determinants of health) insights, if applicable, into one comprehensive view to provide visibility into the members existing medical conditions and to increase the quality of care for our members.

Providers are eligible for added compensation for completing the “Health Condition History” portion of the Appointment Agenda during member visits and submitting the completed Appointment Agendas with corresponding verified and documented diagnoses on qualified claims. Please make sure your medical record documentation supports your diagnoses submitted on claims. Of note, there is an added amount paid for appointment agenda submitted electronically.

Completing agendas via the provider portal is available for **all lines of business** and will provide the most up-to-date information (For a list of available electronic submission methods and our CoC FAQ’s, please see the QR code or URL located below or on the 2025 Continuity of Care Program Guide).

Threshold Percentage of Appointment Agendas Completed	Bonus Paid Per Paper Appointment Agenda Submission	Bonus Paid Per Electronic Appointment Agenda Submission
<50%	\$50	\$100
≥50% to <80%	\$100	\$200
≥80%	\$150	\$300

Thresholds are calculated at the Company, Line of Business, and Provider level.

NEW in 2025: COC Plus (COC+) Earning Opportunities

Complete additional portions of the Appointment Agenda for additional compensation opportunities!

Please submit by July 1, 2025. Date subject to change.

Medicare: Providers can earn an additional **\$150 per Appointment Agenda** for completing the High Risk, Care Guidance, Clinical, and/or Drivers of Health (aka social determinants of health) portions of the Appointment Agenda, if applicable. All boxes in the selected category must have all boxes checked and

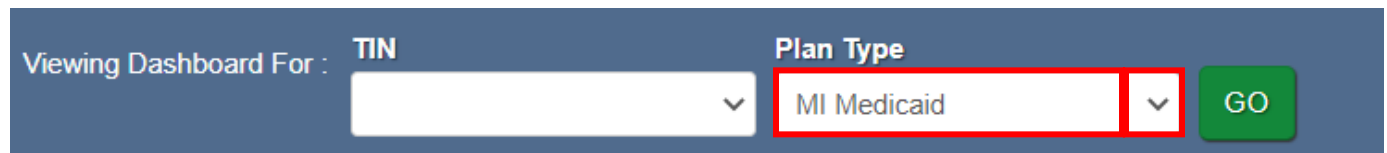
verified to be eligible for the additional earning opportunities recognizing the time it takes for verification and documentation in the medical record for the clinical conditions.

Medicaid/Marketplace: Providers can earn an additional **\$100 per Appointment Agenda** for completing the High Risk, Care Guidance, Clinical, and/or Drivers of Health (aka social determinants of health) portions of the Appointment Agenda, if applicable. All boxes in the selected category must have all boxes checked and verified to be eligible for the additional earning opportunities recognizing the time it takes for verification and documentation in the medical record for the clinical conditions.

Login and Navigation Guide

Step 1. Login to the portal (<https://provider.wellcare.com/>, <https://provider.mimeridian.com> or <https://provider.ambettermeridian.com>)

Step 2. Once logged in, ensure your **Plan Type** is set to the appropriate **Type** and click on the **green GO**.



The screenshot shows a dark blue header bar. On the left, it says "Viewing Dashboard For :". Next to it is a dropdown menu labeled "TIN" with a white box and a downward arrow. To the right of this is another dropdown menu labeled "Plan Type" with a white box containing "MI Medicaid" and a downward arrow. A red rectangle highlights the "Plan Type" dropdown. To the right of the "Plan Type" dropdown is a green button with the text "GO".

Step 3. In the **Useful Links** section, select **Provider Analytics** and agree to terms.

Useful Links

Reports

This repository contains reports that are uploaded and maintained by the health plan.

Provider Analytics [↗](#)

Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.

Patient Analytics

This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

Care & Risk Gaps

Providers, use Centene Clinical Action for High/Risk data in selected population

PAI Provider Survey [↗](#)

This survey enables providers to update their accessibility information.

CoC - Appointment Agenda - 2025

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Coded Thru Claims as of: 1/30/2025 LOB: ALL TIN: NPI:

Member:

Appointment Agendas

Create Date	Active Agenda	Agenda Status	Imputed	Member ID	Plan Member ID	Member Last Name	Member First Name	Pre Auth	NPI	Assessed	Unassessed	Assessed %
2025-02	Y	Not Received	N					NA		0	17	0.0%
2025-02	Y	Not Received	N					NA		0	16	0.0%
2025-02	Y	Not Received	N					NA		0	15	0.0%
2025-02	Y	Not Received	N					NA		0	22	0.0%
2025-02	Y	Not Received	N				N	NA		0	13	0.0%

NPI: Gap Type: (All) Read Only

GapType	Gap Description	Diagnosis/Other Info	Assessment Status	DOS	Mod Date	Mod User	Status	Provider Response
Risk Adjustment CoC	V28_HCC22 - Bladder, Colorectal, and Other Cancers	C20 MALIGNANT NEOPLASM OF RECTUM	Unassessed	02/27/2024				Please Select
	V28_HCC326 - Chronic Kidney Disease Stage 5		Unassessed	12/31/9999				Please Select
	V28_HCC280 - Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders	J44.9 CHRONIC OBSTRUCTIVE PULMONARY DISEASE UNS	Unassessed	02/06/2024				Assessed & Documented as Appropriate Assessed, Not Present Not Assessed, Addressed Previously Not Assessed, Member Referred
	V28_HCC127 - Dementia, Mild or Unspecified	F01.A0 VASC DEM MILD W/O BEHV PSYCH MOOD DIST ANXIETY	Unassessed	06/10/2023				Please Select
	V28_HCC38 - Diabetes with Glycemic Unspecified, or No Complications		Unassessed	12/31/9999				Please Select
	V28_HCC253 - Hemiplegia/Hemiparesis	I69.354 HEMIPLEGIA FLW CEREBRAL INFARCT AFF LT NON-DOM	Unassessed	04/29/2024				Please Select

Status Indicators & Selecting the Appropriate Provider Response

- This condition is 'Unassessed'. The Provider must select the appropriate provider response to the unassessed condition.
 - Provider Response marked active diagnosis, 'Assessed and Documented as Appropriate' waiting on a claim with diagnosis code that maps to the Disease Category listed on the Agenda.
 - No further action is required; Claim has been received with correct diagnosis code or assessed condition is not present or referred.
- **Assessed & Documented as Appropriate** – Gap Description present based on assessment, and provider will be submitting qualified claim with diagnosis code that maps to the Disease Category listed on the Agenda.
 - *This option is applicable when working with high Risk, Quality, Clinical or DOH Gap Types.*
 - **Assessed, Not Present** – Patient is not presenting listed condition that maps to the Disease Category listed on the Agenda. The provider must submit a claim with a 2025 face-to-face visit and submit appropriate codes for conditions the patient is currently presenting.
 - *This option may be applicable when working with high Risk, Quality, Clinical or DOH Gap Types.*
 - **Not Assessed, Addressed Previously** – Provider conducts visit addressing Quality gaps and/or patient medical concerns, Prior High Risk and/or DOH were documented earlier in the year.
 - *This option may be applicable when working with High Risk or DOH Gap Types.*
 - **Not Assessed, Member Referred** – Provider conducts visit addressing Quality gaps and/or patient medical concerns but recognizes care gap is not within the scope of care provided by the primary care provider (PCP) and determines referral is needed.
 - *This option may be applicable when working with Quality or Clinical Gap Types.*

Types of Gaps – High Risk, Risk Adjustment CoC, Quality and DOH

- **High Risk** – provides insight to Member emergency room visits – This section can help to identify preventable ER visits, and/or high utilization, and offer an opportunity to engage with the patient and discuss potential improvements in care to reduce ER utilization
- **Risk Adjustment CoC** – Provides insight on high-risk chronic conditions. Addressing these gaps can ensure better coordinated and comprehensive care for the Member, allowing for a thorough review for risk adjustment.
- **Quality** – Commonly known as HEDIS gaps – This section provides overall care quality insight. Addressing these gaps, can identify areas for improvement and ensure that our Members are receiving the best possible care.
- **Clinical** – provides insight to members who have not had a visit with an assigned Primary Care Provider (PCP). Addressing these clinical gaps can ensure better coordinated and comprehensive care for the Member.
- **DOH** – Also known as Social Determinants of Health (SDOH). Addressing these gaps, can identify non-medical factors that influence health outcomes.

Types of Gaps – Persistency vs. Predictive

- **Diagnosis Predictive Gap** – Questionable code, from something a member may possibly have (no diagnosis showing/blank) **“Possible”** condition based on prior claims data
- **Diagnosis Persistency Gap** – Condition was coded on a claim, in the past, during our “look back period” – The defined time frame in a patient’s medical history that is reviewed to identify relevant diagnosis treatments and or services for HEDIS or Risk Adjustment purposes. This period helps determine care gaps condition status or eligibility for certain quality and risk-based measures.

Suspected Rx/Condition	Type	Source	Diagnosis	Active Diagnosis & Documented	Resolved or Not Present
V24_HCC136 - Chronic Kidney Disease, Stage 5	Persistency Gap	ICD-10	N18.6 END STAGE RENAL DISEASE	☐	☐
V28_HCC48 - Morbid Obesity	Predictive Gap	ICD-10		☐	☐

Quality Bonus Instructions

- Schedule and conduct an exam with the eligible member(s), using the Appointment Agenda as a guide, assessing the validity of the clinical conditions and/or gaps in care on the appointment agenda.
 - If a patient has already had a qualified visit and has been treated in 2025, simply refer to the visit to complete the agenda.

1. SUBMIT THE COMPLETED APPOINTMENT AGENDA

- **Electronic:**
 - Log on to the COC dashboard through our Secure Provider Portal at **provider.wellcare.com**.
 - Specify the clinical conditions and/or gaps/insights that continue to exist or no longer exist using the check box function on the dashboard and submit. **Each gap/insight must have a box checked to be eligible for the additional compensation, recognizing the time it takes to assess the patient's current condition.**
 - For a list of other available electronic submission methods, please see the QR code or URL at the end of this document.
 - Make sure the medical record documentation supports diagnoses, gap closures, screenings/ tests and update conditions that are no longer acute, including use of "history of."
- **Paper:**
 - Print the Appointment Agenda from the dashboard. Specify the clinical conditions and/or gaps/ insights that continue to exist or no longer exist by checking the box on the Appointment Agenda. **Each gap/insight must have a box checked to be eligible for additional compensation.**
 - Sign and date the completed Appointment Agenda.
 - Submit the completed form via fax to **1-813-464-8879** or **secure email** to agenda@wellcare.com or agenda@centene.com.
 - Make sure the medical record documentation supports diagnoses, gap closures, screenings/ tests and update conditions that are no longer acute, including use of "history of."

2. **SUBMIT A CLAIM OR ENCOUNTER** containing the correct International Classification of Diseases, 10th Edition ICD-IO, CPT II, Healthcare Common Procedure Coding System (HCPCS) and/or National Drug Codes (NDC). Upon receipt of the completed documentation, the health plan will verify the corresponding claim information to validate payment eligibility.

Note: Please make sure your patient chart documentation supports the diagnoses and ICD-IO codes that are on a claim or encounter.

- Appropriate documentation of the comprehensive exam must include:
 - Patient name, date of birth, and date of service (DOS) on each page.
 - History.
 - Physical examination.
 - All active and coexisting conditions.
 - Treatment.
 - Provider name, signature, credentials, and date of signature.

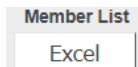
Additional Notes:

- If the diagnosis code(s) being used and coded for a patient is not listed under the condition mapping list – **Assessed, Not Present is acceptable.**
- If the patient is seeing a specialist for the condition(s), the condition(s) does not present itself during a visit, or your provider(s) will/are not going to access and/or code a condition – **Assessed, Not Present** or **Not Assessed, Member Referred is acceptable.**
- The appointment agenda program applies a three-year look-back period. A condition must be documented as “Resolved” for three consecutive years to be removed from the agenda. If the condition is ever coded again, it will automatically be flagged and reappear on the upcoming appointment agenda program.
- If a provider listed on appointment agenda is no longer with the provider group, please review the shared patient(s) under the provider and ensure they are not being seen by another provider within your office.
- If patient(s) are not being seen at your office, please contact the Provider Relations by filling out the Provider Relations Inquiry Form on the Meridian website.
- Claims must be received and paid for all "**Active**" conditions coded to be captured and approved.

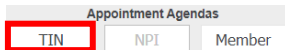
Additional Tips to Get You Started



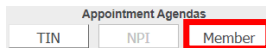
1. Using the **Funnel** icon you can filter based on **LOB, NPI, and Create Date**.



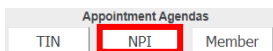
2. **Member List Export (Excel)** Using the “Member List” function provides an Excel spreadsheet containing all CoC Member information available.



3. **Appointment Agendas - TIN** will provide your paper agendas per TIN.



4. **Appointment Agendas – Member** provides the selected members paper agenda.



5. Use the NPI Filter and **Appointment Agendas - NPI** will provide the selected NPI’s agendas.



6. **New Member and Pre Auth**

- New Member – Members 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
- Pre Auth –Marketplace Pre-Auth for high-cost medication. Corresponding HCC will be added to the Agenda during our waves.



7. **Imputes** - Imputed Appointment Agendas are created for Members that are seeing a provider outside of their assigned PCP Tax ID, providing opportunity for those providers to review, assess, document, and earn the Appointment Agenda incentive.

Frequently Asked Questions

Use the QR Code or URL to access CoC Program Frequently Asked Questions:



[Centene CoC Program Frequently Asked Questions \(PDF\)](#)

Have Feedback?

Use the QR Code or URL to share feedback about the CoC Program:



[CoC Program Feedback Survey \(Qualtrics\)](#)