2026
Continuity of Care Plus

PROVIDER PROGRAM GUIDE

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We’re pleased to introduce the 2026 Continuity of Care Plus (CoC+) Program, launching in February 2026.

This initiative supports primary care providers in delivering proactive, preventive care while enhancing clinical quality. Eligible participants may earn up to **$400 per patient** depending on the line of business, by meeting program-specific requirements.

The **CoC+ Program Guide** offers detailed information and answers to common questions to help you participate confidently and make the most of the tools provided.

Thank you for your continued commitment to high-quality care and for partnering with us to improve health outcomes for your patients.

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CoC+ Program Timeline

Below are key dates to know for the 2026 Continuity of Care Plus (CoC+) Program.

January 01, 2026 – December 31, 2026:
Appointment Agendas for all 2026 dates of service are accepted.

February 2026:
The CoC+ program will launch. Appointment Agendas will be available for eligible patients in the Secure Provider Portal.

January 31, 2027:
The deadline to submit completed Appointment Agendas for 2026 dates of service.

How to Participate

We recognize the time and dedication it takes to complete comprehensive appointment agendas, and we sincerely thank you for your commitment to improving patient care through the Continuity of Care Plus program.

To support your workflow, we've designed a simple, streamlined process to help you integrate Continuity of Care Plus tasks into your daily practice with minimal disruption.

Conduct the Visit

Schedule and complete exam with an eligible patient. Use the Appointment Agenda to guide your visit and actively verify the accuracy of each listed insight to ensure the most effective care.

Complete and Submit the Appointment Agenda

The Appointment Agenda can be completed during the visit or after you've used it as a guide for the eligible patient's encounter. Any person in the practice who supports the completion of the Appointment Agenda at the point of care may sign and submit the completed Appointment Agenda.

There are two submission options:

1. **Electronic Submission**

   Complete the Agenda through the Secure Provider Portal.

   - Carolina Complete Health: **provider.carolinacompletehealth.com**
   - Ambetter of North Carolina Inc.: **ambetterofnorthcarolina.com/provider-resources/login.html**

   Other approved electronic submission methods can be found on the CoC+ Provider FAQ (use the QR code or link at the end of this guide to access).

2. **Manual Submission**

   Print and complete by hand, then submit via fax to **1-844-608-0465** or email to **agenda@centene.com**.

To be considered complete, an Appointment Agenda must have a response or checkbox selected for each insight listed.

Submit a Corresponding Claim or Encounter

Document all active conditions and care gaps on a claim using the appropriate coding standards (ICD-10, CPT®, CPT II, HCPCS, or NDC). This claim will serve to validate the responses recorded on the completed Appointment Agenda.

Providers should ensure that the medical record accurately reflects all active conditions and, when relevant, includes resolved or historical conditions. However, **medical records are not accepted as a form of submission**.

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Understanding the Appointment Agenda

The **Appointment Agenda** is a key tool designed to support a more comprehensive and informed patient encounter. Its goal is to provide a clear, point-of-care view of a patient's overall health, helping to guide clinical conversations and evaluate current clinical status.

Appointment Agendas bring together critical insights—including health condition history, HEDIS® measures, pharmacy data, high-risk indicators, clinical information, and drivers of health (social determinants)—into one streamlined view.

Insight Types

Insights on the Appointment Agenda are updated monthly to reflect the most current clinical data available for your patients. Here is a breakdown of the various insight categories included on the Appointment Agenda and some tips on how to complete each section.

TYPE	DESCRIPTION	HOW TO COMPLETE
Risk Adjustment	This section highlights predictive and/or persistent conditions identified through the patient's medical history, including claims that may require clinical attention and annual documentation. These diagnoses should be reviewed and updated as appropriate—some conditions may have resolved, changed in severity, or been replaced by more accurate diagnoses.	Select the answer (or check the box) for the most appropriate response that describes the "status" of the condition. Ensure the appropriate ICD-10 codes are included on a qualified claim for any conditions documented as "active" as well as documented in the medical record.
High Complexity	This section highlights recent health activity that may indicate elevated risk, such as: ✓ Recent emergency room (ER) visits, including date, facility, and chief complaint. ✓ New assessment data suggesting emerging or unmanaged conditions. ✓ Claims utilization patterns that may not align with the patient's documented acuity. These insights can support identification of potentially avoidable ER use or high utilization trends. Use this information to guide meaningful care conversations, enhance care coordination, and reduce unnecessary acute care visits.	Select the answer (or check the box) for the most appropriate response that indicates a conversation was had about the presented insights. Document in the patient's medical record any clinical guidance given and/or efforts to coordinate care.

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TYPE	DESCRIPTION	HOW TO COMPLETE
Quality	This section highlights open Quality Care Gaps identified in collaboration with Centene's Quality department. Addressing these insights supports adherence to evidence-based care standards, supports preventive care, enhances chronic disease management, and ensures patients receive high-quality, comprehensive care.	Select the answer (or check the box) for the most appropriate response that indicates if a presented Quality Care Gap was addressed during the visit. Document all medical recommendations, diagnostic evaluations, and care planning in the patient's medical record. **NOTE:** Quality Care Gaps can be closed through appropriate claims, CPT/CPT II/HCPCS/DX codes, or supporting documentation. CoC+ is separate from other ongoing Quality programs. For more information, please refer to page 9 and reach out to your Provider Engagement Representative.
Clinical	This section highlights potential gaps in care coordination, such as hospital outpatient visits, prescriptions, or specialist services received without prior consultation with the patient's assigned PCP. Addressing these insights supports more coordinated, comprehensive care and strengthens the patient-provider relationship.	Select the answer (or check the box) for the most appropriate response that indicates a conversation was had about the presented insights. Document in the patient's medical record any clinical guidance given and/or efforts to coordinate care.
Drivers of Health	Drivers of Health (Social Determinants of Health) are non-medical factors—such as transportation, housing, or food insecurity—or patterns of high healthcare use that exceed expected needs. These may reflect patient concerns or barriers affecting their ability to maintain health and wellbeing.	As appropriate, discuss with your patient any next steps or available resources to help address the identified concerns. Select the most appropriate response to indicate whether the concern was addressed during the visit, and document in the medical record any guidance or assistance provided.

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Response Options

There are four available responses for each insight listed on the Appointment Agenda. These responses were selected to provide comprehensive options that cover a variety of scenarios for conditions. The response options are listed below along with an explanation of how to apply them.

ACTIVE & DOCUMENTED

The condition remains active, or insight is clinically relevant and should be documented on a claim using appropriate coding standards, when applicable.

RESOLVED/ NOT PRESENT

The condition is resolved, inactive, or the insight is not relevant to the patient's current clinical status.

ADDRESSED PREVIOUSLY

The insight was resolved in a prior visit and does not require further action.

PATIENT REFERRED

The insight requires evaluation by a specialist or another provider.

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Earning Opportunities

The 2026 Continuity of Care Plus (CoC+) Program offers **two distinct opportunities** for primary care providers to earn additional compensation:

1 Risk Adjustment Completion

Earn compensation by completing the **Risk Adjustment** section of the Appointment Agenda. This involves reviewing and updating the patient's active/suspected conditions to ensure accurate and complete documentation.

CAROLINA COMPLETE HEALTH		
THRESHOLD PERCENTAGE OF APPOINTMENT AGENDAS COMPLETED	**PAPER RATE**	**ELECTRONIC RATE**
Less than 50%	**$50**	**$100**
50% to less than 80%	**$100**	**$200**
80% or more	**$150**	**$300**

AMBETTER OF NORTH CAROLINA INC.		
THRESHOLD PERCENTAGE OF APPOINTMENT AGENDAS COMPLETED	**PAPER RATE**	**ELECTRONIC RATE**
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80% or more	**$150**	**$300**

NOTE: Additional compensation is provided for Appointment Agendas submitted electronically. Thresholds are calculated at the company, line of business, and provider levels.

2 Comprehensive Insight Completion

Earn additional compensation by completing all other insights presented on the Appointment Agenda.
These include:

- ✓ High Complexity
- ✓ Quality (Care Guidance)
- ✓ Clinical
- ✓ Drivers of Health (Social Determinants)

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CAROLINA COMPLETE HEALTH	AMBETTER OF NORTH CAROLINA INC.
$100	$100

To maximize your compensation, all sections of the Appointment Agenda must be fully completed, with every box checked. Additionally, a corresponding claim must be submitted with verified diagnoses. All diagnoses must be supported by corresponding medical record documentation.

CAROLINA COMPLETE HEALTH	AMBETTER OF NORTH CAROLINA INC.
Up to $400	Up to $400

NOTES:

- Provider Payments begin in the third quarter of 2026.
- The CoC+ program is in addition to other provider compensation programs offered by our health plan and does not replace them.

Other Provider Compensation Programs

Qualifying providers may be eligible for additional compensation programs, including:

- Pay-for-Performance (P4P)
- RxEffect Provider Program

Speak to your Health Plan Provider Engagement Representative for more information.

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Frequently Asked Questions

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

centene.com/content/dam/corporate/educational-resources/CoC-Program-FAQ.pdf

Have feedback?

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

cnc.sjc1.qualtrics.com/jfe/form/SV_8v9PSQvTzm5f2Si

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CAROLINA COMPLETE HEALTH

1-833-552-3876

carolinacompletehealth.com

AMBETTER OF NORTH CAROLINA INC.

1-833-863-1310

AmbetterHealth.com/en/NC

Additional Information

Patients are selected at the beginning of the program and are subject to change in future programs.
For patient movement, speak with your Health Plan Engagement Representative.

- All CoC+ providers must: (a.) be in a participation agreement with our health plan, either directly or indirectly through a group, from the effective date and continually through the dates the payments are made; and (b.) be in compliance with their participation agreement, including timely completion of required training or education as requested or required by our health plan.
- Any payments earned through this CoC+ program will be in addition to the compensation arrangement set forth in your participation agreement, as well as any other health plan compensation program(s) in which you participate. CoC+ providers who have a contractual or other compensation arrangement with our health plan, either directly or through an IPA or group, may be excluded from participation in the CoC+ program at our health plan's discretion.
- The terms and conditions of the participation agreement, except for appeal and dispute rights and processes, are incorporated into this program, including, without limitation, all audit rights of our health plan. The CoC+ provider agrees that our health plan or any state or federal agency may audit the provider's records and information.
- The program is discretionary and subject to modification because of changes in government healthcare programs or otherwise. Our health plan has the discretion to determine whether the requirements are satisfied and if payments will be made. There is no right to appeal any decision made in connection with the program. If the program is revised, our health plan will send a notice to the CoC+ provider by email or other means of notice permitted under the participation agreement.
- Our health plan reserves the right to withhold any payments that may have otherwise been paid to a CoC+ provider to the extent that such CoC+ provider has received or retained an overpayment, including any money to which the CoC+ provider is not entitled, including but not limited to fraud, waste, or abuse. If our health plan determines that a CoC+ provider has an overpayment, our health plan may offset any payment that may have otherwise been paid to the CoC+ provider against overpayment.
- Our health plan shall make no specific payment, directly or indirectly, under a provider compensation program to a CoC+ provider as an inducement to reduce or limit medically necessary services to an enrollee (patient). This CoC+ program does not contain provisions that provide additional compensation, monetary or otherwise, for withholding medically necessary care. All services should be rendered in accordance with professional medical standards.

Thank you for being a partner in our patients' care.
If you have additional questions, please contact Provider Services.