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Welcome to the 2ND Quarter 2026 Provider Townhall

absolute total care™ Healthy Connections

ambetter. FROM absolute total care™

wellcare® By absolute total care.

Meeting Overview

Q2, 2026 Provider Townhall — today's topics at a glance

1. **Health Plan Updates**
   Pharmacy, prior authorizations , billing requirements, vendor changes & coding changes
2. **Interpreter & Translation Services**
   Language access support for members
3. **Medicaid Member Benefits**
   Health Benefits, Pharmacy Services, and Enhanced Benefits Community Event
4. **Community Events**
5. **Annual Provider Training Requirements**
   Required annual compliance trainings
6. **Medicaid Requirements**
   Provider Enrollment
   Medical Records Review
7. **Electronic Fund transfer**
8. **Claims 411**
   Provider claims training toolkit
9. **Quality Improvement**
   P4Q, quality measure, Risk Adjustement
10. **Accessibility, Availability & Case Management**
    Network standards & member care support

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Health Plan Updates

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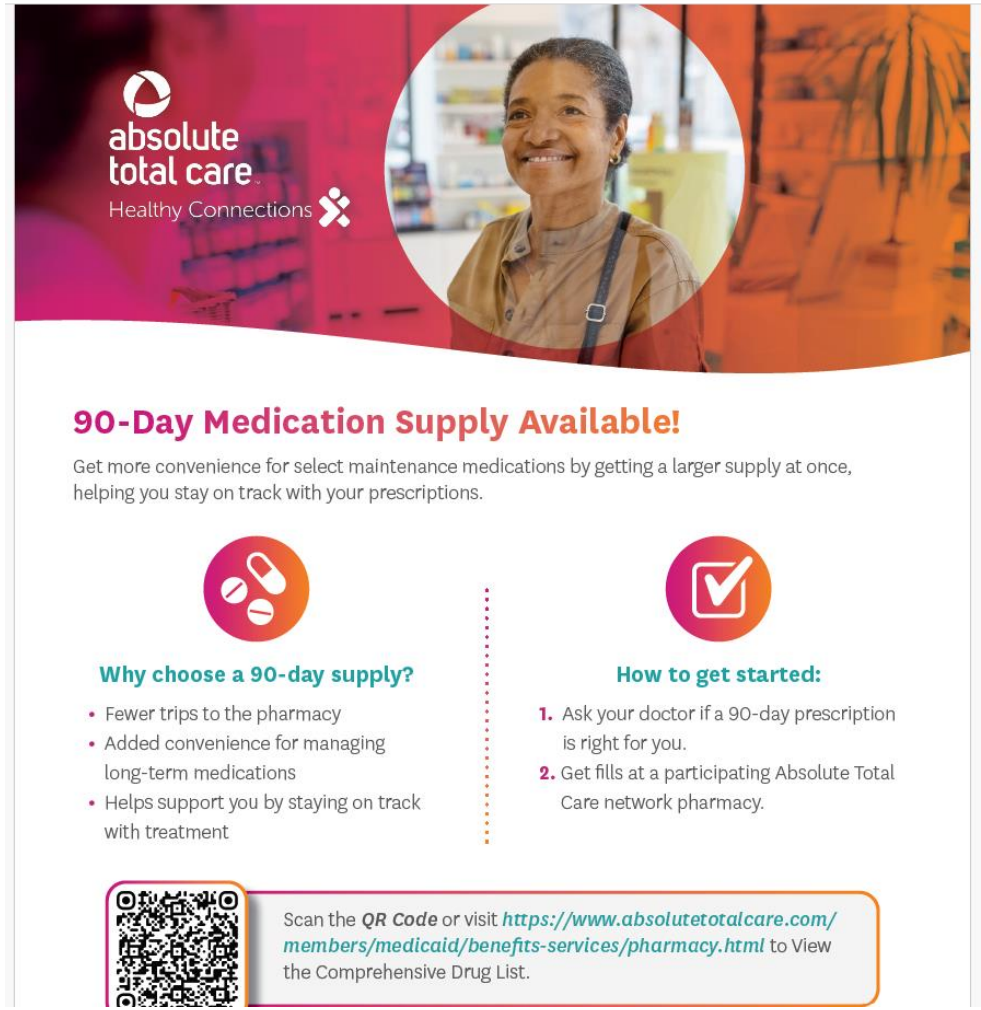
90-Day Medication Supply

Absolute Total Care has been approved by SCDHHS to allow 90 supply prescriptions medications to help control high blood pressure, diabetes and cholesterol for select medications.



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https://www.absolutetotalcare.com/members/medicaid/benefits-services/pharmacy.html.html

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Absolute Total Care 90-Day Supply Medication List

Statins
Atorvastatin
Fluvastatin (capsules only)
Lovastatin
Pravastatin
Rosuvastatin
Simvastatin

ACE Inhibitors and Select Combination Products
Amlodipine-Benazepril
Benazepril
Benazepril-HCTZ
Captopril
Enalapril
Enalapril-HCTZ
Lisinopril
Lisinopril-HCTZ
Trandolapril-Verapamil
Ramipril (preferred effective 10.1.2025)

Leukotriene Receptor Antagonists
Montelukast (chewable tablet, granules, tablet)
Zafirlukast

Biguanides and Combination Products
Glyburide-Metformin
Metformin tablets only (except 625mg strength)
Metformin ER

Sulfonylureas
Glimepiride
Glipizide
Glipizide ER
Glyburide micronized tablet
Glyburide

Beta blockers and combos
Acebutolol
Atenolol
Atenolol-Chlorthalidone
Bisoprolol Fumarate
Bisoprolol-HCTZ
Carvedilol (not ER)
Labetalol
Metoprolol Succinate ER
Metoprolol Tartrate
Nadolol
Propranolol solution/tablet
Propranolol ER
Sotalol tablet/AF tablet

Angiotensin II Receptor Antagonists & Diuretic Combos
Olmesartan-HCTZ
Irbesartan
Irbesartan-HCTZ
Losartan
Losartan-HCTZ
Olmesartan
Telmisartan
Telmisartan-HCTZ
Valsartan
Valsartan-HCTZ

ATC-03242026-M-1.1-WM-N

Prior Authorizations Update: Procedure code 97157 Effective 7/1/2026

Important Prior Authorization Update

Date: 4/8/2026

(Effective July 1, 2026)

As part of our ongoing work to improve the prior authorization (PA) process for providers and members, Absolute Total Care wants to share some important updates to our PA requirements. Our goal is to reduce administrative burden, simplify submission and approval processes, and facilitate timely access to appropriate, high-quality care.

Effective 7/1/2026, prior authorization is required for **Absolute Total Care Medicaid** for procedure code 97157 (multiple-family group adaptive behavior treatment guidance).

For questions about specific prior authorization codes or how these changes may affect your practice, please reach out to your Provider Engagement representative. Thank you for your continued partnership as we work to transform the health of the communities we serve, one person at a time.

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https://www.absolutetotalcare.com/providers/provider-news.html

SCHOOL BASED BEHAVIORAL HEALTH SERVICES BILLING AND PRIOR AUTHORIZATIONS EFFECTIVE 7/15/26

Absolute Total Care is committed to ensuring appropriate access, quality, and program integrity for school-based behavioral health services. This notification provides clarification on covered services, billing requirements, and authorization expectations for Local Education Agencies (LEA) school-based behavioral health services.

Scope and Applicability

This guidance applies to school-based behavioral health services delivered by LEAs and their subcontractors under the Absolute Total Care Medicaid line of business. Providers should submit claims using only the LEA-specific procedure codes and modifiers outlined in the Healthy Connections Medicaid Local Education Agencies (LEA) Services Provider Manual and Fee Schedule. Billing of any other codes or services is not applicable and may result in claim denial.

Authorization Requirements

- For participating providers, prior authorization is required when service utilization exceeds twenty-four (24) units.
- All school-based behavioral health services require prior authorization when rendered by non-participating providers.

Billing and Documentation Requirements

Providers must ensure services are medically necessary, appropriately documented, and billed in accordance with the South Carolina Department of Health and Human Services (SCDHHS) Local Education Agencies (LEA) Services Provider Manual (PDF) requirements.

Providers must also comply with applicable SCDHHS Medicaid provider manuals, including but not limited to:

- Licensed Independent Practitioners (LIP) Rehabilitative Services Manual
- Rehabilitative Behavioral Health Services (RBHS) Manual

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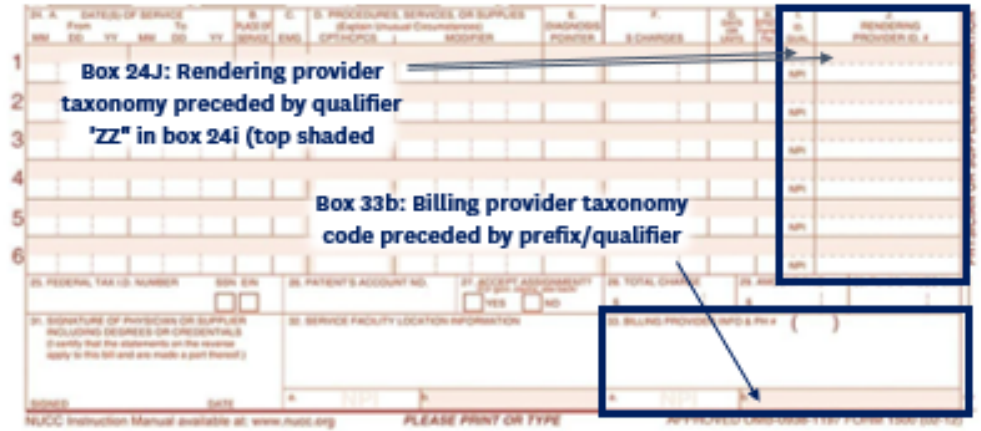
https://www.absolutetotalcare.com/providers/provider-news.html

Provider Billing Alert: Billing and Rendering Provider Taxonomy Requirements Effective 8/1/26

Effective September 1, 2026, all Medicaid claims must include taxonomy code(s) for both the *Billing Provider* and the *Rendering (Attending/Intuitional) Provider*. Federal regulations already require this information on claim submissions. Recent updates on Absolute Total Care claim platforms now allow us to check claims against the requirement.

CMS-1500 Professional Claims - Paper



Electronic Claims - 837P

Rendering Provider – Claim Level EDI HIPAA Version 5010, Loop 2310B:

- Segment: PRV
- Data Element: PRV01 = PE
- Data Element: PRV02 = PXC
- Data Element: PRV03 = Taxonomy Code

Rendering Provider – Line Level EDI HIPAA Version 5010, Loop 2420A:

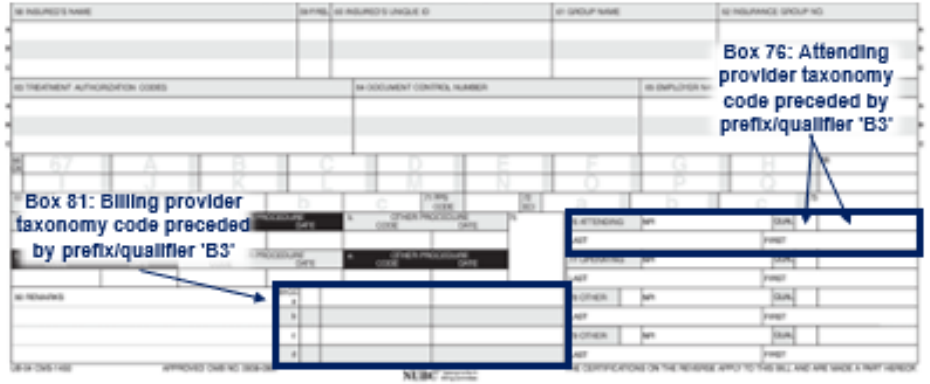
- Segment: PRV
- Data Element: PRV01 = PE
- Data Element: PRV02 = PXC
- Data Element: PRV03 = Taxonomy Code

Billing Provider EDI HIPAA Version 5010, Loop 2000A:

- Segment: PRV
- Data Element: PRV01 = BI
- Data Element: PRV02 = PXC
- Data Element: PRV03 = Taxonomy Code

CMS-1450/UB-04 Institutional Claims - 837I

Below are the fields where rendering and billing provider taxonomy information should be placed.



CMS-1450/UB-04 Institutional Claims - Paper

Attending Provider –EDI HIPAA Version 5010, Loop 2310A:

- Segment: PRV
- Data Element: PRV01 = AT
- Data Element: PRV02 = PXC
- Data Element: PRV03 = Taxonomy Code

Billing Provider EDI HIPAA Version 5010, Loop 2000A:

- Segment: PRV
- Data Element: PRV01 = BI
- Data Element: PRV02 = PXC
- Data Element: PRV03 = Taxonomy Code

Claim Edits Effective September 1, 2026

Claims that are submitted without the billing and rendering provider taxonomy, or have the required information placed in the wrong field, will be denied.

Denial Codes:

- EXev: Rendering Provider Taxonomy Required
- EXEU: Billing Provider Taxonomy Required

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https://www.absolutetotalcare.com/providers/provider-news.html

Physician Evaluation and Management (E&M) code leveling Effective 7/15/26

Effective 7/15/2026, we will begin applying national CPT billing guidelines for the appropriate coding of physician Evaluation and Management (E&M) code levels.

Both Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have documented that E&M services are among the most likely services to be incorrectly coded, resulting in improper payments to practitioners. The OIG has also recommended that payers continue to help to educate practitioners on coding and documentation for E&M services and develop programs to review E&M services billed for by high-coding practitioners.

Overview of Absolute Total Care E&M Program:

- Evaluates and reviews only high-level E&M services based upon diagnostic information that appears on the claim.
- Applies the relevant E&M policy and recoding of the claim line to the corrected E&M level of service.
- Allows reimbursement at the highest E&M service code level for which the criteria is satisfied based on our comparative peer risk adjustment process.

Providers should report E&M service in accordance with American Medical Association's (AMA) CPT Manual and the Centers for Medicare and Medicaid Services (CMS') guidelines for billing E&M service codes; *"Documentation Guidelines for Evaluation and Management".* The proper reporting of E&M Services enables Absolute Total Care to more precisely apply reimbursement-coding guidelines and ensure that an accurate record of patient care history is maintained.
Determinations should be made with reference to accepted standards of medical practice and the medical circumstances of the individual case.

Policy number: CC.PP.066-Leveling of Care Office Based EM Overcoding

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Vendor Transition to Cotiviti for Emergency Department Facility E&M Review Effective 8/1/2026

Absolute Total Care is committed to strengthening the accuracy and consistency of its claims review and payment processes. Effective August 1, 2026, Absolute Total Care will transition from Optum to Cotiviti to review outpatient emergency department Evaluation and Management (E&M) code levels for facility services and assess coding appropriateness.

Payment Policy- CC.PP.80
Policy Name: Leveling of Care: Emergency Department Evaluation and Management Overcoding for Facility Services
Medicare and Marketplace

Payment Policies

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Annual Wellness Visit and Routine Physical Exam Coding Refresher

Wellness Visits

G0402 - The Initial Preventative Physical Examination with EKG (IPPE) is offered once in a lifetime and must occur *within* the first 12 months of Medicare eligibility. This is the "Welcome to Medicare" visit that consists primarily of discussion and personalized prevention planning.

G0438 - The Initial Annual Wellness Visit with Health Risk Assessment (Initial AWV w/ HRA) is offered once in a lifetime and must occur *after* the first 12 months of Medicare eligibility and if the member did not receive an IPPE (G0402). This is very similar to the "Welcome to Medicare" visit as it consists primarily of discussion and personalized prevention planning.

G0439 - The Subsequent Annual Wellness Visit with Health Risk Assessment (Subsequent AWV w/ HRA) is offered once per year and must occur *after* the first 12 months of eligibility and 11 months after receiving and IPPE (G0402) or Initial AWV (G0438).

G0468 - Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

T1015 - Clinic visit/encounter, all-inclusive or just "Clinic service" for short, used in Medical care.

Physical Exam

993XX – The preventative visit with physical exam is offered once per year as an added benefit through Wellcare. (*Preventative visit code selection is age driven*).

99429 - Other Preventive Medicine Services

We hope that this is helpful, and we appreciate the care our providers give to our members!

Wellcare Provider Bulletin

Change in CareCentrix's Medical Necessity Review Criteria for Inpatient Rehabilitation Facility (IRF) and Skilled Nursing Facility (SNF) Authorization Requests Effective 5/1/26

Wellcare is implementing a change to the medical necessity review criteria used by our delegated vendor, CareCentrix, for IRF and SNF post-acute authorization requests.

What Is Changing

Effective 05/01/2026, authorization requests reviewed by CareCentrix will be reviewed using Centers for Medicare & Medicaid Services (CMS) criteria, rather than InterQual® guidelines, for the following service types:

- Inpatient Rehabilitation Facility (IRF) services
- Skilled Nursing Facility (SNF) services

What Is Not Changing

- Authorization submission processes remain the same.
- Required clinical documentation expectations remain unchanged.
- Review time frames and notification processes are not impacted.
- InterQual® criteria will continue to be used for all other applicable service types.

Why This Change Is Being Made

This update aligns IRF and SNF authorization reviews more closely with CMS coverage requirements and supports greater consistency across post-acute care determinations. The use of CMS criteria for these services ensures alignment with Medicare standards and promotes uniform decision-making across all markets.

Provider Action Required

No immediate action is required. Providers should continue submitting authorization requests to CareCentrix in accordance with existing procedures and ensure that submitted clinical documentation supports medical necessity consistent with CMS guidelines for IRF and SNF services.

Questions

If you have questions regarding this change or require additional clarification, please contact your Provider Relations team.

https://www.wellcare.com/en/south-carolina/providers/bulletins

MEMBER ELIGIBILITY

Reminder: Use Paid-through Dates to Verify Member Eligibility

Date: 06/05/26

Verifying member eligibility is more important than ever as members are being affected by Marketplace changes.

Members enrolled in a Marketplace health plan are responsible for completing their premium payments each month. Members that do not make their premium payments in a timely manner enter a Grace Period, which begins with the first month a payment is missed and generally continues for 90 days when a member is receiving a premium subsidy.

When a member does not pay all outstanding premiums within the grace period, coverage may be retroactively terminated to an earlier date, and previous claims may be denied. Providers are encouraged to proactively confirm an Ambetter Health member's status on the date of service or as close to the date of service as possible. Click here to review step-by-step instructions on confirming a member's eligibility status.

Please keep in mind the various status reasons in the Centene Provider portal and Availity.

- **Active:** The member is in good standing and has paid premiums in full.
- **Active – Pending Investigation (Availity Only):** The member is behind in paying the premium.
- **Delinquent (non-Availity Secure Portals Only):** The member is behind in paying the premium and the Claims Paid Through Date is in the future.
- **Suspended (non-Availity Secure Portals Only):** The member is behind in paying the premium and the Claims Paid Through Date is in the past.
- **Inactive:** The member is ineligible, and coverage has been terminated.

Verifying member eligibility helps reduce denied claims, minimizes the administrative burden on your staff, and clarifies when payment may be collected from the member in advance of services. When checking eligibility, please be sure to verify the member eligibility status, the premium paid through date, and the claims paid through date.

Provider Bulletin

Update for HCPCS Codes G0482 and G0483

Date: 06/04/26

In alignment with Clinical Policy CP.MP.50, Drugs of Abuse: Definitive Testing, which is currently in effect, the following HCPCS codes are no longer reimbursable.

- **Code G0482:**
  Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15 to 21 drug class(es), including metabolite(s) if performed.

- **Code G0483:**
  Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed.

Codes G0480 and G0481 are considered covered benefits when medical necessity is indicated.

If you have questions about this bulletin or other provider resources, please contact your Provider Relations Representative.

Intraoperative Neurophysiologic Monitoring (IONM) Update effective 6/16/26

Ambetter from Absolute Total Care is committed to continuously evaluating and improving overall Payment Integrity solutions as required by state and federal governing entities. As part of this process, the following changes to existing review criteria will take effect on or after **June 16, 2026.**

For the Marketplace product, IONM services must be billed in accordance with CMS-recognized payable codes and applicable CMS billing and payment requirements. Services billed using codes that are not recognized or payable under CMS guidance are not eligible for reimbursement.

<u>All the following criteria must be met:</u>

- Monitoring services are provided with exclusive, undivided attention to one patient.
- No more than four (4) units may be billed per 60-minute period.
- Total units billed must not exceed the total monitoring time available.
- The service is not billed by the surgeon or anesthesia provider, as it is included in the global surgical package.
- The service is billed with an appropriate Place of Service (19, 21, 22, or 24).

Covered Services:

Non-Covered Services:

- 95941

Update for Procedure Codes S9083 and S9088 Effective 8/1/2026

Date: 05/07/26

Effective 08/01/2026, the following procedure codes will become reimbursable when billed with place of service 20 (urgent care facilities). Claims submitted with another place of service will be denied, as these codes are not reimbursable for those locations.

- **Code S9083:** Global fee urgent care centers
  - Represents a facility-level global urgent care service.
  - Indicates the member is physically seen in an urgent care setting.
- **Code S9088:** Urgent care add-on code
  - Used only in addition to an E/M or procedure code.
  - Indicates urgent care operational costs.
  - Used when services are provided in person in an urgent care setting.

If you have questions about this bulletin or other provider resources, please contact your Provider Engagement Account Manager.

Ambetter Health Update for HCPCS Code E0486: Effective 07/01/2026

Date: 04/01/26

Effective 07/01/2026, HCPCS code E0486, a custom-fabricated mandibular advancement device (MAD) for obstructive sleep apnea, will require prior authorization.

If you have questions about this bulletin or other provider resources, please contact your Provider Relations Representative.

Interpreter / Translation Services

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Interpreter Services

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Interpreter Request Form

✱ Indicates required field. Please complete all required fields or the request will not be fulfilled.

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*Type of Interpreter

☐ American Sign Language
- ☐ Tactile (Sign language received by sense of touch with one or both hands)
- ☐ Pidgin Signed English (PSE)
- ☐ Signed English
- ☐ Trilingual _____

☐ Foreign Language
- ☐ Spanish
- ☐ Arabic
- ☐ French
- ☐ Other _____

Dialect: _____

*Interpreter Preference

☐ No preference ☐ Female[1] ☐ Male[1]

☐ The gender marked above is required[2]

☐ Request a specific interpreter[3] — Name: _____

If a Member's preference is unavailable, mark any of the following options that may be an acceptable alternative[4]:

☐ Video Remote Interpretation (VRI)

☐ Over the Phone (OPI)/ Tele-language

*Caller Information

Caller type: ☐ Member ☐ Provider ☐ Third Party

Caller name: _____

Callback number: _____

Complete this form on following page.

Absolute Total Care, Wellcare, Wellcare By Absolute Total Care and Ambetter from Absolute Total Care are affiliated products serving Medicaid, Medicare, and Health Insurance Marketplace members, respectively in the State of South Carolina. The information presented here is representative of our network of products. If you have any questions, please contact Provider Relations.

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Internal Approved 05022026

Interpreter Request Form, page 2

✱ Indicates required field. Please complete all required fields or the request will not be fulfilled.

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*Individual Needing Interpreter

*This person is a ☐ Member.

*Member ID: _____

*Plan name or line of business: _____

*Phone number: _____ Alternate phone number: _____

Email address: _____

*Appointment Details

*Appointment date (month, day, year): _____

*Appointment time: _____ ☐ AM ☐ PM *Estimated duration _____

*Time zone: ☐ Eastern ☐ Central ☐ Mountain ☐ Pacific

*Appointment type _____

(Examples: annual physical, physical therapy, surgery, etc.)

If the appointment is for surgery, is the interpreter needed for an extended period? ☐ Yes ☐ No

*Facility name (Name of hospital/clinic): _____

*Appointment street address: _____

*Appointment building/suite/room/floor: _____

*City/State/ZIP: _____

Provider name (name of doctor/therapist): _____

Provider ID: _____

Onsite contact name: _____ Onsite phone: _____

Please email the completed form to InterpreterRequests@centene.com.
Absolute Total Care cannot guarantee an interpreter if the request is received less than 5 business days before the appointment. Requests for interpreters cannot be made more than 30 days in advance of the scheduled appointment. Cancellations should be reported 72 hours before the appointment date.

1 *Absolute Total Care makes every effort to provide an interpreter of the requested gender. An interpreter of a different gender will be provided if an interpreter of the preferred gender is not available.*

2 *Absolute Total Care will attempt to provide the listed interpreter but does not guarantee availability for a specific interpreter.*

3 *Absolute Total Care will attempt to provide the listed interpreter but does not guarantee availability for a specific interpreter.*

4 *Note: Having flexibility to use Video Remote Interpretation (VRI) helps expand the availability to secure an interpreter for ASL and/or rare language.*

Health Benefits, Pharmacy Services, and Enhanced Benefits and Services for Medicaid Members

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Over-the-Counter (OTC) Benefit

- Up to $60 annually per household
  - $15 per household per quarter
  - Unused portion expires each quarter
- How to order or obtain
  - Order online* at ***cvs.com/benefits***
  - Call CVS at ***1-888-262-6298***
  - Shop at any OTC Health Solutions® (OTCHS) enabled CVS store*. Click Store Locator at ***cvs.com/benefits***
- To obtain a Catalog, call CVS at ***1-888-262-6298***

Pay-over option available (members can pay separately if the value at time of purchase exceeds the $15 limit)

myhealthpays™ Dollar Rewards

It's easy to earn myhealthpays™ reward dollars.

After you complete a healthy activity, we will add the reward dollars you have earned directly to your My Health Pays™ Visa® Prepaid Card. We will mail your My Health Pays™ Visa® Prepaid Card to you after you complete your first healthy activity. You can keep earning My Health Pays™ rewards by completing more healthy activities. Your rewards will be added to your card once we are notified.

Get rewarded for focusing on your health! You can earn myhealthpays™ rewards for completing healthy activities like:

- Your initial health screening
- Prenatal and postpartum visits
- Annual cancer screenings
- Annual well visits with your PCP

And many more! View all rewards available at absolutetotalcare.com.

Use your myhealthpays™ rewards to help pay for:

- Utilities
- Transportation
- Phone and Internet Services
- Childcare Services
- Education
- Rent

Or you can use your rewards to:

- Shop at Walmart for everyday items*

Log in to your member account to see your myhealthpays™ rewards

**This card may not be used to buy alcohol, tobacco, or firearms products.*

This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.

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2026 My Health Pays™ Rewards

Healthy Behaviors → **Earn** → **Spend!**

$10 Well Visit with Primary Care Doctor.
Ages 3 and up. One per calendar year.

$20 Infant Well Visit.
Ages 0-30 months. Up to six visits by the 15th month and up to 2 additional visits between the 16th and 30th month. 8 visits/$160 maximum.

Diabetes Care. **Ages 18-75.** One per calendar year.
- **$20** HbA1c test
- **$20** Retinopathy screening (dilated eye exam)

$50 Prenatal Doctor Visit.
One per pregnancy. Must be completed during first trimester or within 42 days of enrollment.

$50 Postpartum Doctor Visit.
One per pregnancy and within 7-84 days after delivery. Must have delivery claim.

$10 Cervical Cancer Screening.
Ages 21-64. One per calendar year.

$20 Breast Cancer Screening.
Ages 40-74. One per calendar year.

$10 Annual Chlamydia Screening.
Ages 16-24. One per calendar year.

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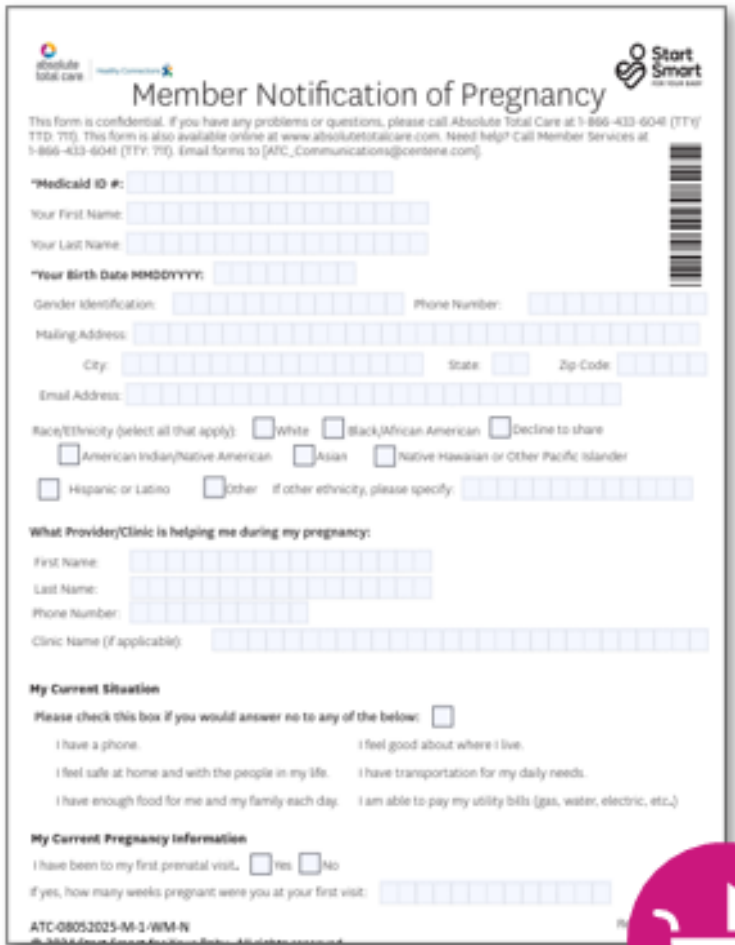
Start Smart for your Baby® (SSFB)

- Programs for pregnant members and their newborns
- Enroll by submitting a Notification of Pregnancy (NOP) form via Online Secure Portal, Health Portal Mobile App, or by mail
- Enhanced benefits
- Case Management program for high-risk pregnancies
- Circumcision covered during initial newborn stay and up to six months after delivery in an office setting
- 24-hour Nurse Advice Line



Member Notification of Pregnancy

This form is confidential. If you have any problems or questions, please call Absolute Total Care at 1-866-433-6041 (TTY/TTD: 711). This form is also available online at www.absolutetotalcare.com. Need help? Call Member Services at 1-866-433-6041 (TTY: 711). Email forms to [ATC_Communications@centene.com].

*Medicaid ID #:

Your First Name:

Your Last Name:

*Your Birth Date MMDDYYYY:

Gender Identification: Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

What Provider/Clinic is helping me during my pregnancy:

First Name:

Last Name:

Phone Number:

Clinic Name (if applicable):

My Current Situation

Please check this box if you would answer no to any of the below:

I have a phone. I feel good about where I live.

I feel safe at home and with the people in my life. I have transportation for my daily needs.

I have enough food for me and my family each day. I am able to pay my utility bills (gas, water, electric, etc.)

My Current Pregnancy Information

I have been to my first prenatal visit. Yes No

If yes, how many weeks pregnant were you at your first visit:

ATC-08052025-M-1-WM-N

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Start Smart for Your Baby®

Start Smart for Your Baby® is a program designed to help you get the customized care you need for a healthy pregnancy and baby. It is already part of your benefits!

Get Started Today!

Go to your doctor as soon as you think you are pregnant. Call us if you need help finding a doctor.

Let us know about your pregnancy. Fill out a pregnancy form so we can personalize the ways we can help you. You could receive a reward for completing the form!

There are three easy ways to do it:

1. Mail in the printed form.
2. Log in to your online member account or mobile app.
3. Call your health plan at the number listed on your ID card.

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Pregnancy Rewards: Diapers

- Members qualify for a package of diapers and wipes after completing each of these visits:
  - Postpartum (7-84 days), 1-month, 2-month, 4-month, 6-month, 9-month and 12-month infant well visits

- Sizes and quantities are:
  - Size 1 (42 per pack)
  - Size 2 (40 per pack)
  - Size 3 (34 per pack)
  - Size 4 (24 per pack)
  - Size 5 (22 per pack)
  - Size 6 (18 per pack)
  - Disposable wipes (42 per pack)

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Pregnancy Rewards: Car Seat, Portable Playpen, or Stroller*

Members who complete ***six*** prenatal visits have can receive a car seat, playpen, or stroller.

- Rear-facing 5-40 pounds
- Forward-facing 22-40 pounds

- Carry bag makes traveling a breeze
- Max weight 40 pounds

- Folds compact in less than a second
- Holds up to 40 pounds

absolute total care | Healthy Connections | Start Smart FOR YOUR BABY*

**limit one item per pregnancy*
***images are examples of items*

Pregnancy Rewards – Breast Pump

Members are eligible for a breast pump who are:

- due to deliver within ***12 weeks*** or
- delivered within the past ***30 days*** (90 days for a NICU baby)

Choose from 7 models!

Zomee Fit


Zomee Z1


Zomee Z2


Minuet


Lansinoh Signature Pro

Motif Twist


Medline with Deluxe Kit

absolute total care | Healthy Connections | Start Smart FOR YOUR BABY®

Pregnancy Rewards – My Health Pays™

Earn up to $100 on your ***My Health Pays™*** card by completing activities related to pregnancy and delivery:

- $50 Prenatal Visit
  - Complete a prenatal visit in the first trimester or within 42 days of enrollment into Absolute Total Care
- $50 Postpartum Visit
  - Complete a postpartum visit 7-84 days after delivery

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Pregnancy Rewards: Postpartum Meals

Reward includes:

- 14 free home-delivered meals
- Meals arrive in one box* and can be kept for up to 2 weeks

Qualifications:

- Members who have a delivery after a minimum of 20 weeks of pregnancy
- Available up to 60 days from date of delivery

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** Box is approximately 15 pounds*

Physical Activity

Sports Activity Fee:

- Reimburse one sports activity registration fee up to $50
- Amount reimbursed onto My Health Pays rewards account
- Limit one reimbursement per year

Sports Physical:

- Members ages 5 - 18
- One sports physical per year with a qualified provider
- No cost

For enrollment and more information:

- Contact Member Services at 1-866-433-6041 (TTY: 711)
- Submit paid registration receipt

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COMMUNITY EVENTS

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COMMUNITY EVENTS

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Join us in the community!

Connect with us at our upcoming community events this year. Learn more about your health plan benefits, access helpful resources, and meet our team in your area. All events are open to members and the community. Please select a month below to find a community event near you. We look forward to seeing you!

- May
- June
- July
- August

Stay Tuned for Future Opportunities!

ATC Community Events

Annual Provider Training Requirements

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Annual Provider Training Requirements

We partner with each of our contracted providers to ensure that you have received the necessary training to deliver quality care to our members and your patients and to be compliant with Centers for Medicare & Medicaid Services (CMS) and state requirements. All Medicare Advantage Organization (MAO) and Dual Eligible Special Needs Plan (D-SNP) contracted providers are required to complete the following trainings within 90 days of contracting and annually thereafter.

Cultural Competency

The ability of healthcare providers and organizations to understand, respect, and effectively respond to the cultural and linguistic needs of diverse patient populations.

General Compliance

Ensures compliance with industry regulations. This reduces the risk of violations that could lead to legal consequences.

Person-Centered Planning

A collaborative approach to care that focuses on an individual's unique goals, preferences, and strengths to guide decision-making and support.

Model of Care (MOC)

A structured approach to delivering healthcare services that outlines how, when, and by whom care is provided to meet patients' needs effectively and efficiently.

Fraud, Waste & Abuse

Intentional deception or misrepresentation (fraud), careless or inefficient use of resources (waste), and practices that are inconsistent with sound fiscal or medical practices (abuse), all of which lead to unnecessary costs to the healthcare system.

https://www.wellcare.com/en/south-carolina/providers/bulletins

Annual Provider Training Requirements

Required Training	Training Location
General Compliance	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html
Fraud, Waste and Abuse	https://cmsnationaltrainingprogram.cms.gov/resources
Model of Care (MOC)	https://www.wellcare.com/south-carolina/providers/medicare/training
Person-Centered Planning	https://www.absolutetotalcare.com/providers/resources/provider-training.html
Cultural Competency	https://www.absolutetotalcare.com/providers/resources/provider-training.html https://www.ahrq.gov/sdoh/clas/index.html

https://www.wellcare.com/en/south-carolina/providers/bulletins

PROVIDER TRAININGS

- Provider Town Halls
- Long-Term Care Clinical Training
- Applied Behavior Analysis Training
- Behavioral Health Training
- Clinical Documentation Improvement (CDI) / Risk Adjustment Webinars
- Opioid Training Toolkit
- Virtual New Provider Orientation Training
- SCDHHS Medicaid Provider Training
- Patient Centered Medical Home Model (PCMH)
- Additional Written Guides
- Medicare Education and Trainings
- Compliance Program and Fraud, Waste and Abuse Training
- Claims Training

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https://www.absolutetotalcare.com/providers/resources/provider-training.html

Clinical & Specialty Education

Please see our training programs below and select the option that best fits your needs.
Information on available continuing education credits is included in each course description.

Provider, Stakeholder, and Caregiver Training

Centene Corporation and its subsidiaries provide industry-informed, evidence-based education to **providers, caregivers, and community stakeholders**. These programs offer a wide range of learning opportunities including topics related to behavioral health, foster care/child welfare, long-term services and supports, integrated care, and culturally appropriate care. Many courses are approved for clinical and continuing education credit.

Offerings emphasize enhancing knowledge, practical care strategies, and access to meaningful resources to support the diverse needs of individuals, children, families, foster and adoptive parents, caregivers, older adults, and vulnerable populations.

Access our **Trainings Available by State** to see what offerings we have in your market.

Centene Institute
FOR ADVANCED HEALTH EDUCATION

The Centene Institute for Advanced Health Education provides empowering **interprofessional continuing education courses** to **providers, clinical employees**, and **other clinicians** at no cost.

Centene Employees:
Visit Centene Institute's Course Catalog for Centene Employees to view courses.

Non-Centene Employees:
Visit Centene Institute's Course Catalog for Non-Centene Employees to view courses.

To learn more about us, visit the Centene Institute's About Us page.

Centene Employee Continuing Education

Centene Corporation provides ongoing professional development and continuing education opportunities for **employees** across all Centene health plans and the enterprise, regardless of state or specialty.

The program offers a broad range of clinical learning options, many of which are approved for continuing education credit, ensuring staff have access to high-quality, evidence-based training to support their growth and professional development.

If you are a Centene employee, visit the **Course Catalog** to explore the continuing education opportunities.

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https://lms.centenetraining.com/

MEDICAID REQUIREMENTS

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Medicaid Provider Enrollment

All practitioners and providers must be enrolled in the South Carolina Healthy Connections Medicaid Program. Practitioners and providers must be contracted and credentialed before accepting or treating members. Please note…Primary Care Physicians (PCPs) are not permitted to accept member assignments until they are fully credentialed.

All practitioners must fulfill the requirements for South Carolina licensure/certification and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession, as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation (SCLLR). All practitioners must also be in compliance with all federal, state, and local laws.
Providers may enroll online through the SCDHHS website by visiting www.scdhhs.gov and navigating to Providers >> Become a Medicaid Provider >> Apply Online.

Medical Records Requests

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Healthy Connections

"As a condition of participation in the Medicaid program, providers are required to document, maintain, and provide immediate access to original health records that fully disclose the medical necessity for treatment and the extent of services provided to Medicaid patients [Social Security Act 1902(a)(27), 1902(a)(57), and 1902(a)(58); 42 CFR 431.107], including associated audit trails.

Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record. When submitting documentation for claims, providers must follow the specific guidelines outlined within each Provider Manual to ensure correct documentation and proper signature is provided".

Medical Records Requests

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Healthy Connections

Record Accessibility Policy

"Providers must have and maintain a health record system that ensures that the record can be accessed and retrieved immediately. Access to all records concerning services and payment, shall be allowed to SCDHHS, the State Auditor's Office (SAO), the South Carolina Attorney General's Office (SCAG), HHS, Government Accountability Office (GAO), and/or their designees, for the purpose of reviewing, copying, and reproducing documents during normal business hours. SCDHHS will accept electronic records and clinical notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §§ 26-6-10 et seq). and the Health Insurance Portability and Accountability Act (HIPAA) electronic health record requirements. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended".

Medical Records Requests

The following must be provided for the dates of service that is requested:

1. Documentation of Evidence-Based Practice Services
2. Consent Form(s)
3. Evidence of Authorization (if applicable)
4. Documentation justifying Medical Necessity
5. Signed Treatment Plan(s)
6. Treatment Progress Documentation
7. Clinical Services Notes that support billed claims
8. Coordination of Care Documentation
9. Discharge/Transition Plan (if applicable)

For more information, please contact your Provider Engagement Account Manager

Electronic Funds Transfer

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PaySpan® Benefits

PaySpan® provides an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment

- Elimination of paper checks/virtual credit card payment.
- Convenient payments and retrieval of remittance information.
- Electronic Remittance Advice (ERAs) presented online.
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System.
- Reduce accounting expenses: Electronic remittance advices can be imported directly into practice management or patient accounting systems.
- Improve cash flow: Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts: You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advices quickly: You can associate electronic payments with ERAs quickly and easily.
- Manage multiple payers: Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts, as desired.

PaySpan®

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- Providers can register using PaySpan's enhanced provider registration process at http://www.payspanhealth.com/.

- Providers can access additional resources by clicking Need More Help on the PaySpan® homepage or link directly to https://www.payspanhealth.com/nps/Support/Index.

- PaySpan® Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the web at https://www.payspanhealth.com/.

PaySpan®

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Paper Checks with PaySpan

Payspan payments that were issued via check are now processed through the Zelis Payments Network. Providers will receive the electronic payments as Automated Clearing House (ACH), honoring the provider's choice to enroll in ACH+.

ACH+ is a service offered by some financial platforms that speeds up the delivery of electronic payments, allowing suppliers to receive funds as quickly as a credit card transaction, but without the associated higher fees and credit card processing requirements. It utilizes the existing (ACH) network to provide faster, non-card electronic payments for businesses, eliminating the delays and costs of traditional methods like checks.

If a provider has questions about how payment was disbursed, how to access funds, the Zelis portal, etc., call center representatives can direct them to Zelis Provider Services via 1-877-828-8770 or ClientService@zelispayments.com.

Claims 411

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Introducing the Claims 411 Training Toolkit

Here at **Absolute Total Care**, we are committed to supporting your success and valuing your feedback.

To assist with meeting these needs, we are excited to share our new **Claims 411 Training Toolkit** — designed to simplify processes and strengthen claim accuracy.

What This Training Provides

- Clear guidance on **eligibility, prior authorization, and claims submission**
  - **Submit clean, compliant claims**
- Insights into **common rejection and denial drivers**
  - **Reduce avoidable denials and rework which decreases operational burden**
- Proven strategies to help improve **first-pass claim acceptance**
  - **Improve reimbursement timeliness and patient outcomes**

Claims 411 Training Toolkit

absolute total care

What's Inside the Toolkit?

- Eligibility Verification Best Practices
- Claim Submission Requirements
- Timeframes by Line of Business
- Common Rejections & Denials
- Prevention Strategies & Best Practices

Where can I find the Toolkit?

Access the Training and Stay Tuned!

👉 **Access the training here:**
https://www.absolutetotalcare.com/providers/resources/provider-training.html

Wellcare Link COMING SOON!

📌 *We recommend sharing the Toolkit with your billing and administrative teams*

Risk Adjustment

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RISK ADJUSTMENT

CONTINUITY OF CARE (COC) INCENTIVE PROGRAM

- Designed to support your outreach to members for annual visits and condition management, which will help us better identify members who are eligible for case management.
- The program achieves this goal by increasing visibility into members' existing medical conditions for better quality of care for chronic condition management and prevention.
- Providers earn bonus payments for proactively coordinating preventive medicine and for thoroughly addressing patients' current conditions to improve health and clinical quality of care.

CLINICAL DOCUMENTATION IMPROVEMENT PROGRAM

- Help providers understand and apply risk adjustment concepts
- Assist in the application of documentation and coding best practices to workflows
- Trainings are scheduled throughout the year and are available to providers

Please contact your Provider Engagement Account Manager for more information regarding these programs.

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Clinical Documentation Improvement (CDI) Webinar Series

January through November 2026

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.

Advance registration is required. Utilize the corresponding registration link provided for each topic to register (links are unique to each webinar). You may download a copy of these pages for access as well.

SCAN ME for registration and additional dates!

OR Click link below for registration and additional dates!

2026 Webinars Registration Page - Google Slides

If you have questions or need assistance with registration, email us at:
CDIWebinars@centene.com

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Join us for a focused overview of the CoC+ program and how it helps providers identify opportunities, use insights more effectively, and support continuity of care.

What We'll Cover

- CoC+ program overview and key components
- How to use Centene Clinical Action (CCA) / CoC+
- Ways to support stronger documentation and follow-up
- How insights can help improve care coordination

Who Should Attend

- Providers / Clinicians
- Care coordinators and care management staff
- Billing and coding specialists
- Office managers / administrators
- Teams using CCA / CoC+

WEBINAR SCHEDULE

DAY/DATE	TIME	REGISTRATION LINK
Tuesday, June 16, 2026	4-5pm ET	Click Here to Register!
Friday, June 26, 2026	8-9am ET	Click Here to Register!
Wednesday, July 1, 2026	11:30-12:30pm ET	Click Here to Register!
Friday, July 10, 2026	9-10am ET	Click Here to Register!
Tuesday, July 14, 2026	3:30-4:30pm ET	Click Here to Register!
Thursday, July 23, 2026	10-11am ET	Click Here to Register!
Monday, July 27, 2026	11am-Noon ET	Click Here to Register!
Tuesday, August 4, 2026	2-3pm ET	Click Here to Register!
Friday, August 14, 2026	8:30-9:30am ET	Click Here to Register!
Tuesday, August 18, 2026	2-3pm ET	Click Here to Register!
Wednesday, August 26, 2026	Noon-1pm ET	Click Here to Register!
Thursday, September 3, 2026	9-10am ET	Click Here to Register!
Wednesday, September 9, 2026	2-3pm ET	Click Here to Register!
Friday, September 16, 2026	8:30-9:30am ET	Click Here to Register!
Thursday, September 24, 2026	4:30-5:30pm ET	Click Here to Register!
Monday, September 28, 2026	11am-Noon ET	Click Here to Register!

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Quality Improvement

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2026 Partnership For Quality Program

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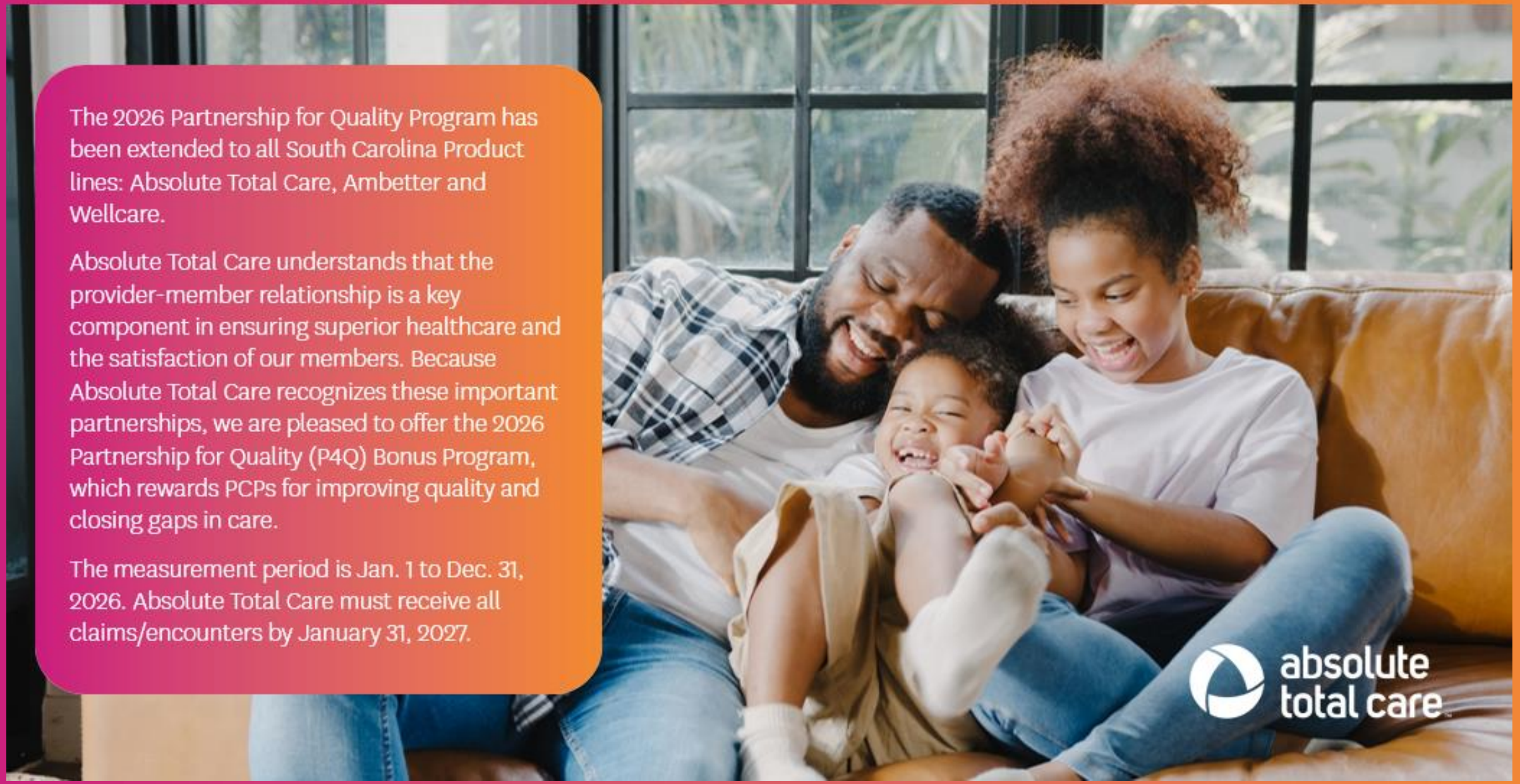
Partnership for Quality (P4Q) Bonus Program



The 2026 Partnership for Quality Program has been extended to all South Carolina Product lines: Absolute Total Care, Ambetter and Wellcare.

Absolute Total Care understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because Absolute Total Care recognizes these important partnerships, we are pleased to offer the 2026 Partnership for Quality (P4Q) Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

The measurement period is Jan. 1 to Dec. 31, 2026. Absolute Total Care must receive all claims/encounters by January 31, 2027.

Wellcare 2026

Primary care providers can earn additional compensation by addressing preventive care activities and closing care gaps for our members.

P4Q Program Instructions

1. Contact patients to schedule an appointment. At the visit, order appropriate tests and preventive screenings, as applicable. Take action to help patients complete all preventive care and close care gaps by **December 31, 2026**.
2. Upon completion of the examination, document care, treatment and diagnosis in the patient's medical record. Submit all applicable diagnoses codes on claims, encounter files and/or approved NCQA supplemental electronic flat files containing all relevant ICD-10, CPT and CPT II codes by **January 31, 2027**.
3. Review and counsel on results of tests and screenings with patients.

Measure	P4Q Amount per Member	P4Q Amount per Clinical Priority Member	Combined P4Q and Clinical Priority Member Earning Potential	Common Ways to Close the Gap
Annual Preventive Visit (APV)	$25	$25	$50	Annual Wellness Visit and/ or Routine Physical Exam
Breast Cancer Screening (BCS)	$50	$10	$60	Mammogram
Controlling High Blood Pressure (CBP)	$100	$25	$125	Documented blood pressure reading
Colorectal Cancer Screen (COL)	$50	$10	$60	Fit kit, colonoscopy, CT colonography
Diabetes – Dilated Eye Exam (EED)	$25	$10	$35	Comprehensive eye exam or retinal screening with proper diagnosis codes
Diabetes HbA1C ≤ 9 (GSD)	$100	$25	$125	Blood test
Kidney Health Evaluation for Patients with Diabetes (KED)	$50	$10	$60	Urine screening and blood test
Medication Adherence – Blood Pressure Medications	$35	N/A	$35	Medication regimen
Medication Adherence – Diabetes Medications	$35	N/A	$35	Medication regimen
Medication Adherence – Statins	$35	N/A	$35	Medication regimen
Osteoporosis Management in Women with Fracture (OMW)	$50	$10	$60	BMD, osteoporosis medication therapy or long-acting osteoporosis medications
Statin Use in Persons with Diabetes (SUPD)	$35	$10	$45	Medication regimen
Medication Reconciliation Post Discharge (TRC)	$50	$10	$60	Medication reconciliation encounter/intervention: 99483, CPT II Code 1111F

https://www.wellcare.com/en/south-carolina/providers/bulletins

P4Q 2026

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Medicaid

Program Measures	Amount Per
ADD - ADHD Maintenance Phase Visit	$50
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$50
EED - Diabetes – Dilated Eye Exam	$50
GSD - Diabetes HbA1c < 8	$50
BPD - Diabetes BP < 140/90	$50
CHL - Chlamydia Screening in Women	$50
CIS - Childhood Immunization Status Combo 10	$50
COL - Colorectal Cancer Screening	$50
IMA - Immunizations for Adolescents Combo 2	$50
KED - Kidney Health for Patients With Diabetes	$50
PPC - Postpartum Visit	$50
PPC - Prenatal Visit (Timeliness)	$50
PRS-E - Prenatal Immunizations	$50
SPC - Statin Therapy for Patients with CVD	$50
SPC - Statin Adherence for Patients with CVD	$50
SPD - Statin Therapy for Patients With Diabetes	$50
SPD - Statin Adherence for Patients with Diabetes	$50

Ambetter

Program Measures	Amount Per
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$50
EED - Diabetes – Dilated Eye Exam	$50
GSD - Diabetes HbA1c ≤ 9	$50
CHL - Chlamydia Screening in Women	$50
CIS - Childhood Immunization Status Combo 10	$50
COL – Colorectal Cancer Screening	$50
IMA - Immunizations for Adolescents Combo 2	$50
KED - Kidney Health for Patients With Diabetes	$50
PDC - Proportion of Days Covered - Diabetes	$50
PDC - Proportion of Days Covered - Statins	$50
PPC - Postpartum Visit	$50
PPC - Prenatal Visit (Timeliness)	$50

CPT II and HCPCS Billing

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We're asking our providers to make sure to use accurate CPT Category II codes and HCPCS codes to improve efficiencies in closing patient care gaps and in data collection for performance measurement. When you verify that you performed quality procedures and closed care gaps, you're confirming that you're giving the best of quality care to our members.

Absolute Total Care allows the billing of these important codes without a denial of "non-payable code" to assist in the pursuit of quality.

The fee schedule includes CPTII and HCPCS codes at a price of $0.01.

How does this help you, our Providers?

- ✓ Fewer dropped codes by Billing Companies due to non-payable codes
- ✓ Better reporting of open and closed care needs for your assigned members
- ✓ Increase in Payment for Quality (P4Q) due to submission of additional codes
- ✓ Collection of HEDIS® measure data year round, resulting in fewer chart requests during chart collection season

What measures do these codes apply to?

- ✓ Controlling Blood Pressure
  - Blood pressure results
- ✓ Comprehensive Diabetes Care
  - Hba1c levels
  - Nephropathy – urine protein tests or treatment
  - Diabetic Retinal Eye Exams, DRE
- ✓ Care of Older Adults
  - Pain Assessment
  - Medication List and Review
  - Functional Status Assessment
- ✓ Medication Reconciliation Post Discharge
  - Medication List and Review after hospital discharge

CPTII Codes and HCPCS Billing PRO_91371E_Approved_01112022.pdf

What measures do these codes apply to?

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Controlling Blood Pressure

- Blood pressure results

A1C levels

Diabetic Retinal Eye Exams

Care of Older Adults

- Pain Assessment
- Medication List and Review
- Functional Status Assessment

Medication Reconciliation Post Discharge

- Medication List and Review after hospital discharge

Electronic Medical Record (EMR) System

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- Allows designated health plan representatives access to your medical records directly through remote access.
- Reduce provider office staff activities regarding HEDIS Hybrid chart chase requests
- Decrease and avoid duplication of over utilization or retrieval efforts
- Lead to improved HEDIS performance reporting

Contact Jane Brown via email at jane.f.brown@centene.com

Supplemental Data Feed

Monthly Supplemental Data Feed

This type of file transfer utilizes specific data extracts from the Electronic Medical Record (EMR). Data is transmitted securely via Secure File Transfer Protocol (SFTP).

Contact Jane Brown via email at jane.f.brown@centene.com

- Close care gaps
- Improve our HEDIS scores
- Potential Compensation
- Reduces request for medical records

CAHPS®
Consumer Assessment of Healthcare Providers and Systems

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MEDICAID

Rating System: HPR (Health Plan Rating System)

What role does CAHPS play?

HPR is based on the performance of dozens of measures of care. There are 3 subcategories: Patient Experience, Rates for Clinical Measures, and NCQA Health Plan Accreditation. CAHPS contributes to the Customer Satisfaction subcategory under Patient Experience.

MEDICARE AND MMP

Rating System: Star Ratings

What role does CAHPS play?

Star Rating is annually calculated using measures from multiple data sources. Data sources include: HEDIS, Pharmacy data, Member Surveys, and Plan Administrations. CAHPS contributes to the Member Surveys subcategory.

MARKETPLACE

Rating System: QRS (Quality Rating System)

What role does CAHPS play?

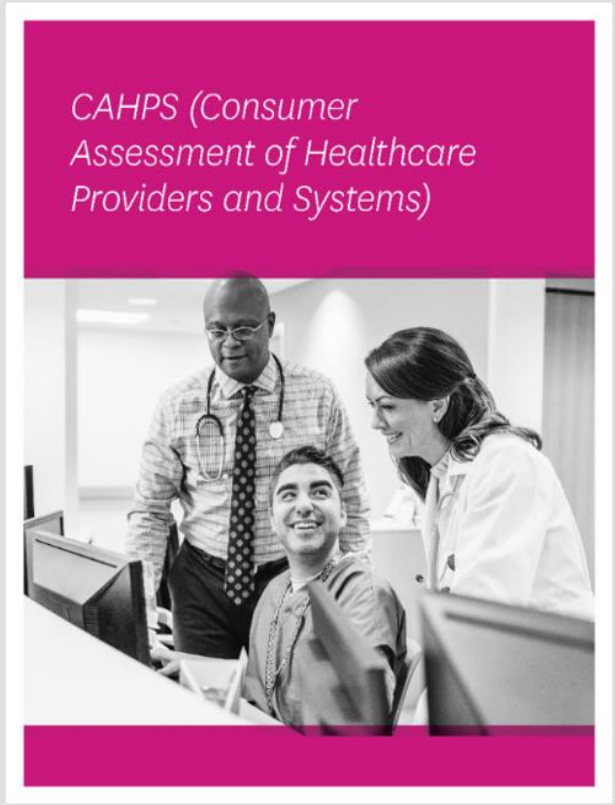
ARS is made up of 3 summary categories: Clinical Quality Management, Enrollee Experience and Plan Efficiency, Affordability and Management. The QHP Enrollee Experience Survey draws heavily form the CAHPS survey. Most survey questions fall under the Enrollee Experience summary indicator, but several questions are included in the Clinical Quality Management and Plan Efficiency, Affordability and Management summary indicators.

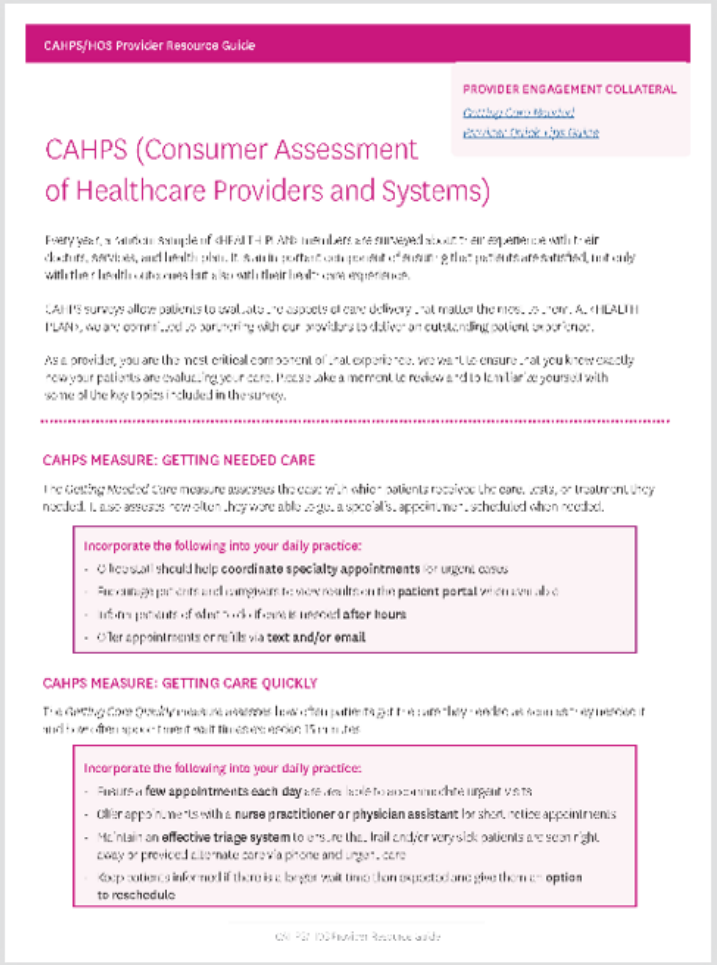
- The CAHPS survey is conducted annually however, the timeline varies slightly by product.
- The image provided reflects a breakdown of each product, important timeframes/deadlines, survey type, survey length, and sample size.

	MEDICAID	MEDICARE	MARKETPLACE
SURVEY TIME PERIOD*	January - May	March - May	February - May
SUBMISSION DEADLINE*	End of May	Mid-June	End of May
SURVEY TYPE/ REQUIREMENT	Adult Child Child CCC	Min. of 600 continuously enrolled members for 6 months required	Min. of 500 continuously enrolled members for 6 months required
SURVEY LENGTH	Adult- 40 questions Child- 41 questions Child CCC- 76 questions	MAPD- 68 questions PDP- 26 questions	68 questions
SAMPLE SIZE	Adult- 1,350 Child- 1,650 Child CCC- 3,490	MAPD- 800 PDP- 1500	1300
SUPPLEMENTAL QUESTIONS	Max of 12	Max of 12	Not Permitted
LANGUAGE	English and Spanish	English, Spanish, Chinese, Vietnamese, and Korean	English, Spanish, and Chinese
BLACK OUT PERIOD	No Blackout Period	February - June	January - May

CAHPS® Provider Resource Guide

[Consumer Assessment of Healthcare Providers and Systems (CAHPS) | Absolute Total Care]



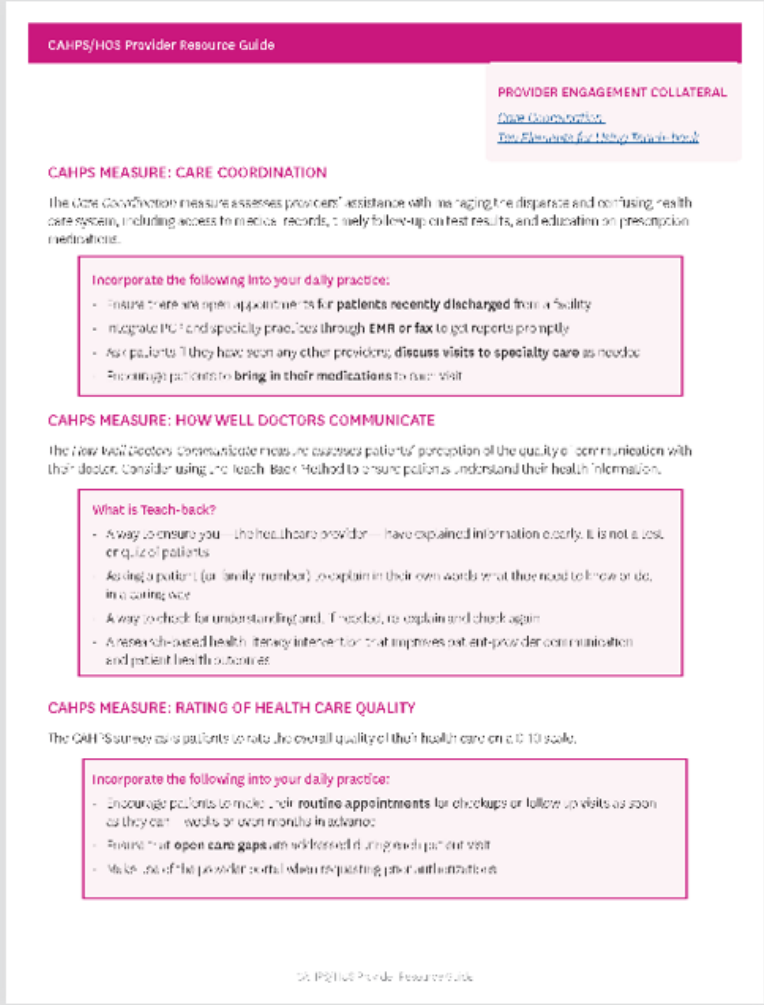

CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL

CAHPS (Consumer Assessment of Healthcare Providers and Systems)

CAHPS MEASURE: GETTING NEEDED CARE

CAHPS MEASURE: GETTING CARE QUICKLY


CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL

CAHPS MEASURE: CARE COORDINATION

CAHPS MEASURE: HOW WELL DOCTORS COMMUNICATE

CAHPS MEASURE: RATING OF HEALTH CARE QUALITY

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Provider Focus Quick Tips

Getting Care Quickly

- Maintain an effective triage system to ensure that frail and/or very sick patients are seen right away or provided alternate care via phone and urgent care.
- For patients who want to be seen on short notice but cannot access their doctor, offer appointments with a nurse practitioner or physician assistant.
- Ensure a few appointments each day are available to accommodate urgent visits.
- Address the 15-minute wait time frame by ensuring patients are receiving staff attention.
- Keep patients informed if there is a wait and give them the opportunity to reschedule.

Rating of Health Care

- Encourage patients to make their routine appointments for checkups or follow up visits as soon as they can – weeks or even months in advance.

Getting Needed Care

- For urgent specialty appointments, office staff should help coordinate with the appropriate specialty office.
- If a patient portal is available, encourage patients and caregivers to view results there.

Care Coordination

- Ensure there are open appointments for patients recently discharged from a facility.
- Integrate PCP and specialty practices through EMR or fax to get reports on time.
- Ask patients if they've seen any other providers. If you are aware specialty care has occurred, please mention it and discuss as needed.
- Encourage patients to bring in their medications to each visit.

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Accessibility and Availability Standards

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Accessibility and Availability

Accessibility is defined as the extent to which a member can obtain needed services in a timely and convenient manner. This includes both telephone access and the ease of scheduling appointments, when applicable.

Availability is defined as the extent to which Absolute Total Care contracts with the appropriate type and number of practitioners and providers necessary to meet the needs of its members within defined geographical areas.

- All Providers must adhere to standards of timeliness for appointments and in-office waiting times.
- These standards take into consideration the immediacy of the Member's needs.
- Absolute Total Care and Wellcare will monitor Providers against the standards for each line of business to help Members obtain needed health services within acceptable appointment times, in-office waiting times and after-hours standards.
- Providers not in compliance with these standards will be required to implement corrective actions.

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Access Standards - Medicaid

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Primary Care Provider (PCP) Appointment Access Standards	
Routine Visits for established patients	Within 15 business days
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24-hour coverage	24 hours a day, 7 days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment

Specialty Care Provider Appointment Access Standards ***NEW*** Obstetrics & Gynecology (OB/GYNs), Oncologists, Retail Pharmacy and Autism Services	
Routine Visits for established patients	Within 15 business days
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24-hour coverage	24 hours a day, 7 days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes

Access Standards - Medicaid

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Behavioral Provider Appointment Access Standards	
Initial visit for routine care	Within 10 business days
Follow-Up routine care for established patients	Within 15 business days
Care for a non-life-threatening emergency	Within 6 hours or referred to the emergency room or behavioral health crisis unit
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24 Hour coverage	24 hours a day, 7 days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in Appointments/non-urgent	Should be seen if possible or schedules for an appointment

Other Required Specialty Care Provider Appointment Access Standards ***NEW***	
Routine Visits for non-symptomatic care	Within 4-12 weeks
Urgent medical condition visits	Within 48 hours
Emergent or emergency visits	Immediately upon referral
Indian Medial Referrals	Allow for Indian Health Care provider referrals of an Indian member

Access Standards – Wellcare by Absolute Total Care

Primary Care and Specialist Appointment Type	Access Standard
PCP-Urgent	Within 24 hours
PCP-Non-urgent	Within 7 business days
PCP-Regular and routine	Within 30 business days
All specialists (including high volume and high impact) - Urgent	Within 24 hours
All specialists (including high volume and high impact) - Non-Urgent	Within 30 business days
Behavioral health provider - Urgent care	48 hours
Behavioral health provider – Initial routine care	Within 10 business days
Behavioral health provider – Non-life-threatening emergency	Within 6 hours
Behavioral health provider – Initial routine care follow-up	Within 10 business days
In-office wait times for all standards	Not to exceed 15 minutes

Access Standards - Ambetter

Appointment Type	Access Standard
PCP's - Routine visit	Within 15 business days of request
PCP's – Adult & Pediatric s Non-urgent/Sick visit	48 hours
PCP's – Adult & Pediatric urgent care	Within 24 hours of member's call
Specialist	Within 30 business days
OBGYN	Within 30 business days
Behavioral Health-Non-Life- Threatening Psychiatric Emergency	Within 6 hours
Behavioral health urgent care	Within 48 hours
Behavioral health-Routine (Initial Assessment)	Within 10 business days
Behavioral health provider – Initial routine care follow-up	Within 10 business days
After Hours Care	Answering service 24 hours a day, 7 days a week or instructions on how to reach a physician
Emergency	24 hours a day, 7 days a week

Case Management

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Case Management Services

Case Management is a FREE service provided by Absolute Total Care to help our members get the care and services they need. Our goal is to support our members in managing their health and improving their quality of life.

How do you use case management program services? Our Case Management services include:

- Referrals to specialists and other services
- Coordinating Care between doctors and other providers
- Developing Care Plans and setting health goals
- Learning About Other Services that can make our member's lives easier

How to become eligible for case management? Members may become eligible through:

- Referrals or medical claims
- A review of medical information by a Care Manager
- After being hospitalized
- A Care Manager may reach out to members to discuss your healthcare needs
- Provider referral

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Scan the QR Code to learn more about our Provider Resources, such as manuals, forms and quick reference guides

Absolute Total Care is committed to giving our providers the tools & support you need.

absolutetotalcare.com

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Appendix

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My Health Pays® Rewards

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You can earn My health pays™ REWARDS from Absolute Total Care when you complete healthy activities!

START EARNING TODAY!

$10 Well Visit with Primary Care Doctor.
Ages 3 and up. One per calendar year.

Diabetes Care. **Ages 18-75.** One per calendar year.
- **$20** HbA1c test
- **$20** Retinopathy screening (dilated eye exam)

$10 Cervical Cancer Screening.
Ages 21-64. One per calendar year.

$20 Breast Cancer Screening.
Ages 40-74. One per calendar year.

$10 Annual Chlamydia Screening.
Ages 16-24. One per calendar year.

$50 Prenatal Doctor Visit.
One per pregnancy. Must be completed during first trimester or within 42 days of enrollment.

$50 Postpartum Doctor Visit.
One per pregnancy and within 7-84 days after delivery. Must have delivery claim.

$20 HPV Vaccine.
Ages 9-13. Two rewards per lifetime.

$20 Infant Well Visit.
Ages 0-30 months. Up to six visits by the 15th month and up to 2 additional visits between the 16th and 30th month. 8 visits/$160 maximum.

IT PAYS TO STAY HEALTHY.

You will receive your My Health Pays Visa® Prepaid Card when you earn your first reward from Absolute Total Care. Each time you complete a qualifying healthy activity, we are notified, and your reward dollars will be added to your existing card. It's that simple!

DON'T FORGET TO KEEP YOUR CARD!

Learn more at **absolutetotalcare.com** or call **1-866-433-6041 (TTY: 711)**

This card is issued by The Bancorp Bank, N.A., pursuant to a license from Visa U.S.A. Inc. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

[My Health Pays® Rewards]

Additional Medicaid Services

Breast Pump-New moms can receive an electric breast pump at no cost. Members are eligible to request the breast pump 12 weeks before delivery and up to 30 days after delivery (within 90 days for NICU babies). Members can call 1-877-394-1860 for more information.	**Reading Skills Development Program** Absolute Total Care provides books and tutoring sessions to qualified members (Pre-K - fifth grade) to improve reading skills at no cost.
Cell Phone Program-The SafeLink program provides free talk, text and data for qualifying Absolute Total Care members. This program provides communication with members' primary care provider, Care Manager, and certain family members instrumental in their care, and our 24/7 nurse advice line. Members can enroll in the program today by visiting the SafeLink website.	**Safe Sleep Kit**-Absolute Total Care provides a safe sleep kit for high-risk members who are engaged in Case Management at no cost.
Diaper Rewards Program-Receive one package of diapers and wipes after completing each of these visits: 6-week postpartum visit; 1, 2, 4, 6, 9, and 12-month infant well visits.	**Smoking Cessation -** Absolute Total Care provides smoking cessation counseling and medications at no cost.
General Education Diploma (GED) Testing-Absolute Total Care provides vouchers for members over the age of 16 to take the GED Exam at no cost.	**Sports Activity Fee** Absolute Total Care covers the sports activity fee for members 5-18 years old. Members can receive up to $50 annually through the My Health Pays rewards program. This benefit covers the program activity/registration fee only.
Housing Assistance-Absolute Total Care assists qualifying members in locating temporary or permanent housing accommodations, accessing community resources and will deliver a Welcome Kit on or near member's move-in day at no cost.	**Start Smart for Your Baby® Educational Program** Absolute Total Care provides pregnancy and postpartum educational information to qualifying members at no cost. Refer to Chapter 9: Case Management to learn more about Absolute Total Care Start Smart for Your Baby® educational program and how to refer members.
MyHealthPays® Rewards Program-Members can earn reward dollars for completing healthy behaviors. Use reward dollars for everyday items at Walmart or to help for utilities, transportation, phone and internet services, childcare services, education and rent.	**Substance Use Disorder Program** Absolute Total Care provides a substance use disorder program for at-risk members at no cost.
Over-the-Counter (OTC) Benefit-Absolute Total Care provides members with a $15 quarterly allowance, up to $60 annually, of OTC products per household. No prescription is required, and items are mailed to the home. Unused funds at the end of each quarter do not carry over.	**Suicide Prevention Program -** Absolute Total Care provides a suicide prevention program for at-risk members at no cost.
Postpartum Meals Absolute Total Care provides qualifying birth parents who have a delivery on record 14 free, home-delivered postpartum meals.	

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THANK YOU FOR JOINING

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Thank You.