Absolute Total Care 2022 Virtual Provider Town Hall 3rd quarter

10/3/2022

Meeting Overview

- Absolute Total Care Healthy Connections Medicaid
- Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan)
- Wellcare by Allwell
- Ambetter from Absolute Total Care
- Wellcare Medicare Plans
- Annual Provider Training Requirements for Medicare
- No-cost interpreter services and oral translation services
- Website Features
- Secure Provider Portal Features
- Eligibility
- Claims 411 – Did You Know?
- Electronic Funds Transfer (EFT)
- Network Development and Participation
- Credentialing Rights
- Balance Billing
- Quality
- CAHPS® -Consumer Assessment of Healthcare Providers and Systems
- Start Smart for Your Baby Q&A

Housekeeping

- Phone lines are muted
- Enter questions in Q&A feature
- Include your name, group name, contact information

Provider Relations Team

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Products offered to our members

Absolute Total Care Healthy Connections Medicaid

- Serving approximately 230,000 members (statewide service area)
- 2022 benefit highlights:
  - Telehealth services for medical and behavioral health*
  - Copay waived for medically necessary COVID-19 testing
  - Boys and Girls Club
  - Boy Scouts and Girl Scouts
  - Step2Success

- **My Health Pays rewards:**

https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards.html

  - Members can earn $5 to $50 by completing healthy behaviors

***ongoing continuation is being evaluated based on Public Health Emergency (PHE)**

Wellcare Prime

- Serving approximately 4,500 dual-eligible members (age 65+)
- 2022 benefit highlights:
  - State-wide service area
  - Telehealth services for medical and behavioral health
  - Transportation: Unlimited one-way rides to plan-approved locations
  - Over-the-counter: $100 per calendar quarter
  - Hearing: One hearing aid per calendar year
  - Fitness: Up to $250 toward gym membership
- My Health Pays rewards-Members can earn $20 by completing healthy behaviors
  - https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards1.html

Wellcare by Allwell

- Wellcare No Premium Medicare (HMO)
- Wellcare Dual Access* (HMO D-SNP) and Wellcare Dual Liberty (HMO D-SNP)
- Serving approximately 3,000 members
  2022 benefit highlights:
  - State-wide service area
  - New plan names and look
  - Telehealth services for medical and behavioral health
  - D-SNP transportation
  - Over-the-counter
  - Dental, hearing, routine vision
  - Fitness

**Wellcare Dual Access and Dual Liberty –Medicaid benefits are paid fee for service (FFS) by SC Department of Health and Human Services SCDHHS*

Wellcare Medicare Advantage PPO

With the Wellcare Medicare Advantage PPO plan, members enjoy the freedom to receive healthcare services from Medicare providers of their choice. As an eligible Medicare provider, Wellcare reimburses you at 100% of the Medicare allowable rate for all plan-covered, medically necessary services for our PPO members – whether you are contracted with us or not.

INCREASED FLEXIBILITY

- The Wellcare Medicare Advantage PPO plan offers members flexibility as they navigate their care journeys. PPO members don't need a referral from a primary care physician for specialist or hospital visits. However, using providers in Wellcare's network may cost less than choosing one that is out-of-network. Medicare providers who do not contract with Wellcare are under no obligation to treat our members, except in emergency situations.

Wellcare Medicare Advantage PPO

In addition, the Wellcare Medicare Advantage PPO plan:

- Offers a simple copayment for doctor visits, hospital stays and many other healthcare services, making healthcare costs more predictable
- Gives members Medicare Parts A, B, and D coverage as well as vision, dental, and hearing benefits not covered by original Medicare
- Covers all original Medicare services and follows original Medicare's coverage rules
- Only covers medically necessary services rendered by providers who are eligible to participate in Medicare

BILLING FOR SERVICES

- If you provide services to a Wellcare PPO member, whether you are in- or out-of-network, we make it easy to seek prior authorizations and submit claims. Please refer to claims submission and provider resources sections.

Ambetter from Absolute Total Care

- Health Insurance Marketplace
- Serving approximately 33,000 members in 42 counties
- 2022 benefit highlights:
  - Service area expanded into 12 new counties
  - $0 copay for telehealth services for medical care
  - Health Savings Accounts
  - Dental
  - Routine vision
  - Virtual plan option
  - Concierge services for disease management
- Balance billing protection via the “No Surprises Act”

**service area excludes Anderson, Cherokee, Spartanburg and Union*

No Surprises Act

The No Surprises Act is specific to the Ambetter (Marketplace) product. If you do not have an Ambetter agreement, please disregard.

- Effective January 1, 2022
- Applies to:
  - Emergency care at out-of-network facilities
  - Post stabilization care at out-of-network facilities
  - Non-emergency services provided by out-of-network providers at in-network facilities, unless notice and consent is given
  - Out-of-network air ambulance services

No Surprises Act, cont.

- No balance billing for out-of-network emergency services.
- No balance billing for non-emergency services rendered by nonparticipating providers at in-network hospitals and ambulatory surgical centers:
  - Emergency Medicine
  - Anesthesiology
  - Pathology
  - Radiology
  - Neonatology
  - Services provided by assistant surgeons, hospitalists, and intensivists
  - Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at the facility

Annual Provider Training Requirements

Absolute Total Care partners with all 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 Medicare-Medicaid Plan (MMP) contracted providers are required to complete the following trainings within 90 days of contracting and annually thereafter:

- General Compliance (Compliance)
- Fraud, Waste, and Abuse
- Model of Care (MOC)*
- Person-Centered Planning**
- Cultural Competency

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

No Cost Interpreter Services and Oral Translation Service

10/3/2022

No Cost Interpreter Services and Oral Translation Service

Absolute Total Care is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. In order to meet this need, Absolute Total Care is committed to the following:

- Having trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed.
- Providing Language Line services that will be available 24 hours a day, seven days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.

No Cost Interpreter Services and Oral Translation Service

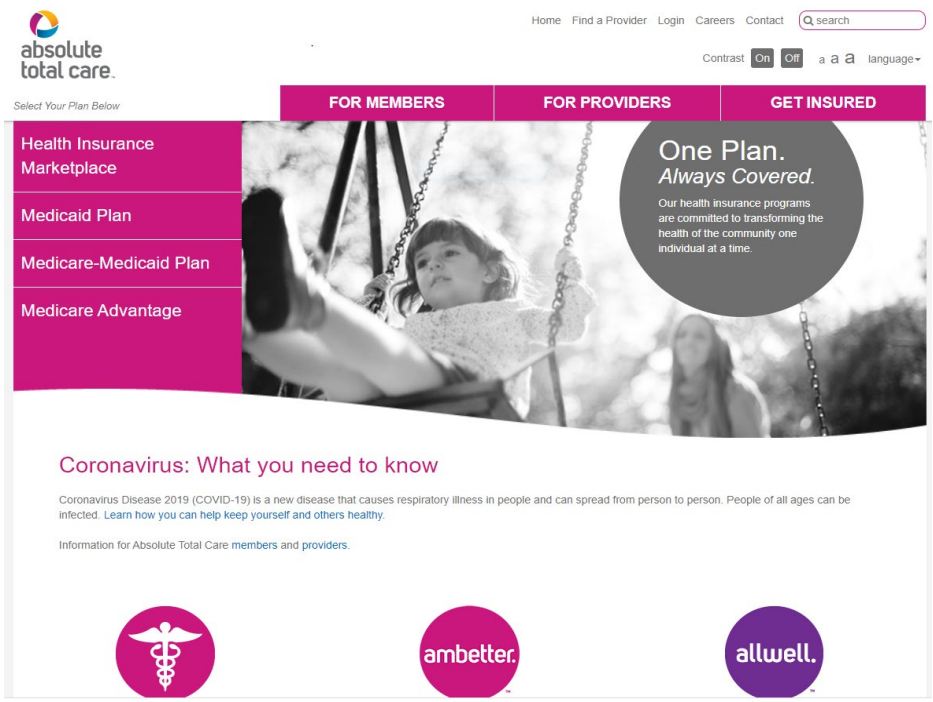
- In-person interpreter services are made available when Absolute Total Care is notified in advance of the member's scheduled appointment.
- Providing TTY access for members who are hearing impaired through 711.
- Absolute Total Care medical advice line, nurse advice line, provider 24-hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.
- Providing or making available Member Services and health education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

For an interpreter for a medical visit, contact Member Services at 1-866-433-6041 (TTY: 711)

ATC Website and Secure Portal

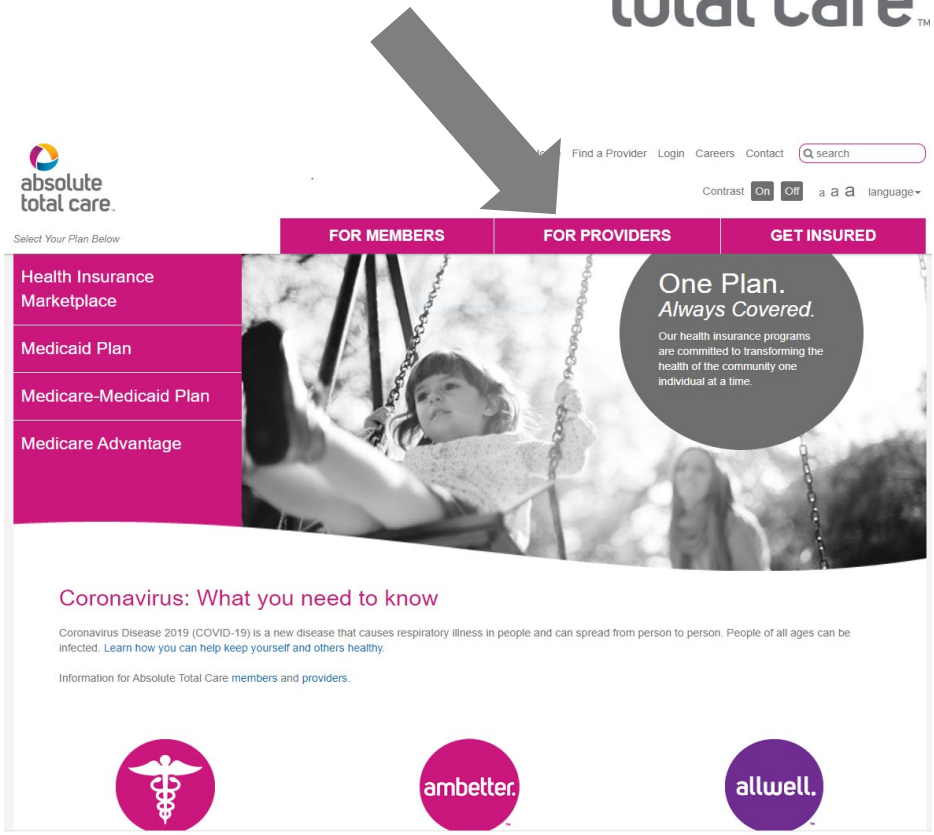
Website

- Website: absolutetotalcare.com



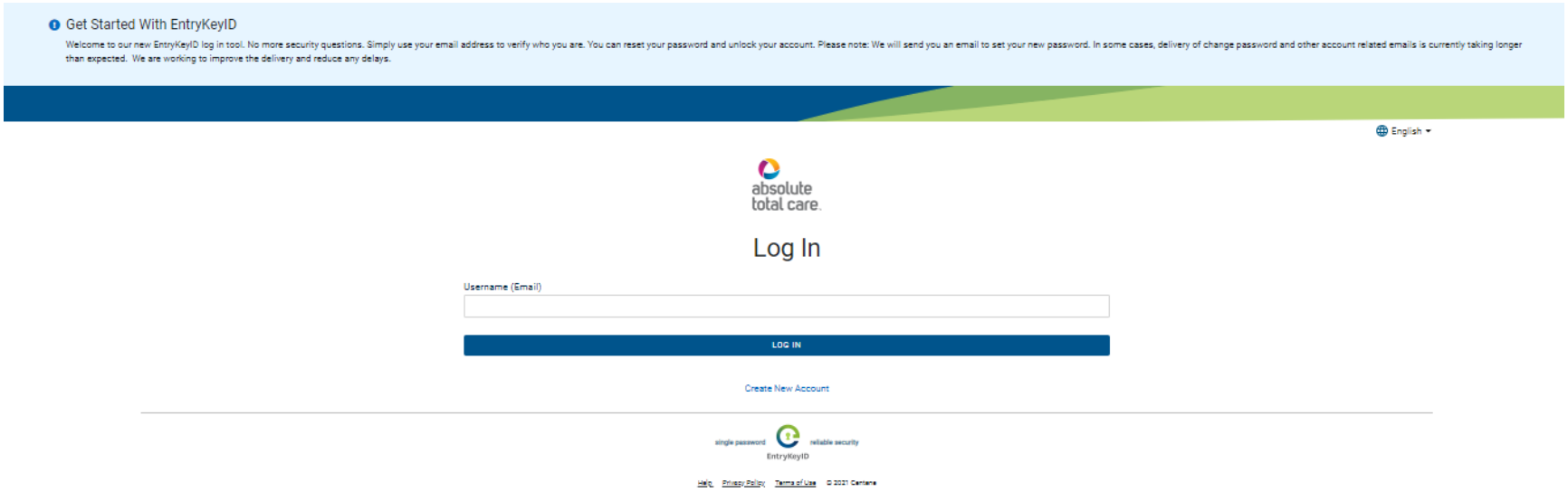
Website

- For Providers section
- Pre-Auth Check Tool
- Clinical and Payment Policies



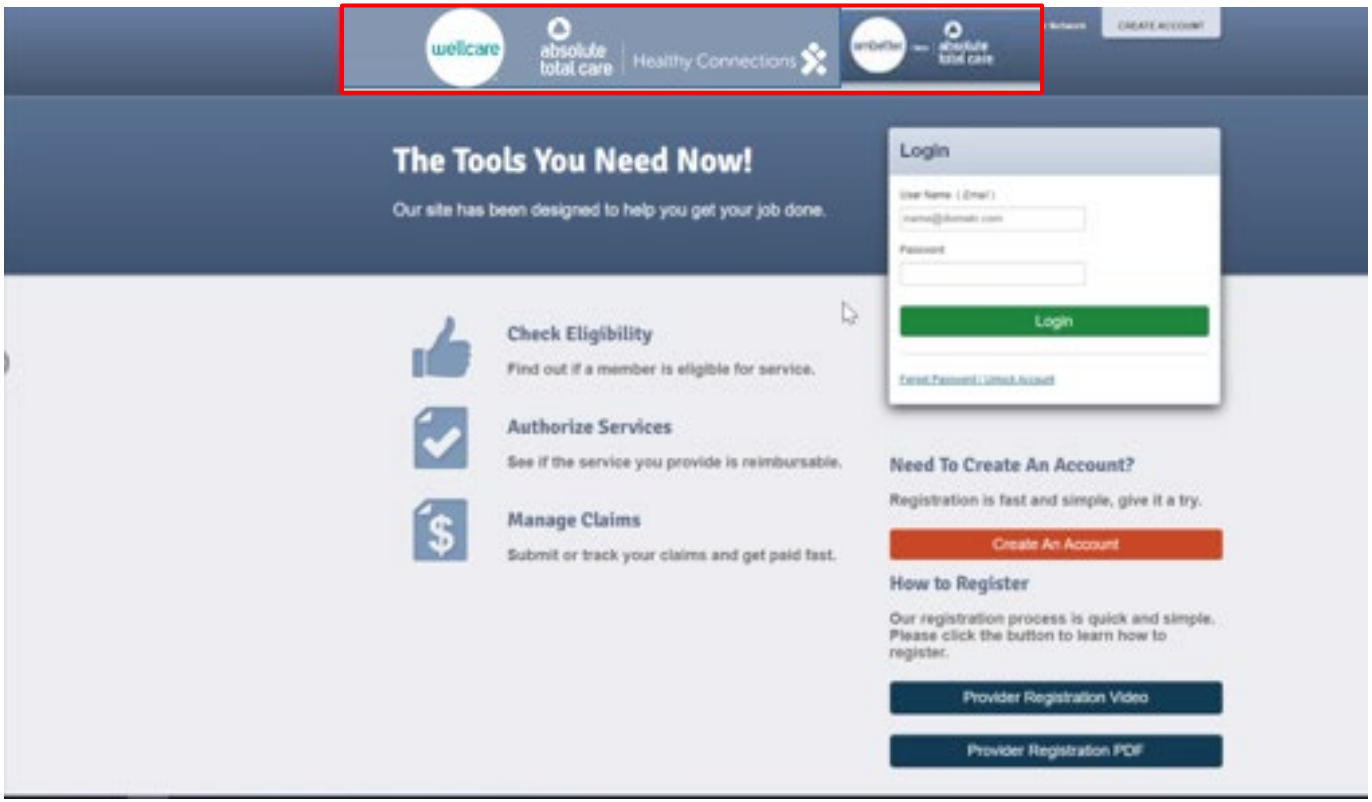
Secure Provider Portal

- Log in: https://www.absolutetotalcare.com/login.html



Secure Provider Portal

Portal Log-In View

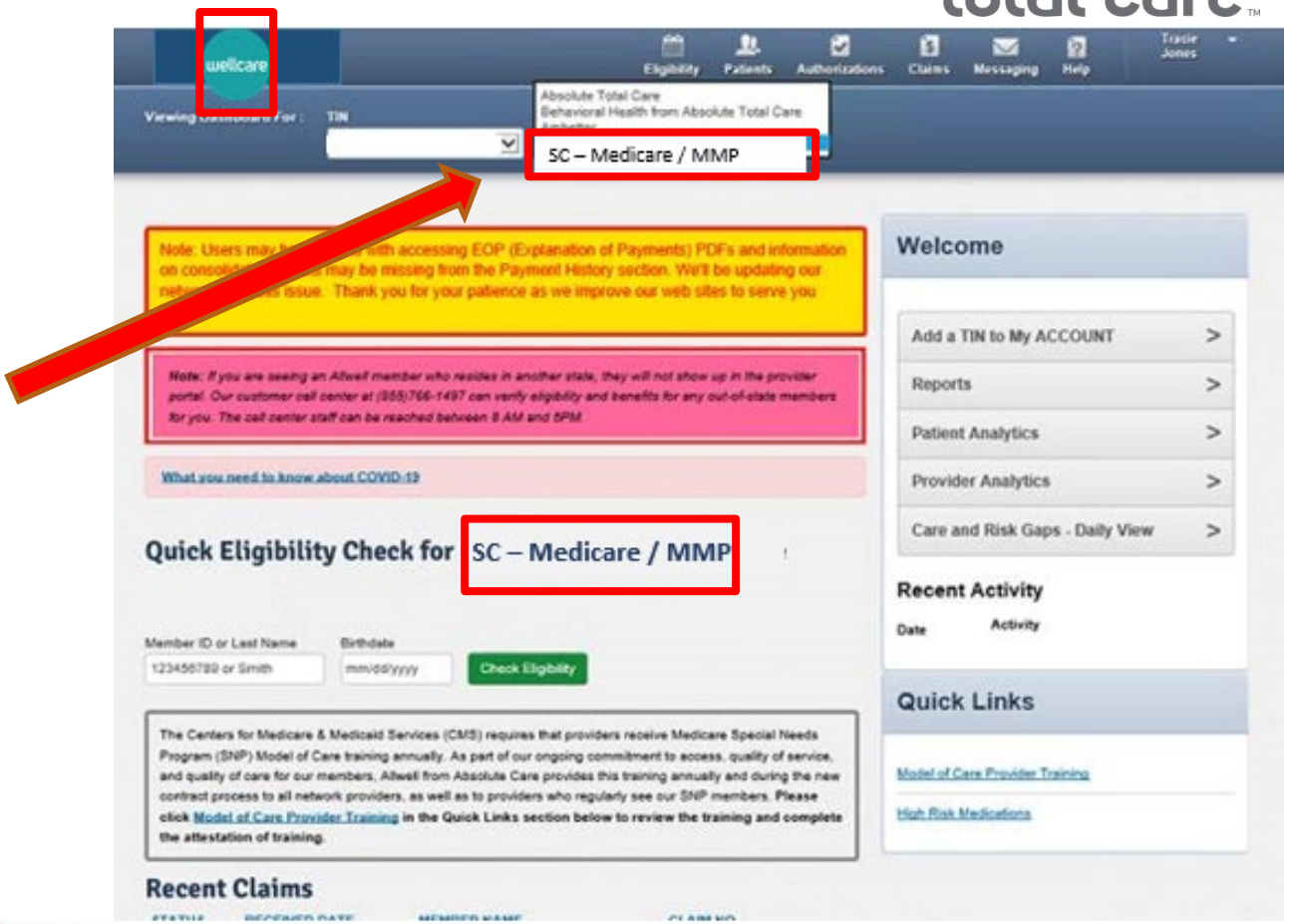


Secure Provider Portal

Portal View Update

Updated logo and plan name in drop down

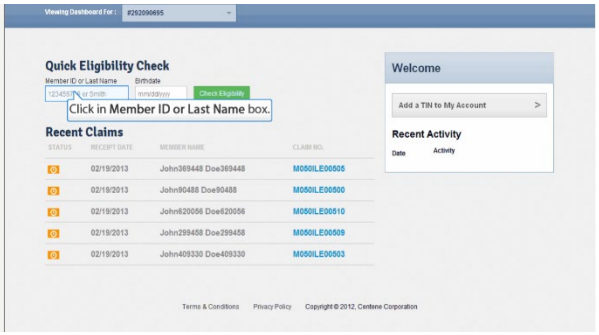
Medicare Advantage and MMP Members

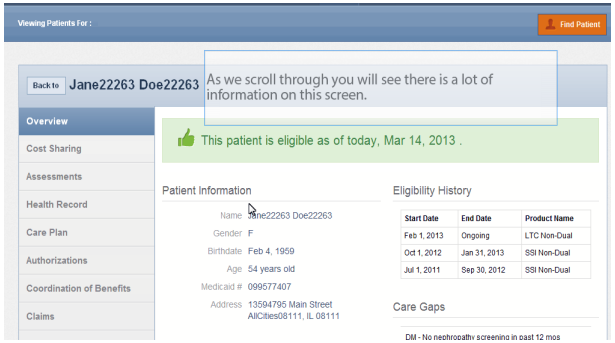


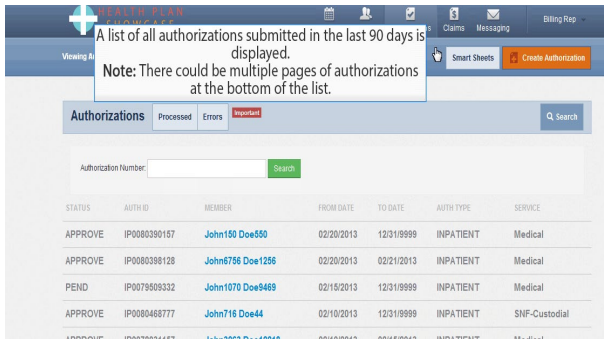
Secure Provider Portal

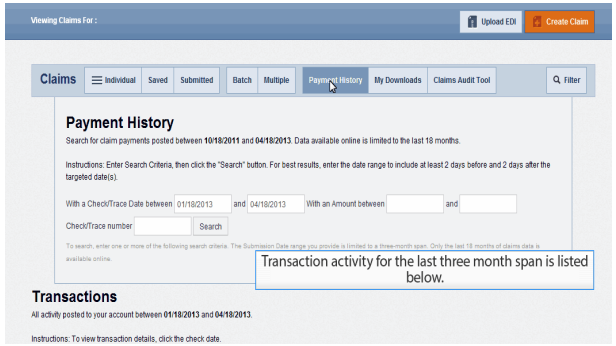
absolute total care™

- Patient information



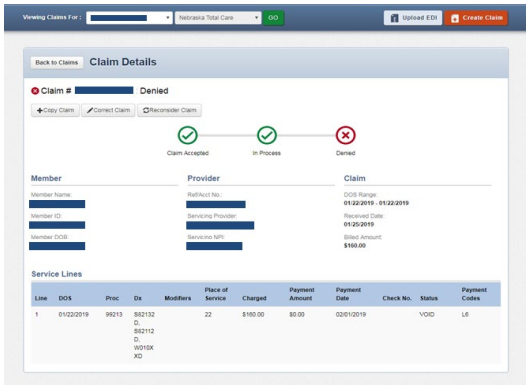


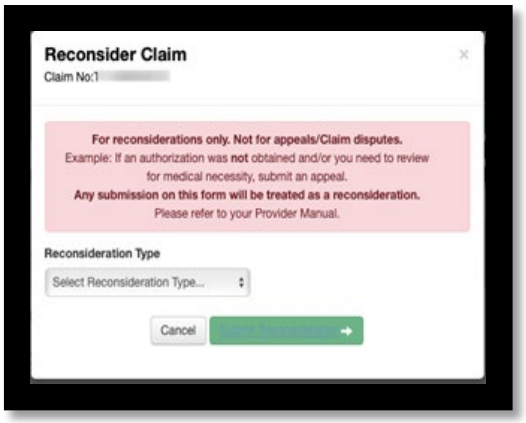


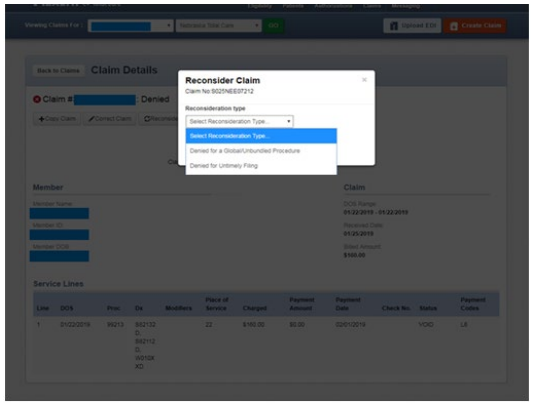


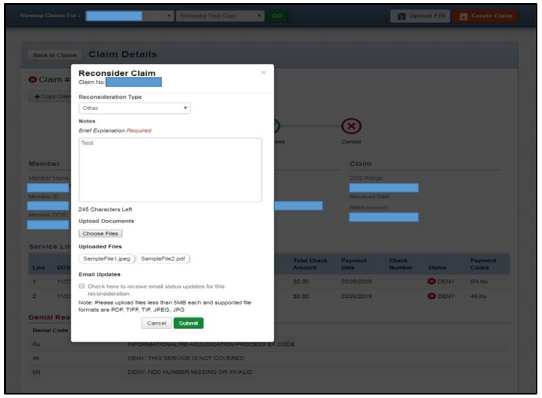
Secure Provider Portal

- Provider reconsideration
  - Review process
  - Correct routing and procedure
  - Most common issues









Eligibility

- Member eligibility should be checked each month and each time prior to rendering services
- The Absolute Total Care Secure Provider Portal or the Interactive Voice Response (IVR) system are available 24 hours a day, seven days a week

  - Absolute Total Care 1-866-433-6041 (Medicaid)
  - Wellcare by Allwell 1-855-766-1497 (Medicare)
  - Ambetter by Absolute Total Care 1-833-270-5443 (Marketplace)
  - Wellcare Prime by Absolute Total Care 1-855-735-4398 (Medicare-Medicaid Plan)
  - Wellcare Medicare 1-866-270-5223 (Medicare)

Claims 411 – Did You Know?

Claims 411 – Did You Know?

- Most common claim rejection
  - Member Not Valid at Date of Service (DOS)
  - Invalid Member
  - Invalid Member DOS
- Always utilize the eligibility tab on the Secure Provider Portal prior to services to avoid these rejections
- Most common claim denial
  - Services Not on the Fee Schedule are Not Separately Reimbursable
  - This Service is Not Covered
  - Duplicate Claim Service
  - CMS Medicaid NCCI Unbundling
  - No Authorization on File that Matches Service(s) Billed

Claims 411 – Did You Know?

- Clinical and payment policies
  - Utilize these policies for any NCCI or HCI edit denials:
    - Denials with a code consisting of lower-case letters is an HCI edit denial and will require medical records to be submitted for review
    - You can find these policies located under Provider Resources tab in the For Providers section on the website
- Pre-authorization
  - The Pre-Auth Check Tool
    - A great tool to utilize to avoid authorization denial
  - All inpatient services require an authorization
    - Professional services being performed per inpatient stay require a separate authorization and must be obtained to avoid claims denying for no authorization on file

Claims 411 – Did You Know?

- Provider news
  - Provider News can be found on the website under the ‘For Providers’ section. In addition to Centene news, you will find articles to include updates to billing, updated codes newly requiring authorizations, CMS and SCDHHS regulation updates, etc.

- Claims must be filed electronically or sent directly to our claims processing center. Claims mailed to the physical office address will be returned and will not be able to be processed. For claims processing efficiency, Absolute Total Care encourages providers to submit claims electronically.

Claims Submission

- Submit following one of the procedures below, according to line of business:

Line of Business	Electronic Claim Submission	Paper Claim Submission
Medicaid	**Secure Provider Portal** **www.Absolutetotalcare.com/login** or **EDI Payer Numbers:** 68069 - Emdeon/WebMD/Envoy/Payerpath 42772 - Relay Health/McKesson 68068 – Behavioral Health	**Absolute Total Care** **P.O Box 3050** **Farmington, MO 63640-3821** **Behavioral Health:** **Absolute Total Care** **P.O. Box 7001** **Farmington, MO 63640-3811**
Marketplace	**Secure Provider Portal** **www.Absolutetotalcare.com/login** or **EDI Payer Number** 68069	**Ambetter from Absolute Total Care** **P.O. Box 5010** **Farmington, MO 63640-5010**
MMP		**Wellcare Prime by Absolute Total Care** **P.O. Box 3060** **Farmington, MO 63640-3822**
Medicare Advantage		**Wellcare By Allwell** **P.O. Box 3060** **Farmington, MO 63640-3822**

Claims Submission - Wellcare

- Claims are not accepted at local office
- Submit following one of the procedures below, according to line of business:

<table>
<tr><th>Line of Business</th><th>Electronic Claim Submission</th><th>Paper Claim Submission</th></tr>
<tr><td>Medicare Advantage</td><td>Register online using the simplified, enhanced provider registration process at PaySpan.com or call 1-877-331-7154
Or
Change Healthcare EDI Clearinghouse
1-877-411-7271.

CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)
<table><tr><th>Claim Type</th><th>Fee-for-Service (CH - Chargeable) Submissions</th><th>Encounter (RF - Reporting only) Submissions</th></tr><tr><td>Professional</td><td>1844</td><td>3211</td></tr><tr><td>Institutional</td><td>8551</td><td>4949</td></tr></table>
If your clearinghouse or billing system is not connected to Change Healthcare and requires a 5-digit Payer ID, please use the following according to Fee-for-Service or Encounters file type:
• Fee-for-Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.
• Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.
<table><tr><th>Claim Type</th><th>FFS (CH - Chargeable) Submissions</th><th>Encounter (RF - Reporting only) Submissions</th></tr><tr><td>Professional or Institutional</td><td>14163</td><td>59354</td></tr></table></td><td>Wellcare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372</td></tr>
</table>

Provider Timeframes
Claim Submission

Claim Adjustments: *Requests to change the initial claim*

Reconsiderations: *Submitted when a provider disagrees with how a clean or adjusted claim was processed*

Disputes: *Submitted when a provider has received an unsatisfactory response to a previous reconsideration request*

Provider Timeframes Claim Adjustments, Reconsiderations, and Disputes

MEDICAID		
Submission Timeframes	**Par**	**Non-Par**
Claim Initial/Resubmission	365	365
Claim Adjustment	365	365
Claim Dispute	60	60
Decision Timeframes	**Par**	**Non-Par**
Dispute Decision	30	30
Mailing Address		
P.O. Box 3050 Farmington, MO 63640-3821		

MARKETPLACE		
Submission Timeframes	**Par**	**Non-Par**
Claim Initial/Resubmission	120	120
Claim Adjustment	60	60
Claim Reconsideration	60	60
Claim Dispute	60	60
Decision Timeframes	**Par**	**Non-Par**
Appeal Decision	30	30
Dispute Decision	30	30
Mailing Address		
P.O. Box 5010 Farmington, MO 63640-5010		

Provider Timeframes Claim Adjustments, Reconsiderations, and Disputes

	MMP		MAPD/D-SNP	
Submission Timeframes	**Par**	**Non-Par**	**Par**	**Non-Par**
Claim Initial/Resubmission	365	365	365	365
Claim Adjustment	365*	365*	90***	365*
Claim Reconsideration	365*	365*	90***	365*
Claim Appeal	60	60**	60	60**
Claim Dispute	60	60	60	60
Decision Timeframes	**Par**	**Non-Par**	**Par**	**Non-Par**
Appeal Decision	30	60	30	30
Dispute Decision	30	30	30	30
Mailing Address				
P.O. Box 3060 Farmington, MO 63640-3822				

*from date of service
**Waiver of Liability required
***from date of last processed claim

Electronic Funds Transfer

Electronic Funds Transfer

Absolute Total Care and PaySpan are in partnership to provide 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.

PaySpan Benefits

- **Elimination of paper checks**
- **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

Electronic Funds Transfer

PaySpan Benefits [CON'T]

- **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.

Electronic Funds Transfer

- 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 payspanhealth.com.

BALANCE BILLING

Balance Billing

- What is balance billing?
  - Seeking payment from members for the difference between the billed charges and the contracted rate paid by the plan
    - Payments less any copays, coinsurance, or deductibles are considered payment in full
- Prohibited by federal law
  - Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances
    - Original Medicare and Medicare Advantage providers and suppliers – not only those that accept Medicaid – must not charge individuals enrolled in the QMB program for Medicare cost-sharing

Balance Billing

- Steps to ensure compliance with QMB billing prohibitions:
  - Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services
  - Ensure that a Member Acknowledgement Statement has been signed by both the provider and the Absolute Total Care member for non-covered services prior to rendering said service
  - If you have erroneously billed these members, recall the charges (including referrals to collection agencies) and refund the invalid payments
  - Healthy Connections prime link https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-healthy-connections-prime-members-0

NETWORK DEVELOPMENT AND PARTICIPATION

Network Development and Participation

- Network participation
  - The enrollment, credentialing and recredentialing processes exist to ensure that participating providers meet and remain compliant to the criteria established by Absolute Total Care, as well as government regulations and standards of accrediting bodies
  - Contracting requests are to be directed to ATC_Contracting@centene.com (Note: This is specific to new agreements only.)
  - To add a new practitioner, providers must submit a Provider Data (Add) Form and Current W-9 to SouthCarolinaPDM@centene.com to begin the credentialing process
    - Refer to the Provider Manual for more information on requirements for network participation
    - This process takes approximately 90 days to complete (follow ups prior to receiving the Welcome Letter can be done so by emailing SouthCarolinaPDM@centene.com)
    - Recredentialing is performed at least every 36 months

Network Development and Participation

- Provider updating existing participating providers and locations may do so by emailing the Provider Data Form (Update) to SouthCarolinaPDM@centene.com

- Network Development
  - To request a new agreement, send an email to ATC_Contracting@centene.com
  - For contract updates and questions (i.e., change of ownership, TIN changes, amendments, etc.), send an email to ATC_Contracting@centene.com

Credentialing Rights

All practitioners requesting participation with ATC have the right to review information obtained by ATC to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, malpractice insurance carriers and the State of South Carolina State Board of Medical Examiners and South Carolina State Board of Nursing for Nurse Practitioners. This does not allow a practitioner to review references, personal recommendations or other information that is peer review protected.

Should a practitioner believe any of the information used in the credentialing/recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the ATC Credentialing Department. Upon receipt of this information, the practitioner will have 14 days to provide a written explanation detailing the error or the difference in information to ATC. ATC's Credentialing Committee will then include this information as part of the credentialing/recredentialing process.

Quality Improvement

Key Quality Improvement Activities

- Path to Successful Member Care
  - Member Visits
  - Preventive Care
  - Annual Screenings
  - Required Immunizations

Post Appointment Survey

Corporate CAHPS Strategy team is sponsoring a Post Appointment Survey via Press Ganey in 2022 on behalf of health plans

What: Post appointment survey consists of 18 questions focused on the visit and member experience with their provider

- In person visits
- Telehealth visits
- Specialist visits- Cardiology, Urology, Orthopedic, Gastroenterology, Psychiatry
- Wait time, ease of scheduling, nursing staff, provider concerns, privacy, overall assessment, comments

Why: In partnership with our provider network, the post-appointment surveys will allow us to enhance the experience our members are receiving when they visit their healthcare providers.

When: Members will receive a post-appointment survey once encounters/claims are received by the plan. Surveys will run year-around as they do not impact CAHPS black-out period.

How: Surveys will go out 30 days post visit date, electronically (text initially, if no response then an email) to members with 3 outreach attempts.

- Members will only receive a survey 1x for every 6 months, with a maximum of 2 surveys per year

Access Improvement Recommendations

Cross Training	• Train all staff to schedule patient appointments
Digital	• Establish online registration service
Non-traditional hours of office practice	• Before 8:00 am and after 5:00 pm some days during the week and weekends
Provide options	• Other physicians, offices, advanced practitioner, etc.
Telephone triage nurses	• Manage urgent calls and situations

Moving Through Your Visit Improvement Recommendations

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Set patient expectations	• Create responses and assist front office staff to discuss delays, walk-in appointments and appointment scheduling with patients
Open access or modified open access schedules	• Dedicated space for scheduled appointments and walk-ins
Remove Hassles	• Review check-in, check-out, referral & scheduling process for redundancies
After care	• Follow-up and Follow-through on commitments to patients and family

Nurse/Assistant Improvement Recommendations

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Enable	• Grant front line staff the authority to say “yes” • Immediate decisions resolve problems and lead to customer satisfaction
Conduct	• Develop service standards for staff • Hold staff accountable for patients and colleague standards
Ensure office staff is knowledgeable of test result time frames	• Help manage patient expectations
Patient Focused	• Avoid multitasking and give 100% attention to patient needs

Care Provider Improvement Recommendations

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Visual Aids	• Increase patient understanding: • Provide visual aids and use three dimensional models • Provide medication calendars with clear instructions
Written Material	• Simple and necessary language for understanding • Highlight key messages, keep materials short
Dedicate time to review medical records	• Demonstrate to patients their visits were anticipated
Offer patients simple and thorough printed materials	• Detailed and concise materials regarding referrals and prescriptions

Overall Assessment Improvement Recommendations

Communicate Data	• Grant front line staff the authority to say “yes” • Immediate decisions resolve problems and lead to customer satisfaction
Conduct post-visit calls	• Determine “who” will make the call and “when” • Create an escalation process for immediate needs
Collaboration	• Share patient experience results during meetings and huddles

CPT II and HCPCS Billing

Important Information on CPT II and HCPCS Codes

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.

CPTII Codes and HCPCS Billing PRO_91371E_Approved_01112022.pdf

What measures do these codes apply to?

- Controlling Blood Pressure
  - Blood pressure results
- Hba1c 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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Remote Access to EMR:

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 Feeds

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Monthly Supplemental Data Feed

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

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

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

CAHPS®
Consumer Assessment of Healthcare Providers and Systems

10/3/2022

Importance of CAHPS®

- CAHPS is a program of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.
- CAHPS is a tool used to evaluate ***member perception and overall satisfaction*** in order to improve ***the member experience.*** CAHPS allows health plans to receive anonymous feedback from its members**.**
- CAHPS is the interaction and conversations with the front desk, any staff, and especially their providers.
- CAHPS survey aims to capture accurate and complete information regarding real experiences with individuals' healthcare.
- CAHPS scores account for CMS Medicare STAR Ratings, NCQA Health Insurance Plan Ratings, CMS Marketplace Quality Rating System (QRS) and SCDHHS Medicaid Quality Withhold Program.

The Clinical Case for Improving Patient Experience

Improving patient experience has an inherent value to patients and families and is therefore an important outcome in its own right. But good patient experience also is associated with important clinical processes and outcomes. For example:

- At both the practice and individual provider levels, patient experience positively correlates to processes of care for both prevention and disease management.
- Patients' experiences with care, particularly communication with providers, correlate with adherence to medical advice and treatment plans.
- Patients with better care experiences often have better health outcomes.

Measures of patient experience also can reveal important system problems, such as delays in returning test results and gaps in communication that may have broad implications for clinical quality, safety and efficiency.

CAHPS® Provider Resource Guide

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

Provider Focus Quick Tips

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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.

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.

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.

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.

START SMART FOR YOUR BABY

Start Smart for Your Baby

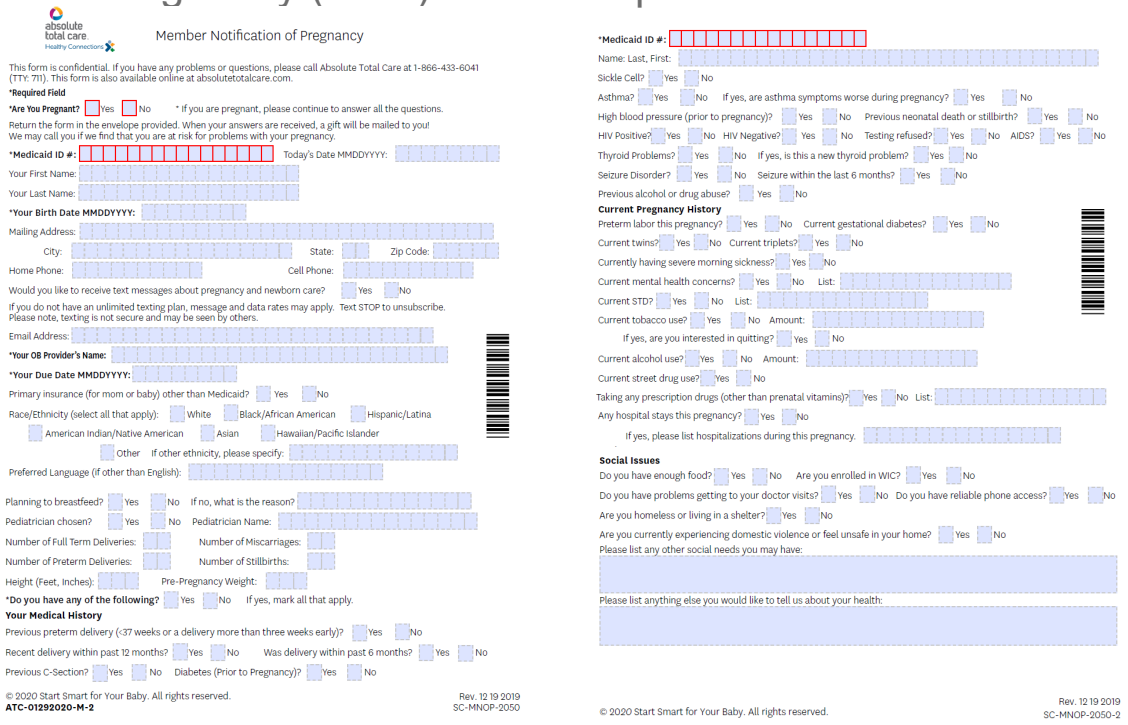
- Program goals
  - Early identification of pregnant members and their risk factors
  - Reducing the risk of pregnancy complications
  - Better birth outcomes
- Strategy
  - Submission of Notification of Pregnancy (NOP) Form
  - High-risk members are prioritized for Care Management Program
  - OB Nurse Care Managers collaborate with members and providers to improve maternal and infant health

Start Smart for Your Baby

- OB incentive reimbursements:
  - Office staff NOP incentive:
    - Provider office staff can be reimbursed up to $25 for each NOP Form, up to a total of $500 for the year
      - $25 check per form submitted during first and second month
      - $20 check per form submitted during third and fourth month
      - $15 check per form submitted during fifth and sixth month
      - If an NOP Form has already been received from another source, subsequent NOP Forms would not be eligible for incentive reimbursement
      - Provider office staff must submit a copy of the NOP Form along with the Pregnancy Incentive Reimbursement Form to receive the incentive

Start Smart for Your Baby

- Notification of Pregnancy (NOP) Form sample



absolute total care Healthy Connections

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: 711). This form is also available online at absolutetotalcare.com.

***Required Field**

***Are You Pregnant?** Yes No * If you are pregnant, please continue to answer all the questions.

Return the form in the envelope provided. When your answers are received, a gift will be mailed to you!
We may call you if we find that you are at risk for problems with your pregnancy.

***Medicaid ID #:** Today's Date MMDDYYYY:

Your First Name:

Your Last Name:

***Your Birth Date MMDDYYYY:**

Mailing Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Would you like to receive text messages about pregnancy and newborn care? Yes No

If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe.
Please note, texting is not secure and may be seen by others.

Email Address:

***Your OB Provider's Name:**

***Your Due Date MMDDYYYY:**

Primary insurance (for mom or baby) other than Medicaid? Yes No

Race/Ethnicity (select all that apply): White Black/African American Hispanic/Latina
American Indian/Native American Asian Hawaiian/Pacific Islander
Other If other ethnicity, please specify:

Preferred Language (if other than English):

Planning to breastfeed? Yes No If no, what is the reason?

Pediatrician chosen? Yes No Pediatrician Name:

Number of Full Term Deliveries: Number of Miscarriages:

Number of Preterm Deliveries: Number of Stillbirths:

Height (Feet, Inches): Pre-Pregnancy Weight:

***Do you have any of the following?** Yes No If yes, mark all that apply.

Your Medical History

Previous preterm delivery (<37 weeks or a delivery more than three weeks early)? Yes No

Recent delivery within past 12 months? Yes No Was delivery within past 6 months? Yes No

Previous C-Section? Yes No Diabetes (Prior to Pregnancy)? Yes No

ATC-01292020-M-2

Rev. 12 19 2019
SC-MNOP-2050

***Medicaid ID #:**

Name: Last, First:

Sickle Cell? Yes No

Asthma? Yes No If yes, are asthma symptoms worse during pregnancy? Yes No

High blood pressure (prior to pregnancy)? Yes No Previous neonatal death or stillbirth? Yes No

HIV Positive? Yes No HIV Negative? Yes No Testing refused? Yes No AIDS? Yes No

Thyroid Problems? Yes No If yes, is this a new thyroid problem? Yes No

Seizure Disorder? Yes No Seizure within the last 6 months? Yes No

Previous alcohol or drug abuse? Yes No

Current Pregnancy History

Preterm labor this pregnancy? Yes No Current gestational diabetes? Yes No

Current twins? Yes No Current triplets? Yes No

Currently having severe morning sickness? Yes No

Current mental health concerns? Yes No List:

Current STD? Yes No List:

Current tobacco use? Yes No Amount:

If yes, are you interested in quitting? Yes No

Current alcohol use? Yes No Amount:

Current street drug use? Yes No

Taking any prescription drugs (other than prenatal vitamins)? Yes No List:

Any hospital stays this pregnancy? Yes No

If yes, please list hospitalizations during this pregnancy.

Social Issues

Do you have enough food? Yes No Are you enrolled in WIC? Yes No

Do you have problems getting to your doctor visits? Yes No Do you have reliable phone access? Yes No

Are you homeless or living in a shelter? Yes No

Are you currently experiencing domestic violence or feel unsafe in your home? Yes No

Please list any other social needs you may have:

Please list anything else you would like to tell us about your health:

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Questions

Adjournment

APPENDIX

ATC Provider Resources

https://www.absolutetotalcare.com/providers/resources/forms-resources.html

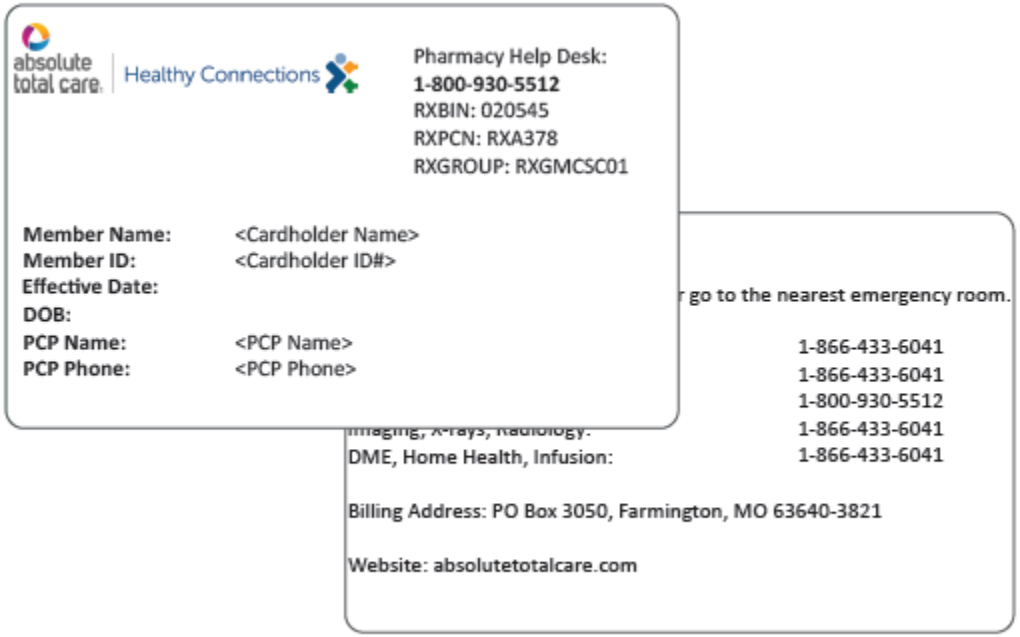
https://ambetter.absolutetotalcare.com/provider-resources/manuals-and-forms.html

Wellcare Provider Resources

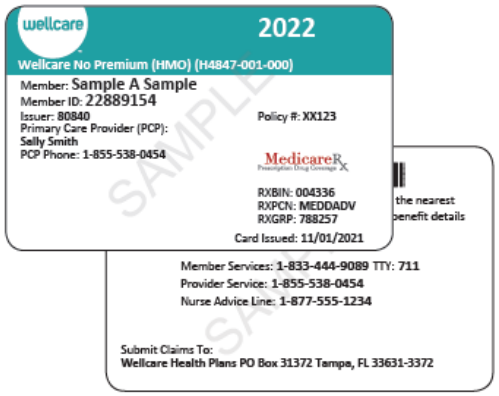
https://www.wellcare.com/South-Carolina/Providers/Medicare/Training/New-Provider-Portal-Overview-Training

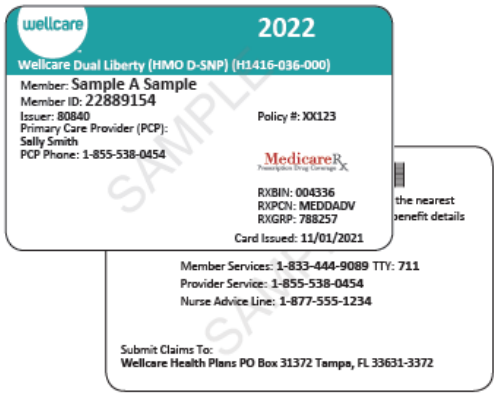
https://www.wellcare.com/Global-Content/Trainings/AcctRegandAffil

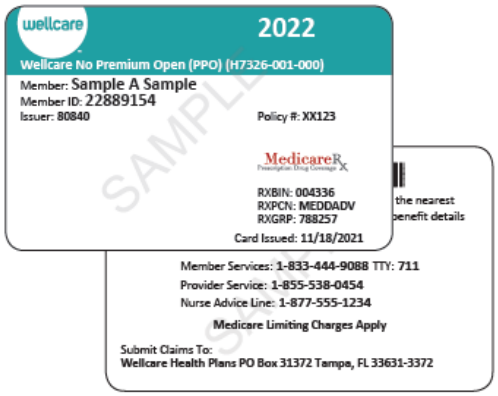
Medicaid Member ID Card



Medicare-Wellcare Member ID Card

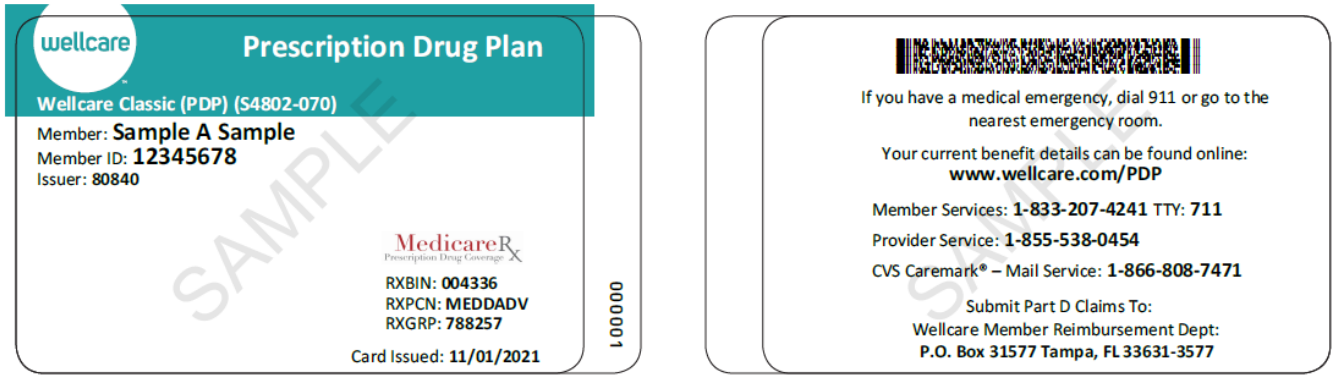






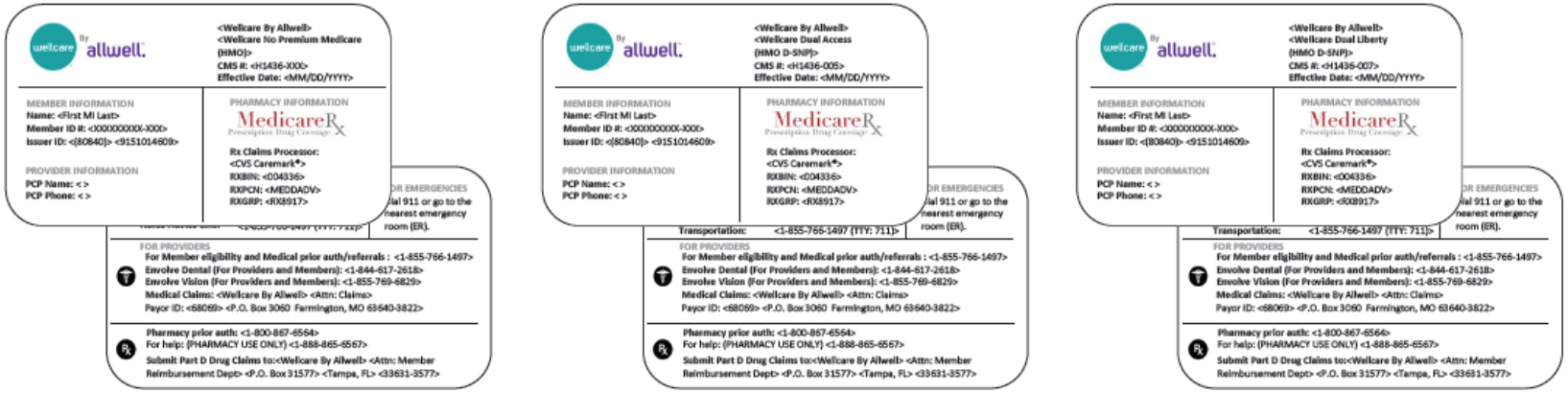
Wellcare Prime by Absolute Total Care (MMP)
Member ID Card

Wellcare Classic Prescription Drug Plan Member ID Card

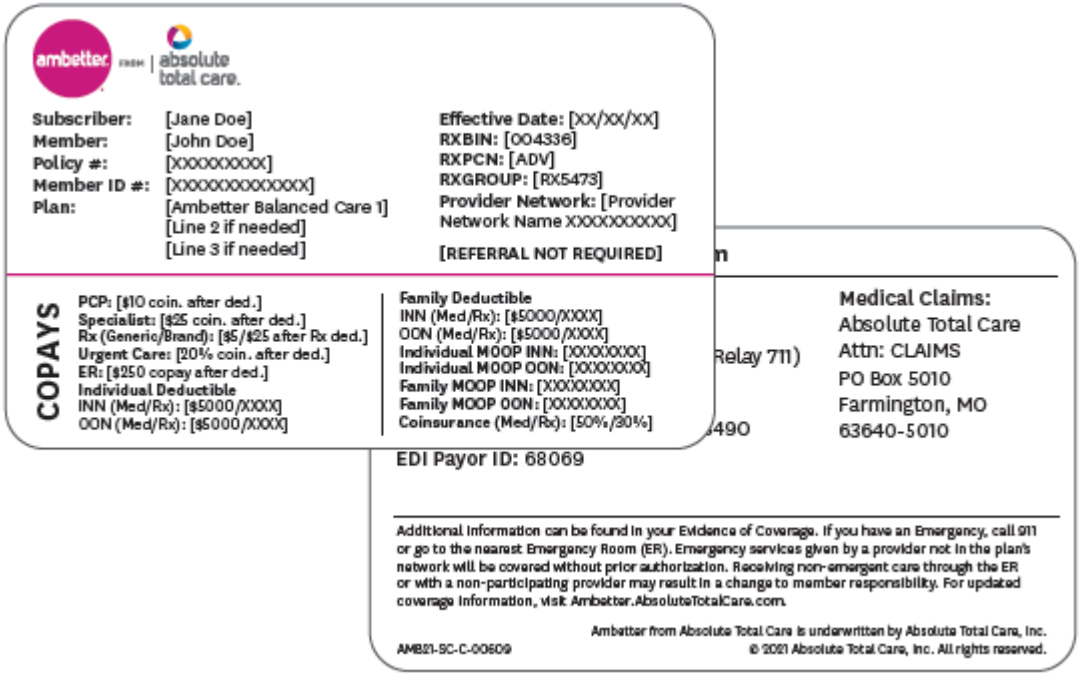


Medicare – Wellcare by Allwell

Member ID Card



Ambetter from Absolute Total Care Member ID Card



Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth St., SW; Suite 4T20
Atlanta, GA 30303

May 19, 2016

TO: **Providers**
SUBJECT: **Prohibition on Balance Billing of Healthy Connections Prime Members**

BALANCE BILLING IS PROHIBITED

Balance billing is the practice in which providers bill dually eligible beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare cost-sharing. This population is exempt from paying any cost-sharing for deductibles, coinsurance and co-payments related to Medicare services and prescription drugs. Healthy Connections Prime Members are considered QMBs. Please be advised that it is **unlawful for providers to "balance bill" any patient who is a member of Healthy Connections Prime** for any covered services. Balance billing for Healthy Connections Prime members is billing the patients for the difference between what the Medicare-Medicaid plan (MMP) pays and the retail price you charge for your services. The provider must accept payment in full from the Medicare-Medicaid plan (MMP) and should not deny any services to members for non-payment. Providers who inappropriately balance bill Healthy Connections Prime members are subject to sanctions and/or termination of their MMP provider agreement.

WHAT CAN BE BILLED TO MEMBERS?

1. For non-covered items and services, providers must give members advance notice that such items or services will be non-covered and have a written agreement with the members for these non-covered items or services. If such notice is not given and the agreement is not in place, providers may not bill members for such items or services.
2. For certain Medicaid-only items and services (such as durable medical equipment and home health agency care), members can be billed the allowable Medicaid co-pays.

ABOUT HEALTHY CONNECTIONS PRIME

Healthy Connections Prime is a new option for South Carolina seniors 65 and older with Medicare and Healthy Connections Medicaid. It is part of a national initiative designed to integrate all the services of Medicare, Medicare Part D and Medicaid into a single set of benefits fully managed by an MMP. Visit the Provider page on the Healthy Connections Prime website (http://www.scdhhs.gov/prime) to learn more details about the program or email PrimeProviders@scdhhs.gov with any questions.

1-855-735-4398
mmp.absolutetotalcare.com

Prohibition on Billing Medicare-Medicaid Plan (MMP) Enrollees for Medicare Cost-Sharing

This communication serves as a reminder that for Wellcare Prime by Absolute Total Care Healthy Connections Prime members, providers **may not bill and/or collect** any Medicare cost-sharing amounts, including deductibles, coinsurance, and copayments that may be represented on the Explanation of Payment (EOP), as they are not the member's responsibility.

This practice, known as "balance billing", is prohibited by Federal Law and as stipulated under your Wellcare Prime/Healthy Connections Prime Provider Services Agreement. **Please be advised that it is unlawful for providers to "balance bill" any patient who is a member of Healthy Connections Prime for any covered services.**

If your patient presented the following Member ID Card, you provided services to Wellcare Prime (Healthy Connections Prime) MMP member:

Wellcare Prime members can be billed for:

- Medicaid participation in cost of care amounts for long-term services and supports as determined by SCDHHS.
- Medicaid copay for Medicaid only covered Durable Medical Equipment (DME) items.

How Wellcare Prime resolves balance billing issues with the provider:

- Wellcare Prime informs the provider that the member has been inappropriately balance billed and educates the provider on balance billing.
- If Wellcare Prime reimbursed the member for an inappropriately balance billed amount, the plan will notify the provider and request reimbursement be made to the plan.
- If after outreach and education efforts to the provider, Wellcare Prime identifies ongoing inappropriate balance billing activities, Wellcare Prime may take disciplinary action up to and including termination of the Provider Agreement.

For more information regarding balance billing please refer to the Wellcare Prime Provider Manual at **absolutetotalcare.com**. You can also refer to CMS' Balance Billing Prohibition Notice at this link (**https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-healthy-connections-prime-members-0**) on the Healthy Connections Prime website. If you have any questions, please contact Member Services at 1-855-735-4398.

Annual Provider Training Requirements

Absolute Total Care partners with all 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 Medicare-Medicaid Plan (MMP) contracted providers are required to complete the following trainings within 90 days of contracting and **annually** thereafter:

- General Compliance (Compliance)
- Fraud, Waste, and Abuse
- Model of Care (MOC)*
- Person-Centered Planning**

General Compliance and Fraud, Waste, and Abuse trainings are posted on the CMS Medicare Learning Network (MLN) website at http://go.cms.gov/mln, and links to the specific trainings can be found in the table below. The MOC training* and Person-Centered Planning training** can be found on the Absolute Total Care website as indicated in the table below. Once practitioners have taken the required trainings, we ask that you attest to their completion by filling out an Attestation Form or submitting CMS certificates of completion. While the training itself must be completed by every participating practitioner, attestation can be completed one time for all practitioners within a given provider group.

Required Training Resources

Required Training	Training Location
General Compliance	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf
Fraud, Waste, and Abuse	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244-Print-Friendly.pdf
Model of Care (MOC)*	https://www.absolutetotalcare.com/providers/resources/provider-training/model-of-care-provider-training.html
Person-Centered Planning**	https://www.absolutetotalcare.com/providers/resources/provider-training.html

*MOC training is required for providers who directly or indirectly facilitate and/or provide Medicare Part C or D benefits for any Allwell from Absolute Total Care HMO SNP Member. Please refer to the Quick Reference Guide for additional information on MOC training.

**Person-Centered Planning training is required for providers who directly or indirectly provide services for our Absolute Total Care MMP members.

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Cultural Competence and Linguistics Appropriate Services (CCLAS) Program

https://www.absolutetotalcare.com/content/dam/centene/absolute-total-care/test/ATC-CCLAS_ProgramDescriptionFinal.pdf

1-855-735-4398
mmp.absolutetotalcare.com

Cultural Competency Quick Reference Guide

What is cultural competency?

- A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups, and the sensitivity to know how these differences influence relationships with members
- It is a set of complimentary behaviors, attitudes, and policies that help professionals work effectively with people of different cultures

Purpose of cultural competency

- Learn about, understand and provide excellent customer service to all members across all segments of the population
- Promote sensitivity to the needs of patients who are members of various racial, religious, age, gender, or ethnic groups
- Accommodate the patient's culturally-based attitudes, beliefs, and needs

You will learn:

- What is cultural competency
- Sources of diversity
- Steps for becoming culturally competent
- Communicating across cultures
- Tips for successful cross-cultural communications

Resources

Resources for Cultural Competency training can be found on Wellcare Prime by Absolute Total Care's website on the Provider Manuals and Forms page (https://www.absolutetotalcare.com/providers/resources/forms-resources.html).

- Medicare-Medicaid Plan (MMP) Provider Manual
- Cultural Competency PDF