Absolute Total Care 2022 Virtual Provider Town Hall 1st quarter

4/7/2022

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
- Website
- Secure Provider Portal
- Eligibility
- Claims 411 – Did You Know?
- Network Development and Participation
- Closing Healthcare Effectiveness Data and Information Set (HEDIS®) Gaps
- Balance Billing
- Start Smart for Your Baby Q&A
- CAHPS®

Housekeeping

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

Provider Relations Team

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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

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

Absolute Total Care Healthy Connections Medicaid

- My Health Pays rewards: https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards.html
- Members can earn $5 to $25 by completing healthy behaviors, including:
  - Getting a flu vaccine (one per flu season)
  - Completing the Health Risk Screening
  - Getting an Annual Well Care Visit with primary care provider (PCP)
  - Getting diabetes care (HBA1c, Kidney, retinopathy)
  - Getting breast and cervical cancer screenings
  - Getting certain immunizations
  - Getting infant well care visits with PCP
  - Getting a postpartum doctor visit

Medicare-Medicaid (MMP) Plan Rebranding

2021

Absolute Total Care (Medicare-Medicaid Plan) or Absolute Total Care

2022

Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan) or Wellcare Prime

Wellcare Prime

- Serving approximately 4,500 dual-eligible members (age 65+)
- 2022 benefit highlights:
  - State-wide service area
  - New plan name and look
  - 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

Wellcare Prime

- My Health Pays rewards: https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards1.html
- Members can earn $20 by completing healthy behaviors, including:
  - Getting a flu vaccine
  - Getting ongoing diabetes care
  - Getting a breast cancer screening
  - Going to a follow-up visit after hospitalization
  - Getting a colon cancer screening

Medicare Advantage Plan Rebranding

absolute total care™

2021

Allwell from Absolute Total Care

allwell. FROM absolute total care.

>

2022

Wellcare by Allwell or Wellcare

wellcare By allwell.™

WellCare

WellCare

>

Wellcare

wellcare

Wellcare by Allwell

- Wellcare No Premium Medicare (HMO)
- Wellcare Dual Access* (HMO D-SNP) and Wellcare Dual Liberty (HMO D-SNP)
- Serving approximately 3,200 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 –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

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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

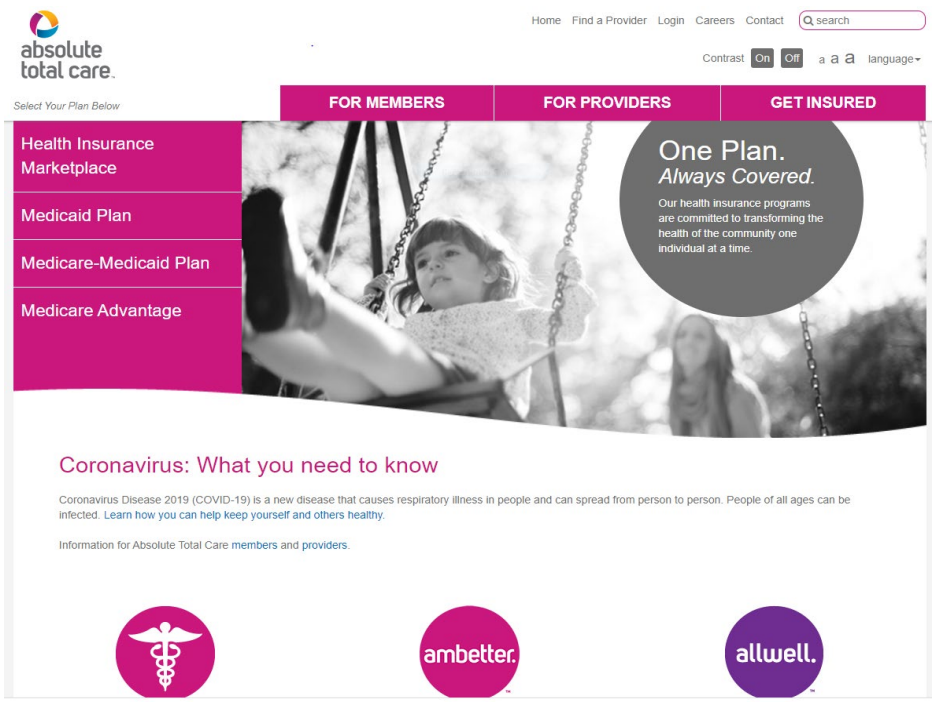
- Health Insurance Marketplace
- Serving approximately 33,000 members in 42 counties
- 2022 benefit highlights:
  - Service area expanded into 12 new counties
  - $0 copay for telehealth services for medical care
  - Health Savings Accounts
  - Dental
  - Routine vision
  - Virtual plan option
  - Concierge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

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

Website and Secure Portal

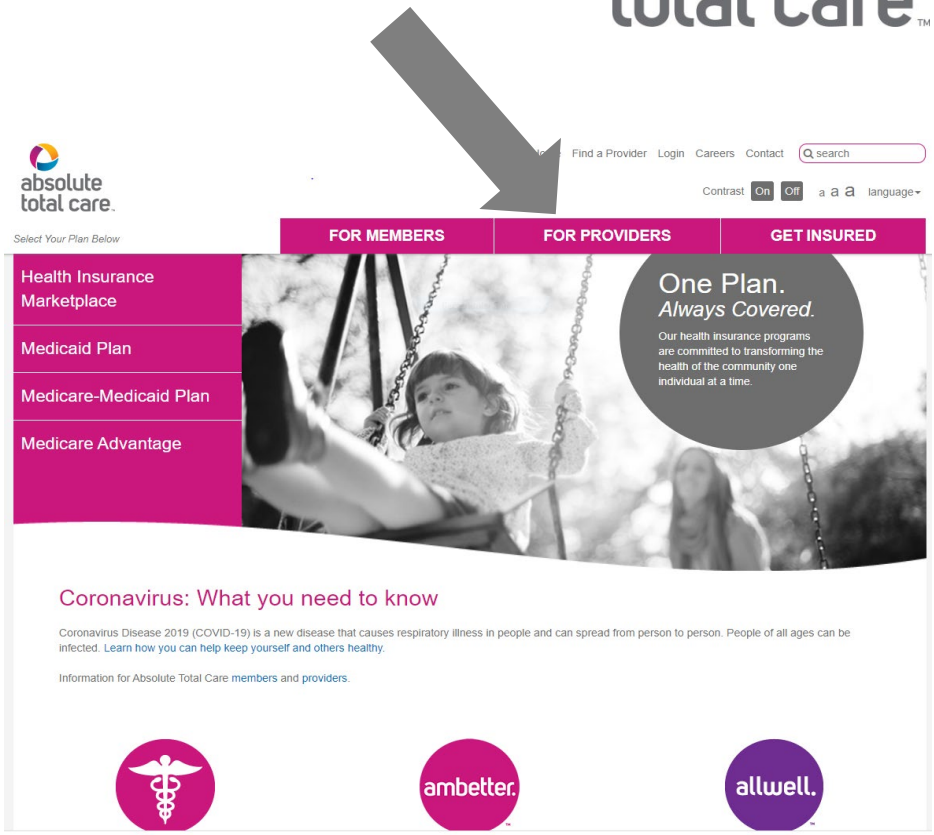
Website

- Website: absolutetotalcare.com



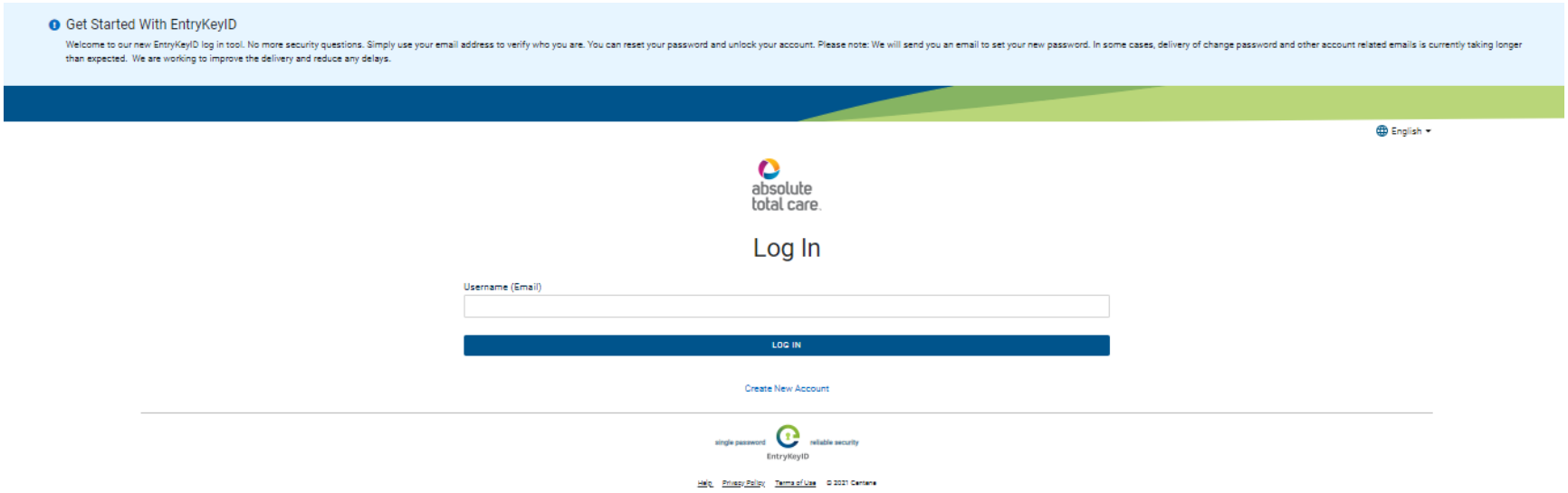
Website

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



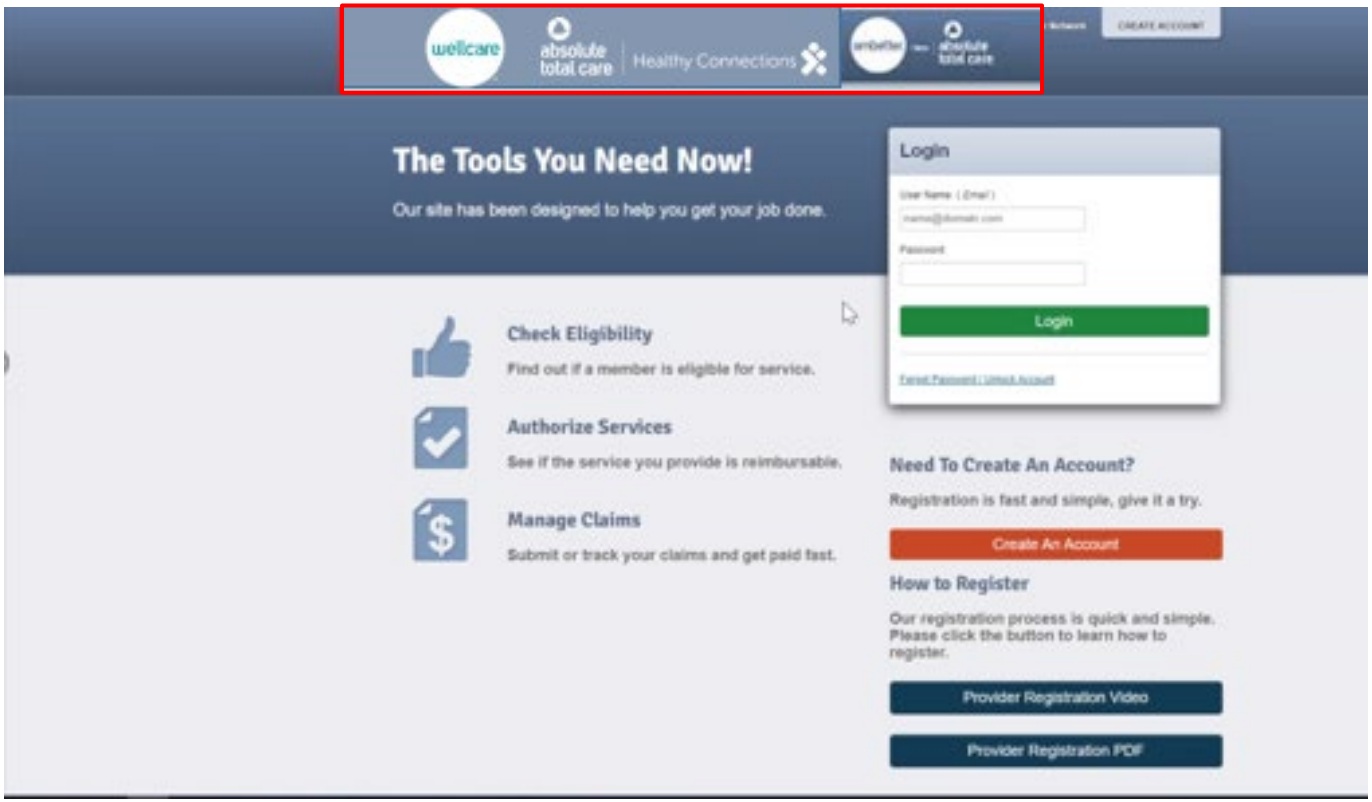
Secure Provider Portal

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



Secure Provider Portal

Portal Log-In View

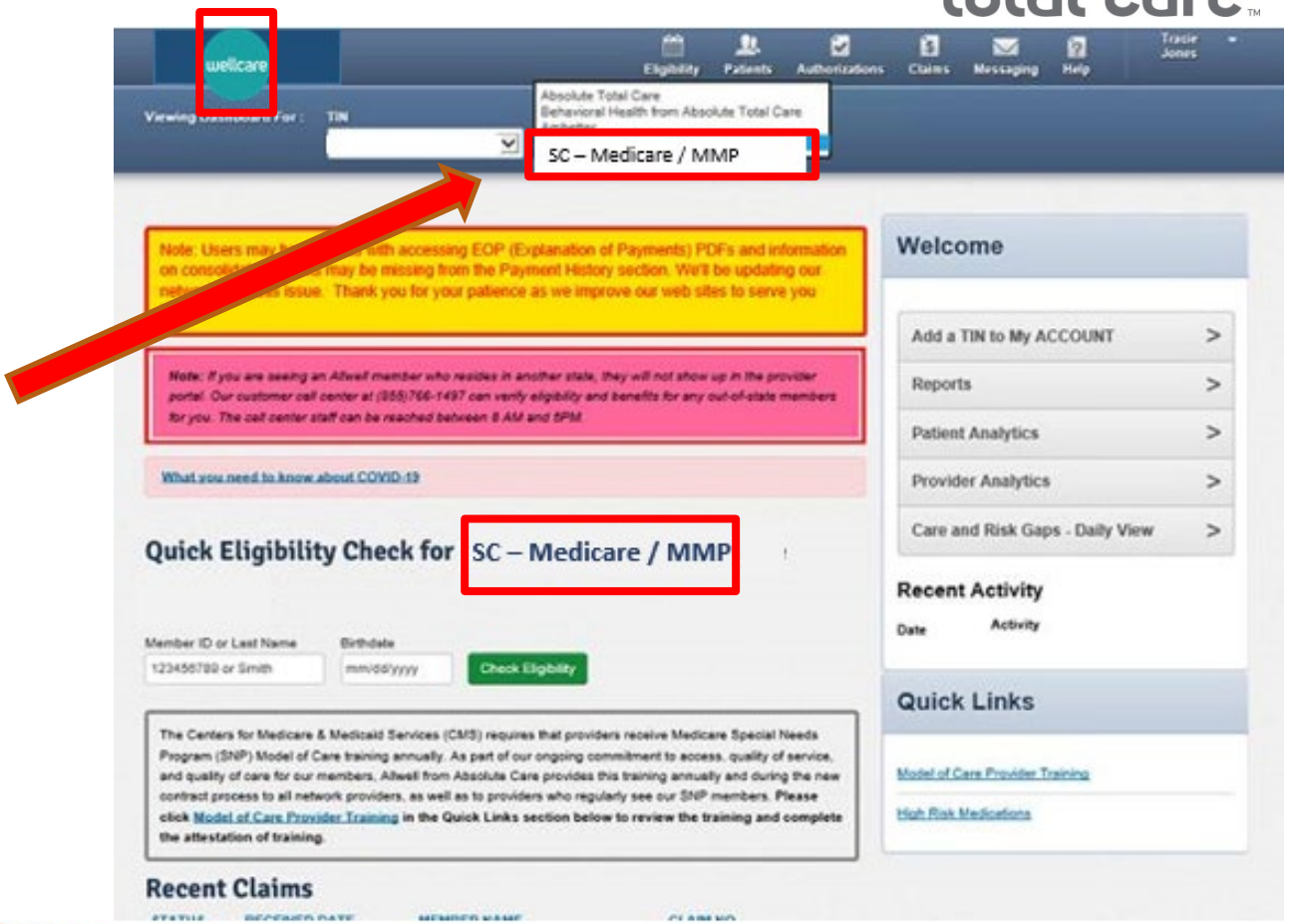


Secure Provider Portal

Portal View Update

Updated logo and plan name in drop down

Medicare Advantage and MMP Members



Secure Provider Portal

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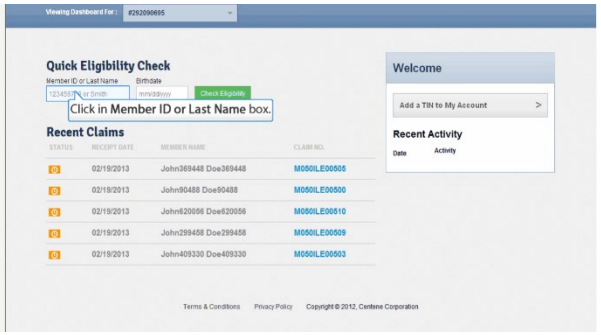
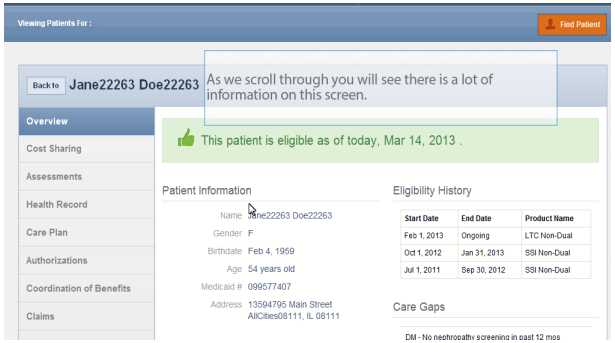
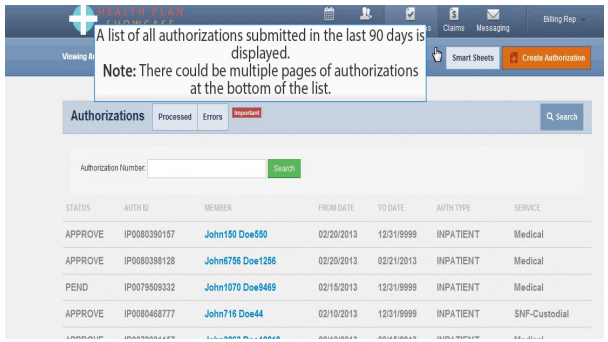
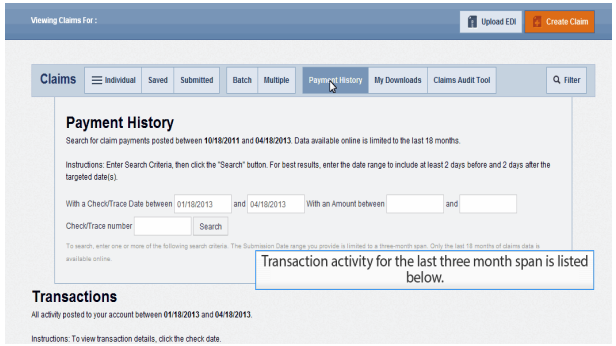
- Patient information









Secure Provider Portal

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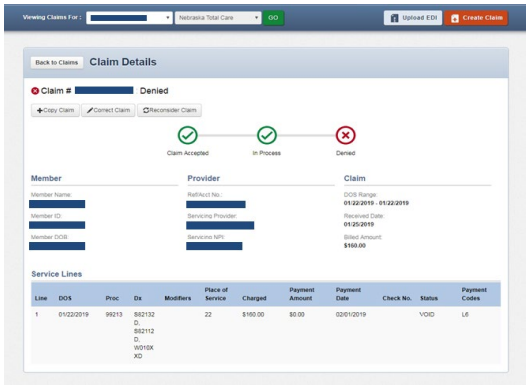
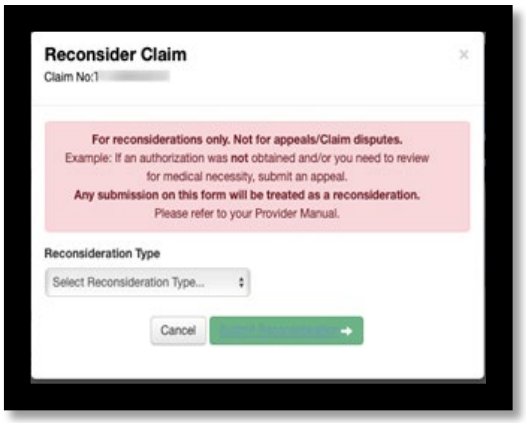
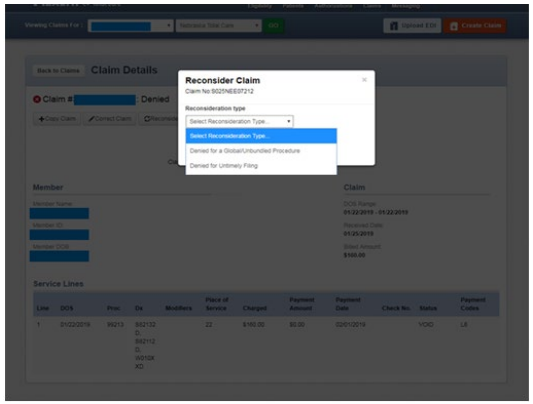
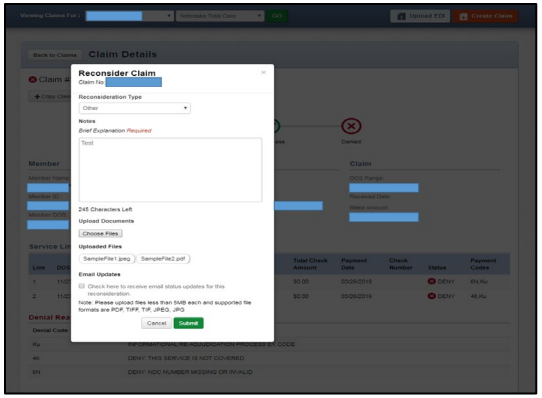
- Provider reconsideration
  - Review process
  - Correct routing and procedure
  - Most common issues









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

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

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

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 to ATC_Contracting@centene.com
  - For contract updates and questions (i.e., change of ownership, TIN changes, amendments, etc.), send an email to to ATC_Contracting@centene.com

Healthcare Effectiveness Data and Information Set (HEDIS®)

4/7/2022

Closing Healthcare Effectiveness Data and Information Set (HEDIS®) Gaps

- Ways to close gaps:
  - Face-to-face contact
  - Email campaigns
  - Clinical days
  - Outreach calls
  - Mailer campaigns

https://www.absolutetotalcare.com/providers/quality-improvement/hedis.html

Key Quality Improvement Activities

- HEDIS Hybrid Chart Chase

What You Should Know About HEDIS and the Data Collection Process

What is HEDIS?
HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Data is gathered through claims and medical records to determine the effectiveness and quality of care provided by the health plan and its network of providers.

HIPAA compliance
Patient protected health information (PHI) will be handled in a careful and confidential manner. As defined by the Health Insurance Portability and Accountability Act (HIPAA), the exchange of PHI is expressly permitted without the consent of the patient for the purpose of treatment, payment and healthcare operations. HEDIS medical record review falls within the scope of healthcare operations; therefore, there is no need to obtain consent from the member in order to release the information requested.

Timing
An Absolute Total Care Representative will be contacting you in the first quarter of 2022 to begin the collection and abstraction process. Your cooperation with this important process is appreciated.

2022 Changes

Changes for Measurement Year (MY) 2022	
New Measures	• Cardiac Rehabilitation (CRE). • Kidney Health Evaluation for Patients With Diabetes (KED). • Osteoporosis Screening in Older Women (OSW).
Retired Measures	• Adult BMI Assessment (ABA). • Medication Management for People With Asthma (MMA). • Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART). ***Note:*** *This measure is retired for MY 2021 but is reported for MY 2020.* • Medication Reconciliation Post-Discharge (MRP). • ***Note:*** *This measure is still collected as an indicator in the Transitions of Care measure.* • Osteoporosis Testing in Older Women (OTO). • Children and Adolescents' Access to Primary Care Practitioners (CAP). • Board Certification (BCR).
Revised Measures	For specific revisions, refer to each measure's *Summary of Changes* or to Appendix 1 for a complete summary. • The former Well-Child Visits in the First 15 Months of Life (W15) measure was revised to Well-Child Visits in the First 30 Months of Life (W30). • The former Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) measures have been combined into Child and Adolescent Well-Care Visits (WCV).

EMR Benefits

Streamlining the data collection process will help:

- Reduce provider office staff activities regarding HEDIS Hybrid chart chase requests
- Decrease and avoid duplication of over utilization of retrieval efforts
- Lead to improved HEDIS performance reporting

START SMART FOR YOUR BABY

Start Smart for Your Baby

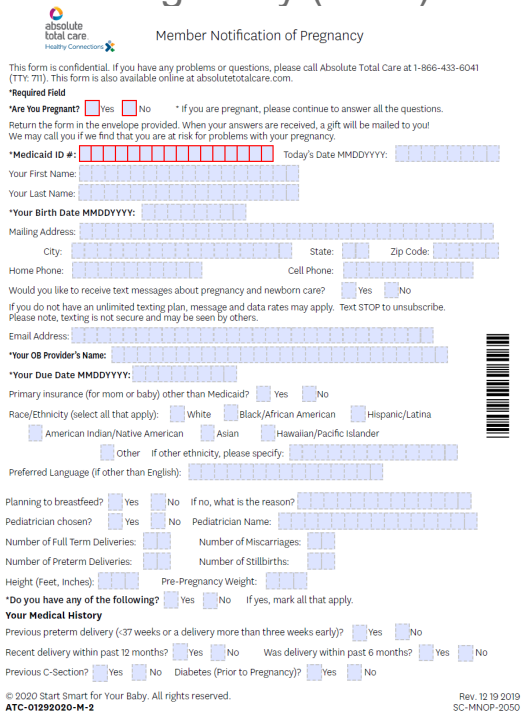
- Program goals
  - Early identification of pregnant members and their risk factors
  - Reducing the risk of pregnancy complications
  - Better birth outcomes
- Strategy
  - Submission of Notification of Pregnancy (NOP) Form
  - High-risk members are prioritized for Care Management Program
  - OB Nurse 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

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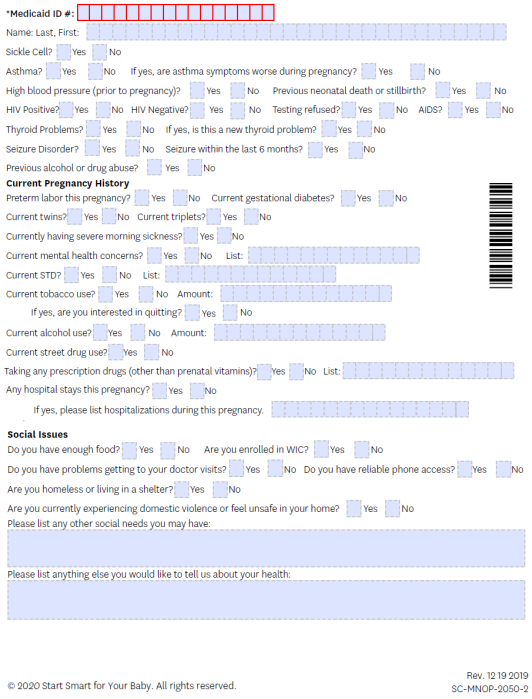

*Medicaid ID #:

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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CAHPS®
Consumer Assessment of Healthcare Providers and Systems

4/7/2022

Introduction to CAHPS®

CAHPS stands for Consumer Assessment of Healthcare Providers and Systems

- Annual survey that captures a patient's experience with all aspects of their healthcare.
- CAHPS surveys ask our members – your patients – topics like provider communication skills, ease of accessing healthcare, and their Health Plan performance.

CAHPS Measures Patient Experience with the Healthcare System

- Care from Health Plan
- Quality of Care
- Clinical visits with Providers (Physician Practices, Hospitals, and Healthcare Facilities)
- Experience with the Health Plan

CAHPS Data Measures

- Patient ease of obtaining information from the Health Plan
- Timeliness of service
- Speed and accuracy of claim processing

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.

CAHPS® Composite Measures

CAHPS surveys consist of several measures of patient experience. These “Composite” measures combine two or more related survey items; rating measures, which reflect respondents’ ratings on a scale of 0 to 10.

Composite Measures
Getting Needed Care
Getting Appointment and Care Quickly
Care Coordination
Customer Service
Rating of Health Plan Quality
Rating of Health Plan
Rating of Drug Plan
Getting Needed Prescription Drugs
Annual Flu Vaccine

Provider Focused Composites

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]

Mock CAHPS Survey Recognition

Absolute Total Care would like to acknowledge and thank all who have been participating in our mock CAHPS scorecard conversations and meetings.

We'd like to acknowledge the groups and practices whose patients scored them in the top box for key CAHPS measures.

- FAMILY PHYSICIANS OF SPARTANBURG
- SOUTH CAROLINA INTERNAL MED ASSOC & REHABILITATION
- FAIRFIELD MEDICAL ASSOCIATES PA
- AFFINITY HEALTH CENTER
- SELF MEDICAL GROUP
- CAROLINA HEALTH CENTERS INC
- NEWBERRY INTERNAL MEDICINE LLC
- HEALTH CARE PARTNERS OF SOUTH CAROLINA
- DIGESTIVE DISEASE ASSOCIATE OF YORK COUNTY

Mock CAHPS Survey Recognition

- TANDEM HEALTH SC
- PIEDMONT PHYSICIAN NETWORK LLC
- C JOANNE BROWNLEE MD
- PIEDMONT FAMILY PRACTICE LLC
- ST FRANCIS PHYSICIAN SERVICES INC
- LIBERTY DOCTORS LLC
- NEW HORIZON FAMILY HEALTH SERVICES INC

A new mock CAHPS Scorecard season will occur after the annual survey!

Thank you to all providers and office staff who serve our members!

Questions

Adjournment

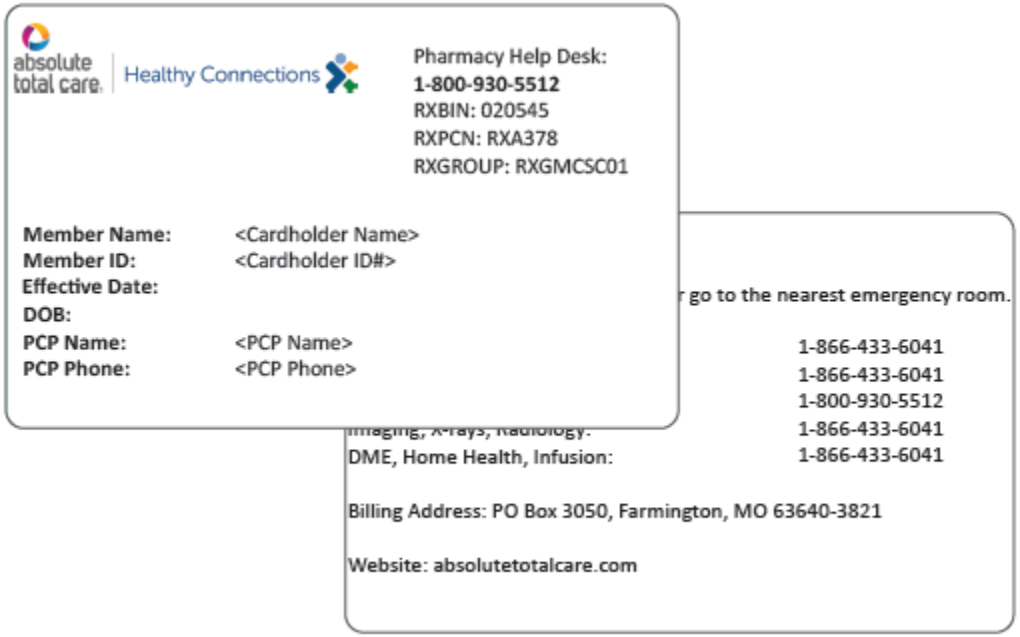
APPENDIX

Provider Resources

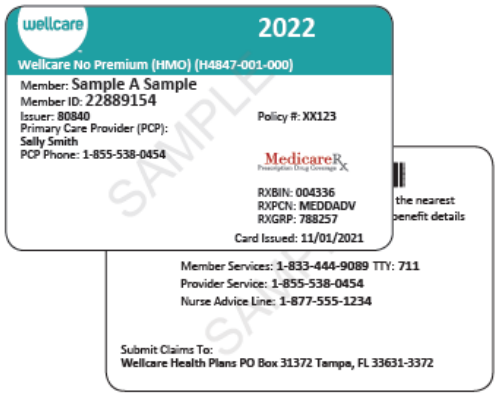
https://www.absolutetotalcare.com/providers/resources/forms-resources.html

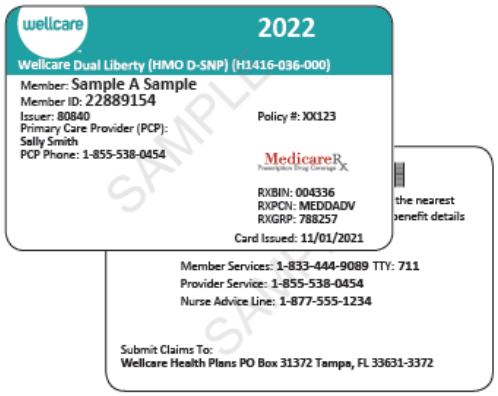
https://ambetter.absolutetotalcare.com/provider-resources/manuals-and-forms.html

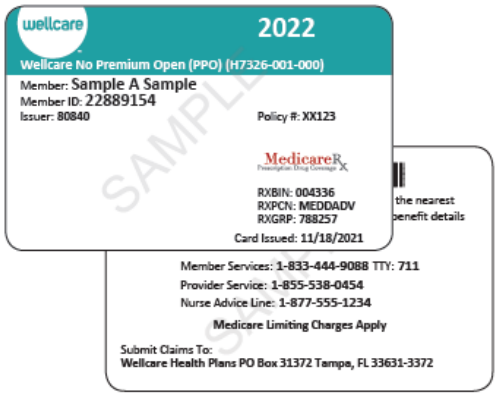
Medicaid Member ID Card



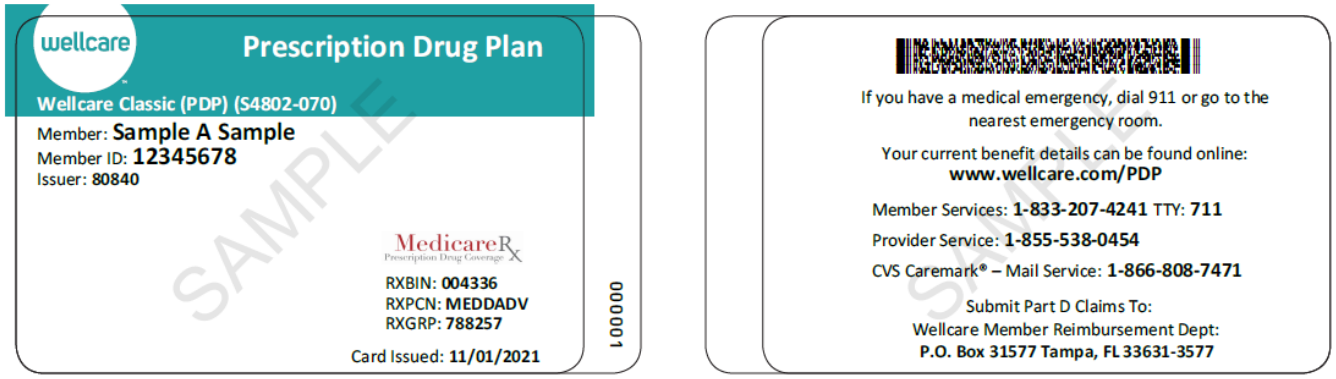
Medicare-Wellcare Member ID Card





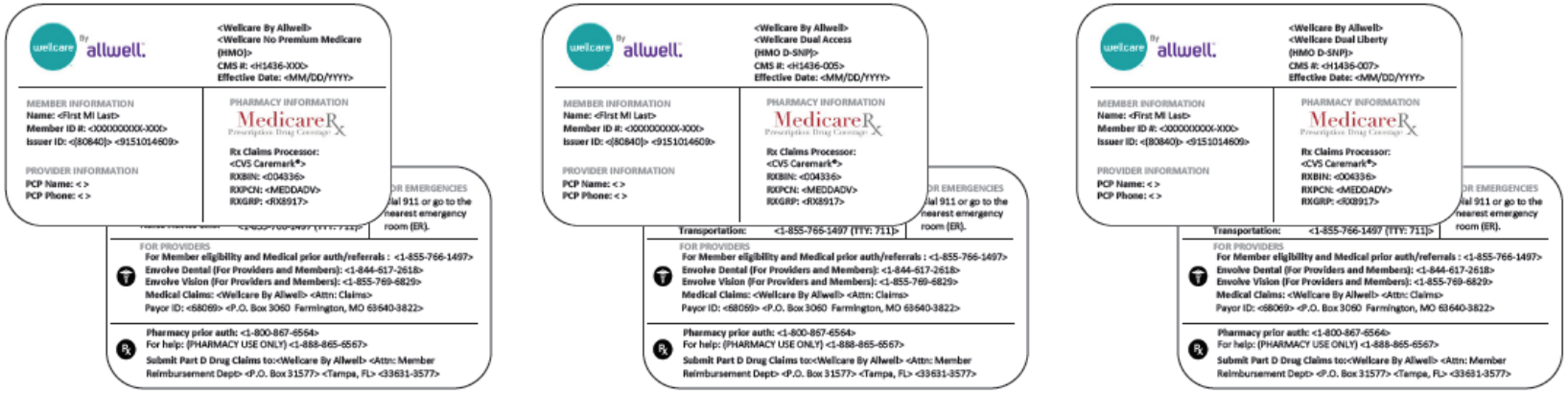


Wellcare Classic Prescription Drug Plan Member ID Card



Medicare – Wellcare by Allwell

Member ID Card



Ambetter from Absolute Total Care Member ID Card