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2025 First Quarter

Provider Webinar

Disclaimer

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- The presentation is a general summary that explains certain aspects of the program but is not a legal document.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the program is constantly changing, and it is the responsibility of each provider to remain abreast of the program requirements. Any regulations, policies, and/or guidelines cited in this publication are subject to change without further notice.
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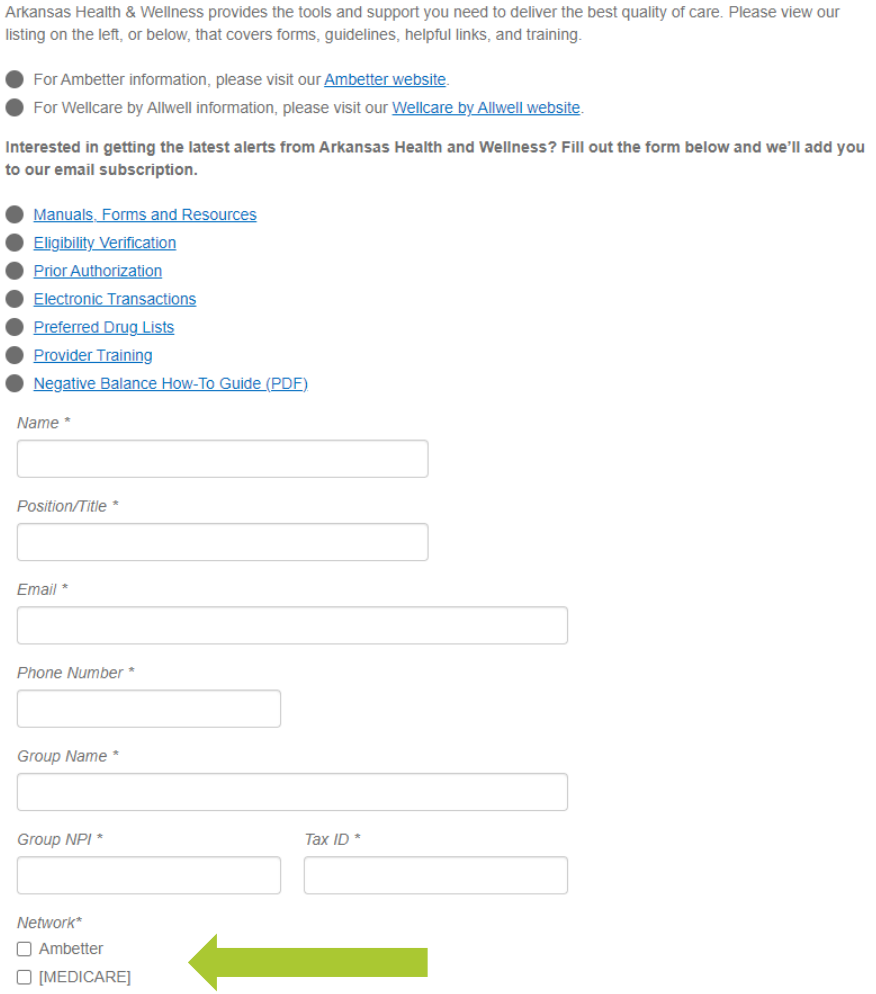
Agenda

- Join Our Email List
- Clinical and Payment Policy Updates
- Availity Essentials
- Appointment Availability
- Prior Authorizations
- Pre-Auth Check Tool
- Secure Provider Portal
- Self-Led Provider Trainings
- Risk Adjustment
- Quality
- Contact Information

n Our Email List Today



Arkansas Health & Wellness provides the tools and support you need to deliver the best quality of care. Please view our listing on the left, or below, that covers forms, guidelines, helpful links, and training.

- For Ambetter information, please visit our Ambetter website.
- For Wellcare by Allwell information, please visit our Wellcare by Allwell website.

Interested in getting the latest alerts from Arkansas Health and Wellness? Fill out the form below and we'll add you to our email subscription.

- Manuals, Forms and Resources
- Eligibility Verification
- Prior Authorization
- Electronic Transactions
- Preferred Drug Lists
- Provider Training
- Negative Balance How-To Guide (PDF)

*Name **

*Position/Title **

*Email **

*Phone Number **

*Group Name **

*Group NPI **

*Tax ID **

*Network**

- [ ] Ambetter
- [ ] [MEDICARE]

Sign up to receive updates:

- https://www.arhealthwellness.com/providers/resources.html
- Choose the network you wish to receive information on: Ambetter or Wellcare by Allwell

Clinical and Payment Policy Updates

nical and Payment Policy Updates (1 of 2)

nsas Health & Wellness routinely amends or implements new policies that can be found on its website.

nt Clinical Policy Updates: Ambetter

spice Services, effective November 1, 2024

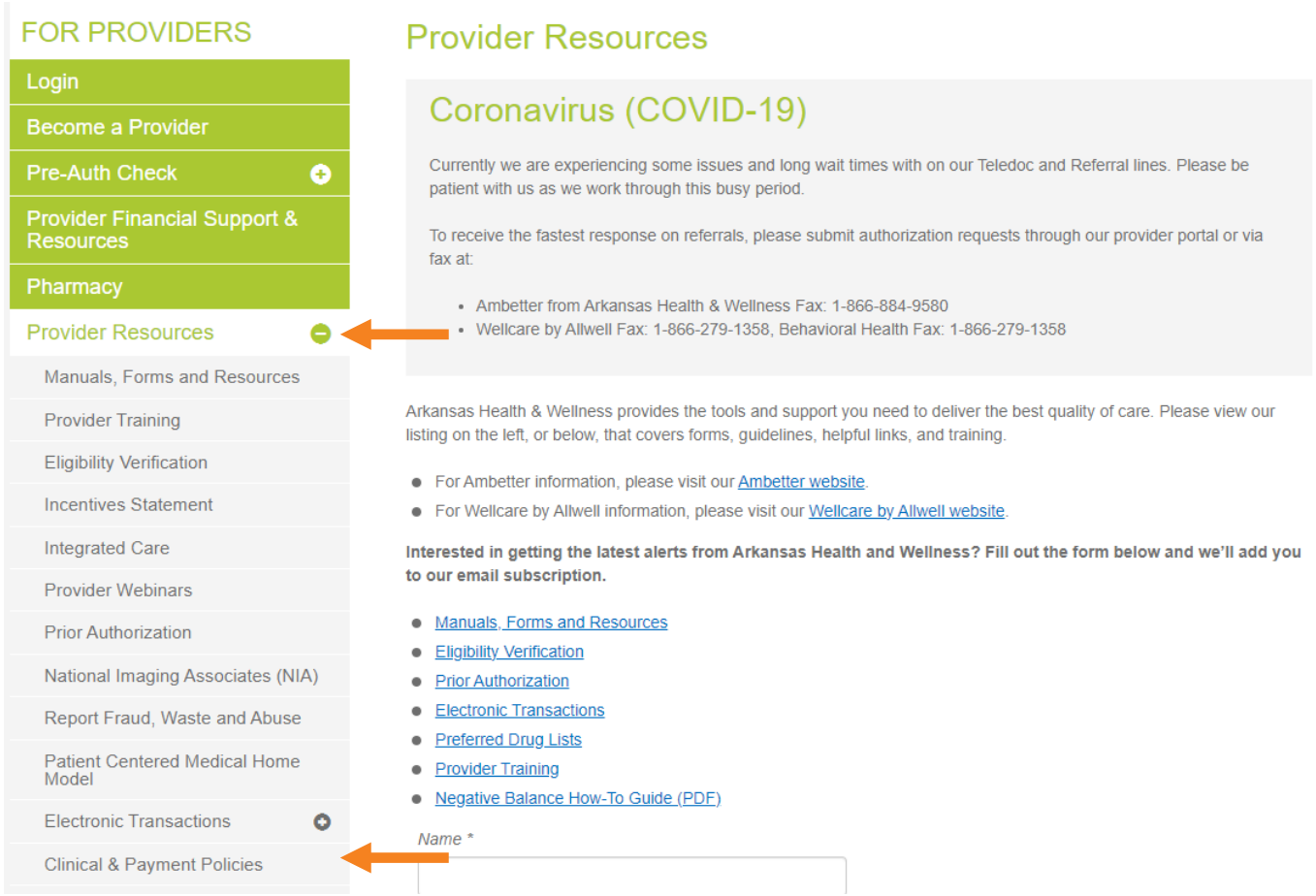
duction Mammoplasty and Gynecomastia Surgery, effective November 1, 2024

nt Payment Policies: Ambetter

G in the Evaluation of Headache, effective November 1, 2024

ergy Testing and Therapy, effective November 1, 2024

ical and Payment Policy Updates (2 of 2)



ility Essentials (1 of 3)

nsas Health & Wellness has chosen a new platform for the Secure Provider Portal. Effective November 18, , you can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and ss Arkansas Health & Wellness payer resources through Availity Essentials.

u are already working in Essentials, log in to your existing Essentials account to enjoy these benefits.

e Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, submit thorizations, and more.

ok for additional functionality in Arkansas Health & Wellness' payer space on Essentials and use the heart n to add apps to My Favorites in the top navigation bar. Access Manage My Organization — save provider ormation in Essentials and auto-populate it to save time and prevent errors.

ou are new to Availity Essentials, getting your Essentials account is the first step toward working with kansas Health & Wellness on Availity.

ility Essentials (2 of 3)

gnate an Availity Administrator for Your Provider Organization

provider organization's designated Availity administrator is the person responsible for registering your organization in tials and managing user accounts. This person should have legal authority to sign agreements for your organization.

does this impact me?	What is my next best step?
the administrator. *the designated Availity administrator y organization.*	Visit Register and Get Started With Availity Essentials to enroll for training and access other helpful resources.
not the administrator. *NOT the designated Availity nistrator for my organization.*	Your designated Availity administrator will determine who needs access to Availity Essentials on behalf of your organization and will add user accounts in Essentials.
not sure. *not sure who will be the designated ity administrator for my organization.*	Share this information with your manager to help determine who will be the designated Availity administrator for your organization.

ility Essentials (3 of 3)

one of our upcoming free webinars, Availity Essentials Overview for Arkansas Total Care, to learn ional tips for streamlining your workflow. We'll show you how to verify eligibility and benefits, it claims, check claim status, submit authorizations, and more.

e excited to welcome you to Availity Essentials, helping you transform the way you impact patient with Arkansas Total Care. If you need additional assistance with your registration, please call ty Client Services at 1-800-AVAILITY (1-800-282-4548). Assistance is available Monday through y from 7 a.m. to 7 p.m. CT.

eneral questions, please reach out to your Arkansas Total Care Provider Relations Representative.

Appointment Availability & Wait Times

pointment Availability & Wait Times (1 of 2)

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better follows the accessibility and ointment wait time requirements forth by applicable regulatory and rediting agencies. Ambetter nitors participating provider pliance with these standards at t annually and will use the results ppointment standards monitoring nsure adequate appointment lability and access to care and to uce inappropriate emergency room zation. The table below depicts the ointment availability for members:

Appointment Type	Access Standard
PCPs - Routine visits	30 calendar days
PCPs - Adult Sick Visit	48 hours
PCPs - Pediatric Sick Visit	24 hours
Behavioral Health – Non-Threatening Emergency	6 hours
Specialist	Within 30 calendar days
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	48 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician
Emergency Providers	24 hours a day, 7 days a week

pointment Availability & Wait Times (2 of 2)

are by Allwell follows the
sibility and appointment wait time
rements set forth by applicable
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der compliance with these standards
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ntment standards monitoring to
e adequate appointment availability
ccess to care and to reduce
ropriate emergency room utilization.

able the right depicts the
ntment availability for members.

Type of Care	Accessibility Standard*
Primary Care	
Emergency	Same day or within 24 hours of member's call
Urgent care	Within 2 days of request
Routine	Within 21 days of request
Specialty Referral	
Emergency	Within 24 hours of referral
Urgent care	Within 3 days of referral
Routine	Within 45 days of referral
Maternity	
1st trimester	Within 14 days of request
2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancies	Within 3 days of identification or immediately if an emergency exists
Dental	
Emergency	Within 24 hours of request
Urgent care	Within 3 days of request
Routine	Within 45 days of request

The in-office wait time is less than 45 minutes, except when the provider is unavailable due to an emergency.

Prior Authorizations

w to Secure Prior Authorization

Authorizations can be requested in the following ways:

cure Provider Portal — preferred and fastest method

Ambetter and Wellcare by Allwell:
Provider.ARHealthWellness.com

one

Ambetter: 1-877-617-0390 (TTY: 1-877-617-0392)

Wellcare by Allwell: 1-855-565-9518 (TTY: 711)

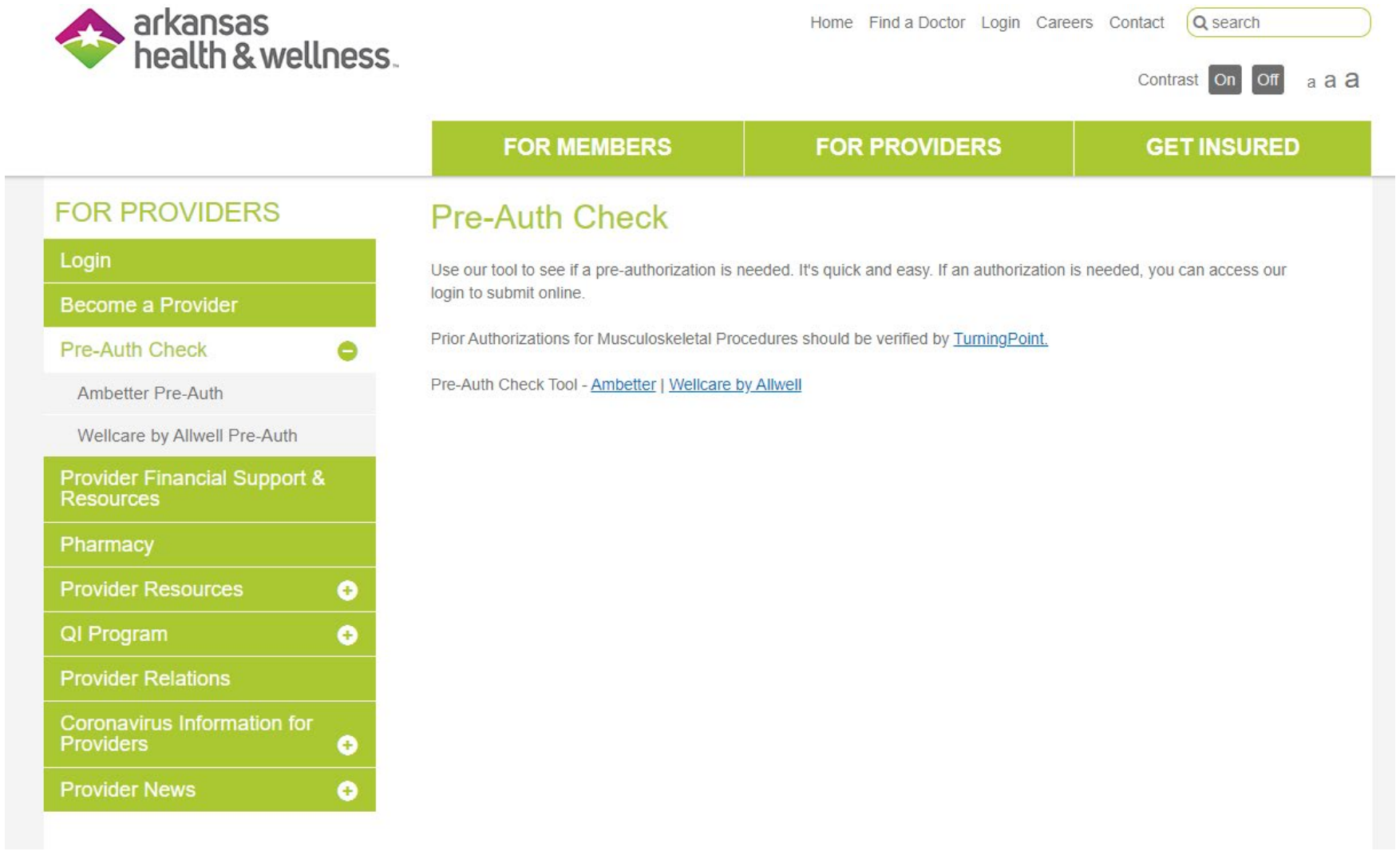
x

P and OP paper forms are available on the website under Provider Resources.

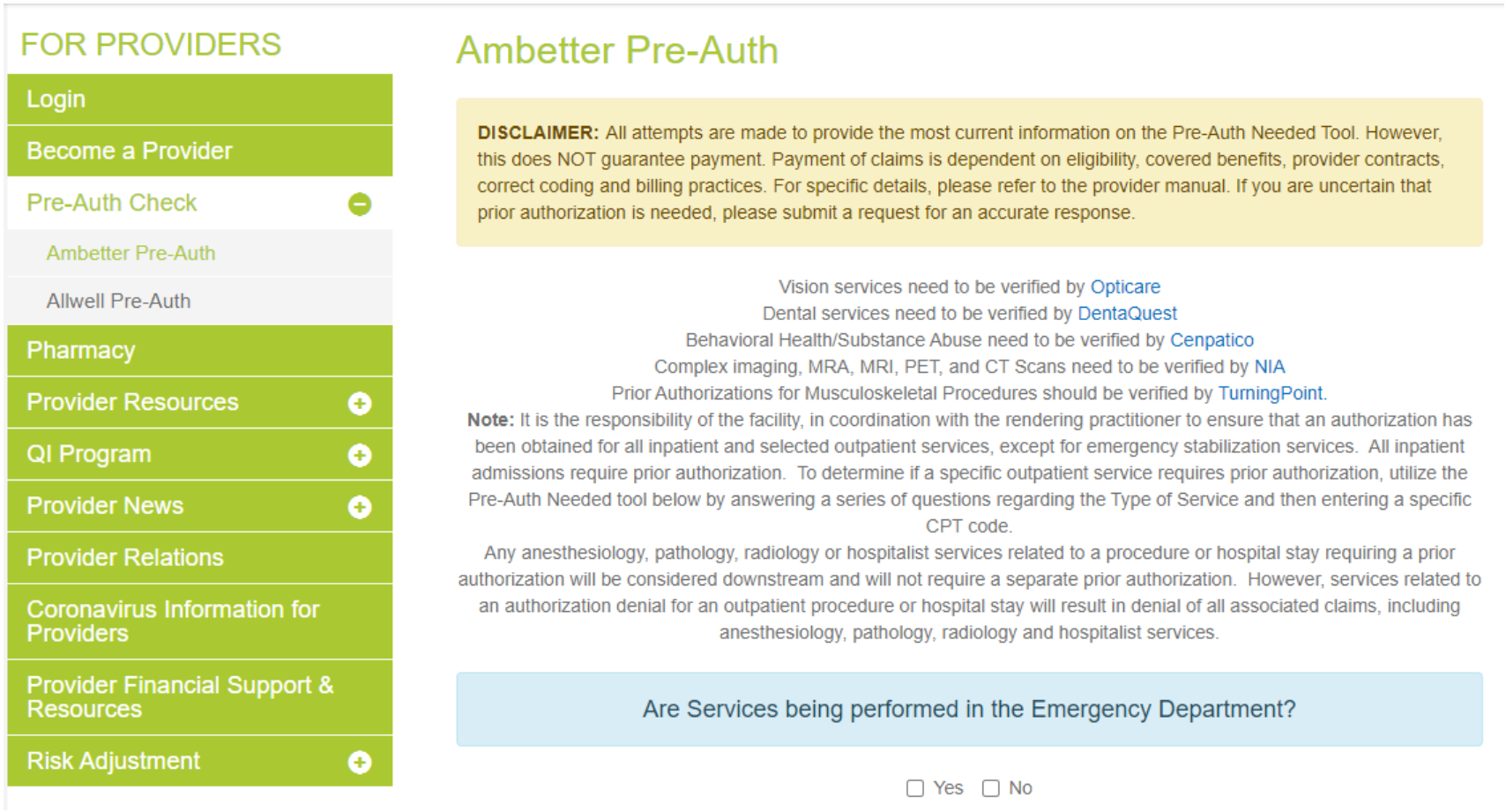
- Ambetter: 1-866-884-9580
- Wellcare by Allwell: 1-833-562-7172

After normal business hours and on holidays, calls are directed to the plan's 24-hour Nurse Advice Line. Notification of authorization will be returned via phone, fax, or web.

-Auth Check Tool (1 of 2)



-Auth Check Tool (2 of 2)

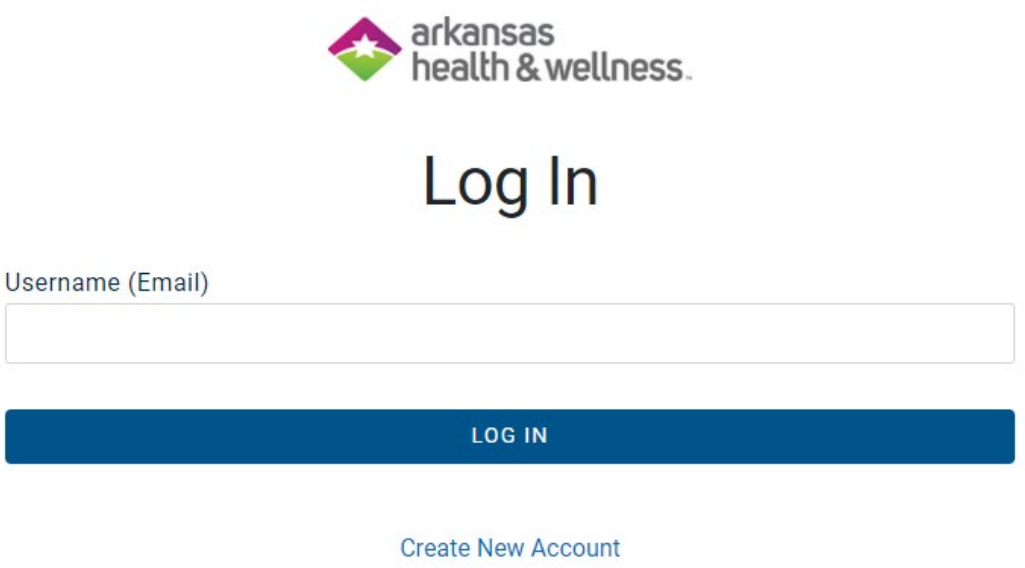


Secure Provider Portal

ure Provider Portal — Create An Account

tration is free and easy

der.ARHealthWellness.com



ure Provider Portal — Features

member eligibility overview page that reflects all critical data in a single view

ility to submit and track the status of claim reconsiderations online

panded free text fields for reconsideration comments and explanations

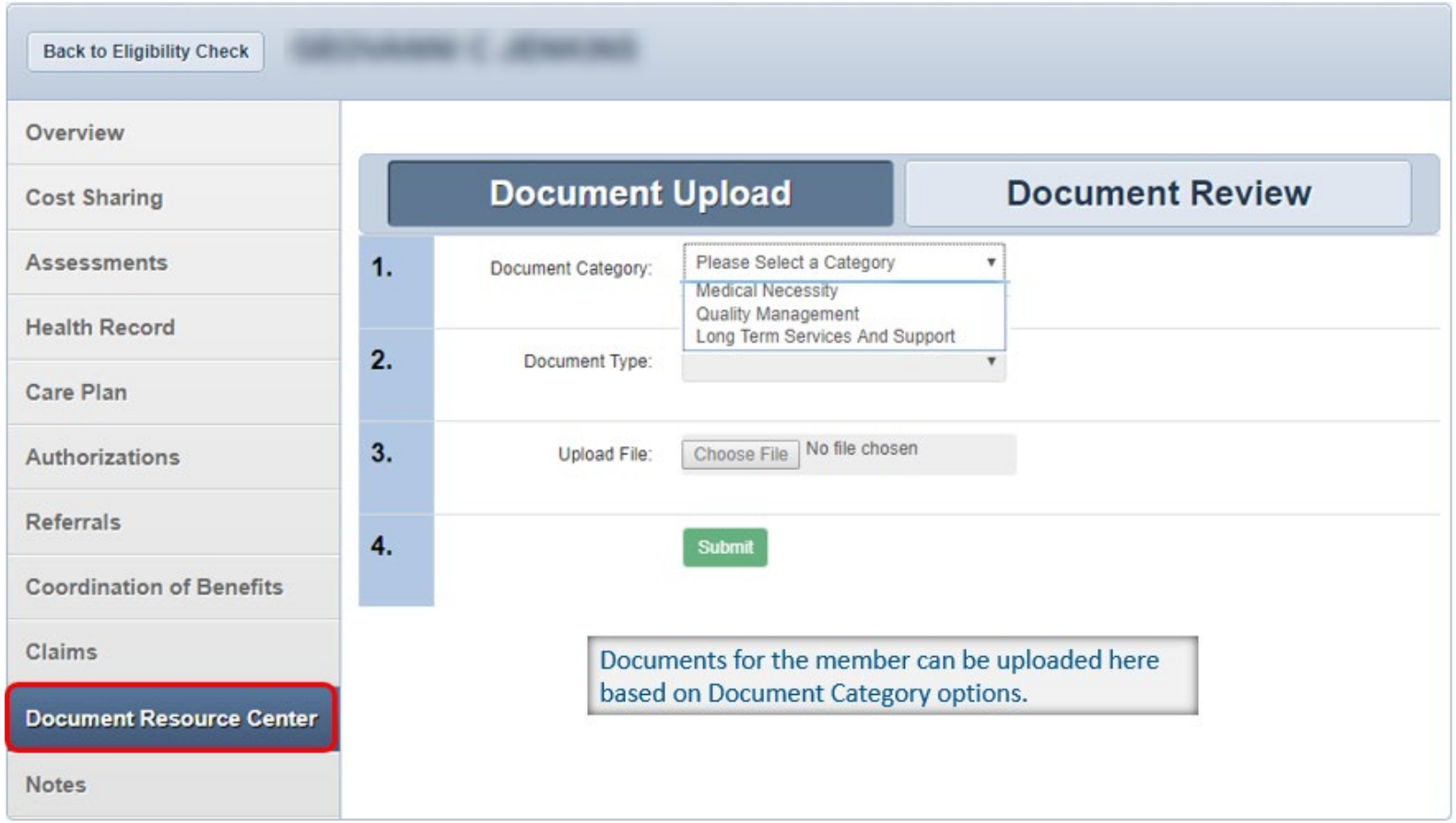
ach required documentation when filing a reconsideration

load records for care gap information.

ceive push notifications regarding reconsideration status changes

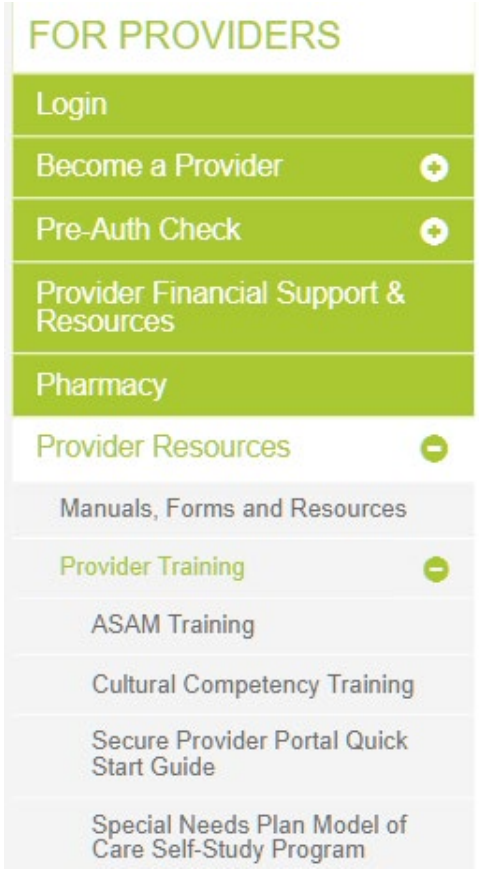
id/Recoup option on claims already adjudicated by the health plan
fer to page 92 of the manual available in the Portal for instructions)

ient Overview — Document Resource Center



Self-Led Provider Trainings

f-Led Provider Trainings (1 of 2)



Provider Training

Welcome to Arkansas Health & Wellness. We thank you for being part of our network of participating physicians, hospitals and other healthcare professionals.

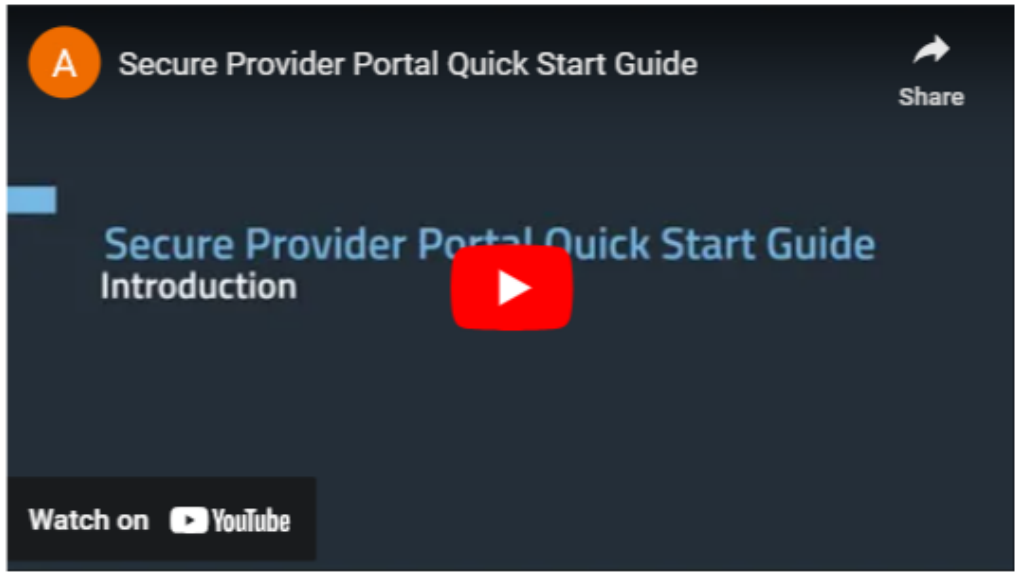
Arkansas Health & Wellness provides several self-led provider trainings. This is an annual training that is offered to every provider and is available 24/7 on the Provider Training Page. After completion of the training, providers will then need to complete the Attestation Form.

- Cultural Competency Training
- Secure Provider Portal Quick Start Guide
- Special Needs Plan Model of Care Self-Study Program
- Allwell 2023 Annual Model of Care Provider Training Letter (PDF)

f-Led Provider Trainings (2 of 2)

Secure Provider Portal Quick Start Guide

Arkansas Health & Wellness provides a Secure Provider Portal quick start guide that delivers a comprehensive overview of the Secure Provider Portal, including registration and account setup, member eligibility and patient listings, health records and care gaps, prior authorizations, claim submission and status, and corrected claims and adjustments. This training is offered to every provider and is available 24/7 on the Provider Training Page. After completion of the training, providers will then need to complete the Attestation Form.



Risk Adjustment

k Adjustment Overview

adjustment is a tool used to predict the likely use and cost of healthcare based on an individual's hcare status or Risk Adjustment Factor (RAF) score, which is contingent on factors such as age, er, community status, and severity of health conditions.

RAF Score								
Age	+	**Gender**	+	Demographic	+	**Diagnosis**	+	**Original Reason for Entitlement**

rarchical Condition Categories (HCC)

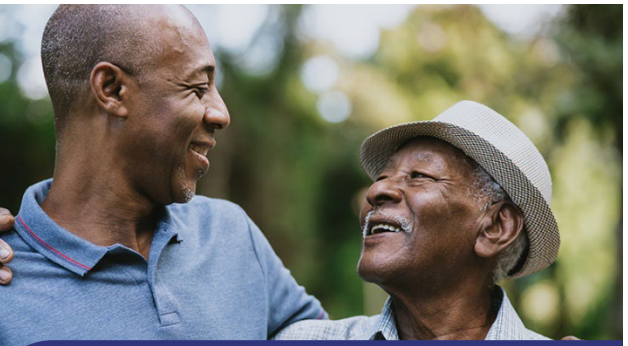
HCCs reflect hierarchies among related disease categories.

- Only the most severe HCC within hierarchy is calculated in RAF.
- HCCs captured from unrelated diagnosis are cumulative.

CMS determines the qualifying ICD-10 diagnosis codes for each category and assigns the risk factor value.

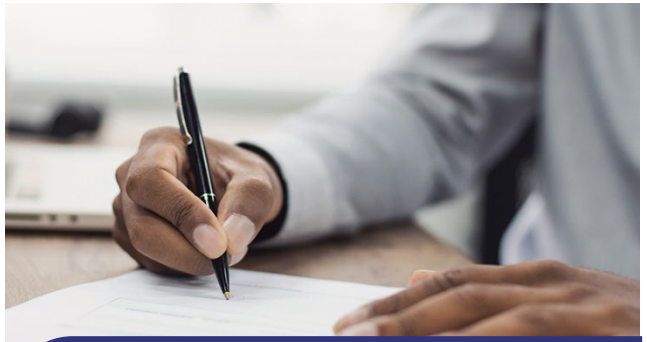
- Not all diagnoses map to an HCC.
- Some diagnoses map to multiple HCCs.

portance of Risk Adjustment



Identify actual disease burden of member and patient population

Improved quality of care through disease management programs



Ensure coverage of health expenditures and appropriate risk premiums

Program Goals

- Assist providers with engaging patients and actively address chronic conditions
- Ensure risk-adjusted conditions are coded accurately and documented annually
- Develop relationships with provider partners to serve as a resource and assist with strategy to target patients
- Increase recapture and persistency rates
- Decrease members without visit (MWOV) rates

us on Documentation

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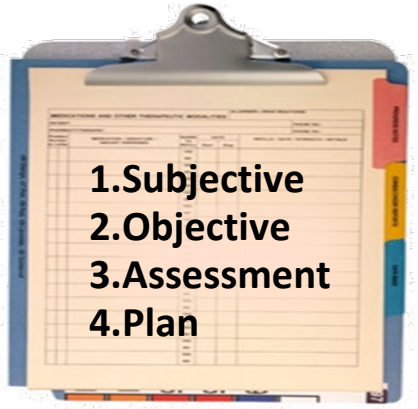
Specificity
ocument condition(s)
ssessed and what is being
one for that condition (Rx,
bs, referrals, monitoring)

Accuracy
- ✓Documentation must support the diagnosis reported
- ✓Watch for conflicting data within note
- ✓Document cause/effect relationships

Complete
- ✓Incorporate/document relevant findings into progress note
- ✓Report diagnosis codes at least once per calendar year

Consistency
hief complaint
PI, PMH, ROS, EXAM
omorbidities affecting
tient care
se standard abbreviations



CMS acceptable signature
- ✓Handwritten
- ✓Electronic
- ✓CMS must be able to determine rendering provider

Documentation should paint a picture with words of the patient's condition and what occurred during each visit.

dical Record Requirements

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Face-to-face encounter	Correct entry for date of service	Two patient identifiers on every page	Acceptable provider type
Proper signature with credentials	Acceptable service type	Use of standard abbreviations	Clear and legible handwriting

k Adjustment Program Initiatives

ntinuity of Care (CoC)	Provider incentive program — Increases visibility into members' existing medical conditions for chronic condition management (PCP only).
Office Assessment (IOA)	Provider incentive program — Supports early detection and ongoing annual assessment of chronic conditions for patients to help improve health outcomes.
inical Documentation Improvement (CDI)	Complimentary review of provider coding and documentation trends with education tailored to review findings.
Annual Chart Review Projects	Vendor works with providers and health plan to retrieve medical records and accurately report members health status in compliance with RA guidelines.

25 Continuity of Care (CoC)

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s a claims-based provider engagement
ram specific to Medicare and Marketplace
djustment. The CoC program provides
ased visibility of member's health
tions for better quality of care through
nic condition management and prevention.

ary care providers (PCPs) can earn up to
–$450 per member for proactively
dinating preventive medicine and
oughly assessing patients' health conditions.

2025 CoC program launches February 12 and through December 31.

Incentive Eligibility Requirements

Provider within assigned TIN must:

- Complete a qualified visit with member during the program year (January–December)
- Prospectively address patient conditions at the point of care utilizing appointment agenda
- Include ICD-10 code(s) for all active conditions (supported in the medical record) on claim for DOS
- Submit completed agenda with 100% of conditions assessed

25 Continuity of Care Plus (CoC+)

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CoC+ program is a separate der incentive program that ers member insights specific uality reporting.

plete additional portions of ppointment agenda to be le for additional pensation!

Additional incentive opportunity:

$150 per Medicare Agenda

$100 per Marketplace Agenda

All boxes related to the high risk, care guidance, clinical, and/or drivers of health portions must be checked and verified where applicable.

All CoC+ insights must be received by July 1 to be eligible for incentive(s).

ta Integrity

Risk adjustment payment methodology used by the Department of Health & Human Services (HHS) for health insurance marketplace mandate the timely and accurate submission of members' diagnostic data, subject to annual review.

To ensure ICD-10-CM codes obtained from claims submissions are accurate and conform to applicable risk adjustment regulation, annual medical record retrieval and review is required. For this reason, we appreciate your cooperation in providing requested medical records through our HIPAA-contracted business partners or to the health plan directly.

k Adjustment Medical Record Requests
n Behavioral Health Providers

cal record requests include:

ogress notes including session start and stop time, treatment type and frequency, diagnosis, treatment n, symptoms, prognosis, and patient progress

eatment summary including client name, date of birth, diagnosis, dates of service, general reason for atment, basic description of client symptoms, treatment plan goals, session modality/frequency verage), length of sessions, progress, and prognosis. A few sentences for each of these areas is fine.

te psychotherapy notes should remain separate from the patient's chart and are not part of the cal record request for risk adjustment purposes.

ocumentation (progress notes, treatment summaries, etc.) must be legible, be signed by the provider ering the services, and include provider's credentials.

ls for Engagement

pective programs are designed to ctively make an event occur to re the diagnostic data in the nt experience period.

e are various types of risk tment programs that can ensure lete and accurate data is itted to CMS.

R Integration

fits of automated data exchange between
r and provider:

reased data accuracy

proved workflow

creased administrative burden

nanced patient care

tter health outcomes

Active EMR with point-to-care alerts:

- **Epic Payor Platform**
- **Healow**
- **Moxe**
- **Athena**

Future Connections: Veradigm (Practice Fusion, All Script, NexGen), VIM, and Oracle

nmary of Best Practices

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- Comply with medical record requests in a timely manner
- Utilize program data and integrate into workflow
- Build rapport with RA specialists to close care gaps
- Follow timely filing rules for claim submissions
- Assess ALL active conditions annually
- Be clear and consistent in medical record
- Code to the highest specificity
- Include ICD-10 code on claim

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Quality Improvement

25 Wellcare Partnership for Quality (P4Q) Program

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2025 P4Q bonus program give providers the opportunity to earn an incentive by addressing preventive measures and closing gaps in members' care.

ecember 31, 2025

act patients to schedule an appointment. At the visit, order appropriate tests and preventive screenings. action to help patients complete all preventive care and close care gaps.

nuary 31, 2026

ment care and treatment (not diagnosis) in the patient's medical record and submit all applicable oses codes on claims, encounter files, and/or approved NCQA supplemental electronic flat files ining all relevant ICD-10, CPT, and CPT II codes.

w and counsel on results of tests and screenings with patients.

25 Ambetter Pay for Performance (P4P) Program

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025 P4P bonus program has four payment cycles. In Cycles 1–3, earnings less than $100 will automatically be rolled over next payment cycle. Any balances under $100 will be disbursed in Cycle 4. Payments for medication adherence ures CBP (controlling high blood pressure) and GSD (diabetes HbA1c ≤ 9) will be included only in Cycle 4.

2025 Measure List	Measure Incentive	Target 1 Pays 75% of Incentive	Target 2 Pays 100% of Incentive
cal Cancer Screening (CCS)	$25	56.90%	65.00%
ectal Cancer Screening (COL)	$25	56.90%	62.80%
and Adolescent Well-Care Visits (WCV)	$25	50.50%	59.60%
olling High Blood Pressure (CBP)	$25	67.80%	72.90%
mic Status Assessment for Patients with Diabetes <9 (GSD)	$25	72.50%	77.40%
xam for Patients with Diabetes (EED)	$25	42.40%	52.90%
nts with Diabetes Kidney Health Evaluation (KED)	$25	46.70%	55.40%
t Cancer Screening (BCS)	$25	71.50%	75.70%
mydia Screening in Women (CHL)	$25	43.80%	51.50%
All-Cause Readmissions (PCR)	$25	64.00%	55.50%

T II Coding

nportant to use accurate CPT II and HCPCS codes to close care gaps and improve collection for performance measurement. When you verify that you performed ty procedures and closed care gaps, you're confirming that you're providing the care to our members.

tive January 1, 2022, Wellcare adds CPT II and HCPCS codes to the fee schedule at e of $0.01. This allows codes to be billed without denial for being "non-payable," ting in fewer dropped codes and better reporting.

dicare Annual Wellness Visit (AWV)

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lule a visit with your member today!

	Wellcare members are covered for:		CODES
ual Wellness (AWV)	This unique to Medicare visit allows you and your patient to meet and discuss their health to create a personalized prevention plan.	1 per calendar year	G0438, G0439*
tine Physical n (RPE)	This Medicare Advantage Supplemental beneft is a comprehensive physical examination to screen for disease and promote preventative care.	1 per calendar year	99381-99387* (new patient) 99391-99397** (established patient)

racted Federally Qualifed Health centers (FQHC) must include G0468 when billing AWV.
be billed with the AWV with a modifer 25.

V Topic Discussions

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to discuss during your patient's Annual Wellness Visit (AWV):

date patient's medical record: including demographics, er treating providers and family history

duct a Social Determinants of Health assessment

cuss Advanced Care planning

een for cognitive impairment, including depression, ntal wellness and emotional health

duct medication reconciliation and extend day fill portunities (mail order or 90 days at retail)

mplete pain and functional assessments; including use of able Medical Equipment (DME)

ess bladder leakage and care options

ate a preventative screening schedule and refer mbers for tests, labs, X-rays (eye exams, colonoscopy, mmograms), counseling and care programs

- Complete the health risk assessment, including functional abilities, ADLS, instrumental ADLs and create an action plan
- Create patient's list of balance/fall risk factors and conditions; including interventions and treatment options
- Check routine measurements: height, weight, blood pressure, etc.
- Review current opioid prescription and screen for potential Substance Use Disorders (SUDs)

Topics to discuss during your patient's Routine Physical Visit:

- Health History
- Vital signs
- Heart, lung, head/neck, abdominal, neurological, dermatological, extremities and gender specific exam

V Quick Reference & Tips

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ople with Diabetes

- nual diabetic retinal eye exam
- iew adherence of diabetes dications (consider 90-day fills maintenance medications)
- l evaluate the addition of a tin to help prevent heart and od vessel diseases
- od pressure monitoring
- ting and control of HbA1c
- ney function tests
- dical attention for hropathy

eded

- eoporosis screening and nagement after fracture
- e for Older Adult

Important Cancer Screenings

- Colon cancer screening (Colonoscopy, Fit DNA test, Cologuard)
- Breast cancer screening
- Prostate cancer screening
- Lung cancer screening

Care for Older Adults

- Medication review and reconciliation by physician
- Functional status assessment
- Pain assessment
- Advance care planning
- Depression screening

Adult Vaccinations

- COVID-19 – initial and follow-up
- Influenza – yearly
- Pneumococcal – one time (may need booster)
- Meningococcal
- Tetanus, diphtheria, pertussis (Td/Tdap)
- Zoster (shingles)
- Hepatitis A
- Hepatitis B

TIPS to Ensure Healthy Outcomes

- Always share tests and screenings results with members, and discuss how they can access them, via a patient portal
- Be sure to submit all applicable conditions, via IDC 10 codes
- Leverage CPT Category II codes to ensure outcomes in order to reduce chart collection events

dication Adherence

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y Measures

are three examples of Centers for Medicare and Medicaid
e Star measures which use adherence to evaluate health plans.

Beneficiaries, ages 18 years and older, who had at least two fills of medication(s) listed below on different dates of service and were 80% or more adherent to their medications.

ity Measure	Description
cation Adherence for Diabetes (DIAB)*	Oral antidiabetic medications defined as Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV inhibitors, GLP-1 receptor agonists, Meglitinides, and SGLT2 inhibitors
cation Adherence for Hypertension (RASA)**	Renin-Angiotensin System (RAS) antagonists defined as ACE inhibitors, ARBs, or Direct Renin Inhibitors
cation Adherence for Cholesterol (Statins)	Statins

ions

age renal disease (ESRD), Hospice, *Insulin use (DIAB only), **Sacubitril/Valsartan use (RASA only).

dication Adherence Tips

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ect LIS Indicator: If the LIS flag reflects 'Yes,' your patient is eligible to fill a 90-day prescription for the same as a 30-day prescription.

est practices to promote medication adherence

escribe 90-day
escriptions supply
r chronic medications,
escribe a 90-day quantity.

Review medications regularly
During each visit, review all medications with the patient. When possible, remove medications no longer needed and reduce dosages.

Check for understanding
Make sure your patients knows why you are prescribing a medication. Clearly explain what they are, what they do and how to manage potential side effects.

ources Available to Members

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are management team has resources available that can help your patients — nembers — reach their health goals. These include assistance with:

- heduling follow-up appointments
- nsportation
- lping keep track of medications
- anaging multiple conditions

al wellness visits, virtual visits, and digital care management opportunities vailable upon request.

Contact Information

vider Services Call Center

line of communication

nbetter Provider Services
877-617-0390 (TTY: 1-877-617-0392)

ellcare by Allwell Provider Services
855-565-9518 (TTY: 711)

presentatives are available Monday rough Friday from 8 a.m. to 5 p.m. CT

Provider Service Representatives can assist with questions regarding:

- Member Eligibility
- Claim Inquiry
- Prior Authorization
- Network Verification
- Appeal Status
- Payment Inquiries
- Check Stop Pay or Check Reissues
- Negative Balance Report
- Provider Demographic Change Request
- Secure Portal Password Reset

vider Inquiries

er speaking with a Provider Service Representative, you will receive a reference number, ich will be used to track the status of your inquiry.

ou need to contact your assigned Provider Relations Representative, you must have the lowing when submitting an email inquiry:

- Reference number assigned by Provider Services
- Provider's Name
- Tax ID
- National Provider Identifier (NPI)
- Summary of the issue
- Claim numbers (if applicable)

oviders@ARHealthWellness.com

ntracting Department

Phone Number: 1-844-631-6830

Hours of Operation: 8 a.m.–4:30 p.m.

Press 1	If you know your party's extension	Press 2	Ambetter	Press 3	Wellcare by Allwell	Press 4	Arkansas Total Care	Press 5	To repeat prompts

Provider Contracting Email Address: ArkansasContracting@Centene.com

- Regular contracting inquiries and contract requests

dentialing Department

- **Arkansas Health & Wellness Credentialing Department**
- **Phone:** 1-844-263-2437
- **Fax:** 1-844-357-7890

- **Provider Credentialing Email:**
- ArkCredentialing@centene.com

ucation Requests

d you like training for you and your staff?

- **You can submit your requests to:**

  Providers@ARHealthWellness.com