WELCOME TO AMBETTER FROM ARKANSAS HEALTH & WELLNESS

AGENDA

- **OVERVIEW**
  - Who We Are
  - Affordable Care Act
  - The Health Insurance Marketplace
- **WHAT YOU NEED TO KNOW**
  - Key Contact Information
  - Provider Toolkit and Manual
  - Provider Relations
  - Public Website and Secure Portal
  - Verification of Eligibility, Benefits and Cost Shares
  - Specialty Referrals
  - Prior Authorization
  - Claims, Billing and Payments
  - Complaints, Grievances and Appeals
  - Specialty Companies and Vendors
- **Q & A**

OVERVIEW

WHO WE ARE

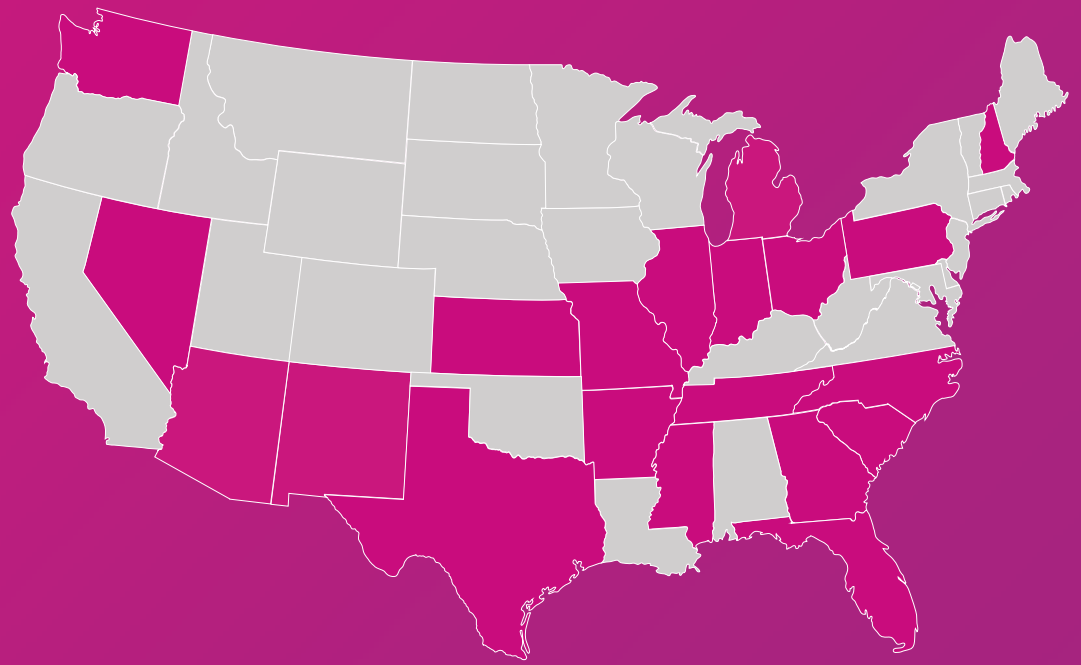
- Ambetter from Arkansas Health and Wellness provides market-leading, affordable health insurance on the Health Insurance Marketplace

- We are certified as a Qualified Health Plan issuer

- Ambetter delivers high quality, locally-based healthcare services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs

#1 carrier
on the health insurance marketplace

2M+
members insured across the country



THE AFFORDABLE CARE ACT

KEY OBJECTIVES OF THE AFFORDABLE CARE ACT (ACA):

- Increase access to quality health insurance
- Improve affordability

ADDITIONAL PARAMETERS:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)

THE AFFORDABLE CARE ACT

REFORM THE COMMERCIAL INSURANCE MARKET – MARKETPLACE OR EXCHANGES

- No more underwriting – guaranteed issue
- Minimum standards for coverage: benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL) – Effective only for the Arkansas market

HEALTH INSURANCE MARKETPLACE

SUBSIDIES COME IN THE FORM OF:

- Advanced Premium Tax Credits (APTC)
- Cost Share Reductions (CSR)

ALL BENEFIT PLANS HAVE COST SHARES IN THE FORM OF COPAYS, COINSURANCE AND DEDUCTIBLES

- Some members will qualify for assistance with their cost shares based on their income level
- This assistance would be paid directly from the government to the member's health plan

HEALTH INSURANCE MARKETPLACE

ONLINE MARKETPLACE FOR PURCHASING HEALTH INSURANCE

POTENTIAL MEMBERS CAN:

- Register
- Determine eligibility for all health insurance programs
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, federally facilitated or state partnership – Arkansas is a stated-based and federally-facilitated Marketplace

THE HEALTH INSURANCE MARKETPLACE IS THE ONLY WAY TO PURCHASE INSURANCE AND RECEIVE SUBSIDIES.

WHAT YOU NEED TO KNOW

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KEY CONTACT INFORMATION

Ambetter from Arkansas Health & Wellness

PHONE

1-877-617-0390

TTY/TDD

1-877-617-0392

WEB

HTTPS://AMBETTER.ARHEALTHWELLNESS.COM

PORTAL

HTTPS://PROVIDER.ARHEALTHWELLNESS.COM

GETTING AQUAINTED

AFTER YOU HAVE COMPLETED THE CREDENTIALING PROCESS, YOU WILL RECEIVE A PROVIDER TOOLKIT. OUR TOOLKIT CONTAINS USEFUL INFORMATION FOR GETTING STARTED AS AN AMBETTER PROVIDER.

While we'll cover some of that information in this presentation, your toolkit has additional information including:

- Welcome Letter
- Ambetter Provider Introductory Brochure
- Secure Portal Setup
- Electronic Funds Transfer Setup
- Prior Authorization Guide
- Quick Reference Guide
- Provider Office Window Decal

THE PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER FROM ARKANSAS HEALTH & WELLNESS.

The Manual includes a wide array of important information relevant to providers, including but not limited to:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives
- And much more!

The Provider Manual can be found in the Provider section of the Ambetter from Arkansas Health & Wellness website at https://ambetter.arhealthwellness.com

PROVIDER SERVICES

- The **Ambetter from Arkansas Health & Wellness** Provider Services department is available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
  - Member Eligibility/Benefits
  - Claim Status
  - Prior Authorization Request
  - Network Verification
  - Appeal Status
  - Check Stop Pay or Check Reissues
  - Negative Balance Report Request
  - Provider Demographic Change Request

- By calling **Ambetter from Arkansas Health & Wellness** Provider Services at 1-877-617-0390**,** providers will be able to access real time assistance for all their service needs

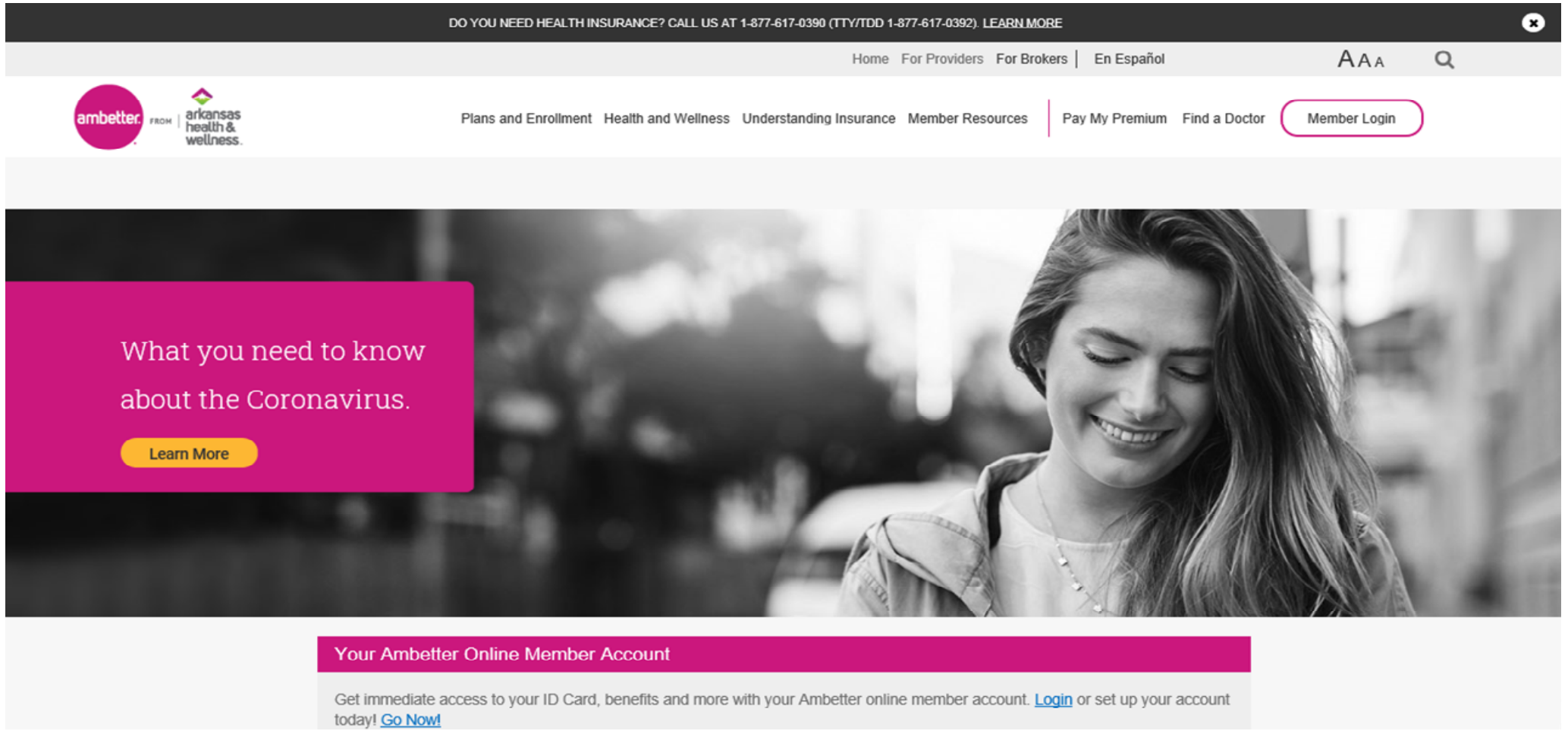
PROVIDER RELATIONS

- As an **Ambetter from Arkansas Health & Wellness** provider, you will have a dedicated Provider Relations Specialist available to assist you
- Our Provider Relations Specialists serve as the primary liaisons between our health plan and provider network
- Your Provider Relation Specialist is here to help with things like:

- ✓Inquiries related to administrative policies, procedures, and operational issues
- ✓Performance pattern monitoring
- ✓Secure Portal registration and Pay Span
- ✓Provider education
- ✓HEDIS/Care gap reviews
- ✓Financial analysis
- ✓EHR Utilization
- ✓Demographic information updates
- ✓Initiate credentialing of a new practitioner

THE AMBETTER PUBLIC WEBSITE

https://ambetter.arhealthwellness.com



THE AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

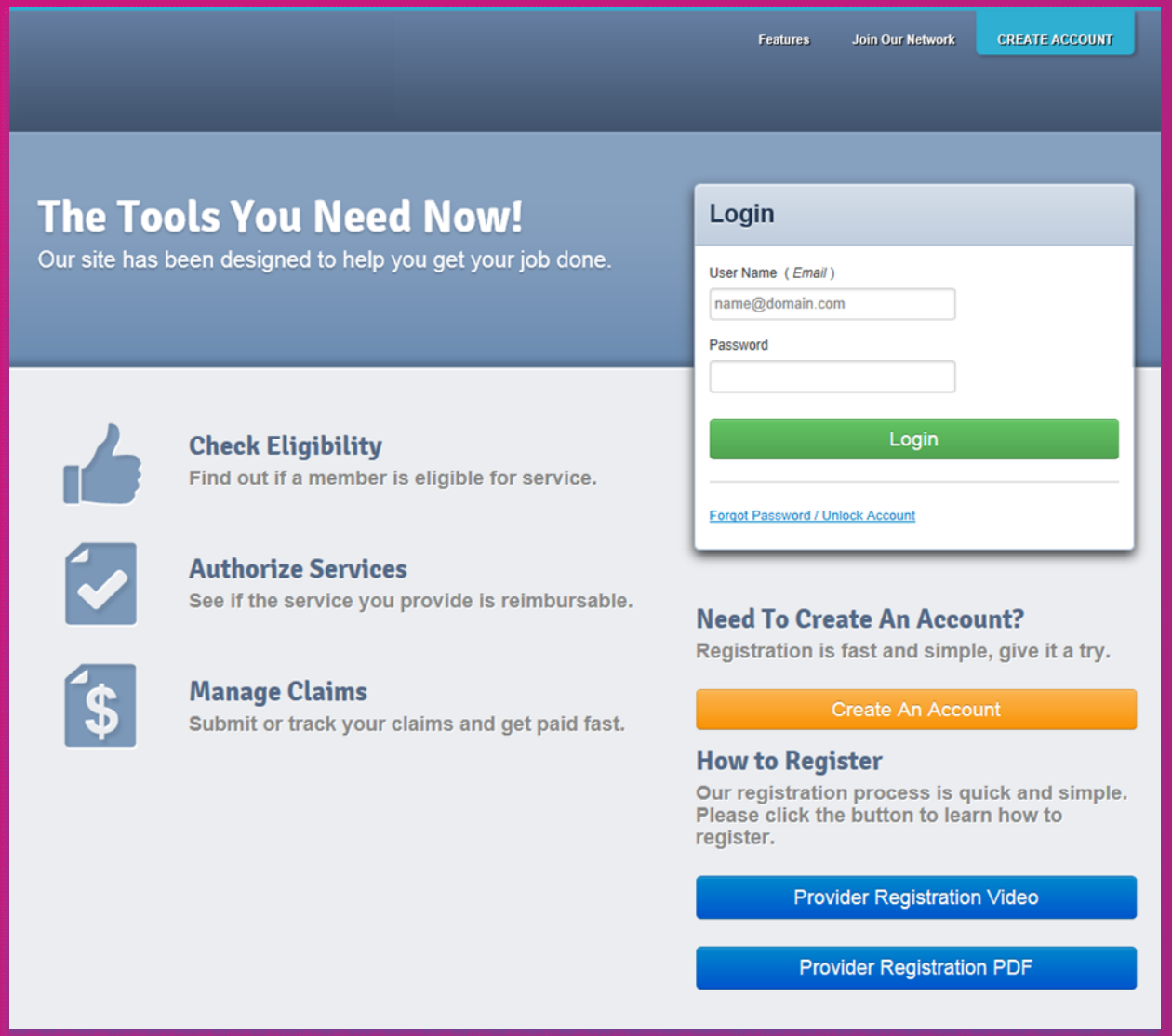
- The Provider and Billing Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- Clinical And Payment Policies
- The Pharmacy Preferred Drug Listing
- And much more!

SECURE PROVIDER PORTAL

Registration is free and easy!

A registration video and PDF are available to assist you.

Contact your Provider Relations Specialist if you have questions.



SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility & patient listings
- Health records & care gaps
- Authorizations
- Claims submissions & status
- Corrected claims & adjustments
- Payments history
- Monthly PCP cost reports
- Provider analytics reports

SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

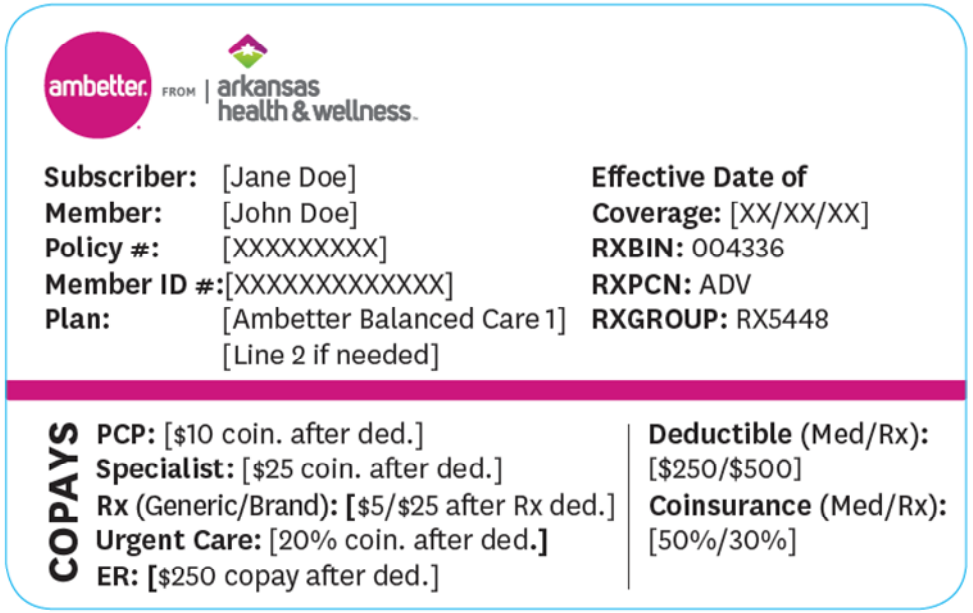
PCP reports available on **Ambetter from Arkansas Health & Wellness** secure provider portal, https://provider.arhealthwellness.com, are generated on a monthly basis and can be exported into a PDF or Excel format.

PCP REPORTS INCLUDE:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High Cost Claims

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

MEMBER ID CARD



**** Possession of an ID Card is not a guarantee of eligibility and benefits***

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

PROVIDERS MUST VERIFY MEMBER ELIGIBILITY

- Every time a member schedules an appointment
- When the member arrives for the appointment

PANEL STATUS

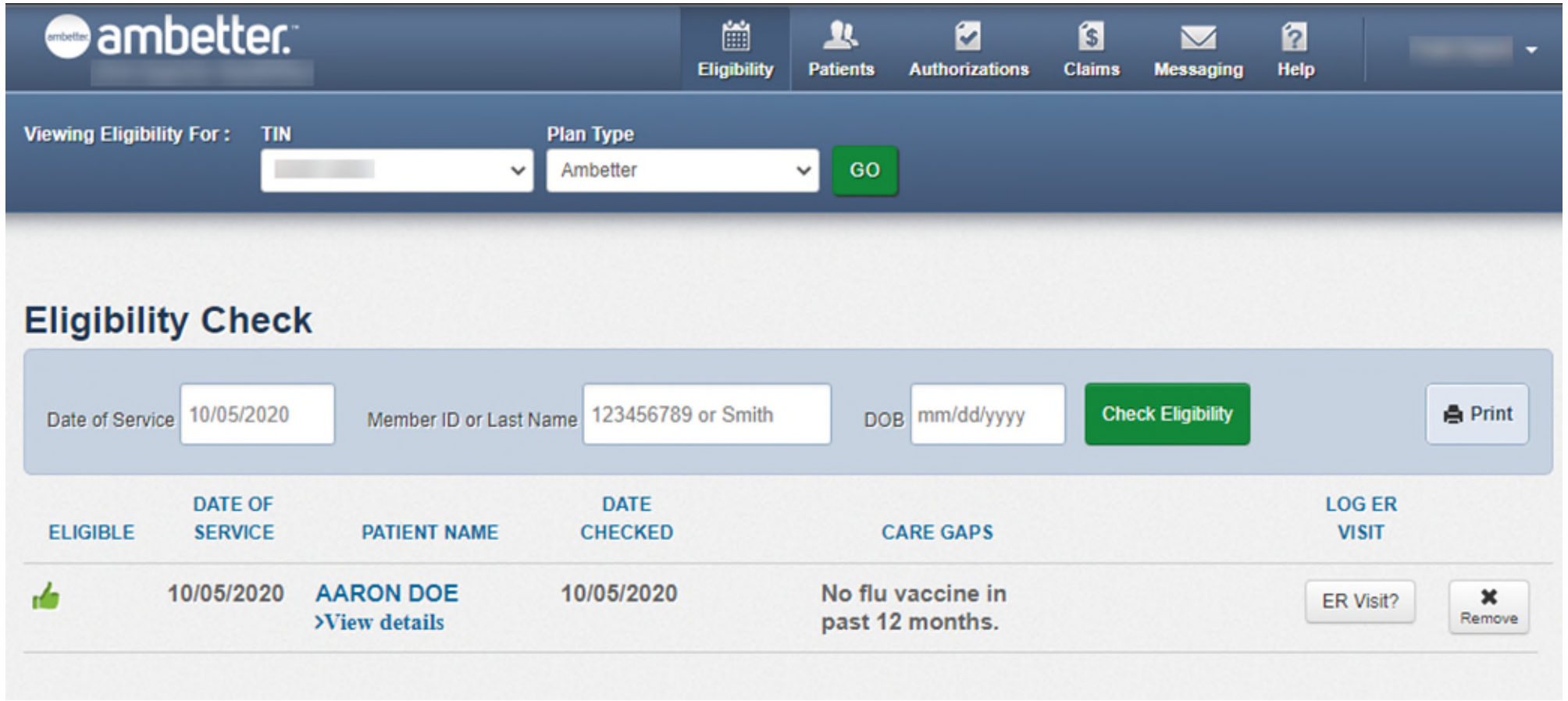
- Primary Care Physicians (PCPs) should confirm that a member is assigned to their patient panel
- This can be done via our Secure Provider Portal
- PCPs can still administer service if the member is not on their panel.
- The member can also request to be reassigned for future PCP visits.

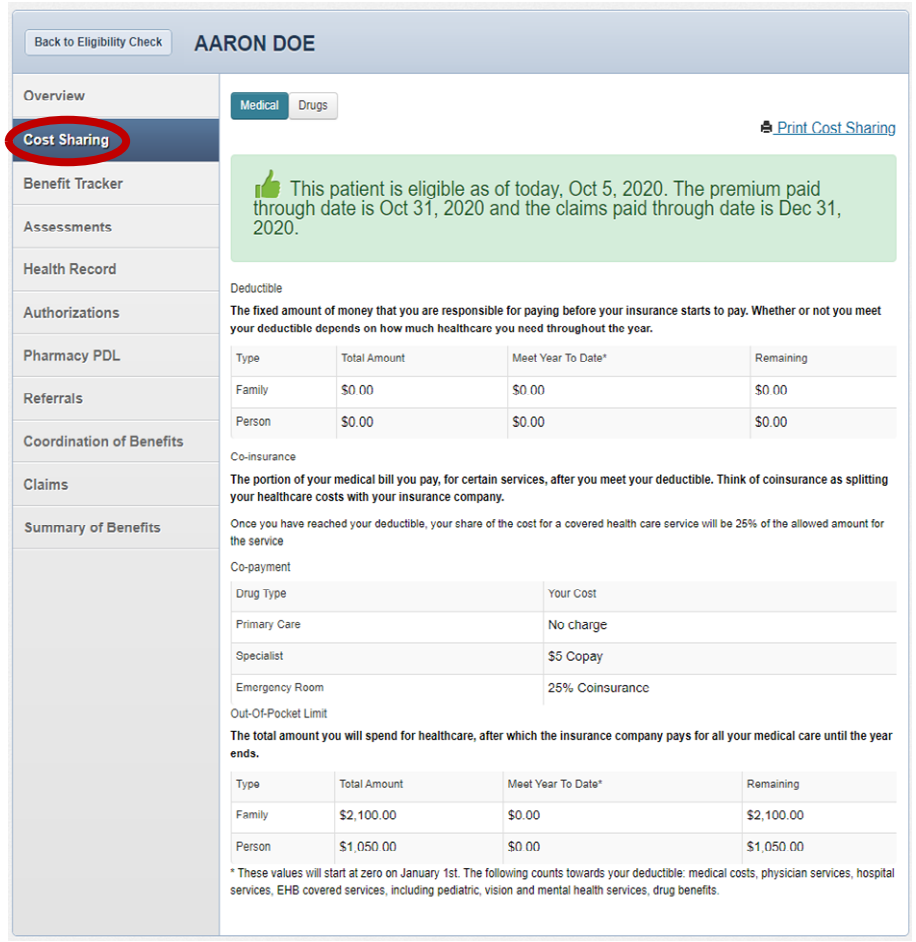
VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN 3 WAYS:

- ✓ **The Ambetter Secure Portal: Provider.Arhealthwellness.com**
- ✓ **24/7 Interactive Voice Response System**
  - Enter the Member ID Number and the month of service to check eligibility
- ✓ **Contact Provider Services: 1-877-617-0390**

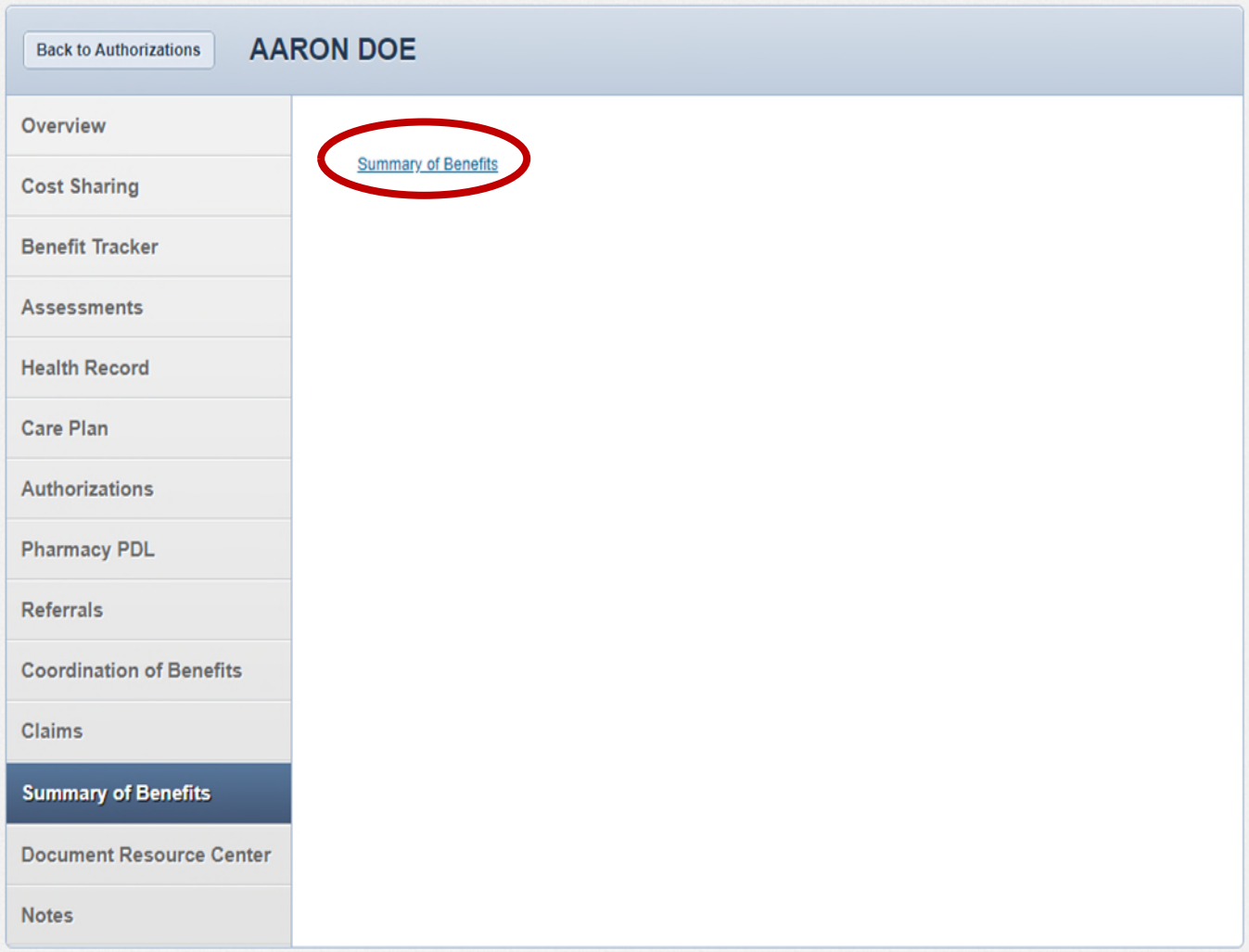
VERIFICATION OF ELIGIBILITY ON THE PORTAL





VERIFICATION OF COST SHARES ON THE PORTAL

VERIFICATION OF BENEFITS ON THE PORTAL



SPECIALTY REFERRALS

WHEN OUR MEMBERS NEED TO VISIT A SPECIALIST, KNOW THAT:

- We educate them to seek care or consultation with their Primary Care Provider (PCP) first.
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers.
- ***REFERRALS ARE NOT REQUIRED FOR MEMBERS TO SEEK CARE WITH IN-NETWORK SPECIALISTS.***

HOW TO SECURE PRIOR AUTHORIZATION

Need a Prior Authorization? Request one in the following ways:

✓ Secure Web Portal

Provider.Arhealthwellness.com

This is the preferred and fastest method.

✓ Phone

1-877-617-0390

✓ Fax

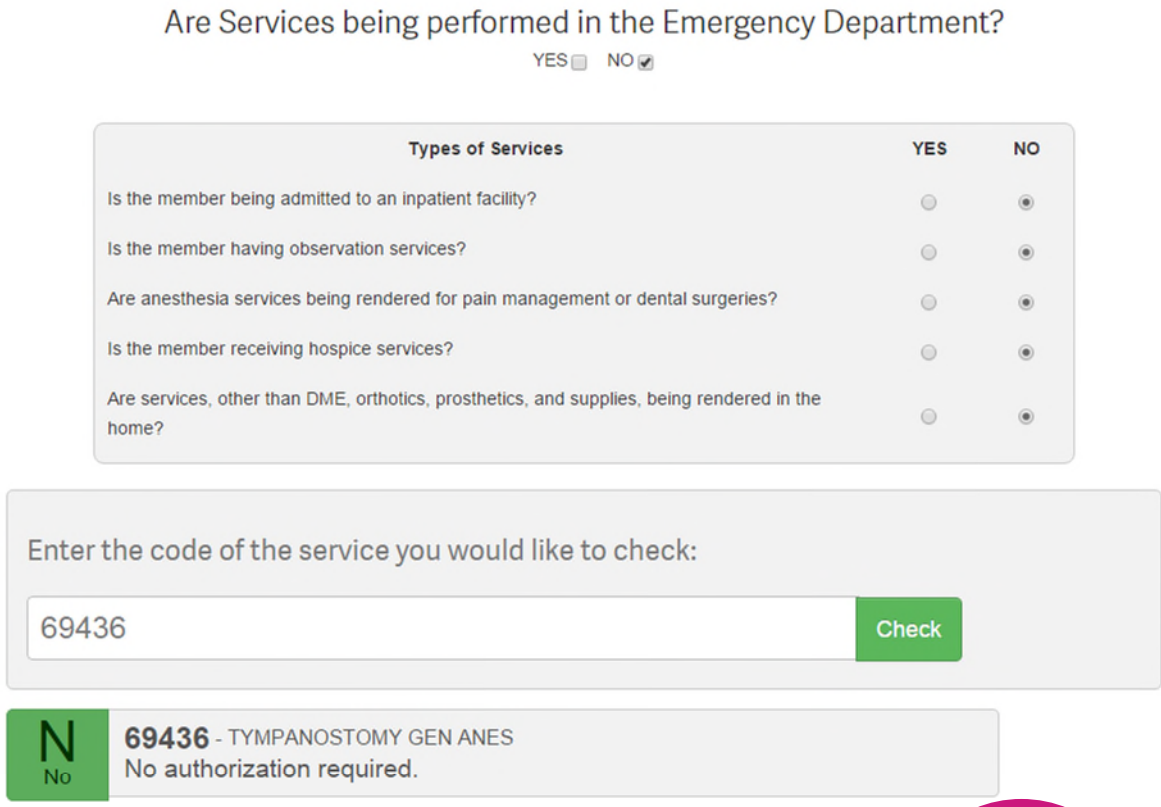
1-866-884-9580

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.

IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization by CPT code.

- Available on the provider section of the Ambetter from Arkansas Health & Wellness website at **https://ambetter.arhealthwellness.com/provider-resources/pre-auth-check.html**



PRIOR AUTHORIZATION REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET) authorized through NIA
- Outpatient therapy (PT, ST, OT) authorized through NIA
- Infertility
- Obstetrical ultrasound
  - Two allowed in 9 month period, any additional will require prior authorization, except those rendered by perinatologists. (***Reference: Payment Policy number CP.MP.38***)
  - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- All Musculoskeletal (Orthopedic, Spine, Neuro, & Pain Management) authorized through Turning Point

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PRIOR AUTHORIZATION REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 business days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Observation stays exceeding 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions -within 1 business day following the date of admission
- Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PRIOR AUTHORIZATION REQUIREMENTS

ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)
- Home health care services including home infusion, skilled nursing, and therapy:
  - Home health services
  - Private duty nursing
  - Adult medical day care
  - Hospice
  - Furnished medical supplies & DME

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PRIOR AUTHORIZATION TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one (1) business day
Observation – 48 hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one (1) business day
Maternity admissions	Notification within one (1) business day
Newborn admissions	Notification within one (1) business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one (1) business day
Outpatient Dialysis	Notification within one (1) business day

UTILIZATION DETERMINATION TIMEFRAMES

Type	Timeframe
Prospective/Urgent	One (1) business day
Prospective/Non-Urgent	Two (2) business days
Emergency services	60 minutes (1 hour)
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

CORRECT CODING FOR PRIOR AUTHORIZATION

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.

- If additional services are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.

- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission or the claim will deny.

- Ambetter will update authorizations but will **not** retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

CLAIMS

WHAT IS A CLEAN CLAIM?

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment.

ARE THERE ANY EXCEPTIONS?

- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible

HOW TO SUBMIT A CLAIM

THE TIMELY FILING DEADLINE FOR INITIAL CLAIMS IS 180 DAYS FROM THE DATE OF SERVICE OR DATE OF PRIMARY PAYMENT WHEN AMBETTER IS SECONDARY.

CLAIMS MAY BE SUBMITTED IN 3 WAYS:

1. **The Secure Provider Portal**
   Provider.Arhealthwellness.com

2. **Electronic Clearinghouse**
   - Payor ID 68069
   - Clearinghouses currently utilized by Ambetter will continue to be utilized
   - For a listing our clearinghouses, please visit our website at https://ambetter.arhealthwellness.com

3. **Mail**
   Ambetter
   Attn: Claims
   P.O. Box 5010
   Farmington, MO 64640-5010

CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, Providers can use the **Reconsider Claim** button on the Claim Details screen within the portal.
- A written request from the provider about a disagreement in the claim processing . Form is available on the website ambetter.arhealthwellness.com/provider-resources/manuals-and-forms.html
- Must be submitted within 180 days of the Explanation of Payment.
- Mail claim reconsiderations to:

  Ambetter from Arkansas Health & Wellness
  Attn: Level 1 – Request for Reconsideration
  P.O. Box 5010
  Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at https://ambetter.arhealthwellness.com/provider-resources/manuals-and-forms.html
- Mail completed Claim Dispute form to:

  Ambetter from Arkansas Health & Wellness
  Attn: Level II – Claim Dispute
  P.O Box 5000
  Farmington, MO 63640-5000

CLAIM SUBMISSION – SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium
- While the member is in a suspended status, claims will be pended
- When the premium is paid by the member, the claims will be released and adjudicated
- If the member does not pay the premium, the claims will be released and the provider may bill the member directly for services

CLAIM SUBMISSION – SUSPENDED STATUS

EXAMPLE TIMELINE OF MEMBER IN SUSPENDED STATUS

- **January 1st**
  Member pays premium
- **February 1st**
  Premium due – member does not pay
- **March 1st**
  Member placed in suspended status
- **April 1st**
  Member remains in suspended status
- **May 1st**
  If premium remains unpaid, member is terminated. Provider may bill member directly for services rendered.

Claims for members in a suspended status are not considered "clean claims".

OTHER HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** be submitted with the rendering provider's taxonomy code
- The claim will deny if the taxonomy code is not present in box 24J shaded area.
- This is necessary in order to accurately adjudicate the claim

AND DON'T FORGET THE CLIA NUMBER!

- If the claim contains CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, co-insurance and any unpaid portion of the deductible may be collected at the time of service

- Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the Secure Provider Portal at Provider.Arhealthwellness.com

- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days

CLAIMS PAYMENTS: ELECTRONIC FUNDS TRANSFER

PAYSPAN: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan Health, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently utilize PaySpan, you will need to register specifically for Ambetter
- **Set up your PaySpan account:**
  - Visit www.payspanhealth.com and click Register
  - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- A provider must exhaust the claims reconsideration and claims dispute process before filing a complaint/grievance or appeal

COMPLAINT/GRIEVANCE

- Must be filed within 30 calendar days of the Notice of Action
- Upon receipt of necessary information, Ambetter will evaluate the request and provide a written response to the provider within 30 calendar days.

COMPLAINTS, GRIEVANCES AND APPEALS

APPEALS

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal

MEDICAL NECESSITY

- Must be filed within 30 calendar days from the Notice of Action
- Ambetter shall acknowledge receipt within 10 business days of receiving the appeal
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 calendar days
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours

COMPLAINTS, GRIEVANCES AND APPEALS

MEMBER REPRESENTATIVES

- Members may designate a provider to act as their representative for filing appeals related to medical necessity
    - Ambetter requires that this designation by the member be made in writing and provided to Ambetter
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual, located on our website at https://ambetter.arhealthwellness.com

OUR SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services Outpatient therapy (PT, ST, OT)	National Imaging Associates	877-617-0390 www.radmd.com
Vision Services	Envolve Vision Benefits	1-877-617-0390 www.envolvevision.com
Dental Services	Dental Health and Wellness	1-877-617-0390 www.dentalhw.com
Pharmacy Services	Envolve Pharmacy Solutions	1-877-617-0390 (Phone) 1-866-399-0929 (Fax)
Orthopedic and Spinal Surgical Services	TurningPoint	1-866-619-7054 (Phone) 501-263-8850 (Phone) 501-588-0994 (Fax) https://myturningpoint-healthcare.com

QUESTIONS?